

No. 19-17213

IN THE UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

CITY AND COUNTY OF SAN FRANCISCO and
COUNTY OF SANTA CLARA,

Plaintiffs-Appellees,

vs.

UNITED STATES CITIZENSHIP AND IMMIGRATION SERVICES, et al.,

Defendants-Appellants,

On Appeal from the United States District Court, Northern District of California
Case No. 4:19-cv-04717-PJH (Hon. Phyllis J. Hamilton)

**OPPOSITION TO DEFENDANTS' MOTION TO
STAY INJUNCTION PENDING APPEAL**

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INTRODUCTION

More than a month after the district court preliminarily enjoined Defendants from applying the final rule *Inadmissibility on Public Charge Grounds*, 84 Fed. Reg. 41,292 (Aug. 14, 2019) (the “Rule”), within the plaintiff jurisdictions, Defendants now seek an “emergency” stay of the injunction pending appeal. To obtain a stay, Defendants must show they will be immediately and irreparably harmed if the injunction remains in effect. They cannot. Defendants have created an “emergency” out of whole cloth. No significant harm will flow from maintaining, for another few months, the status quo that has been in place for decades. The Counties and public, by contrast, will face serious harm if the Rule goes into effect and causes residents to disenroll from public benefits. Such disenrollments would cause economic harms to the Counties and their health systems, which are heavily reliant on Medicaid funding; harm to the public health; and significant administrative costs. Further, Defendants have not made a strong showing of a likelihood of success on the merits. Indeed, all five district courts to consider the Rule have held it unlawful.¹ Defendants’ motion should be denied.

BACKGROUND

Section 212(a)(4) of the Immigration and Nationality Act (INA) permits the federal government to deny admission and green cards to noncitizens it determines are “likely at any time to become a public charge.” 8 U.S.C. §1182(a)(4)(A). Since Congress first used the term “public charge” in immigration law in 1882, courts and administrative agencies have consistently recognized that the term captures the concept of a person primarily or entirely reliant upon the public for

¹ See *Washington v. DHS*, No. 4:19-CV-5210-RMP, 2019 WL 5100717 (E.D. Wash. Oct. 11, 2019); *New York v. DHS*, No. 19-CIV-7777 (GBD), 2019 WL 5100372 (S.D.N.Y. Oct. 11, 2019); *Cook Cty., Illinois v. McAleenan*, No. 19-C-6334, 2019 WL 5110267 (N.D. Ill. Oct. 14, 2019); *CASA De Maryland, Inc. v. Trump*, No. PWG-19-2715, 2019 WL 5190689 (D. Md. Oct. 14, 2019).

survival. In 1999, the Department of Homeland Security’s (DHS) predecessor, the Immigration and Naturalization Service (INS), issued guidance formalizing this understanding. *See Field Guidance on Deportability and Inadmissibility on Public Charge Grounds*, 64 Fed. Reg. 28,689 (May 26, 1999) (“Field Guidance”). Under its Field Guidance—which continues to govern DHS’s public charge assessments today—a noncitizen is likely to become a public charge only if he or she is likely to become “primarily dependent on the government for subsistence.” And public charge determinations consider only two discrete kinds of benefits: (1) cash assistance for income maintenance; or (2) long-term, institutionalized care at public expense. *Id.*

After 140 years, however, DHS changed course when it issued the Rule, which would dramatically overhaul the public charge assessment in two ways relevant to the instant motion.

First, the Rule would replace the longstanding definition of the term “public charge”—a noncitizen *primarily* dependent on the government for support—with a far broader definition that covers any individual who receives an enumerated benefit for more than 12 months within a 36-month period. 8 C.F.R. §212.21(a).

Second, under the Rule immigration officers would for the first time consider health-enhancing non-cash benefits—specifically, non-emergency Medicaid, Supplemental Nutrition Assistance Program (SNAP), and federal housing assistance—in addition to the cash benefits and institutionalized care previously considered. 8 C.F.R. §212.21(b)(2), (6).

The Counties, which operate extensive safety-net healthcare systems, depend on community members enrolling in such benefits. Cty.Supp.Add. 17-18 (Lorenz Decl.) ¶¶14, 19. Indeed, Medicaid funds cover the majority of patients at the Counties’ hospitals. *Id.* at 16 (Lorenz Decl.) ¶9; 6 (Wagner Decl.) ¶4. And for the Counties’ public health departments to prevent communicable disease, all

residents must be able to obtain vaccines and medical treatment. *Id.* at 34 (Cody Decl.) ¶7; *see also id.* at 10-11 (Aragon Decl.) ¶¶7-13. As DHS acknowledged, the Rule would cause immigrants to disenroll from benefits, thereby shifting enormous costs onto the Counties, which are health providers of last resort. *See* 84 Fed. Reg. at 41,300-01 (estimating \$2.5 billion annual reduction in transfer payments).

On October 11, 2019, District Judge Hamilton preliminarily enjoined the Rule within San Francisco and Santa Clara Counties (and within the plaintiffs-appellants states in the related case No. 19-17214). Preliminary Injunction Order (“Order”) at 92 (Attachment A to Defendants’ Emergency Stay Motion (“Mot.”)).

Two weeks later, Defendants moved in the District Court for a stay of the injunction pending appeal. As of the date of this filing, the District Court had not yet ruled on Defendants’ stay motion.

ARGUMENT

A “stay is an intrusion into the ordinary processes of administration and judicial review, and accordingly is not a matter of right.” *Nken v. Holder*, 556 U.S. 418, 427 (2009) (citations and quotation marks omitted). Defendants bear the burden of demonstrating consideration of the following four factors justifies a stay of the injunction: (1) whether Defendants will be irreparably injured absent a stay; (2) whether the Counties will be injured by a stay; (3) the public interest; and (4) whether Defendants have “made a strong showing that [they are] likely to succeed on the merits.” *Id.* at 434. Here, *not one* of these factors favors a stay.

I. Defendants Have Failed To Demonstrate Imminent, Irreparable Harm.

Defendants conceded below that they would not “suffer any hardship in the face of an injunction.” Order 86. They argued only that “Congress has made a policy judgment that aliens should be self-sufficient, and the executive should not be prevented from implementing a rule that advances that policy.” *Id.*; *see also* Cty.Supp.Add. 46-47. The District Court rejected this argument, concluding that

the balance of equities and hardships “tip[s] sharply” in favor of the Counties. Order 86.

Due to the District Court’s preliminary injunction and injunctions entered by four other district courts, the Rule did not go into effect on October 15, as scheduled. Two weeks later, Defendants sought a stay pending appeal from the District Court. Notably, they did not seek to expedite the court’s consideration of that motion, instead noticing it for a regularly scheduled hearing in December. A full two weeks later, on November 11, Defendants filed a “Notice of Waiver of Reply and Hearing.” Defendants did not articulate any specific urgency, but nonetheless asked the District Court to rule on their stay motion three days later, on November 14. Cty.Supp.Add. 49-50. At the case management conference on November 14, the District Judge informed Defendants that she could not meet the recently requested three-day deadline, but would rule “as quickly as we can.” *Id.* at 56. Defendants filed this motion the next day.

After 35 days—during which time DHS has continued to operate under the longstanding Field Guidance—Defendants now request “emergency” relief from this Court. Defendants offer no explanation for this delay, which itself weighs against relief because it indicates that the alleged harm is not as dire as Defendants suggest. *E.g., Lopez v. Heckler*, 713 F.2d 1432, 1435 (9th Cir. 1983) (denying motion for stay on an emergency basis, “especially given the Secretary’s unexplained delay in seeking such relief”). And Defendants fail to identify any cognizable harm they will suffer if the preliminary injunction remains in place, much less harm that requires emergency relief by December 6.

Defendants devote only two sentences to their alleged harm. Mot. 20. Their sole argument is that they will be required to grant lawful permanent resident status to individuals who would be inadmissible under the Rule. *Id.* But Defendants concede the Field Guidance is lawful (*see* Mot. 14), and the preliminary injunction

merely preserves the status quo by continuing in force the Field Guidance that has governed immigration officers' public charge assessments since before DHS's inception. The federal government does not suffer irreparable harm from an injunction that keeps longstanding, lawful procedures in place pending judicial review. *See Feldman v. Ariz. Sec'y of State's Office*, 843 F.3d 366, 369 (9th Cir. 2016) (en banc); *E. Bay Sanctuary Covenant v. Trump*, 932 F.3d 742, 778 (9th Cir. 2018); *Wash. v. Trump*, 847 F.3d 1151 (9th Cir. 2017).

Moreover, Defendants offer no explanation as to why relief is needed by December 6. Defendants have operated under the injunction since October 11, but they offer no evidence of concrete harm that has resulted. And they do not explain what will change on December 6 that requires this Court's immediate intervention. Nor could they. If this Court denies Defendants' motion, Defendants will simply continue to apply the Field Guidance until this appeal is decided on an expedited basis under Circuit Rule 3.3—exactly as they have been doing since the preliminary injunction was issued, and for decades before that.

II. A Stay Will Significantly Harm The Counties And The Public Interest.

Defendants barely even try to deny that the Counties and the public will suffer significant harm if the Rule goes into effect pending appeal. In a single conclusory sentence, Defendants assert that “plaintiffs’ alleged injuries are speculative.” Mot. 20. That is the sum total of Defendants response to the twenty declarations submitted by the Counties and six pages of analysis provided by the District Court on the subject of the Counties’ harm. And it is incorrect.

There is no dispute that if the Rule goes into effect, it will cause individuals—even lawful residents and naturalized citizens who are not subject to public charge assessments—to disenroll from or forgo critical public benefits out of fear of potential immigration consequences. DHS itself acknowledges this fact, projecting that 2.5% of “individuals who are members of households with foreign-

born noncitizens” will disenroll from programs expressly covered by the Rule. 84 Fed. Reg. at 41,463. This is borne out by the Counties’ experiences. As the District Court found, both San Francisco and Santa Clara have *already* experienced a significant decline in certain benefits enrollment among households including noncitizens since the Rule was first proposed. Order 79 (citing declarations). And “strong evidence” indicates “that disenrollment is likely to continue between now and the resolution of this issue on the merits, absent an injunction.” *Id.*²

The District Court then found that this impending disenrollment would cause imminent and irreparable harm to the Counties. Specifically, the District Court agreed that the evidence demonstrated the Counties would (1) lose millions of dollars in Medicaid reimbursement funds as a result of people disenrolling from Medicaid (*id.* at 78-81), and (2) incur substantial new operational costs (*id.* at 81-83).³ Neither of these harms is speculative.

As to the decrease in Medicaid funds, the Counties provide a broad array of health services to low-income residents through their health and hospital systems, many of which are partially reimbursed with federal Medicaid dollars. Order 78. Defendants themselves acknowledge that a significant number of individuals will disenroll from Medicaid as a result of the Rule. This will *ipso facto* result in decreased Medicaid dollars to the Counties. Moreover, the Supreme Court recently concluded that this type of “predictable effect of Government action on the decisions of third parties” is sufficient to establish harm. *Dep’t of Commerce v.*

² The District Court’s factual findings are entitled to deference. *See* Fed. R. Civ. Proc. 52(a)(6); *Teva Pharm. USA, Inc. v. Sandoz, Inc.*, 135 S. Ct. 831, 833 (2015).

³ Because the court found that the Counties sufficiently demonstrated these two injuries, the Court declined to address the Counties other bases for harm and standing: increased costs to their own healthcare operations, public health problems and resulting increased costs, and reduced economic activity due to a decrease in federal funds in the community. Order 78, 83.

New York, 139 S. Ct. 2551, 2566 (2019); *accord Cal. v. Azar*, 911 F.3d 558, 571 (9th Cir. 2018).

Defendants’ argument is even weaker with respect to operational costs. Indeed, Defendants’ assertion that this harm is speculative is particularly tenuous given that these costs are *already* being incurred (Order 81-82 (citing declarations), and that DHS specifically anticipated them when formulating the Rule. *See, e.g.*, 83 Fed. Reg. at 51,260; 84 Fed. Reg. at 41,389.

Finally, Defendants completely fail to acknowledge—let alone dispute—the District Court’s conclusion that “the public interest cuts sharply in favor of an injunction” because “the public interest supports continuing the provision of medical services through Medicaid to those who would predictably disenroll absent an injunction.” Order 87. For instance, the evidence demonstrates that Medicaid disenrollment would lead to decreased vaccination rates, which would “have adverse health consequences not only to those who disenroll, but to the entire populations of the plaintiff states.” *Id.*

III. Defendants Have Not Made a Strong Showing They Are Likely To Prevail On The Merits.

A. Standing And Zone Of Interest.

1. The Counties Have Standing.

As discussed above, the District Court concluded that the Counties demonstrated at least two concrete injuries—the loss of federal funds and increased operational costs. Order 83. Defendants summarily raise several points in support of their assertion that these harms are insufficient to establish standing. None has merit.

Defendants first contend that these harms are too speculative to support standing. Mot. 6. This argument fails for the reasons discussed above.

Next, Defendants assert that *states* may not be harmed because they *pay* a

portion of Medicaid expenses, and those outlays may be reduced. Mot. 7. But this argument is inapplicable to the Counties, which do not make Medicaid outlays. DHS also mentions that it “will not hold the use of *emergency* Medicaid against an alien.” *Id.* (emphasis added). This is similarly irrelevant. Emergency Medicaid is available to a class of immigrants who are *ineligible* for regular Medicaid. It has no bearing on DHS’s projected decline in regular (non-emergency) Medicaid enrollment, and the resulting harms to the Counties.

Finally, Defendants argue that increased operational costs cannot support standing. Mot. 7. Not true. Governmental administrative costs caused by changes in federal policy are cognizable injuries. *See Cal. v. Trump*, 267 F.Supp.3d 1119, 1126 (N.D. Cal. 2017) (“administrative costs” were sufficient to demonstrate standing) (collecting cases); *Dep’t of Commerce v. New York*, 139 S. Ct. 2551, 2565 (2019) (“diversion of resources” is among the injuries sufficient to establish standing); *see also Azar*, 911 F.3d at 573–74.

2. The Counties Are Within The Statute’s Zone Of Interest.

In light of the APA’s “generous review provisions,” which “permits suit for violations of numerous statutes of varying character that do not themselves include causes of action,” a plaintiff falls within the zone of interests of the statute underpinning its APA claim unless its “interests are so marginally related to or inconsistent with the purposes implicit in the statute that it cannot reasonably be assumed that Congress authorized that plaintiff to sue.” *Lexmark Int’l, Inc. v. Static Control Comp., Inc.*, 572 U.S. 118, 130 (2014) (quotation marks and citations omitted). The test reflects a “lenient approach” and is “not especially demanding.” *Id.* (same).

