No. 19-36020

In The United States Court Of Appeals For The Ninth Circuit

JOHN DOE # 1, *et al*.,

***Plaintiffs-Appellees*,**

v.

DONALD TRUMP, *et al*.,

***Defendants-Appellants*.**

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

BRIEF OF *AMICI CURIAE* NATIONAL HEALTH LAW PROGRAM, AND 55 OTHER ORGANIZATIONS, IN SUPPORT OF PLAINTIFFS-APPELLEES' PETITION FOR REHEARING EN BANC

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CORPORATE DISCLOSURE STATEMENT

Pursuant to Federal Rule of Appellate Procedure 26.1 and Circuit Rule 26.1(a), the undersigned counsel certifies that the *amici curiae*, National Health Law Program (NHeLP); American Lung Association; American Medical Student Association; Asian & Pacific Islander American Health Forum; Asian Resources, Inc; Autistic Self Advocacy Network; Bazelon Center for Mental Health Law; Be A Hero Action Fund; California Immigrants Policy Center; Center for Medicare Advocacy; Center for Public Representation; Central Conference of American Rabbis; Community Action Marin; CRLA Foundation; Epilepsy Foundation; Families USA; First Focus on Children; Georgia Advocacy Office; Health Law Advocates, Inc.; If/When/How: Lawyering for Reproductive Justice; Illinois Coalition for Immigrant and Refugee Rights; Justice in Aging; Legal Aid Justice Center; Massachusetts Immigrant and Refugee Advocacy Coalition; Maternal and Child Health Access; Men of Reform Judaism; Mississippi Center for Justice; National Asian Pacific American Women's Forum; National Center for Lesbian Rights; National Center for Youth Law; National Council of Jewish Women; National Council on Independent Living; National Disability Rights Network; National Women's Law Center; Nebraska Appleseed; Nevada County Citizens For Choice; North Carolina Justice Center; Northwest Health Law Advocates; NY Legal Assistance Group (NYLAG); Oasis Legal Services; Planned Parenthood

Federation of America; PRC; Public Justice Center; Reproductive Health Access Project; SC Appleseed Legal Justice Center; Service Employees International Union (SEIU); Shriver Center on Poverty Law; Tennessee Justice Center; TODEC Legal Center; Treatment Action Group; Union for Reform Judaism; Volunteers of Legal Service; We Testify; Western Center on Law & Poverty; Whitman-Walker Institute; and Women of Reform Judaism are not subsidiaries of any other corporation and no publicly held corporation owns 10 percent or more of any *amici curiae* organization's stock.

Dated: January 29, 2021

/s/ Martha Jane Perkins

Martha Jane Perkins

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INTEREST OF *AMICI*[1]

Amici curiae are the National Health Law Program (NHeLP); American Lung Association; American Medical Student Association; Asian & Pacific Islander American Health Forum; Asian Resources, Inc; Autistic Self Advocacy Network; Bazelon Center for Mental Health Law; Be A Hero Action Fund; California Immigrants Policy Center; Center for Medicare Advocacy; Center for Public Representation; Central Conference of American Rabbis; Community Action Marin; CRLA Foundation; Epilepsy Foundation; Families USA; First Focus on Children; Georgia Advocacy Office; Health Law Advocates, Inc.; If/When/How: Lawyering for Reproductive Justice; Illinois Coalition for Immigrant and Refugee Rights; Justice in Aging; Legal Aid Justice Center; Massachusetts Immigrant and Refugee Advocacy Coalition; Maternal and Child Health Access; Men of Reform Judaism; Mississippi Center for Justice; National Asian Pacific American Women's Forum; National Center for Lesbian Rights; National Center for Youth Law; National Council of Jewish Women; National Council on Independent Living; National Disability Rights Network; National Women's Law Center; Nebraska Appleseed; Nevada County Citizens For Choice;

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

North Carolina Justice Center; Northwest Health Law Advocates; NY Legal Assistance Group (NYLAG); Oasis Legal Services; Planned Parenthood Federation of America; PRC; Public Justice Center; Reproductive Health Access Project; SC Appleseed Legal Justice Center; Service Employees International Union (SEIU); Shriver Center on Poverty Law; Tennessee Justice Center; TODEC Legal Center; Treatment Action Group; Union for Reform Judaism; Volunteers of Legal Service; We Testify; Western Center on Law & Poverty; Whitman-Walker Institute; and Women of Reform Judaism (collectively (collectively, "NHeLP *et al.*"),.

