UNITED STATES COURT OF APPEALS
SECOND CIRCUIT

STATE OF NEW YORK, et al.,

Plaintiffs-Appellees,

v.

No. 20-2537

UNITED STATES DEPARTMENT OF HOMELAND SECURITY, et al.,

Defendants-Appellants.

MEMORANDUM OF LAW IN OPPOSITION TO APPELLANTS' EMERGENCY MOTION FOR A STAY PENDING APPEAL AND REQUEST FOR IMMEDIATE ADMINISTRATIVE STAY

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Dated: August 17, 2020

TABLE OF CONTENTS

Page

Page

TABLE OF AUTHORITIES

Cases **Page(s)**

Statutes

Regulations **Page(s)**

Federal

State

Rules

Miscellaneous Authorities

Miscellaneous Authorities **Page(s)**

Miscellaneous Authorities **Page(s)**

PRELIMINARY STATEMENT

Defendants ask this Court to stay a preliminary injunction issued by the United States District Court for the Southern District of New York (Daniels, J.) that temporarily halted implementation of the Public Charge Rule during the national emergency concerning coronavirus disease 2019 (COVID-19). This Court should deny the motion given both its recent conclusion that the Public Charge Rule is unlawful, and the district court's careful factual findings about the Rule's COVID-19-specific harms that warrant suspending the rule during the current public health crisis.

The time-limited preliminary injunction that defendants seek to stay is the second one issued by the district court to suspend the Rule. This Court recently affirmed the first preliminary injunction, as modified to apply to plaintiffs' jurisdictions, based on its determination that the Rule was invalid under the Administrative Procedure Act. Although the Supreme Court stayed the first injunction in January 2020, it later clarified that its stay did not preclude plaintiffs from requesting relief from the Rule based on the COVID-19 crisis, which began after the Court's stay issued.

As the district court properly found, that crisis has reinforced the urgent need to halt the Rule and lift its unlawful impediments to immigrants' access to essential healthcare and economic benefits. The novel coronavirus has triggered a devastating pandemic that has now afflicted more than five million people in the United States with a potentially lethal illness. The rapid and ongoing spread of COVID-19 has not only caused a public-health crisis—it has also wreaked havoc on the economy. But the Rule interferes with efforts to respond effectively to this crisis.

Under these circumstances, there is no basis to stay the district court's time-bound injunction. This Court has already held that the Rule is likely unlawful and is causing irreparable harms to plaintiffs, and that the balance of the equities and the public interest warrant temporarily halting the Rule. The pandemic has made the equities in favor of a preliminary injunction even more compelling given the district court's findings about the public-health and economic harms that the Rule is inflicting on plaintiffs and their residents during the crisis. As the district court found, based on the unrebutted evidence, the Rule hinders plaintiffs' efforts to mitigate COVID-19's spread and the pandemic's economic

fallout, to the detriment of citizens and noncitizens alike. By deterring immigrants from accessing publicly funded healthcare, the Rule makes it more likely that immigrants will suffer serious illness if infected and spread the virus inadvertently to others—risks that are heightened because immigrants constitute a large proportion of the essential workers who interact regularly with the public. And the Rule deters immigrants from accessing supplemental benefits, including nutrition benefits, that are critical for both immigrants and plaintiffs' jurisdictions as a whole to weather the economic crisis.

The Supreme Court's previously issued stay does not alter the analysis given that this Court has already held, after the Supreme Court issued its stay, that the Rule is unlawful and that the balance of the equities and the public interest warrant preliminarily halting the Rule. In any event, whatever import the Supreme Court's stay might have had when it originally issued, such meaning has become inapposite given the overwhelming impact of the new harms caused by the Rule during the pandemic. Those harms decisively support the new injunction, and the Court should accordingly deny defendants' motion for a stay pending appeal.

BACKGROUND

A. The First Preliminary Injunction

The Public Charge Rule modified criteria used by the Department of Homeland Security (DHS) for determining inadmissibility on public charge grounds. 84 Fed. Reg. 41,292 (Aug. 14, 2019). The Rule requires DHS officials to deem an immigrant to be a "public charge" if the immigrant is ever likely to receive any amount of certain "public benefits," including supplemental benefits such as Medicaid, Supplemental Nutrition Assistance Program (SNAP) benefits, and Section 8 housing assistance, during "more than 12 months in the aggregate within any 36-month period." *Id.* at 41,501.

In October 2019, the district court entered its first preliminary injunction, finding the Rule likely invalid under the APA and halting its implementation nationwide.[1] This Court denied defendants' request to stay the first injunction pending appeal. On January 27, 2020, the Supreme Court issued a stay pending the timely filing of a petition for

[1] The district court entered a preliminary injunction in plaintiffs' lawsuit and in a separate lawsuit brought by private organizations. The two lawsuits have since been consolidated.

certiorari and the Supreme Court's resolution of such petition. *Department of Homeland Sec. v. New York*, 140 S. Ct. 599 (2020) (mem.).[2] In reliance on the Supreme Court's stay, defendants began enforcing the Rule on February 24, 2020.

On August 4, 2020, this Court affirmed the district court's first preliminary injunction, as modified to apply only to the plaintiff States' jurisdictions. *New York v. United States Dep't of Homeland Sec.*, No. 19-3591, 2020 WL 4457951, at *30-32 (2d Cir. 2020). The Court held that plaintiffs are likely to succeed on the merits of their claims that the Rule is contrary to the INA and arbitrary and capricious. The Court further held that the equities and public interest weighed in favor of a preliminary injunction, particularly in light of defendants' acknowledgment that the Rule will likely result in "[i]ncreased rates of poverty and housing instability" and "[w]orse health outcomes"—including "[i]ncreased prevalence of communicable diseases." *Id.* at *31. The Rule was

[2] In February 2020, the Supreme Court stayed a preliminary injunction issued by the United States District Court for the Northern District of Illinois that had prevented enforcement of the Rule in Illinois. *Wolf v. Cook Cty., Ill.*, 140 S. Ct. 681, 681 (2020) (Ginsburg, Breyer, Sotomayor, and Kagan, JJ., dissenting).

nevertheless in effect, pursuant to the Supreme Court's stay of the first injunction.

B. The National Emergency Concerning COVID-19

While this Court was considering the first injunction, and shortly after the Supreme Court issued its stay of that injunction, COVID-19 began sweeping across the United States. The spread of COVID-19 has become a severe pandemic that has thrown the country into an unprecedented crisis with devastating consequences for public health and the economy.

COVID-19 has already exacted a staggering toll on plaintiffs and their residents, and the rapid pace of its spread continues. The novel coronavirus can cause life-threatening respiratory illness marked by fever, coughing, and difficulty breathing. Centers for Disease Control & Prevention (CDC), *Coronavirus Disease 2019 (COVID-19): Symptoms* (last updated May 13, 2020) (internet). In the United States, more than five million individuals have confirmed cases of COVID-19, and at least 168,696 people have died from the disease. CDC, *Coronavirus Disease 2019 (COVID-19): Cases, Data & Surveillance: Cases & Deaths in the US* (last updated Aug. 16, 2020) (internet). Plaintiffs and their residents

have been particularly hard hit. In New York, for example, the virus has infected at least 425,508 people and killed at least 25,250 people. New York Dep't of Health, *NYSDOH COVID-19 Tracker* (last updated Aug. 16, 2020) (internet); New York Dep't of Health, *Fatalities by County* (last updated Aug. 16, 2020) (internet).[3]

On March 13, 2020, the President declared a state of national emergency concerning the COVID-19 outbreak, invoking his authority under the National Emergencies Act. Proclamation No. 9994, 85 Fed. Reg. 15,337 (Mar. 13, 2020); *see* 50 U.S.C. § 1601 et seq. The governors of each of the plaintiff States, and the mayor of plaintiff New York City, declared public-health emergencies in their respective jurisdictions based on the COVID-19 pandemic. New York Exec. Order No. 202, 9 N.Y.C.R.R. § 8.202 (2020); Connecticut Office of the Governor, Declaration of Public Health and Civil Preparedness Emergencies (Mar. 10, 2020); Vermont Exec. Order No. 01-20 (2020). In plaintiffs' jurisdictions, state officials and agencies took drastic measures to slow COVID-19's spread, such as requiring all nonessential employees to work from home,

[3] *See* State of Connecticut, *COVID-19 Update August 14, 2020*, at 1 (Aug. 14, 2020) (internet) (50,897 COVID-19 cases in Connecticut).

closing some businesses, and imposing social-distancing and mask requirements on other businesses.

Although some nonessential businesses have begun to reopen in plaintiffs' jurisdictions, and although extraordinary efforts have reduced the numbers of deaths and cases that plaintiffs were previously suffering, the ongoing pandemic continues to impose enormous public health and economic consequences for plaintiffs and their residents. For example, many businesses remain shuttered, and those that have begun to reopen remain subject to stringent health and safety restrictions. *See, e.g.*, *Reopening New York*: *Curbside and In-Store Pickup Retail Guidelines for Employers and Employees* (internet) (mandating physical distancing, reduced capacity, protective equipment, and disinfection protocols). The next few months will also pose unique challenges as school administrators throughout plaintiffs' jurisdictions consider whether and how to reopen schools. *Gov. Cuomo Expresses Concerns About NYC's School Reopening Plan, Says Key Safety Questions Left Unanswered*, CBS New York (Aug. 3, 2020) (internet). And dangerously high rates of infection in more than thirty other States continue to pose risks to plaintiffs, particularly given the practical difficulties in enforcing mandatory quarantine orders for

each traveler arriving from these States. *See* New York Dep't of Health, *COVID-19 Travel Advisory* (last visited Aug. 10, 2020) (internet); Luis Ferré-Sadurní & Nate Schweber, *New York Confronts Second-Wave Risk: Visitors From Florida and Texas*, N.Y. Times (July 20, 2020) (internet).

The risk of another spike in infections in plaintiffs' jurisdictions thus remains high—as outbreaks throughout the country demonstrate. Julie Bosman et al., *After Plummeting, the Virus Soars Back in the Midwest*, N.Y. Times (Aug. 4, 2020) (internet). It is thus critically important for plaintiffs to maintain their COVID-19 policies and continue encouraging their residents to access healthcare and other public benefits that are essential to preventing or mitigating the harms posed by COVID-19.

C. Plaintiffs' Motion to Modify or Clarify the Supreme Court's Stay of the First Preliminary Injunction

In April 2020, plaintiffs filed a motion asking the Supreme Court to temporarily lift or modify its stay, or to clarify that the stay did not preclude plaintiffs from seeking new relief from the district court due to the COVID-19 outbreak. The Supreme Court denied the motion to temporarily lift or modify the stay, but stated that "[t]his order does not preclude a filing in the District Court as counsel considers appropriate."

Department of Homeland Sec. v. New York, No. 19A785, 2020 WL 1969276 (Apr. 24, 2020) (mem.).

D. The Second Preliminary Injunction

Plaintiffs accordingly returned to the district court and sought a second, time-limited preliminary injunction against further implementation of the Rule during the COVID-19 national emergency declared by the President. Plaintiffs submitted extensive evidence—never rebutted by defendants—demonstrating that the Rule is severely impeding efforts to mitigate the dire health and economic harms that the pandemic is inflicting on plaintiffs and the public.

Based on this new evidence, the district court issued a second preliminary injunction halting implementation of the Rule nationwide during the COVID-19 national emergency. (Mem. Decision & Order ("Op.") at 19-21 (S.D.N.Y. July 29, 2020).)

First, the district court rejected defendants' arguments against its jurisdiction to issue a new injunction. As the court explained, "a new, narrowly tailored" injunction based on "new, materially different evidence" did not disturb the first injunction and thus did not interfere with the issues that were then being reviewed in defendants' appeal from

the first injunction. (Op. 20.) The court also stated that, in the alternative, its order would constitute an indicative ruling stating that it would grant the preliminary injunction if this Court were to determine that the court had lacked jurisdiction to grant relief and remanded to the district court to issue a ruling. (Op. 18-19.) *See* Fed. R. Civ. P. 62.1(a).

Second, the court adhered to its prior conclusion, subsequently affirmed by this Court, that plaintiffs are likely to succeed on the merits of their claims that the Rule is unlawful and arbitrary and capricious. (Op. 22.)

Third, the court found that the balance of harms and public interest weighed heavily in favor of preliminarily halting the Rule during the national COVID-19 emergency. (Op. 22-29.) The court found that the Rule is deterring immigrants and their family members from using publicly funded healthcare, seeking testing and treatment for COVID-19, or obtaining treatment for other medical conditions that increase the risk of severe symptoms from COVID-19. These deterrent effects, the court determined, impede efforts to mitigate the disease's spread and increase the risk of infection for all of plaintiffs' residents. The court found that the Rule was also causing many immigrants to forebear from temporarily

using supplemental benefits to weather the economic crisis triggered by COVID-19. And the court concluded that defendants' general interest in implementing the Rule "fails to measure up to the gravity of this global pandemic that continues to threaten the lives and economic well-being" of plaintiffs' residents. (Op. 28.)

On August 12, 2020, Judge Hall issued an administrative stay limiting the second injunction's application to plaintiffs' jurisdictions; accordingly, the Rule remains temporarily halted in New York, Connecticut, and Vermont.

REASONS TO DENY THE MOTION

Because a stay intrudes on "the ordinary processes of administration and judicial review," the party seeking a stay bears the burden of justifying such extraordinary relief. *Nken v. Holder*, 556 U.S. 418, 427 (2009) (quotation marks omitted). The Court considers the likelihood of success of the applicant's arguments, the harm to each side and to the public, and the balance of the equities. *In re World Trade Ctr. Disaster Site Litig.*, 503 F.3d 167, 170 (2d Cir. 2007). Each factor weighs heavily against a stay here.

A. Defendants Have No Likelihood of Success on the Merits.

The Court should deny defendants' motion because they are unlikely to succeed on the merits of their appeal. *See Nken*, 556 U.S. at 426.

1. This Court has already rejected defendants' merits arguments.

Defendants have no likelihood of success on the merits of their appeal from the second preliminary injunction because this Court has already determined that the Rule is likely contrary to law and arbitrary and capricious. *New York*, 2020 WL 4457951, at *13-29. This Court already held based on a record compiled before the COVID-19 crisis that

the balance of the equities and public interest supported halting the Rule. *Id.* at *30-31. Under that binding decision, defendants have no chance of success on the merits.

Defendants misplace their reliance (Emergency Mot. for a Stay ("Mot.") 11-15) on the Supreme Court's previously issued stay of the district court's first injunction. The Supreme Court's stay—issued after truncated briefing on an expedited schedule and without oral argument—cannot plausibly be interpreted as a definitive adjudication on the merits; indeed, the stay says nothing about the merits. And this Court has already necessarily rejected defendants' arguments about the import of the stay by holding, after the stay had issued, that the Rule is likely unlawful. Other circuits' decisions about the Rule (Mot. 14-15) are likewise inapposite because this Court's ruling that the Rule is likely unlawful is controlling law in this circuit.

2. The district court had jurisdiction to issue a new preliminary injunction based on new facts.

Defendants also challenge the district court's jurisdiction to issue a new injunction (Mot. 10-11), but their arguments are incorrect—and now immaterial.

The district court properly found that it had jurisdiction to issue a new, time-limited preliminary injunction based on newly arising facts notwithstanding the appeal that was then awaiting this Court's resolution. An interlocutory appeal "only divests the district court of jurisdiction respecting the questions raised and decided in the order" on appeal. *New York State Nat'l Org. for Women v. Terry*, 886 F.2d 1339, 1350 (2d Cir. 1989) (citations omitted). Here, however, defendants' appeal from the first preliminary injunction did not address the unique harms posed by the COVID-19 crisis. And in issuing its second preliminary injunction, the district court appropriately did not issue any new ruling on the legal arguments that this Court was considering. Instead, the court focused entirely on new facts concerning the pandemic's impacts, which were not—and could not have been—before this Court during the prior appeal or before the Supreme Court when it stayed the first injunction. (Op. 20-22.) *See Webb v. GAF Corp.*, 78 F.3d 53, 55 (2d Cir.

1996); *International Ass'n of Machinists & Aerospace Workers, AFL-CIO v. Eastern Air Lines, Inc.*, 847 F.2d 1014, 1019 (2d Cir. 1988).

More fundamentally, whatever concerns might have previously existed about the risk of improper intrusion on this Court's adjudication of the then-pending appeal, those concerns are now obsolete given that this Court has upheld the earlier injunction and endorsed its legal conclusions and balance of the equities. The divesture rule is judicially crafted and "its application is guided by concerns of efficiency." *United States v. Rogers*, 101 F.3d 247, 251 (2d Cir. 1996). The congruence between this Court's decision affirming the first injunction and the district court's second injunction disposes of any such concerns here. Reversing the second injunction and remanding the case on divesture grounds would simply waste judicial resources given this Court's recent decision.

Finally, even if this Court were to determine that the prior appeal divested the district court of jurisdiction to issue the second injunction, the district court's alternative issuance of an indicative ruling provides a straightforward remedy for any jurisdictional defect: this Court can simply remand so that the district may reissue its second injunction. Fed. R. App. P. 12.1(b).

B. The Balance of Harms and the Public Interest Tip Decisively Against a Stay.

The Court should also deny defendants' motion because the balance of the equities and the public interest amply support the district court's time-limited injunction and weigh heavily against a stay. As the district court found, implementation of the Rule during the ongoing COVID-19 crisis will cause harms to public health and economic welfare by interfering with plaintiffs' attempts to respond to the pandemic and imposing additional, unnecessary burdens on top of the crushing costs from COVID-19.

1. The Public Charge Rule is irreparably harming plaintiffs and the public during the pandemic.

a. The Rule is impeding efforts to mitigate the spread of the virus.

The district court correctly found that the Rule is irreparably harming public health in plaintiffs' jurisdictions during the unprecedented public-health disaster caused by the pandemic. Plaintiffs' unrebutted evidence demonstrated that the Rule is deterring immigrants and their family members from obtaining publicly funded health insurance and medical care, thereby undermining efforts to slow the spread of the virus—putting everyone at higher risk of infection. A stay would

improperly allow these public-health harms to continue while defendants pursue an appeal with no chance of success.

As this Court has recognized and DHS has acknowledged, the Rule's expanded criteria for finding inadmissibility will deter immigrants and their family members from obtaining (or maintaining) Medicaid or other publicly funded health coverage, for fear that using such benefits will jeopardize their ability to obtain lawful permanent resident status. *New York*, 2020 WL 4457951, at *9; 84 Fed. Reg. at 41,422. Indeed, since the Rule took effect, "[d]octors and other medical personnel, state and local officials, and staff at nonprofit organizations have all witnessed immigrants refusing to enroll in Medicaid or other publicly funded healthcare coverage" based on concerns that receiving such coverage "will increase their risk of being labeled a 'public charge'" under the Rule. (Op. 23; *see* Addendum (Add.) 64-65, 71, 80, 194-195.)

As the record established, such avoidance of Medicaid and other publicly funded healthcare programs prevents immigrants from receiving testing or treatment for COVID-19, "which in turn impedes public efforts in [plaintiffs'] jurisdictions to stem the spread of the disease." (Op. 23.) Patients who lack health insurance are less likely to obtain necessary

treatment for COVID-19 because of the prohibitive costs of such care. (Add. 74-75, 78-81, 198.) Dan Witters, *In U.S., 14% With Likely COVID-19 to Avoid Care Due to Cost*, Gallup News (Apr. 28, 2020) (internet). And as the district court emphasized, doctors and others working on the front lines of the crisis have seen many immigrants avoid COVID-19 testing and treatment even if they might be able to obtain publicly funded care, due to fear generated by the Rule. (Op. 23; Add. 23, 132-133, 139-140, 156, 163-164, 174-175, 186-187.)

The district court also properly found that the Rule's deterrent effect jeopardizes the health and safety of not only immigrants and their families but also the public. Without proper testing and treatment, immigrants who become infected are more likely to suffer severe illness or death from the virus, and more likely to spread the virus to other people inadvertently. (Add. 24, 69, 75-76, 81-84.)

As the district court further found, the Rule "is particularly dangerous during a pandemic" because "[i]mmigrants make up a substantial portion" of essential workers, such as home health aides, food delivery workers, and building cleaners, who "have continued to work throughout the national emergency and interact with large swaths of the

population." (Op. 24.) By making immigrant workers "fearful of receiving medical care for a deadly, contagious disease," the Rule is jeopardizing "the health and security of communities" throughout plaintiffs' jurisdictions. (Op. 24-25.)

b. The Public Charge Rule deters access to public benefits that are necessary to respond to the severe economic crisis caused by COVID-19.

As the district court further found, the Rule is also irreparably injuring plaintiffs and the public by deterring immigrants from using supplemental benefits to mitigate the vast economic consequences of the pandemic. (Op. 26.) These irreparable harms further tilt the balance of the equities and the public interest against a stay.

The COVID-19 pandemic has triggered a severe and ongoing economic crisis, with millions of workers losing significant income or their employment. (Add. 83-85.) In July, approximately 16.3 million individuals were unemployed in the United States—an increase of 10.6 million people since February. United States Dep't of Labor, Bureau of Labor Statistics, *Economic News Release: Employment Situation Summary* (Aug. 7, 2020) (internet). Unemployment has also risen steeply in plaintiffs' jurisdictions due to the pandemic. In New York City, for

example, the unemployment rate rose to 20% in June 2020. New York State Dep't of Labor, *State Labor Department Releases Preliminary June 2020 Area Unemployment Rates* (July 21, 2020) (internet); *see* Rich Scinto, *CT Unemployment Rate Around 17 Percent: DOL*, Patch (July 19, 2020) (internet).

The evidence submitted below established that supplemental benefits like Medicaid and SNAP are crucial to helping employed or employable individuals—who are not plausibly public charges, *New York*, 2020 WL 4457951, at *21-24—through an emergency like receiving a pay cut, losing a job, or incurring medical bills for COVID-19 treatment. (Add. 84-85, 140, 158.) As this Court observed, Congress made supplemental benefits programs available "to a broad swath of low- and moderate-income Americans, including those who are productively employed," to assist them in maintaining or achieving higher standards of living. *New York*, 2020 WL 4457951, at *29. By providing such short-term assistance to individuals affected by the pandemic, supplemental benefits promote economic stability and recovery for all of plaintiffs' residents.

But the Rule is deterring immigrants and their families from using supplemental benefits to maintain health and nutrition during the crisis.

(Add. 23, 133, 154-155.) As the district court found, many hard-working immigrants, "who otherwise would not be classified as public charges under any reasonable definition, are experiencing substantial financial burdens" because of the pandemic. (Op. 26.) Yet since the Rule went into effect, immigrants have increasingly been declining to participate in SNAP or other publicly funded nutrition programs due to fear that doing so will jeopardize their immigration status. (Add. 71, 155.)

Immigrants' avoidance of supplemental benefits has already resulted in worse harms to both immigrants and plaintiffs during this difficult economic period. For example, immigrants who decline SNAP for fear of being deemed a "public charge" are increasingly turning to emergency food assistance programs that are already "running out of food at alarming rates." (Add. 158.) Because the second injunction appropriately prevents these irreparable economic harms during the COVID-19 emergency, a stay is not warranted.

c. The alert issued by defendants fails to address the new harms imposed by the Rule during the COVID-19 crisis.

Defendants' response to this unrebutted evidence of harm is to speculate that the Rule will not cause these harms given an "alert" that USCIS issued temporarily limiting the Rule's application. (Mot. 16-17.) The alert states that DHS officials conducting public-charge determinations would not "consider testing, treatment, nor preventative care (including vaccines, if a vaccine becomes available) related to COVID-19 as part of a public charge inadmissibility determination . . . even if such treatment is provided or paid for by one or more public benefits" targeted by the Rule, such as federally funded Medicaid. (Add. 6.) The district court correctly found that the alert does not fully redress the harms caused by the Rule.

As a threshold matter, the alert is itself an admission by defendants that the Rule inherently has the *in terrorem* effect of deterring immigrants from accessing essential health care and other benefits during the COVID-19 pandemic, despite great cost to themselves, their communities, and the public. Contrary to defendants' unsubstantiated contentions, the Rule continues to have such effects even as modified by

the alert. Indeed, after DHS posted the alert, physicians and other front-line workers have continued to see many immigrants and their families declining to obtain COVID-19 testing and treatment based on their persistent concerns about the Rule. (Add. 28-29, 84-85, 132-133.)

Defendants are also wrong to assert (Mot. 17) that the Court must ignore the continuing harms found by the district court because they purportedly result solely from immigrants' "mistaken beliefs about how the Rule will be applied in the COVID-19 context." As an initial matter, this Court has already recognized that the Rule's "predictable effect[s]" irreparably harm plaintiffs—including effects on individuals who are not directly subject to the Rule and whose reactions may be "illogical or unnecessary." *New York*, 2020 WL 4457951, at *9 (quotation marks omitted); *see id.* at *30. The Rule's predictable and continuing deterrent effects remain highly relevant to balancing the equities—particularly when those effects and their resulting harms are not just predictable but *actually happening*. (Op. 21).

In any event, immigrants' concerns about the Rule are hardly mistaken or unreasonable given the alert's limited application. For example, the alert excludes from the public-charge analysis an

immigrant's enrollment in Medicaid "*solely* in order to obtain COVID-19-related testing, treatment, or preventative care." (Op. 25 (quotation marks omitted).) But as defendants do not dispute, "few enroll in Medicaid for a single purpose," and there is no mechanism for a Medicaid applicant to seek coverage solely for COVID-19-related treatment. (Op. 26.) Accordingly, the Rule appears to apply, for instance, to an individual who receives medical treatment for COVID-19-like symptoms but is never tested, perhaps because of a shortage of tests, or who ultimately receives a negative result from a COVID-19 test.

As the district court correctly found, the Rule also continues to apply if immigrants obtain Medicaid for other treatment during the pandemic—including treatment for medical conditions like diabetes and heart disease "that place [them] at increased risk of suffering severe illness or death if they contract COVID-19." (Op. 27; *see* Add. 86.) And the Rule applies whenever federally funded Medicaid is used for other services important for protecting public health during the pandemic, such as, for example, testing and treatment for the flu. (Op. 27.) Indeed, immigrants have been declining Medicaid coverage and delaying medical treatment for serious medical conditions based on concerns about the

Rule—increasing the health risks to themselves and the likelihood that they inadvertently spread the virus to others. (Add. 75, 86, 157, 163, 174-175.)

Moreover, defendants acknowledge that, absent the new preliminary injunction, they would be entitled to fully restore the Rule at any time, or to retroactively change their current policy in the future, even if immigrants relied on the alert to obtain COVID-19-related care. (Op. 27-28.) Given that the alert "may be wiped out at a moment's notice," (Op. 28), the Rule will continue to deter immigrants from accessing healthcare that is essential for both their well-being and the public-health response to the pandemic.

Defendants also have no response to the Rule's continuing application to immigrants' receipt of supplemental benefits other than Medicaid. Despite the economic catastrophe caused by the COVID-19 pandemic, "the Rule offers no meaningful relief or incentive for immigrants" facing sudden financial burdens "to confidently access supplemental benefits, such as SNAP" (Op. 26), that are essential to preserve individual well-being and to prevent the vicious economic downturn that could cripple plaintiffs' finances and public programs for

years. The alert states that DHS officials *may* consider COVID-19-related factors that lead an immigrant to access supplemental benefits—such as enforced social distancing or an employer shutting down. (Add. 6). But this statement is no assurance because defendants retain complete discretion to give such factors any weight they choose, including no weight at all.

Halting the Rule during the COVID-19 emergency will plainly help alleviate the Rule's deterrent effects and the resulting harms to plaintiffs and the public, contrary to defendants' unsupported assertions here (Mot. 18). Assuring immigrants that they need not choose between forgoing essential aid for healthcare, food, or housing or risk their future chances of obtaining LPR status will provide needed clarity and confidence about using the very healthcare and economic benefits that are critical to mitigating the pandemic and its harms. As the district court found, temporarily halting the Rule is "nothing short of critical" now. (Op. 21.)

2. The harms caused by the Rule during the national pandemic vastly outweigh defendants' interests.

In response to the specific and substantial harms that the Rule is causing to plaintiffs and the public during the pandemic, defendants have asserted only their general interest in enforcing the Rule. But even before the COVID-19 crisis, this Court found this generic claim of harm insufficient to defeat a preliminary injunction against the Rule. As this Court explained, "we do not think DHS's inability to implement a standard that is as strict as it would like outweighs the wide-ranging economic harms that await" plaintiffs from implementation of the Rule. *New York*, 2020 WL 4457951, at *30. This Court's ruling and the COVID-19 crisis have made the equities even more lop-sided now.

This Court's recent decision also forecloses defendants' argument (Mot. 2-3) that the Supreme Court's previously issued stay of the district court's first injunction alters the balance of the harms or the public interest. Notwithstanding that stay, this Court squarely held last week that the Rule irreparably harms plaintiffs and the public, and that the balance of the equities tips in favor of preliminarily halting the Rule.

Anyway, whatever the import of the Supreme Court's stay when it originally issued, it simply did not address—and could not have

addressed—the dramatic harms imposed by the Rule during the ongoing and unprecedented COVID-19 crisis. And the Supreme Court's more recent order, which expressly contemplated plaintiffs returning to the district court to seek relief based on COVID-19, further undercuts defendants' assertion that the Supreme Court sought to preempt further relief in this proceeding.

CONCLUSION

The Court should deny defendants' stay motion.

Dated: New York, New York
August 17, 2020

Respectfully submitted,

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CERTIFICATE OF COMPLIANCE

Pursuant to Rules 27 and 32 of the Federal Rules of Appellate Procedure, William P. Ford, an employee in the Office of the Attorney General of the State of New York, hereby certifies that according to the word count feature of the word processing program used to prepare this document, the document contains 5,189 words and complies with the typeface requirements and length limits of Rules 27(d) and 32(a)(5)-(6).

/s/ William P. Ford

Addendum

TABLE OF CONTENTS

PAGE

TABLE OF CONTENTS

PAGE

Exhibits to Goldstein Declaration (cont'd)

TABLE OF CONTENTS

PAGE

Exhibits to Goldstein Declaration (cont'd)

UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF NEW YORK

STATE OF NEW YORK, CITY OF NEW YORK, STATE OF CONNECTICUT, and STATE OF VERMONT, Plaintiffs, v. UNITED STATES DEPARTMENT OF HOMELAND SECURITY; KEVIN K. McALEENAN, *in his official capacity as Acting Secretary of the United States Department of Homeland Security*; UNITED STATES CITIZENSHIP AND IMMIGRATION SERVICES; KENNETH T. CUCCINELLI II, *in his official capacity as Acting Director of United States Citizenship and Immigration Services*; and UNITED STATES OF AMERICA, Defendants.	**CIVIL ACTION NO. 19 Civ. 07777 (GBD)**
MAKE THE ROAD NEW YORK, AFRICAN SERVICES COMMITTEE, ASIAN AMERICAN FEDERATION, CATHOLIC CHARITIES COMMUNITY SERVICES, and CATHOLIC LEGAL IMMIGRATION NETWORK, INC., Plaintiffs, v. KEN CUCCINELLI, in his official capacity as Acting Director of United States Citizenship and Immigration Services; UNITED STATES CITIZENSHIP & IMMIGRATION SERVICES; KEVIN K. McALEENAN, in his official capacity as Acting Secretary of Homeland Security; and UNITED STATES DEPARTMENT OF HOMELAND SECURITY, Defendants.	**CIVIL ACTION NO. 19 Civ. 07993 (GBD)**

DECLARATION OF ELENA GOLDSTEIN

Elena Goldstein, pursuant to penalty of perjury under 28 U.S.C. § 1746, does hereby state the following:

I am an attorney in the Office of the New York State Attorney General and counsel to the Governmental Plaintiffs in this action. I submit this Declaration in support of Plaintiffs' Motion for a Preliminary Injunction or in the Alternative for a Temporary Restraining Order.

Attached to this Declaration are true and correct copies of the following numbered exhibits:

1. Order in *Dep't of Homeland Sec., et al. v. New York, et al.*, 589 U.S. ___ (2020), dated January 27, 2020.

2. Order in *Dep't of Homeland Sec., et al. v. New York, et al.*, No. 19A785, dated April 24, 2020.

3. Order in *Wolf, et al. v. Cook County, et al.*, No. 19A905, dated April 24, 2020.

4. Printout of USCIS Public Charge Alert, dated Mar. 13, 2020.

5. Letter from State Attorneys General to Chad Wolf, Acting Secretary, U.S. Department of Homeland Security et al., dated Mar. 6, 2020.

6. Letter from Oxiris Barbot, MD, Commissioner, Commissioner, New York City Department of Health and Mental Hygiene et al., to Chad Wolf, Acting Secretary, U.S. Department of Homeland Security et al., dated Mar. 18, 2020.

7. Letter from State Attorneys General to Chad Wolf Letter from State Attorneys General to Chad Wolf, Acting Secretary, U.S. Department of Homeland Security et al., dated Mar. 19, 2020.

8. Declaration of Eden Almasude, Psychiatrist, Yale School of Medicine.

9. Declaration of Oxiris Barbot, MD, Commissioner, New York City Department of Health and Mental Hygiene.

10. Declaration of Lawrence L. Benito, Executive Director, Illinois Coalition for Immigrant and Refugee Rights, Chicago, IL.

11. Declaration of Maria Lucia Chavez, Deputy Director of Northwest Immigrant Rights Project, Seattle, WA.

12. Declaration of Sabrina Fong, Deputy Director of Research and Policy Advisor, New York City Mayor's Office of Immigrant Affairs, NY.

13. Declaration of Janel Heinrich, Director of Public Health, Madison and Dane County, Madison, WI.

14. Declaration of Dana Kennedy, Director of Community Partnerships, Center for Health Progress, Denver, CO.

15. Declaration of Camille Kritzman, Case Manager, Integrated Refugee & Immigrant Services, New Haven, CT.

16. Declaration of Leighton Ku, Professor of Health Policy and Management and Director of the Center for Health Policy Research at the Milken Institute School of Public Health, George Washington University in Washington, DC.

17. Declaration of Pedro Moreno, Assistant Professor of Family Medicine, University of California San Francisco, CA.

18. Declaration of Bitta Mostofi, Commissioner, New York City Mayor's Office of Immigrant Affairs, NY.

19. Declaration of Lisa M. Newstrom, Managing Attorney, Santa Clara County Regional Office of Bay Area Legal Aid, San Jose, CA.

20. Declaration of John Paul Newton, Director of the Public Benefits Unit, Bronx Legal Services, New York, NY.

21. Declaration of Rachel Pryor, Deputy Director for Administration, Virginia Department of Medical Assistance Services, Richmond, VA.

22. Declaration of Aaron Coskey Voit, Managing Attorney, Monterey County Medical-Legal Partnership at California Rural Legal Assistance, Inc., Salinas, CA.

23. Declaration of Sarah Nolan, Supervising Attorney, Legal Health Division, New York Legal Assistance Group, New York, NY.

24. Declaration of Theo Oshiro, Deputy Director for Make the Road New York, NY.

25. Declaration of C. Mario Russell, Director, Division of Immigrant and Refugee Services, Catholic Charities Community Services, Archdiocese of New York.

26. Declaration of Jo-Ann Yoo, Executive Director, Asian American Federation, New York, NY.

27. Declaration of Alejandra Aguilar, Lead Health Educator, HIV Navigation Services Unit, East Los Angeles Women's Center, Los Angeles, CA.

Dated: April 28, 2020

By: */s/ Elena Goldstein*

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U.S. Citizenship and Immigration Services

Public Charge

Alert: USCIS encourages all those, including aliens, with symptoms that resemble Coronavirus Disease 2019 (COVID-19) (fever, cough, shortness of breath) to seek necessary medical treatment or preventive services. Such treatment or preventive services will not negatively affect any alien as part of a future Public Charge analysis.

The Inadmissibility on Public Charge Grounds final rule is critical to defending and protecting Americans' health and its health care resources. The Public Charge rule does not restrict access to testing, screening, or treatment of communicable diseases, including COVID-19. In addition, the rule does not restrict access to vaccines for children or adults to prevent vaccine-preventable diseases. Importantly, for purposes of a public charge inadmissibility determination, USCIS considers the receipt of public benefits as only one consideration among a number of factors and considerations in the totality of the alien's circumstances over a period of time with no single factor being outcome determinative. To address the possibility that some aliens impacted by COVID-19 may be hesitant to seek necessary medical treatment or preventive services, USCIS will neither consider testing, treatment, nor preventative care (including vaccines, if a vaccine becomes available) related to COVID-19 as part of a public charge inadmissibility determination, nor as related to the public benefit condition applicable to certain nonimmigrants seeking an extension of stay or change of status, even if such treatment is provided or paid for by one or more public benefits, as defined in the rule (e.g. federally funded Medicaid).