The Counties’ interests are directly “related to” INA Section 212(a)(4) because the Counties administer public benefit programs that are integral to the public charge assessment. *See Cty.Supp.Add.* 24-25 (Shing Decl.) ¶¶4-8; *Id.* at 40

(Márquez Decl.) ¶¶6-7; *Id.* at 2 (Rhorer Decl.) ¶¶3-4. Moreover, Section 212(a)(4) calls for consideration of affidavits of support, which allow the Counties and other governments to recover the costs of benefits they have paid to noncitizens. *See* 8 U.S.C. §§1182(a)(4)(B)(ii), 1183a(a), (b), (e)(2). Thus, the Counties’ interests in administering public benefit programs—and the costs involved in doing so—are “squarely within the challenged statute’s zone of interests.” Order 69; *see also* *Cal. v. Health & Human Servs.*, 351 F.Supp.3d 1267 (N.D. Cal. 2019); *Regents of Univ. of Cal. v. DHS*, 279 F.Supp.3d 1011, 1036 (N.D. Cal.), *aff’d*, 908 F.3d 476 (9th Cir. 2018).

Defendants’ contrary contention (Mot. 7) is wrong not only because the relevant inquiry does not require the Counties to have a “judicially cognizable interest[]” under Section 212(a)(4) (*see Lexmark*, 572 U.S. at 124), but also because, through the affidavit-of-support consideration, Section 212(a)(4) *does* recognize the Counties’ interests.

B. The District Court Correctly Determined That The Rule Is Contrary To Law.

1. The Rule Is Contrary To The Longstanding, Unambiguous Meaning Of The Statute.

The Rule is irreconcilable with the longstanding meaning of “public charge” established and preserved by Congress. Every tool of statutory interpretation makes plain that the term “public charge” has always captured the concept of a person primarily or entirely dependent on the government for subsistence. And even as Congress substantially changed, reorganized, and reenacted immigration law, it never altered that meaning. Its repeated retention of the term reflects its approval of that long-existing interpretation. *Forest Grove Sch. Dist. v. T.A.*, 557 U.S. 230, 239-40 (2009).

Congress first used the term “public charge” in 1882, when it authorized exclusion of “any convict, lunatic, idiot, or any person unable to take care of himself or herself without becoming a public charge.” Immigration Act of 1882, ch. 376, §§1-2, 22 Stat. 214 (Aug. 3, 1882). Congress drew from state “public charge” laws, which described people “incompetent to maintain themselves” and who “might become a heavy and long continued charge to the city, town or state”—“not merely destitute persons, who, on their arrival here, have no visible means of support.” *City of Boston v. Capen*, 61 Mass. 116, 121-22 (1851).⁴

Then and now, in ordinary usage “public charge” referred to a person unable to provide for their own subsistence and dependent upon the public for substantial, long-term support. When describing people, dictionaries define “charge” as a “person...committed or intrusted to the care, custody, or management of another; a trust.” *Charge*, Webster’s Dictionary (1886 Edition), <https://perma.cc/LXX9-KF3K>; *accord Charge*, Merriam-Webster Online, <https://perma.cc/7VZA-BT7X>; see *Freeman v. Quicken Loans, Inc.*, 566 U.S. 624, 633-34 (2012) (contemporaneous dictionary definitions reflect normal usage and govern statutory interpretation). Thus, a *public* charge is a person committed or entrusted to the *public* for custody, care, or management—in other words, a person unable to care for themselves who relies, primarily or entirely, on the public to survive. The term’s plain-text meaning is consistent with its placement alongside “convict, lunatic, [and] idiot,” which described people “incompetent for self-protection” and

⁴ *Yeatman v. King*, 51 N.W. 721, 723 (N.D. 1892) (“affording [poor persons] temporary relief,” could *prevent* them “from becoming a public charge”); *Twp. of Cicero v. Falconberry*, 42 N.E. 42, 44 (Ind. 1895) (“mere fact that a person may occasionally obtain assistance from the county does not necessarily make such person a pauper or a public charge.”); see Neuman, *The Lost Century of American Immigration Law (1776-1875)*, 93 Colum. L. Rev. 1833, 1848-59 (1993).

subject to guardianship and protection by the state. *Penington v. Thompson*, 5 Del. Ch. 328, 350 (1880).

Under the 1882 Act an immigrant could receive temporary aid without becoming a public charge. The 1882 Act itself raised funds to support immigrants in “distress” or who “need public aid” (1882 Act at §§1, 2), even though it barred persons likely to become public charges from entering the country. The 1882 Act’s text, context, design, and structure reflect that Congress sought to prevent foreign nations from “‘send[ing] to this country blind, crippled, lunatic, and other infirm paupers, who ultimately become *life-long dependents* on our public charities.’” 13 Cong. Rec. 5108-10 (June 19, 1882) (statement of Rep. Van Voorhis) (emphasis added).

Even as Congress repeatedly amended the immigration laws, courts recognized that “public charge” connotes a high degree of reliance upon public assistance. *Gegiow v. Uhl*, 239 U.S. 3, 9-10 (1915) (stating that, based on the statutory context, individuals “likely to become a public charge” were those akin to “paupers and professional beggars,” *i.e.*, those requiring long-term public aid). This court and several others held that the public charge provision is “meant...to exclude persons who were likely to become occupants of almshouses for want of means with which to support themselves in the future.” *Ng Fung Ho v. White*, 266 F. 765, 769 (9th Cir. 1920), *Ex parte Mitchell*, 256 F. 229, 232-33 (N.D.N.Y. 1919)), *aff’d in part and rev’d in part on other grounds*, 259 U.S. 276 (1922); *see also Ex parte Horn*, 292 F. 455, 457 (W.D. Wash. 1923) (“public charge” is “a person committed to the custody of a department of a government,” for example, when, “for want of means of support,” she is “sent to an almshouse for support at public expense.” (emphases added)). The modern equivalent of almshouse occupancy is not mere receipt of *some* aid, but a high degree of *dependence* upon governmental assistance.

Following enactment of the Illegal Immigration Reform and Immigrant Responsibility Act of 1996 (IIRIRA), INS concluded that text, historical context, and case law made plain that “public charge” describes people “primarily dependent on the government for subsistence.” Field Guidance, 64 Fed. Reg. at 28,689; *Inadmissibility and Deportability on Public Charge Grounds*, 64 Fed. Reg. 28,676, 28,677 (May 26, 1999). The parties agree that the Field Guidance’s definition of “public charge” is consistent with Section 212(a)(4). Mot. 12. And despite intervening amendments to the INA and Section 212(a)(4) itself, Congress has never disturbed INS’s formulation of the term’s meaning, reflecting its agreement and acceptance. *Forest Grove*, 557 U.S. at 239-40; *Bob Jones Univ. v. United States*, 461 U.S. 574, 600-01 (1983). In short, Section 212(a)(4), “interpreted in its statutory and historical context...unambiguously bars” DHS’s newfound definition. *Whitman v. Am. Trucking Ass’ns*, 531 U.S. 457, 471 (2001); *Esquivel-Quintana v. Sessions*, 137 S. Ct. 1562, 1572 (2017).

2. The Rule Is An Impermissible And Unreasonable Interpretation Of Section 212(a)(4).

Even if “public charge” were to *some* extent ambiguous, this court should not defer to DHS’s interpretation. First, *Chevron* is inapplicable where, as here, Congress has not given the agency the interpretive lawmaking power necessary to authoritatively fill in statutory gaps. *Gonzales v. Oregon*, 546 U.S. 243, 255-56 (2006); see *Epic Sys. Corp. v. Lewis*, 138 S. Ct. 1612, 1629 (2018).

Defendants conflate DHS officials’ broad authority to make factual findings during public charge assessments with interpretive rulemaking authority. Mot. 11-12. While immigration officers’ public charge assessments are “conclusive[] upon matters of fact,” courts may decide whether they “agree with the requirements of the act.” *Gegiow v. Uhl*, 239 U.S. 3, 9 (1915). Further, while Defendants assert the INA delegates authority to the “Executive Branch” (Mot. 11-12), Defendants

never say Congress delegated to *DHS* any authority over the statute's meaning. Nor could they, because the INA grants any such authority instead to the Attorney General, whose determination of "all questions of law shall be controlling" as to other agencies. 8 U.S.C. §1103(a)(1); see *Negusie v. Holder*, 555 U.S. 511, 517 (2009). DHS's authority to issue forms and promulgate reasonable regulations, 8 U.S.C. §1103(a)(3), quite plainly does *not* include any interpretive lawmaking authority. DHS does not even claim deference to its interpretation: it disclaims authority over the State and Justice Departments' Section 212(a)(4) public charge assessments. 84 Fed. Reg. at 41,315, 41,324, 41,461, 41,478.

Moreover, even if Congress *had* granted DHS interpretive lawmaking power, the Rule would fail because it "is unreasonable and not based on a permissible construction of the statute." Order 48.

DHS cannot institute by regulation what Congress has affirmatively rejected. *Albemarle Paper Co. v. Moody*, 422 U.S. 405, 414 n.8 (1975); *INS v. Cardoza-Fonseca*, 480 U.S. 421, 441-43 (1987). And here Congress *rejected* a proposal to define "public charge" in terms strikingly similar to DHS's definition in the Rule. The bill had defined public charge to mean a noncitizen who receives specified means-tested benefits, including those enumerated in the Rule, "for an aggregate period of at least 12 months." 142 Cong. Rec. 24425-27 (Sept. 24, 1996) (*reprinting* H.R. Rep. No. 104-828, at H.R. 2022 at §§532, 551). But days before passage, Congress removed the definition and the specified benefits. 142 Cong. Rec. H12099 (Sept. 28, 1996) (statement of Rep. Smith). And in 2013 Congress again rejected efforts to "*expand*[]" the definition of 'public charge' such that people who received non-cash benefits could not become legal permanent residents." S. Rep. No. 113-40, at 42, 63 (2013).

In addition, DHS's new definition captures individuals receiving on average just *17 cents per day* in nutritional benefits. Order 47. It is flatly unreasonable to

construe the term “public charge” to include a level of assistance that no person could ever truly rely upon.

The Rule is also at odds with the INA’s “design and structure” and the “broader context of the statute as a whole.” *Util. Air Regulatory Grp. v. EPA*, 573 U.S. 302, 321, 325-26 (2014). It undermines the family-reunification principles that undergird federal immigration law.⁵ It dramatically restricts noncitizens’ ability to adjust status based on family ties, and its factors heavily favor wealth and employment over family relationships. *See* 8 C.F.R. §212.22. DHS’s recognition that exclusions will increase under the Rule (*see, e.g.*, 84 Fed. Reg. at 41,479) is confirmed by a recent study’s finding that two-thirds of recent green-card recipients had at least one of the Rule’s negative factors, and nearly half had two. *See* Order 48. Only Congress may make such seismic changes to immigration law. *Am. Trucking Ass’ns*, 531 U.S. at 468 (Congress does not “hide elephants in mouseholes”).

3. **Defendants Misunderstand And Contort The Authorities On Which They Rely.**

Defendants rely on a tortured reading of the affidavit-of-support provision: because sponsors are liable for a noncitizen’s use of a range of benefits, Congress meant that use of *any* such benefit makes a person a public charge. Mot. 9. But this ignores that the very same Congress that adopted this affidavit-of-support provision actually *rejected* that broadened definition of “public charge.” *See* p.13, *supra*.

⁵ *E.g.*, 8 U.S.C. §1151(b)-(d) (70% of annual cap on green cards dedicated to immigrants sponsored by citizen and green-card-holding relatives, and cap excludes citizens’ immediate relatives); H.R. Rep. 82-1365 (1952), *reprinted in* 1952 U.S.C.C.A.N. 1653, 1680, 1691.

Defendants’ heavy reliance on 8 U.S.C. §1601 is also misplaced. As an initial matter, Defendants misconstrue Section 1601, asserting that “self-sufficiency” means *no* receipt of public benefits. Mot. 10. Congress has made clear that it believes *granting* public benefits to some noncitizens is “the least restrictive means available for *achieving* the compelling governmental interest of assuring that aliens be self-reliant in accordance with national immigration policy.” 8 U.S.C. §1601(7) (emphasis added). Further, Section 1601 states principles *not* of the INA, but of the 1996 welfare reform law, over which DHS has no administrative or regulatory authority. DHS cannot leverage its overreading of “self-sufficiency” to construe the INA to exclude people based on the possibility they will use benefits Congress authorized them to receive. *See Epic Sys.*, 138 S. Ct. at 1629 (criticizing agency for similar cross-statutory interpretation). Finally, DHS acknowledges that self-sufficiency is not “the primary purpose of U.S. immigration laws.” 84 Fed. Reg. at 41,306. It is the role of Congress—not DHS—to balance the immigration laws’ purposes.

C. The District Court Correctly Determined That The Rule Is Arbitrary And Capricious.

As the district court laid out, DHS failed to meet its obligations under the APA in at least three respects: (1) DHS asserted that the Rule would be a net health benefit without any analysis or support and in the face of overwhelming evidence to the contrary (Order 58-62); (2) DHS ignored, without explanation, INS’s conclusion in the Field Guidance that dispelling noncitizens’ fear of using public benefits was key to safeguarding public health (*id.* at 62-63); and (3) DHS failed to engage with the full scope of disenrollment impacts and the effects those disenrollments would have on local and state governments (*id.* at 53-59). Each of these infirmities renders the rule invalid.

1. Baseless Assertion Of Net Health Benefits.

DHS agrees the Rule could harm public health and reduce vaccination rates. 84 Fed. Reg. at 41,312-14, 41,384-85. Nonetheless, DHS purported to *justify* the Rule on public health grounds, asserting that it “believes [the Rule] will ultimately strengthen public...health[] and nutrition...by denying admission or adjustment of status to aliens who are not likely to be self-sufficient.” *Id.* at 41,314. DHS offers no evidence or rationale to substantiate its belief in these supposed benefits, and its mere speculation on this point is entitled to no deference. *See Sorenson Commc’ns Inc. v. FCC*, 755 F.3d 702, 708 (D.C. Cir. 2014). Nor did DHS explain how these unsubstantiated, theoretical benefits would outweigh the likely harms of the rule—harms that were thoroughly documented in numerous comments submitted during the rulemaking process. *See* 84 Fed. Reg. at 41,384 (summarizing comments). DHS’s assumption that the Rule will benefit the public health, contrary to all the evidence in front of it and without any support or reasoning undergirding it, demonstrates a failure to engage with the public health implications of the Rule as well as grave issues with its cost-benefit analysis on the health impacts, rendering the Rule invalid. *See Motor Vehicle Mfrs. Ass’n of U.S., Inc. v. State Farm Mut. Auto. Ins. Co.*, 463 U.S. 29, 43 (1983); *Nat’l Ass’n of Home Builders v. EPA*, 682 F.3d 1032, 1039-40 (D.C. Cir. 2012) (where agency conducts cost benefit analysis, serious error in that analysis renders a rule invalid). Tellingly, Defendants make no attempt to rebut the District Court’s conclusion that “DHS’s bare assertion” of public health benefits “simply is not enough to satisfy its obligations.” Order 59; *see* Mot. 19-20.

