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12 CHILDREN’S HOSPITAL ASSOCIATION, AND
THE FEDERATION OF AMERICAN HOSPITALS
13

14 UNITED STATES DISTRICT COURT
15 NORTHERN DISTRICT OF CALIFORNIA

16
17 CITY AND COUNTY OF SAN
FRANCISCO and COUNTY OF SANTA
18 CLARA,

19 Plaintiffs,

20 v.

21 U.S. CITIZENSHIP AND
IMMIGRATION SERVICES, et al.,

22 Defendants.
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Case No. 4:19-cv-04717

**[PROPOSED] AMICI CURIAE BRIEF OF
THE AMERICAN HOSPITAL
ASSOCIATION, AMERICA’S ESSENTIAL
HOSPITALS, ASSOCIATION OF
AMERICAN MEDICAL COLLEGES,
CATHOLIC HEALTH ASSOCIATION OF
THE UNITED STATES, THE
CHILDREN’S HOSPITAL ASSOCIATION,
AND THE FEDERATION OF AMERICAN
HOSPITALS**

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25
26
27
28

TABLE OF CONTENTS

	<u>Page</u>
INTEREST OF AMICI CURIAE	1
SUMMARY OF ARGUMENT	3
ARGUMENT	4
I. THE NEW PUBLIC CHARGE DEFINITION WILL DETER MILLIONS OF IMMIGRANTS AND THEIR FAMILIES, INCLUDING U.S. CITIZEN CHILDREN FROM ACCEPTING AND USING HEALTH CARE AND OTHER SERVICES TO WHICH THEY ARE LEGALLY ENTITLED, YET DHS UNJUSTIFIABLY REFUSED TO CONSIDER THOSE MILLIONS IN PROMULGATING THE PUBLIC CHARGE RULE	4
II. THE PUBLIC CHARGE RULE WILL HARM PATIENTS AND THE HOSPITALS THEY RELY ON FOR CARE	8
A. Reduced Participation In Public Benefits Programs Will Negatively Affect The Health And Financial Stability Of Immigrant Families And Impair The Healthy Development Of Children.	8
B. Reduced Participation In Public Benefits Programs Will Also Increase Uncompensated Care, Straining Hospital Resources And Preventing Hospitals From Adequately Investing In Their Communities.	12
III. THE NEW PUBLIC-CHARGE DEFINITION UNDERMINES CONGRESS’S INTENT TO REDUCE THE UNINSURED POPULATION AND THE RULE’S GOAL OF PROMOTING IMMIGRANTS’ SELF-SUFFICIENCY.	14
CONCLUSION	16

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28

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Page

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1 **INTEREST OF AMICI CURIAE**

2 The American Hospital Association, America’s Essential Hospitals, Association of
3 American Medical Colleges, Catholic Health Association of the United States, Children’s
4 Hospital Association, and Federation of American Hospitals, respectfully submit this brief as
5 amici curiae.¹

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

12 America’s Essential Hospitals is the leading association and champion for hospitals and
13 health systems dedicated to providing high-quality care for all, including underserved and low-
14 income populations. Filling a vital role in their communities, the association’s more than 325
15 member hospitals provide a disproportionate share of the nation’s uncompensated care. Through
16 their integrated health systems, members of America’s Essential Hospitals offer a full range of
17 primary through quaternary care, including a substantial amount of outpatient care in their
18 ambulatory clinics, public health services, mental health services, substance abuse services,
19 specialty care services, and “wraparound” services such as transportation and translation that help
20 ensure that patients can access the care being offered. They do so on a shoe-string budget,
21 providing state-of-the-art, patient-centered care while operating on margins half that of other
22 hospitals.

23 The Association of American Medical Colleges is a not-for-profit association representing
24 all 154 accredited U.S. and 17 accredited Canadian medical schools; nearly 400 major teaching
25 hospitals and health systems; and more than 80 academic and scientific societies. Through these
26

27 ¹ No party’s counsel authored this brief in whole or in part. No party, party’s counsel, or
28 person—other than amici curiae and their counsel—contributed money to fund the preparation or
submission of this brief.

