Nos. 18-587, 18-588, and 18-589

IN THE

Supreme Court of the United States

DEPARTMENT OF HOMELAND SECURITY, ET AL.,

Petitioners,

v.

REGENTS OF THE UNIVERSITY OF CALIFORNIA, ET AL.,

Respondents.

On Writ of Certiorari to the United States Court of Appeals for the Ninth Circuit

BRIEF FOR AMICI CURIAE ASSOCIATION OF AMERICAN MEDICAL COLLEGES, ET AL., IN SUPPORT OF RESPONDENTS

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Additional Captions Listed on Inside Cover

DONALD J. TRUMP, PRESIDENT OF THE UNITED STATES, ET AL.,

Petitioners,

v.

NATIONAL ASSOCIATION FOR THE ADVANCEMENT OF COLORED PEOPLE, ET AL.,

Respondents.

On Writ of Certiorari Before Judgment to the United States Court of Appeals for the District of Columbia Circuit

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KEVIN K. MCALEENAN, ACTING SECRETARY OF HOMELAND SECURITY, ET AL.,

Petitioners,

v.

MARTIN JONATHAN BATALLA VIDAL, ET AL.,

Respondents.

On Writ of Certiorari Before Judgment to the United States Court of Appeals for the Second Circuit

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INTEREST OF AMICI CURIAE

The **Association of American Medical Colleges** ("AAMC") is a non-profit educational association whose members include all 154 accredited U.S. medical schools, nearly 400 major teaching hospitals and health systems, and 80 academic and scientific societies.[1] Through these institutions and organizations, the AAMC represents 173,000 faculty members, 89,000 medical students, and 129,000 resident physicians. Founded in 1876, the AAMC, through its many programs and services, strengthens the world's most advanced medical care by supporting the entire spectrum of education, research, and patient care activities conducted by its member institutions.

The AAMC is joined in this brief by thirty-two organizations whose members include schools, residency programs, and other institutions involved in educating and training health care providers and administrators:

America's Essential Hospitals, American Academy of Child and Adolescent Psychiatry, American Academy of Family Physicians, **American Association of Colleges of Nursing, American Association of Colleges of Pharmacy, American College of Healthcare Executives, American College of Obstetricians and Gynecologists, American College of Physicians, American College of Preventive Medicine, American Dental Education Association,**

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[1] No counsel to a party authored this brief in whole or in part, no such counsel or a party made a monetary contribution intended to fund the preparation or submission of the brief, and no person other than the amici curiae made such a monetary contribution. The parties have consented to the filing of this brief.

American Medical Association, American Medical Student Association, American Nurses Association, American Psychiatric Association, American Public Health Association, American Society of Hematology, American Society of Nephrology, American Thoracic Society, Association of Academic Health Centers, Association of American Indian Physicians, Association of Schools and Programs of Public Health, Association of Schools of Allied Health Professions, Association of University Programs in Health Administration, California Medical Association, Council on Social Work Education, Greater New York Hospital Association, National Council of Asian Pacific Islander Physicians, National Hispanic Medical Association, National Medical Association, Physician Assistant Education Association, Pre-Health Dreamers, and Society of General Internal Medicine. Additional information regarding these organizations is provided in the Addendum to this brief.

SUMMARY OF THE ARGUMENT

The law is clear that the government cannot rescind a longstanding policy without, at a minimum, seriously considering the reliance interests that would be disrupted by such a change in course. Yet in this case, the government failed to make any serious effort to consider any of the substantial reliance interests affected by the rescission of the Deferred Action for Childhood Arrivals ("DACA") program.

This is particularly true with respect to the health care sector, for which the avoidance of unnecessary harm is a guiding principle. At this moment, an estimated 27,000 health care workers and support

staff depend on DACA for their authorization to work in the United States.[2] Among those 27,000 are nurses, dentists, pharmacists, physician assistants, home health aides, technicians, and others. *Id.*

The number also includes nearly 200 medical students, medical residents, and physicians who depend on DACA for their eligibility to practice medicine. If those trainees and physicians retain their work eligibility, each will care for an average of between 1,533 and 4,600 patients a year.[3] Together, over the course of their careers, they will touch the lives of 1.7 to 5.1 million U.S. patients.[4]

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[2] Nicole Prchal Svajlenka, *What We Know About DACA Recipients in the United States*, Ctr. for Am. Progress (Sept. 5, 2019), https://www.americanprogress.org/issues/immigration/news/2019/09/05/474177/know-daca-recipients-united-states/ (estimates based upon occupations under health care practitioners and technical occupations and health care support from the University of Minnesota's Integrated Public Use Microdata Series (IPUMS) USA 2017 American Community Survey occupational classification data).

[3] The Physicians Found., *2018 Survey of America's Physicians* at 57 (2018), https://physiciansfoundation.org/wp-content/uploads/2018/09/physicians-survey-results-final-2018.pdf (data indicating physicians see 20 patients per day on average, and work 230 days per year); Mark Murray et al., *Panel Size: How Many Patients Can One Doctor Manage?*, Family Practice Mgmt. at 47 (April 2007), https://www.aafp.org/fpm/2007/0400/p44.pdf (data indicates each patient is seen by their doctor one to three times a year).

