No. 19-36020

IN THE UNITED STATES COURT OF APPEALS

FOR THE NINTH CIRCUIT

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JOHN DOE #1, et al.,

*Plaintiffs-Appellees,*

*v.*

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

*Defendants-Appellants.*

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On appeal from the United States District Court

for the District of Oregon,

Case No 3:19-cv-01743-SB, Hon. Michael H. Simon

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# ***AMICI CURIAE* BRIEF OF 32 HEALTH POLICY EXPERTS IN SUPPORT OF PLAINTIFFS-APPELLEES' PETITION FOR REHEARING EN BANC**

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## STATEMENT OF INTEREST OF *AMICI CURIAE*

The *amici curiae* are 32 distinguished professors and researchers from the disciplines of economics, public health, health policy, and law, listed in the Appendix, who are experts with respect to the economic and social forces operating in the health care and health insurance markets.[1] *Amici* have closely followed the development, adoption, and implementation of the Affordable Care Act (ACA), Medicaid, and the Children's Health Insurance Program (CHIP). They are familiar with the structure of these programs and the defects in our health care system these programs were enacted to remedy. They are knowledgeable as to the risks and limitations of non-ACA compliant health insurance plans and of relying on one's own resources rather than purchasing insurance. Finally, they are well-informed regarding the nature and causes of health care provider uncompensated care. Previously, many of them submitted an amicus brief in support of Plaintiff-Appellees and the grant of the preliminary injunction.

[1] *Amici* affirms that no counsel for any party authored this brief in whole or in part; no party or party's counsel contributed money to fund preparation or submission of the brief; and no one contributed money to fund the preparation or submission of this brief. Further, all parties consent to the 32 health policy experts submitting this timely amicus brief.

## STATEMENT OF CASE AND SUMMARY OF ARGUMENT

The "Presidential Proclamation on the Suspension of Entry of Immigrants Who Will Financially Burden the United States Healthcare System," Proclamation No. 9945, 84 Fed. Reg. 53991 (Oct. 4, 2019), suspends and limits visas to certain immigrants unless the immigrant purchases or guarantees to purchase and have in operation within 30 days of entry certain specified kinds of health insurance or demonstrates financial capacity to meet "reasonably foreseeable medical costs" to a consular official.

On December 4, 2019, Defendants appealed the District Court's grant of a nationwide preliminary injunction suspending the implementation of the Proclamation. The appeal resulted in three published opinions: *Doe #1 v. Trump*, 944 F.3d 1222 (9th Cir. 2019) ("*Doe I*"), which denied the government's request for an administrative stay; 957 F.3d 1050 (9th Cir. 2020) ("*Doe II*"), which found the Proclamation to be an invalid exercise of executive power and declined to stay the District Court's preliminary injunction; and 984 F.3d 848, 2020 WL 7778213 (9th Cir. Dec. 31, 2020) ("*Doe III*"), which issued an opinion on the merits and reversed the District Court's decision.

The *Doe II* and *Doe III* panels drew very different conclusions about the standards to use in determining how federal law interacts with federal immigration policies and how those standards applied to this Proclamation.

In 2018, the U.S. Supreme Court held that an otherwise discretionary action of the President affecting immigration is illegal if its effect is to "override" a statute adopted by Congress. *Trump v. Hawaii*, 138 S. Ct. 2392, 2411 (2018). Here, the Proclamation overrides an existing statute because it denies legal immigrants' access to subsidized health care coverage made available to them under the ACA. It further overrides the ACA by steering immigrants to non-comprehensive, high cost-sharing plans or to remain uninsured if a consular official determines they have sufficient assets to cover foreseeable medical costs. The result is likely to increase rather than decrease uncompensated care, in contradiction to the Proclamation's stated purpose. Invalidating the Proclamation, thus allowing immigrants to receive comprehensive coverage and protect providers against uncompensated care burdens, is a matter of exceptional importance.

Congress' wisdom in providing comprehensive ACA coverage—including coverage for services such as COVID-19 testing, vaccines, and treatment—to lawfully present immigrants should not be second-guessed under the guise of immigration law or policy.