1 institutions and organizations, the AAMC serves the leaders of America's medical schools and
2 teaching hospitals and their nearly 173,000 faculty members, 89,000 medical students, 129,000
3 resident physicians, and more than 60,000 graduate students and postdoctoral researchers in the
4 biomedical sciences.

5 The Catholic Health Association of the United States is the national leadership
6 organization of the Catholic health ministry, representing the largest not-for-profit providers of
7 health care services in the nation. The Catholic health ministry is comprised of more than 2,200
8 hospitals, nursing homes, long-term care facilities, health care systems, sponsors, and related
9 organizations serving the full continuum of health care across our nation. CHA's Vision for U.S.
10 Health Care calls for health care to be available and accessible to everyone, paying special
11 attention to underserved populations. CHA works to advance the ministry's commitment to a
12 just, compassionate health care system that protects life.

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

20 The Federation of American Hospitals is the national representative of more than 1,000
21 investor-owned or managed community hospitals and health systems throughout the United
22 States. The Federation's members include investor-owned or managed teaching and non-teaching
23 short-stay acute, inpatient rehabilitation, long-term acute care, psychiatric and cancer hospitals in
24 urban and rural communities across America. These hospitals provide a critical range of services,
25 including acute, post-acute, and ambulatory services. Dedicated to a market-based philosophy,
26 the Federation provides representation and advocacy on behalf of its members to Congress, the
27 Executive Branch, the judiciary, media, academia, accrediting organizations, and the public.

28 ///

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

4 SUMMARY OF ARGUMENT

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

8 DHS admits that the Public Charge Rule will deter many immigrants from using public
 9 benefits that they are legally entitled to, including Medicaid, the Supplemental Nutrition
 10 Assistance Program (“SNAP”), and certain housing assistance. But it contends that this “chilling
 11 effect” will be a fairly limited one, reaching only 2.5 percent of the immigrant population. That is
 12 a gross underestimation. In constructing the 2.5 percent figure, DHS ignored historical
 13 consequences of similar legislation, analyses of several medical foundations, and the fact that 14
 14 percent of adults in immigrant families had *already* disenrolled from public services during the
 15 Rule’s comment period. The final percentage is expected to be anywhere between 15 and 35
 16 percent of all immigrants, adding up to between 2.1 and 4.9 million individuals. Samantha
 17 Artiga, Rachel Garfield & Anthony Damico, Kaiser Family Found., *Estimated Impacts of the*
 18 *Proposed Public Charge Rule on Immigrants and Medicaid* 5 (Oct. 2018) (*Kaiser Report*).²

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

27 _____
 28 ² Available at <https://www.kff.org/disparities-policy/issue-brief/estimated-impacts-of-the-proposed-public-charge-rule-on-immigrants-and-medicaid/>.

1 *Public Charge Proposed Rule 5* (Nov. 2018) (*Manatt Report*).³

2 These are not abstract numbers, but real people who will be forced to forgo public benefits
3 to which they are legally entitled. And they will endure worse health outcomes, loss of
4 prescription medication, increased rates of poverty and housing instability, and impaired
5 development of their children.

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

14 **ARGUMENT**

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

21 The Public Charge Rule—and the resulting fear of being labeled a public charge—will
22 discourage millions of legal immigrants and their family members, some of whom are citizens,
23 from using public benefits they are legally entitled to—millions more than DHS acknowledges in
24 in the Rule. One report estimates that as many as 13.2 million Medicaid and Children’s Health
25 Insurance Program (“CHIP”) enrollees could disenroll from these programs as a result of the
26 Rule.⁴ *Manatt Report, supra*, p. 5. This figure includes 4.4 million noncitizen adults and children

27 ³ Available at <https://www.manatt.com/Insights/White-Papers/2018/Medicaid-Payments-at-Risk-for-Hospitals-Under-Publ>.

