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

v.

UNITED STATES CITIZENSHIP AND IMMIGRATION SERVICES, et al.,
Defendants-Appellants

ON APPEAL FROM THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF CALIFORNIA

BRIEF OF AMICI CURIAE PUBLIC HEALTH, HEALTH POLICY, MEDICINE, AND NURSING DEANS, CHAIRS, AND SCHOLARS; THE AMERICAN PUBLIC HEALTH ASSOCIATION; THE AMERICAN ACADEMY OF NURSING; AND PUBLIC HEALTH SOLUTIONS IN SUPPORT OF PLAINTIFFS-APPELLEES AND AFFIRMANCE

Edward T. Waters
Phillip A. Escoriaza
Amanda N. Pervine (*Pro Hac Vice*)
FELDESMAN TUCKER LEIFER FIDELL LLP
1129 20th Street, N.W., Fourth Floor
Washington, D.C. 20036
(202) 466-8960 (telephone)
(202) 293-8103 (facsimile)
ewaters@ftlf.com
pescoriaza@ftlf.com
apervine@ftlf.com

Counsel for *Amici Curiae*

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Pursuant to Rule 29(a)(2) of the Federal Rules of Appellate Procedure and Circuit Rule 29-3, counsel for all parties have consented on the parties' behalf to the filing of this *amici curiae* brief.

The Deans, Chairs, Scholars, the American Public Health Association ("APHA"), the American Academy of Nursing, and Public Health Solutions certify

[1] Pursuant to Rule 29(a)(4)(E) of the Federal Rules of Appellate Procedure, *amici* certify that no party, or counsel for a party, authored this brief in whole or in part or contributed money that was intended to fund preparing or submitting the brief. Preparation of this brief was supported under an award from the Robert Wood Johnson Foundation to the George Washington University Milken Institute School of Public Health. The views expressed by *amici* do not necessarily reflect the position of the Foundation.

that a separate brief is necessary to provide appropriate insight into how vacating the preliminary injunction would have an immediate chilling effect on immigrant participation in essential health programs, negatively impact their overall health outcomes, result in significant disenrollment from health care programs, and create serious public health risks for individuals and communities across the nation.

STATEMENT OF IDENTITY, INTEREST IN CASE, AND SOURCE OF AUTHORITY

The Deans, Chairs, and Scholars are individuals who are recognized among the nation's leading figures in the field of health policy and public health. *Amici* possess particular expertise on health determinants, methods for lowering barriers to effective health care services, and the broader public health consequences of governmental policies. A full list of the Deans, Chairs, and Scholars is included below.

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8. Karen Drenkard, PhD, RN, NEA-BC, FAAN, Associate Dean of Clinical Practice and Community Engagement, School of Nursing Center for Health Policy and Medical Engagement, The George Washington University
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10. Linda P. Fried, MD, MPH, Dean and DeLamar Professor of Public Health, Mailman School of Public Health, Professor of Epidemiology and Medicine, Columbia University
11. Lynn R. Goldman, MD, MPH, MS, Michael and Lori Milken Dean of Public Health, Milken Institute School of Public Health, The George Washington University
12. Mark A. Schuster, MD, PhD, Founding Dean and CEO, Kaiser Permanente Bernard J. Tyson School of Medicine
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19. Thomas E. Burroughs, PhD, MS, MA, Dean and Professor, SLU College for Public Health and Social Justice, Saint Louis University

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3. Claire D. Brindis, DrPH, Caldwell B. Eselystyn Chair in Health Policy, Director, Philip R. Lee Institute for Health Policy Studies, Distinguished Professor of Pediatrics, Division of Adolescent and Young Adult Health and Department of Obstetrics, Gynecology, and Reproductive Health Sciences, University of California, San Francisco
4. David M. Keepnews, PhD, JD, RN, NEA-BC, FAAN, Professor & Interim Chair, Acute & Chronic Care, School of Nursing, The George Washington University
5. Jane Thorpe, JD, Sr. Associate Dean for Academic, Student & Faculty Affairs, Associate Professor and Interim Chair, Department of Health Policy and Management, Milken Institute School of Public Health, The George Washington University
6. Karen A. McDonnell, PhD, Associate Professor and Interim Chair, Department of Prevention and Community Health, Milken Institute School of Public Health, The George Washington University

