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RE: DHS Docket No. USCIS-2010-0012, Proposed Rule: "Inadmissibility on Public Charge Grounds"

Dear Chief Deshommes:

The City of New York ("NYC") and its municipal hospital system, NYC Health + Hospitals ("NYC H+H"), submit this comment in response to the Department of Homeland Security's ("DHS") proposed rule entitled "Inadmissibility on Public Charge Grounds," which was published in the Federal Register on October 10, 2018 ("Proposed Rule").[1] The Proposed Rule would radically reinterpret the term "public charge" as it appears in the Immigration and Nationality Act ("INA") to expand its definition, departing dramatically from longstanding policy. This expansion would unleash a rash of negative consequences upon not just those immigrants it seeks to bar as inadmissible, but upon their entire households, including U.S. citizen children. The Proposed Rule will also impose significant economic costs on NYC.[2]

It is critical that changes to our country's rules avoid creating preventable risks to health, safety, and economic security. NYC strongly opposes the Proposed Rule, and calls upon DHS to withdraw it.

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

[2] The purpose of this Comment is to set forth the harms that the Proposed Rule would inflict upon NYC and its residents. NYC also opposes this Proposed Rule on legal grounds. NYC has advanced its legal arguments against this Proposed Rule through a separate Comment, joined by multiple additional cities. Additionally, this Comment does not exhaust the potential harms of the Proposed Rule upon NYC or discuss an exhaustive list of programs.

I. INTRODUCTION

NYC's Foreign-Born Population

NYC enjoys a proud legacy as the ultimate city of immigrants. For generations, people from around the world have come here to make a better life for themselves and their families. Diversity is perhaps our most distinguishing feature and one of our greatest strengths. Today, of our 8.5 million residents, 3.1 million (or 38 percent) are foreign-born.[3] Of these, most are now U.S. citizens; approximately 1.4 million New Yorkers, or about one in six residents, are noncitizens, many of whom have not yet become a Lawful Permanent Resident ("LPR," also referred to as a "green card holder").[4]

Foreign-born New Yorkers are deeply integrated into NYC life. Approximately 60 percent of New Yorkers (4.9 million people) live in households with at least one foreign-born member.[5] NYC's foreign-born population is a great asset to this city, playing a unique and vital role in stabilizing NYC's population throughout decades when many U.S. cities were facing severe population declines. Most Northeastern and Midwestern cities' populations peaked in 1950 before shrinking dramatically as a result of suburbanization and economic changes. Initially, NYC was not spared from this urban exodus; the same forces drove away 10 percent of NYC's population in the 1970s. However, the flow of new immigrants soon began replenishing NYC's population over the course of the 1980s. NYC rebounded on the heels of a big economic transformation from manufacturing to service industries that acted as a magnet for further immigration. The economic activity of immigrants ushered NYC into an era of renewal and growth and propelled the total city population above the 8 million mark in 2000.[6]

The foreign-born continue to buoy our city and our economy in significant ways. Immigrant New Yorkers have a labor force participation rate of 65.6 percent, which exceeds that of New Yorkers overall (64.8 percent) and of U.S.-born New Yorkers (64.1 percent).[7] The foreign-born comprise nearly half (45 percent) of NYC's workforce.[8] And in 2017, immigrants contributed $195 billion to NYC's Gross Domestic Product (GDP), or about 22 percent of NYC's total GDP.[9] Notably,

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[3] New York City Mayor's Office of Immigrant Affairs, *State of Our Immigrant City* (Mar. 2018), *available at* https://www1.nyc.gov/assets/immigrants/downloads/pdf/moia_annual_report_2018_final.pdf (analyzing 2012-2016 5-Year American Community Survey Public Use Microdata Sample, as augmented by the Mayor's Office for Economic Opportunity).
[4] *Id.*
[5] *Id.*
[6] NYC Department of City Planning, *The Newest New Yorkers: Characteristics of NYC's Foreign-born Population* (Dec. 2013) p. 1, *available at* https://www1.nyc.gov/assets/planning/download/pdf/data-maps/nyc-population/nny2013/nny_2013.pdf.
[7] New York City Mayor's Office of Immigrant Affairs, *State of Our Immigrant City* (Mar. 2018), *available at* https://www1.nyc.gov/assets/immigrants/downloads/pdf/moia_annual_report_2018_final.pdf.
[8] *Id.*
[9] *Id.*

immigrants own 52 percent of NYC's businesses,[10] including over half of NYC's 276,000 individual and family-owned businesses,[11] and create jobs and provide essential goods and services to NYC.

The importance of immigrant New Yorkers to NYC's economy is evidenced by the types of industries in which they are employed. Approximately 25 percent of immigrant New Yorkers work in fields that provide critical services to other New Yorkers—education, health, and human services.[12]

Given the size of NYC's foreign-born population, its embeddedness, and its historic and present-day contributions to this city, NYC has strong interests in ensuring that all New Yorkers are able to access critical health, nutrition, and housing services and resources, in accordance with federal, state, and local laws. From decades of experience, we know that inclusive laws and policies benefit NYC as a whole—its health, safety, and general welfare.

The Proposed Rule

Existing immigration laws provide that an applicant for admission to the United States who is or is likely to become a "public charge" can be denied a green card or visa.[13] Nearly 20 years ago, the federal government limited the public charge inquiry to end damaging confusion and fear about who would face negative immigration consequences due to the public charge test, and to alleviate the public health and nutrition problems that stemmed from this confusion and fear. As a result, current guidance defines a "public charge" as someone who is "primarily dependent on the government for subsistence," and a public charge determination is largely limited in its examination of public benefits use, looking only at cash assistance programs, such as Temporary Assistance for Needy Families ("TANF") or Supplemental Security Income ("SSI"), and institutionalization for long-term care at government expense. Current policy also directs immigration officers to conduct a "totality of the circumstances" test in which they must consider an applicant's age, health, family status, assets, resources, financial status, education, and skills. In addition, the current policy gives significant weight to affidavits of support filed by an intending immigrant's sponsor or other household member.[14] Often such an affidavit is sufficient for an individual to show he or she would not become a public charge.

The Proposed Rule would greatly expand the interpretation and application of "public charge" inadmissibility. The Proposed Rule expands the definition of public charge to one who receives or is likely to receive one or more specified public benefits. To the presently considered benefits, (SSI and TANF) the Proposed Rule would add noncash benefits and programs critical to maintaining a healthy

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[10] *Id.*

[11] Analysis provided by the NYC Office of Management and Budget, using 2017 American Community Survey data.