The rule requires USCIS to consider the receipt of certain cash and non-cash public benefits, including those that may be used to obtain testing or treatment for COVID-19 in a public charge inadmissibility determination, and for purposes of a public benefit condition applicable to certain nonimmigrants seeking an extension of stay or change of status. The list of public benefits considered for this purpose includes most forms of federally funded Medicaid (for those over 21), but does not include CHIP, or State, local, or tribal public health care services/assistance that are not funded by federal Medicaid. In addition, if an alien subject to the public charge ground of inadmissibility lives and works in a jurisdiction where disease prevention methods such as social distancing or quarantine are in place, or where the alien's employer, school, or university voluntarily shuts down operations to prevent the spread of COVID-19, the alien may submit a statement with his or her application for adjustment of status to explain how such methods or policies have affected the alien as relevant to the factors USCIS must consider in a public charge inadmissibility determination. For example, if the alien is prevented from working or attending school, and must rely on public benefits for the duration of the COVID-19 outbreak and recovery phase, the alien can provide an explanation and relevant supporting documentation. To the extent relevant and credible, USCIS will take all such evidence into consideration in the totality of the alien's circumstances.

Inadmissibility on Public Charge Grounds Final Rule

On Feb. 24, 2020, USCIS implemented the Inadmissibility on Public Charge Grounds final rule nationwide, including in Illinois. USCIS will apply the final rule to all applications and petitions postmarked (or, if applicable, submitted electronically) on or after that date. For applications and petitions sent by commercial courier (for example, UPS, FedEx, or DHL), the postmark date is the date reflected on the courier receipt. USCIS will reject any affected application or petition that does not adhere to the final rule, including those submitted by or on behalf of aliens living in Illinois, if postmarked on or after Feb. 24, 2020.

Background

Self-sufficiency has long been a basic principle of U.S. immigration law since our nation's earliest immigration statutes. Since the 1800s, Congress has put into statute that aliens are inadmissible to the United States if they are unable to care for themselves without becoming public charges. Since 1996, federal laws have stated that aliens generally must be self-sufficient. On Aug. 14, 2019, DHS published a final rule regarding how DHS determines if someone applying for admission or adjustment of status is likely at any time to become a public charge.

This final rule also requires aliens seeking to extend their nonimmigrant stay or change their nonimmigrant status to show that, since obtaining the nonimmigrant status they seek to extend to change, they have not received public benefits (as defined in the rule) over the designated threshold.

The Statutory Basis of the Inadmissibility on Public Charge Grounds Final Rule

The primary immigration law today is the Immigration and Nationality Act of 1952 (the INA, or the Act), as amended.

Section 212(a)(4) of the INA (8 U.S.C. § 1182(a)(4)): "Any alien who, in the opinion of the consular officer at the time of application for a visa, or in the opinion of the Attorney General at the time of application for admission or adjustment of status, is likely at any time to become a public charge is inadmissible[…] In determining whether an alien is excludable under this paragraph, the consular officer or the Attorney General shall at a minimum consider the alien's-(I) age; (II) health; (III) family status; (IV) assets, resources, and financial status; and (V) education and skills . . . ."

Section 213 of the INA (8 U.S.C. § 1183): "An alien inadmissible under [section 212(a)(4) of the INA, 8 U.S.C. 1182(a)(4)] may, if otherwise admissible, be admitted in the discretion of the Attorney General (subject to the affidavit of support requirement and attribution of sponsor's income and resources under section 1183a of this title) upon the giving of a suitable and proper bond . . . ."

Section 214(a)(1) of the INA (8 U.S.C. § 1184(a)(1)): "The admission to the United States of any alien as a nonimmigrant shall be for such time and under such conditions as the Attorney General may by regulations prescribe, including when he deems necessary the giving of a bond with sufficient surety in such sum and containing such conditions as the Attorney General shall prescribe, to insure that at the expiration of such time or upon failure to maintain the status under which he was admitted, or to maintain any status subsequently acquired under section 1258 of this title, such alien will depart from the United States."

Section 248(a) of the INA (8 U.S.C. § 1258(a)): "The Secretary of Homeland Security may, under such conditions as he may prescribe, authorize a change from any nonimmigrant classification to any other nonimmigrant classification in the case of any alien lawfully admitted to the United States as a nonimmigrant who is continuing to maintain that status and who is not inadmissible under section 1182(a)(9)(B)(i) of this title (or whose inadmissibility under such section is waived under section 1182(a)(9)(B)(v) of this title) . . . ."

8 U.S.C. § 1601 (PDF)(1): "Self-sufficiency has been a basic principle of United States immigration law since this country's earliest immigration statutes."

8 U.S.C. § 1601 (PDF)(2)(A): "It continues to be the immigration policy of the United States that – aliens within the Nation's borders not depend on public resources to meet their needs, but rather rely on their own capabilities and the resources of their families, their sponsors, and private organizations."

8 U.S.C. § 1601 (PDF) (2)(B): It is also the immigration policy of the United States that "the availability of public benefits not constitute an incentive for immigration to the United States."

The DHS Inadmissibility on Public Charge Grounds Final Rule

Timeline of the Rule's Implementation

On Aug. 14, 2019, the U.S. Department of Homeland Security (DHS) published the Inadmissibility on Public Charge Grounds final rule that codifies regulations governing the application of the public charge inadmissibility grounds. See section 212(a)(4) of the INA, 8 U.S.C. 1182(a)(4).

On Oct. 2, 2019, DHS issued a corresponding correction document, which contains provisions that are effective as if they had been included in the final rule published on Aug. 14, 2019.

On Oct. 10, 2018, DHS issued a Notice of Proposed Rulemaking, which was published in the Federal Register for a 60-day comment period. DHS received and considered over 266,000 public comments before issuing the final rule. The final rule provides summaries and responses to all significant public comments.

The Purpose of the Rule

The final rule enables the federal government to better carry out provisions of U.S. immigration law related to the public charge ground of inadmissibility.

The final rule clarifies the factors considered when determining whether someone is likely at any time in the future to become a public charge, is inadmissible (under section 212(a)(4) of the INA, 8 U.S.C. 1182(a)(4)) and, therefore, ineligible for admission or adjustment of status.

The final rule also requires aliens in the United States who have a nonimmigrant visa and seek to extend their stay in the same nonimmigrant classification or to change their status to a different nonimmigrant classification to demonstrate, as a condition of approval, that they have not received, since obtaining the status they seek to extend or change, public benefits for more than 12 months, in total, within any 36-month period.

The final rule does not create any penalty or disincentive for past, current or future receipt of public benefits by U.S. citizens or aliens whom Congress has exempted from the public charge ground of inadmissibility.

Applicability and Exemptions

The final rule applies to applicants for admission and aliens seeking to adjust their status to that of lawful permanent residents from within the United States. The final rule also applies to applicants for extension of stay and change of status.

The final rule does not apply to:

- U.S. citizens, even if the U.S. citizen is related to a noncitizen who is subject to the public charge ground of inadmissibility; or
- Aliens whom Congress exempted from the public charge ground of inadmissibility, such as:
- Refugees;
- Asylees;
- Afghans and Iraqis with special immigrant visas;
- Certain nonimmigrant trafficking and crime victims;
- Individuals applying under the Violence Against Women Act;
- Special immigrant juveniles; and
- Those to whom DHS has granted a waiver of public charge inadmissibility.

Public Benefits that DHS Will Not Consider

Benefits received by U.S. service members. Under the final rule, DHS will not consider the receipt of public benefits (as defined in the final rule) by an alien who (at the time of receipt, or at the time of filing or adjudication of the application for admission, adjustment of status, extension of stay, or change of status) is enlisted in the U.S. armed forces, or is serving in active duty or in any of the Ready Reserve components of the U.S. armed forces

Benefits received by spouse and children of U.S. service members. DHS also will not consider the receipt of public benefits by the spouse and children of such service members (described above).

Benefits received by children born to, or adopted by, U.S. citizens living outside the United States. The rule further provides that DHS will not consider public benefits received by children, including adopted children, who will acquire U.S. citizenship under section 320 of the INA, 8 U.S.C. 1431, or children, residing outside the United States, of U.S. citizens who are entering the United States for the purpose of attending an interview under section 322 of the INA, 8 U.S.C. 1433.

Certain Medicaid benefits. DHS will not consider the Medicaid benefits received:

- For the treatment of an "emergency medical condition;"
- As services or benefits provided in connection with the Individuals with Disabilities Education Act;
- As school-based services or benefits provided to individuals who are at or below the oldest age eligible for secondary education as determined under State or local law;
- By aliens under the age of 21; and
- By pregnant women and by women within the 60-day period beginning on the last day of the pregnancy.

Benefits received on behalf of a legal guardian. DHS will only consider public benefits received directly by the applicant for the applicant's own benefit, or where the applicant is a listed beneficiary of the public benefit. DHS will not consider public benefits received on behalf of another as a legal guardian or pursuant to a power of attorney for such a person. DHS will also not attribute receipt of a public benefit by one or more members of the applicant's household to the applicant unless the applicant is also a listed beneficiary of the public benefit.

Q. When does the final rule go into effect?

Q. What does the final rule change?

Q. Who is subject to the public charge inadmissibility ground?

Q. Who is exempt from this rule?

Q. Which benefits are considered for the purposes of this rule?

Q. What amount/duration of public benefits matters?

Q. Whose receipt of benefits is considered under this rule?

Q. Which benefits are not considered?

Q. How will DHS determine whether someone is likely at any time to become a public charge for admission or adjustment purposes?

Q. What factors weigh heavily in favor of a determination that someone is likely at any time to become a public charge?

Q. What factors weigh heavily against a determination that someone is likely at any time to become a public charge?

Q. How can I learn more about public charge?

Last Reviewed/Updated: 03/13/2020

Bob Ferguson
ATTORNEY GENERAL OF WASHINGTON
PO Box 40100 • Olympia WA 98504-0100 • (360) 753-6200

March 6, 2020

Chad Wolf
Acting Secretary
U.S. Department of Homeland Security
2707 Martin Luther King Jr. Ave. SE
Washington, DC 20528

Kenneth T. Cuccinelli
Senior Official Performing the Duties of the Director
U.S. Citizenship and Immigration Services
20 Massachusetts Ave. NW
Washington, DC 20001

Dear Acting Secretary Wolf and Senior Official Cuccinelli:

We urge the Department of Homeland Security (DHS) to immediately stop implementation of the *Inadmissibility on Public Charge Grounds* Rule ("Public Charge Rule"), *see* 84 Fed. Reg. 41,292 (Aug. 14, 2019), in the wake of the COVID-19 coronavirus. During the notice-and-comment period for the Rule, DHS received warnings of the potentially devastating effects of the Rule if its implementation were to coincide with the outbreak of a highly communicable disease – a scenario exactly like the one confronting our communities with the COVID-19 public health emergency. Your agency failed to consider such legitimate concerns.

Communities across America are undertaking extensive efforts to limit the spread of COVID-19. Your agency's Public Charge Rule undermines those efforts by deterring individuals from accessing critical health benefits to which they are legally entitled. Failure to immediately stay implementation of the Rule so that we can take the steps necessary to contain and mitigate the outbreak of the disease puts the public health and safety of our communities at increased risk.

The overwhelming evidence – including from the World Health Organization (WHO), Department of Health and Human Services (HHS), and the Centers for Disease Control (CDC) – shows COVID-19 is highly communicable and likely to spread in increasing numbers. On February 26, Dr. Nancy Messonnier, the Director of the CDC's National Center for Immunization and Respiratory Diseases, explained "it's not so much a question of if [community spread] will happen anymore but rather more a question of exactly when this will happen and how many people in this country will have severe illness."[1] Analysis by Trevor Bedford, an investigator and expert in vaccines and infectious diseases at the Fred Hutchinson Cancer Research Center in Seattle, suggests that new coronavirus cases in Western Washington are

[1] *See* https://www.cdc.gov/media/releases/2020/t0225-cdc-telebriefing-covid-19.html

likely doubling every six days.[2] Dr. Messonnier also warned the necessary public health responses may result in "disruption to everyday life [that] may be severe," including interruptions to work and school closures.[3] Despite these warnings, there is still hope the disease may be contained, provided governments at all levels take appropriate and comprehensive steps to limit its transmission. As the Director General of the WHO recently explained, "[w]ith early, aggressive measures, countries can stop transmission and save lives."[4]

CDC's data and public statements underscore the urgent importance of such measures. As of February 26 – just two days after DHS began implementation of the Public Charge Rule – CDC had already documented multiple cases of COVID-19 spreading person-to-person within the United States.[5] CDC further acknowledges "person-to-person spread will [likely] continue to occur, including in the United States."[6] If an individual gets sick with suspected COVID-19 symptoms, CDC urges that they consult with their medical and healthcare professionals, including by "seek[ing] prompt medical attention if [their] illness is worsening."[7] CDC's emphasis on coordination with healthcare professionals closely aligns with similar guidance from WHO, which warns that a successful response will require "all countries to educate their populations, to expand surveillance, to find, isolate, and care for every case, to trace every contact, and to take an all-of-government and all-of-society approach."[8] Inexplicably, DHS contravenes this guidance by implementing a public charge rule punishing certain lawful immigrants for seeking effective medical treatment that might mitigate COVID-19's harmful scope and effect.

DHS's implementation of the Public Charge Rule during this public health crisis is irresponsible and reckless. As noted by Plaintiff States in ongoing litigation challenging the Rule,[9] DHS openly concedes the Rule could lead to "increased prevalence of communicable diseases," [10] disenrollment from public programs,[11] and increased use of emergency rooms as a primary method of health care.[12] Washington State has already had eleven deaths attributable to COVID-19. The State is doing everything in its power to limit the spread of the disease and prevent

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[2] *See* https://bedford.io/blog/ncov-cryptic-transmission/

[3] *See* https://www.cdc.gov/media/releases/2020/t0225-cdc-telebriefing-covid-19.html

[4] https://www.who.int/dg/speeches/detail/who-director-general-s-opening-remarks-at-the-media-briefing-on-covid-19---2-march-2020

[5] https://www.cdc.gov/coronavirus/2019-ncov/cases-in-us.html

[6] https://www.cdc.gov/coronavirus/2019-ncov/summary.html

[7] https://www.cdc.gov/coronavirus/2019-ncov/about/steps-when-sick.html.

[8] https://www.who.int/dg/speeches/detail/who-director-general-s-opening-remarks-at-the-media-briefing-on-covid-19---28-february-2020

[9] *See Washington v. DHS*, Case No. 4:19-cv-05210-RMP, Dkt. No. 158 (E.D. Wa., Sept. 27, 2019); *California v. DHS*, Case No. 4:19-cv-04975-PJH, Dkt. No. 17 (N.D. Cal., Aug. 26, 2019); *New York, et al. v. U.S. Dep't of Homeland Sec.*, Case No. 1:19-cv-07777-GBD, Dkt. No. 35 (S.D.N.Y. Sept. 9, 2019) (explaining that the Final Rule jeopardizes Plaintiffs' ability to reduce the spread of communicable diseases, will cause individuals to disenroll from public programs, and will increase use of emergency departments).

[10] 83 Fed. Reg. at 51,270.

[11] 84 Fed. Reg. at 41,463.

[12] 83 Fed. Reg. at 51,270.

additional fatalities. States, cities, and counties are undertaking similarly dramatic efforts to limit the spread of the disease and mitigate its harmful effects. With this threat looming, however, DHS's policy of deterring immigrants from using the medical benefits to which they are legally entitled directly undermines and frustrates our public health professionals' efforts, putting our communities and residents at unnecessary risk.

You have authority to swiftly correct your agency's failure to consider the Public Charge Rule's risks to public health and safety. We urge that you immediately stay implementation of the Public Charge Rule pending successful containment of COVID-19 to assist our public health professionals and protect our communities.

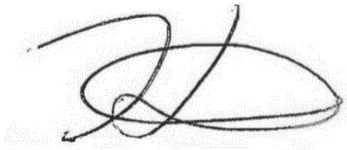
Sincerely,

Bob Ferguson
Washington State Attorney General

Xavier Becerra
California Attorney General

William Tong
Connecticut Attorney General

Kathleen Jennings
Delaware Attorney General



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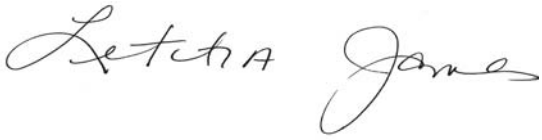

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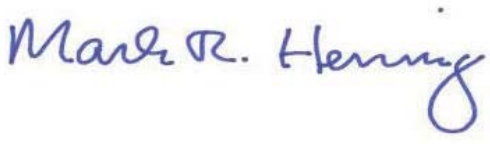

Mark R. Herring
Virginia Attorney General

CC: Vice President Mike Pence
Secretary Alex Azar, U.S. Department of Health and Human Services

March 18, 2020

Chad Wolf
Acting Secretary
U.S. Department of Homeland Security
2707 Martin Luther King Jr. Ave. SE
Washington, DC 20528

Matthew Albence
Senior Official Performing the Duties of the Director
U.S. Immigration and Customs Enforcement
500 12th Street, S.W.
Washington, D.C. 20536

Kenneth T. Cuccinelli
Senior Official Performing the Duties of the Director
U.S. Citizenship and Immigration Services
20 Massachusetts Ave. NW
Washington, DC 20001

Dear Acting Secretary Wolf, Acting Directors Albence and Cuccinelli:

As the leadership of the NYC Department of Health and Mental Hygiene, NYC Health + Hospitals, NYC Department of Social Services and NYC Mayor's Office of Immigrant Affairs, we write to urge the U.S. Department of Homeland Security ("DHS"), and its component agencies U.S. Immigration and Customs Enforcement ("ICE") and U.S. Citizenship and Immigration Services ("USCIS"), to immediately take critical actions as a part of the nationwide COVID-19 pandemic response.

Our city is in the midst of a national effort to limit the spread of COVID-19 and to ensure that those who become severely ill and in need of health services are able to access them without barriers. Through a multilingual messaging campaign and in coordination with elected officials, community partners, and health care providers, we are disseminating guidance to New Yorkers, including urging all New Yorkers to practice good hand hygiene and to stay home if they are feeling sick. We are also advising New Yorkers who are ill that if their symptoms worsen, they should consult with their health care provider.

To minimize the consequences of this pandemic as much as possible, it is critical that all residents of our city are able to follow the guidance issued by public health authorities and that

they seek care when they need it – without fear, and regardless of immigration status or ability to pay.

Unfortunately, we know that many families in our immigrant communities are already fearful due to changes in immigration policy, such as the recently implemented new public charge rule, as well as due to a dramatic increase in immigration enforcement in New York City. Even prior to the current COVID-19 crisis, there was tremendous confusion and fear about the use of health services and other supportive services and possible negative impacts on immigrant families' ability to remain together now or in the future. Thus, for months, our agencies have worked with partners to promote a welcoming message to all New Yorkers to "seek care without fear."

With this pandemic upon us, we are deeply concerned as we reinforce this message and address any fears that will deter immigrants from seeking the care they need. As leaders charged with a duty to protect the health and well-being of the City of New York as a whole, we know that now more than ever, these kinds of barriers to care will only cause harm to public health – and in this case, may lead to increased transmission of disease and adverse health outcomes for individuals. Lives will be lost if action is not taken to address these barriers.

Accordingly, we ask that during this public health crisis, USCIS suspend implementation of the final rule on Public Charge Inadmissibility to facilitate public health efforts to fight the pandemic. The continued implementation of this rule undermines our efforts to mitigate the harm of COVID-19. For well over a year, we have invested tremendous time and resources as a City to combat widespread confusion and fear around the rule. We have engaged extensively with a wide array of stakeholders – medical professionals, patients, staff and clients of City agencies and services, communities and community-based organizations, journalists, and elected officials. Across the board, we have heard confusion and fear about many aspects of the rule, including how a person's use of healthcare could affect their immigration status, even for permanent residents and others not subject to public charge. We continue to undertake robust outreach and education efforts in an attempt to stop misinformation, but the need for this work persists. Against the backdrop of this rapidly spreading virus, our work to protect the health of New Yorkers is hindered by the ongoing implementation of the Public Charge rule.

While we recognize and appreciate the public message USCIS shared on March 13 urging individuals to get necessary medical treatment related to COVID-19 and clarifying, among other things, that care received related to COVID-19 will not be considered in public charge determinations, we remain concerned about the level of public misunderstanding and confusion regarding public charge, especially among those who are not subject to the rule. At this time, from a public health perspective, the strongest possible message we can share to address confusion about public charge and COVID-19 is to affirm that the new rule has been suspended for the duration of this crisis.

In addition, we also urge DHS to take into account the efforts of local and state public health officials during the COVID-19 crisis in its immigration enforcement activities and adjust those activities appropriately by suspending planned escalations in immigration enforcement and accounting for at-risk individuals in making detention determinations. We appreciate the recent public reinforcement of ICE's sensitive locations guidance. However

more can and should be done. In light of significant barriers to care already experienced by immigrant communities, the planned escalations in civil immigration enforcement in New York City and other cities this spring will almost certainly be counterproductive to public health efforts. The arrest and detention of individuals who are most at risk for severe illness (including those with chronic lung disease, heart disease, diabetes, cancer, or weakened immune systems) and the prospective spread of COVID-19 in immigration detention facilities is also of significant concern. We need individuals and families to work with our teams to better understand the spread of the disease and its characteristics. Thus, ICE should suspend escalations in immigration enforcement and any detention determinations must be made with consideration of the current crisis and the risk of diminishing the willingness of individuals to engage with medical providers and public health authorities.

This pandemic requires a coordinated response that sets aside politicized rhetoric and the ongoing immigration debate to lean into what public health experts widely and confidently agree on: the way to mitigate harm from the COVID-19 crisis with the least possible damage is to take every measure available to ensure that every member of our society is equally capable of accessing the health services they need, when recommended by public health officials. We urge you to take these steps without delay.

Sincerely,

Dr. Oxiris Barbot
Commissioner
NYC Department of Health and Mental Hygiene

Dr. Mitchell Katz
President and CEO
NYC Health + Hospitals

Bitta Mostofi
Commissioner
NYC Mayor's Office of Immigrant Affairs

Steven Banks
Commissioner
NYC Department of Social Services

Bob Ferguson
ATTORNEY GENERAL OF WASHINGTON
PO Box 40100 • Olympia WA 98504-0100 • (360) 753-6200

March 19, 2020

Chad Wolf
Acting Secretary
U.S. Department of Homeland Security
2707 Martin Luther King Jr. Ave., SE
Washington, DC 20528

Kenneth T. Cuccinelli
Senior Official Performing the Duties of the Director
U.S. Citizenship and Immigration Services
20 Massachusetts Ave., NW
Washington, DC 20001

Dear Acting Secretary Wolf and Senior Official Cuccinelli:

On March 6, 2020, a coalition of 18 State Attorneys General and over 50 elected officials from the State of Washington, wrote to you urging the Department of Homeland Security (DHS) to immediately halt implementation of the *Inadmissibility on Public Charge Grounds* Rule ("Public Charge Rule") in the wake of the COVID-19 coronavirus. We have not received a response, but on March 13 you posted an "Alert" on the U.S. Customs and Immigration Service (USCIS) website that confirmed DHS would not consider any form of testing or care related to COVID-19 in immigrants' public charge assessment, "even if such treatment is provided or paid for by one or more public benefits, as defined in the rule (e.g. federally funded Medicaid)."[1] Nevertheless, the Alert fails to mitigate the overall harm of the Public Charge Rule, as it emphasizes that DHS will still consider receipt of Medicaid benefits "including those that may be used to obtain testing or treatment for COVID-19" in the public charge determination.

If DHS is attempting to ensure noncitizens in our communities remain enrolled in Medicaid so they can use Medicaid services should they have symptoms of COVID-19, the Alert fails to achieve this. And likewise, if DHS is attempting to ensure that noncitizens seek testing and treatment for COVID-19 without fear of public charge consequences, the Alert also utterly fails to achieve this.

It is not enough to exempt the use of certain Medicaid-paid services from the public charge analysis if enrollment in Medicaid still is considered. While professing to encourage everyone to seek the testing and treatment they need, the Alert provides that Medicaid coverage used to access those services may be counted against noncitizens in the public charge analysis. The Alert fails to recognize that in order to receive adequate health services, our residents need adequate

[1] https://www.uscis.gov/greencard/public-charge.

health insurance benefits. To achieve DHS's stated goal of encouraging noncitizens to seek testing and treatment for COVID-19, noncitizens must be encouraged to enroll or remain enrolled in health insurance programs, including Medicaid, and they must be assured that such enrollment during this dire national health emergency will not be considered in any future public charge determination.

Since we wrote you 13 days ago, the number of deaths from COVID-19 in Washington has increased dramatically—from 11 to 66. Likewise, the number of reported cases has increased nearly twelvefold—from approximately 100 to 1187.[2] In Massachusetts, the number of confirmed cases has increased from 1 to 328.[3] Testing in the United States still lags far behind other countries, however, and the total number of cases likely far eclipses the current numbers of confirmed positives. For example, scientists currently estimate there are likely 5 to 10 undetected cases for every confirmed one.[4] The World Health Organization has declared a global pandemic, and the President has declared a national emergency. Every day, tighter restrictions are placed on travel, schools, restaurants, and bars, with the CDC now formally advising against gatherings of 10 or more people.

Given the grave danger facing our nation's health and economy, it is imperative that DHS not chill immigrants from enrolling in Medicaid or using Medicaid benefits for *any* purpose until the COVID-19 crisis is over. Under the Alert, however, noncitizens who remain enrolled in Medicaid continue to risk their green cards and visas. As DHS previously conceded, this will prompt immigrants to disenroll from Medicaid and lead to an "increased prevalence of communicable diseases,"[5] as the nation is now experiencing at a horrifying rate.

To protect the residents of our states and the rest of the country, we ask that DHS immediately announce that the Rule is stayed pending successful containment of COVID-19. Short of that, however, it is imperative that DHS at least make clear that enrollment in Medicaid and the use of Medicaid benefits for any reason will not be considered in the public charge assessment. Given that these benefits were not considered in the public charge assessment for many years prior to DHS's recent change of policy, it is inexplicably harmful for the agency to begin counting them now, during the outbreak of a lethal global pandemic.

Sincerely,

Bob Ferguson
Washington State Attorney General

Xavier Becerra
California Attorney General

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[2] https://www.doh.wa.gov/Emergencies/Coronavirus.

[3] https://www.mass.gov/info-details/covid-19-cases-quarantine-and-monitoring

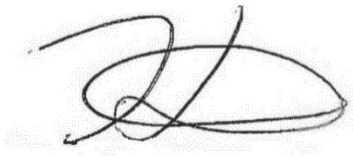
[4] https://www.nytimes.com/2020/03/16/world/live-coronavirus-news-updates.html#link-71630faa (citing https://science.sciencemag.org/content/early/2020/03/13/science.abb3221).

[5] 83 Fed. Reg. at 51,270.

Attorney General of Washington

William Tong
Connecticut Attorney General

Kathleen Jennings
Delaware Attorney General



Karl A. Racine
District of Columbia Attorney General

Clare E. Connors
Hawaii Attorney General

Tom Miller
Iowa Attorney General

Maura Healey
Massachusetts Attorney General

Dana Nessel
Michigan Attorney General

Keith Ellison
Minnesota Attorney General

Aaron D. Ford
Nevada Attorney General

Hector Balderas
New Mexico Attorney General

Gurbir S. Grewal
New Jersey Attorney General

Letitia James
New York Attorney General

Ellen F. Rosenblum
Oregon Attorney General

Josh Shapiro
Pennsylvania Attorney General

Thomas J. Donovan, Jr.
Vermont Attorney General

Mark R. Herring
Virginia Attorney General

CC: Vice President Mike Pence
Secretary Alex Azar, U.S. Department of Health and Human Services

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IN THE UNITED STATES DISTRICT COURT
No. 19A785

In **the**
Supreme Court of the United States

DEPARTMENT OF HOMELAND SECURITY, et al.,

Applicants,

v.

NEW YORK, et al.,

Respondents.

I, OXIRIS BARBOT, M.D., pursuant to 28 U.S.C. Section 1746, declare under penalty of perjury as follows:

1. I am the Commissioner of the New York City Department of Health and Mental Hygiene ("DOHMH"). I am familiar with the matters set forth herein, either from professional knowledge, personal knowledge, conversations with DOHMH staff, or on the basis of documents provided to and reviewed by me. I respectfully submit this Declaration in support of the Respondents' applications in the above-captioned matter.

2. I have over 25 years of experience as a health care provider and public health practitioner. I received a bachelor's degree from Yale University, earned a medical degree from the University of Medicine and Dentistry of New Jersey, and completed my pediatric residency at George Washington University's Children's National Medical Center. From 2014 to 2018, I was First Deputy Commissioner of DOHMH and I oversaw the development and implementation of Take Care New York 2020, New York City's data-driven health agenda focused on

addressing the social determinants of health and engaging communities on issues of health equity. I served as Commissioner of Health for Baltimore City from 2010 to 2014 where I led the development of Healthy Baltimore 2015, a health policy agenda focused on improving health outcomes by focusing on areas where the largest impact could be made to raise quality of life. From 2003 to 2010, I served as medical director of the Office of School Health at the New York City Department of Health and Mental Hygiene and the New York City Department of Education. I practiced primary care pediatrics at Unity Health Care, Inc., a federally qualified health center in Washington, DC, from 1994 to 2003.

3. DOHMH is one of the largest public health agencies in the world. It is responsible for protecting and promoting the health of everyone who lives in, works in or visits New York City.

4. Currently, DOHMH is on the frontlines of the fight against COVID-19 in the City of New York. DOHMH is performing enhanced surveillance to track disease spread; providing guidance to doctors, hospitals, nursing homes, and other healthcare and congregate facilities regarding pandemic planning, testing, infection control, personal protective equipment (PPE), and other matters; testing for COVID-19 in its Public Health Laboratory; distributing PPE, ventilators, and other medical equipment to hospitals, nursing homes, and other high priority healthcare sites; and assisting in creating increased healthcare capacity, including by assisting in transforming external sites such as the Jacob Javits Center. In addition, DOHMH is educating New Yorkers about how to protect themselves from the virus by publicizing accurate information about COVID-19 through a variety of means including posters, flyers, letters, and other written communications available in over 20 languages; a detailed website; advertising,

videos, and social media campaigns; virtual town halls; webinars and other presentation; and targeted outreach to communities.

5. I submitted a declaration in support of Respondents' motion for preliminary relief in the Southern District of New York, expressing my deep concerns about the chilling effect the new public charge rule—the "Final Rule"—would have on residents of the City of New York and in turn, the impact it would have on health in the City of New York as a whole. Since then, my concerns have only intensified.

6. The Final Rule went into effect on February 24, 2020, just days before New York City's first COVID-19 case was confirmed. The Final Rule is especially destructive at a time like this, when all New Yorkers, including those in immigrant communities, urgently need access to health care and health insurance, and when trust between public health authorities and the community is especially crucial.

7. Studies show that low income, minority, and immigrant populations have greater rates of uninsurance and generally have disproportionately adverse impacts during public health crises. Available data suggest that an increased risk of adverse health outcomes is likely among uninsured and minority populations during a pandemic. These populations experience disproportionately poor health outcomes and greater barriers to care during pandemics and during increases in pneumonia and influenza-like illnesses. These poorer health outcomes include increased mortality, more complications, limited access to health care, lower vaccination rates, and greater socioeconomic, cultural, educational, and linguistic obstacles to adoption of pandemic interventions.[1]

[1] *See* e.g. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4809795/pdf/nihms721441.pdf; https://www.sciencedirect.com/science/article/pii/S2352827316300532; https://ajph.aphapublications.org/doi/pdf/10.2105/AJPH.2009.161125; https://ajph.aphapublications.org/doi/pdfplus/10.2105/AJPH.2009.161505.

8. Improving the public health infrastructure and community health safety-net, including improving access to health care and health insurance, is important to ensure that people in immigrant communities participate in the healthful behaviors needed during a public health crisis. DOHMH is doing this by promoting understanding of COVID-19, sharing critical information with New Yorkers about minimizing the likelihood of transmission by staying home and practicing physical distancing and good hand hygiene. DOHMH is also providing information to all New Yorkers about how and when they should seek health care services. And DOHMH continues to perform outreach to immigrant communities to encourage enrollment in appropriate insurance coverage, including Medicaid, the Essential Plan, or commercial plans. New York State has created a special enrollment period for the New York State of Health (NYSOH) exchange, created through the Affordable Care Act (ACA), to allow the uninsured to access coverage during the COVID-19 state of emergency. DOHMH has worked to support the state's efforts by having certified application counselors assist New Yorkers with the enrollment process over the phone. The Final Rule is antithetical to all of these efforts because it disincentives participation in health insurance programs like Medicaid and encourages non-citizens and their families to avoid contact with health providers and government benefit programs.[2]

9. In the early stages of the pandemic, in February and early March, when there was still the possibility that COVID-19 could be contained and broader community transmission averted, DOHMH conducted extensive community outreach to encourage people with possible

[2] Concerns in immigrant communities over seeking health care related to COVID-19 have been documented by many media outlets, including the Wall Street Journal and NBC News. *See e.g.* https://www.wsj.com/articles/rule-barring-immigrants-from-social-programs-risks-worsening-coronavirus-spread-11585137602?mod=searchresults&page=1&pos=1; https://www.nbcnews.com/news/latino/amid-coronavirus-spread-health-advocates-worry-trump-s-immigration-policies-n1150241.

symptoms of COVID-19 to promptly seek medical care so that they could be tested, isolated if positive, and so that DOHMH could conduct contact investigations to help stop the chain of transmission. In outreach meetings with community-based organizations serving immigrant communities conducted between February 27 and March 11, 2020, DOHMH fielded questions and heard confusion about how seeking care related to COVID-19 would impact a public charge determination under the Final Rule. Although the United States Customs and Immigration Services has announced that treatment and preventive services "will not negatively affect any [person] as part of a future Public Charge analysis," media reports suggest that these concerns and confusion may persist, and this concerns me greatly.[3]

10. If people in immigrant communities forego testing or care due to fears about how receipt of such services may affect their immigration status, this could have devastating effects for the individuals themselves and for the larger community. All of New York City benefits when people who are severely ill with COVID-19 disease access the health care services they need. Conversely, if communities avoid testing and care due to fear or confusion, New York City's efforts to mitigate the virus may be negatively impacted. Several vaccines and treatments are under development, with some treatments are already being piloted. If a vaccine or treatment becomes available, unhindered access to care will be all the more critical to ending this pandemic.

11. Concern and anxiety about having contact with health care providers and governmental authorities may also lead non-citizens and their families to avoid participating in public health initiatives and investigations related to COVID-19 disease. It is extremely important that all New York City residents cooperate with DOHMH when it issues advisories

[3] *See e.g.* https://www.nytimes.com/2020/03/18/us/coronavirus-immigrants.html.

and investigates outbreaks of communicable disease. Contact investigations will likely become an important part of reducing the spread of COVID-19 in New York City once there is no longer widespread community transmission and contact investigations can be used to identify and contain cases of illness. Contact investigations require the community to trust DOHMH so that people are willing to speak to DOHMH staff and provide the names and contact information of their family members and friends. If non-citizens and their families are deterred from participating in these investigations due to fear of the Final Rule, this could greatly reduce the effectiveness of DOHMH COVID-19 contact investigations.

12. For the reasons described above, and in my prior declaration, DOHMH opposes implementation of the Final Rule, particularly while New York City and the United States as a whole, addresses the threat of COVID-19.

I declare under penalty that the foregoing is true and correct and of my own personal knowledge.

DATED this 9th day of April 2020 at Queens, New York.

OXIRIS BARBOT, M.D.
Commissioner
New York City Department of Health and Mental Hygiene

No. 19A785

In the
Supreme Court of the United States

DEPARTMENT OF HOMELAND SECURITY, et al.,

Applicants,

v.

NEW YORK, et al.,

Respondents.

