UNITED STATES COURT OF APPEALS FOR THE SECOND CIRCUIT

Thurgood Marshall U.S. Courthouse 40 Foley Square, New York, NY 10007 Telephone: 212-857-8500

MOTION INFORMATION STATEMENT

Docket Number(s): 19-3591

Caption [use short title]

State of New York et al v. US Dept. of Homeland

Motion for: Leave to file Amicus Curiae Brief

Set forth below precise, complete statement of relief sought:

Amici's motion for leave to file brief in support of Plaintiff-Appellees and Affirmance

MOVING PARTY: Amici

OPPOSING PARTY: ______

☐ Plaintiff ☐ Defendant

☐ Appellant/Petitioner ☐ Appellee/Respondent

MOVING ATTORNEY: Phillip A. Escoriaza

OPPOSING ATTORNEY: ______

[name of attorney, with firm, address, phone number and e-mail]

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1129 20th St. N.W. Suite 400
Washington, DC 20036

Court- Judge/ Agency appealed from: USDC Southern District of New York (Hon. George B. Daniels)

Please check appropriate boxes:

Has movant notified opposing counsel (required by Local Rule 27.1):
☑ Yes ☐ No (explain): ______

Opposing counsel's position on motion:
☑ Unopposed ☐ Opposed ☐ Don't Know

Does opposing counsel intend to file a response:
☐ Yes ☐ No ☑ Don't Know

FOR EMERGENCY MOTIONS, MOTIONS FOR STAYS AND INJUCTIONS PENDING APPEAL:

Has this request for relief been made below? ☐ Yes ☐ No

Has this relief been previously sought in this court? ☐ Yes ☐ No

Requested return date and explanation of emergency: ______

Is oral argument on motion requested? ☐ Yes ☑ No (requests for oral argument will not necessarily be granted)

Has argument date of appeal been set? ☐ Yes ☑ No If yes, enter date: ______

Signature of Moving Attorney:

/s/Phillip A. Escoriaza **Date:** 2/6/2020 Service by: ☑ CM/ECF ☐ Other [Attach proof of service]

ORAL ARGUMENT NOT YET SCHEDULED

No. 19-3591

IN THE UNITED STATES COURT OF APPEALS
FOR THE SECOND CIRCUIT

STATE OF NEW YORK, STATE OF CONNECTICUT,
AND STATE OF VERMONT
Plaintiffs-Appellees

v.

UNITED STATES DEPARTMENT OF HOMELAND SECURITY,
CHAD F. WOLF, in his official capacity as Acting Secretary of Homeland Security, UNITED STATES CITIZENSHIP AND IMMIGRATION SERVICES, KENNETH T. CUCCINELLI, in his official capacity as Acting Director of USCIS, and UNITED STATES OF AMERICA
Defendants-Appellants

ON APPEAL FROM THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF NEW YORK

MOTION OF 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
FOR LEAVE TO FILE AMICUS CURIAE BRIEF IN SUPPORT OF PLAINTIFFS-APPELLEES AND AFFIRMANCE

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MOTION FOR LEAVE TO FILE AMICUS CURIAE BRIEF IN SUPPORT OF PLAINTIFFS-APPELLEES AND AFFIRMANCE

PLEASE TAKE NOTICE that certain deans of schools of public health, public policy, and nursing, as well as academic chairs and faculty researchers (the "Deans, Chairs, and Scholars"); (ii) the American Public Health Association ("APHA"); (iii) the American Academy of Nursing (the "Academy"); and (iv) Public Health Solutions ("PHS") (collectively "*Amici*") request leave to file the accompanying *amicus* brief in support of Plaintiffs. A full list of the Deans, Chairs, and Scholars is attached as Exhibit 1. In support of their motion, *amici* state as follows:

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.

The APHA, an organization of nearly 25,000 public health professionals, supports policies and programs that increase and improve access to health, nutrition, and housing services for the nation's most vulnerable populations, and shares the latest research and information, promotes best practices, and advocates for evidence-based public health policies.

The Academy serves the public and the nursing profession by advancing health policy, practice, and science through organizational excellence and effective nursing leadership. The Academy's 2,800 Fellows are nursing's most accomplished leaders in education, management, practice, research, and policy. They have been recognized for their extraordinary contributions to nursing and healthcare.

PHS, first established in 1957, is the largest public health nonprofit organization in New York City and annually serves over 105,000 clients who rely on PHS to access food and nutrition benefits, health insurance, maternal and child health services, reproductive and sexual health care, among other health and social services. PHS delivers services with a strong focus on reducing health disparities to ensure all New York City families live their healthiest lives and reach their full potential.

