No. 19-17214

IN THE

United States Court of Appeals for the Ninth Circuit

STATE OF CALIFORNIA, *et al.*,
Plaintiffs-Appellees,

v.

U.S. DEPARTMENT OF HOMELAND SECURITY, *et al.*,
Defendants-Appellants.

On Appeal from the United States District Court
for the Northern District of California
No. 4:19-cv-04975-PJH
District Judge Phyllis J. Hamilton

BRIEF FOR *AMICI CURIAE* THE AMERICAN HOSPITAL ASSOCIATION, AMERICA'S ESSENTIAL HOSPITALS, ASSOCIATION OF AMERICAN MEDICAL COLLEGES, CATHOLIC HEALTH ASSOCIATION OF THE UNITED STATES, THE CHILDREN'S HOSPITAL ASSOCIATION, AND THE FEDERATION OF AMERICAN HOSPITALS IN SUPPORT OF APPELLEES AND AFFIRMANCE

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CORPORATE DISCLOSURE STATEMENT

Pursuant to Federal Rules of Appellate Procedure 26.1 and 29(a)(4)(A), the undersigned counsel certifies the following:

The American Hospital Association has no parent company and no publicly held company holds more than a ten percent interest in AHA.

America's Essential Hospitals has no parent company and no publicly held company holds more than a ten percent interest in it.

The Association of American Medical Colleges has no parent company, and no publicly held company holds more than a ten percent interest in AAMC.

The Catholic Health Association has no parent company, and no publicly held company holds more than a ten percent interest in CHA.

The Children's Hospital Association has no parent company and no publicly held company holds more than a ten percent interest in it.

The Federation of American Hospitals has no parent company, and no publicly held company holds more than a ten percent interest in the Federation.

/s/ Sean Marotta
Sean Marotta

January 23, 2020

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IDENTITY AND INTEREST OF *AMICI CURIAE*

The American Hospital Association, America's Essential Hospitals, Association of American Medical Colleges, Catholic Health Association of the United States, Children's Hospital Association, and Federation of American Hospitals respectfully submit this brief as *amici curiae*.[1]

The American Hospital Association represents nearly 5,000 hospitals, health systems, and other health care organizations, plus 43,000 health care leaders who belong to professional membership groups. AHA members are committed to improving the health of communities they serve and to helping ensure that care is available and affordable to all. AHA educates its members on health care issues and advocates to ensure that their perspectives are considered in formulating health policy.

America's Essential Hospitals is the leading association and champion for hospitals and health systems dedicated to providing high-quality care for all, including underserved and low-income populations. Filling a vital role in their communities, the association's more than 325 member hospitals provide a disproportionate share of the nation's uncompensated care. Through their

[1] No counsel for any party authored this brief in whole or in part and no entity or person, aside from *amici curiae*, its members, and its counsel, made any monetary contribution intended to fund the preparation or submission of this brief. All parties have consented to this brief.

integrated health systems, members of America's Essential Hospitals offer a full range of primary through quaternary care, including a substantial amount of outpatient care in their ambulatory clinics, public health services, mental health services, substance abuse services, specialty care services, and "wraparound" services such as transportation and translation that help ensure that patients can access the care being offered. They do so on a shoe-string budget, providing state-of-the-art, patient-centered care while operating on margins half that of other hospitals.

The Association of American Medical Colleges is a not-for-profit association representing all 154 accredited U.S. and 17 accredited Canadian medical schools; nearly 400 major teaching hospitals and health systems; and more than 80 academic and scientific societies. Through these institutions and organizations, the AAMC serves the leaders of America's medical schools and teaching hospitals and their nearly 173,000 faculty members, 89,000 medical students, 129,000 resident physicians, and more than 60,000 graduate students and postdoctoral researchers in the biomedical sciences.

The Catholic Health Association of the United States is the national leadership organization of the Catholic health ministry, representing the largest not-for-profit providers of health care services in the nation. The Catholic health ministry is comprised of more than 2,200 hospitals, nursing homes, long-term care

facilities, health care systems, sponsors, and related organizations serving the full continuum of health care across our nation. CHA's Vision for U.S. Health Care calls for health care to be available and accessible to everyone, paying special attention to underserved populations. CHA works to advance the ministry's commitment to a just, compassionate health care system that protects life.

The Children's Hospital Association advances child health through innovation in the quality, cost and delivery of care with our children's hospitals. Representing more than 220 children's hospitals, the Children's Hospital Association is the voice of children's hospitals nationally. With its members, the Association champions policies that enable children's hospitals to better serve children, leverages its position as the pediatric leader in data analytics to facilitate national collaborative and research efforts to improve performance, and spreads best practices to benefit the nation's children.

