No. 19-2222

UNITED STATES COURT OF APPEALS
FOR THE FOURTH CIRCUIT

CASA DE MARYLAND, INC., et al.,
Plaintiffs-Appellees,

v.

DONALD J. TRUMP, in his official capacity,
as President of the United States, et al.;
Defendants-Appellants,

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

AMICUS CURIAE BRIEF OF HEALTH LAW ADVOCATES, INC. AND OTHER ORGANIZATIONS INTERESTED IN PUBLIC HEALTH SUPPORTING PLAINTIFFS-APPELLEES

Gare Smith
Kristyn DeFilipp
Andrew London
Emily J. Nash
FOLEY HOAG, LLP
155 Seaport Blvd.
Boston, MA 02210
gsmith@foleyhoag.com
kdefilipp@foleyhoag.com
alondon@foleyhoag.com
enash@foleyhoag.com
Phone: (617) 832-1000
Attorneys for Amici Curiae

Justin Lowe
Wendy Parmet
HEALTH LAW ADVOCATES, INC.
One Federal Street
Boston, MA 02110
jlowe@hla-inc.org
w.parmet@northeastern.edu
Phone: (617) 275-2981

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Corporate Disclosure Statement

Pursuant to Federal Rule of Appellate Procedure 26.1, counsel for *amici curiae* certifies that, with the exceptions listed below, all *amici* are either 501(c)(3) not-for-profit organizations or unincorporated organizations, all *amici* do not have a parent corporation, and no publicly held corporation owns ten percent or more of *amici's* stock.

- Blue Cross and Blue Shield of Massachusetts, Inc. is a not-for-profit entity organized under Massachusetts law and subject to 501(m);
- Children's Hospital Corporation, which does business as Boston Children's Hospital, has a parent, Children's Medical Center Corporation, both of which are non-profits;
- The Massachusetts Association of Health Plans is a 501(c)(4).

Dated: January 21, 2020

By: /s/ *Gare Smith*

Gare Smith
Kristyn DeFilipp
Andrew London
Emily J. Nash
FOLEY HOAG LLP
155 Seaport Boulevard
Boston, MA 02210-2600
Phone: (617) 832-1000
gsmith@foleyhoag.com
kdefilipp@foleyhoag.com
alondon@foleyhoag.com
enash@foleyhoag.com
Attorneys for Amici Curiae

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Interest of Amici Curiae

Amici are a coalition of non-profit health care providers and organizations, whose respective missions include providing health care and advocating for access to health care for immigrants and other vulnerable populations. These organizations have an interest in ensuring that the immigrant populations they serve are able to access publicly-funded health benefits, which are integral to maintaining individual care and public health throughout the communities where amici are located.

Health Law Advocates ("HLA") is a Massachusetts-based public interest law firm helping low-income individuals overcome barriers to health care. Founded in 1995, HLA provides no-cost legal services to vulnerable individuals, particularly those who are most at risk due to factors such as race, gender, disability, age, immigration status, or geographic location. HLA has represented thousands of Massachusetts health care consumers, including immigrants, in cases involving access to necessary medical services and health insurance. HLA also advocates for public policy reforms, working with consumers and policy makers at the state and federal levels in all three branches of government. HLA was counsel of record in the leading Massachusetts case on immigrant access to state health benefits. *Finch v. Commonwealth Health Ins. Connector Auth.*, 459 Mass. 655 (2011) (*Finch I*) and 461 Mass. 232 (2012) (*Finch II*).

The following organizations join HLA in submitting this brief to the Court:

Arab Community Center for Economic and Social Services

Blue Cross and Blue Shield of Massachusetts, Inc.

Boston Children's Hospital

California Immigrant Policy Center

California Pan-Ethnic Health Network

Charlotte Center for Legal Advocacy

Community Catalyst

Community Healthcare Network

Families USA

Florida Health Justice Project, Inc.

Health Care For All

Health in Justice Action Lab

Korean Community Center of East Bay

Massachusetts Association of Health Plans

Massachusetts Law Reform Institute

Massachusetts League of Community Health Centers

Northeastern University's Center for Health Policy and Law

Public Health Law Watch

The New York Immigration Coalition

Treatment Action Group (TAG)

University of Massachusetts Memorial Health Care, Inc.

Welcome Project, Inc.

Rule 29(A)(4)(E) Statement

No counsel for a party authored this brief in whole or in part and no person or entity, other than amici curiae, their members, or their counsel, has contributed money that was intended to fund preparing or submitting the brief.

I. Introduction

Amici file this brief in support of Appellees' argument that this Court should affirm the District Court's order and preliminary injunction enjoining the Department of Homeland Security's ("DHS") Public Charge Rule (the "Rule"). The Rule alters longstanding interpretation of the public charge provision of the Immigration and Nationality Act ("INA") in a manner that undermines the detailed framework developed by Congress and implemented by the states for providing access to health care, lowering health care costs, and protecting public health. Amici are organizations located throughout the country dedicated to promoting public health, especially in low-income communities. They oppose the Rule

because it contravenes Congressional intent and will have wide-ranging adverse impacts on state health care systems as well as the public's health.

