NO. 19-2222

In The

United States Court of Appeals

For The Fourth Circuit

CASA DE MARYLAND, INC.; ANGEL AGUILUZ; MONICA CAMACHO PEREZ,

Plaintiffs-Appellees,

v.

DONALD J. TRUMP, in his official capacity as President of the United States; CHAD WOLF, in his official capacity as Acting Secretary of Homeland Security; U.S. DEPARTMENT OF HOMELAND SECURITY; KENNETH T. CUCCINELLI, II, in his official capacity as Acting Director, U.S. Citizenship and Immigration Services; U.S. CITIZENSHIP AND IMMIGRATION SERVICES,

Defendants-Appellants.

ON APPEAL FROM THE UNITED STATES DISTRICT COURT
FOR THE District of Maryland AT Case No. 8:19-cv-02715-PWG

BRIEF OF AMICI CURIAE, ET AL. IN SUPPPORT

OF PLAINTIFFS-APPELLEES

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On Appeal from the United States District Court for the District of Maryland, Case No. 8:19-cv-02715-PWG, Judge Paul W. Grimm

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BRIEF OF AMICI CURIAE PUBLIC HEALTH, HEALTH POLICY, MEDICINE, AND NURSING DEANS, CHAIRS, AND SCHOLARS; THE AMERICAN PUBLIC HEALTH ASSOCIATION; AND THE AMERICAN ACADEMY OF NURSING IN SUPPORT OF PLAINTIFFS-APPELLEES AND AFFIRMANCE FOR CONSIDERATION BY THE EN BANC COURT

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Pursuant to Rule 29 of the Federal Rules of Appellate Procedure, counsel for all parties have consented on the parties' behalf to the filing of this *amici curiae* brief. In particular, counsel for Defendants-Appellants confirmed consent to filing this brief "on the understanding that the brief will address recent developments as contemplated by the court's supplemental briefing order." In this vein, we note the Court's supplemental briefing order addresses briefing by the parties: "the *parties*

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

are directed to file supplemental briefs to address *relevant developments* concerning the Public Charge Rule." *CASA de Maryland, et al. v. Trump, et al.*, No. 19-2222, Order (4th Cir. Dec. 14, 2020) (Doc. 158) (emphasis added). *Amici* submit the instant brief for consideration at the merits stage by the *en banc* Court. *Amici* certify that a separate brief is necessary to provide appropriate insight into how, as the nation undertakes unprecedented efforts to protect the population against the public health and economic ravages of coronavirus, the Public Charge Rule has created effective barriers to health care among noncitizen immigrants by causing significant disenrollment from health care programs and other supports critical to stopping the spread of coronavirus. Prompting immigrants to avoid COVID-19 diagnosis, treatment, and vaccination services, the Rule increases serious public health risks for individuals and communities across the nation while negatively impacting health outcomes for all populations in the United States.

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

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

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INTRODUCTION AND SUMMARY OF THE ARGUMENT

The Public Charge Rule ("the Rule") penalizes immigrants for obtaining vital health and nutrition services for which they are eligible. *See* Inadmissibility on Public Charge Grounds, 84 Fed. Reg 41,292 (Aug.14, 2019). Shortly after the Rule went into effect almost eleven months ago, the nation had experienced 1,645 reported COVID-19 cases. *Id*. By the first week of January 2021, the Centers for Disease Control and Prevention ("CDC") reported 21,259,997 COVID-19 cases in the United States, including 1,596,020 new cases in the first seven days of the new year, and 359,849 deaths, for the period of January 21, 2020 through January 7, 2021. CENTERS FOR DISEASE CONTROL AND PREVENTION, *COVID Data Tracker* (Update, Jan. 7, 2021, 6:46 P.M.). These statistics are unprecedented in modern United States history. Yet even as vast measures to protect the health of the United States population continue unabated, the Public Charge Rule works at complete cross purposes. In community after community, the Rule threatens the very effort to protect the population through case-finding, treatment, protection, and ultimately, immunization, that so many health care workers, public health officials, and others have undertaken on the nation's behalf.