The Federation of American Hospitals is the national representative of more than 1,000 investor-owned or managed community hospitals and health systems throughout the United States. The Federation's members include investor-owned or managed teaching and non-teaching short-stay acute, inpatient rehabilitation, long-term acute care, psychiatric and cancer hospitals in urban and rural communities across America. These hospitals provide a critical range of services, including acute, post-acute, and ambulatory services. Dedicated to a market-based

philosophy, the Federation provides representation and advocacy on behalf of its members to Congress, the Executive Branch, the judiciary, media, academia, accrediting organizations, and the public.

Amici's members are deeply affected by the Nation's health care laws. They therefore write to offer guidance, from hospitals' perspective, on the harmful impact the Public Charge Rule, 84 Fed. Reg. 41,292 (Aug. 14, 2019) will have on patients and the hospitals that serve them.

SUMMARY OF THE ARGUMENT

In promulgating the Public Charge Rule, Department of Homeland Security is forcing millions of immigrants to choose between accepting public services and accepting a green card. To many immigrants, that is an impossible choice.

DHS admits that the Public Charge Rule will deter many immigrants from using public benefits that they are legally entitled to, including Medicaid, the Supplemental Nutrition Assistance Program ("SNAP"), and certain housing assistance. But it contends that this "chilling effect" will be a fairly limited one, reaching only 2.5 percent of the immigrant population. That is a gross underestimation. In constructing the 2.5 percent figure, DHS ignored historical consequences of similar legislation, analyses of several medical foundations, and the fact that 14 percent of adults in immigrant families had *already* disenrolled from public services during the Rule's comment period. The final percentage is

expected to be anywhere between 15 and 35 percent of all immigrants, adding up to between 2.1 and 4.9 million individuals. Samantha Artiga, Rachel Garfield & Anthony Damico, Kaiser Family Found., *Estimated Impacts of the Proposed Public Charge Rule on Immigrants and Medicaid* 5 (Oct. 2018) (*Kaiser Report*).[2]

But even these numbers do not reflect the full extent of the chilling effect. When immigrants perceive enrollment in public programs to place their status at risk, they are less likely to enroll their children in those programs, even if their children are U.S. citizens not subject to a public-charge determination. DHS recognizes these additional chilling effects, but dismisses them as "unwarranted choices." 84 Fed. Reg. at 41,313. DHS's belief that these choices are "unwarranted," however, does not make them any less real. And it is U.S. citizens, including 6.7 million citizen children, who are projected to be the hardest hit by the Public Charge Rule. Cindy Mann, April Grady & Allison Orris, Manatt, *Medicaid Payments at Risk for Hospitals Under the Public Charge Proposed Rule* 5 (Nov. 2018) (*Manatt Report*).[3]

These are not abstract numbers, but real people who will be forced to forgo public benefits to which they are legally entitled. And they will endure worse

[2] *Available at* https://www.kff.org/disparities-policy/issue-brief/estimated-impacts-of-the-proposed-public-charge-rule-on-immigrants-and-medicaid/.

[3] *Available at* https://www.manatt.com/Insights/White-Papers/2018/Medicaid-Payments-at-Risk-for-Hospitals-Under-Publ.

health outcomes, loss of prescription medication, increased rates of poverty and housing instability, and impaired development of their children.

Although the Public Charge Rule will have the greatest impact on immigrant communities, the hospitals that serve them will also be affected. Coverage losses will lead to sicker immigrant populations and increased emergency-room visits, resulting in more unnecessary uncompensated care for hospitals and limiting hospital resources for expanding access to health care and other community services. Congress could not have intended these results. On the contrary, Congress has passed laws to decrease the number of uninsured residents in the United States, including laws targeted specifically at the immigrant population. DHS should not be allowed to upend these statutes through a back-door re-definition of "public charge."

Based in part on these considerations, the district court rightly concluded that Plaintiffs are likely to prevail on the merits and will be irreparably harmed if DHS is permitted to implement the Public Charge Rule. This Court should affirm.

ARGUMENT

I. THE NEW PUBLIC CHARGE DEFINITION WILL DETER MILLIONS OF IMMIGRANTS AND THEIR FAMILIES, INCLUDING U.S. CITIZEN CHILDREN, FROM ACCEPTING AND USING HEALTH CARE AND OTHER SERVICES TO WHICH THEY ARE LEGALLY ENTITLED, YET DHS UNJUSTIFIABLY REFUSED TO CONSIDER THOSE MILLIONS IN PROMULGATING THE PUBLIC CHARGE RULE.

