No. 19-36020

In The United States Court Of Appeals For The Ninth Circuit

JOHN DOE # 1, *et al.*,

***Plaintiffs-Appellees*,**

v.

DONALD TRUMP, *et al.*,

Defendants-Appellants.

On Appeal from the United States District Court for the District of Oregon
No. 3:19-CV-1743-SI

BRIEF OF *AMICI CURIAE* NATIONAL HEALTH LAW PROGRAM, AMERICAN PUBLIC HEALTH ASSOCIATION, AND 48 OTHER ORGANIZATIONS, IN SUPPORT OF PLAINTIFFS-APPELLEES, JOHN DOE # 1, *ET AL.* AND AFFIRMANCE

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CORPORATE DISCLOSURE STATEMENT

Pursuant to Fed. R. App. P. 26.1 and Circuit Rule 26.1(a), the undersigned counsel certifies that the *amici curiae*, National Health Law Program (NHeLP); American Public Health Association; American Medical Student Association; Asian & Pacific Islander American Health Forum; Asian Americans Advancing Justice - Los Angeles; Asian Pacific American Labor Alliance; Association of Asian Pacific Community Health Organizations; Autistic Self Advocacy Network; California Immigrant Policy Center; California Latinas for Reproductive Justice; California Nurse-Midwives Association; California Pan-Ethnic Health Network; California Women's Law Center; Center for Law and Social Policy; Chronic Disease Coalition; Citizens for Choice; Coalition for Disability Health Equity; Community Action Marin; Community Catalyst; CRLA Foundation; East Bay Refugee and Immigrant Forum; Families USA; First 5 Marin Children and Families Commission; Health Law Advocates, Inc.; If/When/How: Lawyering for Reproductive Justice; Justice in Aging; Kids Forward; Latino Coalition for a Healthy California; Legal Aid Society of San Mateo County; Maternal and Child Health Access; Muslim Public Affairs Council (MPAC); National Asian Pacific American Women's Forum (NAPAWF); National Center for Law and Economic Justice; National Center for Lesbian Rights; National Center for Transgender Equality; National Coalition for Cancer Survivorship; National Council of Jewish

Women; National Organization for Women Foundation; North Carolina Justice Center; Northwest Health Law Advocates; Oasis Legal Services; Oregon Law Center; Planned Parenthood Federation of America; Service Employees International Union; Shriver Center on Poverty Law; The Children's Partnership; Treatment Action Group (TAG); Union for Reform Judaism, Central Conference of American Rabbis, Women of Reform Judaism, and Men of Reform Judaism; Western Center on Law & Poverty; and Whitman-Walker Institute, (collectively, "NHeLP *et al.*"), are not subsidiaries of any other corporation and no publicly held corporation owns 10 percent or more of any *amici curiae* organization's stock.

Dated: February 6, 2020

/s/ Martha Jane Perkins

Martha Jane Perkins

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Cases

Chamber of Commerce of United States of Am. v. United States Dep't of Labor,
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City & Cty. of San Francisco v. Trump,
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Clinton v. City of New York,
524 U.S. 417 (1998).....19

Gonzales v. Oregon,
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Gundy v. United States,
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King v. Burwell,
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Morris v. California Physicians' Serv.,
918 F.3d 1011 (9th Cir. 2019) 6, 9

Sierra Club v. Trump,
929 F.3d 670 (9th Cir. 2019) 23

Youngstown Sheet & Tube Co. v. Sawyer,
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Constitution and Statutes

U.S. Const. Art. I, § 9, cl. 7.....23

U.S. Const. Art. II, § 3 19

8 U.S.C. § 1182(f)..... 26, 27

8 U.S.C. § 1613 12

8 U.S.C. § 1641 12

26 U.S.C. § 36B 8

26 U.S.C. § 36B(c)(1)(2) 10, 11, 12, 20

26 U.S.C. § 36B(c)(1)(A) 8, 10

26 U.S.C. § 5000A(f)(1)(A)(ii).....16

42 U.S.C. § 300gg..... 8, 16

42 U.S.C. § 300gg-1..... 8, 16

42 U.S.C. § 300gg-3..... 8, 16

42 U.S.C. § 300gg-4..... 8, 16

42 U.S.C. § 300gg-13 8

42 U.S.C. § 300gg-18 .....8, 9

42 U.S.C. § 1396a(a)(10)(A) 14, 15

42 U.S.C. § 1396a(a)(10)(C).....15

42 U.S.C. § 1396a(a)(43).....14

42 U.S.C. § 1396a(k)(1).....16

42 U.S.C. § 1396a(a)(l).....15

42 U.S.C. § 1396b(v)(4)(A).....12

42 U.S.C. § 1396d(a) 15

42 U.S.C. § 1396d(a)(4)(B) 14

42 U.S.C. § 1396d(r).....14

42 U.S.C. § 1396d(r)(5) 15

42 U.S.C. § 1396o 16

42 U.S.C. § 1396o-1 16

42 U.S.C. § 1396u-7(b)(5) 16

42 U.S.C. § 1397gg(e)(1)(N) 12, 13, 20

42 U.S.C. § 18001(a) 10

42 U.S.C. § 18001(d)(1) 10

42 U.S.C. § 18021(a)(1) 7

42 U.S.C. § 18022(b)(1) 7, 16

42 U.S.C. § 18022(b)(4)(C) 7

42 U.S.C. § 18022(b)(4)(D) 7

42 U.S.C. § 18031(b)(1)(A) 6

42 U.S.C. § 18031(c)(1) 7

42 U.S.C. § 18031(c)(1)(A) 7

42 U.S.C. § 18031(c)(1)(C) 7

42 U.S.C. § 18031(c)(1)(D) 9

42 U.S.C. § 18031(c)(1)(E) 9

42 U.S.C. § 18031(d)(2)(B)(1) 6

42 U.S.C. § 18031(e)(3)(A) 9

42 U.S.C. § 18032(f)(3) 12

42 U.S.C. § 18071 8

42 U.S.C. § 18071(c) 8

42 U.S.C. § 18071(e)(1).....11

42 U.S.C. § 18071(e)(2).....11

42 U.S.C. § 18081 12

42 U.S.C. § 18116 16

Children's Health Insurance Program Reauthorization Act of 2009, sec. 214, Pub. L. No. 111-3, 123 Stat. 9 (2009) 12, 13

Patient Protection and Affordable Care Act. Pub. L. No. 111-148, 124 Stat. 119 (2010), as amended, Pub. L. No. 111-152, 124 Stat. 1029 (2010) ..... *passim*

Regulations

42 C.F.R. § 440.210(a)(2) 15

75 Fed. Reg. 74, 865, 45 CFR Part 158, II.A 8, 9

Other Authorities

155 Cong. Rec. S820, (Jan. 26, 2009), https://www.congress.gov/111/crec/2009/01/26/CREC-2009-01-26-pt1-PgS820-2.pdf (statement of Sen. Rockefeller) 14