Scholars

1. Alan B. Cohen, Sc.D., Research Professor, Markets, Public Policy and Law, Boston University Questrom School of Business
2. Allison K. Hoffman, JD, Professor of Law, Penn Law School
3. Amita N. Vyas, PhD, MHS, Associate Professor, Director, Maternal & Child Health Program, Milken Institute School of Public Health, The George Washington University
4. Andy Schneider, JD, Research Professor of the Practice, Center for Children and Families, McCourt School of Public Policy, Georgetown University
5. Benjamin D. Sommers, MD, PhD, Professor of Health Policy & Economics, Harvard T.H. Chan School of Public Health
6. Colleen M. Grogan, PhD, Professor, School of Social Service Administration, University of Chicago
7. Daniel Skinner, PhD, Associate Professor of Health Policy, Ohio University
8. David M. Frankford, JD, Professor of Law, Rutgers University School of Law

9. David Michaels, PhD, MPH, Professor, Department of Environmental and Occupational Health, Milken Institute School of Public Health, The George Washington University
10. Diana J. Mason, RN, PhD, FAAN, Senior Policy Service Professor, Center for Health Policy and Media Engagement, School of Nursing, The George Washington University
11. Dora L. Hughes, MD, MPH, Associate Research Professor, Department of Health Policy and Management, Milken Institute School of Public Health, The George Washington University
12. Harold Pollack, PhD, Helen Ross Professor of Social Services Administration, University of Chicago School of Social Service Administration
13. Janet Heinrich, DrPH, RN, FAAN, Research Professor, Department of Health Policy and Management, Milken Institute School of Public Health, The George Washington University
14. Jeffrey Levi, PhD, Professor of Health Policy and Management, Milken Institute School of Public Health, The George Washington University
15. Jillian Catalanotti, MD, MPH, FACP, Associate Professor of Medicine, Associate Professor of Health Policy and Management, Director, Internal Medicine Residency Programs, The George Washington University
16. Joan Alker, M.Phil, Research Professor, McCourt School of Public Policy, Georgetown University
17. Jonathan Oberlander, PhD, Professor and Chair, Department of Social Medicine, Professor, Department of Health Policy & Management, University of North Carolina at Chapel Hill
18. Julia Zoe Beckerman, JD, MPH, Teaching Associate Professor, Department of Health Policy and Management, Milken Institute School of Public Health, The George Washington University
19. Katherine Horton, RN, MPH, JD, Research Professor in the Department of Health Policy and Management, Milken Institute School of Public Health, The George Washington University
20. Katherine Swartz, PhD, Professor of Health Economics and Policy, Harvard T.H. Chan School of Public Health
21. Krista M. Perreira, PhD, Department of Social Medicine, UNC School of Medicine
22. Lynn A. Blewett, PhD, MA, Professor of Health Policy, University of Minnesota School of Public Health
23. Mark A. Peterson, PhD, Professor of Public Policy, Political Science, and Law, Department of Public Policy, UCLA Meyer and Renee Luskin School of Public Affairs