The Public Charge Rule—and the resulting fear of being labeled a public charge—will discourage millions of legal immigrants and their family members, some of whom are citizens, from using public benefits they are legally entitled to—millions more than DHS acknowledges in the Rule. One report estimates that as many as 13.2 million Medicaid and Children's Health Insurance Program ("CHIP") enrollees could disenroll from these programs as a result of the Rule.[4] *Manatt Report, supra*, p. 5. This figure includes 4.4 million noncitizen adults and children enrolled in Medicaid or CHIP and an additional 8.8 million *citizen* family members, including citizen children, who may disenroll from Medicaid and CHIP out of fear or confusion, even though the Rule does not apply to them directly. *Id.* at 5, 7; Allison Orris et al., *How DHS' Public Charge Rule Will Affect Immigrant*

[4] CHIP is exempted from the Public Charge Rule. As detailed below, however, the Rule's chilling effects will likely decrease CHIP participation as well. *Infra* pp. 10–11.

Benefits, Law360 (Sept. 3, 2019) (*Immigrant Benefits*).[5] The Kaiser Foundation puts this figure at 15 to 35 percent of Medicaid and CHIP enrollees, or between 2.1 and 4.9 million individuals. *Kaiser Report*, *supra*, pp. 1, 5. And these estimates address only those currently enrolled—they do not account for legal immigrants and family members who are eligible for Medicaid or CHIP but who could choose never to enroll out of fear of being labeled a public charge. *Manatt Report*, *supra*, p. 5.

Worse still, these reports analyzed only the proposed Public Charge Rule, and there is good reason to believe that the final Rule's effects will be even more pronounced. This is because, unlike the proposed Rule, the final Rule directs immigration officials to consider *any* past receipts of public benefits in the discretionary public-charge determination, even those below the proposed 12-month threshold that would mandate designation as a public charge. 84 Fed. Reg. at 41,503.

DHS admits to this chilling effect, but estimates that only 2.5 percent of the noncitizen population—or 324,438 individuals—will be impacted. 84 Fed. Reg. at 41,463. DHS's estimate—which ignores the Rule's likely chilling effects—grossly

[5] *Available at* https://www.law360.com/immigration/articles/1193999/how-dhs-public-charge-rule-will-affect-immigrant-benefits.

undercounts both the number of individuals and the benefits programs affected for three reasons.

First, DHS computed the 2.5 percent figure by assuming that the Public Charge Rule will only affect immigrants in the year they are applying for permanent residency. Inadmissibility on Public Charge Grounds, 83 Fed. Reg. 51,114, 51,266 (proposed Oct. 10, 2018). But under the Rule, DHS considers a noncitizen to be a public charge if he uses benefits for 12 months or longer within a 36-month period. 8 C.F.R. § 212.21(a). DHS should have therefore accounted for immigrants who expect to apply for permanent residency within the next three years.

Second, DHS considered disenrollment only from programs it included in the public charge test. But the ambiguity and complexity of the Public Charge Rule could lead many noncitizens and their families to forgo a wide swath of federal, state, and local benefits. *See Manatt Report*, *supra*, pp. 4, 20. And even immigrants who understand the Rule's exact boundaries may disenroll from additional programs out of fear that future immigration policies may consider participation in the currently exempt benefits programs. *See id.* at 7. This fear is well-founded in the current political climate with its "sharper rhetoric about the value of immigration, efforts to reduce legal immigration for the first time in decades, and ramped-up arrests and deportations." Jeanne Batalova et al.,

Migration Policy Institute, *Chilling Effects: The Expected Public Charge Rule and Its Impact on Legal Immigrant Families' Public Benefits Use* 2 (June 2018) (*Migration Policy Institute Report*).[6]

Third, DHS explicitly considered—and dismissed—the Rule's chilling effect on populations not subject to it, including refugees and citizen children in mixed-status families, where the children are Americans and parents are not. DHS "believe[d] that it would be unwarranted for U.S. citizens and aliens exempt from public charge inadmissibility to disenroll from a public benefit program or forgo enrollment in response to this rule when such individuals are not subject to this rule." 84 Fed. Reg. at 41,313. DHS therefore declined to "alter th[e] rule to account for such unwarranted choices." *Id.*

But accounting for disenrollment by those who technically would not be impacted by the Rule would reflect historical drops in benefits use after similar immigration reforms, such as the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA). PRWORA established many of the current restrictions on immigrants receiving federal benefits, leaving the limited list that immigrants can access today. But PRWORA's *de facto* reach extended further, affecting groups like citizen children and refugees whose eligibility was

[6] *Available at* https://www.migrationpolicy.org/research/chilling-effects-expected-public-charge-rule-impact-legal-immigrant-families.

unchanged. *Migration Policy Institute Report*, *supra*, p. 2. Refugees' use of Medicaid, for instance, fell by 39 percent, and their use of food stamps by 60 percent. *Manatt Report*, *supra*, p. 11. Similarly, food-stamp use by citizen children in mixed-status families fell by 53 percent. *Migration Policy Institute Report*, *supra*, p. 15.