The Rule constitutes an impermissible and radical alteration of longstanding policy that is contrary to the intent of Congress. Lacking any legal authority, the Rule's misguided provisions effectively withdraw health care, nutrition and other

services from people qualified to receive them. Especially severe is its impact on Medicaid, since the Rule guts access to accessible insurance during the worst public health crisis this nation has faced in a century. Indeed, under the terms of the Rule, immigrants can be punished simply for being found eligible for Medicaid, Title XIX of the Social Security Act, 42 U.S.C. §§ 1396-1 *et seq.*, even if they never use medical assistance.

The Rule contravenes important components of Congress's carefully calibrated statutory framework for extending health coverage, which culminated with amendments contained in the Patient Protection and Affordable Care Act of 2010 ("ACA"), Pub. L. 111-148. In the face of a public health crisis, the Rule creates perverse incentives for immigrant families (regardless of the immigration status of individual family members) to avoid lifesaving health care for fear of being labeled as public charges. The consequences of the Rule have been catastrophic for individuals, families, and has elevated the already serious threat of illness and death for entire communities.

Ironically, the Rule took effect on February 24, 2020, a few weeks following the first federal public health emergency (PHE) declaration on January 31, 2020 by the Secretary of Health and Human Services pursuant to Section 319 of the Public Health Service Act ("PHSA"), 42 U.S.C. § 247d. *See* Alex M. Azar, II, Secretary, *Determination that a Public Health Emergency Exists*, U.S. DEPT. OF HEALTH AND

HUMAN SERVICES ("HHS") (Jan. 31, 2020). The Secretary has renewed this PHE declaration four times, most recently on January 7, 2021. *See* Azar, *Renewal of Determination that a Public Health Emergency Exists*, HHS (Jan. 7, 2021). Throughout this time, the threat imposed by the Rule has loomed over families and communities, even as the PHE declaration has sought to strengthen the government's response to the emergency through expanded funding, supplies, and the deployment of PHSA funded healthcare personnel to essential front-line duty. *See* 42 U.S.C. §§ 247d(b), (e), (f); §§ 247d-4a, 247d-6b. The administration has insisted on the lawfulness of the Public Charge Rule even as the President, on March 13, 2020, acknowledged that "[t]he spread of COVID-19 within our Nation's communities threatens to strain our Nation's healthcare systems," and issued a proclamation under the National Emergencies Act, 50 U.S.C. § 1621, which activated additional federal resources and authorities to support the country's pandemic response. *See* PROCLAMATION NO. 9994 DECLARING A NATIONAL EMERGENCY CONCERNING THE NOVEL CORONAVIRUS DISEASE (COVID-19) OUTBREAK, 85 Fed. Reg. 15,337 (Mar. 13, 2020).

For the reasons that follow, the District Court correctly enjoined appellants from enforcing, applying, or treating as effective the Public Charge Rule.

ARGUMENT

I. In the Midst of a Pandemic, Medicaid Reforms to Expand Eligibility and Simplify Enrollment and Coverage Continuity

Take on Added Importance, When Access to Health Care is So Critical.

The pandemic has intensified the essential nature of the Medicaid reforms Congress enacted under the Affordable Care Act. The ACA created a health insurance pathway for low income working-age adults previously excluded from coverage despite their economic impoverishment. The ACA reforms expanded the categories of adults who could qualify for coverage while also raising income eligibility rules to 138 percent of the federal poverty level. *See* 42 U.S.C. § 1396a(a)(10)(A)(i)(VIII). In the wake of the Supreme Court's decision in *National Federation of Independent Business v. Sebelius,* 567 U.S. 519 (2012), the expansion effectively became optional, but in states that have adopted the ACA Medicaid expansion, including Maryland, Virginia, and West Virginia, coverage has dramatically improved for low-income working age adults who also satisfy the program's citizenship and legal residency rules. Furthermore, enrollment has stabilized because of other amendments simplifying renewal and continuity of assistance. *See* Anna L. Goldman & Benjamin D. Sommers, *Among Low-Income Adults Enrolled In Medicaid, Churning Decreased After The Affordable Care Act*, HEALTH AFFAIRS (Jan. 2020) (discussing the impact of liberalized Medicaid eligibility as a means of increasing enrollment that led to half a million fewer adults experiencing periods of uninsurance annually).