28 ⁴ CHIP is exempted from the Public Charge Rule. As detailed below, however, the Rule’s chilling effects will likely decrease CHIP participation as well. *Infra* pp. 6–7.

1 enrolled in Medicaid or CHIP and an additional 8.8 million *citizen* family members, including
 2 citizen children, who may disenroll from Medicaid and CHIP out of fear or confusion, even if the
 3 Rule does not apply to them directly. *Id.* at 5, 7; Allison Orris et al., *How DHS' Public Charge*
 4 *Rule Will Affect Immigrant Benefits*, Law360 (Sept. 3, 2019) (*Immigrant Benefits*).⁵ The Kaiser
 5 Foundation puts this figure at 15 to 35 percent of Medicaid and CHIP enrollees, or between 2.1
 6 and 4.9 million individuals. *Kaiser Report, supra*, pp. 1, 5. These estimates address only those
 7 currently enrolled—they do not account for legal immigrants and family members who are
 8 eligible for Medicaid or CHIP but who could choose never to enroll out of fear of being labeled a
 9 public charge. *Manatt Report, supra*, p. 5.

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

16 DHS admits to this chilling effect, but estimates that only 2.5 percent of the noncitizen
 17 population—or 324,438 individuals—will be impacted. 84 Fed. Reg. at 41,463. DHS's
 18 estimate—which ignores the Rule's likely chilling effects—grossly undercounts both the number
 19 of individuals and the benefits programs affected for three reasons.

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

26 ///

27 _____
 28 ⁵ Available at <https://www.law360.com/immigration/articles/1193999/how-dhs-public-charge-rule-will-affect-immigrant-benefits>.

1 Second, DHS considered disenrollment only from programs it included in the public
2 charge test. But the ambiguity and complexity of the Public Charge Rule could lead many
3 noncitizens and their families to forgo a wide swath of federal, state, and local benefits. *See*
4 *Manatt Report, supra*, pp. 4, 20. And even immigrants who understand the Rule’s exact
5 boundaries may disenroll from additional programs out of fear that future immigration policies
6 may consider participation in the currently exempt benefits programs. *See id.* at 7. This fear is
7 well-founded in the current political climate with its “sharper rhetoric about the value of
8 immigration, efforts to reduce legal immigration for the first time in decades, and ramped-up
9 arrests and deportations.” Jeanne Batalova et al., Migration Policy Institute, *Chilling Effects: The*
10 *Expected Public Charge Rule and Its Impact on Legal Immigrant Families’ Public Benefits Use 2*
11 *(June 2018) (Migration Policy Institute Report)*.⁶

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

19 But accounting for disenrollment by those who technically would not be impacted by the
20 Rule would reflect historical drops in benefits use after similar immigration reforms, such as the
21 Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA). PRWORA
22 established many of the current restrictions on immigrants receiving federal benefits, leaving the
23 limited list that immigrants can access today. But PRWORA’s *de facto* reach extended further,
24 affecting groups like citizen children and refugees whose eligibility was unchanged. *Migration*
25 *Policy Institute Report, supra*, p. 2. Refugees’ use of Medicaid, for instance, fell by 39 percent
26 and their use of food stamps by 60 percent. *Manatt Report, supra*, p. 11. Similarly, food-stamp

27 _____
28 ⁶ Available at <https://www.migrationpolicy.org/research/chilling-effects-expected-public-charge-rule-impact-legal-immigrant-families>.

1 use by citizen children in mixed-status families fell by 53 percent. *Migration Policy Institute*
 2 *Report, supra*, p. 15.