24. Maureen Byrnes, MPA, Lead Research Scientist/Lecturer, Department of Health Policy and Management, Milken Institute School of Public Health, The George Washington University
25. Melissa M. Goldstein, JD, Associate Professor, Department of Health Policy and Management, Milken Institute School of Public Health, The George Washington University
26. Michael K. Gusmano, PhD, Associate Professor, School of Public Health, Rutgers, The State University of New Jersey
27. Michael R. Ulrich, JD, MPH, Assistant Professor, Center for Health Law, Ethics, & Human Rights, Boston University School of Public Health, Distinguished Visiting Scholar, Solomon Center for Health Law & Policy, Yale Law School
28. Naomi Seiler, JD, Associate Research Professor, Department of Health Policy and Management, Milken Institute School of Public Health, The George Washington University
29. Neal Halfon, MD, MPH, Professor of Pediatrics, Public Health and Public Policy, Director, UCLA Center for Healthier Children, Families & Communities, UCLA
30. Nicolas P. Terry, Hall Render Professor of Law & Executive Director, Hall Center for Law and Health, Indiana University Robert H. McKinney School of Law
31. Nicole Huberfeld, JD, Professor of Health Law, Ethics & Human Rights, Boston University School of Public Health and Professor of Law, Boston University School of Law
32. Pam Silberman, JD, DrPH, Professor, Director, Executive Doctoral Program in Health Leadership, Department of Health Policy and Management, UNC Gillings School of Global Public Health
33. Rand E. Rosenblatt, JD, Professor Emeritus of Law, Rutgers University School of Law
34. Ross D. Silverman, JD, MPH, Professor of Health Policy & Management, Indiana University Richard M. Fairbanks School of Public Health, Professor of Public Health & Law, Indiana University Robert H. McKinney School of Law
35. Sara Rosenbaum, JD, Harold and Jane Hirsh Professor of Health Law and Policy, Department of Health Policy and Management, Milken Institute School of Public Health, The George Washington University
36. Sylvia A. Law, JD, Elizabeth K. Dollard Professor of Law, Medicine and Psychiatry, Emerita Co-Director, Arthur Garfield Hays Civil Liberties Program, NYU Law School

37. Timothy Stoltzfus Jost, JD, Emeritus Professor, Washington and Lee University School of Law
38. Timothy M. Westmoreland, JD, Professor from Practice, Georgetown University School of Law
39. Wendy K. Mariner, JD, LLM, MPH, Edward R. Utley Professor of Health Law, Boston University School of Public Health, Professor of Law, Boston University School of Law, Professor of Medicine, Boston University School of Medicine
40. William B. Borden, MD, FACC, FAHA, Chief Quality and Population Officer, Associate Professor of Medicine and Health Policy, George Washington University Medical Faculty Associates

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INTRODUCTION AND SUMMARY OF THE ARGUMENT

The Public Charge Rule would penalize for the first time covered immigrants for obtaining medical care through the Medicaid program, Title XIX of the Social Security Act, 42 U.S.C. §§ 1396-1, *et seq*., or for merely being found eligible for the program, even if they never use it. The Rule constitutes an impermissible radical alteration of the program that is contrary to the intent of Congress. Lacking any legal authority, the Rule's misguided provisions reinvent Medicaid, gutting its ability to provide readily accessible, stable, and continuous insurance coverage for the populations it serves. Implementation of the Rule is expected to lead to a steep drop in enrollment as covered adult individuals and their children rapidly move in and out of coverage lest they "overstay their welcome" and end up labeled as public charges. None of the government defendants have authority in law to change long-standing public health policy, yet their proposed Rule contravenes important components of Congress's carefully calibrated statutory framework, culminating with amendments contained in the Patient Protection and Affordable Care Act of 2010 ("ACA"), 124 Stat. 119, whose purpose is to promote adequate health coverage. The District Court correctly enjoined the Rule's implementation.

ARGUMENT

I. Congress has Reformed the Medicaid Program by Simplifying Enrollment, Liberalizing Eligibility and Actively Encouraging Access to Promote Stable Coverage for Eligible Individuals.

Prior to the ACA, Medicaid financial eligibility for low income adults averaged below half the federal poverty level ("FPL") in many states – lower than the minimum wage. Millions of low-income workers did not earn sufficient income to pay for health insurance, yet their earnings made them ineligible to participate in the program. Others were excluded entirely because they were ineligible under traditional program standards. The Affordable Care Act created a pathway to insurance for low income, working-age adults meeting citizenship and legal residency rules, ending Medicaid's historic exclusion of most poor working-age adults. Raising income eligibility standards further reduced the chances that small changes in income would disqualify low income beneficiaries. *See* Anna L. Goldman & Benjamin D. Sommers, *Among Low-Income Adults Enrolled In Medicaid, Churning Decreased After The Affordable Care Act*, Health Affairs (Jan. 2020) (discussing impact of liberalized Medicaid eligibility as a means of increasing enrollment that led to half a million fewer adults experiencing periods of uninsurance annually). The ACA achieved this overarching policy goal by adding a new Medicaid eligibility category consisting of low-income adults, ages 18 through 64, who are not pregnant, parents or caretakers of minor children,

eligible based on disability, or Medicare beneficiaries, whose incomes do not exceed 138 percent of FPL. This group is often termed the ACA Medicaid expansion population (42 U.S.C. § 1396a(a)(10(A)(i)(VIII)).

