Docket No. 19-3591

IN THE
UNITED STATES COURT OF APPEALS
FOR THE SECOND CIRCUIT

STATE OF NEW YORK, CITY OF NEW YORK, *et al.*
Plaintiffs-Appellees,

v.

UNITED STATES DEPARTMENT OF HOMELAND SECURITY, *et al.*,
Defendants-Appellants.

On Appeal from the United States District Court for the Southern District of New York

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BRIEF OF *AMICI CURIAE* THE AMERICAN ACADEMY OF PEDIATRICS; THE AMERICAN MEDICAL ASSOCIATION; THE AMERICAN COLLEGE OF PHYSICIANS; THE AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS; THE NEW YORK STATE AMERICAN ACADEMY OF PEDIATRICS; THE AMERICAN ACADEMY OF PEDIATRICS – VERMONT CHAPTER; AND THE MEDICAL SOCIETY OF THE STATE OF NEW YORK, IN SUPPORT OF PLAINTIFF-APPELLEES AND IN AFFIRMANCE OF THE DECISION BELOW

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CORPORATE DISCLOSURE STATEMENT

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INTEREST OF *AMICI CURIAE*[1]

The American Academy of Pediatrics ("AAP"); the American Medical Association ("AMA"); the American College of Physicians ("ACP"); the American College of Obstetricians and Gynecologists ("ACOG"); the New York State American Academy of Pediatrics ("NYSAAP"); the American Academy of Pediatrics Vermont Chapter ("AAPVT"); and the Medical Society for the State of New York ("MSSNY") (collectively, "*Amici*") are leading medical organizations whose members collectively provide medical care to the most vulnerable groups of people in society, including children, pregnant and postpartum women, and persons who are disabled or those who suffer from chronic illnesses.

The AAP is a non-profit professional membership organization of 67,000 primary care pediatricians, pediatric medical subspecialists, and pediatric surgical specialists dedicated to the health and well-being of infants, children, adolescents, and young adults. AAP believes that the future prosperity and well-being of the United States depends on the health and vitality of all of its children, without exception. Access to health care, nutrition, and housing assistance programs ensures that children grow up healthy and strong. AAP is uniquely positioned to understand

[1] Pursuant to Federal Rule of Appellate Procedure 29(a)(4)(E), *Amici* affirm that no counsel for a party authored this brief in whole or in part and that no person other than *amici* and their counsel made a monetary contribution to the preparation or submission of this brief. The parties have consented to the filing of this brief.

the impact of the Administration's public charge regulation on the health of vulnerable populations, including children.

The AMA is the largest professional association of physicians, residents, and medical students in the United States. Through state and specialty medical societies and other physician groups seated in its House of Delegates, substantially all United States physicians, residents and medical students are represented in the AMA's policymaking process. The AMA was founded in 1847 to promote the science and art of medicine and the betterment of public health, and these remain its core purposes. AMA members practice in every state, including Washington, and in every medical specialty.

The ACP is the largest medical specialty organization and the second-largest physician group in the United States. ACP members include 159,000 internal medicine physicians (internists), related subspecialists, and medical students. Internal medicine physicians are specialists who apply scientific knowledge and clinical expertise to the diagnosis, treatment, and compassionate care of adults across the spectrum from health to complex illness.

The ACOG is the nation's leading group of physicians providing health care for women. With more than 60,000 members—representing more than 90% of all obstetrician–gynecologists in the United States—ACOG advocates for quality health care for women, maintains the highest standards of clinical practice and

continuing education of its members, promotes patient education, and increases awareness among its members and the public of the changing issues facing women's health care. ACOG is committed to ensuring access to the full spectrum of evidence-based quality reproductive health care for all women. ACOG believes that access to essential health care services, such as preventative care and prenatal and postpartum care, as well as stable housing and nutrition are vital to maintaining overall health and well-being for women, children, and families. ACOG members care for women of all socioeconomic backgrounds, including low-income immigrant women and adolescents who use Medicaid to access essential health care, as well as housing and nutrition assistance programs.

The NYSAAP represents more than 5,500 pediatricians across New York State. NYSAAP is committed to supporting and enhancing the health, safety, and well-being of all infants, children, adolescents, and young adults in New York State, no matter where they or their parents were born.

The AAPVT represents over 200 Vermont pediatricians and is dedicated to improving the physical, mental, and social health and well-being of the state's infants, children, adolescents, and young adults. As pediatricians, we understand the vital role that housing, nutrition, and health care access plays in keeping all families healthy.

The MSSNY is New York State's principal non-profit professional organization for physicians, residents and medical students of all specialties. Its mission is to represent the interests of patients and physicians to assure quality healthcare services for all.

Amici support affirmance of the district court's order granting a preliminary injunction. *Amici* respectfully submit this brief to inform the Court of the severe negative impact of the Administration's public charge regulation on the health and well-being of vulnerable populations, including children, pregnant and postpartum women, and individuals with disabilities and chronic health conditions.

