EXHIBIT A

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MARYLAND

CITY OF COLUMBUS, *et al.*, *Plaintiffs,* –v– DONALD J. TRUMP, in his official capacity as President of the United States of America, *et al.*, *Defendants.*	**Civil Action No. 18-cv-2364**

BRIEF OF FAMILIES USA, COMMUNITY CATALYST, THE NATIONAL HEALTH LAW PROGRAM, AND SERVICE EMPLOYEES INTERNATIONAL UNION AS *AMICI CURIAE*, IN SUPPORT OF PLAINTIFFS' OPPOSITION TO DEFENDANTS' MOTION TO DISMISS PLAINTIFFS' AMENDED COMPLAINT

INTEREST OF AMICI CURIAE

Families USA, Community Catalyst, National Health Law Program and Service Employees International Union are non-profit organizations and a health care union all with a longstanding interest in ensuring access to high quality affordable health care and the successful implementation of the Affordable Care Act.

INTRODUCTION

The Patient Protection and Affordable Care Act[1] (the ACA) made health care available to millions of individuals through insurance subsidies and expansion of the federal Medicaid program. From the time the law was passed in 2010 until January 2017, the Obama Administration worked tirelessly to ensure that the law would meet its objectives. Unfortunately,

[1] Pub. L. 111-148, 124 Stat. 119-1045 (2010).

the Trump Administration has, from day one, made repeal of the law its number one priority. *Amici* agree with Plaintiffs that "President Trump and his Administration are waging a relentless campaign to sabotage and ultimately to nullify the [ACA]."

ARGUMENT

I. CONGRESS PASSED THE AFFORDABLE CARE ACT TO ENSURE ACCESS TO AFFORDABLE MEANINGFUL HEALTH CARE.

In 2009, prior to enactment of the ACA, 50 million people in the United States, 17 percent of the population, did not have health insurance.[2] This was frequently because they were denied access or could not afford to buy insurance on the marketplace and did not qualify for Medicaid. Millions of others had purchased health insurance that did not ensure adequate medical care.[3] The ACA dramatically changed health care in the United States: it made Medicaid available to millions of low-income individuals and families that were previously ineligible and it reformed the individual insurance market by establishing standards and providing subsidies for individuals who otherwise could not afford health insurance.

A. The Affordable Care Act Substantially Improved Access to Medicaid, Made Insurance on the Individual Market Affordable to Lower-Income Americans, and Required Insurance to Meet Basic Standards.

Prior to the ACA, most impoverished adults without disabilities who had no dependent children were excluded from Medicaid.[4] The ACA allows states to expand Medicaid to all

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[2] U.S. Dep't of Commerce, Census Bureau, *Income, Poverty, and Health Insurance Coverage in the United States: 2009* 23 tbl.8 (Sept. 2010), https://www.census.gov/prod/2010pubs/p60-238.pdf.

[3] *See* Michelle M. Doty, et.al., *Failure to Protect: Why the Individual Insurance Market Is Not a Viable Option for Most U.S. Families* 9 (The Commonwealth Fund, July 2009), http://www.commonwealthfund.org/~/media/files/publications/issue-brief/2009/jul/failure-to-protect/1300_doty_failure_to_protect_individual_ins_market_ib_v2.pdf.

[4] Christie Provost and Paul Hughes, *Medicaid: 35 years of Service*, 22 Medicare and Medicaid Res. Rev. 141, 142-43 (Fall 2000), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4194689/; Kaiser Family Foundation, *Medicaid Income Eligibility Limits for Children Ages 6-18, 2002-2019 and Medicaid Income*

individuals who have income below 133% of poverty. 42 U.S.C. §1396. By September 2017, more than 12 million people who were newly-eligible for Medicaid had enrolled.[5] To date, 35 states and the District of Columbia have accepted Medicaid expansion.[6]

