UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

MAKE THE ROAD NEW YORK, AFRICAN SERVICES COMMITTEE, ASIAN AMERICAN FEDERATION, CATHOLIC CHARITIES COMMUNITY SERVICES (ARCHDIOCESE OF NEW YORK), and CATHOLIC LEGAL IMMIGRATION NETWORK, INC., Plaintiffs, - against - KEN CUCCINELLI, in his official capacity as Acting Director of United States Citizenship and Immigration Services; UNITED STATES CITIZENSHIP & IMMIGRATION SERVICES; KEVIN K. McALEENAN, in his official capacity as Acting Secretary of Homeland Security; and UNITED STATES DEPARTMENT OF HOMELAND SECURITY, Defendants.	CIVIL ACTION NO. 19-07993

BRIEF OF AMICI CURIAE HEALTH LAW ADVOCATES AND OTHER ORGANIZATIONS INTERESTED IN PUBLIC HEALTH IN SUPPORT OF PLAINTIFFS' MOTION FOR PRELIMINARY INJUNCTION

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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's work in assisting consumer access to health care encompasses all Massachusetts residents. 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 has a direct interest in preserving Massachusetts' health care delivery system. 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 **New York Immigration Coalition ("NYIC")** envisions a New York State that is stronger because all people are welcome, treated fairly, and given the chance to pursue their dreams. The NYIC advocates for laws and policies to improve the lives of immigrants and all New Yorkers, particularly those that live in lower income communities. NYIC opposes the public charge rule because it weaponizes basic needs like nutrition, health care and housing and destabilizes families and children.

Health Care For All ("HCFA") is a non-profit consumer health advocacy organization that advocates for health justice in Massachusetts by promoting health equity and ensuring coverage and access for all. HCFA advocates for policies and practices to advance access to quality, affordable health coverage and care for consumers in Massachusetts, including for

immigrants. HCFA operates a toll-free HelpLine that assists Massachusetts residents in English, Spanish, and Portuguese to apply for, enroll in, and troubleshoot health coverage issues. The HelpLine receives 20,000 calls per year and assists many immigrant individuals and families. HCFA also collaborates with immigrant-serving organizations on advocacy, community events and enrollment assistance. HCFA has a direct interest in preserving and improving the health care system in Massachusetts.

The **Massachusetts Law Reform Institute ("MLRI")** is a statewide legal services support center that provides legal and policy advocacy, training, information, and legal support on issues such as access to health care and other essential benefits that have a broad impact on low-income people, including immigrants. These issues include affordable health insurance options for low and moderate income people, immigrant eligibility for public benefits, and the immigration consequences of receipt of public benefits. MLRI has previously submitted amicus briefs on issues affecting immigrants including their 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).

Community Catalyst is a national, non-profit, non-partisan organization that provides leadership and support to state and local consumer organizations, policymakers and foundations that are working to guarantee access to high-quality, affordable health care for everyone. The organization has an interest in representing consumers at risk of losing critical consumer protections and access to affordable coverage and health care services.

Northeastern University's Center for Health Policy and Law promotes innovative solutions to public health challenges in Massachusetts and around the globe. The Center advances law and policy reforms to strengthen population health, reduce health disparities,

nourish public health programs, and enhance access to affordable, high-quality health care. Housed in the School of Law and firmly rooted in the University's nine academic colleges, the Center conducts and disseminates research and seeks to influence the formulation and implementation of health policy and law, including with respect to protecting vulnerable populations. This brief has been joined by the Center but does not present the view of the law school, University, or individual faculty affiliated with the Center.

Health in Justice Action Lab is an interdisciplinary think tank based at Northeastern University. The Lab's portfolio focuses on advancing public health solutions to address today's critical societal challenges. The statements expressed in this brief do not necessarily represent the views of any individuals or organizations affiliated with Health in Justice.

The **Public Health Law Watch ("PHLW")** is a project of the George Consortium, a nationwide network of over sixty public health law scholars, academics, experts, and practitioners dedicated to advancing public health through law. PHLW's goals are to increase visibility and understanding of public health law issues, identify ways to engage on these issues and provide legal analysis and commentary. The statements expressed here do not necessarily represent the views of any individuals or institutions affiliated with PHLW.