I, Lawrence L. Benito, Executive Director of the Illinois Coalition for Immigrant and Refugee Rights (ICIRR), pursuant to 28 U.S.C. § 1746, hereby declare as follows:

1. I am over the age of 18, competent to testify as to the matters herein and make this declaration based on my personal knowledge. I submit this declaration in support of Respondents' application in the above-captioned matter. In my role as the Executive Director of ICIRR, I am responsible for running all facets of the organization including the leadership of our membership and coalitions.

2. ICIRR is a non-profit organization located in Chicago, Illinois. ICIRR is dedicated to promoting the rights of immigrants and refugees to full and equal participation in the civic, cultural, social, and political life of our diverse society in Illinois and beyond. ICIRR is a membership-based organization, representing nearly 100 nonprofit organizations and social and health service providers throughout Illinois, many of which provide health care, nutrition, housing, and other services for immigrants, including immigrants of color, regardless of their immigration status or financial means. A core mission of ICCIR and its member organizations is to provide

health and social services to immigrant Illinoisans. ICIRR member organizations include community health centers, health and nutrition programs, social service providers and other organizations that work to ensure immigrants receive the supports they need to be successful. Created in 1986, ICIRR has been at the forefront of helping immigrants realize and contribute to the dream that is America. In that time, ICIRR won establishment of an Office of New Americans within the Governor's office (2005) and the Office of the Mayor of the City of Chicago (2011); created the New Americans Initiative (2005), which has helped 534,000 people gain access to citizenship and assisted 105,394 immigrants prepare applications for citizenship; created the Immigrant Family Resource Project ("IFRP") (1999), which has connected more than 500,000 individuals and families to safety net services; and led efforts to create the Cook County Direct Access Program, which has expanded healthcare services to over 25,000 individuals. ICIRR also operates the Immigrant Healthcare Access Initiative ("IHAI"), which works to increase access to care and improve health literacy for tens of thousands of low-income uninsured immigrants in Illinois, in order to reduce their reliance on emergency room care and to improve the overall public health of the community. As a part of IHAI, ICIRR leads the Illinois Alliance for Welcoming Healthcare, an alliance comprised of 25 healthcare providers, including clinics and hospitals, and 20 community-based organizations that convene to create and share best practices in the provision of healthcare services to immigrants and their families. ICIRR also leads the Healthy Communities Cook County ("HC3") coalition, which seeks to address and mitigate barriers to accessing healthcare for the uninsured, regardless of immigration status, through policy and systems change.

3. In spring 2018, in direct response to the Proposed and Final Rule and the growing fear and confusion within immigrant communities, ICIRR co-founded the Protecting Immigrant Families-Illinois coalition ("PIF-IL"). PIF-IL was created specifically to (1) respond to the

proposed changes to the public charge rule; and (2) provide assistance to and accurate information to immigrant communities seeking to safely make use of public benefits for which they are eligible.

4. Since the news leaked about a proposed change to the public charge rule that penalize immigrants who used safety net programs, ICIRR and its member organizations have seen a decrease in immigrants enrolling in public benefit programs and increase in immigrants seeking to disenroll from public benefit programs. In June 2019, ICIRR conducted a survey of its member organizations to document the impact of the Proposed Final Rule on its organizations and the individuals they serve. From responses to that survey, ICIRR ascertained that there was a reduction in enrollment in public benefits programs, even those benefits not subject to the public charge rule, such as unemployment benefits and WIC. The survey also confirmed that immigrants, even those who are not subject to the public charge rule, were attempting to disenroll from SNAP, Medicaid, TANF, and WIC for themselves and even their U.S. citizen children out of fear that the rule will harm their immigration status and options.

5. Since the U.S. Supreme Court decision lifting the Illinois injunction, some organizations who are part of ICIRR's Immigrant Family Resource Program ("IFRP") report receiving an increased number of calls from individuals expressing fears about how the use of public benefits could subject them to the public charge rule. They are either afraid to enroll in public benefits they are eligible for or are seeking to disenroll from public benefits they already receive. In an effort to alleviate those fears and slow declining enrollment, one IFRP organization is planning to record a public charge informational video for the community.

Increased confusion due to the USCIS Public Charge COVID-19 guidance

6. On or around March 13, 2020, the U.S. Citizenship and Immigration Services (USCIS) posted an alert (in English only). This alert explained that while the Public Charge rule

"does not restrict access to testing, screening, or treatment of communicable diseases, including COVID-19," USCIS was nonetheless required to "consider the receipt of certain cash and non-cash public benefits, including those that may be used to obtain testing or treatment for COVID-19 in a public charge inadmissibility determination," including most forms of federally funded Medicaid. *See* https://www.uscis.gov/greencard/public-charge.

7. Due to confusion around this USCIS guidance, ICIRR member organizations and IFRP partners report that some immigrants fear that they cannot access medical treatment or testing for COVID-19 due to the public charge rule.

Increased need for food, housing, and medical assistance in light of COVID-19

8. Since the global health emergency began and Illinois residents became subject to a shelter in place order on March 21, 2020, ICIRR and its member and IFRP partner organizations have received an increase in calls from immigrants seeking assistance with food, housing, and medical care, as well as an increased concern that using public benefits will subject them to the public charge rule.

9. Immigrants in Illinois, including individuals subject to the public charge rule, are predominately employed in fields or industries that are disproportionately impacted by the COVID-19 pandemic, in that they are now either unemployed or considered essential workers. It is predicted that nearly 1.5 million Illinois workers will lose employment or hours due to COVID-19.

10. Out of concern for the public health, Illinois has joined other states in closing all non-essential businesses, including bars, restaurants, and most manufacturing businesses where immigrants are disproportionately employed. Many have now lost their jobs as a result. Immigrants are also disproportionately employed as domestic workers, such as cleaning staff, personal care

aides, or nannies, and many have lost their employment due to their employers' losing their own job or experiencing a decline of income. All these individuals and their families are thus more likely than ever to need public assistance, including SNAP, Medicaid, and housing assistance.

11. At the same time, immigrants also are disproportionately employed in fields deemed essential, including home health care aides and grocery store employees. This essential status and the inability to work from home increases their exposure to COVID-19 and their need for quality treatment and preventative care for themselves and the health of everyone they contact.

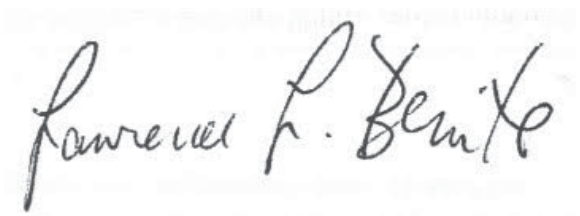
12. Organizations that are part of ICIRR's IFRP network and public benefit coordinators employed at organizations who are a part of PIF-Illinois report an increased volume of calls from immigrants, especially mixed-status households, who have lost employment as a result of COVID-19. These callers report needing cash assistance, free health care, rental assistance, and help feeding their children, including U.S. citizen children. They are seeking information about enrolling in Section 8 or public housing, SNAP, and Medicaid, but they are concerned that such enrollment, including for their U.S. citizen children, will subject them to the public charge rule. They are also afraid to apply for unemployment benefits out of fear of becoming a public charge, even though they will not be subject to the public charge rule for using unemployment benefits. Callers afraid to apply for SNAP are referred to food pantries. Because many food pantries in Latinx neighborhoods in Chicago have either closed or are seeing a marked increase in requests for food assistance, fewer residents will have their food security needs met through local pantries.

13. Since the COVID-19 crisis, fear remains rampant among immigrants calling these organizations for advice regarding medical testing and treatment. Callers are expressing concern that receiving Covid-19 related medical testing or treatment for themselves, their families or their

family members will subject them to public charge. This concern is primarily coming from seniors or individuals with underlying health conditions, even though they are at greater risk of serious health complications or even death due to COVID-19. Many callers are concerned that seeking COVID-19 related medical testing or treatment may risk their ability to stay in the country.

I, Lawrence L. Benito, declare under penalty of perjury that the foregoing is true and correct to the best of my knowledge.

Executed this 9th day of April 2020 in Cook County, Illinois.



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Lawrence L. Benito

No. 19A785

In the
Supreme Court of the United States

DEPARTMENT OF HOMELAND SECURITY, et al.,

Applicants,

v.

NEW YORK, et al.,

Respondents.

I, Maria Lucia Chavez, pursuant to 28 U.S.C. § 1746, hereby declare as follows:

1. I am over the age of 18 and am competent to testify as to the matters herein and make this declaration based on my personal knowledge.

2. I am the Deputy Director of Northwest Immigrant Rights Project (NWIRP). NWIRP is one of the largest nonprofit organizations focused exclusively on providing immigration legal services in the Western United States. NWIRP provides direct legal services to immigrants with low income in Washington State, and engages in systemic advocacy and community education around policies and practices impacting immigrant rights. As an organization, we have over three decades of experience with family-based adjustment of status and consular process, and we have helped thousands apply for this important immigration benefit.

3. In my role as Deputy Director, I provide supervision and oversight of legal services across the organization, serve as an ambassador for NWIRP internally and externally, provide

strategic leadership for the organization, and I provide direct representation and other forms of legal assistance to NWIRP clients.

4. On February 24, 2020, the Department of Homeland Security (DHS) implemented its new public charge rule. As expected, this change created a sense of fear and urgency in both the impacted community members and legal practitioners, including NWIRP's legal advocates.

5. The implementation of the new public charge rule has caused an uptick in avoidance of benefits by immigrants and their family members, including U.S. citizens and lawful permanent residents as well as other immigrants who are otherwise not subject to a public charge analysis. Immigrants are aware that applying for benefits will be considered either a negative factor or have a negative impact in a public charge determination as the rule lists as a factor to be considered whether the applicant for adjustment of status "has applied for, been certified to receive, or received public benefits (as defined in the rule) on or after October 15, 2019" (now February 24, 2020).

6. Since the global health COVID-19 crisis began, immigrant communities have a heightened fear in accessing public benefits, even related to benefits not considered in the new public charge rule analysis, like accessing a COVID-19 hotline service, food banks, or emergency health-related services. NWIRP has observed an increase in calls across our four offices related to accessing benefits and the impact this may have on a client's case or their family member's case. Despite clarification and the new rule's explicit mention that only an applicant's receipt of benefits would be considered, U.S. citizens, lawful permanent residents, and other immigrants who would not be subject to a public charge analysis continue to be confused or hesitant to accessing much needed benefits. For example, a community member who lacks health insurance asked whether this would impact his ability to receive treatment for COVID-19.

7. Since our communities became subject to a "Stay Home, Stay Healthy" emergency order, NWIRP has seen a rise in calls related to unemployment and financial insecurity and how accessing certain benefits could impact a person's case. *See* https://www.governor.wa.gov/news-media/inslee-extends-stay-home-stay-healthy-through-may-4. Our offices have received questions from asylum seekers, U visa applicants, and self-petitioners in need of food stamps for their children or food bank assistance, concerned that these benefits could subject them to a public charge determination. We have also received calls from people with employment authorization wondering whether applying for unemployment would affect their asylum case due to public charge. NWIRP's social services coordinator has connected with three pregnant women who fear accessing care because of the public charge rule even though they are exempt to receive Medicaid in their situation. One woman was unwilling to enroll even after we explained her eligibility.

Access to testing and treatment in light of COVID-19

8. While local efforts have emerged to compile resources and provide frequently asked questions related to medical testing or treatment of COVID-19 and how this access does not have public charge implications on a person's immigration case, immigrants continue to avoid seeking any assistance that in their minds could be considered in a public charge analysis. Instead, community members who may be in need of medical care are reluctant to seek care because their fear of a future case denial based on a public charge determination overcomes any current need.

9. On or around March 13, 2020, U.S. Citizenship and Immigration Services (USCIS) posted an alert (in English only). This alert explained that while the Public Charge rule "does not restrict access to testing, screening, or treatment of communicable diseases, including COVID-19," USCIS was nonetheless required to "consider the receipt of certain cash and non-cash public benefits, including those that may be used to obtain testing or treatment for COVID-19 in a public

charge inadmissibility determination," including most forms of federally funded Medicaid. *See* https://www.uscis.gov/greencard/public-charge. While USCIS encourages people to seek services in this situation, any receipt of this important service could be considered a negative factor in the applicant's totality of circumstances test even if they could submit a statement explaining the impact. This does not in fact reduce fear in communities and confusion related to accessing medical treatment or testing for COVID-19. We recently received a call from a community member asking whether getting assistance for COVID-19 treatment would affect them later as a public charge.

Increase in food insecurity in light of COVID-19

10. During this COVID-19 crisis, NWIRP has limited our direct legal services as our four offices are closed to the public and are conducting most of our services remotely. This past month, however, NWIRP has seen an increase in acting as a resource to community members who have questions about available services and resources due to loss of employment, potential eviction, becoming homeless, and food insecurity. We have heard from a community advocate that on a region of Washington's peninsula there are about 150 families (mix-status families) without work until July as their work is seasonal and they are unable to afford moving to areas where there may have access to more resources. On April 6, 2020, Washington's Governor announced school closures for grades K-12 through the end of the school year. Many community members have had difficulty choosing to care for their children or working, making their family's financial situation even more dire. We have heard from people who are being laid off from their jobs and are lawful permanent residents who are worried about applying for unemployment benefits. They are afraid that this would impact their future application for naturalization or their family member's application for adjustment of status due to a potential finding of public charge. We have been asked by service providers what the impact would be on a youth who is under 21 years of age receiving

mental health services under Medicaid and how that might impact their family-based immigration case in the future, related to public charge.

11. Since the new DHS public charge rule went into effect, NWIRP has yet to file a family-based application for adjustment of status subject to the new rule. Clients are afraid and advocates have found their work has more than doubled. The current COVID-19 crisis has added an extra layer of fear and uncertainty in our community members' lives and has negatively impacted their pursuit for lawful immigration status.

DATED this 7th day of April, 2020 at Seattle, Washington.

Maria Lucia Chavez
Deputy Director
Northwest Immigrant Rights Project

In the
Supreme Court of the United States

DEPARTMENT OF HOMELAND SECURITY, et al.,

Applicants,

v.

NEW YORK, et al.,

Respondents.

I, Sabrina Fong, pursuant to 28 U.S.C. § 1746, hereby declare as follows:

1. I am Deputy Director of Research and Policy Advisor at the City of New York (the "City")'s Mayor's Office of Immigrant Affairs ("MOIA"). MOIA, established in the Charter of the City of New York in 2001 by referendum, develops and implements policies designed to assist immigrants across the City by enhancing their economic, civic, and social integration into the community. In order to achieve that mission, MOIA conducts research and analysis, provides guidance to other City agencies, develops partnerships with community-based organizations, and advocates at all levels of government.

2. I have been employed by MOIA since May 2015, and have held my current role since November 2018. In my capacity as Deputy Director of Research and Policy Advisor, I am responsible for developing MOIA's strategic research initiatives, including by conducting data analysis, working with data experts on their research, data analysis, planning, coordination and

data forecasting, and by translating research and analysis into reports and presentations. As such, I am familiar with research and data analysis undertaken by MOIA.

3. I swear this declaration to describe an analysis that I undertook in April 2020 to quantify the representation of immigrant and non-citizen New Yorkers in certain frontline occupations, namely those occupations requiring in-person interaction with the public, that were among those occupations deemed by New York Governor Andrew Cuomo to be essential to New York during the COVID-19 pandemic, and in particular, to summarize (1) the data that was analyzed, and (2) the analysis that was undertaken, and (3) the results of the analysis. I base my declaration on my own personal knowledge, work performed, and data analysis.

4. On or about March 18, 2020, New York Governor Andrew Cuomo issued Executive Order 202.6 ("Order 202.6"), directing that businesses in New York utilize to the maximum extent possible any telecommuting or work from home procedures and reduce their in-person workforce by at least 50%. Order 202.6 exempted certain essential businesses from the "work from home" directive. Following the issuance of the Order 202.6, the Empire State Development Corporation ("Empire State Development") was to provide a detailed list of "essential businesses" by March 19, 2020. *See* Executive Order 202.6, found at https://www.governor.ny.gov/news/no-2026-continuing-temporary-suspension-and-modification-laws-relating-disaster-emergency.

5. On or about March 19, 2020, Empire State Development announced a list of 12 categories of businesses that were designated as essential during the COVID-19 pandemic: (1) essential health care operations; (2) essential infrastructure; (3) essential manufacturing; (4) essential retail, (5) essential services, (6) news media; (7) financial institutions, (8) providers of basic necessities to economically disadvantaged populations; (9) construction; (10) defense; (11)

essential services necessary to maintain the safety, sanitation and essential operations of residences or other essential businesses; and (12) vendors that provide essential services or products, including logistics and technology support, child care and services. *See* "Governor Cuomo Issues Guidance on Essential Services Under the 'New York State on Pause' Executive Order," found at https://www.governor.ny.gov/news/governor-cuomo-issues-guidance-essential-services-under-new-york-state-pause-executive-order. Within each category of essential businesses, Empire State Development list several sub-categories of essential occupations. For example, essential occupations in the category of essential healthcare operations include doctors, home healthcare workers, hospital staff, medical billing support personnel, and individuals working in research and laboratory services.

6. On March 20, 2020, Governor Cuomo issued Executive Order 202.8 ("Order 202.8" or "New York State of Pause" Order), which expanded the reduction of the in-person workforce in non-essential businesses to 100%. Order 202.8 retained the same exemptions for essential businesses as Order 202.6.

7. It was in this context that I undertook, on behalf of MOIA, an analysis of the designated essential businesses and their component industries and occupations, and the demographic makeup in New York City of those industries and occupations, to better understand the demographics of the New York City population that would be exempted from the Governor's "work from home" directive, and thereby be placed at greater risk of exposure to COVID-19 during the course of performing their essential functions for the benefit of the city and state.

8. The source data for my analysis was the 2018 American Community Survey ("ACS"), an annual survey administered by the United States Census Bureau to a random sample of American households every year, with an estimated response rate of 95%. In particular, I

analyzed the ACS Public Use Microdata Sample at the Community District Level, focusing on the 55 Public Use Microdata Areas that roughly correlate to the Community Districts that make up New York City.

9. Within the 55 Public Use Microdata Areas of New York City, I filtered the ACS microdata by place of birth and citizenship status of respondents, and by those industries and occupations that most closely approximated the businesses deemed to be essential by Empire State Development that could not be done remotely.

10. In conducting the analysis, I matched as closely as possible the Census industry and occupational categories to those identified as "essential businesses" by Empire State Development, erring on the side of under-inclusiveness by omitting categories of industries and occupations where there was not a clear match to those categories identified by New York State as essential.[1] In addition, for some of the industries and occupations falling into the "essential business" categories and sub-categories, working from home may be feasible, allowing in-person interaction with customers to be avoided. Those occupations were also excluded from the analysis.

11. Based on the ACS data, non-citizens make up approximately 16% of the New York City population, and 19% of the New York City workforce. Immigrants make up 44% of the New York City workforce.[2]

12. The top-line findings of my analysis were that non-citizens and immigrants are disproportionately represented in the occupations and industries that have been deemed by the

[1] For example, under the essential businesses guidance provided by Empire State Development, construction workers would only be considered essential where construction was being undertaken for essential structural or emergency repair, and thus I did not include construction workers as falling within essential occupations generally in my analysis.

[2] The term immigrants refers to naturalized U.S. citizens and non-citizens, combined together.

Governor to be essential businesses exempted from the 'New York State on Pause' "work from home" directive. For example, while non-citizens are approximately 19% of the New York City workforce, they are approximately 24% of the workforce in the essential industries—that is the U.S. Census-categorized industries that correspond to Governor's "essential businesses," and approximately 26% of the workforce in essential occupations—that is, the U.S. Census-categorized occupations within the essential industries.[3] Similarly, while immigrants are approximately 44% of the New York City workforce, they represent approximately 56% of the workforce in the essential industries, and 58% of the workforce in essential occupations.

13. The numbers are even more stark when particular occupations are considered—for example in New York City, non-citizens make up 42.4% and immigrants 81.5% of home health aides; non-citizens make up 29.1% and immigrants 68.3% of personal care aides; non-citizens make up 42.3% of cooks and 44.4% of chefs and head cooks, and immigrants 65.5% of cooks, and 71.7% of chefs and head cooks; non-citizens make up 26.9% and immigrants 53.4% of janitors and building cleaners; non-citizens make up 37.1% and immigrants 59.2% of food preparation workers; non-citizens make up 37.3% and immigrants 84.8% of taxi drivers; and non-citizens make up 56.3% and immigrants 87.0% of laundry and dry-cleaning workers.

14. I prepared a spreadsheet of the findings of my analysis, for use by MOIA to help identify, and guide outreach to and protection of non-citizen and immigrant populations in New York City who are particularly at risk for exposure to COVID-19. Attached as **Exhibits A, B, and C** to this declaration are spreadsheets documenting the main findings with regard to the

[3] As the U.S. Census uses them, an "industry" describes the kind of business conducted by a person's employing organization; an "occupation" is the kind of work a person does to earn a living. For example, two people can be in the same industry (medical) but have two very different occupations, such as a nurse in the medical industry or an accountant for that industry.

demographic makeup of the New York City workforce in the industries and occupations that exist within the designated "essential businesses."

15. **Exhibit A** presents a list of the impacted industries by citizenship status.

16. **Exhibit B** presents a list of the impacted occupations by citizenship status.

17. **Exhibit C** presents the New York City population by citizenship status. These percentages help provide broader context to determine what is and is not proportionate.

I declare under penalty of perjury that the foregoing is true and correct and of my own personal knowledge.

DATED this 8th day of April, 2020 at New York, New York.

DocuSigned by:
Sabrina Fong
291C78145775415...

SABRINA FONG
Deputy Director of Research and Policy Advisor
Mayor's Office of Immigrant Affairs
City of New York
253 Broadway, 14th Floor
New York, NY 10007

Exhibit A

Industry recode for 2018 and later based on 2017 IND codes	Born in the U.S.	Born in Puerto Rico, Guam, the U.S. Virgin Islands, or the Northern Marianas	Born abroad of American parent(s)	U.S. citizen by naturalization	Not a citizen of the U.S.	% Non-Citizen	% Foreign-Born
ENT-Drinking Places, Alcoholic Beverages	6,443	108	94	298	1,218	14.9%	18.6%
ENT-Restaurants And Other Food Services	134,053	3,407	4,756	76,190	117,541	35.0%	57.7%
MED-General Medical And Surgical Hospitals, And Specialty (Except Psychiatric And Substance Abuse) Hospitals	116,281	2,917	2,351	83,677	21,837	9.6%	46.5%
MED-Home Health Care Services	27,661	3,768	2,039	59,087	57,119	38.2%	77.6%
MED-Nursing Care Facilities (Skilled Nursing Facilities)	17,681	795	669	23,027	7,051	14.3%	61.1%
MED-Offices Of Dentists	9,957	82	127	4,813	3,420	18.6%	44.7%
MED-Offices Of Optometrists	944	-	-	466	226	13.8%	42.3%
MED-Offices Of Other Health Practitioners	9,416	86	389	3,199	615	4.5%	27.8%
MED-Offices Of Physicians	22,402	602	1,526	14,237	4,899	11.2%	43.8%
MED-Other Health Care Services	17,406	871	173	13,884	5,272	14.0%	50.9%
MED-Outpatient Care Centers	22,819	494	449	9,885	5,132	13.2%	38.7%
MED-Psychiatric And Substance Abuse Hospitals	2,256	-	-	439	119	4.2%	19.8%
MED-Residential Care Facilities, Except Skilled Nursing Facilities	9,729	305	318	5,956	2,905	15.1%	46.1%
MFG-Fruit And Vegetable Preserving And Specialty Foods	1,037	53	-	535	126	7.2%	37.7%
MFG-Medical Equipment And Supplies	2,967	147	144	1,601	969	16.6%	44.1%
MFG-Pharmaceuticals And Medicines	4,275	-	-	3,121	1,787	19.5%	53.4%
NRF-Waste Management And Remediation Services	8,354	288	91	1,598	2,527	19.7%	32.1%
RET-Beer, Wine, And Liquor Stores	2,363	-	39	2,200	358	7.2%	51.6%
RET-Convenience Stores	1,461	120	-	923	611	19.6%	49.2%
RET-Pharmacies And Drug Stores	18,519	408	772	10,428	4,150	12.1%	42.5%
RET-Specialty Food Stores	4,938	-	715	4,072	5,512	36.2%	62.9%
RET-Supermarkets and Other Grocery (Except Convenience) Stores	26,092	947	1,571	15,498	26,129	37.2%	59.3%
SCA-Community Food And Housing, And Emergency Services	8,075	704	84	2,860	1,143	8.9%	31.1%
SRV-Drycleaning And Laundry Services	2,989	60	28	3,380	4,859	42.9%	72.8%
TRN-Bus Service And Urban Transit	35,892	1,434	943	27,658	5,510	7.7%	46.4%
TRN-Services Incidental To Transportation	15,518	328	230	10,308	5,534	17.3%	49.6%
TRN-Taxi And Limousine Service	13,796	574	1,904	42,639	32,571	35.6%	82.2%
TRN-Truck Transportation	8,904	94	472	7,192	6,440	27.9%	59.0%
WHL-Grocery And Related Product Merchant Wholesalers	9,801	680	561	6,537	7,710	30.5%	56.3%
AVERAGE	**562,029**	**19,272**	**20,445**	**435,708**	**333,290**	**24.3%**	**56.1%**

Exhibit B

Occupation recode for 2018 and later based on 2018 OCC codes	Born in the U.S.	Born in Puerto Rico, Guam, the U.S. Virgin Islands, or the Northern Marianas	Born abroad of American parent(s)	U.S. citizen by naturalization	Not a citizen of the U.S.	% Non-Citizen	% Foreign-Born
CLN-Janitors And Building Cleaners	54,768	5,791	1,653	35,371	35,884	26.9%	53.4%
EAT-Chefs And Head Cooks	9,251	328	512	9,722	15,815	44.4%	71.7%
EAT-Cooks	19,424	929	256	13,821	25,258	42.3%	65.5%
EAT-First-Line Supervisors Of Food Preparation And Serving Workers	8,277	302	-	3,660	2,722	18.2%	42.7%
EAT-Food Preparation Workers	14,068	380	745	8,215	13,810	37.1%	59.2%
HLS-Home Health Aides	21,403	2,919	1,462	54,584	59,105	42.4%	81.5%
HLS-Medical Assistants	8,412	397	394	4,963	1,897	11.8%	42.7%
HLS-Nursing Assistants	14,615	482	797	22,750	8,085	17.3%	66.0%
HLS-Other Healthcare Support Workers	1,805	76	390	2,059	571	11.7%	53.7%
HLS-Personal Care Aides	14,645	637	667	19,674	14,619	29.1%	68.3%
HLS-Pharmacy Aides	882	156	-	1,146	121	5.2%	55.0%
MED-Cardiovascular Technologists and Technicians	528	-	-	514	197	15.9%	57.4%
MED-Clinical Laboratory Technologists And Technicians	3,923	-	132	4,562	488	5.4%	55.5%
MED-Emergency Medical Technicians	2,193	129	-	381	403	13.0%	25.2%
MED-Healthcare Diagnosing Or Treating Practitioners, All Other	415	-	-	79	134	21.3%	33.9%
MED-Licensed Practical And Licensed Vocational Nurses	9,696	658	106	10,732	5,292	20.0%	60.5%
MED-Medical Records Specialists	1,346	-	211	902	68	2.7%	38.4%
MED-Miscellaneous Health Technologists and Technicians	1,102	203	-	1,339	429	14.0%	57.5%
MED-Nurse Anesthetists	-	-	-	86	178	67.4%	100.0%
MED-Nurse Practitioners, And Nurse Midwives	1,569	-	64	1,497	68	2.1%	48.9%
MED-Opticians, Dispensing	471	-	-	183	226	25.7%	46.5%
MED-Other Healthcare Practitioners and Technical Occupations	1,059	-	-	839	-	0.0%	44.2%
MED-Paramedics	1,898	106	246	265	-	0.0%	10.5%
MED-Pharmacists	3,745	252	47	2,945	415	5.6%	45.4%
MED-Pharmacy Technicians	2,723	-	193	3,322	575	8.4%	57.2%

MED-Physician Assistants	4,123	-	155	1,998	308	4.7%	35.0%
MED-Physicians	19,382	273	646	10,179	5,020	14.1%	42.8%
MED-Radiologic Technologists And Technicians	1,449	-	-	1,611	227	6.9%	55.9%
MED-Registered Nurses	33,999	210	1,585	33,412	7,226	9.5%	53.2%
MED-Surgeons	693	73	136	67	668	40.8%	44.9%
MED-Surgical Technologists	528	70	-	1,048	319	16.2%	69.6%
MGR-Medical And Health Services Managers	10,786	639	165	6,429	1,460	7.5%	40.5%
PRD-Laundry And Dry-Cleaning Workers	619	77	-	1,642	3,015	56.3%	87.0%
PRS-Childcare Workers	29,775	1,285	676	24,028	24,396	30.4%	60.4%
PRT-Firefighters	7,292	-	219	464	131	1.6%	7.3%
PRT-Police Officers	20,337	829	431	5,895	975	3.4%	24.1%
SAL-Cashiers	57,531	1,876	2,639	25,984	28,043	24.2%	46.5%
SAL-Retail Salespersons	64,293	1,399	2,168	24,778	16,128	14.8%	37.6%
TRN-Ambulance Drivers And Attendants, Except Emergency Medical Technicians	188	-	-	491	383	36.1%	82.3%
TRN-Bus Drivers, Transit And Intercity	10,758	492	143	6,145	2,181	11.1%	42.2%
TRN-Driver/Sales Workers And Truck Drivers	27,258	1,529	665	22,274	26,424	33.8%	62.3%
TRN-Locomotive Engineers And Operators	1,714	-	-	248	336	14.6%	25.4%
TRN-Taxi Drivers	9,692	257	1,725	36,603	28,697	37.3%	84.8%
TRN-Transportation Service Attendants	267	-	-	581	606	41.7%	81.6%
AVERAGE	**498,902**	**22,754**	**19,228**	**407,488**	**332,903**	**26.0%**	**57.8%**

Exhibit C

Source: ACS 1-Year Estimates - Public Use Microdata Sample 2018
Weight used: PWGTP
Citizenship status

Born in the U.S.	4,986,237	
Born in Puerto Rico, Guam, the U.S. Virg	184,825	
Born abroad of American parent(s)	127,593	
U.S. citizen by naturalization	1,765,932	
Not a citizen of the U.S.	1,332,820	15.9%

No. 19A785

In the
Supreme Court of the United States

DEPARTMENT OF HOMELAND SECURITY, et al.,

Applicants,

v.

NEW YORK, et al.,

Respondents.

I, Janel Heinrich, pursuant to 28 U.S.C. § 1746, hereby declare as follows:

1. As the Director of Public Health Madison and Dane County (PHMDC), I lead our City and County Health Department's efforts to ensure healthy people and places throughout Dane County, Wisconsin. PHMDC supports and improves health and wellbeing by delivering programs and services related to individual, community, and environmental health to residents. We do this through the observation, monitoring, education, enforcement, and policy advancement of public health best practices in our community. We work with a wide range of community partners to help connect community members with valuable local, state and federal resources such as nutrition programs, Medicaid-eligible health programs, and other community benefits.

2. At PHMDC, we believe that all residents of Dane County deserve healthy places to live, work, and play. We also believe that the health of all people is interconnected. I submit this declaration in support of the Respondents' application in the above-captioned matter.

3. Beginning with the first proposed changes to the public charge rule in 2017 and especially once the rule was allowed to go into effect, our department has been hearing numerous reports of immigrant residents of Dane County who have disenrolled themselves and family members from public benefit programs to avoid potential complications with their long-term goals of adjusting their immigration status and later pursuing citizenship.

4. PHMDC operates the Dane County office for the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC). WIC is a vital resource for low-income families and promotes long-term positive health outcomes for children and families. In 2019, our project served over 7,000 pregnant and postpartum women, infants, and children under the age of 5. Although WIC was not included in the final public charge rule, since the beginning of 2020, our WIC staff has consistently received calls from participants asking to remove themselves from WIC and other federal programs they are on. Immigrant callers frequently cited "public charge" as their reason for seeking to disenroll and expressed that they now fear using public benefits because it could threaten pending or future efforts to adjust their immigration status. The rule's implementation has clearly increased anxiety and confusion in Dane County's immigrant community. Because of the complex and confusing nature of the public charge rule, Dane County residents believe that they must weigh the important health benefits of participating in WIC and other nutrition and housing programs against the fear of destabilizing their longer-term goals of securing a future in the United States.

5. Many families who receive WIC in Dane County also use the Supplemental Nutrition Assistance Program (SNAP), Medicaid, and public housing resources. In fact, 74.9% of WIC families also participate in SNAP, Medicaid, or both. Since implementation of the public charge rule began in February 2020, we expect that the long-term impact of reducing access to

SNAP will be to increase food and housing insecurity as well as to reduce access to healthcare in Dane County. These concerns are heightened during the current pandemic as families are being told to stay at home, so long as they have access to food and shelter, to reduce the transmission of COVID-19.

6. Dane County emergency food providers like food banks and pantries have reported seeing significant increases in participation by vulnerable groups since March. Additionally, food costs are increasing and there are new challenges for accepting donated food and school-age children remain out of school where many often get free and reduced breakfast and lunch. We are concerned for our emergency food partners' ability to sustain these high levels of emergency feeding indefinitely throughout this crisis. In short, this is a perfect storm for an increase in hunger in our community. Historically, when the economy worsens and hunger increases, hunger increases the most for racial and ethnic minorities, immigrants, families with children, and other vulnerable groups. For this reason, PHMDC believes that our immigrant community will acutely experience the negative public health effects of the pandemic-related economic downturn, and that this harm will be exacerbated by fear and confusion around the public charge rule. Supporting eligible community members' access to food through WIC and SNAP would help ensure that the emergency food safety net remains available and sustainable. The public charge rule has made doing so significantly more difficult.

7. Since the COVID-19 global health emergency began, our community partners have expressed elevated difficulties in supporting the immigrant community in Dane County. The public charge rule has eroded the trust of many of our immigrant households in the institutions of government and healthcare because they are concerned that choosing to access public benefits is necessarily tied to immigration processing and enforcement. That loss of trust has resulted in these

families avoiding contact with supportive services and has increased the difficulty in reaching these communities with important messaging and information about the COVID-19 pandemic such as where households can access resources and what to do in the event that they are exposed to the virus.

8. PHMDC is aware that U.S. Citizenship and Immigration Services (USCIS) issued an alert in March explaining that the public charge rule "does not restrict access to testing, screening, or treatment of communicable diseases, including COVID-19." That notice, however, was only posted only in English and states that USCIS will still "consider the receipt of certain cash and non-cash public benefits, including those that may be used *to obtain testing or treatment* for COVID-19 in a public charge inadmissibility determination," including most types of Medicaid. *See* https://www.uscis.gov/greencard/public-charge (emphasis added). Some Dane County immigrant communities do not appear to be aware of this notice while other immigrant populations we speak to remain concerned about accessing healthcare that would provide access to COVID-19 testing and treatment because of public charge concerns.

9. We believe that in order to ensure all members of our community are able to safely shelter in place and social distance during the COVID-19 pandemic, access to healthcare, food, and housing are paramount. Restricting access to these fundamental, life-sustaining necessities will only worsen the spread of COVID-19. Losing access to such programs will force families to choose between their access to healthcare during this epidemic and how often they eat or whether they can access safe and affordable living conditions. The health of Dane County requires everyone to have access to the necessities they need to be well. The public charge rule has complicated PHDMC's work to advance toward this goal, especially during the COVID-19 pandemic.

DATED this 9th day of April, 2020 at Dane County, WI

Janel Heinrich

No. 19A785

In the
Supreme Court of the United States

DEPARTMENT OF HOMELAND SECURITY, et al.,

Applicants,

v.

NEW YORK, et al.,

Respondents.

