No. 19A785

In the
Supreme Court of the United States

DEPARTMENT OF HOMELAND SECURITY, et al.,

Applicants,

v.

NEW YORK, et al.,

Respondents.

OPPOSITION OF GOVERNMENT PLAINTIFFS TO DEFENDANTS' APPLICATION FOR A STAY OF THE ORDERS ISSUED BY THE UNITED STATES DISTRICT COURT FOR THE SOUTHERN DISTRICT OF NEW YORK

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INTRODUCTION

Defendants—the United States Department of Homeland Security (DHS); Chad F. Wolf, Acting Secretary of DHS; and Kenneth T. Cuccinelli II, Senior Official Performing the Duties of the Director of the United States Citizenship and Immigration Services (USCIS)—seek a stay of an order issued by the United States District Court for the Southern District of New York (Daniels, J.) preliminarily postponing the effective date and enjoining enforcement of a Final Rule by DHS. The Rule radically alters the test for evaluating whether an immigrant is likely to become a "public charge" under 8 U.S.C. § 1182(a)(4)(A), and thus be ineligible for a green card. *See* Inadmissibility on Public Charge Grounds, 84 Fed. Reg. 41,292 (Aug. 14, 2019). The Rule's vast expansion of "public charge"—to include employed individuals who receive any amount of certain means-tested benefits for even brief periods of time—is a stark departure from a more-than-century-long consensus that has limited the term to individuals who are primarily dependent on the government for long-term subsistence.

There is no basis for the truly extraordinary stay that defendants seek. The fundamental purpose of a stay is to preserve the status quo, but the relief that defendants seek here would do the opposite. A stay of the district court's order would allow defendants to immediately implement the Final Rule's unprecedented change to the meaning of "public charge"—one that has never been applied since that statutory term first came into use in the nineteenth century. But defendants have identified no reason whatsoever for such precipitous action. Unlike in other cases, defendants have not claimed that a stay is needed for public safety, national security, or military effectiveness, let alone an emergency touching on any of these areas of concern. There are no imminent discovery obligations or statutory deadlines that defendants must meet. It is undisputed that the current public-charge framework is lawful, even

if defendants would prefer to change it. And four courts of appeals, including the Second Circuit, have agreed to expedite defendants' appeals of various district court orders about the Final Rule and will be ready to issue decisions on the merits within only a month or two. There is thus no compelling reason for this Court to intervene now, before the lower courts can complete their expedited merits review, and disrupt the status quo by endorsing the immediate implementation of the novel Final Rule.

By contrast, granting a stay here would inject confusion and uncertainty into immigration decisions and plaintiffs' administration of their public-benefits programs, and deter potentially millions of noncitizens residing in plaintiffs' jurisdictions from accessing public benefits that they are legally entitled to obtain. Plaintiffs presented extensive, concrete evidence below of the harms that would follow from the Final Rule's significant changes to the public-charge framework. Defendants presented no evidence whatsoever to rebut this showing. The radical disruption of the status quo and the serious harms that the Rule would cause to plaintiffs and the public are enough to deny defendants' motion for a stay.

Defendants have also failed to satisfy the remaining stay factors. A stay is not warranted unless there is a reasonable probability that this Court will grant certiorari. But that inquiry is entirely premature here, when no appellate court has yet decided whether to affirm the preliminary relief issued by various district courts, and when defendants have not sought this Court's direct review of the district court's decision by means of a petition for certiorari before judgment. Defendants assert that this Court would grant certiorari in this case *if* four courts of appeals were to rule a certain way and *if* defendants were then to seek certiorari, but that assertion depends on rank speculation about the future actions of not only the four courts of appeals but also this Court.

Even if this Court were to assume that it will eventually grant certiorari in this case, defendants' request for a stay would fail because they have not met their burden of showing that they would be likely to succeed on the merits. The Final Rule's unprecedented redefinition of "public charge" violates the law because it vastly exceeds the long-established understanding of that term, contrary to Congress's intent to incorporate this consensus understanding into federal immigration law. And the Rule's novel multifactor test for assessing whether an immigrant will likely be a public charge is arbitrary and capricious for multiple reasons, including its arbitrary targeting of even temporary use of benefits and its reliance on multiple factors that have no rational connection to whether an immigrant will receive public benefits at all, let alone become primarily dependent on the government.

Finally, the scope of the preliminary relief ordered below provides no basis for a partial stay. The district court postponed the effective date of the Rule under 5 U.S.C. § 705, a statutory remedy authorized by the Administrative Procedure Act (APA) that, by its plain terms, allows district courts to delay the effect of a rule as a whole. This case thus does not require this Court to address any general question about the scope of district courts' power to grant nationwide equitable relief, although defendants' arguments on that score are meritless in any event. Defendants' motion should thus be denied.

STATEMENT

A. The Public-Charge Statute

Under the Immigration and Nationality Act (INA), noncitizens who lawfully entered the country may adjust their status to legal permanent resident (LPR) if they are "admissible." 8 U.S.C. § 1255(a). One of the narrow categories that would render such a noncitizen inadmissible is if he is "likely at any time to become a public charge." *Id.* § 1182(a)(4). DHS makes public-charge determinations principally for noncitizens who have lawfully entered the country and are thus already living here.[1] *Id.* § 1185(d).

"Public charge" under federal immigration law is a term of art that has developed a settled meaning after more than a century of usage. "Public charge" has never included employed persons who receive modest or temporary amounts of government benefits designed to promote health or upward mobility—individuals now covered by the Final Rule. Instead, from its inception, the term "public charge" has been limited to an individual who does not work and is consequently primarily dependent on the government for long-term subsistence.

This understanding of "public charge" appeared as early as nineteenth-century state laws that required ship captains to execute bonds to support infirm passengers "likely to become permanently a public charge." Ch. 195, § 3, 1847 N.Y. Laws 182, 184; *see* Ch. 238,

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[1] The Immigration and Naturalization Service (INS), a component of the United States Department of Justice (DOJ), made public-charge determinations for applicants living in the country until March 2003, when its authority was delegated to the USCIS, a component of DHS. Two other agencies also apply the public charge statute. Individuals seeking to obtain an immigrant visa must satisfy the Department of State's separate public-charge inquiry, which is conducted abroad by consular officers. 8 U.S.C. §§ 1182(a)(4), 1201(a). And DOJ is authorized to conduct another public-charge inquiry to deport an already admitted LPR who actually becomes a "public charge" within five years of entry from causes that did not arise after entry. *Id.* § 1227(a)(5).

§ 21, 1837 Mass. Acts 270-71. In these statutes, "public charge" referred to "persons utterly unable to maintain themselves," Friedrich Kapp, *Immigration, and the Commissioners of Emigration of the State of New York* 87 (1870). It did not refer to "able-bodied and industrious" immigrants who merely lacked wealth or might receive modest assistance. *See Report of the Commissioners of Alien Passengers and Foreign Paupers*, Mass. S. Doc. No. 14, at 17 (1852). States allowed such employable immigrants to land without any bond, and instead collected a per-immigrant tax that was often used in part to help immigrants find transportation and work. *See Annual Reports of the Commissioners of Emigration of the State of New York* 135 (1861).

In 1882, Congress incorporated this narrow meaning of "public charge" into federal law. Following prior state laws, Congress prohibited any "lunatic, idiot, or any person unable to take care of himself or herself without becoming a public charge" from entering the country. Immigration Act of 1882, ch. 376, § 2, 22 Stat. 214, 214 (1882). "Public charge" thus adhered to its already settled meaning to refer to the fraction of immigrants likely to "become life-long dependents on our public charities." 13 Cong. Rec. 5109 (1882) (Rep. Van Voorhis). Congress did not exclude immigrants who received *any* public benefits. Rather, in the same statute that incorporated the "public charge" concept 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." 1882 Act §§ 1-2, 22 Stat. at 214. Like the prior state taxes, these funds were used in part "for protecting and caring for" immigrants "until they can proceed to other places or obtain occupation for their support." *See* 13 Cong. Rec. 5106 (1882) (Rep. Reagan).

From 1891 to 1951, Congress reenacted public-charge provisions substantially similar to the one in the 1882 Act.[2] Throughout this time, the scope of "public charge" remained limited to individuals likely to rely almost entirely on government support to survive. *See Gegiow v. Uhl*, 239 U.S. 3, 10 (1915); *Howe v. United States*, 247 F. 292 (2d Cir. 1917). "Public charge" did not include an immigrant "able to earn her own living," *Ex parte Mitchell*, 256 F. 229, 230 (N.D.N.Y. 1919), even if he received minor public assistance.

Against this background of nearly a century of statutory and regulatory usage of the term "public charge," Congress enacted the INA's public-charge provision in 1952. Congress declined to enact a new definition of "public charge," thus incorporating that term's well-established meaning into the INA. Federal immigration authorities adhered to this understanding, repeatedly confirming that "public charge" refers narrowly to immigrants who are "incapable of earning a livelihood" to sustain themselves, *In re Harutunian*, 14 I. & N. Dec. 583, 589 (B.I.A. 1974), and does not include employable immigrants who might receive modest amounts of public assistance, *see In re Martinez-Lopez*, 10 I. & N. Dec. 409, 421-22 (A.G. 1962) ("public charge" does not include "healthy person" in "prime of life"); *In re Perez*, 15 I. & N. Dec. 136, 137 (B.I.A. 1974).

In 1996, Congress amended the public charge statute to require DHS to consider certain factors in making public-charge determinations, specifically, an immigrant's age; health; family status; financial resources; and "education and skills." Illegal Immigration Reform and Immigrant Responsibility Act of 1996 (IIRIRA), Pub. L. No. 104-208, 110 Stat. 3009, 3009-674.

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[2] *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.

But Congress did not alter the established meaning of "public charge." To the contrary, Congress rejected a proposal that would have transformed the meaning of "public charge" in the deportation context to mean an immigrant's receipt of any amount of public benefits within a short time period. H.R. Rep. No. 104-828, at 138, 241 (1996) (Conf. Rep.).

Separately, in 1996, Congress enacted a complex set of statutory provisions directed at the use of specific public benefits by specific categories of noncitizens after they had already entered the country or been admitted as LPRs. To satisfy a declared "national policy with respect to welfare and immigration" under which "aliens within the Nation's borders not depend on public resources to meet their needs," 8 U.S.C. § 1601(2)(A), the 1996 provisions and subsequent amendments generally limited LPRs from using Medicaid and Supplemental Nutrition Assistance Program (SNAP) benefits until they had lived here for five years. *Id.* §§ 1612(a)(2)(L), 1613(a). Additional limits on Medicaid and SNAP use apply to LPRs who have sponsors, until the sponsored immigrant has worked a certain amount or become a citizen. *See id.* §§ 1183a(a)(2), 1631(b). (No similar restrictions ultimately applied to LPRs' use of Section 8 housing benefits, many other federal means-tested benefits, or a wide array of federal public benefits that are not means tested.[3] *See id.* §§ 1611(a), (c); 1641(b)(1).) Congress explained that these limitations on

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[3] Congress did not define the term "federal means-tested public benefit" for purposes of its benefits-use provisions. *See* 8 U.S.C. § 1613(a); 8 C.F.R. § 213a.1. The benefit-administering agencies have determined that the only federal means-tested public benefits for purposes of the Welfare Reform Act are Supplemental Security Income, Temporary Assistance for Needy Families, Medicaid, and SNAP. PRWORA: Federal Means-Tested Public Benefits Paid by the Social Security Administration, 62 Fed. Reg. 45,284, 45,284-85 (Aug. 26, 1997); PRWORA: Interpretation of "Federal Means-Tested Public Benefit," 62 Fed. Reg. 45,256, 42,257 (Aug. 26, 1997); Food Stamp Program: Noncitizen Eligibility, and Certification Provisions, 65 Fed. Reg. 10,856, 10,876 (Feb. 29, 2000). Certain statutory limits also apply to social services block grants. 8 U.S.C. § 1612(3)(b)(3)(B).

accessing benefits promoted "self-sufficiency" and prevented "the availability of public benefits" from incentivizing immigration. *Id.* § 1601(3), (6). Again, however, Congress did not amend the definition of "public charge" in the 1996 amendments or thereafter.

In 1999, DHS's predecessor agency (the Immigration and Naturalization Service) issued guidance confirming that the 1996 amendments had not altered the long-settled meaning of "public charge." Consistent with over a century of usage, the guidance explained that "public charge" refers only to individuals "primarily dependent on the government for subsistence," as evidenced by publicly funded long-term institutionalization or cash assistance for income maintenance. Field Guidance on Deportability and Inadmissibility on Public Charge Grounds, 64 Fed. Reg. 28,689, 28,689 (Mar. 26, 1999). The Guidance prohibited consideration of supplemental benefits—such as food stamps, Medicaid, and Section 8 housing—in rendering public-charge determinations because, as the benefit-granting agencies had explained, such benefits are often available to employed individuals "with incomes far above the poverty level" and thus reflect Congress's "broad public policy decisions" about improving public health and upward mobility. *Id.* at 28,692.

B. The Final Rule

In August 2019, DHS issued the Final Rule challenged here. The Rule radically alters the meaning of "public charge" to include, for the first time, an immigrant likely to receive any amount of "public benefit[s]," defined to include certain supplemental benefits such as Section 8 housing assistance, Medicaid, and SNAP benefits. 84 Fed. Reg. at 41,501. The Rule deems an immigrant to be a "public charge" based on short-term receipt of such benefits: a DHS official need merely believe that an immigrant "will receive[ ] one or more public

benefits" during "more than 12 months in the aggregate within any 36-month period" during his life. *Id.* The Rule separately considers the time period for each benefit an immigrant may receive, so that, for example, "receipt of two benefits in one month counts as two months." *Id.*

The Rule sets forth weighted factors that DHS officials must consider to predict whether an applicant is likely to receive an aggregate of 12 months of benefits within any 36-month period during his entire life. Actual receipt of enumerated benefits is a heavily weighted factor counted against an applicant. *Id.* at 41,504. The Rule also lists several other negative factors that support a "public charge" finding, including, low credit scores; lack of English-language skills; merely applying for public benefits; or having a medical condition that requires extensive treatment or interferes with work or school, regardless of whether reasonable accommodations enable the applicant to work or learn.

Heavily weighted positive factors include having household income or assets of at least 250% of the federal poverty guidelines, and having private health insurance not funded with tax subsidies under the Patient Protection and Affordable Care Act (ACA). *Id.* at 41,502-04.

C. Procedural Background

Plaintiffs challenged the Final Rule under the APA, alleging, among other things, that the Rule was contrary to law and arbitrary and capricious.

1. The district court's order of preliminary relief

In October 2019, the district court granted plaintiffs' motion to stay the Rule's effective date pending judicial review, *see* 5 U.S.C. § 705, and for a preliminary injunction. The court concluded that plaintiffs and the public will suffer concrete, irreparable harm absent

preliminary relief; by contrast, the court found that defendants will not suffer any irreparable harm from maintaining the long-existing status quo for a short time. (App. 19a-21a.) On the merits, the court concluded that the Final Rule's transformation of "public charge" to include even temporary receipt of any amounts of supplemental benefits was likely contrary to the INA, and arbitrary and capricious. (App. 11a-18a.)

2. Defendants' expedited appeal

On October 30, defendants filed an interlocutory appeal from the order of preliminary relief. The Second Circuit granted defendants' request to expedite the appeal and set the accelerated briefing schedule that defendants had proposed: defendants filed their opening brief on December 13; plaintiffs' opposition brief is due on January 24; and defendants' reply brief is due on February 14. The Second Circuit has proposed holding oral argument on defendants' appeal during the week of March 2. Notification, No. 19-3591 (Jan. 8, 2020), ECF No. 164.

3. The lower courts' denials of a stay pending appeal

The district court denied defendants' motion for a stay pending appeal. The court concluded that defendants did not have "any rational justification or urgent need" to upend the status quo that had governed public-charge determinations for at least two decades. (App. 56a.) By contrast, the court explained, a stay would cause immediate and irreparable injuries to plaintiffs and the public, including by injecting uncertainty into LPR-status applications and deterring "law-abiding immigrants from receiving available benefits to which they are legally

entitled." (App. 56a.) Moreover, the court concluded, defendants did not have a strong likelihood of success on appeal. (App. 55a-56a.)

The Second Circuit subsequently denied defendants' request to that court for a stay pending appeal or a partial stay limiting the scope of the district court's preliminary relief. The court emphasized that the extraordinary relief of a stay was not warranted given that defendants' appeal had been expedited and oral argument "will be scheduled promptly" after February 14. (App. 65a.) On defendants' objections to the scope of the district court's preliminary relief, the Second Circuit observed that, "[a]s always, the merits panel . . . has full authority to consider the scope of the existing injunction." (App. 65a.)

4. Pending appeals in other courts of appeals

Different plaintiffs separately challenged the Rule in four other district courts. Each of those courts issued orders preliminarily postponing the effective date of the Rule or preliminarily enjoining its implementation. *See Casa de Maryland, Inc. v. Trump*, 2019 WL 5190689 (D. Md. Oct. 14, 2019); *Cook County v. McAleenan*, 2019 WL 5110267 (N.D. Ill. Oct. 14, 2019); *Washington v. DHS*, 2019 WL 5100717 (E.D. Wa. Oct. 11, 2019); *City & County of San Francisco v. USCIS*, 408 F. Supp. 3d 1057 (N.D. Cal. 2019). Defendants have appealed these rulings to the Fourth, Seventh, and Ninth Circuits, respectively.

Defendants sought to stay each district court order pending appeal. On December 23, the Seventh Circuit declined to issue a stay. Order, *Cook County v. Wolf*, No. 19-3169, ECF No. 41. Defendants have not sought from this Court any stay of the Illinois district court's order pending the Seventh Circuit's review of the merits of defendants' appeal.

The Fourth Circuit, over a dissent, stayed the order issued by the Maryland district court, and the Ninth Circuit, over a dissent, stayed the orders issued by the district courts in California and Washington. Order, *Casa de Maryland, Inc. v. Trump*, No. 19-2222 (Dec. 9, 2019), ECF No. 21; Order, *City & County of San Francisco v. USCIS*, No. 19-17213 (Dec. 5, 2020), ECF No. 27.

No court of appeals has yet issued any decision on the merits of any of defendants' appeals. Each court is proceeding on an accelerated briefing schedule, with briefing to be completed in all cases by February 14. The Seventh Circuit has scheduled oral argument on February 26. Argument Notice, No. 19-3169 (Jan. 9, 2020), ECF No. 44. The Second Circuit, as noted, has proposed oral argument for the week of March 2. And the Fourth Circuit has tentatively scheduled oral argument for the week of March 17. Tentative Calendar Order, No. 19-2222 (Dec. 19, 2019), ECF No. 26. As of the date of this brief, the Ninth Circuit had not yet scheduled oral argument.

ARGUMENT

THE COURT SHOULD DENY DEFENDANTS' REQUEST FOR A STAY PENDING THE SECOND CIRCUIT'S IMMINENT REVIEW OF DEFENDANTS' APPEAL

Because a stay intrudes on "the ordinary processes of administration and judicial review," *Nken v. Holder*, 556 U.S. 418, 427 (2009) (quotation marks omitted), defendants bear the "heavy burden" of justifying such "extraordinary" and disruptive relief, *see Whalen v. Roe*, 423 U.S. 1313, 1316 (1975) (Marshall, J., in chambers). Defendants have "an especially heavy burden" here given the truly exceptional nature of their request: they ask this Court to intervene now to stay the district court's order of preliminary relief, even though their already expedited appeal from that order "is pending before" the Second Circuit; three other courts of appeals

are considering defendants' expedited appeals from similar orders issued by other district courts; and all four of the courts of appeals will likely issue decisions on the merits in a matter of months. *Packwood v. Senate Select Comm. on Ethics*, 510 U.S. 1319, 1320 (1994) (Rehnquist, C.J., in chambers).

There is no basis for such extraordinary intervention by this Court. Defendants have not even attempted to identify any urgent need to radically disrupt the status quo that has lawfully governed public-charge determinations for over a century. Instead, they rely on nothing more than their bare desire to implement a new policy in this area. But that interest—which is present in every case where the government has adopted a new policy—is not enough for this Court to exercise its extraordinary powers and effectively endorse a controversial expansion of "public charge" before the lower courts can fully consider defendants' expedited appeals. By contrast, plaintiffs and the public will suffer severe and irreparable harms if this Court were to issue a stay that would allow the Final Rule to come into effect immediately. The balance of the equities alone thus requires the denial of a stay. *See Trump v. International Refugee Assistance Project*, 137 S. Ct. 2080, 2087 (2017) (per curiam).

Given the preliminary posture of this case, and the three other cases currently pending in the courts of appeals, there is also no reasonable basis to assess whether this Court will ultimately grant certiorari. *See Hollingsworth v. Perry*, 558 U.S. 183, 190 (2010). Indeed, defendants have not sought certiorari here, and there is no plausible basis to guess how the Second Circuit will rule, whether the issues raised in that ruling (which may include threshold issues, the merits, or the scope of relief) will warrant further review, or whether the Second Circuit's ruling will conflict with the decision of any other court of appeals. Finally, even if it were possible to

determine whether certiorari would eventually be granted, defendants have failed to meet their burden of showing that they are likely to succeed on the merits of such an appeal.

A. The Balance of Hardships and the Public Interest Weigh Decisively Against Defendants' Request for a Stay That Would Upend the Status Quo for No Good Reason.

1. Defendants have identified no urgent reason for a stay that would disrupt rather than preserve the status quo.

The fundamental purpose of a stay is to preserve the status quo. *See Nken,* 556 U.S. at 429. But the stay requested here would do the opposite by allowing the immediate implementation of a Final Rule that would radically disrupt over a century of settled immigration policy and public-benefits programs. Faced with that disruption, defendants have identified no compelling reason, let alone a time-sensitive one, to implement the Rule immediately: not public safety, not national security, and not foreign policy. Defendants instead claim that they are entitled to a stay merely because they want to implement their chosen policy. But that interest cannot by itself justify this Court's extraordinary intervention—particularly when defendants have conceded that the status quo public-charge framework is both lawful and administrable. The Court should deny the motion on these grounds alone.

As the district court explained, the Rule will upend the status quo that has governed public-charge determinations for over a century by adopting a new definition of "public charge" and a novel multifactor methodology. (App. 21a, 62a.) Unlike in other cases in which the federal government has recently sought stays from this Court, defendants here provide no reason to effect these radical changes *immediately*, before the Second Circuit and three other courts of appeals can adjudicate their expedited appeals. For example, in contrast to other recent

immigration matters, defendants do not claim that a stay is needed to allow the federal government to address any pressing concerns related to national security, foreign relations, or law enforcement. *See* Application for a Stay Pending Appeal 4, *Barr v. East Bay Sanctuary Covenant*, No. 19A230 (U.S. Aug. 26, 2019) ("crisis at the southern border"); Application for a Stay Pending Appeal 2, *Trump v. Sierra Club*, No. 19A60 (U.S. July 12, 2019) ("combatting the enormous flow of illegal narcotics"); Application for a Stay Pending Appeal 25, *Trump v. Hawaii*, No. 17A550 (U.S. Nov. 20, 2017) ("foreign-policy, national-security, and counterterrorism objectives"). Nor do defendants identify any other urgent concern that might warrant precipitous action, such as "a risk to military effectiveness and lethality," Application for a Stay in the Alternative to a Writ of Certiorari Before Judgment 2, *Trump v. Karnoski*, No. 18A625 (U.S. Dec. 13, 2018); or any practical or statutory deadlines, *see* Application, *Sierra Club*, *supra*, at 35-38 (contracting and funding deadlines).

Defendants' silence is unsurprising because no urgent need for a stay exists. There is no dispute that the status quo public-charge framework is lawful and administrable. There is no deadline, let alone an important or imminent one, that DHS might fail to meet absent a stay. And DHS displayed no urgency in promulgating this Final Rule, taking over two years under the current administration to finalize it. *See* 84 Fed. Reg. at 41,292; *cf. Ruckelshaus v. Monsanto Co.*, 463 U.S. 1315, 1317-18 (1983) (Blackmun, J., in chambers) (stay applicants' "failure to act with greater dispatch tends to blunt [their] claim of urgency"). It thus beggars belief that defendants (or the public) would be harmed—let alone irreparably so—by extending for the few months of defendants' underlying appeal the public-charge framework that has been in place for over a century since Congress's initial enactment; for two decades since the 1999 Guidance; and for the first three years of the current administration.

Without any urgent need to support their motion, defendants claim that they are nonetheless entitled to a stay solely because of their desire to "implement[] [their] chosen policy" (Mot. 4). But that interest cannot plausibly justify a stay because it will be present in *every* case where the government seeks to implement a new policy. Granting a stay under these circumstances would transform this Court's intervention in pending litigation from a "rare and exceptional" occurrence into a routine one. *See Fargo Women's Health Org. v. Schafer*, 507 U.S. 1013, 1014 (1993) (O'Connor, J., concurring).

Nor is it sufficient that, under the status quo, defendants will grant LPR status to some immigrants who would otherwise be excluded by the Final Rule. (Mot. 4.) Because defendants are unlikely to succeed on the merits, the public interest weighs against allowing them to implement a policy of dubious legality. *See League of Women Voters of U.S. v. Newby*, 838 F.3d 1, 12 (D.C. Cir. 2016) (government lacks any cognizable "interest in the perpetuation of unlawful agency action"). Moreover, although DHS may not revoke LPR status once granted (Mot. 5), DOJ retains authority to deport a LPR who actually becomes a "public charge" within five years of admission from causes that did not arise after admission. *Id.* § 1227(a)(5). The lack of any need to implement the Rule now warrants denial of a stay. *See International Refugee*, 137 S. Ct. at 2087; *Ruckelshaus*, 463 U.S. at 1317.

2. Disrupting the status quo would wreak havoc on public-charge determinations and public-benefits administration and seriously injure plaintiffs and the public.

By contrast, allowing the Rule to take effect immediately will inject severe confusion and uncertainty into immigration proceedings and public-benefits administration, cause widespread disenrollment from public benefits, undermine the healthcare systems operated by plaintiffs, and harm public health. Such chaos is especially unwarranted here because the courts of appeals and this Court may ultimately agree that the Final Rule must be vacated as either unlawful or arbitrary and capricious—thus subjecting the public-charge framework to massive, short-term fluctuations for no reason at all. The balance of the equities thus tilts decisively against a stay.

Implementing the Rule's radical new definition of public charge and its novel and complex multifactor test will upset the administration of adjustment-of-status decisions issued by both DHS officers and immigration courts during removal proceedings. In place of familiar factors that have dictated public-charge determinations for over a century—such as an applicant's likely ability to work, use of long-term institutional care, or receipt of income maintenance—the Rule imposes a welter of new and differently weighted factors without providing any concrete guidance on how DHS officers will actually evaluate many of these factors. For example, the Rule requires officers to weigh negatively an applicant's low English proficiency, but provides no parameters for how an officer should evaluate applicants' language skills or determine whether a particular skill-level warrants a positive or negative mark. The Rule is similarly unclear about how an officer should determine the weight to give to each particular factor, or about how an officer should ultimately determine whether positive factors outweigh negative ones. Indeed, in the district court, defendants were unable to explain

"how the new framework would operate" in practice or "to provide an example of the 'typical person' that Defendants could predict is going to receive 12 months of benefits in a 36-month period." (App. 16a.) The confusion and uncertainty that will inevitably follow from implementing this untested public-charge framework counsels strongly against allowing defendants to implement that framework immediately, particularly when defendants have not identified any problems from continuing the status quo pending appeal.

A stay would also disrupt plaintiffs' administration of their public-benefit programs. As extensive and unrebutted evidence here established, immediate implementation of the Rule would force plaintiffs to overhaul their systems for determining benefits eligibility and enrollment. If the district court's order were ultimately affirmed, plaintiffs would then be forced to undo all of these major changes. For example, Connecticut currently automatically reenrolls Medicaid beneficiaries each year and automatically confers eligibility for SNAP or Medicaid if an applicant receives other benefits; but because such processes would lead to severe negative consequences for applicants under the Rule, Connecticut would be forced to alter its systems if a stay were to allow the Final Rule to immediately come into effect. (Addendum ("Add.") 49-50.) Similarly, a stay would force New York's Special Supplemental Nutrition Program for Women, Infants, and Children to conduct costly and time-consuming eligibility verification procedures rather than rely on existing streamlined processes that leverage applicants' existing SNAP and Medicaid eligibility. (Add. 180-183.) The imposition of such substantial and irreparable harms on public-benefits administrators is entirely unwarranted when defendants have offered no compelling reason to support the immediate implementation of the Final Rule.

Allowing the Rule to take effect now will also irreparably harm plaintiffs and the public in other ways. As the district court found and DHS acknowledged, the Rule will cause many individuals and their families to forgo supplemental benefits—to which they are legally entitled—to avoid a public-charge finding under the Rule's radical new framework. *See* 84 Fed. Reg. at 41,300, 41,307. These reductions in benefits use will "reduce[ ] revenues for healthcare providers participating in Medicaid," *Inadmissibility on Public Charge Grounds*, 83 Fed. Reg. 51,114, 51,118 (Oct. 10, 2018), including public healthcare facilities operated by plaintiffs. (Add. 47, 54, 102-111; *see* Add. 57-58 (NYC Health + Hospitals expects to lose $42 million in Medicaid revenue in first year of Rule's implementation).) Although defendants claim, without any support, that these losses will be offset by plaintiffs spending less to fund Medicaid (Mot. 17), this argument ignores the fact that plaintiffs' healthcare costs will *increase* as newly uninsured patients avoid preventative care, suffer worse health outcomes, and seek more costly care from public healthcare systems. (Add. 58 (NYC Health + Hospitals expects losses to rise to at least $121 million given increased costs); Add. 103-111, 165-167.)

Public health and economic welfare will be further harmed in plaintiffs' jurisdictions as the Rule causes residents to avoid benefits. For example, as defendants do not contest, families who forgo Section 8 benefits will need to leave their homes, live in more dangerous neighborhoods, and suffer harms to their health, education, and employment. (Add. 15-29, 152-155.) And lower SNAP usage means less nutritious food for families, lower revenues for grocery stores, and economic losses for plaintiffs. (Add. 127-132.)

If the Rule comes into effect immediately, the injuries to plaintiffs and the public will be disruptive, irreparable, and long-lasting. For example, families that disenroll from Section 8 housing cannot easily reenter the program because the waiting lists are long. (Add. 157-158.)

Immigrants deemed "public charges" under the Rule may be forced to leave the country or face removal, 8 U.S.C. § 1227(a)(1)(A); may be subject to multi-year bars to reentering, *id.* § 1182(a)(9)(A)-(B); and will likely lose their path to LPR status or citizenship.

The disruption, confusion, and harm from implementing the Rule immediately weigh strongly against a stay. In urging otherwise, defendants make the conclusory assertion that all of these harms are "speculative." (Mot. 40; *see id.* at 17-18.) But "[i]t is disingenuous for DHS to claim" that the harms "are too attenuated…when it acknowledged these costs in its own rulemaking process." *San Francisco*, 944 F.3d at 787. Indeed, defendants failed to present any evidence below to contradict plaintiffs' extensive factual record demonstrating the harmful effects of the Rule on plaintiffs and the public.

Rather than grapple meaningfully with the largely uncontested harms that will occur (*see* Mot. 17-18, 39-40), defendants make the conclusory and astounding assertion that "whatever" harms plaintiffs and the public "will suffer" are automatically outweighed by defendants' mere preference to implement the Rule now (*id.* at 40). If such empty treatment of "the relative harms to applicant and respondent, as well as the interests of the public at large," *International Refugee*, 137 S. Ct. at 2087 (quotation marks omitted), were enough to obtain a stay here, then applicants, or at least the federal government, may expect to obtain the extraordinary intervention of a stay from this Court in nearly any case. Accordingly, the Court should deny a stay.

B. There Is No Basis to Assess Whether This Court Will Grant Certiorari Given That No Petition for Certiorari Has Yet Been Filed and No Court of Appeals Has Yet Ruled on the Merits of the Orders Below.

The truly extraordinary nature of defendants' stay motion is further highlighted by their request for this Court's premature intervention in ongoing appellate proceedings, before there can be any plausible basis to discern whether this Court's review will be warranted.

Defendants ask this Court to stay the district court's order of preliminary relief when the Second Circuit is currently reviewing that order on an expedited basis; when the Fourth, Seventh, and Ninth Circuits are reviewing similar orders issued by four other district courts; and when decisions on the merits from these courts will likely be issued in a matter of months. Until these courts issue their decisions, there is no reasonable basis to predict how they will rule, whether their decisions will conflict with each other, or whether any issues they address (whether on threshold issues like standing, on the merits, or on the scope of relief) might warrant this Court's review. Defendants thus rely on nothing beyond rank speculation in contending that there is a "reasonable probability" that four Justices will grant certiorari to review the Second Circuit's yet-to-be-issued decision. *See Hollingsworth*, 558 U.S. at 190.

Given the preliminary posture of this case and the other proceedings involving the Final Rule, defendants are simply wrong to contend (Mot. 15-16) that a decision from the Second Circuit upholding the district court's order will "conflict" with contrary decisions from the Fourth or Ninth Circuits. The Fourth and Ninth Circuits have not issued any such "conflicting" decisions because they have not yet had the opportunity to decide whether to uphold the preliminary relief issued by the other district courts. Instead, they have issued only interim stay decisions. But such decisions based on truncated briefing do not dictate, let alone necessarily predict, how the courts will ultimately rule after full briefing, oral argument, and deliberation.

The speculative nature of defendants' predictions is highlighted by the fact that the interim decisions of the Fourth, Seventh, and Ninth Circuits were each issued over a dissent. Given that this Court is "a court of review, not of first view," *Expressions Hair Design v. Schneiderman*, 137 S. Ct. 1144, 1151 (2017) (quotation marks omitted), and given that each of the courts of appeals considering challenges to the Final Rule will likely issue decisions within the next few months, the circumstances here support allowing the issues to percolate in the lower courts.

The preliminary posture of this case also belies defendants' contention (Mot. 16-17) that this Court must intervene now to resolve the scope of relief that district courts may order. In denying defendants' stay motion, the Second Circuit made clear that "the merits panel, as soon as constituted, has full authority to consider the scope of the existing injunction." (App. 65a.) There is no reason for this Court to decide this question now when the Second Circuit has expressly flagged that issue for resolution and is moving expeditiously to complete briefing and hold argument on that question.

C. There Is Not a Fair Prospect That This Court Would Conclude That the District Court Abused Its Discretion in Finding That the Rule is Likely Contrary to Law and Arbitrary and Capricious.

1. The Rule is likely contrary to law.

The district court did not abuse its discretion in finding that the Final Rule's unprecedented definition of "public charge" exceeds the well-established understanding of that term as incorporated into the INA. *See Chevron, U.S.A., Inc. v. Natural Res. Def. Council*, 467 U.S. 837, 842-44 (1984).

a. In the district court, defendants acknowledged that the permissible scope of "public charge" turns on that term's historical meaning. (Mem. in Opp. to Mot. for Prelim. Inj.

13-22 (S.D.N.Y. Sept. 27, 2019), ECF No. 99.) But as the district court properly concluded (App. 13a), the Final Rule's definition of "public charge" represents a sharp and untenable break from that historical meaning and thus exceeds "the bounds of reasonable interpretation." *Utility Air Regulatory Grp. v. EPA*, 573 U.S. 302, 321 (2014).

The Rule now defines "public charge" to include employed immigrants who might "receive only hundreds of dollars, or less, in public benefits." *See* 84 Fed. Reg. at 41,360-61. The Rule also considers disqualifying an applicant's possible receipt of certain supplemental benefits that do not provide long-term subsistence, but instead boost public health and economic mobility. See *infra*, at 26-28. And the Rule's aggregate counting system, which counts each benefit used in a single month as a separate month for calculating the duration of benefits use, means that noncitizens will be considered "public charges" based on the likelihood of using multiple benefits *temporarily*, even for just a few months, to address an acute period of financial strain or emergency.

These changes represent a radical and unprecedented departure from what had previously been a well-settled understanding of "public charge." When Congress originally enacted the public-charge provision in 1882, it adopted the prevailing understanding—reflected in early state laws—that "public charge" was limited to "persons utterly unable to maintain themselves." Kapp, *supra*, at 87. See *supra*, at 4-5. As precedents and contemporaneous sources from this era demonstrate, "public charge" meant individuals "physically and mentally incapacitated for labor," Kapp, *supra*, at 91, not hard-working individuals who might receive minor amounts of assistance. *See, e.g.*, *City of Boston v. Capen*, 61 Mass. 116, 124 (1851) (Massachusetts statute applied to individuals "without means of support"); *American Dictionary of the English Language* (N. Webster 1828 online ed.), *at* https://archive.org/download/

americandictiona01websrich/americandictiona01websrich.pdf (defining the noun "charge" as a "person or thing committed to another[']s custody, care or management") (entry 6). Consistent with this understanding, the 1882 statute excluded the few immigrants unable "to support themselves by honest industry and labor," 13 Cong. Rec. 5112 (Rep. Van Voorhis), while allowing employable immigrants to enter the country subject to a per-person tax used to assist immigrants until they could "obtain occupation for their support," *id.* at 5106 (Rep. Reagan).

This established meaning of "public charge" carried forward through the early twentieth century. As courts and immigration agencies repeatedly made clear, "public charge" is a term of art in immigration law that has always meant individuals unlikely "to earn a living." *Wallis v. United States ex rel, Mannara*, 273 F. 509, 509 (2d Cir. 1921). It has never been understood to include employed or employable immigrants who might receive some modicum of public benefits. *See Gegiow*, 239 U.S. at 10 ("public charge" means persons with "permanent personal objections" preventing them from employment); *Howe v. United States*, 247 F. 292, 294 (2d Cir. 1917) ("We are convinced that Congress meant the act to exclude persons who were likely to become occupants of almshouses for want of means with which to support themselves in the future.").

Congress incorporated this established understanding of "public charge" when it enacted the INA's public-charge provision in 1952, without redefining the term. *See McDermott Int'l, Inc. v. Wilander*, 498 U.S. 337, 342 (1991); *Lorillard v. Pons*, 435 U.S. 575, 580 (1978) ("Congress is presumed to be aware of an administrative or judicial interpretation of a statute and to adopt that interpretation when it reenacts a statute without change."). Indeed, a Senate report about the INA, on which defendants rely (Mot. 25-26), confirms that Congress understood the extensive history of the public-charge provision and the precedents interpreting

it, and retained the preexisting scope of "public charge" rather than expand it. *See* S. Rep. No. 1515, at 45-53, 335-50 (1950).

b. Tellingly, defendants' motion abandons most of the historical sources they referenced below. And the Ninth Circuit's stay order acknowledged the extensive history establishing that "public charge" has a commonly understood meaning of persons "unwilling or unable to care for themselves." *San Francisco*, 944 F.3d at 793.

The few sources cited by defendants and the Ninth Circuit do not support their alternative reading of the historical meaning of "public charge." For example, defendants cite a sentence from a treatise and two dictionaries to argue that "public charge" includes anybody who imposes *any* "money charge" or "expense" on "'the public for support and care.'" (Mot. 24-25.) But that sentence is drawn from a district court case that involved a noncitizen who was institutionalized because he was "unable to care for himself" and would have "starve[d] to death within a short time" absent institutional care. *Ex parte Kichmiriantz*, 283 F. 697, 698 (N.D. Ca. 1922); *see, e.g.*, *Black's Law Dictionary* (3d ed. 1933) (citing *Kichmiriantz*, 283 F. at 698). And the case held that even this noncitizen could not be deemed a public charge because the "money charge" for his institutional care had been paid for by his relatives rather than the public. *Kichmiriantz*, 283 F. at 698.

Defendants and the Ninth Circuit's stay order also badly misread a decision of the Board of Immigration Appeals, *In re B-*, 3 I. & N. Dec. 323 (B.I.A. 1948), as allowing already-admitted LPRs to be deported for failure to repay *any* public benefit they receive. (*See* Mot. 25.) In that decision, the BIA actually narrowed the public-charge provision applicable to admitted LPRs by requiring that, to be deportable, an LPR must *both* have become a "public charge"—i.e., substantially reliant on government funds to survive—*and* actually failed to

repay those funds when demanded. *See In re B-*, 3 I. & N. Dec. at 325 (immigrant institutionalized for eight years). This additional failure-to-repay requirement was thus a further protection against deportation of already-admitted LPRs, *see In re Harutunian*, 14 I. & N. Dec. at 588-89, not an expansion of the meaning of "public charge."[4]

c. Defendants' remaining attempts to support their sweeping new definition of "public charge" are equally unavailing.

First, echoing the Ninth Circuit's flawed reasoning, defendants contend (Mot. 20) that the public-charge statute confers discretion on DHS to determine the definition of "public charge" by rendering inadmissible "[a]ny alien who . . . in the opinion of [DHS] . . . is likely at any time to become a public charge," 8 U.S.C. § 1182(a)(4)(A). But discretion to determine whether "[a]ny alien" meets the statutory standard in a particular case is not the same as discretion to redefine the statutory standard itself. And even if there were some play in the joints in applying the historical meaning of "public charge" to modern benefits programs (*see* Mot. 24-25)—for instance, identifying which current programs serve the truly destitute—that flexibility would not authorize DHS to simply abandon the historical understanding of "public charge" altogether, as the Final Rule does. *See Utility Air*, 573 U.S. at 321-24.

Here, the Final Rule goes far "beyond the meaning that the statute can bear," *MCI Telecommunications Corp. v. AT&T Co.*, 512 U.S. 218, 229 (1994), by adopting the unprecedented view that an individual can become a "public charge" simply by receiving

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[4] Contrary to defendants' contention (Mot. 25 n.4), the BIA did not indicate that the institutionalized LPR in *In re B-* could have been deported for failure to repay incidental expenses. The BIA noted that the LPR was required to pay for her own minor expenses to emphasize that, by contrast, the government could not seek reimbursement for her publicly funded institutional care and therefore could not deport her. *Id.* at 327.

minor and temporary amounts of certain supplemental benefits. Contrary to the unsupported assumptions of defendants and the Ninth Circuit, the supplemental benefits targeted by the Rule do not serve only the truly destitute who might plausibly be "public charges" under the established meaning of the INA. Rather, as DHS's predecessor and the federal agencies that actually administer these benefits made clear in the 1999 Guidance, Congress made these programs available as well to many employed individuals who have "incomes far above the poverty level"—not to support their subsistence, but rather to further "broad public policy decisions" about improving public health, nutrition, and economic opportunities, 64 Fed. Reg. at 28,692. For example, in plaintiffs' jurisdictions, more than 60% of adult Medicaid recipients are working;[5] in New York City, recipients of Section 8 benefits may retain those benefits while earning up to $85,350 annually (Add. 6); and in 2011, 44% of all SNAP participants lived in households with earnings.[6] An individual may be "fully capable of supporting herself without government assistance but elect[] to accept" a supplemental benefit "simply because she is entitled" to use it to obtain more nutritious food, safer housing, or better healthcare. (App. 15a.)

The supplemental benefits targeted by the Rule are a far cry from almshouses, institutional care, or income-maintenance programs—programs that are designed to serve destitute individuals who are "extremely unlikely" to meet their "basic subsistence requirements" without relying

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[5] Kaiser Family Foundation, *Medicaid in Connecticut* (Oct. 2019), *at* http://files.kff.org/attachment/fact-sheet-medicaid-state-CT (67% of adult Medicaid enrollees work); Kaiser Family Foundation, *Medicaid in Vermont* (Oct. 2019), *at* http://files.kff.org/attachment/fact-sheet-medicaid-state-VT (65%); Kaiser Family Foundation, *Medicaid in New York* (Oct. 2019), *at* http://files.kff.org/attachment/fact-sheet-medicaid-state-NY (61%).

[6] U.S. Dep't of Agriculture, *Building a Healthy America: A Profile of SNAP* 1 (2012).

primarily on the government in the long term. Inadmissibility and Deportability on Public Charge Grounds, 64 Fed. Reg. 28,676, 28,678 (May 26, 1999); *see id.* (long-term care institutions provide all subsistence needs); *id.* at 28,687 (Supplemental Security Income protects "from complete impoverishment"). The Rule's inclusion of these supplemental benefits thus stretches "public charge" far past the breaking point of reasonable interpretation.

Second, defendants misplace their reliance on policy statements in the 1996 Welfare Reform Act and related provisions addressing noncitizens' use of public benefits *after* they have already entered the country or been admitted as LPRs. Defendants cite the Welfare Reform Act's goals of furthering "[s]elf-sufficiency" in "immigration policy" and preventing "the availability of public benefits" from incentivizing immigration. 8 U.S.C. § 1601. But Congress effectuated those goals in the 1996 Act by limiting immigrants' use of specific benefits in particular ways, such as by imposing a waiting period for eligibility for already-admitted LPRs and denying benefits altogether to undocumented immigrants. The same Congress pointedly did *not* pursue these "self-sufficiency" goals through amending the threshold public-charge provision. To the contrary, Congress in 1996 affirmatively rejected a proposal to transform the meaning of "public charge" in the deportation context to mean an immigrant's receipt of any amount of public benefits within a short time period. H.R. Rep. No. 104-828, at 138, 241. And in 2013, Congress again rejected an attempt to make a similar change to the meaning of "public charge." *See* S. Rep. No. 113-40, at 42 (2013) (Judiciary Committee report noting that senators opposing amendment cited "strict benefit restrictions and requirements."). There is thus no plausible basis to import the Welfare Reform Act's "self-sufficiency" goals into the public-charge provision. *See Gross v. FBL Fin. Servs., Inc.*, 557 U.S. 167, 174-75 (2009).