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

Immigrants legally entitled to Medicaid have stood to benefit from these eligibility and coverage stability reforms equally with citizens. Extensive research documents that, like citizens, immigrants eligible under traditional or expanded program rules have experienced significantly improved access to care and substantially better health outcomes. Research has also shown the administrative and overall program savings that flow from these reforms. *See* Milda R. Saunders & G. Caleb Alexander, *Turning and Churning: Loss of Health Insurance Among Adults in Medicaid*, JOURNAL OF GENERAL INTERNAL MEDICINE (Dec. 19, 2008) at

133-134 (discontinuity of care resulting from loss of Medicaid coverage leads to worse health outcomes); Andrew B. Bindman, Arpita Chattopadhyay & Glenna M. Auerback, *Interruptions in Medicaid Coverage and Risk for Hospitalization for Ambulatory Care-Sensitive Conditions*, ANNALS OF INTERNAL MEDICINE (Dec. 16, 2008) at 854-60 (finding substantially higher hospitalization rates for ambulatory care-sensitive conditions associated with an interruption in Medicaid coverage); Allyson G. Hall, Jeffrey S. Harman & Jianyi Zhang, *Lapses in Medicaid Coverage: Impact on Cost and Utilization Among Individuals with Diabetes Enrolled in Medicaid*, MEDICAL CARE (Dec. 2008) at 1219-1225 (people with diabetes are more likely to require inpatient or emergency care after lapses in Medicaid coverage, leading to higher program expenditures); *and* Leighton Ku, Patricia MacTaggart, Fouad Pervez & Sara Rosenbaum, *Improving Medicaid's Continuity of Coverage and Quality of Care*, ASSOC. FOR COMMUNITY AFFILIATED PLANS (July 2009) (interruptions in insurance coverage led to expensive hospitalizations or emergency room visits and ultimately higher average monthly Medicaid expenditures per capita). *See also*, Leighton Ku, Erika Steinmetz & Tyler Bysshe, *Continuity of Medicaid Coverage in an Era of Transition*, ASSOC. FOR COMMUNITY AFFILIATED PLANS (Nov. 1, 2015); Laura Summer & Cindy Mann, *Instability of Public Health Insurance Coverage for Children and Their Families: Causes, Consequences, and Remedies*, THE COMMONWEALTH FUND

(June 2006) (churning drives up program administrative costs); Katherine Swartz *et al.*, *Reducing Medicaid Churning: Extending Eligibility for Twelve Months or to End of Calendar Year is Most Effective*, HEALTH AFFAIRS (2015) at 1180-1187 (simulation showed gains in reducing churning yield substantial reduction in Medicaid managed care administrative costs); *and* Andrew B. Bindman, Arpita Chattopadhyay & Glenna M. Auerback, *Medicaid Re-Enrollment Policies and Children's Risk of Hospitalizations for Ambulatory Care Sensitive Conditions*, MEDICAL CARE (Oct. 2008) at 1049-1054 (reforms aimed at increasing eligibility and reducing churn led to $17 million savings in providing hospital care to children in California).

This fundamental shift in Medicaid policy, from limited eligibility and enrollment deterrence to actively encouraging access, simplifying enrollment, liberalizing eligibility, and simplifying renewals, has had a profound and measurable effect, not only on the newly eligible population but on previously eligible individuals who had been unable to overcome past enrollment barriers. These reforms also have reduced the problem of intermittent coverage losses among eligible children and adults because of the challenges created by the eligibility redetermination and renewal process. Research shows that for every 100 newly eligible people who enrolled in Medicaid, another 25 previously-eligible children and 38 previously-eligible adults also enrolled. *See* Stephen Langlois,

Incentives and the Welcome-Mat Effect, HOOVER INSTITUTION (Apr. 24, 2017). As states have expanded Medicaid and simplified the enrollment process, evidence suggests a 4.3 percentage point reduction in enrollment disruption. Goldman & Sommers, *supra*. With coverage stabilization and expansion, Medicaid has been positioned to achieve better coverage and improved health care outcomes over time. *See, e.g.*, MEDICAID AND CHIP PAYMENT AND ACCESS COMMISSION ("MACPAC"), *Medicaid Enrollment Changes Following the ACA* (last visited Dec. 28, 2020) (summarizing enrollment gains flowing from the "welcome mat" effects of reforms).