2. Failure To Explain Departure From Factual Conclusions That Underlay Field Guidance.

Where, as here, an agency changes longstanding policy, it must offer “a reasoned explanation...for disregarding facts and circumstances that underlay or

were engendered by the prior policy.” *Encino Motorcars, LLC v. Navarro*, 136 S. Ct. 2117, 2125-26 (2016). DHS failed to do this. INS adopted the Field Guidance specifically to remedy “confusion” about immigration impacts of receipt of public benefits—confusion INS determined had “an adverse impact not just on the potential recipients, but on public health and the general welfare,” by chilling usage of benefits like SNAP and Medicaid. 64 Fed. Reg. at 28,692. DHS did not even acknowledge this rationale, much less explain why it now believes INS was wrong. Thus, DHS’s response to public health concerns “fails entirely to provide a reasoned explanation for disregarding the facts and circumstances underlying the prior policy,” rendering the Rule invalid. Order 62-63.

3. Failure To Consider Harms To Localities And States.

Defendants cite DHS’s summary assertion that the benefits of the Rule outweigh its harms as evidence DHS properly considered harms to state and local governments. Mot. 17. But DHS failed to “grapple” with those harms, as the APA requires. *See Fred Meyer Stores, Inc. v. NLRB*, 865 F.3d 630, 638 (D.C. Cir. 2017). Instead, DHS simply summarized comments addressing those harms, claimed it had mitigated them, and then improperly dismissed them on the basis that disenrollment and its ensuing harms were hard to quantify. *See* 84 Fed. Reg. at 41,312; *Greater Yellowstone Coal., Inc. v. Servheen*, 665 F.3d 1015, 1028 (9th Cir. 2011). Further, DHS refused to consider costs stemming from persons not subject to the Rule disenrolling from benefits, stating it would “not alter this rule to account for such unwarranted choices.” 84 Fed. Reg. at 41,313. That DHS thinks a cost is caused by irrational action does not relieve DHS of its obligation to consider that cost. *See Michigan v. EPA*, 135 S. Ct. 2699, 2707 (2015) (agency must “pay[] attention to the advantages *and* the disadvantages of [its] decisions.”); Order 59 (collecting cases).

CONCLUSION

Defendants' emergency motion for a stay pending appeal should be denied.

Dated: November 22, 2019 Respectfully submitted,

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CERTIFICATE OF COMPLIANCE

I hereby certify that the foregoing brief complies with the type-volume limitation of Fed. R. App. P. 27(d)(2)(A) because it contains 5,193 words. This brief complies with the typeface and the type style requirements of Fed. R. App. P. 27(d)(1)(E) and 32(a)(5)–(6) because this brief has been prepared in a proportionally spaced typeface using Word 14-point Times New Roman typeface.

November 22, 2019

/s/ Sara J. Eisenberg
SARA J. EISENBERG

CERTIFICATE OF SERVICE

I, CATHERYN DALY, hereby certify that I electronically filed this Opposition to Defendants’ Motion to Stay Injunction Pending Appeal with the Clerk of the Court for the United States Court of Appeals for the Ninth Circuit by using the appellate CM/ECF system on November 22, 2019. I further certify that all participants in the case are registered CM/ECF users and that service will be accomplished by the appellate CM/ECF system.

Executed November 22, 2019, at San Francisco, California.

/s/ Catheryn Daly
CATHERYN DALY

COUNTIES' SUPPLEMENTAL ADDENDUM

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UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF CALIFORNIA

CITY AND COUNTY OF SAN FRANCISCO
and COUNTY OF SANTA CLARA,

Plaintiffs,

vs.

U.S. CITIZENSHIP AND IMMIGRATION
SERVICES; DEPARTMENT OF
HOMELAND SECURITY; KEVIN
McALEENEN, Acting Secretary of Homeland
Security; and KEN CUCCINELLI, in his
official capacity as Acting Director of U.S.
Citizenship and Immigration Services,

Defendants.

Case No. 4:19-cv-04717-PJH

**DECLARATION OF TRENT RHORER IN
SUPPORT OF CITY AND COUNTY OF SAN
FRANCISCO AND COUNTY OF SANTA
CLARA'S MOTION FOR PRELIMINARY
INJUNCTION**

Hearing Date: October 2, 2019
Time: 9:00 am
Judge: Hon. Phyllis J. Hamilton
Place: Oakland Courthouse
Courtroom 3 - 3rd Floor

Trial Date: Not set

1 I, TRENT RHORER, declare as follows:

2 1. I have personal knowledge of the facts set forth in this declaration and, if called as a
3 witness, could and would testify competently to the matters set forth below.

4 2. I am the Executive Director of the San Francisco Human Services Agency (HSA or
5 “Agency”). I have served in this role since October 2000. I have a Master’s degree in Public Policy
6 from the Kennedy School of Government at Harvard University and a Bachelor’s degree in Political
7 Science from the University of California, Los Angeles.

8 3. HSA promotes well-being and self-sufficiency among individuals, families, and
9 communities in San Francisco. The Agency is comprised of three separate departments. Most relevant
10 here, the Department of Human Services (DHS) works with approximately 193,000 San Franciscans
11 each year to provide critical nutrition assistance, income support, CalWORKs and Medi-Cal eligibility,
12 employment, and child welfare services. In addition, the Department of Aging and Adult Services
13 (DAAS) is charged with planning, coordinating, providing, and advocating for community-based
14 services for older adults and individuals with disabilities. Finally, the Office of Early Care and
15 Education (OECE) is charged with aligning and coordinating federal, state, and local funding streams to
16 improve access to high-quality early care and education for children 0-5, and to address the needs of the
17 early care and education workforce.

18 4. Through the Department of Human Services, HSA is responsible for enrollment in and
19 administration of the CalFresh program for residents of San Francisco. Called Supplemental Nutrition
20 Assistance Program (SNAP) at the federal level, CalFresh is a federally mandated, state-supervised, and
21 county-operated program that provides monthly assistance with purchasing food to qualified households.

22 5. From the early 2000s through 2016, the CalFresh caseload in San Francisco grew
23 steadily, reaching approximately 35,000 in November 2016. A number of factors influenced this
24 CalFresh caseload growth, including dedicated outreach, community partnerships, and integration of the
25 CalFresh and Medi-Cal programs in San Francisco. Nonetheless, HSA estimated in our Strategic Plan
26 for 2016-2021 that we are still not reaching 37% of likely eligible individuals.

6. Accordingly, our 2016-2021 Strategic Plan calls for growing the CalFresh caseload from to 50,000 by 2021 through—among other things—community outreach and contracts with outreach partners to generate at least 200 new applications per month.

7. To accomplish this goal, HSA has 14 dedicated outreach workers, 3 outreach supervisors and 1 analysts devoted to CalFresh community outreach. In addition, HSA maintains contracts with community-based organizations for outreach and benefits navigation in order to ensure that San Francisco residents can access services in the most convenient and culturally relevant setting. Current contracts for these programs total more than \$650,000 per year, including contracts with:

- the San Francisco-Marin Food Bank (\$354,475 annually to provides direct application assistance as well as trains and manages a network of nonprofits who provide application assistance to their clients)
- San Diego 2-1-1 (\$297,286 to conduct phone and mail-based outreach and application assistance to households identified by HSA as likely eligible but not yet enrolled).

8. In addition, in order to ensure that low-income individuals who are not enrolled in CalFresh (or need to supplement their CalFresh benefits) have their nutritional needs met, HSA contracts with approximately a dozen community partners to provide food support to hungry or food insecure residents. These include millions of dollars in meal delivery services and a \$521,025 contract with the San Francisco-Marin Food Bank to manage a food pantry network, with services targeted to immigrant populations.

9. I am familiar with the Department of Homeland Security's new rule entitled "Inadmissibility on Public Charge Grounds" ("Final Rule"). I understand that the Final Rule would change longstanding federal policy by allowing federal officials to consider an immigrant's use of non-cash benefits, including those provided under Medicaid and SNAP, when determining whether to allow the immigrant to enter the United States, or adjust his/her immigration status.

10. Although SNAP participation among impacted households has been generally decreasing since President Trump assumed office in January 2017, it dropped most precipitously in fall of 2018 when the proposed public charge rule was announced. I therefore expect that the Final Rule will significantly deter immigrants who are eligible for Medicaid and SNAP benefits from using those

benefits—and will substantially impede our efforts to grow the Cal-Fresh caseload and help low-income San-Franciscans enroll in and maintain all of the public benefits for which they are eligible.

11. HSA has already started expending resources to evaluate whether and in what ways to increase services and spending to combat the chilling effect of the Final Rule and minimize the Rule's impact on our City's vulnerable residents. If the Final Rule goes into effect, HSA will immediately devote additional resources to this conducting analysis, and shortly thereafter expects to begin the process of adding or expanding contracts in some or all of the following areas, as needed:

- a) Outreach and benefits navigation (like those provided by San Diego 2-1-1 and the San Francisco-Marin Food Bank);
- b) Legal education and support to help individuals understand the Final Rule and the potential immigration impacts of utilizing public benefits;
- c) Food and nutrition programs to support the nutritional needs of individuals who disenroll from CalFresh due to fear of the potential immigration consequences—*i.e.*, programs to increase individuals' food purchasing power (such as local food stamp programs) and/or to provide them with food (e.g., meal delivery services and food pantries).

I declare under penalty of perjury that the foregoing is true and correct and that this declaration was executed on August 17, at San Francisco, California.


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UNITED STATES DISTRICT COURT
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Case No. 4:19-cv-04717-PJH

**DECLARATION OF GREG WAGNER IN
SUPPORT OF CITY AND COUNTY OF SAN
FRANCISCO AND COUNTY OF SANTA
CLARA'S MOTION FOR PRELIMINARY
INJUNCTION**

Hearing Date: October 2, 2019
Time: 9:00 am
Judge: Hon. Phyllis J. Hamilton
Place: Oakland Courthouse
Courtroom 3 - 3rd Floor

Trial Date: Not set

1 I, GREG WAGNER, declare as follows:

2 1. I have personal knowledge of the facts set forth in this declaration and, if called as a
3 witness, could and would testify competently to the matters set forth below.

4 2. I am the Chief Financial Officer for the San Francisco Department of Public Health
5 (“SFDPH”). I have served in this role since August 2011. Prior to becoming CFO of SFDPH, I worked
6 in the Mayor’s Office of Public Policy and Finance for five years, and served as the Mayor’s Budget
7 Director from 2009-2011. Prior to joining the Mayor’s Office, I spent several years on the staff of the
8 San Francisco Planning and Urban Research Association, where I led research, policy analysis and
9 advocacy efforts on governance and economic development issues in San Francisco. I hold a Master’s
10 degree in Public Policy from the University of California, Berkeley.

11 3. I have been informed that the United States Department of Homeland Security estimates
12 that 2.5 percent of individuals who live in households with at least one non-citizen will disenroll from or
13 forego Medicaid benefits as a result of the Final Rule entitled “Inadmissibility on Public Charge
14 Grounds” (“Final Rule”). Based on the trends I have observed over the last year since the proposed
15 public charge rule was announced and issued, I believe DHS is underestimating the chilling effect of the
16 Final Rule. But even if DHS is correct that the decrease in Medicaid enrollment will be limited to 2.5%,
17 this decrease will have a significant economic impact on SFDPH.

18 4. California’s Medicaid program (known as Medi-Cal), is the single largest source of
19 funding for services rendered at the Counties’ hospitals and community-based services such as primary
20 care and behavioral health.

21 5. Based on reports generated by the San Francisco Human Services Agency (HSA), I
22 understand that there are 78,038 individuals in San Francisco who receive Medicaid through HSA and
23 who reside in a household with at least one non-citizen. If 2.5% of these individuals (1,951 people)
24 disenroll from Medicaid, SFDPH stands to lose over \$7.5 million in Medicaid reimbursement funds.

25 6. For each additional 1,000 people who disenroll from Medicaid, SFDPH stands to lose an
26 additional \$3.9 million in Medicaid funds.

27 7. Although these individuals will no longer have insurance, they will still get sick and
28 injured, and will still require medical care. SFDPH will continue to provide medical services to them

1 regardless of their immigration status, insurance status, or ability to pay. Unfortunately, because
2 uninsured individuals frequently delay accessing health care, these services will often be provided when
3 individuals present a health condition that is so severe that they require emergency services—which is
4 significantly more costly than routine care. The cost of a clinic visit is hundreds of dollars, compared to
5 the cost of an emergency room visit which may be thousands. And an inpatient hospital stay can cost
6 tens or hundreds of thousands of dollars.

7 8. This inevitable replacement of Medicaid-funded primary care services with unfunded
8 emergency services will irreparably harm SFDPH by imposing significant, unreimbursed costs. San
9 Francisco already spends millions of dollars per year providing “charity care,” discounted care, and
10 other uncompensated care to patients who are not covered by insurance and cannot pay for their care. If
11 San Francisco residents suddenly disenroll from Medicaid in significant numbers, it will dramatically
12 strain many of these local programs by foisting the increasing costs of care entirely onto the City,
13 forcing SFDPH to immediately evaluate restructuring programs, reallocating resources and/or seeking
14 additional local funding.

15
16 I declare under penalty of perjury that the foregoing is true and correct and that this declaration
17 was executed on August 27, at San Francisco, California.

18
19 
20 GREG WAGNER
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28

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UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF CALIFORNIA

CITY AND COUNTY OF SAN FRANCISCO
and COUNTY OF SANTA CLARA,

Plaintiffs,

vs.

U.S. CITIZENSHIP AND IMMIGRATION
SERVICES; DEPARTMENT OF
HOMELAND SECURITY; KEVIN
McALEENEN, Acting Secretary of Homeland
Security; and KEN CUCCINELLI, in his
official capacity as Acting Director of U.S.
Citizenship and Immigration Services,

Defendants.