SUMMARY OF ARGUMENT

The United States Department of Homeland Security ("DHS") has drastically overhauled decades of precedent and Congressional intent by promulgating *Inadmissiblity on Public Charge Grounds*, 84 Fed. Reg. 41292-01 (Aug. 14, 2019) (the "Regulation"). The Regulation dramatically alters the factors considered by immigration officials in evaluating whether a non-citizen seeking to immigrate or adjust their immigration status will become a "public charge."[2] Prior to this Regulation, public charge referred to an individual who was likely to become

[2] Under Section 212(a)(4) of the Immigration and Nationality Act, an individual seeking admission to the United States or seeking to adjust status is inadmissible if the individual is likely at any time to become a public charge. *See* 8 U.S.C. § 1182(a)(4)(A).

primarily dependent on the government for subsistence, such as someone who received cash assistance for income maintenance or was institutionalized in a government-funded long-term care facility.[3] Use of benefits such as health services or nutrition assistance were not considered in the public charge determination.

The Regulation now interprets the public charge designation to apply to an immigrant "who receives one or more public benefits, . . . for more than 12 months in the aggregate within any 36-month period (such that, for instance, receipt of two benefits in one month counts as two months.)."[4] The definition of "public benefits" has also been enlarged to include health, nutrition, and housing programs such as non-emergency Medicaid for non-pregnant adults and Supplemental Nutritional Assistance Program ("SNAP").

Application of the Regulation's totality of circumstances test will have a disparate impact on children, pregnant women, and persons suffering from disabilities and chronic health conditions. The Regulation now categorizes the receipt of public benefits, including health or nutrition assistance, as a "*heavily weighted*" negative factor.[5] Receipt of such public benefits "weigh[s] heavily in favor of a finding that an alien is likely at any time in the future to become a public

[3] Field Guidance on Deportability and Inadmissibility on Public Charge Grounds, 64 Fed. Reg. 28689-01 (May 26, 1999).
[4] 8 CFR § 212.21(a) (2019).
[5] 8 CFR § 212.22(c).

charge,"[6] amplifying the impact of the Regulation on vulnerable populations. The presence of a "heavily weighted" negative factor—such as receipt of health or nutrition assistance—will very likely tip the scales of the totality of circumstances test in favor of a determination that the individual is or will become a public charge.

Though DHS claims the Regulation is intended to promote self-sufficiency, there is no evidence that chilling the use of health and nutrition benefits will increase the income, employment, or educational status of immigrants. *Amici* submit this brief to describe the deleterious impact this Regulation will have on the health of vulnerable populations. These sweeping changes will ultimately result in far greater costs to the public's health than any purported benefit offered by DHS.

ARGUMENT

I. The Regulation Targets Key Health And Nutrition Programs And Allows For Discriminatory Decision Making.

The Regulation upends decades of settled policy with regard to the public charge determination. Historically, an immigrant could be deemed inadmissible if an immigration official concluded that the immigrant was likely to become a public charge—interpreted to mean *primarily dependent on public assistance*. The Regulation now much more broadly defines "public charge" to include anyone who has received or is likely to receive a wide range of public benefits. The programs

[6] 8 CFR § 212.22(c)(1).

targeted by the Regulation include medical benefits such as Medicaid, nutrition benefits such as SNAP, and housing assistance—all of which may be integral to keep immigrants and their family members healthy, fed, and sheltered.[7] The Regulation employs a totality of circumstances test which is so all-encompassing that vulnerable populations such as children, pregnant women and individuals with disabilities are uniquely at risk for discrimination simply because of their age or health status. Moreover, use of these health and nutrition benefits is counted as a "heavily weighted" negative factor, almost certainly resulting in the finding that the individual is likely at any time in the future to become a public charge.

A. Utilization Of Essential Health And Nutrition Programs Are Targeted By The Regulation.

The Regulation expands the definition of "[p]ublic benefit" to include non-cash benefit programs such as SNAP, Medicaid, and Section 8 housing benefits,[8] which have been key to upward mobility for generations of immigrants. This expansion of the public benefit definition will affect many immigrant families, especially those with low to moderate incomes. The Regulation gives immigration officers broad discretion to make a public charge determination based on whether an immigrant may utilize, *at some point in the future*, Medicaid, SNAP, or housing benefits. Certain groups of immigrants, such as parolees or those subject to

[7] 8 CFR § 212.21.
[8] 8 CFR § 212.21(b).

withholding of removal, would be penalized for utilizing Medicaid if they ever sought to adjust their immigration status through a family member. Immigrants with health conditions that require "extensive treatment" who receive health coverage through state-funded programs would be penalized if they cannot demonstrate an ability to purchase private insurance.