Section 212(a)(4) of the INA has long barred admission or adjustment to lawful permanent resident status to persons "likely to become a public charge." For decades, the "public charge" designation was limited to immigrants primarily and permanently dependent on the government for cash assistance or long-term care. It did not include noncitizens who merely accessed or were likely to receive federally-funded health care coverage (or other noncash benefits). In accordance with this understanding, Congress has spoken directly to the ability of noncitizens to access Medicaid and other public health benefits.

Congress's health policy goals are effectuated in large part through partnerships between the Department of Health and Human Services ("HHS") and the states. These Congressionally-authorized federal-state partnerships vividly illustrate the complexity and varied approaches that states have taken with respect to creating health care delivery systems and, in some cases, the significant improvements to public health thereby. Like many states, Maryland, Virginia, and Pennsylvania—the three states in which Appellee CASA de Maryland, Inc. operates—use a combination of federal and state funds to expand health care coverage and reduce the costs of uncompensated care.

DHS' new Rule threatens to unravel the health care system crafted by Congress, HHS, and the states. The Rule dramatically redefines the longstanding meaning of "public charge" to mean "an alien who receives one or more public benefits [including Medicaid] . . . for more than 12 months in the aggregate within any 36 month period" and permits DHS to apply the designation to noncitizens who DHS determines are likely to use such benefits at any time in the future. Inadmissibility on Public Charge Grounds, Final Rule, 84 Fed. Reg. 41292, 41501 (Aug. 14, 2019). Moreover, in making a public charge determination, the Rule requires DHS to treat as a heavily weighted negative factor past receipt of public benefits as well as having a serious medical condition without private insurance or the means to pay for treating the condition. *Id.* at 41504. This framework creates a clear and direct incentive for immigrants seeking future adjustment of status to avoid accessing or utilizing the listed benefits, including Medicaid. The Rule thus clashes with Congress's express intent to encourage the use of public health benefits by those who are lawfully eligible for them.

The Rule will not only harm those immigrants who are subject to the public charge determination and receive the listed benefits. Its stunning breadth, complexity, and likely arbitrary application will deter many more immigrants and U.S. citizens living with immigrant family members from applying for *any* public

benefits for fear of adverse immigration consequences. The Rule also undermines the work of Congress and the states to expand health care coverage to improve health and control costs. Consequently, the Rule vastly exceeds the scope of DHS' authority.

Critically, the Rule will irreparably challenge state health care delivery systems. More people will be uninsured, resulting in poorer health outcomes, poorer public health, and higher costs. These results are in direct conflict with the federal statutory regime for health care.

II. Factual Background

A. Congress Has Spoken on Health Care for Lawfully Present Immigrants.

Medicaid is a federal-state partnership initially created to provide health coverage to certain low-income individuals, including children, parents, pregnant women, elderly individuals, and people with disabilities. Pub. L. No. 89-97, 79 Stat. 286 (1965). The Medicaid statute sets forth baseline requirements for a state to receive federal matching funds, but grants states significant discretion to structure and administer their programs within broad federal parameters. *See* 42 U.S.C. §§ 1396-1, 1396a, 1396b, 1396c. Although states must cover certain mandatory groups and offer certain specified services, states have discretion to

cover other groups and provide additional services. Further, under Section 1115 of the Social Security Act, states may seek waivers from some of these federal requirements to develop "experimental, pilot, or demonstration project[s] which . . . [are] likely to assist in promoting the objectives of [Medicaid]," and which include the expansion of coverage beyond the minimum federal requirements. *See* 42 U.S.C. § 1315(a). The Centers for Medicare & Medicaid Services ("CMS") may approve a Section 1115 waiver only if it furthers the objectives of the Medicaid program, including providing adequate coverage. *See Stewart v. Azar*, 366 F. Supp. 3d 125, 141-43 (D.D.C. 2019) (vacating CMS approval of Kentucky section 1115 waiver imposing work requirements on certain Medicaid beneficiaries because CMS did not adequately consider anticipated coverage losses).

DHS argues that Congress has intentionally curtailed the utilization of public benefits by noncitizens. (Dkt. 22 at 22). This is a gross mischaracterization. Although Congress has established bars for some classes of noncitizens, especially those not lawfully present, from accessing federally-funded benefits, Congress has repeatedly affirmed the eligibility of certain classes of noncitizens for Medicaid *and* has granted states flexibility to expand coverage even further. In 1996, Congress enacted the Personal Responsibility and Work Opportunity Reconciliation Act, Pub. L. No. 104-193, 110 Stat. 2105 (1996) ("PRWORA"),

which allowed "qualified immigrants"[1] to access federal means-tested benefits, including Medicaid and other benefits, subject to a five-year waiting period for most who qualified. PRWORA also excluded certain groups from that five-year bar, including veterans and refugees. 8 U.S.C. § 1613(a). PRWORA has been amended several times. With each amendment, Congress expanded eligibility for immigrants.[2] Further, PRWORA largely gives states a free hand to provide state-funded benefits to all noncitizens. *See* 8 U.S.C. § 1621(d); *Finch v. Commonwealth Health Ins. Connector Auth.*, 459 Mass. 655, 672-73 (2011).[3]

In 2009, Congress expanded noncitizen access to Medicaid by authorizing federally-funded benefits for children and pregnant women who are "lawfully present" in the United States. *See* Children's Health Insurance Program Reauthorization Act of 2009, Pub. L. No. 111-3, 123 Stat. 8 (2009) ("CHIPRA");

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[1] "Qualified immigrants" include legal permanent residents, refugees, asylees, persons granted withholding of removal, battered spouses and children, and other protected groups. 8 U.S.C. § 1641.