## ARGUMENT

All six judges on the *Doe II* and *Doe III* panels generally accepted the concept set forth in *Trump v. Hawaii* that a President may not "expressly override" or cause a "contradiction" with federal statutes. *Doe II*, 957 F.3d at 1062; *id* at 1080 (Bress, J. dissenting); *Doe III*, 2020 WL 7778213, at *7; *id* at *13 (Tashima, J. dissenting).

The majority in *Doe II* and the dissent in *Doe III* took a common-sense view of what needs to be shown to demonstrate a conflict between the Proclamation and statutes like the ACA. *Doe II* concluded that, despite the ACA providing tax credits to legal immigrants to "offset the costs of purchasing an insurance plan," the Proclamation required legal immigrants to instead enroll in insurance plans Congress deemed inadequate.

In contrast, *Doe III* held that the Proclamation does not "expressly override" the ACA because the two "operate in different spheres." The ACA, the majority argued, applies to immigrants already "lawfully present" in the United States, while the Proclamation applies to immigrants seeking to enter the United States. This is a false dichotomy. The ACA permits immigrants entering the United States to rapidly establish eligibility for subsidized coverage, but the Proclamation makes it difficult, if not impossible, for some prospective immigrants to acquire lawful presence and access ACA coverage.

# I. THE PROCLAMATION CONTRAVENES THE ACA BY PREVENTING LEGAL IMMIGRANTS FROM ENROLLING IN HEALTH COVERAGE THEY ARE EXPRESSLY ENTITLED TO.

## A. Congress adopted three federal programs to extend coverage to legal immigrants.

Affordability, protection from discrimination based on health status, and a comprehensive benefit package are essential features to effectively ensure access to health coverage. Three federal programs—Medicaid, the Children's Health Insurance Program (CHIP), and the ACA—work together to help ensure that all U.S. citizens and lawfully present immigrants can obtain adequate health coverage and, therefore, to protect health care providers against the cost of uncompensated care.[2]

In all three of these programs, benefits must be provided without regard to an individual's preexisting health conditions. 42 U.S.C. § 1396(a)(a)(8); 42 U.S.C. § 300gg-4. In addition, these programs all feature a comprehensive benefit package. *See, e.g.,* 42 U.S.C. § 1396d. Private coverage under the ACA must cover ten "essential health benefits"

[2] *Overview of the Affordable Care Act and Medicaid*, Medicaid and CHIP Payment and Access Commission, https://www.macpac.gov/subtopic/overview-of-the-affordable-care-act-and-medicaid (last visited Jan. 28, 2021); *Health Insurance Exchanges 2020 Open Enrollment Report*, CMS.gov (April 1, 2020), https://www.cms.gov/files/document/4120-health-insurance-exchanges-2020-open-enrollment-report-final.pdf (last visited Jan. 28, 2021).

encompassing a full range of health care services, 42 U.S.C. § 18022(b); 42 U.S.C. § 300gg-6, as must Medicaid at a minimum, 42 U.S.C. § 1396u-7(b)(5).

Health insurance is expensive.[3] If not subsidized, premiums would be entirely out-of-reach for a large fraction of families; the average cost of a typical employer health insurance plan represents nearly one-third of U.S. median income.[4] Further, health care costs are heavily skewed, with some individuals incurring costs significantly higher than average: just 5% of the population accounts for 50% of health care spending.[5]

To ensure that health coverage can reach the people most likely to need health care services, insurance needs to be available to everyone regardless of health status. Similarly, the comprehensiveness of coverage is critical to guard against uncompensated care because individuals often cannot predict what forms of health care they will need.

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[3] *2020 Employer Health Benefits Survey*, Kaiser Family Foundation (Oct. 8, 2020), https://www.kff.org/report-section/ehbs-2020-summary-of-findings (last visited Jan. 28, 2021).

[4] Jessica Semega, Melissa Kollar, Emily A. Shrider, and John Creamer, *Income and Poverty in the United States: 2019* (Sept. 15, 2020), https://www.census.gov/library/publications/2020/demo/p60-270.html (last visited Jan. 28, 2021).