[4] This calculation is based on 14.3% of patients being new patients during any given year, *see* Nat'l Ctr. for Health Stat., Ctr. for Disease Control, *National Ambulatory Medical Care Survey: 2016 National Summary Tables* (2016), https://www.cdc.gov/nchs/data/ahcd/namcs_summary/2016_namcs_web_tables.pdf, and an average career length of 35 years,

If DACA is rescinded, however, almost none of these people will be able to serve the American public in their chosen fields. This action would therefore nullify the substantial and long-term investments that DACA recipients, educational institutions, and the public have made in educating and training those recipients to provide needed health care services to the Nation. Their loss will have potentially devastating effects. It can take a decade or more to educate and train a new physician. As health care professional institutions and organizations, *amici* know that the resources to competently train capable physicians, nurses, and other medical and public health professionals are subject to substantial limitations. Each year and each dollar that a school spends to train one future physician or other health care worker is a year or dollar not spent training another. The decision to expend vast amounts of time, money, and effort in educating and training DACA recipients in the health care sector was thus made in reliance on the expectation that such individuals would be able to serve the public once educated and trained. Rescinding the program negates all of that substantial time, money, and effort spent.

Nor is the country prepared to fill the loss that would result if DACA recipients were excluded from the health care workforce. The number of physicians in the United States has not kept pace with our growing and aging population and a commensurate increase in patients needing care for a variety of chronic health conditions. It is estimated that in the next eleven years, the country will have between

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using data from the AAMC's 2019 National Sample Survey of Physicians, (publication forthcoming; data on file with AAMC).

46,900 and 121,900 fewer primary and specialty care physicians than it needs.[5] Shortages in other health professions, such as mental health, dentistry, and nursing, are worsening as well.[6] These shortages will be felt most keenly in medically underserved areas, such as rural settings and poor neighborhoods—precisely the areas in which DACA recipients are likeliest to work.[7]

The risk of a pandemic also continues to grow, since infectious diseases can spread around the globe in a matter of days due to increased urbanization and international travel.[8] These conditions pose a threat to America's health security—its preparedness for and ability to withstand incidents with public-health consequences. To ensure health security, the country needs a robust health workforce. Rescinding DACA, however, would deprive the public of domestically educated, well-trained, and otherwise qualified health

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[5] Ass'n of Am. Med. Colls., *The Complexities of Physician Supply & Demand: Projections from 2017 to 2032* at 2 (Apr. 2019), https://tinyurl.com/yxbh2nhv.

[6] *See* Henry J. Kaiser Fam. Found., *Mental Health Care Health Professional Shortage Areas (HPSAs)* (last visited September 24, 2019), https://tinyurl.com/y9u2g69b; Henry J. Kaiser Fam. Found., *Dental Care Health Professional Shortage Areas (HPSAs)* (last visited September 24, 2019), https://tinyurl.com/yye44kpy.

[7] Angela Chen, PhD et al., *PreHealth Dreamers: Breaking More Barriers Survey Report* at 27 (Sept. 2019), https://tinyurl.com/y436och3.

[8] Office of the Assistant Sec'y for Preparedness and Response, Dep't of Health and Human Servs., *National Health Security Strategy 2019-2002* at 5-6, (last visited Sept. 24, 2019), https://www.phe.gov/Preparedness/planning/authority/nhss/Documents/NHSS-Strategy-508.pdf.

care professionals who have been provided education in reliance on their ability to continue to work in the United States as health care professionals.

As the courts below correctly recognized, the government failed to seriously consider these or any of the other substantial reliance interests engendered by DACA. By rescinding DACA on the basis of a cursory and conclusory analysis that failed to consider real-world effects, the government ignored the significant reliance interests of U.S. health professional schools, hospitals, other institutions, and U.S. patients, as well as those of DACA recipients themselves. The rescission was therefore arbitrary and capricious, and the decisions below should be affirmed.

ARGUMENT

I. AGENCIES CANNOT CHANGE POLICIES WITHOUT FAIRLY ADDRESSING RELIANCE INTERESTS.

Under the Administrative Procedure Act ("APA"), courts must set aside agency actions that are "arbitrary, capricious, [or] an abuse of discretion." 5 U.S.C. § 706(2)(A). That standard requires an agency to "examine the relevant data and articulate a satisfactory explanation for its action." *Motor Vehicle Mfrs. Ass'n of U.S., Inc.* v. *State Farm Mut. Auto. Ins. Co.*, 463 U.S. 29, 43 (1983). An agency acts arbitrarily or capriciously if it "fail[s] to consider an important aspect of the problem" it is addressing. *Id.*

Where—as here—an agency considers reversing or rescinding an existing policy, one "important aspect of the problem," *State Farm*, 463 U.S. at 43, is the possibility that segments of the public may have ordered their affairs in reliance on existing rules. This Court has made clear that in such circumstances,

an agency must—at the very least—"display awareness that it is changing position" and "take[] into account" any "serious reliance interests" fostered by the prior policy. *FCC* v. *Fox Television Stations, Inc.*, 556 U.S. 502, 515 (2009). The agency cannot act in spite of those interests without providing a "reasoned explanation * * * for disregarding facts and circumstances that * * * were engendered by the prior policy." *Id.* at 516. To "ignore such matters" violates the APA. *Id.* at 515.

This Court has applied the *Fox* standard to informal policy statements. In *Encino Motorcars, LLC* v. *Navarro*, 136 S. Ct. 2117 (2016), the Court invalidated a regulation that classified certain employees as subject to federal wage-and-hour laws. *Id.* at 2123, 2126. Because that regulation contravened a prior, informal policy statement excluding those same employees, the Court held that the agency needed to provide more than a "summary discussion" before issuing it. *Id.* at 2126. Indeed, in light of the "serious reliance interests * * * at stake," any "reasoned explanation" had to justify not only the rule the agency adopted, but also the "decision to depart from its existing enforcement policy." *Id.* at 2126-27 (agency had "duty to explain why it deemed it necessary to overrule its previous position"). What might "suffice in other circumstances"—*i.e.*, where an agency is writing on a blank slate—is inadequate where an agency decision reflects a departure from prior enforcement policy. *Id.* at 2126; *see also*, *e.g.*, *Nat'l Lifeline Ass'n* v. *FCC*, 921 F.3d 1102, 1114 (D.C. Cir. 2019) (agency action "was arbitrary and capricious" in "departing from" a prior non-enforcement policy while "failing to consider * * * the reliance interests" of regulated parties and others).