156 Cong. Rec. S2069-07 11

American Cancer Society Cancer Action Network, Inadequate Coverage: An ACS CAN Examination of Short-Term Health Plans (May 13, 2019), https://www.fightcancer.org/sites/default/files/ACS%20CAN%20Short%20Term%20Paper%20FINAL.pdf 22

Larisa Antonisse et al., Kaiser Family Found., *The Effects of Medicaid Expansion under the ACA: Updated Findings from a Literature Review* (Aug. 15, 2019), https://www.kff.org/medicaid/issue-brief/the-effects-of-medicaid-expansion-under-the-aca-updated-findings-from-a-literature-review-august-2019/.....17

Hamutal Bernstein et al., Urban Inst. *One in Seven Adults in Immigrant Families Reported Avoiding Public Benefit Programs in 2018* (2019), https://www.urban.org/sites/default/files/publication/100270/one_in_seven_adults_in_immigrant_families_reported_avoiding_publi_7.pdf 21

Linda J. Blumberg et al. Urban Inst., *Updated: The Potential Impact of Short-Term Limited-Duration Policies on Insurance Coverage, Premiums, and Federal Spending* (Mar. 2018), https://www.urban.org/sites/default/files/publication/96781/2001727_updated_finalized.pdf.....21

Ctrs. for Medicare & Medicaid Servs., *Medicaid and CHIP Coverage of "Lawfully Residing" Children and Pregnant Women* (July 1, 2010), https://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/SHO10006.pdf 13

Sabrina Corlette et al., Urban Inst., *The Marketing of Short-Term Health Plans: An Assessment of Industry Practices and State Regulatory Responses* (Jan. 2019), https://www.urban.org/sites/default/files/publication/99708/moni_stldi_final_0.pdf 25, 26

Executive Committee Meeting to Consider Health Care Reform of the S. Comm. on Finance, 111th Cong., 3-5 (Sept. 22, 2009), available at: https://www.finance.senate.gov/imo/media/doc/092209.pdf 6

Executive Order 13765, Minimizing the Economic Burden of the Patient Protection and Affordable Care Act Pending Repeal, 82 Fed. Reg. 8351 (Jan. 24, 2017)..... 17, 18

Michael E. Fix & Jeffery S. Passel, Urban Inst., *Trends in Noncitizens' and Citizen' Use of Public Benefits Following Welfare Reform: 1994-1997*, (1999), https://www.urban.org/sites/default/files/publication/69781/408086-Trends-in-Noncitizens-and-Citizens-Use-of-Public-Benefits-Following-Welfare-Reform.pdf.....21

Food & Nutrition Serv., U.S. Dep't of Agriculture, *Who is Leaving the Food Stamp Program: An Analysis of Caseload Changes from 1994 to 1997* (1999), https://fns-prod.azureedge.net/sites/default/files/cdr.pdf..... 20, 21

Georgetown Univ. Health Policy Inst., Ctr. For Children & Families, "Health Coverage for Lawfully Residing Children." (2018) https://ccf.georgetown.edu/wp-content/uploads/2018/05/ichia_fact_sheet.pdf 14

Sherry Glied & Benjamin Zhu, "The Unintended Consequences of Requiring Immigrants to Meet 'Reasonably Foreseeable' Costs," To The Point, Commonwealth Fund (Jan. 31, 2020), https://www.commonwealthfund.org/blog/2020/immigrants-foreseeable-medical-costs.....25

Amy Goldstein & Juliet Eilperin, *Affordable Care Act Remains "Law of the Land," but Trump Vows to Explode It*, Wash. Post, Mar. 24, 2017, https://wapo.st/2Do6m8v 17

Health Policy Inst. of Ohio, *Healthcare Data Transparency Basics 2016* (Feb. 2016), https://www.healthpolicyohio.org/wp-content/uploads/2016/03/TransparencyBasics2016.pdf 25

Insured but Not Covered: Hearing Before the Subcomm. On Oversight & Investigations of the H. Comm. on Energy & Commerce, 111th Cong., 2009 WL 3326522 (Oct. 15, 2009).....5

Kleimann Communication Group, *Report on Testing Consumer Understanding of a Short-Term Health Insurance Plan* (Mar. 15, 2019), https://healthyfuturega.org/wp-content/uploads/2019/04/Consumer-Testing-Report_NAIC-Consumer-Reps.pdf.....24

Annie L. Mach & Janet Kinzer, Cong. Research Serv., *Legislative Actions to Modify the Affordable Care Act in the 111th-115th Congresses* (June 27, 2018), https://fas.org/sgp/crs/misc/R45244.pdf.....6

Alexander Marlow, et al., Exclusive—President Donald Trump on Immigration: "I Don't Want to Have Anyone Coming in That's on Welfare" (Mar. 11, 2019), https://www.breitbart.com/politics/2019/03/11/exclusive-president-donald-trump-on-immigration-i-dont-want-to-have-anyone-coming-in-thats-on-welfare/ 18

Medicaid/CHIP Coverage of Lawfully-Residing Immigrant Children and Pregnant Women, Henry J. Kaiser Fam. Found. (Jan. 1, 2019), https://www.kff.org/health-reform/state-indicator/medicaid-chip-coverage-of-lawfully-residing-immigrant-children-and-pregnant-women 14

Nat'l Ass'n of Insurance Comm'rs, Report on Testing Consumer Understanding of a Short-Term Health Plan (April 2019), https://healthyfuturega.org/wp-content/uploads/2019/04/Consumer-Testing-Report_NAIC-Consumer-Reps.pdf 26

Craig Palosky, Kaiser Family Found., *A Comprehensive Review of Research Finds That the ACA Medicaid Expansion Has Reduced the Uninsured Rate and Uncompensated Care Costs in Expansion States, While Increasing Affordability and Access to Care and Producing State Budget Savings* (Aug. 15, 2019), https://www.kff.org/medicaid/press-release/a-comprehensive-review-of-research-finds-that-the-aca-medicaid-expansion-has-reduced-the-uninsured-rate-and-uncompensated-care-costs-in-expansion-states-while-increasing-affordability-and-access-to-c/ 17

Patient Protection and Affordable Care Act, H.R. 3590, 111th Cong. § 1002(c)(1)(C). (2009), https://www.congress.gov/bill/111th-congress/house-bill/3590 (as passed by House, Oct. 8, 2009) 11

Karen Politz et al., Kaiser Family Found., *Understanding Short-Term Limited Duration Health Insurance* (Apr. 23, 2018), https://www.kff.org/health-reform/issue-brief/understanding-short-term-limited-duration-health-insurance/..... 21, 22