I, Dana Kennedy, pursuant to 28 U.S.C. § 1746, hereby declare as follows:

1. I am the Director of Community Partnerships at the Center for Health Progress ("CHP") in Denver, Colorado. In that role, I work to build the capacity of Colorado's healthcare systems to better serve patients, especially focused on healthcare providers providing care to immigrant communities. In partnership with several organizational partners, I offer trainings and direct support to healthcare providers and communities on issues related to the impact of immigration status on the availability of healthcare. As the Director of Community Partnerships, I also collaborate closely with several colleagues at CHP who are in constant, direct communication with immigrant communities concerning their healthcare needs and associated policies that impact their access to healthcare and related resources. I have worked with CHP for three and a half years and for more than fifteen years in the field of community health. I submit this declaration in support of Respondents' application in the above-captioned matter.

2. At the Center for Health Progress, our mission is to create opportunities and eliminate barriers to health equity for Coloradans. Our work with communities throughout

Colorado stems from the belief that all Coloradans should have the opportunity to live a healthy life. As part of this work, we center the leadership of people most impacted systemic inequities in the healthcare system to work with healthcare providers and policymakers to ensure that all individuals and families can get the care they need. CHP partners with and serves communities from diverse backgrounds, including Latino, East African, and Somali immigrants.

3. In my work with CHP, I concentrate on building capacity among healthcare providers, especially those serving large immigrant populations, to better provide service to their patients. To do this most effectively, I regularly solicit feedback from hospitals, clinics, and other healthcare providers as to the issues causing the greatest difficulty in reaching underserved populations and promoting community health. I also regularly interact with benefits enrollment workers based in healthcare clinics to assess their needs and maximize enrollment among eligible members of immigrant populations in benefits programs, including enrollment of U.S. citizen children from immigrant households.

4. State organizers at CHP play a critical role in advancing our mission, each providing one-on-one support to between five and ten immigrant clients who are facing difficulties accessing healthcare every day. Prior to the COVID-19 quarantine, CHP organizers also regularly delivered trainings to larger groups. As part of their work, organizers empower leaders from the community to educate their peers and policymakers concerning the realities of accessing healthcare in the United States. CHP organizers have deep knowledge of the communities they partner with because of their personal experiences as immigrants themselves and/or because they spent decades growing up in the communities they serve. In some cases, CHP organizers have personally navigated healthcare systems as immigrants or have done so for family members. This personal expertise is extremely beneficial in identifying the most pressing challenges that

immigrant communities in Colorado face in obtaining necessary healthcare, such as language barriers, affordability, and fears associated with immigration status. Their personal experiences allow them to better assist Colorado's immigrant communities by providing culturally competent support. I regularly speak with CHP organizers and have personal knowledge of their observations and information they gather from communities they work with.

The Public Charge Rule Has Created Fear and Confusion Among CHP Clients

5. Over the past two years — and especially since the Supreme Court stayed lower court orders preventing the DHS public charge rule from being implemented in January — CHP organizers report that addressing healthcare needs in the immigrant community has become significantly more difficult. For example, some families that organizers speak with have withdrawn their U.S. citizen children from healthcare coverage out of a mistaken fear that their children's coverage will trigger immigration consequences related to public charge. Families are also generally frightened and confused about who the rule applies to and how, and are forgoing services they are eligible for because of this fear. These community members believe that they must make an extremely painful choice between accessing assistance they need and are eligible for and keeping their families together.

6. Confusion and fear among immigrants as to how public charge applies is widespread across a variety of programs. Since the mid-January, 2020, CHP staff have encountered many families who withdrew from healthcare, nutrition, and other support systems, often disenrolling or refraining from enrolling eligible citizen children into those programs. For example, CHP staff counseled a single mother of an autistic U.S. citizen child. The client was afraid to enroll her son in necessary healthcare and educational services because of fear that it would complicate her pending application for adjustment to permanent residency in the United

States, despite the rule's exclusion of benefits received by the eligible citizen children from the public charge test. Similarly, classes of immigrants to whom the public charge rule does not apply, such as Lawful Permanent Residents, have also disenrolled from services out of the mistaken fear that they could face immigration consequences for receiving benefits. In other cases, community members have received the incorrect impression that receiving assistance not covered by the public charge rule, such as accepting donations from food banks or allowing their children to access free school lunch, will have immigration consequences associated with public charge. One particularly troubling example involved a pregnant woman in her third trimester who told CHP staff that she was foregoing prenatal care because she believed that any hospital bills she might accrue would complicate her ability to adjust her immigration status in the future even though medical assistance received while pregnant is not considered during the test. Although CHP organizers spend many hours trying to explain how the complex public charge rule operates and connecting clients to services they are eligible for, it is extremely difficult to combat the fear that the individual has without certainty that they will not be affected by the rule. For this reason, many families continue to disenroll or refrain from enrolling despite our efforts.

7. On April 2, 2020, a CHP organizer spoke with an immigrant mother from El Salvador with questions about healthcare options for her U.S. citizen daughter. The caller is in the process of applying for permanent residence and is fearful of accepting any benefits for her daughter at this time. She informed the CHP organizer that she plans to let her daughter's Medicaid coverage lapse, because she fears that her continued enrollment in the program will count against her as she tries to adjust her status.

The Rule Has Erected Barriers to Healthcare Access

8. Like CHP organizers, healthcare providers have similarly expressed deep concern about their ability to provide services to patients in need because of community fears associated with public charge. Since the beginning of the year, each training I have presented to providers related to healthcare access among immigrants has prompted questions from attendees about the impacts of the public charge rule, even where the training was otherwise unrelated to public charge. Interest among hospital and clinic personnel in providing accurate information and learning ways to overcome fear of public charge in the immigrant community has necessitated additional learning by CHP and demonstrates the scope of the rule's impact on healthcare systems in Colorado. I have witnessed first hand a marked increase in questions about public charge from healthcare clinics and other providers, as well as from human and social services organizations since January 2020.

9. Healthcare clinics, which provide low-cost medical services on a sliding scale for people who do not have health coverage, frequently offer to assist eligible immigrants and their children with enrollment in healthcare services like Medicaid, or for other coverage like Colorado's Child Health Plan Plus. As recently as early April, clinics report that many eligible immigrants have refused enrollment in these programs because of mistaken beliefs about potential immigration consequences for receipt of healthcare benefits under public charge and associated fears. Each clinic that I have spoken to this year about their work with immigrant communities has described this problem.

CHP Clients Remain Fearful of Accepting Healthcare Services During the COVID-19 Pandemic

10. The current national crisis has furthered the need for CHP to assist immigrant families. Due to Colorado's state-wide stay-at-home order in response to the COVID-19 pandemic, CHP closed its offices and stopped providing in-person services to communities. CHP's staff has

shifted to providing services over the phone wherever possible. Call volume since CHP staff began working remotely has been extremely high. During this time, CHP has heard from several immigrant clients who are uninsured or at risk of losing their insurance and has assisted them with access to coverage and/or medical services.

11. Since Monday, March 23, 2020, the majority of calls to CHP have been from clients from immigrant communities who are confused or frightened about how their families will be impacted by COVID-19. Clients have asked for information about symptoms, for simple, understandable descriptions of the meaning of shelter-in-place, as well as questions about how to access needed items like school supplies, and who qualifies as an "essential worker." CHP staff have also received calls from immigrant clients expressing interest in federal support programs available to them due to economic hardship they have experienced because of the pandemic, but who fear accepting assistance because of immigration consequences related to public charge. Some have chosen not to seek out nutritional and health benefits due to public charge related fears.

12. Since closing its offices, CHP has focused on ensuring that individuals without insurance can still access healthcare. As part of this effort, CHP is in frequent contact with healthcare clinics that provide low-cost services and is gathering information about any challenges that healthcare facilities are experiencing in serving immigrant communities, including where community members show symptoms of COVID-19. On Friday, March 27, 2020, I spoke with a community partner concerned with whether and how immigrant clients can access testing for COVID-19 given various barriers to healthcare access they experience. Since then, CHP has increasingly heard from immigrants about their fears related to accessing any COVID-19-related services, other healthcare, or basic support services. While this has always been true to a degree,

we have observed greater anxiety in the community because of the degree of economic uncertainty the country is facing and fears of job loss.

13. On March 20, 2020 at a Pueblo food bank, two CHP organizers spoke with a woman seeking services. She sought out CHP staff to ask whether it was possible to get COVID-19 testing anonymously. Although she and her husband were fearful of flu-like of symptoms, she refused a referral to a clinic because she was afraid that it would impact her immigration status. An executive director of a community development non-profit in Commerce City, Colorado has also reported to me directly that several clients with mixed status families — where some family members have permanent immigration status and others do not — have described flu-like symptoms in their households. These families are afraid to seek medical care at local clinics because they believe that testing and related services could someday count against them under the public charge rule. According to the director, "this puts the rest of their family and the entire community at risk for contracting COVID-19."

14. We are aware that U.S. Citizenship and Immigration Services (USCIS) posted an alert in English only in March explaining that public charge rule "does not restrict access to testing, screening, or treatment of communicable diseases, including COVID-19." This notice also stated that USCIS would still "consider the receipt of certain cash and non-cash public benefits, including those that may be used to obtain testing or treatment for COVID-19 in a public charge inadmissibility determination," including most forms of federally funded Medicaid. *See* https://www.uscis.gov/greencard/public-charge. While we have emphasized the notice in sharing information with our clients, communities that CHP works are typically unaware of this notice until we reach them. Despite this notice, the immigrant populations we speak to remain concerned about accessing healthcare coverage or low-cost care and organizations who work with our

communities continue to ask questions about whether immigrant clients can access COVID-19 testing.

15. The dangers of COVID-19 to the immigrant communities that CHP partners with and serves are extremely worrisome to me and to my colleagues. A significant portion of our client population works in rural towns, such as Fort Morgan, Colorado, where many are employed as essential workers in meatpacking plants, dairies, or sugar beet factories. Our clients in those industries will remain exposed to crowds of their coworkers and will therefore be at greater risk for COVID-19 infections than people who are sheltering-in-place. However, most of our clients who work in Fort Morgan are immigrants — many of whom are uninsured — and would avoid healthcare if they were to show signs of COVID-19 infection either because they cannot afford to pay out-of-pocket costs or because they are afraid that receiving free services would subject them to immigration consequences under the public charge rule. The likelihood that they would avoid care because of economic and immigration concerns risks not only their health, but the health of other people in their workplace. Other clients we serve throughout Colorado in various essential industries face similar risks. They are terrified of being separated from their families. This fear is likely to prompt them to not only refuse to seek care — even in times of serious need — for themselves and also for children who may be exposed to COVID-19, as other clients have prior to the pandemic.

DATED this 9th day of April, 2020 at Denver, Colorado

Dana Kennedy

No. 19A785

In the
Supreme Court of the United States

DEPARTMENT OF HOMELAND SECURITY, et al.,

Applicants,

v.

NEW YORK, et al.,

Respondents.

I, Camille Kritzman, pursuant to 28 U.S.C. § 1746, hereby declare as follows:

1. I am a case manager at Integrated Refugee & Immigrant Services ("IRIS"). IRIS, which primarily serves as a refugee resettlement program based in Connecticut, provides refugees with a variety of services designed to help them on the road to self-sufficiency by providing lifesaving support during their transition to life in the United States. IRIS also works with asylees, individuals seeking asylum in the United States, undocumented immigrants, as well as other non-refugee immigration status. I work as a case manager for immigrants seeking asylum. As a case manager, I help my clients enroll their children in school, assist them in obtaining immigration assistance, and connect my clients with a variety of social services, including services provided by IRIS or the State of Connecticut. I have worked for IRIS for the last year and graduated from the University of Connecticut in 2013. I have personal knowledge of all of the facts set forth in this declaration.

2. Since the Public Charge Rule went into effect at the end of February, I have observed that many of my clients who are eligible for social services have refused to apply for those necessary social services.

3. For example, at the end of February 2020, one of the families that I work with disenrolled from HUSKY, the State of Connecticut's public health coverage program for eligible children, parents, relative caregivers, elders, individuals with disabilities, adults without dependent children, and pregnant women, because they feared that there could be immigration consequences to their continued enrollment. The parents worried that if they enrolled in health insurance, they would risk negative immigration consequences and feared being separated from their child for immigration reasons.

4. The COVID-19 crisis has caused many of my clients to lose their employment, and many face serious food insecurity. However, some of my clients have refused to sign up for food benefits because they fear the immigration consequences of accessing those services. For example, in March of 2020, one family that I work with told me that it was better for them to be without food than to apply for SNAP because they feared adverse immigration consequences. Another client recently refused to sign up to use IRIS's own food pantry because of the Public Charge Rule. I could not convince this client—who is currently unemployed because of the COVID-19 epidemic—to access this necessary food resource, even though use of the food pantry is totally outside of the scope of the Rule.

DATED this 4/10/2020 day of April, 2020 at New Haven, CT

DocuSigned by:
Camille Kritzman
A651A9A47E89494...
CAMILLE KRITZMAN

No. 19A785

In the
Supreme Court of the United States

DEPARTMENT OF HOMELAND SECURITY, et al.,

Applicants,

v.

NEW YORK, et al.,

Respondents.

I, **Leighton Ku**, pursuant to 28 U.S.C. § 1746, hereby declare as follows:

1. My name is Leighton Ku. I have personal knowledge of and could testify in Court concerning the following statements of fact.

2. I am a Professor of Health Policy and Management and Director of the Center for Health Policy Research at the Milken Institute School of Public Health, George Washington University in Washington, DC. I have attached my Curriculum Vitae as Exhibit A to this Declaration.

3. I am a health policy researcher with over 25 years of experience. I have conducted substantial research about immigrant health, and health care and costs. I have authored or co-authored more than a dozen articles and reports about immigrant health issues, including articles in peer-reviewed journals such as Health Affairs and American Journal of Public Health, as well as scholarly reports published by diverse non-profit organizations including the Social Science Research Network, the Migration Policy Institute, the Cato Institute,

and the Commonwealth Fund, as well as many more articles and reports on other subjects. I have testified before the U.S. Senate Finance Committee about immigrant health issues and provided analyses and advice to state governments and non-governmental organizations in many states about immigrant health.

4. I have expertise in quantitative data analysis and have conducted quantitative analyses for most of my career, including analyses for a federal agency and two think tanks and now at a university. I have taught statistical analysis and research methods at the graduate school level for over 25 years, training hundreds of graduate students, as well as dozens of federal and state budget and policy analysts. I have authored or co-authored more than 90 papers in peer-reviewed journals and hundreds of other reports, most of which were quantitative analyses. As a quantitative health data analyst, I have consulted with the Congressional Budget Office and numerous federal and state agencies.

5. I provided expert declarations about the potential effects of the public charge rule in September 2019[1] and January 2020,[2] the President's healthcare proclamation in October 2019 and January 2020,[3] and the effects of terminating DACA on health insurance coverage and states

[1] Declaration of Leighton Ku in Support of Plaintiffs' Motion for a Preliminary Injunction (regarding public charge regulation), *Make the Road New York, et al v Ken Cuccinelli, et al.* in United States District Court, Southern District of New York, Sept. 9, 2019; *State of New York, et al. v. U.S. Department of Homeland Security, et al*. in United States District Court, Southern District of New York, Sept. 9, 2019; *La Clinica de la Raza, et al. v. Donald Trump, et al.* in United States District Court, Northern District of California, September 1, 2019.

[2] Declaration of Leighton Ku in *Make the Road New York, et al. v. Pompeo et al.* ("*MRNY v. Pompeo*") in the United States District Court, Southern District of New York, Dec. 22, 2019. In *MRNY v. Pompeo*, plaintiffs seek not only an injunction of the Department of State public charge rule, but the President's November 4, 2019 Healthcare Proclamation. My declaration was filed in support of the plaintiffs' motion to enjoin both policies.

[3] In addition to submitting a declaration in the *MRNY v. Pompeo* case on the healthcare proclamation, my declaration regarding the healthcare proclamation was filed in the *Doe v. Trump* case filed in the District of Oregon.

in November 2017[4] and in June 2018.[5] I have not provided testimony in any other court cases in the past four years.

6. I also have knowledge of health insurance and employment through my role as a voluntary (unpaid, appointed) Executive Board member for the District of Columbia's Health Benefits Exchange Authority, which governs the District's health insurance marketplace, formed under the federal Affordable Care Act. This includes oversight of health insurance for small businesses as well as individual health insurance in the District of Columbia.

7. I have a Ph.D. in Health Policy from Boston University (1990) and Master of Public Health and Master of Science degrees from the University of California at Berkeley (1979). Prior to becoming a faculty member at George Washington University, I was on the staff of the Urban Institute and the Center on Budget and Policy Priorities.

8. I have been engaged by counsel for the Plaintiffs in this case to analyze the effect of the new public charge rule on Medicaid enrollment, public health, and health systems, and the implications regarding the current coronavirus (COVID-19) pandemic.

Public Charge and Public Health Risks Related to COVID-19

9. The alarming onset of the global pandemic of the novel coronavirus, COVID-19, has created serious public health risks for the United States and other nations. As a contagious virus, COVID-19 is spreading broadly and threatens citizens and immigrants alike. Along with public health measures, such as social distancing and self-quarantines to reduce the risk of infection, medical measures such as testing for COVID-19 and prompt treatment are critical. But

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[4] Declaration of Leighton Ku in *State of New York, et al. v Donald Trump, et al.* in the United States District Court for the Eastern District of New York, Nov. 22, 2017.

[5] Declaration of Leighton Ku in *State of Texas v. United States of America, et al. and Karla Perez, et al., Defendant-Intervenor* in the United States District Court for the Southern District of Texas, Brownsville Division, June 14, 2018.

those who are uninsured will face serious barriers if they are unable to pay for COVID-19 testing, prevention, and treatment, or if they are otherwise deterred from accessing care.[6] Data about the cost of COVID-19 treatment are unclear, but the cost of treatment for one early patient for less than a week of treatment was $34,927.43, an amount greater than the annual income of many low and moderate-income Americans.[7]

10. The Department of Homeland Security's 2019 "public charge" rule makes it extremely difficult for lawful immigrants to gain permanent residency or to adjust their status if they have received federal Medicaid, thereby creating additional risks that they will be uninsured or avoid medical care.[8] (Receipt of federal Medicaid is a highly weighted negative factor in a determination of inadmissibility.) As documented in my declaration dated September 9, 2019, there is strong evidence that the public charge rule creates fear and a "chilling effect" that would lead many members of immigrant families—even family members who are citizens—to avoid federal Medicaid coverage and similar forms of state insurance[9] and to reduce their use of health care services.[10]

11. The threat of COVID-19 and the urgency of the treatment it requires makes the

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[6] Tolbert J. What Issues Will Uninsured People Face with Testing and Treatment for COVID-19? Kaiser Family Foundation. March 18, 2020. https://www.kff.org/uninsured/fact-sheet/what-issues-will-uninsured-people-face-with-testing-and-treatment-for-covid-19/. There is not yet a vaccine to prevent COVID-19 infection, although there are efforts to develop a vaccine. If and when a vaccine becomes available, then lack of insurance could pose a financial barrier to vaccination as well, or otherwise deter noncitizens from accessing a vaccine.

[7] Abrams A. Total Cost of Her COVID-19 Treatment: $34,927.43. *Time.* Mar. 19, 2020. https://time.com/5806312/coronavirus-treatment-cost/.

[8] Department of Homeland Security. Final Regulations: Inadmissibility on Public Charge Grounds. Federal Register. *Federal Register.* Vol. 84, No. 157, pg.: 41290-508. Aug. 14, 2019.

[9] A number of states, such as New York, California the District of Columbia, Illinois and Oregon, offer state-funded Medicaid without federal matching funds (or health insurance akin to Medicaid) to certain low-income immigrants who are not eligible for federally-funded Medicaid, such as children, pregnant women and other adults. The public charge determinations apply only to federally funded Medicaid, but immigrants are likely deterred from these state funded benefits too, since they may not be able to distinguish them from federally funded Medicaid. See L Ku 2019, footnote 1 for more detail about these non-federally funded insurance programs.

[10] *Op cit*, L Ku 2019, footnote 1.

consequences of the chilling effect on accessing health care caused by public charge that I observed in September 2019 even more significant. It has been reported that immigrants are "petrified" about seeking testing and treatment because they worry that the public charge rule could penalize them if they seek care.[11] For example, Rebecca Sanin, president and CEO of the Health and Welfare Council of Long Island, reported recently that nonprofits under her organization's umbrella were "seeing people choosing not to recertify or get services because of the climate of fear and change in policies targeting immigrants."[12] Similarly David Nemiroff, who directs the Long Island Federally Qualified Health Center, said that "[o]ur biggest fear is that people will choose their immigration status over their health care, and where does that leave us regarding COVID-19?"[13] Even if these fears result only in delays in accessing care, not complete avoidance, the public health consequences could be grim if infected persons go undetected and are at increased risk of spreading the disease, or if untreated infections become even more severe.

12. These concerns are consistent with earlier evidence about the adverse consequences of the public charge rule. It is important to remember that immigrant families may include both citizen and non-citizen members; U.S. born children of immigrants are native-born citizens, and many members of immigrant families may also be naturalized citizens or those who have already attained permanent residency. Thus, restrictions under the public charge rule may have serious repercussions for other family members and may affect their behaviors as well. If one member of the family (whether an immigrant or not) goes undetected because of fears about

[11] Jordan M. 'We're Petrified': Immigrants Afraid to Seek Medical Care for Coronavirus. *New York Times.* March 18, 2020. https://www.nytimes.com/2020/03/18/us/coronavirus-immigrants.html

[12] Polsky C. New health care rule draws scrutiny during coronavirus scare. *Newsday.* Mar. 2, 2020. https://www.newsday.com/news/health/coronavirus-immigration-1.42333063

[13] *Ibid.*

the public charge rule, the risk of infection to other members of the family (or household or other community members) rises.

13. Evidence from the late 1990s, when harsh public charge rules and related immigrant restrictions were applied, showed that Medicaid participation fell sharply and U.S.-born citizen children who lived in immigrant families lost benefits, even though these children were eligible and ought not have been affected by these policies; they were harmed by the "chilling effect" that spread through immigrant communities.[14] These fears have arisen again in light of the renewal of harsh public charge policies under the new public charge rules. More recently, even before the current public charge rule went into effect, one in seven members of immigrant families reported avoiding public benefits like Medicaid because they were worried that the public charge rule could lead to adverse immigration consequences against themselves or members of their families.[15] Large numbers of adults in immigrant families reported that they avoided seeking medical care from a doctor, or even talking with teachers or school officials, because of worries that they might be asked about immigration status.[16] Now that the final rule has gone into effect, the repercussions are likely to worsen. In my September 2019 declaration, I drew on evidence from prior research and estimated the public charge rule could cause between

[14] Zimmerman W, Fix M. Declining Immigrant Applications for Medi-Cal and Welfare Benefits in Los Angeles County. Urban Institute. July 1998. https://aspe.hhs.gov/basic-report/declining-immigrant-applications-medi-cal-and-welfare-benefits-los-angeles-county. Fix M, Passel J. Trends in Noncitizens' and Citizens' Use of Public Benefits Following Welfare Reform: 1994-97. Urban Institute. March 1999. https://www.urban.org/research/publication/trends-noncitizens-and-citizens-use-public-benefits-following-welfare-reform.

[15] Bernstein H, Gonzalez D, Karpman M, Zuckerman S. One in Seven Adults in Immigrant Families Reported Avoiding Public Benefit Programs in 2018. Urban Institute. May 2019. https://www.urban.org/sites/default/files/publication/100270/one_in_seven_adults_in_immigrant_families_reported_avoiding_publi_2.pdf

[16] Bernstein H, Gonzalez D, Karpman M, Zuckerman S. Adults in Immigrant Families Report Avoiding Routine Activities Because of Immigration Concerns. Urban Institute. July 2019. https://www.urban.org/sites/default/files/publication/100626/2019.07.22_immigrants_avoiding_activities_final_v2_0.pdf.

1 and 3.2 fewer million members of immigrant families to receive Medicaid. Because of evidence that being uninsured leads to a higher risk of death, the public charge rule could cause about 1,300 to 4,000 additional deaths per year. Given the new evidence about COVID-19, updated estimates of the effects could be even higher.[17]

14. Concerns about immigrants being deterred from accessing appropriate medical care due to the public charge rule have been heightened by the COVID-19 pandemic. Wendy Parmet, Professor of Law at Northeastern University, has written that the public charge rule exacerbates the coronavirus pandemic because it discourages members of immigrant families from seeking medical care. She concluded "the Department of Homeland Security should stay implementation of the public charge rule as a whole—or at least suspend the adverse consequences attached to using Medicaid until after the outbreak passes. There simply is no justification for rushing to implement a rule that may worsen a pandemic. . . . With a pandemic upon us, it doesn't require compassion to ensure that our immigration policies don't threaten public health. It just requires common sense."[18]

15. Because COVID-19 is so recent, we lack authoritative data about the extent to which members of immigrant families and those who are uninsured are deterred from obtaining testing or treatment for COVID-19. But we can draw conclusions about the avoidance of care based on research that immigration status and the lack of insurance coverage are related to health risks during pandemics, using research about the 2009-10 H1N1 influenza (swine flu) pandemic.

16. It has long been recognized that immigrant communities are at elevated risk

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[17] Ku L. New Evidence Demonstrating That the Public Charge Rule Will Harm Immigrant Families and Others. *Health Affairs Blog*. October 9, 2019. https://www.healthaffairs.org/do/10.1377/hblog20191008.70483/full/.

[18] Parmet W. "First Opinion: Trump's Immigration Policies Will Make the Coronavirus Pandemic Worse." *Stat News*. Mar. 4, 2020. https://www.statnews.com/2020/03/04/immigration-policies-weaken-ability-to-fight-coronavirus/.

during pandemics. About a decade ago, the nation experienced the H1N1 influenza pandemic. The Centers for Disease Control and Prevention (CDC) reported that there were about 60.8 million cases in the United States, 274,000 hospitalizations and 12,500 deaths due to H1N1 flu between April 2009 and April 2010.[19] Shortly before the onset of the H1N1 pandemic, CDC convened an expert panel in May 2008 to consider the special challenges of pandemic preparedness of and response for immigrants, who were recognized as a group with special health risks. The panel found that many immigrants are at elevated risk during pandemics because of factors like their limited health insurance coverage, lower vaccination rates, low-incomes, and linguistic and cultural barriers.[20] The panel recommended adopting additional efforts to reduce barriers for immigrants to the receipt of medical care, including efforts to reach out to and communicate with immigrant communities during pandemics.

17. While we lack data about the extent to which immigrants were or have been tested for or treated for H1N1 flu, or for COVID-19, there is evidence that examines the extent to which immigrants obtained medical care through vaccinations. (H1N1 vaccinations became available in late 2009 and early 2010.) Vaccine utilization helps measure the extent to which adults receive medical care to address pandemic infections. A study by researchers at Utah State University highlighted the significance of health insurance coverage for immigrants as a protective factor during pandemics.[21] The study analyzed rates of vaccination for H1N1 influenza in 2010. It found that non-Hispanic white adults were more likely to be vaccinated

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[19] Centers for Disease Control and Prevention. 2009 H1N1 Pandemic. No date. https://www.cdc.gov/flu/pandemic-resources/2009-h1n1-pandemic.html.

[20] Truman B, Tinker T, Vaughan E, et a. Pandemic Influenza Preparedness and Response Among Immigrants and Refugees. *American Journal of Public Health*. 99: S276-S278.

[21] Burger A. Reither E, Hofmann E, Mamelund SE. The Influence of Hispanic Ethnicity and Nativity Status on 2009 H1N1 Pandemic Vaccination Uptake in the United States. *Journal of Immigrant and Minority Health.* 2018; 20:561-68.

than US-born Hispanics, and foreign-born Hispanics were the least likely to be vaccinated. That is, immigrants were less likely to get care than non-immigrants. The study also showed the protective effect of health insurance coverage: those with insurance were twice as likely to be vaccinated as those without insurance. A challenge for immigrants was that immigrant Hispanics were over four times more likely to be uninsured than non-Hispanic whites, creating barriers to getting vaccinated. When the researchers statistically controlled for insurance coverage, Hispanic immigrants were actually slightly more likely to be vaccinated than non-Hispanic white adults. When immigrants have insurance, they are better able to protect themselves through vaccinations; the problem was that so many immigrants are uninsured. This study is consistent with other research that showed how low socioeconomic status was associated with lower H1N1 vaccination rates, while insurance coverage improved vaccination levels.[22]

18. In some cases, uninsured people may be able to receive medical care free through safety net facilities, such as community health centers or government clinics; evidence suggests that the chilling effect leads to reductions in use of services like these, even though the public charge determinations do not apply to such programs. For example, although the public charge rule does not apply to benefits from the Women, Infants and Children (WIC) nutrition assistance program, many immigrants have avoided enrolling in WIC because of public charge fears.[23]

19. The evidence about immigrants' reduced ability to get vaccines, and the improvements that occur when they are able to get insurance, demonstrates (a) that immigrants face greater barriers in getting medical care to protect themselves during pandemics, and (b)

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[22] Maurer J. Inspecting the Mechanism: A Longitudinal Analysis of Socioeconomic Status Differences in Perceived Influenza Risks, Vaccination Intentions and Vaccination Behaviors during the 2009-2010 Influenza Pandemic. *Medical Decision Making.* 2016 October ; 36(7): 887–899.

[23] West M. Fewer Immigrants Sign Up for Food-Subsidy Program. *Wall Street Journal.* Feb. 24, 2020. https://www.wsj.com/articles/fewer-immigrants-sign-up-for-food-subsidy-program-11582584810.

insurance coverage increases immigrants' use of appropriate medical therapies. By discouraging immigrants and other members of their families from using federal Medicaid, the public charge rule creates unnecessary barriers to getting care, such as testing, treatment, or eventually vaccinations that could protect against COVID-19.

20. There could be broader public health repercussions. Since COVID-19 is a communicable disease, higher risk for members of immigrant families creates higher risks of contagion for other members of their communities. Low- and moderate-income immigrants are a large share of the workforce that is essential during pandemics. For example, data from the U.S. Census indicates that immigrants form more than one-third of home health aides and one-quarter of personal care aides, who provide home health care to frail seniors, and constitute one-sixth to one-fifth of the grocery store and food delivery workforce.[24] During the current public health crisis, we are more reliant than ever on workers like these. But if low-wage workers in essential jobs like these—which frequently lack private health insurance coverage—cannot get appropriate medical care and become infected, they could inadvertently increase risks of contagion to their patients and customers, elevating the pandemic risk to others in their communities. That is, protecting immigrants is also in the best interests of non-immigrant members of our communities.

21. Immigrants who are uninsured, due to their concerns about the consequences of the public charge rule and use of Medicaid, place further pressure on the already strained safety net of public and nonprofit hospitals, clinics and emergency rooms, which provide a

[24] New American Economy Research Fund. Immigration & COVID-19. Mar. 26, 2020. https://research.newamericaneconomy.org/report/immigration-and-covid-19/?emci=0ebd83c0-746f-ea11-a94c-00155d03b1e8&emdi=942b7cab-986f-ea11-a94c-00155d03b1e8&ceid=418670; Gelatt J. Immigrant Workers Vital to the U.S. COVID-19 Response, Disproportionately Vulnerable. Migration Policy Institute. March 2020. https://www.migrationpolicy.org/research/immigrant-workers-us-covid-19-response

disproportionate share of care for uninsured and low-income patients. These effects are evenly more strongly felt in areas with larger immigrant populations such as parts of New York, California, Texas, Florida, Illinois, or New Jersey. This was a problem even before COVID-19. In November 2018, prior to final issuance of the public charge regulation, Mitchell Katz, MD, MPH, the executive director of New York City's Health and Hospitals system, who previously led the health departments in Los Angeles County and San Francisco and is one of the nation's foremost authorities on public health care systems stated: "If enacted as proposed, this public charge provision could decrease access to medical care and worsen the health of individuals, threaten public health, and undercut the viability of the health care system."[25] The pressures upon the safety net health care system due to the public charge rule are magnified when the enormous challenges of the COVID-19 pandemic are added. I can illustrate this point using the example of Elmhurst Hospital in the Bronx. Dr. Mitchell Katz recently commented that Elmhurst is most stressed hospital in the New York Health and Hospitals system during the COVID-19 pandemic[26], with a high burden of COVID-19 patients and the related pressure this places on staff, facilities and protective equipment. Elmhurst is a lower-income neighborhood in New York City with a high immigrant population: about 36% of residents are non-citizen immigrants and 32% are naturalized citizens,[27] so public charge rule compounds the problems faced by its public hospital.

22. In the midst of the COVID-19 pandemic, the public charge rule makes it harder for members of immigrant families to seek care because they are more uninsured, which forces

[25] Katz M, Chokshi D. The "Public Charge" Proposal and Public Health: Implications for Patients and Clinicians. *Journal of the American Medical Association*. 2018;320(20):2075-2076. Nov. 27, 2018.

[26] Hicks N, et al. NYC's public hospitals 'holding on' in face of coronavirus, chief says. New York Post. Mar. 26,2020. https://nypost.com/2020/03/26/nycs-public-hospitals-holding-on-in-face-of-coronavirus-chief-says/

[27] National Origin in Elmhurst New York. https://statisticalatlas.com/neighborhood/New-York/New-York/Elmhurst/National-Origin

them to turn to safety net facilities like Elmhurst not only in New York, but in other safety net public hospitals, government clinics and nonprofit community health centers[28] across the United States. Problems related to the pubic charge rule not only increases stress and crowding in these facilities, it also increases the risk of COVID-19 transmission between patients and health care staff. While there has been increase in the use of telehealth services, i.e., digital health care visits in lieu of in-person visits, in recent weeks as a social distancing precaution to reduce the risk of contagion, low-income and immigrant populations have less access to the internet, whether through broadband connections or smartphones.[29] Moreover, while there have been efforts to upgrade the extent to which health insurance can pay for telehealth visits[30], no such mechanism exists for those who are uninsured. As a result, uninsured immigrant patients are likely to be more reliant on in-person care seeking, exacerbating the pressure on safety net health care providers and increasing the risk of patient-health care staff disease transmission.

23. In addition to the health risks of COVID-19 infection, the pandemic is causing unprecedented economic losses that are also placing immigrants at risk as businesses close or scale down during the pandemic. The latest data indicate that more than 10 million Americans filed for unemployment benefits in March, and it seems likely that these numbers will continue to grow.[31] (Because only some are eligible for unemployment benefits, the actual number who

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[28] Stone W. Under Financial Strain, Community Health Centers Ramp Up for Coronavirus Response. National Public Radio. Mar. 24, 2020. https://www.npr.org/sections/health-shots/2020/03/24/821027067/under-financial-strain-community-health-centers-ramp-up-for-coronavirus-response

[29] Anderson M, Kumar M. Digital divide persists even as lower-income Americans make gains in tech adoption. Pew Research Center. May 7, 2019.

[30] Moss K, et al. The Families First Coronavirus Response Act: Summary of Key Provisions. Kaiser Family Foundation. Mar. 20, 2020. https://www.kff.org/global-health-policy/issue-brief/the-families-first-coronavirus-response-act-summary-of-key-provisions/

[31] Heather Long. Over 10 million Americans applied for unemployment benefits in March as economy collapsed. *Washington Post.* April 2, 2020. https://www.washingtonpost.com/business/2020/04/02/jobless-march-coronavirus/

have lost jobs is higher, and the number who have experienced serious income losses is even greater.) As an Executive Board member of the District of Columbia's Health Benefits Exchange Authority, I have been informed that Medicaid applications surged in March; national data are not yet reported. Immigrant workers are disproportionately vulnerable to job and income loss during this economic downturn because they are often employed in industries like hotels, restaurants, construction, and service industries.[32] Millions of Americans, including both immigrants and non-immigrants, who have worked hard are now finding themselves desperately in need of economic and health assistance. While Medicaid serves as a health insurance safety net for most Americans in times of need, those who are non-citizen immigrants are at risk of being determined to be public charges if they enroll in Medicaid because of the policy of U.S. Citizenship and Immigration Service (USCIS). The newly unemployed immigrants—who could number in the millions—may have been employed for years, but they will be placed in jeopardy if they use Medicaid when they lose their jobs and private insurance because of the economic disaster. (Many of those whose incomes fall may be eligible for subsidized insurance using advance premium tax credits under the Affordable Care Act's health insurance marketplaces, but those with incomes below the poverty line are not eligible for the tax-subsidized insurance and could only get coverage from Medicaid or similar state-funded programs.)