For similar reasons, the actual access-to-benefits rules that Congress enacted in 1996 do not support the Rule's redefinition of "public charge" for admissibility purposes. The new eligibility rules were meant to limit certain public benefits to those immigrants who Congress believed displayed adequate "self-sufficiency" and who were not incentivized to enter this country due to "the availability of public benefits." 8 U.S.C. § 1601. But the Final Rule improperly disregards Congress's policy choice by treating the receipt of these benefits as instead automatically indicating that an immigrant is so destitute as to be a "public charge"—precisely the opposite of Congress's judgment. *See Rodriguez v. United States*, 480 U.S. 522, 525-26 (1987) (per curiam) (deciding which "competing values will or will not be sacrificed to the achievement of a particular objective is the very essence of legislative choice").

Third, defendants are fundamentally incorrect in finding support for the Final Rule in statutory provisions requiring some (but not all) applicants to provide affidavits of support from third-party sponsors to avoid being deemed a public charge. (Mot. 20-21.) Contrary to defendants' contention, affidavits of support do not require the sponsor to repay "*any* means-tested public benefit" the applicant may receive. (Mot. 21 (emphasis added).) The repayment obligation does not currently apply to Section 8 housing benefits at all, as the Final Rule does. *See* 8 C.F.R. § 213a.1. See *supra*, at 7. And the affidavits' contractual obligation is substantially narrower than the Final Rule in multiple additional ways—it applies primarily to certain applicants with family-based visas (not employment-based visas), is enforceable only after an immigrant has been admitted, and encompasses only the covered benefits received during defined time periods. 8 U.S.C. §§ 1182(a)(4)(C)-(D), 1183a(2)-(3). This limited post-admission remedy does not remotely suggest that Congress silently transformed the threshold meaning of "public charge" for *all* applicants to include *any* individual likely to receive *any*

means-tested benefits at *any* time in the future—including time periods well beyond which affidavits of support would be enforceable. As the Final Rule acknowledges, affidavits are at most a "separate requirement" in certain cases. 84 Fed. Reg. at 41,448. And such affidavits primarily serve a purpose distinct from the threshold admissibility review: "to provide a reimbursement mechanism" for the government or the LPR *after* the applicant's admission "to recover from the sponsor" who broke a contract to support the LPR, *id.* at 41,320.

Finally, there is also no merit to defendants' assertion (Mot. 22) that a provision prohibiting DHS from considering "any benefits" received by battered immigrants in rendering public-charge determinations necessarily authorizes DHS to consider "any benefits" for other immigrants. 8 U.S.C. § 1182(s); *see id.* § 1641(c). There is no indication that Congress intended a shield for some immigrants to be used as a sword against others. Congress spoke broadly in enacting this provision to make clear its intent to protect vulnerable immigrants who often lack any means of support outside their abusive relationships. *See* Battered Immigrant Women Protection Act, Pub. L. No. 106-386, §§ 1502-1505, 114 Stat. 1464, 1518-27 (2000). Indeed, Congress likely referred to "any benefits" to ensure that battered immigrants could receive any benefits that might actually reflect primary reliance on the government to subsist long-term, such as income maintenance, without risking a public-charge determination. It would be perverse to read into such broad protective legislation, directed at a distinct problem, an implicit intent to *withdraw* similar protections from other immigrants. And such implied intent is particularly implausible when Congress was operating against a backdrop in which the well-settled public-charge framework did not consider receipt of supplemental public benefits.

At base, all of defendants' arguments about these scattershot provisions suffer from the same basic defect: they infer radical changes to the well-established meaning of public charge through provisions that did not alter that meaning, and instead serve very different roles in the complex legislative scheme governing public benefits or immigration. But Congress does not "hide elephants in mouseholes." *Whitman v. American Trucking Ass'ns*, 531 U.S. 457, 468 (2001). And whatever discretion DHS may have to apply the term "public charge," it does not have authority to "undo what [Congress] has done" by radically remaking immigration law and benefit programs—particularly when DHS has no authority over benefits programs or the complex rules that govern them. *See King v. Burwell*, 135 S. Ct. 2480, 2496 (2015). The district court thus properly concluded that DHS likely violated the INA by drastically expanding the meaning of public charge in a way that Congress has not authorized. *See Bob Jones Univ. v. United States*, 461 U.S. 574, 600-01 (1983).

2. The Rule is likely arbitrary and capricious.

The Final Rule is also likely arbitrary and capricious for multiple, independent reasons.

First, as the district court correctly determined (App. 15a), DHS failed to provide any reasonable explanation for determining that likely receipt of *any* amount of supplemental benefits, even temporarily, automatically means that an applicant cannot afford the "basic necessities of life" and is thus a "public charge," 83 Fed. Reg. at 51,159. That determination "rests upon factual findings that contradict those which underlay [defendants'] prior policy." *FCC v. Fox Television Stations, Inc.*, 556 U.S. 502, 515-16 (2009). Based on the expertise of benefit-granting agencies, the 1999 Guidance concluded that receiving supplemental benefits does not automatically suggest that the recipient is unable to afford her basic needs because

such benefits are often available to working individuals to promote public health and upward mobility. 64 Fed. Reg. at 28,692. DHS's failure to provide any rational basis for departing so drastically from these prior findings renders the Rule arbitrary and capricious.

Second, the Rule's aggregate-counting system—which, for example, counts the use of three benefits in one month as three months of benefits use—irrationally undermines DHS's own stated goal of not including as "public charge" immigrants who suffer only a short-term emergency. (*See* App. 16a.) In the Rule, DHS stated that it had imposed a durational threshold requiring likely benefits use for 12 out of 36 months to ensure that "short-term and intermittent access to public benefits" will not render applicants public charges. 84 Fed. Reg. at 41,361. But the aggregate counting system does the opposite by deeming the use of multiple benefits over just a few months to satisfy the Rule's new definition of "public charge." DHS failed to provide any reasoned explanation for arbitrarily shortening the 12-month durational threshold that it selected as the "bright-line rule," 84 Fed. Reg. at 41,360. Although "receipt of multiple benefits" in a single month may indicate that an immigrant used more assistance during that month, *id.* at 41,361, it does not alter the short-term nature of such benefits use.

Third, multiple factors in the Rule's new public-charge test do not reasonably predict that an immigrant is likely to receive supplemental benefits at all—let alone receive them to such an extent she could rationally be considered a public charge. For example, the Rule assigns negative weight to low credit scores, lack of English proficiency, and a larger family. But the data on which DHS relies demonstrate that the vast majority of people with such factors do not use any public benefits *at all*. *See* 83 Fed. Reg. at 51,196 (no benefits use by 75.4% of people who do not speak English well); *id.* at 51,186 (no benefits use by 79.3% of people in families of four). Moreover, the Rule denies the heavily positive factor of having private health insurance

to immigrants who use ACA credits to obtain insurance. But ACA credits are available to immigrants who earn up to 400% of the federal poverty line—approximately $100,000 a year for a family of four—and using such credits to purchase private insurance makes it extremely unlikely that the immigrant will use Medicaid.[7]

Finally, the Rule failed to adequately justify the need to radically alter the well-established public-charge framework, particularly given the grievous harms imposed by the Rule. DHS declared that it lacked information to make such a justification. *See* 84 Fed. Reg. at 41,312-14. But DHS received extensive information on these harms and simply failed to "adequately analyze…the consequences" of its actions. *See American Wild Horse Pres. Campaign v. Perdue*, 873 F.3d 914, 932 (D.C. Cir. 2017). And given the information provided, DHS's conclusion that the Rule "will ultimately strengthen public safety, health, and nutrition," 84 Fed. Reg. at 41,314, is contrary to the evidence and impermissibly based on "sheer speculation." *Sorenson Commc'ns Inc. v. FCC*, 755 F.3d 702, 708 (D.C. Cir. 2014). Moreover, the Rule contains no reasoned explanation for how these harms may be justified by any purported gains: DHS identified no concrete problems caused by the current public-charge regime aside from the fact that it grants LPR status more often than the Rule would.

[7] *See* U.S. Centers for Medicare & Medicaid Services, Federal Poverty Level, *at* https://www.healthcare.gov/glossary/federal-poverty-level-fpl/.

3. The Rule is likely unlawful and arbitrary under the Rehabilitation Act.

The district court correctly concluded that the Rule is likely arbitrary and capricious and contrary to law because it violates Section 504 of the Rehabilitation Act by discriminating against individuals with disabilities. (App. 18a.) Section 504 provides that no individual "shall, solely by reason of her or his disability, be excluded from the participation in, be denied the benefits of, or be subjected to discrimination" under any activity conducted by a federal agency. 29 U.S.C. § 794(a) (emphasis added). This provision does not, as defendants contend (Mot. 30-31), prohibit only public-charge determinations that are based solely on an applicant's disability. Rather, it also prohibits DHS from subjecting an applicant to "a more onerous condition" based solely on disability, *Henrietta D. v. Bloomberg*, 331 F.3d 261, 276 (2d Cir. 2003)—including, as DHS's own regulations provide, different "criteria or methods of administration," 6 C.F.R. § 15.30(b)(4). The Rule violates these principles by automatically "consider[ing] disability as a negative factor in the public charge assessment" (App. 18a).

The Rule is also likely arbitrary and capricious given that it provides no rational basis for concluding that "disability alone is itself a negative factor indicative of being more likely to become a public charge" when reasonable accommodations would allow the applicant to work. (App. 18a.) And the Rule's irrational treatment of individuals with disabilities is compounded by its use of multiple, duplicative factors that essentially double- and triple-count a person's disability against them. For example, a person's disability could underlie both a negative factor for a serious medical condition, and a heavily negative factor for past use of Medicaid (a common resource for people with disabilities who have incomes far above the poverty line). *See* 84 Fed. Reg. at 41,504.

Contrary to defendants' arguments (Mot. 31), Congress's requirement that DHS consider "health" in making public-charge determinations does not authorize the agency to make the irrational conclusion that disability alone—particularly with a reasonable accommodation—will automatically render an applicant incapable of supporting himself. And that conclusion is further belied by the evidence submitted to DHS, which confirms "the reality that many individuals with disabilities live independent and productive lives" (App. 18a).

4. Defendants' threshold arguments lack merit.

The district court correctly determined that plaintiffs have standing and are within the applicable zone of interests.

Article III standing: The "predictable effect[s]" of the Final Rule give plaintiffs standing. *Department of Commerce v. New York*, 139 S. Ct. 2551, 2566 (2019). Plaintiffs presented unrebutted evidence that the Rule will concretely injure plaintiffs' proprietary, economic, and sovereign interests by causing many of plaintiffs' residents to forgo public-benefit programs. Such drops in benefits enrollment will reduce Medicaid revenue, increase costs to healthcare systems, burden plaintiffs' public-benefit programs, and harm plaintiffs' economies. See *supra*, at 17-20. Such injuries are "precisely the kind of 'pocketbook'" injuries that confer standing. *Air Alliance Houston v. EPA*, 906 F.3d 1049, 1059-60 (D.C. Cir. 2018).

Zone of interests: The district court also correctly concluded that plaintiffs are within the INA's zone of interests. Given the APA's "generous review provisions," the zone-of-interests test is satisfied unless plaintiffs' interests are "so marginally related to or inconsistent with the purposes implicit in the statute that it cannot reasonably be assumed that Congress intended to permit the suit." *Clarke v. Securities Indus. Ass'n*, 479 U.S. 388, 399-400 & n.16

(1987) (quotation marks omitted). Plaintiffs easily satisfy this lenient standard here. As defendants acknowledge (Mot. 18), Congress enacted the public-charge provision in part to protect state and city fiscs. But Congress also maintained a narrow meaning of "public charge" to ensure that States and their subdivisions will continue to receive the economic and other benefits that flow from employable immigrants becoming "a valuable component part of the body-politic." 13 Cong. Rec. 5108 (Rep. Van Voorhis). The Rule acknowledges that it will impose substantial costs on these state fiscal interests. The zone-of-interests test is thus satisfied.

D. There Is No Basis to Limit the Scope of the Preliminary Relief Ordered.

Defendants' demand that this Court limit the scope of the district court's injunction ignores the separate provision of the district court's order postponing the Rule's effective date under 5 U.S.C. § 705. Section 705 provides that "[o]n such conditions as may be required and to the extent necessary to prevent irreparable injury," a court "may issue all necessary and appropriate process to postpone the effective date of an agency action or to preserve status or rights pending conclusion of the review proceedings." By authorizing the court to suspend "*the* effective date" of an agency's action, this express statutory remedy applies to a rule as a whole rather than to particular parties or locations. *See Mexichem Specialty Resins, Inc. v. EPA*, 787 F.3d 544, 562 (D.C. Cir. 2015) (Kavanaugh, J., dissenting in part) (§ 705 "authorizes courts to stay agency rules pending judicial review") (emphasis omitted).

The scope of the provisional relief authorized by § 705 parallels the ultimate remedies of vacatur or remand that a court is authorized to issue under the APA—remedies that also apply to an entire regulation, not to particular parties. *See* 5 U.S.C. § 706(2); *National Mining Ass'n v. U.S. Army Corps of Eng'rs*, 145 F.3d 1399, 1409-10 (D.C. Cir. 1998). Likewise, when

agencies have invoked § 705 to postpone the effective dates of their own rules, they have routinely done so on a nationwide basis. *See, e.g.*, *Sierra Club v. Jackson*, 833 F. Supp. 2d 11, 21-22 (D.D.C. 2012). The district court did not abuse its discretion in issuing similar relief under § 705 here. *See West Virginia v. EPA*, 136 S. Ct. 1000 (Mem.) (2016) (staying regulation); Application for Stay of Final Agency Action 5, 13, *West Virginia v. EPA*, No. 15A773 (U.S. Jan 26, 2016) (requesting § 705 stay).

The district court's postponement of the Rule's effective date under § 705 means that this case may not squarely present any issues regarding the scope of courts' "equity jurisdiction" (Mot. 38). Contrary to defendants' conclusory assertion (Mot. 37), a § 705 stay is not "one and the same" as a preliminary injunction. *See Nken*, 556 U.S. at 428, 434 ("An injunction and a stay have typically been understood to serve different purposes."). Although courts have looked to similar factors in issuing both forms of relief, a § 705 stay is directly authorized by statute and does not rely on the courts' inherent authority to issue equitable relief. Moreover, unlike an injunction, a § 705 stay operates on a regulation's effective date rather than directing the "conduct of a party." *See id.* A § 705 stay thus does not risk exposing DHS or its officials to conflicting injunctions issued by different courts.

The prospect that courts may reach different decisions about whether to issue a § 705 stay (Mot. 4, 39) is a feature of Congress's statutory remedies rather than any judicial overreach. The APA authorizes different plaintiffs to challenge the same regulation in different courts, *see* 5 U.S.C. § 703, and each "reviewing court" is authorized to stay a regulation's effective date if circumstances so warrant. When Congress wanted to remove judicial authority to issue a stay under § 705, it knew how to do so. *See, e.g.*, 16 U.S.C. § 1855(f)(1)(A) (§ 705 "not applicable" to judicial review of fishery-management regulations); 15 U.S.C. § 3416(b)

(same for natural gas regulations). The absence of any such limitation here precludes any argument that the district court improperly relied on § 705 to do exactly what Congress authorized—postpone the effective date of the Rule as a whole "pending conclusion of the review proceedings." 5 U.S.C. § 705.

In any event, the district court also properly issued a preliminary injunction without geographic limitation. The "scope of injunctive relief is dictated by the extent of the violation established, not by the geographical" location of plaintiffs. *Califano v. Yamasaki*, 442 U.S. 682, 702 (1979). Here, plaintiffs do not challenge any individual public-charge determination (*see* Mot. 32-36). Rather, plaintiffs claim, and the district court found, that the Rule likely violated the APA—a finding that would require vacatur of the Rule altogether. *See National Mining*, 145 F.3d at 1409-10. The district court's preliminary injunction thus appropriately protects against precisely the harm that plaintiffs ultimately seek to prevent—implementation of an unlawful regulation. *See Madsen v. Women's Health Ctr. Inc.*, 512 U.S. 753, 765 (1994).

Moreover, the district court properly exercised its "sound discretion to consider" both the harms to plaintiffs and "the necessities of the public interest when fashioning injunctive relief." *United States v. Oakland Cannabis Buyers' Coop.*, 532 U.S. 483, 496 (2001) (quotation marks omitted). For example, as the district court found (App. 22a-24a), the preliminary injunction is particularly appropriate here given the immigration context—both because a nationwide scope is necessary to protect plaintiffs and the public from irreparable harms, and in view of the importance of uniformity in the application and enforcement of federal immigration law. An injunction allowing the Rule's disruptive and complicated multifactor system to take effect in some States but not others would likely exacerbate the fear and

confusion about that Rule that is harming plaintiffs, their residents, and the public interest—the very harms that the injunction is meant to prevent. No partial stay is warranted.

CONCLUSION

For the reasons stated above, the Court should deny the motion.

Dated: New York, New York
January 22, 2020

Respectfully submitted,

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ADDENDUM

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

STATE OF NEW YORK, et al., Plaintiffs, v. UNITED STATES DEPARTMENT OF HOMELAND SECURITY, et al., Defendants.	19 Civ. 7777 (GBD) **DECLARATION OF RYAN ALLEN**

Declaration of Ryan Allen

I, **Ryan Allen**, declare pursuant to 28 U.S.C. § 1746 that the following is true and correct:

Background

1. My name is Ryan Allen, and I make this declaration in support of Plaintiffs' Request for a preliminary injunction. I am an Associate Professor of Urban and Regional Planning at the Humphrey School of Public Affairs at the University of Minnesota in Minneapolis, Minnesota. In addition to my role as a faculty member, I am also the Director of Graduate Studies for the Urban and Regional Planning Program at the Humphrey School of Public Affairs.

2. I am a housing and community development researcher with over 12 years of experience as a faculty member. I have conducted substantial research about the experience of immigrants in U.S. housing. I have authored or co-authored over one dozen journal articles and reports about immigrants and housing, including publications in peer-reviewed journals such as *Housing Policy Debate*, *Urban Studies*, *Ethnic and Racial Studies*, and the *Journal of Planning Education and Research*. I have taught graduate courses on immigration, urban planning and

policymaking for over 10 years at the University of Minnesota. I am a faculty affiliate of University of Minnesota Extension, the Minnesota Population Center, and the Department of Sociology, and have served as a visiting scholar at the University of New South Wales in Sydney, Australia. I am frequently invited to give guest lectures on topics related to immigration, housing, economic development, and urban planning, and I serve as a commentator on regional and national media outlets, including National Public Radio and the *Los Angeles Times*.

3. I have a Ph.D. in Urban Studies and a Master's Degree in City Planning, both from the Massachusetts Institute of Technology. Training in both of these degrees emphasizes an interdisciplinary approach, drawing from geography, sociology, economics, political science, and other disciplines, and a mixed-method research approach that incorporates quantitative and qualitative methodologies. Prior to my graduate studies, I was on the staff of the Urban Institute. I have attached my Curriculum Vitae as Exhibit A to this Declaration.

I. Overview and Key Findings

4. The Department of Homeland Security's recently released rule, *Inadmissibility on Public Charge Grounds*, 84 Fed. Reg. 41,292 (August 14, 2019) ("Final Rule"), which directs officials at the Department of Homeland Security (DHS) in U.S. Citizenship and Immigration Services (USCIS) to consider—for the first time—a noncitizen's use or potential use of specified federally subsidized housing programs when determining whether an applicant for legal permanent residency in the United States (a "green card") or an individual applying to enter the United States on certain visas is subject to the "public charge" ground of inadmissibility.

5. The specific federally-subsidized housing programs included in the Final Rule are: Section 8 Housing Choice Voucher Program, Project-Based Section 8 Rental Assistance, and Public Housing (collectively referred to herein as "Federal housing programs").

In addition to Federal housing programs, the Final Rule specifies receipt or potential receipt of SNAP and Medicaid benefits as well as other non-cash benefits that officials should consider when assessing public charge.

6. According to the Final Rule, living in federally subsidized housing and receiving a subsidy in aggregate for more than 12 months during a 36-month period would be considered a heavily-weighted negative factor in determining whether a given applicant for adjustment is a public charge. The Final Rule contains many other features that go beyond the scope of this Declaration.

7. The Final Rule is scheduled to go into effect on October 15, 2019. This declaration describes the following: (1) the Federal housing benefits included in the Final Rule, including supply and demand for these programs, financial eligibility, and immigrant eligibility; (2) the benefits of living in federal housing programs for individuals; and (3) the negative impact the Final Rule will have on noncitizens if it is not enjoined by the Court.

8. It is my opinion that if the Final Rule goes into effect, a certain number of noncitizens who reside in federally-assisted housing will choose to disenroll from the Federal housing programs encompassed by the Final Rule. Using the estimates of disenrollment from DHS (2.5 percent), the result would be substantial harm. As explained herein, given the well-documented positive impact living in federally-assisted housing has on residents, especially children, even a minimal amount of disenrollment can be expected to result in substantial harm. Individuals who disenroll will lose an affordable source of housing and other benefits in the areas of health, educational attainment, and earnings.

II. Background

A. Characteristics of Federal Housing Programs Included in the Final Rule

9. I have been asked by counsel to describe the key features and eligibility criteria of the Federal housing programs included in the Final Rule, including the income households can receive while maintaining eligibility for public housing.

Section 8 Housing Choice Vouchers

10. The Section 8 Housing Choice Voucher Program ("HCV" program) is the largest federally subsidized housing program in the United States, serving approximately 2.5 million households and 5.3 million residents in 2018. First established by the Housing and Community Development Act of 1974, Section 8 Housing Choice Vouchers are used by low-income families to rent housing in the private market. A low-income family that uses a voucher pays 30 percent of its income for rent and utilities (or $50, whichever is larger), and the voucher pays the balance of the rent and utility costs, up to a limit. Local public housing authorities set these limits as a proportion of Fair Market Rents (FMRs), which are adjusted by apartment size and calculated annually by HUD for over 2,600 housing markets across the U.S.[1] FMRs vary considerably in municipalities across the United States and sometimes within municipalities, depending upon rental housing costs in each area.

11. *Initial Eligibility*. To participate in the program, an apartment must be inspected and certified to meet minimum standards related to space and physical quality. In terms of financial eligibility, vouchers tend to be targeted to very needy families, with 75 percent of new families receiving a voucher each year classified as "extremely low income" (generally, household incomes not exceeding 30 percent of the area median income ("AMI") or the federal

[1] Schwartz, Alex F. 2015. *Housing Policy in the United States (Third Edition)*. New York: Routledge.

poverty line, whichever is higher).[2] The balance of new families receiving a voucher must have household incomes no more than 80 percent of the AMI.

Project-Based Section 8 Rental Assistance

12. The Project-Based Section 8 Rental Assistance program ("PBRA") creates multi-year rental assistance agreements with owners of private multi-family properties to make all or some of the units available to low-income families. The PBRA program includes about 1.3 million housing units and approximately 2 million residents nationwide.

13. Similar to the HCV Program, families renting housing in the PBRA program pay 30 percent of their household income (or $25, whichever is greater) each month. A monthly payment to the owner of the building and the PBRA program supplies the balance of the costs associated with maintaining and operating the apartment. In addition, about two-thirds of households living in PBRA housing are headed by seniors (i.e., individuals over age 65) or people with disabilities.

14. *Financial eligibility.* At least 40 percent of units in each building that become vacant are allocated for "extremely low income" families (defined as households earning 30 percent or less of the AMI) and most of the remainder of units are allocated to very low-income families (household incomes of no more than 50 percent of AMI).[3]

Public Housing

15. In contrast to the HCV and PBRA programs described above, public housing is housing that is owned and operated by the federal government under the auspices of local public housing authorities. Families living in public housing contribute 30 percent of their

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[2] "Policy Basics: The Housing Choice Voucher Program." Center on Budget and Policy Priorities, Washington, DC (https://www.cbpp.org/research/housing/policy-basics-the-housing-choice-voucher-program, last accessed on August 21, 2019).
[3] *Ibid.*

income each month toward rent or a minimum rent set by the housing authority. Nationwide the public housing program includes about 1 million units and serves nearly 2 million residents.

16. *Financial eligibility*. At least 40 percent of families newly admitted to the program each year must be "extremely low-income" households, with the balance of households earning no more than 80 percent of the AMI.[4]

Continued eligibility for HCV, PBRA and Public Housing.

17. In order to maintain eligibility for each of the Federal housing benefits, the household's income may not exceed household income limits determined by HUD, generally no greater than 80 percent of the AMI. The below chart lists 50 percent and 80 percent AMI income limits for four-person households in each of the key jurisdictions encompassed by the cases in which I am serving as an expert for fiscal year 2019:

Geographic Area	50% AMI Family Income Limit ($)	80% AMI Family Income Limit ($)
Connecticut	50,450	75,500
New York	41,100	65,750
New York City (Metro Area)	53,350	85,350
Vermont	39,750	63,600

Note: Income limit data are from HUD's FY 2019 Income Limits Documentation System (https://www.huduser.gov/portal/datasets/il/il2019/select_Geography.odn, accessed on September 5, 2019).

18. Note that each of these income limits exceeds 125 percent of the Federal Poverty Guideline for a family four which is $32,187.50. As discussed below, and as these numbers show, many families who use federal housing benefits start out with low income, but

[4] *Ibid.*

having the stability that comes with subsidized rent, they are able to achieve greater economic stability while maintaining eligibility for the Federal housing programs.

B. Volume of Federal Housing Program Units and Demand

19. As Table 1 in Exhibit B describes, in 2018 these programs in aggregate represented 4,827,662 housing units, or 96 percent of the federally subsidized units of housing available in the United States. The supply of these subsidized housing units has shrunk in recent years. In 2015, the available number of housing units in these three programs numbered 4,798,257, about 29,000 more units than in 2018. In addition to representing the vast majority of the federally subsidized housing units, these programs also represent nearly all of the residents living in federally subsidized housing. In 2018, the programs accommodated 9,308,020 individual residents, or about 98 percent of the total residents living in federally subsidized housing units.[5]

20. The current demand for federally subsidized housing units is substantial. Most public housing authorities maintain a wait list for families that are eligible to live in federally subsidized housing, but are unable to move into a unit because none are available. Recent estimates indicate that nationally there are 1.5 families waiting for every Housing Choice Voucher program unit under contract and 1.7 families waiting for every public housing unit.[6]

21. However, these are underestimates because so many public housing authorities ("PHAs") have closed their wait lists. In 2012, about 60 percent of HCV wait lists and 17 percent of public housing wait lists were closed, effectively limiting the number of families that appear on wait lists. If wait lists remained open for all PHAs then presumably the number of

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[5] While there are a variety of other subsidized housing programs operated by HUD, the three programs described above are the largest in terms of number of housing units and number of residents.
[6] Housing Agency Waiting Lists and the Demand for Housing Assistance, 2019. https://www.housingcenter.com/wp-content/uploads/2017/11/waiting-list-spotlight.pdf

eligible families waiting for federally subsidized housing would be significantly larger. After correcting for closed wait lists, nationally there are about 4 families waiting for each HCV unit and 1.8 families for each public housing unit.[7] This translates into a wait of 1.5 years for the median family on the waitlist for HCV and nine months for the median family on the waitlist for public housing.[8] These median values obscure significant variation in wait times, particularly at the high end of the distribution. For example, 25 percent of HCV waitlists had a wait time of 3 years or longer and 25 percent of public housing waitlists had a wait time of 1.5 years or longer.[9]

22. In some cases, waitlists for public housing and HCV are particularly long. For example, counsel has advised me that in New York City the waits can be substantially longer due to low turn-over, high demand, and depending on the type of housing, factors like household size and the availability of the requisite size apartment and other priority factors.

C. Immigrant Eligibility for Federal Public Housing

23. Counsel has advised me that under current law, the following categories of noncitizens are eligible for Federal housing benefits: (a) lawful permanent residents (“LPRs”) (regardless of time in LPR status); (b) refugees; (c) asylees; (d) persons granted parole; (e) persons granted withholding of removal; (f) persons granted 1986 amnesty status (entered U.S. pre-January 1, 1982); (g) lawful U.S. residents under the Compacts of Free Association with Micronesia, the Marshall Islands, Palau, and Guam; (h) certified victims of trafficking; and (i) VAWA self-petitioners (includes VAWA cancellation of removal applicants; VAWA suspension of deportation applicants).

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[7] *Ibid.*

[8] These estimates come from a survey of PHAs in 2015-2016 by the National Low Income Housing Coalition (NLIHC) (https://nlihc.org/sites/default/files/HousingSpotlight_6-1.pdf, last accessed August 21, 2019).

[9] *Ibid.*

24. Noncitizens who do not fall into one of the above categories can live in Federal housing program units, but are required to pay a *pro rata* share of the rent. It is important to note that the income of non-eligible members of families is included in the family income figure used to determine eligibility for living in the housing and the rent that the family owes, despite the fact that non-eligible family members cannot receive a subsidy.

25. A new Rule introduced by HUD for notice and comment on May 10, 2019 (the "Proposed HUD Rule"), would change these rules. Under the proposed new rule, non-eligible noncitizens would not be permitted to remain in HUD-sponsored housing, including public housing, and would not be permitted to live in a household in which HCV or PBRA subsidizes the rent.[10]

26. Noncitizen eligibility for Federal housing programs is limited under current law, but noncitizens have always been present in such programs and have never been categorically excluded by Congress.

27. The United States Housing Act of 1937, sponsored by Representative Henry B. Steagall (D-AL) and Senator Robert F. Wagner (D-NY), created a United States Housing Authority that worked through newly created public housing agencies at the sub-national level to create subsidized rental housing for low-income families. This legislation specified income eligibility criteria, but was silent on other eligibility requirements such as nativity or citizenship. The historical record indicates that many PHAs awarded a substantial number of units to households with noncitizen members. Of the 101,482 residents living in public housing in 1940, a total of 11,174 (11 percent) were foreign born with 8,161 residents

[10] Housing and Community Development Act of 1980: Verification of Eligible Status." Federal Register 84(91), RIN 2501-AD89, Docket No. FR-6124-P-01.

naturalized citizens (8 percent) and 3,013 noncitizens (3 percent).[11] While some local PHAs limited access to public housing to citizens in the early years of the program,[12] Congress passed no legislation that prohibited access to public housing by immigrants regardless of citizenship status.

28. Over the course of the next four decades, Congress modified the public housing program in the United States incrementally in terms of its budget and goals for the number of public housing units it created, while core eligibility features remained consistent. Proposed eligibility requirements for public housing residents changed starting with provisions included in Section 214 of the Housing and Community Development Act of 1980. The next year, Congress proposed wider exclusions for immigrants through a revision of Section 214 in the Omnibus Reconciliation Act of 1981, but the proposed rules for interpreting the regulatory changes were not implemented immediately because Congress did not appropriate funds necessary for implementation and the regulatory changes were challenged by various lawsuits.[13]

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[11] These figures are based on the author's analysis of a unique dataset of all public housing residents in the United States at the time of the 1940 Census. For more information about the dataset, see the following reference: Allen, Ryan and Van Riper, David. Forthcoming. "The New Deal, the Deserving Poor and the First Public Housing Residents in New York City." *Social Science History*. Of the naturalized citizens, it is unclear what percentage began residence in public housing prior to attaining citizenship, but it can be assumed that a number of them did given the noncitizens in public housing in that same year. In comparison, 8.8 percent of the U.S. population was foreign born in 1940 including 5.5 percent naturalized citizens, 2.6 percent noncitizens and 0.6 percent with unreported citizenship status. "1940 Census of Population: Volume 2. Characteristics of the Population." U.S. Census Bureau: Washington, DC. https://www2.census.gov/library/publications/decennial/1940/population-volume-2/33973538v2p1ch2.pdf

[12] Vale, Lawrence J. 2000. *From the Puritans to the Projects: Public Housing and Public Neighbors.* Cambridge, MA: Harvard University Press.

[13] In published notices in the Federal Register, the Department of Housing and Urban Development developed rules for implementation of the new regulations, but failed to specify an effective date for these rules. Dzubow, Jason. 1995. "HUD Shuts the Door: Restrictions on Housing Assistance to Noncitizens." *Georgetown Immigration Law Journal* 9:801-826. Subsequently, Congress barred HUD from implementing the rule and HUD submitted multiple revised versions of the rule to implement the regulations in Section 214 throughout 1986, and delayed implementation of the rule until October 1, 1987.

29. In 1987 Congress amended Section 214 once again to respond to the issues raised in the lawsuits. As amended, Section 214 allowed aliens in federally-subsidized housing who had been temporarily admitted or paroled into the United States as specified in Section 245A of the Immigration and Naturalization Act or who had family members who were ineligible. In the latter case, this provision preserved the integrity of mixed-status families by letting families with some members who are ineligible noncitizens continue to live in subsidized housing. After publishing a rule in 1988 related to this version of Section 214, HUD failed to implement the rule citing a lack of authorization to collect information on citizenship or alien status from residents or applicants to federally subsidized public housing. A final rule to implement Section 214 was published in the Federal Register on March 20, 1995, about 15 years after Congress passed the original restrictions from federally subsidized housing.[14]

Immediate implementation of the rule was delayed for two primary reasons. First, Congress did not allocate to HUD the additional funding required to implement the rule. The failure to allocate the necessary funds is most readily explained by the fact that Congress passed the Immigration Reform and Control Act of 1986 (IRCA), which changed the process used to verify immigrant status. Dzubow, Jason. 1995. "HUD Shuts the Door: Restrictions on Housing Assistance to Noncitizens." *Georgetown Immigration Law Journal* 9:801-826. As a result, it remained unclear what protocols HUD should use to verify immigrant status before Congress issued final guidelines associated with IRCA. Second, a district court in California issued a nation-wide preliminary injunction on implementing the regulation based on arguments made in *Yolano-Donnelly Tenants' Association v. Pierce*. *Yolano-Donnelly Tenants' Association v. Pierce,* E.D. Cal. No. CIV. S-86-846-MLS (1986). In this case the court recognized that implementing the new regulation would result in the eviction of thousands of families currently residing in federally-subsidized housing because either they or some members of their households were ineligible to live in the housing due to a lack of documentation. Dzubow, Jason. 1995. "HUD Shuts the Door: Restrictions on Housing Assistance to Noncitizens." *Georgetown Immigration Law Journal* 9:801-826. The court reasoned that in some cases this would result in the eviction of citizens and properly documented aliens.
An additional lawsuit in 1986, *City of New York v. Pierce*, charged that the regulations would unduly burden the City of New York because it would increase the homeless population and the administrative burden experienced by the City. *City of New York v. Pierce,* 86-CIV-6068, U.S. District Court, Southern District of New York (1986). Together these lawsuits resulted in delayed implementation of the original restrictions to federally subsidized housing for certain groups of immigrants contemplated and enacted by Congress.

[14] Dzubow, Jason. 1995. "HUD Shuts the Door: Restrictions on Housing Assistance to Noncitizens." *Georgetown Immigration Law Journal* 9:801-826.

30. Although the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 called for widespread changes to the eligibility criteria and structure of many parts of the U.S. welfare system, it ultimately did not have a meaningful impact on Federal housing programs.[15] Battered qualified aliens were only recognized as eligible for public housing in 2016.[16]

31. HUD anticipates that the Proposed HUD Rule, if implemented, would have a large impact on the number of noncitizens residing in Federal housing programs. HUD's Regulatory Impact Analysis estimates that 25,045 households living in federally subsidized housing would be affected by this rule change, including a total of 108,104 people.[17] HUD believes that over three-quarters of the households that would be affected by this rule change will terminate housing assistance, with the remaining households splitting apart so that members of the household eligible to receive a subsidy remain in assisted housing. Overall, HUD estimates that 76,141 of the 108,104 individuals living in households that would be affected by this proposed rule change are eligible to receive federal housing subsidies. It is difficult to determine the likely degree of overlap between the households that HUD has estimated would be affected by the Proposed HUD Rule change and the households that may be affected by the Final Rule, but it is safe to assume that there will be at least some overlap given the focus on noncitizens by each rule change. Despite this potential for overlap, in the discussion below regarding the likely

[15] P.L. 104-193 §431(c) (1) (A); 8 U.S.C. §1641, as cited in McCarty, Maggie and Siskin, Alison. 2015. "Immigration: Noncitizen Eligibility for Needs-Based Housing Programs." Congressional Research Service, RL31753.

[16] https://nlihc.org/sites/default/files/Eligibility-of-VAWA-Self-Petitioners_121416.pdf (accessed on September 5, 2019).

[17] "Housing and Community Development Act of 1980: Verification of Eligible Status, Regulatory Impact Analysis." Docket No. FR-6124-P-01, April 15, 2019.

effect of the Final Rule on households with foreign-born members, I do not attempt to capture any of the effects associated with the Proposed HUD Rule.

D. Characteristics of Households Living in Federally Subsidized Housing

32. Table 1 in Exhibit B describes some basic descriptive information about residents living in public housing, the Housing Choice Voucher Program, Project-Based Section 8 developments, and all HUD programs in 2018 in the U.S., Connecticut, New York, Vermont, and New York City. While households earning less than 80 percent of the AMI are eligible for living in public housing or Project Based Section 8 units, or using a Housing Choice Voucher, the majority of households in these programs are classified as very low-income (earning less than 50 percent of AMI). In 2018, 96 percent of households living in Project Based Section 8 units earned less than 50 percent of the AMI in the United States. In the Section 8 Housing Choice Voucher program and public housing 95 percent and 91 percent of households earned less than 50 percent of the AMI in the United States in 2018, respectively. Given the geographical variation in the AMI as described above, even families with income less than 50 percent of the AMI, do not necessarily have income below 125 percent of the FPG.

33. Compared to public housing and the Housing Choice Voucher program, the Project Based Section 8 program tends to have smaller family sizes living in its units. Nationally, the average size of a family in Project Based Section 8 in 2018 was 1.7 people, compared to 2.1 in public housing and 2.3 in Housing Choice Vouchers.

34. I do not have data on the length of stay in Federal housing programs among noncitizens, and they may vary considerably from the length of stay statistics for tenants generally. Nationally, households living in a federally subsidized housing unit typically do not remain in these units for an extended period of time. Based on the most current and comprehensive analysis available using HUD administrative data on exits from assisted

housing,[18] average households living in federally subsidized housing leave assisted housing after about six years.[19] Differences in length of stay in federally subsidized housing by household type can be substantial. For example, in New York City, given the demand for public housing and lack of availability of affordable housing, the low vacancy rate, and the relatively high income a household can have and maintain eligibility, families stay in public housing much longer. Another estimate of length of stays in public housing uses longitudinal data from the Panel Survey of Income Dynamics (1987-2011) and found that most individuals who entered public housing stayed less than five years, with only 12 percent staying longer than 10 years.[20] This evidence suggests that federally-assisted housing serves as a temporary source of support for most families that use it, but that there can be exceptions in housing markets characterized by high rents and low vacancy rates.

[18] In this case, "assisted housing" is a general term that includes the three largest federally subsidized housing programs specified in the Final Rule, plus several smaller programs not included in the Final Rule.
[19] McClure, Kirk. 2018. "Length of Stay in Assisted Housing." *Cityscape* 20(1): 11-38. (https://www.jstor.org/stable/10.2307/26381219)
[20] Dantzler, Prentiss A. 2019. "Reconsidering Poverty Dynamics by Analyzing Housing Spells." *The Social Science Journal* (In Press, https://doi.org/10.1016/j.soscij.2019.06.004).

III. Benefits of Living in Federally Subsidized Housing

35. In connection with preparing this declaration, I have undertaken a review of research conducted regarding the positive impacts of living in housing subsidized by the Federal housing programs that are included in the Final Rule because the benefits, in turn, speak to the harm caused to noncitizen families who lose access to Federal housing programs because of the Final Rule.

36. Research on residents living in federally-assisted housing shows that residing in such housing is associated with positive health and economic outcomes.[21] Living in public housing has positive associations with (a) better health outcomes, (b) educational attainment, (c) employment earnings, and (d) other benefits.

37. *Health outcomes.* A number of studies have found a positive association between living in assisted housing and positive health outcomes for children and adults. Relative to children in families on a waitlist for federally-assisted housing and controlling for neighborhood context, children in families living in public housing have fewer symptoms of mental health stress and experience fewer emotional difficulties.[22] Similarly, relative to adults in families on a waitlist for federally-assisted housing and after controlling for neighborhood-level characteristics, adults in families in public housing had lower odds of being in fair or poor health

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[21] It is important to note that the most methodologically sound research on outcomes associated with living in Federal housing program appropriately controls for the selection bias inherent to applying for and obtaining a unit of assisted housing. Selection criteria for admission to Federal housing programs mean that families are low income, a characteristic that has an independent relationship with educational, employment, health, and other outcomes. It is important to distinguish the relationship between living in housing supplied by a Federal housing program with these outcomes and the relationship between living in a poor family and these outcomes.

[22] Fénelon, Andrew, Slopen, Natalie, Boudreaux, Michel, and Newman, Sandra J. 2018. "The Impact of Housing Assistance on the Mental Health of Children in the United States." *Journal of Health and Social Behavior* 59(3): 447-463.

and lower odds of psychological distress.[23] Children living in assisted housing have lower Blood Lead Levels (BLLs) than children who did not receive housing assistance.[24] Many residents of public housing have poor health, but frequently health problems exist for residents prior to becoming residents of public housing. For example, in a study of Atlanta public housing residents 19 percent were diagnosed with diabetes and 23 percent were diagnosed with asthma, but of those diagnosed with these health problems at least three-quarters received the diagnosis prior to entering public housing.[25] In general, research indicates that public housing tends to provide a safety net for residents that had existing health problems when they arrived in assisted-housing rather than cause these health problems.[26]

38. *Educational achievement.* Much of the available evidence suggests that children living in federally-assisted housing experience comparable or better educational achievement than children who do not live in federally-assisted housing. Children living in public housing are less likely to be held back a grade than those not living in public housing[27] and those living in voucher-assisted housing experience better math achievement.[28] Research that compares educational outcomes for children living in public housing and voucher-assisted

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[23] Fenelon, Andrew, Mayne, Patrick, Simon, Alan E., Rossen, Lauren M., Helms, Veronica, Lloyd, Patricia, Sperling, Jon, and Steffen, Barry L. 2017. "Housing Assistance Programs and Adult Health in the United States." *American Journal of Public Health* 107(4): 571-578.

[24] Ahrens, Katherine A., Haley, Barbara A., Rossen, Lauren M., Lloyd, Patricia C., and Aoki, Yutaka. 2016. "Housing Assistance and Blood Lead Levels: Children in the United States." *American Journal of Public Health* 106(11): 2049-2056; Chiofalo, Jacqueline M., Golub, Maxine, Crump, Casey, and Calman, Neil. 2019. "Pediatric Blood Lead Levels Within New York City Public Versus Private Housing, 2003-2017." *American Journal of Public Health* 109(6): 906-911.

[25] Ruel, Erin, Oakley, Deirdre, Wilson, G. Elton, and Maddox, Robert. 2010. "Is Public Housing the Cause of Poor Health or a Safety Net for the Unhealthy Poor?" *Journal of Urban Health* 87(5): 827-838.

[26] *Ibid.*

[27] Currie, Janet and Yelowitz, Aaron. 2000. "Are Public Housing Project Good for Kids?" *Journal of Public Economics* 75:99-124.