Presidential Proclamation 9945, Suspension of Entry of Immigrants Who Will Financially Burden the United States Healthcare System, In Order To Protect the Availability of Healthcare Benefits for Americans, 84 Fed. Reg. 53,991 (Oct. 9, 2019)..... *passim*

Anne Quito & Amanda Shendruk, "US hospitals are now required by law to post prices online. Good luck finding them," Quartz (Jan. 15, 2019), https://qz.com/1518545/price-lists-for-the-115-biggest-us-hospitals-new-transparency-law/ 24, 25

Jessica Schubel & Matt Broaddus, Ctr. on Budget & Policy Priorities, *Uncompensated Care Costs Fell in Nearly Every State as ACA's Major Coverage Provisions Took Effect* (May 23, 2018), https://www.cbpp.org/research/health/uncompensated-care-costs-fell-in-nearly-every-state-as-acas-major-coverage 17

Donald J. Trump (realDonaldTrump), Twitter (Jul. 18, 2015), https://twitter.com/realDonaldTrump/status/622469994220273664.....18

Laura Ungar, NPR, *A Woman's Grief Led To A Mental Health Crisis And A $21,634 Hospital Bill* (Oct. 31, 2019), https://www.npr.org/sections/health-shots/2019/10/31/771397503/a-womans-grief-led-to-a-mental-health-crisis-and-a-21-634-hospital-bill.....22

U.S. Dep't of Health & Human Servs., Ctrs. for Medicare & Medicaid Servs., *EPSDT: A Guide for States: Coverage in the Medicaid Benefit for Children and Adolescents* (June 2014), https://www.medicaid.gov/medicaid/benefits/downloads/epsdt_coverage_guide.pdf 15

INTEREST OF *AMICI*[1]

The *amici curiae* are the National Health Law Program (NHeLP); American Public Health Association; American Medical Student Association; Asian & Pacific Islander American Health Forum; Asian Americans Advancing Justice - Los Angeles; Asian Pacific American Labor Alliance; Association of Asian Pacific Community Health Organizations; Autistic Self Advocacy Network; California Immigrant Policy Center; California Latinas for Reproductive Justice; California Nurse-Midwives Association; California Pan-Ethnic Health Network; California Women's Law Center; Center for Law and Social Policy; The Children's Partnership; Chronic Disease Coalition; Citizens for Choice; Coalition for Disability Health Equity; Community Action Marin; Community Catalyst; CRLA Foundation; East Bay Refugee and Immigrant Forum; Families USA; First 5 Marin Children and Families Commission; Health Law Advocates, Inc.; If/When/How: Lawyering for Reproductive Justice; Justice in Aging; Kids Forward; Latino Coalition for a Healthy California; Legal Aid Society of San Mateo County; Maternal and Child Health Access; Muslim Public Affairs Council (MPAC); National Asian Pacific American Women's Forum (NAPAWF); National Center

[1] Pursuant to Fed. R. App. P. 29(a)(4)(E), counsel for *amici curiae* states that no counsel for a party authored the brief in whole or in part, and no person other than *amici curiae*, their members, or their counsel made a monetary contribution to its preparation or submission.

for Law and Economic Justice; National Center for Lesbian Rights; National Center for Transgender Equality; National Coalition for Cancer Survivorship; National Council of Jewish Women; National Organization for Women Foundation; ; North Carolina Justice Center; Northwest Health Law Advocates; Oasis Legal Services; Oregon Law Center; Planned Parenthood Federation of America; Service Employees International Union; Shriver Center on Poverty Law; Treatment Action Group (TAG); Union for Reform Judaism, Central Conference of American Rabbis, Women of Reform Judaism, and Men of Reform Judaism; Western Center on Law & Poverty; and Whitman-Walker Institute (collectively, "NHeLP et al.").

While each *amicus* has particular interests, together they share the mission of ensuring all people, including immigrants and their families, can obtain the affordable, comprehensive, quality health care to which they are entitled. *Amici* NHeLP *et al.* work on behalf of low-income populations and immigrants throughout the country to remove barriers to health care using various tools such as providing direct legal and health services, policy advocacy, education, and litigation. *Amici,* collectively bring to this Court an in-depth understanding of the purpose and structure of the Patient Protection and Affordable Care Act and the Medicaid program to provide the Court with accurate information as it considers the impact of the Proclamation on the health care programs Congress has

established. *Amici* NHeLP *et al.* obtained consent of both parties to file an amicus brief in this matter.

INTRODUCTION

Presidential Proclamation 9945 ("Proclamation"), bars the entry of immigrants to the United States unless they demonstrate that they have what the Proclamation deems "approved" coverage, or financial resources to pay for their reasonably foreseeable health care costs. *See* Presidential Proclamation 9945, Suspension of Entry of Immigrants Who Will Financially Burden the United States Healthcare System, In Order To Protect the Availability of Healthcare Benefits for Americans, 84 Fed. Reg. 53,991 (Oct. 9, 2019). The Government tries to characterize the Proclamation as an exercise of the President's foreign relations authority. This framing, however, ignores that the Proclamation has a distinct, domestic purpose and effect: to undermine Congress's chosen scheme for providing health care to newly arrived immigrants.

Congress, through the Affordable Care Act and the Medicaid program, has already prescribed how different categories of newly arrived immigrants may obtain health coverage. It made comprehensive, affordable coverage available through subsidized private plans on the Affordable Care Act's Marketplaces, and, at state option, through Medicaid coverage for lawfully residing children and pregnant women. Notwithstanding Congress's directives, the Proclamation

excludes Medicaid for adults and subsidized Marketplace coverage for all individuals subject to the Proclamation from the list of "approved" plans, meaning that an immigrant must obtain some *other* form of insurance to satisfy the Proclamation's mandates and enter the country. The plans that will be most readily available are short-term, limited duration plans that do not comply with the Affordable Care Act—including that they typically do not provide all categories of "essential health benefits" and often exclude coverage for pre-existing conditions. The Proclamation, therefore, directs immigrants away from the coverage Congress intended them to have, and towards other coverage the President prefers (but which, in many cases, may ultimately not be available to them).

Moreover, the Proclamation, for the first time ever, seeks to use foreign policy powers to regulate domestic health care policy, relying on consular officers at the State Department to implement the policy. The Supreme Court has rejected the suggestion that "Congress would have delegated," important health care policy choices to an agency "which has no expertise in crafting health insurance policy of this sort." *King v. Burwell*, 135 S. Ct. 2480, 2489 (2015). But that is exactly what the Proclamation does: it delegates authority for evaluating the adequacy of various health insurance options to consular officers at the State Department, who lack the necessary health care expertise for such evaluations. In short, the Proclamation represents an effort to disregard a comprehensive health care policy established by

Congress. The Court should reject the President's efforts to supplant Congress's chosen health care policy with his own.

