No. 19A785

In the
Supreme Court of the United States

DEPARTMENT OF HOMELAND SECURITY, et al.,

Applicants,

v.

NEW YORK, et al.,

Respondents.

MOTION BY GOVERNMENT PLAINTIFFS TO TEMPORARILY LIFT OR MODIFY THE COURT'S STAY OF THE ORDERS ISSUED BY THE UNITED STATES DISTRICT COURT FOR THE SOUTHERN DISTRICT OF NEW YORK

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Dated: April 13, 2020

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INTRODUCTION

In January 2020, this Court stayed two orders of preliminary relief issued by the United States District Court for the Southern District of New York (Daniels, J.) pending the Second Circuit's disposition of defendants' appeal and this Court's disposition of any subsequent petition for certiorari, if such a petition is timely filed. (App. 1.) In reliance on the stay order, the United States Department of Homeland Security (DHS) implemented the Public Charge Rule, altering its prior interpretation of "public charge" as well as the test for evaluating whether an immigrant is likely to become a public charge under 8 U.S.C. § 1182(a)(4)(A), and thus be ineligible for a green card. The Rule took effect on February 24, 2020.

Since that time, the novel coronavirus SARS-CoV-2 has triggered a devastating global pandemic, afflicting at least half a million people in the United States with a potentially lethal illness, coronavirus disease 2019 (COVID-19). The rapid and ongoing spread of COVID-19 is causing a nationwide public-health crisis and wreaking havoc on the economy. The President has declared a state of national emergency. And state and local authorities—including plaintiffs here, the States of New York, Connecticut, and Vermont, and the City of New York—have also declared states of emergency and are undertaking extraordinary efforts to stop the spread of COVID-19 and protect the health and well-being of our residents. But the Public Charge Rule is hindering those efforts by deterring immigrants from accessing healthcare and public benefits that are essential tools for protecting the public at large by limiting the spread and severity of COVID-19 and promoting our nation's recovery from the economic crisis that the disease has caused.

Accordingly, plaintiffs respectfully request that the Court temporarily lift or modify its stay to halt implementation of the Public Charge Rule during the national emergency concerning COVID-19 declared by the President. In the alternative, plaintiffs request that the Court clarify

that its stay does not preclude the district court here from considering whether the new circumstances caused by the novel coronavirus warrant temporarily halting implementation of the Rule.[1]

Such narrow and temporary relief from the stay is warranted because the Rule is now causing additional irreparable harms to the public—citizens and noncitizens alike—that were not present when the Court initially considered defendants' motion for a stay. By deterring immigrants from accessing publicly funded healthcare, including programs that would enable immigrants to obtain testing and treatment for COVID-19, 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 make up a large proportion of the essential workers who continue to interact with the public. The Rule also deters access to public benefits, including nutrition benefits, that are critical for both immigrants and the country as a whole to weather the economic crisis triggered by COVID-19. These irreparable harms have tipped the balance of the equities decidedly against maintaining the stay during the national emergency concerning COVID-19.

[1] Plaintiffs here are authorized to state that the plaintiffs in the companion case, *Make the Road New York v. Cuccinelli*, support this motion, including the alternative relief sought. The *Make the Road New York* plaintiffs were parties to the stay proceedings in this Court and are subject to the Court's stay order. Because the two cases are consolidated for pre-trial purposes in the district court, *see* Order, *New York v. Dep't of Homeland Sec.*, No. 19-cv-7777 (S.D.N.Y. Feb. 14, 2020), ECF 142, any relief afforded to plaintiffs here should also apply in that case.

STATEMENT

A. Prior Litigation

In August 2019, DHS issued its Public Charge Rule, which modified its criteria for determining inadmissibility on public charge grounds. 84 Fed. Reg. 41,292 (Aug. 14, 2019). Under the Rule, DHS officials must now deem an immigrant to be a "public charge" if the immigrant is 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" during the immigrant's life. *Id.* at 41,501. In an earlier notice of proposed rulemaking, DHS had acknowledged that this regulatory change could lead immigrants who are otherwise eligible for certain public benefits to disenroll or forgo enrollment in those programs, and that such withdrawal or avoidance "could lead to . . . [i]ncreased prevalence of communicable diseases, including among members of the U.S. citizen population who are not vaccinated." 83 Fed. Reg. 51,114, 51,270 (Oct. 10, 2018).

On October 11, 2019, the district court issued two orders that preliminarily enjoined the enforcement of the Public Charge Rule on a nationwide basis, and postponed the Rule's effective date pursuant to 5 U.S.C. § 705. On January 27, 2020, this Court issued a stay of the district court's orders, thereby allowing the Public Charge Rule to take effect. The stay applies pending disposition of defendants' expedited appeal from the district court's orders in the Second Circuit and disposition of defendants' petition for a writ of certiorari, if such a writ is timely sought.[2] (App.

[2] On March 2, 2020, the Second Circuit heard oral argument on defendants' expedited appeal. That appeal remains pending.

1.) Justices Ginsburg, Breyer, Sotomayor, and Kagan would have denied the application for a stay. (App. 1.)

On February 21, 2020, this Court issued a similar stay of a preliminary injunction issued by the United States District Court for the Northern District of Illinois that had prevented enforcement of the Public Charge Rule in Illinois alone.[3] *Wolf v. Cook Cty., Ill.*, 140 S. Ct. 681, 681 (2019). Justices Ginsburg, Breyer, Sotomayor, and Kagan would have denied the application for a stay. *Id.*

In reliance on this Court's stay orders, defendants began enforcing the Public Charge Rule nationwide on February 24, 2020.

B. The Nationwide COVID-19 Crisis

After the Court issued its stays, coronavirus disease 2019 (COVID-19) began sweeping across the United States. The spread of COVID-19 and the novel coronavirus SARS-CoV-2 that triggers this illness has become a global pandemic that has thrown the country into an unprecedented crisis with devastating consequences for public health and the economy. The novel coronavirus can cause severe and life-threatening respiratory illness marked by fever, coughing, and difficulty breathing. *See* Center for Disease Control & Prevention, *Coronavirus Disease 2019 (COVID-19): Frequently Asked Questions* (internet) (last updated Apr. 11, 2020) (see *What are the symptoms and complications that COVID-19 can cause?*).[4] COVID-19 is already spreading quickly in communities throughout the country, with cases reported in all fifty States. *See* Center

[3] On February 26, 2020, the Seventh Circuit heard oral argument on defendants' appeal in that court. The Seventh Circuit appeal remains pending.

[4] *At* https://www.cdc.gov/coronavirus/2019-ncov/faq.html.

for Disease Control & Prevention, *Coronavirus Disease 2019 (COVID-19): Situation Summary* (Mar. 26, 2020) (internet) (last updated Apr. 7, 2020).[5]

COVID-19 has already exacted a tremendous toll on the nation, and the pace of its spread continues to increase rapidly. In the United States, 525,704 individuals have confirmed cases of COVID-19, and at least 20,486 people have died from the disease. Center for Disease Control & Prevention, *Coronavirus Disease 2019 (COVID-19): Cases in U.S.* (internet) (last updated Apr. 12, 2020).[6] Plaintiffs and their residents have been particularly hard hit. In New York, which has become the current epicenter of the pandemic in the United States, 188,694 people have confirmed cases of COVID-19, and at least 9,384 people have died from the disease. *See* New York Dep't of Health, *NYSDOH COVID-19 Tracker* (internet) (last updated Apr. 12, 2020);[7] New York Dep't Health, *Fatalities by County* (internet) (last updated April 12, 2020).[8] In New York City alone, there are currently more than 104,410 confirmed positive cases and more than 6,182 confirmed deaths. *See* New York City Dep't of Health & Mental Hygiene, *COVID-19: Data: Cases, Hospitalizations and Deaths* (internet) (last updated Apr. 12, 2020).[9] Connecticut and Vermont have also been experiencing rapidly increasing rates of infection, with 12,035 confirmed COVID-19 cases in Connecticut and 727 confirmed cases in Vermont to date. *See COVID-19 Update April*

[5] *At* https://www.cdc.gov/coronavirus/2019-ncov/cases-updates/summary.html.

[6] *At* https://www.cdc.gov/coronavirus/2019-ncov/cases-updates/cases-in-us.html.

[7] *At* https://coronavirus.health.ny.gov/county-county-breakdown-positive-cases.

[8] *At* https://covid19tracker.health.ny.gov/views/NYS-COVID19-Tracker/NYSDOHCOVID-19Tracker-Fatalities?%3Aembed=yes&%3Atoolbar=no&%3Atabs=n.

[9] *At* https://www1.nyc.gov/site/doh/covid/covid-19-data.page.

12, 2020, at 1 (internet) (April 12, 2020);[10] *Novel Coronavirus (COVID-19):* Vermont Dep't of Health, *Coronavirus (COVID-19): Current Activity in Vermont* (internet) (last updated Apr. 12, 2020).[11] And other jurisdictions across the country have likewise seen rising numbers of infections and fatalities. *See, e.g.*, *Corona Virus: Michigan Data* (internet) (last updated Apr. 12, 2020) (24,638 confirmed infections and 1,487 confirmed deaths in Michigan);[12] Florida Dep't of Health, Division of Disease Control and Health Protection, *Florida's COVID-19 Data and Surveillance Dashboard* (internet) (last updated Apr. 12, 2020) (19,347 confirmed infections and 452 confirmed deaths in Florida).[13] These figures likely vastly underrepresent the number of actual infections and related deaths for a number of reasons, including that many people who likely have the virus have not been tested for it. *See* Jacqueline Howard, *US coronavirus death count likely an underestimate. Here's why*, CNN (Apr. 6, 2020) (internet).[14]

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 generally* 50 U.S.C. § 1601 et seq. The President declared that "[t]he spread of COVID-19 within our Nation's communities threatens to strain our Nation's healthcare systems." 85 Fed. Reg. at 15,337. He directed "hospitals and medical facilities throughout the country," many of which are operated by plaintiffs or located within

[10] *At* https://portal.ct.gov/-/media/Coronavirus/CTDPHCOVID19summary 4122020.pdf?la=en.

[11] *At* https://www.healthvermont.gov/response/coronavirus-covid-19/current-activity-vermont.

[12] *At* https://www.michigan.gov/coronavirus/0,9753,7-406-98163_98173---,00.html.

[13] *At* https://experience.arcgis.com/experience/96dd742462124fa0b38ddedb9b25e429.

[14] *At* https://www.cnn.com/2020/04/06/health/us-coronavirus-death-count-cdc-explainer/index.html.

plaintiffs' jurisdictions, "to assess their preparedness posture and be prepared to surge capacity and capability" to address COVID-19. *Id.* He also declared that because additional measures "are needed to successfully contain and combat the virus in the United States," he was authorizing the Department of Health and Human Services and the Social Security Administration to temporarily waive or modify certain requirements of various public-health and medical-insurance related statutes "throughout the duration of the public health emergency declared in response to the COVID-19 outbreak." *Id.*

The governors of each of the plaintiff States, as well as the mayor of plaintiff New York City, have each declared public-health emergencies in their respective jurisdictions based on the COVID-19 pandemic.[15] *See* 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);[16] Vermont Exec. Order No. 01-20 (2020).[17] In each of plaintiffs' jurisdictions, state officials and agencies have also been taking increasingly drastic measures to slow the spread of the novel coronavirus and provide testing and treatment for residents who are already infected. For example, state officials have required all nonessential employees to work from home, closed schools, and issued orders to increase hospital capacity to care for COVID-19 patients.[18]

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[15] New York declared a state of emergency on March 7, 2020; Connecticut, on March 10, 2020; Vermont, on March 13, 2020.

[16] *At* https://portal.ct.gov/-/media/Office-of-the-Governor/News/20200310-declaration-of-civil-preparedness-and-public-health-emergency.pdf?la=en.

[17] *At* https://governor.vermont.gov/sites/scott/files/documents/EO%2001-20%20Declaration%20of%20State%20of%20Emergency%20in%20Response%20to%20COVID-19%20and%20National%20Guard%20Call-Out.pdf.

[18] *See, e.g.*, New York Exec. Order No. 202.4, 9 N.Y.C.R.R. § 8.202.4 (2020) (closing schools in New York); New York Exec. Order No. 202.8, 9 N.Y.C.R.R. § 8.202.8 (2020) (ordering

C. The Importance of Public Benefits in Responding to the COVID-19 Crisis

Experts in infectious disease control and public health have warned that everyone should be minimizing the spread of the virus to the greatest extent possible. *See* Center for Disease Control & Prevention, *Coronavirus Disease 2019 (COVID-19): How to Protect Yourself and Others* (internet) (last updated Apr. 8, 2020).[19] Testing for the novel coronavirus and medical treatment for COVID-19 are critically important to slowing infection rates, preserving hospital capacity and medical equipment, and saving lives. (App. 37, 54-63.) If individuals are deterred from testing and thus do not know that they are infected, they are more likely to inadvertently spread the virus to other people—who will then spread the virus to still more people. (App. 55-56, 61, 63, 114.) *See* Washington State Dep't of Health, *Testing for COVID-19* (internet) (last visited Apr. 12, 2020) (testing allows public-health officials to "keep people with COVID-19 and their contacts away from others to prevent spread of the virus").[20] And if individuals suffering from COVID-19 delay obtaining proper medical care, they are more likely to spread the virus, experience serious illness and need intensive care in a hospital, and potentially die from the disease. (App. 56, 61, 63, 160-161, 225.)