Northwest Health Law Advocates ("NoHLA") is a public interest law firm and advocacy organization representing the interests of low-and moderate-income Washington State residents in improved access to quality health care. NoHLA focuses much of its work on facilitating access for populations experiencing obstacles to accessing health care such as immigrants, older adults, people with disabilities, and LGBT individuals. NoHLA achieves its aims through advocacy on behalf of consumers, analyzing and publicizing the effects of changes

in health law, providing public education and training on issues affecting health care access, and legal advocacy on health care issues of public importance.

Over the last two years, **Charlotte Center for Legal Advocacy** has been working with families who are afraid to use public assistance programs they are eligible to receive due to fears that using those benefits will harm their ability to adjust immigration status or even get them deported. Charlotte Center for Legal Advocacy is certain that many more families will decline critical access to nutrition, health care and housing assistance they are eligible to receive out of fear and confusion from the new Public Charge rule. Instead, of welcoming the "tired, poor, huddled masses" of the world, this rule prohibits all but the wealthiest from accessing our country's immigration system and the freedom, hope and opportunity it provides. This rule makes it nearly impossible for poor people, disabled people, the elderly, or children to adjust their immigration status. Charlotte Center for Legal Advocacy serves hardworking, low-income immigrant families who deserve a fair shot at the opportunity to support their families and keep them together.

The **Latino Coalition for a Healthy California ("LCHC")** fundamentally opposes the newly-finalized Public Charge rule and countless assaults on the Latinx immigrant community. These policies force millions of hard-working immigrants to decide between critical health care and other safety-net programs for their families or risk being penalized in their immigration process. Latinx immigrant families do not deserve to be punished for working hard to achieve the American Dream.

The **California Pan-Ethnic Health Network ("CPEHN")** is a statewide multicultural health advocacy organization. Founded over 25 years ago, CPEHN unites communities of color to achieve health and wellness, and to eliminate persistent health inequities. CPEHN's interest in

the outcome of this case arises out of significant concern that, if implemented, the Public Charge rule would have an adverse impact on the health of California's low-income communities of color, including immigrants and their families. CPEHN has heard numerous stories documenting the harmful impact on community members' seeking care subsequent to the proposed regulation and the finalized rule. While it continues to educate community members around the rule, it is in CPEHN also supports the Plaintiffs in this case.

Since its inception in 1977, **Korean Community Center of the East Bay ("KCCEB")** has served the Korean American community in the Bay Area by providing community leadership, advocacy and direct services in the areas of immigration/citizenship, social services, health and wellness access, domestic violence and sexual assault, youth leadership development, and faith-based community building. The Center's mission is to empower the Korean American and other communities of the Bay Area through education, advocacy, health and wellness services and the development of community-based resources. KCCEB wants to empower low income community to become active members that practice civic duties and the new Public Charge rule is a huge barrier to this mission.

The **California Immigrant Policy Center ("CIPC")** is the premier immigrant rights institution in the state that promotes and protects safety, health and public benefits and integration programs for immigrants, and one of the few organizations that effectively combines legislative and policy advocacy, strategy communications, organizing and capacity building to pursue its mission. CIPC anchors the statewide response to the expansion of the definition of "public charge." CIPC is a constituent-based statewide immigrant rights organization with member organizations that work with directly impacted communities across the state.

As a statewide nonprofit law firm and advocacy organization working specifically in the areas of health law, public benefits, and immigration, the **Kentucky Equal Justice Center** has a strong interest in the outcome of this case.

The **Michigan Immigrant Rights Center** is a statewide nonprofit legal resource center for immigrant communities. The Center serves low income immigrant clients and provides technical assistance to organizations who serve them. The Public Charge rule that is the subject of this litigation directly impacts the Center's clients' and constituents' access to health programs and the delivery of community services related to health care.