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

11 Although it may be ultimately “unclear how many individuals would actually disenroll
 12 from or forego enrollment in public benefits programs” and PRWORA studies “had the benefit of
 13 retrospectiv[ity],” 83 Fed. Reg. at 51,266, DHS cannot ignore past probative evidence simply
 14 because there is *some* uncertainty as to the Public Charge Rule’s effect. *See Michigan v. EPA*,
 15 135 S. Ct. 2699, 2706 (2015) (holding that the process by which an agency reaches its decision
 16 “must be logical and rational” and rest “on a consideration of the relevant factors” (internal
 17 citations and quotation marks omitted)); *Gebhart v. SEC*, 595 F.3d 1034, 1043 (9th Cir.
 18 2010) (reviewing an agency’s factual finding to determine whether it was supported by
 19 “such relevant evidence as a reasonable mind might accept as adequate to support a conclusion”).
 20 DHS was thus wrong to ignore the historical lessons of PRWORA, wrong to disregard the 2018
 21 disenrollment rates, and wrong to conclude that it was not obligated to account for
 22 underenrollment caused by confusion over the Public Charge Rule’s reach. For that reason alone,
 23 the Rule should be enjoined. *See Encino Motorcars, LLC v. Navarro*, 136 S. Ct. 2117, 2125
 24 (2016) (“The agency must examine the relevant data and articulate a satisfactory explanation for
 25 its action including a rational connection between the facts found and the choice made.” (internal

26 _____
 27 ⁷ Available at <https://www.urban.org/urban-wire/public-charge-rule-looming-one-seven-adults-immigrant-families-reported-avoiding-public-benefit-programs-2018>.

28 ⁸ Available at <https://www.kff.org/disparities-policy/fact-sheet/public-charge-policies-for-immigrants-implications-for-health-coverage/>.

1 citations and quotation marks omitted)).

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

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

7 The Public Charge Rule will not just deprive millions of needed public assistance; it will
 8 also harm their health. Most obviously, disenrollment from Medicaid and CHIP will result in
 9 immigrants and their families—including their U.S. citizen children—going without health
 10 insurance. But under virtually every metric, Medicaid enrollees report substantially better access
 11 to healthcare compared to similarly situated uninsured patients. *Manatt Report, supra*, p. 20.
 12 Medicaid coverage translates to regular access to a usual source of care—such as through a
 13 particular clinic or doctor’s office—prescription drugs, early diagnoses and treatments, and
 14 preventative mental-health care. Medicaid & CHIP Payment and Access Commission, *Key*
 15 *Findings on Access to Care* (last visited Aug. 30, 2019);⁹ American Hosp. Ass’n, *The Importance*
 16 *of Health Coverage*, at 2-3 (Nov. 2018);¹⁰ *see also* Larisa Antonisse et al., Kaiser Family Found.,
 17 *The Effects of Medicaid Expansion under the ACA: Updated Findings from a Literature Review*
 18 (Aug. 15, 2019) (reviewing 324 studies and concluding that most of these studies demonstrate
 19 that Medicaid expansion has improved access to care, utilization of services, affordability of care
 20 and even financial security among the low-income population).¹¹

21 But the Public Charge Rule will remove this access for up to 13.2 million immigrants and
 22 their citizen family members. *Manatt Report, supra*, pp. 5, 20. That’s up to 13.2 million people
 23 who will go without basic medical care and who will wait to seek care until they are more
 24 seriously ill and more difficult to successfully treat. *See* Board of Governors of the Fed. Reserve
 25 Sys., *Report on the Economic Well-Being of U.S. Households in 2017*, at 23 (May 2018)

26 ⁹ Available at <http://www.macpac.gov/subtopic/measuring-and-monitoring-access/>.

27 ¹⁰ Available at <https://www.aha.org/system/files/media/file/2019/04/report-coverage-overview-2018.pdf>.