[28] Carlson, Deven, Miller, Hannah, Haveman, Robert, Kang, Sohyun, Schmidt, Alex, and Wolfe, Barbara. 2019. "The Effect of Housing Assistance on Student Achievement: Evidence from Wisconsin." *Journal of Housing Economics* 44(1): 61-73.

housing finds no differences in educational outcomes, suggesting that these housing programs have indistinguishable effects on educational outcomes.[29]

39. *Employment outcomes and earnings.* A variety of research indicates that living in federally-assisted housing either has no effect or improves employment outcomes and earnings. Despite the frequent location of federally-assisted housing in neighborhoods with high rates of poverty, which might be associated with reduced labor force activity, analysis of employment outcomes in the Multi-City Study of Urban Inequality (MSCUI) found no relationship between living in public housing and labor force activity.[30] However, in a study that focused on the effects of living in public housing for a time between 1968 and 1982 on outcomes for young adults, researchers found that every year of residence in public housing between the ages of 10 and 16 increased the probability of working by seven percentage points when the youth was between the ages of 25 through 27.[31] The result of this increased chance of employment increased annual earnings by $1,860.[32]

40. Based on a particularly strong longitudinal research design that compares the earnings of siblings from around the United States who lived in public housing for different lengths of time, the most recent study focused on the relationship between living in federally-assisted housing and earnings found that living in assisted housing as a teenager has a positive association with higher earnings and lower rates of incarceration as an adult. Females receive

[29] Jacob, Brian A. 2004. "Public Housing, Housing Vouchers, and Student Achievement: Evidence from Public Housing Demolitions in Chicago." *American Economic Review* 94(1): 233-258.
[30] Reingold, David A., Van Ryzin, Gregg G., and Ronda, Michelle. 2001. "Does Urban Public Housing Diminish the Social Capital and Labor Force Activity of Its Tenants?" *Journal of Policy Analysis and Management* 20(3): 485-504.
[31] Newman, Sandra J. and Harkness, Joseph M. 2002. "The Long-Term Effects of Public Housing on Self-Sufficiency." *Journal of Policy Analysis and Management* 21(1): 21-43.
[32] *Ibid.*

about a five percent increase in earnings for each additional year in either public housing or voucher housing, while males receive about a five percent increase in earnings for each additional year in public housing and a 2.6 percent increase in earnings for each additional year in voucher housing.[33] Each additional year of living in public housing as a teenager increased estimated total discounted lifetime pre-tax earnings by $45,400 for females and $47,300 for males.[34] For each additional year of living in voucher-assisted housing as a teenager, the estimated total discounted lifetime pre-tax earnings increased by $43,600 for females and $24,100 for males.[35] Based on assumptions about increased tax revenues due to the increased estimated total discounted lifetime pre-tax earnings attributable to living in assisted housing and the cost to the federal government of providing a subsidy for assisted housing, the study concludes that providing public housing and voucher programs are nearly cost-neutral.[36] It is important to point out that the study likely underestimates the benefit of federally-assisted housing because it only estimates the intergenerational financial benefit to the federal government from providing assisted housing to poor families. With increased lifetime earnings, individuals who lived in assisted-housing as teenagers will probably be less likely to use welfare benefits as adults.[37]

[33] Andersson, Fredrik, Haltiwanger, John C., Kutzbach, Mark J., Palloni, Giordano E., Pollakowski, Henry O., and Weinberg, Daniel H. 2018. "Childhood Housing and Adult Earnings: A Between-Siblings Analysis of Housing Vouchers and Public Housing." NBER Working Paper Series, Working Paper 22721 (https://www.nber.org/papers/w22721).
[34] *Ibid.*
[35] *Ibid.*
[36] *Ibid.*
[37] One concern registered about Federal housing programs is that using assisted housing discourages employment and encourages dependence on government benefits. A review of the available early scholarship on the relationship between living in assisted housing and employment found no relationship between the two. Shroder, Mark. 2002. "Does Housing Assistance Perversely Affect Self-Sufficiency? A Review Essay." *Journal of Housing Economics* 11(4): 381-417. A more recent study found a small suppressive effect of using a voucher on labor supply and earnings, though this study is limited to public housing residents in Chicago raising questions about its external validity. Jacob, Brian A. and Ludwig,

41. *Other benefits.* Emerging evidence indicates that children growing up in assisted housing have relatively small chances of returning to assisted housing as adults[38] and living in public housing has no effect on teenage parenthood for females and may decrease the probability of teenage parenthood for males.[39] For families receiving housing assistance as well as cash assistance ("welfare") benefits, receiving federal housing assistance does not appear to have a positive relationship with remaining on welfare[40] and there is some evidence that living in public housing as a child reduces welfare use as an adult by 0.70 of a year.[41] More recent research indicates that welfare use among families living in assisted housing declined after moving into assisted housing, although the rate of welfare use still exceeded that of families not living in assisted housing.[42]

42. At least two causal mechanisms could explain the relationship between living in assisted housing and better health outcomes, educational achievement and increased employment and earnings.

Jens. 2012. "The Effects of Housing Assistance on Labor Supply: Evidence from a Voucher Lottery." *American Economic Review* 102(1): 272-304. Analysis of the Panel Study of Income Dynamics, which included assisted housing residents from across the U.S., found no evidence that moving into assisted housing was associated with sustained reductions in employment, work hours, or earnings. Newman, Sandra, Holupka, C. Scott, and Harkness, Joseph. 2009. "The Long-Term Effects of Housing Assistance on Work and Welfare." *Journal of Policy Analysis and Management* 28(1): 81-101.

[38] Kucheva, Yana A. 2014. "The Receipt of Subsidized Housing across Generations." *Population Research and Policy Review* 33(6): 841-871.

[39] *Ibid.*

[40] Haley, Barbara A. and Dajani, Aref N. 2015. "Addicted to Government? The Impact of Housing Assistance on Program Participation of Welfare Recipients." *Poverty and Public Policy* 7(4): 307-335.

[41] Newman, Sandra J. and Harkness, Joseph M. 2002. "The Long-Term Effects of Public Housing on Self-Sufficiency." *Journal of Policy Analysis and Management* 21(1): 21-43.

[42] *Ibid.*

43. *First*, evidence suggests that families living in voucher-supported housing are less prone to moving[43] and have more stable household compositions.[44] Moving, particularly when it is precipitated by economic necessity or stress, is associated with increased anxiety and depression.[45] Other measures of housing insecurity, such as doubling up, overcrowding, and frequent moves, are associated with poor health outcomes for children, including food insecurity, lower weight, and developmental risk.[46] Women experiencing eviction, a particularly dramatic form of housing insecurity, experienced difficulty obtaining necessities and were more likely to experience depression, poor health outcomes and parenting stress.[47] Finally, frequent moves that include a change in schools for children are associated with poor education outcomes for children.[48] Increased residential stability that accompanies living in assisted housing may promote better health and educational outcomes for children, and improved mental and physical health for adults, eventually leading to better economic outcomes.

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[43] Berger, Lawrence M., Heintze, Theresa, Naidich, Wendy B., and Meyers, Marcia K. 2008. "Subsidized Housing and Household Hardship among Low-Income Single-Mother Households." *Journal of Marriage and the Family* 70:934-949; Gubits, Danile et al. 2016. "Family Options Study: 3-Year Impacts of Housing and Services Interventions for Homeless Families." Office of Policy Development and Research: U.S. Department of Housing and Urban Development.

[44] Carlson, Deven, Haveman, Robert, Kaplan, Thomas, and Wolfe, Barbara. 2012. "Long-Term Effects of Public Low-Income Housing Vouchers on Neighborhood Quality and Household Composition." *Journal of Housing Economics* 21(2): 101-120.

[45] Burgard, Sarah A., Kristin S. Seefeldt, and Sarah Zelner. 2012. "Housing Instability and Health: Findings from the Michigan Recession and Recovery Study." *Social Science & Medicine* 75(12):2215–24.

[46] Cutts, Diana Becker, Alan F. Meyers, Maureen M. Black, Patrick H. Casey, Mariana Chilton, John T. Cook, Joni Geppert, Stephanie Ettinger de Cuba, Timothy Heeren, and Sharon Coleman. 2011. "US Housing Insecurity and the Health of Very Young Children." *American Journal of Public Health* 101(8):1508–14.

[47] Desmond, Matthew, and Rachel Tolbert Kimbro. 2015. "Eviction's Fallout: Housing, Hardship, and Health." *Social Forces* 94(1):295–324.

[48] Crowley, Sheila. 2003. "The Affordable Housing Crisis: Residential Mobility of Poor Families and School Mobility of Poor Children." *The Journal of Negro Education* 72(1): 22-38.

44. *Second*, living in assisted housing is associated with decreased housing cost burden, allowing households to spend a larger proportion of their household incomes on other household expenses that may lead to improved educational, health and economic outcomes. For example, a family spending around 30 percent of its income on housing is associated with increased investment in enrichment activities for children, leading to higher cognitive outcomes.[49] Similarly, living in assisted housing is associated with less material hardship, including food insecurity, residential overcrowding, and postponed healthcare investments, resulting in better health and behavioral outcomes for children.[50] In turn, these outcomes are related to improved educational outcomes, which lead to better employment and earnings outcomes.

IV. The Effect of the Final Rule on Immigrant Use of Assisted Housing

45. The Final Rule requires immigration officials at DHS to determine whether applicants for adjustment of status not exempt from public charge are currently enrolled in a Federal housing program that supplies them with a housing subsidy or whether they are likely to be enrolled in such a program and receive a subsidy at any point in the future.[51] Accordingly, of those persons currently eligible to adjust, or who will be eligible in the future, the Final Rule will likely have a greater impact on those noncitizens predicted to be likely to receive Federal housing benefits at any time in the future than those who are currently receiving Federal housing benefits and who are applying for adjustment. The reasoning behind this

[49] Newman, Sandra J. and Holupka, C. Scott. 2015. "Housing Affordability and Child Well-Being." *Housing Policy Debate* 25(1): 116-151.
[50] Harkness, Joseph and Newman, Sandra J. 2005. "Housing Affordability and Children's Well-Being: Evidence from the National Survey of America's Families." *Housing Policy Debate* 16(2): 223-255.
[51] There are only a few categories of noncitizens eligible for Federal housing programs who are subject to public charge review at the time of adjustment – specifically, citizens of Micronesia, Marshall Islands. Palau and Guam, persons granted withholding of removal and parolees.

assertion is that given supply limitations in Federal housing programs there are many more noncitizens living in families that are eligible for Federal housing programs than there are noncitizens in families that are currently living in housing that is part of a Federal housing program.

46. Counsel has asked me for purposes of this declaration to base my projections of harm on the numbers provided by DHS in the Regulatory Impact Analysis ("RIA") accompanying the Final Rule.[52] I reserve the right to provide additional analyses using different assumptions at a later date.

47. DHS estimates that 8,801 households will disenroll from public housing, the Section 8 Housing Choice Voucher Program, or the Project Based Section 8 Rental Assistance Program. DHS arrives at this number using the fact that 6.97 percent of the U.S. population is a foreign-born noncitizen (based on the 2012-2016 American Community Survey (ACS) 5-year Estimates from the U.S. Census Bureau). DHS multiplies this percentage by 5,051,000, the number of households residing in federally subsidized housing, to arrive at 352,055 as the number of households residing in federally-subsidized housing that contain at least one noncitizen. DHS further assumes that noncitizens that adjust their visa status and trigger a public charge review and determination by immigration officials at USCIS will be affected by the Final Rule. They estimate that approximately 2.5 percent of the foreign-born adjust their status on an annual basis. To determine the number of households that are likely to disenroll, DHS multiplies 2.5 percent and 352,055 households with at least one noncitizen to arrive at a figure of 8,801. They do not estimate the number or citizenship status of people living

[52] "Regulatory Impact Analysis," Inadmissibility on Public Charge Grounds, Final Rule (8 CFR Parts 103, 212, 213, 214, 245, and 248), RIN: 1615-AA22, CIS No. 2637-19, DHS Docket No.: USCIS-2010-0012, August 2019.

in these families, nor do they attempt to estimate the costs or harm that disenrollment will create for these families or individuals.

48. As discussed below, the harm caused by 8,801 households disenrolling from federally-assisted housing benefits is substantial. There are multiple reasons to assume that the actual harm is likely to be greater and to view the 8,801 estimate as very conservative.

49. *First*, the Final Rule indicates that immigration officials will assess the use of benefits over a three year period when determining whether an immigrant should be designated a public charge. Using the logic DHS describes —that is, 2.5 percent of people will disenroll annually—it would be more appropriate to assume 7.5 percent of foreign born noncitizens would disenroll from a benefit at some point in a given three-year period. This would effectively triple DHS's estimate of households that would disenroll from public housing and more closely match the estimate produced by HUD of the number of households living in federally subsidized housing that include at least one non-eligible immigrant (about 25,000).[53]

50. *Second*, DHS's use of the 6.97 percent of the foreign born population to estimate the number of noncitizen households residing in federally subsidized housing is likely to result in an underestimation of the households containing at least one noncitizen residing therein and consequently the number of individuals and households affected by the Final Rule. Using this figure to produce the estimates involves two faulty assumptions. The first mistake is to assume that the distribution of noncitizens in the U.S. population matches the distribution of noncitizens enrolled for or using one of the non-cash benefits named in the Final Rule (SNAP, Medicaid, and Federal housing programs). According to 2017 ACS data, 35 percent of households that contain at least one foreign born member are headed by noncitizens. Among

[53] "Housing and Community Development Act of 1980: Verification of Eligible Status, Regulatory Impact Analysis." Docket No. FR-6124-P-01, April 15, 2019.

households eligible to live in federally-assisted housing, 46 percent of households that contain at least one foreign born member are headed by noncitizens. Being eligible to live in public housing is different than actually living in public housing, but the larger proportion of noncitizens in the eligible pool suggests that DHS underestimates the households with at least one noncitizen in its analysis. The second mistake is to assume that the 6.97 percent of the population who are noncitizens are the only residents that will disenroll due to the Final Rule. Evidence suggests that noncitizens are not alone in changing their behavior because of the Final Rule. A report by researchers at the Urban Institute indicates that noncitizen legal permanent residents and naturalized citizens withdrew from public benefits named in the Final Rule or declared that they would not apply, despite the fact that their immigration status would not be affected by the Final Rule.[54]

51. These flaws in the methodology used by DHS to estimate the chilling effect on foreign-born resident use of federally subsidized housing due to the Final Rule suggest a significant underestimate by DHS of the chilling effect related to the Final Rule.

52. Although I adopt DHS's definition of the chilling effect as a dynamic that causes disenrollment for the purposes of this declaration, other studies have noted that the Final Rule is also likely to cause noncitizens to refrain from applying for benefits implicated by the Final Rule.[55] DHS does not estimate the number of people who would not apply to Federal

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[54] Bernstein, Hamutal, Gonzalez, Dulce, Karpman, Michael, and Zuckerman, Stephen. 2019. "One in Seven Adults in Immigrant Families Reported Avoiding Public Benefit Programs in 2018." Washington, DC: The Urban Institute. (https://www.urban.org/research/publication/one-seven-adults-immigrant-families-reported-avoiding-public-benefit-programs-2018, accessed on August 28, 2019).

[55] Based on research results from a study by the Urban Institute that documented adults living in households with at least one foreign-born member reporting disenrolling from or choosing to not apply to federal benefit programs named in the Final Rule, individuals eligible for Federal housing programs by virtue of their family incomes will likely choose to not apply to Federal housing programs due to concerns about how the Final Rule could affect their immigration status or the immigration status of a

housing programs due to the Final Rule. Nonetheless, the omission of such an estimate from DHS's analysis is another reason the agency's estimates should be viewed as conservative. In future analyses of the chilling effect I may elect to calculate a different chilling effect, using different data and a different methodology.

53. Using the DHS calculation of 8,801 households that would disenroll from Federal housing programs due to Final Rule, I can quantify some of the categories of harm, beyond the immediate harm to the individuals forced to move from their homes after disenrolling.

54. ***Loss of lifetime earnings***. Given the benefits associated with living in federal housing, discussed above in Part III, the chilling effect associated with the Final Rule will be costly for the people who, absent the implementation of the Final Rule, would have continued to live in federal housing. Recent research estimates a substantial increase in life-time earnings for each additional year that a teenager lives in either public housing or voucher-assisted housing.[56] While there are also benefits for young children and adults who live in federal housing, the estimates of increased lifetime earnings for teenagers allow me to make a conservative estimate of the future harm that will occur for people that disenroll from Federal housing programs because of the chilling effect of the Final Rule.

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family member. Bernstein, Hamutal, Gonzalez, Dulce, Karpman, Michael, and Zuckerman, Stephen. 2019. "One in Seven Adults in Immigrant Families Reported Avoiding Public Benefit Programs in 2018." Washington, DC: The Urban Institute. (https://www.urban.org/research/publication/one-seven-adults-immigrant-families-reported-avoiding-public-benefit-programs-2018, accessed on August 28, 2019).

[56] Andersson, Fredrik, Haltiwanger, John C., Kutzbach, Mark J., Palloni, Giordano E., Pollakowski, Henry O., and Weinberg, Daniel H. 2018. "Childhood Housing and Adult Earnings: A Between-Siblings Analysis of Housing Vouchers and Public Housing." NBER Working Paper Series, Working Paper 22721 (https://www.nber.org/papers/w22721).

55. The increased lifetime earnings (discounted to 2000 U.S. dollars) for each additional year that a teenager (aged 13-18) lives in public housing is $24,700 for females and $25,700 for males, or an average of $25,200.[57] The increased lifetime earnings (discounted to 2000 U.S. dollars) for each additional year that a teenager lives in voucher-housing is $23,700 for females and $13,100 for males, or an average of $18,400.[58] According to Table 1 in Exhibit B, public housing and Project-Based Section 8 housing units together accounted for about 47.6 percent of federal housing units, while vouchers accounted for 52.4 percent of federal housing units.[59] Using these proportions, a weighted average of the life-time earnings for each additional year that a teenager lives in federal housing is $21,637. The lifetime earnings figures in this paragraph are discounted to present value.

56. Given that families with children live in public housing for an average of four years,[60] I assume that teenagers who are 13 and 14 live in federal housing for four years before moving out. For teenagers aged 15, 16, 17, and 18, I assume that they live in federal housing for 4, 3, 2, and 1 years respectively. Given variation in length of stay in Federal housing programs by jurisdiction, using this approach will likely underestimate the number of years that teenagers between the ages of 13 and 14 stay in housing in New York and especially the high rent, low vacancy market of New York City. As a result, this approach will likely underestimate the lifetime earnings that these teens could expect to earn if they had not disenrolled from Federal housing programs.

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[57] *Ibid.*
[58] *Ibid.*
[59] I assume that Project-Based Section 8 are more similar to public housing than they are to HCVs, so I treat them as public housing units for the purposes of understanding what effect living in a Project-Based Section 8 unit will have on a teenagers life-time earnings.
[60] McClure, Kirk. 2018. "Length of Stay in Assisted Housing." *Cityscape* 20(1): 11-38. (https://www.jstor.org/stable/10.2307/26381219).

57. Estimating the lifetime earnings that do not accrue to teenagers because they are chilled from living in federal housing due to the Final Rule is a simple matter of arithmetic: ((number of 13-year olds chilled from federal housing x 4 years x $21,637) + (number of 14-year olds chilled from federal housing x 4 years x $21,637) + (number of 15-year olds chilled from federal housing x 4 years x $21,637) + (number of 16-year olds chilled from federal housing x 3 years x $21,637) + (number of 17-year olds chilled from federal housing x 2 years x $21,637) + (number of 18-year olds chilled from federal housing x 1 year x $21,637)) = foregone lifetime earnings.

58. To estimate foregone lifetime earnings it is necessary to calculate the number of people living in the 8,801 families that DHS estimates will disenroll from Federal housing programs if the Final Rule is implemented. To produce this estimate, I use the ACS 50 percent of AMI sample to calculate the average family size of families eligible to live in Federal housing programs. ACS data indicate that 18,352,744 people in the United States live in 6,400,436 families that contain at least one foreign-born member and earn less than 50 percent of AMI.[61] Therefore, the average family size among this population in the United States is 2.87 (18,352,744 / 6,400,436 = 2.867). Using this average family size estimate for the U.S., the 8,801 families estimated to disenroll from Federal housing programs by DHS contain 25,232 people (8,801 x 2.87 = 25,232).

59. To estimate foregone earnings for the people included in the national estimate from DHS I need to calculate the number of people aged 13 to 18 in the estimated

[61] The population estimate comes from Table 2 in Exhibit B. The number of families is based on the author's analysis of 2017 ACS and HUD determined family income limits based on 50 percent AMI. Steven Ruggles, Sarah Flood, Ronald Goeken, Josiah Grover, Erin Meyer, Jose Pacas and Matthew Sobek. IPUMS USA: Version 9.0 [dataset]. Minneapolis, MN: IPUMS, 2019. https://doi.org/10.18128/D010.V9.0.

chilled population of 25,232 people. To achieve this I use the ACS 50 percent AMI data on the distribution of teenagers in the eligible population in Table 3 in Exhibit B. I divide the number of 13 through 18 year olds in this population by the total population amount to calculate the proportion of the total population that is each age. Next I multiply the proportion of each age group by the chilled population estimated by DHS (25,232) to determine the number of people for each age in the population. I present these results in Table 4 in Exhibit B.

60. Once I have estimated the number of teenagers in this population it is a simple matter of arithmetic to estimate the total foregone earnings among teenagers that DHS estimates would disenroll from Federal housing programs ((number of 13 year olds x 4 years x $21,637) + …+ (number of 18 year olds x 1 year x $21,637)). For the United States, the foregone earnings total $183,569,800.

61. As stated earlier, it is also important to note that DHS estimates of the number of people subject to a chilling effect are likely to be an underestimate. The Urban Institute's report indicates that nearly 20 percent of adults living in low income families reported disenrolling from or choosing to not apply to federal non-cash benefits named in the Final Rule (compared to 13.7 percent in the overall sample).[62] Since families living in Federal housing programs are low income, they may disenroll at greater rates than the 2.5 rate DHS estimates.

62. With these limitations in mind, the analysis of the chilling effect presented in this declaration has erred on the side of caution by using conservative estimates of the chilling effect. I also confine my estimates of the foregone earnings to teenagers disenrolling from Federal housing programs due to the Final Rule despite the fact that the benefits of public

[62] Bernstein, Hamutal, Gonzalez, Dulce, Karpman, Michael, and Zuckerman, Stephen. 2019. "One in Seven Adults in Immigrant Families Reported Avoiding Public Benefit Programs in 2018." Washington, DC: The Urban Institute. (https://www.urban.org/research/publication/one-seven-adults-immigrant-families-reported-avoiding-public-benefit-programs-2018, accessed on August 28, 2019).

housing for young children and adults are substantial and their disenrollment will presumably cause them harm as well.

63. In this declaration I come to the conclusion that implementation of the Final Rule will result in harm to families that disenroll from Federal housing programs because they fear that remaining in these programs will affect their immigration status or the immigration status of a family member. Because living in Federal housing programs confers substantial benefits to residents, disenrolling will cause these individuals to experience substantial costs, including worse educational outcomes, lower earnings, and poorer health. Using the DHS estimate of chilling effect, I estimate that the foregone lifetime earnings of the teenagers who would disenroll due to the Final Rule would be $183,569,800.

I declare under penalty of perjury that the foregoing is true and correct.

Executed on this 9th day of September, 2019.

Ryan Allen

EXHIBIT B

Table 1: Characteristics of Federally Subsidized Housing Programs

	Public Housing	Housing Choice Vouchers	Project Based Section 8	Summary of All HUD Programs
United States				
Subsidized units available	1,015,505	2,527,803	1,284,354	5,035,824
Total number of residents	1,985,172	5,259,207	2,063,641	9,535,360
People per unit	2.1	2.3	1.7	2.1
Household income per year (mean)	$ 15,183	$ 14,863	$ 12,863	$ 14,347
% very low income (< 50% AMI)	91	95	96	94
Connecticut				
Subsidized units available	14,104	42,329	23,731	82,830
Total number of residents	25,824	87,246	36,173	152,497
People per unit	2.0	2.3	1.6	2.0
Household income per year (mean)	$ 15,986	$ 16,722	$ 15,172	$ 16,090
% very low income (< 50% AMI)	96	96	99	97
New York				
Subsidized units available	200,076	258,322	107,384	592,467
Total number of residents	408,772	526,365	169,931	1,134,562
People per unit	2.2	2.3	1.7	2.1
Household income per year (mean)	$ 22,550	$ 17,318	$ 17,260	$ 19,046
% very low income (< 50% AMI)	87	95	94	92
Vermont				
Subsidized units available	1,291	7,756	3,392	12,866
Total number of residents	2,035	13,589	4,851	20,911
People per unit	1.7	2.0	1.5	1.8
Household income per year (mean)	$ 16,722	$ 15,431	$ 15,624	$ 15,579
% very low income (< 50% AMI)	93	95	93	95
New York City				
Subsidized units available	170,039	146,134	62,785	393,993
Total number of residents	357,293	292,078	106,883	773,577
People per unit	2.2	2.3	1.8	2.1
Household income per year (mean)	$ 23,534	$ 17,830	$ 18,658	$ 20,388
% very low income (< 50% AMI)	87	95	92	91

Note: Picture of Subsidized Housing (POSH), Department of Housing and Community Development, 2018 (https://www.huduser.gov/portal/datasets/assthsg.html).

Table 2: People Living in Households with a Foreign-Born Person, Eligible to Live in Federal Housing (50% AMI), 2017

	Estimate	Lower Bound	Upper Bound
Native-Born Citizen	**7,464,412**	7,334,584	7,594,240
Foreign-Born Naturalized Citizen	**4,409,184**	4,346,268	4,472,100
Foreign-Born Non-Citizen	**6,479,148**	6,371,779	6,586,517
Total	**18,352,744**	18,143,312	18,562,176

Note: Based on author's analysis of 2017 ACS and HUD determined family income limits based on 50% area median incomes. Steven Ruggles, Sarah Flood, Ronald Goeken, Josiah Grover, Erin Meyer, Jose Pacas and Matthew Sobek. IPUMS USA: Version 9.0 [dataset]. Minneapolis, MN: IPUMS, 2019. https://doi.org/10.18128/D010.V9.0

Table 3: Number and Percent of People Aged 13 to 18 Eligible to Live in Federal Housing Programs (50 Percent AMI), 2017

	Number	Lower Bound	Upper Bound	**Percent**	Lower Bound	Upper Bound
Age 13	**368,873**	352,100	385,646	**2.0%**	1.9%	2.1%
Age 14	**366,068**	349,473	382,663	**2.0%**	1.9%	2.1%
Age 15	**330,126**	314,863	345,389	**1.8%**	1.7%	1.9%
Age 16	**337,771**	322,407	353,135	**1.8%**	1.8%	1.9%
Age 17	**312,068**	297188.3817	326947.618	**1.7%**	1.6%	1.8%
Age 18	**273,140**	258454.8185	287825.181	**1.5%**	1.4%	1.6%
Total	**1,988,046**	1940189.006	2035902.99	**10.8%**	10.7%	11.0%

Note: Based on author's analysis of 2017 ACS and HUD determined family income limits based on 50% area median incomes. Steven Ruggles, Sarah Flood, Ronald Goeken, Josiah Grover, Erin Meyer, Jose Pacas and Matthew Sobek. IPUMS USA: Version 9.0 [dataset]. Minneapolis, MN: IPUMS, 2019. https://doi.org/10.18128/D010.V9.0

Table 4: Number of Teenagers in the Department of Homeland Security's Chilling Estimate for the U.S.

	Number	Lower Bound	Upper Bound
Age 13	**507**	484	530
Age 14	**503**	480	526
Age 15	**454**	433	475
Age 16	**464**	443	486
Age 17	**429**	409	450
Age 18	**376**	355	396
Total	**2,733**	2667	2799

Note: Based on the proportion of people from each age group in the population eligible to live in Federal housing programs (Table 3), multiplied by the number of people estimated to live in families that DHS estimates will disenroll from Federal housing programs due to implementation of the Final Rule (25,232).

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF NEW YORK

STATE OF NEW YORK, CITY OF NEW YORK, STATE OF CONNECTICUT, and STATE OF VERMONT, Plaintiffs, v. UNITED STATES DEPARTMENT OF HOMELAND SECURITY; KEVIN K. McALEENAN, in his official capacity as Acting Secretary of the United States Department of Homeland Security; UNITED STATES CITIZENSHIP AND IMMIGRATION SERVICES; KENNETH T. CUCCINELLI II, in his official capacity as Acting Director of United States Citizenship and Immigration Services; and UNITED STATES OF AMERICA, Defendants.	**CIVIL ACTION NO. 1:19-cv-07777** **DECLARATION OF DEIDRE S. GIFFORD, M.D., M.P.H.**

I, Dr. Deidre S. Gifford, pursuant to 28 U.S.C. Section 1746, declare under penalty of perjury as follows:

1. I am the Commissioner-Designate of Connecticut's Department of Social Services ("DSS"). I respectfully submit this Declaration to place before the Court certain testimony and documents relevant to the relief requested in the above-captioned case. I am familiar with the matters set forth herein, either from professional knowledge, conversations with DSS staff, or on the basis of documents and information that have been provided to me and that I have reviewed.

2. I am a medical doctor with an M.D. from Cornell University Medical College. I trained in obstetrics and gynecology at University Hospitals of Cleveland and the UCLA Medical

Center. I hold an M.P.H. in epidemiology and a B.S. from the University of California, Los Angeles.

3. In May of 2019, I was nominated by Connecticut Governor Ned Lamont to serve as DSS Commissioner. I have served as Commissioner-Designate since June 21, 2019, pending confirmation by the Connecticut General Assembly. Immediately before assuming my current role, I served as Deputy Director of the Center for Medicaid and CHIP Services (CMCS) at the federal Centers for Medicaid and Medicare Services, an office within the U.S. Department of Health and Human Services. I have also been Medicaid Director in the Rhode Island Executive Office of Health and Human Services and Director of State Policy and Programs at the National Association of Medicaid Directors (NAMD).

4. Created in 1993 when the Connecticut General Assembly merged two existing state agencies, DSS is charged by statute with administering key social support programs including, but not limited to: Medicaid; the Supplemental Nutrition Assistance Program (SNAP); Temporary Assistance for Needy Families (TANF); energy assistance for low-income families (LIHEAP); state supplements to the federal Supplemental Security Income (SSI) program (State Supplement); and federally-funded assistance programs for refugees and asylees. The DSS Commissioner is authorized to establish rules, regulations, and policies to carry out the Department's statutory responsibilities, including administering and operationalizing rules, regulations, and policies that determine how public assistance programs are provided in Connecticut.

5. DSS is working towards a Connecticut where every resident has the opportunity to be healthy, secure, and thriving. We fulfill our mission of enhancing the well-being of Connecticut's individuals, families, and communities through delivering and funding a wide range of health and human services programs and services. Every year, we serve about 1 million

Connecticut residents of all ages – approximately 28% of the state's total population – across all of the state's 169 cities and towns.

6. DSS delivers services to Connecticut residents through more than 1,700 full-time staff members working at a central office and 12 field offices across the state. To promote easy and seamless access for residents, DSS has created a web portal, ConneCT, through which residents can obtain information about, apply for, and manage their participation in many of the critical services and supports that DSS provides. In compliance with the Affordable Care Act, DSS has also created a system to support state-based marketplace determinations of eligibility for Medicaid, CHIP, and qualified health plans (QHPs). The state-based marketplace is operated in conjunction with our partner, Access Health CT.

7. I am aware of, and strongly oppose, the public charge rule (the "Final Rule" or the "Rule") promulgated by the federal Department of Homeland Security. I understand that, among many troubling provisions, the Final Rule instructs immigration officials to consider an expanded range of public benefits in determining whether an immigrant is subject to a public charge inquiry. That expanded range of benefits, in my understanding, would include Medicaid and the Supplemental Nutrition Assistance Program (SNAP). Both of those programs are administered in Connecticut by DSS.

8. The Final Rule will severely and irreparably harm Connecticut and its residents. DSS strives to make Connecticut and its residents healthier and more economically secure. The Final Rule will directly frustrate those goals, leaving our residents less healthy and less secure, and damaging our statewide economy.

9. The Rule will disincentivize immigrants and their families from participating in public benefits programs. And many immigrants who are not directly implicated by the Rule will,

out of fear or confusion, disenroll from or avoid enrolling in public benefits programs. The rules for determining whether someone is a "public charge" are technical and complex, and so are the eligibility rules for many of the benefits programs in which immigrants and their families may participate. For instance: In Connecticut, Medicaid – a benefit susceptible to public charge analysis – and CHIP – a benefit that is excluded from the analysis under the Final Rule – are both known as HUSKY. (They are called "HUSKY A" and "HUSKY B," respectively.) Potential recipients apply for both benefits through the same portal. It seems likely that many recipients do not know the distinction: Instead, they simply know that they receive public health insurance benefits, and that those benefits are now under threat.

10. So the number of low-income immigrant families that choose not to receive benefits if the Final Rule is implemented would likely exceed — by a sizable amount — the number that would ultimately be subject to a "public charge" determination. Analysis of American Community Survey data suggests that nearly 200,000 Connecticut residents – fully 5.6% of our state's population – could be deterred, or "chilled," from participating in public benefits programs. This population comprises non-citizen residents of Connecticut, and their family members, with incomes less than 250% of the federal poverty level – residents who are likely to qualify for benefits that DSS delivers and therefore likely to experience hunger and endure unmet health needs if they are deterred from participating.

11. By disincentivizing, discouraging, and frightening families away from accessing vital health and food benefits, the Rule will leave up to 200,000 individuals in Connecticut, including children who are U.S. citizens, vulnerable to a lack of preventive health care or nutritious foods – benefits that have been shown to improve both short- and long-term health for individuals

and advance population-scale public health interests such as curbing the spread of communicable diseases and reducing chronic health conditions.

12. In addition to the projected public health harms, analysts project that because of enrollment losses in federally-subsidized programs, states will suffer cuts in federal funding, significant economic ripple effects, and thousands of lost jobs because of the Final Rule. The Fiscal Policy Institute looked at the results for Connecticut, and all 49 other states, if the potentially-chilled population avoids benefits because of the Rule. Even a low-end estimate of a 15% disenrollment rate in SNAP and Medicaid among the potentially-chilled population as a result of the rule is calculated to cost the state $79 million in federal funding; $154 million in economic ripple effects; and 1,046 jobs lost. If benefits disenrollment hits the higher-end mark of 35%, Connecticut will suffer a $183 million drop in federal funding; $359 million in ripple effects; and the loss of 2,441 jobs.

13. Finally, implementing the Rule would force DSS to expend resources and take on other administrative burdens that it cannot recover.

By Reducing SNAP Participation, the Final Rule Will Cause Irreparable Harm to the Health and Wellbeing of Connecticut Residents and to the State's Economy

14. The purpose of the federally-funded Supplemental Nutrition Assistance Program (SNAP) is to reduce hunger and malnutrition by supplementing the food purchasing of eligible low-income individuals and families, including low-income working people, senior citizens, and the disabled. SNAP eligibility and benefit levels are based on household size, income, and other factors, including immigration status.

15. SNAP provides nutrition for some of Connecticut's most vulnerable residents; lifts families out of poverty; and boosts our state economy. Reducing SNAP participation without

reducing underlying poverty will irreparably harm the health of the state's residents and damage our economy.

16. Over the course of CY 2018, a total of 493,600 Connecticut residents – nearly 14% of the state population – received SNAP benefits, including 168,489 children under the age of 18. Each month during CY 2018, on average nearly 16,000 non-citizens including over 3,000 non-citizen children received SNAP benefits. Over 5% of SNAP recipients lived in households with at least one non-citizen.

17. SNAP is narrowly targeted to help Connecticut's most vulnerable residents. In Fiscal Year 2017, 73% of Connecticut's SNAP households had incomes below the federal poverty line – including 32% of recipients whose incomes were at or below 50% of the poverty line. Between 2009 and 2012 – the most recent years for which such data is available – SNAP lifted an average of 70,000 Connecticut residents out of poverty every year.

18. The Final Rule will disincentivize and discourage Connecticut residents from participating in SNAP, whether or not their immigration status is actually implicated by the rule. Individuals whose immigration status is subject to the Final Rule will likely be disincentivized from applying for or continuing to receive those benefits implicated by the Final Rule, including SNAP. Additionally, policy experts agree that individuals whose immigration status may not be implicated by the Final Rule could also forgo benefits that the Final Rule covers – like SNAP – because of fear or confusion. DSS expects that the Final Rule will drive many Connecticut residents to disenroll, or to refrain from enrolling, in SNAP.

19. By disincentivizing enrollment or continued participation in SNAP, the Final Rule will likely result in food insecurity for a large population of immigrants and their families in Connecticut. Food insecurity generally means that individuals have challenges meeting basic food

needs because of a lack of money or resources. Food insecurity is costly for individuals and families. Because of food insecurity, individuals may face poor physical and mental health, reduced nutrient intake, and an increase in the likelihood of experiencing chronic diseases.

20. SNAP is particularly important for children, and depriving children and their families of SNAP does lifelong damage. Research shows that children of immigrants who receive SNAP benefits are more likely to be in good or excellent health, be food secure, and reside in stable housing. Compared to children in immigrant families without SNAP, families with children who participate in the program have more resources to afford medical care and prescription medications. Each additional year of SNAP eligibility for young children with immigrant parents is associated with health benefits in later childhood and adolescence.

21. By reducing SNAP participation, the Final Rule will also harm our state's economy. In 2017, the average Connecticut SNAP household member received $133 in monthly benefits. In total that year, Connecticut SNAP recipients spent $653.08 million at some 2,600 approved authorized retail locations. Those expenditures buoyed the state's economy: USDA's Economic Research Service has shown that for every dollar in SNAP benefits received, there is an approximate $1.79 in increased economic activity, and every billion dollars in SNAP benefits creates between 8,900 and 17,900 full-time jobs.

By Reducing Medicaid Enrollment, the Final Rule Will Cause Irreparable Harm to the Health and Wellbeing of Connecticut Residents and to the State's Economy

22. DSS supports the medical, dental, and behavioral health of nearly 850,000 Connecticut residents through administering the HUSKY Health programs, which include both Medicaid and the Children's Health Insurance Program. In CY 2018, 566,045 Connecticut residents participated in Medicaid (called "HUSKY A" in Connecticut), and 31,672 Connecticut residents participated in CHIP ("Husky B").

23. Medicaid is an important source of primary health insurance coverage and supplementary coverage for low-income residents and the most vulnerable Connecticut residents. Medicaid enrollees do not pay premiums and have little to no out-of-pocket costs for many services.

24. In Connecticut, nearly 161,000 citizen-children under the age of 18 have at least one foreign-born parent. An estimated 45,000 children with noncitizen parents – including children who are either naturalized or U.S.-born – participate in Medicaid or CHIP. As I noted above: Analysts have estimated that the Final Rule may deter 15%-35% of such eligible children from participating in Medicaid and CHIP, meaning that up to 15,750 U.S. citizen children in Connecticut may lose health care coverage under the Rule. Furthermore, the total number of Connecticut children otherwise eligible for Medicaid who may lose coverage due to confusion and concern about the Rule is likely to be greater, because Connecticut is one of the states that opts to provide Medicaid insurance for lawfully present immigrant children under the age of 21, without regard to the 5-year waiting period for qualified aliens.

25. Medicaid and CHIP have helped reduce the number of uninsured Connecticut residents. In Connecticut, the uninsured rate for people making less than 200% of the Federal Poverty Level fell from 27% in 2013 to 15% in 2017, while the overall uninsured rate fell from 9% to 6%. But the final rule, by deterring Medicaid and CHIP participation, will reverse this important public health progress.

26. Some people who are kept from Medicaid access by the Final Rule will likely go without coverage, with negative effects for their own health and productivity and the health and productivity of their families.

27. *Diminished public health.* By decreasing access to health insurance, the Final Rule will leave many Connecticut residents without preventive care, potentially leading to more acute and less treatable conditions in the future. Access to health insurance also improves the likelihood that patients receive recommended and potentially life-saving care. Studies have also shown that expanded Medicaid is associated with positive outcomes including lower mortality rates, higher cancer detection rates, and lower infant mortality rates.

28. *Harms to maternal health.* Medicaid also provides essential prenatal care to pregnant women, covering a full spectrum of prenatal and postpartum care services that are typically associated with positive health outcomes for mothers and children. Although the Final Rule excludes pregnant women who access Medicaid, because of the Final Rule's chilling effect, including Medicaid as a public benefit for purposes of a public charge determination could induce pregnant immigrants to refuse crucial prenatal care. Inadequate prenatal care increases the risk of premature birth, low birth weight, and a range of poor health outcomes for babies who, in many instances, will be U.S. citizens.

29. *Harms to children's health.* Although it excludes Medicaid coverage received by children under 21 years of age from the definition of "public benefit," the Final Rule will nevertheless discourage parents from enrolling their eligible children in Medicaid. By confusing and intimidating parents, the Rule will negatively impact long-term outcomes for children, including education and employment – both of which contribute to self-sufficiency and decrease the likelihood of needing public assistance in the future. Children's well-being is inseparable from their parents' and families' well-being, so help received by parents is central to children's health and well-being in the short- and long-term. Children thrive when their parents can access needed health care, and when their families have enough to eat and a roof over their heads. Conversely,

parents' stress and health challenges impede effective caregiving and can undermine children's development. A parent's lack of access to health insurance can jeopardize a child's health and performance in school.

30. Without coverage, children will likely suffer the consequences of inconsistent well-child visits and primary care, resulting in potentially serious health issues. Instead of early treatment for illness, children without health coverage will resort to emergency room visits for treatment of more serious conditions, at a greater cost than doctor's office visits.

31. Lack of primary care for some children has a ripple effect in the community, putting every child at risk. For example: Uninsured children are more likely to skip immunizations, increasing the likelihood that communicable diseases will spread.

32. *A less-productive workforce*. By disincentivizing Medicaid participation, the Rule will reduce economic productivity and create instability in Connecticut's workforce. Having a reliable source of health insurance, such as Medicaid, improves individuals' overall health and well-being. Workers who receive Medicaid report performing better in their jobs and feeling better prepared to seek a new or better job. Likewise, jobseekers report feeling better prepared to enter the workforce when they have Medicaid coverage. Without stable, affordable health insurance, and the preventive care it provides, individuals that forgo Medicaid because of the Final Rule are likely to spend more time suffering from preventable illnesses and thus missing work. Working parents are at increased risk of harm; not only is their own health at risk, but they may be forced to take time off from work to care for children who are sicker due to lack of preventive care.

33. *Decreased financial self-sufficiency.* Workers with affordable health care – like Medicaid – enjoy improved financial well-being and self-sufficiency. Financial security and self-sufficiency are improved when a person can pay their medical bills, and Medicaid coverage puts

full payment within reach for many. Other studies have shown that insurance coverage results in higher credit scores and lower medical debt, and reduces the probability of new bankruptcy filings. By contrast, individuals without health insurance have a harder time paying their medical bills and overall have worse financial health than those with coverage. Immigrants who are saddled with medical debt and low credit scores will be less likely to contribute to Connecticut's economic growth.

34. *Rising costs of health care and other social supports.* Of course, some Connecticut residents who lose or are deterred from obtaining Medicaid coverage as a result of the Final Rule will still receive care – but the cost of that care will be borne by individuals, hospitals, and state and local governments. And because people without health insurance tend to wait longer to seek care during a health crisis, the care they eventually receive will be more costly, forcing state and local public health programs to undergo significant financial strain as immigrants rely on these expensive services instead of Medicaid. Connecticut Medicaid has extensive preventative medical, behavioral health and dental services, and has greatly increased provider capacity to support members. These preventative services enable early identification of chronic and acute health care conditions; support effective self-management; and often eliminate or forestall the need for high cost hospital and nursing facility care.

35. Reducing low-income immigrants' access to Medicaid will leave many of them covered only for care in hospital emergency departments. Not only will this exacerbate the costs of uncompensated care, but it will likely negatively influence people's work readiness and capacity to retain employment; compromise their ability to retain stable housing; and have cascade effects on their overall economic security. In the absence of Medicaid benefits, people will likely fall back

on state, local, and nonprofit supports – including interventions designed to respond to homelessness – that could otherwise be entirely avoided.

36. Increasing the number of uninsured patients will, as was the case historically, expose hospitals to significant costs of uncompensated care, and will also reduce the overall pool of patients being served. The Affordable Care Act's (ACA) Medicaid expansion was of considerable support to hospitals in providing health care coverage for over a quarter of a million people in Connecticut, reducing uncompensated care. Medicaid expansion had an important role in mitigating hospital closures and improving the overall financial profile of hospitals, particularly in rural areas with higher rates of uninsured adults. The contraction of coverage that is likely to result from implementation of this Rule could result in more hospital closures.

37. The Final Rule will also have a devastating impact on Connecticut's Federally Qualified Health Centers (FQHCs). One analysis estimates the cost of the Rule to Connecticut FQHCs at between $4.4 million and $11.4 million, with dozens of employees being laid off and significant loss of care capacity as a result.

The Final Rule Will Impose Significant and Unrecoverable Costs and Administrative Burdens on DSS

38. The Final Rule will interfere with DSS' statutory obligations to assist vulnerable Connecticut families, and will create new and costly administrative and logistical burdens for the state.

39. *Information collection and document production for the federal government.* The Final Rule will burden the state by forcing it to collect information and produce new documentation in response to federal government demands. The Rule appears to require applicants for status adjustment to gather and submit detailed supporting documentation about public benefits that they may have received. But DSS does not have such standardized historical documentation

readily available. Developing standardized documentation of public benefits will be expensive and time-consuming, and require work across multiple computer systems. Further, the United States Citizenship and Immigration Services will likely request additional information from benefit-granting agencies if it has insufficient information to determine whether a public charge bond has been breached. These requests from USCIS will create additional work for DSS with time needed to review, process, and respond to requests.