The **Florida Health Justice Project's** mission is to improve access to health care as a human right, and we engage in comprehensive advocacy to expand health care access and promote health equity for vulnerable Floridians. The chilling effect of the recently finalized rule, "Inadmissibility on Public Charge Grounds," will cause well over 100,000 members of immigrant families across Florida to lose access to vital programs which impact health equity, including Medicaid and SNAP. The Project opposes this rule's implementation.

The **Maine Immigrant Rights Coalition** joins this brief to help to ensure that the new Public Charge rule does not put Maine people at risk. This rule change is already creating fear and anxiety, and MIRC has received reports of Maine families who are afraid to apply for programs like WIC. MIRC is the leading voice advocating for immigrants in Maine and knows that healthy and thriving immigrant communities contribute to the well-being of the state.

Community Healthcare Network's mission is to provide access to quality, culturally-competent and comprehensive community-based primary care, mental health and social services for diverse populations in underserved communities throughout New York City. The new Public Charge Rule threatens the health and well-being of these communities by causing individuals to

disenroll from critical benefit programs. CHN strongly opposes the new rule and the harmful outcomes it will cause our patients.

The **Arab Community Center for Economic and Social Services ("ACCESS")** has seen the impact the Public Charge rule has had on immigrant communities. Many of ACCESS's clients have requested to be disenrolled from Medicaid, as well as multiple other public benefits, that contribute to the overall well-being of individuals and families. This rule jeopardizes the health and well-being of many immigrant communities.

As an organization dedicated to reaffirming the right to health care for communities affected by HIV, Hepatitis C, and tuberculosis, **Treatment Action Group ("TAG")** is strongly opposed to the expansion of the definition of inadmissibility on public charge grounds. TAG is deeply concerned that the Public Charge Rule will inhibit access to state health exchanges and will prevent many immigrants from seeking life-saving health care. This rule will undoubtedly harm the health of immigrants, their communities, and the broader American public.

Based in Somerville, Massachusetts, the **Welcome Project** builds the collective power of immigrants to participate in and shape community decision through programming that strengthens the capacity of immigrant youth, adults, and families to advocate for themselves and influence schools, government, and other institutions. The Welcome Project has seen many of our constituents afraid to seek medical insurance, including those needing maternal care due to the changes to the Public Charge rule. The Public Charge rule hurts the overall health of our communities and the health of the Project's constituents.

Families USA is a national, non-partisan, non-profit organization that has represented the interests of health care consumers and promoted health care reform in the United States for more than 35 years. Its mission is to promote the best possible health, and accessible and affordable

health care, for all. Families USA commented on the harm that would be wrought by the Public Charge rule.

UMass Memorial Health Care, Inc. ("UMass Memorial") is a private, non-profit, charitable health care system based in Worcester, Massachusetts. UMass Memorial is the largest health care provider in Central Massachusetts and provides more care to the poor and underserved than any other provider in Central Massachusetts. UMass Memorial is one of only two "Essential MassHealth Hospital" systems in the state, based upon its provision of a disproportionate share of services to vulnerable populations. At the same time, UMass Memorial is an academic medical center that provides highly complex medical services unavailable elsewhere in Central New England. UMass Memorial is deeply concerned about the impact implementation of the new Public Charge rule would have on its patients, on public health, on essential health systems like UMass Memorial and on the local economy.

II. Corporate Disclosure Statement

HLA, HCFA, MLRI, NoHLA, the Charlotte Center for Legal Advocacy, LCHC, CPEHN, KCCEB, the California Immigrant Policy Center, the Kentucky Equal Justice Center, the Michigan Immigrant Rights Center, the Florida Health Justice Project, the Maine Immigrant Rights Coalition, NYIC, Community Healthcare Network, ACCESS, TAG, the Welcome Project, Families USA, UMass Memorial, and Community Catalyst are non-profit organizations with no parent corporations and no stock.

Northeastern University's Center for Health Policy and Law and the Health in Justice Action Lab are unincorporated organizations of Northeastern University, a non-profit organization with no parent corporation and no stock.

The Public Health Law Watch is an unincorporated consortium of academics and practitioners.