Individuals who lack health insurance are much less likely to obtain necessary treatment for COVID-19 because of the prohibitive costs of medical care and hospital stays. (App. 54-55, 58-61, 175.) A recent report from a nonprofit organization that analyzes healthcare costs estimated

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all nonessential workers in New York to work from home); New York Exec. Order No. 202.10, 9 N.Y.C.R.R. § 8.202.10 (2020) (ordering various measures to increase hospital capacity); Connecticut Exec. Order No. 7H (2020) (ordering all nonessential workers in Connecticut to work from home); Vermont Exec. Order No. 01-20, add. 6 (2020) (ordering all nonessential businesses in Vermont to cease in-person business operations).

[19] *At* https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/prevention.html.

[20] *At* https://www.doh.wa.gov/Emergencies/NovelCoronavirusOutbreak2020COVID19/TestingforCOVID19.

that a six-day hospital stay for COVID-19 treatment will cost approximately $73,300. FAIR Health, *COVID-19: The Projected Economic Impact of the COVID-19 Pandemic on the US Healthcare System* 2, 8, 13, 16 (Mar. 25, 2020). And the cost of treatment will be higher for patients who suffer more severe symptoms or require longer hospital stays. *See* Center for Disease Control & Prevention, *Coronavirus Disease 2019 (COVID-19): Interim Clinical Guidance for Management of Patients with Confirmed Coronavirus Disease (COVID-19)* (internet) (last updated Apr. 6, 2020) (median time in intensive care unit for severely ill COVID-19 patient ranges from ten to twelve days, and median length of hospitalization among survivors ranges from ten to thirteen days).[21]

Many immigrants residing in plaintiffs' jurisdictions and in other jurisdictions are highly vulnerable to COVID-19 because they work in industries that have been deemed "essential" and thus continue to operate during the crisis. For example, executive orders in New York, Connecticut, and Vermont that direct residents to work from home do not apply to workers in essential sectors such as healthcare, grocery stores, food and retail delivery, building maintenance, farms and agriculture, and sanitation. *See* New York Exec. Order No. 202.8, *supra*; Connecticut Exec. Order No. 7H § 1 (2020) (internet);[22] Vermont Exec. Order No. 01-20, add. 6 (2020) (internet).[23] Because immigrants compose a significant proportion of the workers in these front-line industries, they must often interact with others or spend time in high-risk environments—such as providing healthcare in hospitals, caring for the aging in nursing homes, cleaning and

[21] *At* https://www.cdc.gov/coronavirus/2019-ncov/hcp/clinical-guidance-management-patients.html.

[22] *At* https://portal.ct.gov/-/media/Office-of-the-Governor/Executive-Orders/Lamont-Executive-Orders/Executive-Order-No-7H.pdf?la=en.

[23] *At* https://governor.vermont.gov/sites/scott/files/documents/ADDENDUM%206%20TO%20EXECUTIVE%20ORDER%2001-20.pdf.

disinfecting public spaces, and preparing or delivering food and supplies to other residents who are required to stay at home. (*See* App. 126-127, 225.) These workers are as a result more likely to be exposed to the virus, and, without adequate testing and treatment, these workers, if infected, are more likely to suffer worse health outcomes and to spread the virus to others inadvertently. (*See* App. 55-56, 61, 63, 114; *see also* App. 225 (immigrant workers in Colorado meatpacking plants and dairies are essential workers at high risk of contracting and spreading COVID-19).)

In addition to the urgent public-health crisis, the COVID-19 pandemic has also triggered a severe economic crisis, with millions of workers losing significant income or their employment, and thereby needing to turn to supplemental benefit programs like Medicaid and SNAP in order to weather this economic crisis. (*See* App. 63-65.) Approximately sixteen million individuals applied for unemployment benefits in the three-week period from March 19 to April 4. Patricia Cohen & Tiffany Hsu, *'Sudden Black Hole' for the Economy With Millions More Unemployed*, N.Y Times (Apr. 10, 2020) (internet).[24] And the number of individuals seeking unemployment benefits in plaintiffs' jurisdictions has steeply increased due to the pandemic. In New York, for example, the number of new unemployment claims rose from 14,272 in the week ending March 21, 2020, to 79,999 in the week ending March 28, 2020—an increase of 460%. News Release, United States Dep't of Labor, *Unemployment Insurance Weekly Claims* 7 (Apr. 2, 2020) (internet).[25] In that same week, the rate of unemployment-insurance claims in Connecticut rose by approximately 620% compared to the prior week, and in Vermont the rate increased by approximately 450%. *Id.* Immigrant workers, particularly in the hospitality and service industries, have been

[24] *At* https://www.nytimes.com/2020/04/09/business/economy/unemployment-claim-numbers-coronavirus.html.

[25] *At* https://oui.doleta.gov/press/2020/040220.pdf.

disproportionately impacted by layoffs and furloughs. (App. 119 (immigrants in New York have lost jobs in restaurants and as domestic workers); App. 202-203 (immigrants in Illinois have lost jobs as domestic workers, personal care aides, and nannies).)

Workers who lose their jobs because of the pandemic are likely to turn temporarily to supplemental benefit programs, including Medicaid and SNAP, until they can get back on their feet. (*See* App. 63-65.) For example, many workers who lose their jobs and their employer-sponsored health insurance because of the pandemic are likely to need Medicaid coverage until they can find another job. (*See* App. 64-65.) And SNAP benefits respond rapidly to changing economic conditions by allowing newly eligible individuals to obtain benefits and allowing existing participants to receive higher amounts of benefits if their incomes decrease. U.S. Dep't of Agriculture, *Building a Healthy America: A Profile of the Supplemental Nutrition Assistance Program*, at 1, 3 (Apr. 2012). Programs like SNAP will also be particularly important to immigrants and their family members, many of whom are ineligible for unemployment insurance benefits or certain COVID-19 related benefits recently enacted by Congress. *See* Coronavirus Aid, Relief, and Economic Security Act, Pub. L. No. 116-136, § 6428(d), 134 Stat. 281, 335 (2020).

D. The Harms Imposed by the Public Charge Rule and the COVID-19-Related Guidance Issued by the Department of Homeland Security

As DHS has acknowledged, *e.g.*, 83 Fed. Reg. at 51,270, and the record evidence here confirms, the Public Charge Rule's expansion of the grounds for deeming immigrants inadmissible as a public charge has already deterred many immigrants from using supplemental public benefits, including Medicaid and SNAP benefits, or led them to disenroll from programs that provide such benefits. Since the Public Charge Rule came into effect following this Court's stay orders, increasing numbers of immigrants have begun forbearing from Medicaid coverage and other

publicly funded healthcare benefits based on concerns that using such benefits will render them a "public charge" and thus jeopardize their ability to obtain legal permanent resident (LPR) status and, eventually, citizenship. (App. 194-195, 220-222.) Immigrants have also increasingly been declining to use SNAP benefits, as well as other nutrition programs, such as the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), that are not implicated in the public-charge analysis.[26] (App. 139-140, 178-179, 194-196.) And the Public Charge Rule's deterrent effects have not been limited to the LPR applicants or public-benefit programs that are directly subject to the Rule, since substantial fear and confusion, along with the complicated nature of many benefits programs, have led immigrants and their family members to avoid state-funded health insurance programs, reduce their use of medical services, and forbear from using other public benefits not covered by the Rule. (App. 145-146, 194-195, 220-222.)

The Rule's impacts have become particularly acute as the COVID-19 crisis has escalated. See *infra*, at 18-24. As a result, on March 6, the Attorneys General of the plaintiff States, fifteen other state Attorneys General, and over fifty other elected officials sent a letter to DHS requesting that the agency temporarily halt implementation of the Public Charge Rule given the harms to public health from implementing the Rule during the COVID-19 crisis. (App. 40-43; *see also* App. 226-229 (letter from New York City agencies to DHS).) DHS did not respond.

On March 13, DHS posted an alert on the website of the U.S. Citizenship and Immigration Services (USCIS). The alert stated that DHS officials conducting public-charge determinations

[26] Agencies and nonprofit organizations that work with immigrants experienced a substantial increase in inquiries about the Public Charge Rule after the Rule took effect in February 2020. (App. 116 (during February 2020, calls to New York City's immigration-related telephone hotline "increased to 2,973, a 57% increase from the monthly average in 2019," and the "number of those calls that related to the Rule also increased"); App. 171 (health educator received "more questions about public charge" during February and March than she had ever previously received).)

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. (App. 44.) However, the alert also stated that the Rule will still require DHS officials to treat as a negative factor an applicant's receipt of public benefits, including federally funded Medicaid, even when such benefits "may be used to obtain testing or treatment for COVID-19." (App. 44.) Thus, under the alert, an LPR applicant who obtains or maintains Medicaid coverage that helps him access COVID-19 testing or treatment will still receive an automatic negative factor in the public-charge analysis based on his Medicaid coverage, even if his COVID-19 test or treatment will not itself be considered. *See* 84 Fed. Reg. at 41,422 (DHS will consider "any application, approval, or certification for, or receipt of, public benefits as a negative factor").

DHS's alert appears to leave in place other aspects of the Rule during the COVID-19 crisis, even though these aspects of the Rule deter immigrants from using supplemental benefits that will help plaintiffs' residents and the country recover from the current economic crisis. Thus, an applicant who applies for SNAP benefits because a COVID-19 public-health order forced him out of his job will continue to receive a negative factor in the public-charge inquiry. *See* 84 Fed. Reg. at 41,422. At most, the alert states that an applicant may inform DHS if "disease prevention methods" such as social distancing prevent him from working or attending school during the outbreak, and DHS officials will consider such information to the extent it is "relevant and credible."[27] (App. 44.)

[27] After DHS posted the alert on its website, the Attorneys General of the plaintiff States and fifteen other state Attorneys General sent DHS another letter explaining that the alert did not

ARGUMENT

THE COURT SHOULD TEMPORARILY LIFT OR MODIFY ITS STAY DURING THE NATIONAL PUBLIC-HEALTH EMERGENCY CREATED BY THE COVID-19 PANDEMIC

Pursuant to Rules 21 and 23 of the Rules of this Court; the All Writs Act, 28 U.S.C. § 1651; and § 705 of the Administrative Procedure Act, 5 U.S.C. § 705, plaintiffs request that the Court temporarily lift or modify its stay to halt implementation of the Rule until the end of the national emergency declared by the President on March 13 concerning the COVID-19 pandemic. *See* Proclamation No. 9994, *supra*. Such targeted relief is warranted despite this Court's prior ruling on petitioners' stay application because the unprecedented public-health and economic crisis facing the country has dramatically shifted the balance of equities in allowing defendants to enforce the Public Charge Rule while the Second Circuit considers defendants' appeal.

As explained further below, the Rule's deterrent effect on immigrants' access to healthcare and other public benefits for which they are indisputably eligible is impeding efforts to stop the spread of the coronavirus, preserve scarce hospital capacity and medical supplies, and protect the lives of everyone in our communities—citizens and noncitizens alike. In particular, the Rule is deterring many immigrants and their family members, including those who are U.S. citizens, from seeking testing or treatment for COVID-19, obtaining publicly funded health insurance, and using other supplemental benefits such as SNAP. Without proper testing and medical care, immigrants are more likely to suffer serious illness or death from COVID-19, and more likely to spread the novel coronavirus to others inadvertently. And immigrants who delay needed medical care, whether for COVID-19 or other serious conditions, are more likely to use hospitals, emergency

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address the harms imposed by the Public Charge Rule during the pandemic. (App. 48-51.) DHS did not respond to this letter.

rooms, and publicly funded clinics when they fall ill, thereby taxing public-health systems that are already under intense strain.

The record that this Court considered in issuing a stay in these proceedings did not and could not include these newly apparent harms. In light of these new circumstances, the Court should temporarily lift or modify its stay to halt implementation of the Public Charge Rule during the national emergency concerning COVID-19. Alternatively, this Court should clarify that its stay does not preclude the lower court from considering whether the new circumstances presented by the COVID-19 crisis warrant a narrow and time-limited delay of the Public Charge Rule.

A. Plaintiffs Seek Temporary Relief from the Stay Tailored to the National COVID-19 Crisis.

Plaintiffs are not seeking wholesale reconsideration of this Court's previous decision to stay the district court's preliminary injunction and § 705 orders. Rather, the drastically changed circumstances presented by the COVID-19 crisis provide new grounds for this Court to consider whether the balance of the equities continues to support a stay of the lower court's orders. To respond to these circumstances, this Court can either temporarily lift its stay during the national emergency, thereby allowing the district court's orders of preliminary relief to take effect; or temporarily postpone the effective date of the Rule under 5 U.S.C. § 705 until the national emergency ends.[28] Pursuant to the National Emergencies Act, the COVID-19 national emergency will end when the President issues a proclamation terminating the emergency, Congress enacts

[28] Section 705 provides that "[o]n such conditions as may be required and to the extent necessary to prevent irreparable injury, the reviewing court, including the court to which a case may be taken on appeal from or on application for certiorari or other writ to a reviewing court, may issue all necessary and appropriate process to postpone the effective date of an agency action or to preserve status or rights pending conclusion of the review proceedings." 5 U.S.C. § 705.

into law a joint resolution terminating the emergency, or the President declines to renew the emergency at any annual expiration of the declaration, whichever is earlier. *See* 50 U.S.C. § 1622.