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

1 (“Among the uninsured, 42 percent went without medical treatment due to an inability to pay,
2 versus 25 percent among the insured.”).¹²

3 Without insurance, immigrants are also likely to forgo important preventative health care
4 and services, including vaccinations and screening for communicable diseases. *See* City of
5 Chicago, Comment Letter on Proposed Rule: Inadmissibility on Public Charge Grounds, DHS
6 Dkt. No. USCIS-2010-0012 (Dec. 10, 2018)¹³. DHS acknowledges as much, admitting that the
7 Public Charge Rule will increase the prevalence of disease “among members of the U.S. citizen
8 population who are not vaccinated.” 83 Fed. Reg. at 51,270. In response, DHS offers only that it
9 “does not intend to restrict the access of vaccines for children or adults or intend to discourage
10 individuals from obtaining the necessary vaccines to prevent vaccine-preventable diseases.” 84
11 Fed. Reg. at 41,384. DHS further assumes that many individuals will still have access to
12 vaccinations because the Rule “does not consider receipt of Medicaid by a child under age 21, or
13 during a person’s pregnancy, to constitute receipt of public benefits.” *Id.* Additionally,
14 “[v]accinations obtained through public benefits programs are not considered public benefits
15 under 8 CFR 212.21(b), although if an alien enrolls in Medicaid for the purpose of obtaining
16 vaccines, the Medicaid itself qualifies as a public benefit.” *Id.* at 41,384-85. This response in and
17 of itself illustrates the complexity of the Public Charge Rule, undermining DHS’s determination
18 that immigrants will be able to effectively parse through these provisions and get the medical care
19 they require without being deemed a public charge. In any event, DHS concedes that even this
20 complex arrangement will solve only a “substantial portion, though not all, of the vaccinations
21 issue.” *Id.* at 41,384.

22 Reduced participation in Medicaid and CHIP will also make it harder for immigrant
23 families to afford care. Even with providers doing all they can to assist low-income patients,
24 Medicaid coverage is essential to keeping families out of debt, with one study estimating that
25 Medicaid lifted an estimated 2.6 to 3.4 million patients out of poverty in 2010. Benjamin D.

26
27 ¹² Available at <https://www.federalreserve.gov/publications/files/2017-report-economic-well-being-us-households-201805.pdf>.

28 ¹³ Available at <https://www.regulations.gov/document?D=USCIS-2010-0012-50648>.

1 Sommers & Donald Oellerich, *The Poverty-Reducing Effect of Medicaid*, 32 J. Health Econ. 816
 2 (2013); *see also* Karina Wagnerman, Georgetown University Health Policy Institute, *Medicaid:
 3 How Does It Provide Economic Security for Families?*, at 1 (Mar. 2017) (finding that the share of
 4 low-income families having trouble paying medical bills has decreased by almost 30 percent from
 5 2011 to 2016, the same period during which Medicaid expanded).¹⁴ By restricting immigrants’
 6 access to Medicaid and CHIP, the Public Charge Rule threatens families’ ability to afford needed
 7 care, and further jeopardizes their health.

8 The Public Charge Rule’s consequences fall even harder on children, who will likely
 9 disenroll from public benefits even though the Rule does not consider benefits receipt by children
 10 in public-charge determinations. Medicaid coverage has been shown to promote positive health,
 11 educational, and earnings outcomes lasting well into adulthood. *Manatt Report, supra*, p. 20;
 12 Karina Wagnerman, Alisa Chester & Joan Alker, Georgetown University Health Policy Institute,
 13 *Medicaid Is a Smart Investment in Children*, at 1 (Mar. 2017) (*Georgetown Report*).¹⁵
 14 Disenrollment from Medicaid will have correspondingly long-lasting effects. For example,
 15 studies find that Medicaid availability in childhood leads to decreased healthcare use in
 16 adulthood. *Id.* at 4; Michel H. Boudreaux, Ezra Golberstein & Donna D. McAlpine, *The Long-
 17 Term Impacts of Medicaid Exposure in Early Childhood: Evidence from the Program’s Origin*,
 18 45 J. Health Econ. 161 (2016). And childhood Medicaid availability significantly reduces
 19 mortality due to treatable causes later in life, with some populations experiencing reductions as
 20 high as 20 percent. *Georgetown Report, supra*, p. 5. Other lasting benefits of childhood
 21 Medicaid availability include improved test scores, a decreased high school dropout rate,
 22 increased college attendance, increased wages, and increased productivity in adulthood. *Id.* at 1,
 23 6. DHS should not be permitted to force families to choose between their green-card eligibility
 24 and the adverse effects of raising uninsured children.