[12] New York City Mayor's Office of Immigrant Affairs, *State of Our Immigrant City* (Mar. 2018), *available at* https://www1.nyc.gov/assets/immigrants/downloads/pdf/moia_annual_report_2018_final.pdf.

[13] INA Section 212(a)(4). An individual seeking admission to the United States or seeking to adjust status to that of an LPR (green card holder) is inadmissible if the individual, "at the time of application for admission or adjustment of status, is likely at any time to become a public charge."

[14] An Affidavit of Support, or a Form I-864, is filed by a sponsor on behalf of certain green card applicants to demonstrate to immigration officials that the applicant has adequate means of financial support in the United States. The form is considered a contract between the green card applicant and the sponsor as well as between the sponsor and the U.S. government, in which the sponsor promises to support the applicant if he is unable to do support himself on his own.

and productive society: Medicaid, Supplemental Nutrition for Needy People ("SNAP," known commonly as Food Stamps), the Housing Choice Voucher Program and Project-Based Rental Assistance ("Section 8"), Subsidized Housing under the Housing Act of 1937, and Medicare Part D subsidies (prescription assistance for seniors). Additionally, the Proposed Rule would add a requirement that nonimmigrant visa holders seeking an extension or change of status must demonstrate that they have not received nor are likely to receive a specified public benefit.

Further, the Proposed Rule would expand the reach of the public charge test greatly to those who have not previously used a specified public benefit. It sets forth a much stricter "totality of the circumstances" test for public charge determinations, even where an individual may present an otherwise sufficient affidavit of support from a sponsor.

In sum, this Proposed Rule represents a dramatic departure from existing federal policy that will inflict serious harms on immigrants, their households, and beyond, as further detailed below.

The Proposed Rule Will Harm Hundreds of Thousands of NYC Immigrants and Their Families and Household Members, including U.S. Citizens.

Using augmented American Community Survey data, NYC analyzed how many New Yorkers may be impacted by one or both parts of the proposed public charge test due to the receipt of one or more of the enumerated public benefits and/or the stricter totality of the circumstances test. Potential impacts also include withdrawal from benefits and services due to fear or confusion about the scope of the rule. Taking this range of impacts together, NYC estimates that the proposed rule, if implemented, could potentially impact about 1.5 million U.S. citizen and noncitizen New Yorkers.[15] Of this potentially affected population, hundreds of thousands of U.S. citizen, LPR, and other noncitizen New Yorkers may be "chilled" from utilizing public benefits for which they are eligible.[16] These New Yorkers—including LPRs, refugees, asylees, and other noncitizens exempt from the public charge test under immigration law, as well as U.S. citizens—may well fear that their own use of benefits could damage the immigration prospects for their noncitizen household members despite the fact that the Proposed Rule would not impute one household member's benefits usage to another household member.[17]

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[15] NYC Mayor's Office of Immigrant Affairs, Mayor's Office of Economic Opportunity, and Department of Social Services, *Expanding Public Charge Inadmissibility: The Impact on Immigrants, Households, and the City of New York* (Dec.2018), *available at* https://www1.nyc.gov/assets/immigrants/downloads/pdf/research_brief_2018_12_01.pdf.

[16] *Id.* Note that NYC's estimates and methodology are not identical to those of other researchers who have modeled impact from the proposed rule. Differences are attributable to different data sources and jurisdictions modeled. However, NYC's principal findings are largely consistent other researchers' findings. *See, e.g.*, Wimer, Christopher, Matthew Maury, and Veyom Bahl (2018). Public Charge: How a new policy could affect poverty in New York City. New York, NY: Robin Hood; Donald Kerwin, Robert Warren, and Mike Nicholson, Center for Migration Studies, *Proposed Public Charge Rule Would Significantly Reduce Legal Admissions and Adjustment to Lawful Permanent Resident Status of Working Class Persons* (2018); Randy Capps, Mark Greenberg, Michael Fix, and Jie Zong, Migration Policy Institute, *Gauging the Impact of DHS' Proposed Public-Charge Rule on U.S. Immigration* (2018); Shawn Fremstad, Center for American Progress, *Trump's 'Public Charge' Rule Would Radically Change Legal Immigration* (2018).

[17] *Id.*

NYC estimates that impacted New Yorkers also include:

- Noncitizens who are eligible for certain limited New York State ("NYS") public benefits as persons in the United States "permanently residing under color of law" ("PRUCOL"), family members of U.S. citizens with approved family member petitions to live permanently in the United States, and persons granted deferred action, including the recipients of Deferred Action for Childhood Arrivals (DACA).[18] These individuals may be in a position to seek a visa or permanent resident status in the future.

- Individuals and families who receive benefits and seek services (or live in households with those who do) from NYC's public and private hospitals, from its world-renowned public health infrastructure, from its near-universal public health insurance programs and from its fabric of social safety net programs that address food, shelter, and other basic human needs.

- Vulnerable populations such as:
    - 72,000 U.S. citizen children,
    - 29,000 people with disabilities, and
    - 30,000 seniors (aged 65 and over)[19]

According to administrative data, over 220,000 NYC noncitizens lawfully receive Supplemental Nutrition Assistance (SNAP), cash assistance (Temporary Assistance for Needy Families or the State/City Safety Net Program), or both; and 54,000 receive Supplemental Security Income and/or an add-on NYS supplement (SSI/SSP). Projecting direct impacts to them is primarily based on the "chilling effect" – *i.e.* the fear and confusion that causes immigrants and citizens alike to withdraw from or forgo benefits and services. Looking at these noncitizens only, and these three benefits, and assuming a 20 percent withdrawal rate[20] would result in an annual direct loss of $235 million in benefits to them.[21]

The Citywide Chilling Effect Will In Turn Increase Poverty Among Affected Households

NYC examined the impact of the Proposed Rule upon the poverty rate of the population that it anticipates to be chilled from lawful use of public benefits due to confusion and fear about the scope of

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[18] *Id.*
[19] *Id.*

[20] NYC assigned a potential withdrawal rate of 20 percent as a conservative approximation of the chilling effect rate, based on the rates observed following the 1996 Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) and the implementation of DHS's Secure Communities immigration enforcement initiative. *See, e.g.*, Michael Fix and Ron Haskins, *Welfare Benefits for Non-citizens*, The Brookings Institution (Feb. 2, 2002), *available at* https://www.brookings.edu/research/welfare-benefits-for-non-citizens; Marcella Alsan & Crystal Yang, *Fear and the Safety Net: Evidence from Secure Communities*, pages 22-24, National Bureau of Economic Research (2018), *available at* http://www.nber.org/papers/w24731.pdf.

