No. 19-2222

UNITED STATES COURT OF APPEALS
FOR THE FOURTH CIRCUIT

CASA DE MARYLAND, INC., *et al*.,

Plaintiffs-Appellees,

versus

DONALD J. TRUMP, in his official capacity
as President of the United States, *et al*.,

Defendants-Appellants.

On Appeal From the United States District Court
for the District of Maryland

BRIEF FOR AMICI CURIAE AMERICAN ACADEMY OF PEDIATRICS; MARYLAND CHAPTER, AMERICAN ACADEMY OF PEDIATRICS; VIRGINIA CHAPTER, AMERICAN ACADEMY OF PEDIATRICS; THE AMERICAN MEDICAL ASSOCIATION; THE MARYLAND STATE MEDICAL SOCIETY; THE AMERICAN COLLEGE OF PHYSICIANS; AND THE AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS, IN SUPPORT OF PLAINTIFFS-APPELLEES

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CORPORATE DISCLOSURE STATEMENT

Amicus Curiae American Academy of Pediatrics ("AAP") is a 501(c)(3) not for profit charitable organization incorporated in Illinois. AAP has no parent corporation. It does not issue stock.

Amicus Curiae Virginia Chapter, American Academy of Pediatrics ("AAP-VA") is a 501(c)(3) not for profit charitable organization incorporated in Virginia. AAP-VA has no parent corporation. It does not issue stock.

Amicus Curiae Maryland Chapter, American Academy of Pediatrics ("MDAAP") is a 501(c)(6) not for profit charitable organization recognized in the state of Maryland. MDAAP has no parent corporation. It does not issue stock.

Amicus Curiae the American Medical Association ("AMA") is a 501(c)(3) not for profit charitable organization incorporated in Illinois. AMA has no parent corporation. It does not issue stock.

Amicus Curiae the American College of Physicians ("ACP") is a 501(c)(3) not for profit charitable organization incorporated in Delaware. ACP has no parent corporation. It does not issue stock.

Amicus Curiae the Maryland State Medical Society ("MedChi") is a 501(c)(3) not for profit charitable organization incorporated in Maryland. MedChi has no parent corporation. It does not issue stock.

Amicus Curiae the American College of Obstetricians and Gynecologists ("ACOG") is a 501(c)(6) not for profit charitable organization incorporated in Illinois. ACOG has no parent corporation. It does not issue stock.

TABLE OF CONTENTS

TABLE OF AUTHORITIES

Page(s)

Statutes

Other Authorities

INTEREST OF *AMICI CURIAE*

The American Academy of Pediatrics ("AAP"); Virginia Chapter, American Academy of Pediatrics ("AAP-VA"); Maryland Chapter, American Academy of Pediatrics ("MDAAP"); the American Medical Association ("AMA"); the Maryland State Medical Society ("MedChi"); the American College of Physicians ("ACP"); and the American College of Obstetricians and Gynecologists ("ACOG") (collectively, "*Amici*") respectfully submit this brief as *amici curiae* to support affirmance of the district court's order granting preliminary injunction. *Amici* are leading medical organizations in the United States whose members collectively provide medical care to the most vulnerable groups of people in society, including children, pregnant women, and persons who are disabled or those who suffer from chronic illnesses.

The AAP is a non-profit professional membership organization of 67,000 primary care pediatricians, pediatric medical subspecialists, and pediatric surgical specialists dedicated to the health and well-being of infants, children, adolescents, and young adults. AAP believes that the future prosperity and well-being of the United States depends on the health and vitality of all of its children, without exception. Access to health care, nutrition, and housing assistance programs ensures that children grow up healthy and strong. AAP is uniquely positioned to understand

the impact of the Administration's public charge regulation on the health of vulnerable populations, including children.

The mission of the AAP-VA is the attainment of optimal health, safety and well-being of Virginia's children and promotion of pediatricians as the best qualified of all health professionals to provide child health care.

Since its inception in 1950, the MDAAP has a long and distinguished history of advocacy and support of Maryland's children and adolescents and their health care needs. Its mission "To support and encourage pediatricians in the promotion of optimal health for all of Maryland's children and adolescents" speaks to that commitment. The MDAAP initiates and supports programs that respond to the needs of children and adolescents and their healthcare providers through collaborative and creative programming with other public and private organizations.

Amicus curiae the AMA is the largest professional association of physicians, residents and medical students in the United States. Additionally, through state and specialty medical societies and other physician groups seated in its House of Delegates, substantially all U.S. physicians, residents and medical students are represented in the AMA's policy making process. AMA members practice in every state and in every medical specialty. The AMA was founded in 1847 to promote the art and science of medicine and the betterment of public health, and these remain its

core purposes. The AMA is exceptionally well-suited to appreciate the impact of the Regulation on the health of vulnerable populations.

MedChi is a statewide, non-profit association of Maryland physicians. It is the largest physician organization in Maryland and was founded in 1799. Today, MedChi's mission is to serve as Maryland's foremost advocate and resource for physicians, their patients, and the public health. The AMA and MedChi appear on their own behalves and as representatives of the AMA Litigation Center[1].

Amicus curiae the ACP is the largest medical specialty organization and the second-largest physician group in the United States. ACP members include 159,000 internal medicine physicians (internists), related subspecialists, and medical students. Internal medicine physicians are specialists who apply scientific knowledge and clinical expertise to the diagnosis, treatment, and compassionate care of adults across the spectrum from health to complex illness.