25 ///

26 _____
 27 ¹⁴ Available at <https://ccf.georgetown.edu/wp-content/uploads/2017/03/Medicaid-and-Economic-Security.pdf>.

28 ¹⁵ Available at <https://ccf.georgetown.edu/wp-content/uploads/2017/03/MedicaidSmartInvestment.pdf>.

1 The Rule’s effect on patients’ health goes beyond just Medicaid and CHIP, with DHS
2 officials directed to consider public-benefits programs like food stamps and housing assistance.
3 Both have a well-documented impact on health status, particularly for children. Food insecurity
4 has been consistently linked to impaired growth, poor cognitive development, and obesity in
5 children. Patrick H. Casey, *Children in Food-Insufficient, Low-Income Families: Prevalence,*
6 *Health, and Nutrition Status*, 155 *Archives Pediatrics Adolescent Med.* 508, 508 (2001). Food-
7 insecure households are also often forced to choose between spending money on food and
8 spending money on medication, resulting in medication underuse. Dena Herman et al., *Food*
9 *Insecurity and Cost-Related Medication Underuse Among Nonelderly Adults in a Nationally*
10 *Representative Sample*, 105 *Am. J. Pub. Health* e48, e49 (2015) (finding that 26 percent of
11 households that reported food insecurity also reported skipping medications to save money). And
12 housing insecurity and homelessness are associated with higher risks of lead poisoning, gunshot
13 injuries, asthma due to increased air pollutants and allergens, and alcohol-related injuries in
14 children and adolescents. Paula Braveman & Laura Gottlieb, *The Social Determinants of Health:*
15 *It’s Time to Consider the Causes of the Causes*, 129 *Pub. Health Reports* 19, 22–23 (2014).
16 Children exposed to housing insecurity and homelessness likewise experience emotional and
17 psychological stressors arising from chronically inadequate resources that are associated with
18 increased vulnerability to a range of adult diseases, such as heart attacks, strokes, and smoking-
19 related cancers. *Id.* at 23–24.

20 These harms to health constitute precisely the kind of irreparable harm warranting a
21 preliminary injunction. *State v. Bureau of Land Mgmt.*, 286 F. Supp. 3d 1054, 1076 (N.D. Cal.
22 2018); *see also id.* (explaining that “substantial detrimental effects on public health,” unlike pure
23 economic cost, tip the balance in favor of granting the injunction); *State v. Azar*, 385 F. Supp. 3d
24 960, 969 (N.D. Cal. 2019) (finding that public health consequences can form the basis for finding
25 irreparable harm); *cf. Harris v. Bd. of Supervisors*, 366 F.3d 754, 766 (9th Cir. 2004) (holding
26 that reducing available public healthcare facilities would cause irreparable harm). The Court
27 should grant one.

28 ///

1 **B. Reduced Participation In Public Benefits Programs Will Also Increase**
 2 **Uncompensated Care, Straining Hospital Resources And Preventing**
 3 **Hospitals From Adequately Investing In Their Communities.**

4 Noncitizens and their families that drop or forgo Medicaid or CHIP coverage as a result of
 5 the Public Charge Rule will continue to have the same health care needs. But now they will
 6 likely postpone treatment, forcing hospitals to provide uncompensated care in emergency rooms
 7 for conditions that could have been treated, or even prevented, through primary-care visits. These
 8 added costs will likely prevent hospitals from fully serving their patients and communities.