Equally significant, the Regulation's chilling effect will impact many additional families. The Regulation has already resulted in widespread confusion and fear throughout the immigrant community, causing many to forgo assistance for which they are legally entitled under federal or state law, such as accessing emergency care in hospitals[9] or children's health insurance coverage.[10] There was an increase in the child uninsurance rate from 5% in 2017 to 5.5% in 2018 which is largely because of a decline in children's Medicaid and the Children's Health Insurance Program (CHIP) coverage rates.[11] Rates of decline were highest for Hispanic children.[12] This puts parents and children at risk for poorer health

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[9] The Emergency Medical Treatment & Labor Act ensures public access to emergency medical services regardless of ability to pay. 42 CFR § 489.24 (1986).

[10] Edward R. Berchick & Laryssa Mykyta, *Children's Public Health Insurance Coverage Lower Than in 2017*, United States Census Bur. (Sept. 2019), https://www.census.gov/library/stories/2019/09/uninsured-rate-for-children-in-2018.html (reporting that Hispanic children were more likely to be uninsured than children from other races and non-Hispanic origin groups. Between 2017 and 2018, the uninsured rate increased 1.0 percentage point for Hispanic children and 0.5 percentage points for non-Hispanic Whites).

[11] *Id.*

[12] *Id.*

outcomes, additional economic hardship, and long-term consequences.

B. The Totality Of Circumstances Test Is So Vague It Will Result In Discriminatory Decision Making.

The Regulation is likely to be applied by immigration officers in an inconsistent and discriminatory manner. The Regulation states that the public charge determination "must be based on *the totality of the alien's circumstances by weighing all factors* that are relevant to whether the alien is more likely than not . . . to receive one or more public benefits . . . ."[13] While the Regulation states that the determination is based on a totality of circumstances, the immigration officer is instructed to consider a set of minimum factors (age, health, family status, education and skills, and financial status), heavily weighted negative factors (*e.g.*, employment status, receipt of public benefits, diagnosis of an extensive medical condition without adequate private insurance), and heavily weighted positive factors (household income of at least 250% of the federal poverty guidelines, employment with an income of at least 250% of federal poverty guidelines, and private health insurance).[14] There is no guidance provided on how to balance the competing factors, especially when some factors have more impact than others.

Most significantly, the application of each of these factors will have a disparate impact on vulnerable populations. The inclusion of "health" as a factor in

[13] 8 CFR § 212.22(a) (emphasis added).
[14] 8 CFR § 212.22(b), (c).

this analysis will likely result in discrimination against persons with a wide variety of health conditions. The Regulation states:

> DHS will consider whether the alien's health makes the alien more likely than not to become a public charge at any time in the future, including 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 and care for himself or herself, to attend school, or to work upon admission or adjustment of status.[15]

This vague definition of "medical condition" is overbroad and unworkable. There is no guidance provided as to what "extensive medical treatment" consists of, or what type of medical condition would rise to the level of "interfer[ing]" with work or school. This could include anything from a condition necessitating the use of expensive medical equipment such as a power wheelchair to a child's learning disability that requires an Individualized Education Plan.

Further, the immigration official may rely on evidence that includes, *but is not limited to*, (i) an immigration medical examination, or if the immigration officer finds the report to be incomplete, (ii) evidence of such a medical condition.[16] There is no explicit requirement of the type or quality of such "evidence," including whether the evidence must be documented by a medical professional. The immigration officer is not limited to these two categories of evidence. The

[15] 8 CFR § 212.22(b)(2)(i).
[16] 8 CFR § 212.22(b)(2)(ii).

Regulation provides no restrictions on what the immigration officer can consider when evaluating an immigrant's health. This provision has the potential to allow an immigration official to act as an unqualified medical expert, with no oversight.[17]

The Regulation expands the definition of public benefit and relies on an ambiguous "totality of circumstances" test to evaluate whether an immigrant is or will become a public charge.[18] The application of this Regulation will have a negative impact on the health of immigrants and their families and an even more severe effect on vulnerable populations, including children, pregnant women, and individuals with disabilities.

II. Citizen And Non-Citizen Children Will Be Harmed By The Regulation.

The Regulation will have a devastating impact on children in this country—increasing the likelihood that immigrant children will be designated a public charge and reducing access to health and nutrition benefits for all children, including U.S. citizens.

A. The Totality Of Circumstances Test Will Disproportionally Impact Non-Citizen Children.

Immigrant children are plainly disadvantaged by the Regulation's "totality of

[17] Not only is it manifestly unjust for an immigration officer, with no medical training, to make a determination about the health status of an immigrant, such a scenario contravenes 42 CFR § 34 *et seq*. (setting forth the requirements for medical examinations of aliens).