[5] Bradley Sawyer and Gary Claxton, *How do health expenditures vary across the population?* Kaiser Family Foundation (Jan. 16, 2019), https://www.healthsystemtracker.org/chart-collection/health-expenditures-vary-across-population (last visited Jan. 28, 2021).

At the time the ACA was adopted, 46.5 million non-elderly Americans, 17.8% of the population, lacked health coverage.[6] By 2016, the ACA had driven the number of uninsured and uninsurance rates down dramatically, to 26.7 million and 10%,[7] respectively. Gaps in coverage also became shorter and access to health care improved.[8] As access to comprehensive health coverage increased, provider uncompensated care decreased. Between 2013 and 2015, total hospital charity care and bad debt (the two components of uncompensated care) decreased by $8.6 billion nationwide. In some states, uncompensated care dropped by as much as 63 or 64%. The share of hospital operating expenses consumed by uncompensated care dropped 30% nationally, from 4.4% in 2013 to 3.1% in 2015.[9]

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[6] Jennifer Tolbert, Kendal Orgera, Natalie Singer and Anthony Damico. *Key Facts about the Uninsured Population*, Kaiser Family Foundation (Dec. 13, 2019), https://www.kff.org/uninsured/issue-brief/key-facts-about-the-uninsured-population (last visited Jan. 28, 2021).

[7] *Id*.

[8] Herman K. Bhupal, Sara R. Collins, and Michelle M. Doty, *Health Insurance Coverage Eight Years After the ACA*, The Commonwealth Fund (Feb. 7, 2019), https://www.commonwealthfund.org/publications/issue-briefs/2019/feb/health-insurance-coverage-eight-years-after-aca (last visited Jan. 28, 2021); Sherry A. Glied, Stephanie Ma and Anais Borja, *Effect of the Affordable Care Act on Health Care Access*, The Commonwealth Fund, (May 8, 2017), https://www.commonwealthfund.org/publications/issue-briefs/2017/may/effect-affordable-care-act-health-care-access (last visited Jan. 28, 2021).

[9] *Report to Congress on Medicaid and CHIP*, Medicaid and CHIP Payment and Access Commission, (March 2018), https://www.macpac.gov/wp-

### B. The Proclamation directly overrides the ACA by ruling out health care coverage options that Congress made available for immigrants.

In lieu of conforming to, or even recognizing, the statutory scheme that Congress adopted in extending coverage to legal immigrants under the ACA or to children and pregnant women under Medicaid or CHIP in States that have chosen to exempt them from Medicaid's five-year bar,[10] the Proclamation instead sets its own domestic health insurance standards for legal immigrants. The Proclamation lists nine forms of "approved health insurance" in which immigrants can enroll before they enter the country or must promise to enroll in within 30 days. Excluded from the list are the very forms of coverage that Congress has expressly designated as tools to ensure immigrants have affordable access to insurance.[11]

Among the options that qualify as "approved health insurance," the Proclamation lists "a health plan offered in the individual market within a

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content/uploads/2018/03/Report-to-Congress-on-Medicaid-and-CHIP-March-2018.pdf (last visited Jan. 28, 2021).

[10] Medicaid.gov, *Medicaid and CHIP Coverage of Lawfully Residing Children & Pregnant Women*, https://www.medicaid.gov/medicaid/enrollment-strategies/medicaid-and-chip-coverage-lawfully-residing-children-pregnant-women (last visited Jan. 28, 2021)

[11] The Proclamation recognizes Medicaid coverage as "approved health insurance" but only for persons under 19; it does *not* include Medicaid coverage for adults aged 19-20 and pregnant women who may legally be entitled to it. *Compare* Proclamation, Sec. 1(c), *with* 42 U.S.C. § 1396b(v)(4) (Medicaid options).

State" so long as the plan is "unsubsidized." By limiting enrollment to *un*subsidized ACA coverage, the Proclamation directly contravenes the ACA.