I. Introduction

This case asks whether the Department of Homeland Security ("DHS") may alter the longstanding interpretation of a federal statute in a manner that undermines the detailed framework developed by Congress and implemented by the states for providing access to health care for low income and working class families. Amici are organizations located throughout the country dedicated to promoting public health, especially in low-income communities. They oppose the Public Charge Rule (the "Rule") because it contravenes Congressional intent and will have wide-ranging adverse impacts on public health.

Section 212(a)(4) of the Immigration and Nationality Act ("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 repeatedly expanded noncitizens' access to Medicaid and other public health benefits in order to improve health outcomes and control costs.

Congress's health policy goals are effectuated in large part through partnerships between the Department of Health and Human Services ("HHS") and the states. These Congressionally-authorized federal-state partnerships vividly illustrate the complexity and varied approaches that states have taken with respect to creating health care delivery systems and, in some cases, the significant improvements to public health thereby. For example, Massachusetts, a national leader in health care coverage whose 2006 state health reform was widely seen as a model for the Affordable Care Act, has achieved near-universal coverage, including for many noncitizens,

thereby spreading costs across providers and payers. Other states including Plaintiffs have achieved similar success.

DHS' new Rule threatens to unravel the health care system crafted by Congress, HHS, and the states. The Rule dramatically redefines the longstanding meaning of "public charge" to mean "an alien who receives one or more public benefits [including Medicaid] . . . for more than 12 months in the aggregate within any 36 month period." 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 consider multiple factors including past receipt of public benefits and certain medical conditions. *Id.* at 41504. This framework creates a clear and direct incentive for immigrants seeking or who may in the future seek adjustment of status to avoid accessing benefits, including Medicaid. The Rule thus clashes with Congress's express intent to encourage the use of public health benefits.

The harm caused by the Rule will not be limited to immigrants who are subject to the public charge determination and receive the listed benefits. The Rule's stunning breadth, complexity and likely arbitrary application will deter many more immigrants and U.S. citizens living with immigrant family members, from applying for *any* public benefits for fear of incurring adverse immigration consequences. The Rule undermines the attempts of Congress' and states to expand health care coverage in order to improve health and control costs. Consequently, the Rule vastly exceeds the scope of DHS' authority.

The Rule will immediately and 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 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, they have discretion to cover additional groups or provide additional services. In addition, 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 will likely argue that Congress has acted to curtail the utilization of public benefits by noncitizens. This is false. Congress has repeatedly affirmed the eligibility of certain classes of noncitizens for Medicaid and within those parameters has given states broad flexibility. In 1996, Congress enacted the Personal Responsibility and Work Opportunity Reconciliation Act,

Pub. L. No. 104-193, 110 Stat. 2105 (1996) ("PRWORA"), which allowed "qualified immigrants"[1] to access federal means-tested benefits, including Medicaid and other benefits, subject to a five-year waiting period for most who qualified. PRWORA also excluded certain groups from that five-year bar, including veterans and refugees. 8 U.S.C. § 1613(a). PRWORA has been amended several times, and with each amendment Congress expanded eligibility for immigrants.[2] Further, PRWORA largely gives states a free hand to provide state-funded benefits to all noncitizens. *See* 8 U.S.C. § 1621(d); *Finch v. Commonwealth Health Ins. Connector Auth.*, 459 Mass. 655, 672-73 (2011).[3]

In 2009, Congress expanded noncitizen access to Medicaid by authorizing federally funded benefits for children and pregnant women "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"); codified at 42 U.S.C. § 1396b(v)(4)(A).[4] One year later, the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119-1025 (2010) ("ACA") permitted states to expand Medicaid coverage to eligible adults (including certain noncitizens) 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

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

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

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

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

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

B. The Flexibility Provided Under Federal Law Has Allowed States to Advance a Culture of Coverage.

Congress has delegated to the states, under federal oversight and approval, the implementation of health care programs designed to increase access to care for citizens and noncitizens alike. States like New York and Massachusetts (and others) leverage this federal support alongside state funds to create integrated health care delivery systems with the express goal of achieving high rates of coverage, improving health outcomes and stabilizing costs.[6]