Amicus curiae ACOG is the nation's leading group of physicians providing health care for women. With more than 60,000 members—representing more than 90% of all obstetrician–gynecologists in the United States—ACOG advocates for quality health care for women, maintains the highest standards of clinical practice and continuing education of its members, promotes patient education, and increases

[1] The Litigation Center is a coalition among the AMA and the medical societies of every state.

awareness among its members and the public of the changing issues facing women's health care. ACOG is committed to ensuring access to the full spectrum of evidence-based quality reproductive health care for all women. ACOG believes that access to essential health care services, such as preventative care and prenatal and postpartum care, as well as stable housing and nutrition are vital to maintaining overall health and well-being for women, children, and families. ACOG members care for women of all socioeconomic backgrounds, including low-income immigrant women and adolescents who use Medicaid to access essential health care, as well as housing and nutrition assistance programs. ACOG has previously appeared as amicus curiae in various courts throughout the country, including the United States Supreme Court. In addition, ACOG's work has been cited by numerous courts seeking authoritative medical data regarding prenatal and postpartum care, childbirth, and contraception.

RULE 29(A)(4)(E) STATEMENT

Counsel for Amici Curiae obtained consent from counsel of all parties prior to filing this brief. No party's counsel authored this brief in whole or in part, no party or party's counsel contributed money that was intended to fund preparing or submitting this brief, and no one other than Amici Curiae, their members, or their counsel contributed money intended to fund preparing or submitting this brief.

BACKGROUND AND SUMMARY OF ARGUMENT

The United States Department of Homeland Security ("DHS") has drastically overhauled decades of precedent and Congressional intent by promulgating *Inadmissiblity on Public Charge Grounds*, 84 Fed. Reg. 41292-01 (Aug. 14, 2019) (the "Regulation"). The Regulation dramatically alters the factors considered by immigration officials in evaluating whether a non-citizen seeking to immigrate or adjust their immigration status will become a "public charge."[2] Prior to this Regulation, public charge referred to an individual who was likely to become primarily dependent on the government for subsistence, such as someone who received cash assistance for income maintenance or was institutionalized in a government-funded long-term care facility.[3] The use of benefits such as health services or nutrition assistance were not considered in the public charge determination.

The Regulation now interprets public charge to be an immigrant "who receives one or more public benefits, . . . for more than 12 months in the aggregate

[2] Under Section 212(a)(4) of the Immigration and Nationality Act ("INA"), an individual seeking admission to the United States or seeking to adjust status is inadmissible if the individual is likely at any time to become a public charge. *See* 8 U.S.C. § 1182(a)(4)(A).

[3] Field Guidance on Deportability and Inadmissibility on Public Charge Grounds, 64 Fed. Reg. 28689-01 (May 26, 1999).

within any 36-month period (such that, for instance, receipt of two benefits in one month counts as two months.)."[4] The definition of "public benefits" has also been enlarged to now include health, nutrition, and housing programs such as non-emergency Medicaid for non-pregnant adults and Supplemental Nutritional Assistance Program ("SNAP").

Application of the Regulation's totality of the circumstances test and consideration of the minimum factors[5] (age, health, family status, education and skills, and financial status) will have a disparate impact on certain groups including children, pregnant women, and persons suffering from disabilities and chronic health conditions. Significantly, the Regulation now categorizes the receipt of public benefits as a "*heavily weighted*" negative factor.[6] The definition of public benefits now includes health and nutrition programs.[7] Receipt of such public benefits "weigh[s] heavily in favor of a finding that an alien is likely at any time in the future to become a public charge,"[8] amplifying the impact of the Regulation on vulnerable

[4] 8 C.F.R. § 212.21(a).

[5] 8 C.F.R. § 212.22(a), (b).

[6] 8 C.F.R. § 212.22(c).

[7] 8 C.F.R. § 212.21 (except for non-citizen immigrants under 21 years old or pregnant women or up to 60 days postpartum).

[8] 8 C.F.R. § 212.22(c)(1).

populations. The presence of a "heavily weighted" negative factor—such as receipt of health or nutrition assistance—will very likely tip the scales of the totality of the circumstances test in favor of a determination that the individual is or will become a public charge.

Though DHS claims the Regulation is intended to promote self-sufficiency, there is no evidence that chilling the use of health and nutrition benefits will result in an increase in income, employment, or educational status of immigrants. *Amici* submit this brief to describe the deleterious impact this Regulation will have on the health of vulnerable populations. These sweeping and detrimental changes will ultimately result in far greater costs to the public's health than any purported benefit offered by DHS.

ARGUMENT

I. THE PUBLIC CHARGE REGULATION TARGETS KEY HEALTH AND NUTRITION PROGRAMS AND ALLOWS FOR DISCRIMINATORY DECISION MAKING

The Regulation upends decades of settled policy with regard to public charge. Historically, an immigrant could be deemed inadmissible if an immigration official concluded that the immigrant was likely to become a public charge—interpreted to mean *primarily dependent on public assistance*. The Regulation now broadly defines "public charge" to include anyone who has received or is likely to receive a wide range of public benefits. The programs targeted by the Regulation include

medical benefits such as Medicaid, nutrition benefits such as SNAP, and housing assistance—all of which may be integral to keep immigrants and their family members healthy, fed, and sheltered.[9] The Regulation employs a "totality of the circumstances" test which is so all-encompassing that vulnerable populations such as children, pregnant women and individuals with disabilities are uniquely at risk for discrimination under the test simply because of their age or health status. And, as explained in more detail below, the receipt of certain health and nutrition benefits are counted as a "heavily weighted" negative factor, almost certainly resulting in the finding that the individual is likely at any time in the future to become a public charge.