Case No. 4:19-cv-04717-PJH

**DECLARATION OF TOMÁS ARAGÓN IN
SUPPORT OF CITY AND COUNTY OF SAN
FRANCISCO AND COUNTY OF SANTA
CLARA'S MOTION FOR PRELIMINARY
INJUNCTION**

Hearing Date: October 2, 2019
Time: 9:00 am
Judge: Hon. Phyllis J. Hamilton
Place: Oakland Courthouse
Courtroom 3 - 3rd Floor

Trial Date: Not set

1 I, TOMÁS ARAGÓN declare as follows:

2 1. I have personal knowledge of the facts set forth in this declaration and, if called as a
3 witness, could and would testify competently to the matters set forth below.

4 2. I am the Health Officer of the City and County of San Francisco (“San Francisco”) and
5 the Director of the Population Health Division of the San Francisco Department of Public Health
6 (“SFPDH”). I have held both positions since December, 2010.

7 3. As the Health Officer, I exercise leadership and legal authority to protect and promote
8 health throughout San Francisco. In California, each county is required to appoint a physician Health
9 Officer. Health Officers are charged with the duty to enforce and observe all orders, ordinances, and
10 statutes related to public health. In the event of an emergency, Health Officers may take preventative
11 measures as may be necessary to protect and preserve the public health from any public health hazard.
12 Health Officers are also authorized to control contagious, infectious, and communicable diseases and
13 take preventative measures as may be necessary to prevent and control the spread of disease.

14 4. As the Director of SFPDH’s Population Health Division, I direct public health services. I
15 am responsible for the vision, mission, strategy, leadership and administration of the division, including
16 the provision of core public health functions and essential public health services. In San Francisco, core
17 public health functions include environmental health, communicable disease control, maternal, child,
18 adolescent, and family health care, immunization, emergency medical services, public information and
19 promotion of community health. Essential public health services include (1) conducting and
20 disseminating assessments on population health status; (2) investigating health problems and
21 environmental health hazards in the community; (3) informing and educating people about public health
22 issues and functions; (4) engaging the community to identify and address health problems; (5)
23 developing public health policies and plans; (6) enforcing public health laws that protect health and
24 ensure safety; (7) promoting strategies to improve access to health care services; (8) ensuring a
25 competent workforce and professional growth; (9) ensuring continuous quality and performance
26 improvement; and (10) contributing to and applying the evidence base of public health.

27 5. Prior to becoming the Health Officer and Director of the Population Health Division, I
28 held various positions within SFPDH from 1996-2010, including Director of Chronic Disease

1 Epidemiology, Director of Community Health Epidemiology and Disease Control, as well as Physician
2 Provider at the Tom Waddell Health Center.

3 6. I am familiar with the Department of Homeland Security's new rule entitled
4 "Inadmissibility on Public Charge Grounds" ("Final Rule"). I understand that the Final Rule would
5 allow federal officials to consider an immigrant's use of non-cash benefits, including those provided
6 under Medicaid and the Supplemental Nutrition Assistance Program, when determining whether to
7 allow the immigrant to enter the United States, or adjust his/her immigration status. The Kaiser Family
8 Foundation predicts that this policy change will lead to broad decreases in participation in Medicaid
9 among legal immigrant families and their primarily U.S.-born children beyond those directly affected by
10 the change, and that decreased participation in Medicaid will contribute to more uninsured individuals
11 and negatively affect the health and financial stability of families and the growth and health
12 development of their children. I strongly agree with this prediction.

13 7. There is no question that the Final Rule will harm individual and family health. But it
14 will also have a serious, adverse impact on population health by increasing the risk of communicable
15 diseases and microbial threats and triggering mental health crises and substance use.

16 8. When people have regular access to primary health care, they can be screened for
17 communicable diseases, and if their screening indicates that they have a particular disease, they can
18 begin early treatment, and take steps to avoid transmission in the community. If immigrants are deterred
19 from using Medicaid-funded services and avoid primary care treatment, they will miss the opportunity
20 to be screened and diagnosed for communicable diseases. As a result, they will not know to receive
21 treatment for the disease, and they will not take steps to prevent transmission, resulting in a more
22 significant threat of an outbreak.

23 9. For example, measles is a highly infectious airborne disease that can spread when we fail
24 to vaccinate enough people to achieve herd immunity. The Final Rule will likely reduce the number of
25 people who are vaccinated for measles, thereby resulting in increases of measles outbreaks in San
26 Francisco.

27 10. Similarly, the Final Rule increases the risk of a tuberculosis outbreak. Since 2018, the
28 majority of patients who have been seen at San Francisco's Tuberculosis Clinic are foreign-born. The

Final Rule will deter these immigrants from being screened for tuberculosis, which will delay diagnosis and treatment until they are symptomatic and infectious. Large community outbreaks of tuberculosis are often attributable to this gap between the onset of disease and delayed diagnosis.

11. In recent years, urban areas throughout the United States have experienced outbreaks of Hepatitis A. To date, San Francisco has avoided a Hepatitis A outbreak by conducting a mass vaccination campaign. The Final Rule will deter immigrants from participating in such a campaign, creating a significant risk of a hepatitis A outbreak.

12. San Francisco is also likely to see increased transmission of syphilis and human immunodeficiency virus (HIV) if the Final Rule goes into effect. To date, San Francisco has worked hard to prevent an epidemic of congenital syphilis. And we are leading the world in Getting to Zero: zero HIV infections, zero HIV deaths, and zero HIV stigma. However, the Final Rule threatens our success, and the health of our residents, by deterring people from seeking the screening that can result in early diagnosis, treatment, and prevention of transmission.

13. San Francisco also faces emerging microbial threats that can be imported into our city when people travel here from other countries. These microbial threats include, but are not limited to, the Ebola virus, Middle East Respiratory Syndrome (MERS), and new subtypes of influenza A, including avian influenza. All immigrants in San Francisco must feel safe to access medical services for any symptoms they may experience. The Final Rule will deter immigrants from seeking screening and treatment, and will therefore result in an increase of microbial threats being introduced into our city. San Francisco is at particular risk of this threat because we are an international transportation hub.

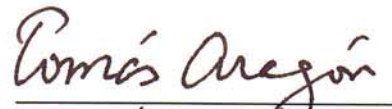
14. By including federally subsidized housing among the public benefits that will cause an immigrant to be considered a public charge, the Final Rule will deter immigrants from availing themselves of one of the few sources of affordable housing in our city, forcing them to double up with other families, or become homeless. Overcrowding that occurs in these situations leads to increased transmission of infectious diseases, including but not limited to, tuberculosis, respiratory viruses, and gastrointestinal infections.

15. One of the most significant consequences of the Final Rule will be stress among low-income immigrant families and young children. This stress—which will be exacerbated by increased

1 poverty, food insecurity, housing instability, untreated mental illness, and untreated substance use—will
2 impact child neurodevelopment, and will be one of the biggest, long-term impacts of the Final Rule.
3 These children have more problems with executive function (attention, memory, judgement, planning,
4 mental flexibility, learning, and emotional regulation), are more likely to develop chronic diseases and
5 mental illness, and are more likely to take behavioral risks (smoking, substance use, unsafe sex).

6 16. As Health Officer, I fully appreciate the responsibility of the City and County to address
7 all threats to population health, and I take that responsibility very seriously. I have no doubt that the
8 Final Rule will increase the risk of communicable diseases and microbial threats and trigger mental
9 health crises and substance use, and in so doing, will require the San Francisco to assume significant
10 costs to do what it can to contain these threats to the best of our ability. We are already devoting
11 resources to prepare for how best to adjust our programs to account for these elevated threats to public
12 health, and will continue to work to ensure that we are best able to protect and promote the public
13 health.

14
15 I declare under penalty of perjury that the foregoing is true and correct and that this declaration
16 was executed on August 27, at San Francisco, California.

17 
18 TOMÁS ARAGÓN

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CITY AND COUNTY OF SAN FRANCISCO

COUNTY OF SANTA CLARA

UNITED STATES DISTRICT COURT

NORTHERN DISTRICT OF CALIFORNIA

CITY AND COUNTY OF SAN FRANCISCO
and COUNTY OF SANTA CLARA,

Case No. 4:19-CV-04717 PJH

Plaintiffs,

**DECLARATION OF COUNTY OF
SANTA CLARA HOSPITALS AND
CLINICS CHIEF EXECUTIVE
OFFICER PAUL E. LORENZ IN
SUPPORT OF COUNTIES' MOTION
FOR PRELIMINARY INJUNCTION**

vs.

DEPARTMENT OF HOMELAND
SECURITY; U.S. CITIZENSHIP AND
IMMIGRATION SERVICES; KEVIN
McALEENEN, Acting Secretary of Homeland
Security; and KEN CUCCINELLI, in his
official capacity as Acting Director of U.S.
Citizenship and Immigration Services,

Hearing Date: October 2, 2019
Time: 9:00 am
Judge: Hon. Phyllis J. Hamilton
Place: Oakland Courthouse
Courtroom 3 - 3rd Floor
Trial Date: Not set

Defendants.

I, PAUL E. LORENZ, declare as follows:

1. I have personal knowledge of the facts set forth in this declaration. I am a resident of the State of California. I submit this declaration in support of the City and County of San Francisco and County of Santa Clara's Motion for Preliminary Injunction. If called as a witness, I could and

1 would testify competently to the matters set forth herein.

2 2. I am the Chief Executive Officer of the hospitals and clinics owned and operated by
3 the County of Santa Clara ("County"), which includes Santa Clara Valley Medical Center ("Valley
4 Medical Center"), O'Connor Hospital, and St. Louise Regional Hospital. I have held this position
5 since March 2019, and I have served as Chief Executive Officer of Valley Medical Center since
6 November 2012. Prior to my current role with the County of Santa Clara, I served as the Chief
7 Deputy Director of the Ventura County Health Care Agency for the County of Ventura. I have
8 served in public healthcare for over 27 years.

9 3. The County of Santa Clara has owned and operated Valley Medical Center for more
10 than one hundred years. On March 1, 2019, the County assumed ownership and operations of
11 O'Connor Hospital, St. Louise Regional Hospital, and the De Paul Health Center. Together, the
12 County's three hospitals have an annual operating budget of approximately \$2.5 billion dollars.

13 **A. Background on the County's Health System**

14 4. The County's Health System is a fully integrated and comprehensive public
15 healthcare delivery system that includes three hospitals and a network of clinics. This system
16 provides a full range of health services, including emergency and urgent care, ambulatory care,
17 behavioral health services, comprehensive adult and pediatric specialty services, the highest-level
18 neonatal intensive pediatric care unit, women's and reproductive health services, and other critical
19 and specialty healthcare services. Valley Medical Center, for example, includes an acute-care
20 hospital with 731 licensed beds, as well as numerous primary and specialty care clinics. In fiscal
21 year 2017, there were more than 800,000 outpatient visits to Valley Medical Center's primary care
22 clinics, express care clinics, specialty clinics, and emergency department, and over 120,000 days of
23 inpatient stays in the hospital. Valley Medical Center's hospital is a Level 1 Adult Trauma Center
24 and Level 2 Pediatric Trauma Center, capable of providing care to seriously injured patients. In
25 2018, Valley Medical Center's hospital had an average daily census of 363 patients admitted to
26 inpatient care and handled 3,087 births and 88,856 emergency department visits.

27 5. O'Connor Hospital, located in San José, provides emergency medical services, urgent
28 care services, primary care, hospital care, and reproductive-health services. O'Connor Hospital

1 operates a nationally recognized acute care hospital with 334 licensed acute beds and 24 licensed
2 skilled nursing facility (SNF) beds. It handled an estimated 51,948 emergency visits, 4,311 surgical
3 cases, and 1,631 births in 2018.

4 6. St. Louise Regional Hospital, located in the City of Gilroy, provides a wide range of
5 high-quality inpatient and outpatient medical care. St. Louise Regional Hospital operates the only
6 acute care hospital in the southern, rural part of the County, specializing in maternal child health
7 services, emergency services, women's health, breast cancer care, imaging, surgical and specialty
8 procedures, and wound care. The hospital operates 72 licensed, acute beds and 21 licensed skilled
9 nursing facility (SNF) beds. Saint Louise Regional Hospital plays a critical health care and
10 especially emergency care role in the southern region of the County, exemplified recently by the fact
11 that Saint Louise treated scores of patients from the recent mass shooting as the Gilroy Garlic
12 festival on July 28, 2019 that occurred just a few miles away from this hospital.

13 **B. The Importance of Public Benefit Programs to the County's Health System**

14 7. The County of Santa Clara Health System is the only public safety-net healthcare
15 provider in Santa Clara County, and the second largest such provider in the State of California. The
16 County's Health System provides the vast majority of the healthcare services available to low-
17 income and underserved patients in the County. In fiscal year 2017, there were more than 800,000
18 outpatient visits to Valley Medical Center's primary care clinics, express care clinics, specialty
19 clinics, and emergency department, and over 120,000 days of inpatient stays in the hospital. In fiscal
20 year 2017, patients who were uninsured, or reliant on California's Medicaid program (Medi-Cal)¹ or
21 Medicare, the federal insurance program for elderly and disabled individuals, were responsible for
22 approximately 88% of outpatient visits (amounting to over 700,000 visits) and approximately 85%
23 of inpatient days (amounting to over 100,000 inpatient days).

24 8. Generally, safety-net providers have a primary mission to care for the indigent
25 population as well as individuals who are uninsured, underinsured, or covered by Medicaid, which is
26

27
28 ¹ Medi-Cal is the name of the program by which California implements the Medicaid program in this
state. To receive Medicaid services in California a person must enroll for Medi-Cal benefits.

1 the federal healthcare insurance program for low-income individuals. Because of this primary
2 mission, safety-net providers are by their nature extremely dependent upon public benefit programs,
3 such as Medicaid, that provide reimbursements for care provided to patients who lack other means to
4 pay for healthcare.

5 9. The County's Health System is extremely dependent on Medicaid reimbursements. In
6 fiscal year 2017, Valley Medical Center received hundreds of millions of dollars in Medicaid/Medi-
7 Cal reimbursements. Overall, nearly two-thirds of the County's patients are Medi-Cal enrollees.
8 For example, in Fiscal Year 2018, Medi-Cal enrollees constituted approximately 67 percent of
9 Valley Medical Center's patient visits and around 59 percent of hospital patient days.

10 10. The County's Health System invested in primary care capacity and preventative care
11 based on the County's expectation that its residents would enroll in the government benefits they
12 need. It made substantial commitments—in physical infrastructure, electronic health record
13 infrastructure, long-term budgeting, human capital, research, and much more. These programmatic
14 investments changed how, where, and in what way the County's Health System operates every day.
15 The County's commitments cannot be undone without tremendous cost, an intervening period of
16 confusion and massive adjustment and, in the meantime and beyond, great harm to the health and
17 wellbeing of our residents.