The ACA reforms, in fact, were not an altogether-startling departure from previous policy but evolved from decades of efforts to make Medicaid work better for citizens and legal immigrants alike. These reforms included expanded coverage for children and pregnant women, 42 U.S.C. § 1396a(a)(10)(A)(i)(IV); easing access to benefits through outstationed enrollment and presumptive eligibility, *id*. § 1396a(a)(55); improved coverage options for low income parents with children enacted in the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA), Pub. L. 104-193; and special eligibility reforms for people diagnosed with breast or cervical cancer, enhanced coverage options for children and adults with disabilities, and greater financial supports for both hospital and community-based health care safety net providers such as

community health centers whose focus has long been on medically underserved communities where immigrants disproportionately reside. *See* ACA, Pub. L. 111-148, §§ 5508, 5601(a)(1), 10501, 10503; *see also* Coronavirus Aid Relief and Economic Security Act (CARES Act), Pub. L. 116-136 (Mar. 27, 2020), § 3831 (health center program funding extension).

Through all these reforms, enacted over decades, Congress has sought to promote – not hinder – access to coverage for low income people including eligible immigrants. The Centers for Medicare and Medicaid Services ("CMS"), the agency within HHS that oversees implementation of Medicaid, has played a high visibility and active role in making eligibility, enrollment, and renewal easier and faster, for all populations, and immigrants, in particular. *See* CMS, *Dear State Health Official Letter Re: Medicaid and CHIP Coverage of "Lawfully Residing" Children and Pregnant Women* (SHO# 10-006 CHIPRA# 17, July 1, 2010) (discussing eligibility of lawfully residing immigrant children and pregnant women); *see also*, CMS, *Enrollment Strategies* (discussing strategies to facilitate coverage such as "presumptive eligibility," "express lane eligibility," "continuous eligibility," and lawfully residing immigrant children and pregnant women). In addition, regulations CMS issued in 2012 provided extensive guidance to states regarding ACA-driven enrollment and renewal simplification reforms. *See* KAISER FAMILY FOUNDATION, *Medicaid Eligibility, Enrollment Simplification, and*

Coordination under the Affordable Care Act: A Summary of CMS's March 23, 2012 Final Rule (Dec. 2012).

II. The Public Charge Rule Fundamentally Cripples the Design and Effectiveness of the Medicaid Program Contrary to Congressional Intent, Thereby Creating Perverse Incentives for At-Risk Noncitizen Immigrant Populations to Shun Health Care and Pandemic Supports when Most Needed.

The effect of the Public Charge Rule is to nullify these reforms and reverse decades of gains, not only for those immediately affected, but also for family members untouched by the Rule but caught in its documented chilling effect as otherwise-eligible individuals forgo enrollment to protect themselves against the severe consequences that can flow from the terms of the Rule. Where the Rule does not cause avoidance of essential health care and public health services entirely, including Medicaid, it has the potential to reduce Medicaid coverage to *at most* sporadic, brief spurts of emergency assistance. This represents not only a clear break from settled Medicaid law as it has evolved over decades but poses a fundamental public health threat as at-risk immigrants avoid coverage, or worse, care altogether. In short, at the greatest time of need, the Rule is designed to operate in direct opposition to the modern Medicaid program.

The Rule sweeps a broadly restructured Medicaid into the definition of who is a "public charge," imposing severe time limits that effectively strip the program of its objective to provide stable coverage over time. The Rule treats most forms

of Medicaid as indicative of public charge status; at most, its terms relegate Medicaid-eligible immigrants who are its target to the marginal backwaters of short-term coverage. The Rule extends vastly beyond the narrow, long term institutional care circumstances, as outlined in the previous 1999 policy, under which receipt of Medicaid could trigger a public charge determination. By punishing individuals who receive 12 months or more of Medicaid coverage in a 36-month period, the Rule effectively reduces Medicaid to an emergency assistance benefit that, at best, functions as a series of isolated, brief coverage bursts. In doing so, the Rule directly undermines Medicaid's core purpose, as it has emerged under the modern program, to provide stable insurance over time. It achieves this result by imposing on medical assistance a regulatory superstructure that causes Medicaid to function in a manner that is the precise opposite of what decades of statutory terms have been designed to achieve. The vision of the Rule is short term emergency aid at most; the vision of Medicaid, by contrast, is stable insurance coverage.