Under the ACA, participating health insurers must offer "qualified health plans" that meet minimum federal standards in the individual market. *See* 42 U.S.C. § 18021. A qualified individual may enroll in "any" qualified health plan that is available to them and for which they are eligible. 42 U.S.C. § 18032(a)(1), (d)(3)(C). The ACA expressly defines "qualified individual" to include those who are lawfully present in the United States. *Id.* at (f)(3). Further, qualifying individuals whose household income is between 100 and 400% of the Federal Poverty Level—or, in the case of legal immigrants, ineligible for Medicaid, and below 100%—may receive subsidies known as premium tax credits to reduce premiums for a qualified health plan. 26 U.S.C. § 36B(c)(1). But these subsidies are available only to consumers who enroll in coverage through a Health Insurance Exchange established under the ACA. Thus, while qualified health plans may be offered outside of an Exchange, consumers who enroll in non-Exchange plans will not qualify for ACA subsidies.

By limiting enrollment to *un*subsidized coverage in the individual market, the Proclamation overrides the ACA by ignoring its express requirements, including the law's "[s]pecial rule for certain individuals

lawfully present." 26 U.S.C. § 36B(c)(1)(B). Under this special rule, adult legal immigrants subject to the five-year bar on Medicaid,[12] whose income is below 100% of the Federal Poverty Level, can enroll in subsidized ACA coverage through the Exchanges.

This attention to ensuring coverage for immigrants was deliberate, not accidental. The Senate Finance Committee specifically considered and rejected an amendment that would have imposed a five-year ban on lawfully present immigrants receiving subsidies under the ACA.[13] Near the end of Congressional deliberations, Senator Menendez observed that "[c]ertain lawfully present immigrants...are not eligible for Medicaid due to their immigration status," but that "health reform does not leave them in the cold" because they would be "eligible for premium tax credits in the exchange."[14] It is clear Congress enabled access to ACA coverage and subsidies for lawfully present immigrants consistent with the law's broader goal of expanding access to affordable coverage and reducing uncompensated care.

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[12] Generally, an adult alien who enters the U.S. is not eligible for any Federal means-tested public benefit, including most forms of Medicaid, "for a period of 5 years beginning on the date of the alien's entry into the United States." 8 U.S.C. § 1613.

[13] Executive Committee Meeting To Consider Health Care Reform, U.S. Senate, Committee on Finance, October 1, 2009 at 254-263, https://affordablecareactlitigation.files.wordpress.com/2018/09/100109-1.pdf. (last visited Jan. 28, 2021).

[14] 156 Cong. Rec. S2079 (March 25, 2010); *see also* 26 U.S.C. § 36B(c)(1)(B).

Ignoring this history and ACA eligibility rules, the Proclamation instead requires low- and middle-income legal immigrants to forego a health insurance benefit that Congress expressly made available to ensure access to comprehensive, affordable coverage. In other words, the Proclamation, by ruling out as "approved health insurance" all subsidized coverage under the ACA as well as all Medicaid coverage for persons over 18, improperly overrides the Medicaid and ACA statutes.

Doe III concluded that the Proclamation does not "expressly override" the ACA "because the two provisions operate in different spheres." 2020 WL 7778213, at *10. According to the majority, the Proclamation requires proof of approved health insurance *before* an immigrant can receive an immigrant visa whereas the ACA allows subsidies for legal immigrants who are *already* in the country. *Id*. The majority reasoned that nothing prevents legal immigrants from enrolling in subsidized ACA coverage once they have entered the country and gained lawful permanent residency. *Id*.; *see also id*. at n.10 (taking the questionable position that an immigrant can obtain a visa by representing that she is purchasing unsubsidized insurance, but can then turn around after entry to obtain subsidized insurance). This position, in addition to ignoring explicit statutory language extending ACA subsidies to legal immigrants, is factually inaccurate and misunderstands ACA eligibility.

First, the majority anticipates that, in one "sphere," "initial coverage" will be "by unsubsidized insurance" because ACA subsidy eligibility is limited only to those who are already in the United States. *Id*. That is true, but the same residency requirement applies equally to unsubsidized ACA coverage. *See* Dkt. 61 (Decl. Louise Norris at ¶ 10–11). And the view—that a just-admitted alien is barred from applying for subsidized ACA coverage for at least 30 days—conflicts with the ACA. The statute imposes no such delay and does not prevent legal immigrants from applying for subsidized ACA coverage immediately upon obtaining United States residency. In fact, an individual qualifies for a special enrollment period to enroll in subsidized ACA coverage after gaining lawfully present immigration status. *See* 45 C.F.R. § 155.420(a)(5).