40. *The costs of enrollee churn.* The Rule will force DSS to expend resources on enrollee "churn," to cover the transaction costs involved in participants leaving and re-enrolling in state programs. If the Final Rule becomes effective, DSS anticipates that many immigrants and family members of immigrants will terminate their participation in programs like SNAP and Medicaid. But, because these programs meet vital needs for families, some of these families would likely return to the caseload as services are needed, then request that assistance be discontinued at a later time in an attempt to limit the negative consequences of receiving assistance for a prolonged period of time. This on-again-off-again enrollment not only yields negative results for families, but also results in duplicative and expensive work for state agencies: In one study of SNAP-related churn, the costs averaged $80 for each instance of churn that requires a new application.

41. *Responding to consumer inquiries.* The 837-page Final Rule is overwhelmingly complex. Connecticut residents will be confused, and they will seek guidance and instruction from DSS. In response, DSS will experience increased call volume and walk-in traffic from consumers concerned about the new policies. Advising a family on whether they would be subject to a public charge determination and how receipt of various benefits might play out can require technical knowledge of immigration law beyond the expertise of most state employees or the state's call

center contractors. We anticipate that these activities will occupy significant staff time and will displace other vital program administration responsibilities for DSS.

42. *Modifying existing communications, web portals, and forms related to public charge.* For almost twenty years, Connecticut has worked under consistent and clear rules about when a resident's use of public benefits could result in a public charge determination. The new rules, in addition to being vastly more complex, carry dramatically different and more onerous penalties for a much large swath of the department's clients. In order to properly inform clients of the new risks, a wide variety of forms, notices, websites, software applications and training materials will need to be modified *before* the rule goes into place.

43. Connecticut has created two integrated web-based applications for residents to apply for state and federal benefits. Residents apply for SNAP and some medical coverage through ConneCT, and most use Access Health CT to apply for Medicaid. If the Final Rule takes effect, these systems will need to be radically revised. Eligibility determinations will need to be delinked where the provision of one type of benefit automatically confers eligibility for another, and consumers will need to be provided with clear and accurate information about the nature of the programs to which they are applying and the implications of that application for their immigration status. Our information technology department anticipates costs in the millions of dollars for the programming work on the portals alone.

44. If the Rule takes effect, in addition to notifying thousands of current non-citizen beneficiaries who have already been determined eligible, the state must immediately plan to halt automated Medicaid benefit renewals for current beneficiaries (a process required by the Affordable Care Act) in order to give clients an opportunity to evaluate the new rules. These renewals are generally triggered approximately 60 days in advance of the expiration of the prior

period of eligibility – or around September 1st for benefits expiring in October. Stopping this process and developing notices and procedures to support this change in operations requires costly and intensely rapid system changes. DSS reasonably anticipates a deluge of questions regarding application of this massive new rule, draining capacity for other work and increasing operational costs.

45. An additional example of the challenges faced by DSS concerns benefits that automatically confer eligibility for other benefits. For instance, a non-citizen may file an application with DSS requesting only cash assistance. If DSS determines the non-citizen is eligible for State Supplement and grants this benefit, the computerized eligibility system will automatically grant Medicaid coverage as well, because eligibility rules provide that a recipient of State Supplement is categorically eligible for Medicaid coverage. Because the Final Rule changes the definition of "public charge" to mean an "alien who receives one or more designated public benefits for more than 12 months in the aggregate within any 36-month period receipt (such that, for instance, receipt of two benefits in one month counts as two months)," 84 Fed. Reg. 41,295 (Aug. 14, 2019), and because non-emergency Medicaid is, in most instances, now one of the designated public benefits considered for public charge purposes, DSS will need to reprogram its computer eligibility system to "delink" these two benefits. DSS will need to create new correspondence for these situations that clearly explains a non-citizen's options and the potential ramifications of accepting Medicaid coverage. DSS will incur a cost for making these changes to its computer system and correspondence, and for providing training to its staff.

46. If implemented, the Rule will impose administrative burdens and costs on the state's health insurance Marketplace. Federal law requires state health insurance Marketplaces to first determine Medicaid eligibility for anyone applying for subsidized health insurance

coverage. Therefore, all applicants for Marketplace programs, including individuals seeking to apply enroll in CHIP, the Basic Health Program, or a Qualified Health Plan with an Advance Premium Tax Credit (APTC), must be found ineligible for Medicaid before their eligibility can be determined for other programs. As such, the state's information technology system is currently set up so that a Medicaid application is a threshold requirement before applications for other programs are permitted.

47. If enacted, the Rule will require Connecticut to make changes to its online eligibility platform and consumer notices to ensure immigrant applicants are informed of the potential risk that applying for or renewing existing health insurance may pose to their immigration status. Changing this platform would be tremendously costly and time-consuming for Connecticut to implement.

I declare under penalty of perjury under the laws of the State of Connecticut and the United States of America that the foregoing is true and correct.

DATED this August 27, 2019 at Hartford, Connecticut.

DEIDRE S. GIFFORD, MD, MPH
Commissioner

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF NEW YORK

STATE OF NEW YORK, CITY OF NEW YORK, STATE OF CONNECTICUT, and STATE OF VERMONT,

Plaintiffs,

v.

UNITED STATES DEPARTMENT OF HOMELAND SECURITY; KEVIN K. McALEENAN, *in his official capacity as Acting Secretary of the United States Department of Homeland Security*; UNITED STATES CITIZENSHIP AND IMMIGRATION SERVICES; KENNETH T. CUCCINELLI II, *in his official capacity as Acting Director of United States Citizenship and Immigration Services*; and UNITED STATES OF AMERICA,

Defendants.

CIVIL ACTION NO. 19-CV-07777

DECLARATION OF DR. MITCHELL KATZ

I, Mitchell Katz, M.D., pursuant to 28 U.S.C. Section 1746, declare under penalty of perjury as follows:

1. I am the President and Chief Executive Officer ("CEO") of New York City Health and Hospitals Corporation ("NYC Health + Hospitals"). I respectfully submit this Declaration in my capacity as President and CEO of NYC Health + Hospitals in order to place before the Court testimony relevant to the relief requested in this action. I am familiar with the

matters set forth herein, either from professional knowledge, conversations with NYC Health + Hospitals staff, or on the basis of documents that have been provided to and reviewed by me. I have also familiarized myself with the public charge inadmissibility rule (the "Public Charge Rule" or "the Rule") in order to understand its immediate impact upon NYC Health + Hospitals and its patients.

2. This Declaration provides: (i) general information on my background and NYC Health + Hospitals' mission and work; (ii) examples of the Public Charge Rule's harmful effect on NYC Health + Hospitals' patients; (iii) an analysis of the impact the Public Charge Rule will have on the NYC Health + Hospitals' patients; and (iv) an assessment of the significant costs and burdens the Public Charge Rule will impose on the administration of our already overburdened facilities.

My Professional Background

3. I have dedicated my career to the service of public health systems. I have served as President and CEO at NYC Health + Hospitals since January 8, 2018. Before coming to NYC Health + Hospitals, I was the Director of the Los Angeles County ("LAC") Health Agency, which has a budget of $7 billion, 28,000 employees, and a large number of community partners. I also served as the Director of the LAC Department of Health Services, the second largest public safety-net health care system in the United States.

4. Prior to working in Los Angeles, I served as the Health Officer of the San Francisco Department of Health for 13 years. I worked on funding needle exchange programs, creating Healthy San Francisco (a health access program), outlawing the sale of tobacco at pharmacies, and winning ballot measures for rebuilding San Francisco's public hospitals.

5. I am a graduate of Yale College and Harvard Medical School, completed an internal medicine residency at the University of California, San Francisco Medical School and

was a Robert Wood Johnson Clinical Scholar. Currently, I am the Deputy Editor of JAMA Internal Medicine and an elected member of the National Academy of Sciences.

6. In addition to my administrative leadership roles, throughout my professional career, I have continued to provide direct care to patients and currently provide primary care at one of NYC Health + Hospitals' federally qualified health center sites.

NYC Health + Hospitals' Work and Mission

7. NYC Health + Hospitals is New York City's municipal hospital system and the largest public health care system in the United States. Our dedicated, culturally competent, diverse workforce of 40,000-plus health care professionals protects and promotes the health and well-being of 8.5 million New York City residents across all five boroughs. We estimate more than 40 percent of NYC Health + Hospitals' patients were born outside the United States. In its role as the public health care safety net, NYC Health + Hospitals' mission is to deliver the best care for all patients, regardless of ability to pay.

8. With an operating budget of approximately $8 billion, NYC Health + Hospitals is an integrated health care system consisting of: eleven acute care hospitals; five post-acute/long-term care facilities; a federally qualified health center consisting of a network of ambulatory care clinics offering primary care services across the five boroughs; a certified home health agency; and one of the largest correctional health services in the nation.

9. NYC Health + Hospitals' wholly-owned subsidiaries include: "MetroPlus," a low to no-cost health insurance plan serving more than 500,000 New York residents; and "OneCity Health," the largest Medicaid Performing Provider System in the State composed of hundreds of health care providers, community-based organizations, and health systems.

10. On August 1, 2019, NYC Health + Hospitals began implementing NYC Care, a healthcare access program that guarantees low-cost and no-cost services to New York City

residents who do not qualify for public insurance coverage or cannot afford health insurance. This program is entirely funded by New York City and all health care services provided under the NYC Care program are currently provided through NYC Health + Hospitals.

Impact of the Public Charge Rule on NYC Health + Hospitals Patients Seeking Healthcare and Coverage for Care

11. Staff at NYC Health + Hospitals has already seen how fear and confusion wrought by the Public Charge Rule has led, and will continue to lead, our patients and their families to avoid obtaining critical health care services and coverage for those services. As the examples I provide below demonstrate, this fear and confusion has had a chilling effect on our patients—immigrants not targeted by the Public Charge Rule (for example those with Green Cards or visas not targeted by the Public Charge Rule) are declining needed services and immigrant patients are avoiding services that would not be subject to the Public Charge Rule. Some of NYC Health + Hospitals' patients have already declined to enroll in, or have requested to disenroll from, Medicaid and its MetroPlus health plan. Others have opted out of the Women, Infants, and Children ("WIC") program, a supplemental nutrition initiative for women, infants, and children.

12. After the proposed rule was published and before the Rule was finalized, an infant girl was admitted to an NYC Health + Hospitals inpatient setting in Manhattan due to severe anemia and malnutrition. Her parents have three children, all born in the United States. The parents told our staff that they had avoided applying for WIC and Supplemental Nutrition Assistance Program ("SNAP") because others in their immigrant community had warned them that the children's receipt of food assistance might be held against the parents in the future. NYC Health + Hospitals gave the parents nutritional advice and provided calories to the girl while she was at the hospital. She was able to rebound. She stopped losing weight. Her anemia

turned around. The parents experienced this fear of using benefits for their children even though the proposed rule clearly stated that usage of any new benefits added to the Rule, before the Rule becomes effective, would not be used against applicants subject to the Rule.

13. After the Public Charge Rule came out, an uninsured couple did not want to apply for insurance or for H+H Options (NYC Health + Hospitals' sliding fee scale program) due to fear that they might be deemed public charges. The couple said they were advised by their attorney to not apply for health insurance programs because the act can adversely affect their legal status as well as their sponsor. The couple was apprehensive even though H+H Options is not implicated by the Rule and the Rule had not yet taken effect.

14. In the Summer of 2019 after the Rule was published, a patient in Queens who was enrolled in Medicaid managed care requested to cancel his insurance coverage because of what he heard on the news relating to the Public Charge Rule. A staff member referred the patient to an immigration legal hotline we make available to our patients. Although it was unclear whether this individual would have been subject to the public charge test after the Rule's effective date on October 15, 2019, his enrollment prior to this date would not be used in a public charge determination. The patient was extremely fearful and adamant about his desire to cancel his existing coverage.

15. In another instance during the Summer of 2019 after the Rule was finalized, two women participating in a breast cancer program at one of our acute care facilities in Manhattan declined to pursue follow-up care. These women were enrolled in H+H Options and each reported that she was declining follow-up care out of fear that continued participation in H+H Options would adversely affect her immigration case. Our staff explained that the Rule does not apply to H+H Options, but the patients still refused care.

16. As these examples show, the Public Charge Rule has had an actual chilling effect on New York City residents receiving care at NYC Health + Hospitals—including immigrants who are not directly targeted by its provisions and others who are too afraid to access benefits and services that are not affected by the Rule. Even if NYC Health + Hospitals continues its significant investment in educational efforts to help its immigrant patients understand the Rule's application, based on the pervasive fear and reactions we have seen, we believe that the chilling effect will continue.

Sensitivity Analysis of the Public Charge Rule on NYC Health + Hospitals Patients

17. NYC Health + Hospitals staff has conducted an analysis of how the Public Charge Rule may affect its patients and will continue to update the analysis as data becomes available. NYC Health + Hospitals estimates that, based on data from the 2017 American Community Survey and NYC Health + Hospitals' data for fiscal year 2018, approximately 283,000 patients may be noncitizens (including 163,000 insured patients and 120,000 uninsured/self-pay patients) and will either be directly affected by or be subject to the chilling effect of the Public Charge Rule and respond similarly to the patients whose stories are shared above.

18. NYC Health + Hospitals has modeled a range of potential patient responses to the Rule in its first year of implementation: disenrolling from federally-subsidized Medicaid and Medicaid managed care plans; reducing use of primary care and preventive services resulting in poorer health outcomes and more costly care; and providing incomplete contact or insurance information to avoid diagnoses and utilization being tied to themselves (i.e., "collectability"), resulting in lower collectability and reimbursement for NYC Health + Hospitals.

19. For each type of patient response, NYC Health + Hospitals modeled a worst, medium, and best case scenario. For example, the medium case scenario for potential patient responses regarding disenrollment from Medicaid assumes 20 percent disenrollment by

potentially directly affected patients. This assumption is based on a conservative estimate of the chilling effect resulting from the passage of the Personal Responsibility and Work Opportunity Act of 1996. Under the medium case scenario, 11,200 Medicaid patients would disenroll and become uninsured and NYC Health + Hospitals could face a net financial loss of $42 million due to reduction in Medicaid reimbursement in the first year of the Rule's implementation. Layering in the medium case scenario for potential responses of patients, including a reduction in their use of primary care and preventive services as well as a reduction of the cost collectability from these patients, the potential loss is $121 million in the first year. The potential loss encompassing all types of potential patient responses to the Rule could range from $50 million in the best case scenario to as much as $187 million in the worst case scenario.

20. In addition to the potential financial impact of patient responses, NYC Health + Hospitals estimates it would cost up to $1.8 million over the first year to implement necessary administrative steps to respond to the rule change. This reflects costs for multiple rounds of staff training for key frontline personnel, outreach, preparation of education materials, and additional financial counseling and legal services to support our patients.

21. Although not reflected in the above estimate of the Rule's impact on NYC Health + Hospitals, MetroPlus, the managed care plan owned by NYC Health + Hospitals, faces a potential financial loss resulting from decreased enrollment and the cost of implementation. Based on experiences to date, it is expected that a number of individuals will disenroll from their Medicaid coverage through MetroPlus for fear of its impact on their immigration status. The Rule will force MetroPlus to invest significant resources in staff training and member outreach to ensure its membership understands the Rule's impact and implications for their health care coverage.

Increased Administrative Burdens on NYC Health + Hospitals

22. The Rule has imposed, and will continue to impose administrative burdens and costs on NYC Health + Hospitals. Staff will need to be retrained to be prepared to understand questions from certain patients and make necessary referrals to pro bono immigration legal service attorneys. Education materials will need to be prepared, translated, and distributed. The administrative and implementation costs, as well as the on-the-ground support needed for staff regarding this rule, will be felt for years to come.

23. ***NYC Care***: We expect that the Rule will shift health and medical costs covered by federal funds to the City of New York. Individuals who forgo Medicaid or other health insurance programs may seek services under NYC Care. NYC Care is available to all New York City residents regardless of their ability to pay and enrollment in NYC Care is not included in the public charge determination. Alternatively, some Medicaid or even NYC Care patients may disengage from health care entirely, posing individual and public health risk, as well as the potential for long-term increases in emergency care.

24. ***Staff training and resources***: Since the proposed Public Charge Rule was released in the Fall of 2018, NYC Health + Hospitals has spent hundreds of staff hours to analyze its impact and educate its staff and community members on the proposed Rule and now the final Rule.

25. ***Contact center***: NYC Health + Hospitals runs numerous telephonic contact centers to answer questions, including but not limited to those about insurance matters and eligibility for services. Beyond its core staff, an "overflow" model is used such that when call volumes are high, the "overflow" volume is transferred to an outside vendor which charges based on call volume. Given the inherent complexities among various types of health insurance coverage available to our patients, the Rule could cause an increase in calls

as patients seek information about the health care access, their insurance coverage, and the potential impacts of the Rule. Such an increase in volume would place a financial burden on NYC Health + Hospitals for every minute of additional "overflow" call time needed to support our patients.

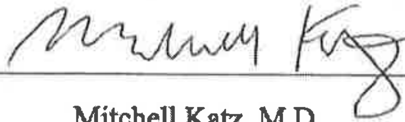
26. ***LegalHealth Partnership with New York Legal Assistance Group ("NYLAG")***: NYC Health + Hospitals has a long-standing partnership with NYLAG to provide pro bono legal services for its patients on a range of issues, including immigration matters. NYC Health + Hospitals provides this service through NYLAG at all of its hospitals and many neighborhood clinics. Telephonic services are also provided, and a new hotline has been established in order to specifically handle calls related to public charge issues. NYC Health + Hospitals pays for this service and provides physical space at its facilities to host these services. If more patients were to call with concerns about the Rule, there may be a need for increased legal capacity, which would come at greater cost to NYC Health + Hospitals.

CONCLUSION

27. For these reasons, NYC Health + Hospitals opposes implementation of the Rule given its destructive, far-reaching, and irreversible consequences on the economy, health, and administration of NYC Health + Hospitals and in turn, the City of New York. I respectfully request that this Court grant plaintiffs' motion for a preliminary injunction.

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

Executed on this 6th day of September, 2019



Mitchell Katz, M.D.
President and Chief Executive Officer
New York City Health and Hospitals Corporation

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

STATE OF NEW YORK, et al., Plaintiffs, v. UNITED STATES DEPARTMENT OF HOMELAND SECURITY, et al., Defendants.	19 Civ. 7777 (GBD)

I, **Leighton Ku**, declare pursuant to 28 U.S.C. § 1746 that the following is true and correct:

1. My name is Leighton Ku. I have personal knowledge of and could testify in Court concerning the following statements of fact.

2. I am a Professor of Health Policy and Management and Director of the Center for Health Policy Research at the Milken Institute School of Public Health, George Washington University in Washington, DC. I have attached my Curriculum Vitae as Exhibit A to this Declaration.

3. I am a nationally-known health policy researcher with over 25 years of experience. I have conducted substantial research about immigrant health, and health care and costs. I have authored or co-authored more than a dozen articles and reports about immigrant health issues, including articles in peer-reviewed journals such as Health Affairs and American Journal of Public Health, as well as scholarly reports published by diverse non-profit organizations including the Social Science Research Network, the Migration Policy Institute, the Cato Institute and the Commonwealth Fund, as well as many more articles and reports on other subjects. I have testified before the U.S. Senate Finance Committee about immigrant health

issues and provided analyses and advice to state governments and non-governmental organizations in many states about immigrant health.

4. I have expertise in quantitative data analysis and have conducted quantitative analyses for most of my career, including analyses for a federal agency, two think tanks and now at a university. I have taught statistical analysis and research methods at the graduate school level for over 25 years, training hundreds of graduate students, as well as dozens of federal and state budget and policy analysts. I have authored or co-authored more than 90 papers in peer-reviewed journals and hundreds of other reports, most of which were quantitative analyses. As a quantitative health data analyst I have consulted with the Congressional Budget Office and numerous federal and state agencies.

5. I provided expert declarations about the effects of terminating DACA on health insurance coverage and states in *State of New York, et al. v Trump, et al.*[1] in November 2017 and in *State of Texas v. United States, et al. and Karla Perez, et al.* in June 2018.[2] On September 1, 2019 I provided an expert declaration very similar to the current one regarding the public charge rule in *La Clinica de la Raze, et al, v Donald Trump, et al.,* in the U.S. District Court, Northern District of California..[3] I have not provided testimony in any other court cases in the past four years.

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1 Declaration of Leighton Ku in *State of New York, et al. v Donald Trump, et al.* in U.S. District Court for the Eastern District of New York. Nov. 22, 2017.

2 Declaration of Leighton Ku in *State of Texas v. United States of America, et al. and Karla Perez, et al., Defendant-Intervenor* in U.S. District Court for the Southern District of Texas, Brownsville Division, June 14, 2018.

3 Ku L. Declaration in Support of Plaintiffs' Motion for a Preliminary Injunction, *La Clinica de la Raza, et al. v. Donald Trump, et al.* United States District Court, Northern District of California, September 1, 2019. https://healthlaw.org/resource/declaration-of-leighton-ku-in-la-clinica-de-la-raza-v-trump/.

6. I also have knowledge of health insurance and employment through my role as a voluntary (unpaid, appointed) Executive Board member for the District of Columbia's Health Benefits Exchange Authority, which governs the District's health insurance marketplace, formed under the federal ACA. This includes oversight of health insurance for small businesses as well as individual health insurance in the District of Columbia.

7. I have a PhD. in Health Policy from Boston University (1990) and Master of Public Health and Master of Science degrees from the University of California at Berkeley (1979). Prior to becoming a faculty member at George Washington University, I was on the staff of the Urban Institute and the Center on Budget and Policy Priorities.

8. I have been engaged by counsel for the Plaintiffs in this case to evaluate the effect of the new public charge rule on Medicaid enrollment, public health, and health systems.

Overview

9. This declaration examines the potential effects of the final regulation issued by the U.S. Department of Homeland Security (DHS) regarding inadmissibility on public charge grounds on August 14, 2019 ("the public charge rule" or "the rule"),[4] specifically the health consequences and effects of the rule related to the receipt of health insurance benefits under the federal Medicaid[5] program. In this declaration I:

(A) summarize key aspects of the public charge rule,

(B) describe the Medicaid program, and provisions related to lawful immigrants,

[4] Department of Homeland Security. Final Regulations: Inadmissibility on Public Charge Grounds. Federal Register. *Federal Register.* Vol. 84, No. 157, pg: 41290-508. Aug. 14, 2019.

[5] Unless otherwise specified, my use of the term "Medicaid" refers only to federally-funded Medicaid which is considered a "public benefit" under the public charge rule.

(C) demonstrate how the public charge rule will have severe repercussions and create "chilling effects" that cause substantial numbers of members of immigrant families, including citizens in those families, to disenroll or forego Medicaid or other public benefits, even if they are not applying for adjustment in immigration status,

(D) describe serious flaws in estimates by the Department of Homeland Security about the number of members of immigrant families who may forego or drop Medicaid coverage due to the public charge rule,

(E) produce independent, evidence-based analyses and estimate that between 1.0 million and 3.1 million members of immigrant families would drop or forego Medicaid coverage or disenroll due to the public charge rule,

(F) explain the documented benefits of Medicaid coverage and discuss the serious health harms that are likely to befall members of immigrant families, including premature death, due to dropping Medicaid coverage in response to the public charge rule,

(G) analyze other consequences of the public charge rule including financial harm to state and local governments, such as New York and California, and to health care providers, such as community health centers and safety net hospitals, and to the patients they serve,

(H) discuss other health-care-related harms from other provisions of the rule, such as provisions related to private health insurance or savings for medical care, and

(I) explain why public charge policies, which rely on current or past characteristics of immigrants, specifically receipt of Medicaid, do not accurately predict immigrants' future economic status.

I conclude that the public charge rule will lead between 1.0 to 3.1 million members of immigrant families, many of whom are United States citizens, to disenroll from or forego Medicaid benefits each year, even though they are eligible. Those harmed are disproportionately low-income members of racial and ethnic minority groups, especially Latino and Asian families, and many have serious chronic health problems. The loss of Medicaid will substantially reduce their ability to access affordable health care and will lead to serious health problems for many, such as diabetics who will no longer be able to afford insulin or other medications or medical services. As a result, there could be as many as 1,300 to 4,000 excess premature deaths per year. The reduction in Medicaid revenue, and subsequent increase in the number of low-income uninsured people will also cause financial harm to health care providers, especially safety net facilities like community health centers and safety net hospitals, as well as to local and state governments.

A. Summary of the Revised Public Charge Rule

10. Section 531 of the Illegal Immigration Reform and Immigrant Responsibility Act of 1996 (IIRIRA) included five criteria that could be considered when making public charge determinations for admissibility to the United States, approval of lawful permanent residency (LPR) or other adjustments of immigration status: age; health; family status; assets, resources and financial status; and education and skills.[6] In 1999, the Immigration and Naturalization Service (INS), which oversaw the immigration system at the time, specified that being primarily

[6] Public Law 104-208, Div C. Section 531, 8 USC 1182(1)(4).

dependent on cash assistance income maintenance (e.g., Supplemental Security Income (SSI) or Temporary Assistance for Needy Family (TANF) benefits) or institutionalized for long-term care at government expense (e.g., nursing home expenses paid by Medicaid) could result in public charge determinations.[7] The INS explained that this was consistent with a historical approach to the concept of public charge, that it would apply to those who were "primarily dependent" on the government for income or for institutionalization. Non-cash benefits, such as Medicaid (other than the long-term care benefits mentioned above), the Children's Health Insurance Program (CHIP), or the Supplemental Nutrition Assistance Program (SNAP), were not to be considered in determining public charge status under the 1999 guidance.

11. Under the new public charge rule, DHS will now include the receipt of non-cash benefits such as Medicaid, SNAP, and public housing as grounds to make a public charge determination to deny status adjustments, including approval for lawful permanent residency.

12. Under § 212.22(c)(1)(ii) of the final regulation, the following will be considered a "heavily weighted negative factor" in consideration of a determination of public charge inadmissibility: "The alien has received or has been certified or approved to receive one or more of the public benefits, as defined in § 212.21(b) for more than 12 months in the aggregate within any 36-month period, beginning no later than 36 months prior to the alien's application for admission for admission or adjustment of status on or after October 15, 2019." The public benefits in § 212.21(b) include non-cash benefits like Medicaid, SNAP, and public housing, and cash benefits like Temporary Assistance for Needy Families (TANF) and Supplemental Security Income (SSI). Section 212.21(b) indicates that receipt of Medicaid counts as a highly weighted negative factor, except for certain circumstances, such as the receipt of Medicaid due to

[7] Immigration and Naturalization Service. Notice: Field Guidance on Deportability and Inadmissibility on Public Charge Grounds. (Federal Register. Mar. 26, 1999. Pg. 28689-92).

emergency medical conditions, Medicaid services received under the Individuals with Disabilities Education Act, school-based Medicaid services and services provided to immigrants under the age of 21 or a woman who is pregnant (up to 60 days postpartum).

13. If the immigrant receives two or more benefits, the receipt of each benefit will be summed in reaching the 12-month limit; i.e., an immigrant who receives Medicaid, SNAP and public housing benefits for more than four months each would exceed the 12-month criterion. An immigrant may be considered "likely to become a public charge" if the immigration officer believes he or she will receive one or more of these benefits. Applying for Medicaid (or related benefits) after October 15, 2019 will not be considered "receipt" of benefits, but can be considered in determining public charge status (§ 212.22(b)(4)(E)).

14. Other factors which will be considered negative factors include: having an income below 125% of Federal Poverty Guidelines ("FPG"), being a child or elderly, low education, poor health, being uninsured and having been denied entry or adjustment in the past.

15. Although certain exclusions apply with respect to receipt of Medicaid benefits, many Medicaid enrollees with such exclusions are still at risk of public charge determinations for other reasons. For example, children or pregnant women enrolled in Medicaid could still be deemed public charges because they are: under 18 (§ 212.22(b)(1)), have serious health problems (§212.22(b)(2) and §212.22(c)(1)(iii)(A)), are members of large families (§212.22(b)(3)), have incomes below 125 percent of federal poverty guidelines (§212.22(b)(4)), or for other related reasons. For example, an immigration officer could interpret that pregnancy (and subsequent labor and delivery) constitutes a "medical condition that is likely to require extensive medical treatment or institutionalization" (§212.22(b)(2) and §212.22(c)(1)(iii)(A)) which therefore authorizes a public charge determination, even though the child born would be a native-born

U.S. citizen. In fact, a pregnant woman could be considered a public charge even if she has not been enrolled in Medicaid, simply because of her health condition.

B. Brief Description of Medicaid

16. Medicaid, authorized under Title XIX of the Social Security Act, provides health insurance coverage to low-income populations. As of May 2019, 65.7 million individuals were enrolled in federally-funded Medicaid, about 20% of the U.S. population. (An additional 6.6 million children were enrolled in CHIP; as noted below some of these children could be considered Medicaid recipients as well, depending on how states have decided to structure their programs.)[8] Medicaid is the nation's largest health insurance program. Medicaid is an entitlement program whose eligibility rules and benefit levels are established by federal and state laws and regulations; total spending is not limited by appropriations limits. The Centers for Medicare and Medicaid Services, which administers Medicaid, does not provide detailed information about the immigration status of Medicaid participants.

17. Medicaid serves a wide range of low-income beneficiaries including children, the elderly, persons with disabilities, non-elderly adults and pregnant women. Eligibility is based on multiple criteria including age, income, category (e.g., child, adult, elderly, pregnant woman), disability status, state residency and immigration status. Medicaid offers a broad health benefit, including preventive and primary health care, acute medical care, emergency and inpatient hospital care, and long-term care services. Children on Medicaid receive other important services, including dental care and therapies that address developmental problems. For the

[8] Centers for Medicare and Medicaid Services. May 2019 Medicaid & CHIP Enrollment Data Highlights. https://www.medicaid.gov/medicaid/program-information/medicaid-and-chip-enrollment-data/report-highlights/index.html. Accessed Aug. 19, 2019. This is the number reported by the federal agency, there may be many others, as described below, who are enrolled in state-funded Medicaid plans, who might also disenroll or forego coverage due to the public charge rule.

elderly or disabled who also participate in Medicare, Medicaid can provide "wrap around" insurance that covers fees not covered by Medicare, such as Medicare deductibles or copayments, or for certain services like long-term care or hearing aids not covered by Medicare.

18. Medicaid is a joint federal-state program. Within the federal regulatory framework, states have great flexibility to establish policies. The federal government funds the majority of Medicaid expenditures based on a federal medical assistance percentage (FMAP), which annually establishes the percent of total Medicaid expenditures that will be paid by the federal government, while state or local governments fund the remaining costs. Under Medicaid, 36 states (plus the District of Columbia) cover non-elderly adults with family incomes up to 138 percent of the federal poverty level (about $29,435 per year for a family of three), but 14 states have not expanded Medicaid as permitted by the Patient Protection and Affordable Care Act, and many do not provide any coverage to non-elderly adults without dependent children.[9] The range of income eligibility criteria in Medicaid is very broad. At the high end, in the District of Columbia, adults with incomes up to 221 percent of the poverty level are eligible for Medicaid. Thirty-six states use 138 percent of the poverty level as the income cutoff. At the low end, twelve states use a threshold below 50 percent of the federal poverty level.[10] The lowest threshold is in Texas where Medicaid eligibility for parents ends at 17 percent of poverty ($3,600 per year for a family of three) and non-disabled, non-elderly adults without dependent children are not eligible at all, regardless of income. Thus, eligibility criteria related to use of Medicaid would only affect very poor parents in Texas, but may affect low-income working class adults in

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9 Kaiser Family Foundation. Medicaid Income Eligibility Limits as a Percent of the Federal Poverty Level. https://www.kff.org/health-reform/state-indicator/medicaid-income-eligibility-limits-for-adults-as-a-percent-of-the-federal-poverty-.level/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D. Accessed July 26, 2019.

10 *Ibid.*

36 states and the District of Columbia. Moreover, predicting future Medicaid use would depend heavily on predicting where an individual will live in the future.

19. Medicaid Eligibility for Legal Immigrants. Special policies exist for Medicaid eligibility for legal immigrants. Citizens, including naturalized citizens and citizen children with noncitizen parents, are eligible for Medicaid and CHIP on the same terms as U.S.-born citizens. Undocumented immigrants are not eligible for Medicaid or CHIP benefits. The Personal Responsibility and Work Opportunities Reauthorization Act of 1996 (PRWORA)[11] restricted legal immigrants' eligibility for certain means-tested programs, including Medicaid. In 2009, Congress modified the rules under Section 214 of the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) and gave states the option to expand eligibility for lawfully residing children and pregnant women. This section is sometimes called the "ICHIA" provision, named after a legislative proposal, Immigrant Children's Health Improvement Act, that evolved into Section 214.[12] Federal policies as of July 23, 2019 (prior to issuance of the final regulation) are summarized by the Department of Health and Human Services' HealthCare.gov website:

> Immigrants and Medicaid and CHIP
>
> Immigrants who are "qualified non-citizens" are generally eligible for coverage through Medicaid and the Children's Health Insurance Program (CHIP), if they meet their state's income and residency rules.
>
> In order to get Medicaid and CHIP coverage, many qualified non-citizens (such as many LPRs or green card holders) have a 5-year waiting period. This means they must wait 5 years after receiving "qualified" immigration status before they can get Medicaid and CHIP coverage. There are exceptions. For example, refugees, asylees, or LPRs who used to be refugees or asylees don't have to wait 5 years.
>
> The term "qualified non-citizen" includes:
>
> - Lawful Permanent Residents (LPR/Green Card Holder)

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11 See 8 USC 1601-1646.

12 Public Law No: 111-3 (02/04/2009).

- Asylees
- Refugees
- Cuban/Haitian entrants
- Paroled into the U.S. for at least one year
- Conditional entrant granted before 1980
- Battered non-citizens, spouses, children, or parents
- Victims of trafficking and his or her spouse, child, sibling, or parent or individuals with a pending application for a victim of trafficking visa
- Granted withholding of deportation
- Member of a federally recognized Indian tribe or American Indian born in Canada

Medicaid & CHIP Coverage for Lawfully Residing Children and Pregnant Women.

States have the option to remove the 5-year waiting period and cover lawfully residing children and/or pregnant women in Medicaid or CHIP. A child or pregnant woman is "lawfully residing" if they're "lawfully present" and otherwise eligible for Medicaid or CHIP in the state….

Getting emergency care

Medicaid provides payment for treatment of an emergency medical condition for people who meet all Medicaid eligibility criteria in the state (such as income and state residency), but don't have an eligible immigration status.

Medicaid, CHIP, and "public charge" status

Applying for Medicaid or CHIP, or getting savings for health insurance costs in the Marketplace, doesn't make someone a "public charge." This means it won't affect their chances of becoming a Lawful Permanent Resident or U.S. citizen.

There's one exception. People receiving long-term care in an institution at government expense may face barriers getting a green card.

Department of Health and Human Services. Coverage for lawfully present immigrants. https://www.healthcare.gov/immigrants/lawfully-present-immigrants/. Accessed July 23, 2019

20. The provisions decribed above concern eligibility for immigrants under *federal* Medicaid policies that govern the availability of federal funds (i.e., FMAP). But many states extend Medicaid or similar health insurance coverage to additional immigrants, including legal immigrants who do not meet federal criteria as well as undocumented immigrants, using state funds. In July 2019, California enacted Senate Bill 104 which will extend "eligibility for full-

scope Medi-Cal benefits to individuals 19 to 25 years of age, inclusive, and who are otherwise eligible for those benefits but for their immigration status."[13] (Medi-Cal is California's name for Medicaid.) This expands upon a 2015 California law (SB 75) that expanded Medi-Cal eligibility for children 0 to 18 regardless of immigration status.[14] The District of Columbia, Illinois, Maryland (in some counties), Massachusetts, New York and Oregon provide state-funded health insurance coverage to income-eligible children regardless of immigration status.[15] Sixteen states provide prenatal care coverage to income-eligible women regardless of immigration status (Arkansas, California, Illinois, Louisiana, Massachusetts, Michigan, Missouri, Nebraska, New Jersey, New York, Oklahoma, Oregon, Rhode Island, Tennessee, Texas and Washington)[16]

21. The public charge rule only applies to federally-funded Medicaid and does not count state-funded assistance in public charge determinations.[17] However, it is important to note that numerous state programs are called or considered Medicaid (often under a state-specific name, like Medi-Cal in California, Arizona Health Care Cost Containment System (AHCCCS) in Arizona or MassHealth in Massachusetts) although the source of funds may not include federal Medicaid funds. As a result, many participants may not know whether the "Medicaid" in which

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[13] California Senate Bill 104. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201920200SB104. Accessed July 23, 2019.

[14] California Senate Bill 75. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201520160SB75. Accessed July 23, 2019.

[15] National Immigration Law Center. Medical Assistance Programs for Immigrants in Various States. Jan. 2018 update. https://www.nilc.org/wp-content/uploads/2015/11/med-services-for-imms-in-states.pdf.

[16] *Ibid.*

[17] *E.g.*, the preamble (Federal Register, Aug. 14, 2019, page 41313) says: "Notwithstanding the inclusion of SNAP as a designated public benefit, DHS will not consider for purposes of a public charge inadmissibility determination whether applicants for admission or adjustment of status are receiving food assistance through other programs, such as exclusively state-funded programs, food banks, and emergency services, nor will DHS discourage individuals from seeking such assistance."

they are enrolled is Medicaid that counts under the rule or instead another form of government subsidized health insurance.

22. New York offers health coverage to residents who are not eligible for federally-funded Medicaid, including many immigrants. These programs include state-funded Medicaid, Child Health Plus (New York's version of CHIP) and Essential Plan, a Basic Health Program authorized under the Affordable Care Act.[18] These programs provide services similar to Medicaid.. These programs are not federal Medicaid, and are not cited as a heavily-weighted negative factor under the public charge rule, but many recipients may not be able to distinguish these programs from federal Medicaid. State and federal Medicaid are indistinguishable to participants. Most Medicaid recipients in New York are covered through private Medicaid managed care plans, and most health insurance companies that offer Medicaid plans also provide coverage in the other programs listed above. In many cases, the insurance cards for these various programs look almost identical. Thus, many New Yorkers who are covered under these programs could be confused about whether they are in federally-funded Medicaid. As I explain below, this confusion will likely result in New Yorkers mistakenly disenrolling from healthcare coverage programs that are not federally-funded Medicaid in order to avoid potential negative consequences when seeking an adjustment of status for immigration purposes.

23. The draft form USCIS I-944, titled "Declaration of Self-Sufficiency,"[19] must be completed by those applying for adjustment of status and will be used by DHS officials to determine public charge status. It is long and extremely complicated; its complexity (and lack of clarity) could lead to many erroneous determinations of public charge status by DHS officials.

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[18] https://info.nystateofhealth.ny.gov.

[19] US Citizenship and Immigration Service. Declaration of Self Sufficiency. USCIS I-944. OMB No. 1615-0142. https://www.regulations.gov/document?D=USCIS-2010-0012-63772.

The form is 19 pages long and asks for detailed information and documentation related to income, prior year tax filings, assets (including bank accounts, homes and cars), home value appraisals, mortgages, a credit score from within the past year, proof of education (such as degrees or transcripts), and occupational licenses, in addition to information about public benefit use. More pertinent to Medicaid, Form I-944 asks "Have you EVER received or are currently certified to receive in the future any of the following benefits," one of which is "federal-funded Medicaid." If the answer is yes, it asks for the beginning and ending dates of receiving Medicaid and the total value of benefits received.

24. There are at least three flaws that could lead to erroneous reporting using Form I-944. First, it is not clear whether "you" in the sentence above applies to the individual or to his or her whole household. Because this question is in a section titled "You and Your Household Members' Assets, Resources and Financial Status," the implication is that "you" means the entire household. This can produce errors since an immigrant applicant might not receive Medicaid him or herself, while another family member, such as a U.S.-born citizen child, spouse or other household member is the recipient. But the public charge rule is supposed to apply only to the applicant's use of benefits, not the use of benefits by other family members. The form, however, could lead to the determination that the immigrant applicant used Medicaid and is therefore a public charge, even though the immigrant him or herself did not actually receive Medicaid, only another household member. Second, many, perhaps most, applicants will not know if the Medicaid they received is "federal-funded Medicaid" or not. Presumably, DHS used this phrase to differentiate the benefit from state-funded medical assistance programs, such as those described above. But the definitions and names may not be clear to enrollees. All Medicaid programs are state-administered, they sometimes have names other than Medicaid

(e.g., Medi-Cal in California, Arizona Health Care Cost Containment System (AHCCCS) in Arizona or MassHealth in Massachusetts) and the insurance card many enrollees receive may only have the name of a private managed care plan (e.g., Aetna or United) that is contracted to provide Medicaid benefits; thus many applicants will be unable to report if they used "federal-funded Medicaid." Finally, Form I-944 asks for the dollar amount received. Almost no Medicaid recipient knows the dollar value of benefits received; it is not reported to them, and it is unclear whether such information could be obtained on demand, so how could they know? DHS provides no guidance on this point. The net effect is that it will be extremely difficult for an immigrant applying for adjustment of status to complete these parts of the I-944 correctly, leading to a substantial risk of erroneous public charge determinations. There is the further risk that many applicants may simply give up due to confusion and will therefore not apply for permanent residency or other status adjustments—even if they are individuals who are unlikely to be deemed public charges based on their receipt of public benefits.

C. The Public Charge Rule Will Have Substantial and Broad Effects in Reducing Immigrants' Participation: the "Chilling Effect"

25. The public charge rule is ostensibly targeted at certain federal public benefits, including Medicaid. In reality, a substantial share of candidates for adjustment of status do not receive these benefits because they are already ineligible to receive them under existing law. Thus, the rule is not only disconnected from the reality of immigrants' actual federal benefits usage, it also poses a significant threat to lawful use of benefits by members of immigrant families who are not covered by the rule. In both the preamble to the rule and the regulatory

impact analysis that accompanies the rule,[20] DHS acknowledges that a large number of immigrants and members of their families who are eligible for Medicaid will lose benefits but declares that these are "indirect effects" of the rule, as the rule itself does not change the eligibility criteria for Medicaid or other programs. DHS concedes, however, that many members of immigrant families who are lawfully eligible for these programs will disenroll or forego enrollment in order to avoid a public charge determination, though as explained below its estimates of the number of people who will drop coverage is seriously flawed.

26. While the specifics of who is subject to the public charge rule are detailed in the more than 200-page regulation and preamble, experience and research indicates there will be much broader "chilling effects" for those in immigrant families, including U.S.-born citizen children, naturalized citizens, lawful permanent residents and others who are not specifically described by the rule. In this context, "chilling effect" refers to the likelihood that many members of immigrant families will disenroll or forego participation in public benefit programs, even if they are lawfully eligible, because they are fearful of harmful repercussions for themselves or members of their family. As described below, these fears extend beyond the directly affected immigrants, but creep out to other family members, who may be citizens, already have green cards, or whose benefit use is excluded from consideration. Stated differently, the chilling effect extends far beyond the specific individuals eligible for an adjustment of status who, in DHS's view, rationally choose to forego public benefits in order to reduce the odds of a public charge determination. Many who are supposed to be exempt from the rule, such as pregnant women or refugees fleeing persecution in their homelands, will be understandably confused about the rule and will avoid Medicaid too.

[20] Dep't of Homeland Security. "Regulatory Impact Analysis: Inadmissibility on Public Charge Grounds." Aug. 2019. https://www.regulations.gov/document?D=USCIS-2010-0012-63741.

27. While the details of the public charge rule matter, the effects can be much larger and broader because of the ways that immigrant families perceive these rules. DHS references the existence of chilling effect in its regulatory impact analysis.[21] On pages 90 and 91, DHS cites one study from the US Department of Agriculture which estimated that legal immigrants' food stamp participation fell by 54 percent after the immigrant restrictions in the 1996 PRWORA went into effect[22] and another Urban Institute report which found that welfare enrollment by foreign-born individuals, including both citizens and non-citizens, fell by 21 percent in the years after PRWORA's immigrant restrictions.[23] DHS, moreover, was well aware of potential chilling effects because various comments on the proposed rule raised concerns about them.

28. The most direct, recent evidence of the magnitude of the chilling effects comes from a study conducted by the non-partisan Urban Institute,[24] which was based on a nationally representative survey conducted in December 2018, after the proposed rule was released in October 2018 and included a sample of 2,950 adults in immigrant families (i.e., at least one person in the family was an immigrant). The survey, called the Well-Being and Basic Needs Survey, was a nationally representative sample of adults 18 to 64. It is based on a stratified random sample drawn from Ipsos' Knowledge Panel, a probability-based online basis; it included an oversample of noncitizen respondents. The survey was conducted in English and

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21 *Ibid.*

22 Genser J. Who is leaving the Food Stamp Program: An analysis of Caseload Changes from 1994 to 1997. Food and Nutrition Service, USDA. 1999. Available at https://www.fns.usda.gov/snap/who-leaving-food-stamp-program-analysis-caseload-changes-1994-1997.