As the courts below recognized, the government's decision to end DACA "demonstrates no true cognizance of the serious reliance interests at issue." *NAACP* v. *Trump*, 315 F. Supp. 3d 457, 473 (D.D.C. 2018). Respondents have raised this issue in broad terms. *See* Br. for Regents of Univ. of Cal., at 40-43. As further shown below, the issue is substantial and far-reaching: health professional schools, hospitals, and other institutions have made significant, long-term investments of time and money in the training of DACA recipients wholly in reliance on these individuals' continued work authorization under DACA. These investments were made amidst severe shortages of trained health care workers, where the nation needs every single one available. Nothing in the record shows that the government considered these or any other disruptions of significant reliance interests at all, much less gave them the serious consideration that the law requires. And because the courts below correctly found that the government did not, this Court should affirm the judgments and hold that DACA's rescission was arbitrary and capricious.

II. LOSS OF DACA STATUS FOR HEALTH CARE TRAINEES AND PROFESSIONALS WOULD NULLIFY SUBSTANTIAL INVESTMENTS MADE BY SCHOOLS, OTHER INSTITUTIONS, AND RECIPIENTS, TO THE PUBLIC'S SIGNIFICANT DETRIMENT.

A. Recipients Depend On DACA For Their Work Eligibility.

The reliance interests in this case arise because DACA is the sole source of work authorization for

most of its recipients.[9] Such authorization is critical to anyone seeking to practice medicine or otherwise work in the health care sector in the United States. Federal law prohibits anyone from hiring or from continuing to employ any person who is not authorized by the federal government to work. *See* 8 U.S.C. §§ 1324a(a)(1)-(2), (h)(3).

As relevant here, only three classes of noncitizens are eligible for work authorization: those who are lawfully admitted to the United States, those who have visas, and those eligible to apply for work authorization owing to specific circumstances. *See* 8 C.F.R. § 274a.12. By definition, DACA recipients have entered the country without legal authorization, and thus are only eligible—if at all—for work authorization under the third category.

DACA thus provides its recipients with a way to be self-sufficient and contribute to the U.S. workforce and economy. Any noncitizen "who has been granted deferred action" may apply for and receive authorization so long as "the alien establishes an economic necessity for employment." 8 C.F.R. § 274a.12(c)(14).

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[9] *See* Shoba Sivaprasad Wadhia, *Demystifying Employment Authorization & Prosecutorial Discretion in Immigration Cases*, 6 Colum. J. Race & L. 1, 3 (2016) (DACA provides a route to work authorization that the "vast majority" of its recipients would otherwise lack).

B. Medical Schools, Teaching Hospitals, And Other Educational And Health Care Institutions Expended Vast Amounts Of Time, Money, And Other Resources In Reliance On DACA.

Medical schools, teaching hospitals, and other health care institutions have invested heavily in DACA recipients, in reliance on the premise that they would be legally authorized to perform the jobs for which they have been, or are being, trained. Those investments, moreover, were made to serve the public interest, as the country faces an ever-increasing shortage in the number of health care professionals.

Since 1982, students who arrived in the United States without legal authorization as children have been able to benefit from public K-12 education. *Plyler* v. *Doe,* 457 U.S. 202, 223 (1982). Some of these children have found ways to pay for college educations. However, prior to DACA, medical school was not a realistic option for undocumented immigrants who were brought to the U.S. as children. Without formal recognition of deferred action status from the government, undocumented immigrants were legally foreclosed from working as licensed physicians and thus could not meet the technical standards for admission into most medical schools. There are a limited number of seats in medical schools, and each medical school takes seriously its responsibility to the public to use every available seat to produce a physician capable of contributing to the health care workforce. Consequently, before 2013 no medical school had any published policy allowing undocumented immigrants to be accepted into their programs.

DACA changed this calculus. As related by one department chair, DACA provided the "missing link" for medical schools to accept qualified noncitizens because it offered a route to work permits for recipients.[10] In the autumn of 2013, the first DACA recipients entered medical school, and in the ensuing years the number of DACA applicants and matriculants steadily grew. As of the 2019 application cycle, 65 medical schools across the country have reported admissions policies that include DACA recipients. Those schools include Alpert Medical School at Brown University, Georgetown University School of Medicine, Harvard Medical School, Stritch School of Medicine at Loyola University ("Stritch"), Michigan State University College of Human Medicine, University of Minnesota Medical School, University of Nevada Reno School of Medicine, Medical College of Wisconsin, Yale School of Medicine, and others. According to AAMC data, nearly 200 DACA recipients have matriculated into medical school, and many of them have graduated and entered or completed their medical residencies.

It was DACA that allowed medical schools to accept and train nearly all of these students. For example, Rosa Aramburo graduated college with degrees in biology and literature. *Id*. One of her college advisors wrote to the department chair of medical education at Stritch that "one of the brightest students he had ever encountered was about to slip through the cracks because of her undocumented status." *Id*.

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[10] Sarah Conway & Alex V. Hernandez, *Loyola's DACA Medical Students, Largest Group in the Country, Plagued with Uncertainty*, Chicago Trib. (Sept. 13, 2017), https://tinyurl.com/y485wmxu.

Dr. Aramburo's talent and drive, along with DACA's extension of work authorization, inspired Stritch to admit her. She has since earned her M.D. and is now in the first year of her Obstetrics and Gynecology residency.