The Public Charge Rule is headed in the same direction. Approximately 14 percent of adults in immigrant families have already opted to not participate in public-benefits programs following the publication of just the *proposed* Rule. Hamutal Bernstein et al., Urban Institute, *With Public Charge Rule Looming, One in Seven Adults in Immigrant Families Reported Avoiding Public Benefit Programs in 2018* (May 21, 2019);[7] *see also* Kaiser Family Found., *Changes to "Public Charge" Inadmissibility Rule: Implications for Health and Health Coverage* (Aug. 12, 2019) (noting that multiple providers have reported decreases in CHIP and Women, Infants, and Children enrollment—programs exempted by the Public Charge Rule).[8]

Although it may be ultimately "unclear how many individuals would actually disenroll from or forego enrollment in public benefits programs" and

[7] *Available at* https://www.urban.org/urban-wire/public-charge-rule-looming-one-seven-adults-immigrant-families-reported-avoiding-public-benefit-programs-2018.

[8] *Available at* https://www.kff.org/disparities-policy/fact-sheet/public-charge-policies-for-immigrants-implications-for-health-coverage/.

PRWORA studies "had the benefit of retrospectiv[ity]," 83 Fed. Reg. at 51,266, DHS cannot ignore past probative evidence simply because there is *some* uncertainty as to the Public Charge Rule's effect. *See Michigan v. EPA*, 135 S. Ct. 2699, 2706 (2015) (holding that the process by which an agency reaches its decision "must be logical and rational" and rest "on a consideration of the relevant factors" (internal citations and quotation marks omitted)); *Gebhart v. SEC*, 595 F.3d 1034, 1043 (9th Cir. 2010) (reviewing an agency's factual finding to determine whether it was supported by "such relevant evidence as a reasonable mind might accept as adequate to support a conclusion"). DHS was thus wrong to ignore the historical lessons of PRWORA, wrong to disregard the 2018 disenrollment rates, and wrong to conclude that it was not obligated to account for underenrollment caused by confusion over the Public Charge Rule's reach. For that reason alone, the district court was right to enjoin the Rule. *See Encino Motorcars, LLC v. Navarro*, 136 S. Ct. 2117, 2125 (2016) ("The agency must examine the relevant data and articulate a satisfactory explanation for its action including a rational connection between the facts found and the choice made." (internal citations and quotation marks omitted)).

II. THE PUBLIC CHARGE RULE WILL HARM PATIENTS AND THE HOSPITALS THEY RELY ON FOR CARE.

A. Reduced Participation In Public Benefits Programs Will Negatively Affect The Health And Financial Stability Of Immigrant Families And Impair The Healthy Development Of Children.

The Public Charge Rule will not just deprive millions of needed public assistance; it will also harm their health. Most obviously, disenrollment from Medicaid and CHIP will result in immigrants and their families—including their U.S. citizen children—going without health insurance. But under virtually every metric, Medicaid enrollees report substantially better access to healthcare compared to similarly situated uninsured patients. *Manatt Report*, *supra*, p. 20. Medicaid coverage translates to regular access to a usual source of care—such as through a particular clinic or doctor's office—prescription drugs, early diagnoses and treatments, and preventative mental-health care. Medicaid & CHIP Payment and Access Commission, *Key Findings on Access to Care* (last visited Aug. 30, 2019);[9] American Hosp. Ass'n, *The Importance of Health Coverage*, at 2-3 (Nov. 2018);[10] *see also* Larisa Antonisse et al., Kaiser Family Found., *The Effects of Medicaid Expansion under the ACA: Updated Findings from a Literature Review*

[9] *Available at* http://www.macpac.gov/subtopic/measuring-and-monitoring-access/.

[10] *Available at* https://www.aha.org/system/files/media/file/2019/04/report-coverage-overview-2018.pdf.