ARGUMENT

I. Congress Made Comprehensive, Affordable Coverage Available to Lawfully Present Immigrants.

A. Lawfully Present Immigrants are Expressly Included in the Affordable Care Act's Provisions Designed to Expand Access to Affordable, Comprehensive Coverage.

In 2010, Congress passed, and the President signed, the Patient Protection and Affordable Care Act. Pub. L. No. 111-148, 124 Stat. 119 (2010), as amended, Pub. L. No. 111-152, 124 Stat. 1029 (2010) (collectively the "Affordable Care Act" or "ACA"). The ACA "grew out of a long history of failed health insurance reform," *King*, 135 S. Ct. at 2485. Congress understood the widespread problems in the American health care system. This included "the problem of underinsurance, which happens when people pay for health insurance but aren't adequately protected from high medical expenses." *Insured but Not Covered: Hearing Before the Subcomm. On Oversight & Investigations of the H. Comm. on Energy & Commerce*, 111th Cong., 2009 WL 3326522, 1 (Oct. 15, 2009) (opening statement of Rep. Waxman, Chairman, H. Comm. On Energy & Commerce). Congress also recognized that insurance plans often did not cover medically necessary, but high-cost services, or provide a "core set of benefits to ensure coverage for essential health care services." *Id*.

Congress understood that the only way to address these problems was to comprehensively reform American health care. *See Executive Committee Meeting to Consider Health Care Reform of the S. Comm. on Finance*, 111th Cong., 3-5 (Sept. 22, 2009), available at: https://www.finance.senate.gov/imo/media/doc/092209.pdf. The ACA "contains hundreds of . . . provisions that address health care access, costs, and quality." Annie L. Mach & Janet Kinzer, Cong. Research Serv., *Legislative Actions to Modify the Affordable Care Act in the 111th-115th Congresses*, 2 (June 27, 2018), https://fas.org/sgp/crs/misc/R45244.pdf. Indeed, courts have recognized that the Affordable Care Act represents a comprehensive, interlocking set of reforms. *See, e.g.*, *King*, 135 S. Ct. at 2485 (describing the ACA's "interlocking reforms designed to expand coverage in the individual health insurance market."); *Morris v. California Physicians' Serv.*, 918 F.3d 1011, 1015 (9th Cir. 2019) ("the ACA represented the most significant regulatory overhaul and national expansion of health care coverage since Medicare and Medicaid in 1965.").

One central reform was the creation of health care "exchanges," also known as Marketplaces, that allow individuals to purchase "qualified health plans" ("QHPs"). 42 U.S.C. § 18031(b)(1)(A). Plans must be certified as a QHP to be offered on the exchanges. *Id.* § 18031(d)(2)(B)(1) ("An Exchange may not make available any health plan that is not a qualified health plan."). *See also id.*

§ 18031(c)(1) (defining minimum requirements for certification as a "qualified health plan"); *id*. § 18021(a)(1) (defining "qualified health plans").

Congress established numerous requirements to ensure that QHPs would be able to meet the needs of low-income individuals and individuals with substantial health needs. For instance, Congress directed that qualified health plans avoid marketing practices that "have the effect of discouraging the enrollment in such plans by individuals with significant health needs," and that they include "community providers . . . that serve predominately low-income, medically underserved individuals." 42 U.S.C. § 18031(c)(1)(A), (C). Congress also required QHPs to cover "essential health benefits," including among others, maternity and newborn care, mental health and substance use disorder services, and prescription drugs. *Id.* § 18022(b)(1). Moreover, Congress directed the Secretary of the Department of Health and Human Services ("HHS"), when implementing the essential health benefits, to "take into account the health care needs of diverse segments of the population, including women, children, persons with disabilities, and other groups." *Id.* § 18022(b)(4)(C). In addition, the HHS Secretary must ensure that essential health benefits are not "subject to denial to individuals against their wishes on the basis of the individuals' age or expected length of life or of the individuals' present or predicted disability, degree of medical dependency, or quality of life." *Id*. § 18022(b)(4)(D).

QHPs, like other insurers, are subject to the reforms that prohibit insurers from refusing to cover preexisting conditions, 42 U.S.C. § 300gg-3, turning individuals away because of their health conditions, *see id.* §§ 300gg, 300gg-1, and charging people more because of preexisting health issues, *id.* § 300gg-4.

Congress also enacted reforms to ensure that QHPs are affordable. First, the ACA created premium tax credits to subsidize the cost of purchasing health insurance on the exchanges. 26 U.S.C. § 36B. Generally, tax credits are available to individuals with incomes between 100% and 400% of the Federal Poverty Level (FPL). *Id.* § 36B(c)(1)(A). Second, Congress created protections against costs, such as deductibles, co-payments, and co-insurance, that stem from utilizing particular services. It directed that some services, such as preventive services, must be available without any cost-sharing. 42 U.S.C. § 300gg-13. Congress also established cost-sharing reductions in 42 U.S.C. § 18071, which requires insurers to "reduce the applicable out-of pocket [sic] limit" by set amounts depending on household income. *Id.* § 18071(c). Insurers are reimbursed by the federal government for the costs of such reductions. Congress also requires QHPs to spend at least 80 percent of their premium income on health care claims and health quality improvement. *See Id.* § 300gg-18; *see also* 75 Fed. Reg. 74,865, 45 CFR Part 158, II.A. When insurers do not spend at least 80 percent of their premium income in this way, the insurers are required to "provide rebates to enrollees." *See*

42 U.S.C. § 300gg-18. *See also* 75 Fed. Reg. 74,865, 45 CFR Part 158, II.A; *Morris*, 918 F.3d at 1014-15 ("The purpose of the MLR is thus to encourage use of premium income to provide benefits to insureds and discourage its use to offset administrative costs, thus serving the primary goal of expanding affordable care.").

Additionally, Congress directed that the HHS Secretary set up a comprehensive reporting system for QHPs, requiring QHPs to report on various quality metrics and enrollee satisfaction criteria. 42 U.S.C. §§ 18031(c)(1)(D)-(E), (H)-(I), 18031(c)(4). Congress ensured that consumers would have accurate information about QHPs by requiring the plans to report—to HHS and to the public—data on enrollment, disenrollment, claims payment policies and practices, including claims that were denied, and data on cost-sharing and payments for out of network coverage. *Id.* § 18031(e)(3)(A). In short, Congress set up a detailed system to ensure that QHPs provided affordable, comprehensive, quality care.

The ACA expressly included lawfully present immigrants throughout its reforms, ensuring that they would have access to affordable, comprehensive, and quality coverage.