[21] NYC Department of Social Services; New York State Office of Temporary and Disability Assistance; September 2018

the public charge rule change. NYC estimates that, even using conservative withdrawal rate assumptions, the Proposed Rule could increase the poverty rate for this population by 3.8 percentage points, from a 25.3 percent poverty rate now to a projected 29.1 percent.[22]

The Proposed Rule could also dramatically increase child poverty within this group. NYC estimates that child poverty in this population would increase by 9.1 percentage points—from 19.8 percent to 28.9 percent with even a modest decline in benefit use. Due to the magnitude of the affected population projections, NYC anticipates that the expanded rule could have a significant impact on citywide poverty overall.

I. THE PURPORTED BENEFITS OF THE PROPOSED RULE ARE OUTWEIGHED BY NEGATIVE IMPACTS THE RULE WILL HAVE ON NEW YORKERS— BOTH U.S. CITIZENS AND IMMIGRANTS— AND THE IMPOSITION OF SIGNIFICANT COSTS ON NYC TAXPAYERS.

DHS alleges that the primary purpose of the Proposed Rule is to: (1) promote self-sufficiency and (2) decrease spending by the federal government. In reality, the Proposed Rule is an attempt to unlawfully shift federal costs authorized by Congress to protect the health and well-being of immigrants and U.S. citizens to state and local governments and their taxpayers. As discussed in a companion comment joined by 30 local governments addressing the legal insufficiencies of the Proposed Rule, for more than one hundred years, federal laws, judicial case law and administrative guidelines have established a public charge rule meant to ensure that immigrants do not depend on the government for subsistence through cash assistance for income maintenance or long term care at the government's expense.[23] By rendering some immigrants potentially inadmissible because they have either used non-cash public benefits to which they are legally entitled, or are simply at the beginning of their socioeconomic journey in the United States, the Proposed Rule runs counter to what Congress, federal agencies charged with administering public benefits, and cities and states across the nation have determined to be sound public policy.

DHS admits that the purported federal savings will impose financial and non-monetized costs on states and localities, including worse health outcomes, increased use of emergency rooms and emergent care as a method of primary health care, increased prevalence of communicable diseases, increases in uncompensated care, increased rates of poverty and housing instability, and reduced productivity and educational attainment. However, DHS ignores that the Proposed Rule will have the following adverse impacts on U.S. citizens and immigrants alike: (1) the creation of a potential health crisis; (2) the resulting imposition of significant financial costs on NYC and its taxpayers; and (3) the destabilization of education outcomes for U.S. citizen and immigrant children.

A. THE PROPOSED RULE WOULD CREATE A PUBLIC HEALTH CRISIS FOR U.S. CITIZENS AND IMMIGRANTS.

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[23] *See* Multi-City comment, Tracking No. 1k2-9719-hjz0 at pp. 1-19.

The NYC Department of Health and Mental Hygiene ("NYC Health Department") and NYC H+H have determined that the Proposed Rule will burden local health systems and negatively affect the broader health and economic activity of the region. The NYC Health Department is one of the largest public health agencies in the world, and is the nation's oldest public health agency, with more than 200 years of leadership in the field. Among its mandates is to protect and promote the healthcare of 8.5 million diverse New Yorkers. The NYC Health Department studies the patterns, causes, and effects of health and disease conditions in NYC, and operates clinics that offer New Yorkers sexual health, immunization, and tuberculosis ("TB") services. NYC H+H is the nation's largest municipal health system and NYC's public safety net health care system. It operates an integrated health care system of hospitals, neighborhood health centers, long-term care facilities, nursing homes, and home care. Largely consistent with the size of NYC's foreign-born population, more than 40 percent of NYC H+H patients were born outside the United States.

Many lessons were learned after the passage in 1996 of the Personal Responsibility and Work Opportunity Reconciliation Act ("PRWORA"), which changed lawfully present immigrants' eligibility for Medicaid. The law was associated with a 23 percent decrease in Medicaid enrollment among low-income adult LPRs and 58 percent decrease among adult refugees, even though refugees were exempt from the PRWORA change to Medicaid eligibility. The same study also established that declines in immigrants' Medicaid participation were directly correlated to increases in the proportion of the uninsured population.[24]

The Proposed Rule replicates the PRWORA by penalizing non-citizens who have enrolled into Medicaid or Medicare Part D Low Income Subsidy Program for more than 12 months in the aggregate within a 36 month period when they seek adjustment of status. In addition, the Proposed Rule imposes a more exacting totality of the circumstances inquiry, even for those immigrants who have not used Medicaid or any other covered public benefits, by including health status among the variables that could negatively impact an immigrant's public charge determination. From a health perspective, the Proposed Rule will result in: (1) community-wide fear and confusion about the consequences of the use of public health insurance and programs, nutrition, and housing benefits; and (2) the reluctance of immigrants to make necessary visits to a heath care professional or seek medical treatment due to fear of what impact those medical care consultations might have on their immigration status. In turn, these dynamics will increase the number of immigrants forgoing health care coverage and exacerbate population health issues.[25]

The Proposed Rule Would Have a Chilling Effect on Health Benefits Utilization

As NYC's single largest provider of care to Medicaid recipients and the uninsured, NYC H+H estimates that in the first year following the implementation of the Proposed Rule, 350,000 of its patients could change their behavior in some way, such as dropping Medicaid coverage, avoiding doctor's preventive care visits and not addressing urgent health concerns.

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[24] Fix M, Passel J. Urban Institute Discussion Paper, The scope and impact of welfare reform's immigrant provisions (2002). http://webarchive.urban.org/Uploadedpdf/410412_discussion02-03.pdf

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

In fact, the chilling effect resulting from the Proposed Rule has already begun. For example, numerous frontline staff members within NYC H+H, the NYC Health Department, and community partners, have observed and reported that patients are already disenrolling from health insurance coverage and WIC benefits due to fear of the Proposed Rule. Also, there is ongoing concern that patients will forgo prenatal and postnatal care, fail to fill needed prescriptions for communicable diseases such as TB, and/or decline to enroll in non-medical benefits they need to survive. Disenrollment is expected to increase should the Proposed Rule go into effect. As described below, these patients' decisions, driven by fear of potential repercussions under this proposal, could mean an increase in maternal morbidity, infant mortality, low birth weight, or children born preterm, and greater exposure among the general population to communicable diseases.

