No. 18-5478

In the United States Court of Appeals for the Sixth Circuit

STATE OF TENNESSEE, by and through the Tennessee General Assembly, *et al.*,

Plaintiffs-Appellants,

v.

UNITED STATES DEPARTMENT OF STATE, *et al.*,

Defendants-Appellees.

On Appeal from the United States District Court
for the Western District of Tennessee
No. 1:17-cv-01040-STA-egb

BRIEF OF *AMICI CURIAE* NATIONAL HEALTH LAW PROGRAM AND NATIONAL IMMIGRATION LAW CENTER IN SUPPORT OF DEFENDANTS-APPELLEES, UNITED STATES DEPARTMENT OF STATE *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 and National Immigration Law Center are not subsidiaries of any other corporation and no publicly held corporation owns ten percent or more of the organizations' stock.

Date: October 19, 2018

/s/ Sarah L. Grusin
Sarah L. Grusin

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INTEREST OF *AMICI*[1]

The *amici curiae* file this brief pursuant to Fed. R. App. P. 29. All parties have consented to its filing. The **National Health Law Program** is a 50-year-old public interest law organization that engages in education, litigation, and policy analysis to advance access to quality health care and protect the legal rights of low-income and underserved people.

The **National Immigration Law Center** is a national non-profit organization dedicated to defending and advancing the rights of low-income immigrants and refugees.

Together, *amici* have extensive experience with Medicaid and refugee resettlement. They bring to the Court an in-depth understanding of the history of both programs, and particularly the relationship between immigration policies and Medicaid eligibility and funding over time.

SUMMARY OF ARGUMENT

Appellants' burden to show an unconstitutional exercise of Congress's Spending power in the Medicaid program is high: Appellants must identify a statutory provision that created some new, unforeseen, and substantial policy

[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.

change. Appellants cannot do so here because there has been no statutory change whatsoever, let alone a coercive one. Instead, the obligation that Appellants complain of—the requirement to provide Medicaid to refugees—has been part of Medicaid's requirements since its inception in 1965, including when Tennessee opted into the program in 1968. Appellants ignore this history, and instead mix and match requirements from Medicaid and the refugee resettlement program in an attempt to show that Tennessee's obligation to provide Medicaid coverage to refugees somehow stems from the creation of the refugee resettlement program in 1980. It does not. Correctly locating the obligation to provide Medicaid to refugees in the Medicaid statute, rather than the refugee resettlement program, unravels Appellants' argument because Tennessee simply cannot be coerced by the very terms it agreed to when it opted into Medicaid.

BACKGROUND

Medicaid was enacted in 1965 as amendments to the Social Security Act. Social Security Amendments of 1965, Title XIX, Pub. L. No. 89-97, 79 Stat. 344 (1965). Medicaid is structured as a federal-state cooperative program. The federal government reimburses states for a substantial portion of "the total amount expended . . . as medical assistance under the State plan." 42 U.S.C. § 1396b(a)(1), (b) (establishing reimbursement formulas). To receive federal Medicaid funding, a state must operate its program according to a state plan that has been approved by

the Secretary of the Department of Health and Human Services ("Secretary" of "HHS"). *Id.* § 1396a. The state plan must describe the state's program and affirm its commitment to comply with the requirements imposed by the Medicaid Act and its associated regulations. *Id.*

The Medicaid Act describes the population groups that are eligible to receive coverage. Some populations are "mandatory" while others are "optional." The mandatory eligibility groups were initially tied to receipt of various forms of federally-funded public assistance. Participating States were required to cover "all individuals" receiving such assistance. Social Security Amendments of 1965, § 1902(a)(10), Pub. L. No. 89-97, 79 Stat. 286, 345 (1965). States choosing to participate in Medicaid could not opt out of covering members of mandatory coverage groups, which included people with low incomes under 21 years of age, certain parents with dependent children, and individuals who are 65 years of age or older, blind, or disabled. *Id.* States were given the option to provide medical assistance to individuals who were not otherwise eligible for financial assistance programs but were nonetheless unable to "meet the costs of necessary medical or remedial care and services." *Id.* § 1902(a)(10)(B). This group is referred to as the optional "medically needy." *Id.*