[2] Balanced Budget Act of 1997, Pub. L. No. 105-33, T. V, § 5561 (August 5, 1997) (exempting Medicare); *id.* at § 5565 (exempting certain groups); Pub. L. No. 105-306, § 2 (Oct. 28, 1998) (extending SSI and categorical Medicaid eligibility); Pub. L. No. 110-328, § 2 (Sep. 30, 2008) (extending SSI and categorical Medicaid eligibility for refugees); Pub. L. No. 110-457, Title II, Subtitle B, § 211(a) (Dec. 23, 2008) (expanding definition of qualified aliens to include trafficking victims).

[3] PRWORA requires states to legislate to expand coverage. 8 U.S.C. § 1621(d).

codified at 42 U.S.C. § 1396b(v)(4)(A).[4] One year later, the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119-1025 (2010) ("ACA"), permitted states to expand Medicaid coverage to eligible adults (including certain noncitizens) with incomes under 133% of the federal poverty level, 42 U.S.C. § 1396a(a)(10)(A)(ii)(XX), and created "Exchanges" to facilitate a centralized marketplace for individuals, including lawfully present immigrants, to access private health coverage and potentially receive federal subsidies and tax credits. *See* 42 U.S.C. § 18032(f)(3); 26 U.S.C. § 36(c)(B); 42 U.S.C. § 18071(b).

Congress enacted all of this legislation regarding immigrant eligibility for federal health care programs against the backdrop of DHS's longstanding interpretation of a "public charge." In fact, the public charge guidance published by the then-Immigration and Naturalization Service ("INS") in 1999 was issued after PRWORA was enacted to clarify the relationship between the receipt of federal, state, or local benefits and the INA's public charge provision. Field Guidance on Deportability and Inadmissibility on Public Charge Grounds, 64 Fed. Reg. 28689-01, 28689-92 (May 26, 1999) (noting it was designed to address

[4] *See also* SHO# 10-006, Center for Medicare & Medicaid Services, 4 (July 1, 2010), https://www.medicaid.gov/federal-policy-guidance/downloads/sho10006.pdf (noting CMS interpreted "lawfully present" to be broader than PRWORA's "qualified immigrants").

"adverse impact . . . on public health and the general welfare" caused by confusion that had "deterred eligible aliens and their families, including U.S. citizen children, from seeking important health and nutrition benefits that they are legally entitled to receive.").[5] That guidance remained in effect as Congress expanded noncitizens' eligibility for Medicaid in CHIPRA and the ACA.

B. The Flexibility Provided Under Federal Law Has Allowed States to Expand Coverage, Control Costs, and Protect Public Health.

Congress has delegated to the states, under federal oversight and approval, the implementation of health care programs designed to increase access to care for low-income citizens and noncitizens alike. States have leveraged this federal support alongside state funds to create integrated health care delivery systems with the express goal of achieving high rates of coverage, improving health outcomes, and stabilizing costs.[6]

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[5] In 2000, USCIS issued a Massachusetts Edition "Fact Sheet" specifically stating that "[a]n alien will **not** be considered a "public charge" for using health care benefits." *See* USCIS, *Fact Sheet*, (Oct. 18, 2000), https://www.uscis.gov/sites/default/files/files/pressrelease/Charge.pdf.

[6] *See, e.g.*, Sidney D. Watson et al., *Symposium: The Massachusetts Plan and the Future of Universal Coverage: State Experiences: The Road from Massachusetts to Missouri: What Will It Take for Other States to Replicate Massachusetts Health Reform?*, 55 U. Kan. L. Rev. 1331, 1355 (June 2007) (stating that Massachusetts' success in establishing near-universal coverage is largely due to federal matching funds).

States have invested millions of state and federal dollars to make it *easier* for individuals to enroll in coverage for which they are eligible. In the ACA, Congress required states to adopt integrated systems for state health care exchanges, so states can determine an individual's eligibility for federal and state funded programs with a single application. 42 U.S.C. § 18083. Maryland, like many other states, unified and realigned its health care eligibility determination system to simplify the application process and facilitate access to coverage. These efforts, coupled with expanded Medicaid eligibility, have succeeded. Maryland has observed a significant increase in health care coverage. Since 2012, Maryland's uninsured rate decreased by more than one-third, declining from approximately 10% in 2012 to approximately 6% of the population in 2018.[7] These achievements are due largely to the support and statutory direction provided by Congress.