In the alternative, plaintiffs request that the Court clarify that its stay order does not preclude the lower court from considering whether the new circumstances arising out of the COVID-19 pandemic warrant temporary relief halting implementation of the Public Charge Rule. *Cf. Cities Serv. Gas Co. v. Mobil Oil Corp.*, 487 U.S. 1245 (1988) (modifying stay and remanding to district court to consider whether to approve parties' proposed settlement). In making such a determination, the lower court could consider evidence and issue factual findings about, inter alia, the proper duration and scope of any temporary relief. And the district court's findings and determinations would then be subject to appellate review.

Plaintiffs are seeking temporary relief directly from this Court rather than from the district court or Second Circuit as an initial matter because of the urgency of the COVID-19 pandemic and substantial doubt as to whether the lower courts could provide any meaningful relief given the Court's stay. *See Heckler v. Turner*, 468 U.S. 1305 (1984) (Rehnquist, J, in chambers) (issuing stay where grant of certiorari made it doubtful that lower courts "had the authority to modify the injunction"). The Court's stay applies until both the Second Circuit resolves defendants' appeal and this Court resolves a petition for certiorari, if any such petition is timely filed. Accordingly, the district court's orders will remain stayed, and the Rule will remain in effect, even if the Second Circuit affirms the district court's decision to postpone the effective date of the Rule during this litigation. This Court is thus the appropriate forum to either modify the stay or clarify that the stay does not preclude the district court from considering whether the current COVID-19 crisis warrants temporary, tailored relief from the Public Charge Rule.

B. The COVID-19 Pandemic Has Drastically Changed the Balance of the Equities Against Enforcing the Public Charge Rule During the Current National Emergency.

The appropriateness of a stay pending appeal is "an exercise of discretion and judgment" that depends primarily on the "equities of a given case." *Trump v. International Refugee Assistance Project*, 137 S. Ct. 2080, 2087 (2017). In the course of exercising such discretion, a court "'may mold its decree to meet the exigencies of the particular case.'" *Id.* (quoting 11A Charles A. Wright, Arthur R. Miller & Mary Kay Kane, *Federal Practice and Procedure* § 2947 (3d ed. Aug. 2019 update) (Westlaw)). And a court may lift or modify a previously granted stay when new circumstances arise that significantly alter the balance of the harms to the public or the parties. *See, e.g.*, *King v. Smith*, 88 S. Ct. 842, 843 (1968) (Black, J., in chambers) (vacating previously issued stay where subsequent events meant that stay would further harm public welfare and the plaintiffs); *Orloff v. Willoughby*, 72 S. Ct. 998, 998-99 (1952) (Douglas, J., in chambers) (modifying previously issued stay). Indeed, the Court always retains authority to alter an ongoing equitable order "if satisfied that what it has been doing has been turned through changing circumstances into an instrument of wrong." *United States v. Swift & Co.*, 286 U.S. 106, 114-15 (1932); *see Pasadena City Bd. of Educ. v. Spangler*, 427 U.S. 424, 437 (1976) ("[S]ound judicial discretion may call for the modification of the terms of an injunctive decree if the circumstances, whether of law or fact, obtaining at the time of its issuance have changed, or new ones have since arisen." (quotation marks omitted)).

The Court should exercise its discretion to temporarily lift or modify the stay here. The catastrophic COVID-19 pandemic has drastically altered the nature and magnitude of the irreparable harms faced by plaintiffs, their residents, and the nation due to the Public Charge Rule

and tipped the balance of the equities decisively against maintaining the stay while the national COVID-19 emergency continues.

1. The Public Charge Rule is impeding efforts to mitigate the spread of the virus.

The Public Charge Rule is irreparably harming public health in plaintiffs' jurisdictions and throughout the country during the unprecedented public-health disaster caused by the COVID-19 pandemic. By deterring immigrants and their family members from obtaining publicly funded health insurance and medical care, the Rule is undermining efforts to slow the spread of the virus—putting everyone at higher risk of infection. A temporary lifting or modification of the stay is thus warranted to prevent these dangerous public-health harms.

As DHS itself has acknowledged, the Public Charge Rule's expanded criteria for finding inadmissibility will deter immigrants from enrolling (or maintaining enrollment for) themselves and their family members in Medicaid, due to the understandable fear that even just applying for Medicaid will be deemed a negative factor in any future public-charge analysis. *See* 84 Fed. Reg. at 41,422. Widespread fear and confusion about the Rule are also driving many immigrants to forgo *any* publicly funded health coverage for fear that using such supplemental public benefits will jeopardize their ability to obtain LPR status and, eventually, citizenship. (App. 60, 171-173, 217, 220-222.) Indeed, since the Rule took effect, medical personnel, state and local officials, and staff at nonprofit organizations have encountered many immigrants who have refused to enroll in Medicaid or other publicly funded healthcare coverage based on concerns that receiving such coverage will increase the risk of being deemed a "public charge" under the Rule. (*See, e.g.*, App. 187 (patients at health clinics in Virginia refusing to participate in financial screening needed for care because screening involves Medicaid application); App. 220-221.)

Such avoidance of Medicaid and other publicly funded healthcare programs will prevent immigrants from receiving testing for the novel coronavirus or treatment for COVID-19, materially impeding public-health officials' efforts to stem the current crisis. Without Medicaid or other health insurance, the costs of COVID-19 treatment are prohibitively high for most patients—particularly if they develop severe symptoms necessitating hospitalization. For example, recent analyses of healthcare costs estimate that a six-day hospital stay for COVID-19 treatment will cost approximately $73,300 (see *supra*, at 8-9)—far more than the annual income of many low- and moderate-income Americans. (*See* App. 55 (cost of treatment for one early COVID-19 patient for less than a week of treatment was $34,927.43).) And since the pandemic began, doctors and others working on the front lines of the crisis have seen many immigrants avoid COVID-19 testing and treatment altogether, even if they might be able to obtain publicly funded care, due to the substantial fear generated by the Public Charge Rule. (App. 113, 120, 160-161, 167-168, 187, 224.)

These effects of the Public Charge Rule on COVID-19 testing and treatment are not hypothetical or speculative. For example:

- A physician in Connecticut has spoken with patients who had symptoms consistent with COVID-19, but were afraid to obtain COVID-19 testing or seek treatment due to concerns about the Public Charge Rule and fears that they could not afford to pay for treatment. (App. 113.)

- The New York Legal Assistance Group has already observed immigrants and their family members declining or delaying medical treatment they needed because of COVID-19, due to concerns about the Public Charge Rule. (App. 145-146.)

- Telephone hotlines operated by Catholic Charities Community Services, Archdiocese of New York, in partnership with state or city agencies in New York, have been receiving public-charge-related inquiries from callers who are fearful of seeking medical treatment for COVID-19. (App. 150-151.)

- Staff at Bronx Legal Services in New York have spoken with noncitizen clients who are afraid to obtain COVID-19 testing or treatment because they fear that doing so will require them to obtain Medicaid coverage. (App. 140.)

- Multiple other community organizations in New York City have reported that immigrant clients are afraid to obtain testing or treatment for COVID-19, even if they are feeling ill, based on concerns that doing so will jeopardize their immigration status. (App. 120-121.)

- Physicians in Monterey County, California, are working with an increasing number of immigrant patients who have symptoms of COVID-19, but are refusing to seek medical care for these symptoms based on concerns about the Public Charge Rule and the costs of treatment. (App. 160-161, 167-168.)

- Nonprofit organizations in Chicago, Illinois, have received calls from immigrants who are afraid to seek virus-related testing and treatment because of the Public Charge Rule. Many of these immigrants are seniors or individuals with underlying health conditions, who are at greater risk of suffering severe illness or death from COVID-19. (App. 202-203.)

- In February and March 2020, even as the COVID-19 crisis became increasingly severe, health clinics in Virginia have continued to see an increasing number of immigrant families declining to seek Medicaid coverage (or withdrawing from existing coverage) because of the Public Charge Rule. (App. 186-187.)

- During the past two months, a health educator in Los Angeles, California, has worked with multiple clients who have forgone publicly funded health insurance benefits for themselves or their citizen children based on fears about the Public Charge Rule. (App. 172-173.)

Immigrants' inability or unwillingness to obtain testing and treatment for COVID-19 due to their concerns about the Public Charge Rule jeopardizes the health and safety of not only immigrants and their families but also the public at large. Without proper testing and treatment, immigrants and their family members who become infected are more likely to suffer severe illness or death from the virus. (App. 55-56, 114.) Immigrants who lack testing and treatment are also more likely to spread the virus to other people inadvertently, contributing to the current exponential growth of infection rates and fatalities. (App. 55-56, 61-63, 114, 160-161, 225.)

This risk of virus spread is further increased by the high number of immigrants who work in essential industries and who thus must continue to work outside of their homes and interact with others by, for example, providing healthcare, preparing and delivering food to residences, cleaning hospitals and public spaces, and caring for the sick or aging. See *supra*, at 9-10. Indeed, in New York City, the current epicenter of the COVID-19 crisis, noncitizens make up approximately 42.4% of home health aides, 42.3% of cooks, 37.1% of food preparation workers, and 26.9% of janitors and building cleaners. (App. 126-127.) And in other areas of the country, large numbers of noncitizens continue to work in essential industries such as agriculture or food packing and distribution. (App. 163-164, 203, 225.) By deterring these essential workers from obtaining health insurance and medical care for COVID-19, the Public Charge Rule is increasing the risk of infection for the public at large.

The Public Charge Rule further impedes current attempts to stem the COVID-19 crisis by deterring immigrants and their family members from obtaining needed medical treatment for preexisting conditions that either make individuals more vulnerable to the virus or make their COVID-19 symptoms worse. Immigrants who decline Medicaid or other health insurance coverage because of the Rule often stop seeking primary care for conditions like diabetes, asthma, and heart disease. (App. 141.) But these conditions put patients at higher risk of suffering severe symptoms or death from COVID-19. (App. 66, 141.) For example, staff at Bronx Legal Services have already seen noncitizen clients who declined Medicaid coverage rather than risk their immigration status, did not treat their serious medical conditions as a result, and have now fallen extremely ill with COVID-19 symptoms such as shortness of breath, high fevers, headaches, body aches, and chills. (App. 141; *see also* App. 145-146 (staff at New York Legal Assistance Group have seen clients declining or delaying medical treatment based on concerns about the Public

Charge Rule).) Such uninsured individuals will wait to seek medical care until their condition gets serious (*see* App. 56, 66, 186), thus further straining hospitals and clinics that are already reaching capacity and facing challenges obtaining ventilators and other critical medical supplies. And without insurance, these patients will likely be forced to make in-person visits to hospitals and clinics rather than use telehealth services, placing themselves and medical staff at higher risk of infection. (App. 63.) These substantial harms to public health warrant lifting or modifying the stay temporarily during the COVID-19 pandemic.

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

The Public Charge Rule is further injuring plaintiffs and the public interest by undermining efforts to mitigate the vast economic consequences of the COVID-19 pandemic. The unemployment rates in plaintiffs' jurisdictions and across the country are already reaching unprecedented levels due to the virus outbreak. See *supra*, at 10-11. And the economic downturn is likely to grow worse as the virus continues to spread. (App. 63-65.) Supplemental benefits like Medicaid and SNAP are crucial to helping employable individuals through a sudden emergency like losing a job or incurring substantial medical bills for COVID-19 treatment. (*See* App. 64-65, 121, 142, 202-203.) And by providing short-term help to individuals until they can get back on their feet, supplemental benefits promote economic stability and recovery for all of plaintiffs' residents and the nation.

Many hard-working immigrants, who are not "public charges" under any reasonable interpretation of that term, have begun to face sudden financial strains as their employers cut jobs due to the current economic crisis and government mandates ordering "nonessential" businesses to limit their services or have their employees work from home. (*See* App. 63-65, 121.) Indeed,

the U.S. Bureau of Labor Statistics recently estimated that between February and March 2020, the number of immigrant adults who are unemployed rose by 26%. (App. 64-65.) But the Public Charge Rule is deterring immigrants and their family members from using such benefits to maintain health and nutrition during the crisis. (*See* App. 113, 138-139, 161.) These irreparable harms further warrant lifting or modifying the stay temporarily during the current national emergency.

For example, 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. (App. 26-27, 138, 161, 217.) The Rule's deterrent effect on SNAP usage has become particularly inequitable during the COVID-19 pandemic, when many hard-working immigrants have suddenly lost substantial amounts of income or their employment. Indeed, under the Rule, using SNAP for just a few months during the current economic crisis places an LPR applicant at risk of being deemed a public charge. *See* 84 Fed. Reg. at 41,422 (mere application for SNAP is negative factor); *id.* at 41,506 (using SNAP and another public benefit during a single month counts as two months of benefits use for calculating heavily weighted negative factor of 12 out of 36 months of benefits use).

Immigrants' avoidance of the public benefits covered by the Rule 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, such as food pantries. (App. 142, 203; *see also* App. 156-157 (Make the Road New York has been receiving many calls from immigrants seeking food assistance, including from food pantries).) But many food pantries have closed or sharply reduced their hours due to COVID-19. And many of the emergency food programs that are still operating

"are running out of food at alarming rates." (App. 142; *see* App. 179 (food banks and pantries are facing increased food costs and "new challenges for accepting donated food"); App. 203 (many food pantries in Chicago, Illinois have "either closed or are seeing a marked increase in requests for food assistance").) The Court should lift or modify its stay temporarily to avoid such irreparable public-health and economic harms.