The list of mandatory and optional populations has evolved over time. From 1965 to present, Congress has incrementally expanded and modified eligibility

categories, sometimes with a great deal of precision and sometimes more broadly. Sara Rosenbaum, *Medicaid at Forty: Revisiting Structure and Meaning in A Post-Deficit Reduction Act Era*, 9 J. Health Care L. & Pol'y 5, 17 (2006). Today, the mandatory populations are described in Section 1396a(a)(10)(A)(i) and optional categories are described in Section 1396a(a)(10)(A)(ii) and Section 1396a(a)(10)(C). Although the eligibility groups have changed over time, the Medicaid statute has consistently mandated that once a population group is listed in the state plan, the state must cover *all* individuals in that covered population group who meet the financial eligibility criteria, and are residents of the state in which they apply. 42 U.S.C. § 1396a(a)(10)(A), (b)(2), (3). A state cannot, therefore, decide to cover subsets of a population group, even optional groups, that are described in the statute. *Id.* § 1396a(a)(10)(B); *see also* Social Security Amendments of 1965, § 1902(a)(10)(A)(i)-(ii), (B)(i)-(ii), Pub. L. No. 89-97 79 Stat. 345 (1965).

States do not have to participate in Medicaid, but all do. The State of Tennessee has participated since 1968. Opinion 3.

ARGUMENT

I. Refugees Have Always Been Eligible for Medicaid.

Groups of immigrants, including refugees, have been part of Medicaid's mandatory coverage groups from its inception. At the time of enactment in 1965,

and by its terms, the Medicaid Act did not exclude otherwise-eligible refugees from eligibility. In fact, the Act was "silent on the availability of Medicaid to aliens." *Lewis v. Thompson*, 252 F.3d 567, 571 (2d Cir. 2001).

This contrasted with the Medicare program, enacted at the same time, which expressly limited eligibility to citizens or "alien[s] lawfully admitted for permanent residence who ha[ve] resided in the United States during the 5 years immediately preceding the month in which he applies for enrollment" in Medicare. Social Security Amendments of 1965, Pub. L. No. 89-97, § 1836, 86 Stat. 1329, 1372 (1965). Medicaid, unlike Medicare, contained no federal limitation on immigrant eligibility. Therefore, so long as an individual—citizen or immigrant—was described in one of the covered population groups described in the statute, they were eligible because states were required to provide coverage to "*all* individuals" who are described in a population group. Social Security Amendments of 1965, § 1902(a)(10), Pub. L. No. 89-97, 79 Stat. 345 (1965) (emphasis added). These were the terms in place when Tennessee opted into Medicaid in 1968.

In 1971, the Department of Health, Education, and Welfare (HEW)—predecessor to HHS in administering Medicaid at the federal level—promulgated regulations confirming the absence of any federal limit on the Medicaid eligibility of immigrants. Although Medicaid eligibility was, at that time, still largely tied to eligibility for cash assistance, the 1971 regulations made clear that even if states

had restrictions on immigrants' eligibility in their cash programs, they were *not* required to carry those citizenship restrictions into the Medicaid program. Specifically, the regulations authorized states to provide Medicaid coverage to individuals "without regard to citizenship status, even though all of the State's financial assistance plans contain such a requirement." 36 Fed. Reg. 3872 (Feb. 27, 1971), codified at 45 C.F.R. § 248.50 (1971).

Despite the absence of a federal limitation on immigrant eligibility, some states attempted to impose their own eligibility restrictions, limiting coverage to citizens or relying on durational residency requirements to exclude recent immigrants. The Supreme Court held in *Graham v. Richardson* that these state restrictions were unconstitutional. 403 U.S. 365, 374 (1971). The Court concluded that such restrictions violated the Equal Protection Clause of the Fourteenth Amendment, encroached upon the exclusive power of the federal government to execute immigration policy, and that "a State's desire to preserve limited welfare benefits for its own citizens is inadequate to justify . . . making noncitizens ineligible for public assistance." *Id.*

Following that decision, HEW issued a notice of proposed rulemaking to amend the 1971 regulations to conform to the Court's holding. HEW proposed amending the regulations so that "a State plan may not exclude an otherwise eligible individual solely on the basis that he is not a citizen or because of his alien

status." Notice of Proposed Rule Making, 37 Fed. Reg. 11977 (June 16, 1972). Before the rule was finalized, however, Congress amended the federal statute governing eligibility for Supplemental Security Insurance ("SSI") (one of the financial assistance programs authorized by the Social Security Act), to require that an individual must either be a citizen or "an alien lawfully admitted for permanent residence or otherwise permanently residing in the United States under color of law," or "PRUCOL." Social Security Amendments of 1972, Pub. L. No. 92-603 § 1614, 86 Stat. 1329, 1471 (1972).