Massachusetts, the home of amici HLA and others, provides another example of how states have leveraged federal support to improve their health care

[7] *State Health Facts, Maryland: Health Coverage & Uninsured*, The Kaiser Family Foundation (accessed January 7, 2020), https://www.kff.org/state-category/health-coverage-uninsured/?state=MD.

delivery systems.[8] In 2006, Massachusetts enacted landmark health reform legislation ("Chapter 58") that aimed to "expand access to health care for Massachusetts residents, increase the affordability of health insurance products, and enhance accountability of [the] state's health system." *See* An Act Providing Access to Affordable Quality, Accountable Health Care, Ch. 58 of the Ma. Acts of 2006 at Preamble. The many reforms introduced in Chapter 58[9] were largely made possible by an influx of federal funds.[10] Ultimately, nearly half of the financing for Chapter 58's reforms came from and were approved by the federal government. *See* McDonough, *supra* n.8, at 426. Chapter 58 included state-funded coverage for classes of lawful immigrants not eligible for federally-funded Medicaid under PRWORA under a state program called Commonwealth Care, Mass. Gen. L. c.

[8] *See* John E. McDonough et al., *The Third Wave of Massachusetts Health Care Access Reform*, Health Affairs Vol. 25, No. Supplement 1 (2006), https://www.healthaffairs.org/doi/10.1377/hlthaff.25.w420.

[9] Among other provisions, Chapter 58 expanded children's eligibility for the state's publicly-funded programs, MassHealth from 200% of FPL to 300%; *see id.* at § 26; and established a sliding-scale subsidized health insurance program for uninsured individuals with household incomes up to 300% of the FPL who were ineligible for MassHealth or any other coverage; *see id.* at § 45.

[10] *See id.* at § 112 (State must request amendment to Section 1115 waiver to seek maximum federal reimbursement for subsidized health insurance programs).

118H § 1, and for elderly and disabled lawfully present noncitizens in a separate state-funded medical assistance program. Mass. Gen. L. c. 118E § 16D.

In Massachusetts, many of the health care benefit programs are publicly branded under the same name, "MassHealth," which incorporates federal Medicaid, the Children's Health Insurance Program ("CHIP"), and fully state-funded programs such as the Children's Medical Security Plan. *See* 130 C.M.R. § 501.003(B). Should the Rule take effect, many applicants may be unaware if they have applied for benefits subject to it because they cannot apply for state benefits, private non-group coverage with Advance Premium Tax Credits, or Emergency Medicaid (all of which are outside the scope of the Rule) without simultaneously applying for federal Medicaid. *See* 130 C.M.R. 501.004(B)(3) (requiring a "single, streamlined application" to determine eligibility for MassHealth and the Exchanges); 130 C.M.R. § 502.001(A). Once approved, residents do not always know which program(s) they have been approved for, or whether their benefits are funded through state or state and federal sources. Indeed, everyone approved for MassHealth gets the same membership card.

In the two years after Chapter 58's passage, insurance rates for adults in Massachusetts jumped from 86% to 95.5%, a number that has stayed largely steady

since.[11] Eighty-seven percent of Massachusetts adults report having a place, other than an emergency department, to seek preventative care.[12]

C. The Rule Stigmatizes Public Health Benefits.

Historically, the term "public charge" was used to refer only to those who are primarily and permanently dependent upon the government. By redefining the term to include anyone who uses public health benefits for which they are legally eligible for 12 out of 36 months, the Rule effectively stigmatizes *everyone* who uses such benefits, even for a short period of time.

The Rule further discourages noncitizens from utilizing health benefits for which they are eligible by treating past receipt or approval to receive Medicaid as a heavily weighted negative factor. The Rule will also heavily weigh negatively if an immigrant has a serious medical condition and is uninsured and "has neither the prospect of obtaining private health insurance, or the financial resources to pay for reasonably foreseeable medical costs related to the medical condition." 84 Fed.

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[11] *See* Sharon K. Long & Thomas H. Dimmock, *Summary of Health Insurance Coverage and Health Care Access and Affordability In Massachusetts: 2015 Update*, 1 (Mar. 23, 2016), https://bluecrossmafoundation.org/sites/default/files/download/publication/MHRS_2015_Summary_FINAL_v02.pdf.

[12] *Id.* at 2.

Reg. at 41501. On the other hand, possession of unsubsidized private health insurance is a heavily weighted positive factor. 84 Fed. Reg. at 41504. These provisions of the Rule effectively put people who have chronic health conditions and receive health benefits or who have no benefits at all into a category previously reserved for the destitute and incompetent.

This mischaracterization of people who utilize publicly-funded health benefits, in combination with the confusion created by the Rule's complexity and discretionary nature, will stigmatize and deter the use of public health benefits. Immigrants who are subject to the Rule will not be the only ones who will be inclined to disenroll from or decline benefits, so too will immigrants who are not subject to the Rule, as well as their family members. DHS acknowledges this anticipated disenrollment, but discounts it as a matter of an "unwarranted choice." 84 Fed. Reg. 41313.

III. Argument

A. The Rule Impermissibly Impinges on the Detailed Federal Statutory Scheme for Immigrant Access to Health Care.

DHS's authority to promulgate regulations affecting health policy is limited by a fundamental legal axiom—federal administrative agencies may not regulate in ways that run counter to a federal statutory scheme, *see FDA v. Brown &*

Williamson Tobacco Corp., 529 U.S. 120 (2000). This is particularly true where Congress, in acknowledging the traditional state role in matters of health and safety, defers to states, with the approval and endorsement of HHS, to implement and administer complex health care systems.[13] The Rule violates Congress's detailed statutory framework by penalizing and stigmatizing access to health care, thereby undermining state health care systems.