The Proposed Rule Would Reduce Health Insurance Coverage and Health Care Access

Impeding access to health insurance coverage and prescription assistance, as the Proposed Rule would, would deter impacted families from seeking medical treatment. For low-income individuals in the United States, Medicaid has often served as the only source of health insurance coverage that allowed them to maintain or improve health and protect their financial security against catastrophic health expenses. The impact of the Affordable Care Act's ("ACA") Medicaid expansion in New York highlights this point: between 2013 and 2016, the proportion of the uninsured population in NYS declined by 42.8 percent (about 900,000 people).[26] While the proportion of New Yorkers with coverage increased for all insurance types, the most significant coverage gains were attributable to Medicaid.[27] In NYC alone, 3.5 million residents—more than 40 percent of NYC's population—are enrolled in Medicaid.[28]

Immigrants are already less likely to enroll in Medicaid and more likely to be uninsured than the U.S.-born population due to the restrictions on their eligibility.[29] In addition, household immigration status negatively affects Medicaid enrollment even among eligible adults.[30] The Proposed Rule will likely further dampen immigrants' access to health insurance despite its critical role in maintaining and improving health.

It is well established that health insurance coverage plays a critical role in enhancing one's access to needed care and maintaining or improving health status. There is strong evidence that insurance coverage is associated with having a consistent source of care and being able to afford needed care, both of which are factors typically associated with better health outcomes.[31] Health

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[26] NYS Health Foundation, Success in the Empire State: Health Insurance Coverage Trends, November 2017, https://nyshealthfoundation.org/wp-content/uploads/2017/11/success-in-the-empire-state-health-insurance-trends-NY.pdf.

[27] *Id.*

[28] New York State Department of Health, Medicaid Global Spending Cap Report, July 2018. https://www.health.ny.gov/health_care/medicaid/regulations/global_cap/monthly/sfy_2018-2019/docs/july_2018_report.pdf.

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

[30] Cohen MS, Schpero WL. Household immigration status had differential impact on Medicaid enrollment in expansion and nonexpansion states. Health Affairs 2018;37(3):394-402.

[31] Shartzer A, Long SK, Anderson N. Access to care and affordability have improved following Affordable Care Act implementation; problems remain. Health Affairs 2016;35:161-168. Collins SR, Gunja MZ, Doty MM et al., the Commonwealth Fund, Americans' experiences with ACA Marketplace and Medicaid coverage: access to care and satisfaction (2016). https://www.commonwealthfund.org/publications/issue-briefs/2016/may/americans-experiences-aca-

insurance also plays a major role in access to primary care[32] and evidence-based preventive health care that in turn directly improves health, including screenings for hypertension,[33] high cholesterol,[34] HIV,[35] and cervical, prostate, and breast cancer.[36] Health insurance is also positively associated with use of contraceptives[37] and access to prenatal care.[38] The data is clear: access to health insurance, which for 40 percent of New Yorkers is Medicaid, and Medicare Part D subsidies yields vital health outcomes. DHS's proposal to impede access to Medicaid through the backdoor of immigration status is counter to this body of evidence.

In addition, adults with health insurance are more likely to be able to effectively manage and control existing chronic illnesses[39] and tend to increase utilization of prescription drugs.[40] In fact, Medicare Part D low-income subsidies lessen the burden of premium payments and limit price sensitivity for low-income Medicare beneficiaries. Forcing Medicare beneficiaries to forgo the Part D subsidies would increase the out of pocket burden for accessing drugs, which has been shown to decrease the use of essential drugs and increase serious adverse events (including emergency department visits) associated with such reduction.[41] Here again, DHS's Proposed Rule would fly in the face of evidence indicating that Medicare Part D prescription subsidies contribute critically to the use of essential medicines, and to public health generally.

The Proposed Rule Would Have a Disproportionate Health Impact On Women, Infants And Children

The impact of the Proposed Rule would be particularly devastating for the health outcomes of infants, children, and women[42] (including pregnant women[43]). Reduced access to prenatal care for

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marketplace-and-medicaid-coverage Centers for Disease Control, National Center for Health Statistics Fact Sheet: Health Insurance and Access to Care (2017). https://www.cdc.gov/nchs/data/factsheets/factsheet_hiac.pdf. Starfield B, Shi L, Macinko J. Contribution of primary care to health systems and health. Milbank Q 2005;83:457-502.

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

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

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

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

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

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

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

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

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

[41] Tamblyn R, Laprise R, Hanley JA et al. Adverse events associated with prescription drug cost-sharing among poor and elderly persons. JAMA 2001;285(4):421-429.

[42] Gunja MZ, Collins SR, Doty MM et al. the Commonwealth Fund Issue Brief, How the Affordable Care Act has helped women gain insurance and improved their ability to get health care (2017) https://www.commonwealthfund.org/publications/issue-briefs/2017/aug/how-affordable-care-act-has-helped-women-gain-insurance-and

immigrant mothers would result still births, preterm births, and babies being born sick and with complications (which can have a negative health impact throughout life). Medicaid and the Child Health Insurance Program (CHIP) have been shown to improve access (especially for children) to preventive care, including dental care[44] and immunization,[45] reduce infant and child mortality,[46] reduce risk of disability, obesity, and hospitalizations in adulthood,[47] and improve educational outcomes.[48]

Experience has shown that women and children are more likely to be "chilled" in their response to hostile immigration policies pertaining to public benefits, even when such policies do not directly target them. The PRWORA was associated with an increase of about 10 percent in the proportion of foreign-born single women who were uninsured, which was significantly higher than the increase among their U.S.-born counterparts.[49] The PRWORA was also associated with a 150 percent increase in the proportion of the uninsured among immigrant children, including U.S.-citizen children living with foreign-born mothers, despite the fact that these children's eligibility for insurance benefits was not affected by the law.[50] The chilling effect of the Proposed Rule is even more likely due to the DHS's conflicting representations regarding the use of benefits by children. Indeed, DHS's purported intent to exempt public benefits used by children is explicitly contradicted by DHS's request for comments concerning the consideration of benefits utilized solely by children. *See, infra*, at pp. 12-13.

If an eligible immigrant family opts-out of Medicaid or CHIP for their child due to confusion and fear associated with the Proposed Rule, that child would not receive the routine and preventative healthcare that is essential to preventing serious illness from arising and spreading to other students in the educational environment. As a result, the Proposed Rule could result in a disruption to the educational process for many of the 1.1 million students within the NYC Department of Education school system.