Furthermore, to credit the Rule with even this crabbed vision of Medicaid as a source of sporadic emergency assistance may be to overstate the level of public benefits the Rule will tolerate before triggering sanctions. By making health status the basis for a public charge determination, the Rule inevitably escalates fear that use of Medicaid, in and of itself, will provide the basis for a public charge

determination. Furthermore, by expanding the inquiry into the health of other members of a covered immigrant's household, the Rule carries the potential to deter Medicaid enrollment on a widespread basis, even in the case of exempt populations such as children. *See* 84 Fed. Reg. 41,501 (8 C.F.R. § 212.21(d)).

Various provisions in the Public Charge Rule operate against the very fabric of the Medicaid program by deterring the use of benefits. With limited exceptions for children and pregnant women, the Rule defines a public charge as an individual who receives a public benefit, defined to include Medicaid, among other forms of "noncash assistance," "in any twelve months over a thirty-six month period," and receipt of two benefits in one month would count as two of those twelve months. *See* 84 Fed. Reg. 41,501 (8 C.F.R. § 212.21(a)). Under this standard, even a few months of Medicaid enrollment, when coupled with other public benefits, could trigger public benefits sanctions. By its own design, the Rule renders its exceptions illusory, triggering a widespread chilling effect on all household members of covered immigrants. Evidence of precisely this effect comes from reports suggesting that immigrants are not merely avoiding Medicaid but are asking to be disenrolled from the program as protection from the Rule's harsh consequences. *See* Jennifer Tolbert *et al.*, *Impact of Shifting Immigration Policy on Medicaid Enrollment and Utilization of Care Among Health Center Patients*, KAISER FAMILY FOUNDATION (Oct. 2019) at 6 (discussing declining rates of health

services utilization among immigrant adults reported by health centers after publication of the proposed public charge rule); *see also, e.g.*, New York City Mayor's Office of Immigrant Affairs, Mayor's Office for Economic Opportunity & New York City Department of Social Services, *Expanding Public Charge Inadmissibility: The Impact on Immigrants, Households, and the City of New York* (Dec. 2018) at 8.

In this way, the Rule effectively becomes a deterrent to the use of any public benefit for fear of triggering the harsh consequences that follow a public charge determination. It creates a strong incentive to avoid Medicaid entirely or to limit the use of the program to the shortest possible time period, for example, enrolling just long enough to cover an emergency hospital visit with disenrollment in the month immediately thereafter. Thus, for example, a person who has a medical emergency related to COVID-19, or the inability to manage diabetes because of poverty, might accept a brief period of enrollment in order to cover the cost of emergency care, with immediate disenrollment as soon as she believes she is stable. This choice, a perfectly logical response to the Rule's twelve months out of any thirty-six months test, directly contravenes the "welcome mat" purpose of recent Medicaid reforms for people who are eligible for assistance yet are subject to the Rule. Even if the Rule does not prompt people to avoid help entirely, it will trigger churn – the very problem that the Medicaid reforms were specifically

designed to address. In this regard, as noted above, the evidence shows that, following churn, it takes months to regain enrollment and months more to resume utilization. This in turn leads to greater overall program costs and worse health outcomes among impacted populations. *See* Eric T. Roberts & Craig Evan Pollack, *Does Churning in Medicaid Affect Health Care Use?*, MEDICAL CARE (May 2016) at 483-89.

The Rule goes beyond deterring use of Medicaid. Should there be any doubt that the "welcome mat" is no longer out for immigrants, the Rule makes an immigrant's health an express factor to be considered, *see* 84 Fed. Reg. 41,502 (8 C.F.R. § 212.22(b)(2)), specifically "whether the alien has been diagnosed with a medical condition that is likely to require extensive medical treatment or institutionalization or that will interfere with the alien's ability to provide care for himself or herself, to attend school, or to work upon admission or adjustment of status." Conceivably any condition requiring ongoing health care could be considered a condition "likely to require extensive medical treatment," since the Rule gives the phrase "extensive medical treatment" no guardrails. Indeed, certification for Medicaid by a health care provider that offers health insurance outreach and enrollment services (common, per statute, at health centers and safety net hospitals) could be considered evidence of the need for "extensive" medical treatment. Medicaid's fundamental role in American society is to embrace health

risks among the most vulnerable members of the population – not to punish people for securing the medical care for which they are eligible. Yet this is precisely what the Rule does.