An administrative agency's regulatory power is no greater than the authority granted by Congress. *See, e.g.*, *Brown & Williamson*, 529 U.S. at 161; *ETSI Pipeline Project v. Missouri*, 484 U.S. 495, 516 (1988) ("[T]he Executive Branch is not permitted to administer [a statute] in a manner that is inconsistent with the administrative structure that Congress enacted into law.").[14] The scope of an

[13] *See, e.g.*, *Medtronic, Inc. v. Lohr*, 518 U.S. 470, 485 (1996); *New York State Conf. of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 661 (1995); *Gibbons v. Ogden*, 22 U.S. 1, 203 (1824).

[14] If DHS were correct that Congress gave the Secretary absolute discretion to redefine the term "public charge," this provision of the INA would implicate the non-delegation doctrine. *See Gundy v. United States*, 139 S. Ct. 2116, 2129 (2019) ("a delegation is permissible if Congress has made clear to the delegee 'the general policy' he must pursue and the 'boundaries of his authority'"); *Doe v. Trump*, No. 3:19-cv-1743-SI, 2019 U.S. Dist. LEXI 205080, *30-*39 (D. Or. Nov. 26, 2019) (enjoining Presidential proclamation that was issued pursuant to statutory authority that provided no intelligible principle for the President's use of discretion). The INA's public charge provision only passes constitutional scrutiny, however, if

agency's regulatory authority on a particular topic, though granted by one statute, may also "be affected by other Acts, particularly where Congress has spoken subsequently and more specifically to the topic at hand." *Id.* at 133. Therefore, when determining whether an agency's rule conflicts with a legislative scheme, "a reviewing court should not confine itself to examining a particular statutory provision in isolation," but rather must construe the regulation within the requisite statutory context. *Brown & Williamson*, 529 U.S. at 132.

The Rule does not operate outside of the heavily legislated health care field. To the contrary, it is designed to interact – and interfere -- with health care laws and regulations, as it creates legal consequences for using health benefits created by specific federal statutes enacted after the INA. Since Congress first codified the "public charge" term in immigration law in the 1880s, it has reaffirmed its meaning on multiple occasions without ever defining it to mean use of public health benefits. *See* 22 Stat. 214 (1882); Pub. L. No. 96, § 2, 34 Stat. 898, 898-99 (1907); Pub. L. No. 414, ch. 2, § 212(a)(15), 66 Stat. 163, 183 (1952); 8 U.S.C. 1182(a)(4) (1996). Moreover, since the provision was enacted, Congress

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DHS's discretion is bounded by Congress' intended use of the term, which the Rule ignores.

has explicitly provided health care access and benefits to various classes of noncitizens. *See* PRWORA, 8 U.S.C. §§ 1621(d), 1622 (extending federal health benefits to qualified immigrants); CHIPRA, 42 U.S.C. § 1396b(v)(4) (authorizing immediate Medicaid coverage access to immigrant children and pregnant women); ACA, 42 U.S.C. §§ 18071(b) (defining lawfully present for purposes of enrolling in ACA qualified health plans). In each landmark health care bill, Congress has specifically established or increased immigrants' eligibility for health care benefits.

Congress did not enact this health care legislation with a blind eye to the "public charge" provision of the INA. Far from it. Providing noncitizens with access to health care benefits was consistent with the interpretation of "public charge" that had been in effect since the 1880s, which, as explained in a 1999 INS proposed rule, appropriately focused on persons who required "complete, or nearly complete, dependence on the Government rather than the mere receipt of some lesser level of financial support."[15] Indeed, Congress underscored its steadfast

[15] *Inadmissibility and Deportability on Public Charge Grounds*, 64 Fed. Reg. 28676, 28677 (Proposed May 26, 1999); *see id.* ("This primary dependence model of public assistance was the backdrop against which the 'public charge' concept in immigration law developed in the late 1800s."); *see also* An Act to Regulate Immigration, c. 376 § 2, 22 Stat. 214 (1882).

interpretation of "public charge" even while enacting health legislation.[16] For example, in 1996, Congress passed the Illegal Immigration Reform and Immigrant Responsibility Act of 1996, Pub. L. No. 104-208, 110 Stat. 3009 (1996) ("IIRIRA"), which, despite imposing restrictions on immigrant eligibility for certain public benefits, retained the prior definition of "public charge."[17] Congress did this against the backdrop of PRWORA, enacted only one month earlier, which allowed states to expand access to health benefits in conjunction with its stated goal of self-sufficiency. 8 U.S.C. §§ 1601, 1621, 1622. Thus, Congress continued to provide certain classes of noncitizens with health care benefits, understanding that doing so would not affect these individuals' potential classification as a "public charge" because the definition for that phrase had not changed.

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[16] As the District Court noted, Congress in fact rejected multiple attempts to define "public charge" in the way that DHS now does through administrative rulemaking. *Casa De Maryland, Inc. v. Trump*, Case No. 8:18-cv-02715-PWG at 29 (D. Md Oct. 14, 2019) (slip opinion).