23 Fix M, Passel J. Trends in Noncitizens' and Citizen' Use of Public Benefits Following Welfare Reform: 1994-1997. 1999. The Urban Institute. https://www.urban.org/research/publication/trends-noncitizens-and-citizens-use-public-benefits-following-welfare-reform.

24 Bernstein H, Gonzalez D, Karpman M, Zuckerman S. One in Seven Adults in Immigrant Families Reported Avoiding Public Benefit Programs in 2018. Urban Institute. May 2019. https://www.urban.org/sites/default/files/publication/100270/one_in_seven_adults_in_immigrant_families_reported_avoiding_publi_2.pdf.

Spanish. To ensure that the findings corresponded to nationally accepted representativeness, the data were weighted based on benchmarks drawn from the Census Bureau's American Community Survey. The researchers found that:

- Overall, about one-seventh (13.7%) of all adults in immigrant families reported that they avoided noncash public benefits in the past year because of concerns that they or a family member could be disqualified from obtaining a green card (lawful permanent resident status). Hispanics, low-income members of immigrant families, and immigrant families with children were more likely than other groups to avoid such benefits.
- The rate of avoidance was higher (20.7%) among low-income members of immigrant families whose incomes were below 200% of the federal poverty line ($25,100 for a family of four in 2018); this subpopulation is more likely to need public benefits and more prone to suffer long-term consequences from their avoidance.
- Of those who said they avoided noncash benefits, 46% said they avoided receiving Supplemental Nutrition Assistance Program (SNAP) benefits, 42% said they avoided Medicaid or CHIP, and 33.4% said they avoided public housing subsidies.
- These concerns were greatest among Hispanics (20.6%), more than double the levels expressed by non-Hispanic whites (8.5%).
- The share avoiding benefits was higher (17.4%) among immigrant families with children, but was still substantial in families without children (8.9%).
- Avoidance of public benefits occurred even in families where all the foreign-born members were naturalized citizens (9.3%) and where all the noncitizen family members were already permanent residents (14.7%). In other words, avoidance

occurred even in families in which *no one* was subject to denial of an adjustment of status due to a public charge determination.

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

These data form a credible lower bound of the impact of the public charge rule; it is reasonable to believe that the effects will be even larger once the public charge rule is implemented and enforced. Implementation, denials of adjustment applications, and word of mouth in the immigrant community will cause far more members of immigrant families to avoid Medicaid and related programs.

29. An example of the dramatic effect of the implementation of public charge rules can be seen from statistics from the State Department reporting on visa denials following the January 2018 issuance of a revised public charge policy in its *Foreign Affairs Manual*, which is used by consular offices across the globe in determining who can receive visas to enter the United States.[25] The revised State Department policy was a precursor to DHS's public charge rule. It revises how sponsor affidavits of support and the use of noncash benefits by applicants, family members, and sponsors are evaluated prior to entry to the United States. The number of visa applications denied on the basis of public charge determinations rose from 1,076 in 2016, using earlier public charge guidance, to 3,237 in 2017, at which time public charge restrictions

[25] National Immigration Law Center. Changes to "Public Charge" Instructions in the U.S. State Department's Manual. Aug. 7, 2018. https://www.nilc.org/issues/economic-support/public-charge-changes-to-fam/ https://www.nilc.org/wp-content/uploads/2018/02/PIF-FAM-Summary-2018.pdf.

first came under discussion. The number of public-charge visa denials jumped to 13,450 in 2018 after more restrictive guidance was issued.[26] By comparison, the number of visa applications denied due to drug abuse, criminal activity or terrorism remained relatively stable: 4,991 denied in 2016, 4,652 in 2017 and 4,916 in 2018.[27] In other words, in 2018, after the public charge changes were implemented, the State Department denied about 12 times as many visa applicants due to public charge than in 2016 before the rule was modified, whereas the number of denials based on these other categories remained relatively constant. The level of denials rose even in 2017, when the issue was being discussed and then surged after formal adoption. These data collectively suggest that the rise in public charge denials was not due to a fundamental change in the composition of applicants but instead due to increasingly stringent criteria in public charge determinations. As rates of denials increase under the new rule, the corresponding chilling effect will also increase. Similarly, after the DHS public charge rule is implemented, the number of denials of adjustment applications on the basis of public charge can also be expected to surge. As the rate of denial increases under the rule, the corresponding chilling effect will also increase.

30. Other research on the chilling effect has also shown that policies designed to limit participation by noncitizen immigrants have repercussions on others, including citizen children in immigrant families. Soon after the 1996 PRWORA immigrant restrictions were enacted, data showed that there were significant reductions in use of Medicaid and similar

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[26] Based on statistics from Table XX of the State Department's Annual Reports of the Visa Office for 2016, 2017 and 2018. https://travel.state.gov/content/travel/en/legal/visa-law0/visa-statistics.html. These statistics do not include counts of cases subsequently overturned. Since then, the State Department issued slightly lower numbers, as cited by Hesson T, Exclusive: Visa denials to poor Mexicans skyrocket under Trump's State Department. Politico, Aug. 7, 2019. https://www.politico.com/story/2019/08/06/visa-denials-poor-mexicans-trump-1637094

[27] Based on statistics from Table XX of the State Department's Annual Reports of the Visa Office for 2016, 2017 and 2018. https://travel.state.gov/content/travel/en/legal/visa-law0/visa-statistics.html.

benefits among citizen children in immigrant families, despite the fact that these citizen children remained eligible. Participation also fell sharply among refugees, who were exempt from PRWORA eligibility changes.[28] A rigorous analysis by researchers at Columbia University and the University of Illinois at Chicago found that the reduction in participation by U.S.-born citizen children in immigrant families was slightly higher than for children in immigrant families born outside the U.S. (18% reduction for U.S.-born citizen children vs. 14% reduction for foreign-born children).[29]

31. It is clear from its regulatory impact analysis that DHS was aware of at least two research reports[30] about chilling effects and, given the numerous comments in response to the proposed regulation received, ought to have been aware of other related evidence, such as the reports cited above, but disregarded them in its final analysis. All of the available analyses, including those two studies cited by DHS and other reports cited in the paragraph above, find that changes in policies aimed at noncitizen immigrants have substantial and broad repercussions and lead to reductions in participation by others, including citizen members in immigrant families.

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[28] Zimmerman W, Fix M. Declining Immigrant Applications for Medi-Cal and Welfare Benefits in Los Angeles County. Urban Institute. July 1998. https://aspe.hhs.gov/basic-report/declining-immigrant-applications-medi-cal-and-welfare-benefits-los-angeles-county. Fix M, Passel J. Trends in Noncitizens' and Citizens' Use of Public Benefits Following Welfare Reform: 1994-97. Urban Institute. March 1999. https://www.urban.org/research/publication/trends-noncitizens-and-citizens-use-public-benefits-following-welfare-reform.

[29] Kaushal N, Kaestner R. Welfare Reform and Health Insurance of Immigrant. *Health Services Researc*h. 2005; 40(3): 697-721.

[30] The DHS regulatory impact analysis cites Genser J. Who is leaving the Food Stamp Program: An analysis of Caseload Changes from 1994 to 1997. Food and Nutrition Service, USDA. 1999. Available at https://www.fns.usda.gov/snap/who-leaving-food-stamp-program-analysis-caseload-changes-1994-1997 and Fix M, Passel J. Trends in Noncitizens' and Citizen' Use of Public Benefits Following Welfare Reform: 1994-1997. 1999. The Urban Institute. https://www.urban.org/research/publication/trends-noncitizens-and-citizens-use-public-benefits-following-welfare-reform.

32. There could be multiple reasons for the chilling effect. First of all, the policies are very complicated and difficult to understand. For example, the final public charge rule is 217 pages long in the *Federal Register* (three columns with a small font size) and is highly technical. Even the DHS website[31] which tries to summarize the rule in plain language is 15,572 words long, or about 60 double-spaced, typed pages. According to a readability scoring system called the Gunning Fog index, a person would need over 14 years of formal education (completed sophomore year of college) in order to read the information in the website easily.[32] Many, whether immigrant or U.S.-born, lack the literacy or time to comprehend such policies. (About half of Americans 18 to 64 have less than this level of education.[33]) Moreover, there are many technical immigration and public assistance issues embedded in the rule that require sophisticated understanding of policies to comprehend.

33. The extent to which immigrants take actions to avoid Medicaid or similar benefits after implementation of the rule is intensified by the climate of fear that already exists in immigrant communities. Since the rule was released, there has been substantial publicity pointing out that immigrants may face negative consequences for using these benefits, turning speculative suspicions into concrete hazards. As described earlier, the implementation of public charge policies in the State Department led to a massive increase in public charge denials.

[31] US Citizenship and Immigration Services, DHS. Final Rule on Public Charge Grounds of Inadmissibility. Aug. 2019. https://www.uscis.gov/legal-resources/final-rule-public-charge-ground-inadmissibility. Accessed Aug 15, 2019.

[32] To get this assessment, I copied the entire text of the DHS website notice into an online Tests Document Readability Calculator found at https://www.online-utility.org/english/readability_test_and_improve.jsp on Aug. 15, 2019.

[33] Author's analysis of the Census Bureau's 2018 Current Population Survey. https://www.census.gov/cps/data/cpstablecreator.html.

D. Serious Flaws in the Department of Homeland Security's Regulatory Impact Analysis

34. The DHS analysis of the impact of the rule is flawed because it relies on faulty assumptions to determine that only 2.5% of Medicaid recipients will be affected, fails to account for the three-year lookback of benefit use as provided by the DHS rule, and uses a severe undercount of the total number of Medicaid recipients in its calculations.

35. DHS presented its analysis of the potential effects of the public charge rule in a Regulatory Impact Analysis.[34] Evidence cited by DHS in its regulatory impact statement indicates that participation reductions among members of immigrant households have been as high as 21 percent[35] or 54 percent[36] following prior changes to laws affecting immigrants' access to public benefits. The preamble to the final rule itself, however, relies on the lowest of the agency's estimates of the potential impact. DHS's analyses of the chilling effect included critical omissions and was seriously flawed.

36. In Table 14 of the impact analysis, DHS begins by reporting that 34,706,865 people are Medicaid recipients and, based on 2012-2016 Census data, proceeds to estimate that 3,069,651 Medicaid recipients are members of households including foreign-born non-citizens. In Table 16, it estimates that 2.5 percent of the estimated Medicaid recipients (76,741 people) are "members of households that include foreign-born non-citizens expected to disenroll or forego

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[34] Dept of Homeland Security. "Regulatory Impact Analysis: Inadmissibility on Public Charge Grounds." Aug. 2019. https://www.regulations.gov/document?D=USCIS-2010-0012-63741. Department of Homeland Security. Economic Analysis Supplemental Information for Analysis of Public Benefits Programs. Undated. https://www.regulations.gov/document?D=USCIS-2010-0012-63742.

[35] Genser J. Who is leaving the Food Stamp Program: An analysis of Caseload Changes from 1994 to 1997. Food and Nutrition Service, USDA. 1999. Available at https://www.fns.usda.gov/snap/who-leaving-food-stamp-program-analysis-caseload-changes-1994-1997.

[36] Fix M, Passel J. Trends in Noncitizens' and Citizen' Use of Public Benefits Following Welfare Reform: 1994-1997. 1999. The Urban Institute. https://www.urban.org/research/publication/trends-noncitizens-and-citizens-use-public-benefits-following-welfare-reform.

enrollment based on a 2.5% rate of disenrollment or foregone enrollment." The 2.5 percent avoidance rate is based on DHS's estimate of the share of non-citizens who seek to adjust their immigration status each year, such as applying for lawful permanent resident status. DHS presumes that all immigrants who are adjusting status that year drop Medicaid, but that no others do so. (Using a similar logic, DHS estimates that 129,563 will disenroll or forego SNAP benefits and 8,801 will avoid federal rental assistance.) In Table 17, DHS estimates that this would lead to a $1.06 billion reduction in federal spending for Medicaid benefits per year, which is about two-thirds of the $1.46 billion in federal public benefit payments foregone annually; the remainder is other lost benefits, including SNAP, TANF, Supplemental Security Income and federal rental assistance.

37. In Table 18, DHS provides alternative budget estimates that acknowledge that it might be more appropriate to consider a three-year lookback period given that public charge determinations focus on receipt of public benefits during the prior 36-month period. Assuming people avoid benefits for three years, not just one, the total projected annual foregone benefits (from all public benefit programs including Medicaid) would total $4.4 billion, or three times the $1.46 billion cited in the final regulation as the official estimate. It also notes that "the number of people who may disenroll from or forego enrollment in public benefit programs in one year could be as many as the combined three-year total," i.e., it could be three times higher based on the three-year lookback period in the rule. In Table 19, DHS provides alternative evidence-based participation loss estimates much higher than 2.5 percent of the immigrant population that could

reach as high as 21 percent or 54 percent, based on prior research about chilling effects; these lead DHS to estimate Medicaid enrollment losses between 644,627 and 1,657,612 individuals.[37]

38. Despite these alternative estimates, the official estimate used by DHS in the final rule is based on the lowest of these estimates, shown in Table 8 of the preamble for the rule, based on the reduction in federal benefit payments that would otherwise have been made on behalf of members of immigrant families who avoided Medicaid and other benefits.[38] Table 8 also notes that there could be other costs, including "Potential lost productivity, Adverse health effects, Additional medical expenses due to delayed health care treatment," but makes no effort to quantify them.

39. Although the regulatory impact analysis included alternative estimates of effects that could be over twenty times larger -- up to 1.66 million losing Medicaid (Table 19, page 100 of the impact analysis) rather than 76,741 – DHS chose to use the lowest estimates as the basis of impact for the final rule. DHS says: "While previous studies examining the effect of PRWORA in 1996 showed a reduction in enrollment from 21 to 54 percent, it is unclear how many individuals would actually disenroll from or forego enrollment in public benefits programs due to the final rule. The previous studies had the benefit of retrospectively analyzing the chilling effect characterized by disenrollment or forgone enrollment after passage of PRWORA using actual enrollment data, instead of being limited to prospectively estimating the number of

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[37] For the 21 percent estimate, DHS cites Genser J. Who is leaving the Food Stamp Program: An analysis of Caseload Changes from 1994 to 1997. Food and Nutrition Service, USDA. 1999. Available at https://www.fns.usda.gov/snap/who-leaving-food-stamp-program-analysis-caseload-changes-1994-1997. For 54 percent, it cites Fix M, Passel J. Trends in Noncitizens' and Citizens' Use of Public Benefits Following Welfare Reform: 1994-1997. 1999. The Urban Institute. https://www.urban.org/research/publication/trends-noncitizens-and-citizens-use-public-benefits-following-welfare-reform.

[38] Dept of Homeland Security. *Federal Register*, Vol. 84, Issue 157, Aug. 14, 2019, pg. 41489.

individuals who may disenroll or forego enrollment in the affected public benefits programs. This economic analysis must rely on the latter."[39] In essence, DHS says that although there is historical evidence that there could be a large chilling effect, it cannot use that evidence because it is about retroactive analysis of a somewhat different policy and DHS must assess changes prospectively before the public charge policy goes into effect. DHS furthermore says that its estimate should be related to the number who have to adjust status each year, but it presents no evidence that effects would occur only in that year (and in fact it also indicates that a three-year timeframe might be more appropriate).

40. DHS's estimate flouts substantial evidence, including the recent Urban Institute report, that chilling effects are often far broader than the targeted individuals. I note that the Urban Institute report was released in May 2019; those data were available before DHS completed its August 2019 impact analysis. DHS disregards standard methods for sound policy analysis and research by rejecting actual evidence-based research findings and substituting a flawed metric that yields disenrollment estimates far below the range of other estimates. (The alternative estimates that I produce in the next section are more strongly based on recent and directly relevant evidence.)

41. It is noteworthy that DHS only discusses its estimate of 2.5 percent of immigrants adjusting status annually, rather than its own alternative estimate that the rate could be three times higher, based on the three-year lookback period actually included in the rule. DHS disregards the research evidence of the scope of effects caused by prior immigration policy changes to select a much lower number and also disregards a three-times higher rate that better corresponds with the rule.

[39] DHS, Regulatory Impact Analysis, pages 91-92, just before Table 16.

42. The only estimate in the preamble of the number who are expected to disenroll from or forego Medicaid, SNAP or public housing benefits is the reference to 2.5 percent of members of non-citizen households receiving benefits on page 41313 of the rule. It is only in the regulatory impact analysis that DHS converts this to actual human terms – reporting that 76,741 people would lose Medicaid. But this estimate is far too low.

43. As noted before DHS primarily assumes that 2.5 percent of members of non-citizen households will avoid Medicaid participation because 2.5 percent of immigrants seek to adjust immigration status each year. But since the public charge rule uses a three-year lookback period – receipt of benefits of at least 12 months out of the last 36 months – a more appropriate factor, even accepting DHS's baseline estimate, would be three times higher, or 7.5 percent.[40] In addition, as the Urban Institute analyses and other prior studies of chilling effects described earlier indicate, chilling effects are much broader and affect many who are in naturalized citizen households, mixed-status households and are likely to deter participation regardless of when the immigrant is considering applying for adjustment.

44. There are additional serious flaws with the DHS analysis. First of all, DHS begins with an estimate that there are 34.7 million Medicaid recipients, based on a five-year average of data from 2012 to 2016.[41] However, more recent reports show that 65.7 million

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[40] This is because each year there would be a new group of individuals looking ahead to an adjustment of status in 36 months, so the dollar value associated with their Medicaid avoidance must be added to the group that already began avoiding Medicaid. In any given year, three years' worth of expected adjusters—those applying in one year, those applying in two years, and those applying in three years—would be avoiding Medicaid.

[41] Department of Homeland Security. Economic Analysis Supplemental Information for Analysis of Public Benefits Programs. Undated. https://www.regulations.gov/document?D=USCIS-2010-0012-63742.

individuals were enrolled in Medicaid in May 2019.[42] DHS begins by underestimating the total number of people on Medicaid by about half, which affects all subsequent calculations. Because the Affordable Care Act's Medicaid expansion was largely implemented in 2014, inclusion of data from earlier years vastly reduces the average number of Medicaid participants per year. Further, several states, including Virginia, Pennsylvania, and Indiana expanded Medicaid after 2014, making the use of this five-year average even more flawed. Even if one accepted other parts of the DHS methodology, this flaw alone leads to a serious underestimate, even if the 2.5 percent assumption was correct.

45. Moreover, because DHS uses this flawed participation estimate to compute the average Medicaid expenditure per person, this leads to an unjustifably high estimate of the cost of federal Medicaid benefits per person, $13,755 per person (Table 17.) In contrast, an official estimate by the Department of Health and Human Services of federal Medicaid expenditures per person was $5,522 per person for 2019.[43]

E. Evidence-Based Estimates of the Effect of the Public Charge Rule in Reducing Medicaid Participation by Members of Immigrant Families

46. In this section, I provide an evidence-based analysis of the potential effects of the public charge rule on Medicaid participation by members of immigrant families, based on research and experience regarding the chilling effects. The summary of these calculations are shown in Table 1 below. Overall, these estimates indicate that between 1.0 million and 3.1

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[42] Centers for Medicare and Medicaid Services. May 2019 Medicaid & CHIP Enrollment Data Highlights. https://www.medicaid.gov/medicaid/program-information/medicaid-and-chip-enrollment-data/report-highlights/index.html. Accessed Aug. 20, 2019.

[43] US Department of Health and Human Services. 2017 Actuarial Report on the Financial Outlook for Medicaid. https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/ActuarialStudies/Downloads/MedicaidReport2017.pdf

million members of immigrant families will forego Medicaid or disenroll due to the final public charge rule, each year after full implementation. This includes between 0.6 and 1.8 million adults 21 or older who will not receive Medicaid and between 0.4 and 1.2 million children 21 or younger who will not receive Medicaid because they are members of immigrant families, even if they remain eligible for benefits.

Table 1.
Estimates of Medicaid Enrollment Losses Due to the Final Public Charge Regulation

Number of People Potentially at Risk	**Number or % Affected**
1. Number of Medicaid Enrollees, May 2019 (1)	65,663,268
2. Percent of Medicaid Enrollees Who Are Members of Low-income Immigrant Families (b)	25.17%
3. Estimated Number of Members of Low-Income Immigrant Families Enrolled in Medicaid (#1 times #2)	16,526,558
4. Adults 21 or Older Who Are Members of Low-Income Immigrant Families Enrolled In Medicaid (b)	6,946,405
5. Children Under 21 Who Are Members of Low-Income Immigrant Families Enrolled in Medicaid (b)	9,580,153
Low and High Estimates of Number of Members of Immigrant Families Who Disenroll or Forego Medicaid Benefits Due to Public Charge Regulation	
6. Low Estimate Adult Medicaid Reduction (c)	603,920
7. High Estimate Adult Medicaid Reduction(d)	1,813,012
8. Low Estimate of Child Medicaid Reduction(e)	416,258
9. High Estimate of Child Medicaid Reduction (f)	1,248,773
10. Low Estimate of Total Medicaid Reduction (#6 + #8)	**1,020,178**
11. Low Percent Reduction in Total Medicaid Enrollment (#10/#3)	**6.2%**
12. High Estimate of Total Medicaid Reduction (#7 + #9)	**3,061,785**
13. High Percent of Total Medicaid Reduction (#12/#3)	**18.5%**

a. Centers for Medicare and Medicaid Services. May 2019 Medicaid & CHIP Enrollment Data Highlights.
b. Author's analysis of CDC's 2017 National Health Interview Survey. Low-income means family income below 200% of the poverty line. Immigrant family means the head of household and/or spouse is a foreign-born immigrant. Line 3 = lines 4 plus 5.
c. Based on estimates from Bernstein, et al. (2019): 20.7% of members of immigrant families avoiding public benefits times 42.0% = 8.69% of adults in immigrant households.
d. Assumes that after implementation and enforcement begin, the impact is three times higher = 26.1%.
e. Assumes half the level of adult loss because receipt of Medicaid by children under 21 is not counted as a heavily weighted factor. 8.69%* times 50% = 4.35%.
f. Assumes that after implementation and enforcement, the impact is three times higher = 13.0%.
Note: Numbers may not sum due to rounding.

47. My estimates are conservative and evidence-based, using the most recent data and evidence available, and present a range of effects due to the uncertainty surrounding

implementation and application of the rule, public awareness and behavioral responses. Although there is ample evidence, cited earlier, that a chilling effect will reduce immigrants' use of public benefits, some uncertainty exists because it is not completely clear how these rules will be implemented, publicized, or perceived by the immigrant community. Thus, I provide low and high estimates, expecting that the "true" impact would fall in between those limits. Although my estimates of those who lose coverage are higher than the 76,741 estimate used by DHS, they are more conservative than other independent estimates. For example, in October 2018, the Kaiser Family Foundation estimated that between 2.1 and 4.9 million members of immigrant families could lose Medicaid due to the proposed public charge rule.[44] The Migration Policy Institute estimated, based on earlier estimates of chilling effect losses under PRWORA, that 5.4 million to 16.2 million immigrants and members of their families could disenroll from public benefit programs.[45]

48. My calculations begin with the number of people receiving Medicaid as of May 2019, as reported by the Centers for Medicare and Medicaid Services, 65.7 million.[46] Note that because this data represents only federally-funded Medicaid, it is a conservative starting point because it does not include individuals enrolled in state-funded programs who may drop coverage. The federal agency does not have administrative data showing the immigration status

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[44] Artiga S, Garfield R, Damico A. Estimated Impacts of the Proposed Public Charge Rule on Immigrants and Medicaid. Kaiser Family Foundation. Oct. 2018. https://www.kff.org/report-section/estimated-impacts-of-the-proposed-public-charge-rule-on-immigrants-and-medicaide-key-findings/.

[45] Batalova J, Fix M, Greenberg M. Chilling Effects: The Expected Public Charge Rule and Its Impact on Legal Immigrant Families' Public Benefit Use. Migration Policy Institute. June 2018. https://www.migrationpolicy.org/research/chilling-effects-expected-public-charge-rule-impact-legal-immigrant-families.

[46] *Ibid*.

of Medicaid participants, so I analyzed data from the 2017 National Health Interview Survey, [47] which is a nationally representative survey conducted by the Centers for Disease Control and Prevention of demographic and health characteristics of the non-institutionalized American population, often used for research like this that includes immigration, socioeconomic and health characteristics. I identify immigrant-headed families, i.e., where the respondent or spouse is a foreign-born immigrant.[48] Because Medicaid is a program for low-income people, I limit the analyses to those who report having incomes below 200 percent of the federal poverty line. As seen in Table 1, about one-quarter of Medicaid enrollees, 16.5 million, are members of a low-income immigrant family. Of the 16.5 million members of immigrant families, 6.9 million are adults 21 or older and 9.6 are children under 21. A large share of the members of immigrant families, especially children, are U.S. citizens. As described above, there is ample evidence that policies aimed at non-citizen immigrants also have harmful effects on their citizen children, because of the chilling effect.

49. To estimate the effects of the public charge rule in causing people to forego or disenroll from Medicaid, I use estimates from the Urban Institute's May 2019 study,[49] described

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[47] Centers for Disease Control and Prevention. National Center for Health Statistics. National Health Interview Survey. https://www.cdc.gov/nchs/nhis/index.htm. I downloaded the 2017 data and conducted statistical analyses using standard statistical methods; 2017 is the last year for which population characteristics and income were available as of August 2019.

[48] I use the population of immigrant families, which includes some naturalized citizens, rather than of families containing one or more non-citizens, as DHS used. I use this population to align with the estimates of the Urban Institute report by Bernstein, et al. (2019), which found that 20.7% of adults in immigrant households avoided noncash benefits due to the chilling effect. While DHS used a base of non-citizen households, in that case the percentage of people avoiding benefits would be higher. That would produce a smaller population base, but a higher percentage of people affected, which ought to produce a similar level of estimates. Moreover, as the Urban Institute report found, and other studies corroborate, even citizens are affected by the chilling effect.

[49] Bernstein H, Gonzalez D, Karpman M, Zuckerman S. One in Seven Adults in Immigrant Families Reported Avoiding Public Benefit Programs in 2018. Urban Institute. May 2019. Adults in Immigrant Families Report Avoiding Routine Activities Because of Immigration Concerns. Urban Institute. July 24, 2019. https://www.urban.org/research/publication/adults-immigrant-families-report-avoiding-routine-activities-because-immigration-concerns.

earlier, which is the only study that provides direct evidence about the extent to which the public charge rule and fears about risking permanent resident (green card) status influence use of noncash benefits, including Medicaid. The public charge rule was proposed in October 2018, and the survey was fielded soon thereafter in December 2018. Its findings are comparable to prior studies about the effects of PRWORA immigrant benefit restrictions, but more specific about the reaction to the public charge rule and based on data from late 2018. The study found that 20.7% of members of low-income immigrant families avoided non-cash benefits due to green card concerns and that 42 percent of those who avoided noncash benefits specifically avoided Medicaid or CHIP; this leads to an estimate that 8.7 percent of low-income adults in immigrant families (20.7 percent times 42 percent) will forego or disenroll from Medicaid as the low estimate. This is the low estimate because those levels of avoidance were occurring before there was any implementation or enforcement of the policy and before there was as much publicity about impending changes in the public charge rules.

50. Because of evidence that effects increase after policies are adopted (including data about public charge denials at the State Department and about the consequences of implementation of PRWORA immigrant restrictions), I set a high estimate at three times that level (26.1 percent reduction), assuming that additional awareness increases avoidance. A few factors led me to conservatively determine that a three-fold increase is reasonable. First, the Urban Institute found that almost one third (31 percent) of immigrants who avoided benefits said they had heard a lot about the proposed rule; it is reasonable to assume that awareness and avoidance will rise sharply after implementation and enforcement.[50] Second, visa denials rose from 1,076 in 2016, prior to the implementation of recent State Department public charge

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[50] *Ibid.*

policies, to roughly three times more (3,237) in 2017 when the changes were under consideration, to an additional four-fold increase (to 13,450) in 2018 after the change was implemented.[51] Large reductions in applications occurred in the wake of implementation of PRWORA immigrant restrictions; for example, in Los Angeles County the number of enrolled citizen children with immigrant parents fell by 48 percent from 1996-98, despite the fact that citizen children remained eligible for coverage.[52] It is reasonable to assume that awareness of risks associated with public charge and avoidance will increase substantially after implementation, based on prior experiences.

51. For children, I use a similar approach, but reduce the estimated effects for children by 50 percent, compared to the level for adults. The final regulation excludes Medicaid benefits received by children under 21 from being considered as a heavily weighted factor. Despite this shift from the proposed rules, there is still strong evidence that children in immigrant families will be harmed, including citizen children, as found in the research on the impact of PRWORA immigrant restrictions, cited earlier. Moreover, as explained before, the confusing directions for Form I-944 about how to report use of Medicaid by the family suggest that erroneous determinations of public charge status could be common because immigrants might report other family members' use of Medicaid rather than their own, such that families could be penalized for their children's use of Medicaid benefits.

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[51] Based on statistics from Table XX of the State Department's Annual Reports of the Visa Office for 2016, 2017 and 2018. https://travel.state.gov/content/travel/en/legal/visa-law0/visa-statistics.html. These statistics do not include counts of cases subsequently overturned. Since then, the State Department issued slightly lower numbers, as cited by Hesson T, Exclusive: Visa denials to poor Mexicans skyrocket under Trump's State Department. Politico, Aug. 7, 2019. https://www.politico.com/story/2019/08/06/visa-denials-poor-mexicans-trump-1637094

[52] Zimmerman W, Fix M. Declining Immigrant Applications for Medi-Cal and Welfare Benefits in Los Angeles County. Urban Institute. July 1998. https://aspe.hhs.gov/basic-report/declining-immigrant-applications-medi-cal-and-welfare-benefits-los-angeles-county.

52. Finally, there is ample evidence indicating that parental participation in Medicaid affects children's participation: when parents gain Medicaid coverage, their children are more likely to enroll, even if the eligibility criteria for children do not change. My research demonstrated this relationship about twenty years ago[53] and the effect has been confirmed in multiple studies since.[54] Evidence indicates that the reverse holds true too; when parents lose Medicaid coverage, many of their children disenroll too, even though the children remain eligible. For example, in 2012 the state of Maine cut Medicaid eligibility for parents. Although eligibility levels for children did not change, about 6,000 Maine children lost Medicaid benefits.[55] Insurance coverage is often considered as a family matter, so policies that force parents off trigger the loss of children's insurance coverage too. Since DHS only announced the change in policy that exempts consideration of Medicaid benefits received by children under 21 as a heavily weighted negative factor in early August, I am not aware of any direct evidence showing how this might reduce effects for children, so I determined that a 50 percent reduction was a reasonable estimate, splitting the difference between no effect and the full adult effect. Thus, in Table 1, I estimate that the number of children in immigrant families who lose Medicaid will range from 0.4 million to 1.25 million.

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[53] Ku L, Broaddus M. The Importance of Family-Based Insurance Expansions: New Research on the Effects of State Health Reforms, Center on Budget and Policy Priorities, September 5, 2000.

[54] *E.g.*, Georgetown University Health Policy Institute. Health Coverage for Parents and Caregivers Helps Children. Mar. 2017. https://ccf.georgetown.edu/wp-content/uploads/2017/03/Covering-Parents-v2.pdf. Hudson J, Moriya A. Medicaid Expansion for Adults Had Measurable 'Welcome Mat' Effects on Their Children. *Health Affairs.* 36(9): 1643-51. Haley J, et al. Uninsurance and Medicaid/CHIP Participation among Children and Parents. Urban Institute. Sept. 2018. https://www.urban.org/sites/default/files/publication/99058/uninsurance_and_medicaidchip_participation_among_children_and_parents_updated_1.pdf. Hamersma S. Kim M, Timpe B. The Effect of Parental Medicaid Expansions on Children's Health Insurance Coverage. *Contemporary Economic Policy.* 37(2):297-311.

[55] Maine Children's Alliance. Ensuring Health Coverage for Maine Families with Children in 2014. 2014. http://www.mekids.org/assets/files/issue_papers/healthcoverage_children_2014.pdf.

53. Taken together, these analyses indicate that between 1.02 million and 3.06 million members of low-income immigrant families will lose Medicaid coverage after the public charge rule is fully implemented and enforced. This corresponds to a 6.2 percent to 18.5 percent loss of Medicaid among those who are members of low-income immigrant families.

54. Using additional data from the 2017 National Health Interview Survey, we can also describe some characteristics of those who could be harmed by the public change rule.

- The low-income adults on Medicaid in immigrant families are about twice as likely to have serious health problems as adults who are not in immigrant families and not on Medicaid. Almost one-third (29 percent) of the low-income immigrant group report being in fair or poor health, compared with 11 percent of non-immigrant non-Medicaid adults. About one-quarter (27 percent) of the immigrant group report having a functional limitation, such as difficulty walking, vision problems or having a health problem that impairs work versus 15 percent of the non-immigrant, non-Medicaid adults. The burdens of the public charge rule will fall disproportionately on those with poorer health. Because the low-income adults on Medicaid in immigrant families are less healthy, they are more likely to need medical care and are more likely to experience harm to their health if they must forego Medicaid. In addition, the public charge rule also penalizes applicants in general if they are in poor health.
- Those affected by the public charge rule are far more likely to be members of racial/ethnic minorities. The low-income members of immigrant families receiving Medicaid group are 56 percent Hispanic, 13 percent non-Hispanic white, 9 percent non-Hispanic black and 21 percent Asian. In comparison, those who are not in immigrant families and not on Medicaid are 80 percent white, 7 percent Hispanic, 11

percent non-Hispanic black, 2 percent Asian and 1 percent other/mixed race. Those who are harmed by the public charge rule are far more likely to be Hispanic or Asian and much less likely to be non-Hispanic whites.

F. Harm to Members of Immigrant Families Due to the Loss of Medicaid Benefits Due to the Public Charge Rule

55. A substantial body of research has demonstrated how Medicaid helps improve access to health care, helps people recover from illness or stay healthy, reduces mortality and has other important socially beneficial effects. Much of this literature has developed because of the Medicaid expansions that occurred under the Affordable Care Act or other high quality research studies. In turn, this means that the loss of Medicaid benefits, as caused by the public charge rule, will create serious harm for those who lose Medicaid benefits due to the public charge rule.

56. A March 2018 review of the literature by the Kaiser Family Foundation identified over 200 studies about the effects of Medicaid expansions across a variety of areas.[56] The review found that Medicaid expansions (a) increased insurance coverage and reduced the number of uninsured, benefiting both rural and urban residents and those who are African-American, white and Latino, (b) strengthened access to health care services, increasing the ability of people to obtain preventive, primary and acute care services, medication and mental health care, (c) increased low-income families' financial security, (d) improved a variety of health outcomes, and (e) reduced uncompensated care costs and stabilized safety net health care providers. A more focused review on health benefits conducted by faculty at Harvard University and

[56] Antonisse L, Garfield R, Rudowitz R, Artiga S. The Effects of Medicaid Expansion under the ACA: Updated Findings from a Literature Review. Kaiser Family Foundation. Mar. 2018. https://www.kff.org/medicaid/issue-brief/the-effects-of-medicaid-expansion-under-the-aca-updated-findings-from-a-literature-review-march-2018/.

published in the *New England Journal of Medicine* found consistent evidence that expanding health insurance coverage, especially Medicaid, improves access to and utilization of appropriate health care such as cancer screening, improves assessments of health, eases depression and increases financial security.[57] A recent study demonstrated that receiving Medicaid during pregnancy or early childhood can lead to demonstrable long-term benefits, including reductions in chronic disease hospitalizations for problems like diabetes or obesity as well as higher high school graduation rates.[58]

57. A new analysis by researchers at the University of Michigan, the National Institutes of Health, the Census Bureau and the University of California at Los Angeles found that expanding Medicaid eligibility was associated with significantly lower mortality, particularly disease-related deaths (e.g., as opposed to accidents) and the effect increases over time.[59] Specifically, it estimated that Medicaid expansions were associated with 0.13 percent reduction in the mortality rate. If we assume that this estimated change in mortality rates can be applied to the number of persons that I have projected to lose Medicaid coverage, the public charge rule could eventually increase the number of premature deaths by between 1,300 and 4,000 (0.13 percent times 1.02 million to 3.06 million losing Medicaid coverage). This corroborates an earlier study that examined the reduction in mortality after Massachusetts increased insurance coverage under its state health reform, which found that every increase in

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[57] Sommers B Gawande A, Baicker K. Health Insurance Coverage and Health — What the Recent Evidence Tells Us. *New England Journal of Medicine.* 2017 Aug 10; 377(6): 586-93.

[58] Miller S, Wherry L. The Long-Term Effects of Early Life Medicaid Coverage. *J Human Resources*. 2019; 54(3): 786-821.

[59] Miller S, Altekruse S, Johnson N, Wherry L. Medicaid and Mortality: New Evidence from Linked Survey and Administrative Data. NBER Working Paper No. 26081. July 2019. www.nber.org/papers/w26081.

insurance coverage by 830 people prevented one death per year, (0.12 percent),[60] almost the same as the rate cited above. I note that mortality rates might be slightly lower among those in immigrant families. Other research indicates that immigrants have slightly lower mortality rates than those who are native-born, so the effect might be less pronounced.[61] On the other hand, evidence indicates that the loss of health services for low-income people, many with poor health, would lead to more serious health problems, including higher mortality.

58. As noted earlier, a significant share of the immigrants who could be affected by the public charge rule have fair or poor health or have limitations because of health problems. This is because the final rule assigns negative weight to individuals who have a serious medical condition. Analyses of the 2018 Medical Expenditure Panel Survey reveal more detail about disease prevalence among immigrant adults now covered by Medicaid.[62] About 14 percent of low-income immigrant adults enrolled in Medicaid report having diabetes, 27 percent have high blood pressure, 29 percent have high cholesterol, 3.4 percent have a history of cancer, and 5 percent have a history of coronary heart disease. These are all serious chronic diseases, which generally require ongoing medical care and/or medication.

59. To illustrate the consequences of the loss of Medicaid insurance coverage, I present a hypothetical example about problems for a person with diabetes. Loss of Medicaid would make it much harder for a diabetic to continue to afford insulin or other diabetes-related

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60 Sommers B, Long S, Baicker K, Changes in Mortality after Massachusetts Health Care Reform: A Quasi-Experimental Study, *Ann. Intern. Med*. 2014; 160(9): 585-93.

61 Singh G, Miller B. Health, Life Expectancy, and Mortality Patterns Among Immigrant Populations in the United States. *Can J Public Health.* 2004; 95(3): I14-21. Singh G, et al. Immigrant Health Inequalities in the United States: Use of Eight Major National Data Systems. *Scientific World Journal*. 2013; Article ID 512313, 21 pages http://dx.doi.org/10.1155/2013/512313.

62 Author's analysis of the 2017 Medical Expenditure Panel Survey, conducted by the federal Agency for Healthcare Research and Quality. https://meps.ahrq.gov/mepsweb/index.jsp.

medications or other medical care. The average cost of insulin (without insurance) was $450 per month in 2016, compared to $234 in 2012.[63] When diabetes is adequately controlled, diabetics can function well in work and other normal activities of life, but the loss of medical care could lead to severe medical problems, including death and impairments such as heart disease, loss of vision or amputation.[64] With adequate medical care, an immigrant could hold a job, go to school, support a family and pay taxes, but the loss of Medicaid could put all of that at risk and lead to serious, long-term health problems.

60. A recent study examined some of the medical needs of children who could be affected by the public charge rule, looking at children who lived with at least one noncitizen adult, based on analyses of the 2015 Medical Expenditure Panel Survey. Of these children: 11 percent had asthma, 18 percent had experienced gastrointestinal problems, 14 percent had the flu, and 9 percent had neuromuscular problems. Forty percent needed care for an illness or injury and 18 percent needed medication.[65] Forgoing Medicaid could have serious medical consequences for these children that could not only impair their health, but reduce their opportunities to function well in school.

61. The public charge rule creates other harms for immigrants. As noted earlier, many in immigrant families are already under serious psychological stress due to the public charge rule and perceptions of other Trump Administration policies. The loss of Medicaid would compound these problems. Research has shown that receiving Medicaid helps reduce

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[63] Thomas K. Express Scripts Offers Diabetes Patients a $25 Cap for Monthly Insulin. *New York Times.* Apr. 3, 2019.

[64] American Diabetes Association. Standards of Medical Care in Diabetes—2019. *Diabetes Care*. 2019 Jan. (supplement)

[65] Zallman L, et al. Implications of Changing Public Charge Immigration Rules for Children Who Need Medical Care. *JAMA Pediatr*. Published online July 1,m 2019. https://jamanetwork.com/journals/jamapediatrics/fullarticle/2737098.

depression and increases the ability to get access to mental health care services.[66] It also increases financial security, since beneficiaries know that their medical expenses will be covered.

62. Another harm of the public charge rule is the risk of family separation. As noted by the Cato Institute, about 40 percent of those subject to the public charge rule are spouses or minor children.[67] If they do not meet the public charge rule's requirements, their ability to remain in the United States – and their ability to remain with their citizen or permanent resident spouses or children – is jeopardized, increasing the risk of family separation. This risk increases the pressure for immigrant families to avoid public benefits, while also adding to their psychological distress.

G. Harm to State and Local Governments and Health Care Facilities Due to the Public Charge Rule

63. The harm caused by the public charge rule extends beyond the harm caused to members of immigrant families; there are broader repercussions that would create serious harm to state and local governments, health care providers and other members of these communities who are not in immigrant families. Safety net health care providers will lose Medicaid revenue, which will threaten their ability to serve their communities, including patients who are not members of immigrant families. Many state or local governments will be forced to spend more to provide health care to indigent patients, increasing their state and local budget pressures. Finally, the loss of federal Medicaid revenue (as well as the loss of federal SNAP benefits) would have broader effects on state and local economies and employment.

[66] Baicker K, et al. The Effect of Medicaid on Management of Depression: Evidence from the Oregon Health Insurance Experiment. *Milbank Q*. 2018 Mar; 96(1): 29–56.

[67] Bier D. An Explanation of the Public Charge Rule: Frequently Asked Questions. Cato Institute. Aug. 12, 2019. https://www.cato.org/blog/explanation-public-charge-rule-frequently-asked-questions

64. The problem can be clearly understood in the case of health care. If fewer people have Medicaid coverage, then health care providers, such as hospitals or community health centers, will collect less insurance revenue; this is particularly a problem for safety net health care providers that care for a large number of Medicaid patients. But uninsured patients still need medical care and often seek care at these facilities as uninsured patients. Safety net facilities often continue to care for uninsured patients, whether because of legal mandates or because of their mission to serve needy patients. For example, as a condition of receiving federal funds under Section 330 of the Public Health Service Act, community health centers must serve all patients, regardless of their ability to pay for care.[68] Thus, the health center must continue to provide care, even if patients are uninsured and cannot pay.

65. In this section, I summarize data from several reports that were released in late 2018 that examine the effects of the public charge rule, as it was proposed in October 2018. If these analyses were conducted now the results might be slightly different because of changes in the final regulation, such as the exclusion of consideration of Medicaid benefits used by children and pregnant women or the availability of more recent information. But the general methods used in these reports appear technically reasonable and the direction of findings should be approximately valid, even if they were revised in light of the final regulation or more recent data.

66. In a November 2018 report, I and colleagues at George Washington University examined the financial impact of the then-proposed public charge rule for community health centers.[69] The key results from that report are reproduced in Table 2 below. Nationwide, we

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[68] 42 U.S.C. 254b(k)(3)(G).

[69] Ku L, Sharac J, Gunsalus R, Shin P, Rosenbaum S. How Could the Public Charge Proposed Rule Affect Community Health Centers? Policy Brief # 55. Geiger Gibson RCHN Community Health Research Collaborative. Nov 2018. https://publichealth.gwu.edu/sites/default/files/downloads/GGRCHN/Public%20Charge%20Brief.pdf.

estimated that health centers would sustain between $345 and $623 million in lost Medicaid revenue. In order to make up for that loss in revenue, we considered scenarios in which they would either reduce the number of patients served or reduce their staffing. We estimated that this would cause health centers to serve between 295,000 and 538,000 fewer patients or reduce staffing by around 3,400 to 6,100 staff. Because health centers cannot discriminate and must serve all patients regardless of their ability to pay (or their immigration status), they must lower their overall patient caseloads, which would result in losses in the broader patient community and most of those patients would not be immigrants or members of immigrant families, or reduce staff, most of whom are not immigrants. The public charge rule would have repercussions that reduce services for broader communities, not just members of immigrant families.

67. The report estimated that community health center losses in New York state could be between $55 and $102 million, in California from $126 to $240 million, in Connecticut from $4.4 to 11.4 million and in Vermont from $166,000 to $293,000.