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

Furthermore, the Rule's public charge test intensified the problems it created by focusing broadly on health conditions and requiring speculation regarding an individual's possible future use of Medicaid or other noncash benefits, as a measure of whether that individual is a public charge. *See* 84 Fed. Reg. 41,501 (8 C.F.R. § 212.21(c)). The very purpose of Congress's Medicaid reforms was to encourage early and sustained use of health care over time in order to promote and maintain health and reduce health risks. By purporting to peer into the future in

order to conjecture about individuals' health and health care use, the Rule propelled public policy in exactly the opposite direction from the course set by Congress through careful Medicaid redesign. Rather than coming forward, immigrants with health conditions (or whose spouses or children have health conditions) have shielded their need for care, not just by avoiding Medicaid (which could be viewed as signaling a need for care) but avoiding care entirely. In other words, the Rule's perverse incentives steer people away, not toward, health care, on the theory that by enrolling in Medicaid they signal the need for medical care. Research exemplified this impact, yet defendants went forward with implementation regardless. *See, e.g.*, Tolbert *et al*., *supra* (health centers report declines in services utilization by immigrant adults after publication of the proposed public charge rule); Hamutal Bernstein *et al*., *Amid Confusion over the Public Charge Rule, Immigrant Families Continued Avoiding Public Benefits in 2019*, URBAN INSTITUTE (May 2020) (15.6 percent of adults in households with at least one foreign born member reported chilling effects on their participation in noncash public benefits, including 26.2 percent of participants in low-income households, that is, under 200 percent of the federal poverty level); Jennifer M. Haley *et al*., *One in Five Adults in Immigrant Families with Children Reported Chilling Effects on Public Benefit Receipt in 2019*, URBAN INSTITUTE (June 2020).

As if to reinforce this complete departure from sound health policy, the Rule compounds its impact on settled Medicaid policy by making merely being found eligible for Medicaid an additional factor prompting a public charge determination. *See* 84 Fed. Reg. 41,502 (8 C.F.R. § 212.21(e)) (receipt of benefits happens when a "benefit-granting agency provides a public benefit . . . to an alien as a beneficiary, whether in the form of cash, voucher, services, or insurance. Certification for future receipt. . . may suggest a likelihood of future receipt"). The plain meaning of this is that certification by any entity – including a community health center, public hospital, local public health agency or any other safety net provider – that a person is in fact eligible for Medicaid could *in and of itself* be used as sufficient evidence for a determination that a person is a public charge. This again directly contravenes the "welcome mat" focus of Medicaid reforms, because it forces individuals to turn away from Medicaid assistance entirely to avoid the mere appearance of being a public charge.

In this vein, public health expert Dr. Leighton Ku estimates that between 1 million and 3.1 million members of immigrant families will forgo Medicaid or disenroll following the Rule's implementation. This includes between 600,000 and 1.8 million adults, 21 or older, who will not receive Medicaid, and between otherwise eligible 400,000 to 1.2 million children, 21 or younger, who will not receive Medicaid because they are members of immigrant families. *See*

Declaration of Leighton Ku in Support of Plaintiffs' Motion for a Preliminary Injunction, *State of New York et al. v. U.S. Dept. of Homeland Security et al.*, 1:19-cv-07777-GBD-OTW (S.D.N.Y. Sept. 9, 2019) (Doc. 34-11, ¶ 46); *see also* Declaration of Leighton Ku in the Supreme Court of the United States, *Dept. of Homeland Security et al. v. New York et al.*, No. 19A785 (S. Ct. Apr. 13, 2020) at ¶ 13. Dr. Ku goes on to state that "[b]ecause 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." *Id.*; *see also,* Ku Declaration (Sept. 9, 2019), *supra*, ¶ 57. The Rule clearly triggered multiple barriers to adequate health coverage at a time when the country faces the health and economic ravages of the pandemic.