Although these amendments did not alter Medicaid eligibility, HEW revised the notice of proposed rulemaking so that the Medicaid regulations would mirror the PRUCOL language that now governed SSI. 38 Fed. Reg. 16910-11 (June 27, 1973). HEW acknowledged concerns raised in response to the first proposed rule—which would have precluded *any* restrictions on the basis of immigration status—including "that this policy would raise caseloads beyond the State's fiscal capacity or require a corresponding reduction in assistance to citizens and lawfully admitted aliens." *Id*. In response to these fiscal concerns, HEW required state plans to "exclude any individual who is not lawfully in this country," but nonetheless required states to cover immigrants within the PRUCOL category. *Id*.

The 1973 regulations were the first federal restriction on immigrants' eligibility for Medicaid. But notably, even after this restriction, states were still

required to cover refugees because they are lawfully present and "permanently residing under color of law." The Social Security Amendments of 1972, which added the PRUCOL language to SSI, expressly included refugees under the PRUCOL umbrella. *See* Social Security Amendments of 1972, Pub. L. No. 92-603, 86 Stat. 1329, 1471 (1972) (PRUCOL includes "any alien who is lawfully present in the United States as a result of the application of the provisions of section 203(a)(7) . . . of the Immigration and Naturalization Act."); Immigration and Nationality Act Amendments of 1965, Pub. L. No. 89-236, 79 Stat. 912-13 (amending section 203(a)(7) to include immigrants who have fled certain countries or areas "because of persecution or fear of persecution on account of race, religion, or political opinion" or "that they are persons uprooted by catastrophic natural calamity"). Indeed, even though the precise definition of PRUCOL was flexible at the margins, refugees always fit squarely under this designation. *See, e.g.*, *Holley v. Lavine*, 553 F.2d 845, 850-51 (2d Cir. 1977) (citing refugee status as "illustrative" example of persons within PRUCOL category for purposes of AFDC eligibility); *Berger v. Heckler*, 771 F.2d 1556, 1572 (2d Cir. 1985) (reviewing history of PRUCOL designation, which shows that even narrow definition included refugees and political asylees).[2]

[2] *See also* Richard A. Boswell, *Restrictions on Non-Citizens' Access to Public Benefits: Flawed Premise, Unnecessary Response*, 42 UCLA L. Rev. 1475, 1488 (1995) ("Persons who are generally regarded as PRUCOL are persons admitted as

In 1986, Congress incorporated the PRUCOL language into the Medicaid statute itself with the Omnibus Budget Reconciliation Act of 1986. See Pub. L. No. 99-509 § 9046, 100 Stat. 1874 (Oct. 21, 1986), *amending* 42 U.S.C. § 1396(b). The bill specified that federal Medicaid funding would only be provided to reimburse state costs for medical assistance provided to immigrants who are "lawfully admitted for permanent residence or otherwise permanently residing in the United States under color of law." *Id.* Finally, in 1990, federal Medicaid regulations codified this longstanding understanding and expressly categorized refugees, among others, as PRUCOL immigrants. 55 Fed. Reg. 36819-20 (Sep. 7, 1990), codified as 42 C.F.R. § 435.408 (1990).

Appellants incorrectly assert that 8 U.S.C. § 1612, passed as part of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 ("PRWORA"), is the source of states' obligation to provide Medicaid coverage to refugees. OB at 9; Pub. L. No. 104-193, 110 Stat. 2105 (1996). But as the history makes clear, that obligation long predates the 1996 law. In fact, PRWORA severely *limited* the categories of immigrants who are eligible for public benefits, including Medicaid. Congress eliminated the PRUCOL category, and instead defined a list of "qualified aliens" who were generally eligible for federal benefits, including Medicaid. 8 U.S.C. §§ 1611-13, 1641. Although the list of qualified

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refugees or granted asylum, aliens paroled into the United States, those granted suspension of deportation, applicants for registry, and Cuban-Haitian entrants.")

aliens excluded some noncitizens from Medicaid who had previously been eligible, it maintained the eligibility of refugees. 8 U.S.C. § 1612(a)(2)(A)(i); *see also Bruns v. Mayhew*, 750 F.3d 61, 63 (1st Cir. 2014). Refugees maintained initial eligibility for Medicaid, but PRWORA, for the first time, put a time limit on the requirement to provide coverage by granting states the option to stop providing Medicaid coverage to refugees after seven years. 8 U.S.C. § 1612(b)(1), (2)(A)(i).

Thus, as the District Court concluded, and the history above confirms, the only statutory changes related to immigrant eligibility for Medicaid since Tennessee opted into the program have restricted, not expanded, Tennessee's obligations to provide Medicaid to immigrants, including refugees. And while there have been several different statutory and regulatory changes since Medicaid was enacted in 1965, the policy of requiring coverage for refugees that are otherwise Medicaid eligible has remained fundamentally unchanged.