18 **C. County Residents Have Forgone or Disenrolled from Health Insurance and Health**
19 **Benefits Because of the Rule**

20 11. I am generally familiar with the Department of Homeland Security's (DHS)
21 rulemaking regarding Inadmissibility on Public Charge Grounds, including the proposed rule
22 announced in September 2018 and the final rule published in August 2019. The County Health
23 System has experienced drop-offs in enrollment and participation in public benefit and healthcare
24 programs associated with this rulemaking.

25 12. In the months after DHS issued the proposed rule, data from the County Health
26 System's Gilroy clinic has shown that participants in the County's Women, Infants, and Children
27 program (WIC)—which provides food, nutrition education, and breastfeeding support to pregnant
28 and breastfeeding women and their young children—were returning unused WIC vouchers. I

1 understand this to be due to fear of immigration-related consequences of the proposed rule, even
2 though WIC is not implicated by the proposed or final rule. Some of these women—such as a
3 malnourished pregnant mother with advanced anemia who returned her WIC vouchers in February
4 2019—declined these services at great cost to their health and that of their babies. For months after
5 the proposed rule was issued, many WIC participants refused to even answer phone calls from staff
6 in the County’s WIC program.

7 13. Since the final rule was announced in August 2019, my staff report that still more
8 women who need and qualify for WIC have declined it—including women such as a recent patient at
9 a County clinic in Gilroy whose mental and physical health was deteriorating without basic food and
10 nutrition, but who my staff understood to have declined WIC due to fear of the Rule. The Rule has
11 also deterred pregnant women in the County from accessing non-emergency pregnancy-related
12 services, including the critical prenatal care that protects the health of both mother and unborn child.

13 **D. The County Incurs Greater Costs When County Residents Forgo Health Insurance and**
14 **Health Benefits**

15 14. The County bears substantial direct costs when County residents forgo or decline
16 public health insurance and health benefits. The County is responsible for offering health care
17 services to its poor uninsured and underinsured residents. The County’s emergency departments
18 must screen and potentially stabilize or treat patients irrespective of their ability to pay for the
19 emergency services they need.² The County must provide basic health services to its uninsured,
20 indigent residents.³ And the County’s federally qualified health centers must serve all County
21 residents, including patients who cannot afford the services they need and utilize.⁴

22 15. The County bears greater uncompensated care costs when it provides health care
23 services to uninsured patients than it does when it provides the same services to patients insured by
24 Medi-Cal or other health insurance plans. As a longtime administrator of public health systems, I
25

26
27 ² Emergency Medical Treatment and Active Labor Act (EMTALA), 42 U.S.C. § 1395dd.

28 ³ Cal. Welf. & Inst. Code § 17000.

⁴ Public Health Services Act, Section 330, 42 U.S.C. §§ 254b.

1 am familiar with research regarding the high cost of serving uninsured populations, and in my
2 professional experience working in the public health and health care field for nearly thirty years, I
3 am aware of literature showing that on average each newly uninsured patient increases hospital
4 uncompensated care costs by approximately \$800 annually.⁵ Indeed, we have determined that each
5 uninsured patient that accesses our emergency department services, on average costs us \$450 in
6 uncompensated costs per visit. In fiscal year 2019, this added up to over \$2.5 million in
7 uncompensated care costs in the emergency department.

8 16. Uninsured patients also utilize more expensive and less effective health care services
9 than patients with Medi-Cal or other health insurance. Without access to the primary care,
10 prescription drugs, and early diagnosis and treatment that health insurance and public benefits
11 enable, County residents are more likely to fill the County's ambulances and public emergency
12 rooms and to seek care later, when they are sicker and more costly to treat. Indeed, treatment in an
13 emergency rather than primary care setting is generally an order of magnitude more expensive. And
14 I am aware of literature, for example, stating that whereas a primary care visit costs between \$100
15 and \$200 on average, an emergency room visit on average costs around \$2,000—and can be
16 significantly more.⁶ The County bears massive, but avoidable, direct costs from the less effective,
17 less timely, and more expensive care County residents seek when they lack health insurance
18 coverage or health care benefits. Such unnecessary costs are multiplied across all our uninsured
19 residents in each of their encounters with the County's safety-net Health System.

20 17. Following the 2014 expansion of Medi-Cal eligibility and a related rise in insurance
21 rates related to the Affordable Care Act implementation, the County's Health System was able to
22 pilot dramatic system improvements due to increased health insurance access. For instance, the
23 County launched a chronic conditions care management program that decreased participants'
24 emergency department visits by more than fourfold. These improvements helped ensure that

27 ⁵ See Craig Garthwaite, et al., *Hospitals as Insurers of Last Resort*, 10 Am. Econ. J.: Applied Econ. 1
28 (2018).

1 patients were seen in more appropriate and cost-effective primary and preventive care settings, rather
2 than very costly emergency settings. Attached as **Exhibit A** is a report documenting the benefits of
3 expanding Medi-Cal coverage in our community.

4 18. The County cannot provide timely, less expensive, and more effective health care
5 services to residents who are afraid to seek government-funded care. And the County's ability to
6 pay for system improvements is undercut when it receives lower reimbursements for providing more
7 expensive and less effective services to County residents who forgo health insurance and health
8 benefits for non-emergency care.

9 **E. Programmatic and Administrative Costs of Disenrollment on the County.**

10 19. Because of the importance of our patients enrolling in Medi-Cal, our Patient Benefits
11 Services Department assists patients with Medi-Cal enrollment. Were patients to disenroll or forgo
12 Medi-Cal, it would put strain on our resources as we would seek to help and encourage eligible
13 persons to enroll or reenroll in Medi-Cal, to the extent enrollment would not result in other negative
14 consequences for the patient. Already, the County's Health System has invested over 270 staff
15 hours in education and assessments responding to the rule.

16 20. The County has allocated its budgets, employed and trained staff, and structured its
17 health programs (including its federal and state funding utilization) based on the core expectation
18 that County residents will enroll in the benefits that they are eligible for and need.

19 21. The County's Health System cannot simply redeploy the social workers in its clinics
20 to provide the medical care in its emergency departments if patients shift from federally funded
21 primary care to accessing emergency department.

22 22. Similarly, the County's Health System can neither undo its fiscal commitments nor
23 redo its budget to swiftly or effectively respond to significant drop-offs in enrollment in federal
24 benefits. The highly regulated, non-fungible health funding that the County's health-system receives
25 and relies on has already been obligated and cannot be redeployed. The Health System's funding
26 streams—which are often highly negotiated, multi-year, multi-entity obligations—cannot be

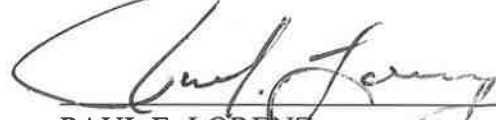
27 ///

28 ///

1 unwound without great cost.

2 I declare under penalty of perjury under the laws of the United States that the foregoing is
3 true and correct and that this declaration was executed on August 27, 2019 in San José, California.

4
5 Respectfully submitted,

6 
7
8 PAUL E. LORENZ

9 2071471

EXHIBIT A

IMPACT OF MEDI-CAL EXPANSION: SANTA CLARA VALLEY HEALTH & HOSPITAL SYSTEM

What has coverage expansion meant to SCVHHS?

Fewer Uninsured Patients: In Santa Clara County, Medi-Cal expansion and Covered California have reduced the uninsured rate **from 10.9% to 4.9%** for Santa Clara County residents. Santa Clara Valley Medical Center: Hospital and Clinics is the primary care provider to more than **68,000 people** who have gained coverage through Medi-Cal since 2014.

Higher Value Care: The expansion of Medi-Cal has created a more stable coverage landscape, which has enabled Santa Clara Valley Health & Hospital System to **focus investments** on better care coordination, increased access, and improved health outcomes for patients.

Santa Clara Valley Medical Center: Hospital and Clinics (SCVMC) was able to undertake efforts to expand its primary care capacity, strengthen its technology infrastructure, and better manage its patient population. SCVMC increased its primary care paneled capacity by **20%** between November 2013 and February 2017, and decreased wait times for primary care appointments from 53 days to **less than 48 hours** with the implementation of urgent care and same day appointment availability throughout its Ambulatory Care clinics. SCVMC also developed a program to provide care management support for patients with chronic conditions, which resulted in **more than four times fewer emergency department visits** among program participants.

These improvements help ensure that patients can be seen in more appropriate and cost-effective primary and preventive care settings, rather than in very costly emergency settings.

What happens to Santa Clara County if coverage expansion is repealed?

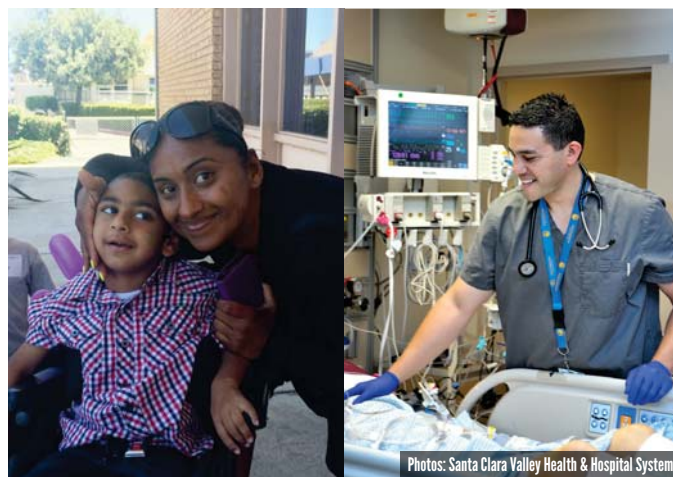
More Uninsured: An estimated **187,000 individuals** would lose coverage through Medi-Cal or Covered California in Santa Clara County.

Economic Impact: A repeal of the Medi-Cal expansion could result in Santa Clara Valley Health & Hospital System losing over **\$250 million** in revenue every year.

We urge that any action to repeal the Affordable Care Act preserve the Medicaid expansion and be coupled with an adequate, simultaneous replacement that ensures the same level of coverage and quality of benefits.

A repeal of the Medi-Cal expansion could result in SCVHHS losing over **\$250 million in revenue every year.**

A dramatic increase in the number of uninsured, coupled with a loss of funding, could destabilize Santa Clara County's health care delivery system.



Photos: Santa Clara Valley Health & Hospital System

What happens to California if coverage expansion is repealed?

More Uninsured: CA's uninsured rate is expected to double, to **over 17%**.

Economic Impact: The state estimates a **\$16 billion loss** in federal revenue with the repeal of the Medicaid expansion and **another \$5 billion** with the elimination of tax subsidies for enrollees in Covered California.

Job Loss: An estimated **200,000 Californians** could lose their jobs, with most losses projected in health care.

ABOUT SANTA CLARA VALLEY HEALTH & HOSPITAL SYSTEM

Santa Clara Valley Health & Hospital System (SCVHHS) is Santa Clara County's public health care system, and SCVMC is at the heart of the county's health care safety net, providing inpatient, emergency, primary, and specialty care.

SCVMC's **574 bed hospital** delivers nearly **25,000 admissions** annually and its ED and county-wide health centers provide nearly **800,000 outpatient visits** annually.

Santa Clara Valley Health & Hospital System is one of the largest employers in the county, providing **more than 7,500 jobs**.

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UNITED STATES DISTRICT COURT

NORTHERN DISTRICT OF CALIFORNIA

CITY AND COUNTY OF SAN
FRANCISCO and COUNTY OF SANTA
CLARA,

Plaintiffs,

vs.

DEPARTMENT OF HOMELAND
SECURITY; U.S. CITIZENSHIP AND
IMMIGRATION SERVICES; KEVIN
McALEENEN, Acting Secretary of
Homeland Security; and KEN
CUCCINELLI, in his official capacity as
Acting Director of U.S. Citizenship and
Immigration Services,

Defendants.

Case No. 4:19-cv-04717-PJH

DECLARATION OF ANGELA SHING, COUNTY OF SANTA CLARA DIRECTOR OF DEPARTMENT OF EMPLOYMENT & BENEFITS SERVICES, IN SUPPORT OF THE COUNTIES' MOTION FOR PRELIMINARY INJUNCTION

Hearing Date: October 2, 2019
Time: 9:00 am
Judge: Hon. Phyllis J. Hamilton
Place: Oakland Courthouse
Courtroom 3 - 3rd Floor
Trial Date: Not set

1 I, Angela Shing, declare as follows:

2 1. I am a resident of the State of California. I submit this declaration in support of
3 the City and County of San Francisco and County of Santa Clara's Motion for Preliminary
4 Injunction. I have personal knowledge of the facts set forth in this declaration. If called as a
5 witness, I could and would testify competently to the matters set forth herein.

6 2. I am currently the Director for the Department of Employment and Benefits
7 Services (DEBS) in the County of Santa Clara's Social Services Agency (SSA), where I oversee a
8 staff of approximately 1,600 administering the CalFresh, Medi-Cal, CalWorks, and General
9 Assistance programs. I have over 17 years of experience working inside and outside of
10 government agencies to improve service delivery and program operations. Prior to my current
11 position, I served in Solano County as the Health and Social Services Deputy Director, leading
12 the Employment and Eligibility Division, where I oversaw a staff of approximately 400 in the
13 administering the benefit and services programs of CalFresh, CalWORKs, Medi-Cal, and General
14 Assistance. Prior to joining Solano County, I held multiple roles with the San Francisco Human
15 Services Agency acting as a technical (eligibility computer systems) and subject matter
16 (Affordable Care Act) expert as a senior level manager in the administration of public assistance
17 programs. Prior to working in direct county government administration, I was a management
18 consultant with Deloitte Consulting, focusing on state and local government, where I became
19 acquainted with the workings of 37 of California's 58 counties. I hold a Master's in Public Policy
20 from the University of Southern California and a Bachelor's Degree in Political Science and
21 Sociology from Boston College.

22 3. Santa Clara County is home to a multi-cultural population of approximately 1.9
23 million residents and is the most populous county in Northern California. The County's
24 immigrant population has grown significantly and, based on recent U.S. Census data, now
25 comprises approximately 38% of the region's total population.

26 4. SSA provides a wide array of social services to residents throughout Santa Clara
27 County, including in all 15 cities within the County and in the County's unincorporated areas.
28 SSA serves all eligible residents, including many immigrant individuals and families, by

1 providing necessary resources and aid to promote their health, safety, and well-being, regardless
2 of immigration status, ability to pay, race, religion, gender identity, or sexual orientation.

3 5. In SSA, DEBS provides low-income county residents with access to public
4 programs that provide health coverage, employment services, foster care benefits, nutrition,
5 homeless assistance, and support for basic living costs. In doing so, it promotes the transition of
6 public assistance recipients to employment and self-sufficiency.