In addition, the Proposed Rule may cause immigrant parents to forgo or disenroll from federal housing subsidies and SNAP, without considering the follow-on consequences of such disenrollment upon education and employment outcomes. The absence of safe and stable housing and nutrition could negatively impact a child's overall well-being and ability to learn and concentrate in a school environment.[51] In fact, access to SNAP during early childhood (ages 0-4) is associated with a greater

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[43] Haas JS, Udvarhelyi IS, Morris CN et al. The effect of providing health coverage to poor uninsured pregnant women in Massachusetts, JAMA 1993:269(1)87-91.

[44] Lipton BJ, Wherry LR, Miller S. Previous Medicaid expansion may have had lasting positive effects on oral health of non-Hispanic black children. Health Affairs 2016;35(12):2249-2258.

[45] Holl JL, Szilagyi PG, Rodewald LE et al. Evaluation of New York state's Child Health Plus: access, utilization, quality of health care, and health status. Pediatrics 2000;105(Supplement E1):711-718.

[46] Bhatt CB, Beck-Sague CM. Medicaid expansion and infant mortality in the United States. Am J Public Health 2018;108(4);565-567. Murphey D., Child Trends Research Brief: Health Insurance Coverage Improves Child Well-Being (2017), https://www.childtrends.org/wp-content/uploads/2017/05/2017-22HealthInsurance_finalupdate.pdf

[47] Miller S Wherry LR. The long-term effects of early life Medicaid coverage. J Human Resources, 2018:0816_8173R1.

[48] Cohodes S, Grossman D, Kleiner S et al. The effect of child health insurance access on schooling: Evidence from public insurance expansions. J Human Resources 2016;51(3):727-759.

[49] Kaushal N, Kaestner R. Welfare reform and health insurance of immigrants. Health Service Research 2005;40(3):697-721.

[50] *Id.*

[51] *See* https://www.urban.org/sites/default/files/publication/25331/412554-Housing-as-a-Platform-for-Improving-Education-Outcomes-among-Low-Income-Children.PDF; Page, M. (March 2017). The intergenerational transmission of poverty and the long reach of child health and nutrition programs. UC Center Sacramento: Bacon Public Lectureship and While Paper. Accessed at http://uccs.ucdavis.edu/events/event-files-and-images/BaconWhitePaper_2.23.17.pdf.

likelihood of economic self-sufficiency in adulthood, driven largely by higher levels of educational attainment, as well as improved health.[52] Children in SNAP households are at reduced risk for poor educational outcomes such as repeating a grade,[53] and girls in families enrolled in SNAP during the child's gestation and early childhood are more likely to have increased educational and employment outcomes, and less likely to receive public assistance.[54] In failing to account for the downstream and long-term benefits of housing and health assistance to children, DHS's Proposed Rule has failed to acknowledge the full scope of its impact on U.S. citizen and immigrant children.

The Children's Health Insurance Program (CHIP) (Section G)

Despite DHS's recognition that noncitizen participation in this program is relatively low, DHS is considering including the Children's Health Insurance Program ("CHIP") in a final rule, because "these benefits relate to a basic living need (*i.e.* medical care), [and] receipt of these benefits suggests a lack of self-sufficiency."[55] NYC strongly opposes the possible inclusion of CHIP in the final rule.

In NYC and NYS, children's health insurance coverage is nearly universal, due largely to the robust coverage provided by Child Health Plus, a state-sponsored health insurance for children that is funded by CHIP. According to 2016 U.S. Census data only 2.06 percent of children in NYC are uninsured. NYC has close to 130,000 children covered by CHIP, comprising 38 percent of the total CHIP enrollees in NYS. As discussed below, existing literature provides ample evidence of the importance of CHIP and other public health insurance programs on children's health outcomes. Moreover, Medicaid and CHIP together cover 48% of children in the United States with special health care needs and those with behavioral health needs.[56]

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[51] Hoynes H., Schanzenbach D., & Almond D. (2016). Long-run impacts of childhood access to the safety net. *The American Economic Review, 106(4)*, 903-934.
[52] *See id.*
[53] Beharie B., Mercado M & McKay M. (2017). A protective association between SNAP participation and educational outcomes among children of economically strained households. *J Hunger Environ Nutr, 12(2),* 181-192.
[54] Hoynes H., Schanzenbach D., & Almond D. (2016). Long-run impacts of childhood access to the safety net. *The American Economic Review, 106(4)*, 903-934.
[55] 83 Fed. Reg. 51174.

[56] Musumeci M, Foutz J. Kaiser Family Foundation Issue Brief. Medicaid's role for children with special health care needs: a look at eligibility, services, and spending (2018). https://www.kff.org/medicaid/issue-brief/medicaids-role-for-children-with-special-health-care-needs-a-look-at-eligibility-services-and-spending/ Garfield RL, Beardslee WR, Greenfield SF et al. Behavioral health services in separate CHIP programs on the eve of parity. Adm Policy Ment Health 2012;39(3):147-157. MACPAC Issue Brief, Medicaid Access in brief: children's use of behavioral health services (2016). https://www.macpac.gov/wp-content/uploads/2016/06/Childrens-access-to-behavioral-health-services.pdf

Loss of this vital insurance coverage through CHIP could lead to interruptions in treatment provided to these children and result in the disruption of their development, school readiness, and overall wellbeing. Studies have shown that, particularly for children with chronic conditions, shifting from CHIP to employer-sponsored insurance or ACA Marketplace plans may lead to a significant increase in healthcare costs borne directly by children and their families.[57] Here again, DHS's contemplated regulatory change fails to account for the short-term and long-term detriments of impeding access to health insurance which will do nothing to improve and will in fact undermine the "self-sufficiency" of impacted beneficiaries.

Receipt of Past Benefits by Certain Immigrant Children (Section H)

In addition, NYC opposes DHS's proposal that it consider an immigrant's past receipt of benefits from when he or she was still a child, or under the age of majority, during a public charge determination. NYC anticipates that this would prevent immigrants from seeking health services for their children, even when not subject to the Proposed Rule.

It is repugnant to public policy that the choice a parent makes concerning the health insurance or nutritional needs of his or her family would subsequently be held against a child by the federal government. The principle that a child should not be punished for the choice of his or her parent is recognized across the federal government, most notably in the justice systems and courts. Moreover a parent's failure to provide food or care would jeopardize that parent's parental rights. DHS's proposal sets up a "Catch-22" for immigrant parents and holds minors responsible for their parents' decisions.