II. *NFIB v. Sebelius* Cannot Apply Absent a Change in the Medicaid Statute.

Without identifying any clear policy change, Appellants have not even made the threshold showing necessary to invoke the Supreme Court's decision in *National Federation of Independent Business v. Sebelius*, 567 U.S. 519 (2012). In *NFIB*, the Court considered the addition of a new eligibility population to the Medicaid program. To add this population, Congress added Subsection VIII to Section 1396a(a)(10)(A)(i), to create a new mandatory population. *See* 42 U.S.C.

§ 1396a(a)(10)(A)(i)(VIII). Adding new paragraphs to Section 1396a(a)(10)(A)(i) is the approach Congress regularly takes when adding mandatory populations. For example, Congress has amended Section 1396a(a)(10)(A)(i) to expand medical assistance to low-income pregnant women, emancipated children, and former foster youth. *See* Medicare Catastrophic Coverage Act of 1988, § 302, Pub. L. No. 100-360, 102 Stat. 750; Omnibus Budget Reconciliation Act of 1989, § 6401, Pub. L. No. 101-239, 103 Stat. 2258; Omnibus Budget Reconciliation Act of 1990, § 4601, Pub. L. No. 101-508, 104 Stat. 1388; Patient Protection and Affordable Care Act, § 2004, Pub. L. No. 111-148, 124 Stat. 119.

NFIB set out a test to determine whether statutory changes, such as these, constitute permissible alterations or amendments to a program, or are instead unconstitutional coercion. 567 U.S. at 583-84 (controlling opinion).[3] The Court concluded that the Affordable Care Act's Medicaid expansion was coercive because states "could hardly anticipate" the addition of the new expansion population based on the statute's original terms. *Id.* at 587. At the same time, however, the Court affirmed that the addition of other populations—such as pregnant women or former foster care youth—was predictable, and not coercive, because those expansions "merely altered and expanded the boundaries of"

[3] Chief Justice Roberts' plurality opinion is the controlling opinion for the Court. *Mississippi Comm'n on Envtl. Quality v. E.P.A.*, 790 F.3d 138, 184 & n.22 (D.C. Cir. 2015) (per curiam); *Mayhew v. Burwell*, 772 F.3d 80, 88 (1st Cir. 2014).

existing eligibility categories. *Id.* at 583 (controlling opinion). The Court's coercion analysis turned on whether the change imposed a new and unforeseeable requirement on states, thereby "pressuring the States to accept policy changes." *Id.* at 580.

Appellants invoke *NFIB*, but have not identified any policy change whatsoever, let alone one that is new and unanticipated. Instead, Appellants complain of the very bargain Tennessee agreed to when it first adopted Medicaid: to provide coverage to *all* individuals within the covered population groups that meet the income and residency requirements, including refugees. 42 U.S.C. § 1396a(a)(10)(A); *see also Bruns*, 750 F.3d at 63. Moreover, without identifying any change in the statute, it is impossible for this Court to even apply *NFIB*'s test to determine whether a particular change amounts to a "mere alteration" or is a coercive new requirement.

The structure of the statute itself underscores why *NFIB* is inapposite. In distinguishing between mere alterations and coercive new conditions, the *NFIB* Court compared several different populations that Congress added to Medicaid. 567 U.S. at 583-84. For each population that the Court considered, Congress added a paragraph to the list of mandatory populations in the statute. *See, e.g.*, 42 U.S.C. § 1396a(a)(10)(A)(i)(VIII) (expansion population); § 1396a(a)(10)(A)(i)(III) (pregnant women); § 1396a(a)(10)(A)(i)(IX) (former foster care youths). There has

been no equivalent addition here. In fact, there is no eligibility category for "refugees" in the Medicaid statute at all. *See generally* 42 U.S.C. § 1396a(a)(10). Instead, Tennessee's obligation to provide Medicaid benefits to refugees stems from its basic obligation under the Medicaid Act to provide coverage to "all individuals" who fall within a covered population group and satisfy the income requirements. *Id.* at § 1396a(a)(10)(i). In other words, refugees are not categorically eligible for Medicaid by virtue of their refugee status. Rather, refugees are eligible for Medicaid because they are people—people who have low incomes and meet the eligibility requirements of the state plan because they are pregnant, have disabilities, or are parents or caretakers.