First, Congress took immediate action to ensure that individuals, both citizens and immigrants, with preexisting conditions could have access to coverage. Though enacted in 2010, most of the Affordable Care Act's reforms did not take effect until 2014. In the interim, Congress directed the HHS Secretary to

create within 90 days of the ACA's enactment, "a temporary high risk health insurance pool program to provide health insurance coverage for eligible individuals," which remained in place until January 1, 2014. 42 U.S.C. § 18001(a). Congress specifically directed that people who are "lawfully present," including newly arriving immigrants, were included within the definition of "eligible individuals" who could obtain immediate coverage through the pool. *Id.* § 18001(d)(1).

Second, Congress explicitly provided for lawfully present immigrants to receive affordable, comprehensive coverage through QHPs. With respect to the premium tax credits, it created a "special rule for certain individuals lawfully present in the United States." 26 U.S.C. § 36B(c)(1)(2). Premium tax credits are generally available for individuals, including lawfully present immigrants, with incomes between 100% and 400% FPL. *Id.*§ 36B(c)(1)(A). In addition, for "alien[s] lawfully present in the United States, but not eligible for the [M]edicaid program under title XIX of the Social Security Act by reason of such alien status," Congress also extended the tax credits to those with incomes *below* 100% FPL. *Id.* The statute thus ensures that all lawfully residing immigrants in the United States, with incomes below 400% FPL, are eligible for some form of comprehensive, affordable coverage, either through Medicaid or through subsidized plans on the Marketplace if Medicaid is unavailable.

Congress also expressly included lawfully residing immigrants in the statutory provisions establishing the cost-sharing reductions. 42 U.S.C. § 18071(e)(1)-(2) (directing that "no cost-sharing reduction . . . shall apply," "[i]f an individual . . . is *not* lawfully present," and defining "lawfully present" to mean an "alien lawfully present in the United States," for the period the cost-sharing reduction is claimed).

The legislative history of the ACA underscores Congress's interest in providing comprehensive coverage to immigrants. In earlier versions, Congress noted that extending coverage to lawfully present immigrants would "prevent adverse financial and medical consequences of uncompensated care." Patient Protection and Affordable Care Act, H.R. 3590, 111th Cong. § 1002(c)(1)(C). (2009), https://www.congress.gov/bill/111th-congress/house-bill/3590 (as passed by House, Oct. 8, 2009). Ultimately, to address this problem, Congress established a system where all lawfully residing immigrants may obtain coverage through either Medicaid or the Marketplace, including providing subsidies for those with income below 400 percent FPL to make the coverage affordable. *See* 26 U.S.C. § 36B(c)(1)(2). *See also* 156 Cong. Rec. S2069-07, 156 Cong. Rec. S2069-07, S2079 (statement of Mr. Baucus) ("health reform does not leave [lawfully present immigrants] in the cold," because if they are "otherwise ineligible for Medicaid, [they] are eligible for premium tax credits in the exchange.").

In sum, Congress explicitly referenced lawfully present immigrants throughout the ACA and enacted numerous protections to ensure that those groups would be included within the comprehensive reforms and protections it enacted. *See also* 42 U.S.C. §§ 18032(f)(3), 18081. The text and structure of the ACA thus demonstrate Congress's clear intent that all lawfully present immigrants, including those newly arriving, would be included in the ACA's comprehensive framework.

B. Congress Created State Options to Provide Medicaid Coverage to Lawfully Residing Children and Pregnant Women.

As the Affordable Care Act recognized, some lawfully residing immigrants may be eligible for the Medicaid program under Title XIX of the Social Security Act. *See* 26 U.S.C. § 36B(c)(1)(2). Specifically, Congress has identified certain categories of "qualified" immigrants who are eligible for Medicaid. *See* 8 U.S.C. § 1641. Within the group of qualified immigrants, some, such as legal permanent residents, are subject to a five-year waiting period, while others are eligible for Medicaid immediately. *Id.* § 1613.

In addition, Congress has given states the option to make Medicaid coverage available to certain groups of lawfully residing immigrants. Specifically, states have the option to cover all lawfully residing pregnant women and children up to age 21. 42 U.S.C. § 1396b(v)(4)(A) (2012). *See also*, Children's Health Insurance Program Reauthorization Act of 2009 ("CHIPRA"), sec. 214, Pub. L. No. 111-3, 123 Stat. 9 (2009); 42 U.S.C. §§ 1396b(v)(4)(A), 1397gg(e)(1)(N). The structure

of the CHIPRA option for children emphasizes the importance Congress placed on the Medicaid program: States taking this option must cover lawfully residing children in Medicaid alone, or through a combination of CHIP and Medicaid, but may not rely solely on CHIP. *See* Ctrs. for Medicare & Medicaid Servs., *Medicaid and CHIP Coverage of "Lawfully Residing" Children and Pregnant Women*, 2 (July 1, 2010), https://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/SHO10006.pdf (hereinafter "CMS, *Lawfully Residing*") ("[t]he law does not permit States to cover these groups only in CHIP, without also extending the option to Medicaid."); *see also* 42 U.S.C. § 1397gg(e)(1)(N). Congress thus demonstrated its clear preference that Medicaid cover this population.

The lawfully residing category covers a wide range of statuses, including newly arriving immigrants targeted by the Proclamation. *See* CMS, *Lawfully Residing* at 2-4. There is no waiting period within the lawfully residing category. Thus, in states taking the option, pregnant women and children up to age 21, who arrive with a qualified status that would otherwise be subject to a five-year waiting period—such as legal permanent resident—may receive coverage immediately through the lawfully residing category. *Id.* at 1-2, 5. Furthermore, states taking up this option "must offer coverage to all such individuals who meet this definition of lawfully residing, and may not cover a subgroup or only certain groups." *Id.* at 4.

The lawfully residing option is an important source of coverage for immigrants. As of January 2019, 35 States opt to cover lawfully residing children, and 25 cover pregnant women. *Medicaid/CHIP Coverage of Lawfully-Residing Immigrant Children and Pregnant Women*, Henry J. Kaiser Fam. Found. (Jan. 1, 2019), https://www.kff.org/health-reform/state-indicator/medicaid-chip-coverage-of-lawfully-residing-immigrant-children-and-pregnant-women. At the end of 2012, 62 percent of immigrant children had health coverage through Medicaid or CHIP in states that took this option. *See* Georgetown Univ. Health Policy Inst., Ctr. For Children & Families, "Health Coverage for Lawfully Residing Children." (2018) https://ccf.georgetown.edu/wp-content/uploads/2018/05/ichia_fact_sheet.pdf.