More broadly, DACA recipients, like their citizen counterparts, were selected for admission to medical school because of their academic and personal achievements. Many were high school valedictorians. Most have undergraduate degrees in complex sciences, such as integrative biology, neurology, physics, and molecular and cellular biology. Many have impressive volunteer and leadership experiences. All scored competitively on the Medical College Admission Test. Moreover, the very fact of their having met the rigorous qualifications for admission to medical school is a testament to their determination and fortitude—precisely the attributes one looks for in a physician.

Teaching hospitals have also invested substantial time and money in training residents with DACA-dependent work authorization. There are currently an estimated 41 medical residents with DACA status, including many whose residencies are nearly complete. The direct training costs for these residents has been estimated at $157,602 per resident, per year.[11] Based upon available data, the AAMC

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[11] Health Res. & Servs. Admin., U.S. Dep't of Health & Human Servs., *Cost Estimates for Training Residents in a Teaching Health Center* at 2 (last visited Sept. 24, 2019), https://bhw.hrsa.gov/sites/default/files/bhw/grants/thc-costing-fact-sheet.pdf. This number does not include indirect costs or those associated with the physical space and equipment retrofitting required to host and train medical residents.

estimates that, as of February 2019, hospitals in the U.S. have invested approximately $5 million training medical residents with DACA status.[12] Accompanying this significant financial investment is an investment of tens of thousands of hours in supervision, training, and administration. As with all physicians' residency training, enormous resources have been expended with the expectation of a return on that investment in the form of highly-trained professionals able to serve the public by practicing medicine independently. These investments would not have been made but for reliance on DACA recipients' continued eligibility to work in the U.S.

Other health professional schools have invested in the training of DACA recipients for the health care workforce. DACA recipients are also pursuing or have obtained graduate degrees in medical sciences. With the support of privately funded fellowships or in collaboration with universities, these individuals are researching radiation sensors, the role of cholesterol regulation in breast cancer cells, the formation of genetic abnormalities associated with cancer, changes in the structure and function of proteins that may result in autoimmune disorders, and cognitive

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[12] According to available self-reported AAMC data, most recently updated in February 2019, there was one DACA resident in 2016-2017, eight DACA residents in 2017-2018, and twenty DACA residents in 2018-2019. Because the AAMC has not collected data on DACA status consistently across programs, these numbers are not comprehensive. The five million dollar figure quoted above does not include costs associated with an additional 20 or more DACA residents who began residencies in 2019. (Data on file with AAMC).

neuroscience, among other things.[13] As with other health care professionals, these researchers' ability to continue their work in their fields is contingent upon work authorization.

All of these institutions have invested money, time, and other resources into DACA recipients' training and development because of the promise presented by these bright learners, eager to contribute their talents to the health care workforce. Institutions would not have made these investments but for their reliance on the continued work authorization afforded by the DACA program.

C. DACA Recipients Relied On Their Eligibility To Work When They Decided To Invest Their Own Time, Effort, And Resources In A Health Care Career.

Thousands of DACA recipients have also invested vast amounts of their own time, effort, and resources to be able to serve the United States health care system. Health professional education is expensive, and financing that education presents even greater challenges for most DACA recipients than it does for citizens.

The necessary financial investments only increase with medical school. Many DACA recipients patch together tuition with merit-based scholarships and private loans, all provided and accepted with the expectation that they will be eligible for future employment in the field in which they are being

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[13] Evelyn Valdez-Ward, *The End of DACA Would Be a Blow to Science*, Sci. Am. Blog Network (Dec. 12, 2018), https://blogs.scientificamerican.com/voices/the-end-of-daca-would-be-a-blow-to-science/.

trained.[14] Because most DACA students are not eligible for federal loans,[15] most finance their education through the private sector. Their only realistic route to repay those loans turns on their ability to practice medicine after residency, which in turn is dependent on their continued work authorization through DACA.

Even apart from financial investments, DACA recipients have made substantial investments of both time and effort in the reasonable expectation that they will practice in their chosen field. Physicians, for example, between post-graduate preparatory courses, four years of medical school, and three to nine years in internships, residencies, and fellowships, may spend more than half of their lives in training before being able to independently practice.[16] Like others pursuing a career in medicine, DACA recipients who are or will become physicians have delayed making an income for four or more years after graduating college, and may have instead accrued debt, so that they could acquire the skills they will need to treat patients. Other health care workers make similar sacrifices.

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[14] Pre-Health Dreamers, *Frequently Asked Questions & Answers about Medical School for Pre-med Undocumented Students Across the Nation* at 11-14 (last visited Sept. 24, 2019), https://tinyurl.com/yyhcsqkt.

[15] *See* Fed. Student Aid, U.S. Dep't of Educ., *Who Gets Aid: Non-U.S. Citizens* (last visited Sept. 24, 2019), https://studentaid.ed.gov/sa/eligibility/non-us-citizens ("Undocumented students, including DACA recipients, are not eligible for federal student aid.").

[16] Amy E. Thompson, MD, *A Physician's Education*, J. Am. Med. Assoc. (Dec. 10, 2014), https://jamanetwork.com/journals/jama/fullarticle/2020375.

D. Rescinding DACA Will Nullify These Investments And Worsen A Shortage Of Health Care Professionals In The United States.

Each DACA recipient in the health care sector embodies a substantial, irreplaceable investment of time and resources made with the reasonable expectation that that recipient would be eligible to put his or her education and training into practice. Every dollar or hour invested in a DACA recipient's education and training during the past seven years is a dollar or hour not invested in someone else's.