24. New data confirm that job loss has been more severe among immigrants and that the demand for Medicaid coverage will rise greatly, although immigrants face barriers accessing Medicaid benefits because of the public charge rule. New data from the federal Bureau of Labor Statistics shows that immigrants are losing employment faster than the native-born. Between February and March 2020, the government estimates that the number of immigrant adults who

[32] Gelatt J., *op cit.*

are unemployed rose by 31 percent in just one month, while the number of native-born adults unemployed grew by 14 percent.[33] Unemployment is rising rapidly and immigrants are disproportionately at risk. Preliminary analyses by Health Management Associates project how health insurance coverage will change because of rising unemployment; they estimate that, depending on how high U.S. unemployment levels rise, the number of Americans with employer-sponsored coverage could fall from 163 million (pre-COVID) to between 129 and 151 million, the number on Medicaid could rise from 71 million (pre-COVID) to 82 to 94 million, and the number of uninsured could rise from 29 million (pre-COVID) to as high as 30 to 40 million.[34] In the face of rising unemployment and poverty, Medicaid will prevent millions from becoming uninsured and help maintain their access to medical care. Unfortunately, the public charge rule sharply reduces the ability of immigrants (and their family members) to get Medicaid coverage, lest its use threatens their immigration status, and thereby lowers their access to medical care.

25. In late March 2020, the USCIS posted new guidance about public charge and COVID-19 on its website.[35] The new guidance states: "USCIS encourages all those, including aliens, with symptoms that resemble Coronavirus Disease 2019 (COVID-19) (fever, cough, shortness of breath) to seek necessary medical treatment or preventive services. Such treatment or preventive services will not negatively affect any alien as part of a future Public Charge analysis." However, the guidance then continues to state that the receipt of Medicaid benefits

[33] Comparison of data for February 2020 and March 2020, based on Table A-7 from U.S. Bureau of Labor Statistics. The Employment Situation: March 2020. Apr. 3, 2020 and The Employment Situation: February 2020. Mar. 6, 2020. https://www.bls.gov/news.release/pdf/empsit.pdf.

[34] Health Management Associates. COVID-19 Impact on Medicaid, Marketplace, and the Uninsured, by State. Apr. 3, 2020. https://www.healthmanagement.com/wp-content/uploads/HMA-Estimates-of-COVID-Impact-on-Coverage-public-version-for-April-3-830-CT.pdf

[35] U.S. Citizenship and Immigration Services. Public Charge. New undated Alert https://www.uscis.gov/greencard/public-charge. Accessed on March 25, 2020.

can be used as grounds for a determination of inadmissibility, which is core tenet of the public charge rule.

26. A key deficiency in the USCIS policy is that health insurance is the primary method used to pay for medical care, such as testing and treatment. Access to Medicaid creates access to medical care, including testing, treatment, and prevention services. Studies have consistently shown, for example, how the recent expansion of Medicaid eligibility under the Affordable Care Act led to greater use of medical care, including vaccinations and HIV testing.[36] When people are uninsured, they are less able to use medical care because they have financial barriers that deter them from care; they may avoid or delay care, or health care providers might refuse to provide care if they cannot pay. Thus, even though USCIS says that COVID-19 testing and treatment will not count in public charge determinations, it has created a Catch-22, since the Medicaid coverage that would make such services affordable could trigger a public charge determination of inadmissibility which jeopardizes immigrants' ability to remain in the United States. Thus, immigrants are still going to encounter barriers getting COVID-19 care because of the core public charge rule, despite the new statement. Moreover, since much of the medical harm of COVID-19 is related to other medical problems, such as heart disease, asthma, or diabetes, effective treatment may involve care for other medical problems for which insurance is necessary.

27. A second deficiency is that the major response to the public charge rule has been fear and confusion in immigrant communities; it is hard to believe that this new administrative

[36] Tummalapalli S.L., Keyhani S. Changes in Preventative Health Care After Medicaid Expansion. *Medical Care*. 2020 Feb 5. Online ahead of print. Mahmoudi E, Cohen A, Buxbaum J, Richardson CR, Tarraf W. Gaining Medicaid Coverage During ACA Implementation: Effects on Access to Care and Preventive Services. *Journal of Health Care for the Poor and Underserved*. 2018;29(4):1472-1487.

clarification (on a somewhat obscure federal website) will undo the greater confusion and chilling effect that the public charge regulation has already engendered. As described above, fears about public charge have deterred many from enrolling in programs like WIC, even though public charge does not apply to that benefit, and have also caused members of immigrant families who are citizens to withdraw from benefits even though they are also not supposed to be affected. Even if some COVID-19 services are free, the shadow of the public charge rule will keep many from using the services.

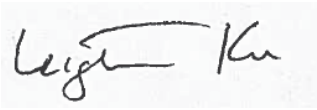
28. As noted earlier, a number of states, including New York, California, Illinois, Oregon and the District of Columbia, offer state-funded Medicaid or similar insurance benefits to certain immigrants without federal matching funds. The public charge rule does not apply to these non-federally funded benefits, but the chilling effect of the public charge rules can deter eligible immigrants from using these benefits as well and continue to reduce access to medical care. USCIS has failed to ensure that immigrants and members of their families are aware that these non-federally funded benefits remain safe.

29. Cancelling or suspending the public charge rule is the more effective way to ensure access to appropriate medical services in order reduce the risks of the COVID-19 pandemic for immigrants, members of their families, and the communities in which they live, and to ensure that everyone has access to appropriate medical care. Such an approach is more consistent with sound public health policy.

30. This is a public health emergency of national scope, which merits prompt national policy responses. Cases of COVID-19 infection, which exceeded 427,000 as of April 9, 2020, have been identified in every state in the Union. The number of reported cases has been the highest in New York State (over 149,000), but as of April 9, the majority of states have reported

more than 1,000 cases, including New Jersey, California, Washington state, Florida, Massachusetts, Texas, Illinois, Louisiana, Michigan, Mississippi, North Carolina, South Carolina Ohio, Pennsylvania, Tennessee, Colorado, Arizona, Indiana, Iowa, Missouri, Nevada, Connecticut, Virginia, the District of Columbia, Idaho, Utah, Kansas, Arkansas, Minnesota, Wisconsin and Kentucky.[37] These numbers are expected to grow and spread across the nation in the coming weeks.

DATED this 13th day of April, 2020 at Washington, D.C.



Leighton Ku

[37] Centers for Disease Control and Prevention. COVID-19 Cases in the United States. Updated as of April 9, 2020. https://www.cdc.gov/coronavirus/2019-ncov/cases-updates/cases-in-us.html.

EXHIBIT

A

CURRICULUM VITAE

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Summary

Leighton Ku, PhD, MPH, is a professor of health policy and management at the George Washington University (GW). He is a nationally known health policy and health services scholar with more than 25 years of experience. He has examined topics such as national and state health reforms, access to care for low-income populations, Medicaid, preventive services, the health care safety net, cost and benefits of health services, and immigrant health. He has authored or co-authored more than 90 peer-reviewed articles and 200 policy briefs and other translational reports. He directs the Center for Health Policy Research, a multidisciplinary research center, which includes physicians, attorneys, economists, health management and policy experts and others, with more than 20 faculty and dozens of staff; it has a research portfolio in excess of $25 million. He has been principal investigator for a large number of studies with support from the National Institutes of Health, Centers for Disease Control and Prevention, Centers for Medicare and Medicaid Services, the Commonwealth Fund and Robert Wood Johnson Foundation, and other sources. In the course of his career at GW, the Center on Budget and Policy Priorities and the Urban Institute, he has worked with federal and state executive and legislative agencies, health care organizations, advocates and others in research, technical assistance, strategic advice and advocacy. As a faculty, he has taught research methods and policy analysis at the graduate level for more than 25 years and guided numerous students through dissertations and other research. As a member of his community, he helped establish and guide the District of Columbia's Health Benefits Exchange Authority as a founding member of its Executive Board.

Education

1990	Ph.D., Health Policy, Boston University (Pew Health Policy Fellow in a joint program of Boston University and Brandeis University)
1979	M.P.H., Public Health, University of California, Berkeley
1979	M.S., Nutritional Sciences, University of California, Berkeley
1975	A.B. (honors), Biochemistry, Harvard College

Professional Background

2015 – present	Co-Director, PhD Health Policy Program. First at GW Trachtenberg School of Public Policy and Administration, now at Milken Institute School of Public Health.
2012 - present	Executive Board, District of Columbia Health Benefit Exchange Authority (voluntary position).
2008 - present	Director, Center for Health Policy Research, The George Washington University

2008 - present	Professor of Health Policy and Management (with tenure), Department of Health Policy and Management, Milken Institute School of Public Health, The George Washington University.
2015- 2016	Interim Chair, Department of Health Policy and Management
2000 - 2008	Senior Fellow, Center on Budget and Policy Priorities, Washington, DC
1992 - present	Professor in Public Policy and Public Administration, Trachtenberg School of Public Policy and Administration, The George Washington University. Secondary appointment. Began as Associate Professorial Lecturer.
1990 - 2000	Principal Research Associate. The Urban Institute, Washington, DC. Began as Research Associate I.
1989 - 1990	Research Manager, SysteMetrics/McGraw-Hill, Cambridge, MA.
1987 - 1989	Pew Health Policy Fellow, Health Policy Institute, Boston University and the Heller School, Brandeis University
1980 - 1987	Program Analyst, Office of Analysis and Evaluation and Supplemental Food Programs Division, Food and Nutrition Service, U.S. Dept. of Agriculture, Alexandria, VA and Washington, DC.
1975 - 1976	Registered Emergency Medical Technician, Dept. of Health and Hospitals, Boston, MA

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[Aggregate measures of scholarly productivity: H-index = 44, I10-index = 119 (according to Google Scholar as of June 26, 2019.]

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[Note between 2000 and 2008, I was working at the Center on Budget and Policy Priorities and was not principally working on refereed publications.]

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Ku L, Bruen B. The Continuing Decline in Medicaid Coverage, Assessing the New Federalism Brief A-37, The Urban Institute, December 1999.

Ku L, Ullman F, Almeida R, What Counts? Determining Medicaid and CHIP Eligibility for Children, Assessing the New Federalism Discussion Paper 99-05, Washington, DC: The Urban Institute, 1999.

Ku L, Hoag S. Medicaid Managed Care and the Marketplace: State Health Reforms in Hawaii, Oklahoma, Rhode Island and Tennessee, Report to the Health Care Financing Administration from the Urban Institute and Mathematica Policy Research, February 1998.

Ku L, Kessler B. The Number and Cost of Immigrants on Medicaid: National and State Estimates, Report to the Office of the Assistant Secretary for Planning and Evaluation from the Urban Institute, December 1997. [PR]

Ku L, Berkowitz, A., Ullman F, Regenstein M. Health Policy for Low-Income People in Mississippi, Assessing the New Federalism, Washington, DC: The Urban Institute, December 1997. [PR]

Nichols L, Ku L, Norton S, Wall S. Health Policy for Low-Income People in Washington Assessing the New Federalism, Washington, DC: The Urban Institute, November 1997. [PR]

Ku L, Wall S. The Implementation of Oklahoma's Medicaid Reform Program: SoonerCare, Report to the Health Care Financing Administration from the Urban Institute and Mathematica Policy Research, October 1997. [PR]

Ku L, Coughlin T, The Use of Sliding Scale Premiums in Subsidized Insurance Programs, Urban Institute Working Paper, March 1997. [PR]

Ku L, Coughlin T, How the New Welfare Reform Law Affects Medicaid, Assessing New Federalism Policy Brief No. A-7, the Urban Institute, February 1997. [PR]

Wooldridge J., Ku L, Coughlin T, Dubay L, Ellwood MR, Rajan S, Hoag S., Reforming State Medicaid Programs: First Year Implementation Experiences from Three States, Mathematica Policy Research, January 1997. [PR]

Wooldridge J, Ku L, Coughlin T, Dubay L, Ellwood MR, Rajan S, Hoag S. Implementing State Health Care Reform: What Have We Learned from the First Year? The First Annual Report of the Evaluation of Health Reform in Five States. Report to the Health Care Financing Administration, from Mathematica Policy Research Inc. and the Urban Institute, December 1996. [PR]

Ku L, Wade M, Dodds S. How Cost-Reimbursement Affected Patients, Health Centers and Medicaid: The Federally Qualified Health Center Program, Report to the Health Care Financing Administration, from the Urban Institute and Mathematica Policy Research, Inc., August 1996.

Long S, Ciemnecki A, Coughlin T, Kenney G, Ku L, Mitchell J, Rajan S, Rosenbach M, Thornton C, Wade M, Zuckerman S. Designing an Evaluation of the Medicaid Health Reform Demonstrations, Report to the Health Care Financing Administration, from the Urban Institute, Center for Health Economics Research and Mathematica Policy Research, Inc., Feb. 1996.

Holahan J, Coughlin T, Liu K, Ku L, Kuntz C, Wade M, Wall S. Cutting Medicaid Spending in Response to Budget Caps, Report to the Kaiser Commission on the Future of Medicaid, Sept. 1995. [PR]

Wade M, Ku L, Dodds S. (1995). The Impact of the Medicaid FQHC Program on Center Users, FQHCs and the Medicaid Program, Urban Institute Working Paper 06428-03, May 1995.

Ku L, Coughlin T. Medicaid Disproportionate Share and Related Programs: A Fiscal Dilemma for the States and the Federal Government, Report to the Kaiser Commission on the Future of Medicaid from the Urban Institute, December 1994.

Holahan J, Coughlin T, Ku L, Lipson D, Rajan S. Increasing Insurance Coverage through Medicaid Waiver Programs, Urban Institute Working Paper 06433-005-01, November 1994.

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Ku L, Publicly Supported Family Planning in the United States: Financing of Family Planning Services. Report to the Kaiser Family Foundation, The Urban Institute, June 1993.

Holahan J, Coughlin T, Ku L, Heslam D, Winterbottom C, The States' Response to Medicaid Financing Crisis: Case Studies Report, Health Policy Center Report 6272-02, The Urban Institute, December 1992 (revised).

Sonenstein F, Ku L, Juffras J, Cohen B. Promising Prevention Programs for Children, Report to the United Way of America, The Urban Institute, March 1991.

Ellwood MR, Ku L. Summary and Policy Recommendations: Studies on Health Care Services to Severely Disabled Children, Report Submitted to the Office of the Assistant Secretary for Planning and Evaluation, DHHS, Lexington, MA: SysteMetrics/ McGraw-Hill, August 1990.

Ku L, Who's Paying the Big Bills?: Very High Cost Pediatric Hospitalizations in California in 1987, Report to Office of the Assistant Secretary for Planning and Evaluation, DHHS, Lexington, MA: SysteMetrics/McGraw-Hill, August 1990.

Sonenstein F, Ku L, Adams EK, Orloff T. Potential Research Strategies to Evaluate the Effect of Transitional Medicaid and Child Care Benefits, Report to the Office of the Assistant Secretary for Planning and Evaluation, DHHS, Lexington, MA: SysteMetrics/McGraw-Hill, May 1990.

HIV/AIDS and Reproductive Health

Lindberg L, Ku L, Sonenstein F. Minor Mothers and Adult Fathers: Age Differences Between Teen Mothers and Their Partners, Urban Institute Working Paper, 1996.

Sonenstein FL., Pleck JH, Ku L. Why Young Men Don't Use Condoms: Factors Related to Consistency of Utilization, Sexuality and American Policy Seminar Series, Kaiser Family Foundation and American Enterprise Institute for Public Policy Research, Washington, D.C., May 1995.

Ku L and the NSAM Study Team, Preliminary Results of the Pretest for the National Survey of Adolescent Males, Report to the Centers for Disease Control and Prevention and the National Institute for Child Health and Human Development, November 1994.

Ku L, Levine G, Sonenstein F, State STD Reporting Rules and Research Surveys, Report to the Centers for Disease Control and Prevention, September 1994.

Sonenstein F, Pleck J, Ku L, The Male Side of the Equation, TEC Networks, 33:3-4, June 1992.

Sonenstein F, Pleck J, Ku L, Influences on Adolescent Male Premarital Sexual Behavior, Final Report to the Office of Population Affairs, DHHS from Urban Institute, May 1992.

Sonenstein F, Pleck J, Ku L, Sex and Contraception Among Adolescent Males, TEC Networks, 29:1-3, June 1991.

Sonenstein F, Pleck J, Calhoun C, Ku L, 1988 National Survey of Adolescent Males: A User's Guide to the Machine Readable Files and Documentation, Data Set G6, Data Archives on Adolescent Pregnancy and Pregnancy Prevention, Los Altos, CA: Sociometrics Corp, 1991.

Sonenstein F, Pleck J, Calhoun C, Ku L, Determinants of Contraceptive Use by Adolescent Males, Final Report to the National Institute for Child Health and Human Development, Urban Institute, February 1991.

Food and Nutrition Policy

Ku L, Debating WIC, The Public Interest, 135: 108-12, Spring 1999. [PR]

Ku L, Cohen B, Pindus N. Full Funding for WIC: A Policy Review, Washington, DC: Urban Institute Press, 1994.

Ku L, Long S, Brayfield A. and others, Low-Income Children's Nutritional Needs and Participation in USDA's Food Assistance Programs. Final Report to the Food and Nutrition Service, USDA from the Urban Institute, September 1993.

Ku L, Institutional Participation in the National School Lunch and Breakfast Programs, Final Report to the Food and Nutrition Service, USDA from the Urban Institute, March 1993.

Ku L, Reported Meal Production Costs and Reimbursement Rates in the National School Lunch Program, Draft Report to the Food and Nutrition Service, USDA from the Urban Institute, April 1992.

Ku L, Brayfield A, and others, Evaluation of Low-Income Children's Nutritional Needs and Participation in USDA's Food Assistance Programs: Conceptual Assessment. Report to Food and Nutrition Service, USDA from the Urban Institute, February 1992.

Ku L, McKearn M. Effects of the Temporary Emergency Food Assistance Program (TEFAP) on Displacement of Commercial Sales, (with the Economic Research Service and Mathematica Policy Research), Report to Congress, U.S. Dept. of Agriculture, August 1987.* [PR]

Ku L, Dalrymple R., Differences Between SIPP and Food and Nutrition Service Program Data on Child Nutrition and WIC Program Participation, Survey of Income and Program Participation (SIPP) Working Papers, No. 8707, Bureau of the Census, May 1987.

Ku L, Nutritional Research Relating to Infant Feeding in the WIC Program, Report to the Assistant Secretary for Food and Consumer Services, June 1986.*

Richman L, Hidelbaugh T, McMahon-Cox N, Ku L, Dayton CM, Goodrich N. Study of WIC Participant and Program Characteristics, Report to Congress, Food and Nutrition Service, U.S. Dept. of Agriculture (with Ebon Research Systems and Abt Associates Inc.), April 1986. [PR]

Ku L, Abbot J, Forchheimer M. The Feasibility, Costs and Impacts of a Universal School Lunch Program, Draft Report to Congress, U.S. Dept. of Agriculture, June 1985.

Puma M, Ku L, Economic Analysis of the Temporary Emergency Food Assistance Program, Report to Congress, Food and Nutrition Service, U.S. Dept. of Agriculture, May 1985.* [PR]

Ku L, Nichols A. Report on the Food Bank Demonstration Project, Report to Congress, Food and Nutrition Service, U.S. Dept. of Agriculture, April 1984.* [PR]

* These reports were issued as official Agency or Department reports with no listed authors. In addition, Leighton Ku wrote numerous proposed and final regulations and legislative and budget reports while on the staff of the Food and Nutrition Service. In many cases, these were published in the Federal Register, Congressional Record and related Federal series.

Selected Presentations and Testimony

Han X, Ku L. Enhancing Staffing in Rural Community Health Centers Can Improve Behavioral Health Care**.** Health Affairs press briefing, National Press Club, Washington DC, Dec. 4, 2019

Ku, L. Testimony: Economic and Employment Benefits of Expanding Medicaid in North Carolina. Field Hearing, North Carolina Assembly. Winston-Salem, NC. Aug. 16, 2019. Similar presentation at Field Hearing, North Carolina Legislature, Raleigh, NC, Oct. 1, 2019.

Ku L. Current Threats to Medicaid. Dialogue on Diversity. Unidos US. Washington, DC. June 26, 2019.

Ku, L, Rosenbaum S, Keith K, Blumberg L, Sidhu A. Health Policy Goes to Court: Collaborations of Law and Research. AcademyHealth Annual Research Conf. Washington, DC. June 2, 2019

Ku L, Brantley E, Pillai D. The Effects of SNAP Work Requirements in Reducing Participation and Benefits. AcademyHealth Annual Research Conf. Washington, DC. June 4, 2019

Brantley E, Pillai D, Ku L. Factors Affecting Enrollment in Public Programs. AcademyHealth Annual Research Conf. Washington, DC. June 2, 2019

Ku, L. Immigrants and American Health Policy. Boston College. Global Migration Conference: Inclusion and Exclusion. Boston MA April 12, 2019.

Ku, L. Medicaid Policy in the States. Scholars Strategy Network National Leadership Conference, Washington DC. Jan. 18, 2019.

Ku, L. Health Insurance Coverage for DC Latinos. DC Latino Health Leadership Symposium. Washington DC. Jan. 9, 2019.

Seiler N, Ku L. Medicaid's Role in Addressing the Opioid Crisis. GW seminar, Nov. 16, 2017.

Ku L. Medicaid: Addressing Tobacco & Opioid Addictions. Presentation at Addressing Addiction: Policy Prescriptions to Preventing Opiate Abuse and Tobacco Use. Health Policy Institute of Ohio, Columbus, OH, Sept. 26, 2017.

Ku L. Economic and Employment Effects of the Better Care Reconciliation Act. Testimony to the Maryland Legislative Health Insurance Coverage Protection Commission, Maryland House of Delegates, Annapolis, MD. Aug. 1, 2017. Similar presentation at REMI webinar, Aug. 2, 2017.

Ku L. Economic and Employment Effects of the American Health Care Act. Presentation at AcademyHealth Annual Research Conference, New Orleans, June 25, 2017. Similar presentations at Policy in the Trump Era: National, State, and Regional Economic Impacts Conference, Hall of States, Washington, D.C. June 19, 2017 and at Medicaid Policy Conference, Council of State Governments, Washington, DC, June 29, 2017.

Ku L. Repealing Obamacare: Effects on the Health Workforce. Presentation at AcademyHealth Annual Research Conference, New Orleans, June 26, 2017.

Brantley E, Ku L. Promoting Tobacco Cessation: The Role of Medicaid and Other Policies. Poster at AcademyHealth Annual Research Conference, New Orleans, June 26, 2017.

Ku L. The Future of Medicaid. Conference on Obamacare After Obama. Southern Illinois Healthcare/Southern Illinois University School of Law. Springfield, IL, May 19, 2017.

Brantley E, Ku L. Linking Data to Uncover Medicaid's Role in Cessation. National Conference on Tobacco or Health, Austin TX, March 23, 2107.

Ku L. The Future of Medicaid and the Safety Net. Health Policy Expert Series. Milken Institute School of Public Health. March 21, 2017.

Ku L. Financial Consequences of ACA Repeal. Podcast, Feb. 15, 2017 http://www.commonwealthfund.org/interactives-and-data/multimedia/podcasts/new-directions-in-health-care/the-impact-of-aca-repeal

Ku L. Repealing Health Reform: Economic and Employment Consequences for States. REMI Seminar, Washington, DC. Jan. 27, 2016. Similar national webinar Feb. 1, 2017.

Ku L. Pay for Success Demonstrations of Supportive Housing for Chronically Homeless Individuals: The Role of Medicaid. Association for Public Policy and Management Research Conference, Washington, DC. Nov. 4, 2016.

Ku L. Immigrants and Community Health Centers. Pennsylvania Association of Community Health Centers, Lancaster PA. Oct. 12, 2016.

Ku L. Moving Medicaid Data Forward (discussant). Mathematica Policy Research, Washington, DC Oct. 11, 2016.

Ku L. Medicaid Can Do More to Help Smokers Quit, Michael Davis Lecture, University of Chicago, Oct. 4, 2016. Similar seminar at Univ. of Maryland, Sept. 15, 2016.

Ku L, Borkowski L. Publish or Perish: Advice for Publishing for Peer-Reviewed Journals in Health Policy. GW Department of Health Policy & Management seminar, Sept. 20, 2016.

Ku L . Family Planning, Health Reform and Potential Restrictions on Coverage or Access, presented at Contraception Challenged: Putting *Zubik v. Burwell* in Context, sponsored by National Family Planning and Reproductive Health Association meeting at Capitol Visitors Center, Washington, DC, June 7, 2016.

Ku L Russell T. et al. Debate on the Role of Public Programs in Care for the Poor. Benjamin Rush Institute, Washington, DC, April 1, 2016.

Brantley E, Ku L. Improved Access and Coverage Under The ACA: Are Immigrants at the Table?, presented at GW Research Day, March 30, 2016. (Won prize for best policy and practice research.)

Ku L. The Role of the Health Care Safety Net, Virginia Commonwealth University, Richmond, March 17, 2016.

Ku L, Steinmetz E, Bysshe T. Medicaid Continuity of Coverage in an Era of Transition. Webinar for Association of Community-Affiliated Plans, Nov. 2, 2015.

Ku L Bruen B, Steinmetz E, Bysshe T. Trends in Tobacco Cessation Among Medicaid Enrollees, presented at AcademyHealth Annual Research Meeting, Minneapolis, June 15, 2015.

Ku L. Using Economic Impact Analysis in Medicaid Advocacy, presented at AcademyHealth Annual Research Meeting, Minneapolis, June 13, 2015.

Ku L. The Translation of Health Services Research into Policy Related to the Affordable Care Act, Presented at American Association of Medical Colleges, March 20, 2015.

Ku L. Policy and Market Pressures on Safety Net Providers, National Health Policy Conference, Feb. 10, 2015.

Ku L. 'Economic and Employment Costs of Not Expanding Medicaid in North Carolina, Cone Health Foundation, Greensboro, NC, Jan. 9, 2015.

Ku L . Health Reform: How Did We Get Here, What the Heck Is Going On and What Next? Keynote Address: Medical Librarians Association, Alexandria VA, Oct. 20, 2014.

Ku L. Health Reform and the Safety Net. Testimony before Maryland Community Health Resources Commission. Annapolis, MD, Oct. 2, 2014.

Ku L. Some Key Issues in Health Reform. Presented at American Association for the Advancement of Science Health Policy Affinity Group Meeting, Washington, DC July 24, 2014.

Ku L, Curtis D. Barlow P. District of Columbia's Health Benefits Exchange at the Launch of a State-Based Exchange: Challenges and Lessons Learned Georgetown Law School Summer Session on Health Reform, July 23, 2014.

Ku L. The Big Picture on Medicaid for State Legislators Presented at Council of State Governments. Medicaid Workshop for Health Leaders, Washington, DC June 20, 2014.

Ku L, Frogner B, Steinmetz E, Pittman P. Many Paths to Primary Care: Flexible Staffing and Productivity in Community Health Centers, Presented at Annual Research Conference AcademyHealth, San Diego, CA, June 10, 2014.

Ku L, Zur J., Jones E, Shin, P, Rosenbaum S. How Medicaid Expansions and Post-ACA Funding Will Affect Community Health Centers' Capacity. Presented at Annual Research Conference AcademyHealth, San Diego, CA, June 9, 2014.

Ku L. Critical Issues for Community Health Centers, Alliance for Health Reform briefing, Commonwealth Fund, Washington, DC. May 16, 2014.

Ku L. Immigrants' Health Access: At the Nexus of Welfare, Health and Immigration Reform, Keynote talk at Leadership Conference on Health Disparities, Harvard Medical School, Boston, MA May 6, 2014.

Ku L. Wellness and the District of Columbia. District of Columbia Chamber of Commerce forum, Washington, DC, March 11, 2014.

Ku L. Health Care for Immigrant Families: A National Overview. Congressional Health Justice Summit, Univ. of New Mexico - Robert Wood Johnson Center for Health Policy, Albuquerque, NM, Sept. 7, 2013.

Ku L. Health Reform: Promoting Cancer Prevention and Care. Talk to DC Citywide Navigators Network, Washington, DC, July 15, 2013.

Ku L. Analyzing Policies to Promote Prevention and Health Reform. Seminar at the Centers for Disease Prevention and Promotion, Atlanta, GA. July 10, 2013.

Ku L. Medicaid: Key Issues for State Legislators. Council on State Governments, Medicaid Workshop for Health Leaders, Washington, DC, June 22, 2013.

Ku L, Steinmetz E. Improving Medicaid's Continuity of Care: An Update. Association of Community Plans Congressional Briefing, May 10, 2013.

Ku L (with Brown C, Motamedi R, Stottlemeyer C, Bruen B) Economic and Employment Impacts of Medicaid Expansions. REMI Monthly Policy Seminar, Washington, DC, April 24, 2013.

Ku L. Building Texas' Primary Care Workforce, Legislative Briefing: Health Care Coverage Expansion & Primary Care Access in Texas, Center on Public Priorities and Methodist Healthcare Ministries, Texas Capitol, Austin, TX, Mar. 8, 2013

Ku L, Jewers M. Health Care for Immigrants: Policies and Issues in a New Year. Presentation to Conference on After the Election: Policies Affecting Young Children of Immigrants, Migration Policy Institute, Washington, DC, Jan. 17, 2013.

Ku L. Health Reform and the New Health Insurance Exchanges: Issues for Indiana Families, Indiana

Family Impact Seminar at Indiana State Legislature, Nov. 19, 2012.

Ku L. Pediatric Preventive Medical and Dental Care: The Role of Insurance and Poverty, AcademyHealth Annual Research Meeting, Orlando, FL, June 24, 2012.

Ku L. A Medicaid Tobacco Cessation Benefit: Return on Investment, Webinar for Partnership for Prevention and Action to Quit, Feb. 8, 2012.

Ku L. Safety Net Financing Issues, Webinar for National Workgroup on Integrating a Safety Net, National Academy for State Health Policy, Feb. 6, 2012

Ku L. How Medicaid Helps Children: An Introduction. Briefing to Congressional Children's Health Caucus, Jan. 25, 2012

Ku L. Market Access Webinar: Provider Access: Coordinating Medicaid & Exchanges: Continuity of Services & the Role of Safety Net Providers, Webinar for Center for Consumer Information and Insurance Oversight, Centers for Medicare & Medicaid Services, Dec. 15, 2011.

Ku L. The Safety Net: An Evolving Landscape, Presented to Grantmakers in Health, Washington, DC. Nov. 3, 2011. [Similar talks in Orlando, FL to Blue Cross Blue Shield of Florida Foundation, Feb. 17, 2012 and in Williamsburg, VA to Williamsburg Community Health Foundation Apr. 3, 2012 and to Virginia Health Foundation, Nov. 13, 2012]

Ku L. Open Access Publishing. Presented at forum for GW Medical Center faculty and staff, Oct. 24, 2011.

Ku L, Levy A. Implications of Health Reform for CDC's Cancer Screening Programs: Preliminary Results, Presentation to National Breast and Cervical Cancer Early Detection Program and Colorectal Cancer Control Program Directors Meeting, Atlanta, GA, Oct. 21, 2011.

Ku L. Coordinating Medicaid & Exchanges: Continuity of Services & the Role of Safety Net Providers, Presented to America's Health Insurance Plans, Washington, DC. Sept. 16, 2011.

Ku L. The Potential Impact of Health Reform on CDC's Cancer Screening Programs: Preliminary Results, Presented to NBCCEDP Federal Advisory Committee Meeting, Atlanta, GA, Jun. 17, 2011. (Similar presentations to the American Cancer Society, Sept. 2011.)

Ku L. Crystal Balls and Safety Nets: What Happens After Health Reform? Presented at AcademyHealth, Seattle, WA, June 2011.

Ku L. Strengthening Primary Care to Bend the Cost Curve: Using Research to Inform U.S. Policy, International Community Health Center Conference, Toronto, Canada, June 2011

Ku L. Integrating/Coordinating Care for Safety Net Providers: Issues and Local Examples, International Community Health Center Conference, Toronto, Canada, June 2011.

Ku L. Health Reform: Federal Implementation and More Unanswered Questions Presented at American Society of Public Administration, Baltimore, MD, Mar. 14, 2011.

Ku L. Key Issues in the Confusing World of Health Reform, Presented to Industrial College of the Armed Forces, National Defense University, Washington, DC, Feb. 25, 2011.

Ku L. Reducing Disparities and Public Policy Conflicts, Institute of Medicine Workshop on Reducing Disparities in Life Expectancy, Washington, DC, Feb. 24, 2011.

Ku L. Primary Care, Hospitalizations and Health Reform, American Enterprise Institute Workshop, Washington, DC, Feb. 17, 2011.

Ku L. The Promise and Perils of Health Policy for Asians in the United States, Invited keynote talk at 4th International Asian Health and Wellbeing Conference, Univ. of Auckland, New Zealand, NZ, July 6, 2010. Similar talk at symposium sponsored by the New Zealand Office of Ethnic Affairs, Wellington, NZ, July 8, 2010.

Ku L, Strengthening Primary Care to Bend the Cost Curve: The Expansion of Community Health Centers Through Health Reform, Briefing for Senate and House staff and media, convened by Sen. Bernie Sanders (VT), Russell Senate Office Building, June 30, 2010.

Ku L. Ready, Set, Plan, Implement. Executing Medicaid's Expansion, *Health Affairs* Conference on Health Reform, Washington, DC, June 8, 2010.

Ku L. Coordinating Care Among Safety Net Providers, Primary Care Forum, National Academy of State Health Policy, Alexandria, VA, June 2, 2010.

Ku L. Title VI: The Role of Culturally Competent Communication in Reducing Ethnic and Racial Health Care Disparities, National Minority AIDS Education and Training Center Spring Symposium, Howard Univ. May 29, 2010.

Ku L. American Health Reform as Massive Incrementalism, American Association for Budget and Program Analysis, Nov. 24, 2009.

Ku L. The Health Care Safety Net and Health Reform, National Academy of Public Administration, Conference on Health Care for the Future, Nov. 22, 2009.

Ku L. The Health of Latino Children, National Council of La Raza Symposium on Latino Children and Youth, Oct. 22, 2009.

Ku L. What the Obama Administration Will Mean for Child Health, AcademyHealth preconference session on Child Health, Chicago, IL June 2009.

Ku L. Immigrants and health reform, 6th Annual Immigration and Law Conference, Georgetown Univ. Law School, Migration Policy Institute and Catholic Legal Immigration Network, Washington, DC, June 24, 2009.

Ku L. From the Politics of No! to the Potential for Progress, invited keynote talk about immigrant policy and research to Society for Research in Child Development, Denver, CO, April 1, 2009.

Ku L. Strengthening the Primary Care Safety Net, National Association of Community Health Centers, Policy and Issues Conference, March 26, 2009.

Ku L. The Dial and the Dashboard: Assessing the Child Well-Being Index, Presentation to the Board of the Foundation for Child Development, March 3, 2009.

Ku L. Key Data Concerning Health Coverage for Legal Immigrant Children and Pregnant Women, invited presentation to Senate staff, Jan. 13, 2009.

Ku L. Comparing the Obama and McCain Health Plans, George Washington Univ. Medical School Alumni Conference, Sept. 27, 2008.

Ku L. The Future of Medicaid, Medicaid Congress, sponsored by Avalere Health and Health Affairs, Washington, DC, June 5, 2008.

Ku L. A Brief Appreciation of Health Advocates: Progress Made, Some Setbacks, Challenges Ahead, Public Interest Law Center of Philadelphia Conference, Philadelphia, PA, May 14, 2008.

Ku L. Financing Health Care Reform in New Jersey: Making Down Payments on Reform, Rutgers-AARP Conference, New Brunswick, NJ. Mar. 18, 2008

Ku L, Perez T, Lillie-Blanton M. Immigration and Health Care-What Are the Issues, Kaiser Family Foundation Health Cast, webcast interview March 12, 2008.

Ku L. How Research Might Affect SCHIP Reauthorization, Child Health Services Research Meeting at AcademyHealth, Orlando, FL, June 2, 2007.

Ku L. Immigrant Children and SCHIP Reauthorization, Capital Hill Briefing conducted by the Population Resource Center, April 20, 2007.

Ku L. Health Policy and Think Tanks, Robert Wood Johnson Health Policy Fellows, Institute of Medicine, June 2006. Similar talk in other years.

Ku L. Medicaid Reform and Mental Health, National Alliance for the Mentally Ill, Annual Conference, Austin, TX, June 20, 2005.