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

By revising its application of the Public Charge Rule during the current COVID-19 crisis, USCIS has effectively acknowledged the Rule's deterrent effect on immigrants' willingness to obtain necessary medical care. On March 13, USCIS issued an alert that purports to limit this deterrent effect by providing that "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 . . . 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)." (App. 44.) But this alert does not fully address the grave harms that the Rule is causing during the ongoing pandemic and is thus no substitute for the relief requested here.

First, although the alert excludes "testing, treatment, [and] preventative care . . . related to COVID-19" from future public-charge determinations (App. 44), it simultaneously continues to treat as an automatic negative factor an LPR applicant's application for or receipt of public benefits "that may be used to obtain testing or treatment for COVID-19," including federally funded Medicaid (App. 44). In other words, an LPR applicant who applies for federally funded Medicaid will have that application count against him in the public-charge inquiry, even if subsequently obtained COVID-19 treatment paid for by federally funded Medicaid does not itself count in the

public-charge inquiry. See *supra*, at 13. But deterring immigrants from accessing the public benefits that they need to get healthcare effectively prevents them from getting necessary testing and treatment for COVID-19. This aspect of the alert thus preserves the very problem USCIS has purported to address.

Second, the alert does not provide sufficiently clear direction to assure immigrants that they will not be penalized in a future public-charge determination for accessing critical healthcare now. For example, it is unclear how the alert would apply to an individual who receives medical treatment for COVID-19-like symptoms but is never tested, perhaps because of a shortage of testing kits. Furthermore, although the alert clarifies that the Public Charge Rule will not apply to state or local benefits, it is unclear how an immigrant is supposed to discern or control whether federal, state, or local benefits apply—especially if she may require urgent or emergency care. And under the alert, an LPR applicant will continue to be penalized for having Medicaid coverage to obtain treatment for medical conditions such as asthma, diabetes, or heart disease, even though these conditions place patients at high risk of suffering more severe symptoms or death if they contract COVID-19.

Tellingly, even after DHS posted the alert on its website, the Rule has continued to deter immigrants from accessing needed medical care during the pandemic. For example, in the weeks following DHS's issuance of the alert, physicians and others working on the front lines of the current emergency have continued to see many immigrants and their family members expressing fear about and declining to obtain COVID-19 testing and treatment based on their persistent concerns about the Public Charge Rule. (*See, e.g.*, App. 167, 187-188, 208, 224.) Given the alert's statement that the Public Charge Rule will continue to penalize immigrants who access federally funded Medicaid during the pandemic, the alert has likely increased fear and confusion about the

Rule and thus increased the Rule's dangerous deterrent effects, rather than alleviating such harms to public health. (*See* App. 140, 157-158, 202.)

Third, the alert is limited to testing and treatment for COVID-19, but the Public Charge Rule will also deter immigrants from accessing public benefits that are especially critical for their well-being in light of the dire public-health and economic crisis that COVID-19 has triggered. In just the last three weeks, this country has lost approximately sixteen million jobs, with worse losses likely to follow. See *supra*, at 10. Placing immigrants in a situation where they must choose between forgoing essential aid for healthcare, food, or housing or risking their future chances of obtaining LPR status is particularly inequitable during this unprecedented moment in our history, and will inhibit the country's ability to recover from the current economic crisis.

* * *

The nature and magnitude of the harms currently being imposed by the Rule warrant temporary relief from the stay, particularly when these harms were not known to the parties or the Court when the Court considered defendants' stay application. *See King*, 88 S. Ct. at 842. Although this case has always concerned issues of public health and welfare, the COVID-19 outbreak and its ramifications on public health and the economy present sudden and stark new circumstances not previously considered by the Court and have vastly changed and amplified the irreparable harms caused by the Rule. And the likelihood of these harms occurring is no longer a prediction. The Rule's devastating effects are happening now. Given these new circumstances, the Court should modify or lift its stay temporarily to meet the exigencies and equities of the current public-health and economic crisis.

CONCLUSION

The Court should temporarily lift or modify its stay to halt implementation of the Public Charge Rule during the national emergency declared on March 13, 2020. In the alternative, the Court should clarify that its stay does not preclude the district court from considering whether changed circumstances from the COVID-19 outbreak warrant temporary relief from implementation of the Public Charge Rule.

Dated: New York, New York
April 13, 2020

Respectfully submitted,

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SUPREME COURT OF THE UNITED STATES

No. 19A785

DEPARTMENT OF HOMELAND SECURITY, ET AL. *v.* NEW YORK, ET AL.

ON APPLICATION FOR STAY

[January 27, 2020]

The application for stay presented to JUSTICE GINSBURG and by her referred to the Court is granted, and the District Court's October 11, 2019 orders granting a preliminary injunction are stayed pending disposition of the Government's appeal in the United States Court of Appeals for the Second Circuit and disposition of the Government's petition for a writ of certiorari, if such writ is timely sought. Should the petition for a writ of certiorari be denied, this stay shall terminate automatically. In the event the petition for a writ of certiorari is granted, the stay shall terminate upon the sending down of the judgment of this Court.

JUSTICE GINSBURG, JUSTICE BREYER, JUSTICE SOTOMAYOR, and JUSTICE KAGAN would deny the application.

JUSTICE GORSUCH, with whom JUSTICE THOMAS joins, concurring in the grant of stay.

On October 10, 2018, the Department of Homeland Security began a rulemaking process to define the term "public charge," as it is used in the Nation's immigration laws. Approximately 10 months and 266,000 comments later, the agency issued a final rule. Litigation swiftly followed, with a number of States, organizations, and individual plaintiffs variously alleging that the new definition violates the Constitution, the Administrative Procedure Act, and the immigration laws themselves. These plaintiffs have urged courts to enjoin the rule's enforcement not only as it applies

to them, or even to some definable group having something to do with their claimed injury, but as it applies to *anyone*.

These efforts have met with mixed results. The Northern District of California ordered the government not to enforce the new rule within a hodge-podge of jurisdictions—California, Oregon, Maine, Pennsylvania, and the District of Columbia. The Eastern District of Washington entered a similar order, but went much farther geographically, enjoining the government from enforcing its rule globally. But both of those orders were soon stayed by the Ninth Circuit which, in a 59-page opinion, determined the government was likely to succeed on the merits. Meanwhile, across the country, the District of Maryland entered its own universal injunction, only to have that one stayed by the Fourth Circuit. And while all these developments were unfolding on the coasts, the Northern District of Illinois was busy fashioning its own injunction, this one limited to enforcement within the State of Illinois.

If all of this is confusing, don't worry, because none of it matters much at this point. Despite the fluid state of things—some interim wins for the government over here, some preliminary relief for plaintiffs over there—we now have an injunction to rule them all: the one before us, in which a single judge in New York enjoined the government from applying the new definition to anyone, without regard to geography or participation in this or any other lawsuit. The Second Circuit declined to stay this particular universal injunction, and so now, after so many trips up and down and around the judicial map, the government brings its well-rehearsed arguments here.

Today the Court (rightly) grants a stay, allowing the government to pursue (for now) its policy everywhere save Illinois. But, in light of all that's come before, it would be delusional to think that one stay today suffices to remedy the problem. The real problem here is the increasingly common practice of trial courts ordering relief that transcends the

cases before them. Whether framed as injunctions of "nationwide," "universal," or "cosmic" scope, these orders share the same basic flaw—they direct how the defendant must act toward persons who are not parties to the case.

Equitable remedies, like remedies in general, are meant to redress the injuries sustained by a particular plaintiff in a particular lawsuit. When a district court orders the government not to enforce a rule against the plaintiffs in the case before it, the court redresses the injury that gives rise to its jurisdiction in the first place. But when a court goes further than that, ordering the government to take (or not take) some action with respect to those who are strangers to the suit, it is hard to see how the court could still be acting in the judicial role of resolving cases and controversies. Injunctions like these thus raise serious questions about the scope of courts' equitable powers under Article III. See *Trump* v. *Hawaii*, 585 U. S. ___, ___ (2018) (THOMAS, J., concurring); Bray, Multiple Chancellors: Reforming the National Injunction, 131 Harv. L. Rev. 417, 471–472 (2017) (Bray); Morley, De Facto Class Actions? Plaintiff- and Defendant-Oriented Injunctions in Voting Rights, Election Law, and Other Constitutional Cases, 39 Harv. J. L. & Pub. Pol'y 487, 523–527 (2016).

It has become increasingly apparent that this Court must, at some point, confront these important objections to this increasingly widespread practice. As the brief and furious history of the regulation before us illustrates, the routine issuance of universal injunctions is patently unworkable, sowing chaos for litigants, the government, courts, and all those affected by these conflicting decisions. Rather than spending their time methodically developing arguments and evidence in cases limited to the parties at hand, both sides have been forced to rush from one preliminary injunction hearing to another, leaping from one emergency stay application to the next, each with potentially nationwide stakes, and all based on expedited briefing and little

opportunity for the adversarial testing of evidence.

This is not normal. Universal injunctions have little basis in traditional equitable practice. Bray 425–427. Their use has proliferated only in very recent years. See *Trump*, 585 U. S., at ___–___ (THOMAS, J., concurring) (slip op., at 8–9). And they hardly seem an innovation we should rush to embrace. By their nature, universal injunctions tend to force judges into making rushed, high-stakes, low-information decisions. Bray 461–462. The traditional system of lower courts issuing interlocutory relief limited to the parties at hand may require litigants and courts to tolerate interim uncertainty about a rule's final fate and proceed more slowly until this Court speaks in a case of its own. But that system encourages multiple judges and multiple circuits to weigh in only after careful deliberation, a process that permits the airing of competing views that aids this Court's own decisionmaking process. *Ibid.* The rise of nationwide injunctions may just be a sign of our impatient times. But good judicial decisions are usually tempered by older virtues.

Nor do the costs of nationwide injunctions end there. There are currently more than 1,000 active and senior district court judges, sitting across 94 judicial districts, and subject to review in 12 regional courts of appeal. Because plaintiffs generally are not bound by adverse decisions in cases to which they were not a party, there is a nearly boundless opportunity to shop for a friendly forum to secure a win nationwide. *Id.*, at 457–461. The risk of winning conflicting nationwide injunctions is real too. *Id.*, at 462–464. And the stakes are asymmetric. If a single successful challenge is enough to stay the challenged rule across the country, the government's hope of implementing any new policy could face the long odds of a straight sweep, parlaying a 94-to-0 win in the district courts into a 12-to-0 victory in the courts of appeal. A single loss and the policy goes on ice—possibly for good, or just as possibly for some indeterminate

period of time until another court jumps in to grant a stay. And all that can repeat, *ad infinitum*, until either one side gives up or this Court grants certiorari. What in this gamesmanship and chaos can we be proud of?

I concur in the Court's decision to issue a stay. But I hope, too, that we might at an appropriate juncture take up some of the underlying equitable and constitutional questions raised by the rise of nationwide injunctions.

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

STATE OF NEW YORK, CITY OF NEW YORK, STATE OF CONNECTICUT, and STATE OF VERMONT,

Plaintiffs,

-against-

UNITED STATES DEPARTMENT OF HOMELAND SECURITY; SECRETARY KEVIN K. MCALEENAN, *in his official capacity as Acting Secretary of the United States Department of Homeland Security, agent of Acting Secretary of the United States Department of Homeland Security*; UNITED STATES CITIZENSHIP AND IMMIGRATION SERVICES; DIRECTOR KENNETH T. CUCCINELLI II, *in his official capacity as Acting Director of United States Citizenship and Immigration Service*; and UNITED STATES OF AMERICA,

Defendants.

MEMORANDUM DECISION AND ORDER

19 Civ. 7777 (GBD)

GEORGE B. DANIELS, United States District Judge:

Plaintiffs the State of New York, the City of New York, the State of Connecticut, and the State of Vermont bring this action against Defendants the United States Department of Homeland Security ("DHS"); the United States Citizenship and Immigration Services ("USCIS"); Secretary Kevin K. McAleenan, in his official capacity as Acting Secretary of DHS; Director Kenneth T. Cuccinelli II, in his official capacity as Acting Director of USCIS; and the United States of America. (Compl. for Declaratory and Injunctive Relief ("Compl."), ECF No. 17.) Plaintiffs challenge Defendants' promulgation, implementation, and enforcement of a rule, Inadmissibility on Public Charge Grounds, 84 Fed. Reg. 41,292 (Aug. 14, 2019) (to be codified at 8 C.F.R. pts. 103, 212, 213, 214, 245, 248) (the "Rule"), which redefines the term "public charge" and establishes new criteria for determining whether a noncitizen applying for admission into the

United States or for adjustment of status is ineligible because he or she is likely to become a "public charge." (*See id.* ¶ 2.) Plaintiffs seek, *inter alia*, (1) a judgment declaring that the Rule exceeds Defendants' statutory authority, violates the law, and is arbitrary and capricious and an abuse of discretion; (2) a vacatur of the Rule; and (3) an injunction enjoining DHS from implementing the Rule. (*Id.* at 83–84.)