For that reason, the resources expended on DACA recipients' educations cannot ever be recouped. If those individuals are prevented from working in the U.S., their abrupt absence will leave a critical gap in the health professional workforce. While the medical field has worked to expand its training capacity, it cannot backfill such a significant number of trainees. Even if new resources were suddenly found to educate and train replacement physicians, it would be ten years before any of those physicians had the training and preparation to practice medicine independently. Because of these limitations, medical schools and teaching hospitals strive not to lose a single medical student or resident. The loss of all DACA medical students and residents if DACA is rescinded would mark a concrete and enduring loss to medical schools, teaching hospitals, and the U.S. public at large.

In addition to the harm to educational institutions, rescinding DACA also threatens to exacerbate a broader threat facing the country. Over the next decade, the United States will face increased health care challenges arising from its aging population. By 2050, adults over the age of 65 will make up 20% of

the population, outnumbering children for the first time in U.S. history.[17] Almost half of the population is expected to have at least one chronic disease by 2020, and as the population ages this number will increase.[18] Due in large part to the aging population, the growth in demand for health care services workers in the next decade is projected to outstrip that of any other occupational group.[19]

This increase in demand will be met by a projected decrease in supply. More than a third of all currently active physicians will be 65 or older within the next decade, and will retire at a rate faster than new graduates can replace them.[20] The AAMC's workforce studies have projected a future shortfall of between 46,900 to 121,900 primary and specialty care physicians by 2032.[21] Shortages are and will continue to be experienced in other health care professions as well.[22]

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[17] U.S. Census Bureau, *Older People Projected to Outnumber Children for First Time in U.S. History* (Sept. 6, 2018).

[18] Wullianallur Raghupathi & Viju Raghupathi, *An Empirical Study of Chronic Diseases in the United States: A Visual Analytics Approach to Public Health*, 15 Int'l J. Envtl. Res. & Pub. Health 431, 431 (Mar. 2018), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5876976/.

[19] Bureau of Labor Stat., U.S. Dep't of Labor, *Occupational Outlook Handbook: Healthcare Occupations* (September 4, 2019), https://www.bls.gov/ooh/healthcare/home.htm.

[20] Ass'n of Am. Med. Colls., *supra* note 5, at x, 4.

[21] *Id.* at 1-2.

[22] Ctr. For Health Workforce Studies, SUNY-Albany Sch. of Pub Health, *Health Care Employment Projections, 2016-2026: An Analysis of Bureau of Labor Statistics Projections by Setting and by Occupation* at 3 (Feb. 2018), https://tinyurl.com/y58hfz6x

These shortages are nationwide. Texas, for example, has nearly 1,200 health professional shortage areas (HPSAs) that have been designated by the Health Resources and Services Administration (HRSA).[23] Nationwide, there are 6,782 dental HPSAs, with 56 million affected people, requiring 9,951 additional practitioners to fill the gaps. Over the next decade, thirty-seven states will have a shortage of primary care physicians, seven will face a shortage of nurses, and there will be shortages among cardiologists, gastroenterologists, hematologists, oncologists, and pulmonologists.[24] Across the nation,

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(projecting annual need of 37,000 new physicians, nurse practitioners, and physician assistants). The Henry J. Kaiser Family Foundation similarly estimates a nationwide shortage of 6,894 mental-health professionals and 10,635 dental health professionals. Henry J. Kaiser Fam. Found., *supra* note 6.

[23] *See generally* Health Res. & Servs. Admin., U.S. Dep't of Health & Human Servs., *Health Professional Shortage Areas* (last visited Sept. 24, 2019), https://bhw.hrsa.gov/shortage-designation/hpsas.

[24] Nat'l Ctr. For Health Workforce Analysis, U.S. Dep't of Health & Human Servs., *State-Level Projections of Supply and Demand for Primary Care Practitioners: 2013-2025*, at 5 (Nov. 2016), https://bhw.hrsa.gov/sites/default/files/bhw/health-workforce-analysis/research/projections/primary-care-state-projections2013-2025.pdf; Nat'l Ctr. For Health Workforce Analysis, U.S. Dep't of Health & Human Servs., *Supply and Demand Projections of the Nursing Workforce: 2014-2030*, at 4-5 (July 21, 2017), https://bhw.hrsa.gov/sites/default/files/bhw/nchwa/projections/NCHWA_HRSA_Nursing_Report.pdf (identifying shortages of RNs in 7 states and shortages of LPNs in 33 states); Nat'l Ctr. For Health Workforce Analysis, U.S. Dep't of Health & Human Servs., *National and Regional Projections of Supply and Demand for Internal Medicine Subspecialty Practitioners: 2013-2025*, at 4 (Dec. 2016), https://bhw.hrsa.gov/sites/default/files/bhw/health-workforce-

HRSA has identified more than 5,000 areas in the U.S. with a shortage of mental-health professionals, which means that less than half of this nation's need for mental health treatment is being addressed.[25] By removing current and expected health professionals from practice, rescinding DACA will only worsen these shortages.

DACA health care workers are an important part of the nation's response to health care shortages in regions and communities with insufficient access to health care or culturally responsive care, as these are the communities where DACA recipients have shown a propensity to work. According to a survey of undocumented youth interested in health careers conducted in 2016, 97% expressed plans to ultimately work in the neighborhoods in which they grew up, or other underserved areas.[26] That number is consistent with other studies demonstrating that individuals who are under-represented in medicine are twice as likely to pursue careers working with underserved populations.[27]

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analysis/research/projections/internal-medicine-subspecialty-report.pdf.

[25] *See* Health Res. & Servs. Admin., U.S. Dep't of Health & Human Servs., *Map Tool—Shortage Areas*, (last visited Sept. 24, 2019), https://data.hrsa.gov/hdw/tools/MapTool.aspx (showing mental health shortage areas).

[26] Chen, *supra* note 7, at 27 .

