19-3591

United States Court of Appeals
for the
Second Circuit

STATE OF NEW YORK, CITY OF NEW YORK, STATE OF CONNECTICUT, STATE OF VERMONT,
Plaintiffs-Appellees,

v.

UNITED STATES DEPARTMENT OF HOMELAND SECURITY, SECRETARY CHAD F. WOLF, in his official capacity as acting secretary of the United States Department of Homeland Security, UNITED STATES CITIZENSHIP AND IMMIGRATION SERVICES, DIRECTOR KENNETH T. CUCCINELLI II, in his official capacity as acting director of United States Citizenship and Immigration Service, UNITED STATES OF AMERICA,
Defendants-Appellants.

On Appeal from the United States District Court for the Southern District of New York, No. 19-cv-7777 (Judge George B. Daniels)

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

Lisa C. Wood
Foley Hoag LLP
155 Seaport Boulevard
Boston, MA 02210-2600
Phone: (617) 832-1000
LWood@foleyhoag.com

January 31, 2020

Attorney for Amici Curiae

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.[1]

- 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 31, 2020

/s/ *Lisa C. Wood*
Lisa C. Wood
Kristyn DeFilipp
Andrew London
Emily J. Nash
FOLEY HOAG LLP
155 Seaport Boulevard

[1] Pursuant to Rule 29(a)(4)(E) of the Federal Rules of Appellate Procedure and Local Rule 29.1 of the Second Circuit, *amici* certify that 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.

Boston, MA 02210-2600
Phone: (617) 832-1000
lwood@foleyhoag.com
kdefilipp@foleyhoag.com
alondon@foleyhoag.com
enash@foleyhoag.com
Attorneys for Amici Curiae

Table of Contents

Table of Authorities

Cases

Statutory Authorities

Rules and Regulations

Additional Authorities

Interest of Amici Curiae

Amici are 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, including New York.

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

Children's Defense Fund - California

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

Maine Immigrants' Rights Coalition

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)

UMass Memorial Health Care, Inc.

Welcome Project, Inc.

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 directly addressed 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 to reform their health care delivery systems. In some cases, these reforms have permitted significant improvements to public health. Like many states, Connecticut, New York, and Vermont use a combination of federal and state funds to expand health care coverage and reduce the costs of uncompensated care.

DHS's 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 disincentive for immigrants seeking future adjustment of status to access or utilize 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 potential 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's 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. 30 at 28-29). 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"[2] 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.[3] 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).[4]

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");

---

[2] "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.

[3] 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).

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

codified at 42 U.S.C. § 1396b(v)(4)(A).[5] 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

[5] *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.").[6] 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.[7]

---

[6] 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.

[7] *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. For example, New York has unified and realigned its health care eligibility determination system to simplify the application process.[8] To facilitate this centralized system, the state legislature enacted legislation in 2012 that shifted the administration of Medicaid from county and city governments to the state Department of Health. *See* Section 6 of Part F of Chapter 56 of the Laws of 2012. The New York Department of Health's state-based health insurance exchange, the New York State of Health (NYSOH), is charged with facilitating enrollment in all health coverage programs offered by the state. Eligibility determinations, enrollment, and renewal for most state and federal programs that use income-based eligibility criteria (including Medicaid) are conducted statewide via the NYSOH online application. New York is seeking to further integrate its eligibility systems to "provide clients with a seamless, integrated approach to application and enrollment which will make

[8] *See generally* "Medicaid Eligibility, Enrollment, and Renewal Processes and Systems Study: Case Study Summary Report – New York," State Health Access Data Assistance Center (October 19, 2018), https://www.macpac.gov/wp-content/uploads/2018/11/New-York-Summary-Report.pdf.

applying for and renewing health and human services benefits a faster and simpler process."[9]

These efforts, coupled with expanded Medicaid eligibility, have succeeded. Rates of uninsured residents have declined in New York since the passage of the ACA, from 10.7% in 2013 to 5.7% in 2018.[10] The State's reduction in its number of uninsured residents is associated with a parallel reduction in uncompensated care costs for medical services, which dropped by an estimated $642 million between 2013 and 2015 alone.[11]

---

[9] "REQUEST FOR INFORMATION RFI # 000550 - Integrated Eligibility System – Innovation Landscape," New York Office of Information Technology Services (Aug. 21, 2018), https://its.ny.gov/document/rfi-000550-integrated-eligibility-system.