While each *amicus* has particular interests, together they work to ensure all people, including immigrants and their families, obtain affordable, comprehensive, quality health care. *Amici* NHeLP *et al.* advocate for low-income populations and immigrants nationwide to remove barriers to health care using various tools such as providing direct legal and health services, policy advocacy, education, and litigation. *Amici* NHeLP *et al.* collectively bring to the Court an in-depth understanding of the purpose and structure of the Patient Protection and Affordable Care Act and Medicaid as it considers the impact of the Proclamation on the health care programs Congress established. *Amici* NHeLP *et al.* obtained consent of both parties to file this brief.

SUMMARY OF ARGUMENT

On October 9, 2019, the President issued Presidential Proclamation 9945 purportedly to address "uncompensated care costs" incurred by uninsured, lawfully present immigrants. *See* Presidential Proclamation 9945, Suspension of Entry of Immigrants Who Will Financially Burden the United States Healthcare System, In Order To Protect the Availability of Healthcare Benefits for Americans, 84 Fed. Reg. 53991 (Oct. 9, 2019). The solution offered by the Proclamation: bar the entry of immigrants to the United States unless they demonstrate they have "approved" coverage or the financial resources to pay for reasonably foreseeable health care costs. *Id*.

Congress, through the Affordable Care Act (ACA) and the Medicaid program, has already "stepped into this space and solved the exact problem" addressed by the Proclamation. *Trump v. Hawaii*, 138 S. Ct. 2392, 2411-12 (2018). The sweeping and interlocking reforms in the ACA, together with the state Medicaid coverage option for "lawfully residing" children and pregnant women, create a carefully-tailored scheme to reduce uncompensated care by providing comprehensive and affordable coverage to newly-arrived immigrants.

The panel's decision offers a cramped and novel interpretation of these health care statutes. It focuses on two isolated statutory provisions, while ignoring the broader context and structure of the ACA and Medicaid Act's interlocking

reforms. *Cf. King v. Burwell*, 135 S. Ct. 2480, 2485 (2015) (describing ACA's "interlocking reforms designed to expand coverage"); *Morris v. California Physicians' Serv.*, 918 F.3d 1011, 1015 (9th Cir. 2019) ("Composed of ten titles spanning over 900 pages and hundreds of provisions, the ACA brought sweeping reforms to our health care system."). A complete view of the text, structure, and legislative history reveals that Congress intended the comprehensive plans offered in the ACA and Medicaid program to be the chief solution to uncompensated care for lawfully present immigrants.

The panel's approach ignores the serious practical consequences the Proclamation would have on the intricate scheme Congress established. Notwithstanding Congress's directives, the Proclamation excludes Medicaid for adults and subsidized Marketplace coverage for all individuals from the list of "approved" plans, meaning that an immigrant must obtain some *other* form of insurance to satisfy the Proclamation's mandates. The plans that will be most readily available are short-term, limited duration plans that do not comply with the ACA's requirements for covering essential health benefits, non-discrimination provisions, or cost protections. The Proclamation, therefore, directs immigrants away from the coverage Congress expressly intended them to have.

Finally, the panel's opinion, for the first time ever, condones using foreign policy powers to regulate domestic health care policy and requires consular

officers at the State Department to implement a complex health care policy. The Supreme Court has rejected the suggestion that "Congress would have delegated" important health care policy choices to an agency "which has no expertise in crafting health insurance policy of this sort." *King*, 135 S. Ct. at 2489. The panel's decision authorizing that delegation is in direct conflict with this precedent. The Court should grant rehearing *en banc*.

ARGUMENT

I. The Panel Decision Raises Issues of National Importance by Creating an Irreconcilable Conflict Between the Proclamation and Congress's Scheme to Provide Comprehensive, Affordable Coverage.