The funding structure of the Medicaid program further bolsters the conclusion that refugees are not a distinct eligibility group, but rather participate in the Medicaid program on the same terms as any individual described in a covered population. Medicaid is jointly funded by the states and the federal government. States are reimbursed with federal dollars for a certain percentage of their costs for the Medicaid program. The federal-share is calculated according to a formula called the Federal Medical Assistance Percentage ("FMAP"). 42 U.S.C. § 1396b(a)(1). The FMAP for most populations and services is calculated annually based on a formula in the Medicaid statute. *See* § 42 U.S.C. §§1301(a)(8), 1396d(b). Congress has, however, established enhanced FMAPs for certain

covered populations. For instance, if a state elects to provide coverage to individuals eligible based on a breast or cervical cancer diagnosis—an optional group—it receives an enhanced FMAP for services provided to that group. *See* 42 U.S.C. § 1396d(b). The Medicaid expansion population that the Court considered in *NFIB*, likewise receives an enhanced FMAP.[4] 42 U.S.C. § 1396d(y). Again, there is no equivalent for refugees. Just as there is no eligibility category for refugees, there is no special FMAP based on immigration status. Instead, Tennessee is entitled to federal reimbursement for refugees, as it is for all other enrollees, based on the FMAP associated with their particular eligibility groups and based on the services that they use.

At bottom, Appellants' argument amounts to a policy disagreement with Congress's decision not to specifically *exclude* refugees from Medicaid eligibility. But that decision does not violate the Tenth Amendment, especially when Tennessee opted into the program on those terms. The fundamental bargain of the Medicaid Act is that the federal government provides funding to the states in exchange for states covering the mandatory (and if selected, optional) population

[4] Other variations in the FMAP include that, since 1976, the federal government has matched the cost of services furnished to Medicaid-eligible Native Americans and Alaska Natives through Indian Health Service and tribal facilities at an FMAP of 100 percent. *See* Indian Health Care Improvement Act of 1976, § 402(e), Pub. L. No. 94-437, 90 Stat. 1400, codified at 42 U.S.C. § 1396(b). Some jurisdictions also have set FMAPs: the FMAP for the District of Columbia is 70 percent, and the FMAPs for Puerto Rico and the territories are 55 percent. 42 U.S.C. § 1396d(b).

groups. Refugees have *always* been eligible for Medicaid if they fall within one of the covered population groups and meet income requirements. *Bruns*, 750 F.3d at 63. There is simply no new condition on Tennessee's Medicaid funding. *Mayhew v. Burwell*, 772 F.3d 80, 89 (1st Cir. 2014). Accordingly, Congress's exercise of the spending power is valid because Tennessee "voluntarily and knowingly," accepted the terms of the deal in 1968. *NFIB*, 567 U.S. at 577; *Mayhew*, 772 F.3d at 89-90.

III. Appellants Incorrectly Conflate the Refugee Resettlement Program with State Medicaid Obligations.

Appellants ignore the history of Medicaid eligibility, and instead incorrectly conflate the refugee resettlement program with the separate obligations under Medicaid. *See* OB at 19 (asserting that providing Medicaid benefits requires Tennessee to "fund[] the refugee resettlement program."). But they are distinct programs, with distinct funding mechanisms and eligibility requirements. The State's obligations under Medicaid are—and have always been—independent of the availability of federal funding for the refugee resettlement program.

A. Federal Funding for Medicaid and the Refugee Resettlement Program are Appropriated, Calculated, and Administered Separately.

The availability, amount, and purpose of funding differs significantly between Medicaid and the refugee resettlement program. Moreover, there are separate and distinct conditions attached to the funds available under each statute.

Medicaid funds are appropriated for the purpose of "enabling each State . . . to furnish medical assistance" and "rehabilitation and other services" to families and individuals "whose income and resources are insufficient to meet the costs of necessary medical services." 42 U.S.C. § 1396-1. To obtain federal funding, states must operate their Medicaid programs through a state Medicaid plan which has been submitted to and approved by the Secretary of HHS, and which complies with the provisions of the Medicaid statute. Once the state plan is approved, the federal government pays the state the statutorily established federal share "of the total amount expended . . . as medical assistance under the State plan." 42 U.S.C. § 1396b(a)(1).

The Refugee Act of 1980 authorizes payments for a wide range of services with the goal of enabling refugees to become economically self-sufficient. *See* Refugee Act of 1980, Pub L. No. 96-212, 94 Stat. 102 (codified as amended in various sections of 8 U.S.C.). Those services include: employment training, English language courses, cash assistance, initial health screenings and medical assistance, and other social services. *See generally* 8 U.S.C. § 1522. The funds are distributed by the Director of the Office of Refugee Resettlement ("ORR") and may be made to a wide-variety of entities, including public or private nonprofit agencies, local health agencies, as well as states. *Id.* The funds for the refugee resettlement program, unlike Medicaid funding, are discretionary and do not

automatically respond to changes in program use. Instead, the Act authorizes the Director to make payments only "to the extent of available appropriations." 8 U.S.C. § 1522(a)(1)(A). Moreover, the Director must "make a periodic assessment, based on refugee population and other relevant factors, of the relative needs of refugees for assistance and services under this subchapter and the resources available to meet such needs," and allocate funds accordingly. *Id.* § 1522(a)(3).