Ku L. Cost-sharing in Medicaid and SCHIP: Research and Issues, National Association of State Medicaid Directors, Washington, DC, Nov. 18, 2004. Similar talk given to National Academy of State Health Policy, St. Louis, MO, Aug. 2, 2004.

Ku L. Coverage of Poverty-Level Aged and Disabled in Mississippi's Medicaid Program, Testimony to Mississippi Senate Public Health and Welfare Committee, Aug. 24, 2004

Ku L. Medicaid Managed Care Issues, Testimony to Georgia House of Representatives Appropriations Committee, March 2, 2004.

Ku L. Medi-Cal Budget Issues, Testimony to Joint Hearing of California Senate Budget and Health and Human Services Committees, Feb. 26, 2003.

Ku L .New Opportunities to Improve Health Care Access and Coverage, American College of Emergency Physicians, May 1, 2001.

Ku L,. Medicaid DSH and UPL: Perplexing Issues, National Association of Public Hospitals Health Policy Fellows Conference, Washington, DC, Mar. 20, 2001.

Ku L, Insurance Coverage and Health Care Access for Immigrant Families, Testimony Before the U.S. Senate Finance Committee, Washington, DC, March 13, 2001.

Ku L. Increasing Health Insurance Coverage for Low-Income Families and Children, Insuring the Uninsured Project Conference, Sacramento, CA, Feb. 13, 2001.

Ku L, Concerning the Healthy Families Program Parent Expansion Proposal, Testimony Before a Joint Hearing of the California Senate Health and Human Services and Insurance Committees and Budget and Fiscal Review Subcommittee # 3, Sacramento, CA, January 30, 2001.

Ku L, Insurance Trends and Strategies for Covering the Uninsured, National Health Law Program Conference, Washington, DC, Dec. 3, 2000.

Ku L, Improving Health Care Access and Coverage: New Opportunities for States in 2001, Midwest Leadership Conference, Council of State Governments, Minneapolis, MN, August 6, 2000.

Ku L, Health Care for Immigrants: Recent Trends and Policy Issues, Alliance for Health Reform, Washington, DC, August 2, 2000. Similar talks in Miami at Florida Governor's Health Care Summit and in San Diego at California Program on Access to Care conference.

Ku L, Matani S, Immigrants' Access to Health Care and Insurance on the Cusp of Welfare Reform, presented at Association for Health Services Research Conference, Los Angeles, CA, June 25, 2000.

Ku L, Matani S. Immigrants and Health Care: Recent Trends and Issues, presented to the Association of Maternal and Child Health Programs meeting, Washington, DC, March 7, 2000.

Ku L, Ellwood MR., Hoag S, Ormond B, Wooldridge J. Building a Newer Mousetrap: the Evolution of Medicaid Managed Care Systems and Eligibility Expansions in Section 1115 Projects, presented at American Public Health Association meeting, Chicago, IL, Nov. 10, 1999.

Ku L. Young Men's Reproductive Health: Risk Behaviors and Medical Care", presented at D.C. Campaign to Prevent Teen Pregnancy Meeting, Washington, DC, Oct. 19, 1999.

Ku L, Medicaid and Welfare Reform: Recent Data, presented at Getting Kids Covered Conference, sponsored by National Institute for Health Care Management and Health Resources and Services Administration, Washington, DC, Oct. 6, 1999.

Ku L, Garrett B. How Welfare Reform and Economic Factors Affected Medicaid Participation, presented at Association for Health Services Research meeting, Chicago, IL, June 29, 1999.

Ku L. Recent Factors Affecting Young Men's Condom Use, presented to conference sponsored by National Campaign to Prevent Teen Pregnancy and Advocates for Youth, Washington, DC, February 1999.

Medicaid, Welfare Reform and CHIP: The Growing Gulf of Eligibility Between Children and Adults, presented to National Association of Public Hospitals and Health Systems, Washington, DC, and to Generations United, Washington, DC, September 1998.

Ku L. Sliding Scale Premiums and Cost-Sharing: What the Research Shows presented at workshop on CHIP: Implementing Effective Programs and Understanding Their Impacts, Agency for Health Care Policy and Research User Liaison Program, Sanibel Island, FL, June 30, 1998.

Ku L, Sonenstein F, Boggess S, Pleck J. Understanding Changes in Teenage Men's Sexual Activity: 1979 to 1995, presented at 1998 Population Association of America Meetings, Chicago, IL, April 4, 1998.

Ku L. Welfare Reform, Immigrants and Medicaid presented at Annual Meeting of the Association of Maternal and Child Health Programs, Washington, DC, March 9, 1998. Similar talk presented at Association for Health Services Research Meeting, Washington, DC, June 23, 1998.

Ku L. Medicaid Policy and Data Issues: An Overview presented to National Committee on Vital and Health Statistics, DHHS, September 29, 1997.

Ku L. How Welfare Reform Will Affect Medicaid Coverage presented to National Ryan White Title IV Program Conference, Washington, DC, November 8, 1996.

Ku L, Rajan S, Wooldridge J, Ellwood MR, Coughlin T, Dubay L. Using Section 1115 Demonstration Projects to Expand Medicaid Managed Care in Tennessee, Hawaii and Rhode Island, presented at Association of Public Policy and Management, Pittsburgh, Nov. 1, 1996.

Ku L. The Federal-State Partnership in Medicaid: Is Divorce Inevitable or Would Therapy Be Enough? presented to Council of State Governments Conference on Managing the New Fiscal Federalism, Lexington, KY, May 10, 1996.

Ku L. The Male Role in the Prevention of Teen Pregnancy, presented to the Human Services Committee, National Council of State Legislatures, Washington, DC, May 9, 1996

Ku L. Implications of Converting Medicaid to a Block Grant with Budget Caps, presented to American Medical Association State Legislation Meeting, Aventura, FL, Jan. 1996 and to the American Psychiatric Association Public Policy Institute, Ft. Lauderdale, FL, March 1996.

Ku L. Medicaid: Program Under Reconstruction, presented at Speaker's Forum at New York City Council, September 12, 1995.

Ku L. State Health Reform Through Medicaid Section 1115 Waivers, presented at Pew Health Policy Conference, Chicago, IL, June 3, 1995.

Ku L. Setting Premiums for Participants in Subsidized Insurance Programs, presented at Conference on the Federal-State Partnership for State Health Reform, sponsored by HCFA, the National Academy of State Health Policy and RTI, March 15, 1995.

Ku L. Medicaid Disproportionate Share and Related Programs: A Fiscal Dilemma for the Federal Government and the States, with Teresa Coughlin, presented to the Kaiser Commission on the Future of Medicaid, November 13, 1994.

Ku L. Full Funding for WIC: A Policy Review, with Barbara Cohen and Nancy Pindus, presented at Dirksen Senate Office Building, Washington, DC, in a panel hosted by the Center on Budget and Policy Priorities, Bread for the World, the Food Research and Action Center and the National Association of WIC Directors, May 5, 1994.

Ku L. The Financing of Family Planning Services in the U.S., presented at the Institute of Medicine, National Academy of Sciences on February 15, 1994 and at the American Public Health Association meeting, San Francisco, CA, October 25, 1993.

Ku L. Using SUDAAN to Adjust for Complex Survey Design in the National Survey of Adolescent Males, with John Marcotte and Karol Krotki, briefing at National Institute of Child Health and Human Development, Rockville, MD, April 2, 1992.

Ku L. The Association of HIV/AIDS Education with Sexual Behavior and Condom Use Among Teenage Men in the United States with Freya Sonenstein and Joseph Pleck, presented at the Seventh International Conference on AIDS, Florence, Italy, June 1991.

Ku L. Patterns of HIV-Related Risk and Preventive Behaviors Among Teenage Men in the United States, with Freya Sonenstein and Joseph Pleck, paper presented at the Sixth International Conference on AIDS, San Francisco, CA, June 23, 1990.

Ku L. Trends in Teenage Childbearing, Pregnancy and Sexual Behavior, paper presented at the American Sociological Association Meeting, Washington, D.C., August 15, 1990.

Ku L. Research Designs to Assess the Effect of WIC Participation by Pregnant Women on Reducing Neonatal Medicaid Costs, briefing to Congressional staff, February 1987.

Ku L. Testimony about the Special Supplemental Food Program for Women, Infants and Children (WIC), with Frank Sasinowski, presented to House Education and Labor Committee on behalf of the American Public Health Association, March 1983.

Media

Leighton Ku has extensive experience with electronic and print media. He has been interviewed by ABC, NBC, CBS, Fox, PBS, National Public Radio, CNN, Bloomberg TV, BBC and other television or radio news broadcasts and webcasts. He has been quoted or his research has been cited in the *New York Times, Los Angeles Times, Washington Post, Wall Street Journal, USA Today, Christian Science Monitor, Huffington Post, Forbes, Fortune, US News and World Report, Politico, The Hill, Buzzfeed,* and trade publications, such as *Modern Health Care, Nation's Health* or *CQ HealthBeat, Kaiser Health News*, etc. He has been an online contributor to the *Washington Post.* He was a regular panelist on a radio talk show about health policy, broadcast on WMAL in the Washington DC region. He has been cited as an expert by *PolitiFact* and related fact-checking sources.

Service and Honors

Member, Executive Board, District of Columbia Health Benefits Exchange Authority (2012-now) (The board governs the new health insurance exchange for the District of Columbia, based on the Patient Protection and Affordable Care Act. This is a voluntary, unpaid position, appointed by the Mayor and approved by the City Council. I was reappointed in 2018.) Chair of the Research Committee and the Information Technology Committee. Led working groups that developed the financial sustainability plan for the Exchange, dental plans, standardized benefit plans and changes required in light of threats to the Affordable Care Act.

One of three top reviewers of the year, *Milbank Quarterly,* December 2019

Social Science Research Network, one of five most downloaded papers in field, Oct-Dec. 2018.

Commonwealth Fund, two of the top ten most frequently downloaded reports (2017).

Commonwealth Fund, one of top ten most frequently downloaded reports (2006).

Award for promoting racial and economic justice, Mississippi Center for Justice, 2005

Service award from the National WIC Directors Association (2002).

Choice (the magazine of the American Library Association for academic publications), top ten academic books of the year (1994)

Pew Health Policy Fellow, Boston University and Brandeis University, 1987-1990.

Other Service

Submitted expert witness declaration in a federal lawsuit regarding the President's proclamation which would have denied visas to those without approved forms of health insurance, Declaration in Support of Plaintiffs' Motion for a Preliminary Injunction (regarding Presidential Proclamation on Visas and Health Insurance), *John Doe #1, et al. v Donald Trump, et al.* United States District Court, District of Oregon, filed November 8, 2019. [Resulted in an injunction prohibiting implementation of the visa denials.]

Submitted expert witness declaration in federal lawsuits on public charge regulations and health, including *La Clinica de la Raza, et al. v. Donald Trump, et al.* United States District Court, Northern District of California, September 1, 2019. *Make the Road New York, et al v Ken Cucinelli, et al.* United States District Court, Southern District of New York, Sept. 9, 2019. *State of New York, et al. v. U.S. Department of Homeland Security, et al.* United States District Court, Southern District of New York, Sept. 9, 2019. [Resulted in injunctions prohibiting implementation of the public charge regulations.]

Helped develop and cosigned *amicus* briefs on behalf of public health scholars in key federal lawsuits, including *King v Burwell* (health insurance exchanges), *Stewart v Azar* (approval of Kentucky work requirement waiver, versions 1 and 2), *Gresham v Azar* (approval of Arkansas work requirements). *Texas v Azar* (constitutionality of ACA), *Philbrick v Azar* (approval of New Hampshire work requirement) and *Massachusetts v. US Dept of Health and Human Service* (contraceptive mandate).

Parliamentarian, Milken Institute School of Public Health, 2019

Member, Technical Expert Panel, AHRQ Panel on Future of Health Services Research, RAND, 2019.

Served as expert witness in federal lawsuits on immigration and health, including *State of Texas v United States and Perez* and *State of New York v Trump* (Deferred Action for Childhood Arrivals). 2018.

Co-Director, PhD Health Policy Program. First at GW Trachtenberg School of Public Policy and Administration, now at Milken Institute School of Public Health, 2015-now

Served as search committee member, chair, Department of Health Policy and Management, 2019 and 2020 and faculty, Dept. of Exercise and Nutrition Sciences, 2019.

Search committee, Associate Provost for Graduate Studies, George Washington Univ, 2019

Member, AcademyHealth/NCHS Health Policy Fellowship Program board. 2016-17.

Affiliated faculty, Jacobs Institute of Women's Health, 2015-now.

Advisory Board, Remaining Uninsured Access to Community Health Centers (REACH) Project, Univ. of California Los Angeles, 2015-17.

Member, DC Metro Tobacco Research and Instruction Consortium (MeTRIC). 2014- present

Member, Health Workforce Research Institute, GW, 2013-present.

Member, National Advisory Board, Public Policy Center of University of Iowa, 2014-18.

Chair/Vice Chair, Advocacy Interest Group, AcademyHealth, 2014-17.

Member, Advisory Committee on Non-Health Effects of the Affordable Care Act, Russell Sage Foundation, Dec. 2013.

Member, Technical Expert Group on the Affordable Care Act and the National Survey of Family Growth, National Center for Health Statistics, Centers for Disease Control and Prevention, Nov. 2013

Member, Steering Committee, GW Institute of Public Policy, 2013-now

Member, External Review Committee for Department of Family Science for the University of Maryland School of Public Health, 2012.

GW Faculty Senator, representing School of Public Health and Health Services, 2010-12.

Member of numerous University, School and Departmental committees. 2008-present.

Member or chair, numerous faculty and dean search committees, Milken Institute School of Public Health and School of Nursing, George Washington University. 2008-present.

National Institutes of Health, member of various grant review study sections (1996-now).

Invited reviewer. Committee on National Statistics. National Academy of Sciences. Databases for Estimating Health Insurance Coverage for Children. 2010-11.

Grant reviewer. Robert Wood Johnson Public Health and Law program. 2010.

Invited reviewer, Institute of Medicine report on family planning services in the U.S., 2009.

External reviewer for faculty promotion and tenure for Harvard School of Public Health, Harvard Medical School, Univ. of California at Los Angeles and at San Diego, Boston University, Baruch College, George Mason University, University of Maryland, University of Iowa, Kansas University, Portland State University, etc., 2008-present.

Submitted expert witness affidavits/declarations in federal, state and local lawsuits including: *Texas v United States* and *New York, et al. v. Trump* (Deferred Action for Childhood Arrivals), *Wood, et al. v. Betlach,* (Medicaid cost sharing), *Lozano v. City of Hazleton* (immigrant rights), *Spry, et al., v. Thompson* (Medicaid cost-sharing), *Dahl v. Goodno* (Medicaid cost-sharing), *Newton-Nations, et al., v. Rogers* (Medicaid cost-sharing) and *Alford v. County of San Diego* (cost-sharing for a local health program).

Board Member and Treasurer, Alliance for Fairness in Reforms to Medicaid (2002-2008)

Urban Institute, founding member, Institutional Review Board (1997-2000)

National Health Research Institute (Taiwan's NIH) grant reviewer (1999).

Urban Institute, member, Diversity Task Force (1995)

Pew Health Policy Fellow, Boston University and Brandeis University, 1987-1990.

Consultant Services

Consortium of law practices, including Justice Action Center, Paul Weiss, National Health Law Program and New York State Attorney General, 2019
Mexican American Legal Defense and Educational Fund, 2018
New Jersey State Attorney General, 2018
New York State Attorney General, 2017
First Hospital Foundation, Philadelphia PA, 2017
Wilmer Hale/Planned Parenthood Federation, 2017
Centers for Disease Control and Prevention, 2016

Professional Society Memberships and Service

AcademyHealth (formerly Association for Health Services Research), Program Selection Committees (multiple years), chair Advocacy Interest Group (2014-16).
American Public Health Association
Association of Public Policy and Management, Program Selection Committees (many years)

Editorial Peer Review Service

Associate editor, *BMC Health Services Research,* 2009 – 2013.

Reviewer for numerous journals, including *Health Affairs, New England Journal of Medicine, Journal of the American Medical Association, Milbank Quarterly, Pediatrics, American Journal of Public Health, Inquiry, Medical Care, HSR, Medicare and Medicaid Research Review, American Journal of Preventive Medicine, Family Planning Perspectives, Journal of Association of Public Policy and Management, Nicotine and Tobacco Research, Maternal and Child Health, Journal of Health Care for the Poor and Underserved, JAMA-Internal Medicine*, *Public Administration Review* (1990 to now). In 2017, I reviewed 16 manuscripts for journals. External reviewer for RAND Corporation, National Academy of Science, Oxford Univ. Press, etc.

Awarded as one of three top reviewers of the year, *Milbank Quarterly,* December 2019

Public Health Practice Portfolio

Member, Executive Board, District of Columbia Health Benefits Exchange Authority (2012-now). The board governs the new health insurance exchange for the District. (Nominated by the Mayor and appointed by the City Council; reappointed in 2017). Chair of the IT and Eligibility Committee, Research Committee and various working groups.

Member, Technical Expert Group, the Future of Health Services Research, for Agency for Healthcare Research and Quality, conducted by RAND. Jan. 2019.

Expert Advisor, Russell Sage Foundation. Non-health effects of the Affordable Care Act. (2013).

Expert Advisor, Revisions to the National Survey of Family Growth, National Center for Health Statistics, CDC (2013)

Member, Technical Advisory Committee for Monitoring the Impact of the Market Reform and Coverage Expansions of the Affordable Care Act, sponsored by ASPE. (2013)

Member, Technical Advisory Group for the Design of the Evaluation of the Medicaid Expansion Under

the ACA, sponsored by ASPE (2012)

Member, National Workgroup on Integrating the Safety Net, National Academy of State Health Policy, July 2011 – 2013.

Member, National Advisory group for Iowa Safety Net Integration project, 2011-2013.

Foundation for Child Development, Selection Committee, Young Scholars Program, 2008-2015.

Foundation for Child Development, Advisory Committee, Child Well-Being Index, 2008-present

Member, National Advisory Board, Center on Social Disparities on Health, University of California at San Francisco, 2005-2008.

National Campaign to Prevent Teen Pregnancy, Member, Effective Programs and Research Task Force (2000)

Doctoral Students Mentored/Advised

Dissertations Completed
Prof. Peter Shin (chair)
Prof. Megan McHugh
Dr. Sarah Benatar
Dr. Emily Jones (chair)
Dr. Saqi Cho (chair)
Dr. DaShawn Groves (chair)
Dr. Heitor Werneck
Dr. Brad Finnegan (chair)
Dr. Maliha Ali
Dr. Christal Ramos
Dr. Qian (Eric) Luo
Dr. Bill Freeman
Dr. Serena Phillips
Dr. Julia Strasser
Dr. Kristal Vardaman (chair)
Dr. Brian Bruen
Dr. Xinxin Han (chair)
Dr. Jessica Sharac (chair)
Dr. Nina Brown
Dr. Mariellen Jewers (chair)
Dr. Leo Quigley (chair)
Dr. Erin Brantley
Dr. Roberto Delhy

In Progress
Evelyn Lucas-Perry (chair)
Kyle Peplinski (chair)
Shin Nozaki
Brent Sandmeyer (chair)

Other Student Advising

Co-Director, Health Policy PhD Program.
Faculty advisor, MPH, health policy. Provide guidance to about a dozen MPH students per cohort.
Faculty Advisor, GW Health Policy Student Association, 2016-now

No. 19A785

In the
Supreme Court of the United States

DEPARTMENT OF HOMELAND SECURITY, et al.,

Applicants,

v.

NEW YORK, et al.,

Respondents.

I, Pedro Moreno, pursuant to 28.U.S.C. 1746, hereby declare as follows

1. I am an Assistant Professor of Family Medicine at the University of California San Francisco. I am a member of the COVID-19 Leadership Team in the Monterey County Health Department Clinics. On the Leadership Team my role is to lead other physicians at the Health Department clinics in providing medical and social services to patients affected by COVID-19.

2. For the last 22 years I have provided medical care to immigrant families in the Alisal Health Center, a Federally Qualified Community Health Center in Salinas, California. Many of my patients work in the fields harvesting vegetables and berries, and in processing plants that package salads and other agricultural products. In my clinic I work closely with a multidisciplinary team of social workers, public health nurses, physicians, and mental health professionals to provide medical and social services to primarily immigrant farmworker families.

3. Our region, the Salinas Valley in California, is also known as the "Salad Bowl of the United States." Our immigrant farmworkers feed America and are considered "essential workers," exempt from the California Shelter in Place Order. Every day they ride crowded buses to work in the fields to harvest our nation's vegetables, risking being infected with COVID-19.

4. In Monterey County, we are in the early stages of the pandemic. So far, I have seen an increasing number of patients each week with symptoms of possible COVID-19. Some of these patients have told me that they are afraid to seek medical care in our hospital. They don't have health insurance and are fearful to receive expensive

bills if they visit the emergency room. They are also fearful of negative immigration consequences if they use publicly subsidized medical services due to the public charge rule. I am deeply afraid that these farmworkers who don't receive medical attention with early COVID-19 will spread the infection in our community.

5. I understand that state-funded services, emergency health services, and COVID-19 testing and treatment are supposed to be exempt from consideration under the public charge rule. My patients' fears and concerns about the risks associated with use of public benefits, however, apply even to services exempted by the rule.

6. I have patients with symptoms of COVID-19, and I have advised them to stay at home. However, some have told me they cannot stop working because they have no other income or resources, and their families will otherwise go hungry. They are afraid to apply for nutrition assistance programs, such as CalFresh, the California Supplemental Nutrition Assistance Program, due to fear that if they receive those benefits, the public charge rule will negatively affect their immigration status in the future.

7. I have also witnessed many farmworkers who are suffering with extreme anxiety and depression since the beginning of the COVID-19 epidemic. Unfortunately, they report to me that they are afraid to receive behavioral health services due to fears that receipt of those services will negatively affect their immigration status.

8. I am aware of USCIS's March 13th announcement concerning COVID-19 and public charge. Fear and confusion has persisted in my patient population in regards to the public charge and access to COVID-19 related care and other benefits, even after this guidance was issued. Many of my patients appear unaware of the guidance. I am not able to advise my patients about particular immigration consequences that they or their family members could likely face given their particular circumstances and benefits utilization.

9. I believe some of my farmworker patients have already been infected with COVID-19 by other farmworkers in the fields. Unfortunately, many of them are afraid to seek medical care due to the public charge rule, and are already spreading the infection in our community. This interferes with my and my colleagues' work to mitigate the risks of COVID-19 to our farmworking community.

Dated this 6th day of April, 2020 at Salinas, California

Pedro Moreno

DR. PEDRO MORENO, MD

No. 19A785

In the
Supreme Court of the United States

DEPARTMENT OF HOMELAND SECURITY, et al.,

Applicants,

v.

NEW YORK, et al.,

Respondents.

I, Bitta Mostofi, pursuant to 28 U.S.C. § 1746, hereby declare as follows:

1. I am the Commissioner of the City of New York (the "City")'s Mayor's Office of Immigrant Affairs ("MOIA"). I have worked at MOIA since 2014, becoming Acting Commissioner in 2017 and appointed Commissioner in 2018. As Commissioner, I provide advice and guidance to the Mayor, his staff in other divisions of the Mayor's Office, and to other City agencies, on a range of issues related to immigration. I also guide and oversee the work of approximately 70 City employees assigned to work on fulfilling MOIA's mission.

2. MOIA, established in the Charter of the City of New York in 2001 by referendum, develops and implements policies designed to assist immigrants across the city by enhancing their economic, civic, and social integration into the community. In order to achieve that mission, MOIA conducts research and analysis, provides guidance to other City agencies, develops partnerships with community-based organizations, and advocates at all levels of government.

3.Ā I swear this declaration to describe the way in which the rule entitled "Inadmissibility on Public Charge Grounds," (the "Rule"), which the Department of Homeland Security ("DHS") began implementing on February 24, 2020, has fostered widespread confusion, uncertainty, and fear among members of New York City's immigrant community in the midst of a public health crisis, when we can least afford the potential devastating consequences of that confusion, uncertainty and fear on the food security and health of immigrant communities in the city, and on the public health of the city as a whole. I base my declaration on my own personal knowledge and observations, on regular briefings that I receive from MOIA's staff, and on my review of the business records of the City and its agencies.

4.Ā Given MOIA's mission, and its strong relationships with the immigrant community, ethnic media, as well as with non-governmental organizations that serve the immigrant community, we have taken the lead on and coordinated much of the City's response to the expanded scope of the Rule. Through this work, we have engaged a wide range of stakeholders—from health care leaders to social service organizations to legal service providers and other local government leaders—to raise awareness about the Rule and to mitigate its impact on New York City's immigrant communities.

ActionNYC Immigration Hotline

5.Ā Among the many steps that the City has taken to empower immigrants in New York City to make informed decisions about their lives, including their benefit utilization in the face of the expanded Rule, is the expansion of ActionNYC, the City's central immigration-related telephone hotline. ActionNYC, overseen and funded by the City through MOIA in partnership with the City University of New York, is the City's program to connect immigrant New Yorkers to free, safe, and high-quality immigration legal services in their community and their language. It

operates through a citywide hotline, a centralized appointment-making system, and accessible service locations at 21 community-based organizations, rotating public school locations, and public hospitals.

6.Ā The City, through MOIA, has expanded the staffing and capacity of the citywide ActionNYC hotline, operated by Catholic Charities, in response to significant developments in immigration law such as the expansion of public charge. In the months leading up to and following publication of the final Rule in August 2019, MOIA worked closely with Catholic Charities to prepare the ActionNYC hotline for an anticipated surge in demand, tasking it with, among other things, (1) expanding its scope to address immigrant New Yorkers' questions about the categories of people to whom public charge applies; (2) connecting immigrants in need of legal assistance with a City-funded ActionNYC navigation team qualified to provide legal screening, advice, and assistance, including assistance in the process of preparing and filing public charge-related immigration forms; and if necessary, (3) referring immigrants with more complex public charge-related legal needs to specialists at the Legal Aid Society.

7.Ā In January and February 2020, with the announcements and attendant media coverage about the fact that the Supreme Court had stayed the nationwide preliminary injunction that had been holding in abeyance the final Rule, and that USCIS would begin implementation of the Rule in late February, the ActionNYC hotline saw considerable spikes in activity. Average monthly call volume to the hotline in 2019 was 1,888, however, the volume of calls to the hotline increased in January and February 2020. Notably, on January 27, 2020, the Supreme Court stayed the nationwide preliminary injunction, and on January 30, 2020, USCIS announced that the Rule would take effect on February 24th. Following those events in late January, there was a spike in calls to the hotline: prior to January 27th, the average daily call volume in FY2020 was 99; on

January 27th and 28th, daily call volume jumped by 35% and 77%, respectively, to 134 and 175 calls. Similarly, on January 30th, the hotline received 137 calls, a 38% increase from the FY2020 daily average.

8.Ā During February 2020, calls to the ActionNYC hotline increased to 2,973, a 57% increase from the monthly average in 2019. In addition, there was another substantial spike in calls beginning when the Rule took effect: 201 calls were received on February 24th, and 263 on February 25th, increases of 103% and 166%, respectively, over the FY2020 average daily call volume. In addition to an increase in total calls to the hotline, the number of those calls that related to the Rule also increased: at least 544 calls to ActionNYC in February and March 2020 concerned public charge. Alarmingly, in February 2020, nine callers to the hotline were so insistent on disenrolling from public benefits—even though they were entitled to the benefits and not subject to a public charge test—that hotline operators had to refer them to specialists at the Legal Aid Society for more in-depth counseling on the public charge rule.

9.Ā This past month, as the COVID-19 pandemic became an increased threat to the health, safety and well-being of New Yorkers, calls to the ActionNYC continued at rates 15% higher than the 2019 average. For example, in March 2020, the ActionNYC hotline received 2,166 calls, and 7% of those calls related to public charge. In addition, in the second half of March as NYC began to implement stay at home policies, the ActionNYC hotline received 12 calls related to the implications of the Rule for COVID-19. These calls were from immigrants with legal permanent resident status who had lost their jobs, and were concerned about whether having applied for or received unemployment benefits would be held against them if they sought to adjust their immigration status in the future. These calls demonstrate the continued confusion about and chilling effect of the Rule, even amongst those to whom it does not apply.

Community Outreach in Light of COVID-19

10.Ā Over the past two years, as changes to public charge inadmissibility were rumored, proposed, and then enacted, the City became aware of a high likelihood of chilling effect on use of benefits within immigrant communities. First, a survey that MOIA commissioned in 2018 found that 76% of non-citizens surveyed would consider withdrawing from, or not applying for, public benefits, as a result of the public charge rule. Monitoring of calls to the ActionNYC hotline has confirmed that benefit disenrollment is a real concern: just since October 2019, hotline operators have referred 23 callers for a more in-depth public charge-related benefits screening when they insisted on disenrolling from public benefits despite being exempt from a public charge test.

11.Ā As a result, MOIA has focused substantial resources on community outreach, undertaken in coordination with our community partners, in an effort to counteract that chilling effect. MOIA's outreach efforts have continued since the expanded Public Charge Rule came into effect on February 24, 2020, and they continue now during the public health crisis that has engulfed the city. As part of this outreach, MOIA's staff has listened to community concerns about the changes to public charge, and has sought to correct misinformation and misunderstandings about this very complex topic, and to urge immigrants to make use of the substantial legal and informational resources that the City has made available before making any decisions about forgoing medical care, and about enrollment in or disenrollment from benefits. MOIA has also focused its efforts on assessing community needs in light of the COVID-19 crisis.

12.Ā During MOIA's recent outreach engagements, immigrants—directly or through community organizations working on their behalf—have shared the agonizing decisions they face of whether or not to seek out desperately needed SNAP, Medicaid, and other benefits because of fears that it may result in them being separated from their loved ones, or may put at risk their

dreams of obtaining or extending a visa or obtaining a green card, in hopes of eventually becoming American citizens.

13. As troubling as the chilling effect of Public Charge has always been to the City, we are even more concerned that during the COVID-19 pandemic that chilling effect can and will have deadly consequences. Specifically, it has become apparent that certain immigrants are making the decision to forego medical screening and treatment due to fear about the public charge implications of seeking that treatment. While USCIS apparently recognized this potential chilling effect of public charge, and issued guidance aimed at counteracting it, our observations suggest that it has not been successful in achieving that goal.

14. On or around March 13, 2020, the U.S. Citizenship and Immigration Services (USCIS) posted an alert (in English only). This alert explained that while the Public Charge rule "does not restrict access to testing, screening, or treatment of communicable diseases, including COVID-19," USCIS was nonetheless required to "consider the receipt of certain cash and non-cash public benefits, including those that may be used to obtain testing or treatment for COVID-19 in a public charge inadmissibility determination," including most forms of federally funded Medicaid. *See* https://www.uscis.gov/greencard/public-charge.

15. Since that time, and despite that guidance, we have heard from our community partners that immigrants continue to be hesitant to seek out medical care, even when they are manifesting symptoms of illness. For example, on March 24, 2020, a community partner who provides services to food service workers in the City reported that members of its constituency, despite feeling ill, are afraid to seek treatment in public hospitals for fear of immigration consequences. Similarly, another community partner who works on behalf of youth and their families, described fear within the community about seeking medical care because of immigration

status. Finally, yet another community partner, this one a neighborhood-based family and social services organization serving immigrant communities in Brooklyn, reported that immigrants it served were afraid to seek out and obtain COVID-19 testing due to fear about how that might impact their status.

16.Ā Through our recent community outreach, we have also learned that New York City's immigrant communities have been drastically and negatively impacted by the slowdown and shutdown of so many industries that make up the City's economic engines due to COVID-19, resulting in a desperate need for assistance with rent, food, and medication. Community partners have reported that the city's restaurant and domestic workers have been incredibly hard hit, and with little to no savings, these workers are facing a need to go out and perform jobs that no one else wants to do, despite the fact that doing so would expose themselves to risk. We have also learned that many in the immigrant community are struggling due to a lack of access to paid medical leave, and ineligibility to receive federal aid or unemployment benefits due to either the nature of the work they perform, or their immigration status.

17.Ā On the other hand, other community partners report that even those immigrant New Yorkers who may be eligible for federal disaster aid or other public benefits are hesitant to apply for or accept such benefits, and have expressed a fear that accepting any public benefits might result in a public charge determination that would carry negative immigration consequences. For example, during a conversation among over 400 members of an online chat group operated by a community partner serving a defined immigrant community, at least 10 participants—most of whom had applied for or been granted asylum—asked whether applying for SNAP or cash benefits from the City would adversely affect their applications for green cards and/or citizenship. Another example is a construction worker from Brooklyn who is unemployed due to COVID-19 and has a

pending green card application, including a scheduled interview. This worker asked whether an application for unemployment benefits could negatively impact his green card application, and our staff was able to direct him to the ActionNYC hotline for further guidance.

18.Ā Based on MOIA's information and outreach, it appears likely that USCIS' March 13, 2020 statement that it would "consider the receipt of certain cash and non-cash public benefits, including those that may be used to obtain testing or treatment for COVID-19 in a public charge inadmissibility determination," contributes significantly to the fear and confusion we are seeing in the immigrant community, despite our efforts to encourage community members to seek and accept public benefits where they are eligible for them.

19.Ā Based on what we have learned in the course of our community outreach efforts, we have serious concerns that the chilling effect of the public charge rule is interfering with the City's ability to effectively respond to the medical, and economic needs of immigrant communities during the COVID-19 pandemic.

I declare under penalty of perjury that the foregoing is true and correct and of my own personal knowledge.

DATED this __9th__ day of April, 2020 at New York, New York

BITTA MOSTOFI
Commissioner
Mayor's Office of Immigrant Affairs
City of New York
253 Broadway, 14th Floor
New York, NY 10007

No. 19A785

In the
Supreme Court of the United States

DEPARTMENT OF HOMELAND SECURITY, et al.,

Applicants,

v.

NEW YORK, et al.,

Respondents.

I, Lisa M. Newstrom, pursuant to 28 U.S.C. § 1746, hereby declare as follows:

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

2. I am Managing Attorney of the Santa Clara County Regional Office of Bay Area Legal Aid ("BayLegal"), the largest provider of legal services to the poor in the San Francisco Bay Area and one of the largest in California. BayLegal and its predecessor organizations have practiced poverty law in this region for over 50 years. In the Bay Area, approximately 1.5 million people live in poor or low-income households (under 200% of the federal poverty measure).

3. I submit this declaration in support of Respondents' application in the above-captioned matter.

4. In this declaration, I explain how the public charge rule—the Final Rule on Inadmissability on Grounds of Public Charge (84 Fed. Reg. 41292)—has impacted the clients of Bay Area Legal Aid ("BayLegal"), particularly during the COVID-19 crisis. The rule has a chilling effect that prevents families from getting needed health care or food assistance even when the assistance is critical in the face of the COVID-19 pandemic, and even when getting the assistance would not actually harm the family's immigration status under the new public charge rule. Based on my experience, I believe there is a significant risk that the public charge rule will cause some people to avoid testing and treatment for COVID-19, which would endanger their own lives and place entire communities at risk.

Background

5. Bay Area Legal Aid has regional offices serving the counties of Santa Clara, San Francisco, Alameda, Contra Costa, San Mateo, Marin, and Napa. Our staff protects and advances the rights of low-income families, immigrants, and language minorities in domestic violence, public benefits, healthcare, consumer protection, and housing matters before the courts, administrative agencies, and legislative bodies. We have 147 staff members, including 100 attorneys and 10 legal advocates, providing free legal services across these seven counties.

6. BayLegal's primary client intake mechanism is through our Legal Advice Line and Health Consumer Center hotlines. These hotlines are staffed by attorneys and trained legal advocates

working under the close supervision of attorneys, and perform eligibility screening, including gathering client demographic data, as well as providing advice and counsel to eligible individuals on a wide range of practice areas, including matters related to immigration, domestic violence, Section 8, public housing, Medi-Cal (California's Medicaid program), Supplemental Security Income ("SSI"), CalWORKs (California's TANF program), and CalFresh (California's SNAP, or "food stamps" program). Nearly all the immigrant clients BayLegal serves are lawful permanent residents or humanitarian immigrants such as domestic violence survivors who qualify for U non-immigrant status ("U visa") or human trafficking survivors who qualify for T nonimmigrant status ("T visa"), and all our immigrant clients are eligible for legal services per 45 C.F.R. § 1626.4-5.