The ACA furthered the goal of stable, continuous coverage for the poor through amendments aimed at easing access to health coverage through simplified enrollment and renewal in accessible locations. This structural change, central to Medicaid reform efforts, reduced "churn" – that is, the constant disenrollment of people with Medicaid coverage over time. The literature underscores that churn has a major impact on *any* coverage and on the *continuity* of coverage. Any coverage is better than none, but the lack of continuous coverage over time – a particularly common phenomenon in the case of Medicaid – is associated with impaired access to care (given the role of health insurance in enabling health care access), reduced likelihood of getting care when needed or of having a regular source of care, reduced use of preventive care and decreased ability to manage long-term and serious health conditions over time.

Recent Medicaid reforms have reduced churning substantially, meaning that millions of individuals, including immigrants subject to defendants' Rule, have experienced vastly improved access to care and substantially better health outcomes, in turn leading to significant administrative and overall program savings. *See* Milda R. Saunders & G. Caleb Alexander, *Turning and Churning:*

Loss of Health Insurance Among Adults in Medicaid, Journal of General Internal Medicine (Dec. 19, 2008) *at* 133-134 (discontinuity of care due to loss of Medicaid coverage leads to worse health outcomes); Andrew B. Bindman, Arpita Chattopadhyay & Glenna M. Auerback, *Interruptions in Medicaid Coverage and Risk for Hospitalization for Ambulatory Care-Sensitive Conditions*, Annals of Internal Medicine (Dec. 16, 2008) *at* 854-60 (finding substantially higher hospitalization rates for ambulatory care-sensitive conditions associated with an interruption in Medicaid coverage); Allyson G. Hall, Jeffrey S. Harman & Jianyi Zhang, *Lapses in Medicaid Coverage: Impact on Cost and Utilization Among Individuals with Diabetes Enrolled in Medicaid*, Medical Care (Dec. 2008) *at* 1219-1225 (diabetic individuals more likely to require inpatient or emergency care after lapses in Medicaid coverage, leading to higher program expenditures); *and* Leighton Ku, Patricia MacTaggart, Fouad Pervez & Sara Rosenbaum, *Improving Medicaid's Continuity of Coverage and Quality of Care*, Assoc. for Community Affiliated Plans (July 2009) (interruptions in insurance coverage led to expensive hospitalizations or emergency room visits and ultimately higher, average monthly Medicaid expenditures per capita). *See also*, Leighton Ku, Erika Steinmetz & Tyler Bysshe, *Continuity of Medicaid Coverage in an Era of Transition*, Assoc. for Community Affiliated Plans (Nov. 1, 2015); Laura Summer & Cindy Mann, *Instability of Public Health Insurance Coverage for Children and Their Families:*

Causes, Consequences, and Remedies, The Commonwealth Fund (June 2006) (churning drives up program administrative costs); Katherine Swartz, Pamela Farley Short, Deborah Roempke Graefe & Namrata Uberoi, *Reducing Medicaid Churning: Extending Eligibility for Twelve Months or to End of Calendar Year is Most Effective*, Health Affairs, (2015) *at* 1180-1187 (simulation showed gains in reducing churning yield substantial reduction in Medicaid managed care administrative costs); *and* Andrew B. Bindman, Arpita Chattopadhyay & Glenna M. Auerback, *Medicaid Re-Enrollment Policies and Children's Risk of Hospitalizations for Ambulatory Care Sensitive Conditions*, Medical Care, (Oct. 2008) *at* 1049-1054 (reforms aimed at increasing eligibility and reducing churn led to $17 million savings in costs of children hospital care in California).