9 Hospitals do their part to lessen the burden on patients struggling with health care costs, in
 10 part by providing tremendous amounts of uncompensated care—care for which the hospital
 11 receives no payment at all—to immigrants and other uninsured patients. In 2017, for example,
 12 uncompensated care totaled \$38.4 billion. American Hosp. Ass’n, *Uncompensated Hospital Care*
 13 *Cost Fact Sheet*, at 3 (Jan. 2019).¹⁶ This level of uncompensated care will increase if immigrants
 14 and their families disenroll from Medicaid and CHIP to avoid being labeled a public charge.
 15 *Immigrant Benefits, supra*. According to some estimates, hospitals are at risk of spending as
 16 much as \$17 billion dollars every year in additional uncompensated care costs from the Public
 17 Charge Rule. *Manatt Report, supra*, p. 5 (estimating that, in 2016, Medicaid and CHIP provided
 18 \$7 billion for noncitizen enrollees and \$10 billion for citizen enrollees who have a noncitizen
 19 family member). California hospitals account for over \$5 billion of that amount. *Id.* at 17.

20 The Public Charge Rule will also force hospitals to provide uncompensated care in one of
 21 the most expensive settings: The emergency room. Even DHS admits that the Public Charge
 22 Rule may lead to “increased use of emergency rooms and emergent care as a method of primary
 23 healthcare due to delayed treatment.” 84 Fed. Reg. at 41,384. That is, as patients delay
 24 preventative care, they will force hospitals to treat far more expensive and dangerous medical
 25 conditions that could have been caught much earlier but now present as emergencies. *Manatt*
 26 *Report, supra*, p. 20.

27 DHS contends that these effects will be mitigated by the Rule’s exemption for patients

28 ¹⁶ Available at <https://www.aha.org/system/files/2019-01/uncompensated-care-fact-sheet-jan-2019.pdf>.

1 who access Medicaid benefits to treat emergency conditions. 84 Fed. Reg. at 41,384. But many
2 immigrants may not be aware that emergency services are excluded, or may not know if someone
3 in their household is experiencing a true medical emergency as DHS chooses to define it. What’s
4 more, extending care only when a patient is in crisis will result in treatment of costly acute
5 conditions at a hospital emergency room instead of preventative care at clinics and doctors’
6 offices. *See Manatt Report, supra*, p. 20; Linda S. Baker & Laurence C. Baker, *Excess Cost of*
7 *Emergency Department Visits for Nonurgent Care*, 13 Health Affairs 162 (Nov. 1994) (noting
8 that providing services at hospital emergency rooms is more costly than providing the same
9 services at doctors’ offices); *cf.* Sean Elliott, *Staying Within the Lines: The Question of Post-*
10 *Stabilization Treatment for Illegal Immigrants Under Emergency Medicaid*, 24 J. Contemp.
11 Health L. & Pol’y 149, 163 (2007) (explaining that a narrow definition of “emergency medical
12 condition” in the context of Medicaid coverage for undocumented immigrants will prove more
13 costly overall because failure to properly treat the underlying condition will only result in the
14 recurrence of the emergency situation and the patient’s return to the emergency room). Studies
15 show that increased emergency-care volume has been associated with increased mortality, delays
16 in treatment, and increased rates of patient elopement. *See Winston Liaw et al., The Impact of*
17 *Insurance and a Usual Source of Care on Emergency Department Use in the United States*, 2014
18 Int. J. Family Med. 1, 1 (2014).

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

26 Finally, all hospitals will struggle to maintain their support for community-based
27

28 ¹⁷ Available at <https://www.regulations.gov/document?D=USCIS-2010-0012-45033>.

1 programs, including promoting vaccinations. *Id.* Community immunity is achieved only when a
 2 sufficient proportion of a population is immune to an infectious disease, making the disease’s
 3 spread from person to person unlikely. *See* U.S. Department of Health and Human Services,
 4 *Vaccines Protect Your Community* (Dec. 2017).¹⁸ Because many immigrants reside close to each
 5 other, clusters of unvaccinated individuals are likely to arise, increasing the risk of an outbreak.
 6 The Public Charge Rule will therefore harm not just immigrant families and hospitals, but the
 7 entire community.