(Aug. 15, 2019) (reviewing 324 studies and concluding that most of these studies demonstrate that Medicaid expansion has improved access to care, utilization of services, affordability of care and even financial security among the low-income population).[11]

But the Public Charge Rule will remove this access for up to 13.2 million immigrants and their citizen family members. *Manatt Report, supra*, pp. 5, 20. That's up to 13.2 million people who will go without basic medical care and who will wait to seek care until they are more seriously ill and more difficult to successfully treat. *See* Board of Governors of the Fed. Reserve Sys., *Report on the Economic Well-Being of U.S. Households in 2017*, at 23 (May 2018) ("Among the uninsured, 42 percent went without medical treatment due to an inability to pay, versus 25 percent among the insured.").[12]

Without insurance, immigrants are also likely to forgo important preventative health care and services, including vaccinations and screening for communicable diseases. *See* City of Chicago, Comment Letter on Proposed Rule: Inadmissibility on Public Charge Grounds, DHS Dkt. No. USCIS-2010-0012 (Dec.

[11] *Available at* https://www.kff.org/medicaid/issue-brief/the-effects-of-medicaid-expansion-under-the-aca-updated-findings-from-a-literature-review-august-2019/.

[12] *Available at* https://www.federalreserve.gov/publications/files/2017-report-economic-well-being-us-households-201805.pdf.

10, 2018).[13] DHS acknowledges as much, admitting that the Public Charge Rule will increase the prevalence of disease "among members of the U.S. citizen population who are not vaccinated." 83 Fed. Reg. at 51,270. In response, DHS offers only that it "does not intend to restrict the access of vaccines for children or adults or intend to discourage individuals from obtaining the necessary vaccines to prevent vaccine-preventable diseases." 84 Fed. Reg. at 41,384. DHS further assumes that many individuals will still have access to vaccinations because the Rule "does not consider receipt of Medicaid by a child under age 21, or during a person's pregnancy, to constitute receipt of public benefits." *Id.* Additionally, "[v]accinations obtained through public benefits programs are not considered public benefits under 8 CFR 212.21(b), although if an alien enrolls in Medicaid for the purpose of obtaining vaccines, the Medicaid itself qualifies as a public benefit." *Id.* at 41,384-85. This response in and of itself illustrates the complexity of the Public Charge Rule, undermining DHS's determination that immigrants will be able to effectively parse through these provisions and get the medical care they require without being deemed a public charge. In any event, DHS concedes that even this complex arrangement will solve only a "substantial portion, though not all, of the vaccinations issue." *Id.* at 41,384.

[13] *Available at* https://www.regulations.gov/document?D=USCIS-2010-0012-50648.

Reduced participation in Medicaid and CHIP will also make it harder for immigrant families to afford care. Even with providers doing all they can to assist low-income patients, Medicaid coverage is essential to keeping families out of debt, with one study estimating that Medicaid lifted an estimated 2.6 to 3.4 million patients out of poverty in 2010. Benjamin D. Sommers & Donald Oellerich, *The Poverty-Reducing Effect of Medicaid*, 32 J. Health Econ. 816 (2013); *see also* Karina Wagnerman, Georgetown University Health Policy Institute, *Medicaid: How Does It Provide Economic Security for Families?*, at 1 (Mar. 2017) (finding that the share of low-income families having trouble paying medical bills has decreased by almost 30 percent from 2011 to 2016, the same period during which Medicaid expanded).[14] By restricting immigrants' access to Medicaid and CHIP, the Public Charge Rule threatens families' ability to afford needed care, and further jeopardizes their health.

The Public Charge Rule's consequences fall even harder on children, who will likely disenroll from public benefits even though the Rule does not consider benefits receipt by children in public-charge determinations. *See supra* pp. 9-11 (discussing how the ambiguity and complexity of the Public Charge Rule could lead many parents to disenroll their children from benefits programs—exactly what

[14] *Available at* https://ccf.georgetown.edu/wp-content/uploads/2017/03/Medicaid-and-Economic-Security.pdf.

happened after enactment of PRWORA). Medicaid coverage has been shown to promote positive health, educational, and earnings outcomes lasting well into adulthood. *Manatt Report*, *supra*, p. 20; Karina Wagnerman, Alisa Chester & Joan Alker, Georgetown University Health Policy Institute, *Medicaid Is a Smart Investment in Children*, at 1 (Mar. 2017) (*Georgetown Report*).[15] Disenrollment from Medicaid will have correspondingly long-lasting effects. For example, studies find that Medicaid availability in childhood leads to decreased healthcare use in adulthood. *Id.* at 4; Michel H. Boudreaux, Ezra Golberstein & Donna D. McAlpine, *The Long-Term Impacts of Medicaid Exposure in Early Childhood: Evidence from the Program's Origin*, 45 J. Health Econ. 161 (2016). And childhood Medicaid availability significantly reduces mortality due to treatable causes later in life, with some populations experiencing reductions as high as 20 percent. *Georgetown Report*, *supra*, p. 5. Other lasting benefits of childhood Medicaid availability include improved test scores, a decreased high school dropout rate, increased college attendance, increased wages, and increased productivity in adulthood. *Id.* at 1, 6. DHS should not be permitted to force families to choose between their green-card eligibility and the adverse effects of raising uninsured children.