[10] *See* "Health Insurance in the United States: 2017 – Table 6," United States Census Bureau (Sept. 12, 2018), https://www.census.gov/data/tables/2018/demo/health-insurance/p60-264.html.*See* Jessica Schubel and Matt Broaddus, "Uncompensated Care Costs Fell in Nearly Every State as ACA's Major Coverage Provisions Took Effect: Medicaid Waivers That Create Barriers To Coverage Jeopardize Gains," Center on Budget and Policy Priorities (May 23, 2018), https://www.cbpp.org/research/health/uncompensated-care-costs-fell-in-nearly-every-state-as-acas-major-coverage.

[11] *See* Jessica Schubel and Matt Broaddus, "Uncompensated Care Costs Fell in Nearly Every State as ACA's Major Coverage Provisions Took Effect: Medicaid Waivers That Create Barriers To Coverage Jeopardize Gains," Center on Budget and Policy Priorities (May 23, 2018), https://www.cbpp.org/research/health/uncompensated-care-costs-fell-in-nearly-every-state-as-acas-major-coverage.

Similarly, Connecticut and Vermont have leveraged federal dollars to expand coverage in their states. Both states have created their own health insurance exchanges to facilitate their residents' access to coverage and expanded eligibility under their state Medicaid programs. [12] Between 2013 and 2018, Connecticut reduced its uninsured rate from 9% to 5%.[13] Vermont experienced a comparable improvement, moving from a 7% uninsured rate in 2013 to just 4% in 2018.[14] These achievements are due largely to the support and guidance afforded by Congress.[15]

---

[12] 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.

[13] *State Health Facts, Connecticut: Health Coverage & Uninsured*, The Kaiser Family Foundation (accessed January 29, 2020), https://www.kff.org/state-category/health-coverage-uninsured/?state=CT.

[14] *State Health Facts, Vermont: Health Coverage & Uninsured*, The Kaiser Family Foundation (accessed January 29, 2020), https://www.kff.org/state-category/health-coverage-uninsured/?state=VT.

[15] Massachusetts, the home of *amici* HLA and others, provides another example of how states have leveraged federal support to improve their health care delivery systems. Many of the health care benefit programs in Massachusetts are publicly branded under the same name, "MassHealth," which incorporates federal Medicaid, the Children's Health Insurance Program ("CHIP"), and fully state-funded programs. *See* 130 C.M.R. § 501.003(B). Many applicants may be unaware if they have applied for benefits subject to the Rule 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)

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 whether 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. Reg. at 41501. On the other hand, possession of unsubsidized private

---

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.

health insurance is a heavily weighted positive factor. 84 Fed. Reg. at 41504. These provisions of the Rule effectively treat those who use publicly-supported health benefits as acting in an undesirable or discouraged manner. Instead, states and HHS encourage enrollment in publicly-supported health benefits because of the positive impact expanded coverage has on the entire health delivery system.

The Rule's 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 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, which operate with the approval of HHS, to implement and administer complex health care systems.[16] 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.").[17] The scope of an

[16] *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).

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

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 federal and state 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 and never defined it to include 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 has explicitly provided health care access and benefits to various classes of noncitizens and granted states the authority to expand access even further. *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."[18] Indeed, Congress underscored its steadfast narrow interpretation of "public charge" even while enacting health legislation. 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)

[18] *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).

("IIRIRA"), which, despite imposing restrictions on immigrant eligibility for certain public benefits, retained the prior definition of "public charge."[19] 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.

Given that Congress established this comprehensive health care regime against the backdrop of the longstanding statutory and administrative interpretation of a "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

[19] *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").

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's 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.[20] 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's 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 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

[20] 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.

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.[21] 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.[22]

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

[21] 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).

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

of local issues long authorized by Congress. The Rule will compel states 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 to effectuate such reorganization. *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 City of L.A. v. Barr*, 929 F.3d 1163, 1176-77, (9th Cir. 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 New York, over 6 million people are enrolled in Medicaid, and an additional 396,351 children are enrolled in Child Health Plus (New York's version of CHIP).[23] The State of New York estimates that up to 2 million current enrollees in New York public health care programs, noncitizens and their citizen children, may disenroll from benefits.[24]

---

[23] Complaint at 78-79, *State of New York v. U.S. Dep't of Homeland Sec.*, No. 19-cv-7777 (S.D.N.Y. Aug. 21, 2019).

[24] *Id.* at 61.