Second, selecting health insurance in the United States is often a long-term commitment. Individuals who enroll in *un*subsidized coverage in the individual market cannot simply change their mind and enroll in subsidized ACA coverage, as the majority suggests. As noted above, gaining a lawfully present immigration status qualifies one for a special enrollment period. But, for someone who enters the country with this status already, simply wanting to switch to a subsidized plan, on its own, would not be grounds to switch. Consequently, immigrants who enroll in unsubsidized coverage to comply

with the Proclamation are likely to be locked into that plan until the next open enrollment period.

The same limits apply for many other types of "approved health insurance." While the loss of minimum essential coverage is considered a qualifying event that triggers a special enrollment period, 45 C.F.R. 155.420(d)(1)(i), products such as short-term plans and visitor health insurance plans do not qualify as minimum essential coverage so the loss of those products does not trigger a special enrollment period.[15] Thus, individuals who enroll in those products to comply with the Proclamation may not be able to enroll in subsidized ACA coverage until the next open enrollment period, leaving them vulnerable to denied benefits and high out-of-pocket costs and leaving providers with more uncompensated care.

The Proclamation has long-term implications for the health and financial well-being of legal immigrants. The portrayal of the Proclamation as a limited "threshold" issue that does "nothing [to] prevent[] the alien from then obtaining subsidized insurance" in the future, 2020 WL 7778213, at *10, is simply inaccurate and again underscores the breadth of ACA regulation in the arena of domestic health insurance.

[15] Healthcare.gov, Types of Health Insurance that Count as Coverage, https://www.healthcare.gov/fees/plans-that-count-as-coverage (last visited Jan. 28, 2021).

In complying with the Proclamation, legal immigrants face limits on access to subsidized ACA coverage, forcing them forego benefits expressly extended by Congress. A clearly unlawful situation as a President's edict "expressly overrides" and "contradicts" federal statutes. *See Trump v. Hawaii*, 138 S. Ct. at 2411; *Doe III*, 2020 WL 7778213, at *7.

### C. The Proclamation further contravenes the ACA by requiring enrollment in plans that are unavailable, unlikely to be available to immigrants, or do not satisfy the ACA.

Of the nine forms of acceptable coverage listed in the Proclamation, many are unavailable, or unlikely to be available, to immigrants. Medicare is only available to immigrants who have been in the country for at least five years. Employer-based coverage, assuming it is even offered by an employer, would only be available to immigrants who already have a job that provides health insurance at the time they enter the country and is usually subject to waiting periods that can last as long as 90 days. 42 U.S.C. § 300gg–7. Immigrants will generally be ineligible to be enrolled in a family member's coverage unless they are the children or spouse of a person already enrolled in coverage. Tricare is only available to members of the military and their families and survivors.[16]

[16] Tricare.mil, *Eligibility* (last visited Jan. 28, 2021).

That leaves unsubsidized individual coverage, catastrophic plans, short-term plans, visitor's plans, or having sufficient resources to cover "reasonably foreseeable medical costs." These options are either unaffordable, discriminatory, or non-comprehensive, or all of the above, and therefore unlikely to be effective in preventing uncompensated care.

**Unsubsidized individual health plans, including catastrophic plans**, are expensive and are only available once an immigrant establishes residency in a state, and in any case will often not be available within 30 days of arrival because of rules regarding when coverage becomes effective.[17] *See* Dkt. 61 (Decl. Louise Norris at ¶ 10–11).