To receive any funds under the Refugee Act, a state is required to submit to the Director of ORR a refugee resettlement plan that describes how the State will use the funds to provide English-language training, provide employment services, and ensure the care and supervision of unaccompanied minors. *See* 8 U.S.C. § 1522(a)(6)(A)(i)-(ii), (iv). States must also designate a State-employee who will coordinate public and private resources, and must submit annual reports describing the use of funds. *Id.* § 1522(a)(6)(A)(iii), (B)-(C). In exchange for meeting these conditions, the federal government provides federal funds to support the state's resettlement efforts.

The Refugee Act defines how those federal funds may be used. The Director is authorized to provide payments towards refugees' medical assistance to cover "100 per centum of the . . . medical assistance provided to any refugee during the thirty-six month period beginning with the first month in which such refugee has

entered the United States." *Id.* § 1522(e)(1). For refugees who are not eligible for Medicaid "on account of any resources or income requirement of [the state Medicaid] plan," funds may only be used for medical assistance "during the one-year period after entry."[5] *Id.* § 1522(e)(5). For refugees who are Medicaid-eligible, the Act permits the Director to provide funds to states, to cover the costs of providing medical assistance, but those funds "shall only be used for the non-Federal share," of Medicaid costs. 8 U.S.C. § 1522(e)(4).

Appellants complain that Congress's decision to reduce these supplemental funds is coercive. *See, e.g.*, OB at 46, 57-58. But Tennessee cannot be surprised by the reduction: the Refugee Act's reference to payments "to the extent of available appropriations" put Tennessee on notice that this funding was not an indefinite guarantee.[6] 8 U.S.C. § 1522(a)(1)(A).

More importantly, Appellants' argument misunderstands the purpose and structure of the Refugee Act funding. The Refugee Act established a new (discretionary) federal funding stream to encourage states to take on more comprehensive efforts to support refugee resettlement. States that elect to

[5] This program is known as Refugee Medical Assistance and is fully federally funded. *See* 45 C.F.R. §§ 400.02, 400.90.

[6] As Appellants acknowledge themselves, even when funds are available, they may only be used for the first thirty-six months of Medicaid costs. 8 U.S.C. § 1522(e)(1); OB at 6. Appellants' claim that states are entitled to 100% reimbursement for *all* refugees' Medicaid expenses finds no support in the Medicaid or Refugee Acts.

undertake specified refugee resettlement efforts are entitled to federal funds to support their efforts—and those federal funds can be used to defray some of the state share of Medicaid costs that the state would otherwise be obligated to pay. The additional funding towards the state share of Medicaid costs in the Refugee Act was simply part of the financial inducement for states to participate in the new refugee resettlement program.

The availability of new funding to cover the "non-Federal" share of costs did not alter the existing conditions attached to the *federal share* of Medicaid costs. Congress did not threaten existing federal Medicaid funding if a state chose not to participate in the refugee resettlement program.[7] Instead, a state that never elected to participate in the refugee resettlement program would simply not be entitled to any supplemental funds towards the state share of Medicaid costs. They would, however, still be entitled to the federal share of Medicaid costs, if they continued to comply with the provisions of the Medicaid Act, which were unchanged.

In short, States are free to take or leave the refugee resettlement deal, but that has no bearing on their participation in Medicaid. When Tennessee withdrew

[7] Indeed the terms of the deal for the existing federal share of Medicaid funds did not change at all: Congress, for instance, did not adjust the FMAP to create a special reimbursement rate for refugees (as Congress has done for other populations, *see supra* note 4). Rather, states receive the same partial-reimbursement under the FMAP formulas for services provided to refugees as they would for any other Medicaid-eligible individual. Moreover, the FMAP structure further undermines Appellants' assertion that states are entitled to 100% reimbursement for all refugees' Medicaid expenses.

from the refugee resettlement program, it lost the option to obtain funding towards the *state share* of Medicaid costs (should Congress make appropriations available). But to continue receiving the *federal share* of Medicaid funding, Tennessee must continue to meet the requirements of the Medicaid Act. What Appellants' argument ignores is that covering refugees is one of those requirements. *See supra* at 4-9.