7. BayLegal handles over 12,000 cases annually, and our intake units at the Legal Advice Line and Health Consumer Center handle over 26,000 calls per year. We also provide legal services to thousands of individuals each year through pro per clinics.

8. I have served as Managing Attorney in Santa Clara County since 2013. Over the last six years, I have supervised attorneys and advocates who provide free legal services to Santa Clara residents in a number of areas, including eligibility for public benefits, immigration law, rights of survivors of domestic violence and human trafficking, housing law, and others.

9. To demonstrate the way that the public charge rule has impacted BayLegal, I provide information known to me as a longtime legal aid attorney and as a manager at Bay Area Legal Aid, as well as limited information about some people who are suffering harm as a result of the chilling effect caused by the public charge rule. By making this declaration I do not waive any attorney-client privilege or client confidentiality.

Systemic Barriers Complicating Application of the Public Charge Rule

10. It is very difficult for recipients of aid to obtain the information necessary to determine whether the public charge rule applies to them, including: documentation in plain language that explains what benefits they have received, what funding streams were implicated in the provision of that aid,

which members of a household received aid, and in which months the aid was received (especially if that receipt was several years in the past).

11. In my experience, local welfare agencies often provide documentation of aid that is unclear, contains errors, and is rife with abbreviations and terms of art that are unfamiliar to the general public. When an agency has made an error and later corrects it—for example, by granting aid to a household member who is ineligible for benefits, and then rescinding that aid—it is often impossible to get accurate documentation or timelines showing all the relevant facts.

12. USCIS officials regularly display a lack of understanding about public benefits programs. For example, BayLegal often asks USCIS to waive filing fees for indigent clients. In connection with our fee waiver petitions, we regularly provide USCIS with documentation that our clients receive means-tested public benefits. We regularly receive incorrect rejections from USCIS decision-makers who are confused by state-specific names for programs (e.g. in California, Medicaid is called Medi-Cal), or by similar-sounding programs (e.g. confusing Supplemental Security Income (SSI) with State Disability Insurance (SDI)). BayLegal attorneys are usually able to correct the mistakes made by USCIS. However, given our limited resources we are able to help only a small fraction of the people who need assistance.

13. Based on my experience, I believe that immigrants subject to the public charge rule would need the help of skilled legal experts if they are to successfully obtain all relevant information from the benefit-granting agencies needed to show whether they have received benefits that triggered the proposed public charge rule, and to explain and negotiate with USCIS to ensure that the information is reviewed correctly. However, there are not enough lawyers available and with the expertise to provide such help; further, even with legal representation it may at times be impossible to obtain documentation from the benefits programs that USCIS can understand. As a result, I believe many eligible immigrants will be too afraid to seek the aid they need – including testing and care during the COVID 19 pandemic.

Public Charge Rule Has a Dangerous Chilling Effect

14. In my experience as both a public benefits practitioner and a manager of other attorneys practicing in this area, I have observed that the recently enacted public charge rule has caused a chilling

effect, preventing needy immigrants—including those fleeing human trafficking, and asylees—from getting the food and medical care that are essential to survival. It has this effect even for families that are eligible for aid and who are exempt from the public charge rule, and for whom immigration status would be unaffected by receiving aid. And it has this effect even during the current public health emergency. This is because the public charge rule is extremely confusing—both for advocates and for immigrants who are less familiar with our legal system and may have limited English proficiency.

15. As explained above, there are multiple iterations of multiple categories of public benefit programs, and it requires extreme technical proficiency to parse which versions of which aid programs might trigger a presumption that a person is a "public charge," and which do not. There are also a wide variety of different categories of immigration status, some of which are categorically exempted from the public charge exclusion rule, and others of which are at risk of being deemed a public charge if they receive aid. To complicate things further, many families have members each of which has *different* immigration status, different eligibility for benefits, and different risk of being deemed a public charge if they receive aid. As a result, most immigrants—and most immigration advocates—do not know whether they will put their immigration status at risk if they apply for food aid or medical care that their families need.

16. For our humanitarian immigrant clients who are fleeing abuse or exploitation, being denied the ability to adjust their immigration status, and therefore having to return to their country of origin would be devastating. Clients who are asylees and refugees may face persecution, war, and deadly threats if they return, while survivors of domestic violence or human trafficking may face recurrent abuse, loss of the legal protections from their abuser or trafficker, and retaliation for having cooperated with American law enforcement. In short, for many of these immigrants, risking their ability to stay in the United States is risking death.

17. USCIS can take years to process and approve applications for humanitarian immigration status, and this prolongs the period of uncertainty during which immigrants must make decisions about accessing needed services. For example, anticipated wait time for USCIS to adjudicate a U visa application for a noncitizen survivor of domestic violence is more than 7 years, and it can take another 6

or more years after receiving the U visa before that same immigrant is eligible to apply for lawful permanent residency and have their adjustment of status adjudicated.

18. Even for lawful permanent residents who may have been in the United States for decades, and who are not usually subject to the public charge rule, a decision to apply for benefits can pose risk. As the immigrant or family members abroad get older, I have observed several times how a short trip to visit family can be complicated by a sudden health crisis that requires a lengthier stay, and after 180 days outside the United States, the lawful permanent resident may need to seek readmission—triggering the public charge grounds of exclusion. Predicting whether such a situation may arise in the next 36 months (the look-back period for considering receipt of benefits as a heavily negative factor) can feel like an impossible gamble.

19. I and those under my supervision in the local offices who handle immigration, housing, and public benefits cases have also seen an increase in inquiries from clients, the general public, and community-based organizations concerned that the new public charge rule is causing people to drop essential health or food programs out of fear for their immigration status. Specifically, over the past few weeks our Legal Advice Line and Health Consumer Center hotlines have seen an increase in calls from people who need financial assistance, public benefits, or health care due to the public health crisis. For those callers who are immigrants or in mixed-status households, we are frequently getting questions about whether it is safe for them to get the health care and economic supports they need, and for which they legally qualify, or whether doing so will endanger their immigration status.

20. Most of the fears we have heard in our local offices are from lawful permanent residents and survivors of domestic violence, who are contemplating dropping healthcare and nutrition programs, as well as employment support programs. Many of these clients have U.S. citizen children who will also lose access to public benefits programs if their parents simply drop out or refuse to apply for the programs they need.

21. The aid programs that our clients and potential clients are dropping (or considering dropping) most frequently are those that provide basic essentials: food (CalFresh and the Women Infants and Children nutrition program); health care—particularly for children—under Medi-Cal (the state version of Medicaid); and services for pregnant women.

22. Among the sorts of public charge concerns our staff attorneys have handled are: a crime victim with a U visa dropping health coverage during treatment for cancer due to fear of triggering public charge; multiple calls from people afraid to access work supports and food assistance, such as a U visa holder afraid to get CalWORKs for herself or her U.S. citizen children; immigrants avoiding public food programs and going to food banks; and lawful permanent residents afraid that getting health insurance for their U.S. citizen children will keep them from naturalizing.

23. I and the staff attorneys working under my supervision regularly reassure many of these exempt clients that they should not be subject to the new public charge rule, and can receive the aid they need without fear of immigration consequences; but we are regularly told by our clients that they are still afraid or unwilling to access the public benefits for which they and their children might otherwise qualify.

24. The public health crisis caused by COVID-19 has forced BayLegal to adapt its services to address the most pressing of our clients' legal needs, while keeping up with ever-changing operating rules of courts and administrative agencies, yet we have still had to expend significant resources addressing fears about public charge. Even in the face of this crisis, I have received inquiries from immigration attorneys outside our organization who are afraid that their clients cannot access essential services because of the public charge rule. For example, I have learned of clients who are survivors of human trafficking, and who were laid off when their employers closed down because of COVID-19, but who are too scared to apply for Unemployment Insurance Benefits.

25. In my capacity as Managing Attorney, I am aware that BayLegal attorneys have also spoken with numerous immigrant crime victims in the past few weeks who have lost jobs or income due to COVID-19 and are too worried to get the help they need, including state-funded Medi-Cal and nutrition assistance, for fear it will prevent them from getting U.S. citizenship or lawful permanent residence. Examples include:

a. a low-income crime victim with a U visa recently gave birth to a U.S. citizen child, but even as the public health crisis was developing, she was afraid to seek public health insurance for herself and her newborn due to public charge;

b. a crime victim with a U visa whose work hours were cut, and who could no longer afford to feed her family, but is too afraid to get food benefits for herself and her children;

c. another crime victim with a U visa whose employer closed due to COVID-19 public health restrictions, and although the individual has the right to seek Unemployment Insurance Benefits—and needs those benefits for the economic survival of their family—they are too afraid to apply for aid;

d. A fourth crime victim with a U visa who cancelled nutrition assistance for herself and her child in the midst of economic hardship because she was worried about public charge; and

e. another crime victim with a U visa who lost her job due to the pandemic, but was afraid to apply for Unemployment Insurance Benefits—and was even considering whether she should cancel basic nutrition assistance for herself and her U.S. citizen children because of public charge.

26. In my capacity as Managing Attorney, the attorneys staffing our Legal Advice Line and Health Consumer Center hotlines also report numerous calls in the past few weeks from lawful permanent residents or U.S. citizens in mixed-status families suffering under the current pandemic and afraid to get nutrition or health programs they or their families need because of public charge. Examples include:

a. a single parent with lawful permanent residency who was planning to cancel Medi-Cal coverage for herself and her U.S. citizen children in the midst of the pandemic because she was afraid she would lose her immigration status and be separated from her family;

b. a mother who is a U.S. citizen with U.S. citizen children, and who needs subsidized healthcare, nutrition assistance, and housing, who was afraid to apply for these benefits because she was afraid it would hurt the immigration status of her husband, a lawful permanent resident;

c. a young lawful permanent resident who lost her job and was afraid to apply for Medi-Cal health coverage for fear of public charge;

d. a U.S. citizen who lost his job and needed to make sure his family could get health care, but was worried about getting Medi-Cal for himself and his family because his wife and one child were lawful permanent residents;

e. a developmentally-disabled U.S. citizen child whose parents, here on employment visas, were afraid to get the Medi-Cal-funded developmental services their child needed; and

f. a young father who was working despite the pandemic, but was worried he needed to drop necessary Medi-Cal coverage for himself, his spouse, and their children due to public charge.

Conclusion

27. In the midst of the COVID-19 pandemic, BayLegal is regularly responding to inquiries from people who should not be directly impacted by the rule–including citizens, lawful permanent residents, and humanitarian immigrants–but who are nonetheless afraid. My direct impressions based on the nature and type of legal inquiries we are receiving from the general public, from community based organizations providing services to immigrants, and from other legal service providers, is that the numbers of people who will disenroll from benefits or forego benefits for which they or their children are eligible is much higher than the 2.5% estimate USCIS anticipates as the number of eligible immigrants and mixed-status households who will forego needed aid due to the rule.

28. I believe this chilling effect will cause lawful permanent residents, domestic violence survivors, survivors of human trafficking, and U.S. citizen children with immigrant parents to go without healthcare, nutrition assistance, and housing assistance they need to survive during the COVID-19 pandemic. Without access to essential programs, individuals may become sick with the virus and suffer irreparable harm to their physical and economic wellbeing – and also increase the risk of infection in the communities where they live.

I declare under penalty of perjury that the foregoing is true and correct and that this declaration was executed on April 3, 2020, in Fremont, Alameda County, California.

Lisa Newstrom

Lisa M. Newstrom

No. 19A785

In the
Supreme Court of the United States

DEPARTMENT OF HOMELAND SECURITY, et al.,

Applicants,

v.

NEW YORK, et al.,

Respondents.

I, John Paul "Jack" Newton, pursuant to 28 U.S.C. § 1746, hereby declare as follows:

1. I am over the age of eighteen. I am an attorney licensed to practice law before the State of New York. I am also admitted to appear before the District Court for the Southern District of New York.
2. I am the Director of the Public Benefits Unit ("PBU") at Bronx Legal Services ("BxLS").
3. BxLS is a constituent corporation of Legal Services NYC ("LSNYC"), which is the largest provider of free civil legal services in the nation.
4. The public charge rule changes have made us all more vulnerable to this new global health crisis. In the recent weeks and months, COVID-19 has created new emergencies, new problems, and new inequities among and for noncitizen New Yorkers. This virus has created new ways in which the new public charge rules are irreparably harming noncitizens, their families, and the communities in which we live.

The Public Benefits Unit at Bronx Legal Services

5. The PBU of BxLS is the largest single team of public advocates in the State of New York,

with 21 advocates, including attorneys, paralegals, and masters-level social workers. Our PBU works to obtain, retain, or increase a wide spectrum of vital public benefits administered by the New York City Department of Social Services ("DSS"), the New York State of Health ("NYSOH"), the New York State Department of Health ("SDOH"), and other related city and state agencies.

6. From January 1, 2019, through March 25, 2020, we handled almost 3,500 individual public benefits cases, helping over 6,800 Bronx residents. More than one-quarter of our clients are noncitizens, and more than one-third of client households contain at least one noncitizen.

7. Our PBU provides representation, advocacy, advice, and assistance on a number of different public benefits, including:

   a. Cash public assistance benefits, including those funded by federal Temporary Assistance for Needy Families ("TANF") monies[1] and those funded by New York;[2]

   b. Supplemental Nutrition Assistance Program ("SNAP") benefits,[3] formerly known as Food Stamps;

   c. Child care benefits for recipients of public assistance with work requirements;[4]

   d. Women, Infants, & Children ("WIC") benefits,[5] which is a voucher program that covers certain nutritious foods for children under age 5, pregnant women, and new mothers;

   e. Public health insurance such as Medicaid,[6] Medicare,[7] and Essential Plans

[1] *See, e.g.*, N.Y. Soc. Serv. L. § 349.
[2] *See, e.g.*, N.Y. Soc. Serv. L. § 159.
[3] *See* 7 U.S.C. § 2011, *et seq.*
[4] *See* N.Y. Soc. Serv. L. § 410-w.
[5] *See* 42 U.S.C. § 1786.
[6] *See generally* 42 U.S.C. § 1396, et seq.; N.Y. Soc. Serv. L. §§ 122, 131, & 363-369.
[7] 42 U.S.C. § 1395, *et seq.*

administered by NYSOH;[8]

f. Personal care/home care services[9] for disabled, infirm, and elderly clients who want to age in place as an alternative to institutionalization;

g. Veteran's benefits; and,

h. HIV/AIDS Services Administration ("HASA")[10] benefits.

8. In addition to our direct legal services, which are the heart of our practice, we also maintain deep roots in the communities we serve by running clinics and conducting outreach, community trainings, and other events. Since January 2019, our PBU conducted over 42 different trainings or clinics, reaching over 1,800 people.

Public Charge Trainings & Consultations

9. After the announcement of the proposed public charge changes in October 2017, our PBU immediately saw a spike in requests for advice and information about how the receipt of public benefits will affect people's immigration status. Within the first few days after the proposed public charge rules were initially reported in the press, we received calls from dozens of social services agencies and individual clients who were concerned about the changes. Many of the individuals had closed their public benefits cases, and those of their citizen children, as a precautionary measure even before receiving any advice.

10. Those first two weeks highlighted the fear among noncitizen clients and communities, as well as in the social service agencies helping these communities, and the need for us to provide accurate information expeditiously. We created a flyer with our hotline number and invited people to call our hotline for a consultation on public charge issues.

11. As of late March 2020 and excluding the flood of inquiries we initially received in October

[8] 42 U.S.C. § 18001, *et seq.*
[9] *See, e.g.,* N.Y. Soc. Serv. L. § 365-a.
[10] *See, e.g.,* N.Y.C. Admin. Code §§ 26-126, -127, & -128; 18 N.Y.C.R.R. § 352.3(k).

2017, our PBU has conducted almost 600 individual consultations for noncitizens about the public charge rule. Around 75% of our consultations include concerns or questions noncitizens have about the receipt of SNAP and/or Medicaid.

12. PBU has conducted several different public charge-related events, including community-facing trainings, clinics for people with questions about how public charge will affect them, and different trainings on the public charge doctrine for advocates. The community events that we have held were flooded with attendees. We could not possibly meet individually with every person who attended our public charge community clinics and trainings.

13. Attendance at our community trainings markedly increased in winter 2019-2020, drawing in audiences of approximately double the size we had been experiencing in summer 2019.

14. Thus, our perspective about what the changes to the public charge doctrine have done, will do, and are doing to our noncitizen clients is based on our on-the-ground experience providing direct services to thousands of individuals.

COVID-19 Has Accelerated & Amplified the Harm of the Public Charge Rule Changes

15. In a matter of days, our country's economic, public benefits, and public health systems changed due to COVID-19. As employment collapsed practically overnight, we were reminded of the central role that access to health care, nutrition, and subsistence benefits has not only in the well-being of individuals but also in the health and vibrancy of communities, neighborhoods, and cities. Unfortunately, the changes to the public charge rule – and the fear surrounding it – gravely threaten the ability of noncitizens, their families, and our communities to remain healthy.

16. Because SNAP and Medicaid were added to public charge consideration for essentially the first time in history, these benefits quickly became the focus for noncitizens' growing fears

surrounding the consequences of obtaining assistance. In recent months, we have seen noncitizens disenrolling themselves (and, at times, their citizen children or other family members) from Medicaid and nutritional support programs, like SNAP and WIC.

17. As a result, the most frequent questions we receive from noncitizens and their advocates are, "Will using Medicaid cause my children or me to be deported? Is it safe for us to use Medicaid?"

18. Many New Yorkers mistakenly believe they are receiving Medicaid as defined in the public charge rule, due to misunderstanding of the program in general. As a result, thousands of people *think* they receive Medicaid when, in fact, they are in receipt of other low-cost health insurance programs. Unfortunately, the misinformation and fear has taken on a life of its own, and we have seen hundreds of clients close their "Medicaid" cases for themselves, their citizen children, and other family members.

19. Particularly in Queens and the Bronx, we have encountered many noncitizens who are afraid to get COVID-19 testing. First and foremost, the reason we have heard time and again behind the reluctance to get tested is simple: people are afraid that testing requires Medicaid, which would get them deported. Rather than promoting the public good, the public charge doctrine is endangering our communities by deterring people from obtaining COVID-19 testing and assistance that is critical to flattening the curve and reducing transmission.

20. The "guidance" issued by the United States Citizenship and Immigration Services ("USCIS") in recent weeks about public charge and accessing care for COVID-19 has not offered any comfort or clarity for both advocates and noncitizen community members. If anything, it only introduced more fear among noncitizen communities, since the alert seems to equivocate on how, whether, when or if seeking COVID-19 treatment would trigger public charge issues.

Without Medicaid, Noncitizens Stop Treating Chronic Conditions

21. Disenrollment from Medicaid has a very real consequence: people stop attending primary care appointments and stop seeking medical help, until there are life-threatening emergencies. While this result is dire in any circumstance – from diabetes management to early breast cancer screenings – the COVID-19 pandemic has potentially made early access to care a life-or-death decision for individuals, their families, and their communities. Primary care is critical in treating asthma and hypertension, which, along with diabetes, are underlying conditions that have been associated with more severe COVID-19 complications.

22. In the span of a few weeks, we have begun to see first-hand what delayed primary care has done to noncitizens who were afraid to use Medicaid, though I fear the suffering will continue to grow as the COVID-19 pandemic peaks in New York City. Our clients have left conditions untreated because they closed Medicaid cases to be "safe" and because "it wasn't worth the risk to treat asthma" only to fall extremely ill with shortness of breath, high fevers, headaches, body aches, and chills. One of our clients is now hospitalized.

23. We also have HIV-positive clients who closed out their HASA benefits when the public charge rules went into effect. HASA benefits include health and nutrition support benefits for people living with HIV/AIDS. Lack of consistent HIV care causes viral loads to skyrocket and immune systems to crash. With COVID-19 now a global pandemic, we are terrified what will happen to HIV-positive noncitizens who have foregone public health insurance, like Medicaid, and other benefits out of fear that they will be deported.

Significant increases in requests for public benefits assistance since COVID-19

24. Comparing the weeks before COVID-19 with the most recent two weeks, we have seen an 850% increase in requests for assistance with public benefits issues.

25. A substantial part of that increase includes requests for assistance from noncitizens who are trying to access health care without insurance. Although almost all of the people seeking our assistance were otherwise eligible for low- or no-cost insurance programs, they had disenrolled from, or wanted to avoid enrolling in, health insurance plans out of fear that they or their families would be deported.

26. Since the public charge changes went into effect in late February 2020, we have seen an increase in noncitizen clients seeking emergency food assistance, including food pantries. Even in families in which only citizen children are eligible for SNAP, we have seen a reluctance to use or receive the benefit out of fear of deportation and family separation. The hunger we have seen in our noncitizen clients has become so severe that we now bring Food Bank NYC booklets to our intake meetings in anticipation of the need for pantry assistance.

27. The advent of COVID-19 has turned unreliable access to nutrition into a public health crisis, rendering noncitizens and their neighbors more vulnerable to the ravages of COVID-19. We also saw a wave of unemployment crash down on low-income New Yorkers – particularly those most vulnerable to job loss, including noncitizens who are home health aides, caregivers, cleaners, and janitors – which has immeasurably exacerbated and increased the need for SNAP and nutrition supports generally. Right now in the Bronx, virtually all of the food pantries have closed or sharply reduced hours due to COVID-19, which eliminates a vital lifeline for noncitizens who are hungry. The few pantries that remain open during this crisis are running out of food at alarming rates, with a significant portion of people seeking their help being noncitizens.

28. The public charge rule changes drove and are driving noncitizens and their families off of critical benefits, including low-cost health insurance and SNAP, and have rendered low-

income noncitizens even more susceptible to this virus, and in doing so have made all of us less safe.

DATED this 7th day of April, 2020, at New York, NY

Signed:

John Paul "Jack" Newton (JP 1976)
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No. 19A785

In the
Supreme Court of the United States

DEPARTMENT OF HOMELAND SECURITY, et al.,

Applicants,

v.

NEW YORK, et al.,

Respondents.

I, Rachel Pryor pursuant to 28 U.S.C. § 1746, hereby declare as follows:

1. I serve as the Deputy Director for Administration for the Virginia Department of Medical Services ("DMAS") since October 2018. Prior to my appointment, I served as the Senior Health Policy Advisor on the Democratic Staff of the Energy and Commerce Committee in the U.S. House of Representatives, managing a broad legislative portfolio that included Medicaid & CHIP, Medicare, and Long-Term Care issues. I have a Masters in Social Work from the University of Maryland with a dual Clinical/Policy focus, and a Juris Doctor from Georgetown University Law Center.

2. I submit this declaration in support of Plaintiffs' application in the above-captioned matter. I have compiled the information in the statements set forth below either through personal knowledge, through the DMAS personnel who have assisted me in gathering this information, or

on the basis of documents that I have reviewed. I have also familiarized myself with the Public Charge Final Rule ("Rule") in order to understand its immediate impact upon DMAS.

3. As Deputy Director, I work directly with the DMAS Director and the Virginia Secretary for Health and Human Resources on high-level policy and strategic issues. I directly supervise a team of more than 150 staff members, overseeing all eligibility and enrollment operations, appeals operations, legislation and all regulatory and policy functions for the Agency. DMAS incudes more than 700 full-time, wage and contract individuals, and a wide range of programs and projects. The Agency oversees a broad portfolio of services and works extensively with state, local, tribal and community partners to improve the health and well-being of Virginians through access to high quality health care coverage. The biennial budget for DMAS is roughly $27 billion, approximately 60% of which is federal funding.

4. DMAS administers Virginia's Medicaid and Children's Health Insurance ("FAMIS") programs. Through the Medallion 4.0 and Commonwealth Coordinated Care ("CCC") Plus managed care programs, more than 1.5 million Virginians access primary and specialty health services, inpatient care, behavioral health, and addiction and recovery treatment services. In addition, Medicaid long-term services and supports enable thousands of Virginians to remain in their homes or to access residential and nursing home care. Medicaid members historically have included children, pregnant women, parents and caretakers, older adults, and individuals with disabilities. In 2019, Virginia expanded the Medicaid eligibility rules to make health care coverage available to over 400,000 newly eligible, low-income adults.

5. DMAS works with a multitude of community partners throughout the Commonwealth of Virginia who represent Medicaid/FAMIS beneficiaries in issues to DMAS,

including the Virginia Health Care Foundation ("VHCF") and the Virginia Poverty Law Center ("VPLC").

6. The VHCF is a non-profit public/private partnership established by Virginia's General Assembly in 1992 with the mission of increasing access to primary health care for uninsured and medically underserved Virginians. VHCF operates a number of programs and provides grants throughout the state to fulfill its mission. A number of these grants fund a cadre of 23 Outreach Workers who provide 1:1 application assistance to those eligible for Virginia's Medicaid and FAMIS health insurance programs.

7. The DMAS contracts with VHCF to fund and oversee nine of these outreach workers and to provide "SignUpNow" workshops to train individuals who help their clients or patients apply for Medicaid. DMAS and VHCF have worked hand-in-hand for 20 years to maximize enrollment in state-sponsored health insurance and address policy and system issues that create barriers to achieving this mutual objective.

8. The VPLC is a statewide non-profit organization that provides training to local legal aid program staff, private attorneys, and low-income clients relating to the legal rights of low-income Virginians. The VPLC is a community partner that brings forward Medicaid issues on behalf of DMAS recipients.

9. The DMAS has received reports from the Virginia Department of Social Services ("DSS"), our community partners, and health care advocates, prior to the release of the February 24, 2020 new U.S. Citizenship and Immigration Services ("USCIS") guidance and since the release of the guidance, that individuals have requested the closure of their Medicaid benefits because of the Rule.

10. DMAS has also received information from community partners both before and after USCIS issued guidance relating to the rule and COVID-19 treatment in mid-March reflecting that immigrant families are still very confused about their rights to benefits and the possible impact of the Rule. DMAS has been informed by a community partner that the fear even keeps immigrant families from coming to assisters or asking additional questions.

11. VHCF outreach workers have experienced the chilling effect of the Rule, prior to the release of the March USCIS guidance and since the release of the guidance, on individuals seeking health care and applying for Medicaid/FAMIS since the start of the pandemic. Even when outreach workers try to assure families that it is ok to apply for Medicaid/FAMIS, outreach workers are seeing an increasing number of families who ultimately decide not to apply and in some cases, withdraw from coverage.

12. One outreach worker reported to DMAS she has heard from families and local human services providers that the immigrant community is very concerned about medical bills due to the lack of health insurance, so they are not going to the doctor if they present symptoms of COVID-19. They will wait to go to the emergency room when the condition gets serious.

13. During various outreach events occurring in February and March 2020 at Northern Virginia free clinics, five families did not want to apply for Medicaid for their children due to the fear of the Rule. All family members were green card holders and were looking into applying for citizenship.

14. The VHCF outreach workers have had some clients withdraw new applications and clients who were already covered cancel because of the public charge. New clients calling for information about the programs are hesitant to apply.

15. During the week of March 9, 2020 one VHCF outreach worker met with a family from Venezuela that did not apply for health insurance benefits because they fear this would affect their ability to adjust their immigration status. The mother works for a Richmond area human services organization. She did come to the appointment and said that she felt very hesitant to submit an application for her two children because of the public charge rule. Based on the information provided by the worker, she decided to not apply.

16. Over the past eight weeks, staff at several health safety net organizations has shared with a VHCF outreach worker that prospective patients have refused to go through the clinic's financial screening process, because it includes submitting a Medicaid application prior to determining their eligibility for clinic services.

17. One family with a child who has autism and many medical needs in the Richmond area withdrew their Medicaid application due to fear of the Rule.

18. On or around March 13, 2020, USCIS posted an alert (in English only). This alert explained that while the Rule "does not restrict access to testing, screening, or treatment of communicable diseases, including COVID-19," USCIS was nonetheless required to "consider the receipt of certain cash and non-cash public benefits, including those that may be used to obtain testing or treatment for COVID-19 in a public charge inadmissibility determination," including most forms of federally funded Medicaid. *See* https://www.uscis.gov/greencard/public-charge.

19. Despite this guidance, outreach workers continue to report that immigrants are confused and are deterred from accessing medical treatment or testing for COVID-19.

20. Prior to the release of the March 13 USCIS guidance and since the release of the guidance, navigators and community partners (food banks, free clinics, and hospitals) have

reported immigrants throughout Virginia expressing concerns with the Rule and terminating/avoiding enrollment in public benefits.

21. For example, a client who entered the United States with an approved asylum applied for FAMIS only for her three children, all under the age of five years-old, at the end of March 2020. On April 3, 2020, the parent called and requested that the applications for all three children be withdrawn due to concern with the Rule.

DATED this 7th day of April, 2020

Rachel Pryor, Deputy Director
Virginia Department of Medical Assistance Services

No. 19A785

In the
Supreme Court of the United States

DEPARTMENT OF HOMELAND SECURITY, et al.,

Applicants,

v.

NEW YORK, et al.,

Respondents.

I, Aaron Coskey Voit, pursuant to 28 U.S.C. § 1746, hereby declare as follows:

1. I am over the age of eighteen. I am an attorney licensed to practice law before the State of California.
2. I am the Managing Attorney of the Monterey County Medical-Legal Partnership at California Rural Legal Assistance, Inc. ("CRLA").
3. CRLA is a Legal Services Corporation (LSC), which provides free legal services to more than 40,000 rural, low-income Californians every year.
4. The Monterey County Medical-Legal Partnership provides free legal services to hundreds of patients every year at the Monterey County Health Department's nine Federally Qualified Health Centers, which serve more than 40,000 low-income primary care patients every year. A team of three full-time CRLA attorneys is on site at the County's safety net healthcare clinics every week working alongside healthcare providers to assist patients with health-harming legal needs.
5. Since the beginning of 2018, the Monterey County Medical-Legal Partnership has provided

services to more than 145 patients with legal needs related to public benefits. Since the beginning of 2018, the Medical-Legal Partnership has also provided training to over 750 doctors, physician's assistants, nurse practitioners, medical assistants, social workers, and social services providers regarding public benefits.

6. Monterey County declared a COVID-19 State of Emergency on March 6, 2020, and issued a Shelter in Place order on March 17, 2020. I am part of the Monterey County Health Department's COVID-19 Social Determinants of Health Team.

7. In Monterey County, many low-income residents are reluctant to access emergency healthcare and social services in response to the COVID-19 pandemic because they fear how the new public charge rules will impact them. The new public charge rules took effect on February 24, 2020, only weeks before Monterey County issued its COVID-19 Shelter-In-Place Order. COVID-19 has prevented planned public charge community education campaigns from moving forward, and there remains a significant chilling effect in the community that is preventing many residents from accessing needed healthcare and social services to cope with COVID-19.

Monterey County residents are vulnerable to forgoing needed healthcare and social services because of lack of information regarding the new public charge rules.

8. Thirty percent of Monterey County residents are foreign-born.[1]

9. Nearly 1 in 4 households in Monterey County relies on income related to agriculture. While estimates vary from year to year, Monterey County is home to as many as 90,000 farmworkers every year. Crops grown in Monterey County supply large percentages of total national pounds produced each year: 61% of leaf lettuce, 57% of celery, 48% of broccoli,

[1] U.S. CENSUS BUREAU, American Community Survey (ACS) and Puerto Rico Community Survey (PRCS), 5-Year Estimates, https://www.census.gov/quickfacts/montereycountycalifornia.

38% of spinach, and 28% of strawberries.[2]

10. The agricultural workers that CRLA serves are predominantly immigrants, mostly from Mexico.

11. Most of the farmworkers in this area do not speak English, and some only speak indigenous languages. Language barriers deter access to guidance on public charge currently being disseminated – only 33% of farmworkers report being able to speak English well and nearly as many (27%) report they cannot speak English at all.[3] Most are Spanish speakers, but many only speak indigenous languages, such as Mixtec, Zapotec, or Triqui. Many of the Mexican indigenous languages are only oral, meaning there is not commonly understood written language.

12. Only 39% of farmworkers have schooling beyond the ninth grade. In contrast, 96.5% of all U.S. adults 24 years or older, have completed the eighth grade.[4] Many farmworkers cannot read or write in English or Spanish. Many do not know how to operate a computer.

13. Many farmworkers in Monterey and Santa Cruz Counties live and work in remote, rural areas that are severely underserved by medical and social services providers.

14. There are significant barriers to disseminating information in farmworker communities that CRLA serves. The rural nature of farmwork means that residents are spread out over wide geographic areas. Many farmworkers cannot read and cannot access written informational materials, even if the materials are also in Spanish. Other farmworkers are able to read, but have never used a computer and do not have an email address.

15. Due to these barriers, effective community education in farmworker communities typically

[2] MONTEREY COUNTY FARM BUREAU, Facts Figures, and FAQs, http://montereycfb.com/index.php?page=facts-figures-faqs.
[3] U.S. DEP'T OF LABOR, EMP'T & TRAINING ADMIN., NATIONAL AGRICULTURAL WORKERS SURVEY (NAWS), PUBLIC DATA SETS, http://www.doleta.gov/agworker/naws.cfm.
[4] U.S. DEP'T OF LABOR, EMP'T & TRAINING ADMIN., NATIONAL AGRICULTURAL WORKERS SURVEY (NAWS), PUBLIC DATA SETS, http://www.doleta.gov/agworker/naws.cfm.

requires face-to-face meetings and outreach at large events where agencies can work with trusted community leaders to help disseminate information in-person.

The roll-out of the new public charge rules created significant confusion about when they took effect, whom they applied to, and which public benefits they included.

16. On October 10, 2018, the Department of Homeland Security (DHS) proposed a change to the long-standing public charge policy by excluding anyone who is likely to use certain health care, nutrition or housing programs in the future. The publication of this proposed rule created significant anxiety and confusion about whom the public charge test applied to, and what public benefits were included in the test.

17. The Final Rule, published on August 8, 2019, included some changes from the proposed rule published the year prior. These changes created further confusion about the new public charge rules.

18. DHS issued a correction of the final rule on October 2, 2019, contributing to still more confusion about the contents of the new public charge rules.

19. Following publication of the final rule, states, counties and non-profit organizations filed a total of nine legal challenges to the rule and multiple federal courts issued preliminary injunctions blocking implementation of the rule.

20. On January 27, 2020, the U.S. Supreme Court stayed the preliminary injunction from New York that prevented the DHS public charge rule from taking effect. The DHS rule went into effect nationwide on February 24, 2020.

21. The ever changing status and contents of the new public charge rules, including expansive language in the February 5, 2020 USCIS policy alert, created an urgent need for community

education to clarify when the new rules went into effect, to whom they applied, and what public benefits they considered.

COVID-19 has prevented necessary community education efforts about the new public charge rules.

22. On February 24, 2020, when the new public charge rules went into effect, there remained significant confusion among Monterey and Santa Cruz County residents about when the rule would go into effect, and what the new rules entailed. In the following days and weeks, CRLA fielded questions nearly every day from patients and healthcare providers about the new public charge rules.

23. On February 6, 2020, in anticipation of the new public charge rules going into effect, the CRLA began planning a public charge community education campaign. This community education campaign involved nearly every civil legal services non-profit in Monterey and Santa Cruz Counties—more than ten different organizations.

24. On February 25, 2020, representatives from civil legal services providers in Monterey and Santa Cruz Counties met in Salinas, California to plan the public charge community education campaign. The plans entailed in-person community education through town hall events in as many as ten different locations in Monterey and Santa Cruz Counties. The plans for in-person town hall events featured participation from more than ten agencies and included transportation assistance for participants, simultaneous interpretation into indigenous languages, and a community participatory theater performance.

25. On March 6, 2020, Monterey County declared a COVID-19 State of Emergency. On March 17, 2020, Monterey County issued a Shelter in Place order. With the prohibition on public gatherings and orders regarding social distancing and sheltering in place, it is no longer

feasible to move forward with the public charge community education campaign.

26. Due to COVID-19, all of CRLA's 18 offices across the state are closed to walk-ins and members of the public cannot come to us in-person for a legal consultation. Ordinarily, the vast majority of our consultations with the public usually take place in-person. While rural Californians always face increased challenges in accessing civil legal aid, it is now more difficult than ever for them to get assistance for urgent legal needs.

COVID-19 has stymied public charge community education efforts, and there is still significant confusion about the new public charge rules that is causing Monterey County residents to forgo medically necessary COVID-19 related healthcare.