Together, this constellation of federal Medicaid policy reforms has expanded access to health coverage by promoting what the literature terms a "welcome mat" effect – not only for newly-eligible adults but for their children as well, in expansion and non-expansion states – by making it easier to qualify for Medicaid and remain enrolled over time, reducing the likelihood of churn. *See* Julie Hudson & Asako S. Moriya, *Medicaid Expansion for Adults Had Measurable "Welcome Mat" Effects on Their Children*, Health Affairs (2017) *at* 1643-51 (Medicaid expansion led to 5.7 percent gain in coverage for children of newly eligible adults, more than double the 2.7 percentage point enrollment increase among children in

non-expansion states due to Medicaid enrollment streamlining reforms). This fundamental shift in Medicaid law – from limited eligibility and enrollment deterrence to actively encouraging access, simplifying enrollment, liberalizing eligibility, and simplifying renewals – has had a profound and measurable effect, not only on the newly eligible population but on previously eligible individuals who had been unable to overcome past enrollment barriers. In fact, for every 100 newly eligible people who enrolled in Medicaid, another 25 previously-eligible children and 38 previously-eligible adults also enrolled. *See* Stephen Langlois, *Incentives and the Welcome-Mat Effect*, Hoover Institution (Apr. 24, 2017).

Starting in the 1980s with presumptive eligibility, outstation enrollment and other Medicaid reform amendments leading to the ACA, Congress has promoted – not hindered – securing adequate health coverage for low income individuals. These reforms include the following key provisions in the Medicaid statute, all codified at 42 U.S.C. § 1396a:

1. § 1396a(a)(10)(A)(i)(IV): Original eligibility expansions for low income children and pregnant women, broadened under the ACA to include all children through age 18.
2. § 1396a(a)(10(A)(i)(VIII): The ACA newly eligible, low-income adult category.

3. § 1396a(a)(47): Presumptive (i.e., temporary) eligibility for pregnant women and designating hospitals as qualified entities for purposes of making "presumptive eligibility" determinations and enrolling women.
4. § 1396a(a)(55): Outstationed enrollment at community health centers and "disproportionate share" hospitals ("DSHs").
5. § 1396a(e)(4) – (6): Continuous eligibility for children and pregnant women without interruption or the need to re-enroll.
6. § 1396a(e)(12): State option of 12 months of continuous eligibility without the need for redetermination for children under 19.
7. § 1396a(e)(13): "Express lane" (fast track) eligibility for children, including an option for automatic enrollment without a formal application using other program data already on file (for instance, Supplemental Nutrition Assistance Program, "SNAP").
8. § 1396w-3: Enrollment simplification and coordination with state health insurance exchanges, including: online enrollment and renewal; streamlined data exchange among Medicaid, CHIP ("State Children's Health Insurance Program," Title XXI of the Social Security Act, 42 U.S.C. §§ 1397aa, *et seq*.) and Exchanges to ensure coordinated enrollment determinations to reduce duplicate application burdens for people who are unsure of which program they are eligible for; affirmative enrollment outreach to, among

other populations, "racial and ethnic minorities"; and general streamlined enrollment obligations.

Collectively, these key Medicaid reforms have reduced churn considerably. Coverage disruption fell by 4.3 percentage points in states that simplified the enrollment process and expanded Medicaid. Previous research estimated the prevalence of churning among Medicaid and other subsidized coverage sources at between 31 and 50 percent. Goldman & Sommers, *supra*. Greater coverage accessibility and stability has positioned the Medicaid program to achieve better coverage and improved health care outcomes over time. *See, e.g.*, Medicaid and CHIP Payment and Access Commission (MACPAC), *Medicaid Enrollment Changes Following the ACA* (summarizing enrollment gains flowing from the "welcome mat" effects of reforms).

The Centers for Medicare and Medicaid Services ("CMS"), the agency within the United States Department of Health and Human Services ("HHS") that oversees implementation of Medicaid, has played a high visibility and active role in making eligibility, enrollment, and renewal easier and faster, for all populations and for immigrants in particular. *See* CMS, *Dear State Health Official Letter Re: Medicaid and CHIP Coverage of "Lawfully Residing" Children and Pregnant Women* (SHO# 10-006 CHIPRA# 17, July 1, 2010) (discussing eligibility of lawfully residing immigrant children and pregnant women); *see also*, CMS,