When enacting this option, Congress emphasized the importance of providing these groups comprehensive coverage. *See, e.g.*, 155 Cong. Rec. S820, S822 (Jan. 26, 2009), https://www.congress.gov/111/crec/2009/01/26/CREC-2009-01-26-pt1-PgS820-2.pdf (statement of Sen. Rockefeller) ("This is not about immigration. It is about health care for kids who need it . . . The bottom line is that both U.S. citizen children and children in this country legally should have timely access to health care, period."). Indeed, the benefits under this option are robust. For children under age 21, states are required to provide Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services. 42 U.S.C. §§ 1396a(a)(10)(A), 1396a(a)(43), 1396d(a)(4)(B), 1396d(r). EPSDT requires that

the services listed in the Medicaid Act at 42 U.S.C. § 1396d(a) must be provided to a child if they are "necessary . . . to correct or ameliorate defects and physical and mental illnesses and conditions . . . regardless of whether or not such services are covered" for adults. *Id*. § 1396d(r)(5). Services must be covered if they correct, compensate for, improve, or prevent a condition from worsening, even if the condition cannot be prevented or cured. U.S. Dep't of Health & Human Servs., Ctrs. for Medicare & Medicaid Servs., *EPSDT: A Guide for States: Coverage in the Medicaid Benefit for Children and Adolescents* 10 (June 2014), https://www.medicaid.gov/medicaid/benefits/downloads/epsdt_coverage_guide.pdf. For pregnant women, states must cover pregnancy-related services, including services for other conditions that might complicate pregnancy, and 60-days post-partum pregnancy-related services. 42 U.S.C. §§ 1396a(a)(10)(A), (C), 1396a(l); 42 C.F.R. §§ 440.210(a)(2).

II. The Proclamation Conflicts with Congress's Directives.

The Proclamation requires immigrants to obtain certain "approved" forms of insurance. Proclamation § 1(a). Would-be immigrants who rely on short-term limited duration or visitor health insurance plans to satisfy the Proclamation's requirements must demonstrate that they will hold this insurance for at least 364 days. Proclamation §§ 2(b)(iii), (vii). According to the Government, this is

necessary to "ensure that immigrants entering the country carry a minimum level of insurance." Gov't Br. at 29; *see also id.* at 43.

The President, however, is not writing on a blank slate. As described above, Congress has been concerned about immigrants lacking insurance and has taken action to address that problem, including by directing that Medicaid and subsidized Marketplace coverage are available to lawfully residing immigrants. *See supra* at Section I. Unlike certain "approved" plans under the Proclamation, both Marketplace and Medicaid coverage qualify as "minimum essential coverage" under Congress's definition, and protect against uncompensated care by providing cost-protections, ensuring comprehensive benefits, and prohibiting discrimination based on health needs, health status, national origin, and other factors. *See 2*6 U.S.C. § 5000A(f)(1)(A)(ii) (defining minimum essential coverage); 42 U.S.C. §§ 1396o, 1396o-1 (establishing Medicaid premium and cost-sharing protections); 42 U.S.C. § 18022(b)(1) (establishing essential health benefits); 42 U.S.C. § 1396a(k)(1) (requiring that individuals covered under Medicaid expansion receive "benchmark coverage" defined in statute); 42 U.S.C. § 1396u-7(b)(5) (requiring plans offering benchmark or benchmark-equivalent coverage to include essential health benefits). 42 U.S.C. §§ 300gg, 300gg-1, 300gg-3, 300gg-4 (preexisting condition protections); 42 U.S.C. § 18116 (prohibiting discrimination in health programs and health activities on the basis of race, sex, national origin,

and other factors). Moreover, because Medicaid and Marketplace coverage offer comprehensive benefits, they have been shown to reduce uncompensated care costs—the purported basis for the Proclamation, *see* Proclamation at 1.[2]

Even before signing the Proclamation, the President made clear that he disagrees with Congress's directives in the ACA and Medicaid program. For instance, President Trump has vowed to "explode" the Affordable Care Act and the Medicaid program. *See* Amy Goldstein & Juliet Eilperin, *Affordable Care Act Remains "Law of the Land," but Trump Vows to Explode It*, Wash. Post, Mar. 24, 2017, https://wapo.st/2Do6m8v. On the day he took office, President Trump signed an Executive Order calling on federal agencies to undo the ACA "[t]o the maximum extent permitted by law." Executive Order 13765, Minimizing the

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[2] *See, e.g.*, Craig Palosky, Kaiser Family Found., *A Comprehensive Review of Research Finds That the ACA Medicaid Expansion Has Reduced the Uninsured Rate and Uncompensated Care Costs in Expansion States, While Increasing Affordability and Access to Care and Producing State Budget Savings* (Aug. 15, 2019), https://www.kff.org/medicaid/press-release/a-comprehensive-review-of-research-finds-that-the-aca-medicaid-expansion-has-reduced-the-uninsured-rate-and-uncompensated-care-costs-in-expansion-states-while-increasing-affordability-and-access-to-c/; Larisa Antonisse et al., Kaiser Family Found., *The Effects of Medicaid Expansion under the ACA: Updated Findings from a Literature Review* (Aug. 15, 2019), https://www.kff.org/medicaid/issue-brief/the-effects-of-medicaid-expansion-under-the-aca-updated-findings-from-a-literature-review-august-2019/; Jessica Schubel & Matt Broaddus, Ctr. on Budget & Policy Priorities, *Uncompensated Care Costs Fell in Nearly Every State as ACA's Major Coverage Provisions Took Effect* (May 23, 2018), https://www.cbpp.org/research/health/uncompensated-care-costs-fell-in-nearly-every-state-as-acas-major-coverage.

Economic Burden of the Patient Protection and Affordable Care Act Pending Repeal, 82 Fed. Reg. 8351 (Jan. 24, 2017).

He has also targeted immigrants' access to health care. For instance, shortly after announcing his candidacy for President, he tweeted, "It's a national embarrassment that an illegal immigrant can walk across the border and receive free health care. . . ." Donald J. Trump (realDonaldTrump), Twitter (Jul. 18, 2015), https://twitter.com/realDonaldTrump/status/622469994220273664. He has repeated similar claims while in office, targeting immigrants' use of government-funded programs. For instance, in an interview with Breitbart News published on March 11, 2019, President Trump was quoted as saying, "I don't want to have anyone coming in that's on welfare." Alexander Marlow, et al., Exclusive—President Donald Trump on Immigration: "I Don't Want to Have Anyone Coming in That's on Welfare" (Mar. 11, 2019), https://www.breitbart.com/politics/2019/03/11/exclusive-president-donald-trump-on-immigration-i-dont-want-to-have-anyone-coming-in-thats-on-welfare/.