A. Utilization of Essential Health and Nutrition Programs Are Targeted By The Regulation

The Regulation expands the definition of "[p]ublic benefit" to include significant non-cash benefit programs including SNAP, Medicaid, and Section 8 housing benefits.[10] These types of non-cash public benefit programs have been key to upward mobility for generations of immigrants. This expansion of the definition of public benefit will affect many immigrant families, especially those with low to moderate incomes. For example, the Regulation gives immigration officers broad

[9] 8 C.F.R. § 212.21.

[10] 8 C.F.R. § 212.21(b).

discretion to make a public charge determination based on whether an immigrant may utilize, at some point in the future, Medicaid, SNAP, or housing benefits. Certain groups of immigrants, such as parolees or those subject to withholding of removal, would be penalized for utilizing Medicaid if they ever sought to adjust their immigration status through a family member. Immigrants with health conditions that require "extensive treatment" who receive health coverage through state-funded programs would be penalized if they cannot demonstrate an ability to purchase private insurance.

Equally significant, the Regulation's chilling effect will impact many additional families. The Regulation has already resulted in widespread confusion and fear throughout the immigrant community, causing many to forego such assistance including assistance for which they are legally entitled under federal or state law, such as accessing emergency care in hospitals[11] or children's health insurance coverage.[12] In fact, there was an increase in the child uninsurance rate

[11] The Emergency Medical Treatment & Labor Act (EMTALA) of 1986 ensures public access to emergency medical services regardless of ability to pay. 42 C.F.R. § 489.24.

[12] Edward R. Berchick & Laryssa Mykyta, *Children's Public Health Insurance Coverage Lower Than in 2017*, United States Census Bureau (Sept. 10, 2019) (*available at* https://www.census.gov/library/stories/2019/09/uninsured-rate-for-children-in-2018.html) (reporting that Hispanic children were more likely to be uninsured than children from other races and non-Hispanic origin groups. Between

from 5% in 2017 to 5.5% in 2018 which is largely because of a decline in children's Medicaid and CHIP coverage rates.[13] Rates of decline were highest for Hispanic children.[14] This puts parents and children at risk for poorer health outcomes, additional economic hardship, and long-term consequences.

B. The Totality of the Circumstances Test Is So Vague It Will Result In Discriminatory Decision Making

The Regulation is problematic in that its application by immigration officers is likely to result in inconsistent and discriminatory outcomes. The Regulation states that the public charge determination "must be based on *the totality of the alien's circumstances by weighing all factors* that are relevant to whether the alien is more likely than not…to receive one or more public benefits . . . ."[15] While on its face, the Regulation describes the determination as based on a totality of the circumstances, it is anything but. The immigration officer is instructed to consider a set of minimum factors (age, health, family status, education and skills, and financial status), heavily weighted negative factors (e.g., employment status, receipt of public benefits, diagnosis of an extensive medical condition without adequate

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2017 and 2018, the uninsured rate increased 1.0 percentage point for Hispanic children and 0.5 percentage points for non-Hispanic Whites).

[13] *Id.*

[14] *Id.*

[15] 8 C.F.R. § 212.22(a) (emphasis added).

private insurance), and heavily weighted positive factors (household income of at least 250% of the federal poverty guidelines, employment with an income of at least 250% of federal poverty guidelines, and private health insurance).[16] There is no guidance provided on how to balance the competing factors, especially when in many cases some factors have more impact than others.

Most significantly, the application of each of these factors will have a disparate impact on vulnerable populations. The inclusion of "health" as a competing factor in the Regulation's balance test will likely result in discrimination across the board. The Regulation states:

> DHS will consider whether the alien's health makes the alien more likely than not to become a public charge at any time in the future, including whether the alien has been diagnosed with a medical condition that is likely to require extensive medical treatment or institutionalization or that will interfere with the alien's ability to provide and care for himself or herself, to attend school, or to work upon admission or adjustment of status.[17]

This implicit definition of "medical condition" is overbroad and therefore unworkable. There is no guidance provided as to what "extensive medical treatment" consists of, or what type of medical condition would rise to the level of "interfer[ing]" with work or school. This vague standard could include anything

[16] 8 C.F.R. § 212.22(b), (c).

[17] 8 C.F.R. § 212.22(b)(2)(i).

from a condition requiring the use of expensive medical equipment such as a power wheelchair to a child's learning disability that requires an Individualized Education Plan.

The Regulation further provides that the immigration official can rely on evidence that includes, *but is not limited to*, (i) an immigration medical examination, or if the immigration officer finds the report to be incomplete (ii) evidence of such a medical condition.[18] There is no further requirement of the type or quality of such "evidence," including whether the evidence must be documented by a medical professional. Moreover, the Regulation expressly states that the immigration officer is not limited to these two categories of evidence. The Regulation provides no restrictions on what the immigration officer can consider when evaluating an immigrant's health. This provision has the potential of allowing an immigration official to act as an unqualified medical expert, with no oversight.[19]

The Regulation expands the definition of public benefit and relies on an ambiguous "totality of circumstances" test to evaluate whether an immigrant is or

[18] 8 C.F.R. § 212.22(b)(2)(ii).

[19] Not only is it manifestly unjust for an immigration officer, with no medical training, to make a determination about the health status of an immigrant, such a scenario contravenes 42 C.F.R. § 34 *et seq* (setting forth the requirements for medical examinations of aliens).

will become a public charge.[20] The application of this Regulation will have a negative impact on the health of immigrants and their families and an even more severe effect on the health of vulnerable populations, including children, pregnant women, and individuals with disabilities. The impact of this rule on each of these vulnerable populations is set forth in more detail below.