[27] Andrea N. Garcia et al., *Factors Associated with Medical School Graduates' Intention to Work with Underserved Populations: Policy Implications for Advancing Workforce Diversity*, Acad. Med. (Sept. 2017), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5743635/.

DACA recipients currently in health professional schools have discussed painful childhood experiences that motivated them to pursue careers in the medical profession: family members unnecessarily suffering—and even dying—from treatable conditions like diabetes, breast cancer, stroke, heart conditions, prostate cancer, and anemia due to a lack of access to care. "The older I got," says Ali Torabi, a medical student at Stritch, "the more I recognized the disparities between my community and the communities that had access to health care. I've had injuries where I've avoided going to the hospital * * * because broken bones are expensive."[28] Blanca Morales, a fourth-year medical student at Harvard, recalls how some of her family members with diabetes went without medical support. "I remember thinking that we have all this new technology and these new advances in managing diabetes, but we can't access them." *Id.* For these young people, becoming a physician for the underserved is not just a profession but a calling. As Hector Perez, a public health graduate student at Columbia, puts it: "my passion for public health arose from my undocumented immigrant identity."[29] "Seeing * * * all the extra hurdles you have to go through when you are underprivileged," says Sharjeel

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[28] Gabrielle Redford, DACA Students Risk Everything to Become Doctors (Sept. 17, 2018), https://www.aamc.org/news-insights/daca-students-risk-everything-become-doctors.

[29] Hector Sanchez Perez, *Student Blog: I'm a Mailman Dreamer* (Feb 20, 2018), https://www.mailman.columbia.edu/public-health-now/news/student-blog-im-mailman-dreamer.

Syed, a medical student at Stanford, "makes me want to * * * create solutions."[30]

States have recognized the criticality of DACA recipients to health care in rural and underserved areas. After the Arkansas Board of Nursing announced in 2017 that it would no longer license DACA recipients to practice, the state legislature quickly reversed course in light of the impact of the loss of these trained nurses. The legislature instead recognized that Arkansas was "suffering from a nursing shortage across the state," such that it was "in the best interest of the State of Arkansas to make full use of the skills and talents in the state by ensuring that an individual who is work-authorized under the [DACA] policy is able to obtain an occupational or professional license and practice his or her occupation or profession."[31] Similar bills have been passed in other states with health care shortages, such as Nebraska, Indiana, and Nevada.[32]

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[30] Redford, *supra* note 30.

[31] H.B. 1552, 92d Gen. Assemb., Reg. Sess., § 1(a)(6) (Ark. 2019), http://www.arkleg.state.ar.us/assembly/2019/2019R/Bills/HB1552.pdf.

[32] A.B. 275, 80th Sess., § 2 (Nev. 2019), https://legiscan.com/NV/text/AB275/id/2030359/Nevada-2019-AB275-Enrolled.pdf ("The Legislature hereby finds and declares that * * * It is in the best interests of this State to make full use of the skills and talents of every resident of this State [and] it is the public policy of this State that each resident of this State, regardless of his or her immigration status, is eligible to receive the benefit of applying for a license, certificate or permit pursuant to 8 U.S.C. 1621(d)."); S.E.A. 419, 120th Gen. Assemb., 2d Reg. Sess., § 1(C) (Ind. 2018), http://iga.in.gov/static-documents/3/5/f/f/35ff8b3b/SB0419.05.ENRH.pdf (expands eligibility for professional licensure to individuals who have been "authorized by the federal

Illinois has also applied DACA recipients' willingness to work in underserved communities as part of its strategy to address state health care shortages. In 2013, Illinois provided financial resources to enable DACA medical and dental students in the State with education and training in order to serve underserved communities in the State.[33] Under that program, loan recipients agree to a yearly service obligation that requires them to work in a primary-care specialty in one of several types of underserved areas in the state of Illinois. For each year of funding recipients receive from Illinois, they agree to spend a year serving a population in need. *Id*. Loan recipients under this program who have graduated medical school are currently in medical residencies and have not yet begun their service obligations. To date, Illinois has invested millions in these students to address its underserved populations. If the administration is permitted to rescind DACA, Illinois will lose not only the money it has already invested (which would otherwise be recouped through loan repayment funded by recipients' earnings as physicians) but also the promise of needed care in shortage areas.

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government to work in the United States"); L.B. 947, § 3(a) (Neb. 2016), https://nebraskalegislature.gov/FloorDocs/104/PDF/Slip/LB947.pdf ("The Legislature finds that it is in the best interest of the State of Nebraska to make full use of the skills and talents in the state by ensuring that a person who is work-authorized is able to obtain a professional or commercial license and practice his or her profession.").

[33] *See* Ill. Fin. Auth., Board Book, at 53 (July 9, 2013), https://tinyurl.com/yxqa2cjw (describing program); Ill. Fin. Auth., Resolution 2013-0709-AD05 (July 9, 2013), https://tinyurl.com/y6o23j96 (approving program).

These states' investments into DACA health care professionals was made in the context of what was known and projected about shortages. However, if DACA is rescinded, these projections will change, and our nation's health needs will deepen. A rescission of DACA is a threat to public health: the sudden loss of employment by roughly a million people will likely result in a concomitant reduction in their living conditions, their mental health, and their ability to seek preventative health care.[34] The impact will not be contained to the undocumented immigrant community, and will put additional pressure on the nation's health care infrastructure,[35] as the need for health care professionals increases at the same time that tens of thousands of health care professionals are excluded from the workforce.

In addition to providing much-needed health care, physicians also contribute to the economies of the communities in which they work. A 2018 study by the American Medical Association showed that, on average, every physician supports the employment of over seventeen other people, generates $3.2 million dollars of economic activity, contributes $1.4 million to workers' wages and benefits, and generates $126,129

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[34] Atheendar S. Venkataramani, M.D., Ph.D. & Alexander C. Tsai, M.D., Ph.D., *Dreams Deferred—The Public Health Consequences of Rescinding DACA*, 377 New Eng. J. Med. 1707, 1708 (Nov 2, 2017).