[15] *Available at* https://ccf.georgetown.edu/wp-content/uploads/2017/03/MedicaidSmartInvestment.pdf.

The Rule's effect on patients' health goes beyond just Medicaid and CHIP, with DHS officials directed to consider public-benefits programs like food stamps and housing assistance. Both have a well-documented impact on health status, particularly for children. Food insecurity has been consistently linked to impaired growth, poor cognitive development, and obesity in children. Patrick H. Casey, *Children in Food-Insufficient, Low-Income Families: Prevalence, Health, and Nutrition Status*, 155 Archives Pediatrics Adolescent Med. 508, 508 (2001). Food-insecure households are also often forced to choose between spending money on food and spending money on medication, resulting in medication underuse. Dena Herman et al., *Food Insecurity and Cost-Related Medication Underuse Among Nonelderly Adults in a Nationally Representative Sample*, 105 Am. J. Pub. Health e48, e49 (2015) (finding that 26 percent of households that reported food insecurity also reported skipping medications to save money). And housing insecurity and homelessness are associated with higher risks of lead poisoning, gunshot injuries, asthma due to increased air pollutants and allergens, and alcohol-related injuries in children and adolescents. Paula Braveman & Laura Gottlieb, *The Social Determinants of Health: It's Time to Consider the Causes of the Causes*, 129 Pub. Health Reports 19, 22–23 (2014). Children exposed to housing insecurity and homelessness likewise experience emotional and psychological stressors arising from chronically inadequate resources that are associated with increased

vulnerability to a range of adult diseases, such as heart attacks, strokes, and smoking-related cancers. *Id.* at 23–24.

These harms to health constitute precisely the kind of irreparable harm warranting a preliminary injunction. *M.R. v. Dreyfus*, 697 F.3d 706, 732 (9th Cir. 2012); *see also id.* (holding that beneficiaries of public assistance "may demonstrate a risk of irreparable injury by showing that enforcement of a proposed rule may deny them needed medical care" (internal citations and quotation marks omitted)); *California v. U.S. Dep't of Health & Human Servs.*, 941 F.3d 410, 431 (9th Cir. 2019) (affirming district court's conclusion that public health consequences can form the basis for finding irreparable harm); *cf. Harris v. Bd. of Supervisors*, 366 F.3d 754, 766 (9th Cir. 2004) (holding that reducing available public healthcare facilities would cause irreparable harm). The district court correctly granted one, and this Court should affirm.

B. Reduced Participation In Public Benefits Programs Will Also Increase Uncompensated Care, Straining Hospital Resources And Their Ability To Adequately Invest In Their Communities.

Noncitizens and their families that drop or forgo Medicaid or CHIP coverage as a result of the Public Charge Rule will continue to have the same health care needs. But now they will likely postpone treatment and be forced to seek care in emergency rooms for conditions that could have been treated, or even prevented, through primary-care visits, resulting in increased uncompensated care for

hospitals. These added costs will constrain the ability of hospitals to fully serve their patients and communities.

Hospitals do their part to lessen the burden on patients struggling with health care costs, in part by providing tremendous amounts of uncompensated care—care for which the hospital receives no payment at all—to immigrants and other uninsured patients. In 2018, for example, uncompensated care totaled $41.3 billion. Am. Hosp. Ass'n, Fact Sheet: Uncompensated Hospital Care Cost (Jan. 2020), available at https://tinyurl.com/rcwcrxw.[16] This level of uncompensated care will increase if immigrants and their families disenroll from Medicaid and CHIP to avoid being labeled a public charge. *Immigrant Benefits*, *supra.* According to some estimates, hospitals are at risk of spending as much as $17 billion dollars every year in additional uncompensated care costs from the Public Charge Rule. *Manatt Report*, *supra*, p. 5 (estimating that, in 2016, Medicaid and CHIP provided $7 billion for noncitizen enrollees and $10 billion for citizen enrollees who have a noncitizen family member). California hospitals account for over $5 billion of that amount. *Id.* at 17.