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

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

Massachusetts provides one example of how states have leveraged federal support to improve their health care delivery systems.[7] In 2006, Massachusetts enacted landmark health reform legislation ("Chapter 58") that aimed to "expand access to health care for Massachusetts residents, increase the affordability of health insurance products, and enhance accountability of [the] state's health system." *See id.* at Preamble of Ch. 58. The many reforms introduced in Chapter 58[8] were largely made possible by an influx of federal funds.[9] Ultimately, nearly half of the financing for Chapter 58's reforms were sourced from and approved by the federal government. *See* McDonough, *supra* n.7, at 426. Chapter 58 included state-funded coverage for classes of lawful immigrants not eligible for federally-funded Medicaid under PRWORA under a state program called Commonwealth Care, Mass. Gen. L. c. 118H § 1, and for elderly and disabled lawfully present noncitizens in a separate state-funded medical assistance program. Mass. Gen. L. c. 118E § 16D.

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, Massachusetts uses an Integrated

establishing near-universal coverage is largely due to federal matching funds); The Blue Ribbon Comm'n on Health Care Medicaid Expansion Working Grp., *Summary of Findings and Recommendations on the MassHealth Medicaid Expansion*, 6 (1995), http://archives.lib.state.ma.us/bitstream/handle/2452/49338/ocm33130222.pdf ("[T]he expansion of Medicaid, along with other waiver programs, would attempt to [shift] care from the emergency room and acute hospital settings, where health care services are more expensive, to primary care settings.")

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

[8] Chapter 58 expanded MassHealth eligibility for children from 200% of FPL to 300%; *see id.* at § 26; established a sliding-scale subsidized health insurance program for uninsured individuals with household incomes up to 300% of the FPL who were ineligible for MassHealth or any other coverage; *see id.* at § 45; and established the Commonwealth Health Insurance Connector Authority ("Connector"), tasked with implementing key elements of Chapter 58 health reform policies. *See id.* at § 101.

[9] *See id.* at § 112 (State must request amendment to Section 115 waiver to seek maximum federal reimbursement for subsidized health insurance programs).

Eligibility System that determines an applicant's eligibility for *all* state and federally funded health care programs via a single application. Many of these benefits are publicly branded under the same name, "MassHealth," which incorporates federal Medicaid, the Children's Health Insurance Program ("CHIP"), and fully state-funded programs such as MassHealth Limited and the Children's Medical Security Plan. *See* 130 C.M.R. § 501.003(B). Providers are incentivized to assist patients in completing benefit applications and choosing appropriate coverage. *See* 130 C.M.R. § 450.231(D). Many applicants may be unaware they applied for benefits subject to the Rule because applicants cannot apply for state benefits, private non-group coverage, or Emergency Medicaid (all of which are outside the scope of the Rule) without simultaneously applying for federal Medicaid. *See* 130 C.M.R. 501.004(B)(3) (requiring a "single, streamlined application" to determine eligibility for MassHealth and the Exchanges); 130 C.M.R. § 502.001(A). Once approved, residents do not always know which program(s) they have been approved for, or whether their benefits are funded through state or state and federal sources. Indeed, everyone approved for MassHealth gets the same membership card.

New York State, like Massachusetts, has unified and realigned its health care eligibility determination system to simplify the application process.[10] 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 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

[10] 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.

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 applying for and renewing health and human services benefits a faster and simpler process."[11]

In this manner, New York and Massachusetts, like many states, seek to facilitate access to coverage.[12] These efforts have succeeded. In the two years after Chapter 58's passage, insurance rates for adults in Massachusetts jumped from 86% to 95.5%, a number that has stayed largely steady since.[13] Eighty-seven percent of Massachusetts adults report having a place, other than an emergency department, to seek preventative care.[14] Massachusetts' approach has also help contain health care costs: total spending growth has been below the national growth rate of 3.5%, and growth in commercial health coverage between 2012 and 2016 was below the national average, saving a total of $5.9 billion compared to the national average.[15] Similarly, uninsured rates have declined in New York since the passage of the ACA, from 10.7% in 2013 to 5.7% in

[11] "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.