The Proposed Rule Would Reduce Immunization Coverage and Herd Immunity, and Prevent Timely Diagnosis, and Treatment of Infectious Diseases

The Proposed Rule also threatens to undermine safe and cost effective public health interventions for communicable diseases, such as the flu, TB, and hepatitis. Infectious disease is wholly unrelated to immigration status, but disease prevention requires the participation of the entire population. As large groups of people, regardless of immigration status, fall out of care and do not receive health education and counseling, immunizations and other prophylaxis, routine testing, and timely treatment for communicable disease, the health of the entire U.S. population is placed at risk. Long term, as vaccine coverage decreases, herd immunity decreases, increasing the risk of disease outbreaks and inflicting untold consequences on communicable disease trajectories in the United States. Since vaccines are not 100 percent effective, even vaccinated persons face an increased risk of disease as rates of infection rise.

Although the Proposed Rule exempts immunization and testing and treatment for communicable diseases from consideration during a public charge determination, such an exception would do nothing to blunt the negative impact of the Proposed Rule on utilization of these services. First, due to the fear and confusion triggered by the Proposed Rule, it is unlikely immigrants will even

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[57] Perez A, Davidoff AJ, Gross CP et al., Low-income children with chronic conditions face increased costs if shifted from CHIP to Marketplace plans. Health Affairs 2017;36(4):616-625. Strane D, French B, Eder J et al., Low-income working families with employer-sponsored insurance turn to public insurance for their children. Health Affairs 2016;35(12):2302-2309.

be aware of this exception or understand its application in the context of immigration proceedings, particularly given the emphasis placed on health in the proposed totality of the circumstances test.

Second, the exceptions in the Proposed Rule for vaccinations and communicable disease testing and treatment ignore the fact that health services are not delivered in silos: counseling, prophylaxis, and screening for infectious diseases are often embedded in more wide-reaching and routine clinical services such as sick visits and annual check-ups. As a result, patients may not receive the education and counseling they need to make healthy choices, such as taking steps that have been shown to greatly reduce the risk of sexually transmitted infectious. Delays in care can lead to transmission of these infectious diseases.

Similarly, the need for vaccinations may not even be known without more regular contact with healthcare providers. Under the Proposed Rule, such exams will become too costly for many people who forgo Medicaid and other publicly funded health insurance. In fact, past research has observed marked differences in adult vaccination rates between the insured and uninsured. A study of 2012 National Health Interview Survey data showed that among adults, vaccination coverage was as much as three times higher for those with health insurance than for the uninsured.[58] In addition, vaccination coverage was higher for respondents who had a regular physician and for those who had more contacts with a physician.[59]

Further, parents may be less likely to enroll their children in Medicaid and Child Health Plus, particularly if CHIP will be part of the public charge determination. While uninsured children might still be eligible for vaccines distributed through the federal Vaccines for Children program, there may be reluctance to accept publically-funded vaccines due to fear of negative immigration consequences. In the 2017-2018 flu season, there were 185 pediatric deaths in the United States (five of which were in NYC), approximately 80 percent of pediatric flu deaths occurred in children who had not been vaccinated.[60] As discussed above, CHIP provides vital insurance coverage, resulting in both short–term and long-term benefits, and ultimately, the very "self-sufficiency" that the Proposed Rule purports to advance.

Numerous states have recognized the importance of delivering infectious and communicable disease screening and treatment in routine health care settings For example, since the passage of the

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[58] Influenza vaccination coverage (age ≥18 years) with or without health insurance was 44.3% versus 14.4%, respectively; pneumococcal vaccination coverage (age 18-64) with high-risk conditions was 23.0% versus 9.8%; tetanus and diphtheria toxoid (Td) coverage (age ≥18 years) was 64.5% versus 53.2%s; tetanus, diphtheria, and acellular pertussis (Tdap) coverage (age ≥18 years) was 15.7% versus 8.4%; hepatitis A coverage (age 18-49 years) was 19.8% versus 16.6%; hepatitis B coverage (age 18-49 years) was 38.0% versus 27.5%; shingles coverage (age ≥60 years) was 20.8% versus 6.1%; and human papillomavirus coverage (women aged 18-26 years) was 39.8% versus 20.9%. Lu PJ, O'Halloran A, Williams WW. Impact of health insurance status on vaccination coverage among adult populations. *Am J Prev Med.* 2015;48(6):647-661.

[59] Lu PJ, O'Halloran A, Williams WW. Impact of health insurance status on vaccination coverage among adult populations. *Am J Prev Med.* 2015;48(6):647-661.

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

ACA, New York and many other states require Medicaid to cover all preventive services recommended by the U.S. Preventive Services Task Force without cost sharing, including screening and counseling for sexually transmitted infections, screening for latent TB infection in adult populations at increased risk, hepatitis A vaccination for children and people at increased risk for infection, as well as hepatitis B vaccination for children, adults at risk, adults requesting protection, and pregnant women.

Finally, the Proposed Rule leaves significant room for discretion in application concerning treatment for communicable diseases. For example, the Proposed Rule fails to specify whether Medicaid payments for the treatment of health issues ancillary to a communicable disease are exempt from a public charge determination. These health issues could include, for example opportunistic infections and liver complications from hepatitis B and C.

The Proposed Rule Would Create Food-Insecurity and a Resulting Negative Health Impact

The Proposed Rule's inclusion of SNAP benefits in the public charge determination will discourage immigrants from utilizing these critical food and nutrition benefits, the positive outcomes of which transcend nutrition alone.

For example loss of SNAP benefits will also increase financial constraints among low-income immigrant families. Most immediately, food-insecure households may have to choose between spending limited resources on food or on other needs, including healthcare. Households reporting very low food security have also reported skipping medications to save money.[61]

Ultimately, the lack of proper food, nutrition, and medication leads to significant health problems and resulting expenses. Food insecurity is linked to serious health conditions such as diabetes, obesity, complications in pregnancy, low birth weight, and mental health problems.[62] Also, food-insecure children are almost twice as likely to experience poor physical and mental health compared to children in food-secure families, including increased risk for anemia, asthma, and depression.[63]

In contrast, SNAP has been shown to be associated with better health and, correspondingly, reduced health care costs. Food-insecure households spend 45 percent more on medical care compared to food-secure households, while low-income adults enrolled in SNAP spent 25 percent less on medical care compared to those not enrolled.[64] In addition, the use of SNAP benefits is associated with

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

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

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

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

reduced hospital admissions among older adults, and fewer sick days and outpatient visits among adults overall.[65]

The Proposed Rule again is deficient for its failure to consider the manifold benefits of nutrition assistance programs such as SNAP, and hence their vital contributions to recipients' "self-sufficiency."