Contrary to the panel's conclusion that the Proclamation and ACA operate in "different spheres," *Doe #1 v. Trump*, 984 F.3d 848, 866 (9th Cir. 2020), the Proclamation directly conflicts with the policies established in the ACA and the Medicaid Act. Together, these statutes ensure that "lawfully present" immigrants—including recent entrants—are eligible for either Medicaid coverage or subsidized Marketplace plans. *See* 26 U.S.C. § 36B(c)(1)(B) (premium tax credits available to "lawfully present" immigrants who are ineligible for Medicaid). As Congress explained in an early ACA draft, extending quality, comprehensive coverage to immigrants "prevent[s] adverse financial and medical consequences of uncompensated care." Patient Protection and Affordable Care Act, H.R. 3590, 111th Cong. § 1002(c)(1)(C) (2009) (as passed by House, Oct. 8, 2009). The

scheme ultimately enacted "does not leave [lawfully present immigrants] in the cold," because if they are "otherwise ineligible for Medicaid, [they] are eligible for premium tax credits in the exchange." 156 Cong. Rec. S2069-07, S2079 (Statement of Mr. Baucus). In short, Congress sought to avoid uncompensated care costs by ensuring that lawfully present immigrants could enroll in either Medicaid or subsidized plans under the ACA, which demonstrably reduce uncompensated care costs.[2]

The Proclamation, however, requires immigrants to obtain what it deems "approved" coverage, but excludes the coverage Congress prescribed: subsidized Marketplace plans and, for individuals over 18 years old, Medicaid. Proclamation §§ 1(a), 1(b)(ii), 1(c). Instead, the Proclamation directs new immigrants to enroll in

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

plans such as short-term limited duration plans or visitor plans. *Id.* § 2(b)(iii), (vii). In the ACA, however, Congress prohibited such short-term plans from being sold on the Marketplaces, precisely because they are not subject to the ACA's protections and evidence shows that they result in underinsurance and increased uncompensated care.[3] *See* 42 U.S.C. § 18031(d)(2)(B)(1). The panel's isolated view of just two ACA and Medicaid provisions ignores Congress's consistent emphasis on providing *comprehensive* coverage and authorizes the President to undermine and override the intricate health care scheme Congress crafted.

A. Congress Expressly Included "Lawfully Present" Immigrants in the Affordable Care Act's Scheme to Reduce Uncompensated Care Costs.

In 2010, Congress passed the Patient Protection and Affordable Care Act. Pub. L. No. 111-148, 124 Stat. 119 (2010), as amended, Pub. L. No. 111-152, 124 Stat. 1029 (2010). The ACA "grew out of a long history of failed health insurance

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[3] *See, e.g.*, Linda J. Blumberg et al. Urban Inst., *Updated: The Potential Impact of Short-Term Limited-Duration Policies on Insurance Coverage, Premiums, and Federal Spending* (Mar. 2018), https://www.urban.org/sites/default/files/publication/96781/2001727_updated_finalized.pdf; Karen Politz et al., Kaiser Family Found., *Understanding Short-Term Limited Duration Health Insurance* (Apr. 23, 2018), https://www.kff.org/health-reform/issue-brief/understanding-short-term-limited-duration-health-insurance/; Laura Ungar, NPR, *A Woman's Grief Led To A Mental Health Crisis And A $21,634 Hospital Bill* (Oct. 31, 2019), https://www.npr.org/sections/health-shots/2019/10/31/771397503/a-womans-grief-led-to-a-mental-health-crisis-and-a-21-634-hospital-bill; American Cancer Society Cancer Action Network, *Inadequate Coverage: An ACS CAN Examination of Short-Term Health Plans* (May 13, 2019), https://www.fightcancer.org/sites/default/files/ACS%20CAN%20Short%20Term%20Paper%20FINAL.pdf.

reform." *King*, 135 S. Ct. at 2485. Congress understood the widespread problem of uncompensated health care. Notably, Congress identified not only lack of insurance, but "the problem of *under*insurance, which happens when people pay for health insurance but aren't adequately protected from high medical expenses." *Insured but Not Covered: Hearing Before the Subcomm. On Oversight & Investigations of the H. Comm. on Energy & Commerce*, 111th Cong., 2009 WL 3326522, 1 (Oct. 15, 2009) (opening statement of Rep. Waxman, Chairman, H. Comm. On Energy & Commerce). Congress recognized that existing plans often did not cover medically necessary, but high-cost services, or provide a "core set of benefits to ensure coverage for essential health care services," leaving individuals without coverage and resulting in uncompensated care. *Id*.