27. Since Monterey County declared a COVID-19 State of Emergency, the Monterey County Medical-Legal Partnership has been inundated with questions related to public charge. I have personally spoken with multiple patients that have refused to seek COVID-19 related treatment because they fear the new public charge rules. I spoke with a patient that said they would refuse COVID-19 related treatment even after I counseled them on the contents of the March 13, 2020 USCIS Policy Alert regarding public charge and COVID-19.

28. I have also received inquiries from several Monterey County Health Department doctors that report some of their patients have refused needed COVID-19 related services due fear about the new public charge rules.

29. Since Monterey County declared a COVID-19 State of Emergency, I have not spoken with any patients that were familiar with the recent USCIS alert that COVID-19 treatment or preventative services will not negatively affect any alien as part of a future public charge analysis.

30. Given the confusion created in the roll-out of the new public charge rules and the current

limitations on community education due to COVID-19 shelter-in-place orders, the USCIS alert is not sufficient to inform residents and advocates on how, whether, when or if seeking COVID-19 treatment would trigger public charge issues. As a result, the new public charge rules are presently causing Monterey County residents to forgo medically necessary COVID-19 related care.

DATED this 9th day of April, 2020 at Salinas, CA

Signed: [s] DocuSigned by: Aaron Voit 3D5C91A810AD498...

Aaron Voit
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Declaration of the New York Legal Assistance Group

I, Sarah Nolan, under penalty of perjury, hereby declare:

1. My name is Sarah Nolan. I am a Supervising Attorney in the LegalHealth division of the New York Legal Assistance Group (NYLAG). I have nine years of experience providing immigration legal services and developing legal services programs in New York City.
2. NYLAG is a not-for-profit legal services organization located in New York City. NYLAG uses the power of the law to help New Yorkers in need combat social and economic injustice. We address emerging and urgent legal needs with comprehensive, free civil legal services, impact litigation, policy advocacy, and community education. NYLAG serves immigrants, veterans, seniors, the homebound, families facing foreclosure, renters facing eviction, low-income consumers, those in need of government assistance, children in need of special education, domestic violence victims, people with disabilities, patients with chronic illness or disease, low-wage workers, low-income members of the LGBTQ community, Holocaust survivors, as well as others in need of free legal services.
3. NYLAG's LegalHealth Unit is the nation's largest medical-legal partnership, with clinics at 36 hospitals and community health organizations in New York City, Westchester County and Long Island. LegalHealth complements health care with legal care by providing free legal services onsite at medical facilities and training health care professionals to understand the legal issues their patients face as well as their role in addressing these issues. The majority of LegalHealth's clients are individuals with chronic and serious illnesses, including cancer, end-stage renal disease, high blood pressure, diabetes, HIV, asthma and heart disease. LegalHealth's immigration practice provides comprehensive legal services on a wide range of issues, including naturalization, adjustment of status, relative petitions, asylum, U & T Visas and VAWA self-petitions, medical deferred action, visa extensions and Special Immigrant Juvenile Status (SIJS).
4. NYLAG's attorneys, especially in LegalHealth's medical-legal partnership setting, have a unique perspective about how the public charge inadmissibility rule has profoundly impacted immigrants as they grapple with difficult decisions about their health care and immigration status. In December 2018, NYLAG submitted public comments objecting to the proposed changes to the rule. Our comments detailed the myriad ways in which our clients' fear of the public charge rule has led to serious health consequences for themselves and their families. Since the proposed rule was first leaked, and through the present, our attorneys have advised many clients who express profound fear that receiving medical care

for themselves or their families will cause them to be denied their green cards on public charge grounds. We have had to explain to doctors and social workers why patients they were treating successfully may have suddenly disappeared or refused to continue their care. We have seen that immigrants across the spectrum—from lawful permanent residents seeking to naturalize, to those applying for humanitarian relief or family-based adjustment of status to the undocumented—are all worried about the implications of the rule changes on their immigration status. Our public comments provided numerous case examples of how this fear has lead immigrants to forego life-saving treatment, discontinue chronic care disease management, and decline preventive care for themselves and their family members.

5. LegalHealth also has a unique perspective on the devastating impact of the public charge rule because of our close relationships with medical professionals, who have continually sought our advice on how to combat the widespread chilling effect on immigrant families' willingness to apply for Medicaid and seek healthcare. In response, LegalHealth has conducted or participated in over 30 trainings and community events related to public charge in partnership with New York City Health + Hospitals, the Greater New York Hospital Association (GNYHA), Mt. Sinai Hospital, Weill Cornell Hospital, National Center for Medical Legal Partnership, and others. LegalHealth trains medical professionals about the rule, how to communicate with patients and how to refer concerned patients for legal advice. To supplement our training program, LegalHealth set up a specialized hotline to provide information about the public charge rule to our partner health care professionals and patients.
6. Even with the extensive efforts by NYLAG's LegalHealth unit and other advocates to train and provide information and advice to health professionals and immigrant communities, we continue to observe a high level of ongoing confusion and fear about the public charge rule.
7. Now, with New York as the epicenter of the worldwide COVID-19 pandemic, with a staggering 159,937 cases to date, including 7,067 deaths, we are facing an unprecedented public health crisis. The impact of pandemic among immigrant communities will be even more catastrophic as a result of the continued fear in immigrant communities related to public charge.
8. NYLAG revised its materials after March 14, 2020 to reflect the USCIS announcement that COVID-19 related treatment would not be considered in the public charge analysis. With our extensive experience over two years trying to allay fear and confusion among immigrants related to public charge, we believe this announcement on it own is not nearly sufficient to overcome the newly-emerging fears around public charge in the current COVID-19 crisis.
9. Since March 2020, NYLAG's LegalHealth unit has observed that community

members are already declining or delaying seeking health treatment and applying for benefits that are needed because of the COVID-19 pandemic because of public charge concerns as demonstrated by the following examples.

10. A LegalHealth client with a pending U visa who is residing in a shelter had COVID-19 like symptoms and was seriously ill, but did not want to go to a hospital for testing and treatment out of fear it would impact her pending application.
11. A lawful permanent resident who lost his job recently called the LegalHealth public charge hotline with concerns that receiving Medicaid and applying for unemployment would impact his permanent residency.
12. NYLAG has received requests for assistance from temporary non-immigrants in New York, such as those on B2 visas, who intended to return to their home countries but are now unable to because of travel restrictions and cancelled flights. Most urgently, these immigrants who were not planning to remain in the U.S., are now scrambling to figure out how to continue to support themselves here. Some now require medical care that they were not intending to receive in the U.S., such as emergency labor and delivery services, treatment for cancer, or treatment for COVID-19. Several clients have expressed concern about how they will support themselves now without causing public charge problems in the future.
13. NYLAG has also received questions from immigrants who are concerned about applying for unemployment benefits, emergency benefits, or cash assistance after losing a job due to the closures related to the COVID-19 pandemic. Clients have expressed fear that applying for or receiving these benefits will have a negative impact on their current immigration status or on a pending application for benefits.
14. As with health-related benefits, this fear of applying for benefits needed because of COVID-19 related job losses exists among those not subject to public charge inadmissibility. For example, a NYLAG client who is a lawful permanent resident and wishes to eventually apply for citizenship expressed concerns about applying for public assistance after recently losing a job due to the COVID-19 crisis.
15. The above examples provide clear evidence that immigrants, regardless of their legal status, remain extremely fearful of accessing healthcare and benefits as a result of the public charge rule. These fears are now causing immigrant clients to delay seeking urgently needed medical and financial help related to COVID-19, compounding the harms already caused by this public health crisis of unprecedented scale and scope.

I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct.

Dated: New York, New York
April 10, 2020

Sarah Nolan
Supervising Attorney, LegalHealth
New York Legal Assistance Group
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212-613-5059

UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF NEW YORK

STATE OF NEW YORK, CITY OF NEW YORK, STATE OF CONNECTICUT, and STATE OF VERMONT, Plaintiffs, v. UNITED STATES DEPARTMENT OF HOMELAND SECURITY; KEVIN K. McALEENAN, *in his official capacity as Acting Secretary of the United States Department of Homeland Security*; UNITED STATES CITIZENSHIP AND IMMIGRATION SERVICES; KENNETH T. CUCCINELLI II, *in his official capacity as Acting Director of United States Citizenship and Immigration Services*; and UNITED STATES OF AMERICA, Defendants.	**CIVIL ACTION NO. 19 Civ. 07777 (GBD)**
MAKE THE ROAD NEW YORK, AFRICAN SERVICES COMMITTEE, ASIAN AMERICAN FEDERATION, CATHOLIC CHARITIES COMMUNITY SERVICES, and CATHOLIC LEGAL IMMIGRATION NETWORK, INC., Plaintiffs, v. KEN CUCCINELLI, in his official capacity as Acting Director of United States Citizenship and Immigration Services; UNITED STATES CITIZENSHIP & IMMIGRATION SERVICES; KEVIN K. McALEENAN, in his official capacity as Acting Secretary of Homeland Security; and UNITED STATES DEPARTMENT OF HOMELAND SECURITY, Defendants.	**CIVIL ACTION NO. 19 Civ. 07993 (GBD)**

DECLARATION OF THEO OSHIRO

I, Theo Oshiro, pursuant to 28 U.S.C. § 1746, hereby declare as follows:

1. I am a Deputy Director for Make the Road New York ("MRNY"), where I am responsible for overseeing our services teams, which include our legal, health, and adult

education departments. I submit this declaration in support of the Plaintiffs' Motion for a Preliminary Injunction and Stay or Temporary Restraining Order Pending National Emergency in the above-captioned cases. I submitted a declaration dated September 9, 2019 in support of Plaintiffs' motion to enjoin the Rule on a preliminary basis in *MRNY* v. *Cuccinelli*. Following the Court's issuance of a stay, the Rule became effective on February 24, 2020.

Make the Road New York

2. MRNY is a non-profit community-based membership organization, which has been in existence for over 20 years, and is dedicated to building the power of immigrant and working-class communities to achieve dignity and justice through organizing, policy innovation, transformative education, and survival services. MRNY currently has over 200 staff members, who provide services to thousands of individuals a year, including both members, students and clients from the community. Our membership comprises more than 24,000 low-income New Yorkers, many of them from immigrant communities. We operate five community centers in the state of New York: in Brooklyn, Queens, Staten Island, Long Island and Westchester County, each of which are areas of the State widely affected by the COVID-19 pandemic.

3. Over the past several weeks, we have seen how the COVID-19 pandemic has rapidly caused a pervasive health crisis in the New York City metropolitan area and a massive increase in food instability and unemployment, especially acute in the communities MRNY serves. During this time, MRNY has been at the front lines of working with, supporting, and educating immigrant communities on their rights in the COVID-19 crisis. We are providing food assistance, including distribution of food, to hundreds of families through our food pantries in Queens and Brooklyn, and are raising and disseminating a million dollars to meet immediate needs, including emergency food visa cards, and funds to cover expenses for individuals who

have lost immediate relatives due to COVID-19. We are also holding regular information and Know Your Rights (KYR) sessions on Facebook Live and other online platforms; conducting a high volume of health insurance and services screenings; and handling a similarly high volume of questions through our workers' rights, housing and immigration legal teams. We have also been helping hundreds of community members connect by phone to medical providers who can advise the individual if they should go to the hospital for treatment, or if it is safe for them to stay home. We continue to follow up with these individuals to ensure they are safe and have all the support they need.

The Public Charge Rule and COVID-19

4. Since it was announced, the public charge Rule has placed our clients' and members' health and security in jeopardy. Even before the Rule became effective on February 24, 2020, we saw the Rule cause enormous fear in the immigrant communities MRNY serves, driving people to consider withdrawing from life-saving health and nutritional benefits due to concerns that receipt would endanger their immigration status. This included many people who are not subject to public charge but were nonetheless reluctant to keep or apply for benefits, including benefits that are explicitly not considered under the Rule.

5. When the Court granted the stay of the district court's preliminary injunction on January 27, 2020 and the Rule became effective on February 24, 2020, the impact of the Rule on our members and clients became even greater. We are especially concerned that the COVID-19 crisis has accelerated the deleterious effects of the Rule on our clients and their communities at an alarming rate and actively undermines MRNY's efforts and those of other organizations and state agencies to assist families in need access health care, food, and other assistance.

6. The stakes for families reluctant to access government assistance because of the Rule have become even greater with the unfolding of the COVID-19 crisis. MRNY's communities have been devastated by the current crisis. The organization has provided financial support to the families of 38 of our members, clients or students who have lost a loved one to coronavirus; many of those who have died are from communities or groups (such as trans women of color) that have historically lacked access to healthcare. These consequences show that fear of accessing health care, including COVID-19 testing and treatment, because of public charge implications can have life-altering health consequences for our clients; other members of their households, including U.S. citizens; and their neighbors and communities. Fear of accessing food assistance and other benefits because of public charge consequences can also result in people staying in unsafe work situations, and for those who are unemployed, simply going hungry.

7. Since the first stay-at-home order was issued for New York City on March 22, 2020, we have seen clients reluctant to access health and other benefits in three main areas of our work: (a) screening clients for health insurance and SNAP eligibility and helping individuals access medical care; (b) providing food assistance to clients and members and advising them on how to access other vital social support services; and (c) advising workers about benefits and protections available to them, including unemployment insurance, food assistance, and health insurance. In each area, clients and members express fear that public charge will result in them or their family members being penalized for using such assistance or benefits, including from MRNY's own food pantries and crisis-support funds.

8. MRNY's health team conducts hundreds of individual health consultations per month in order to assist people in accessing healthcare. In the course of these consultations, a

large number of people express fear of accessing health benefits due to concerns about public charge.

9. MRNY's immigration and workers practices have also fielded a large volume of questions and concerns from members and clients about accessing unemployment insurance, healthcare, food assistance, and even school resources based on public charge consequences. For instance, many individuals have expressed concerns over whether accepting food through food pantries, MRNY's own emergency food program, or the NYC meal program will negatively impact their immigration cases. Similarly, MRNY's workers team has fielded questions from several clients who qualify for unemployment insurance but are fearful of accessing it given public charge concerns. The workers team has also referred individuals concerned with accessing healthcare due to public charge concerns to MRNY's health team. Some clients have even expressed fear that accessing resources from their children's schools for purposes of remote learning and food support will have negative immigration consequences.

10. The clients expressing these fears include people to whom public charge is not applicable because they are LPRs or hold other status not affected. For example, parents have expressed concern about applying for SNAP benefits for their U.S.-citizen children and how their immigration cases will be impacted if they were to apply, as have individuals who are not be impacted by the public charge rule at all based on their available immigration relief such as U nonimmigrant visa.

11. Although our counseling and consultations often result in clients resolving their confusion about the public charge rule, the fear that our members and clients express demonstrates that many individuals in New York's immigrant communities are currently actively deterred from accessing benefits. In addition, the need to screen, counsel and reassure people

causes delay in obtaining necessary benefits. And we know based on our work that there are many more New Yorkers for whom the issue is not delay, but downright refusal to access benefits they need because of the public charge consequences.

12. On March 13, 2020, U.S. Citizenship and Immigration Services (USCIS) posted an English-only alert explaining that while the Public Charge rule "does not restrict access to testing, screening, or treatment of communicable diseases, including COVID-19," USCIS was nonetheless required to "consider the receipt of certain cash and non-cash public benefits, including those that may be used to obtain testing or treatment for COVID-19 in a public charge inadmissibility determination," including most forms of federally funded Medicaid. *See* https://www.uscis.gov/greencard/public-charge. The apparent internal contradiction of the statement has not helped us to alleviate client concerns about benefits use during the COVID-19 pandemic and public charge inadmissibility. In fact, it has only created more confusion for our clients and required us to expend additional resources to adequately provide counsel.

13. *First*, for those clients who are subject to public charge, specifying that the negatively-weighed circumstances related to COVID-19 – which could include the use of benefits that do count in the public charge analysis, reduced income and resources due to unemployment, an interruption in school, and chronic health conditions resulting from the virus – will be considered in the totality of the circumstances is too vague and open to broad interpretation to be helpful. As a result, it provides little clarity or comfort to clients trying to balance their urgent need for assistance during the pandemic with their long-term dreams of permanent residence in the U.S.

14. *Second*, the alert is not being broadly distributed and, as a single website posting in English, is not reaching the communities who need this reassurance. Most of our clients would

never see the USCIS alert unless we showed it to them. The alert is difficult to locate on the agency's website. It is only posted in connection with information on public charge, and does not appear in connection with the information posted about COVID-19. None of the clients we discussed with were familiar with it.

15. Absent relief from the Court, which would send a clear message to immigrants that access to health and other supplemental benefits is of paramount importance during this public health crisis, we will continue to see immigrants in the communities we serve delaying, deferring or avoiding access to life-saving health and food resources.

16. We know that not everyone seeks out our services. While we try our best to reach as many individuals as possible, and even if we are provided with additional resources, there will continue to be frightened and vulnerable members of the immigrant communities that we are unable to reach and who are at risk of getting infected with COVID-19, and who lack access to key information and resources to access healthcare, benefits and support services.

DATED this 28th day of April, 2020

Croton-on-Hudson, NY

Theo Oshiro

No. 19A785

In the
Supreme Court of the United States

DEPARTMENT OF HOMELAND SECURITY, et al.,

Applicants,

v.

NEW YORK, et al.,

Respondents.

I, C. Mario Russell, pursuant to 28 U.S.C. § 1746, hereby declare as follows:

1. My name is Mario Russell, and I serve as the Director of the Division of Immigrant and Refugee Services, Catholic Charities Community Services, Archdiocese of New York ("CCCS-NY"). I submit this declaration in support of Respondents' application to modify the Court's January 27, 2020, stay of the district court's October 11, 2019 order preliminarily enjoining the U.S. Department of Homeland Security's (DHS) public charge rule, (the "Rule") in the above-captioned case, and the related case *Make the Road New York, et al.* v. *Cuccinelli, et al.*, ("*MRNY* v. *Cuccinelli*"), which is currently the subject of a pending appeal before the Second Circuit Court of Appeals. I submitted a declaration dated September 9, 2019, in support of

Plaintiffs' motion to enjoin the Rule on a preliminary basis in *MRNY* v. *Cuccinelli*. Following the Court's issuance of a stay, the Rule became effective on February 24, 2020.

Catholic Charities Community Services, Archdiocese of New York

2. CCCS-NY is a nonprofit organization with program sites and affiliates located throughout New York City and the Lower Hudson Valley. Our staff reaches immigrant and rural community residents in all five New York City boroughs and seven upper counties, including Westchester, Rockland, Putnam, Orange, Ulster, Sullivan, and Dutchess.

3. CCCS-NY's mission is to provide high quality human services to New Yorkers of all nationalities and religions who are in need, especially the most vulnerable: the newcomer, the family in danger of becoming homeless, the hungry child, developing youth, and persons struggling with mental health issues. CCCS-NY's mission is grounded in the belief in the dignity of each person and the building of a just and compassionate society.

4. CCCS-NY has been pursuing this mission since 1949 through a network of programs and services that enable participants to access eviction/homelessness prevention; tenant education and financial literacy training; case management services to help people resolve financial, emotional and family issues; long-term disaster case management services to help hurricane survivors rebuild their homes and lives; emergency food and access to benefits and other resources; immigration legal services; refugee resettlement; English as a second language services; specialized assistance for the blind; after-school and recreational programs for children and youth; dropout prevention and youth employment programs; and supportive housing programs for adults with severe mental illness.

Impact on Clients Using CCCS-NY's Immigration Hotlines

5. CCCS-NY's Immigrant and Refugee Services Division operates two hotlines that are fundamental to the provision of legal services and legal information to immigrants in both New York City and New York State. The ActionNYC hotline partners with the New York City Mayor's Office of Immigrant Affairs ("MOIA"). The hotline serves as the primary number New York City residents can call when they have immigration law questions. Depending on the issue they present they are referred to one of 21 legal services providers contracted with MOIA to handle cases. The New Americans Hotline partners with the New York Department of State Office of New Americans ("ONA"). The hotline is toll-free; it refers immigrants from around the state to immigration services and provides callers with accurate information regarding issues of concern in the immigrant community. In 2019 Catholic Charities operators staffing these two lines answered a combined total of 43,000 calls in 18 languages and made referrals to legal service providers throughout New York State. Before the Rule took effect, CCCS-NY saw spikes in call volume to these hotlines when the proposed and final versions of the Rule were published in the Federal Register in October 2018 and August 2019, respectively.

6. Over the past couple of weeks, CCCS-NY has fielded calls through these two hotlines related to the intersection of COVID-19 and the Rule. Of the approximately 60 calls related to public charge, approximately 40% involved specific mention of COVID-19 as the specific reason for seeking supportive benefits. Many of these callers expressed fear of seeking medical treatment for COVID-19 and enrolling in SNAP for their children. Others asked questions about whether they will be able to access unemployment benefits in the wake of a job loss. Given the pervasiveness of infection in the areas we serve and the extraordinary rise in unemployment, we believe the vast majority of inquiries during this recent period were triggered

by fear of the public charge consequences of seeking benefits (*e.g.*, medical insurance, SNAP, housing assistance) needed because of COVID-19.

7. Overall, these calls demonstrate a high level of confusion, panic, and misinformation concerning the Rule, particularly as it relates to individuals' ability to access benefits during this crisis.

Impact on Clients Obtaining Legal Services from CCCS-NY

8. The Immigrant and Refugee Services Division also provides legal services directly to immigrant clients. These services include assistance with immigration applications (including adjustment applications), removal defense, and work authorization, integration, and case management support, support to unaccompanied minors, job development, English and civics, and citizenship preparation. During 2019, the Immigrant and Refugee Services programming directly assisted over 20,000 individuals—children, families, workers—in New York. Because our ability to contact individuals is limited by New York's lockdown order and the CDC's social distancing guidance, we are hindered in getting information to individuals who may be affected by the Rule.

9. In the last couple of weeks, the questions that our clients have presented during these sessions have been similar to those we have seen through our hotline operations. These revolved around capacity to care for their families during a uniquely difficult economic period and how to navigate the legal and practical issues they face as a result. Individuals who are in need of supplemental benefits to get through this difficult period are reluctant to accept any aid for fear of being deemed public charges. For example, even clients who are not subject to public charge – such as when adjustment of status will be based on humanitarian status (*e.g.*, Asylum,

Special Immigrant Juvenile status)—have expressed fear of collecting unemployment after losing their job due to COVID-19.

Need to Suspend the Rule

10. Suspending the Rule during this period of national crisis would allow our clients and the communities we serve to meet their immediate needs for health care and supplemental benefits for which they are eligible and need to get through this crisis without risking their immigration status. This would alleviate some of the confusion and fear that we have observed, and would further the goals articulated by government actors of providing relief to those impacted by COVID-19. Suspending the Rule during this period of national crisis would also allow CCCS-NY to better advise our clients, and callers to our hotlines, regarding the benefits that are eligible to them, and would be able to make referrals to these programs without individuals needing to choose between accepting help and the facing the prospect of negative immigration consequences.

I declare under penalty of perjury that the foregoing is true and correct.

Executed this 27th day of April, 2020
New York, New York.

C. Mario Russell, Esq.

UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF NEW YORK

STATE OF NEW YORK, CITY OF NEW YORK, STATE OF CONNECTICUT, and STATE OF VERMONT,

Plaintiffs,

v.

UNITED STATES DEPARTMENT OF HOMELAND SECURITY; KEVIN K. McALEENAN, *in his official capacity as Acting Secretary of the United States Department of Homeland Security*; UNITED STATES CITIZENSHIP AND IMMIGRATION SERVICES; KENNETH T. CUCCINELLI II, *in his official capacity as Acting Director of United States Citizenship and Immigration Services*; and UNITED STATES OF AMERICA,

Defendants.

CIVIL ACTION NO. 19 Civ. 07777 (GBD)

MAKE THE ROAD NEW YORK, AFRICAN SERVICES COMMITTEE, ASIAN AMERICAN FEDERATION, CATHOLIC CHARITIES COMMUNITY SERVICES, and CATHOLIC LEGAL IMMIGRATION NETWORK, INC.,

Plaintiffs,

v.

KEN CUCCINELLI, in his official capacity as Acting Director of United States Citizenship and Immigration Services; UNITED STATES CITIZENSHIP & IMMIGRATION SERVICES; KEVIN K. McALEENAN, in his official capacity as Acting Secretary of Homeland Security; and UNITED STATES DEPARTMENT OF HOMELAND SECURITY,

Defendants.

CIVIL ACTION NO. 19 Civ. 07993 (GBD)

DECLARATION OF JO-ANN YOO

JO-ANN YOO declares:

1. I am the Executive Director at the Asian American Federation ("AAF"), where I am responsible for overseeing the administration, programs, fundraising, and strategic plan of the organization. I have held this position since January 1, 2014.

2. I submit this declaration in support of the Plaintiffs' Motion for a Preliminary Injunction and Stay or Temporary Restraining Order Pending National Emergency in the above-captioned cases. I submitted a declaration dated September 9, 2019, in support of Plaintiffs' motion to enjoin the U.S. Department of Homeland Security's (DHS) public charge rule (the "Rule") on a preliminary basis in *Make the Road New York* v. *Cuccinelli*.

3. AAF is a non-profit umbrella leadership and organizational development network based in lower Manhattan and Flushing, Queens, with a mission of building the influence and well-being of the Asian American community. AAF represents over 70 community services agencies throughout the Northeast who work in health and human services, education, economic development, civic participation, and social justice, and are focused on serving low-income Asian American immigrants and their families.

4. During the COVID-19 crisis, AAF's member agencies have observed the heart-wrenching choices faced by non-citizens—particularly low-income Asian-American non-citizens—as they must choose between their families' economic survival and protecting their own health. I have heard stories from these groups that parents in mixed-status families (*i.e.*, where some members of the family are citizens and others are non-citizens) are seeking jobs out of a need to put food on the table, despite the risks to their personal safety from exposure to COVID-19. The executive director of one member agency told me: "When I asked [these individuals] what they plan to do if they catch the virus, they said, 'being at home isn't going to

feed my family. I have to work any job despite the risks. Coronavirus doesn't matter. I have no choice.'"

5. AAF's member agencies have also reported that, since the COVID-19 pandemic began, the individuals they serve have been afraid to apply for any form of public benefits, even if they are legally eligible for them, out of fear that doing so will adversely affect their immigration status due to the operation of the Rule. Our member agencies further report that other individuals who have been receiving such benefits decide not to recertify their eligibility for similar reasons. During the COVID-19 crisis, AAF's member agencies have fielded questions from these individuals about immigration consequences of applying for and/or receiving such benefits.

6. Additionally, because these non-citizens are choosing to forego benefits to which they are entitled, AAF's member agencies have been forced to try to cobble together alternative forms of non-governmental assistance. The need for such assistance is particularly acute given the difficult economic situation that has left many people out of work or otherwise struggling.

I declare under penalty of perjury that the foregoing is true and correct.

Executed on April 28, 2020
New York, New York

Jo-Ann Yoo

No. 19A785

In the
Supreme Court of the United States

DEPARTMENT OF HOMELAND SECURITY, et al.,

Applicants,

v.

NEW YORK, et al.,

Respondents.

I, Alejandra Aguilar, pursuant to 28 U.S.C. § 1746, hereby declare as follows:

1. I am the Lead Health Educator in the HIV Navigation Services unit of the East Los Angeles Women's Center ("ELAWC"). In this role, I provide health education, support services, and links to HIV testing and treatment to clients throughout East Los Angeles. I also provide support to ELAWC's Rape Crisis Center by connecting people who have experienced domestic abuse, sexual assault, and human trafficking to support services and counseling. During my fifteen years of employment and consulting as a health educator at ELAWC, I have provided healthcare navigation and other services to hundreds of predominantly immigrant clients and have personally observed their efforts to secure essential healthcare. I submit this declaration in support of Respondents' application in the above-captioned matter.

2. The mission of the East Los Angeles Women's Center is to ensure that all women, girls and their families live in a place of safety, health, and personal well-being, free from violence and abuse, with equal access to necessary health services and social support, with

an emphasis on Latino communities. The vast majority of clients ELAWC serves are immigrant women — most of whom are monolingual Spanish speakers — and their families living below the federal poverty line. Most of our clients are also uninsured or underinsured. These clients represent extremely underserved segments of the population with needs that stem from their transition out of dangerous situations, including people who have experienced sexual assault, survivors of domestic abuse, and individuals who are homeless or at risk of homelessness. ELAWC plays a critical role in connecting clients who have immediate healthcare, housing, and nutritional needs with partners who provide these services or who can enroll them in benefits programs. Additionally, ELAWC provides two forms of shelter for survivors of sexual assault, domestic abuse, human trafficking, and/or other trauma: a hospital-based shelter and separate transitional housing for women and families who are moving out of dangerous situations.

3. Prior to government-mandated quarantine, I provided frequent in-person community presentations on several health-related topics, including linkage to health services; HIV navigation; HIV prevention; general wellness; and crisis support. I prepared for these presentations by consulting with healthcare providers and enrollment specialists to better inform clients of the agencies and organizations who can enroll clients in appropriate medical coverage or provide free or low-cost medical care. I also provided one-on-one navigation— typically serving between three and five clients a day — in person and by phone.

4. Since California's mandatory quarantine went into effect on March 13, 2020, I have moved to taking calls from clients and providing health navigation services over the phone, as well as connecting people with crisis counseling and connecting them to other resources.

The Rule has Led to Fear and Confusion

5. Since approximately two years ago, when reports about changes to public charge policies in immigration began reaching the communities I work in, I have continuously answered questions from clients who are afraid to use services for fear of impacting their eligibility for future adjustments to their immigration status. In the last two months — after the Supreme Court's order staying injunctions blocking the DHS public charge rule's implementation throughout the country — I have received more questions about public charge than I ever have previously.

6. To help resolve fear and confusion about public charge in our client communities, ELWAC has invited immigration attorneys and partner organizations to speak to our clients about changes to the immigration system. This information has been helpful to those who we are already assisting, but I am concerned that others in the community whom we have not yet reached remain misinformed and confused about how the public charge framework operates. Recent contact with new clients has confirmed this apprehension, as clients who come into initial contact with our organization misunderstand the public charge rule and how it impacts them.

7. Unless clients actively reach out to us or we are able to locate them through outreach services, they are extremely unlikely to receive accurate information about who public charge applies to and how. In many initial meeting with my clients, they have expressed a mistaken belief that receiving any state or local healthcare assistance, such as state health insurance through Medi-Cal or My Health LA, a low-cost healthcare plan for people in Los Angeles county without health insurance, would result in future immigration consequences and that they should therefore avoid them. Although I am able to correct these misunderstandings

when I meet with clients, I am sure that countless others who I do not reach will continue to make choices that impact their health and wellbeing based on misinformation.

8. In particular, these concerns have been particularly acute for clients who are at risk of contracting HIV. At present, I estimate that one out of every ten calls I receive for HIV prevention services are questions about immigration consequences for HIV testing and treatment because of the public charge rule.

Clients have Avoided or Withdrawn from Benefits Since the Rule Took Effect

9. In the past two months, several clients have told me that they will forgo or withdraw from medical and nutritional benefits due to fear over the public charge Rule. It is especially troubling that clients who are at risk of having contracted HIV have decided to avoid testing and free treatment because they fear that getting tested *or* the fact of having HIV will have immigration consequences.

10. Similarly, clients we serve with children — where many of those children are U.S. citizens — who are eligible for coverage and services are frightened that they will be unable to pursue immigration relief like adjustment to permanent residence if their children receive this support. Some clients have discontinued vital services for their children like medical coverage through Medi-Cal, Special Supplemental Nutrition Program for Women, Infants, and Children ("WIC"), and other programs out of fear of public charge consequences.

11. One of my sessions from late February 2020 with a client who works in food service with several other immigrants provides an example of the level of misinformation in the community and its broad impact. This client had previously withdrawn from Medi-Cal after hearing about public charge. At the time she came in to ELAWC, she was spending more of her pay on out-of-pocket medical costs for herself and for her citizen children. After withdrawing

from Medi-Cal, she told several coworkers that she had withdrawn and why, and many of those coworkers (who also had citizen children) also withdrew. These families were especially frightened of seeking care after the public charge rule went into effect and continued to avoid medical care through various illnesses — only visiting the doctor and paying out of pocket when they were desperate —as of early March 2020.

12. On March 20, 2020, I counseled a client's daughter. My client's daughter is a college student in the DACA program who is five months pregnant. My client requested that I speak to her daughter because she was avoiding prenatal care. The daughter had visited the doctor only once for a pregnancy test, when she was seen her based on presumptive eligibility for Medi-Cal. When my client's daughter learned that she would need to visit a county office to be fully enrolled in Medi-Cal to receive future coverage, she avoided doing so because she was afraid that the public charge rule would impact her ability to adjust her immigration status in the future. At that time, she used the internet to research whether public charge would apply in her situation, but she was confused by the information she found. Because she was afraid of jeopardizing her future in the United States and could not afford to pay for care without health coverage, she stopped visiting the doctor for prenatal visits.

13. I am also aware of a woman who is avoiding medical care while awaiting adjudication of a U-visa application. She has an eight-year-old daughter who is a U.S. citizen. After learning about the public charge rule, she withdrew her family from Medi-Cal out of fear that receipt of state medical benefits would make her ineligible for the visa. She has since stopped taking her daughter to physicals or dental examinations because she cannot afford them and will only take her to the doctor when she is very sick. For her family's illnesses, she uses over-the-counter medications. I have explained to her that the public charge rule would not apply

to her family if her daughter continued to receive benefits that she is eligible for, but she will not re-enroll due to serious fears about potential separation from her daughter.

14. The client stories above are representative of many others that my colleagues have described to me since the public charge rule took effect. Before our offices closed due to COVID-19, clients were so afraid of immigration consequences under public charge that they where reluctant to share their name and demographic information on sign-in sheets that we use for documentation purposes.

15. The COVID-19 pandemic has dramatically changed our operations and has provoked serious fear in our client communities. As part of my health education with clients, I am now providing basic information about COVID-19, sharing available resources related to the virus, offering hygiene education, and offering sanitizers when we have access to those items. ELAWC's hospital-based and transitional shelters are still open and operational as emergency resources and each is at full capacity. The health vulnerabilities of people with HIV and at risk of contracting HIV and the dangers of COVID-19 infection are of special concern due to the acute danger infection poses to people with compromised immune systems.

16. Since the COVID-19 global health emergency began, I have experienced an increase in the volume of calls to our HIV information line. The majority of this increase has been sparked by COVID-19. Clients are anxious about the pandemic's impact on their health. Fear is especially acute among HIV-positive patients. During the week of March 22 to March 28, 2020, alone, I received more calls than I typically receive in a whole month.

17. On or around March 13, 2020, the U.S. Citizenship and Immigration Services (USCIS) posted an alert (in English only). This alert explained that while the public charge rule "does not restrict access to testing, screening, or treatment of communicable diseases, including

COVID-19," USCIS was nonetheless required to "consider the receipt of certain cash and non-cash public benefits, including those that may be used to obtain testing or treatment for COVID-19 in a public charge inadmissibility determination," including most forms of federally funded Medicaid. *See* https://www.uscis.gov/greencard/public-charge. My clients have not indicated to me that they have seen or heard about this notice. ELAWC health navigators are still receiving questions from clients who are confused about how and when the public charge rule applies to them.

COVID-19 Has Amplified Clients' Fear of Using Benefits

18. The effects of COVID-19 on my clients are even greater because of the economic shocks the pandemic has created in the community. Financial uncertainty among my clients who have lost jobs and income because of the pandemic is particularly troubling because many can no longer afford to pay out of pocket for medical costs when they need healthcare if they are not insured. Public charge makes this challenge more complicated because clients are also unwilling to seek out health coverage that they may be eligible for. This combination of factors means that many of our clients will avoid medical treatment altogether, even though the COVID-19 pandemic makes that treatment more important than ever.

19. I believe our clients and other community members are more likely to avoid healthcare because they do not have the money to pay for it and are fearful of the immigration consequences of receiving government healthcare benefits because of the public charge rule. Studies show that survivors of abuse and survivors of sexual assault are more likely to be impacted by chronic conditions like diabetes or hypertension.[1] I believe that these conditions may mean that COVID-19 is more dangerous to our clients.

[1] https://bmcpublichealth.biomedcentral.com/articles/10.1186/1471-2458-14-1286

DATED this ninth day of April, 2020 at Los Angeles, California

AlejandraA

Alejandra Aguilar