The Proposed Rule Would Create Housing Instability and a Resulting Negative Health Impact

The Proposed Rule's inclusion of federal housing subsidies in the public charge determination will discourage immigrants from utilizing these benefits, and the negative impact will be widespread. DHS seeks to include housing subsidies in the proposed expanded definition of public charge purportedly to better ensure self-sufficiency among immigrants; however, housing programs can help stabilize families financially to achieve self-sufficiency and maintain their health and well-being. In fact, the Family Self-Sufficiency (FSS) program through the U.S. Department of Housing and Urban Development ("HUD") is demonstrating positive results in helping families attain housing stability without public assistance. A national snapshot of FSS program evaluations recently published by HUD cites that 37 percent of FSS graduates left housing assistance within one year of graduation. [66]

Moreover, immigrants withdrawing from or forgoing public housing due to the Proposed Rule would lead to a rise in homelessness among immigrant families, including U.S. citizen children. Research shows that housing subsidies help reduce the risk of becoming homeless for at-risk families, and that families living in subsidized housing are 74 percent less likely to remain in a homeless shelter or on the street than families without a housing subsidy.[67]

The potential negative health impacts of homelessness on children, including U.S. citizens, are undeniable. Indeed, homelessness has a particularly adverse impact on children and youth including poor physical, social, and mental health outcomes, cognitive development, and educational outcomes. In addition, schooling for homeless children is often interrupted and delayed, with homeless children being twice as likely to have a learning disability, repeat a grade, or to be suspended from school.[68] Ultimately, DHS ignores this robust evidence that housing assistance does not render families reliant on the government, but instead helps stabilize them and put them on a path to "self-sufficiency."

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

[66] *See* https://www.hudexchange.info/resources/documents/FSS-25-Years.pdf; https://homeforallsmc.org/wp-content/uploads/2017/05/Impact-of-Affordable-Housing-on-Families-and-Communities.pdf

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

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

B. THE PROPOSED RULE WOULD IMPOSE SIGNIFICANT COSTS ON NYC TO ADDRESS A PUBLIC HEALTH CRISIS

DHS improperly refused to prepare a federalism impact statement to assess whether the Proposed Rule will impose substantial direct compliance costs on State and local governments.[69] As demonstrated below, the withdrawal from or forgoing of public benefits by immigrants will force NYC to make significant expenditures to meet its obligations to protect the health and well-being of New Yorkers.

Emergency Medical Costs

Uninsured individuals who lack access to primary care are more likely to use emergency rooms for preventable care or nonemergency conditions that could have been avoided through timely use of primary care.[70] In addition, communities with high uninsurance rates are more likely to have unmet health needs, even for individuals who are insured due to the spillover effect.[71] In addition, given the health problems related to inadequate nutrition noted above, food insecurity is also associated with increased use of healthcare services, including more emergency room visits and hospital admissions, while SNAP participation is associated with lower healthcare expenditures.[72]

Because NYC H+H provides health care services to NYC irrespective of insurance coverage or ability to pay, NYC H+H would be obligated to cover the emergency medical costs of immigrant patients currently covered by Medicaid who withdraw from coverage due to the Proposed Rule. These decisions could have a negative financial impact on NYC H+H of as much as $362 million annually, in addition to the direct impact on the well-being of the estimated 350,000 New Yorkers and their families as they face new barriers to receive or maintain care.

Uncompensated Health Care Costs and Reduction in Vital Health Services

Uninsurance significantly increases uncompensated health care costs and reduces the availability of vital health services at local hospitals; this would in turn negatively impact broader community health.

While an uninsured person, on average, incurs lower medical expenses than the insured due to their lower health service utilization rates, they pay a much higher share of their care out of pocket compared to the insured and often cannot afford it.[73] The recent data show that over 70 percent of care

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[69] *See* Multi-City comment, Tracking No. 1k2-9719-hjz0 at pp 21-23.

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

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

[72] Berkowitz S. Seligman H., & Basu S. (2017). Impact of food insecurity and SNAP participation on healthcare utilization and expenditures. University of Kentucky Center for Poverty Research Discussion Paper Series, DP2017-02. Accessed at https://uknowledge.uky.edu/ukcpr_papers/103/ .

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

provided to the uninsured is uncompensated.[74] Health systems, particularly hospitals and community-based providers, bear the vast majority of such uncompensated care costs: in 2016, hospitals alone provided $38.3 billion in uncompensated care, with government funding offsetting only 65 percent of such costs.[75]

Each newly uninsured individual is associated with a $900 increase in uncompensated care annually; some recent Medicaid disenrollment has likely resulted in even larger per capita uncompensated cost growth.[76] Contrary to DHS's assertion that immigrants' disenrollment from public health insurance would lead to reduction in the government expenditure,[77] studies have shown that the money states "save" from not expanding Medicaid and enrolling people into the program is less than the uncompensated care costs generated by such action.[78] Of the 350,000 H+H patients that could be impacted by this proposal, approximately 200,000 have Medicaid. If 20 percent of those Medicaid patients were to disenroll from coverage, about 40,000 NYC H+H patients could lose coverage.

Increased Costs for Clinic Services and Disease Prevention and Control Programming

There may also be increases in direct costs to the NYC Health Department for clinic services and resulting from uncompensated care. Pursuant to New York State Law and regulations, the Health Department is obligated to provide (itself or through a third-party) certain vaccinations for children,[79] and testing and care for sexually transmitted infections[80] and TB,[81] and cannot withhold care if the patient is unable to pay.

Costs for Staff Resources and Training

Should the Proposed Rule be finalized and implemented, NYC will be required to expend considerable financial and staff resources to educate and train NYC employees about how the rule change affects agency activity, as well as respond to client requests.