Congress understood that the only way to address these problems was to comprehensively reform American health care, through a series of interrelated reforms. *See Executive Committee Meeting to Consider Health Care Reform of the S. Comm. on Finance*, 111th Cong., 3-5 (Sept. 22, 2009), available at: https://www.finance.senate.gov/imo/media/doc/092209.pdf. The ACA "contains hundreds of . . . provisions that address health care access, costs, and quality." Annie L. Mach & Janet Kinzer, Cong. Research Serv., *Legislative Actions to Modify the Affordable Care Act in the 111th-115th Congresses*, 2 (June 27, 2018), https://fas.org/sgp/crs/misc/R45244.pdf. As discussed below, Congress expressly

included "lawfully present" immigrants throughout. *See, e.g.*, 42 U.S.C. §§ 18001(d)(1); 18032(f)(3).

One central reform was the creation of health care "exchanges," also known as Marketplaces, that allow individuals to purchase "qualified health plans" (QHPs). 42 U.S.C. § 18031(b)(1)(A). Plans must be certified as a QHP to be offered on the exchanges. *Id.* § 18031(d)(2)(B)(1). *See also id.* § 18031(c)(1) (defining minimum requirements for certification as a "qualified health plan"); *id.* § 18021(a)(1) (defining "qualified health plans").

Congress established numerous requirements to ensure that QHPs would solve the twin problems of being un- and under-insured. Crucially, Congress required QHPs to cover "essential health benefits," including among others, maternity and newborn care, mental health and substance use disorder services, and prescription drugs. *Id.* § 18022(b)(1). It required that some critical services, such as preventive services, must be available without any cost-sharing. 42 U.S.C. § 300gg-13. Moreover, QHPs, like other insurers, are subject to the reforms that prohibit insurers from refusing to cover preexisting conditions, 42 U.S.C. § 300gg-3, turning individuals away because of their health conditions, *see id.* §§ 300gg, 300gg-1, and charging more because of preexisting conditions, *id.* § 300gg-4. Additionally, the Secretary of Health and Human Services must ensure that the robust essential health benefits are actually available to all of a plan's enrollees and

are not "subject to denial to individuals against their wishes on the basis of the individuals' age or expected length of life or of the individuals' present or predicted disability, degree of medical dependency, or quality of life." *Id.* § 18022(b)(4)(D).

Congress also enacted reforms ensuring that QHPs are affordable. First, the ACA created premium tax credits to subsidize the cost of purchasing health insurance on the exchanges. 26 U.S.C. § 36B. Generally, tax credits are available to any "applicable taxpayer" with income between 100% and 400% of the Federal Poverty Level (FPL). *Id.* § 36B(c)(1)(A). Congress also created a "special rule for certain individuals lawfully present in the United States." 26 U.S.C. § 36B(c)(1)(B). Congress extended the tax credits to those with incomes *below* 100% FPL for "alien[s] lawfully present in the United States, but not eligible for the [M]edicaid program . . . by reason of such alien status." *Id.* The statute thus ensures that all lawfully present immigrants in the United States, with incomes below 400% FPL, are eligible for some form of comprehensive, affordable coverage, either through Medicaid or through subsidized plans on the Marketplace if Medicaid is unavailable.

Second, Congress established cost-sharing reductions in 42 U.S.C. § 18071, which require insurers to "reduce the applicable out-of pocket [sic] limit" by set amounts depending on household income. *Id.* § 18071(c). As with premium tax

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

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

As the ACA recognized, some immigrants may be eligible for Medicaid. *See* 26 U.S.C. § 36B(c)(1)(B). Specifically, Congress identified certain categories of "qualified" immigrants who are Medicaid-eligible. *See* 8 U.S.C. § 1641. Some qualified immigrants, such as legal permanent residents, however, are subject to a five-year waiting period. *Id.* § 1613.