Prior to the ACA, most lower-income Americans not eligible for Medicaid were unable to purchase insurance on the individual market either because it was too expensive or it was unavailable to them. Because hospitals participating in Medicare were required to provide emergency medical care to uninsured individuals, the cost of this uncompensated care was passed on to other consumers. The average portion of premiums attributable to uncompensated care was $1,000 for a family with private coverage.[7] Moreover, before the ACA, approximately 42.7 percent of people who *applied for coverage* in the individual market were denied insurance due to pre-existing conditions.[8] The coverage for those who were able to purchase insurance was often inadequate since it did not include important services such as prescription drugs, maternity care and mental health.[9] More than 105 million Americans had health insurance that capped their

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Eligibility Limits for Parents, 2002-2019, https://www.kff.org/data-collection/trends-in-medicaid-income-eligibility-limits/ (last visited Jun. 4, 2019).

[5] *See* Ctrs. for Medicare & Medicaid Servs., *July-September 2017 Medicaid MBES Enrollment Report* (Nov. 2018), https://data.medicaid.gov/Enrollment/2017-3Q-Medicaid-MBES-Enrollment/rxbg-jqed. https://aspe.hhs.gov/system/files/pdf/255516/medicaidexpansion.pdf.

[6] Families USA, *A 50-State Look at Medicaid Expansion* (Nov. 2018), https://familiesusa.org/product/50-state-look-medicaid-expansion. Additionally, Idaho and Nebraska voters approved ballot measures to expand Medicaid which have not yet implemented expansions.

[7] Patient Protection and Affordable Care Act, Pub. L. No. 111-148, §§ 1501(a)(2)(F), 124 Stat. 119, 908 (2010).

[8] Families USA calculations based on America's Health Ins. Plans Ctr. for Policy Research, *Individual Health Insurance 2009: A Comprehensive Survey of Premiums, Availability, and Benefits* 10 tbl.6 (Oct. 2009), https://kaiserhealthnews.files.wordpress.com/2013/02/2009individualmarketsurveyfinalreport.pdf.

[9] *See* Dania Palanker, et al., *Eliminating Essential Health Benefits Will Shift Financial Risk Back to Consumers* (The Commonwealth Fund, Mar. 24, 2017, http://www.commonwealthfund.org/publications/blog/2017/mar/eliminating-essential-health-benefits-financial-risk-consumers.

lifetime and annual benefits.[10] The lack of coverage, inadequate coverage and capped benefits caused otherwise preventable deaths. A Families USA study showed that in 2010 alone, 26,100 premature deaths were the result of inadequate health coverage.[11] By 2007, more than 60 percent of all personal bankruptcies were related to medical costs.[12]

The ACA helped populations with income between 100 and 400 percent of the federal poverty line by providing premium tax credits. The ACA also improved individual coverage, providing for guaranteed availability and assuring that it covered essential benefits, such as maternity and newborn care, prescription drugs, mental health services and preventive care services. As a result, the drop in the uninsured rate in 2014 was the largest since Medicare was enacted and Medicaid first ramped up in the early 1970s.[13] By 2016, the ACA helped lower the number of people without health insurance by more than 20.0 million people.[14]

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[10] *See* Office of the Assistant Sec'y for Planning and Evaluation, U.S. Dep't of Health and Human Servs., *Under the Affordable Care Act, 105 Million Americans No Longer Face Lifetime Limits on Health Benefits* 1-2 (Issue Brief, Mar. 5, 2012), https://aspe.hhs.gov/basic-report/under-affordable-care-act-105-million-americans-no-longer-face-lifetime-limits-health-benefits.

[11] Families USA, *Dying for Coverage: The Deadly Consequences of Being Uninsured*, 2 tbl.1 (June 2012), http://familiesusa.org/product/dying-coverage-deadly-consequences-being-uninsured.

[12] From 2001 to 2007, the share of personal bankruptcies that was related to medical expenses rose by almost 50 percent. David U. Himmelstein, et al., *Medical Bankruptcy in the United States, 2007: Results of a National Study*, American Journal of Medicine, 122 Am. J. of Med. 741 (2009), http://www.pnhp.org/new_bankruptcy_study/Bankruptcy-2009.pdf.