For example, NYC H+H would be required to undertake extensive and costly staff education and training for an estimated 10,000 frontline staff, including medical providers, social workers, registration staff, and hundreds of financial counselors across dozens of sites who screen and help patients apply for health insurance every day. NYC H+H would also need to conduct ongoing patient communications and outreach efforts to ensure hundreds of thousands of New Yorkers currently using its services continue to feel welcome at NYC H+H, and that new and potential patients know they can

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[74] *Id.*
[75] Coughlin TA, Holahan J, Caswell et al. An estimated $84.9 billion in uncompensated care was provided in 2013; ACA payment cuts could challenge providers. Health Affairs, 2014;33(5):807-814.
[76] Garthwaite C, Gross T, Notowidigdo MJ. NBER Working Paper, Hospitals as insurers of last resort (2015), https://www.nber.org/papers/w21290
[77] 83 Fed. Reg. 51114, 51117 (Oct. 10, 2018).
[78] Garthwaite C, Gross T, Notowidigdo MJ. NBER Working Paper, Hospitals as insurers of last resort (2015), https://www.nber.org/papers/w21290
[79] NY Pub Health Law §§ 602, 613.
[80] 10 NYCRR § 23.2.
[81] NY Pub Health Law §2202.

receive care without fear at NYC's municipal health system. Ultimately, NYC H+H may need to spend approximately $750,000 for staff training and support during the first year of the Proposed Rule's implementation.

In addition, DHS's additional documentary requirements included in the Proposed Rule will impose significant costs on NYC. The proposed new form, the I-944 "Declaration of Self-Sufficiency," is the principal tool through which DHS will gather the information necessary to make public charge inadmissibility determinations under the Proposed Rule. DHS has invited comment on the impact of the new form.[82] This form effectively puts the onus on the immigrant applicant to demonstrate affirmatively that she is not a public charge.

DHS has quantified the (exorbitant and likely underestimated) cost to applicants associated with filing a Form I-944, but it has failed to quantify the costs that the new form will impose on state and local benefit-administering agencies.[83] Indeed, DHS has not even acknowledged that such agencies are obviously among the "affected public" implicated by this Proposed Rule.[84] As such, DHS's estimates of the "total public burden" in both hours and cost to the public cannot possibly be accurate.[85]

The Form I-944 will impose significant costs upon NYC, in terms of staff and staff hours to provide such documentation to New Yorkers who lack it. Additionally, some NYC agencies may be forced to create entirely new methods of records-keeping serving no purpose other than to accommodate the proposed public charge rule and the Form I-944.

Strain on Food/Nutrition Resources

If immigrant families choose to forgo SNAP benefits because of the Proposed Rule, such actions will place a greater strain on State and local nutrition assistance, such as food pantries. There is already a gap in pantry capacity. This has been true since the Food Bank for New York City and City Harvest were founded in the early-1980s. Although food insecurity incidence is trending downward nationwide as unemployment rates drop, in 2016, 1.4 million NYC households were considered food insecure for at least some time during the year.[86]

Consequently, NYC, through the Emergency Food Assistance Program, and the NYS Department of Health, through the Hunger Prevention and Nutrition Assistance Program, have already committed significant resources to purchase food for pantries. Over the past four years, NYC has almost doubled financial investments, and all New Yorkers may access food pantries regardless of ability to pay. Additional investments to provide nutritional assistance to immigrants forced to forgo SNAP benefits will create a significant financial burden for NYC.

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[82] 83 Fed. Reg. 51114, 51284
[83] 83 Fed. Reg. 51114, 51253-55
[84] 83 Fed. Reg. 51114, 51284
[85] *See* 83 Fed. Reg. 51114, 51285 for DHS's estimates of the total public burden in hours and in cost.
[86] Food Bank for NYC 2016 Annual Report, *available at* https://1giqgs400j4830k22r3m4wqg-wpengine.netdna-ssl.com/wp-content/uploads/Food-Bank-For-NYC-FY2016-Annual-Report.pdf.

C. THE PROPOSED RULE WOULD CREATE AN OVERALL NEGATIVE ECONOMIC IMPACT

As discussed above, the Proposed Rule would result in New Yorkers withdrawing from or forgoing public benefits for which they are eligible, even where not subject to a public charge determination, as a result of the "chilling effect." This would result in these New Yorkers having less money to spend on necessities like food, and in turn, in losses to the economy due to diminished spending, lower business revenue, and losses in job creation. It is well-documented that the economic gains from many public benefits are even greater than the volume of direct assistance, due to a "multiplier" effect. The economic ripple effects of SNAP illustrate this point well. SNAP benefits are spent at local food retailers, with SNAP recipients spending more dollars on food at local retailers compared to eligible non-recipients.[87] The U.S. Department of Agriculture has estimated that during times of economic downturn, every additional $5 in SNAP benefits generates up to $9 of economic activity, and every $1 billion increase in SNAP benefits results in 8,900 full-time equivalent jobs.[88] Research conducted after temporary increases in SNAP expired found that household grocery store spending declined by $0.37 for every $1 lost in SNAP benefits.[89]

These economic ripple effects of the use of SNAP benefits also extend to other benefits like cash assistance. NYC estimates that 220,000 noncitizens receive SNAP and/or cash assistance, and the 54,000 receive SSI and/or SSP.[90] Even a 20 percent withdrawal rate among this population, from these benefits alone, would produce a large economic impact, beyond the direct loss of $235 million in benefits.[91] To get a full picture of the economic loss that NYC might experience as a result of the rule, NYC would have to include benefits implicated by the Proposed Rule but not administered directly by NYC. It would also have to consider tax revenue implications of the prospective lower rate of green card obtainment. It is well documented that obtaining a green card enables immigrants to earn higher wages,[92] and thus contribute more significantly to NYC's tax base.

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[87] U.S. Department of Agriculture, "The Benefits of Increasing the Supplemental Nutrition Assistance Program Participation in Your State," December 2011, https://www.fns.usda.gov/sites/default/files/bc_facts.pdf.
[88] Economic Research Service, US Department of Agriculture. (2010). The Food Assistance National Input-Output Multiplier (FANIOM) Model and the stimulus effect of SNAP. Accessed at www.ers.usda.gov/publications/err103.
[89] Bruich G. (2014). The effect of SNAP benefits on expenditures: new evidence from scanner data and the November 2013 benefit cuts. Access at http://scholar.harvard.edu/files/bruich/files/bruich_2014b.pdf.
[90] NYC Mayor's Office of Immigrant Affairs, Mayor's Office of Economic Opportunity, and Department of Social Services, *Expanding Public Charge Inadmissibility: The Impact on Immigrants, Households, and the City of New York* (December 2018), *available at* https://www1.nyc.gov/assets/immigrants/downloads/pdf/research_brief_2018_12_01.pdf.
[91] NYC Department of Social Services; New York State Office of Temporary and Disability Assistance; September 2018.
[92] *See*, e.g., Sherrie A. Kossoudji and Deborah A. Cobb-Clark, *Coming out of the Shadows: Learning about Legal Status and Wages from the Legalized Population*, 20 Journal of Labor Economics 598 (2002).