Table 2.
Potential Effect of Proposed Public Charge Rule on Community Health Center Revenue and the Potential Reduction in the Number of Patients Served or the Number of Health Center Staff Needed to Compensate for the Loss of Medicaid Revenue

	Loss of Health Center Medicaid Revenue Due to Public Charge Rule		Potential Compensatory Actions Due to the Loss of Medicaid Revenue			
			Reduce Number of Patients Served		Reduce Number of Health Center Staff	
	Low Estimate	High Estimate	Low Estimate	High Estimate	Low Estimate	High Estimate
Total, U.S.	**-$345,673,184**	**-$623,753,853**	**-294,642**	**-537,683**	**-3,373**	**-6,075**
Alabama	-$225,564	-$526,557	-365	-851	-2	-6
Alaska	-$471,897	-$996,953	-149	-315	-3	-7
Arizona	-$10,595,610	-$12,817,305	-9,900	-11,976	-116	-141
Arkansas	-$394,544	-$771,900	-425	-832	-5	-9
California	-$126,143,256	-$240,183,200	-102,201	-194,595	-1,139	-2,169
Colorado	-$5,696,253	-$11,848,222	-5,143	-10,697	-63	-131
Connecticut	-$4,408,901	-$11,391,917	-4,208	-10,873	-44	-113
Delaware	-$553,818	-$852,250	-696	-1,071	-6	-9
Dist. of Columbia	-$9,953,898	-$14,464,689	-4,258	-6,188	-106	-154
Florida	-$7,813,025	-$15,909,023	-9,334	-19,006	-94	-192
Georgia	-$254,034	-$820,574	-310	-1,003	-3	-10
Hawaii	-$1,008,457	-$1,650,632	-736	-1,205	-10	-16
Idaho	-$225,677	-$900,226	-202	-805	-2	-9
Illinois	-$5,948,171	-$13,574,467	-7,417	-16,927	-64	-147
Indiana	-$1,817,859	-$2,930,274	-2,312	-3,727	-20	-32
Iowa	-$1,963,423	-$2,414,045	-2,249	-2,765	-19	-24
Kansas	-$471,669	-$789,340	-623	-1,042	-6	-10
Kentucky	-$1,951,046	-$2,143,024	-2,062	-2,265	-22	-24
Louisiana	-$155,599	-$563,779	-164	-595	-2	-6
Maine	-$233,447	-$457,375	-224	-438	-2	-5
Maryland	-$1,782,988	-$3,300,834	-1,628	-3,013	-20	-37
Massachusetts	-$32,471,101	-$44,392,363	-23,251	-31,787	-335	-458
Michigan	-$3,839,013	-$6,084,838	-3,899	-6,180	-40	-64
Minnesota	-$2,658,967	-$5,351,271	-2,530	-5,093	-25	-49
Mississippi	-$9,842	-$210,900	-15	-312	0	-2
Missouri	-$345,504	-$1,286,065	-417	-1,552	-4	-15
Montana	-$137,605	-$197,994	-124	-179	-1	-2
Nebraska	-$623,129	-$849,313	-742	-1,012	-8	-11
Nevada	-$581,865	-$1,463,941	-390	-981	-8	-20
New Hampshire	-$366,666	-$666,839	-290	-528	-4	-7
New Jersey	-$2,799,363	-$7,001,699	-3,406	-8,520	-27	-66
New Mexico	-$3,349,127	-$5,363,475	-2,693	-4,313	-35	-56
New York	-$55,237,669	-$101,597,422	-41,733	-76,758	-495	-911
North Carolina	-$1,070,195	-$3,276,186	-1,376	-4,211	-12	-38
North Dakota	-$273,951	-$370,515	-300	-405	-3	-5
Ohio	-$1,401,176	-$2,540,892	-1,799	-3,262	-16	-29
Oklahoma	-$312,067	-$1,079,861	-373	-1,291	-4	-12
Oregon	-$8,251,838	-$15,300,182	-4,890	-9,066	-80	-148
Pennsylvania	-$7,616,148	-$12,335,111	-7,967	-12,903	-83	-135
Rhode Island	-$3,003,273	-$4,439,375	-3,036	-4,488	-33	-49
South Carolina	-$209,046	-$1,263,821	-203	-1,227	-2	-15
South Dakota	-$485,598	-$597,119	-614	-755	-6	-7
Tennessee	-$347,224	-$938,841	-533	-1,440	-5	-12
Texas	-$13,410,285	-$26,466,577	-17,137	-33,822	-156	-308
Utah	-$1,369,508	-$2,516,979	-1,426	-2,622	-16	-29
Vermont	-$166,063	-$293,264	-167	-295	-2	-3
Virginia	-$458,375	-$1,173,334	-577	-1,477	-5	-13
Washington	-$19,832,337	-$32,646,223	-17,036	-28,043	-190	-312
West Virginia	-$172,518	-$330,056	-214	-409	-2	-4
Wisconsin	-$2,708,512	-$4,285,574	-2,806	-4,439	-28	-44

Source: Ku, Sharac, Gunsalus, Shin & Rosenbaum. 2018.

68. Similar analyses were conducted about the impact of the proposed public charge rule on the Medicaid revenues of hospitals across the country by Manatt Health, on behalf of America's Essential Hospitals, the Association of American Medical Colleges, the American Hospital Association, the Catholic Health Association of the United States, the Children's Hospital Association, and the Federation of American Hospitals.[70] Like the community health center report, this November 2018 report was issued before the final regulation was issued. Results today might differ somewhat, although the general nature and magnitude of results ought to remain similar. This report analyzed the potential effect of the loss of Medicaid revenues in every state and in many metropolitan areas across the nation. Like health centers, hospitals would need to compensate for the loss of revenue by reducing the number of patients served, including many who are not in immigrant families, reducing services and/or reducing staffing. Overall, the report concluded that American hospitals could lose an estimated $17 billion, harming them and the communities they serve. Because hospitals are so much larger and provide much costlier care, the size of the losses is far higher for hospitals than community health centers. The losses reported in this report include all types of hospitals, but the losses will be higher in hospitals that serve more Medicaid patients or in areas with higher immigrant populations, many of which are public hospitals or hospitals that receive substantial state or local subsidies. Table 3 provides the estimates of hospital losses by state; Table 4 shows them instead arrayed by metropolitan areas.

[70] Mann C, Grady A, Orris A. Medicaid Payments to Hospitals at Risk Under the Proposed Public Charge Rule. Nov. 2018. https://www.manatt.com/Manatt/media/Documents/Articles/Medicaid-Payments-at-Risk-for-Hospitals-Under-the-Public-Charge-Proposed-Rule_Manatt-Health_Nov-2018.PDF.

Table 3.
Potential Medicaid/CHIP Hospital Payment Losses Due to Proposed Public Charge Rule by State (2016, $ in millions)

State	$ millions
Alabama	$48
Alaska	$23
Arizona	$383
Arkansas	$24
California	$5,168
Colorado	$234
Connecticut	$163
Delaware	$31
District of Columbia	$117
Florida	$785
Georgia	$243
Hawaii	$51
Idaho	$27
Illinois	$554
Indiana	$117
Iowa	$57
Kansas	$40
Kentucky	$85
Louisiana	$52
Maine	$7
Maryland	$254
Massachusetts	$457
Michigan	$246
Minnesota	$157
Mississippi	$17
Missouri	$93
Montana	$6
Nebraska	$32
Nevada	$223
New Hampshire	$25
New Jersey	$608
New Mexico	$126
New York	$2,710
North Carolina	$216
North Dakota	$7
Ohio	$170
Oklahoma	$98
Oregon	$186
Pennsylvania	$216
Rhode Island	$51
South Carolina	$54
South Dakota	$5
Tennessee	$96
Texas	$1,923
Utah	$70
Vermont	$3
Virginia	$112
Washington	$329
West Virginia	$8
Wisconsin	$68
Wyoming	$1
Total, U.S.	**$16,771**

Source: Mann, Grady & Orris, 2018.

Table 4.
Potential Medicaid/CHIP Hospital Payment Losses Due to Proposed Public Charge Rule by Metropolitan Area (2016, $ in millions)

Metropolitan Area	$ millions
Atlanta-Sandy Springs-Roswell, GA	$183
Baltimore-Columbia-Towson, MD	$136
Boston-Cambridge-Newton, MA-NH	$365
Chicago-Naperville-Elgin, IL-IN-WI	$548
Dallas-Fort Worth-Arlington, TX	$421
Denver-Aurora-Lakewood, CO	$169
Detroit-Warren-Dearborn, MI	$136
El Paso, TX	$156
Fresno, CA	$214
Houston-The Woodlands-Sugar Land, TX	$634
Las Vegas-Henderson-Paradise, NV	$132
Los Angeles-Long Beach-Anaheim, CA	$1,978
McAllen-Edinburg-Mission, TX	$124
Miami-Fort Lauderdale-West Palm Beach, FL	$529
Minneapolis-St. Paul-Bloomington, MN-WI	$136
New York-Newark-Jersey City, NY-NJ-PA	$3,113
Philadelphia-Camden-Wilmington, PA- NJ-DE-MD	$232
Phoenix-Mesa-Scottsdale, AZ	$301
Portland-Vancouver-Hillsboro, OR-WA	$137
Riverside-San Bernardino-Ontario, CA	$572
Sacramento–Roseville–Arden-Arcade, CA	$198
San Antonio-New Braunfels, TX	$181
San Diego-Carlsbad, CA	$387
San Francisco-Oakland-Hayward, CA	$506
San Jose-Sunnyvale-Santa Clara, CA	$365
Seattle-Tacoma-Bellevue, WA	$178
Washington-Arlington-Alexandria, DC- VA-MD-WV	$256
Yuba City, CA	$115
All other	$4,365
Total, U.S.	**$16,771**

Source: Mann, Grady & Orris, 2018.

69. The Manatt report estimated that hospital losses due to the proposed public charge rule in New York State could total $2.7 billion, in California $5.2 billion, in Connecticut $163 million and in Vermont $3 million. In the New York City-Newark metropolitan area the losses could be $3.1 billion and losses could reach $2.0 billion in the Los Angeles area.

70. Public health directors have commented on the major damage engendered by the public charge policies. In November 2018, Mitchell Katz, MD, MPH, who directs New York City's Health and Hospitals system and previously led the health departments of Los Angeles County and San Francisco and is one of the nation's foremost authorities on public health and health care systems stated: "If enacted as proposed, this public charge provision could decrease access to medical care and worsen the health of individuals, threaten public health, and undercut the viability of the health care system."[71]

71. The results of the loss of Medicaid benefits would spill over into harm for hospitals, clinics and related facilities, both because of their underlying commitments to serve disadvantaged patients, but in many cases because of state laws that require them to provide care to the indigent who are otherwise uninsured. For example, under Section 2807-k(9-a) of the New York State Public Health Law, the state requires that hospitals must limit what they can charge low-income uninsured patients, effectively requiring them to accept losses to care for such patients.[72] Section 17000 of the California Welfare and Institutions Code requires cities and counties to assume responsibilities for care: "Every county and every city and county shall relieve and support all incompetent, poor, indigent persons, and those incapacitated by age, disease, or accident, lawfully resident therein, when such persons are not supported and relieved

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[71] Katz M, Chokshi D. The "Public Charge" Proposal and Public Health: Implications for Patients and Clinicians. *Journal of the American Medical Association*. 2018;320(20):2075-2076. Nov. 27, 2018.

[72] New York State Department of Health. Understanding Your Financial Aid Rights. https://profiles.health.ny.gov/hospital/pages/financial_aid_info. Accessed Aug. 22, 2019.

by their relatives or friends, by their own means, or by state hospitals or other state or private institutions." Similar laws at state and local levels across the country that require efforts to provide indigent care and the loss of Medicaid coverage by millions of members of immigrant families would shift costs and burdens onto states, local governments and health care providers, as well as reducing access to care by those who lose their insurance.

72. Other researchers have analyzed broader economic consequences of the public charge rule. For example, a report by researchers at the University of California[73] estimated the impact of the proposed public charge rule on California. The researchers began by estimating the potential loss of Medicaid and SNAP (called Medi-Cal and CalFresh in California) benefits by members of immigrant families in California, then estimated the level of federal revenue (Medicaid matching funds and federal SNAP payments) would be lost, a combined loss of $1.7 billion in federal benefits received in California. Because these benefits pay for health care services and food, the lost federal revenue decreases money going to pay hospitals, doctors' offices, grocery stores, and other businesses, and this in turn lower payments made to staff and to vendors, such as food producers, which have effects that multiply through the economy. The researchers then used economic models to estimate the number of jobs that would be lost due to the reduction in federal revenue. They estimated that this could cost California 17,700 jobs, about half of which are in health care, 10 percent in the food sector and the rest in other areas of the state's economy.

73. The reports cited above are just a portion of the analyses, mostly conducted soon after the proposed public charge rule was released, that attempt to demonstrate the economic

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[73] Ponce N, Lucia L, Shimada T. Proposed Changes to Immigration Rules Could Cost California Jobs, Harm Public Health. UCLA Center for Health Policy Research. Dec. 2018. https://healthpolicy.ucla.edu/publications/Documents/PDF/2018/publiccharge-factsheet-dec2018.pdf.

harm that would occur among community health centers, hospitals, states and local areas. Despite the diversity in data, methods and issues examined, they are consistent in indicating that the public charge rule would have broad and harmful effects on state and local governments, health care providers and the communities they serve.

H. Other Harmful Health Care Aspects of the Public Charge Rule

74. The public charge rule includes other provisions that relate to health insurance coverage or health status. Not only is the receipt of Medicaid a heavily weighted negative factor, so are: (a) having a serious medical condition that could result in hospitalization or extensive medical care or interfere with the ability to work or (b) being uninsured with no prospect of obtaining private insurance, nor having the ability to pay for care (§212.22(c)(1)(iii)). In contrast, heavily weighted positive factors include having an income greater than 250 percent of the federal poverty line or having private insurance, not including private coverage obtained through the Health Insurance Marketplace (also known as "Obamacare") subsidized with premium tax credits (§212.22(c)(2)).

75. Table 5 presents data on the health insurance coverage of adults who are low-income (with incomes below 200 percent of poverty) members of immigrant families and of low-income and upper-income families without immigrants, based on further analyses of the 2017 National Health Interview Survey.[74] Low-income members of immigrant families are much more likely to be uninsured (38 percent) than low-income adults not in immigrant families (19 percent) and higher-income adults not in immigrant families (7 percent). Moreover, members of

[74] Author's analysis of the 2017 National Health Interview Survey. https://www.cdc.gov/nchs/nhis/index.htm.

low-income immigrant families are less likely to be covered by private insurance, Medicaid or other insurance than low-income adults who are not in immigrant families.

Table 5.
Health Insurance Coverage of Adult (21-64) Members of Immigrant Families and Those Who are Not Members of Immigrant Families, 2017

	Low-income Member of Immigrant Family	Low-income Not Member of Immigrant Family	Not Low-income Not Member of Immigrant Family
Private Insurance	28.5%	35.4%	83.4%
Health Insurance Marketplace	1.5%	1.2%	1.3%
Medicaid /CHIP	29.0%	35.7%	4.2%
Other (e.g., Medicare, military)	3.0%	8.6%	3.8%
Uninsured	38.0%	19.1%	7.3%
Total	100.0%	100.0%	100.0%

Source: Author's analysis of 2017 National Health Interview Survey

76. Medicaid eligibility for non-citizen immigrants was sharply restricted by PRWORA; analyses show that non-citizen immigrants are much less likely to get Medicaid than low-income citizens.[75] But the largest reason that immigrants are less insured is that, although they have high labor participation rates, immigrants often work in jobs, such as construction, agriculture, hospitality or food processing jobs, that do not offer insurance to their employees.[76] Immigrants are simply less likely to be offered insurance, whether by the government or by their employers. The public charge rule creates a further disadvantage to the uninsured, which

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[75] Ku L, Bruen B. Poor Immigrants Use Public Benefits at a Lower Rate than Poor Native-Born Citizens, *Economic Development Bulletin* No. 17, Washington, DC: Cato Institute. March 4, 2013 http://www.cato.org/sites/cato.org/files/pubs/pdf/edb17.pdf.

[76] Buechmuller T, LoSasso T, Lurie I, Dolfin S. Immigrants and Employer-Sponsored Health Insurance. *Health Services Research* 2007; 42(1): 286-310.

disproportionately harms low-income members of immigrant families, particularly Latinos, despite their participation in the workforce.

77. Having private insurance is a heavily weighted positive factor in public charge determinations, but immigrants have lower opportunities to get private insurance than those who are not in immigrant families. Data from the 2017 National Health Interview Survey indicate that 21 percent of immigrants who lack coverage report that it was because it was not offered in their jobs, because they were rejected by an insurance company, lost their job or changed companies, changed family status (e.g., divorced), or because the cost was too high, compared to 10 percent of low-income adults not in immigrant families and 4 percent of higher income adults not in immigrant families. In addition, since those who get insurance through the Health Insurance Marketplaces with federal tax subsidies cannot count that insurance as a heavily weighted positive factor, about 1.5 percent of the low-income members of immigrant families will not receive this positive factor either.

78. Under the public charge rule, members of immigrant families can be penalized if they use Medicaid or are uninsured. Any expectation that they may make up this gap by gaining private insurance is unrealistic. For example, in 2018, the average total cost of health insurance in an employer-sponsored plan was $6,715 for single person and was $19,565 for a family; these levels are out of reach for almost all low-income immigrants if they are not offered insurance by their employers or get federal tax premiums to help them buy coverage through Health Insurance Marketplaces. Less than a third of the adults in low-income immigrant families (28.5 percent) have the private insurance that could count as a highly weighted positive factor; most of the rest would face negative immigration consequences under the rule.

I. Current or Past Status of Immigrants Does Not Predict Their Future Economic Success

79. According to DHS, the overarching goal of its revised public charge policies is to "better ensure that applicants for admission to the United States and applicants for adjustment of status to lawful permanent residency…are self-sufficient."[77] To accomplish this DHS will use current or past characteristics of immigrant applicants, such as use of public benefits, being uninsured or having a low income, to effectively predict the future economic status of immigrants.

80. A fundamental question is whether receiving Medicaid interferes with a recipient's economic status or employment. The strongest evidence comes from a rigorous study conducted in Oregon by Harvard University researchers that found that receiving Medicaid did not significantly discourage employment or lower earnings by low-income adults.[78] Medicaid did not harm their chances of employment or earnings; it just gave them health insurance coverage to address their medical needs. This study used a randomized experiment, the strongest possible evaluation design, to compare those who received Medicaid and those who did not and found that those who gained Medicaid coverage had equivalent employment rates and earnings levels as those who did not. Receiving Medicaid does not make recipients less likely to work or able to meet their economic needs. Instead it provides health insurance coverage that helps them meet their health care needs that can help them maintain employment and well-being.

81. Research and experience also indicates the hazard of predicting future economic status based on past performance. Immigrants are often initially disadvantaged when they first arrive in the United States; they have limited American job experience and have not developed

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[78] Baicker K, Finkelstein A, Song J, Taubman A. The Impact of Medicaid on Labor Market Activity and Program Participation: Evidence from the Oregon Health Insurance Experiment. *American Economic Review.* 2014, 104(5): 322–328.

the social and business networks that enable people to find better work, but their status improves rapidly. Research consistently shows that when immigrants first enter, they tend to have lower incomes than similar U.S.-born adults, but their earnings grow rapidly as they remain in the US and gain experience, skills and opportunities, enabling them to integrate into the economic mainstream.[79] The prototypical immigrant success story is one of a person who comes to the U.S. with nothing in his or her pocket, but, through hard work and persistence, eventually becomes a success. For example, analyses of Census data reveal that immigrants without a high school education, such as those targeted by the public charge rule, initially have lower average incomes than similar U.S.-born citizens (with the same gender, age, and education), but the immigrants' incomes catch up and then surpass their U.S.-born peers within six or seven years.[80] Public charge policies make it harder for the immigrant to remain in the U.S. and thus jeopardize their ability to improve their economic status. There is even stronger evidence of the economic and educational success of "second generation" immigrants, the U.S.-born children of immigrants.[81] Public charge policies that reduce the ability of immigrants or their children to remain in the United States could short-circuit their subsequent economic well-being.

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[79] *See, e.g.*, Chiswick B. The effect of Americanization on the earnings of foreign-born men. *Journal of Political Economy* October 1978: 897–922; Duleep H, Dowhan D. Research on immigrant earnings. *Social Security Bulletin*. 2008; 68(1): 31-50; Kaushal N, et al. Immigrant employment and earnings growth in Canada and the USA: evidence from longitudinal data. *Journal of Population Economics*. 2016; 29(4): 1249–1277; Borjas G, Friedberg R. Recent trends in the earnings of new immigrants to the United States. National Bureau of Economic Research Working Paper 15406. Oct.2009.

[80] Ku L, Pillai D. The Economic Mobility of Immigrants: Public Charge Rules Could Foreclose Future Opportunities. Nov. 15, 2018. Social Science Research Network. http://ssrn.com/abstract=3285546.

[81] Pew Research Center. Second-Generation Americans: A Portrait of the Adult Children of Immigrants. Feb. 2013. https://www.pewresearch.org/wp-content/uploads/sites/3/2013/02/FINAL_immigrant_generations_report_2-7-13.pdf; Doung M, et al. Generational Differences in Academic Achievement Among Immigrant Youths: A Meta-Analytic Review. *Review of Education Research*. 2016; 86(1): 3-41.

I declare under penalty of perjury that the foregoing is true and correct.

Executed on this 9th day of September, 2019.

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Leighton Ku

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

STATE OF NEW YORK, et al., Plaintiffs, v. UNITED STATES DEPARTMENT OF HOMELAND SECURITY, et al., Defendants.	19 Civ. 7777 (GBD)

I, **Diane Whitmore Schanzenbach**, declare pursuant to 28 U.S.C. § 1746 that the following is true and correct:

1. My name is Diane Whitmore Schanzenbach. I make this declaration in support of Plaintiffs' Request for a preliminary injunction.

Background

2. I am the Director of the Institute for Policy Research at Northwestern University, where I am also the Margaret Walker Alexander Professor of Social Policy and Economics. For the past two decades, I have conducted and published numerous peer-reviewed research studies and book chapters on the Supplemental Nutrition Assistance Program, commonly known as SNAP. I recently served as a member of the Institute of Medicine's Committee on Examination of the Adequacy of Food Resources and SNAP Allotments, and the Committee on National Statistics of the National Academy of Sciences Committee on Improving Consumer Data for Food and Nutrition Policy Research for the Economic Research Service, United States Department of Agriculture (USDA). I was previously the Director of the Hamilton Project, an economic policy initiative at the Brookings Institution. I hold a Ph.D. in economics from Princeton University. My declaration draws primarily from research that I have conducted or

reviewed that use economic and econometric methods to consider the role of SNAP and other influences on food consumption, food insecurity, economic well-being, and other outcomes. My Curriculum Vitae is attached as Exhibit A to this declaration.

3. I have previously testified before the House Agriculture Committee and the U.S. Senate Committee on Agriculture, Nutrition and Forestry regarding SNAP. I have previously provided an expert declaration in *Texas Taxpayer & Student Fairness Coalition, et al. v. Edgewood Independent School District, et al. v. Robert Scott*, Cause No. D-1-GN-11-003130 (200th Judicial District, Texas). I have not provided testimony in any other litigation.

4. I have been engaged by counsel for Plaintiffs in this case to evaluate the effect of the new public charge rule ("the public charge rule" or "the Rule")[1] on the use of SNAP benefits and the resulting effects on individuals, communities, and the nation.

Summary

5. As described below, from my expert review, I conclude that because of the chilling effects of the public charge rule, enrollment among SNAP households with immigrant members will decline by nearly 20 percent and that 524,897 households will not participate in SNAP due to the Rule. These households include 1.78 million individuals, many of whom are citizens. The loss of SNAP benefits will cause substantial harm to households and their communities, and will especially cause harm to young children in those households; 35 percent of participating SNAP households with noncitizen members had a young child between ages 0 and 4 in the household. Research reviewed below suggests that the loss of these benefits will have lasting impacts on health and well-being in the short-, medium, and long-term. I also conclude that the annual economic loss from foregone SNAP benefits due to the Rule will be

[1] Inadmissibility on Public Charge Grounds, 84 Fed. Reg. 41,292 (Aug. 14, 2019) (to be codified at 8 C.F.R. pts. 103, 212, 213, 214, 245, 248).

$2.0 billion and that the economic multiplier impacts of these losses yields a likely annual economic loss of $3.2 billion.

6. My findings show that the Department of Homeland Security (DHS) and U.S. Citizenship and Immigration Service (USCIS) misunderstand the supplemental nature of SNAP. Participating SNAP households with immigrant members on average receive a minority of their total resources from SNAP payments. In data from 2017, over half of SNAP households with immigrant members that did not contain an elderly or disabled member had earnings in the month they received benefits.

7. I also found significant problems in DHS's estimates. First, DHS substantially understates the number of immigrant households that may be impacted. I estimate that there are 2.6 million households on SNAP that include noncitizen members, and these households include 6.5 million people who receive SNAP, and 8.9 million individuals overall in the households, whereas DHS estimates that there are 1.5 million households on SNAP that include noncitizen members, and these households include 5.1 million individuals.

8. Second, DHS compounds this error by making an unreasonable estimate of a likely disenrollment effect based on chilling effects estimates that are substantially outside of the range of credible social science estimates. A justifiable estimate is that enrollment among SNAP households with immigrant members will decline by around 20 percent. I estimate that 524,897 households will not participate in SNAP due to the Rule. These households include 1.78 million individuals, whereas DHS estimates that there will be 65,612 households and 222,868 households that will not participate.

9. I predict the annual total amount of foregone SNAP benefits due to the Rule will be $2.0 billion. This figure is about 10 times greater than DHS's estimates,[2] which are flawed both in terms of the number of SNAP households with immigrant members and in the likely rate of disenrollment or foregone enrollment. Including the economic multiplier impacts of these losses yields a likely annual economic loss of $3.2 billion. The estimated lost benefits to the state of New York will be $179 million annually, which will result in $287 million in lost economic activity. Connecticut is estimated to lose $22.7 million in benefits and $36.3 million in economic activity. Vermont is estimated to lose $1.0 million in benefits and $1.6 million in economic activity.

I. Background on SNAP

A. Overview of SNAP

10. The Supplemental Nutrition Assistance Program (SNAP), previously known as the Food Stamp Program, is a cornerstone of the U.S. safety net. SNAP is the only social benefits program universally available to low-income Americans, and, in 2018, it assisted 40 million people in a typical month—about one out of every eight Americans. Overall, $60.6 billion was spent on benefits in 2018. SNAP benefits typically are paid once per month on an electronic benefits transfer card that can be used in a food retailer's checkout line like a debit card, to purchase eligible goods which include most foods that are intended to be taken home and eaten.

11. SNAP is designed to prop up families' purchasing power when their incomes are low, and helps to buffer households' economic shocks due to job loss or other income declines. SNAP also has a stated goal of strengthening the agricultural economy, and every $1 increase in

[2] *See* Regulatory Impact Analysis, Inadmissibility on Public Charge Grounds, Table 22.

SNAP benefits has been shown to increase economic activity in the economy by $1.60.[3] In addition, SNAP plays an important role as an automatic stabilizer, responding powerfully and quickly in times of economic downturns. During a recession, as unemployment rises, many families' incomes fall, making more of them eligible for SNAP benefits (or making those already eligible for SNAP eligible for larger benefits). Benefits are quickly spent, generally in the local economy, providing an economic stimulus.[4]

12. SNAP benefits are designed to fill the gap between a family's resources that are available to purchase food and the price of a low-cost food diet. Maximum benefits vary by household size. The maximum monthly benefit for a family of three in fiscal year 2019 is $505, or about $17 per day. Most families do not receive the maximum benefit because they have some resources (for example, earnings) that they can spend on groceries, and SNAP benefits are reduced accordingly. The average monthly SNAP benefit received for a family of three in 2019 is $378, or a little over $12 per family per day (approximately $4 per person per day).[5]

13. By design, SNAP can very quickly adapt to declining economic conditions. During a recession as more households become eligible for the program they can be quickly enrolled, with total program outlays automatically increasing along with need. SNAP payments and caseloads increased in the wake of the Great Recession, and, at their peak in 2012, 15 percent of the population participated in SNAP.[6] As the economy has recovered and unemployment rates have declined, caseloads have fallen such that by 2018 the participation rate

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[3] Bivens, Josh. 2011. Method memo on estimating the jobs impact of various policy changes. Report, Economic Policy Institute.

[4] Hoynes, Hilary and Diane Whitmore Schanzenbach. 2019. Strengthening SNAP as an Automatic Stabilizer. In Boushey, Heather, Ryan Nunn and Jay Shambaugh, eds., Recession Ready: Fiscal Policies to Stabilize the American Economy.

[5] *See* CBPP, A Quick Guide to SNAP Eligibility and Benefits, https://www.cbpp.org/research/food-assistance/a-quick-guide-to-snap-eligibility-and-benefits.

[6] Schanzenbach, Diane Whitmore. 2017. The Future of SNAP: Continuing to Balance Protection and Incentives. In Reforming the Farm Bill, American Enterprise Institute.

fell to 12.3 percent of the population, with the Congressional Budget Office predicting further declines in the coming years as long as the economy continues to thrive.[7] This feature of SNAP means that a household's likelihood of participating in SNAP varies due to macroeconomic conditions that are out of their control.

B. Eligibility for SNAP

14. Under federal rules, to be eligible for SNAP a household's income and assets must meet three tests. First, their gross monthly income (before any deductions are applied) must be no higher than 130 percent of the poverty line, unless there is an elderly or disabled member in the household. Second, their net income must be no higher than 100 percent of the poverty line (after a series of deductions—including a standard deduction available to all households, some earned income, childcare expenses, legally obligated child support, housing costs that exceed half of the family's net income, and medical expenses for elderly or disabled household members).[8] Third, the household's assets must fall below $2,250, or $3,500 (which generally include bank accounts, but not other significant assets such as retirement savings, most automobiles, or homes of residence) for households with an elderly or disabled member. States have the option to raise the gross income and asset limits; in 2019, 31 states have adopted higher income and asset limits, and another nine states have adopted higher asset limits only.[9] As a result, many SNAP participants have income above the poverty line and many have significant assets.[10,11] During normal economic times, unemployed, nondisabled childless adults (also

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7 Greenstein, Robert, Brynne Keith-Jennings, and Dottie Rosenbaum. 2018. Factors Affecting SNAP Caseloads. Center on Budget and Policy Priorities.

8 All SNAP households are eligible for the standard deduction, 69 percent claim the shelter deduction, and 31 percent claim the earnings deduction. Childcare, child support, and medical expense deductions are claimed by four, two, and six percent, respectively (CBPP, A Quick Guide to SNAP Eligibility and Benefits).

9 Schanzenbach, Diane. 2019. Who Would Be Affected by Proposed Changes to SNAP? Econofact.

10 Schanzenbach, Diane. 2019. Who Would Be Affected by Proposed Changes to SNAP? Econofact.

11 Ratcliffe, Caroline, Signe-Mary McKernan, Laura Wheaton, Emma Kalish, Catherine Ruggles, Sara Armstrong, and Christina Oberlin. 2016. Asset Limits, SNAP Participation and Financial Stability. Urban Institute Report.

known as ABAWDs, or "able-bodied adults without dependents") are subject to a 20-hour-per-week work requirement in order to receive benefits.

15. Some noncitizens are eligible for SNAP, and may be awarded benefits if they also satisfy the program's other eligibility requirements such as income and resource limits. Noncitizens may be eligible if they are in a qualified aliens category and, in most cases, meet one additional condition. Qualified aliens include: lawfully admitted for permanent residence (LPRs, or green card holders) also including Amerasian immigrants; asylees; parolees; deportation (or removal) withheld; conditional entrants; Cuban or Haitian entrants; battered noncitizens; refugees; trafficking victims; Iraqi and Afghan Special Immigrants; certain American Indians born abroad; and certain Hmong or Highland Laotian tribal members. In addition, most qualified aliens must also meet one of the following conditions to be eligible for SNAP: five years of United States residence; 40 qualifying work quarters; under the age of 18; blind or disabled; elderly who lawfully resided in the U.S. on August 22, 1996; and active duty military (excluding National Guard) or honorably discharged veterans. Noncitizens that are tourists or students are generally not eligible. Undocumented noncitizens have never been eligible for SNAP, though such individuals may live in a household that receives SNAP benefits for other members.

16. In some cases, an intending immigrant undergoing adjustment would be eligible for SNAP before his or her green card application is approved. More commonly, the applicant undergoing the public charge determination only would be eligible for SNAP five years after he or she adjusts. But an adjusted LPR may be eligible for SNAP sooner if he or she is under age 18, in receipt of a disability-based benefit, can be credited with 40 qualifying quarters of work, or was lawfully residing in the United States and 65 or older when PRWORA was signed into law on August 22, 1996.

C. Background on Characteristics of SNAP Users

17. USDA collects information on participating SNAP households in its "Quality Control (QC) Data," which are publicly available on the agency's website.[12] In this section, I use these data to describe SNAP households in the 50 states plus the District of Columbia, broken into two groups: (1) all households on SNAP, for comparison; and (2) households that receive SNAP benefits and contain at least one member who is a noncitizen, whether or not the noncitizen member(s) are eligible for or themselves participate in SNAP. DHS's Regulatory Impact Analysis issued with the Rule stated that it based its calculations on the total share of foreign-born noncitizens as a percentage of the U.S. population,[13] and my analysis mirrors that approach. As shown in Table 1, 11.3 percent of SNAP households have a noncitizen household member (column 2).

18. As shown in Table 1, 11.3 percent of SNAP households have a noncitizen household member (column 2). Households with noncitizens are more likely than households on SNAP in general to have any child or a young child (age 0 to 4) in the household and less likely to have an elderly or disabled member as the overall caseload. Households with noncitizens have larger household sizes than SNAP households overall, and all else equal, that implies that they will receive larger SNAP benefits due to the larger household size.

Table 1: Demographic Characteristics of SNAP Households (2017)

	All SNAP Households (1)	SNAP Households with Any Noncitizen

[12] The SNAP QC data are generated from monthly reviews of SNAP cases conducted by state SNAP agencies, to assess the accuracy of eligibility determinations and benefit calculations. The public-use database contains detailed demographic, economic, and SNAP eligibility information for a nationally representative sample of approximately 45,500 SNAP units. The data are released annually, and are available at the following website: https://www.fns.usda.gov/resource/snap-quality-control-data.

[13] *See* Regulatory Impact Analysis, Inadmissibility on Public Charge Grounds, Table 14.

		(2)
Share of HH's on SNAP	100.0%	11.3%
Share of HH's with children aged 0–4	20.4%	34.6%
Share of HH's with children < age 18	41.7%	67.4%
Share of HH's w/elderly or disabled member	44.4%	28.3%
Average household size	2.18	3.33

19. SNAP households with noncitizens are substantially more likely to include someone who is employed (measured as having earnings greater than zero) than the overall SNAP caseload. Among SNAP households that do not contain an elderly or disabled member, 58.7 percent of households with noncitizen members have earnings in a given month, compared with 31.4 percent of SNAP households overall. In my calculations, earnings are measured as a snapshot — measuring those having positive earnings in the month that they participated in the SNAP QC data collection. Studies that use different datasets that can follow SNAP participants over time (including in months that they do not receive SNAP benefits) estimate even higher shares of employment.[14] SNAP participants tend to work in sectors that have variable hours and higher rates of job turnover and unemployment.[15] As a result, measuring employment in a single month for this population understates the share that will be employed at some point in the months surrounding SNAP receipt. Consistent with this increased likelihood of having earnings, SNAP comprises a smaller share of the total household budget for households with noncitizen

14 These studies follow SNAP participants in general, and due to data limitations cannot reliably separate immigrant SNAP participants. Longitudinal studies find that 74 percent of adults on SNAP work in the year before or after they receive SNAP benefits. About two-thirds of SNAP recipients are not expected to work, primarily because they are children, elderly or disabled. See Center on Budget and Policy Priorities. 2019. Policy Basics: The Supplemental Nutrition Assistance Program (SNAP).

15 Butcher, Kristin F. and Diane Whitmore Schanzenbach. 2018. Most Workers in Low-Wage Labor Market Work Substantial Hours, in Volatile Jobs. Center on Budget and Policy Priorities. Policy Futures Report.

members than it does for the overall caseload.[16] Reflecting in part larger household sizes, households with noncitizens receive more in monthly SNAP benefits than the overall caseload.

Table 2: Economic Characteristics of SNAP Households (2017)

	All SNAP Households (1)	SNAP Households with Any Noncitizen (2)
Share with earnings (among households without elderly/disabled members)	31.4%	58.7%
SNAP as a share of total income	36.9%	35.0%
Average monthly SNAP benefits	$244.90	$305.60

Because the data contains information on detailed citizenship status for each household member, I can describe mixed-status households which include noncitizens as well as citizens. Among SNAP households with a married couple head and at least one child in the household, I calculate that 13.6 percent of spouses have different immigration statuses from one another. As shown in Table 3 below, 5.7 percent of SNAP households overall have at least one noncitizen parent and at least one citizen child (including 4.8 percent with only a citizen child or children, and 0.9 percent that have at least two children, at least one of whom is a citizen and at least one of whom is not). The majority of mixed-status families have young children, ages 0 to 4, in the household. Prior research (further described below) suggests that a substantial share of citizen children with immigrant parents dropped off SNAP when many immigrants were temporarily barred from the program in 1996, even though citizen children were still eligible for SNAP.[17] Research also shows that the impact of SNAP on later-life economic and health outcomes is important for

[16] SNAP as a share of total income is calculated as SNAP benefits as a share of SNAP benefits plus earnings plus unearned income.

children through age 18, and is particularly large for young children, underscoring the need to protect young children from the loss of SNAP benefits.[18]

Table 3: Characteristics of Households Receiving SNAP, by Citizenship of Parents and Children (2017)

	Citizen Parent, Citizen Child (1)	Noncitizen Parent, Citizen Child (2)	Noncitizen Parent, Mixed-status Children (3)	Noncitizen Parent, Noncitizen Child (4)
Share of total caseload	33.5%	4.8%	0.9%	0.6%
Household contains a young child (0–4)	49.6%	53.1%	60.4%	14.0%
Average benefit	$402.12	$353.71	$337.02	$340.84

D. Positive Impacts to Individuals and Families Who Receive SNAP

20. Many studies have documented a range of positive impacts of SNAP benefits on those who participate, both in the short-run and for children in the medium- and long-run. Loss of access to SNAP benefits will cause substantial harm to households and their communities, and will especially cause harm to young children in those households.[19]

21. Studies show that SNAP reduces poverty: SNAP kept 8.4 million people out of poverty in 2015 (the most recent data available), including 3.8 million children. It also lifted 4.7 million people, including 2.0 million children out of deep poverty, defined as household income

[17] East, Chloe N. Forthcoming. The Effect of Food Stamps on Children's Health: Evidence from Immigrants' Changing Eligibility. *Journal of Human Resources.*

[18] Hoynes, Hilary, Diane Whitmore Schanzenbach, and Douglas Almond. 2016. Long-run impacts of childhood access to the safety net. *American Economic Review* 106 (4): 903–34.

[19] Most of the SNAP studies described below measure the impact on participants generally—not just on immigrants, however, it is reasonable to assume that SNAP impacts on immigrants are similar to those on participants overall. This assumption can be tested in the case of pregnant women's access to SNAP. Studies of the overall SNAP population and those limited to immigrants show that SNAP benefits have similar positive impacts on birth outcomes for both groups. *See* Almond, Douglas, Hilary W. Hoynes, and Diane Whitmore Schanzenbach. 2011. Inside the war on poverty: The impact of food stamps on birth outcomes. *The Review of Economics and Statistics* 93.2 (2011): 387–403. *See also* East, Chloe N. Forthcoming. The Effect of Food Stamps on Children's Health: Evidence from Immigrants' Changing Eligibility. *Journal of Human Resources.*

below half of the poverty threshold.[20] SNAP participation has been shown to reduce food insecurity and improve dietary quality,[21] and also improves measures of economic distress such as falling behind on mortgage or utility payments or forgoing medical treatment due to lack of resources.[22]

22. SNAP has long-lasting positive effects: Recent research has documented important benefits of SNAP beyond the short-term "in the moment" reductions in poverty and food insecurity. SNAP is a very good investment that helps prevent lasting negative effects of inadequate childhood resources, demonstrably improving children's health in the short, medium, and long run, and children's economic outcomes in the long run.

23. Some of the best evidence comes from studies of birth cohorts that had differential access to SNAP—then called the food stamp program—when it was originally introduced in the 1960s as part of the War on Poverty. Congress phased in the program across different counties over the span of a decade, which provides researchers the opportunity to statistically isolate the program's impact by comparing children born at different times—and living in different counties in the same states—during the rollout period.

24. One study using this design demonstrates that when a pregnant woman had access to the program during her third trimester, her baby weighed more at birth, and was also less likely to weigh below the clinical threshold of low birth weight.[23] This outcome was significant

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[20] Wheaton, Laura and Victoria Tran. 2018. The Antipoverty Effects of the Supplemental Nutrition Assistance Program. The Urban Institute.

[21] Bitler, Marianne P. 2016. The Health and Nutrition Effects of SNAP: Selection into the Program and a Review of the Literature on its Effects. In *SNAP Matters: How Food Stamps Affect Health and Well-Being*, J. Bartfeld, C. Gundersen, T. Smeeding, and J. Ziliak (eds.), Redwood City, CA: Stanford University Press, 134-160.

[22] Shaefer, H. Luke and Italo. A. Gutierrez. 2013. The Supplemental Nutrition Assistance Program and material hardships among low-income households with children. *Social Service Review* 87 (4): 753–779.

[23] Almond, Douglas, Hilary W. Hoynes, and Diane Whitmore Schanzenbach. 2011. Inside the war on poverty: The impact of food stamps on birth outcomes. *The Review of Economics and Statistics* 93.2 (2011): 387–403.

because a child that has a weight below this clinical threshold is more likely to encounter health and development problems.[24]

25. Subsequent studies evaluate adult outcomes for those given access to SNAP during childhood, and find that SNAP causes improvements in education, health, and economic outcomes. In particular, access to SNAP from conception through age 5 increased a child's likelihood of graduating from high school by 18 percentage points.[25]

26. Adult health—measured as an index comprising obesity, high blood pressure, diabetes, heart disease and heart attack—was markedly improved if the individual had access to the program during early childhood.[26] Looking at a broader range of economic and education outcomes, among women SNAP access improved an index of adult economic outcomes including educational attainment, employment, earnings, family income, and reduced the likelihood that they would be poor or participate in SNAP or TANF (the cash welfare program) during adulthood. There were positive impacts on economic and education outcomes for SNAP access from age 6 through 18 as well as from conception through age 5.[27]

27. More recent research extends this work and finds that early life access to SNAP benefits leads to improvements in long-term earnings and education, and reductions in mortality and criminal activity.[28] In other words, SNAP provides critical benefits to children, which increases their health and human capital accumulation during childhood, which, in turn, helps

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[24] Figlio, D., Guryan, J., Karbownik, K. and Roth, J., 2014. The effects of poor neonatal health on children's cognitive development. *American Economic Review*, 104 (12), 3921–55.

[25] Hoynes, Hilary, Diane Whitmore Schanzenbach, and Douglas Almond. 2016. Long-run impacts of childhood access to the safety net. *American Economic Review* 106 (4): 903–34.

[26] *Ibid.*

[27] Impacts of SNAP access in later childhood did not impact health outcomes, though. See Hoynes, Hilary, Diane Whitmore Schanzenbach, and Douglas Almond. 2012. Long-run impacts of childhood access to the safety net. *NBER Working Paper 18535*.

[28] Bailey, Martha, Hilary Hoynes, Maya Rossin-Slater, and Reed Walker. 2019. Is the Social Safety Net a Long-Term Investment? Large-Scale Evidence from the Food Stamps Program. *Goldman School of Public Policy Working Paper*.

them to escape poverty when they grow up. A decline in the availability of benefits is likely to lead to worse outcomes for these children in adulthood.[29]

28. Other high-quality evidence on the impact of SNAP are based on a policy change which temporarily barred many legal immigrants from the program. In 1996 after the passage of the Personal Responsibility and Work Opportunity Act as part of welfare reform, many legal immigrants were barred from SNAP participation.[30] In 1998 and 1999, a few states began restoring benefits using their own state funds. At the Federal level, benefits were restored in April 2003 for many immigrants. One study focuses on these SNAP immigrant eligibility changes to investigate the impact on U.S. citizen children born to immigrants.[31] Even though the children's eligibility for SNAP remained unchanged, a substantial share of them stopped participating in SNAP when their parent(s) lost access to the program. The study finds that SNAP participation rates among children of immigrants declined by eight percentage points when their parent(s) lost access, and that on average this policy change resulted in $185 in monthly SNAP benefits lost per household. The study then estimates the impact of this decline in SNAP participation during early childhood (conception through age 4) on subsequent health (measured at ages 6–16), and finds declines in parent-reported health and increases in school absences. Furthermore, loss of access to SNAP among pregnant women in their third trimester due to this policy change resulted in lower birth weights and an increased likelihood of a low birth weight birth.

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[29] Hoynes, Hilary W. and Diane Whitmore Schanzenbach. 2018. Safety Net Investments in Children. *Brookings Papers on Economic Activity*, Spring.