Plaintiffs now move pursuant to Federal Rule of Civil Procedure 65 for a preliminary injunction enjoining Defendants from implementing or enforcing the Rule, which is scheduled to take effect on October 15, 2019. (Pls.' Notice of Mot., ECF No. 33.) They also move under the Administrative Procedure Act, 5 U.S.C. § 705, for a stay postponing the effective date of the Rule pending adjudication of this action on the merits. (*Id.*) Plaintiffs' motion for a preliminary injunction and stay of its effective date is GRANTED.[1]

I. FACTUAL BACKGROUND

A. Current Framework for Public Charge Determination.

The Immigration and Nationality Act (the "INA") provides that the federal government may deny admission or adjustment of status to any noncitizen who it determines is "likely at any time to become a public charge." 8 U.S.C. § 1182(a)(4)(A). In 1996, Congress enacted two pieces of legislation focusing on noncitizens' eligibility for public benefits and on public charge determinations. It first passed the Personal Responsibility and Work Opportunity Reconciliation Act, Pub. L. No. 104-193, § 403, 110 Stat. 2105, 2265–67 (1996) (the "Welfare Reform Act"), which established a detailed—and restrictive—scheme governing noncitizens' access to benefits. It also passed the Illegal Immigration Reform and Immigrant Responsibility Act of 1996, Pub. L. No. 104-208, § 531, 110 Stat. 3009, 3674–75 (1996) ("IIRIRA"), which amended the INA

[1] This Court also grants, under separate order, the same preliminary injunction and stay in a related action, *Make the Road New York v. Cuccinelli*, 19 Civ. 7993 (GBD).

by codifying five factors relevant to a public charge determination. Specifically, IIRIRA provides that in assessing whether an applicant is likely to fall within the definition of public charge, DHS should, "at a minimum," take into account the applicant's age; health; family status; assets, resources, and financial status; and education and skills. 8 U.S.C. § 1182(a)(4)(B)(i).

In 1999, DHS's predecessor, the Immigration and Naturalization Service ("INS"), issued its Field Guidance on Deportability and Inadmissibility on Public Charge Grounds, 64 Fed. Reg. 28,689 (May 26, 1999) (the "Field Guidance"), as well as a parallel proposed rule, 64 Fed. Reg. 28,676, which "summarize[d] longstanding law with respect to public charge and provide[d] new guidance on public charge determinations" in light of IIRIRA, the Welfare Reform Act, and other recent legislation. 64 Fed. Reg. at 28,689. Both the Field Guidance and proposed rule defined "public charge" as a noncitizen who has become or is likely to become "primarily dependent on the government for subsistence, as demonstrated by either (i) the receipt of public cash assistance for income maintenance or (ii) institutionalization for long-term care at government expense." *Id.* (internal quotation marks omitted). Consistent with the INA, INS regulations, and several INS, Board of Immigration Appeals, and Attorney General decisions, they instructed INS officials to evaluate a noncitizen's likelihood of becoming a public charge by examining the totality of the noncitizen's circumstances at the time of his or her application. *Id.* at 28,690. The Field Guidance noted that "[t]he existence or absence of a particular factor should never be the sole criterion for determining if an alien is likely to become a public charge." *Id.* (emphasis omitted). Although the parallel proposed rule was never finalized, the Field Guidance sets forth the current framework for public charge determinations.

B. The 2018 Proposed Rulemaking and Rule.

On October 10, 2018, DHS published a notice of proposed rulemaking, Inadmissibility on Public Charge Grounds, 83 Fed. Reg. 51,114 (Oct. 10, 2018), which withdrew the 1999 proposed rule that INS had issued with the Field Guidance. *Id.* at 51,114. This newly proposed rule sought, among other things, to redefine "public charge," and to amend the totality-of-the-circumstances standard that is currently used in public charge determinations. *See id.* The notice provided a 60-day period for public comments on the proposed rule. *Id.* DHS collected 266,077 comments, "the vast majority of which opposed the rule." 84 Fed. Reg. at 41,297; *see also id.* at 41,304–484 (describing and responding to public comments).

Subsequently, on August 14, 2019, DHS issued the Rule. It was finalized, with several changes, as the proposed rule described in the October 2018 notice. *Id.* at 41,292; *see also id.* at 41,297–303 (summarizing changes in Rule).

Under the Rule, "public charge" is to be defined as any noncitizen "who receives one or more public benefits . . . for more than 12 months in the aggregate within any 36-month period." *Id.* at 41,501. The Rule defines "public benefit," in turn, as both cash benefits and noncash benefits such as Supplemental Nutrition Assistance Program, Medicaid, and public housing and Section 8 housing assistance. *Id.* Each benefit is to be counted separately in calculating the duration of use, such that, for example, receipt of two benefits in one month would count as two months. *Id.*

The Rule also provides a new framework for assessing whether a noncitizen is likely at any time to become a public charge. Specifically, the Rule enumerates an expanded non-exclusive list of factors relevant to analyzing whether a person is likely to receive 12 months of public benefits within 36 months. *See id.* at 41,502–04. It includes, for example, family size, English-language

proficiency, credit score, and any application for the enumerated public benefits, regardless of the actual receipt or use of such benefits. *Id.* The Rule designates the factors as "positive," "negative," "heavily weighted positive," or "heavily weighted negative," and instructs the DHS officer to "weigh" all such factors "individually and cumulatively." *Id.* at 41,397; *see also id.* at 41,502–04. Under this framework, if the negative factors outweigh the positive factors, the applicant would be found likely to receive 12 months of public benefits in the future. The applicant would then be found inadmissible as likely to become a public charge. Conversely, if the positive factors outweigh the negative factors, the applicant would not be found inadmissible as likely to receive 12 months of public benefits and thereby become a public charge. *Id.* at 41,397.

DHS published various corrections to the Rule as recently as October 2, 2019. Inadmissibility on Public Charge Grounds; Correction, 84 Fed. Reg. 52,357 (Oct. 2, 2019). None of these corrections materially alter the new public charge determination framework as outlined above. The Rule, as corrected, is set to go into effect on October 15, 2019.

II. LEGAL STANDARD

"[A] preliminary injunction is 'an extraordinary remedy never awarded as of right.'" *Benisek v. Lamone*, 138 S. Ct. 1942, 1943 (2018) (per curiam) (citation omitted). To obtain a preliminary injunction, the moving party must establish "that he is likely to succeed on the merits, that he is likely to suffer irreparable harm in the absence of preliminary relief, that the balance of equities tips in his favor, and that an injunction is in the public interest." *Winter v. Nat. Res. Def. Council, Inc.*, 555 U.S. 7, 20 (2008).

III. PLAINTIFFS HAVE DEMONSTRATED A LIKELIHOOD OF SUCCESS ON THE MERITS OF THEIR CLAIMS

The Administrative Procedure Act ("APA") authorizes judicial review of agency rules. Under the APA, a reviewing court must "hold unlawful and set aside agency action" that is "in

excess of statutory jurisdiction, authority, or limitations"; is "not in accordance with law"; or is "arbitrary, capricious, [or] an abuse of discretion." 5 U.S.C § 706(2)(A), (C). Here, Plaintiffs are likely to succeed on the merits of their claim that the Rule conflicts with the APA in all of these respects.

A. Plaintiffs Satisfy the Threshold Justiciability Requirements.

As a preliminary matter, Defendants raise several arguments that Plaintiffs' claims are not justiciable. Specifically, they assert that Plaintiffs lack standing, the claims are not ripe for judicial review, and Plaintiffs fall outside the zone of interests regulated by the Rule.

1. Plaintiffs Have Standing.

Article III of the U.S. Constitution limits the judicial power of federal courts to "Cases" or "Controversies." U.S. Const. art. III, § 2, cl. 1. To invoke this power, a plaintiff must have standing to sue. *Clapper v. Amnesty Int'l USA*, 568 U.S. 398, 408 (2013) (citation omitted). The plaintiff bears the burden of establishing standing, *Rajamin v. Deutsche Bank Nat'l Tr. Co.*, 757 F.3d 79, 84 (2d Cir. 2014) (citing *Lujan v. Defs. of Wildlife*, 504 U.S. 555, 560–61 (1992); *Premium Mortg. Corp. v. Equifax, Inc.*, 583 F.3d 103, 108 (2d Cir. 2009)), and such burden applies to each claim and form of relief sought, *DaimlerChrysler Corp. v. Cuno*, 547 U.S. 332, 352 (2006). To demonstrate Article III standing, the plaintiff must show that (1) "it has suffered a concrete and particularized injury that is either actual or imminent," (2) "the injury is fairly traceable to the defendant," and (3) "it is likely that a favorable decision will redress that injury." *Massachusetts v. EPA*, 549 U.S. 497, 517 (2007) (citing *Lujan*, 504 U.S. at 560–61). "[T]he presence of one party with standing is sufficient to satisfy Article III's case-or-controversy requirement." *Rumsfeld v. Forum for Acad. & Institutional Rights, Inc.*, 547 U.S. 47, 52 n.2 (2006) (citation omitted).

Defendants, focusing on the first element, argue that Plaintiffs have not alleged any injury sufficient to confer standing. They principally argue that Plaintiffs' claims of irreparable injury "consist of potential future harms that, if they ever came to pass, would be spurred by decisions of third parties not before the Court," and that these injuries are therefore too attenuated and speculative. (Mem. of Law in Opp'n to Pls.' Mot. for a Prelim. Inj. ("Defs.' Opp'n"), ECF No. 99, at 7). In Defendants' view, the Rule governs only DHS personnel and certain noncitizens, but does not directly affect Plaintiffs, either by requiring or forbidding any action on Plaintiffs' part or by expressly interfering with any of Plaintiffs' programs. (*Id.*) Defendants argue that in the context of challenges to federal immigration policies, courts have found state standing only where "the States' claims arise out of their proprietary interests as employers or operators of state universities." (*Id.*) They further insist that certain of Plaintiffs' alleged injuries, such as the health effects arising from noncitizens forgoing health care, "would be borne by [the] affected individuals, not [Plaintiffs]." (*Id.* at 9.) Finally, Defendants dismiss the alleged programmatic and administrative harm as "[b]ureaucratic inconvenience" and "voluntary expenditures" that do not give rise to standing. (*Id.* at 10.)

Plaintiffs sufficiently allege "concrete and particularized" injuries. They adequately demonstrate, for example, that the Rule will have a chilling effect and decrease enrollment in benefits programs, which will harm Plaintiffs' proprietary interests as operators of hospitals and healthcare systems. (Pls.' Reply in Supp. of Their Mot. for Prelim. Inj. and Stay Pending Judicial Review ("Pls.' Reply"), ECF No. 102, at 1.) Namely, Plaintiffs allege that this drop in participation will reduce Plaintiffs' consumers and revenue, including through Medicaid participants, while simultaneously shifting costs of providing emergency healthcare and shelter benefits from the federal government to Plaintiffs, who offer subsidized healthcare services. (*Id.*) Other injuries

include increased healthcare costs as noncitizen patients avoid preventative care; programmatic costs since Plaintiffs are the administrators of the public benefits implicated by the Rule;[2] and economic harm, including $3.6 billion in "economic ripple effects," 26,000 lost jobs, and $175 million in lost tax revenue. (Mem. of Law in Supp. of Pls.' Mot. for Prelim. Inj. and Stay Pending Judicial Review ("Pls.' Mem."), ECF No. 35, at 10–13.) Such actual and imminent injuries are "fairly traceable" to Defendants' promulgation of the Rule. Accordingly, Plaintiffs have standing to assert their claims.

2. Plaintiffs' Claims Are Ripe for Judicial Review.

To be justiciable, Plaintiffs' claims must also be ripe—that is, they "must present 'a real, substantial controversy, not a mere hypothetical question.'" *Nat'l Org. for Marriage, Inc. v. Walsh*, 714 F.3d 682, 687 (2d Cir. 2013) (quoting *AMSAT Cable Ltd. v. Cablevision of Conn.*, 6 F.3d 867, 872 (2d Cir.1993)). "Ripeness 'is peculiarly a question of timing,'" and "[a] claim is not ripe if it depends upon 'contingent future events that may not occur as anticipated, or indeed may not occur at all.'" *Id.* (quoting *Thomas v. Union Carbide Agric. Prods. Co.*, 473 U.S. 568, 580–81 (1985)).

"Ripeness encompasses two overlapping doctrines concerning the exercise of federal court jurisdiction." *Entergy Nuclear Vt. Yankee, LLC v. Shumlin*, 733 F.3d 393, 429 (2d Cir. 2013) (citing *Reno v. Catholic Soc. Servs., Inc.*, 509 U.S. 43, 57 n.18 (1993)) (internal quotation marks omitted). The first, constitutional ripeness, "overlaps with the standing doctrine, 'most notably in the shared requirement that the plaintiff's injury be imminent rather than conjectural or hypothetical.'" *In re Methyl Tertiary Butyl Ether (MTBE) Prods. Liab. Litig.*, 725 F.3d 65, 110

[2] Plaintiffs allege that such programmatic costs include those associated with updating Plaintiffs' "enrollment, processing, and recordkeeping systems; retraining staff and preparing updated materials; and responding to public concerns." (*Id.* at 3.)

(2d Cir. 2013) (quoting *Ross v. Bank of Am., N.A.*, 524 F.3d 217, 226 (2nd Cir. 2008)). Prudential ripeness, meanwhile, is "'an important exception to the usual rule that where jurisdiction exists a federal court must exercise it,' and allows a court to determine 'that the case will be better decided later.'" *Id.* (quoting *Simmonds v. Immigration Naturalization Serv.*, 326 F.3d 351, 357 (2d Cir. 2003)). In determining whether a case is prudentially ripe, courts examine "(1) whether [the case] is fit for judicial decision and (2) whether and to what extent the parties will endure hardship if decision is withheld." *Simmonds*, 326 F.3d at 359 (citing *Abbott Labs. v. Gardner*, 387 U.S. 136, 148–49 (1967)).