Enrollment Strategies (discussing strategies to facilitate coverage such as "presumptive eligibility," "express lane eligibility," "continuous eligibility," and lawfully residing immigrant children and pregnant women). For instance, CMS issued regulations in 2012 that provided extensive guidance to states regarding ACA-driven enrollment and renewal simplification reforms. *See* Kaiser Family Foundation, *Medicaid Eligibility, Enrollment Simplification, and Coordination under the Affordable Care Act: A Summary of CMS's March 23, 2012 Final Rule* (Dec. 2012). By contrast, the Public Charge Rule would nullify these strategies and reverse their gains, not only for those adults who would be immediately affected but also to the extent it gives rise to a documented chilling effect when otherwise-eligible individuals forgo enrollment to avoid the Rule's policy of punishment and exclusion of immigrants. Indeed, the Rule works to reduce coverage under Medicaid to *at most* sporadic, brief spurts of emergency assistance, a clear break from settled Medicaid law as it has evolved over decades.

II. The Public Charge Rule will Fundamentally Cripple the Design and Effectiveness of the Medicaid Program Contrary to Congressional Intent.

The Rule sweeps a broadly restructured Medicaid into the definition of who is a "public charge," imposing severe time limits that effectively strip the program of its objective to provide stable coverage over time, relegating eligible individuals who are the target of the Rule to the marginal backwaters of short-term coverage.

The Rule goes vastly beyond the limited situations in which Medicaid could conceivably be implicated in a public charge determination under current (1999) guidelines, namely a small number of long-term institutional residents. The Rule effectively reinvents Medicaid as an emergency assistance benefit that, at best, functions as a series of isolated, short term brief coverage bursts, which, as discussed below, may not exceed twelve months in any period of thirty-six months. By doing so, the Rule directly undermines Medicaid's core purpose – to function as stable insurance for the poor. The Rule achieves this result by superimposing a different regulatory vision for the program– one that completely departs from a series of carefully designed statutory reforms. Under the Rule, Medicaid degrades into short-term emergency assistance, completely parting from a program that was reformed to expand coverage and simplify enrollment as a means of reducing "churn," and instead leading to reduced access to care and poorer health outcomes due to periodic coverage loss that is followed by long periods of ineligibility.

Worse still, the Rule discourages even brief enrollment spurts in times of true emergency by making health status itself a basis for punishment. By threatening those who need health care, the Rule inevitably escalates fear that use of Medicaid, in and of itself, will provide the basis for a public charge determination. Furthermore, by expanding the inquiry into the health of other members of a covered immigrant's household, the Rule carries the potential to

deter Medicaid enrollment on a widespread basis, even in the case of exempt populations, such as children. *See* 84 Fed. Reg. 41,501 (proposed 8 C.F.R. § 212.21(d)).

Various provisions in the Public Charge Rule operate against the very fabric of the Medicaid program by deterring use of benefits. With limited exceptions for children and pregnant women, the Rule defines a public charge as an individual who receives a public benefit, defined to include Medicaid, among other forms of "noncash assistance," "in any twelve months over a thirty-six month period," and receipt of two benefits in one month would count as two of those twelve months. *See* 84 Fed. Reg. 41,501 (proposed 8 C.F.R. § 212.21(a)). Under this standard, even a few months of Medicaid enrollment, when coupled with other public benefits, could trigger public benefits sanctions. By its own design, the Rule renders its exceptions illusory, triggering a widespread chilling effect on all household members of covered immigrants. Evidence of precisely this effect comes from reports suggesting that immigrants are not merely avoiding Medicaid but are asking to be disenrolled from the program as protection from the Rule's harsh consequences. *See* New York City Mayor's Office of Immigrant Affairs, Mayor's Office for Economic Opportunity & New York City Department of Social Services (2018), *Expanding Public Charge Inadmissibility: The Impact on Immigrants, Households, and the City of New York* (Dec. 2018) *at* 8; *see also,*

Jennifer Tolbert et al., *Impact of Shifting Immigration Policy on Medicaid Enrollment and Utilization of Care Among Health Center Patients*, Kaiser Family Foundation (Oct. 2019) *at* 6 (discussing declining rates of health services utilization among immigrant adults reported by health centers after publication of the proposed public charge rule).