[18] 8 CFR § 212.22(a).

circumstances" test—the child's age itself will count against them as a negative factor.[19] A child will also be penalized by the "education and skills" factor, as it is unlikely the child could demonstrate "adequate education and skills to either obtain or maintain lawful employment."[20] Additional negative factors are related to larger family size (implicated if the child has siblings) or if the child resides in a single parent household.[21] If the child has a medical condition that requires "extensive medical treatment" or "interfere[s]" with the child's ability to attend school, this will count as an additional negative factor.[22] One study reported that 4.8 million children in need of medical attention live in households with at least one noncitizen adult and are insured by Medicaid or CHIP.[23] This includes a significant number of children with at least one potentially life-threatening condition or illness, including asthma, influenza, diabetes, epilepsy, or cancer.[24] Children who live with such medical conditions and who reside in households that cannot afford private health insurance,

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[19] 8 CFR § 212.22(b)(1) ("When considering an alien's age, DHS will consider whether the alien's age makes the alien more likely than not to become a public charge at any time in the future, such as by impacting the alien's ability to work, including whether the alien is between the age of 18 and the minimum 'early retirement age' for Social Security . . . .").
[20] 8 CFR § 212.22(b)(5).
[21] 8 CFR § 212.21(d)(2); 8 CFR § 212.22(b)(3).
[22] 8 CFR § 212.22(b)(2).
[23] Leah Zallman et al., *Implications of Changing Public Charge Immigration Rules for Children Who Need Medical Care,* 173 JAMA Pediatrics E4-E5 (July 1, 2019) (defining "in need of medical attention" in the study as "children with a current or recent medical diagnosis, disability, and/or need for specific therapy").
[24] *Id.*

would be penalized with a heavily weighted negative factor under §212.22(c)(1)(iii).

The Regulation does exempt from the public benefits definition the receipt of Medicaid benefits by immigrants under the age of 21.[25] But a child under the age of 18, unemployed, and living in a single parent household already has three negative factors weighing against them. If that child also suffers from a disability that requires "extensive medical treatment," such as severe asthma, this would be a fourth negative factor. The totality of circumstances test will make it uniquely difficult for children, particularly those with health challenges or those in lower income households, to avoid being labeled a public charge.

B. Children's Health Will Be Harmed By The Public Charge Regulation.

The impact of the Regulation on the health and well-being of all children in immigrant families cannot be understated. Many such families rely on government programs for preventive, rehabilitative, habilitative, and emergency health needs as well as supplemental nutrition. This Regulation will cause, or already has caused, families to disenroll from these programs.[26]

The Regulation will have a chilling effect on the utilization of programs specifically identified, such as SNAP and Medicaid. The fear and confusion over

[25] 8 CFR § 212.21(a)(5)(iv).
[26] Lena O'Rourke, *Trump's Public Charge Proposal Is Hurting Immigrant Families Now*, Protecting Immigrant Families (Apr. 2019), https://www.chn.org/wp-content/uploads/2019/04/ProtectingImmigrantFamilies.pdf.

what is covered by the Regulation will also result in a chilling effect on programs that are not explicitly called out, such as CHIP, the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), and state-funded Medicaid programs.

This chilling effect is real, measurable, and exacerbated by the final Regulation. After the Regulation was published, but before it was even finalized, many immigrant families began avoiding government healthcare programs and regular doctor's appointments.[27] A study reported that one-seventh of all adults in immigrant families reported avoiding non-cash public benefits over the past year because of fear that their legal immigration status would be harmed.[28] Low-income members of immigrant families reported even higher rates of avoidance.[29] Of this group that avoided benefits, 46% avoided nutrition benefits (SNAP), 42% avoided medical benefits (Medicaid and CHIP), and 33% avoided public housing subsidies.[30] This chilling effect was measurable even before the final Regulation was published, and it is expected that the rates of avoidance will be markedly higher once it is enforced.

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[27] *Id.*
[28] Hamutal Bernstein et al., *One in Seven Adults in Immigrant Families Reported Avoiding Public Benefit Programs in 2018*, Urban Inst. (May 2019), https://www.urban.org/sites/default/files/publication/100270/one_in_seven_adults_in_immigrant_families_reported_avoiding_publi_2.pdf.
[29] *Id.*
[30] *Id.*

Children will lose health coverage—whether due to chilling effects or their households being directly targeted by this Regulation—to potentially disastrous effects.[31] A study found that disenrollment of children in need of medical care would likely contribute to child deaths and future disability.[32] Foregoing regular treatment for such children will likely lead to increased health care costs and disastrous outcomes.[33] For these vulnerable children, the loss of health coverage would be catastrophic.

Whether or not a parent has health care coverage profoundly affects the health and well-being of their children. Parents with coverage are more likely to have children enrolled in coverage, and parents who lose coverage are more likely to allow their children's coverage to lapse.[34] The benefits to providing insurance coverage to children are wide ranging, including improving children's access to

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[31] Michael Karpman & Genevieve M. Kenney, *Health Insurance Coverage for Children and Parents: Changes Between 2013 and 2017*, Urban Inst. (Sept. 7, 2017), http://hrms.urban.org/quicktakes/health-insurance-coveragechildrenparents-march-2017.html.