The Public Charge Rule will also force hospitals to provide uncompensated care in one of the most expensive settings: The emergency room. Even DHS admits that the Public Charge Rule may lead to "increased use of emergency rooms

[16] *Available at* https://tinyurl.com/rcwcrxw.

and emergent care as a method of primary healthcare due to delayed treatment." 84 Fed. Reg. at 41,384. That is, as patients delay preventative care, their conditions will require hospitals to treat far more expensive and dangerous medical conditions that could have been caught much earlier but now present as emergencies. *Manatt Report*, *supra*, p. 20.

DHS contends that these effects will be mitigated by the Rule's exemption for patients who access Medicaid benefits to treat emergency conditions. 84 Fed. Reg. at 41,384. But many immigrants may not be aware that emergency services are excluded, or may not know if someone in their household is experiencing a true medical emergency as DHS chooses to define it. What's more, extending care only when a patient is in crisis will result in treatment of costly acute conditions at a hospital emergency room instead of preventative care at clinics and doctors' offices. *See Manatt Report*, *supra*, p. 20; Linda S. Baker & Laurence C. Baker, *Excess Cost of Emergency Department Visits for Nonurgent Care*, 13 Health Affairs 162 (Nov. 1994) (noting that providing services at hospital emergency rooms is more costly than providing the same services at doctors' offices); *cf.* Sean Elliott, *Staying Within the Lines: The Question of Post-Stabilization Treatment for Illegal Immigrants Under Emergency Medicaid*, 24 J. Contemp. Health L. & Pol'y 149, 163 (2007) (explaining that a narrow definition of "emergency medical condition" in the context of Medicaid coverage for undocumented immigrants will

prove more costly overall because failure to properly treat the underlying condition will only result in the recurrence of the emergency situation and the patient's return to the emergency room). Studies show that increased emergency-care volume has been associated with increased mortality, delays in treatment, and increased rates of patient elopement. *See* Winston Liaw et al., *The Impact of Insurance and a Usual Source of Care on Emergency Department Use in the United States*, 2014 Int. J. Family Med. 1, 1 (2014).

The Public Charge Rule's increase in uncompensated care will fall hardest on hospitals operating in predominantly immigrant and lower-income communities. *Law360*, *supra*. A sharp rise in uninsured patients will force hospitals in already precarious positions to make difficult operational and financial decisions, including whether they must limit certain other services, close free clinics, or shut some services down entirely. *See* America's Essential Hospitals, Comment Letter on Proposed Rule: Inadmissibility on Public Charge Grounds, DHS Dkt. No. USCIS-2010-0012 (Dec. 10, 2018).[17]

Finally, all hospitals will struggle to maintain their support for community-based programs, including promoting vaccinations. *Id.* Community immunity is achieved only when a sufficient proportion of a population is immune to an

[17] *Available at* https://www.regulations.gov/document?D=USCIS-2010-0012-45033.

infectious disease, making the disease's spread from person to person unlikely. *See* U.S. Department of Health and Human Services, *Vaccines Protect Your Community* (Dec. 2017).[18] Because many immigrants reside close to each other, clusters of unvaccinated individuals are likely to arise, increasing the risk of an outbreak. The Public Charge Rule will therefore endanger not just immigrant families and hospitals, but the entire community.

III. THE NEW PUBLIC CHARGE DEFINITION UNDERMINES CONGRESS'S INTENT TO REDUCE THE UNINSURED POPULATION AND THE RULE'S GOAL OF PROMOTING IMMIGRANTS' SELF-SUFFICIENCY.

Congress has long sought to increase the rate of insurance coverage for individuals residing in the United States, including for immigrants. Congress has also long supported hospitals that serve those populations. The Patient Protection and Affordable Care Act ("ACA"), for example, is meant to "achieve[] near-universal coverage," "reduc[e] the number of the uninsured," "lower health insurance premiums," "significantly increas[e] health insurance coverage," and "improve financial security" of U.S. residents generally. Patient Protection and Affordable Care Act, 42 U.S.C. § 18091(2)(C), (D), (E), (F), (G); *see also National Fed'n of Indep. Bus. v. Sebelius*, 567 U.S. 519, 596 (2012) ("A central aim of the ACA is to reduce the number of uninsured U.S. residents.").

[18] *Available at* https://www.vaccines.gov/basics/work/protection.