One can conceive of no issue of greater ripeness than that presented here. The Rule is scheduled to go into effect in a matter of *days*, at which point hundreds of thousands of individuals who were previously eligible for admission and permanent residence in the United States will no longer be eligible because of this change of law. Adverse consequences and determinations will soon begin to have their effect. The Rule is intended to immediately cause the immigrant population to avoid public benefits. Plaintiffs must be prepared to immediately adjust to the results of this change in policy.

No further factual predicate is necessary for purposes of determining ripeness, where there is clearly a legal question about whether the Rule exceeds Defendants' delegated authority, violates the law, and is arbitrary and capricious. Moreover, for the same reasons that Plaintiffs sufficiently allege an injury under the standing inquiry, they have shown that they will endure significant hardship with any delay. Accordingly, Plaintiffs' claims are ripe for review, both constitutionally and prudentially.

3. Plaintiffs Are Within the Zone of Interests Regulated By the Rule.

The final threshold question raised by Defendants is whether Plaintiffs have concerns that "fall within the zone of interests protected by the law invoked." *Lexmark Int'l, Inc. v. Static Control Components, Inc.*, 572 U.S. 118, 129 (2014) (citation and internal quotation marks omitted). The zone-of-interests test is "not 'especially demanding,'" particularly with respect to the APA and its "generous review provisions." *Id.* at 130 (citation and internal quotation marks omitted). Indeed, in the APA context, the Supreme Court has "often 'conspicuously included the word "arguably" in the test to indicate that the benefit of any doubt goes to the plaintiff.'" *Id.* (citation omitted). "The test forecloses suit only when a plaintiff's 'interests are so marginally related to or inconsistent with the purposes implicit in the statute that it cannot reasonably be assumed that Congress intended to permit the suit.'" *Match-E-Be-Nash-She-Wish Band of Pottawatomi Indians v. Patchak*, 567 U.S. 209, 225 (2012) (citation omitted).

Plaintiffs plainly fall within the INA's zone of interests. The interests of immigrants and state and local governments are inextricably intertwined. Among a state government's many obligations are representing and protecting the rights and welfare of its residents. As administrators of the public benefits programs targeted by the Rule, (*see* Pls.' Mem. at 14–17; Pls.' Reply at 4 (noting INA's direct reference to states' roles as benefit administrators)), Plaintiffs' interests are all the more implicated. Furthermore, the zone-of-interests test "does not require the plaintiff to be an intended beneficiary of the law in question," but instead allows parties simply "who are injured" to seek redress. *Citizens for Responsibility & Ethics in Wash. v. Trump*, No. 18-474, 2019 WL 4383205, at *16 (2d Cir. Sept. 13, 2019). The Supreme Court has consistently found that economic injuries like those alleged here satisfy the test. *See, e.g.*, *Bank of Am. Corp. v. City of Miami*, 137 S.Ct. 1296, 1304–05 (2017) (finding city's discriminatory lending claims

within zone of interests of Fair Housing Act, despite economic nature of harms alleged and absence of any indication that Act was intended to protect municipal budgets).

B. Plaintiffs Sufficiently Allege That the Rule Exceeds Statutory Authority and Is Contrary to Law.

Turning to the merits of Plaintiffs' claims, Plaintiffs argue that the Rule violates the APA because it exceeds DHS's delegated authority under the INA and is contrary to law. *See* 5 U.S.C § 706(2)(A), (C). In analyzing an agency's interpretation of a statute and whether the agency's action exceeds statutory authority, courts often apply the two-step framework articulated in *Chevron U.S.A., Inc. v. Natural Resources Defense Council, Inc.*, 467 U.S. 837 (1984). "[T]he question . . . is always whether the agency has gone beyond what Congress has permitted it to do[.]" *City of Arlington v. FCC*, 569 U.S. 290, 298 (2013). Under *Chevron*, courts first ask whether the statute is clear. *Chevron*, 467 U.S. at 842. If so, "that is the end of the matter[,] for the court, as well as the agency, must give effect to the unambiguously expressed intent of Congress." *Id.* at 842–43. Where there is ambiguity, however, courts then ask whether the agency's interpretation of the statute is reasonable. *Id.* at 843–44. Such deference "is premised on the theory that a statute's ambiguity constitutes an implicit delegation from Congress to the agency to fill in the statutory gaps." *FDA v. Brown & Williamson Tobacco Corp.*, 529 U.S. 120, 159 (2000). Notwithstanding this implicit delegation, "agencies must operate 'within the bounds of reasonable interpretation,'" and "reasonable statutory interpretation must account for both 'the specific context in which . . . language is used' and 'the broader context of the statute as a whole.'" *Util. Air Regulatory Grp. v. EPA*, 573 U.S. 302, 321 (2014) (citations omitted).

1. Long-Standing Definition of "Public Charge."

Plaintiffs argue that the new Rule's definition of "public charge" is a drastic deviation from the unambiguous and well-established meaning of the term that has existed for over 130

years. (Pls.' Mem. at 2, 19–24.) They assert that the term has consistently been interpreted narrowly to mean "an individual who is or is likely to become primarily and permanently dependent on the government for subsistence." (*Id.* at 3.) Going as far back as 1882, when Congress passed the first federal immigration statute, Plaintiffs note that the statute rendered excludable "convicts, lunatics, idiots, and any person unable to take care of himself without becoming a public charge," (*id.* at 20 (quoting Immigration Act of 1882, ch. 376, 22 Stat. 214, 47th Cong. (1882))), and that it sought to "prevent long-term residence in the United States of those 'who ultimately become *life-long dependents* on our public charities,'" (*id.* (quoting 13 Cong. Rec. 5108-10 (June 19, 1882) (statement of Rep. Van Voorhis)).) As Plaintiffs note, "[f]ar from excluding as public charges immigrants who received temporary assistance, the same law authorized immigration officials to provide 'support and relief' to immigrants who may 'need public aid' after their arrival." (*Id.* (quoting Immigration Act of 1882 at §§ 1, 2).)

Plaintiffs point to court decisions in the years that followed, confirming this definition of "public charge," as well as the INA itself, which adopted this interpretation upon its passage in 1952. (*Id.* at 21–22.) According to Plaintiffs, federal agencies have also consistently viewed "public charge" to mean someone who is "primarily dependent on the government for cash assistance or on long-term institutionalization," as evidenced by (1) INS's 1999 Field Guidance, which formally codified this definition; (2) INS's "extensive[]" consultations with other agencies prior to issuing the guidance; and (3) the Department of Justice's use of the "primarily dependent" standard in the deportation context. (*Id.* at 22–23.)

In opposition, Defendants assert that the definition of "public charge" in the Rule "is consistent with the plain meaning of the statutory text, which 'is to be determined at the time that it became law.'" (Defs.' Opp'n at 13 (quoting *One West Bank v. Melina*, 827 F.3d 214, 220 (2d

Cir. 2016)).) They direct this Court to dictionaries used in the 1880s, when the Immigration Act of 1882 was passed, which allegedly "make clear" that a noncitizen becomes a "public charge" "when his inability to achieve self-sufficiency imposes an 'obligation' or 'liability' on 'the body of the citizens' to provide for his basic necessities." (*Id.* at 13–14.)

Upon review of the plain language of the INA, the history and common-law meaning of "public charge," agency interpretation, and Congress's repeated reenactment of the INA's public charge provision without material change, one thing is abundantly clear—"public charge" has *never* been understood to mean receipt of 12 months of benefits within a 36-month period. Defendants admit that this is a "new definition" under the Rule. (*Id.* at 5.) And at oral argument, they did not dispute that this definition has *never* been referenced in the history of U.S. immigration law or that there is *zero* precedent supporting this particular definition. (*See, e.g.*, Tr. of Oral Arg. dated Oct. 7, 2019 at 51:8–11, 52:1–3.) No ordinary or legal dictionary definition of "public charge" references Defendants' proposed meaning of that term. As such, Plaintiffs raise a compelling argument that Defendants lack the authority to redefine "public charge" as they have.

2. Congress's Intent.

Nor is there any evidence that Congress intended for a redefinition of "public charge," and certainly not in the manner set forth in the Rule. No legislative intent or historical precedent alludes to this new definition. Defendants have made no showing that Congress was anything but content with the current definition set forth in the Field Guidance, which defines public charge as someone who has become or is likely to become primarily dependent on the government for cash assistance. Indeed, Congress has repeatedly endorsed this definition and rejected efforts to expand it. For example, during the 1996 debate over IIRIRA, several members of Congress tried and failed to extend the meaning of public charge to include the use of non-cash benefits. *See* 142

Cong. Rec. S11612, at S11712 (daily ed. Sept. 16, 1996). Congress rejected similar efforts in 2013 because of its "strict benefit restrictions and requirements." S. Rep. 113-40, at 42 (2013).

In addition, if Congress wanted to deny immigrants any of the public benefits enumerated in the Rule, it could have done so, as it similarly has in the past. The Welfare Reform Act, for example, restricted certain noncitizens' eligibility for certain benefits. Specifically, it provided that only "qualified" noncitizens—which, in most cases, meant those who had remained in the United States for five years—could have access to most federal means-tested public benefits. 8 U.S.C §§ 1612, 1613. Therefore, the absence of any Congressional intent to redefine public charge also counsels in favor of a preliminary injunction.

C. Plaintiffs Sufficiently Demonstrate That the Rule Is Arbitrary and Capricious.

Plaintiffs additionally argue that the Rule is arbitrary and capricious. *See* 5 U.S.C. § 706(2)(A). "The scope of review under the 'arbitrary and capricious' standard is narrow[.]" *Motor Vehicle Mfrs. Ass'n of U.S., Inc. v. State Farm Mut. Auto. Ins. Co.*, 463 U.S. 29, 43 (1983). Nevertheless, the APA requires an agency to "engage in 'reasoned decisionmaking,'" *Michigan v. EPA*, 135 S. Ct. 2699, 2706 (2015) (citation omitted), and to "articulate a satisfactory explanation for its action," *State Farm*, 463 U.S. at 43 (citation omitted). An agency rule is arbitrary and capricious if the agency:

> relied on factors which Congress has not intended it to consider, entirely failed to consider an important aspect of the problem, offered an explanation for its decision that runs counter to the evidence before the agency, or is so implausible that it could not be ascribed to a difference in view or the product of agency expertise.

Id. Where an agency action changes prior policy, the agency need not demonstrate "that the reasons for the new policy are *better* than the reasons for the old one." *FCC v. Fox Television Stations, Inc.*, 556 U.S. 502, 515 (2008). It must, however, "show that there are good reasons for the new policy." *Id.* This requirement is heightened where the "new policy rests upon factual

findings that contradict those which underlay its prior policy," *id.* (citation omitted), as "a reasoned explanation is needed for disregarding facts and circumstances that underlay or were engendered by the prior policy," *id.* at 516.

1. Defendants' Justification of Rule.

Here, Defendants fail to provide any reasonable explanation for changing the definition of "public charge" or the framework for evaluating whether a noncitizen is likely to become a public charge. As noted above, "public charge" has never been interpreted as someone "who receives one or more public benefits . . . for more than 12 months in the aggregate within any 36-month period." 84 Fed. Reg. at 41,501. This new definition essentially changes the public charge assessment into a *benefits* issue, rather than an inquiry about *self-subsistence*, such that any individual who is deemed likely to accept a benefit is considered a public charge. Receipt of a benefit, however, does not necessarily indicate that the individual is unable to support herself. One could envision, for example, a scenario where an individual is fully capable of supporting herself without government assistance but elects to accept a benefit, such as public housing, simply because she is entitled to it. Under the Rule, although this individual is legally entitled to public housing, if she takes advantage of this right, she may be penalized with denial of adjustment of status. There is no logic to this framework. Moreover, considering that the federal welfare program was not established in the United States until the 1930s, whereas the concept of public charge existed at least as early as 1882, there *must* be some definition of public charge separate and apart from mere receipt of benefits.

At oral argument, Defendants were afforded numerous opportunities to articulate a rational basis for equating public charge with receipt of benefits for 12 months within a 36-month period, particularly when this has never been the rule. Defendants failed each and every time. When

asked, for example, why the standard was 12 months and 36 months as opposed to any other number of months, Defendants merely responded that they do not need to "show a case from 100 years ago that also adopted this precise 12[/]36 standard." (Tr. of Oral Arg. dated Oct. 7, 2019 at 53:14–20.) Defendants were asked to explain how the new framework would operate and to provide an example of the "typical person" that Defendants could predict is going to receive 12 months of benefits in a 36-month period. (*Id.* 68:11–80:123.) Defendants again stumbled along and were unable to adequately explain what the determinative factor is under the Rule, what individual would fall across the line and be considered a public charge, and what evaluation of the factors enumerated in the Rule would make the DHS officer confident that she could make an appropriate prediction. (*Id.*) And yet, according to Defendants, the Rule is intended to "provide[] a number of concrete guidelines to assist in making [the public charge] determination" and is "designed . . . to make it more predictable for people on both sides of the adjudicatory process." (*Id.* at 80:20–23.) Quite the opposite appears to be the case.

Defendants suggest that the totality-of-circumstances test remains and that receipt of benefits for 12 months out of a 36-month period is only one of several factors to be considered. (*Id.* at 52:17–22.) This characterization of the Rule is plainly incorrect. Under the Rule, receipt of such benefits is not *one* of the factors considered; it is *the* factor. That is, if a DHS officer believes that an individual is likely to have benefits for 12 months out of a 36-month period, the inquiry ends there, and the individual is *automatically* considered a public charge. As such, Defendants are not simply expanding or elaborating on the list of factors to consider in the totality of the circumstances. Rather, they are entirely reworking the framework, and with no rational basis.