Following these stated policy preferences, the Proclamation excludes from the list of approved plans the very types of coverage Congress prescribed for lawfully residing immigrants: subsidized Marketplace plans and, for individuals over 18 years old, Medicaid coverage. Proclamation at §§ 1(b)(ii), 1(c). The President's policy preferences, however, do not vest the President with authority to

re-write domestic health care policy that Congress has duly enacted. *See Clinton v. City of New York*, 524 U.S. 417, 444 (1998) (rejecting as unconstitutional Presidential action that "is rejecting the policy judgment made by Congress and relying on his own policy judgment."). The President must faithfully execute, not rewrite Congress's choices. U.S. Const. Art. II, § 3. At the same time, the non-delegation principle dictates "Congress . . . may not transfer to another branch powers which are strictly and exclusively legislative," including the power to establish a statute's "intelligible principle." *Gundy v. United States*, 139 S. Ct. 2116, 2123 (2019) (internal quotes omitted). Thus, the Take Care clause and non-delegation principles form two sides of the same coin: Congress may not delegate its legislative authority to define a law's intelligible principle and, in "faithfully execut[ing]" that law, the Executive may not exercise that core legislative power. Indeed, where, as here,

> the President takes measures incompatible with the expressed or implied will of Congress, his power is at its lowest ebb, for then he can rely only upon his own constitutional powers minus any constitutional powers of Congress over the matter. Courts can sustain exclusive presidential control in such a case only by disabling the Congress from acting upon the subject.

Youngstown Sheet & Tube Co. v. Sawyer, 343 U.S. 579, 637-38 (1952) (Jackson, J. concurring).

The President's actions here undermine both the express and implied will of Congress. As evidenced by the text, structure, and legislative history of the ACA,

Congress has directed that funds *should* be spent on immigrant health care. In fact, Congress specified a preference for Medicaid coverage among the insurance programs available to that population: where Medicaid funds are available, an individual is not eligible for premium tax credits. *See* 26 U.S.C. § 36B(c)(1)(2). Moreover, States may not rely solely on CHIP funding for lawfully residing immigrants without also providing Medicaid coverage. *See* 42 U.S.C. § 1397gg(e)(1)(N). Congress, thus, codified both its preference that immigrants receive Medicaid when they are eligible, and the backstop to provide Marketplace eligibility when they are not-—including eligibility for premium tax credits and cost-sharing reductions to make coverage affordable.

By excluding Medicaid (for individuals above age 18) and subsidized Marketplace coverage (for all individuals subject to the Proclamation) from the list of "approved" coverage, the Proclamation all but requires individuals to enroll in some other kind of insurance plan. Furthermore, the President's action will deter enrollment in Medicaid and the Marketplaces, even among individuals *not* subject to the Proclamation, by increasing confusion and fear about participating in these programs. Evidence shows that this type of "chilling effect" routinely extends beyond immigrants directly regulated, and can deter enrollment in public programs among those who remain eligible. *See, e.g.*, Food & Nutrition Serv., U.S. Dep't of Agriculture, *Who is Leaving the Food Stamp Program: An Analysis of Caseload*

Changes from 1994 to 1997, 2-3 (1999), https://fns-prod.azureedge.net/sites/default/files/cdr.pdf (limiting lawful immigrant's food stamp eligibility deterred enrollment among U.S.-born children who remained eligible); Michael E. Fix & Jeffery S. Passel, Urban Inst., *Trends in Noncitizens' and Citizen' Use of Public Benefits Following Welfare Reform: 1994-1997*, 1, 4 (1999), https://www.urban.org/sites/default/files/publication/69781/408086-Trends-in-Noncitizens-and-Citizens-Use-of-Public-Benefits-Following-Welfare-Reform.pdf (describing "chilling effects" and noting, in particular, that refugee participation in Medicaid and other benefits programs declined following eligibility restrictions, despite protections maintaining their eligibility); Hamutal Bernstein et al., Urban Inst. *One in Seven Adults in Immigrant Families Reported Avoiding Public Benefit Programs in 2018*, 1-2 (2019), https://www.urban.org/sites/default/files/publication/100270/one_in_seven_adults_in_immigrant_families_reported_avoiding_publi_7.pdf. As a result, the Proclamation directs immigrants and their families—whether or not they are actually subject to the Proclamation—away from the coverage Congress approved, and which demonstrably reduces uncompensated care costs, and towards the coverage the President prefers, which does not.[3]

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[3] *See, e.g.*, Linda J. Blumberg et al. Urban Inst., *Updated: The Potential Impact of Short-Term Limited-Duration Policies on Insurance Coverage, Premiums, and Federal Spending* (Mar. 2018), https://www.urban.org/sites/default/files/publication/96781/2001727_updated_finalized.pdf; Karen Politz et al., Kaiser

The Government points out that there are *other* forms of coverage available in emerging private markets, designed to meet the requirements of the Proclamation. Gov't Br. at 7, 48. But these emerging markets, which exist outside the comprehensive scheme established by the ACA, and are not subject to the ACA's requirements and protections for consumers, actually demonstrate how the Proclamation thwarts Congress's purpose. Unregulated markets such as these are precisely what Congress, through the ACA, sought to mitigate. These new markets are not subject to any of the quality or reporting requirements of qualified health plans, and do not offer the essential health benefits or any of the cost-sharing protections of the ACA or Medicaid. In fact, the specific website the Government cites, www.insubuy.com, underscores the problems created by unregulated markets. None of the original plan documents are available for the plans listed on this website, making it impossible to even tell what services are actually covered. Moreover, plans that do not provide comprehensive benefits, as required by the ACA, actually increase uncompensated care—undermining both Congress'

Family Found., *Understanding Short-Term Limited Duration Health Insurance* (Apr. 23, 2018), https://www.kff.org/health-reform/issue-brief/understanding-short-term-limited-duration-health-insurance/; Laura Ungar, NPR, *A Woman's Grief Led To A Mental Health Crisis And A $21,634 Hospital Bill* (Oct. 31, 2019), https://www.npr.org/sections/health-shots/2019/10/31/771397503/a-womans-grief-led-to-a-mental-health-crisis-and-a-21-634-hospital-bill; American Cancer Society Cancer Action Network, *Inadequate Coverage: An ACS CAN Examination of Short-Term Health Plans* (May 13, 2019), https://www.fightcancer.org/sites/default/files/ACS%20CAN%20Short%20Term%20Paper%20FINAL.pdf.

purpose in enacting the ACA and the President's stated purpose in the Proclamation, *see* Proclamation at 1. The Proclamation, therefore, conflicts with the "implied will" of Congress. *See Youngstown*, 343 U.S. at 637.

Finally, the Proclamation infringes on Congress's constitutional powers. The President's basis for excluding Medicaid coverage and subsidized Marketplace plans from the list of "approved health insurance" is that both use federal funds.[4] *See* Proclamation at 1 ("the uninsured strain Federal and State government budgets through their reliance on publicly funded programs, which ultimately are financed by taxpayers."). The decision whether to spend federal funds on health coverage for immigrants is a choice for Congress, not the President. *See* U.S. Const. art. I, § 9, cl. 7; *Sierra Club v. Trump*, 929 F.3d 670, 694 (9th Cir. 2019) (Congress has "exclusive power of the purse."); *City & Cty. of San Francisco v. Trump*, 897 F.3d 1225, 1234 (9th Cir. 2018) ("[W]hen it comes to spending, the President has none of his own constitutional powers to rely upon.") (internal quote omitted).