[17] *See* 8 U.S.C. § 1182; Immigration and Naturalization Serv., Dep't of Justice, Public Charge; INA Sections 212(A)(4) and 237(A)(5)—Duration of Departure for legal permanent residents and Repayment of Public Benefits (Dec. 16, 1997) (explaining that IIRIRA "has not altered the standards used to determine the likelihood of an alien to become a public charge nor has it significantly changed the criteria to be considered in determining such a likelihood").

Given the comprehensive health care regime that Congress established in light of longstanding statutory and administrative interpretations of public charge, the Rule exceeds the scope of DHS's authority. In *Brown & Williamson*, the Supreme Court held that the Food and Drug Administration ("FDA") could not regulate tobacco products where such regulation ran counter to the purpose of the Food, Drug, and Cosmetic Act ("FDCA") and other statutes that related to tobacco, but not FDA authority, which were passed after the FDCA provisions upon which FDA relied. 529 U.S. at 133-55. Although "the supervision of product labeling to protect consumer health is a substantial component of the FDA's regulation of drugs and devices," the laws enacted after the FDCA addressing tobacco and health foreclosed the FDA's regulation of tobacco. *Id.* at 155-56. Likewise, although DHS is authorized to administer and enforce laws relating to immigration and naturalization, health care legislation from the last twenty-five years—bolstered by immigration legislation during the same period and prior—forecloses DHS's regulation of immigrants' access to health care, especially in ways that run directly counter to Congress' more recent health care legislation. DHS's proclaimed jurisdiction over this field is especially tenuous here, as it usurps the authority of an entirely different federal agency, HHS, the designated agency over matters of health policy.

DHS's overreach is further apparent from the text of the Rule. Addressing commenters' concerns about Medicaid's inclusion in the public charge consideration, DHS responded that "the total Federal expenditure for the Medicaid program overall is by far larger than any other program for low-income people." 84 Fed. Reg. at 41379.[18] The cost of Medicaid is not DHS's concern. Congress delegated the implementation and administration of Medicaid, including the cost of the program, to HHS and the states. *See* 42 U.S.C. §§ 1396, 1396-1, 1315(a). Moreover, the cost of Medicaid is consistent with Congress' intent in establishing and expanding the program's reach. *See, e.g.*, *NFIB v. Sebelius*, 567 U.S. 519, 627-31 (2012) (Ginsburg, J., dissenting) ("Expansion has been characteristic of the Medicaid program."). At no time has Congress authorized DHS to reduce federal health care spending, let alone penalize individuals for using the benefits for which Congress determined they should be eligible.

The Rule is also inconsistent with Congressional intent because it interferes with the states' ability to manage their health care systems. Federal health laws deliberately rely on state participation and administration of many health care

[18] This assertion belies the Rule's purported purpose of promoting self-sufficiency. The overall cost of the Medicaid program bears no relationship to whether its beneficiaries are self-sufficient.

benefits. *See* Social Security Act Title XIX; *Wis. Dep't of Health & Family Servs. v. Blumer*, 534 U.S. 473, 495 (2002) ("The Medicaid statute . . . is designed to advance cooperative federalism."). This evinces Congress's express recognition of the well-settled principle, sounding in federalism, that states play a significant role in health policy. *See, e.g.*, *Jacobson v. Massachusetts*, 197 U.S. 11, 25 (1905) (protecting public health and safety fall within states' police powers). This principle lies at the core of the Social Security Act and was reaffirmed by Congress when it expressly recognized the states' role in regulating health care in Medicaid, PRWORA, CHIPRA, and the ACA.[19] The Supreme Court likewise underscored the role of states in health care policy in *Sebelius*, 567 U.S. at 536 ("[T]he facets of governing that touch on citizens' daily lives are normally administered by smaller governments closer to the governed."). States have relied upon this principle, as well as the specific statutory authorizations described above, to enact laws providing access to affordable health care for their residents.[20]

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[19] 8 U.S.C. §§ 1621(d), 1622; 42 U.S.C. § 1396b(v)(4); 26 U.S.C. § 36(c)(B); 42 U.S.C. § 18071(b).

[20] Courts accordingly treat federal regulation in areas traditionally occupied by the states with requisite wariness. *See Rice v. Santa Fe Elevator Corp.*, 331 U.S. 218, 230 (1947) (courts "start with the assumption that the historic police powers of the States were not to be superseded by the Federal Act unless that was the clear and

DHS's assertion that the Rule falls within the realm of immigration law, not health care law, cannot save the Rule. DHS's authority over immigration matters, although broad, is not unbounded, especially when it intrudes upon state regulation of local issues long authorized by Congress. The Rule will compel states, like Maryland, to restructure their health care benefit programs and eligibility systems to disaggregate those benefits covered by the Rule from those that are not. Where Congress has already authorized states to develop complex health care systems through decades of legislation and regulation, the federal government executive branch may not commandeer state resources. *See New York v. United States*, 505 U.S. 144, 161 (1992) ("Congress may not… [compel States] to enact and enforce a federal regulatory program"). Recognizing this principle, several courts struck down the INA provision prohibiting states from restricting the exchange of information related to immigration status with federal officials. *See New York v. U.S. Dep't of Justice*, 343 F. Supp. 3d 213, 234-35 (S.D.N.Y. 2018); *City of Chi. v. Sessions*, 321 F. Supp. 3d 855, 872 (N.D. Ill. 2018); *City of Phila. v. Sessions*, 309 F. Supp. 3d 289, 331 (E.D. Pa. 2018), *aff'd*, 916 F.3d 276 (3d Cir. 2019); *but see*

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manifest purpose of Congress"); *Medtronic*, 518 U.S at 485 (noting the "historic primacy of state regulation of matters of health and safety").