Defendants also fail to demonstrate rational relationships between many of the additional factors enumerated in the Rule and a finding of benefits use. One illustrative example is the addition of English-language proficiency as a factor. Defendants do not dispute that there has never been an English-language requirement in the public charge analysis. They argue, however, that it was "entirely reasonable" to add English proficiency as a factor, given the requirement in the INA to consider an applicant's "education and skills," and the "correlation between a lack of English language skills and public benefit usage, lower incomes, and lower rates of employment." (Defs.' Opp'n at 27.) Defendants' suggestion that an individual is likely to become a public charge simply by virtue of her limited English proficiency is baseless, as one can certainly be a productive and self-sufficient citizen without knowing *any* English. The United States of America has no official language. Many, if not most, immigrants who arrived at these shores did not speak English. It is simply offensive to contend that English proficiency is a valid predictor of self-sufficiency.[3]

In short, Defendants do not articulate why they are changing the public charge definition, why this new definition is needed now, or why the definition set forth in the Rule—which has absolutely no support in the history of U.S. immigration law—is reasonable. The Rule is simply a new agency policy of exclusion in search of a justification. It is repugnant to the American Dream of the opportunity for prosperity and success through hard work and upward mobility. Immigrants have always come to this country seeking a better life for themselves and their posterity. With or without help, most succeed.

[3] Similarly, it is unclear how the credit score of a new immigrant—who, for example, may have only recently opened her first credit account and therefore has a short credit history, which would negatively impact her credit score—is indicative of her likelihood to receive 12 months of public benefits. Defendants blithely argue that a low credit score "is an indication that someone has made financial decisions that are not necessarily entirely responsible" and that "those irresponsible financial decisions may be the product of someone who doesn't have very much money to work with." (Tr. of Oral Arg. dated Oct. 7, 2019 at 86:16–20).

2. Rehabilitation Act.

Plaintiffs further argue that the Rule discriminates against individuals with disabilities, in contravention of Section 504 of the Rehabilitation Act, Pub. L. No. 93-112, 87 Stat. 394 (1973) (codified at 29 U.S.C. § 794). Section 504 provides that no individual with a disability "shall, solely by reason of her or his disability, be excluded from the participation in, be denied the benefits of, or be subjected to discrimination . . . under any program or activity conducted by any Executive agency." 29 U.S.C. § 794(a). DHS, in particular, is prohibited from denying access to benefits and services on the basis of disability, 6 C.F.R. § 15.30(b)(1), and from using discriminatory criteria or methods of administration, *id.* § 15.30(b)(4). *See also id.* § 15.49. "Exclusion or discrimination [under Section 504] may take the form of disparate treatment, disparate impact, or failure to make reasonable accommodation." *B.C. v. Mount Vernon Sch. Dist.*, 837 F.3d 152, 158 (2d Cir. 2016).

The Rule clearly considers disability as a negative factor in the public charge assessment. Defendants acknowledge that disability is "one factor . . . that may be considered" and that it is "relevant . . . to the extent that an alien's particular disability tends to show that he is 'more likely than not to become a public charge' at any time." (Defs.' Opp'n at 30 (quoting 84 Fed. Reg. at 41,368).) Defendants do not explain how disability alone is itself a negative factor indicative of being more likely to become a public charge. In fact, it is inconsistent with the reality that many individuals with disabilities live independent and productive lives. As such, Plaintiffs have raised at least a colorable argument that the Rule as to be applied may violate the Rehabilitation Act, and further discovery and development of the record is warranted prior to its implementation.

IV. PLAINTIFFS HAVE DEMONSTRATED THAT THEY WILL SUFFER IRREPARABLE HARM ABSENT A PRELIMINARY INJUNCTION

"A showing of irreparable harm is 'the single most important prerequisite for the issuance of a preliminary injunction.'" *Faiveley Transp. Malmo AB v. Wabtec Corp.*, 559 F.3d 110, 118 (2d Cir. 2009) (citation omitted). "To satisfy the irreparable harm requirement, Plaintiffs must demonstrate that absent a preliminary injunction they will suffer 'an injury that is neither remote nor speculative, but actual and imminent,' and one that cannot be remedied 'if a court waits until the end of trial to resolve the harm.'" *Grand River Enter. Six Nations, Ltd. v. Pryor*, 481 F.3d 60, 66 (2d Cir. 2007) (citation omitted). However, Plaintiffs need only show "a *threat* of irreparable harm, not that irreparable harm already ha[s] occurred." *Mullins v. City of New York*, 626 F.3d 47, 55 (2d Cir. 2010).

The irreparable injury to Plaintiffs by shifting the burden of providing services to those who can no longer obtain federal benefits without jeopardizing their status in the United States, and the immediate response that is necessary by this shift of burden to Plaintiffs, is a direct and inevitable consequence of the impending implementation of the Rule. As discussed above, Plaintiffs allege that their injuries will include proprietary and economic harm, as well as increased healthcare and programmatic costs, and that they will suffer substantial hardship without a preliminary injunction. *See supra* Parts III.A.1–2. Plaintiffs provide declarations extensively describing and calculating such injuries. (*See* Decl. of Elena Goldstein, ECF No. 34 (attaching additional declarations and comment letters on proposed rule).)

No less important is the immediate and significant impact that the implementation of the Rule will have on law-abiding residents who have come to this country to seek a better life. The consequences that Plaintiffs must address, and America must endure, will be personal and public disruption, much of which cannot be undone. Overnight, the Rule will expose individuals to

economic insecurity, health instability, denial of their path to citizenship, and potential deportation—none of which is the result of any conduct by those such injuries will affect. It is a rule that will punish individuals for their receipt of benefits provided by our government, and discourages them from lawfully receiving available assistance intended to aid them in becoming contributing members of our society. It is impossible to argue that there is no irreparable harm for these individuals, Plaintiffs, and the public at large.

V. THE BALANCE OF HARDSHIPS AND PUBLIC INTEREST TIP IN PLAINTIFFS' FAVOR

Finally, Plaintiffs must demonstrate that "the balance of equities tips in [their] favor" and that "an injunction is in the public interest." *Winter*, 555 U.S. at 20. "These factors merge when the Government is the opposing party." *Nken v. Holder*, 556 U.S. 418, 435 (2009). In assessing these factors, the court must "balance the competing claims of injury and must consider the effect on each party of the granting or withholding of the requested relief," as well as "the public consequences in employing the extraordinary remedy of injunction." *Winter*, 555 U.S. at 24 (citations omitted).

Here, preventing the alleged economic and public health harms provides a significant public benefit. As discussed above, these harms are not speculative or insufficiently immediate. In fact, the notice of proposed rulemaking itself acknowledged that the Rule could cause "[w]orse health outcomes"; "[i]ncreased use of emergency rooms and emergent care as a method of primary health care due to delayed treatment"; "[i]ncreased prevalence of communicable diseases, including among members of the U.S. citizen population who are not vaccinated"; "[i]ncreases in uncompensated care in which a treatment or service is not paid for by an insurer or patient"; "[i]ncreased rates of poverty and housing instability"; "[r]educed productivity and educational attainment"; and other "unanticipated consequences and indirect costs." 83 Fed. Reg. at 51,270.

Moreover, there is no public interest in allowing Defendants to proceed with an unlawful, arbitrary, and capricious rule that exceeds their statutory authority. *See Planned Parenthood of N.Y.C., Inc. v. U.S. Dep't of Health & Human Servs.*, 337 F. Supp. 3d 308, 343 (S.D.N.Y. 2018) ("It is evident that '[t]here is generally no public interest in the perpetuation of unlawful agency action.' . . . The inverse is also true: 'there is a substantial public interest in 'having governmental agencies abide by the federal laws that govern their existence and operations.'" (quoting *League of Women Voters of U.S. v. Newby*, 838 F.3d 1, 12 (D.C. Cir. 2016)).)

To be sure, Defendants have a legitimate interest in administering the national immigration system. However, that interest is not paramount in this instance, particularly where Defendants fail to demonstrate why or how the current public charge framework is inadequate. Defendants have applied their current rules for decades, and the current concept of "public charge" has been accepted for over a century. Aside from conclusory allegations that they will "be harmed by an impediment" to administering the immigration system, (Defs.' Opp'n at 38), Defendants do not—and cannot—articulate what actual hardship they will suffer by maintaining the status quo.

Accordingly, because Plaintiffs are likely to succeed on the merits and to suffer irreparable harm absent preliminary relief, and the balance of hardships and public interest tip in their favor, Plaintiffs are entitled to a preliminary injunction.

VI. THE INJUNCTION SHOULD APPLY NATIONWIDE

As to the scope of the relief, a nationwide injunction is necessary. The scope of preliminary injunctive relief generally should be "no broader than necessary to cure the effects of the harm caused by the violation" and "not impose unnecessary burdens on lawful activity." *Church & Dwight Co. v. SPD Swiss Precision Diagnostics, GmBH*, 843 F.3d 48, 72 (2d Cir. 2016) (citations omitted). However, there is no requirement that an injunction affect only the parties in the suit.

See Califano v. Yamasaki, 442 U.S. 682, 702 (1979) ("[T]he scope of injunctive relief is dictated by the extent of the violation established, not by the geographical extent of the plaintiff class.")

Here, a nationwide injunction is appropriate. First, national immigration policies, such as the Rule, require uniformity. *Hawaii v. Trump*, 878 F.3d 662, 701 (9th Cir. 2017), *rev'd on other grounds*, 138 S. Ct. 2392 (2018); *see also Batalla Vidal v. Nielsen*, 279 F. Supp. 3d 401, 438 (E.D.N.Y. 2018) (granting nationwide injunction preventing rescission of Deferred Action for Childhood Arrivals program in part because "there is a strong federal interest in the uniformity of federal immigration law"); U.S. Const. art. I, § 8, cl. 4 ("The Congress shall have Power . . . To establish a[] uniform Rule of Naturalization."). A geographically limited injunction that would result in inconsistent applications of the Rule, and different public charge determinations based upon similar factors, is inimical to this need for uniformity in immigration enforcement.

Indeed, at least nine lawsuits have already been filed challenging the Rule, including *State of California v. U.S. Department of Homeland Security*, 19 Civ. 4975 (PJH) (N.D. Cal.) and *State of Washington v. United States Department of Homeland Security*, 19 Civ. 5210 (RMP) (E.D. Wash.).[4] In just these two actions alone, Plaintiffs include the State of California, District of Columbia, State of Maine, Commonwealth of Pennsylvania, State of Oregon, State of Washington, Commonwealth of Virginia, State of Colorado, State of Delaware, State of Illinois, State of Maryland, Commonwealth of Massachusetts, Attorney General Dana Nessel on behalf of the People of Michigan, State of Minnesota, State of Nevada, State of New Jersey, State of New Mexico, and State of Rhode Island. Combined with the instant action, that means that nearly *two*

[4] In addition to the instant action and the related action both before this Court, these other actions include *Mayor and City Council of Baltimore v. United States Department of Homeland Security*, 19 Civ. 2851 (PJM) (D. Md.); *Casa De Maryland, Inc. v. Trump*, 19 Civ. 2715 (PWG) (D. Md.); *City and County of San Francisco v. U.S. Citizenship and Immigration Services*, 19 Civ. 4717 (PJH) (N.D. Cal.); *La Clinica De La Raza v. Trump*, 19 Civ. 4980 (PJH) (N.D. Cal.); and *Cook County, Illinois v. McAleenan*, 19 Civ. 6334 (GF) (N.D. Ill.).

dozen jurisdictions have already brought suit. It would clearly wreak havoc on the immigration system if limited injunctions were issued, resulting in different public charge frameworks spread across the country, based solely on geography. *Batalla*, 279 F. Supp. at 438 (granting nationwide injunction where more limited injunction "would likely create administrative problems for the Defendants").

There is no reasonable basis to apply one public charge framework to one set of individuals and a different public charge framework to a second set of individuals merely because they live in different states. It would be illogical, for example, if a New York resident was eligible for adjustment of status but a resident of a sister state with the *same exact* background was not eligible, only because the second resident had the misfortune of living somewhere not covered by a limited injunction.

Relatedly, a nationwide injunction is necessary to accord Plaintiffs and other interested parties with complete redress. In particular, an individual should not have to fear that moving from one state to another could result in a denial of adjustment of status. For example, if the injunction were limited to New York, Connecticut, and Vermont, and a New York resident moved to New Jersey where the injunction would not apply, this individual could there be considered a public charge and face serious repercussions simply for crossing state borders. "[F]reedom to travel throughout the United States has long been recognized as a basic right under the Constitution." *United States v. Guest*, 383 U.S. 745, 758 (1966) (citations omitted). It has been considered a "right so elementary [that it] was conceived from the beginning to be a necessary concomitant of the stronger Union the Constitution created." *Id.*; *see also Griffin v. Breckenridge*, 403 U.S. 88, 105 (1971) ("Our cases have firmly established that the right of interstate travel is constitutionally protected, does not necessarily rest on the Fourteenth Amendment, and is

assertable against private as well as governmental interference.") The Supreme Court's recognition of the preeminence of this right lends further support for a nationwide injunction that would not interfere with individuals' ability to move from one place to another. *See, e.g.*, *Batalla*, 279 F. Supp. 3d at 438 (finding nationwide injunction appropriate "partly in light of the simple fact that people move from state to state and job to job").