[35] Osea Giuntella & Jakub Lonsky, *The Effect of DACA on Health Insurance, Access to Care, and Health Outcomes*, at 14, IZA Inst. of Labor Econ. Discussion Paper Series (Apr. 2018) (Concluding that a rescission of DACA could have detrimental effects on DACA recipients, health care providers, and public health officials).

in state and local tax revenue.[36] Physicians also act as financial multipliers in the communities they serve by providing cost-efficient preventative care and adding jobs to the local economy. For every DACA student or physician who loses work authorization, cities, states, and the country will lose these significant benefits.

The effects of rescinding DACA will extend far beyond the impact on DACA recipients themselves. For years, health professional schools, hospitals, and even states themselves have invested substantially in educating and training DACA recipients under the expectation that they would be able to return that investment with a lifetime of practice that benefits the public in ways that will be crucial over the next decades. These serious reliance interests warranted consideration before the government decided to rescind DACA.

III. THE GOVERNMENT ACTED ARBITRARILY AND CAPRICIOUSLY IN FAILING TO TAKE ACCOUNT OF ANY OF THESE AND OTHER SERIOUS RELIANCE INTERESTS.

Nothing in the government's effort to justify its change in position even attempts to take account of the weighty reliance interests set forth above. To the contrary, the government provided only a brief statement that to the extent reliance interests exist, they

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[36] Am. Med. Ass'n, *2018 American Medical Association Economic Impact Study*, (last visited Sept. 24, 2019), https://www.physicianseconomicimpact.org/.

are less important than DACA's supposedly "questionable legality," along with unspecified "other reasons for ending" it. *NAACP*, 315 F. Supp. 3d at 473.

Even now, the government all but dismisses reliance interests. In barely more than a page of its brief, the government argues that DACA could not have engendered any reliance interests because it was not intended to confer any "substantive right," and that whatever reliance interests may have arisen were overcome by the "legal and institutional concerns" arising from DACA itself. *See* Pet. Br. 42-43; *Regents* Pet. App. 101a, 125a.

Neither of these arguments justifies the government's failure to consider reliance interests. By definition, where an agency has the ability to reverse an existing regulatory program, that program will not confer permanently vested rights. This Court has made clear, however, that in these circumstances, the agency must still give serious consideration to reliance interests that would be disrupted by that action. This Court has further held that even informal policy statements issued through an opinion letter may suffice to engender serious reliance interests. *See*, *e.g.*, *Encino Motorcars*, 136 S. Ct. at 2123, 2126. Likewise here, the government's reliance on a single, boilerplate statement at the end of a memorandum that accompanied DACA's issuance, *see Regents* Pet. App. 101a, does not address any of the practical effects that DACA has had on the medical profession and others over the years since DACA was put in place.

Nor has the government adequately addressed reliance issues through its assertion that its "legal and institutional concerns" outweighed those reliance interests. *See* Pet. Br. 42-43. That argument is no better than the reasoning this Court found

insufficient in *Encino Motorcars*. *Compare Regents* Pet. App. 125a, *with Encino Motorcars*, 136 S. Ct. at 2126-27.

In any event, to the extent the government acknowledged reliance interests, its consideration was limited to the reliance interests of DACA recipients themselves. *See Regents* Pet. App. 125a (noting that "neither any individual's reliance * * * nor the sympathetic circumstances of DACA recipients as a class" sufficed to avoid rescinding DACA). It did not consider the reliance interests of any other group, such as the effects rescinding DACA would have on American health care. This includes the effects on our health professions and educational communities, like the ones *amici* represent, who have already invested substantial and irreplaceable resources educating and training DACA recipients to care for the American public.[37] The government's analysis therefore does not comport with the requirement to consider reliance interests beyond parties directly subject to a regulatory change. *See*, *e.g.*, *Nat'l Lifeline Ass'n*, 921 F.3d at 1114-15.

In sum, the government's analysis and stated rationale are plainly deficient. Accordingly, the lower courts were correct that rescinding DACA without

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[37] The institutional expenditures set forth above reflected entirely reasonable reliance on DACA's continuing viability. As late as April 23, 2017—just months before the current administration attempted to rescind the program—President Trump assured the country that "the dreamers should rest easy," because he was only "after the criminals." Interview by Julie Pace with Donald Trump, Associated Press (Apr. 23, 2017), https://tinyurl.com/lr7z7ye.

considering weighty, unaddressed reliance interests was arbitrary and capricious.

CONCLUSION

For the foregoing reasons and those in the respondent's brief, the judgment should be affirmed.

Respectfully submitted,

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ADDENDUM

AMICI CURIAE

America's Essential Hospitals—an association of more than 300 hospitals and health systems dedicated to high-quality care for all, including the most vulnerable, and that provide specialized, lifesaving services, train the health care workforce, advance public health and health equity, and coordinate care.

American Academy of Child and Adolescent Psychiatry—a medical membership association established by child and adolescent psychiatrists in 1953. With over 9,500 members strong, AACAP is the leading national medical association dedicated to treating and improving the quality of life for the estimated 7-15 million American youth under 18 years of age who are affected by emotional, behavioral, developmental and mental disorders.

American Academy of Family Physicians—represents 134,600 family physicians, family-medicine residents, and medical students from all fifty states, the District of Columbia, Guam, Puerto Rico, the Virgin Islands, and the Uniformed Services of the United States.