City of L.A. v. Barr, 2019 U.S. App. LEXIS 20706, at *23-24 (9th Cir. July 12, 2019) (reversing judgment below).

This Court must be "guided to a degree by common sense as to the manner in which Congress is likely to delegate a policy decision of such economic and political magnitude to an administrative agency." *Brown & Williamson*, 529 U.S. at 133. Given the statutory scheme that has authorized state expansions of health care eligibility to noncitizens over the past twenty-five years, it strains credulity that Congress would have intended DHS to issue a regulation that undermines and stigmatizes the very rights that Congress explicitly extended to immigrants.

B. The Rule will Irreparably Disrupt State Health Systems.

1. The Rule Stigmatizes Public Benefits and Erects Barriers to Insurance.

As DHS acknowledged, the Rule will create a barrier for millions of noncitizens accessing health insurance. 84 Fed. Reg. 41485 (DHS anticipates many noncitizens and U.S. citizens in mixed status households will disenroll from public benefits). However, DHS failed to adequately consider the effects of this barrier on state health care systems.

In Maryland, an estimated 385,000 people, including 136,000 children, could be discouraged from obtaining critical public benefits.[21] Over 100,000 immigrant families in Pennsylvania are enrolled in the state's Medicaid program.[22] In 2019, Virginia expanded its Medicaid program, covering over 300,000 additional residents.[23] Some of those gains will be lost as noncitizens and citizens in families with noncitizens disenroll from the program out of fear of the potential negative consequences on a future application to adjust status.

The Rule's stigmatization of these benefits has already begun, discouraging even noncitizens who are not covered by the Rule from accessing public benefits for which they are eligible. Health care providers in Maryland have already begun to report that after the Proposed Rule was released, refugees and asylees began withdrawing from coverage and individuals began refusing assistance from food

[21] Maryland Office of the Attorney General, Comment Letter to Proposed Rule on Inadmissibility on Public Charge Grounds (Feb. 5, 2019), https://www.regulations.gov/document?D=USCIS-2010-0012-45749.

[22] The Honorable Mark R. Herring et al, Comment Letter to Proposed Rule on Inadmissibility on Public Charge Grounds (Dec 10, 2018), https://www.regulations.gov/document?D=USCIS-2010-0012-17123.

[23] Complaint at 102, *State of Washington et al v. U.S. Dep't of Homeland Sec. et al*, No. 19-5210 (E.D. Wash. Aug. 14, 2019).

pantries out of fear of a public charge determination even though the Rule was not in effect and does not apply to them. [24]

The harm from the Rule will not only be immediate, it is irreparable. Uninsured people reduce their use of primary care and delay treatment. They also become sicker, are unable to treat chronic conditions, and develop preventable medical complications. The uninsured frequently seek medical care only when their needs are most acute, relying on more expensive emergency services.[25] Therefore, the Rule will not only leave many people uninsured, it will almost certainly cause them to be less healthy and require hospitals and the state to bear more costs. Such diminished health outcomes constitute a well-established basis for an injunction. *See, e.g., Rodde v. Bonta*, 357 F.3d 988, 999 (9th Cir. 2004) (finding denial of Medicaid causing delayed or lack of necessary treatment, increased pain, and medical complications is irreparable harm).

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[24] Monica Guerrero Vazquez et al, Comment Letter to Proposed Rule on Inadmissibility on Public Charge Grounds (Feb. 5, 2019), https://www.regulations.gov/document?D=USCIS-2010-0012-32828; Gustavo Torres, CASA, Comment Letter to Proposed Rule on Inadmissibility on Public Charge Grounds (Feb. 5, 2019), https://www.regulations.gov/document?D=USCIS-2010-0012-46286.

[25] USCIS, Inadmissibility on Public Charge Grounds, Notice of Proposed Rulemaking, 83 Fed. Reg. 51114, 51270 (Oct. 10, 2018).

2. Less Insurance Will Limit Services for Citizens and Noncitizens Alike.

By stigmatizing public health insurance and disincentivizing people from enrolling in such programs, the Rule jeopardizes the health care systems of states that have worked to provide coverage to all or most of their lawful residents. These systems rely on the enrollment of all eligible individuals to reduce costs and maintain the public's health. Within integrated health care systems, the Rule's impact cannot be confined to those who are directly subject to the Rule.