[12] In the ACA, Congress required states to adopt similar integrated eligibility systems. 42 U.S.C. § 18083.

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

[14] *Id.* at 2.

[15] *2017 Annual Health Care Trends Report*, Mass. Health Policy Comm'n, 4 (March 2018), *https://www.mass.gov/files/documents/2018/03/28/Cost%20Trends%20Report%202017.pdf.*

2018.[16] 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.[17] These achievements are due largely to the support and flexibility afforded by Congress.

C. The Rule Stigmatizes Public Health Benefits.

Historically, "public charge" was used only to refer to those who are primarily and permanently dependent upon the government. By redefining the term to include anyone who has used 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 weight negatively if an immigrant has a serious medical condition and is uninsured and "has neither the prospect of obtaining private health insurance, or the financial resources to pay for reasonably foreseeable medical costs related to the medical condition." 84 Fed. Reg. at 41501. On the other hand, possession of unsubsidized private health insurance is a heavily weighted positive factor. 84 Fed. Reg. at 41504.

This mischaracterization of people who rely on publicly-funded health benefits, in

[16] *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 Nealry Ever 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.

[17] *See* Jessica Schubel and Matt Broaddus, "Uncompensated Care Costs Fell in Nealry Ever 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.

combination with the confusion created by the Rule's complexity and discretionary nature, stigmatizes and deters the use of public health benefits. Not only will immigrants subject to the Rule be inclined to disenroll from or decline benefits, immigrants who are not subject to the Rule, as well as their family members will do likewise. DHS acknowledges this anticipated disenrollment, but discounts it as a matter of an "unwarranted choice." 84 Fed. Reg. 41313. Given the integrated and complex nature of many state health systems that does not allow applicants to pick which benefits they access, disenrollment is not "unwarranted" and in many instances is not a choice at all, because in many instances immigrants can only avoid the Rule by avoiding all benefits entirely.

III. Argument

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

DHS has framed the Rule as immigration-focused, falling squarely within its authority to regulate under the INA,[18] but the Rule crosses well into the existing health care framework. DHS's authority to promulgate regulations affecting health policy is limited by a fundamental legal axiom—federal regulation may not run counter to a federal statutory scheme, *see FDA v. Brown & Williamson*, 529 U.S. 120 (2000). This is particularly true where the federal government, in acknowledging the traditional state role in matters of health and safety,[19] defers to states to implement and administer complex health care systems. The Rule violates the detailed statutory framework established by Congress by undermining state health care systems

[18] 84 Fed. Reg. 41295 (citing 8 U.S.C. § 1103, *et seq.*).

[19] *See, e.g.*, *Medtronic v. Lohr*, 518 U.S. 470, 485 (1996); *N.Y. State Blue Cross Plans v. Travelers*, 514 U.S. 645, 661 (1995); *Gibbons v. Ogden*, 22 U.S. 1, 203 (1824).

through penalizing and stigmatizing access to health care.

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."). 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 scope of an 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.

The Rule cannot evade the heavily legislated health care field in which it operates. Since Congress first codified the "public charge" term in immigration law in the 1880s, it has reaffirmed its meaning on multiple occasions. *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). During this same time period, Congress has taken several opportunities to provide health care access and benefits to noncitizens. *See* PRWORA, 8 U.S.C. §§ 1621(d), 1622 (extending federal health benefits to qualified immigrants); CHIPRA, 42 U.S.C. § 1396b(v)(4) (authorizing immediate Medicaid coverage access to immigrant children and pregnant women); ACA, 42 U.S.C. §§ 18071(b) (defining lawfully present for purposes of enrolling in ACA qualified health plans). In each landmark health care bill, Congress has specifically established or increased immigrants' eligibility for health care benefits.