And although PRWORA limited immigrants' access to *federal* benefits, Congress was sufficiently concerned with immigrants' access to necessary services that it contained multiple provisions allowing States to extend public benefits to qualified immigrants. 8 U.S.C. § 1612(b). Similarly, PRWORA authorizes States to provide nutrition assistance to certain immigrants who are ineligible for SNAP. *Id.*

And, as far back as 1981, Congress has been concerned with the "greater costs it found to be associated with the treatment of indigent patients." *D.C. Hosp. Ass'n v. District of Columbia*, 224 F.3d 776, 777 (D.C. Cir. 2000). Congress thus amended the Medicaid Act to provide additional funds for "hospitals which serve a disproportionate number of low-income patients with special needs." 42 U.S.C. § 1396a(a)(13)(A)(iv). Congress's "intent was to stabilize the hospitals financially and preserve access to health care services for eligible low-income patients." *Virginia, Dep't of Med. Assistance Servs. v. Johnson*, 609 F. Supp. 2d 1, 3 (D.D.C. 2009).

The Public Charge Rule risks unravelling this framework by effectively denying public benefits to 13.2 million lawful immigrants and their families, including 6.7 million citizen children. *Manatt Report*, *supra*, p. 9. Indeed, the 6.7 million citizen children are potentially the largest demographic at risk of losing public benefits under the Public Charge Rule, as compared to only 3.6 million

noncitizen adults, 0.9 million noncitizen children, and 2.1 million citizen adults. *Id.* Underenrollment in health, nutrition, and housing services has particularly devastating and long-lasting effects on children, *supra*, pp. 16–19, and DHS should not be permitted to cause these effects by expanding the definition of "public charge." *See Whitman v. American Trucking Ass'ns*, 531 U.S. 457, 468 (2001) (finding it "implausible" that Congress intended to give federal agencies the power to make major policy decisions through interpretation of "modest" statutory terms).

Not only that, but the Public Charge Rule undermines the very goals it sets out to achieve. According to DHS, one of the main purposes of the new public charge definition is to "promote the self-sufficiency of aliens within the United States." 84 Fed. Reg. at 41,309. But non-cash public benefits like affordable health insurance are essential for individuals to achieve self-sufficiency by allowing them to stay healthy, be able to work, and care for their families. *See* Larisa Antonisse & Rachel Garfield, Kaiser Family Found., *The Relationship Between Work and Health: Findings from a Literature Review* (Aug. 7, 2018);[19] *see also* Allan Dizioli and Roberto Pinheiro, *Health Insurance as a Productive Factor*, 40 Labour Econ. 1-24 (June 2016) (finding that workers with health insurance miss approximately 75 percent fewer work days and are more productive

[19] *Available at* https://www.kff.org/medicaid/issue-brief/the-relationship-between-work-and-health-findings-from-a-literature-review/.

at work than their uninsured peers).[20] Even the Immigration and Naturalization Service has recognized as much, determining that receipt of benefits in the short-run leads to self-sufficiency over the long-term. 1999 Field Guidance on Deportability and Inadmissibility on Public Charge Grounds, 64 Fed. Reg. 28,689, 28,692 (May 26, 1999) (explaining that "certain federal, state, and local benefits" are being made available to families with incomes above the poverty level to "assist[] working-poor families in the process of becoming self-sufficient").

In sum, the Public Charge Rule contradicts Congress's intent to reduce the number of uninsured residents and even undermines the very self-sufficiency goals it sets out to achieve. The district court correctly enjoined the Rule, and this Court should affirm.

[20] *Available at* https://www.sciencedirect.com/science/article/abs/pii/S0927537116300021.

CONCLUSION

For the forgoing reasons, the Court should affirm the decision below.

Respectfully submitted,

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January 23, 2020

CERTIFICATE OF COMPLIANCE

1. This motion complies with the type-volume limitations of Federal Rule of Appellate Procedure 29(a)(5) because it contains 5,329 words, excluding the parts of the brief exempted by Federal Rule of Appellate Procedure 32(f).

2. This brief complies with the typeface requirements of Federal Rule of Appellate Procedure 32(a)(5) and the typestyle requirements of Federal Rule of Appellate Procedure 32(a)(6) because it has been prepared in a proportionally spaced typeface using Microsoft Office Word 2010 in Times New Roman 14-point font.

/s/ Sean Marotta
Sean Marotta

CERTIFICATE OF SERVICE

I certify that I electronically filed the foregoing with the Clerk of the Court for the United States Court of Appeals for the Ninth Circuit by using the appellate CM/ECF system on January 23, 2020. I certify that all participants in the case are registered CM/ECF users and that service will be accomplished by the appellate CM/ECF system.

/s/ Sean Marotta
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