In this way, the Rule effectively becomes a deterrent to use any benefit for fear of triggering the harsh consequences that follow a public charge determination. It creates a strong incentive to avoid Medicaid entirely or to limit use of the program to the shortest possible time period, for example, enrolling just long enough to cover an emergency hospital visit with disenrollment in the month immediately thereafter. Thus, for example, a person who has a medical emergency related to her inability to manage her diabetes because of her poverty might accept a brief period of enrollment in order to cover the cost of emergency care, with immediate disenrollment as soon as she believes she is stable. This choice, a perfectly logical response to the Rule's twelve months out of any thirty-six months test, directly contravenes the "welcome mat" purpose of recent Medicaid reforms for people who are eligible for assistance yet are subject to the Rule. Even if the Rule does not prompt people to avoid help entirely, it will trigger churn – the very problem that the Medicaid reforms were specifically designed to address.

The Rule demonstrates that defendants are prepared to implement a policy whose clear consequence will be to deter Medicaid enrollment entirely and churn people through the program, thereby interrupting coverage on a large scale. In this regard, as noted above, the evidence shows that, following churn, it takes months to regain enrollment and months more to resume utilization. In turn, this leads to greater overall program costs and worse health outcomes among impacted populations. *See* Eric T. Roberts & Craig Evan Pollack, *Does Churning in Medicaid Affect Health Care Use?*, Med Care. (May 2016) *at* 483-89.

Defendants are not content to deter use of Medicaid. In addition, should there be any doubt that the "welcome mat" is no longer out for immigrants, the final Rule makes a covered individual's health an express factor to be considered, *see* 84 Fed. Reg. 41,502 (proposed 8 C.F.R. § 212.22(b)(2)), specifically "whether the alien has been diagnosed with a medical condition that is likely to require extensive medical treatment or institutionalization or that will interfere with the alien's ability to provide care for himself or herself, to attend school, or to work upon admission or adjustment of status." Conceivably any condition, requiring ongoing health care, could be considered a condition "likely to require extensive medical treatment," since the Rule gives the phrase "extensive medical treatment" no guardrails. Indeed, certification for Medicaid by a health care provider offering health insurance outreach and enrollment services (common, per statute, at health

centers and safety net hospitals) could be considered evidence of the need for "extensive" medical treatment. By contrast, as noted, the current (1999) standard for public charge determinations is limited to long term institutional care, thereby protecting all but the most severely and permanently disabled patients from the threat of being deemed a public charge. Medicaid's fundamental role in American society is to embrace health risks among those most vulnerable members of the population – not to punish people for securing the medical care for which they are eligible. Yet this is precisely what the Rule would do.

The utter absence of any rational justification for pushing people out of health insurance – and indeed, out of health care entirely – is underscored by defendants' failure, in their impact analysis, to consider the Rule's consequences. Defendants completely ignore the Rule's impact on health, health care or associated costs and offer no analysis of any gains in health or health care that full implementation of the Rule would tangibly achieve. Defendants' decision to ignore these huge consequences is perhaps understandable, since the overwhelming evidence discussed above shows the individual and community-wide consequences of pushing millions of low-income and vulnerable people out of the health care system.

Furthermore, the Rule's public charge test intensifies the problems it creates by focusing broadly on health conditions and abandoning the 1999 guidelines'

narrow emphasis on long term institutional care. It does so by requiring speculation regarding an individual's possible future use of Medicaid or other noncash benefits, as a measure of whether an individual is a public charge. *See* 84 Fed. Reg. 41,501 (proposed 8 C.F.R. § 212.21(c)). This forecasting feature can be expected to intensify the Rule's destructive impact. The very purpose of Congress's Medicaid reforms was to encourage early and sustained use of health care over time in order to promote and maintain health and reduce health risks. By peering into the future in order to conjecture about health and health care use, the Rule propels public policy in exactly the opposite direction from the course set by Congress through careful Medicaid redesign. Rather than coming forward, immigrants with health conditions (or whose spouses or children have health conditions) will attempt to shield their need for care, not just by avoiding Medicaid (which could be viewed as signaling a need for care) but avoiding care entirely. In other words, the Rule's perverse incentives can be expected to steer people away, not toward, health care, on the theory that by enrolling in Medicaid they signal the need for medical care. Research exemplifies this impact. *See, e.g.,* Tolbert et al., *supra* (health centers report declines in services utilization by immigrant adults after publication of the proposed public charge rule).