INTEREST OF *AMICI* AND REASONS WHY THE MOTION SHOULD BE GRANTED

Amici seek to inform the Court about the public health impact of the "Public Charge" Rule and believe this case provides an appropriate vehicle for the Court to find that Defendants' approval of the Rule and their intention to implement the Rule are contrary to federal law and detrimental to public health.

Pursuant to Rule 29 of the Federal Rules of Appellate Procedure, an amicus curiae may file a brief only by leave of court or if the brief states that all parties have consented to its filing. Plaintiffs and defendants have indicated that they consent to the filing of this brief. For the foregoing reasons, *amici* request that the Court grant leave to file the attached *amicus* brief.

CONCLUSION

For the foregoing reasons, *amici's* motion for leave to file the attached *amicus* brief should be granted.

DATED: January 31, 2020

Respectfully submitted,

/s/ Phillip A. Escoriaza

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EXHIBIT 1

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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.

CERTIFICATE OF SERVICE

I hereby certify that on January 31, 2020, I caused the foregoing document to be served on the parties' counsel of record electronically by means of the Court's CM/ECF system.

/s/ Phillip A. Escoriaza

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CERTIFICATE AS TO PARTIES, RULINGS, AND RELATED CASES

All parties appearing before the District Court and this Court are listed in the Brief for Appellants (Document 129, Dec. 13, 2019) at 9 and all references to the ruling at issue appear therein. This case was previously before this Court on Appellants' Motion for a Stay Pending Appeal, which this Court denied (Document 162, Jan. 8, 2020). Substantially similar issues appear in *Make the Road New York, et al. v. Cuccinelli*, *et al.*, No. 19-3595, which is pending before this Court.

CORPORATE DISCLOSURE STATEMENT[1]

Pursuant to Rule 26.1 of the Federal Rules of Appellate Procedure, *amici curiae* submit the following corporate disclosure statement:

Amici deans, chairs and scholars are individuals and, as such, do not have a parent company and no publicly held company has a ten percent or greater ownership interest in any said *amici*. *Amici* American Public Health Association, American Academy of Nursing and Public Health Solutions do not have a parent

[1] Pursuant to Rule 29(a)(4)(E) of the Federal Rules of Appellate Procedure and Local Rule 29.1 of the Second Circuit, *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.

company and no publicly held company has a ten percent or greater ownership interest in them.

STATEMENT OF CONSENT AND SEPARATE BRIEFING

Pursuant to Rule 29(a)(2) of the Federal Rules of Appellate Procedure and Local Rule 29.1 of the Second Circuit, 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 ("PHS") certify 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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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. *See* Inadmissibility on Public Charge Grounds, 84 Fed. Reg 41,292 (Aug.14, 2019). 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 the 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 the 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 over time of people with Medicaid coverage. The literature underscores that churn has a major impact on *any* coverage and on the *continuity* of coverage. Any coverage of course is better than no coverage, but the lack of continuous coverage over time, which is 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 providing hospital care to children 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 L. 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 et seq.:

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 reenroll.
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 on the law an utterly different regulatory vision for the program 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 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. This in turn 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 Rule makes an immigrant'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 that offers 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 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 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). There is no justification to implement a Rule so lacking in foresight particularly when on January 30, 2020, the World Health Organization declared a Public Health Emergency of International Concern, and the U.S. along with the global community addresses the outbreak of Novel Coronavirus 2019. *See* World Health Organization, *Statement on the Second Meeting of the International Health Regulations (2005) Emergency Committee Regarding the Outbreak of Novel Coronavirus (2019-nCoV)* (Jan. 30, 2020); *see also* Alex M. Azar II, Secretary of

Health and Human Services, *Determination that a Public Health Emergency Exists*, U.S. Dept. of Health and Human Services (Jan. 31, 2020) (declaring, pursuant to § 319 of the Public Health Service Act, 42 U.S.C. § 247d, that a public health emergency has existed since Jan. 27, 2020 as a result of confirmed cases of 2019 Novel Coronavirus).

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 again 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.

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 31, 2020

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CERTIFICATE OF SERVICE

I HEREBY CERTIFY that on this 31st 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").

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CERTIFICATE OF COMPLIANCE

Pursuant to Rules 29(a)(5), 32(a)(7)(B) and 32(g)(1) of the Federal Rules of Appellate Procedure and Second Circuit Local Rules 29.1(c) and 32.1(a)(4), 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 3,645 words, complies with the type-volume limitation.

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