II. BOTH CITIZEN AND NON-CITIZEN CHILDREN WILL BE HARMED BY THE PUBLIC CHARGE REGULATION

The Regulation will also have a devastating impact on children in this country—increasing the likelihood that immigrant children will be designated a public charge and reducing access to health and nutrition benefits for all children, including U.S. citizens.

A. The Totality of Circumstances Test Will Disproportionally Impact Non-Citizen Children

Immigrant children are plainly disadvantaged by the Regulation's "totality of circumstances" public charge test. At the very least, a child's age will count against him or her as a negative factor.[21] A child will also be penalized by the "education and skills" factor, as it is unlikely the child could demonstrate "adequate education

[20] 8 C.F.R. § 212.22(a).

[21] 8 C.F.R. § 212.22(b)(1) ("When considering an alien's age, DHS will consider whether the alien's age makes the alien more likely than not to become a public charge at any time in the future, such as by impacting the alien's ability to work, including whether the alien is between the age of 18 and the minimum 'early retirement age' for Social Security . . . .").

and skills to either obtain or maintain lawful employment."[22] Additional negative factors are related to larger family size (implicated if the child has siblings) or if the child resides in a single parent household.[23] If the child has a medical condition that requires "extensive medical treatment" or "interfere[s]" with the child's ability to attend school, this will count as a negative factor under the Regulation as well.[24] One study reported that 4.8 million children in need of medical attention live in households with at least one noncitizen adult and are insured by Medicaid or CHIP.[25] This includes a significant number of children with at least one potentially life-threatening condition or illness, including asthma, influenza, diabetes, epilepsy, or cancer.[26] Children who live with such medical conditions, and who reside in households that cannot obtain or afford private health insurance, would be penalized with a heavily weighted negative factor under §212.22(c)(1)(iii).

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[22] 8 C.F.R. § 212.22(b)(5).

[23] 8 C.F.R. § 212.21(d)(2); 8 C.F.R. § 212.22(b)(3).

[24] 8 C.F.R. § 212.22(b)(2).

[25] Leah Zallman, *Changing Public Charge Immigration Rules: The Potential Impact on Children Who Need Care*, California Health Care Foundation (Oct. 2018) (*available at* https://www.chcf.org/publication/changing-public-charge-immigration-rules/) (defining "in need of medical attention" in the study as "children with a current or recent medical diagnosis, disability, and/or need for specific therapy").

[26] *Id.*

The Regulation does exempt from the public benefits definition the receipt of Medicaid benefits by immigrants under the age of 21.[27] But a child under the age of 18, unemployed, and living in a single parent household already has three negative factors weighing against him or her. If that child also suffers from a disability, such as severe asthma, that requires "extensive medical treatment," this would be a fourth negative factor. The "totality of circumstances" test will make it uniquely difficult for children, particularly those with health challenges or those in lower income households, to avoid being determined a public charge.

B. Children's Health Will Be Harmed By The Public Charge Regulation

The impact of the Regulation on the health and well-being of all children in immigrant families cannot be understated. Many such families rely on government programs for preventive, rehabilitative, habilitative, and emergency health needs as well as supplemental nutrition. This Regulation will cause, or already has caused, families to disenroll from these programs.[28]

The Regulation will have a chilling effect on programs specifically identified, such as SNAP and Medicaid. The fear and confusion over what is covered by the

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[27] 8 C.F.R. § 212.21(a)(5)(iv).

[28] *See* Lena O'Rourke, *Trump's Public Charge Proposal Is Hurting Immigrant Families Now*, Protecting Immigrant Families (Apr. 2019) (*available at* https://www.chn.org/wp-content/uploads/2019/04/ProtectingImmigrantFamilies.pdf).

Regulation will also result in a chilling effect on programs that are not explicitly called out, such as the Children's Health Insurance Program (CHIP), the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), and state-funded Medicaid programs.

This chilling effect is real, measurable, and exacerbated by the final Regulation. When the Regulation was published, before it was even finalized, immigrant families shied away from government healthcare programs and regular doctor's appointments.[29] A study reported that one-seventh of all adults in immigrant families reported avoiding non-cash public benefits over the past year because of fear that their legal immigration status would be harmed.[30] Low-income members of immigrant families reported even higher rates of avoidance.[31] Of this group that avoided benefits, 46% avoided nutrition benefits (SNAP), 42% avoided medical benefits (Medicaid and CHIP), and 33% avoided public housing subsidies.[32] Notably, this chilling effect was measurable before the final Regulation was

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[29] *Id.*

[30] Hamutal Bernstein *et al.*, *One in Seven Adults in Immigrant Families Reported Avoiding Public Benefit Programs* in 2018, Urban Institute (May 2019) (*available at* https://www.urban.org/sites/default/files/publication/100270/one_in_seven_adults_in_immigrant_families_reported_avoiding_publi_2.pdf).

[31] *Id.*

[32] *Id.*

published, and it is expected that the rates of avoidance will be markedly higher once it is enforced.

Children will lose health coverage—whether due to chilling effects or their households being directly targeted by this Regulation—to potentially disastrous effects.[33] A study found that disenrollment of children in need of medical care would likely contribute to child deaths and future disability.[34] Foregoing regular treatment for such children will likely lead to increased health care costs and disastrous outcomes.[35] For these vulnerable children, the loss of health coverage would be catastrophic.