In sum, the Proclamation's text, structure, and practical effects run entirely counter to the health care policy Congress enacted in the Affordable Care Act and the Medicaid program. The Proclamation, therefore, does "not direct that a

[4] Notably, the President's concern with use of federal funds did not extend to Medicare or TRICARE, which do count as "approved" under the Proclamation. This inconsistent reasoning underscores that the Proclamation is driven by a desire to re-write domestic health care policy according to the President's preferences and undermine the ACA and the Medicaid program.

congressional policy be executed in a manner prescribed by Congress—it directs that a presidential policy be executed in a manner prescribed by the President." *Youngstown*, 343 U.S. at 588.

III. The Proclamation Impermissibly Delegates Implementation Of Health Care Policy to the Department of State And Consular Officers Who Lack Expertise.

The Proclamation directs that an intending immigrant must "establish . . . to the satisfaction of a *consular officer*," that they will have "approved health insurance," or the "financial resources to pay for reasonably foreseeable medical costs." Proclamation, §§ 1(a), 3 (emphasis added). It authorizes the Secretary of State to "establish standards and procedures governing such determinations." *Id.*

Those determinations are complex and require detailed knowledge of medicine and health insurance markets. For instance, studies reveal that consumers and non-experts, such immigrant visa applicants, often lack health care literacy and are unable to accurately estimate out-of-pocket costs for health care services events like hospital stays and laboratory tests. *See, e.g.*, Kleimann Communication Group, *Report on Testing Consumer Understanding of a Short-Term Health Insurance Plan* (Mar. 15, 2019), https://healthyfuturega.org/wp-content/uploads/2019/04/Consumer-Testing-Report_NAIC-Consumer-Reps.pdf. Moreover, prices for health care services are often not available, or are very difficult to find. *See*, *e.g.*, Anne Quito & Amanda Shendruk, "US hospitals are now required by law to post prices

online. Good luck finding them," Quartz (Jan. 15, 2019), https://qz.com/1518545/price-lists-for-the-115-biggest-us-hospitals-new-transparency-law/. Even where published transparency tools are available, they are not specific enough to accurately predict the cost of a particular service for a particular person. *See, e.g.*, Health Policy Inst. of Ohio, *Healthcare Data Transparency Basics 2016*, 3-4 (Feb. 2016), https://www.healthpolicyohio.org/wp-content/uploads/2016/03/TransparencyBasics2016.pdf. Those tools reflect only the average price, and do not account for geographic variations, or different prices within different plans that result from confidentially negotiated rates. *Id.* at 1, 3-4. Moreover, even with knowledge of the potential costs of treatment, it is not possible to predict how much any particular individual is likely to spend. A recent study found that "between 54 percent and 83 percent of people would not spend the average 'reasonably foreseeable' cost during their second year after diagnosis." Sherry Glied & Benjamin Zhu, "The Unintended Consequences of Requiring Immigrants to Meet 'Reasonably Foreseeable' Costs," To The Point, Commonwealth Fund (Jan. 31, 2020), https://www.commonwealthfund.org/blog/2020/immigrants-foreseeable-medical-costs.

Furthermore, consumers and lay people often have difficulty distinguishing ACA-compliant plans from non-compliant plans when shopping for health coverage. *See, e.g.*, Sabrina Corlette et al., Urban Inst., *The Marketing of Short-*

Term Health Plans: An Assessment of Industry Practices and State Regulatory Responses (Jan. 2019), https://www.urban.org/sites/default/files/publication/99708/moni_stldi_final_0.pdf; Nat'l Ass'n of Insurance Comm'rs, *Report on Testing Consumer Understanding of a Short-Term Health Plan* (April 2019), https://healthyfuturega.org/wp-content/uploads/2019/04/Consumer-Testing-Report_NAIC-Consumer-Reps.pdf. Non-compliant plans often market themselves in ways that suggest they are ACA-compliant, and short-term plans often provide incomplete and insufficient information about covered services, cost-sharing, or rates. Corlette et al., *The Marketing of Short-Term Health Plans* at 2, 6-7.

The Department of State and its consular officers are simply not equipped to evaluate an individual's medical conditions, predict the likely costs of treatment for those conditions, or assess and distinguish among different types of health coverage to determine whether they qualify as one of the "approved" plans.

This mismatch between the health care expertise required to implement the Proclamation and the knowledge and skills of the Department of State demonstrates that the President has overstepped the bounds of 8 U.S.C. § 1182(f). The Supreme Court has rejected the suggestion that "Congress would have delegated" important health care policy choices to an agency "which has no expertise in crafting health insurance policy of this sort." *King*, 135 S. Ct. at 2489. Likewise, "the Supreme Court has been skeptical of federal regulations crafted

from long-extant statutes that exert novel and extensive power over the American economy." *Chamber of Commerce of United States of Am. v. United States Dep't of Labor*, 885 F.3d 360, 387 (5th Cir. 2018). But that is precisely what the Proclamation claims to do: exert novel and extensive power over the American health care market to, purportedly, address the economic impacts of uncompensated care. It is implausible that Congress intended, in 8 U.S.C. § 1182(f) to grant the President broad authority to create new health care markets or otherwise restructure domestic health care policy. The authority the President delegated to consular officers and the Secretary of State is thus, "both beyond [their] expertise and incongruous with the statutory purposes and design," of both the INA and the ACA. *Gonzales v. Oregon*, 546 U.S. 243, 267 (2006).

CONCLUSION

In sum, the Proclamation directly undermines the health care policy that Congress has enacted for newly arrived immigrants. The President's efforts to undermine domestic health care policy through foreign policy powers oversteps his Constitutional authority and should be rejected.

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CERTIFICATE OF COMPLIANCE

I hereby certify that this brief complies with the requirements of Fed. R. App. P. 32(a)(5) and (6) because it has been prepared in 14-point Times New Roman, a proportionally spaced font. I certify that the foregoing brief complies with the requirements of Fed. R. App. P. 32(a)(7)(B) and 29(a)(5), and that the total number of words in this brief is 5,800 according to the count of Microsoft Word, excluding the parts of the brief exempted by Fed. R. App. P. 32(f).

Date: February 6, 2020

/s/ Martha Jane Perkins
Martha Jane Perkins

CERTIFICATE OF SERVICE

I certify that on February 6, 2020, I electronically filed the forgoing brief with the Clerk of the Court by using the CM/ECF system.

Date: February 6, 2020

/s/ Martha Jane Perkins
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