**Short-term coverage** is not subject to the insurance reforms Congress adopted under the ACA and has many serious limitations that render it of little value in protecting immigrants and likely to leave providers with high volumes of uncompensated care. *See, e.g.*, Dkt. 56 (Decl. Sarah Lueck); Dkt. 57 (Decl. Dania Palanker); *and* Dkt. 64 (Decl. Stacey Pogue). For example, individuals may be turned down based on preexisting conditions or face benefit exclusions based on prior health care needs; that

[17] Centers for Medicare and Medicaid Services, *The Unsubsidized Uninsured: The Impact of Premium Affordability on Insurance Coverage* (Jan. 2021), https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/Uninsured-Affordability-in-Marketplace.pdf (last visited Jan. 28, 2021).

is, they will be able to purchase a plan, but the plan will expressly exclude a particular type of care (like chemotherapy), or care for a specified condition (like cancer), or care for a named organ system (like the lungs). Some short-term plans do not even cover basic needs, such as preventive care, mental health needs, substance use disorder treatment services, prescription drugs, and none cover maternity care.[18] Some short-term plans also impose limits on the number of services an enrollee can receive (visit limits) or the amount paid per visit (leaving the enrollee subject to balance billing).

Moreover, short-term coverage only meets the conditions of the Proclamation if it is available for at least 364 days.[19] Short-term coverage is only available in 27 states for this length of time, and it is totally prohibited in 5 states.[20]

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[18] *See* Karen Pollitz, Michelle Long, Ashley Semanskee and Rabah Kamal, *Understanding Short-Term Limited Duration Health Insurance*, Kaiser Family Foundation (Apr. 23, 2018), https://www.kff.org/health-reform/issue-brief/understanding-short-term-limited-duration-health-insurance/ (last visited Jan. 28, 2021).

[19] Health Reform, *ACA Open Enrollment: For Consumers Considering Short-Term Policies*, Kaiser Family Foundation (Oct. 25, 2019), https://www.kff.org/health-reform/fact-sheet/aca-open-enrollment-for-consumers-considering-short-term-policies/ (last visited Jan. 28, 2021).

[20] Justin Giovannelli, JoAnn Volk, and Kevin Lucia, *States Work to Make Individual Market Health Coverage More Affordable, But Long-Term Solutions Call for Federal Leadership*, The Commonwealth Fund (Jan. 15, 2020), https://www.commonwealthfund.org/publications/issue-briefs/2020/jan/states-make-indivldual-coverage-more-affordable-federal-needed (last visited Jan. 28, 2021).

All of these gaps are especially pernicious in light of the COVID-19 pandemic: people enrolled in short-term plans have far less financial protection if they need treatment for COVID-19 than people enrolled in ACA plans.[21] And enrollment in short-term plans, which are not required to cover the COVID-19 vaccine, could pose an additional barrier to efforts to ensure that all residents, including legal immigrants, are vaccinated.[22]

**Visitor insurance** poses all the same problems. Dkt. 61 (Decl. Louise Norris at ¶ 4). It will usually not cover preexisting conditions or include comprehensive benefits, such as maternity, mental health, substance use disorder treatment, or pharmaceuticals. *Id*. It often has high deductibles, out-of-pocket limits, and may impose annual and lifetime limits on coverage. That is, it suffers from the same gaps as short-term coverage, and leaves immigrants without coverage for significant medical costs and providers with uncompensated care obligations. Dkt. 56 (Decl. Sarah Lueck at ¶ 11).

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[21] *See* Emily Curran, Kevin Lucia, JoAnn Volk, and Dania Palanker, *In the Age of COVID-19, Short-Term Plans Fall Short for Consumers Facts about the Uninsured Population*, The Commonwealth Fund (May 12, 2020), https://www.commonwealthfund.org/blog/2020/age-covid-19-short-term-plans-fall-short-consumers (last visited Jan. 28, 2021).

[22] *See* Samantha Artiga, Nambi Ndugga, and Olivia Pham, *Immigrant Access to COVID-19 Vaccines: Key Issues to Consider*, Kaiser Family Foundation (Jan. 13, 2021), https://www.kff.org/racial-equity-and-health-policy/issue-brief/immigrant-access-to-covid-19-vaccines-key-issues-to-consider/ (last visited Jan. 28, 2021).