Whether or not a parent has health care coverage can have a profound effect on the health and well-being of their children. Parents who are enrolled in coverage are more likely to have children enrolled in coverage, and parents who lose coverage are more likely to allow their children's coverage to lapse.[36] It is well documented

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[33] Michael Karpman & Genevieve M. Kenney, *Health Insurance Coverage for Children and Parents: Changes Between 2013 and 2017*, Urban Institute (Sept. 7, 2017) (*available at* http://hrms.urban.org/quicktakes/health-insurance-coveragechildrenparents-march-2017.html).

[34] *See* Leah Zallman *et al., Implications of Changing Public Charge Immigration Rules for Children Who Need Medical Care,* JAMA Pediatr., 173(9) at E4, E5 (July 1, 2019).

[35] *Id*.

[36] Adam Searing & Donna Cohen Ross, *Medicaid Expansion Fills Gaps in Maternal Health Coverage Leading to Healthier Mothers and Babies*, Georgetown University Health Policy Institute (May 2019) (*available at* https://ccf.georgetown.edu/wp-

that children who access health care early on have long-term improved health and educational outcomes. For example, increased access to health insurance such as Medicaid in early childhood leads to long-term health improvements such as a decline in prevalence of high blood pressure, reduced adult hospitalizations, reduction in self-reported rates of disability, and reduced mortality in teenage and adult years.[37] The benefits to providing insurance coverage to children are wide ranging, including improving children's access to health and dental care, improving parental satisfaction, and saving money.[38] Access to health insurance during

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content/uploads/2019/05/Maternal-Health-3a.pdf); Julie L. Hudson & Asako S. Moriya, *Medicaid Expansion For Adults Had Measurable 'Welcome Mat' Effects On Their Children*, Health Affairs, 36(9) 1643-1651 (2017) (*available at* https://www.healthaffairs.org /doi/pdf/10.1377/hlthaff.2017.0347).

[37] Karina Wagnerman, *et al*., *Medicaid Is A Smart Investment in Children*, Georgetown University Health Policy Institute (March 2017) (*available at* https://ccf.georgetown.edu/wpcontent/uploads/2017/03/ MedicaidSmartInvestment.pdf).

[38] Lisa Clemens, *et al*., *How Well Is CHIP Addressing Oral Health Care Needs and Access for Children?*, Academic Pediatrics 15:13 Suppl., (May-June 2015) (*available at* https://www.sciencedirect.com/science/article/pii/ S1876285915000649); Zhou J. Yu, *et al*., *Associations among dental insurance, dental visits, and unmet needs of US children*, Journal Am. Dental Assoc., 148(2): 92-99 (Feb. 2017) (*available at* https://www.sciencedirect.com/science/article/abs/pii/S0002817716309047); Glenn Flores, *et al*., *The health and healthcare impact of providing insurance coverage to uninsured children: A prospective observational study*, BMC Public Health, 17:553 (May 2017).

childhood also increases the likelihood of graduating from high school and attending college, as well as achieving a higher earning potential.[39]

Furthermore, access to nutritious food is fundamental to the healthy development of all children. SNAP is the largest federal nutrition program that allows recipients to buy healthy food. Children in immigrant families that receive SNAP benefits are more likely to be in good or excellent health, be food secure, and reside in stable housing.[40] These families have more resources to afford medical care and prescription medications, compared to families who do not participate in SNAP.[41] Significantly, an additional year of SNAP eligibility for young children with immigrant parents is associated with significant health benefits in later childhood and adolescence.[42]

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[39] *Id.*

[40] Children's HealthWatch, *Report Card On Food Security & Immigration: Helping Our Youngest First-Generation Americans To Thrive* (February 2018) (*available at* http://childrenshealthwatch.org/wp-content/uploads/Report-Card-on-Food-Insecurity-and-Immigration-Helping-Our-Youngest-First-Generation-Americans-to-Thrive.pdf).

[41] *Id.*

[42] Chloe N. East, *The Effect of Food Stamps on Children's Health: Evidence from Immigrants' Changing Eligibility*, J. Human Resources (Sept. 2018), (*available at* http://www.chloeneast.com/uploads/8/9/9/7/8997263/east_fskids_r_r.pdf).

These results are not surprising: nutrition is one of the greatest environmental influences on fetal and infant development.[43] A healthy balance of essential nutrients during a child's formative periods is imperative for normal brain development.[44] Neuroscientists describe such formative periods as "critical periods" and "sensitive periods" to emphasize the vulnerability of a child's developing brain.[45] During such periods, nutrient deficiencies can have irreversible long-term consequences such as preventing children from fully developing their potentials in sensori-motor, cognitive-language, and social-emotional functions.[46] Such failures to optimize brain development early in life have substantial and long-lasting ramifications. Studies have shown that children that do not meet certain developmental milestones are less likely to remain and succeed in school, less likely

[43] *See* Peter J. Morgane *et al.*, *Effects of prenatal protein malnutrition on the hippocampal formation*, Neuroscience and Biobehavioral Rev. 26(4):471-483 (2002).

[44] *See* Sarah E. Cusick & Michael K. Georgieff, *The Role of Nutrition in Brain Development: The Golden Opportunity of the "First 1000 Days"*, J. Pediatrics 175:16-21 (Aug. 2016).