Congress did not enact this health care legislation with a blind eye to the "public charge" provision of the INA. Far from it. Providing noncitizens with access to health care benefits was consistent with the interpretation of "public charge" that had been in effect since the 1880s, which, as explained in a 1999 INS proposed rule, appropriately focused on persons who required "complete, or nearly complete, dependence on the Government rather than the mere receipt of some lesser level of financial support."[20] Indeed, Congress underscored its steadfast interpretation of "public charge" even while enacting health legislation. In 1996, Congress passed the Illegal Immigration Reform and Immigrant Responsibility Act of 1996 ("IIRIRA"), which, despite imposing restrictions on immigrant eligibility for certain public benefits, retained the prior definition of "public charge."[21] Congress did this even though only one month earlier it enacted PRWORA, which identified self-sufficiency as its goal that DHS relies on, while allowing states to expand access to health benefits. 8 U.S.C. §§ 1601, 1621, 1622. Against this backdrop, with its continued commitment to the longstanding definition of "public charge," Congress continued to provide noncitizens with health care benefits, understanding that doing so would not affect these individuals' potential classification as a "public charge."

Given the comprehensive health care regime that Congress established in light of longstanding statutory and administrative interpretations of public charge, the Rule exceeds the

[20] *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).

[21] *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").

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 statutes passed in the decades that followed. 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. Here, 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. Indeed, DHS's proclaimed jurisdiction over this field is more tenuous than the FDA's in *Brown & Williamson*, as it threatens to usurp the authority of 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 responds 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.[22] The cost of Medicaid is not DHS's concern. Congress delegated the implementation and administration of Medicaid, including the cost of the program, to HHS and the states. *See* 42 U.S.C. §§ 1396, 1396-1, 1315(a). Moreover, the cost of Medicaid is consistent with Congress' intent in establishing and expanding the program's reach. *See, e.g.*, *NFIB v. Sebelius*, 567 U.S. 519, 627-31 (2012) (Ginsburg, J., dissenting) ("Expansion has been characteristic of the Medicaid program."). At no time has

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

Congress authorized DHS to reduce federal health care spending, and DHS has no legitimate authority to criticize Medicaid expenditures, 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 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 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 repeated by Congress when it expressly recognized states' role in regulating health care in Medicaid, PRWORA, CHIPRA, and the ACA.[23] 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.[24]

[23] 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).

[24] 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"); *see also Murphy v. Nat'l Collegiate Athletic Ass'n*, 138 S. Ct. 1461, 1475 (2018); *Jones v. Rath Packing Co.*, 430 U.S. 519, 526 (1977) (assumption that historical state powers are not to be preempted "provides assurance that the 'federal-state balance' will not be disturbed unintentionally by Congress or unnecessarily by the courts") (quoting *United States v. Bass*, 404 U.S. 336, 349 (1971)).

DHS's assertion that the Rule falls within the realm of immigration law, not health care law, cannot end the inquiry. The federal government's authority over immigration matters, although broad, is not unbounded, especially when it intrudes upon state regulation of local issues long authorized by Congress. Where Congress has already authorized states to develop complex health care systems through decades of legislation and regulation by one agency, the federal government executive branch may not commandeer state resources. *See New York v. United States*, 505 U.S. 144, 161 (1992). Recognizing this principle, several courts, including this Court, 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*, 2019 U.S. App. LEXIS 20706, at *23-24 (9th Cir. July 12, 2019) (reversing judgment below).

This Court must be "guided to a degree by common sense as to the manner in which Congress is likely to delegate a policy decision of such economic and political magnitude to an administrative agency." *Brown & Williamson*, 529 U.S. at 133. Given the statutory scheme that has authorized state expansions of health care eligibility to noncitizens over the past twenty-five years, it strains credulity that Congress would have intended DHS to pass 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 Massachusetts, roughly 1.8 million state residents, including 264,000 noncitizens are enrolled in MassHealth.[25] The Rule's stigmatization of these benefits has already begun, discouraging even noncitizens who are not covered by the Rule from accessing public benefits for which they are eligible. After the Proposed Rule was released, refugees and asylees began withdrawing from coverage and individuals began refusing assistance from food pantries out of fear of a public charge determination even though the Rule was not in effect and would not apply to them. [26] HLA and HCFA have received numerous calls from individuals who were not subject to the Proposed Rule, but who nevertheless disenrolled from health coverage or refused covered services. One asylum applicant sought to disenroll from public health insurance benefits and believed that he should pay the Commonwealth back for his past medical claims to avoid jeopardizing his asylum application. Likewise, HCFA has received an increased number of calls from immigrants asking whether they should disenroll their children from coverage under CHIP or withdraw from solely state-funded programs.