III. The Public Charge Rule is Jeopardizing Nationwide Efforts to Overcome the Pandemic's Public Health and Economic Ravages by Making Noncitizen Immigrants Forgo Coronavirus Diagnosis, Treatment and Vaccination and Decline Other Critical Economic Supports.

The impact of the COVID-19 pandemic has dramatically heightened the health and health care risks posed by the Rule particularly among populations with substantial noncitizen representation that are disproportionately exposed to the coronavirus. Counties with higher poverty levels and higher representation of racial and ethnic minorities, including noncitizen immigrants, show significantly

higher infection and death rates compared to richer, more ethnic/racially homogenous areas. *See* Samrachana Adhikari *et al*., *Assessment of Community-Level Disparities in Coronavirus Disease 2019 (COVID-19) Infections and Deaths in Large US Metropolitan Areas*, JAMA NETWORK OPEN (July 28, 2020). In fact, Latinos and other racial/ethnic minorities have markedly higher rates of hospitalization and death due to COVID-19 compared to Caucasian populations. *See* CDC, *COVID-19 Hospitalization and Death by Race/Ethnicity* (Nov. 2020).

Noncitizens are more vulnerable to contracting the coronavirus as a result of their overrepresentation among the poor, the uninsured, and the workforce in vital sectors that cannot accommodate remote work, including in essential jobs such as agriculture, where noncitizens represent 42 percent of the workforce, housekeeping and janitorial staff, construction, and restaurant and food services. *See* Samantha Artiga & Matthew Rae, *Health and Financial Risks for Noncitizen Immigrants due to the COVID-19 Pandemic*, KAISER FAMILY FOUNDATION (Aug. 18, 2020). This places noncitizen workers at a disproportionate risk of contracting COVID-19 while at work. *Id*. For example, many of the largest clusters of COVID-19 cases outside of prisons have occurred in food production facilities with large immigrant workforces. *See* Anya Jabour, *Immigrant Workers Have Borne the Brunt of COVID-19 Outbreaks at Meatpacking Plants*, THE WASHINGTON POST (May 22, 2020). Despite their clearly heightened risks of exposure, one third of immigrants

have no health coverage, leaving them vulnerable to high medical bills in the event that they do contract the coronavirus. Artiga & Rae, *supra*. The Rule has complicated this level of precariousness for covered immigrants and their families.

The Rule's impact extends to the safety net infrastructure upon which poor urban and rural communities depend for primary health care. Immigrants are disproportionately likely to be poor and in greater need for safety net services such as community health centers provide. Immigrants in many communities across the United States obtain comprehensive, primary care services at their local health centers, which serve one in twelve people in the United States regardless of ability to pay. *See* 42 U.S.C. § 254b (authorizing federal grants to health centers to operate in medically underserved areas). For half a century, health centers have been the main source of community-based, cost-effective and accessible health services to underserved, low-income persons. Most health center patients (82 percent) are publicly insured or uninsured. *See* NACHC, *Community Health Center Chartbook 2020* (Jan. 2020), Fig. 1-5. Health center patients are disproportionately poor: 91 percent of health center patients are under 200 percent of the Federal Poverty Line ("FPL"); 69 percent of patients are at or below 100 percent FPL; 48 percent of patients are Medicaid beneficiaries; and 23 percent are uninsured. *Id*. Figs. 1-8, 2-9 and 2-11. With 13,000 service sites, the country's 1,400 health centers serve 1 in 3 people living in poverty, 1 in 5 residents of rural

areas, 1 in every 9 children in the United States, 1 in 8 people of a racial or ethnic minority, and 1 in every 6 Medicaid beneficiaries. *Id.* Fig. 1-1.

Immigrants' avoidance of Medicaid coverage in response to the Rule's threat to immigrant status will inevitably lead to substantial health center revenue decline, reduced patient capacity and increasing operating loss as more patients forgo coverage and, if they seek care, are provided services on an uninsured basis. The pandemic has led to even larger revenue loss for health centers, estimated at $4 billion or 13 percent of 2019 reported revenue in the first eight months of the crisis alone. As of December 2020, weekly visits to health centers stood at 17 percent less than pre-pandemic levels, 6 percent of staff members were unable to work and 5 percent of 13,000 service sites were closed. The more individuals forgo coverage for fear of the Rule's immigration consequences, the greater the pressure on health centers to continue fulfilling their mission at greater financial peril. *See* Peter Shin, Jessica Sharac, Erin Brantley & S. Rosenbaum, *How the COVID-19 Pandemic has Intensified the Impact of the Public Charge Rule on Community Health Centers, their Patients and their Communities*, GW HEALTH POLICY & MANAGEMENT MATTERS (Dec. 17, 2020).