Congress also gave states the option to make Medicaid coverage available to certain "lawfully residing" immigrants immediately, including pregnant women and children up to age 21. 42 U.S.C. § 1396b(v)(4)(A). *See also*, Children's Health Insurance Program Reauthorization Act of 2009, § 214, Pub. L. No. 111-3, 123 Stat. 9 (2009); 42 U.S.C. § 1397gg(e)(1)(N). The structure of this option emphasizes the importance Congress placed on Medicaid: States taking this option for children must provide coverage in Medicaid alone or through a combination of Medicaid and the Children's Health Insurance Program (CHIP), but may not rely

solely on CHIP.[4] *See* Ctrs. for Medicare & Medicaid Servs., *Medicaid and CHIP Coverage of "Lawfully Residing" Children and Pregnant Women*, 2 (July 1, 2010), https://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/SHO10006.pdf (hereinafter "CMS, *Lawfully Residing*"); *see also* 42 U.S.C. § 1397gg(e)(1)(N). Congress thus demonstrated its clear preference that Medicaid cover this population.

The "lawfully residing" category is broad and includes newly arriving immigrants targeted by the Proclamation. *See* CMS, *Lawfully Residing* at 2-4. There is no waiting period within this category, and states may not impose their own. States adopting this option "must offer coverage to all such individuals who meet this definition of lawfully residing, and may not cover a subgroup or only certain groups." *Id.* at 4. Thus, in states taking the option, pregnant women and children up to age 21, who arrive with a qualified status that would otherwise be subject to a five-year waiting period—such as legal permanent resident—may receive coverage immediately. *Id.* at 1-2, 5. *See also* 155 Cong. Rec. S820, S822 (Jan. 26, 2009), (Statement of Sen. Rockefeller) ("All lawfully present children should have timely access to health care in the United States."); 115 Cong. Rec. S1050 (Jan. 29, 2009) (Statement of Mrs. Boxer) (bill gives "States the option to

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[4] CHIP provides coverage to children whose family income is above the Medicaid income limits, but too low to afford private insurance.

cover legal immigrant children and pregnant women under Medicaid and CHIP with no waiting period.”).

Through this option, immigrants obtain comprehensive coverage. Medicaid, like Marketplace coverage, qualifies as “minimum essential coverage” under Congress’s definition, and protects against uncompensated care by providing cost-protections and ensuring comprehensive benefits. *See* 26 U.S.C. § 5000A(f)(1)(A)(ii) (defining minimum essential coverage); 42 U.S.C. §§ 1396o, 1396o-1 (establishing Medicaid premium and cost-sharing protections); 42 U.S.C. § 18022(b)(1) (establishing essential health benefits); 42 U.S.C. § 1396a(k)(1) (requiring that individuals covered under Medicaid expansion receive “benchmark coverage” defined in statute); 42 U.S.C. § 1396u-7(b)(5) (requiring plans offering benchmark or benchmark-equivalent coverage to include essential health benefits).

Indeed, the benefits under the Medicaid option are robust. For children under 21, states are required to provide Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services. 42 U.S.C. §§ 1396a(a)(10)(A), 1396a(a)(43), 1396d(a)(4)(B), 1396d(r). EPSDT requires that the services listed in the Medicaid Act at 42 U.S.C. § 1396d(a) must be provided to a child if they are “necessary . . . to correct or ameliorate defects and physical and mental illnesses and conditions . . . regardless of whether or not such services are covered” for adults. *Id.* § 1396d(r)(5). For pregnant people, states must cover pregnancy-related services,

including services for conditions that might complicate pregnancy, and 60-days post-partum pregnancy-related services. 42 U.S.C. §§ 1396a(a)(10)(A), (C), 1396a(l); 42 C.F.R. § 440.210(a)(2).