[45] *Id.*

[46] *Id.*; *see also* Susan P. Walker, *et al.*, *Child development: risk factors for adverse outcomes in developing countries*, Lancet 369:145-157 (2007).

to earn higher incomes as adults, and less likely to provide adequate nutrition and educational opportunities to their own children.[47]

Disincentivizing the use of SNAP or other public food security benefits by immigrant families will result in enduring damage to the collective health and proper development of all children in such families.[48] Such damage will only be compounded over time as affected children suffer from higher likelihoods of falling short of their full developmental potential, lower achievement in school, and having less satisfaction from their professional careers.[49] Access to medical care and adequate nutrition allows early identification of any issues before they become more serious or costly to treat. Given the serious and irreparable health risks to children that will directly result from a lack of access to health and nutrition programs, enforcement of the Regulation should be enjoined.

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[47] *See e.g.*, Anthony Lake, *Early childhood development – global action is overdue,* Lancet 378:1277-1278 (2011); Patrice L. Engle, *et al.*, *Strategies for reducing inequalities and improving developmental outcomes for young children in low-income and middle-income countries*, Lancet 378:1339-1353 (2011); Susan P. Walker, *et al.*, *Inequality in early childhood: risk and protective factors for early child development*, Lancet 378:1325-1338 (2011).

[48] *See* Leah Zallman, *et al.*, *Implications of Changing Public Charge Immigration Rules for Children Who Need Medical Care*, JAMA Pediatr. 173(9) at E4-E5 (2019).

[49] *Id.* at E5.

III. THE PUBLIC CHARGE REGULATION WILL ACT AS A BARRIER TO HEALTH CARE FOR PREGNANT AND POSTPARTUM WOMEN

In addition to children, the Regulation will greatly hamper the ability of pregnant and postpartum women to obtain or maintain legal immigration status. Equally important, the Regulation will have a tragic effect on the health of this population.

A. The Totality of Circumstances Test Will Disproportionally Impact Pregnant and Postpartum Women

Under the Regulation's totality of circumstances test, women may be penalized for being pregnant or for having given birth. As discussed above in Section I.B., the Regulation explicitly mandates that a heavily-weighted negative factor is the immigrant's "health," including diagnosis of a medical condition requiring extensive medical treatment or interfering with care, school, or work."[50] If the individual does not have private health insurance, this will be considered as an additional heavily weighted negative factor.[51] If an individual has one or more heavily weighted negative factors, "DHS generally will not favorably exercise discretion to allow submission of a public charge [surety] bond."[52] A pregnant

[50] 8 C.F.R. § 212.22(b)(2).

[51] 8 C.F.R. § 212.22(c)(1)(iii)(B).

[52] 8 C.F.R. § 213.1(b).

woman (or one who has recently given birth)—especially a woman who has suffered serious pregnancy-related complications—who is unable to afford private insurance to cover their birth or postpartum care will plainly be penalized. Moreover, while the Regulation exempts receipt of Medicaid benefits for women who are pregnant and for 60 days postpartum as a factor in the public charge determination, Medicaid-eligible immigrants who utilize the program after the 60-day postpartum period, including immigrants who become eligible for coverage after meeting the "five year bar" would be given a "heavily weighted negative factor."[53] In many cases, this will include pregnant and postpartum women.

B. Pregnant and Postpartum Women Will Be Directly Harmed By The Public Charge Regulation

As with other vulnerable populations, the Regulation will have the effect of reducing the use of social safety net programs by women who have recently experienced pregnancy. These barriers to prenatal and postnatal care will have a drastic impact on the health of these women, their babies, and other family members. Regular prenatal care is proven to help prevent and detect serious pregnancy complications in the mother, including hypertension, infection, and anemia.[54] Not

[53] 8 C.F.R. § 212.22(c)(1).

[54] Jonas J. Swartz, *et al.*, *Expanding prenatal care to unauthorized immigrant women and the effect on infant health*, Obstet. Gynecol. 130(5): 938–945 (2017) (citing Laurence Mbuagbaw, *et al.*, *Health system and community level interventions for*

surprisingly, lack of adequate prenatal care contributes to higher rates of maternal mortality.[55]

The lack of prenatal care can have serious implications for children, affecting their birth and early health outcomes.[56] Prenatal care has been shown to be associated with decreased incidence of low birth weight and newborn death.[57] For example, researchers studying the expansion of the Emergency Medicaid Plus program in Oregon, which resulted in expanding access to prenatal care, found "a significant decrease in both the probability of extremely low birth weight infants and infant death with access to prenatal care."[58] The decrease in infant mortality associated with expanded access to prenatal care was so great that it measured

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improving antenatal care coverage and health outcomes, Cochrane Database Syst Rev. 12:1-157 (2015)).

[55] Emily E. Petersen, *et al.*, *Vital Signs: Pregnancy-Related Deaths, United States, 2011–2015, and Strategies for Prevention, 13 States*, 2013–2017, MMWR Morb Mortal Wkly Rep 68(18): 423-429 (May 10, 2019); *see also* Sarah Partridge, *et al.*, *Inadequate Prenatal Care Utilization and Risks of Infant Mortality and Poor Birth Outcome: A Retrospective Analysis of 28,729,765 U.S. Deliveries over 8 Years*, Am J Perinatology 29:787-794 (2012).

[56] Megan M. Shellinger, *et al.*, *Improved Outcomes for Hispanic Women with Gestational Diabetes Using the Centering Pregnancy Group Prenatal Care Model*, Maternal and Child Health Journal 21(2):297-305 (2016).