[13] Jason Furman & Matt Fiedler, *2014 Has Seen Largest Coverage Gains in Four Decades, Putting the Uninsured Rate at or Near Historic Lows*, Executive Office of the President Council of Economic Advisors (Dec. 18, 2014, 11:00AM), https://obamawhitehouse.archives.gov/blog/2014/12/18/2014-has-seen-largest-coverage-gains-four-decades-putting-uninsured-rate-or-near-his.

[14] Office of the Assistant Sec'y for Planning and Evaluation, U.S. Dep't of Health and Human Servs., *Health Insurance Coverage and the Affordable Care Act, 2010–2016*, (Issue Brief, Mar. 3, 2016), https://aspe.hhs.gov/system/files/pdf/187551/ACA2010-2016.pdf; Executive Office of the President Council of Economic Advisors, *2017 Economic Report of the President* 196 (2017), https://obamawhitehouse.archives.gov/sites/default/files/docs/chapter_4-reforming_health_care_system_2017.pdf; Kaiser Family Foundation, *Key Facts About the Uninsured Population* (Dec. 7, 2018), https://www.kff.org/uninsured/fact-sheet/key-facts-about-the-uninsured-population/.

B. The Obama Administration Issued Regulations and Adopted Policies That Advanced the Purposes of the Affordable Care Act.

Following passage of the ACA, the Obama Administration worked tirelessly to ensure that all consumers would have access to adequate and affordable health coverage. The Administration worked to ensure that consumers would be aware of and understand the types of coverage available and be able to enroll in adequate health coverage, with premium subsidies for those who were eligible. To increase awareness, the Obama Administration undertook significant outreach efforts. During its last year in office, it spent $100 million on advertising open enrollment.[15] To help consumers understand and enroll in the marketplace and determine if they are eligible for subsidies, CMS also funded a navigator program; in 2016 there was $63 million in funding for navigators[16] and by 2016 some 5600 Assister programs were in place.[17]

The Obama Administration also took steps to ensure that consumers were not directed to or relying on substandard policies, including short-term limited duration insurance (STLDI) and Association Health Plans (AHPs) sold to individuals and small groups. STLDI is a type of insurance that historically has been used to provide stop-gap coverage. 83 Fed. Reg. 38,212, 38,213 (Aug. 3, 2018).[18] Because it is exempt from Federal individual market requirements, it can exclude coverage for preexisting conditions, charge a higher rate based on an individual's health history and health status, exclude benefits such as prescription drugs, maternity care,

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[15] US Government Accountability Office, HHS Should Enhance Its Management of Open Enrollment, GAO-18-565, July 2018, https://www.gao.gov/assets/700/693362.pdf.

[16] Karen Pollitz, J. T., *2016 Survey of Health Insurance Marketplace Assister Programs and Brokers.* Washington, DC: Kaiser Family Foundation (2016), https://www.kff.org/health-reform/report/2016-survey-of-health-insurance-marketplace-assister-programs-and-brokers/.

[17] Karen Pollitz, J. T., *Data Note: Further Reductions in Navigator Funding fo Federal Marketplace States* (Sept. 24, 2018), https://www.kff.org/health-reform/issue-brief/data-note-further-reductions-in-navigator-funding-for-federal-marketplace-states/.

[18] Bernadette Fernandez et al., *Background Information on Health Coverage Options Addressed in Executive Order 13813* at i-ii, Congressional Research Services, https://fas.org.sgp/crs/misc/R45216.pdf.

mental health services and substance use disorder services, include a dollar cap on services, and not limit consumer out-of-pocket expenses. In response to concerns that some STLDI was being sold for longer periods and even as a primary form of coverage, CMS revised its regulations to limit the terms of STLDI to fewer than 3 months. 81 Fed. Reg. 75,316 (Oct. 31, 2016).