[32] Leah Zallman et al., *infra*.

[33] *Id*.

[34] Adam Searing & Donna Cohen Ross, *Medicaid Expansion Fills Gaps in Maternal Health Coverage Leading to Healthier Mothers and Babies*, Georgetown Univ. Health Policy Inst. (May 2019), https://ccf.georgetown.edu/wp-content/uploads/2019/05/Maternal-Health-3a.pdf; Julie L. Hudson & Asako S. Moriya, *Medicaid Expansion for Adults Had Measurable 'Welcome Mat' Effects On Their Children*, 36 Health Affairs 1643 (2017).

health and dental care, improving parental satisfaction, and saving money.[35] Increased access to health insurance such as Medicaid in early childhood leads to long-term health improvements such as a decline in prevalence of high blood pressure, reduced adult hospitalizations, reduction in self-reported rates of disability, and reduced mortality in teenage and adult years.[36] Access to health insurance during childhood also increases the likelihood of graduating from high school and attending college, as well as achieving a higher earning potential.[37]

Access to nutritious food is also fundamental to the healthy development of all children. SNAP is the largest federal nutrition program that helps recipients buy healthy food. Children in immigrant families that receive SNAP benefits are more likely to be in good or excellent health, be food secure, and reside in stable housing.[38]

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[35] Lisa Clemens et al., *How Well Is CHIP Addressing Oral Health Care Needs and Access for Children?*, 15 Academic Pediatrics 13 Suppl. (2015); Zhou J. Yu et al., *Associations Among Dental Insurance, Dental Visits, and Unmet Needs of US Children*, 148 Journal Am. Dental Assoc. 92 (2017); Glenn Flores et al., *The Health and Healthcare Impact of Providing Insurance Coverage to Uninsured Children: A Prospective Observational Study*, 17 BMC Public Health 553 (2017).

[36] Karina Wagnerman et al., *Medicaid Is A Smart Investment in Children*, Georgetown Univ. Health Policy Inst. (March 2017) https://ccf.georgetown.edu/wpcontent/uploads/2017/03/MedicaidSmartInvestment.pdf

[37] *Id.*

[38] Children's HealthWatch, *Report Card on Food Security & Immigration: Helping Our Youngest First-Generation Americans to Thrive* (Feb. 2018), http://childrenshealthwatch.org/wp-content/uploads/Report-Card-on-Food-Insecurity-and-Immigration-Helping-Our-Youngest-First-Generation-Americans-to-Thrive.pdf.

These families have more resources to afford medical care and prescription medications, compared to families who do not participate in SNAP.[39] Significantly, an additional year of SNAP eligibility for young children with immigrant parents is associated with significant health benefits in later childhood and adolescence.[40]

These results are not surprising: nutrition is one of the greatest environmental influences on fetal and infant development.[41] A healthy balance of essential nutrients during a child's formative periods is imperative for normal brain development.[42] Neuroscientists describe such formative periods as "critical periods" and "sensitive periods" to emphasize the vulnerability of a child's developing brain.[43] Nutrient deficiencies can have irreversible long-term consequences such as stunting sensori-motor, cognitive-language, and social-emotional functions.[44] Such failures to optimize brain development early in life have substantial and long-lasting ramifications. Studies have shown that children who do not meet certain

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[39] *Id.*

[40] Chloe N. East, *The Effect of Food Stamps on Children's Health: Evidence from Immigrants' Changing Eligibility,* Journal of Human Resources (Sept. 2018), http://www.chloeneast.com/uploads/8/9/9/7/8997263/east_fskids_r_r.pdf.

[41] Peter J. Morgane et al., *Effects of Prenatal Protein Malnutrition on the Hippocampal Formation*, 26 Neuroscience and Biobehavioral Rev. 471 (2002).

[42] Sarah E. Cusick & Michael K. Georgieff, *The Role of Nutrition in Brain Development: The Golden Opportunity of the "First 1000 Days"*, 175 Journal of Pediatrics 16 (2016).

[43] *Id.*

[44] *Id.*; *see also* Susan P. Walker et al., *Child Development: Risk Factors for Adverse Outcomes in Developing Countries*, 369 Lancet 145 (2007).

developmental milestones are less likely to remain and succeed in school, less likely to earn higher incomes as adults, and less likely to provide adequate nutrition and educational opportunities to their own children.[45]

Disincentivizing the use of SNAP or other public food security benefits by immigrant families will result in enduring damage to the health and development of all children in such families.[46] Such damage will be compounded over time as affected children have higher likelihoods of falling short of their full developmental potential, lower achievement in school, and having less professional career satisfaction.[47] Access to medical care and adequate nutrition allows early identification of issues before they become more difficult and costly to treat. The Regulation will restrict access to health and nutrition programs and directly result in irreparable health risks to children.