[25] Mass. Office of Medicaid, *Comments on Inadmissibility on Public Charge Grounds Docket No. USCIS-2010-0012* (Dec. 10, 2018), www.mass.gov/files/documents/2018/12/10/public-charge-MassHealth-public-comments.pdf.

[26] Christina Jewett et al., *Under Trump Proposal, Lawful Immigrants Might Be Inclined to Shun Health Benefits*, Wash. Post (May 11, 2018), https://www.washingtonpost.com/national/health-science/under-trump-proposal-lawful-immigrants-might-be-inclined-to-shun-health-benefits/2018/05/11/d17c0aa4-54fb-11e8-a6d4-ca1d035642ce_story.html.

The Commonwealth estimates approximately 39,600 to 92,400 Massachusetts residents will disenroll from MassHealth as a result of the Public Charge Rule.[27] Another 60,000 lawfully present individuals are likely to forgo coverage through the Health Connector due to the confusion between affected and unaffected programs and affected and unaffected immigrant groups.[28]

The harm done by this stigmatization is not only 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.[29] 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 constitutes a well-established basis for an injunction. *See, e.g., Rodde v. Bonta*, 357 F.3d 988, 999 (9th Cir. 2004) (finding denial of Medicaid causing delayed or lack of necessary treatment, increased pain, and medical complications is irreparable harm).

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

By stigmatizing public health insurance, the Rule jeopardizes the health care systems of states that have worked to provide coverage to all lawful residents. These systems rely on the

[27] Complaint ¶ 217, *State of Washington, et al. v. United States Dept. of Homeland Security*, E.D. Wash. Case No. 4:19-cv-05210 (Dkt. No. 1, Aug. 14, 2019).

[28] *Id.* at ¶ 220.

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

enrollment of all eligible individuals. Within integrated health care systems, the Rule's impact cannot be confined to those who are directly affected by 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 who rely on Medicaid for financial support. In expansion states such as Massachusetts, Medicaid provides 48% of revenue for community health centers.[30] Disenrollment of only 50% of noncitizen patients from Medicaid could cause community health centers to lose $346 million per year. The resulting service cuts could result in 295,000 fewer patients being able to access primary care services.[31]

A decline in preventative care will lead to a sicker population that needs 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 closures.[33] Absent adequate revenue from private payers, such providers cannot cover an increase in uncompensated care costs without cutting services that will necessarily affect all patients, including citizens.

3. Ripple Effects on the Health Care Delivery System

[30] 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.

[31] *Id.* at 5.

[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).

Other Providers. As safety-net health care providers face increased financial pressures and reductions to services, other medical providers, including teaching hospitals, will be forced to absorb additional uninsured patients. These providers will experience strains on their emergency rooms, as uninsured patients rely more heavily on emergency services. All patients will experience increased wait times, and quality of care will also likely be diminished as emergency room personnel 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 through increased cost-sharing. And, as health care costs rise, underinsured rates increase as consumers tend to purchase policies with less coverage, which may also lead to significant medical debt when medical needs arise.

States. The Rule will result in significant financial and administrative burdens on state budgets. Massachusetts, for example, has spent substantial time and money developing its public health care system. Now the Commonwealth may need to completely restructure its Integrated Eligibility System and the Health Connector to enable noncitizens to maintain access to plans on the Exchange without jeopardizing their immigration status. Similarly, Massachusetts may need to revise its individual coverage mandate to prevent inadvertent immigration consequences on residents. These consequences may compel the Health Connector to revise its customer service and data reporting protocols and eligibility and information management systems to assure that

immigrants' past benefits are properly reported. This overhaul will be costly and will undermine the purpose of the system.

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

IV. Conclusion

For the foregoing reasons, Plaintiffs' Motion for Preliminary Injunction should be granted.

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