A larger uninsured population will generate significant new uncompensated care costs. These will fall disproportionately on providers in low-income communities with fewer privately insured patients. In expansion states such as Maryland, Pennsylvania, and Virginia, Medicaid provides 48% of revenue for community health centers.[26] Disenrollment of only 50% of noncitizen patients from Medicaid could cause community health centers to lose $346 million per year

[26] Leighton Ku et al., *How Could the Public Charge Proposed Rule Affect Community Health Centers?*, Geiger Gibson/RCHN Community Health Foundation Research Collaborative, Policy Issue Brief # 55, 3 (Nov. 2018), https://publichealth.gwu.edu/sites/default/files/downloads/GGRCHN/Public%20Charge%20Brief.pdf.

nationally. The resulting service cuts could result in 295,000 fewer patients nationwide being able to access primary care services.[27]

A decline in preventative care will lead to a sicker population that needs more expensive acute and inpatient care. In 2017, three-quarters of patients at safety net hospitals were uninsured or covered by Medicare or Medicaid.[28] Access to Medicaid is associated with improved financial performance and a substantial reduction in hospital closures.[29] Absent adequate revenue from private payers, such safety-net hospitals cannot cover the increase in uncompensated care costs that will result from the Rule without cutting services that will necessarily affect all patients, including citizens.

3. The Rule Will Have Adverse Ripple Effects on the Health Care Delivery System

Other Providers. As safety-net health care providers face increased financial pressures and reductions to services, other medical providers, including teaching hospitals, will be forced to absorb additional uninsured patients. These

[27] *Id.* at 5.

[28] America's Essential Hospitals, *Essential Data: Our Hospitals, Our Patients*, 5 (Apr. 2019), https://essentialhospitals.org/wp-content/uploads/2019/04/Essential-Data-2019_Spreads1.pdf.

[29] Richard C. Lindrooth et al., *Understanding the Relationship between Medicaid Expansions and Hospital Closures*, 37 Health Affairs 111 (2018).

providers will experience strains on their emergency departments, as uninsured patients rely more heavily on emergency services. All patients will experience increased wait times, and quality of care will likely be diminished as emergency department personnel and safety net providers work under increased pressure.

Individuals with Private Insurance. The Rule encourages the use of private insurance, but fails to take into account its impact on the private insurance market. By increasing uncompensated care, the Rule will destabilize the health insurance marketplace. Higher rates of uncompensated care will likely force medical providers to offset these uncompensated costs by charging higher rates to insured patients. These costs will likely be passed on to consumers. As health care costs rise, underinsured rates will increase as consumers tend to purchase policies with less coverage, which may also lead to significant medical debt when medical needs arise.

States. The Rule will result in significant financial and administrative burdens on state budgets. If only 15 percent of Marylanders directly impacted by the rule were to withdraw from the services they would otherwise be entitled to receive, the State would face an estimated loss of $120 million in federal funding

and $238 million in reduced revenue.[30] In a comment on the Proposed Rule, Pennsylvania estimated that it would lose up to $220 million in federal funds as a result of noncitizens disenrolling from Medicaid.[31] This loss of federal money would reduce Pennsylvania's total economic activity by over half-a-billion dollars.[32]

Maryland will also need to restructure its health care eligibility determination system to enable noncitizens to maintain access to plans on the Health Insurance Exchange without jeopardizing their immigration status. Similarly, Massachusetts may need to revise its individual coverage mandate to prevent inadvertent immigration consequences on residents. These consequences may compel the Massachusetts Health Connector, the Massachusetts Health Insurance Exchange, to revise its customer service and data reporting protocols and eligibility and information management systems to assure that immigrants' past benefits are properly reported. This overhaul will be costly and will undermine the purpose of the system.

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[30] Maryland Office of the Attorney General, *supra* n.21.

[31] The Honorable Mark R. Herring et al, *supra* n.22.

[32] *Id.*

Public Health. People without health insurance tend to wait to seek care until they present with acute medical problems. This undermines public health. Communicable disease (e.g. measles, HIV/AIDS, Hepatitis C, etc.) proliferate more quickly when people do not have early access to vaccines or treatment. The Rule's chilling effects will also result in less treatment for non-communicable diseases, such as substance use disorders. *See* 84 Fed. Reg. 41385 (DHS acknowledging those with substance abuse disorder will likely disenroll from treatment). Such reductions in treatment will spillover beyond individual patients imposing costs and health risks to the public health as a whole.

These impacts were not contemplated by the INA, DHS's sole basis of authority. Moreover, each of these impacts contradict Congress' intent as codified in Medicaid and the ACA.

IV. Conclusion

For the foregoing reasons, the appeal should be denied and the Court should affirm the Order below.

DATED this 21st day of January

FOLEY HOAG LLP

/s/ Gare Smith
Gare Smith
Kristyn DeFilipp
Andrew London
Emily Nash
Foley Hoag LLP
155 Seaport Boulevard
Boston, MA 02210-2600
Phone: (617) 832-1000
kdefilipp@foleyhoag.com
alondon@foleyhoag.com
enash@foleyhoag.com

HEALTH LAW ADVOCATES, INC.

/s/ Justin Lowe
Justin Lowe
Wendy Parmet
Health Law Advocates, Inc.
One Federal Street
Boston, MA 02110
Phone: (617) 275-2981
jlowe@hla-inc.org
w.parmet@northeastern.edu

Attorneys for Amici Curiae

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Dated: January 21, 2020

/s/ *Gare Smith*
Gare Smith

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I, Gare Smith, certify that on January 21, 2020, I electronically filed the forgoing document with the Clerk of the Court for the United States Court of Appeals for the Fourth Circuit by using the CM/ECF system. Participants in this case are registered CM/ECF users, and service will be accomplished by the appellate CM/ECF system.

/s/ *Gare Smith*
Gare Smith