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[45] Anthony Lake, *Early Childhood Development – Global Action Is Overdue*, 378 Lancet 1277 (2011); Patrice L. Engle et al., *Strategies for Reducing Inequalities and Improving Developmental Outcomes for Young Children in Low-income and Middle-income Countries*, 378 Lancet 1339 (2011); Susan P. Walker et al., *Inequality in Early Childhood: Risk and Protective Factors for Early Child Development*, 378 Lancet 1325 (2011).

[46] Leah Zallman et al., *infra*.

[47] *Id.* at E5.

III. The Regulation Will Be A Barrier To Health Care For Pregnant And Postpartum Women.

In addition to its effect on children, the Regulation will negatively impact the ability of pregnant and postpartum women to obtain or maintain legal immigration status and will have a tragic effect on their health.

A. The Totality Of Circumstances Test Will Disproportionally Impact Pregnant And Postpartum Women.

Under the totality of circumstances test, women may be penalized for being pregnant or for having given birth. The Regulation explicitly mandates that a heavily-weighted negative factor is the immigrant's "health," including diagnosis of a medical condition requiring extensive medical treatment or interfering with care, school, or work."[48] If the individual does not have private health insurance, this is an additional heavily weighted negative factor.[49] If an individual has one or more heavily weighted negative factors, "DHS generally will not favorably exercise discretion to allow submission of a public charge [surety] bond."[50]

A woman who is pregnant or has recently given birth—especially a woman who has suffered serious pregnancy-related complications—who is also unable to afford private insurance to cover her birth or postpartum care will be penalized. Moreover, while the Regulation exempts receipt of Medicaid benefits for women

[48] 8 CFR § 212.22(b)(2).
[49] 8 CFR § 212.22(c)(1)(iii)(B).
[50] 8 CFR § 213.1(b).

who are pregnant and for 60 days postpartum as a factor in the public charge determination, Medicaid-eligible immigrants who utilize the program after the 60-day postpartum period, including immigrants who become eligible for coverage after meeting the "five year bar" would be given a "heavily weighted negative factor."[51] In many cases, this will include pregnant and postpartum women.

B. Pregnant And Postpartum Women Will Be Directly Harmed By The Regulation.

As with other vulnerable populations, the Regulation will reduce the use of social safety net programs by women who have recently experienced pregnancy. These barriers to accessing prenatal and postnatal care will have a drastic impact on the health of these women, their babies, and other family members. Regular prenatal care is proven to help prevent and detect serious pregnancy complications in mothers, including hypertension, infection, and anemia.[52] Not surprisingly, lack of adequate prenatal care contributes to higher rates of maternal mortality.[53]

Lack of prenatal care can have serious implications for children, affecting

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[51] 8 CFR § 212.22(c)(1).

[52] Jonas J. Swartz et al., *Expanding Prenatal Care to Unauthorized Immigrant Women and the Effect on Infant Health*, 130 Obstetrics & Gynecology 938 (2017).

[53] Emily E. Petersen et al., *Vital Signs: Pregnancy-Related Deaths, United States, 2011–2015, and Strategies for Prevention, 13 States*, 2013–2017, 68 MMWR Morbidity & Mortality Weekly Rep. 423 (May 10, 2019); *see also* Sarah Partridge et al., *Inadequate Prenatal Care Utilization and Risks of Infant Mortality and Poor Birth Outcome: A Retrospective Analysis of 28,729,765 U.S. Deliveries over 8 Years*, 29 Am. Journal of Perinatology 787 (2012).

their birth and early health outcomes.[54] Prenatal care is associated with decreased incidence of low birth weight and newborn death.[55] For example, researchers studying the expansion of the Emergency Medicaid Plus program in Oregon, which resulted in expanding access to prenatal care, found "a significant decrease in both the probability of extremely low birth weight infants and infant death with access to prenatal care."[56] The decrease in infant mortality associated with expanded access to prenatal care was so great that it measured "greater than the 30-year reduction in infant mortality from Sudden Infant Death Syndrome (SIDS) associated with the 'Back to Sleep' campaign."[57]

The United States has the highest rate of maternal deaths in the developed world and one of the highest rates of infant mortality.[58] These rates are even higher in low-income communities and among women of color.[59] The CDC has identified contributing factors to maternal mortality and strategies to prevent future pregnancy-