B. Individual Eligibility for Medicaid does not Depend on the Refugee Resettlement Program.

Like the funding mechanisms and attached conditions, individual eligibility for Medicaid and the refugee resettlement program are independent of one another. Not all refugees who participate in the refugee resettlement program are eligible for Medicaid. In fact, the Refugee Act of 1980 recognized as much, authorizing the Director to use the available resettlement funds to provide "medical assistance . . . to any refugee, during the one-year period after entry, who does not qualify for assistance under a State plan approved under title XIX of the Social Security Act [the Medicaid program] on account of any resources or income requirement of such plan." 8 U.S.C.A. § 1522.

Nor do all refugees who are eligible for Medicaid participate in the refugee resettlement program. For instance, refugees may move to the State independently of the resettlement program, a process often referred to as "secondary migration." *Cf.* 8 U.S.C. § 1522(a)(2)(C)(iii)(IV) (directing the Director to track and take into

account "secondary migration" of refugees when allocating funds and identifying resettlement locations). But those families are still entitled to Medicaid if they meet the income and categorical requirements set out in the state Medicaid plan. Likewise, even today, several categories of immigrants who do *not* participate in the refugee resettlement program are nonetheless eligible for Medicaid, including: lawful permanent residents, individuals paroled in the United States for more than one year, certain battered immigrants, and individuals granted withholding of removal. 8 U.S.C. § 1641(b); 8 U.S.C. § 1101(a)(20). Nor are refugees the only group exempt from the five-year waiting period; asylees, Cuban and Haitian entrants, Amerasian immigrants, and any qualified immigrants with certain military connections, or who have continuously resided in the United States since 1996 are also exempt. 8 U.S.C. § 1613(a)-(b); §1612(b)(2)(A)(i). Participation in the refugee resettlement program is, thus, neither necessary nor sufficient to establish Medicaid eligibility, and Appellants' assertion that "similarly situated persons admitted through normal immigration procedures would not be Medicaid eligible," is simply wrong. OB at 46.

It is worth noting that this description of Medicaid eligibility requirements also refutes Appellants' puzzling assertion that refugees are given some sort of "preferential treatment" over immigrants admitted through "regular means." OB at 50. Setting aside that Tennessee never explains what it means by "regular

means"—and that admission as a refugee is a lawful and federally-regulated process—refugees *are* subject to the same Medicaid eligibility rules, and receive the same benefits, as several other categories of immigrants.[8] *See supra* at 20-21.

Finally, even if there was some sort of preferential treatment, it is legally irrelevant to Appellants' Spending Clause claim. Congress, of course, may lawfully use its spending power to "encourage a State to regulate in a particular way, and influence a State's policy choices." *NFIB*, 567 U.S. at 576 (internal quotes and alterations omitted). A Spending Clause claim, therefore, does not turn on whether a particular statutory change provides any group with "preferential" treatment. Instead, the legitimacy of Congress's use of the spending power depends on whether Congress has enacted a post-acceptance condition that coerces the State

[8] Appellants' discussion of the public charge rule is likewise inaccurate and incomplete. *See* OB at 51-53. Contrary to Appellants' implication, refugees are not the only groups exempt from the public charge determination at admission. In fact, asylees, survivors of trafficking and other serious crimes, self-petitioners under the Violence Against Women Act, special immigrant juveniles, certain people who have been paroled into the U.S., and several other categories of noncitizens are not subject to the public charge test at admission, and, therefore, need not demonstrate "self-sufficiency." *See* 8 U.S.C. §§ 1109(c); 1157(c)(3); 1182(a)(4)(E)(i)-(ii); 1182(d)(13)(A); 1255(h); 8 C.F.R. § 244.3(a). Moreover, the public charge regulations are a red herring: under current rules, receipt of Medicaid—other than certain limited long-term institutional care—does *not* factor into the public charge determination. *See* Immigration and Naturalization Service, "Field Guidance on Deportability and Inadmissibility on Public Charge Grounds," 64 Fed. Reg. 28689, 28693 (Mar. 26, 1999), https://www.gpo.gov/fdsys/pkg/FR-1999-05-26/pdf/99-13202.pdf. The public charge rules, therefore, have no bearing whatsoever on refugees' Medicaid eligibility or Tennessee's obligations to cover the various population groups identified in the Medicaid Act.

into accepting an unforeseen and substantial policy change. *NFIB*, 567 U.S. at 577, 580. Neither the Refugee Act of 1980 nor the Welfare Reform Act of 1996 changed Tennessee's obligations to provide Medicaid to refugees. Tennessee is not coerced by the very terms it agreed to when it opted into the Medicaid program. *Mayhew*, 772 F.3d at 89-90 (holding that Affordable Care Act's requirement to continue covering 19- and 20-year-olds was not coercive because "[s]uch a mandatory coverage requirement was in place when Maine joined Medicaid in 1966," even though intervening legislation made covering certain 19- and 20-year-olds optional).