In addition to avoiding long-standing public assistance programs in a time of nationwide economic insecurity, immigrant families are also avoiding pandemic relief programs. Further indicative of the Rule's chilling effects, organizations

report that the immigrant populations they serve are avoiding relief programs, such as enhanced unemployment benefits, the Paycheck Protection Program, and stimulus payments. This, in addition to avoidance of long-standing public aid programs, will disproportionally impact immigrant families who are already experiencing dire economic straits as they face even more severe job losses than the general population. *See* George J. Borjas & Hugh Cassidy, *The Adverse Effect of the COVID-19 Labor Market Shock on Immigrant Employment (No. w27243)*, NATIONAL BUREAU OF ECONOMIC RESEARCH (2020).

Finally, public trust in health care providers and the authorities in general is imperative for carrying out a successful nationwide coronavirus vaccination campaign. However, the Rule's perverse effects drive immigrant communities to avoid health care settings and other venues where they could receive safety net program supports for fear of the immigration consequences. For instance, implementation of the Rule has caused many noncitizens to avoid health care settings altogether. *See* Natalie Hernandez, *Summary of Research at the Intersection of Public Charge and Health*, PROTECTING IMMIGRANT FAMILIES (June 2020); July Lee *et al*., *Opportunities for Supporting Latino Immigrants in Emergency and Ambulatory Care Settings*, JOURNAL OF COMMUNITY HEALTH (July 22, 2020). Latinos, who make up a significant percentage of immigrants to the United States, exhibit low vaccine trust, as do uninsured adults. *See* William Wan,

Coronavirus vaccines face trust gap in Black and Latino communities, study finds, THE WASHINGTON POST (Nov. 23, 2020); Sarah Kreps *et al*., *Factors associated with U.S. adults' likelihood of accepting COVID-19 vaccination*, JAMA NETWORK OPEN (Oct. 20, 2020). Immigrant participation in vaccination efforts will be vital to reaching herd immunity; yet immigrants' overrepresentation in groups with Rule-driven low vaccine trust will be significantly problematic to achieving adequate vaccination results. Clearly, the Rule threatens to slow down vaccination progress by discouraging immigrants from securing vaccination and obtaining other key health care services at a time when they need them most urgently.

Against the backdrop of a world-wide pandemic, this Rule, so lacking in foresight, "has demonstrably failed the first real world test of its application." *See State of New York et al. v. U.S. Dept. of Homeland Security et al*., 1:19-cv-07777-GBD-OTW (S.D.N.Y. July 29, 2020) (Memorandum Decision and Order) (Doc. 195) at 29. The Rule discourages noncitizens from seeking diagnosis, treatment, vaccination and other preventive measures critical to stopping, treating and preventing coronavirus transmission. The Rule also discourages noncitizens from securing safety net supports at a time of widespread economic malaise and uncertainty, which in turn exacerbates the heightened risks of infection seen across immigrant populations, which contribute in turn to worse health outcomes for the entire United States.

CONCLUSION

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

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Respectfully submitted,

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CERTIFICATE OF COMPLIANCE

Pursuant to Fed. R. App. P. 32(g)(1), the undersigned hereby certifies that this brief complies with the type volume limitation of Fed. R. App. P. 32(a)(7)(B)(i).

1. Exclusive of the exempted portions of the brief, as provided in Fed. R. App. P. 32(f), the brief contains 5,268 words.

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CERTIFICATE OF SERVICE

I HEREBY CERTIFY that on this 8th day of January, 2021, the foregoing Brief of *Amici Curiae* Deans, Chairs, Scholars, the American Public Health Association, and the American Academy of Nursing in Support of Plaintiffs-Appellees and Affirmance has been served by this Court's Electronic Case Filing System ("ECF").

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