[30] The rules were different for immigrants who were in the country before August 22, 1996 when welfare reform was enacted and for those who arrived after welfare reform. This study is limited to those who arrived prior to welfare reform.

[31] East, Chloe N. Forthcoming. The Effect of Food Stamps on Children's Health: Evidence from Immigrants' Changing Eligibility. *Journal of Human Resources.*

E. Positive Impacts to Society of SNAP for Immigrant Families.

29. There are a number of spillover impacts onto society at large from SNAP participation among immigrant families. SNAP has an important direct stimulus impact on the economy. Its recipients quickly spend the benefits, providing a relatively rapid fiscal stimulus to the local economy including the retail, wholesale, and transportation systems that deliver the food purchased. The USDA estimates that every $5 in new SNAP benefits generates as much as $9 of economic activity.[32] This translates into almost 10,000 jobs from $1 billion dollars in additional SNAP spending. The Congressional Budget Office estimates that on average $1 in changed SNAP spending yields $1.50 in economic benefits, while Mark Zandi of Moody's Analytics' Economy.com estimates the benefits to be $1.70 for every dollar in changed SNAP spending. In the simulations that follow, I adopt the midpoint between these estimates, $1.60 for every $1 in changed SNAP spending.[33]

30. Many of the direct effects described in the section above also have spillover impacts to the broader society. Increased food insecurity will likely increase demand at food banks and other food charities.[34] Decreases in SNAP participation result in worse health outcomes,[35,36] and are associated with increased health care expenditures.[37] There are expected education costs as well. Declines in SNAP participation increase school absence rates[38] and

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[32] Hanson, Kenneth. 2010. The Food Assistance National Input-Output Multiplier (FANIOM) Model and Stimulus Effects of SNAP. USDA, Economic Research Service, *Economic Research Report Number 103*.

[33] *See* Bivens, Josh. 2011. Method memo on estimating the jobs impact of various policy changes. Report, Economic Policy Institute.

[34] Bazerghi, C., McKay, FH, and Dunn M. 2016. The Role of Food Banks in Addressing Food Insecurity: A Systematic Review. *Journal of Community Health* 41(4): 732–40.

[35] East, Chloe N. Forthcoming. The Effect of Food Stamps on Children's Health: Evidence from Immigrants' Changing Eligibility. *Journal of Human Resources.*

[36] Hoynes, Hilary, Diane Whitmore Schanzenbach, and Douglas Almond. 2016. Long-run impacts of childhood access to the safety net. *American Economic Review* 106 (4): 903–34.

[37] Berkowitz, Seth, Hilary K. Seligman, and Sanjay Basu. 2017. Impact of Food Insecurity and SNAP Particpation on Healthcare Utilization and Expenditures. University of Kentucky Center for Poverty Research White Paper.

[38] East, Chloe N. Forthcoming. The Effect of Food Stamps on Children's Health: Evidence from Immigrants' Changing Eligibility. *Journal of Human Resources.*

reduce participation in school meals.[39] Another study has shown that math and reading test scores in grades 3 through 8 are lower when SNAP benefits are inadequate.[40] Fewer resources for children can drive up education costs in the short- and medium-run due to increased need for special education, more grade retentions, and higher absenteeism.[41] Many of the long-run impacts on economic and health outcomes from children's access to SNAP also have social aspects. For example, increased earnings result in decreased costs for future social benefits programs and increased tax revenues; removing children from SNAP would reverse these long-term gains.[42]

II. Likely Adverse Impacts of Public Charge Rule

A. Impact on Noncitizen Households

31. To determine the likely impact of the Public Charge rule, one must estimate the number of people living in households that participate in SNAP that also have a noncitizen member of the household, in order to determine the population "at risk" of nonparticipation in SNAP. One must also estimate the share of this group who will drop off of SNAP or will forego applying for benefits due to the Rule. Multiplying the "at risk" population by the share who are likely to drop off gives the number of people expected to exit or forego SNAP due to the Rule. Estimating the average benefit per person in households with immigrants allows for calculation of the total dollar amount of benefits expected to be lost. Finally, to assess the overall economic impact of the lost SNAP payments one must multiply benefits by an accepted macroeconomic

[39] Davis, Lisa. 2019. Protecting Children's Access to School Meals by Maintaining Broad-Based Categorical Eligibility in SNAP. Testimony before the House Committee on Agriculture, Subcommittee on Nutrition, Oversight and Operations, U.S. House of Representatives.

[40] Gassman-Pines, Anna and Laura Bellows. 2018. Food Instability and Academic Achievement: A Quasi-Experiment Using SNAP Benefit Timing. *American Educational Research Journal* 55(5): 897-927.

[41] Shepard, Donald S., Elizabeth Setren, and Donna Cooper. 2011. Hunger in America: The Suffering We All Pay For. Center for American Progress Report.

[42] Hoynes, Hilary, Diane Whitmore Schanzenbach, and Douglas Almond. 2016. Long-run impacts of childhood access to the safety net. *American Economic Review* 106 (4): 903-34.

"multiplier." This is an underestimate of the true costs of the lost SNAP benefits, however, because it fails to quantify the long-term costs to children in these households and the attendant social costs described above.

32. It is important to base the analysis on all SNAP households that contain noncitizens, because research has shown that there are important spillover effects from SNAP rule changes that affect noncitizens, even onto groups that are not directly affected by the rule changes. For example, studies of the 1996 policy change which temporarily barred many legal immigrants from the program document that groups living in households with noncitizens who generally were not themselves barred from participation reduced their participation in SNAP, including refugees[43] and citizen children of noncitizen parents.[44] A recent study asked adults in immigrant families whether they or a family member did not participate in a government benefits program in 2018 for fear of risking future green card status, and found that adults in 20.7 percent of low-income immigrant families reported avoiding public benefits. Even though the Rule would only directly impact adults who do not hold a green card, nonetheless there were reports of benefit avoidance even among households with immigration and citizenship statuses that would never be subject to the Rule.[45] These studies imply that analysis of the impact of the Rule should be based on all SNAP households with noncitizen members.

33. Table 4 below presents estimates of the number of SNAP households, and the number of individuals residing in those households, that contain noncitizen members. Columns 1

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[43] Fix, Michael E. and Jeffery S. Passel. 1999. Trends in Noncitizens' and Citizens' Use of Public Benefits Following Welfare Reform. Urban Institute Report.

[44] East, Chloe N. Forthcoming. The Effect of Food Stamps on Children's Health: Evidence from Immigrants' Changing Eligibility. *Journal of Human Resources.*

[45] Bernstein, Hamutal, Dulce Gonzalez, Michael Karpman, and Stephen Zuckerman. 2019. One in Seven Adults in Immigrant Families Reported Avoiding Public Benefit Programs in 2018. Urban Institute.

and 2 list the average annual number of households and persons on SNAP from fiscal year 2013 to 2017, drawn from publicly available USDA sources.[46]

34. In column 3, I present the number of SNAP households containing a noncitizen member, which I calculated from the 2013–2017 USDA SNAP Quality Control (QC) data, using sampling weights provided in the dataset. The number of SNAP households containing a noncitizen member I calculate is 2.6 million, which is 1.7 times the number reported by DHS. The implied share of SNAP households with noncitizen members (dividing column 3 by column 2 in row A) is 11.83 percent. In column 4, I calculate from the SNAP QC data the number of people residing in SNAP households that contain noncitizen members, and find that the population is 8.9 million people.[47] This number includes 4.5 million children under the age of 18, and 1.6 million children aged 0 to 5.

Table 4: Estimates of Numbers of People in SNAP Households with Noncitizens

	People on SNAP(1)	**Households on SNAP(2)**	**# HH's on SNAP w/ Noncitizen Members(3)**	**# People in SNAP HH's w/ Noncitizen Members(4)**	**% HH w/ Noncitizen Member(5)**
A. QC estimates: Any noncitizen in SNAP HH	45,291,847	22,193,029	2,624,483	8,896,997	0.1183
B. DHS reported	45,294,831	22,195,369	1,547,017	5,182,502	0.0697

35. Next, in Table 5, I estimate annual SNAP benefits received by households with noncitizen members.[48] I calculate annual SNAP benefits per recipient[49] to be $1,556, and annual SNAP benefits per participating household to be $3,794.

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[46] Data are available here: https://fns-prod.azureedge.net/sites/default/files/resource-files/SNAPsummary-8.pdf.

[47] Note that not all of these individuals living in SNAP households are themselves receiving SNAP benefits; some are ineligible or otherwise not participating, although other member(s) of their households participate in SNAP. The average household size among SNAP households with noncitizen members in the SNAP QC data is 3.39.

[48] The SNAP QC data measure monthly SNAP benefits, and to translate this into an annual estimate I multiply the monthly benefit by 12.

Table 5: Estimates of Annual SNAP Benefits in SNAP Households with Noncitizens

	Average SNAP/Recipient Annual Benefits(1)	**Average SNAP/Household Annual Benefits**(2)
A. QC estimates: Any noncitizen in SNAP HH	$ 1,556.10	$ 3,793.68
B. DHS reported	$ 1,527.59	$ 3,117.41

36. Next, I calculate the number of individuals and households that would be expected to disenroll from SNAP or avoid enrolling in SNAP due to the public charge rule. The social science research indicates that many immigrants will avoid participating in SNAP even if they are still eligible for the program. A number of research estimates, described below, imply that participation will decline by around 20 percent.

37. Some of the best estimates from the research literature of the likely disenrollment impact come from studies that investigated the barring of many immigrants from SNAP in 1996, followed by the subsequent restoration of eligibility for many immigrants. These studies show that disenrollment impacts will not only impact those who lose eligibility directly, but also establish a chilling effect onto other populations that also reduce their participation in response to policy changes. One study finds that U.S. citizen children, who did not experience any changes in SNAP eligibility, were less likely to enroll in SNAP when their immigrant parent(s) lost access.[50] The magnitude of the enrollment decline implies a 19.3 percent decline in the levels of SNAP participation among U.S. citizen children with immigrant parents.[51] A different study

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[49] SNAP benefits per recipient are calculated as household SNAP benefits divided by the number of household members participating in SNAP. On average, there are 2.46 household members who receive SNAP benefits, and 3.42 household members in total, including those who do not receive SNAP benefits.

[50] East, Chloe N. Forthcoming. The Effect of Food Stamps on Children's Health: Evidence from Immigrants' Changing Eligibility. *Journal of Human Resources.*

[51] To arrive at an estimate of implied caseload decline, I estimated the likelihood that citizen children living with noncitizen adults participate in SNAP in 2016, and calculated the decline in number of participants if the likelihood were to decline by eight percentage points, as estimated by East. *See* East, Chloe N. Forthcoming.

using a broader measure of participation in social benefits programs after many immigrants lost access to SNAP estimated a 21 percent decline in immigrants' use of social benefits programs after welfare reform.[52] This study also found similar sharp declines among refugees, even though few refugees lost their eligibility to participate in the programs.

38. Studying the landscape today, a 2019 Urban Institute report finds that 20.7 percent of adults in low-income immigrant families did not participate in a social benefits program because of the "chilling effects" of the proposed changes to the public charge rule.[53]

39. Together, these studies have two implications. First, the expected decline in participation will impact more than the groups directly impacted by the Rule, but will also impact other groups such as refugees and citizen members of households containing noncitizens. Second, a reasonable assumption of the likely magnitude of the decline in SNAP participation will be around 20 percent.[54]

40. In Table 6 below, I calculate the predicted declines in SNAP participation based on the range of findings from the studies described above. Assuming a 20 percent nonparticipation rate, I predict that 1.78 million people will be living in the 524,897 households that are predicted not to participate in SNAP. I also provide predictions based on each study described above, with nonparticipation rates estimated to be 19.3 percent, 20.7 percent, and 21.0

The Effect of Food Stamps on Children's Health: Evidence from Immigrants' Changing Eligibility. *Journal of Human Resources.*

[52] Fix, Michael E. and Jeffery S. Passel. 1999. Trends in Noncitizens' and Citizens' Use of Public Benefits Following Welfare Reform. Urban Institute Report.

[53] Bernstein, Hamutal, Dulce Gonzalez, Michael Karpman and Stephen Zuckerman. 2019. One in Seven Adults in Immigrant Families Reported Avoiding Public Benefit Programs in 2018. Urban Institute.

[54] Although there have already been reports of disenrollment, there will be more. The prior studies (East; Fix and Passel) find that disenrollment continues for several years after a policy change until the total impact on enrollment is realized, and the same is expected in this case. In addition, the recent Urban Institute study (Bernstein et al.) finds that 31 percent of adults in immigrant families who had heard a lot about the Rule avoided benefits. The avoidance rates were smaller for those who had heard "some" about the proposed rule (fifteen percent avoided benefits) and those who had heard "nothing at all" about the proposed rule (six percent avoided benefits). As the Rule receives additional publicity while it is scheduled to go into effect, more families will know more about it, and they will become more likely to avoid benefits.

percent, respectively. For completeness, I also present estimates based on the DHS preferred estimate for nonparticipation, which is 2.5 percent, well out of the range of the prior studies. DHS also considers a 54 percent nonparticipation effect, which is from an estimate of the impacts of welfare reform on SNAP participation among immigrants published by the USDA's Food and Nutrition Service's Office of Analysis, Nutrition and Education. The number of non-participating households are 65,612 at DHS's 2.5 percent rate, and 1.42 million at the 54 percent rate.

Table 6: SNAP Non-participation due to Public Charge Rule, Various Assumptions

	Person-level Analysis(1)	**Household-level Analysis**(2)
A. 20% Assumption	1,782,947	524,897
B. 19.3% Assumption (East 2018)	1,720,544	506,525
C. 20.7% Assumption (Urban Institute 2019)	1,845,350	543,268
D. 21% Assumption (Urban Institute 1999)	1,872,094	551,141
E. DHS's 2.5% Assumption	222,868	65,612
F. 54% Assumption (Genser, FNS, USDA)	4,813,957	1,417,221

41. To calculate the economic impacts of SNAP non-participation due to the public charge rule, I multiply annual SNAP benefits per SNAP household containing noncitizens (Table 5, row A, column 2) by the predicted number of households that will not participate (Table 6, row A, column 2).

42. The estimated dollar value of annual foregone SNAP benefits is shown below in Table 7 in row C, and is estimated to be $2.0 billion.[55] As described above, since SNAP benefits are quickly spent, generally in the recipient's local community, this will have spillover effects to other aspects of the economy such as food retailers. As discussed above, to account for these

[55] Parallel calculations using person-level predictions instead of household-level predictions yield estimates that are 11 percent larger.

spillover effects, macroeconomists multiply changes in SNAP payments by a fiscal multiplier to account for the total economic impact. The median SNAP fiscal multiplier described in a recent report on fiscal multipliers is 1.6.[56] Accounting for this SNAP fiscal multiplier effect, the estimated annual direct economic cost of the public charge rule will be $3.2 billion. The USDA estimates that the SNAP multiplier could be as high as 1.8. On the low side, Blinder and Zandi estimate that during good economic times it could be 1.22. Using these fiscal multipliers, the range of total economic impact could be as high as $3.6 billion or as low as $2.4 billion.[57] Note that these estimates do not include all costs. For example, they do not include the long-term harm that would be expected to occur for children in affected households, and they do not include administrative costs to SNAP.

Table 7: Estimated Cost of SNAP Non-Participation due to Public Charge Rule

A. Annual benefits per HH	$ 3,793.68
B. Number of nonparticipating HH's	524,897
C. Estimated annual foregone SNAP benefits	$ 1,991,289,733
D. Row C times 1.6 fiscal multiplier	$ 3,186,063,574
E. Comparison: DHS estimate of foregone SNAP benefits	$ 197,919,143
F. Ratio: Economic cost/DHS calculations (Row D/Row E)	16

43. The noncitizen population is not uniformly distributed across states, so some states will incur larger costs than others. Table 8 below, presents estimates of the share of the total noncitizen population by state, averaged over 2013–2017 and including the District of

[56] As described above, I took the median SNAP multiplier of a range of estimates used by experts. *See* Bivens, Josh. 2011. Method memo on estimating the jobs impact of various policy changes. Economic Policy Institute Report. The United States Department of Agriculture has used a slightly higher multiplier of 1.79. *See* https://www.ers.usda.gov/publications/pub-details/?pubid=44749.

[57] *See* Hanson, Kenneth. 2010. The Food Assistance National Input-Output Multiplier (FANIOM) Model and Stimulus Effects of SNAP. USDA, Economic Research Service, *Economic Research Report Number 103*. *See also* Schanzenbach, Diane Whitmore, Ryan Nunn, Lauren Bauer, David Boddy, and Greg Nantz. 2016. Nine Facts about the Great Recession and Tools for Fighting the Next Downturn. The Hamilton Project at the Brookings Institution Report.

Columbia, for New York, Connecticut, and Vermont.[58] I estimate the cost of foregone SNAP benefits to each state, assuming the costs per state are in proportion to the share of the noncitizen population that reside in each state. New York is predicted to lose $179 million in SNAP benefits annually, which translates to a predicted decline in economic activity of $323 million. The estimated annual total in the states of New York, Connecticut, and Vermont together is $203 million in SNAP benefits and $366 million in economic activity.

Table 8: Estimated Cost of SNAP Nonparticipation due to Public Charge Rule, Selected States

	State's Share of Noncitizen Population(1)	**Estimated Annual Foregone SNAP Benefits**(2)	**Including Economic Multiplier Effect**(3)
New York	0.0902	$ 179,634,190	$ 287,414,704
Connecticut	0.0114	$ 22,673,423	$ 36,277,477
Vermont	0.0005	$ 990,145	$ 1,584,233
NY + CT + VT	0.1021	$ 203,297,758	$ 325,276,413

B. Basis of My Conclusions and Flaws in DHS Analysis

44. My estimated cost of SNAP nonparticipation is 16 times the DHS estimate.[59] My estimate is based on sound social science principles using appropriate data. In contrast, DHS's analysis is not based on reasonable assumptions and does not use appropriate data.

45. The DHS deficiencies are revealed by examining three differences in calculations. *First*, I estimate that the number of households on SNAP with noncitizen members is 1.7 times

[58] Numbers drawn from Kaiser Family Foundation reports on state noncitizen populations, see https://www.kff.org/other/state-indicator/distribution-by-citizenship-status/

[59] *See* Regulatory Impact Analysis, Inadmissibility on Public Charge Grounds, Table 17.

the number estimated by DHS.[60] *Second*, I assume a 20 percent nonparticipation impact, 8 times larger than the DHS assumption of 2.5 percent. *Third*, I estimate the costs based on a direct measure of benefits paid to SNAP households with noncitizens. I describe each difference in more detail below.

46. First, DHS's incorrect estimates of the number of SNAP households including noncitizens are presented in row B of Table 4.[61] I calculate this number from the SNAP QC data, which are the appropriate source for this information and is the administrative data source that USDA uses to measure characteristics of the SNAP caseload.[62] DHS could have also done this analysis. The data on actual SNAP participation is readily available. Instead, DHS chose a crude method of calculating the number of these households—it simply assumed that the percentage of households containing foreign-born noncitizens on SNAP was equal to the proportion of households containing foreign-born noncitizens relative to the overall number of U.S. households (*i.e.*, 6.97%). DHS estimated the number of households containing foreign-born noncitizens participating in SNAP by multiplying the number of households on SNAP by the 6.97 percent, which DHS reports to be the Census Bureau's estimate of the share of the overall U.S. population that are foreign-born noncitizens.[63] DHS's method results in a substantial underestimate; calculated from the SNAP QC data, we see that the share of households on SNAP with noncitizen members is actually 11.83 percent. Correcting the flawed DHS assumption

[60] I also estimate SNAP benefits per household containing noncitizen members to be 94 percent of the DHS estimate. This difference would imply that in this step I would calculate a smaller total cost than DHS.

[61] These are reproduced from Regulatory Impact Analysis, Inadmissibility on Public Charge Grounds, Table 14.

[62] *See* Lauffer, Sarah, Alma Vigil, Chrystine Tadler, and Elaine Wilcox-Cook. 2018. Technical Documentation for the Fiscal Year 2017 Supplemental Nutrition Assistance Program Quality Control Database and the QC Minimodel. Mathematica Policy Research Report.

[63] The DHS estimate of the average number of people on SNAP and households on SNAP (2013–2017) differs slightly from my calculations; this is likely due to the release of revised data between the time when their analysis was conducted in 2018 and when mine was conducted in 2019. Note that DHS reports in the footnotes to Table 14 that they estimate the number of households by dividing the number of people by an average household size of 2.64. This appears to be incorrect, and they appear to have obtained the data on household participation directly from USDA.

increases the number of SNAP households with noncitizens by 70 percent, to 2.6 million households.[64]

47. Second, DHS estimates the potential SNAP nonparticipation rate due to the public charge rule change to be 2.5 percent. They come to this by estimating that 2.5 percent of foreign-born noncitizens apply for an adjustment of status, and that the impact of the public charge rule will primarily impact this group. This ignores potential spillover impacts onto other groups, and assumes that the impacts are limited only to the group applying for an adjustment of status in one particular year. As described above, research suggests the DHS assumption is far too low. Research based on the impacts of welfare reform as well as current estimates on the share of immigrants avoiding participation in public benefits clearly show that the nonparticipation impacts will spill over to a larger group. For example, prior research found declines in participation among refugees and citizens residing in households with noncitizens, even though their eligibility for SNAP and other benefits programs was not substantially changed.[65] This prior research estimates a nonparticipation response around 20 percent, which is eight times the DHS estimate.

48. Third, DHS underestimates the average SNAP benefit for households with noncitizens. In its calculations, DHS uses overall average SNAP benefits per recipient. This is an inaccurate estimate, because it does not account for different characteristics among households with noncitizens that affect benefit amounts, such as larger household sizes and a higher

[64] As shown in Table 5, the DHS estimates of average SNAP benefits per person or household differ from the ones I calculate from the SNAP QC data. At the household level, I estimate SNAP benefits to be 22 percent higher than those estimated by DHS.

[65] *See* East, Chloe N. Forthcoming. The Effect of Food Stamps on Children's Health: Evidence from Immigrants' Changing Eligibility. *Journal of Human Resources. See also* Fix, Michael E. and Jeffery S. Passel. 1999. Trends in Noncitizens' and Citizens' Use of Public Benefits Following Welfare Reform. Urban Institute Report.

likelihood of having earnings.[66] As above, DHS could have used SNAP QC administrative data to produce a more appropriate estimate for its calculations.

Together, these differences imply that my estimate of the economic cost of the predicted decline in SNAP participation due to the public charge rule is 16 times the cost predicted by DHS (see Table 7, Row F).[67]

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66 *See* Tables 1 and 2 in this Declaration.

67 Without the fiscal multiplier effect, my estimates of the value of foregone SNAP benefits is 10 times the DHS estimate.

I declare under penalty of perjury that the foregoing is true and correct.

Executed on this 9 day of Sept, 2019.

Diane Whitmore Schanzenbach

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF NEW YORK

STATE OF NEW YORK, CITY OF NEW YORK, STATE OF CONNECTICUT, and STATE OF VERMONT,

Plaintiffs,

v.

UNITED STATES DEPARTMENT OF HOMELAND SECURITY; KEVIN K. McALEENAN, *in his official capacity as Acting Secretary of the United States Department of Homeland Security*; UNITED STATES CITIZENSHIP AND IMMIGRATION SERVICES; KENNETH T. CUCCINELLI II, *in his official capacity as Acting Director of United States Citizenship and Immigration Services*; and UNITED STATES OF AMERICA,

Defendants.

CIVIL ACTION NO. 19-cv-07777

DECLARATION OF RUTHANNE VISNAUSKAS IN SUPPORT OF NEW YORK'S MOTION FOR A PRELIMINARY INJUNCTION

DECLARATION OF NEW YORK STATE HOMES AND COMMUNITY RENEWAL IN SUPPORT OF
PLAINTIFFS' MOTION FOR A PRELIMINARY INJUNCTION

I, RuthAnne Visnauskas, declare under penalty of perjury, pursuant to 28 U.S.C. § 1746, that the following is true and correct:

1. I am the Commissioner and Chief Executive Officer of New York State Homes and Community Renewal (NYSHCR). I submit this declaration in support of Plaintiffs' motion for a Preliminary Injunction in the above-captioned action challenging the Inadmissibility on

Public Charge Grounds Final Rule. I am familiar with the matters set forth herein based on a career spanning more than 18 years in financing, developing, and rehabilitating affordable housing in New York State, and revitalizing disinvested communities through housing-based initiatives. Prior to my role as Commissioner and Chief Executive Officer of NYSHCR, I served as the Managing Director of the Housing Advisory Board for the Robin Hood Foundation, where we funded initiatives to increase the quality and quantity of affordable housing for low-income New Yorkers. Before joining the Robin Hood Foundation, I worked at the New York City Department of Housing Preservation and Development (NYC HPD), where I also briefly served as Commissioner. At NYC HPD, I continued to promote the agency's mission of developing and preserving affordable housing in New York City and enforcing the City's Housing Maintenance Code.

Overview of NYSCHR

2. NYSHCR is New York State's affordable housing umbrella agency,[1] with a mission to build, preserve, and protect affordable housing and increase home ownership across New York State.

3. As Commissioner and Chief Executive Officer, it is my role to advance this mission and to carry out initiatives that further these goals. NYSHCR offers numerous programs to develop, preserve, and protect affordable housing within the State of New York. NYSHCR finances new construction and rehabilitation of affordable multifamily rental properties through State and Federal Low-Income Housing Tax Credits, loan programs, U.S. Department of Housing and Urban Development (HUD) housing assistance, and tax-exempt or taxable bonds.

[1] NYSCHR is comprised of five New York State agencies – the Division of Housing and Community Renewal, the Housing Trust Fund Corporation, the Housing Finance Agency, the State of New York Mortgage Agency, and the Affordable Housing Corporation.

NYSHCR also invests in communities to increase affordable housing, develop small businesses, and repair infrastructure. In addition, NYSHCR is tasked with enforcing New York State Rent Regulation Laws and protecting the rights of tenants who are facing harassment or rental overcharge by their landlord.

4. Overall, NYSHCR provides financing and/or regulatory oversight to approximately 400,000 affordable housing units in almost 10,000 buildings throughout the State. In addition, NYSCHR administers Section 8 Housing Choice Vouchers for approximately 44,332 individuals and families and oversees approximately 900,000 rent-regulated housing units pursuant to New York state law.

5. NYSHCR is also a Public Housing Authority (PHA) that administers the HUD Section 8 program in 51 counties throughout New York State. Most counties and/or municipalities with large populations also administer their own Section 8 and Federal Public Housing programs through their local PHA directly with HUD. NYSHCR does not administer Federal Public Housing as none exists in its portfolio. There are over 130 PHAs in New York State in addition to the NYSHCR PHA.

New York Housing Market is Highly Competitive

6. NYSHCR carries out its mission in the midst of, and in response to, a housing market plagued by low vacancies and high rents. The vacancy rate in New York State for non-rural areas is 4.3% compared to 6.1% nationally.[2] Nearly 80% of New Yorkers living in non-rural areas confront a rental housing market that has less than a 5% vacancy rate. Extremely low vacancy rates can be found throughout New York: Albany (4.8%), Buffalo (4.9%), New Rochelle (3.8%), Troy (4.3%) White Plains (2.3%) and New York City (3.4%).

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[2] Census data.

7. In addition, the median rent in New York State, $1,075, is hundreds of dollars higher than the national median rent ($827).[3] The disparity is wider for many other municipalities including New Rochelle ($1,324), White Plains ($1,599), Hempstead ($1,237), New York City ($1,213) and Manhattan in particular ($1,512).

The Receipt of Federal Public Housing Assistance by Non-Citizens

8. Pursuant to Section 214 of the Housing and Community Development Act of 1980, federal housing assistance is only available to limited groups of non-citizens.

9. Additionally, Section 214 allows for the receipt of prorated housing benefits by so-called "mixed-status families" in which some members are U.S. citizens or eligible noncitizens and others are ineligible noncitizens. In these households, federal housing benefits are only paid on behalf of the eligible family members. The ineligible members must pay their portion of the rent. Additionally, ineligible members' income is calculated in the total household income thereby reducing the housing subsidy the household receives as a whole. The combination of proration and higher work income in mixed-status families means that generally, mixed-status families receive less federal subsidy than fully eligible families.

10. In New York State, approximately 3,000 of these "mixed-status" families receive public housing assistance.[4] According to HUD, of the 25,000 mixed-status families nationwide in federally-assisted housing, 71 percent are eligible members. Of those, 73 percent are children. Of the 29 percent of the ineligible household members, 93 percent are adult, 5 percent are children and 2 percent are elderly.

[3] For purposes of this declaration, "median rent" includes both private and public housing rents and does not differentiate between types of apartments (e.g. studios, 1-bedroom, etc.).

[4] On May 10, 2019, HUD posted a proposed rule that would severely curtail access to these prorated benefits among mixed-status families. (Docket No. FR-6124-P-011). Through its Regulatory Impact Analysis for that proposed rule, HUD estimated that there are approximately 3,000 of these mixed-status families are in New York.

Primary Programs Implicated by the Public Charge Rule

11. The Public Charge Rule extends the public charge analysis to a broad array of federal programs administered by NYSHCR and other New York PHAs. These include Section 8 Housing Choice Vouchers, Project-Based Vouchers, Veteran Affairs Supportive Housing (HUD VASH) vouchers, Project-Based Rental Assistance and Federal Public Housing.

12. The Section 8 Housing Choice Voucher (HCV) program (also called the tenant-based voucher program) is the federal government's major program for assisting very low-income families, the elderly, veterans (through the HUD-VASH program), persons with disabilities and those in homeless shelters or at risk of becoming homeless, including survivors of domestic violence, to afford decent, safe and sanitary housing in the private market. The subsidy is paid on behalf of households directly to a private landlord. The family is then required to pay the difference between the actual rent charged by the landlord and the amount subsidized by the program, which is no more than 30 percent of the family's gross income (and 40 percent in limited instances). HCV vouchers are portable and can be used by the participating family in a unit of their choice including apartments, single-family homes and townhouses that pass an inspection proving that it meets the standards of health and safety set by HUD.

13. HUD-VASH vouchers are a collaborative effort between HUD and the United States Department of Veterans Affairs (VA) to move veterans and their families out of homelessness and into permanent housing. VASH combines HCV rental assistance for homeless veterans with clinical and supportive services provided by the VA's health care system. NYSHCR administers 1,055 HUD-VASH vouchers.

14. Project-Based Vouchers (PBVs) are a subset of the HCV program, and are housing subsidies that are attached to specific dwelling units through contracts between the PHA

and rental property owners that have an initial term of 20 years. Unlike HCVs, the subsidy does not travel with individual tenants as they move. NYSHCR utilizes PBVs as a component in financing larger affordable housing developments.

15. NYSHCR is currently administering 44,332 vouchers (including HCVs, PBVs and HUD-VASH vouchers) on behalf of participating families throughout New York State. Of these families, 73% are female-headed, 39% have children under 18, 23% have a person with a disability, 31% are elderly and 43% are race or ethnic minorities of which 27% are African American and 14% are identified as Hispanic. Only 3% of households count welfare (TANF, General Assistance, or Public Assistance) as the household's major source of income. The average family expenditure for rent is $451 a month and the average federal spending per unit is $864 a month.

16. Another program that NYSHCR administers is Project-Based Rental Assistance. This assistance is provided to private owners of multifamily housing to lower rental costs. In 2018, NYSHCR administered this assistance to over 92,000 apartments in 986 buildings for approximately 150,000 people statewide. Of this population, 58% are elderly, 23% are families with children, and 12% have a family member who is disabled. In addition, 25% identified as African-American/Black, 34% as Hispanic and 6% as Asian. The average family expenditure for rent is $399 per month.

17. Although not administered by NYSHCR, Federal Public Housing is operated by PHAs with HUD funding pursuant to the United States Housing Act of 1937 (42 U.S.C.A. § 1437). Unlike HCVs and Project-Based Rental Assistance, where the subsidy is unit by unit, all units in Federal Public Housing are subsidized. Public housing residents must have incomes below 80% of the Area Median Income (AMI).

18. Under all of these programs, an individual's benefit is tied to his or her income. Therefore, families can have work income and still be eligible for these housing benefits.

NYSCHR's Federal Housing Assistance Programs are Vital to Promoting Housing Stability and Reducing Homelessness

19. The very purpose of federal housing programs such as the Section 8 Housing Choice Voucher Program is to house those that are vulnerable to homelessness and unsafe living conditions. The United States Housing Act of 1937, which first established the federal public housing program, declared that it was the policy of the United States "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 of the nation." [5]

20. NYSHCR and other PHAs in New York use federal housing assistance to promote housing stability and reduce homelessness. They are used to house veterans with supportive services, the elderly and disabled who live with fixed incomes, economically disadvantaged parents with children who struggle to work and pay rent in a tight and expensive housing market, and the homeless, including survivors of domestic violence, who use vouchers as a pathway out of homelessness and abusive situations. In addition, project-based vouchers are used to build and rehabilitate thriving communities with deeper affordability and accessibility features for those with disabilities.

The Public Charge Rule Dramatically Undermines NYCHR's Work by Creating a Chilling Effect on Uptake of Subsidized Housing

21. Because of the Final Rule, for the first time, a public charge determination will take into account housing benefits received on behalf of individuals residing in New York. This

[5] P.L. 75-412.

change creates a confounding scenario where families who are legally entitled to housing benefits will either have to make the choice to forgo housing benefits or have their receipt of these benefits be weighed against them in a public charge determination.

22. For example, a family with a member who is a parolee can receive a Section 8 voucher that is not prorated because parolees are eligible for federal housing assistance. However, if that member seeks to adjust their status to a Legal Permanent Resident through a family-based visa petition because he or she is marrying a U.S. citizen, that person will be subject to a public charge determination based on his or her lawful receipt of federal housing benefits. To avoid this, this person may seek to disenroll himself or his entire family, which may include U.S. citizen children. The effect of disenrolling himself or his family would result in a steep increase in rent they must pay if they are participants in a Section 8 voucher program. If he disenrolls the family while in public housing, it means they would have to move out or be evicted from the unit.

23. The 3,000 mixed-status families that currently make use of pro-rated federal housing benefits may be concerned that continued receipt of public housing benefits on behalf of any members of the household will negatively reflect on a public charge determination. Accordingly, the Final Rule may result in mixed-status households, including U.S. citizen children and other citizen household members, disenrolling from federal housing benefits, increasing the risk of housing instability. DHS acknowledges as much in the preamble to the Final Rule, noting that "U.S. citizens who are members of mixed-status households" are among those who will opt to forgo benefits. 84 Fed. Reg. 41300.

24. In addition, the chilling effect from the Final Rule could extend well beyond New York's approximately 3,000 mixed-status families to non-citizens who are lawfully entitled to

receive public housing benefits and are not subject to the public charge test, but, because of fear and confusion, may dis-enroll even from housing programs that are not covered by the Final Rule such as those financed with Low Income Housing Tax Credits.

Deterring Families from Accessing Housing Benefits Leads to Housing Instability and Homelessness

25. If the Final Rule goes into effect, New York families whose members cease participation in subsidized housing programs will have to move out of their homes or experience substantial rent increases with loss of subsidy.

26. In a search for other affordable housing options, they will face a highly competitive market with very low rates of affordability and/or vacancy. The burdens of a move are well-known and include the search process and potentially thousands of dollars of necessary expenses such as deposits, brokers fees, up-front rent payments, storage and moving fees, as well as potential loss of hourly wages as they engage in the housing search process. Recipients of housing assistance often do not have these economic resources to move. The difficulty confronted by these families will be compounded by the fact that similarly situated families will be searching simultaneously. Families facing this process may be forced into temporary and unstable living situations, including moving in with other families, shelters and other transient arrangements, while they search for stable and affordable housing. The combined effect of these factors is that families, many with U.S. citizen and otherwise eligible children, may be left homeless, overcrowded or in otherwise substandard housing conditions that do not meet housing quality and safety standards that are a hallmark of Section 8 programs.

Irreparable Harm to Health and Well-Being of New Yorkers

Limiting Availability of Affordable Housing for Families Is Detrimental

27. New York State and its residents will be harmed if powerful affordable housing tools are removed from the State's arsenal to confront difficult housing market forces. Homelessness, experienced by tens of thousands of New Yorkers on any given day, is often the acute part of a larger episode of housing stability that for many families can last months or years. A major contributing factor to a family's housing instability is a lack of affordable housing, which is felt by many throughout the State. Section 8 and other federal housing assistance provide the exact tools to help combat this instability, reduce resulting homelessness and minimize the personal and societal costs of such instability.

28. Research has shown the importance of access to affordable housing across numerous aspects of families' lives. Studies have found that increasing access to affordable housing for families leads to increased stability, including fewer moves and a lower likelihood of homelessness.[6] This stability manifests in numerous positive outcomes.

29. For example, families living in affordable housing who are not cost-burdened by high-cost rent are better able to invest in themselves and their futures. One study found that in 2011, families living in affordable housing were able to spend five times as much money on healthcare compared to families cost-burdened by rent, as well as more on nutrition and retirement savings.[7] Such stability also allows families to avoid the negative outcomes associated with overcrowding, substandard housing and frequent moves, such as lifelong

[6] Enterprise Community Partners, "Impact of Affordable Housing on Families and Communities: A Review of the Evidence Base" (2014), available at https://www.enterprisecommunity.org/resources/impact-affordable-housing-families-and-communities-review-evidence-base-13210.

[7] Enterprise Community Partners, "Impact of Affordable Housing on Families and Communities: A Review of the Evidence Base" (2014), available at https://www.enterprisecommunity.org/resources/impact-affordable-housing-families-and-communities-review-evidence-base-13210.

physical and mental health harms, lack of access to nutritious and sufficient food. Specifically, one study found that individuals who are residentially stable and not cost-burdened are far less likely to complain of mental distress and difficulty sleeping, which can lead to negative mental and physical health outcomes.[8] Further, access to affordable housing has been identified as critical in avoiding the negative educational outcomes for children associated with housing instability and homelessness, such as poor academic performance, low school attendance, grade retention and dropping out.

Housing Instability and Homelessness Have Lifelong Negative Impacts on Children

30. As the Commissioner of NYSHCR, I am aware of a multitude of harms attending housing instability and homelessness. Housing instability and homelessness have drastic negative consequences for individuals, especially children, across a wide array of areas. There is clear evidence linking childhood homelessness with lifelong health problems. Homelessness and other forms of housing instability are associated with increased hospital visits and mental health problems, such as depression and anxiety.[9] Child poverty and housing instability also cause severe stress. This type of stress in children "disrupts normal brain and organ development and, consequently, damages brain architecture and neurocognitive systems."[10] These health consequences may be felt by these children for the rest of their lives.

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[8] Enterprise Community Partners, "Impact of Affordable Housing on Families and Communities: A Review of the Evidence Base" (2014), available at https://www.enterprisecommunity.org/resources/impact-affordable-housing-families-and-communities-review-evidence-base-13210.

[9] Meredith Horowki, *Housing Instability and Health: Findings from the Michigan Recession and Recovery Study*, National Poverty Center Policy Brief #29 (March 2012), http://www.npc.umich.edu/publications/policy_briefs/brief29/NPC%20Policy%20Brief%20-%2029.pdf.

[10] Heather Sandstrom et al., *The Negative Effects of Instability on Child Development: A Research Synthesis*, Urban Institute, 13 (September 2013), https://www.urban.org/sites/default/files/publication/32706/412899-The-Negative-Effects-of-Instability-on-Child-Development-A-Research-Synthesis.PDF.

31. A lack of access to safe and affordable housing can also limit a child's educational opportunities and exacerbate child poverty. Statistically, homeless children have lower passing rates across a number of academic subjects, have higher rates of absenteeism, and are more likely to face disciplinary action than children who live in stable housing.[11] Additionally, children who lack safe and secure housing will suffer long-term negative economic consequences.[12] Housing instability can also lead directly to employment insecurity among adults.[13]

The Final Rule Increases Costs for State and Local Governments

32. The Final Rule will place significant new costs and administrative burdens on New York State and local governments within the State as families with noncitizen members refrain from participating in affordable and sustainable housing options. Limiting families' access to affordable, long-term housing only exacerbates chronic and destabilizing housing conditions, resulting in greater costs to the State and a detrimental social impact.

33. The State and local governments will bear the financial brunt of increased homelessness and housing instability caused by the Final Rule, both in the short- and long-term. The lack of participation in affordable housing programs will increase emergency shelter use, which will place a substantial financial strain on states and municipalities.

34. Short-term costs include an increase in emergency shelter use as families turn away from available affordable housing programs to which they are legally entitled. This will

[11] Anne Ray et al. *Homelessness and Education in Florida: Impacts on Children and Youth*, Shimberg Center for Housing Studies, University of Florida, and Miami Homes for All (December 2017), http://www.shimberg.ufl.edu/publications/homeless_education_fla171205RGB.pdf.
[12] Will Fisher, *Research Shows Housing Vouchers Reduce Hardship and Provide Platform for Long-Term Gains Among Children*, Center on Budget and Policy Priorities (October 7, 2015), https://www.cbpp.org/sites/default/files/atoms/files/3-10-14hous.pdf.
[13] Matthew Desmond and Carl Gersheson, *Housing and Employment Security Among the Working Poor*, Soc. Problems 1 (2016), https://academic.oup.com/socpro/article/63/1/46/1844105.

place a significant burden on the State and local governments, as it is many times more expensive to house a family in an emergency shelter than it is to provide long-term housing through Section 8 or public housing.

35. Long-term economic costs of homelessness and housing instability, including an increase in health, public assistance and educational costs, will further the regressive impact of the Final Rule on New York State and local governments. Research indicates that unstable housing among families with children will cost the U.S. health care system an estimated $111 billion in expenditures through 2027.[14] Increased housing instability caused by the Final Rule could substantially increase these numbers.

36. In addition, State and local governments will have to make up for the shortfall in funding as per-family housing subsidies increase due the replacement of higher-income pro-rated mixed-status families by fully eligible families with generally less income. With fewer families served with the same amount of federal funding, the State and local governments will face the resulting increased need for affordable options and/or homeless services.

37. Finally, NYSHCR will be required to undertake a significant public information campaign in response to the Final Rule. In order to serve the residents of New York State, NYSHCR must take on the increased expenses and administrative burdens of educating affected communities of their rights and risks under this new legal framework, including costs associated with increased calls, staff training, and preparing guidance materials. This process is particularly costly in light of the confusion generated by the proximity between this Final Rule and HUD's recent Proposed Rule governing the receipt of prorated benefits by mixed-status families. In addition to direct outreach regarding the impact of the Rule, NYSHCR plans to work with

[14] Ana Poblacion et al., *Stable Homes Make Healthy Families*, Children's HealthWatch (July 2017), https://bit.ly/2hDjRE2.

partners and community organizations to disseminate information because NYSHCR fears that many in vulnerable populations affected by the Rule will be reluctant to seek guidance from government agencies for assistance. This will create additional administrative and financial burdens.

The Final Rule Imposes Significant Administrative Harms On NYSCHR

38. There are significant programmatic and structural difficulties that would prevent individuals who terminate their housing benefits in reliance on this Final Rule from reenrolling in their benefits at a later date.

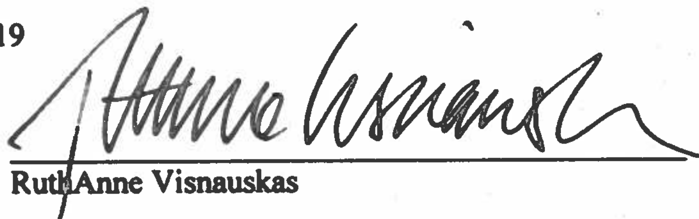
39. All federal housing programs in New York State have waiting lists. Therefore, vacancies in these programs are filled almost immediately. Any individual who terminates their housing benefits would not simply be able to recover their Housing Choice Voucher or return to their old apartment or neighborhood if, at some future date, this Rule was either enjoined or revoked. The voucher allotment would have been given to someone else and/or the relevant housing unit filled with a new family from the waitlist. It would be impossible to remove the successor family from reoccupied apartments as they now have a legal right to reside there.

40. In some contexts, the effects of disenrollment and re-enrollment will be particularly costly. For example, NYSHCR currently has no policies or procedures in place to assist individuals in reentering federal housing programs after termination because re-enrollment is rare. If the Final Rule were to go into effect, NYSHCR would need to devise policies and procedures to address how to assist families that may relinquish their housing because of fear, but then may subsequently seek housing because of a change in circumstances. If the Final Rule were to go into effect and not be immediately enjoined, NYSHCR would need to devise policies and procedures to address terminated families that reenroll at a later time when the Rule is finally

enjoined or invalidated by the court. This would be a complex and time-consuming process, which would create substantial administrative costs for the agency.

I declare under penalty of perjury that the foregoing is true and correct.

Executed on this 6 th day of September, 2019



RuthAnne Visnauskas

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF NEW YORK

STATE OF NEW YORK, et al.,

Plaintiffs,

v.