7 6. As the Director for DEBS, I am responsible for overseeing several County services
8 and benefits programs, including CalFresh (California's implementation of the federal
9 Supplemental Nutrition Assistance Program) and Medi-Cal (California's implementation of
10 Medicaid), among others.

11 7. DEBS provides services, training, and outreach to County residents and families.
12 DEBS has over 100 benefits managers and supervisors, and over 700 eligibility workers whose
13 role it is to help eligible County residents apply for and receive federal, state, and local benefits.
14 Under my direction, DEBS also publishes reports and statistical information on benefits
15 application and service rates. The purpose of providing this information is to identify trends,
16 predictions, and potential gaps in benefits programs so that the County may understand and better
17 serve its residents.

18 8. The benefits enrollment process is resource- and time-intensive. There are several
19 hurdles to reaching eligible would-be benefits recipients and educating them on the availability of
20 County services, including such barriers to access as limited and/or unavailable transportation and
21 technology. As part of the normal course of operations, DEBS staff spend a significant number
22 of hours planning and conducting outreach, as well as collaborating with community partners, to
23 engage eligible county residents to apply for, and maintain compliance in program requirements
24 for, relevant public assistance programs.

25 9. As a part of my professional duties and responsibilities for supervision of benefits
26 programs, I have become familiar with the rule on *Inadmissibility on Public Charge Grounds*, 84
27 Fed. Reg. 157 ("Public Charge Rule" or "Rule"). I understand the Rule expands the definition of
28 "public charge" in the immigration process for certain noncitizens to include consideration of

1 participation in certain non-cash benefits programs such as food and nutritional assistance for
2 low-income children and families (e.g., CalFresh) and basic health and well-being programs (e.g.,
3 Medi-Cal), among others.

4 10. From the time the Rule was proposed in October 2018, I have overseen staff in
5 both Solano County and Santa Clara County, and staff in both counties have observed that the
6 Rule has led to confusion and fear among the residents served.

7 11. The population we serve faces significant barriers and challenges that DEBS seeks
8 to help them overcome – homelessness, substance abuse, domestic violence, poverty, hunger,
9 often times lack of access to transportation, technology and other conveniences. The Public
10 Charge Rule has made our efforts at outreach, education, and enrollment even more challenging,
11 as we now have to combat an additional hurdle—the confusion, fear, and distrust of government
12 by noncitizens, and citizens, resulting from the Rule. Rebuilding trust will take more County
13 resources and more DEBS staff time, both to help County residents enroll in programs for which
14 they and their children are eligible and to help those eligible persons who have discontinued
15 benefits feel comfortable enough to reenroll.

16 12. My team in DEBS has worked hard to counteract the impacts and confusion
17 caused by the proposed Rule. We have spent over 1,000 hours answering questions about the
18 impact of the Rule, processing requests for disenrollment, analyzing the impact of the Rule on
19 program services and clients, engaging in discussions with community partners (e.g., food banks,
20 school districts, and others) about the impacts of the Rule, and on other education and outreach.
21 Despite these efforts, otherwise eligible recipients and would-be recipients have informed DEBS
22 staff that they are concerned and are afraid of the Public Charge Rule and its consequences.

23 **Impacts of the Rule on County of Santa Clara's CalFresh Program and Clients**

24 13. CalFresh, California's version of the federal Supplemental Nutrition Assistance
25 Program (SNAP), provides monthly nutrition benefits to individuals and families with low
26 income and provides economic benefits to communities. CalFresh is the largest food program in
27 California. CalFresh is federally mandated, state-supervised, and county-administered. CalFresh
28

1 benefits stretch food budgets, allowing individuals and families to afford nutritious food,
2 including more fruit, vegetables, and other healthy foods.

3 14. The vast majority of residents in Santa Clara County who apply for and receive
4 nutrition support from CalFresh are United States citizens. As of July 2019, in our County there
5 are about 74,000 citizen individuals (adult and children) receiving CalFresh and just over 6,000
6 noncitizen individuals (adult and children) receiving CalFresh.

7 15. The demographics of the clients receiving benefits are as diverse as the County
8 population itself. In terms of ethnicity, CalFresh recipients are White, Vietnamese, African
9 American, Filipino, and Hispanic, among many others. In terms of age, everyone from infants, to
10 teenagers, to adults, to the elderly receive CalFresh, with infants and children up to 17 years old
11 making up approximately 38% of the recipients.

12 16. Qualified non-citizens are eligible to apply for and receive CalFresh benefits, for
13 themselves and their eligible infants, children, and other household members.

14 17. A household's CalFresh allotment is based on the household's net monthly income
15 and the number of individuals in the household. The minimum monthly allotment for 1- and 2-
16 person households is \$15. This amounts to \$180 per year, in CalFresh support. This is equivalent
17 to 50 cents of food assistance per day.

18 18. If it takes effect, the Public Charge Rule would damage the County's ability to
19 support residents with nutrition assistance through the CalFresh program, and eligible children,
20 families, and adults will likely be deprived of access to basic nutrition and food needs. Some of
21 those effects are likely already occurring in our County.

22 19. In recent months, the County, SSA, and DEBS have invested significant resources
23 in educating the community and individuals with outreach efforts, training our hundreds of
24 eligibility workers, and implementing programs to expand access to food and nutritional support
25 through CalFresh.

26 20. For example, on May 7, 2019, SSA and Second Harvest Food Bank of Santa Clara
27 and San Mateo Counties co-hosted a Community Convening Session entitled, "Get CalFresh
28 Food and Keep SSI Benefits." The Community Convening Session targeted local non-profits and

1 community-based organizations that work with SSI/SSP recipients. Subject matter experts from
2 SSA and Second Harvest Food Bank provided a workshop for the County's broad network of
3 partners on how to help SSI/SSP recipients obtain and keep both CalFresh and SSI/SSP benefits.

4 21. On June 1, 2019, low-income seniors and people with disabilities who receive
5 Supplemental Security Income/State Supplementary Payments (SSI/SSP) became eligible for
6 CalFresh food assistance in Santa Clara County. There are approximately 43,000 elderly and
7 disabled SSI/SSP recipients in Santa Clara County; approximately 13,000 of whom will likely
8 meet the requirements to begin receiving CalFresh. For low-income community members
9 susceptible to hunger and food insecurity, this historic expansion of CalFresh is a critical tool in
10 providing access to good nutrition.

11 22. On June 18, 2019, we partnered with the Santa Clara County Office of Education
12 and several school districts to help expand access to free and/or reduced-price meals under a
13 variety of federal programs, particularly for children in historically low-income communities and
14 communities of color. Individual children can apply for and be certified for free- and reduced-
15 price meals based on participation in CalFresh. Additionally, through Direct Certification for
16 Assistance Programs, students receiving CalFresh or other benefits may be automatically entitled
17 to receive free- and reduced-price meals, and no application is necessary. And, under what is
18 known as a community eligibility provision, schools and school districts with a minimum
19 identified student percentage of 40% are eligible to receive free breakfast and lunch for all
20 students at the school or school district. Identified students are those who are directly certified for
21 meals at no cost on the basis of their participation in CalFresh, CalWORKs, the Food Distribution
22 Program on Indian Reservations, and Medi-Cal, and the extension of these benefits go to students
23 within the same household. Also included are students certified as homeless, migrant, foster,
24 runaway, or participating in the Head Start program. To the extent the Public Charge Rule results
25 in a decline of participation by eligible children in qualifying federal programs (e.g., CalFresh or
26 Medi-Cal), it will also mean students and entire school districts may be deprived of access to free-
27 and reduced-price meals at school. This would result in students in low-income school districts
28 having greater food insecurity and less access to staple meals for which they are eligible.

23. Despite these County efforts, however, there has still been a decline in CalFresh participation by eligible noncitizens since October 2018.

24. From October 2018 to May 2019, the number of households receiving CalFresh benefits with at least one noncitizen household member has declined from approximately 15,000 to around 12,000 (an approximate decrease of 20%); while, over this same time the number of households receiving CalFresh benefits where all individuals in the household are citizens remained flat at approximately 26,000.

25. DEBS staff were able to estimate the economic impact of potential disenrollment/foregoing of CalFresh benefits by noncitizens in our County. Specifically, based on the period July 2018 to June 2019, the average CalFresh benefit amount per person was \$1,559 and the average discontinuance pattern for immigrants was 4.9%, which results in an estimated economic impact in the County of over \$416,000. If 25% of immigrants chose to disenroll or forego CalFresh benefits as a result of fear or confusion regarding the Public Charge Rule, the estimated economic impact to the County is approximately \$2.1 million in lost food support and nutrition for some of the County's families most in need, and a corresponding loss to grocery stores, family-run food stores, farmer's markets, and participating restaurants in the County. These children and families who are no longer receiving CalFresh benefits will have to turn elsewhere for basic food and nutrition needs, and many will look to the County and County partners (such as community-based organizations, food banks, and others) to provide additional resources and services, or simply go without.

Impact of the Rule on County of Santa Clara's Medi-Cal Programs and Clients

26. Medi-Cal is California's implementation of the federal Medicaid program. Medi-Cal is a public health program that offers health coverage for low or no cost. Implementation of the Affordable Care Act in 2014 significantly extended Medi-Cal eligibility in California.

27. Noncitizens adults who do not qualify for full scope Medi-Cal benefits may apply for full scope benefits on behalf of their eligible dependent children who qualify for full scope Medi-Cal benefits. This may be the case with mixed status households with 1 or more non-citizen parents with citizen children.

1 28. Since October 2018, significant numbers of eligible noncitizens have either
2 declined to enroll in or disenrolled from Medi-Cal.

3 29. For example, the number of non-citizen adults receiving Medi-Cal has dropped
4 from over 97,000 in October 2018 to approximately 90,000 by the summer of 2019 (an
5 approximate decrease of 7%). This is in contrast to the population of citizen adults receiving
6 Medi-Cal, whose numbers over the same period have remained largely flat, at just over 134,000
7 in October 2018 and just under 134,000 in July 2019.

8 30. As measured by households, the divergence between those with at least one
9 noncitizen and those with only citizens is even more stark. From October 2018 to July 2019,
10 Medi-Cal participation by households with only citizens *increased* from approximately 120,000
11 to approximately 128,000 (an approximate increase of 6%), while participation by households
12 with at least one noncitizen *decreased* from approximately 96,000 to approximately 83,000 (an
13 approximate decrease of 13.5%).

14 31. The economic value of Medi-Cal benefits is difficult to measure because the true
15 value depends not just on the Medi-Cal health coverage but also on the type and cost of medical
16 care services actually used. In addition, in the absence of Medi-Cal health coverage, the
17 alternative medical services for the population served would likely be urgent care or emergency
18 services, rather than preventative care, which would be a tremendous higher out of pocket cost to
19 the consumer, as well as to the provider of services such as the County. With that caveat,
20 however, DEBS staff were able to estimate the economic impact of potential disenrollment /
21 forgoing of Medi-Cal benefits by noncitizens in our County. Based on that estimation, the
22 economic impacts of the drop-off in Medi-Cal coverage are likely even greater than the fiscal
23 impacts on the County's CalFresh program and recipients.

24 32. Specifically, based on a Kaiser Family Foundation report, the average Medi-Cal
25 provider spending per an enrollee in California is \$4,193 annually as of fiscal year 2014, and the
26 actual average discontinuance pattern of immigrants in DEBS from July 2018 to June 2019 is
27 1.9%, which would result in an estimated economic impact in the County of approximately \$4.6
28 million. If 25% of immigrants chose to disenroll or forego Medi-Cal as a result of fear or

1 confusion from the Public Charge Rule, the estimated fiscal impact to the County is
2 approximately \$63.5 million. These children and families who are no longer receiving Medi-Cal
3 will have to turn elsewhere for preventative healthcare and medical emergencies, and many will
4 look to the County, hospitals, clinics, and community partners for additional resources on basic
5 aid and emergency services, often at significantly higher out of pocket cost and cost to provider.

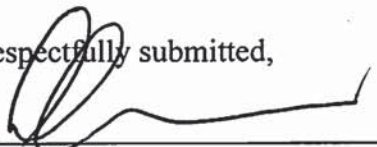
6 *****

7 33. Based on my experience in managing county benefits programs, knowledge of the
8 county residents applying for and receiving benefits, and direct observations as the Director of
9 DEBS and as an executive in other counties, I anticipate that if it goes into effect, the Public
10 Charge Rule will have a devastating effect on County benefits programs and direct services we
11 provide to infants, children, and families in need and on the County's obligations to provide basic
12 services to its most vulnerable residents. DEBS and the County as a whole will be strained to
13 address the aftermath of: more children in our County going hungry even though they and their
14 families are eligible for food and nutrition assistance; low-income students in schools and entire
15 school districts being deprived of free- and reduced-price meals and thus making it harder to
16 concentrate and learn as they go through the school day hungry; eligible working adults not
17 having access to basic support while they transition to full employment, making it harder for them
18 to obtain self-sufficiency; and eligible families going without basic medical care because they are
19 confused and frightened about seeking such care for themselves and for their infants and children.

20
21 I declare under penalty of perjury under the laws of the United States of America that the
22 foregoing is true and correct and that this declaration was executed on August 28, 2019 in San
23 José, California.

24 Dated: August 28, 2019

Respectfully submitted,



Angela Shing

Director of Department of Employment and
Benefits Services, County of Santa Clara

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CITY AND COUNTY OF SAN FRANCISCO

COUNTY OF SANTA CLARA

UNITED STATES DISTRICT COURT

NORTHERN DISTRICT OF CALIFORNIA

CITY AND COUNTY OF SAN FRANCISCO
and COUNTY OF SANTA CLARA,

Case No. 4:19-CV-04717 PJH

Plaintiffs,

**DECLARATION OF SARA CODY,
M.D., HEALTH OFFICER AND
DIRECTOR OF COUNTY OF SANTA
CLARA PUBLIC HEALTH
DEPARTMENT IN SUPPORT
OF COUNTIES' MOTION FOR
PRELIMINARY INJUNCTION**

vs.

DEPARTMENT OF HOMELAND
SECURITY; U.S. CITIZENSHIP AND
IMMIGRATION SERVICES; KEVIN
McALEENEN, Acting Secretary of Homeland
Security; and KEN CUCCINELLI, in his
official capacity as Acting Director of U.S.
Citizenship and Immigration Services,

Hearing Date: October 2, 2019
Time: 9:00 am
Judge: Hon. Phyllis J. Hamilton
Place: Oakland Courthouse
Courtroom 3 - 3rd Floor
Trial Date: Not set

Defendants.