American Association of Colleges of Nursing—is the national voice for academic nursing. Representing over 825 member schools offering baccalaureate and graduate programs in nursing at public and private universities nationwide, AACN works to establish quality standards for nursing education; assists schools in implementing those standards; influences the nursing profession to improve health care; and promotes public support for professional nursing education, research, and practice.

American Association of Colleges of Pharmacy—represents pharmacy education in the United States to advance pharmacy education, research, scholarship, practice, and service in partnership with members and stakeholders, to improve health for all.

American College of Healthcare Executives—an international professional society of more than 48,000 healthcare executives who lead hospitals, healthcare systems, and other healthcare organizations.

American College of Obstetricians and Gynecologists—is a not-for-profit educational and professional organization with more than 58,000 members dedicated to the healthcare of women.

American College of Physicians—represents 159,000 internal-medicine physicians (internists), related subspecialists, and medical students.

American College of Preventive Medicine—a professional medical society of more than 2,700 preventive medicine and public health physicians who manage, research, and influence population health.

American Dental Education Association—the "Voice of Dental Education," with members that include all 68 U.S. dental schools, over 1,000 allied and advanced dental-education programs, 60 corporations, and more than 20,000 individuals.

American Medical Association—the largest professional association of physicians, residents, and medical students in the United States. The AMA appears on its own behalf and as a representative of the Litigation Center of the American Medical Association and the State Medical Societies.

American Medical Student Association—represents the concerns of more than 30,000 physicians-in-training in the United States.

American Nurses Association—represents the interests of the nation's approximately 4 million registered nurses. ANA's membership consists of both individual members and organizational members, which include over 35 affiliate member specialty nursing organizations and 50 state or constituent nursing associations. Together, ANA and its members work to find solutions to issues that face the nursing profession.

American Psychiatric Association—represents more than 38,500 medical doctors involved in clinical psychiatric practice, research, academia, and education of psychiatrists needed to prevent, diagnose, and treat mental health and substance use disorders. Its membership represents the diversity of the patients for whom they care.

American Public Health Association— an organization of nearly 25,000 public health professionals, champions the health of all people and all communities, strengthens the profession of public health, shares the latest research and information, promotes best practices, and advocates for public-health issues and policies grounded in research.

American Society of Hematology—the world's largest professional society of hematologists, including clinicians and researchers, who are dedicated to furthering the understanding, diagnosis, treatment, and prevention of disorders affecting the blood.

American Society of Nephrology—Since 1966, ASN has been leading the fight to prevent, treat, and cure kidney diseases throughout the world by educating health professionals and scientists, advancing research and innovation, communicating new knowledge, and advocating for the highest quality care for patients. ASN has more than 20,000 members representing 131 countries.

American Thoracic Society—a medical professional organization of over 16,000 members dedicated to the prevention, detection, treatment, and cure of pulmonary disease, critical care illness and sleep disordered breathing through research, education, clinical care, and advocacy.

Association of Academic Health Centers—a not-for-profit association dedicated to advancing the nation's health and well-being through the vigorous leadership of academic health centers.

Association of American Indian Physicians—more than 412 American Indian/Alaskan Native residents, licensed or retired Allopathic or Osteopathic physicians, committed to pursuing excellence in Native American health care by promoting education in the medical disciplines, honoring traditional healing principles and restoring the balance of mind, body, and spirit.

Association of American Medical Colleges—represents all 154 accredited U.S. medical schools; nearly 400 major teaching hospitals and health systems, and 80 academic societies.

Association of Schools and Programs of Public Health—represents more than 120 schools and

programs accredited by the Council on Education for Public Health.

Association of Schools of Allied Health Professions—a national association comprised of 127 not-for-profit universities focused on issues impacting allied health education.

Association of University Programs in Health Administration—a global network of colleges, universities, faculty, individuals, and organizations dedicated to the improvement of health and healthcare delivery through excellence in healthcare management and policy education and scholarship, by promoting the value of university-based management education for leadership roles in the health sector.

California Medical Association—a nonprofit, incorporated professional association for physicians with approximately 45,000 members throughout the state of California. For more than 150 years, CMA has promoted the science and art of medicine, the care and well-being of patients, the protection of public health, and the betterment of the medical profession. CMA's physician members practice medicine in all specialties and settings, and is dedicated to the health of all patients in California.

Council on Social Work Education—represents over 800 accredited baccalaureate and master's degree social work programs, as well as individual social work educators, practitioners, and agencies dedicated to advancing quality social work education.

Greater New York Hospital Association—represents more than 160 hospitals and health systems located throughout New York, New Jersey, Connecticut, Pennsylvania, and Rhode Island. All of

GNYHA's members are either not-for-profit entities, charitable organizations, or publicly sponsored institutions that provide services that range from state-of-the-art, acute tertiary services to basic primary care, and, with their related medical schools, provide medical education and training and undertake cutting-edge medical research.

National Council of Asian Pacific Islander Physicians—represents Asian American, Native Hawaiian, and Pacific Islander physicians committed to the advancement of the health and well-being of their patients and communities, and supports the professional development of Asian American and Pacific Islander medical students and residents.

National Hispanic Medical Association—represents the interests and concerns of 50,000 licensed physicians committed to the mission to improve the health of Hispanic populations with affiliated Hispanic medical societies, resident and medical-student organizations, and other public and private partners.

National Medical Association—the largest and oldest national organization representing the interests of more than 30,000 African-American physicians and the patients they serve.

Physician Assistant Education Association—represents over 240 physician assistant programs across the nation.

Pre-Health Dreamers—a network and community of over 800 health career bound undocumented students across 42 different states.

Society of General Internal Medicine—represents more than 3,300 of the world's leading

academic general internists, who are dedicated to improving access to care for vulnerable populations, eliminating healthcare disparities, and enhancing medical education.