UNITED STATES DEPARTMENT OF HOMELAND SECURITY, et al.,

Defendants.

CIVIL ACTION NO. 19-cv-7777

DECLARATION OF HOWARD A. ZUCKER, M.D., J.D.

I, HOWARD A. ZUCKER, M.D., J.D., pursuant to 28 U.S.C. Section 1746, declare under penalty of perjury as follows:

1. I am the Commissioner of Health of the State of New York. I make this declaration in my capacity as Commissioner after consultation with New York State Department of Health ("Department") staff implementing the initiatives detailed below. I respectfully submit this Declaration in order to place before the Court certain testimony and documents relevant to the relief requested. I am familiar with the matters set forth herein, either from professional knowledge, conversations with Department staff, or on the basis of documents that have been provided to and reviewed by me.

2. I have extensive medical knowledge, particularly in the fields of pediatric medicine and care. I am board-certified in six specialties/subspecialties and trained in pediatrics at Johns Hopkins Hospital, anesthesiology at the Hospital of the University of Pennsylvania, pediatric critical care medicine/pediatric anesthesiology at The Children's Hospital of

Philadelphia, and pediatric cardiology at Children's Hospital Boston/Harvard Medical School. I was a professor of clinical anesthesiology at Albert Einstein College of Medicine of Yeshiva University and pediatric cardiac anesthesiologist at Montefiore Medical Center in the Bronx. I also served as associate professor of clinical pediatrics and anesthesiology at Columbia University College of Physicians & Surgeons and pediatric director of the ICU at New York Presbyterian Hospital. I am a former Columbia University Pediatrics Teacher of the Year.

3. As Commissioner of Health, I must "take cognizance of the interests of health and life of the people of the state, and of all matters pertaining thereto and exercise the functions, powers and duties of the department prescribed by law." Public Health Law ("PHL") §206(1)(a).

4. The Department's mission is to protect, improve, and promote the health, productivity and well-being of all New Yorkers, which includes refugees and other non-citizens. Consistent with this mission, the Department administers a wide range of public health programs. These programs address emergency preparedness and response, disease prevention and control, environmental health protection, and promotion of healthy lifestyles. In addition to administering these programs, the Department also manages the Medicaid program for the State; administers NY State of Health, New York State's Insurance Marketplace ("NY State of Health Marketplace"); conducts healthcare surveillance in hospitals, home care agencies, and nursing homes throughout the state; conducts research and maintains diagnostic and reference laboratories at the Wadsworth Center, New York State's premier public health lab; and owns and operates four veterans' homes and Helen Hayes Hospital.

5. As Commissioner of Health, I am deeply troubled by the destructive and far-reaching health, economic, and programmatic consequences of the Inadmissibility on Public

Charge Grounds Final Rule, to be codified at 8 CFR Parts 103, 212, 213, 214, 245, and 248 (the "Final Rule" or the "Rule"). The Fiscal Policy Institute estimates that 24 million individuals, 2.1 million of whom reside in New York, will be harmed by the Final Rule.[1] This means that over 2 million New Yorkers could face hunger, forego care for treatable medical conditions, and develop serious chronic health conditions if the Rule is implemented.

6. The Department administers several programs that will be directly or indirectly implicated by the Final Rule, including Medicaid[2], the Essential Plan[3] (New York State's Basic Health Program), Child Health Plus[4] (New York State's version of the Children's Health Insurance Program), Qualified Health Plans[5] (QHP), and the Special Supplemental Nutrition Assistance Program for Women, Infants, and Children (WIC).

[1] Fiscal Policy Institute, "Only Wealthy Immigrants Need Apply: How a Trump Rule's Chilling Effect Will Harm New York," (Oct. 2018), http://fiscalpolicy.org/wp-content/uploads/2018/10/US-Impact-of-Public-Charge.pdf.

[2] The term "Medicaid," as used throughout, means the New York State- and federally-funded healthcare program for low-income New Yorkers whose income and/or resources are below certain levels. It also includes state-funded Medicaid for individuals who are ineligible for federally funded Medicaid due to their immigration status. Eligible populations include children, pregnant women, single individuals, families, and individuals certified blind or disabled. In addition, certain persons with medical bills may be eligible for Medicaid if paying such bills allows them to spend down their income and resources to meet required Medicaid income levels. Medicaid enrollees do not pay premiums and have little to no out-of-pocket costs for many services. The term "Medicaid" does not include the Essential Plan, Child Health Plus, or Qualified Health Plans.

[3] The Affordable Care Act provides states with the option of creating a Basic Health Program (BHP). 42 USC § 18051. New York established a BHP, called the Essential Plan. NY Social Services Law § 369-gg. The Essential Plan covers New Yorkers who are not eligible for Medicaid and have incomes up to 200 percent of the federal poverty level. The Essential Plan lowers monthly premiums to $20 or $0, depending on income, and provides comprehensive benefits with no annual deductibles, free preventive care, and low copayments.

[4] Eligibility for Child Health Plus begins where Medicaid eligibility ends (223 percent of the federal poverty level for children under 1 year and 154 percent of the federal poverty level for children over 1 year). There is no Child Health Plus premium for children in households with incomes below 160 percent of the federal poverty level, and a sliding scale premium for those in households with incomes between 160 and 400 percent of the federal poverty level. Households with incomes above 400 percent of the federal poverty level have the option to purchase Child Health Plus or Qualified Health Plan coverage at full premium. 95 percent of children enrolled in Child Health Plus are enrolled with no premium or sliding scale premiums, and 5 percent are enrolled with full premiums.

[5] Qualified Health Plans are health plans that have been certified by and are available through the Marketplace in accordance with the Affordable Care Act and federal regulations. 42 § USC 18021(a). Enrollment in a Qualified Health Plan with financial assistance is available for individuals who have a household income at or below 400 percent of the federal poverty level, and do not have access to other affordable health insurance that meets minimum essential coverage.

7. Individuals whose immigration status is subject to the Final Rule could be disincentivized from applying for or continuing to receive benefits implicated by the Final Rule, such as Medicaid, and not seek medical care as a result. Many others will be indirectly impacted by the Final Rule, notwithstanding that they are not covered by it, and/or that the public benefit for which they are eligible is not a program implicated by the Final Rule, such as WIC, the Essential Plan, Child Health Plus, fully State-funded Medicaid, and Medicaid for children under 21, pregnant women, and women during the 60 days following childbirth. Policy experts agree that individuals will be frightened and confused about the potential consequences of applying for benefits and therefore will forego public assistance altogether.[6] This consequence is the "chilling effect" of the Final Rule.

8. New York State's economy will undoubtedly suffer because of the direct and indirect consequences of the Final Rule. Specifically, the Final Rule will cause a reduction in health insurance coverage, an increase in uncompensated healthcare costs faced by all healthcare providers, and a decrease in the stability and productivity of New York's workforce.

9. The Final Rule will also have irreparable consequences on the health and well-being of New Yorkers. Programs like Medicaid, the Essential Plan, Child Health Plus, QHPs, and WIC help ensure that families, including families with U.S. citizen children living with an immigrant caretaker, have access to basic human needs such as food and medical care. By disincentivizing access to these vital benefits, the Final Rule will leave millions of individuals in New York State, including U.S. citizen children, without access to preventive healthcare or nutritious foods – benefits that have been shown to improve both short- and long-term health and advance public health interests such as curbing the spread of communicable diseases and

[6] *Id.*

reducing chronic health conditions. Because 94 percent of children under age six living in the U.S. with at least one non-citizen parent are U.S. citizens,[7] there is a strong government interest in ensuring that these children have access to public benefits for which they are eligible to better their health and improve their economic security.

10. The Final Rule will also impose significant administrative burdens on New York State. The Final Rule will require NYSDOH to advise immigrant applicants to the NY State of Health Marketplace of the potential risk of applying for health insurance. Additionally, decreased participation in Medicaid among WIC families (primarily because of the indirect effects of the Final Rule) would have a significant and costly impact on WIC's certification process. The additional time spent on income certification in clinics will increase administrative costs, strain WIC resources, and divert staff time from important public health initiatives – like offering breastfeeding support – to conducting managerial tasks.

11. For these reasons, as described in detail below, the Department strongly opposes the Final Rule.

Irreparable Harm to New York State's Economy Caused by Disincentivizing Medicaid Participation and Enrollment

12. Medicaid is an important source of primary health insurance coverage and supplementary coverage for low-income residents and the most vulnerable New Yorkers. During the 2019 fiscal year, Medicaid provided comprehensive health insurance coverage to 6,243,498 New Yorkers, including children, pregnant women, single individuals, families, and individuals certified blind or disabled. Medicaid enrollees do not pay premiums and have little to no out-of-pocket costs for many services.

[7] Migration Policy Inst., *"Children in U.S. Immigrant Families,"* https://www.migrationpolicy.org/programs/data-hub/charts/children-immigrant-families (accessed June 28, 2019) (based on 1990 Decennial Census and 2016 American Community Survey data).

13. By making health insurance more affordable, programs like Medicaid have helped reduce the number of uninsured New Yorkers. The NY State of Health Marketplace uses a single application that helps people check their eligibility for Medicaid, Child Health Plus, the Essential Plan, and QHPs and enroll in these programs if they are eligible. Financial assistance is available to applicants to help them afford health insurance purchased through the Marketplace. Family members who may be eligible for different programs are able to apply together in a streamlined manner. In 2013, at the inception of NY State of Health Marketplace, the uninsured rate in New York was 10 percent. This rate has been reduced to 4.7 percent due to the gains in coverage made through NY State of Health Marketplace, including Medicaid. As a result, New York hospitals have reported a dramatic decrease in self-pay hospital utilization because patients have gained insurance. According to NYSDOH administrative data, New York State Institutional Costs Reports show a 23 percent reduction in self-pay hospital emergency room visits, a 40 percent reduction in self-pay inpatient services, and a 17 percent reduction in self-pay outpatient visits from 2013 to 2015.

14. The Department estimates that the Final Rule could disincentivize up to 2 million New Yorkers from applying for or continuing to receive health insurance, given the number of non-citizens and their children currently enrolled in Medicaid, the Essential Plan, Child Health Plus, and QHPs.

15. The Department anticipates that these individuals will be affected by the Final Rule due to confusion about the potential consequences of applying for food, health, and housing supports for which they qualify.[8] Others may not understand whether they receive the type of benefit directly implicated in the Final Rule. For example, New Yorkers receiving Medicaid

[8] Fiscal Policy Institute, *supra*, note 1.

may not know whether they are receiving state-only funded Medicaid or federally-funded Medicaid. Indeed, even before the Final Rule has gone into effect, consumers have been calling NY State of Health Marketplace's customer service center, participating health plans, and certified Assistor agencies who help consumers apply for coverage, inquiring about canceling their Medicaid or other health insurance coverage because of the Final Rule.

16. By disincentivizing enrollment or continued participation in health insurance programs like Medicaid, the Final Rule will increase uncompensated care and reverse important progress in making healthcare more accessible. Individuals without coverage will still need and receive care. With no insurance to pay for the care received, those costs will be borne by the healthcare delivery system.[9]

17. Moreover, because individuals without health insurance tend to wait longer to seek care during a health crisis, the care they eventually receive, often from emergency departments, is more costly and not compensated to the healthcare provider.

18. By disincentivizing enrollment or continued participation in health insurance coverage for individuals who are eligible for such coverage under federal law, the Final Rule will drive up the State's uninsured rate, resulting in increased uncompensated care costs to the healthcare delivery system. Federal and State Disproportionate Share Hospital (DSH) funding is a pre-determined amount of money intended to reimburse healthcare providers for the services they provide to patients who are unable to pay for the cost of their care.[10] However, these funds are already insufficient and federal funding is scheduled to be reduced further.[11] As such, already strained DSH funds will not cover the additional financial burden caused by the Final

[9] Coughlin, Teresa A. "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/
[10] See N.Y. Public Health Law §§ 2807-c, 2807-k(5-a)(d); 42 USCS § 1396r-4(f)((7).
[11] 42 USCS § 1396r-4(f)((7)(A).

Rule. Pending cuts by the Federal government to Medicaid DSH funds, in concert with the Rule, will exacerbate hospitals' financial status.

19. Increasing the number of uninsured patients will also weaken hospitals' financial footing. Medicaid expansion was associated with fewer hospital closures and stronger hospital financial performances.[12] The contraction of coverage that is likely to result from implementation of this Rule could result in public hospital closures, all of which are heavily reliant on state funding and predominantly serve lower-income populations.

20. Medicaid also provides affordable health insurance to children and their families. More than one third, or 34 percent, of Medicaid enrollees statewide are children.

21. By indirectly discouraging parents from enrolling eligible children in Medicaid and other forms of health insurance coverage, the Final Rule will negatively impact long-term outcomes for these children, including their education and employment, both of which contribute to self-sufficiency and decrease the likelihood of needing public assistance in the future.

22. For example, reduced vaccination rates among children can have extensive consequences on a child's education. PHL § 2164 requires those with a parental relationship to a child to vaccinate their children against serious diseases, including measles, chicken pox, whooping cough, and others. Unvaccinated children cannot be admitted to or attend any public, private, or parochial school (which includes a child caring center, day nursery, day care agency, nursery school, kindergarten, elementary, intermediate, or secondary school) in excess of 14 days unless certain limited exceptions are met. *See* PHL § 2164[7][a], [8]; Education Law § 914[1]; 10 NYCRR § 66-1.3.

[12] Lindrooth, Richard C., et al. "Understanding the relationship between Medicaid expansions and hospital closures." *Health Affairs* 37.1 (2018): 111-120. https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2017.0976

23. Parents who do not vaccinate their children, and whose children do not have a valid medical exemption, still must ensure that their children of compulsory school age are educated and, thus, would need to provide home instruction for those children. *See* Education Law § 3205. In order to provide such homeschooling, immigrant parents may be forced to reduce their work hours or leave the workforce entirely in order to homeschool their children.

24. Uninsured children are more likely to miss immunizations.[13] Therefore, by discouraging non-citizens from participating or enrolling in affordable health insurance options, like Medicaid, the Final Rule jeopardizes the ability of children of non-citizen parents to attend public, private, or parochial school in New York State, and may reduce the self-sufficiency of immigrant families by forcing some parents to leave the workforce in order to homeschool their children.

25. The Final Rule will also have additional negative impacts on New York's workforce. Having a reliable source of health insurance, such as Medicaid, improves individuals' overall health and well-being. Working individuals who receive Medicaid report performing better in their jobs and feeling more prepared to seek a new or better job.[14] Likewise, jobseekers report feeling better prepared to enter the workforce when they have affordable health insurance coverage.

26. Additionally, without stable, affordable health insurance, and the preventive care it provides, individuals that forego health insurance because of the Final Rule are likely to spend more time suffering from preventable illnesses and thus missing work. Working parents are at

[13] Hill HA, Elam-Evans LD, Yankey D, Singleton JA, Kang Y. Vaccination Coverage Among Children Aged 19–35 Months — United States, 2017. MMWR Morb Mortal Wkly Rep 2018;67:1123–1128. DOI: http://dx.doi.org/10.15585/mmwr.mm6740a4external icon
[14] Tipirneni, Renukha et al. 2017. "Medicaid Expansion Helped Enrollees Do Better at Work or in Job Searches." Institute for Health Care Policy & Innovation, University of Michigan. https://ihpi.umich.edu/news/medicaid-expansion-helped-enrollees-do-better-work-or-job-searches

increased risk of harm; not only is their own health at risk, but they may be forced to take time off from work to care for children who are sicker due to lack of preventive care. By disincentivizing health coverage for lower-income populations, the Final Rule will reduce economic productivity and create instability in New York State's workforce.

27. Access to affordable health coverage like Medicaid helps improve self-sufficiency and therefore advances financial well-being. Most individuals who receive Medicaid are not offered employment-based health insurance, and it is cost prohibitive for the few who are. By providing an affordable alternative, Medicaid improves health and increases self-sufficiency by allowing individuals to work regularly. Numerous studies document the positive effects that the Affordable Care Act (ACA), and particularly Medicaid expansion, has played in improving financial well-being of previously uninsured individuals. Financial security and self-sufficiency are improved when a person can pay their medical bills, and Medicaid coverage puts full payment within reach for many.[15] Other studies have shown that insurance coverage results in higher credit scores, lower medical debt, and reduces the probability of new bankruptcy filings.[16]

28. The Rule will harm financial well-being by removing an affordable health insurance option for many immigrants in New York State. Individuals without health insurance have a harder time paying their medical bills and overall have worse financial health than those with coverage. When saddled with medical debt and low credit scores, these immigrants will be less likely to contribute to New York State's economic growth.

[15] Hu, Luojia and Kaestner, Robert and Mazumder, Bhashkar and Miller, Sarah and Wong, Ashley, The Effect of the Patient Protection and Affordable Care Act Medicaid Expansions on Financial Wellbeing (2016-09-21). FRB of Chicago Working Paper No. WP-2016-10. Available at SSRN: https://papers.ssrn.com/sol3/papers.cfm?abstract_id=2857533.

[16] Antonisse, L., et al. "The effects of Medicaid expansion under the ACA: updated findings from a literature review." San Francisco (CA): Henry J. Kaiser Family Foundation; 2018 Mar. https://www.kff.org/medicaid/issue-brief/the-effects-of-medicaid-expansion-under-the-aca-updated-findings-from-a-literature-review-march-2018/

29. By creating confusion about the consequences of receiving non-private, subsidized health insurance, the Final Rule makes it more difficult for immigrants to remain in the country if they access affordable health insurance. As such, the Rule will negatively impact the labor force of the healthcare industry, potentially causing the healthcare industry to face a labor shortage, particularly in New York State, where the share of foreign-born health industry workers is more than double the national level.[17]

Irreparable Harm to New York State's Economy Caused by the Chilling Effect on WIC Participation

30. Each month, the WIC program serves approximately 380,000 prenatal and postpartum women, infants and children up to age five in New York. WIC promotes healthy pregnancies and births by reducing preterm births, low birthweight, and other complications. WIC also works to prevent infant mortality and ensure adequate nutrition in the critical first year through breastfeeding support and preventing iron deficiency.

31. By promoting positive birth outcomes and healthy babies, WIC reduces the first-year medical cost burden on both individual families and the broader healthcare system, leading to significant healthcare cost savings overall. The average preterm birth costs $49,033 in first-year medical expenses compared to a mere $4,551 for an uncomplicated birth.[18] Meanwhile, an increase of just one pound at birth for a very low birthweight baby can save approximately $28,000 in first-year medical costs.[19] WIC's prenatal intervention has reduced the incidence of low birthweight by approximately one-third and reduced preterm births by 29 to 48 percent.[20]

[17] *Id.*
[18] Institute of Medicine, Preterm Birth: Causes, Consequences, and Prevention (2006).
[19] March of Dimes, "The Cost of Prematurity and Complicated Deliveries to U.S. Employers" (2008).
[20] Kathryn Fingar, et al., "Reassessing the Association between WIC and Birth Outcomes Using a Fetuses-at-Risk Approach," 21 *J Maternal and Child Health* 825 (2017).

32. Additionally, for every dollar spent on WIC, there are associated savings in Medicaid costs during the first 60 days after birth, from $1.77 to $3.13 for newborns and mothers and from $2.84 to $3.90 for newborns only.[21] The associations are larger when costs from days 61 through one year are included.[22]

33. The Department expects WIC participation to decline due to the chilling effects caused by this Rule. Individuals who are not directly impacted by the Rule will forego public assistance, like WIC, due to the fear and confusion generated by this Rule.[23] The widespread chilling effect of the Rule on WIC participation can already be seen. Since the Rule was proposed, WIC agencies in at least 18 states have seen drops in WIC enrollment of up to 20 percent. In New York State, Public Health Solutions, the largest WIC provider in the state, saw WIC caseloads fall after press coverage of the proposed public charge changes.[24]

34. Lower WIC enrollment will financially strain New York State's economy due to higher healthcare costs associated with low birthweights and childbirth complications. From its inception, WIC has been recognized by Congress as a "program that, in the long run, will save this country money by heading off disease and the handicapping of children in the early formative months and years in such a way as to avoid much more costly results to our society later on."[25] Reduced WIC participation will frustrate these goals, and the costs will be borne by New York State.

[21] U.S. Dep't of Agriculture, *The Savings in Medicaid Costs for Newborns and their Mothers from Prenatal Participation in the WIC Program* (1990), https://www.fns.usda.gov/wic/savings-medicaid-costs-newborns-and-their-mothers-resulting-prenatal-participation-wic-program.
[22] U.S. Dep't of Agriculture, *WIC Medicaid II Feasibility Study: Final Report* (2018), https://www.fns.usda.gov/wic/special-supplemental-nutrition-program-women-infants-and-children-wic-medicaid-ii-feasibility-study
[23] Fiscal Policy Institute, *supra*, note 1.
[24] Helena Bottemiller Evich, "Immigrants, fearing Trump crackdown, drop out of nutrition programs," *Politico* (online, Sept. 3, 2018), https://www.politico.com/story/2018/09/03/immigrants-nutrition-food-trump-crackdown-806292.
[25] 124. Cong. Rec. S11466 (daily ed. July 21, 1978) (statement of Sen. McGovern).

35. WIC also improves access to nutritious foods like whole grains and vegetables. Access to healthy foods improves early childhood eating habits while also reducing the prevalence of pediatric obesity. By reducing childhood obesity rates, WIC significantly reduces long-term healthcare expenditures. The Medicaid costs of a child being treated for obesity are estimated at $6,730 annually, while the average healthcare costs for children covered by Medicaid is $2,446.39. As WIC works to provide nutritious foods and educate families on healthy eating habits, WIC's preventive role in reducing childhood obesity leads to additional healthcare savings.

36. In New York State, retailers authorized to accept WIC are required to stock fresh produce. Research indicates that the vast majority of WIC participants purchase their supplemental WIC foods at the same store where they do most of their other food shopping.[26] In the 2016 fiscal year, $3.95 billion was spent on the redemption of WIC foods at over 45,000 unique vendor sites.[27] In 2018, in New York State, WIC participants purchased approximately $370 million worth of WIC foods at nearly 3,000 retailers statewide. As a result, the WIC program has led to increased expenditures in retail grocery stores and improved access to healthy foods for all consumers. Changes to the WIC food package in 2009, including the addition of a cash-value voucher (CVV) for fruits and vegetables, further advanced access to healthy foods for all shoppers.[28]

[26] U.S. Dep't of Agriculture, "Where Do WIC Participants Redeem Their Food Benefits? An Analysis of WIC Food Dollar Redemption Patterns by Store Type" (Apr. 2016), https://www.ers.usda.gov/webdocs/publications/44073/57246_eib152.pdf?v=0

[27] U.S. Dep't of Agriculture, "WIC Program: Food Cost," https://fns-prod.azureedge.net/sites/default/files/pd/24wicfood$.pdf (data as of Oct. 5, 2018); U.S. Dep't of Agriculture, "Where Do WIC Participants Redeem Their Food Benefits? An Analysis of WIC Food Dollar Redemption Patterns by Store Type" (Apr. 2016), https://www.ers.usda.gov/webdocs/publications/44073/57246_eib152.pdf?v=0.

[28] Tatiana Andreyeva, et al., "Positive Influence of the Revised Special Supplemental Nutrition Program for Women, Infants, and Children Food Packages on Access to Healthy Foods," 112 *J. of the Amer. Academy of Nutrition & Dietetics* 850 (June 2012); June Tester, et al., "Healthy food availability and participation in WIC in food stores around lower- and higher-income elementary schools," 14 *Public Health Nutr.* 960 (Sept. 2015).

37. WIC's positive health outcomes are also associated with a long-term increase in economic productivity. Early brain development – which is linked to the attainment of adult economic productivity – is deeply impacted by access to adequate nutrition and healthcare in the prenatal and early childhood periods.[29] Prenatal and early childhood access to nutrition support and health services ensures that children grow up to be healthier and achieve more in school.[30] These children are more likely to be active participants in the workforce and become self-sufficient in adulthood.[31] Indeed, WIC's role in reducing childhood obesity can help address the significant costs (estimated at $4.3 billion annually) associated with obesity-related absenteeism in the workplace.[32]

38. By decreasing WIC enrollment, the Rule will have long-term effects on not only individual health, but also New York's workforce. Reduced WIC participation can threaten children's academic success and contribute to the prevalence of obesity in New York and, ultimately, obesity-related absenteeism. Overall, these effects will lead to decreased economic output in New York State.

[29] Institute of Medicine, *From Neurons to Neighborhoods: The Science of Early Childhood Development* (2000) ("[V]irtually every aspect of early human development, from the brain's evolving circuitry to the child's capacity for empathy, is affected by the environments and experiences that are encountered in a cumulative fashion, beginning in the prenatal period and extending throughout the early childhood years.").
[30] Hilary Hoynes, et al., "Long-Run Impacts of Childhood Access to the Safety Net," 106 *Amer. Economic Review* 903 (Apr. 2016); Stavros Petrou, "Economic consequences of preterm birth and low birthweight," 110 *BJOG: an Int'! J. of Obstetrics and Gynaecology* 17 (Apr. 2003) (noting that babies with low birthweight are 50% more likely to be in special education programs).
[31] *See* Hilary Hoynes, et al., "Long-Run Impacts of Childhood Access to the Safety Net," 106 *Amer. Economic Review* 903 (Apr. 2016) (finding increased economic outcomes for women who were raised on nutrition assistance programs, including increases in educational attainment, earnings, income, and decreases in welfare participation).
[32] John Cawley, John Rizzo & Kara Haas, "Occupation-specific Absenteeism Costs Associated with Obesity and Morbid Obesity," 49 *J. of Occupational and Environmental Med.* 1317; *see also* Donna Gates, et al., "Obesity and Presenteeism: The Impact of Body Mass Index on Workplace Productivity," 50 *J of Occupational and Environmental Med.* 39 (2008).

Irreparable Harm to the Health and Well-Being of New Yorkers Caused by Disincentivizing Medicaid Participation and Enrollment

39. Medicaid provides both primary health insurance coverage and supplementary coverage for low-income residents and vulnerable individuals. Health insurance increases the likelihood of people having both a usual source of care and access to care when they need it. Access to health insurance also improves the likelihood that patients receive recommended and potentially life-saving care.[33] Studies have also shown expanded Medicaid is associated with positive outcomes including lower mortality rates, higher cancer detection rates, and lower infant mortality rates.[34]

40. The Rule will severely diminish immigrants' access to health insurance. Many immigrant families have limited access to employer-sponsored insurance. If there is access to employer sponsored health coverage, it is often unaffordable for individuals with incomes below the Medicaid income level. For example, it would cost a household of three about 20 percent of household income to enroll in employer-sponsored health insurance. Medicaid is thus often the only affordable health insurance option.

41. By including Medicaid in the public charge test for some immigrant categories, the Department anticipates that many non-citizens will disenroll from or choose not to enroll in Medicaid due to a misunderstanding about the scope of Medicaid's implication in the public charge test. Likewise, the Department expects that many immigrants may choose not to enroll in, or disenroll from, other low-cost health insurance programs, such as the Essential Plan, Child Health Plus, and QHPs, out of concern that receipt of any form of public assistance will harm their ability to adjust status. In so doing, the Final Rule will effectively leave many non-citizens

[33] Baicker, Katherine, et al. 2013. "The Oregon Experiment-Medicaid's Effects on Clinical Outcomes." New England Journal of Medicine 368, no. 18: 1713-1722. https://www.nejm.org/doi/full/10.1056/nejmsa1212321
[34] Antonisse, L., *supra*, note 16.

without a viable insurance alternative. Without access to health insurance, these New Yorkers will go without preventive care, potentially leading to more acute and more difficult-to-treat conditions in the future.

42. By increasing uninsurance rates, the Final Rule will also worsen children's health and well-being. A parent's poor health and lack of access to health insurance can jeopardize a child's health and performance in school.[35] Additionally, studies suggest that expanding coverage eligibility to adults has, in some cases, caused significant reductions in children's uninsured rates.[36] Therefore, a reduction in the number of insured parents could lead to a reduction in insurance coverage among their children, regardless of whether their children are directly impacted by the Rule.

43. Without coverage, children will likely suffer the consequences of inconsistent well-child visits and primary care, resulting in potentially serious health issues. Instead of early treatment for illness, children without health coverage will resort to emergency department visits for treatment of more serious conditions, at a greater cost than doctor's office visits.

44. Finally, New York State has made great strides towards ending the HIV/AIDS epidemic through programs linked to Medicaid. The Medicaid Redesign Team Housing Contracts offer affordable housing for high-need Medicaid recipients living with HIV; residents are charged only 30 percent of their monthly adjusted income as rent. Further, the New York State Medicaid Program for Persons with HIV assists approximately 67,000 New Yorkers living with HIV by allowing them to receive their healthcare and other support services through the

[35] Institute of Medicine Committee on the Consequences of Uninsurance, "Family Well-Being and Health Insurance Coverage," Health Insurance Is a Family Matter, (Washington, DC: National Academics Press, 2002), available online at https://www.ncbi.nlm.nih.gov/books / NBK221008/.
[36] "Medicaid Expansion: Good for Parents and Children." 2014. Center for Children and Families, Georgetown University Health Policy Institute. https://ccf.georgetown.edu/wp-content/uploads/2013/12/Expanding-Coverage-for-Parents-Helps-Children-2013.pdf

Medicaid program. The care and treatment of persons living with HIV leads to viral suppression, which improves health and prevents transmission of HIV. Likewise, treatment of persons at risk for HIV with pre-exposure prophylaxis (PrEP) prevents acquisition of HIV.

45. If the Rule goes into effect, New York State's progress in combating the HIV/AIDS epidemic will be stalled and the spread of life-threatening communicable diseases will likely rise. As more than half of persons living with HIV in New York State receive care through the Medicaid program, disincentivizing HIV-positive immigrants from enrolling in Medicaid due to the Rule's chilling effects would effectively prevent them from receiving life-saving healthcare and prescription drugs that maximize virus suppression and prevent further transmission. In addition, those at risk for HIV who would otherwise be eligible for Medicaid may forego treatment with PrEP due to their inability to pay for preventive care visits or medication, thus putting more New Yorkers at risk of HIV.

46. Additionally, most housing programs supported by the Medicaid Redesign Team Housing Contract are currently at capacity, and several have waiting lists. Due to the limited capacity of these facilities, paired with the lack of alternative affordable housing in many communities, HIV-positive persons may be at increased risk of homelessness if they choose to disenroll in Medicaid out of fear generated by the Final Rule.

Irreparable Harm to the Health and Well-Being of New Yorkers Caused by the Chilling Effect on WIC Participation

47. WIC aims to reach eligible women as early as possible to maximize the program's impact on the pregnancy and reduce the risk of adverse birth outcomes including infant mortality, premature birth, and low birth weight. Longer participation in WIC throughout the pregnancy is associated with lower risk of preterm birth and a greater chance

of preventing low- or very low-birthweight.[37] In addition to having serious health complications, low-birthweight babies are also more likely to die in the first year of life.[38] Over 23,000 infants die each year in the United States.[39] WIC's intervention plays a significant role in reducing perinatal and infant mortality by ensuring adequate nutrition and healthy development in pregnancy and the first few weeks of life.[40]

48. The Department expects that the chilling effects of the Rule will cause fewer non-citizen mothers to participate in WIC, which puts their U.S. children at risk of birth complications, malnutrition, and even death.

49. WIC continues to offer health benefits after pregnancy has ended. WIC promotes and supports breastfeeding in several key ways, including providing educational materials, one-on-one consultations with peer and professional staff, group classes and support groups, and 24/7 hotlines for questions. The WIC program also works to establish community partnerships to ensure systematic community support for breastfeeding in all settings, and each local WIC provider must employ breastfeeding experts and peer counselors.

50. The highly successful breastfeeding peer counselor program, along with other initiatives, has helped improve the breastfeeding rates of WIC mothers nationally, from 42 percent in 1998 to 71 percent in 2016, and has contributed to a reduction in breastfeeding

[37] Kathryn Fingar, et al., "Reassessing the Association between WIC and Birth Outcomes Using a Fetuses-at-Risk Approach," 21 *J Maternal and Child Health* 825 (2017); Ralitza Gueorguieva, et al., "Length of prenatal participation in WIC and risk of delivering a small-for-gestational-age infant: Florida, 1996-2004," 13 *J of Maternal Child Health* 479 (2009); Marianne Bitler & Janet Currie, "Does WIC Work? The Effects of WIC on Pregnancy and Birth Outcomes," 1 *J of Policy Analysis & Mgmt.* 73 (2005).
[38] Lehman Black, et al., "Effects of birth weight and ethnicity on incidence of sudden infant death syndrome," 108 *J of Pediatrics* 209 (Feb. 1986).
[39] Kenneth Kochanek, et al., "Mortality in the United States, 2016," *CDC-National Center for Health Statistics Data Brie/No. 293* 6 (December 2017). https://www.cdc.gov/nchs/products/databriefs/db293.htm
[40] Kathryn Fingar, et al., "Reassessing the Association between WIC and Birth Outcomes Using a Fetuses-at-Risk Approach," 21 *J Maternal and Child Health* 825 (2017).

disparities.[41] WIC mothers have also been choosing to breastfeed for longer, with one-month postpartum rates having risen 85 percent between 1998 and 2013 and the rate for 3- to 12-month-old babies having doubled during the same time period.[42]

51. There is strong evidence of the strong positive health impacts of breastfeeding. Infants breastfed for 3 months are 30 percent less likely to have type 1 diabetes.[43] Breastfeeding is associated with lower rates of pediatric overweight or obesity,[44] and reduced risk of other chronic diseases such as cardiovascular disease, hypertension, and some forms of cancer.[45] Breastfeeding is also positively correlated with cognitive development.[46]

52. Many immigrant mothers will likely disenroll from, or choose not to enroll in, WIC out of concern that participation will affect their immigration status. These mothers will be left without access to the breastfeeding support services offered through WIC. As a result, the Department expects fewer immigrant mothers to breastfeed, or to breastfeed for a shorter period. By hindering breastfeeding education and support, the Rule puts U.S. citizen children at greater risk of short- and long-term adverse health impacts correlated with reductions in breastfeeding, including diabetes, obesity, and chronic disease, as well as reduced cognitive development.

[41] U.S. Dep't of Agriculture, "WIC Participant and Program Characteristics 2016 Final Report," 142 (Apr. 20, 2018), https://fns-prod.azureedge.net/sites/default/files/ops/WICPC2016.pdf.
[42] U.S. Dep't of Agriculture, "WIC Infant and Toddler Feeding Practices Study – 2: Infant Year Report," https://fns-prod.azureedge.net/sites/default/files/ops/WIC-ITFPS2-Infant.pdf (Jan. 2017).
[43] Bernardo Horta, et al., "Long-term consequences of breastfeeding on cholesterol, obesity, systolic blood pressure, and type 2 diabetes: a systematic review and meta-analysis," 104 *Acta Paediatrica* 30 (2015).
[44] Laurence Grummer-Strawn & Zuguo Mei, "Does Breastfeeding Protect Against Pediatric Overweight? Analysis of Longitudinal Data From the Centers for Disease Control and Prevention Pediatric Nutrition Surveillance System," 113 *Pediatrics* 81 (2004).
[45] Colin Binns, et al., "The Long-Term Public Health Benefits of Breastfeeding," 28 *Asia Pacific J. of Public Health* 7 (Jan. 2016).
[46] *Id.*

53. WIC also offers preventative nutrition assistance through its nutritious food package, which was overhauled in 2009 to offer greater access to whole-grain foods, fruits, and vegetables for WIC participants. The 2009 food package changes resulted in a marked increase in whole-grain and vegetable consumption among WIC participants, and a similarly significant reduction in whole milk consumption.[47] These changes have contributed to a modest decline in severe childhood obesity among young children of WIC families, highlighting how WIC's health benefits continue past the infancy period.[48] Only 13.9% of children aged two to five are obese,[49] and yet pediatric obesity is known to be a significant cause of adult obesity and can lead to serious chronic health conditions, including heart disease, some types of cancers, type-2 diabetes, and hypertension.[50]

54. WIC's food package also leads to higher iron intake, which is a critical supplement for those at risk of iron deficiency.[51] Notably, there remain nearly 200,000 annual ambulatory care visits as a result of anemia, with most cases due to a nutritional deficiency; approximately 5,200 individuals died as a result of iron-deficiency anemia in 2015.[52]

55. If allowed to go into effect, the Final Rule will discourage eligible families from enrolling in WIC. Consequently, otherwise eligible families will not have access to

[47] Shannon Whaley, et al., "Revised WIC Food Package Improves Diets of WIC Families," 44 *J. of Nutrition Educ. and Behavior* 204 (2012); June Tester, et al., "Revised WIC Food Package and Children's Diet Quality," 137 *Pediatrics* (May 2016).
[48] Liping Pan, et al., "Trends in Severe Obesity Among Children Aged 2 to 4 Enrolled in Special Supplemental Nutrition Program for Women, Infants, and Children From 2000 to 2014," 172 *Pediatrics* 232 (2018).
[49] Craig Hales, et al., "Prevalence of Obesity Among Adults and Youth: United States, 2015-2016," NCHS Data Brief No. 288 (Oct. 2017), https://www.cdc.gov/nchs/data/databriefs/db288.pdf.
[50] Nat'l Institutes of Health, "Clinical Guidelines on the Identification, Evaluation, and Treatment of Overweight and Obesity in Adults," NIH Pub. No. 98-4083, 100 (Sept. 1998), https://www.nhlbi.nih.gov/files/docs/guidelines/ob_gdlns.pdf.
[51] *See* Steven Yen, "The effects of SNAP and WIC programs on nutrition intakes of children," 35 *Food Policy* 576 (2010).
[52] Ctrs. for Disease Control and Prevention, "National Center for Health Statistics: Anemia or Iron Deficiency," (Mar. 2017), https://www.cdc.gov/nchs/fastats/anemia.htm.

the nutritious food package offered by WIC. Impeded access to healthy foods will put many U.S.-citizen children at risk of anemia and pediatric obesity and open the door to the long-term health consequences of an unhealthy diet, including adult obesity and chronic disease.

Increased Administrative Burdens and Costs on New York State

56. If implemented, the Final Rule will impose administrative burdens and costs on NYSDOH, including those imposed on the NY State of Health Marketplace.

57. Federal law requires the health insurance Marketplaces to use a single streamlined application process. 42 USC § 18083; 45 CFR § 155.405(a). Under this application process, Marketplaces must determine Medicaid eligibility for anyone applying for subsidized health insurance coverage. 42 USC § 18083(a); 45 CFR §§ 155.305(c), 155.310(b). Therefore, all applicants for Marketplace programs, including individuals seeking to apply for enrollment in Child Health Plus, the Essential Plan, or a QHP with an Advance Premium Tax Credit (APTC), must be found ineligible for Medicaid before their eligibility can be determined for other programs. As such, the State's information technology system is currently set up so that a Medicaid application is a threshold requirement, before applications for other programs are permitted.

58. Marketplaces are also legally constrained from determining eligibility only for a particular insurance affordability program. 45 CFR §§ 155.305(c)-(g), 155.310(b). NY State of Health Marketplace thus must evaluate eligibility for all potential subsidized programs, including Medicaid.

59. Accordingly, even if non-citizens choose not to enroll in Medicaid out of fear that their participation will affect their ability to adjust their immigration status, the Department will be legally and administratively constrained from allowing them to apply for

other forms of low-cost health insurance, such as Child Health Plus, the Essential Plan, or a QHP.

60. As a result, these individuals may forego health insurance altogether unless the Department is able to effectively communicate to non-citizens the narrow scope of Medicaid's implication in the Final Rule.

61. In total, NY State of Health Marketplace's increased Customer Service Center volume following the Final Rule's implementation could cost the state millions of dollars.

62. In addition, NYSDOH will have to expend resources preparing for implementation of the Final Rule before the October 15, 2019 effective date. For example, NYSDOH has developed materials to communicate with consumers about these rule changes.

63. The Final Rule, if enacted, will also impose significant costs on the WIC program.

64. WIC works in tandem with Medicaid and SNAP to advance public health, as WIC's targeted intervention for pregnant women, new mothers, and young children complements the broader purpose of Medicaid to provide health coverage and SNAP to ensure adequate nutrition for low-income families. In New York State, 86.2 percent of WIC participants are also enrolled in Medicaid.

65. Congress has recognized the connection between these programs by authorizing adjunctive eligibility.[53] Adjunctive eligibility permits individuals to be automatically income-eligible for WIC if they or certain family members participate in Medicaid, SNAP, Temporary Assistance for Needy Families (TANF), or other benefit

[53] Pub. L. No. 101-147 § 123 (Nov. 10, 1989) [codified in 42 USC §1 786(d)(2)(A)(ii), (iii)].

programs at the discretion of the state. In 2016, 74.9 percent of WIC participants reported receiving at least one of the adjunctively-eligible programs, and it is possible that even more WIC participants are adjunctively eligible through family members.[54]

66. Determining income eligibility is one of the most burdensome elements of the WIC certification process. WIC routinely certifies participants to ensure continuing eligibility, and certification periods last for one year, at most.[55] With few exceptions, a participant must be physically present in the WIC clinic each time that participant is certified, including infants and young children.[56] Adjunctive eligibility therefore promotes efficiency by streamlining the certification process and reducing burdens on both clinics and participants.

67. Income certification through adjunctive eligibility also takes less time than income screening involving pay stubs or other financial documents.[57] These efficiency gains have helped reduce barriers to WIC participation, maximize clinic time for WIC's public health services, and free WIC funding for nutrition education and breastfeeding support.

68. Due to the benefits of adjunctive eligibility rules, New York State has streamlined documentation requirements to create a smoother process for applicants to join WIC. Families may now use their smart phones and tablets to prove eligibility in some cases. For example, families can use online accounts to show they are enrolled in adjunct programs

[54] U.S. Dep't of Agriculture, "WIC Participant and Program Characteristics 2016 Final Report," 31-32 (Apr. 20, 2018), https://fns-prod.azureedge.net/sites/default/files/ops/WICPC2016.pdf.
[55] 7 C.F.R. § 246.7(g)(l).
[56] *Id.* § 246.7(0).
[57] *See* National WIC Association, "WIC State Directors Value Medicaid Adjunctive Eligibility" (2015), https://s3.amazonaws.com/aws.upl/nwica.org/medicaid-ae-study.pdf.

like Medicaid. New York State has also invested in a long-term streamlining initiative to integrate eligibility systems across programs and state agencies.

69. The inclusion of Medicaid and SNAP in public charge review will decrease participation in Medicaid and SNAP among WIC families. Because New Yorkers are expected to be deterred from participating in SNAP and Medicaid due to the chilling effects of the Rule (in addition to decreased participation in other health insurance coverage options), the Department's efforts to improve efficiency by streamlining the WIC certification process will be impeded by the Final Rule. By reducing the number of families that are eligible through an adjunct program, WIC staff will spend additional time conducting income certification. Estimates show that income screening using pay stubs or financial documents costs $12.50 per participant, whereas the administrative costs for income screening with adjunctive eligibility is only $3.75 per participant.[58] The additional $8.75 per participant cost – if applied to the whole program – could add significant new pressures on WIC's budget.

70. Additional administrative costs would be financed through WIC's "Nutrition Services & Administrative" (NSA) grant. The NSA grant finances not only administrative costs, but also WIC's wide-ranging public health and education efforts.[59] About one-third of the total NSA grant (approximately 9.5 percent of total WIC funding) is used for program administration, as WIC seeks to maximize available funding for nutrition education, breastfeeding support, or other client services.[60] Increased income screening in the clinics will require more of the NSA grant to be devoted to administrative costs, thereby reducing

[58] *Id.*
[59] 42 U.S.C. § 1786(b)(4).
[60] U.S. Dep't of Agriculture, "WIC Nutrition Services and Administration Cost Study" (Nov. 2017), https://fns-prod.azureedge.net/sites/default/files/ops/WICNSACostStudy.pdf.

funding for WIC's important nutrition education classes, breastfeeding support, and public health screenings and referrals for immunizations, tobacco cessation, postpartum depression, opioids, and more.

71. The Department anticipates that a substantial number of New Yorkers will forego enrollment in Medicaid and SNAP due to the chilling effects of the Final Rule, resulting in adjunctive eligibility in WIC being substantially impaired. Should that occur, WIC agencies will have to hire additional staff to conduct longer certification appointments,[61] which would diminish the capacity of WIC agencies and clinics to attract specialized staff with expertise in nutrition education and breastfeeding support, such as Registered Dietitians (RDs) or International Board Certified Lactation Consultants (IBCLCs).

CONCLUSION

72. For these reasons, the Department opposes implementation of the Final Rule given its destructive, far-reaching, and irreversible consequences on the economy, health, and administration of New York State, and I respectfully request that this Court grant the relief Plaintiffs request.

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

DATED this 6th day of September, 2019 at New York, New York.

HOWARD A. ZUCKER, M.D., J.D.
Commissioner
New York State Department of Health

[61] National WIC Association, *supra*, note 57.