As if to reinforce this complete departure from sound health policy, the Rule compounds its impact on settled Medicaid policy by making merely being found

eligible for Medicaid an additional factor prompting a public charge determination. *See* 84 Fed. Reg. 41,502 (proposed 8 C.F.R. § 212.21(e) (receipt of benefits happens when a "benefit-granting agency provides a public benefit . . . to an alien as a beneficiary, whether in the form of cash, voucher, services, or insurance. Certification for future receipt. . . may suggest a likelihood of future receipt"). The plain meaning of this is that certification by any entity – including a community health center, public hospital, or local public health agency – that a person is in fact eligible for Medicaid could *in and of itself* be used as sufficient evidence for a determination that a person is a public charge. This directly contravenes the "welcome mat" focus of Medicaid reforms, because it forces individuals to turn away from Medicaid assistance entirely to avoid the mere appearance of being a public charge. Defendants lack any legal authority to implement a Rule that clearly erects multiple barriers to adequate health coverage.

STATEMENT OF RELATED CASES

Pursuant to Circuit Rule 28-2.6, substantially similar issues appear in these cases pending before this Court: *City and County of San Francisco, and County of Santa Clara v. United States Citizenship and Immigration Services, et al.*, No. 19-17213; *State of California, et al. v. United States Department of Homeland Security, et al.*, No. 19-17214; and *State of Washington, et al. v. United States Department of Homeland Security, et al.*, No. 19-35914.

CONCLUSION

For the foregoing reasons, the judgment of the District Court and its ruling granting Plaintiffs' motion for issuance of a preliminary injunction should be affirmed.

January 23, 2020

Respectfully submitted,

/s/ Edward T. Waters

Edward T. Waters
Phillip A. Escoriaza
Amanda N. Pervine (*Pro Hac Vice*)
FELDESMAN TUCKER LEIFER FIDELL LLP
1129 20th Street, N.W., Fourth Floor
Washington, D.C. 20036
(202) 466-8960 (telephone)
(202) 293-8103 (facsimile)
ewaters@ftlf.com
pescoriaza@ftlf.com
apervine@ftlf.com

Counsel for *Amici Curiae*

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that on this 23rd day of January, 2020, the foregoing Brief of *Amici Curiae* Deans, Chairs, Scholars, the American Public Health Association, the American Academy of Nursing and Public Health Solutions in Support of Plaintiffs-Appellees and Affirmance has been served by this Court's Electronic Case Filing System ("ECF").

/s/ Edward T. Waters

Edward T. Waters
Phillip A. Escoriaza
Amanda N. Pervine (*Pro Hac Vice*)
FELDESMAN TUCKER LEIFER FIDELL LLP
1129 20th Street, N.W., Fourth Floor
Washington, D.C. 20036
(202) 466-8960 (telephone)
(202) 293-8103 (facsimile)
ewaters@ftlf.com
pescoriaza@ftlf.com
apervine@ftlf.com

Counsel for *Amici Curiae*

CERTIFICATE OF COMPLIANCE

Pursuant to Federal Rules of Appellate Procedure 29(a)(5), 32(a)(5), and 32(a)(6), I hereby certify that the foregoing Brief of *Amici Curiae* Deans, Chairs, Scholars, the American Public Health Association, the American Academy of Nursing and Public Health Solutions in Support of Plaintiffs-Appellees and Affirmance, which consists of 3,561 words, complies with the type-volume limitation.

Respectfully submitted,

/s/ Edward T. Waters

Edward T. Waters
Phillip A. Escoriaza
Amanda N. Pervine (*Pro Hac Vice*)
FELDESMAN TUCKER LEIFER FIDELL LLP
1129 20th Street, N.W., Fourth Floor
Washington, D.C. 20036
(202) 466-8960 (telephone)
(202) 293-8103 (facsimile)
ewaters@ftlf.com
pescoriaza@ftlf.com
apervine@ftlf.com

Counsel for *Amici Curiae*