I, SARA H. CODY, M.D., declare as follows:

1. I have personal knowledge of the facts set forth in this declaration. I am a resident of the State of California. I submit this declaration in support of the City and County of San Francisco and County of Santa Clara's Motion for Preliminary Injunction. If called as a witness, I could and

1 would testify competently to the matters set forth herein.

2 2. I am the Director of the County of Santa Clara (“County”) Public Health Department,
3 as well as the Health Officer for the County and each of the 15 cities located within Santa Clara
4 County. I have held the Health Officer position from 2013 to the present and have held the Public
5 Health Department Director position from 2015 to the present. In these roles, I provide leadership
6 on public health issues for all of Santa Clara County and oversee approximately 450 Public Health
7 Department employees, who provide a wide array of services to safeguard and promote the health of
8 the community.

9 3. Prior to becoming the Health Officer for the County and each of its cities, I was
10 employed for 15 years as a Deputy Health Officer/Communicable Disease Controller at the County’s
11 Public Health Department, where I oversaw surveillance and investigation of individual cases of
12 communicable diseases, investigated disease outbreaks, participated in planning for public health
13 emergencies, and responded to Severe Acute Respiratory Syndrome (SARS), influenza A virus
14 subtype H1N1 (also known as “swine flu” or H1N1), and other public health emergencies.

15 4. The mission of the Public Health Department is to promote and protect the health of
16 Santa Clara County’s entire population. None of Santa Clara County’s 15 cities have a health
17 department. All 15 cities, and all Santa Clara County residents, rely on the Public Health
18 Department to perform essential public health functions. The work of the Public Health Department
19 is focused on three main areas: (1) infectious disease and emergency response, (2) maternal, child,
20 and family health, and (3) healthy communities. The Public Health Department’s work is guided by
21 core public health principles of equity, collaboration and inclusion, and harm prevention. This
22 work—in particular, infectious disease control and emergency response—is critical to the health of
23 the entire community countywide.

24 5. The Public Health Department also provides direct services that primarily benefit
25 low-income persons, children, people of color, and people living with chronic diseases, such as
26 HIV/AIDS. These services include screenings and treatment for highly contagious diseases
27 (including sexually transmitted diseases) and immunizations. We also provide case management for
28 mothers with high-risk pregnancies to ensure they are linked to appropriate care. To provide these

critical services, the Public Health Department depends heavily on reimbursement through public benefit programs, including programs established by the federal government such as Medicaid (known as Medi-Cal in California).¹ For example, the County's Public Health Department received \$6.1 million in Medi-Cal payments and \$2.4 million in Medicare payments in Fiscal Year 2016 for health care provided to patients with Medi-Cal or Medicare coverage. Given increases in the population of the County, these numbers have likely increased in more recent years.

A. Due to the Rule, County Residents Are Forgoing and Declining Critical Services at Great Cost to Themselves and to the County

6. I am generally familiar with the Department of Homeland Security's (DHS) rulemaking regarding Inadmissibility on Public Charge Grounds, including the proposed rule announced in September 2018 and the final rule published in August 2019. I am greatly concerned that the final rule will increase the spread of communicable diseases—a risk that is not at all hypothetical. The Public Health Department provides essential outreach and education, screening, case management and contact investigations, and ensures treatment for highly contagious diseases and in some cases treats people who have been exposed to contagious diseases. The health of our entire community is threatened when people forgo care for these diseases.

7. For example, the County has the fourth highest rate of tuberculosis (TB) in California, and California has highest rate of TB in the continental United States, and more cases of tuberculosis than any other state or territory. The majority of TB patients in the County are foreign born (due to exposure in countries where TB remains endemic). An estimated 160,000 people in the County (or nearly 10% of the County's population) may have latent TB infection (LTBI), that is, they are infected with the bacteria that causes TB, but do not have symptoms of the disease and are not contagious. Treatment of LTBI decreases the risk of developing TB disease by more than 90 percent, and thus during routine preventive care, the U.S. Preventive Services Task Force

¹ Medi-Cal is the name of the program by which California implements the Medicaid program in this state. To receive Medicaid services in California a person must enroll for Medi-Cal benefits.

1 recommends that primary care providers screen asymptomatic adults at increased risk for LTBI.
2 However, screening for LTBI requires individuals to seek primary care.

3 8. Since the proposed rule was announced, the County has seen cancellations of primary
4 care appointments, and the Public Health Department has witnessed County residents with positive
5 TB screens declining needed evaluation and LTBI treatment, even though its cost would be covered
6 by Medi-Cal or other public programs. Some patients have explained their decision to decline
7 treatment as motivated by fear of using government-funded services due to the new public charge
8 rule. Failure to treat LTBI imperils the health of both the individual patient and our entire
9 community. When County residents are discouraged from accessing primary care or preventative
10 treatment, there is a much greater risk that LTBI will progress to active TB, which is contagious. If
11 a person with LTBI progresses and develops active TB, they can then spread the TB infection to
12 people with whom they live or work or to anyone with whom they are in close and prolonged
13 contact. TB can be very severe and even fatal; nearly ten percent of patients who develop active TB
14 die. The spread of TB imposes enormous fiscal and health costs on the County and our community.
15 Indeed, while LTBI is relatively inexpensive to treat, an active case of TB costs tens of thousands of
16 dollars to treat. And the costs of treating an outbreak of TB can easily rise into the millions of
17 dollars.

18 **B. Critical Public Health Services that Require Participants to Apply for Other**
19 **Government-Funded Benefits Will Be Reduced Due to the Rule**

20 9. Many services provided by the Public Health Department require patients to apply for
21 other benefits for which they may be eligible. Patients who fear applying for or utilizing
22 government-funded benefits due to the Rule may now lose access to these other critical public health
23 services.

24 10. The Public Health Department provides essential HIV-related health services to
25 County residents under the federal Ryan White HIV/AIDS Program. As a payor of last resort, the
26 Ryan White Program conditions its funding on patients' enrollment in other programs for which they
27 are eligible—including Medi-Cal. Individuals who fear applying for Medi-Cal because of potential
28 immigration consequences under the Rule must then also forgo the Ryan White Program's assistance

1 to receive life-saving medication and associated support. Adequate treatment and adherence to the
2 medication regimen is not only important for the health of the HIV-infected individual receiving
3 treatment, it is central to prevention as well. Persons who are not adequately treated have a higher
4 “viral load” and are at increased risk of transmitting HIV to others. Increased incidence of HIV
5 translates to increased costs of acute, chronic, and preventive care for other newly infected people.

6 11. Together with the State, the Public Health Department administers the California
7 Children’s Services program (CCS), which helps treat children and young adults with certain serious
8 medical conditions such as cystic fibrosis and cerebral palsy. However, to qualify for CCS, an
9 individual who CSS believes is eligible for Medi-Cal eligible must apply for Medi-Cal.² Due to this
10 application requirement, County residents may lose access to critical CCS services if they are wary
11 of applying for or utilizing Medi-Cal because of the Rule.

12 12. The Public Health Department also offers nutrition education to children in schools
13 through the CalFresh Healthy Living Program. The program encourages children to increase their
14 consumption of fruit and vegetables, to drink more water, and to boost their physical activity. Its
15 creative interventions—including adding harvest items to school lunch menus each month,
16 distributing flavored water, and offering structured physical activity at recess—help prevent costly
17 lifelong conditions such as obesity and diabetes. Access to adequate nutrition leads to better health
18 and life outcomes for children later in life. However, the Public Health Department can only offer
19 CalFresh Healthy Living Program in schools where fifty or more percent of students apply for free
20 or reduced-price lunches. If schools no longer meet this threshold because parents are afraid to
21 apply for free or reduced-price lunches for their children, these CalFresh Healthy Living Program
22 will no longer receive federal funding to serve the at-risk children in these schools.

23 **C. The Rule’s Administrative Costs.**

24 13. The Public Health Department has already expended over 150 staff hours trying to
25 respond to the Rule, long before it takes effect. Staff have participated in and plan to participate in
26

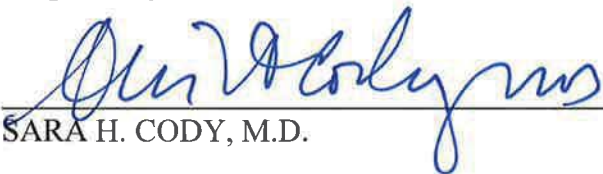
27
28 ² California Department of Health Care Services, *Information About California Children’s Services (CCS)*,
<https://www.sccgov.org/sites/phd/services/CCS/Documents/Applications/application-eng.pdf>.

1 staff education and assessments related to the Rule. And we are having to expend additional
2 resources to determine what other actions are necessary to respond to elevated public health risks
3 stemming from the Rule.

4 14. For decades, the Public Health Department has expended significant resources to gain
5 the trust of the residents it serves. This trust building is necessary for the Public Health Department
6 to carry out its work protecting the public health, and it requires significant resources and staff
7 investments. I am greatly concerned that the Rule is undermining the trust that the Public Health
8 Department needs and has worked for decades to develop. I anticipate that the Public Health
9 Department will need to expend substantial resources conducting outreach, educating residents, and
10 rebuilding that trust over the coming months and years. To rise to meet these new and expanded
11 needs, the Public Health Department would need additional resources and funding.

12 I declare under penalty of perjury under the laws of the United States that the foregoing is
13 true and correct and that this declaration was executed on August 28, 2019 in San José, California.

14
15 Respectfully submitted,

16 
17 SARA H. CODY, M.D.
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Attorneys for Plaintiff
COUNTY OF SANTA CLARA

UNITED STATES DISTRICT COURT

NORTHERN DISTRICT OF CALIFORNIA

CITY AND COUNTY OF SAN FRANCISCO
and COUNTY OF SANTA CLARA,

Plaintiffs,

vs.

DEPARTMENT OF HOMELAND
SECURITY; U.S. CITIZENSHIP AND
IMMIGRATION SERVICES; KEVIN
McALEENEN, Acting Secretary of Homeland
Security; and KEN CUCCINELLI, in his
official capacity as Acting Director of U.S.
Citizenship and Immigration Services,

Defendants.

Case No. 4:19-cv-04717-PJH

**DECLARATION OF COUNTY OF SANTA
CLARA CHIEF OPERATING OFFICER
MIGUEL MÁRQUEZ IN SUPPORT OF
COUNTIES' MOTION FOR
PRELIMINARY INJUNCTION**

Hearing Date: October 2, 2019
Time: 9:00 am
Judge: Hon. Phyllis J. Hamilton
Place: Oakland Courthouse
Courtroom 3 - 3rd Floor
Trial Date: Not set

1 I, MIGUEL MÁRQUEZ, declare as follows:

2 1. I am Chief Operating Officer for the County of Santa Clara (“County”). I submit
3 this declaration in support of the City and County of San Francisco and County of Santa Clara’s
4 Motion for a Preliminary Injunction. I have personal knowledge of the facts set forth in this
5 declaration and, if called as a witness, I could and would testify competently to the matters set
6 forth herein.

7 2. I have been the Chief Operating Officer for the County since August 2016. In this
8 capacity, I supervise and oversee the County’s operations. I have been privileged to serve in
9 high-level roles at the County and other public entities for nearly twenty years. From 2012 to
10 2016, I served as an Associate Justice on California’s Sixth District Court of Appeal. For three
11 years before my appointment to the Court of Appeal, I served as the County Counsel and Acting
12 County Counsel for the County of Santa Clara. In this capacity, I advised the County’s Board of
13 Supervisors, the County’s executive management team, and staff throughout the County
14 organization on a broad range of legal issues, including issues involving finance, local
15 governance, and local policy. Before joining the County, I served as counsel to several other
16 public entities, including in governance, finance, and policy matters.

17 3. I have a deep understanding of the County’s policies, structure, operations, and
18 processes. I have been integrally involved in the development and implementation of County
19 policies and budget processes, including those concerning the County’s provision of public
20 benefits, health services, and other programs that serve the County’s residents, including its
21 immigrant communities.

22 4. The County has about 1.9 million residents, thirty-eight percent of whom are
23 foreign-born—the highest percentage of any California county. The County has a strong interest
24 in ensuring that all of its residents, including immigrants and their families, have access to health
25 and safety-net services and the support they need to build healthy, thriving communities.

26 5. The County provides immigrant-focused community services through the Office of
27 Immigrant Relations (“OIR”), which works to understand the needs of immigrant communities in
28 the County, collaborates and supports organizations working to improve the lives of immigrants

1 in the County, and promotes effective coordination of services to facilitate full inclusion of the
2 County's immigrant communities. As part of these efforts, OIR administers a grant program
3 initiated by the County's Board of Supervisors in 2016 to support nearly twenty community-
4 based organizations (CBOs) operating in the County in providing free and low-cost legal
5 assistance to immigrants and their families, funding approximately \$3.5 million in Fiscal Year
6 2017-2018. For Fiscal Year 2018-2019, the County's total support for immigration-related
7 services amounted to nearly \$5.5 million. This is because of separate programming that began a
8 few years prior in which the County began to provide funds to local nonprofits to provide legal
9 services for immigration cases and proceedings involving unaccompanied minors and families
10 with children as well as some other forms of legal assistance.

11 6. The County also serves as the frontline administrator of a range of safety-net
12 benefits and programs that serve the most vulnerable residents in the County. In addition, the
13 County runs and oversees most public health functions in Santa Clara County, including disease
14 control and prevention and a multi-billion-dollar health and hospital system that serves, among
15 other things, as a provider of last resort, offering care to low-income and vulnerable residents
16 regardless of their ability to pay.

17 7. A significant number of these programs are either wholly or partially funded by
18 enrollment-based federal programs, such as Medicaid (known in California as Medi-Cal), the
19 Supplemental Nutrition Assistance Program (SNAP, known in California as CalFresh),
20 Supplemental Security Income (SSI), and Temporary Assistance for Needy Families (TANF,
21 known in California as CalWORKS). Large numbers of noncitizens in the County live in
22 families in which at least one person receives these types of benefits. For example, as of July
23 2019, approximately 72,400 individuals live in families in which at least one person received
24 Medi-Cal. Most of these benefits are provided through programs established by the federal
25 government but which are administered by the County, often along with the State of California.

26 8. In conjunction with these federal programs, the County provides a wide range of
27 programs supported by local or joint state-local funding. These programs promote resident and
28 community health and well-being and support County residents at nutritional risk, such as infants,

1 children, and expecting mothers. For the County's local programs to be successful and
2 sustainable, it is critical and often mandatory that residents enroll—and remain enrolled—in
3 federal benefit programs for which they are eligible as a prerequisite for receiving certain services
4 from the County. The County's local programs offer complementary services that supplement
5 and fill gaps in federal benefit programs. Together, these programs enable the County to operate
6 a comprehensive and highly complex health and safety-net system.