Legislative history confirms that Congress intended this Medicaid option to reduce health care costs by expanding comprehensive coverage. *See* 155 Cong. Rec. S1028 (Jan. 29, 2009) (Statement of Sen. Durbin) ("Covering uninsured children and pregnant women through Medicaid can reduce unnecessary hospitalizations by 22 percent. Preventing unnecessary hospital visits results in substantial savings in uncompensated care."); 155 Cong. Rec. S966 (Jan. 28, 2009) (Statement of Sen. Snowe) (Medicaid coverage will "address inefficient health care spending by ensuring access to preventive care, as opposed to relying on expensive emergency room care."); 155 Cong. Rec. H259 (Jan. 14, 2009) (Statement of Mr. Kucinich) ("This provision will . . . save States money by allowing them to move routine care from the emergency room to the doctor's office.").

C. The Proclamation Creates a Direct Conflict with Congress's Carefully Crafted Health Care Scheme and Raises Important Separation of Powers Questions.

This case raises important separation of powers questions about the President's obligation to "faithfully execute[]" the laws Congress enacted. U.S. Const. Art. II, § 3. The panel decision elides these questions, dismissing the separation of powers concerns in a one-sentence footnote. *Doe #1*, 984 F.3d at 869

n.12. But the consequence of the decision is to vest the President with authority to re-write and override domestic health care policy that Congress has duly enacted. *Contra Clinton v. City of New York*, 524 U.S. 417, 444 (1998) (rejecting as unconstitutional Presidential action that "is rejecting the policy judgment made by Congress and relying on his own policy judgment."); *Youngstown Sheet & Tube Co. v. Sawyer,* 343 U.S. 579, 637-38 (1952) (Jackson, J. concurring).

The Proclamation undermines both the express and implied will of Congress. It excludes Medicaid and subsidized Marketplace plans from "approved" coverage because they use federal funds. But, as evidenced by the text, structure, and legislative history of the ACA and Medicaid Act, Congress has directed that funds *should* be spent on immigrant health care. In fact, Congress specified a preference for Medicaid coverage among the insurance programs available to that population: where Medicaid funds are available, an individual is not eligible for premium tax credits. *See* 26 U.S.C. § 36B(c)(1)(B). Moreover, States may not rely solely on CHIP funding for "lawfully residing" immigrants without also providing Medicaid coverage. *See* 42 U.S.C. § 1397gg(e)(1)(N). The decision whether to spend federal funds on health coverage for immigrants is a choice for Congress, not the President. *See* U.S. Const. art. I, § 9, cl. 7; *Sierra Club v. Trump*, 929 F.3d 670, 694 (9th Cir. 2019) (Congress has "exclusive power of the purse."); *City & Cty. of San Francisco v. Trump*, 897 F.3d 1225, 1234 (9th Cir. 2018) ("[W]hen it comes to

spending, the President has none of his own constitutional powers to rely upon.") (quote omitted). The panel's decision permits the President to second-guess Congress's spending choices, raising issues of national importance.

Moreover, the practical effect of the Proclamation undermines the ACA. As the Government's briefing acknowledged, following the Proclamation, new private markets emerged. Gov't Br. at 7, 48. These emerging markets, however, exist outside the comprehensive scheme established by the ACA and are not subject to the ACA's numerous requirements and consumer protections. Unregulated markets such as these are precisely what Congress sought to mitigate because they contribute to uncompensated care.

The panel's assertion that the Proclamation and health care statutes operate in "different spheres" does not resolve these critical separation of powers questions. First, it is factually incorrect. Contrary to the panel's declaration that the Proclamation applies only to immigrants "seeking to enter," *Doe #1*, 984 F.3d at 867 (quoting Proclamation, 84 Fed. Reg. at 53992), the Proclamation intends to impact immigrants' health coverage decisions well after entry. The Proclamation's primary directive is to require immigrants to show that they will obtain insurance by 30 days *after* entry. Proclamation § 1(b). In fact, the panel itself acknowledged that immigrants "need not necessarily obtain that coverage before entry." *Doe #1*, 984 F.3d at 857. Moreover, if immigrants use short-term or visitor plans (which do

not comply with the ACA's requirements), they must demonstrate that the plans provide coverage "for a minimum of 364 days." Proclamation §§ 1(b)(iii), (vii). Requiring immigrants to obtain inadequate insurance for a year after entry is anathema to the directives in the ACA and Medicaid. Thus, the panel decision, by reading both the Proclamation and the ACA narrowly, vests the President with authority to enact his policy preferences over those Congress enacted.