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

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

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

24 And, as far back as 1981, Congress has been concerned with the “greater costs it found to
 25 be associated with the treatment of indigent patients.” *D.C. Hosp. Ass’n v. District of Columbia*,
 26 224 F.3d 776, 777 (D.C. Cir. 2000). Congress thus amended the Medicaid Act to provide
 27 additional funds for “hospitals which serve a disproportionate number of low-income patients

28 ¹⁸ Available at <https://www.vaccines.gov/basics/work/protection>.

1 with special needs.” 42 U.S.C. § 1396a(a)(13)(A)(iv). Congress’s “intent was to stabilize the
 2 hospitals financially and preserve access to health care services for eligible low-income
 3 patients.” *Virginia, Dep’t of Med. Assistance Servs. v. Johnson*, 609 F. Supp. 2d 1, 3 (D.D.C.
 4 2009).

5 The Public Charge Rule risks unravelling this framework by effectively denying public
 6 benefits to 13.2 million lawful immigrants and their families, including 6.7 million citizen
 7 children. *Manatt Report, supra*, p. 9. Indeed, the 6.7 million citizen children are potentially the
 8 largest demographic at risk of losing public benefits under the Public Charge Rule, as compared
 9 to only 3.6 million noncitizen adults, 0.9 million noncitizen children, and 2.1 million citizen
 10 adults. *Id.* Underenrollment in health, nutrition, and housing services has particularly devastating
 11 and long-lasting effects on children, *supra*, pp. 10–12, and DHS should not be permitted to cause
 12 these effects by expanding the definition of “public charge.” *See Whitman v. American Trucking*
 13 *Ass’n*, 531 U.S. 457, 468 (2001) (finding it “implausible” that Congress intended to give federal
 14 agencies the power to make major policy decisions through interpretation of “modest” statutory
 15 terms).

16 Not only that, but the Public Charge Rule undermines the very goals it sets out to achieve.
 17 According to DHS, one of the main purposes of the new public charge definition is to “promote
 18 the self-sufficiency of aliens within the United States.” 84 Fed. Reg. at 41,309. But non-cash
 19 public benefits like affordable health insurance are essential for individuals to achieve self-
 20 sufficiency by allowing them to stay healthy, be able to work, and care for their families. *See*
 21 Larisa Antonisse & Rachel Garfield, Kaiser Family Found., *The Relationship Between Work and*
 22 *Health: Findings from a Literature Review* (Aug. 7, 2018)¹⁹; *see also* Allan Dizioli and Roberto
 23 Pinheiro, *Health Insurance as a Productive Factor*, 40 *Labour Econ.* 1-24 (June 2016) (finding
 24 that workers with health insurance miss approximately 75 percent fewer work days and are more
 25 productive at work than their uninsured peers).²⁰ Even the Immigration and Naturalization
 26

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

28 ²⁰ Available at <https://www.sciencedirect.com/science/article/abs/pii/S0927537116300021>.

1 Service has recognized as much, determining that receipt of benefits in the short-run leads to self-
2 sufficiency over the long-term. 1999 Field Guidance on Deportability and Inadmissibility on
3 Public Charge Grounds, 64 Fed. Reg. 28,689, 28,692 (May 26, 1999) (explaining that “certain
4 federal, state, and local benefits” are being made available to families with incomes above the
5 poverty level to “assist[] working-poor families in the process of becoming self-sufficient”).

6 In sum, the Public Charge Rule contradicts Congress’s intent to reduce the number of
7 uninsured residents and even undermines the very self-sufficiency goals it sets out to achieve.
8 The Court should not allow the Rule to go into effect.

9 **CONCLUSION**

10 For the foregoing reasons and those in Plaintiffs’ briefs, the Court should grant a
11 preliminary injunction.

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