7 9. If County residents were to forego or disenroll from public benefit programs
8 despite continued need for assistance, the County would be forced to devote substantial local
9 resources to meeting these residents' escalating needs as they would not otherwise receive
10 primary care and other critical services available to individuals enrolled in benefit programs.
11 This, in turn, would divert needed County resources and threaten the viability of important locally
12 funded County programs. The County would need to immediately consider funding reallocations,
13 program restructuring, and new expenditures to address continuing—and growing—community
14 needs. Disenrollment from Medicaid and SNAP alone would require County agencies and
15 departments to both reallocate funds and seek significant amounts of additional funds to protect
16 public health and address community health care needs.

17 10. I am familiar with the Department of Homeland Security's (DHS) rulemaking
18 regarding Inadmissibility on Public Charge Grounds. Because this rulemaking is of great concern
19 to the County's immigrant communities, OIR has tracked it closely and has been required to
20 expend substantial resources engaging with the community regarding the proposed and final
21 rules. Since DHS announced its proposed public charge rule in October 2018, five full-time OIR
22 staff have spent more than 700 hours engaging in outreach and education with CBOs and
23 immigrant communities about their public charge-related concerns and fears, and fielding
24 questions from community members about the impact of the proposed and final rule. Since DHS
25 submitted the public charge rule for publication in the Federal Register on August 12, 2019, OIR
26 already has had to expend scores of hours digesting the rule, creating literature to inform the
27 community about the rule, meeting with community groups, and exploring means of obtaining
28 additional County funding for public charge-related direct legal services, given the rapidly

1 increasing need for residents to find free or low-cost immigration and public benefit legal
2 services. OIR expects to commit even greater amounts of staff time in the coming months to
3 engage in community outreach, provide trainings, and offer other programming related to the
4 public charge rule.

5 11. Many other County agencies and departments will also incur significant
6 administrative costs to mitigate the upheaval caused by the public charge rule. These costs
7 include answering questions about the public charge rule, processing public benefit disenrollment
8 requests, assessing programmatic impacts, reviewing and potentially altering policies and
9 procedures, receiving and providing trainings, and conducting community outreach. Although a
10 significant investment of resources, these programmatic responses are essential to mitigating the
11 serious fiscal and public health harms caused by the public charge rule and to ensuring that the
12 overall health and well-being of our residents and communities is not harmed.

13 I declare under penalty of perjury under the laws of the United States that the foregoing is
14 true and correct and that this declaration was executed on August 28, 2019 in San José,
15 California.

16 Respectfully submitted,

17 
18 MIGUEL MÁRQUEZ

Pages 1 - 117

UNITED STATES DISTRICT COURT

NORTHERN DISTRICT OF CALIFORNIA

Before The Honorable Phyllis J. Hamilton, Judge

STATE OF CALIFORNIA, ET AL.,	)	
	)	
Plaintiffs,	)	
	)	
VS.	)	NO. CV 19-04975-PJH
	)	
U.S. DEPARTMENT OF HOMELAND	)	
SECURITY, ET AL.,	)	
	)	
Defendants.	)	
	)	
CITY AND COUNTY OF SAN	)	
FRANCISCO, ET AL.,	)	
	)	
Plaintiffs,	)	
	)	
VS.	)	NO. CV 19-04717-PJH
	)	
U.S. CITIZENSHIP AND	)	
IMMIGRATION SERVICES, ET AL.,	)	
	)	
Defendants.	)	
	)	
LA CLINICA DE LA RAZA, ET AL.,	)	
	)	
Plaintiffs,	)	
	)	
VS.	)	NO. CV 19-04980-PJH
	)	
DONALD J. TRUMP, ET AL.,	)	
	)	
Defendants.	)	
	)	

Oakland, California
Wednesday, October 2, 2019

TRANSCRIPT OF PROCEEDINGS

Reported By: Pamela Batalo-Hebel, CSR No. 3593, RMR, FCRR
Official Reporter

(Appearances listed on the following pages)

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BY: KUNTAL CHOLERA
ERIC J. SOSKIN
ASSISTANT ATTORNEYS GENERAL

1 My main point is that the balance-of-equities discussion
2 is not supposed to be just a free-floating combination --
3 free-flowing weighting by the Court of different policy
4 considerations. There has been a policy judgment made here,
5 and it was made by Congress in 1996 when it passed Section
6 1601. And I mentioned the statute when I started, and that's
7 the statute that says that it is the immigration policy of the
8 United States that aliens within the nation's borders not
9 depend on public resources to meet their needs and that the
10 availability of public benefits not constitute an incentive for
11 immigration to the United States.

12 So any balance-of-equities consideration here has to
13 weight Congress's policy judgment as expressed in that statute
14 very heavily. And this goes to a point we discussed earlier,
15 why the Agency decided to change course from the 1999 Guidance.
16 This does factor into the balance of equities.

17 Part of the reason the Agency changed course was because
18 the old guidance was not implementing Congress' policy judgment
19 in Section 1601 as evidenced by the fact that very few people
20 were being deemed public charges. So I think it's just
21 important to recognize that it is Congress's policy judgment in
22 Section 1601, not the Plaintiffs' own policy judgment that is
23 entitled the to -- to weight here.

24 **THE COURT:** All right. So you are not arguing there
25 be any hardship on the part of the government to continue to --

1 to implement and execute a Rule, according to practice, over
2 the last two decades?

3 **MR. DAVIS:** Well, Your Honor, I don't think that's the
4 relevant question here. I think --

5 **THE COURT:** That's the question I asked. So you're
6 not arguing that it would be any sort of a hardship for the
7 government to continue to do what it has been doing for the
8 pendency of this action, which you argue is just a few months?

9 **MR. DAVIS:** Your Honor, what we're arguing is that
10 there's an inherent harm to the public interests whenever the
11 government is enjoined from pursuing a policy. I'm not arguing
12 the kind of hardship question that Your Honor is asking about.

13 **THE COURT:** All right.

14 Let's turn to the question of whether or not in the event
15 that the Court determines that a preliminary injunction is
16 appropriate, what the scope of the injunction should be.

17 I will simply say that I found the Plaintiffs' briefing on
18 this matter to be entirely insufficient on the question.

19 Plaintiffs, all the Plaintiff organizations and entities, are
20 asking for a nationwide injunction, but you have devoted in
21 your -- each of your briefs two paragraphs to the question.

22 You've cited a lot of generic case law in which the Ninth
23 Circuit recognizes the authority of district courts to enter
24 nationwide preliminary injunctions and the earlier cases that
25 emphasize the need to have uniformity in immigration policy,

CERTIFICATE OF REPORTER

I certify that the foregoing is a correct transcript
from the record of proceedings in the above-entitled matter.

DATE: Thursday, October 3, 2019

Pamela Batalo Hebel

Pamela Batalo Hebel, CSR No. 3593, RMR, FCRR
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Attorneys for Defendants

**IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF CALIFORNIA**

CITY AND COUNTY OF SAN FRANCISCO, *et al.*,

Plaintiffs,

v.

U.S. CITIZENSHIP AND IMMIGRATION
SERVICES, *et al.*,

Defendants.

Case No. 19-cv-4717-PJH

**NOTICE OF WAIVER OF REPLY
AND HEARING**

Date: December 4, 2019

Time: 9:00 am

Judge: Hon. Phyllis J. Hamilton

In connection with Defendants' Motion to Stay Injunction Pending Appeal (ECF No. 120), Defendants hereby provide notice that they waive their right under the Local Rules to file a reply in support of that motion. In light of the Court's ruling on Plaintiffs' motion for preliminary injunction and the associated hearing, Defendants also submit that a hearing is unnecessary to resolve

Defendants' instant motion.

Given the harms and other issues identified in Defendants' motion, Defendants respectfully request that the Court rule on the motion by November 14, 2019, after which Defendants intend to seek relief in the U.S. Court of Appeals for the Ninth Circuit.

Dated: November 8, 2019

Respectfully submitted,

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Assistant Attorney General

ALEXANDER K. HAAS
Director, Federal Programs Branch

/s/ Joshua M. Kolsky
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Attorneys for Defendants

Pages 1 - 28

UNITED STATES DISTRICT COURT

NORTHERN DISTRICT OF CALIFORNIA

Before The Honorable Phyllis J. Hamilton, Judge

STATE OF CALIFORNIA, ET AL.,	)	
	)	
Plaintiffs,	)	
	)	
VS.	)	NO. CV 19-04975-PJH
	)	
U.S. DEPARTMENT OF HOMELAND	)	
SECURITY, ET AL.,	)	
	)	
Defendants.	)	
	)	
CITY AND COUNTY OF SAN	)	
FRANCISCO, ET AL.,	)	
	)	
Plaintiffs,	)	
	)	
VS.	)	NO. CV 19-04717-PJH
	)	
U.S. CITIZENSHIP AND	)	
IMMIGRATION SERVICES, ET AL.,	)	
	)	
Defendants.	)	
	)	
LA CLINICA DE LA RAZA, ET AL.,	)	
	)	
Plaintiffs,	)	
	)	
VS.	)	NO. CV 19-04980-PJH
	)	
DONALD J. TRUMP, ET AL.,	)	
	)	
Defendants.	)	
	)	

Oakland, California
Thursday, November 14, 2019

TRANSCRIPT OF PROCEEDINGS

Reported By: Pamela Batalo-Hebel, CSR No. 3593, RMR, FCRR
Official Reporter

(Appearances listed on the following page)

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ASSISTANT UNITED STATES ATTORNEY

Thursday - November 14, 2019

2:03 p.m.

P R O C E E D I N G S

---000---

THE CLERK: Calling Civil Cases 19-4717-PJH, 19-4975-PJH, and 19-4980-PJH: City and County of San Francisco, et al. vs. U.S. Citizenship and Immigration Services, et al.; State of California, et al. vs. U.S. Department of Homeland Security, et al.; and La Clinica De La Raza, et al. vs. Trump, et al.

Counsel, please step forward and state your appearances.

MS. RICH: Anna Rich on behalf of the Plaintiff States.

THE COURT: Good afternoon.

MS. EISENBERG: Sara Eisenberg on behalf of the Plaintiff Counties.

THE COURT: Good afternoon.

MR. ESPÍRITU: Nicholas Espíritu on behalf of the La Clinica plaintiffs.

THE COURT: Could you say your name again?

MR. ESPÍRITU: Nicholas Espíritu.

THE COURT: Good afternoon.

MR. ESPÍRITU: Good afternoon.

THE COURT: The rest of you?

MR. RAJENDRA: Good afternoon, Your Honor. Raphael Rajendra from the County of Santa Clara on behalf of the

1 Plaintiffs in 4717.

2 **THE COURT:** Good afternoon.

3 **MS. EDWARDS:** And Luke Edwards also from the County of
4 Santa Clara on behalf of the County.

5 **THE COURT:** Good afternoon.

6 And you're here by yourself?

7 **MR. KOLSKY:** Yes, Your Honor. Good afternoon. Josh
8 Kolsky on behalf of the Defendants in the three cases.

9 **THE COURT:** Good afternoon.

10 All right. I would like to do them separately. There are
11 obviously some overlapping case management issues, but I'd like
12 to talk to counsel for each case separately, at least initially
13 because there are some differences in the causes of action that
14 are asserted, etc.

15 We will start first with the City and County of
16 San Francisco, the 4717 case, and who -- come to the podium.
17 You will need -- just bring all your things up there. You are
18 going to have to stay up there.

19 All right. Now, mainly the issue that we need to address
20 today is the scheduling of future proceedings in the case. I
21 did get the request from the Defense for waiving the hearing
22 and reply on the motion to stay the preliminary injunction that
23 was noticed for hearing for December 4th. I'm busy, and, no,
24 I'm not going to meet the deadline that you requested. We'll
25 do our best, but I've got a lot of other things on my plate

1 besides these cases.

2 But can you tell me what the urgency is?

3 **MR. KOLSKY:** Your Honor, for the reasons we described
4 in our motion to stay, the longer the preliminary injunction
5 stays in place, the Government has to adjust status of
6 applicants under the previous version and not under the --

7 **THE COURT:** Under the existing version?

8 **MR. KOLSKY:** Correct. Under the 1999 Field Guidance
9 as opposed to the now-enjoined rule, and if the injunction is
10 later lifted, there's no practical way to go back and reverse
11 those adjustments of status, and so in light of that and in
12 light of the other concerns addressed in the declaration filed
13 in support of that motion, we think it's important to seek a
14 stay of the injunction as soon as possible, and that's why we
15 are hoping for a quick ruling from the Court.

16 **THE COURT:** And are you required to request this Court
17 to stay before you can ask the Ninth Circuit to stay? I
18 noticed that you noticed your appeal already.

19 **MR. KOLSKY:** Yes, Your Honor. And we -- my
20 understanding -- we have separate appellate attorneys who are
21 handling the Ninth Circuit proceedings. My understanding is
22 that we can go to the Ninth Circuit before this Court has
23 ruled, but obviously we have started here and we've asked this
24 Court for a stay.

25 **THE COURT:** Right. But I'm not talking so much

1 about -- there are two proceedings. One is the proceedings on
2 the request for a stay; the other is the appeal that was filed
3 on this Court's order granting the preliminary injunction.

4 Right?

5 **MR. KOLSKY:** Correct.

6 **THE COURT:** And you applied for a stay separate and
7 apart from the other appeal; correct?

8 **MR. KOLSKY:** We --

9 **THE COURT:** And I was just asking, because you can
10 always ask the Ninth Circuit for a stay because you want the
11 stay pending their adjudication of your appeal, I assume.

12 **MR. KOLSKY:** Correct.

13 **THE COURT:** All right.

14 **MR. KOLSKY:** My understanding is that we have to
15 ask --

16 **THE COURT:** You have to ask here first?

17 **MR. KOLSKY:** -- the district court for a stay before
18 we can ask the Ninth Circuit.

19 **THE COURT:** Okay. That's what I suspected. Okay.
20 All right.

21 So, anyway, we'll get to it as quickly as we can.

22 **MR. KOLSKY:** Thank you, Your Honor.

23 **THE COURT:** All right. Now, in terms of what has been
24 proposed here, it seems to me that you've all agreed with this
25 November date for production of the administrative record, so

CERTIFICATE OF REPORTER

I certify that the foregoing is a correct transcript
from the record of proceedings in the above-entitled matter.

DATE: Monday, November 18, 2019

Pamela Batalo Hebel

Pamela Batalo Hebel, CSR No. 3593, RMR, FCRR
U.S. Court Reporter