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[54] Megan M. Shellinger et al., *Improved Outcomes for Hispanic Women with Gestational Diabetes Using the Centering Pregnancy Group Prenatal Care Model*, 21 Maternal & Child Health Journal 297 (2016).
[55] *Id.*
[56] *Id.*
[57] *Id.* The "Back to Sleep" campaign was created to encourage parents to put their infants to sleep on their backs in order to reduce the rate of SIDS. Following the initiation of the "Back to Sleep" campaign in 1994, the number of infants dying from SIDS decreased by almost 50%. *See* Felicia L. Trachtenberg et al., *Risk Factor Changes for Sudden Infant Death Syndrome After Initiation of Back-To-Sleep Campaign*, 129 Pediatrics 630 (2012).
[58] Emily E. Petersen et al., *infra*.
[59] *Id.*

related deaths. These factors include community factors (*e.g.*, unstable housing, access to clinical care, and limited access to transportation) and system factors (*e.g.*, inadequate receipt of care and case coordination or management).[60]

Strategies to address community factors include "increasing availability and use of group prenatal care, prioritizing pregnant and postpartum women for temporary housing programs, improving availability of transportation services covered by Medicaid, improving access to healthy foods, and promoting healthy eating habits and weight management strategies."[61] Strategies to address system factors include "extend[ing] expanded Medicaid coverage eligibility for pregnant women to include one year of postpartum care."[62] Thus, even if immigrant women are not penalized for using Medicaid during their pregnancy and immediately after birth, they will be penalized for accessing these types of medical safety-net programs that are demonstrated to reduce maternal mortality.

Moreover, DHS trivializes the immense cost of inadequate prenatal care to society. Inadequate prenatal care is associated with an increased risk of preterm births. The medical costs for a preterm baby are much greater than for a healthy newborn.[63] Specifically, the economic burden associated with preterm birth in the

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[60] *Id.* at 428, Table 3.
[61] *Id.*
[62] *Id.*
[63] Institute of Medicine, *Preterm Birth: Causes, Consequences and Prevention* (Richard E. Behrman & Adrienne Stith Butler eds., 2007).

United States was at least $26.2 billion annually, or $51,600 per infant born preterm.[64] To put it in perspective, the average preterm/low birth weight hospitalization cost $15,100 with a 12.9 day length of stay, whereas, an uncomplicated newborn hospitalization cost $600 with a 1.9 day stay.[65]

Postpartum care is equally crucial to the health and well-being of mothers, newborns, and families. For example, foregoing postpartum care could result in women enduring postpartum depression without proper medical, social, and psychological care or skipping doctor's visits that address infant feeding, nutrition, and physical activity. [66] Other postpartum health issues, such as chronic disease management, could also remain unaddressed.[67]

The Regulation is highly likely to irreparably damage the health and well-being of immigrant pregnant and postpartum women, and the health and cognitive development of millions of infants and young children.

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[64] *Id.*

[65] Rebecca B. Russell et al., *Cost of Hospitalization for Preterm and Low Birth Weight Infants in the United States*, 120 Pediatrics E1 (2007).

[66] The Am. College of Obstetricians and Gynecologists, *Committee Opinion: Optimizing Postpartum Care* (May 2018), https://www.acog.org/-/media/Committee-Opinions/Committee-on-Obstetric-Practice/co736.pdf?dmc=1&ts=20191223T2132352470.

[67] *Id.*

IV. The Regulation Will Particularly Harm Individuals With Disabilities And Chronic Health Conditions.

The Regulation will directly harm the health of immigrants with disabilities, creating a strong incentive for these individuals to avoid accessing necessary health and other non-cash benefit programs and making it harder to successfully apply for a visa or permanent legal status.

A. The Totality Of Circumstances Test Will Disproportionally Impact Individuals With Disabilities.

Receipt of non-cash public benefits including Medicaid, inadequate private insurance, and a diagnosis with a medical condition that "will require extensive medical treatment" or "interfere with the individual's ability to support himself or herself" are all heavily weighted negative factors in the public charge determination.[68] As a result, this Regulation will have a devastating impact on the ability of immigrants with disabilities and chronic health conditions to obtain, adjust, or maintain legal residency in the United States.

B. Individuals With Disabilities Will Suffer Negative Consequences To Their Health And Well-Being.

The Regulation acts as a significant roadblock for immigrants with disabilities and their families to become and remain self-sufficient. Public benefit programs, including Medicaid, are essential to facilitate educational and employment opportunities for people with disabilities and chronic conditions. Medicaid covers

[68] 8 CFR § 212.22(c)(1).

primary care, preventative care, medical treatment, and supportive services for people with disabilities.[69] For many, Medicaid is the *only* source for critical community living supports such as personal care services, nursing services, respite, intensive mental health services and employment supports.

There is a strong link between Medicaid and the ability of individuals with disabilities to live independently. Medicaid is critical to help ensure that individuals with disabilities can attend school and work.[70] For example, more than 150,000 individuals with disabilities participate in Medicaid buy-in programs, which provide Medicaid coverage for those who participate in the labor force.[71] Medicaid buy-in participants earn more, work more, contribute more in taxes, and rely less on food stamps than people with disabilities who are not enrolled.[72] For individuals with intellectual or developmental disabilities, Medicaid provides supportive services to

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[69] Cong. Research Serv., *Who Pays For Long-Term Services and Supports?* (Aug. 22, 2018), https://fas.org/sgp/crs/misc/IF10343.pdf.