Finally, the Proclamation also allows an immigrant to establish that he "possesses the **financial resources to pay for reasonably foreseeable medical costs**." 84 Fed. Reg. at 53991. But many medical expenses are not foreseeable, like a new cancer diagnosis, a future pregnancy, or COVID-19 treatment. One study estimated that inpatient COVID-19 treatment could cost more than $20,000 for patients with employer-based coverage,[23] while uninsured patients have faced widely varying costs for COVID-19 treatment.[24] And, even when a condition is known, health care costs are opaque and it can be impossible to assess "reasonably foreseeable" costs for an individual. To the extent it was ever reasonable to expect to be able to estimate health care costs in advance, the pandemic makes it impossible for consular officials or applicants to assess "reasonably foreseeable medical costs" with any degree of accuracy.

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[23] Matthew Rae, Gary Claxton, Nisha Kurani, Daniel McDermott, and Cynthia Cox, *Potential Costs of COVID-19 Treatment for People with Employer Coverage*, Kaiser Family Foundation (Mar. 13, 2020), https://www.healthsystemtracker.org/brief/potential-costs-of-coronavirus-treatment-for-people-with-employer-coverage/ (last visited Jan. 28, 2021).

[24] *See* Abby Goodnough, Trump Program to Cover Uninsured COVID-19 Patients Falls Short of Promise, *New York Times* (Aug. 29, 2020), https://pnhp.org/news/emergency-health-care-coverage-for-covid-19-falls-short-of-promise/ (last visited Jan. 28, 2021); Abigail Abrams, Total Cost of Her COVID-19 Treatment: $34,927.43, *Time* (Mar. 19, 2020), https://time.com/5806312/coronavirus-treatment-cost/ (last visited Jan. 28, 2021).

## II. THE PROCLAMATION WILL NOT REDUCE THE RATE AT WHICH IMMIGRANTS GENERATE UNCOMPENSATED CARE BURDENS.

By driving immigrants into unaffordable or skimpy coverage, the Proclamation would achieve results directly opposite to those it purports to address.

For example, consider a woman who becomes pregnant after entering the United States. If she had enrolled in Medicaid or CHIP, which she would be entitled to in most states and territories if her income was in the appropriate range, she would have complete coverage for labor, delivery, and prenatal care with no or very limited cost-sharing.

If she were not able to access Medicaid or CHIP and enrolled in subsidized coverage under the ACA, she would have income-adjusted premiums and cost-sharing similarly ensuring coverage for her pregnancy. *See* 42 U.S.C. § 18022(b), § 18071; 26 U.S.C. § 36B.

But neither form of coverage satisfies the Proclamation. Assuming she cannot afford a full price ACA plan, under the Proclamation she would instead be forced to obtain a short-term plan, a visitor plan, or remain uninsured on the basis of having sufficient resources to pay reasonably foreseeable costs. *None* of these forms of "coverage" would compensate providers for the costs associated with her prenatal care, labor, and delivery:

short-term plans universally exclude maternity benefits, visitor's plans are expected to do the same, and the pregnancy would not have been "reasonably foreseeable" at the time of entry. In these situations, the entire maternity event is potentially uncompensated care.[25]

## CONCLUSION

While en banc review is rare, it is necessary here. The Proclamation essentially bars immigrants from access to coverage that they have a right to under the ACA. The Proclamation is contrary to law, would impose irreparable harm on the plaintiffs, and is contrary to the public interest. The panel's decision in Doe III should be reviewed and reversed by an en banc panel of this Court.

Dated: January 29, 2021

Respectfully Submitted,

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[25] In some circumstances, providers may be reimbursed for the costs of labor and delivery by "emergency Medicaid" coverage. 42 U.S.C. § 1396b(v). But this is not a form of coverage; it is a tool to compensate providers after the fact for delivering uncompensated care.

**UNITED STATES COURT OF APPEALS**
**FOR THE NINTH CIRCUIT**

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Case No 3:19-cv-01743-SB, Hon. Michael H. Simon

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# APPENDIX TO *AMICI CURIAE* BRIEF OF 32 HEALTH POLICY EXPERTS IN SUPPORT OF PLAINTIFFS-APPELLEES' PETITION FOR REHEARING EN BANC

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