Accordingly, this Court grants a nationwide injunction, as well as a stay postponing the effective date of the Rule pending a final ruling on the merits, or further order of the Court.[5]

VII. CONCLUSION

Plaintiffs' motion for issuance of a preliminary injunction, (ECF No. 33), is GRANTED.

Dated: New York, New York
October 11, 2019

SO ORDERED.

George B. Daniels

GEORGE B. DANIELS
United States District Judge

[5] The standard for a stay under 5 U.S.C. § 705 is the same as the standard for a preliminary injunction. *Nat. Res. Def. Council v. U.S. Dep't of Energy*, 362 F. Supp. 3d 126, 149 (S.D.N.Y. 2019). Accordingly, this Court grants the stay for the same reasons it grants the injunction.

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

STATE OF NEW YORK, CITY OF NEW YORK, STATE OF CONNECTICUT, and STATE OF VERMONT,

Plaintiffs,

-against-

UNITED STATES DEPARTMENT OF HOMELAND SECURITY; SECRETARY KEVIN K. MCALEENAN, *in his official capacity as Acting Secretary of the United States Department of Homeland Security, agent of Acting Secretary of the United States Department of Homeland Security*; UNITED STATES CITIZENSHIP AND IMMIGRATION SERVICES; DIRECTOR KENNETH T. CUCCINELLI II, *in his official capacity as Acting Director of United States Citizenship and Immigration Service*; and UNITED STATES OF AMERICA,

Defendants.

ORDER GRANTING PLAINTIFFS' MOTION FOR A PRELIMINARY INJUNCTION

19 Civ. 7777 (GBD)

GEORGE B. DANIELS, United States District Judge:

WHEREAS on September 9, 2019, the State of New York, the City of New York, the State of Connecticut, and the State of Vermont (the "State Plaintiffs") filed a Motion for Preliminary Injunction in Case No. 19 Civ. 7777 (GBD) (S.D.N.Y.) (the "State Action") to enjoin defendants from implementing or enforcing the Final Rule of the Department of Homeland Security titled "Inadmissibility on Public Charge Grounds," 84 Fed. Reg. 41,292 (the "Rule") pursuant to Federal Rule of Civil Procedure 65, or to postpone the effective date of the Rule pursuant to 5 U.S.C. § 705;

WHEREAS also on September 9, 2019, Make the Road New York, African Services Committee, Asian American Federation, Catholic Charities Community Services, and Catholic Legal Immigration Network, Inc. (the "Organizational Plaintiffs," and, together with the State

Plaintiffs, "Plaintiffs") similarly filed a Motion for Preliminary Injunction in Case No. 19 Civ. 7993 (GBD) (S.D.N.Y.) (the "Organizational Action," and, together with the State Action, the "Actions") to enjoin defendants from implementing or enforcing the Rule pursuant to Federal Rule of Civil Procedure 65, or to postpone the effective date of the Rule pursuant to 5 U.S.C. § 705 (together with the State Plaintiffs' motion, the "Motions");

WHEREAS on September 27, 2019, Kenneth T. Cuccinelli II, United States Citizenship & Immigration Services, Kevin K. McAleenan, Department of Homeland Security, and the United States of America (as to the State Action only) ("Defendants") submitted briefs in opposition to the Motions;

WHEREAS on October 4, 2019, Plaintiffs filed replies in further support of the Motions;

WHEREAS *amici* have filed briefs in support of or opposition to the Motions;

WHEREAS on October 7, 2019, this Court held a hearing on the Motions at which counsel for all parties presented oral argument;

WHEREAS this Court, having considered the Motion and the documents filed therewith, as well as all other papers filed in the Actions, and having heard oral arguments from the parties, finds good cause to grant the Motions because:

1. Plaintiffs are likely to succeed on the merits of their claims under the Administrative Procedure Act, and, with respect to the Organizational Plaintiffs, under the United States Constitution;
2. Plaintiffs will suffer irreparable harm if the Rule becomes effective; and
3. The balance of equities and the interests of justice favor issuance of a preliminary injunction;

It is hereby ORDERED that, pursuant to Federal Rule of Civil Procedure 65(a), Defendants are RESTRAINED AND ENJOINED from:

1. Enforcing, applying or treating as effective, or allowing persons under their control to enforce, apply, or treat as effective, the Rule; and
2. Implementing, considering in connection with any application, or requiring the use of any new or updated forms whose submission would be required under the Rule, including the new Form I-944, titled "Declaration of Self Sufficiency," and the updated Form I-485, titled "Application to Register Permanent Residence of Adjust Status"; and,

It is hereby FURTHER ORDERED that, pursuant to 5 U.S.C. § 705, the effective date of the Rule is STAYED and POSTPONED *sine die* pending further Order of the Court such that, if this Order is later terminated and the Rule goes into effect, the Rule's stated effective date of October 15, 2019, as well as any references in the Rule to October 15, 2019, including but not limited those contained in proposed 8 CFR §§ 212.20, 212.22(b)(4)(i)(E), 212.22(b)(4)(ii)(E)(1), 212.22(b)(4)(ii)(E)(2), 212.22(b)(4)(ii)(F), 212.22(c)(1)(ii), 212.22(d), 214.1, 248.1(a), and 248.1(c)(4), shall be replaced with a date after this Order is terminated.

Dated: New York, New York
October 11, 2019

SO ORDERED.

George B. Daniels

GEORGE B. DANIELS
United States District Judge

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

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

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

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.

Last Reviewed/Updated: 03/13/2020

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.

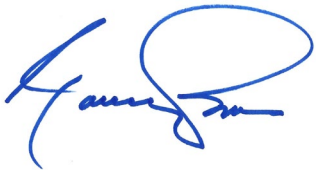
Since we wrote you 13 days ago, the number of deaths from COVID-19 in Washington has increased dramatically—from 11 to 66. Likewise, the number of reported cases has increased nearly twelvefold—from approximately 100 to 1187.[2] In Massachusetts, the number of confirmed cases has increased from 1 to 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.

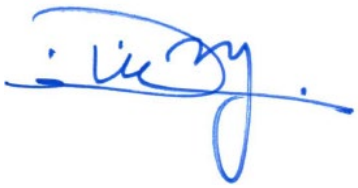
Sincerely,

Bob Ferguson
Washington State Attorney General



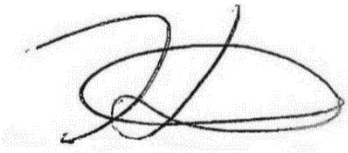
Xavier Becerra
California Attorney General

[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.



William Tong
Connecticut Attorney General

Kathleen Jennings
Delaware Attorney General



Karl A. Racine
District of Columbia Attorney General

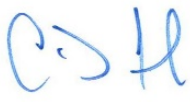
Clare E. Connors
Hawaii Attorney General

Tom Miller
Iowa Attorney General

Maura Healey
Massachusetts Attorney General

Dana Nessel
Michigan Attorney General

Keith Ellison
Minnesota Attorney General



Aaron D. Ford
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Gurbir S. Grewal
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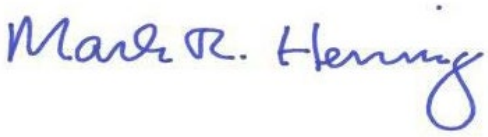
Letitia James
New York Attorney General

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

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

[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

[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

[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)

[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

[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 2020 and March 2020, the government estimates that the number of immigrant adults

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

who are unemployed rose by 26% in one month alone, while the number of native-born adults unemployed grew by 19%.[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] U.S. Bureau of Labor Statistics. The Employment Situation: March 2020. Table A7. Apr. 3, 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 10th 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, 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.

Rajan S, Coughlin T, Ku L, Holahan J, Lipson, D. Increasing Insurance Coverage through Medicaid Waiver Programs: Case Studies, Urban Institute Working Paper 06433-005-02, November 1994.

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, Eden Almasude, pursuant to 28 U.S.C. § 1746, hereby declare as follows:

1. I am currently a second-year resident physician in psychiatry at the Yale School of Medicine ("Yale"). I graduated from the University of Minnesota Medical School in 2018.

2. In the two years since becoming a resident physician in psychiatry at Yale, I have worked in numerous medical facilities in and around New Haven, including the Yale New Haven Hospital, the Connecticut Mental Health Center (CMHC), Yale Health (a medical and mental health clinic servicing the Yale University community), the Yale Psychiatric Hospital (YPH) (an inpatient facility specializing in the rapid assessment and treatment of acute and severe psychiatric symptoms), and the West Haven VA Medical Center. I currently treat patients at CMHC, a community health center that provides mental health services for 5,000 people in the Greater New Haven area each year, including many immigrants. In the course of my work as a resident physician, I regularly consult with my colleagues, including doctors, medical students, social workers, and other healthcare professionals.

3. During this public health crisis, many of my patients are understandably anxious and fearful, and many of my clients have lost their jobs. Myself and other clinicians regularly discuss these issues with our clients as part of our therapeutic process.

4. In recent weeks, two patients receiving outpatient treatment reported concerns about going to the hospital for COVID-19 care because they worried that any benefits that they might use to access that care—including even the Yale Freecare Program, which I understand is not subject to the Public Charge Rule—might negatively impact their immigration status.

5. As part of my work, I have received reports of multiple patients who had symptoms consistent with COVID-19 but were afraid to go to the hospital or even obtain COVID-19 testing because they were concerned about the public charge consequences of testing and treatment and feared that a huge hospital bill would leave their families destitute. Immigrants' concerns and fears are ongoing during this crisis.

6. Recently, one of my clients described how they had lost their income and were facing food insecurity. However, they did not want to seek food stamp benefits because they worried that it looked "bad" on an immigration application to get such benefits.

7. I am also a member of the New Haven Medic Collective, a mutual aid medical collective in New Haven comprised of working clinicians. The Medic Collective provides public health and information to callers over the telephone. During the COVID-19 public health crisis, our collective regularly advises patients whether and when they should go to a hospital to obtain medical treatment.

8. As part of my work at the Medic Collective, I am aware of at least three individuals who were afraid to get tested for COVID-19 because, among other things, they worried that getting tested or being admitted to the hospital would count against them for immigration purposes. These calls took place during the last few weeks, since the COVID-19 pandemic became of acute concern

in Connecticut. Clinicians such as myself and other doctors on the front lines of this crisis are ill-equipped to advise patients as to the immigration consequences of their decisions to seek testing and treatment.

9. When immigrants or their family members are fearful of obtaining the testing and treatment that they need, they are at a higher risk of complications for COVID-19. In addition, without timely and appropriate testing and treatment, their households and other contacts are also much more likely to spread the illness. As a medical professional, the Public Charge Rule is a critical barrier to care and is contributing to the spread of illness in our communities.

DATED this 6th day of April, 2020 at PLACE

DR. EDEN ALMASUDE

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. 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. 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. 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. 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. 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. 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. 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. 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. 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. 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. 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. 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. 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. 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

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
294C78145775445...

SABRINA FONG
Deputy Director of Research and Policy Advisor
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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%
PRF-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%

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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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
7 Hanover Square, 18th Floor
New York, NY 10004
212-613-5059

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 9th day of April, 2020
New York, New York.

C. Mario Russell, Esq.

No. 19A785

In the
Supreme Court of the United States

DEPARTMENT OF HOMELAND SECURITY, et al.,

Applicants,

v.

NEW YORK, et al.,

Respondents.

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 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.

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 lost over ten members or immediate family of staff, many of them 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 the Court lifting the stay of the injunction, 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 10th 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, 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, 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 BD5E91A810AD498...

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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, 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

Alejandra Aguilar

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, 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.

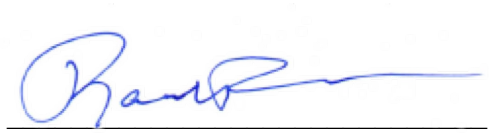
19. Despite this guidance, outreach workers continue to report that immigrants are confused and are deterred from accessing medical treatment or testing for COVID-19.

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, 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 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, 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.

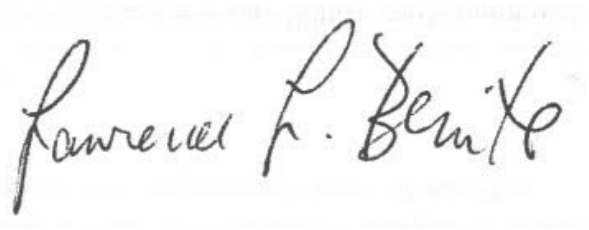
12. Organizations that are part of ICIRR's IFRP network and public benefit coordinators employed at organizations who are a part of PIF-Illinois report an increased volume of calls from immigrants, especially mixed-status households, who have lost employment as a result of COVID-19. These callers report 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

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.

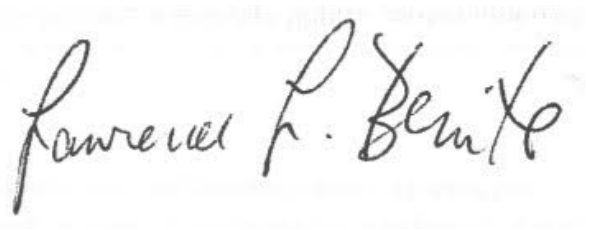
12. Organizations that are part of ICIRR's IFRP network and public benefit coordinators employed at organizations who are a part of PIF-Illinois report an increased volume of calls from immigrants, especially mixed-status households, who have lost employment as a result of COVID-19. These callers report 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, 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

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

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