[57] *Id.*

[58] *Id.*

"greater than the 30-year reduction in infant mortality from Sudden Infant Death Syndrome (SIDS) associated with the "Back to Sleep" campaign."[59]

Moreover, it is well established that the United States has the highest rate of maternal deaths in the developed world and one of the highest rates of infant mortality.[60] These rates are even higher in low-income communities and among women of color.[61] The CDC has identified contributing factors to maternal mortality and strategies to prevent future pregnancy-related deaths. These factors include community factors (*e.g.*, unstable housing, access to clinical care, and limited access to transportation) and system factors (*e.g.*, inadequate receipt of care and case coordination or management).[62]

Strategies to address community factors include "increasing availability and use of group prenatal care, prioritizing pregnant and postpartum women for

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[59] *Id.* The "Back to Sleep" campaign was created to encourage parents to put their infants to sleep on their backs in order to reduce the rate of SIDS. Following the initiation of the "Back-to-Sleep" campaign in 1994, the number of infants dying from SIDS decreased by almost 50%. *See* Felicia L. Trachtenberg, *et al.*, *Risk Factor Changes for Sudden Infant Death Syndrome After Initiation of Back-To-Sleep Campaign*, Pediatrics 129(4):630-638 at 631 (April 2012).

[60] Emily E. Petersen, *et al.*, *Vital Signs: Pregnancy-Related Deaths, United States, 2011–2015, and Strategies for Prevention, 13 States*, 2013–2017, MMWR Morb Mortal Wkly Rep 68(18): 423-429 (May 10, 2019).

[61] *Id.*

[62] *Id.* at 428, Table 3.

temporary housing programs, improving availability of transportation services covered by Medicaid, and improving access to healthy foods and promoting healthy eating habits and weight management strategies."[63] Strategies to address system factors include "extend[ing] expanded Medicaid coverage eligibility for pregnant women to include one year of postpartum care."[64] Thus, even if immigrant women are not penalized for using Medicaid during their pregnancy and immediately after birth, they will be penalized for accessing these types of medical safety-net programs that are demonstrated to reduce maternal mortality.

Moreover, DHS trivializes the immense cost of inadequate prenatal care to society. Inadequate prenatal care is associated with an increased risk of preterm babies, and the Institute of Medicine estimates that the medical costs for a preterm baby are much greater than for a healthy newborn.[65] Specifically, the economic burden associated with preterm birth in the United States was at least $26.2 billion annually, or $51,600 per infant born preterm.[66] To put it in perspective, the average

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[63] *Id.*

[64] *Id.*

[65] Institute of Medicine, *Preterm Birth. Causes, Consequences and Prevention* (Richard E. Behrman & Adrienne Stith Butler eds., 2007).

[66] *Id.*

preterm/low birth weight hospitalization cost $15,100 with a 12.9 day length of stay, whereas, an uncomplicated newborn hospitalization cost $600 with a 1.9 day stay.[67]

Postpartum care is equally crucial to the health and well-being of mothers, newborns, and families. For example, foregoing postpartum care could result in women enduring postpartum depression without proper medical, social, and psychological care or skipping doctor's visits that address infant feeding, nutrition, and physical activity.[68] Other postpartum health issues, such as chronic disease management could also remain unaddressed.[69]

Unless enjoined, the Regulation is highly likely to cause irreparable damage to the health and well-being of immigrant pregnant and postpartum women, as well as the health and cognitive development of millions of infants and young children.

IV. THE PUBLIC CHARGE REGULATION WILL ALSO PARTICULARLY HARM INDIVIDUALS WITH DISABILITIES AND CHRONIC HEALTH CONDITIONS

The Public Charge Regulation will directly harm the health of immigrants with disabilities and make it harder for them to successfully apply for a visa or

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[67] Rebecca B. Russell, *et al*., *Cost of Hospitalization for Preterm and Low Birth Weight Infants in the United States,* Pediatrics 120(1) E1-E9 (2007).

[68] The American College of Obstetricians and Gynecologists, *Committee Opinion: Optimizing Postpartum Care* (May 2018) (*available at* https://www.acog.org/-/media/Committee-Opinions/Committee-on-Obstetric-Practice/co736.pdf?dmc=1&ts=20191223T2132352470).

[69] *Id.*

permanent legal status. Of even greater concern, the Regulation creates a strong incentive for these individuals to avoid accessing necessary health and other non-cash benefit programs.

A. The Totality of Circumstances Test Will Disproportionally Impact Individuals with Disabilities

Receipt of non-cash public benefits including Medicaid, inadequate private insurance, and a diagnosis with a medical condition that "will require extensive medical treatment" or "interfere with the individual's ability to support himself or herself" are all heavily weighted negative factors in the public charge determination.[70] As a result, this Regulation will have a devastating impact on the ability of immigrants with disabilities and chronic health conditions to obtain, adjust, or maintain legal residency in the United States.

B. Individuals with Disabilities Will Suffer Negative Consequences To Their Health And Well-Being

The Regulation acts as a significant roadblock for immigrants with disabilities and their families to become and remain self-sufficient. Public benefit programs, including Medicaid, are essential to facilitate educational and employment opportunities for people with disabilities and chronic conditions. Medicaid covers primary care, preventative care, medical treatment, and supportive services for

[70] 8 C.F.R. § 212.22(c)(1).

people with disabilities.[71] For many, Medicaid is the *only* source for critical community living supports (like personal care services, nursing services, respite, intensive mental health services and employment supports).