In sum, the Proclamation's text, structure, and practical effects run entirely counter to the health care policy Congress enacted. The Proclamation, therefore, does "not direct that a congressional policy be executed in a manner prescribed by Congress—it directs that a presidential policy be executed in a manner prescribed by the President." *Youngstown*, 343 U.S. at 588.

II. The Panel Decision Conflicts with Supreme Court Precedent By Condoning the Delegation of Health Care Policy to the State Department And Consular Officers Who Lack Expertise.

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

Those determinations are complex, requiring detailed knowledge of medicine and health insurance markets. Studies reveal that consumers and non-experts often lack health care literacy and are inaccurately estimate out-of-pocket costs for health care services like hospital stays and laboratory tests. *See, e.g.*, Kleimann Communication Group, *Report on Testing Consumer Understanding of a Short-Term Health Insurance Plan* (Mar. 15, 2019), https://healthyfuturega.org/wp-content/uploads/2019/04/Consumer-Testing-Report_NAIC-Consumer-Reps.pdf. Moreover, prices for health care services are often not available or are very difficult to find. *See*, *e.g.*, Anne Quito & Amanda Shendruk, "US hospitals are now required by law to post prices online. Good luck finding them," Quartz (Jan. 15, 2019), https://qz.com/1518545/price-lists-for-the-115-biggest-us-hospitals-new-transparency-law/. Even knowing the potential costs of treatment, it is not possible to predict how much any particular individual is likely to spend. A recent study found that "between 54 percent and 83 percent of people would not spend the average 'reasonably foreseeable' cost during their second year after diagnosis." Sherry Glied & Benjamin Zhu, "The Unintended Consequences of Requiring Immigrants to Meet 'Reasonably Foreseeable' Costs," To The Point, Commonwealth Fund (Jan. 31, 2020), https://www.commonwealthfund.org/blog/2020/immigrants-foreseeable-medical-costs. Finally, short-term plans often do not provide complete information about covered services, cost-

sharing, or rates. Sabrina Corlette et al., Urban Inst., *The Marketing of Short-Term Health Plans: An Assessment of Industry Practices and State Regulatory Responses,* 2, 6-7 (Jan. 2019), https://www.urban.org/sites/default/files/publication/99708/moni_stldi_final_0.pdf.

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

This mismatch between the health care expertise required to implement the Proclamation and the competencies of the State Department demonstrates that the President has overstepped the bounds of 8 U.S.C. § 1182(f). The Supreme Court rejected the suggestion that "Congress would have delegated" important health care policy choices to an agency "which has no expertise in crafting health insurance policy of this sort." *King*, 135 S. Ct. at 2489. Likewise, "the Supreme Court has been skeptical of federal regulations crafted from long-extant statutes that exert novel and extensive power over the American economy." *Chamber of Commerce of United States of Am. v. United States Dep't of Labor*, 885 F.3d 360, 387 (5th Cir. 2018). But the Proclamation does just that: exerting novel and extensive power over domestic health care to, purportedly, address the economic impacts of uncompensated care. The authority the President delegated to the State

Department is "both beyond [its] expertise and incongruous with the statutory purposes and design," of the INA and the ACA. *Gonzales v. Oregon*, 546 U.S. 243, 267 (2006). The panel decision conflicts with these well-established precedents.

CONCLUSION

For the foregoing reasons, the court should grant *en banc* rehearing.

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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 4181 words according to the count of Microsoft Word, excluding the parts of the brief exempted by Fed. R. App. P. 32(f).

Date: January 29, 2021

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CERTIFICATE OF SERVICE

I certify that on January 29, 2021, I electronically filed the forgoing brief with the Clerk of the Court by using the CM/ECF system.

Date: January 29, 2021

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