IV. An Increase in the Number of Refugees Does Not Convert Congress's Lawful Exercise of Spending Power into Coercion.

Appellants' last complaint is that changes in the number of refugees—not the statute itself—transform Congress's lawful exercise of spending power into an unconstitutionally coercive one. Appellants cite no authority whatsoever for this sweeping position. *See* OB at 59-60. In any event, the potential for large increases in the number of refugees was entirely predictable when Tennessee opted into the program. As the District Court correctly highlighted, "periodic international humanitarian crises accompanied by refugees has always been foreseeable." Op. at 21. Indeed, prior to 1968 when Tennessee opted into Medicaid, there was already a substantial history of congressional adjustments and increases in the number of refugees admitted to the United States. *See, e.g.*, Displaced Persons Act of 1948,

Pub. L. No. 80-774, 62 Stat. 1009; Refugee Relief Act of 1953, Pub. L. No. 83-203, 67 Stat. 400; Azorean Refugee Act of 1958, Pub. L. No. 85-892, 72 Stat. 1712; Fair Share Refugee Act of 1960, Pub. L. No. 86-648, 74 Stat. 504; Migration and Refugee Assistance Act of 1962, Pub. L. No. 87-510, 76 Stat. 121. And by 1965, Congress had passed amendments to the Immigration and Nationality Act establishing a permanent, statutory basis for the admission of refugees. The Immigration and Nationality Act Amendments of 1965, Pub. L. No. 89-236, 79 Stat. 911.

There are other legal pitfalls to Appellants' argument. First, any numerically-driven test is inconsistent with the *NFIB* Court's explicit embrace of prior Medicaid expansions. The Court approved expansions of Medicaid before the Affordable Care Act, even though some expansions, such as for pregnant women, added millions to Medicaid and certainly had large impacts on state budgets. *See NFIB*, 567 U.S. at 584-85 (concluding that Medicaid amendment covering "pregnant women and increasing the number of eligible children . . . can hardly be described as a major change in a program that—from its inception—provided healthcare for 'families with dependent children.'"); *see also id*. at 627-28 (Ginsburg, J., dissenting in relevant part) ("[t]hese amendments added millions to the Medicaid-eligible population"). Thus, the Supreme Court's analysis rejected any purely-numerical, or budgetary, approach to Spending Clause cases. *See also*

Mayhew, 772 F.3d at 92 (rejecting argument that requirement to maintain coverage for a specific population was "'coercive' because 'when a federal program is as large as Medicaid is . . . , the State has no option but to participate," since "[t]hat is not the test *NFIB* has adopted.") (ellipsis in original).

Finally, the sheer breadth of Appellants' enrollment-based argument should give the Court pause. Medicaid, a safety-net program for low-income individuals, is designed to be responsive to changes in external factors, for instance, expanding significantly during recessions and contracting when the economy is stronger. *See* Laura Snyder & Robin Rudowitz, Kaiser Family Found. *Trends in State Medicaid Programs: Looking Back and Looking Ahead*, Section 1 (Jun. 21, 2016), https://www.kff.org/medicaid/issue-brief/trends-in-state-medicaid-programs-looking-back-and-looking-ahead/view/print/. Adopting Appellants' enrollment-growth reasoning here would permit states to opt out of Medicaid during economic downturns, when the program is needed most.

CONCLUSION

Medicaid is an essential program that provides health coverage to people who generally cannot afford the cost of medical care or insurance. In exchange for federal funding, States have always been required to provide Medicaid coverage to individuals who meet Medicaid's various financial, residency, and categorical requirements. Appellants' argument is nothing more than a policy disagreement

with Congress's decision not to specifically exclude refugees from the program, a disagreement which does not amount to a Tenth Amendment violation. Appellants' descriptions of the refugee resettlement and Medicaid programs are incorrect and incomplete, ignoring the distinct structure, purpose, and funding mechanisms that Congress carefully delineated for the two programs. Tennessee's obligation to provide Medicaid coverage to refugees is a long-standing Medicaid requirement, not a coercive component of the refugee resettlement program. The Court should affirm.

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Respectfully submitted,

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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 5,972 according to the count of Microsoft Word, excluding the parts of the brief exempted by Fed. R. App. P. 32(f).

Date: October 19, 2018

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CERTIFICATE OF SERVICE

I certify that on October 19, 2018, I electronically filed the forgoing brief with the Clerk of the Court by using the CM/ECF system.

Date: October 19, 2018

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