There is a strong link between Medicaid and the ability of individuals with disabilities to live independently, and Medicaid is critical to help ensure that individuals with disabilities can attend school and work.[72] For example, more than 150,000 individuals with disabilities participate in Medicaid buy-in programs, which provides Medicaid coverage for those who participate in the labor force.[73] It is well documented that these Medicaid buy-in participants earn more, work more, contribute more in taxes, and rely less on food stamps than people with disabilities

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[71] Congressional Research Service, *Who Pays For Long-Term Services and Supports?* (Aug. 22, 2018) (*available at* https://fas.org/sgp/crs/misc/IF10343.pdf).

[72] The Center on Budget and Policy Priorities, *Medicaid Works for People with Disabilities* (Aug. 29, 2017) (*available at* https://www.cbpp.org/research/health/medicaid-works-for-people-with-disabilities).

[73] Brigitte Gavin and Marci McCoy-Roth, *Review of studies regarding the Medicaid Buy-In Program*, Boston University, Sargent College, Center for Psychiatric Rehabilitation, (2011) (*available at* http://www.bu.edu/drrk/research-syntheses/psychiatric-disabilities/medicaid-buy-in/); Social Security Administration, Continued Medicaid Eligibility (Section 1619(B)) (*available at* https://www.ssa.gov/disabilityresearch/wi/1619b.htm); Medicaid and CHIP Payment and Access Commission, Promoting Continuity of Medicaid Coverage among Adults under Age 65 (Mar. 2014) (*available at* https://www.macpac.gov/publication/ch-2-promoting-continuity-of-medicaid-coverage-among-adults-under-age-65/).

who are not enrolled.[74] For individuals with intellectual or developmental disabilities, Medicaid provides more supportive services to facilitate employment.[75] The role of Medicaid to support individuals with disabilities so that they can remain productive members of their community cannot be understated.

The number of individuals who will be irreparably harmed by the Regulation is significant and includes both children and adults. Rates of children with a disability have increased, including children with neurodevelopmental conditions.[76] Health conditions correlated with childhood disabilities range from autism spectrum disorder to cerebral palsy to juvenile idiopathic arthritis.[77] Habilitation and rehabilitation therapies are crucial to help such children attain developmentally appropriate functional skills and provide adaptive strategies to lessen impacts of

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[74] Brigitte Gavin and Marci McCoy-Roth, *supra*.

[75] Department of Health and Human Services, Centers for Medicare and Medicaid Services, Updates to the §1915 (c) Waiver Instructions and Technical Guide regarding employment and employment related services (Sept. 16, 2011) (*available at* https://downloads.cms.gov/cmsgov/archived-downloads/CMCSBulletins/downloads/CIB-9-16-11.pdf) (discussing the use of waiver supports to increase employment opportunities for individuals with disabilities).

[76] Amy Houtrow, *et al.*, *Prescribing Physical, Occupational, and Speech Therapy Services for Children with Disabilities*, Pediatrics 143(4) (2019) (*available at* https://pediatrics.aappublications.org/content/pediatrics/143/4/e20190285.full.pdf).

[77] *Id.*

functional deficits.[78] These therapies play a significant role in improving the health and well-being of children with disabilities.[79]

Approximately one-third of working age adults enrolled in Medicaid have a disability.[80] In 2015 people with disabilities made up 26 percent of SNAP participants.[81] Blocking or disincentivizing access to medical and nutrition benefits will result in worse medical outcomes and food insecurity for an already vulnerable population.

CONCLUSION

The Regulation dramatically increases the likelihood that lawfully present immigrants and their families will forego health and nutrition benefits to avoid negatively impacting their immigration status. The harmful impact of this Regulation will most severely threaten the health and well-being of vulnerable

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[78] *Id.*

[79] *Id.*

[80] *See, e.g.*, Nationwide Adult Medicaid CAHPS, *Health Care Experiences of Adults with Disabilities Enrolled in Medicaid Only: Findings from a 2014-2015 Nationwide Survey of Medicaid Beneficiaries* (2016) (*available at* https://www.medicaid.gov/medicaid/quality-of-care/downloads/performance-measurement/namcahpsdisabilitybrief.pdf).

[81] Steven Carlson, *et al.*, *SNAP Provides Needed Food Assistance to Millions of People with Disabilities*, Center for Budget and Policy Priorities (2017) (*available at* https://www.cbpp.org/research/food-assistance/snap-provides-needed-food-assistance-to-millions-of-people-with).

children, pregnant and postpartum women, and individuals with disabilities. On behalf of their patients, members, and the communities they serve, amici curiae urge this Court to affirm the district court's order granting preliminary injunction and to prevent further harm and damage to the health of these groups.

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Respectfully submitted,

By: */s/ Susan M. Krumplitsch*

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CERTIFICATE OF COMPLIANCE

Pursuant to Federal Rule of Appellate Procedure 32(g), the undersigned counsel for *amici curiae* certifies that this brief:

(i) complies with the type-volume limitation of Fourth Circuit Rules of Appellate Procedure 29(a)(5) and 32(a)(7)(B) because it contains 6,496 words, including footnotes and excluding the parts of the brief exempted by Rule 32(f); and

(ii) complies with the typeface requirements of Fourth Circuit Rule of Appellate Procedure 32(a)(5) and the type style requirements of Rule 32(a)(6) because it has been prepared using Microsoft Office Word 2016 and is set in Times New Roman font in a size equivalent to 14 points or larger.

By: */s/ Susan M. Krumplitsch*

CERTIFICATE OF SERVICE

I hereby certify that on January 17, 2020, I electronically filed the foregoing with the Clerk of the Court for the United States Court of Appeals for the Seventh Circuit using the Court's CM/ECF system. I certify that all participants in the case are registered CM/ECF users and that service will be accomplished by the CM/ECF system.

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