[70] Center on Budget & Policy Priorities, *Medicaid Works for People with Disabilities* (Aug. 29, 2017), https://www.cbpp.org/research/health/medicaid-works-for-people-with-disabilities.

[71] Brigitte Gavin & Marci McCoy-Roth, *Review of Studies Regarding the Medicaid Buy-In Program*, Boston Univ., Sargent College, Center for Psychiatric Rehabilitation, (2011), http://www.bu.edu/drrk/research-syntheses/psychiatric-disabilities/medicaid-buy-in/); Social Security Admin., Continued Medicaid Eligibility (§ 1619(B)), https://www.ssa.gov/disabilityresearch/wi/1619b.htm; Medicaid and CHIP Payment and Access Comm'n., Promoting Continuity of Medicaid Coverage among Adults under Age 65 (Mar. 2014), https://www.macpac.gov/publication/ch-2-promoting-continuity-of-medicaid-coverage-among-adults-under-age-65/.

[72] Brigitte Gavin & Marci McCoy-Roth, *infra*.

facilitate employment.[73] The role of Medicaid in supporting individuals with disabilities so that they can remain productive members of their community cannot be understated.

The number of individuals who will be irreparably harmed by the Regulation is significant and includes both children and adults. Rates of children diagnosed with a disability have increased, including children with neurodevelopmental conditions.[74] Health conditions correlated with childhood disabilities range from autism spectrum disorder to cerebral palsy to juvenile idiopathic arthritis.[75] Habilitation and rehabilitation therapies are crucial to help children with disabilities attain developmentally appropriate functional skills and provide adaptive strategies to lessen impacts of functional deficits.[76] These therapies play a significant role in improving the health and well-being of children with disabilities.[77]

Approximately one-third of working-age adults enrolled in Medicaid have a

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[73] Department of Health and Human Services, Centers for Medicare and Medicaid Services, *Updates to the §1915(c) Waiver Instructions and Technical Guide Regarding Employment and Employment Related Services* (Sept. 16, 2011), https://downloads.cms.gov/cmsgov/archived-downloads/CMCSBulletins/downloads/CIB-9-16-11.pdf (discussing the use of waiver supports to increase employment opportunities for individuals with disabilities).

[74] Amy Houtrow et al., *Prescribing Physical, Occupational, and Speech Therapy Services for Children with Disabilities*, 143 Pediatrics e20190285 (2019).

[75] *Id.*

[76] *Id.*

[77] *Id.*

disability.[78] In 2015 people with disabilities made up 26% of SNAP participants.[79] Blocking or disincentivizing access to medical and nutrition benefits will result in worse medical outcomes and food insecurity for this already vulnerable population.

CONCLUSION

The Regulation dramatically increases the likelihood that lawfully present immigrants and their families will forgo health and nutrition benefits to avoid negatively impacting their immigration status. The health and well-being of vulnerable children, pregnant and postpartum women, and individuals with disabilities will be most severely threatened.

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[78] *See, e.g.*, Nationwide Adult Medicaid CAHPS, *Health Care Experiences of Adults with Disabilities Enrolled in Medicaid Only: Findings from a 2014-2015 Nationwide Survey of Medicaid Beneficiaries* (2016), https://www.medicaid.gov/medicaid/quality-of-care/downloads/performance-measurement/namcahpsdisabilitybrief.pdf.

[79] Steven Carlson et al., *SNAP Provides Needed Food Assistance to Millions of People with Disabilities*, Center for Budget and Policy Priorities (2017), https://www.cbpp.org/research/food-assistance/snap-provides-needed-food-assistance-to-millions-of-people-with.

On behalf of their patients, members, and the communities they serve, *Amici* urge this Court to affirm district court's order granting preliminary injunction.

Respectfully submitted,

January 31, 2020

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CERTIFICATE OF COMPLIANCE

Pursuant to Federal Rule of Appellate Procedure 32(g), the undersigned counsel for *amici curiae* certifies that this brief:

(i) complies with the type-volume limitation of Second Circuit Rules of Appellate Procedure 29 because it contains 5,976 words, including footnotes and excluding the parts of the brief exempted by Federal Rule of Appellate Procedure 32(f); and

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By: */s/ Maureen P. Alger*

CERTIFICATE OF SERVICE

I hereby certify that on January 31, 2020, I electronically filed the foregoing with the Clerk of the Court for the United States Court of Appeals for the Second Circuit using the Court's CM/ECF system. I certify that all participants in the case are registered CM/ECF users and that service will be accomplished by the CM/ECF system.

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