Similarly, in Connecticut, 566,045 residents participate in Husky A (the State's Medicaid Program) and an additional 31,672 resident children participate in Husky B (Connecticut's version of CHIP). [25] These enrollment figures include 45,000 children with noncitizen parents. Many of these families are likely to withdraw from coverage in order to avoid a public charge determination that they or a family member may fear, even though a family member's use of benefits is not considered under the Rule. The State of Connecticut anticipates that between 6,750 and 15,750 children may lose health care benefits due to the Rule.[26]

The Rule's stigmatization of these benefits has already begun, discouraging even noncitizens who are not subject to the Rule from accessing public benefits for which they are eligible. Health care providers across the country have already reported that after the Proposed Rule was released, noncitizens, including those not covered by the Rule, and citizens living in mixed status families began withdrawing from coverage for fear of a public charge determination – even though the Rule was not in effect and does not apply to them. [27]

---

[25] *Id*. at 25.

[26] *Id*. at 61.

[27] Health Justice Project, Beazley Institute, Loyola University Chicago School of Law, Comment Letter on Proposed Final Rule on Inadmissibility on Public Charge

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.[28] 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., Fishman v. Paolucci*, 628 Fed. Appx. 797, 800 (2d Cir. 2015) ("the wrongful denial of Medicaid benefits… is the type of non-monetary, imminent harm that is properly characterized as irreparable").

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

By stigmatizing public health insurance and disincentivizing people from

---

Grounds, 2 (Dec. 10, 2018), https://www.regulations.gov/document?D=USCIS-2010-0012-54996; Prairie State Legal Services, Comment Letter on Proposed Final Rule on Inadmissibility on Public Charge Grounds, 1 (Dec. 10, 2018), https://www.regulations.gov/document?D=USCIS-2010-0012-45064.

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

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 Connecticut, New York, and Vermont, Medicaid provides 48% of revenue for community health centers.[29] Disenrollment of only 50% of noncitizen patients from Medicaid would cause community health centers to lose at least $346 million per year nationally, including approximately $4 million in Connecticut, $55 million in New York, and $166,000 in Vermont.[30] The resulting service cuts would

[29] 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.

[30] *Id.* at 6.

cause at least 295,000 patients nationwide to lose access to primary care services, including 4,000 in Connecticut, 41,000 in New York, and 167 in Vermont.[31]

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.[32] Access to Medicaid is associated with improved financial performance and a substantial reduction in hospital closures.[33] 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

[31] *Id.*

[32] 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.

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

teaching hospitals, will be forced to absorb additional uninsured patients. These 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 create significant financial and administrative burdens on state budgets. The Rule will result in decreased Medicaid enrollment that will in turn reduce the federal matching funds that states receive to support its Medicaid program. Connecticut, New York and Vermont will face combined losses of

between $1.1 and $2.7 billion in federal funds.[34] The states will subsequently face a reduction of revenues stemming from the decreased economic activity that these federal funds support. In the three Plaintiff states alone, the Rule will result in between $2.3 billion and $5.5 billion in lost economic activity and tens of thousands of lost jobs.[35]

The Rule will also result in direct costs to the states. For example, New York expects to spend $8.3 million in direct costs to assist consumers in accessing health care benefits not covered by the Rule without jeopardizing their immigration status.[36]

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.[37] The

[34] Complaint, *supra* note 23, at 65.

[35] *Id.*

[36] *Id*. at 73.

[37] The current coronavirus outbreak illustrates the need to encourage everyone, including noncitizens to seek medical treatment if they potentially have an infectious disease. By discouraging noncitizens and members of their family from utilizing public health benefits and seeking health care, the Rule may dissuade

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's 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.

---

them from obtaining timely diagnosis and treatment in the midst of a potential pandemic.

DATED this 31st day of January 2020

FOLEY HOAG LLP

/s/ Lisa C. Wood
Lisa C. Wood
Kristyn DeFilipp
Andrew London
Emily Nash
E. Jacqueline Chávez
Foley Hoag LLP
155 Seaport Boulevard
Boston, MA 02210-2600
Phone: (617) 832-1000
lwood@foleyhoag.com
kdefilipp@foleyhoag.com
alondon@foleyhoag.com
enash@foleyhoag.com
jchavez@foleyhoag.com

HEALTH LAW ADVOCATES, INC.

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

Attorneys for Amici Curiae

Certificate of Compliance

This brief complies with the type-volume limitation of Fed. R. App. P. 32(a)(7) because this brief contains 6,379.

This brief complies with the typeface requirements of Fed. R. App. P. 32(a)(5) and the type-style requirements of Fed. R. App. P. 32 (a)(6) because this brief has been prepared in a proportionally spaced typeface using Microsoft Word 2016 in 14-point Times New Roman Font.

Dated: January 31, 2020

/s/ *Lisa C. Wood*
Lisa C. Wood

Certificate of Service

I, Lisa C. Wood, certify that on January 31, 2020, I electronically filed the forgoing document with the Clerk of the Court for the United States Court of Appeals for the Second 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/ *Lisa C. Wood*
Lisa C. Wood