The AHP is a type of Multiple Employer Welfare Arrangement (MEWA) which not only skirts critical insurance market consumer protections but has been associated with fraud when sold to small groups and individuals.[19] The ACA addressed some of the problems associated with AHPs by including criteria for bona fide associations that can legitimately be considered MEWAs.[20] In 2011 guidance, the Obama Administration determined that, in most cases, the size of the individual employer participating in an association, and not the size of the association, determines whether an employer's coverage is subject to small group, large group, or individual health insurance market rules; hence, health insurance policies sold through an association to individuals must comply with the ACA's individual market protections, while associations marketed to small employers must comply with small-group coverage rules.[21]

II. THE TRUMP ADMINISTRATION HAS ISSUED REGULATIONS AND ADOPTED POLICIES THAT ARE NOT ONLY INCONSISTENT WITH THE ACA BUT ALSO DESIGNED TO SABOTAGE THE ACT IN ITS ENTIRETY.

Since taking office, the Trump Administration has made it its mission to adopt policies designed to undermine and sabotage the ACA. Although *amici* agree that all of the actions identified by plaintiffs are problematic and inconsistent with the Administration's obligation to

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[19] Mila Kofman, J.D, *Association Health Plans: Loss of State Oversight Means Regulatory Vacuum and More Fraud*, Georgetown University (2005), https://hpi.georgetown.edu/ahp/.

[20] US District Court for the District of Columbia Opinion, State of New York v U.S. Department of Labor, et al, Civil Action 18-1747, March 28, 2019, https://ecf.dcd.uscourts.gov/cgi-bin/show_public_doc?2018cv1747-79.

[21] *See* CMS Insurance Standards Bulletin Series (September 1, 2011), https://www.cms.gov/CCIIO/Resources/Files/Downloads/association_coverage_9_1_2011.pdf.

faithfully execute the ACA, this brief will focus on those actions that more significantly impact lower income citizens. These include efforts designed to make it more difficult for such individuals to sign up for coverage and efforts to make substandard coverage available. These actions will result in higher premiums and no or inadequate coverage.

A. Drastic Cuts to Outreach and Enrollment Assistance Undercut the Purpose of the ACA, Which is to Make Healthcare Available to More Consumers.

Evidence from 2014 showed that people living in areas with a greater number of ads sponsored by the federal government were significantly more likely to shop for and enroll in marketplace plans.[22] Nevertheless, the Trump administration has cut the marketing and advertising budget for the federal marketplaces -- by 85%.[23] For the 2018 enrollment period, the Trump Administration spent 90 percent less than what the Obama Administration had spent for 2017 open enrollment.[24] This will result in decreased enrollment in marketplace plans.

Likewise, administrative actions that slashed funding for navigators have significantly decreased in-person, unbiased enrollment assistance, eliminating it entirely in some states and areas. In 2017, the Centers for Medicare & Medicaid Services (CMS) reduced navigator funding by 43 percent in the 34 states that use the federal marketplace. In September 2018, the Administration further reduced funding by an additional $10 million.[25] CMS also eliminated the

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[22] S. Gollust, et al, "TV Advertising Volumes Were Associated with Insurance Marketplace Shopping and Enrollment In 2014," *Health Affairs*, Vol 37, No. 6 (June 2018), https://www.healthaffairs.org/doi/10.1377/hlthaff.2017.1507.

[23] S. Corlette and R. Schwab, *States Lean In as the Federal Government Cuts Back on Navigator and Advertising Funding for the ACA's Sixth Open Enrollment* (Oct. 26, 2018), https://www.commonwealthfund.org/blog/2018/states-lean-federal-government-cuts-back-navigator-and-advertising-funding.

[24] US Government Accountability Office, HHS Should Enhance Its Management of Open Enrollment, GAO-18-565 (July 2018), https://www.gao.gov/assets/700/693362.pdf.

[25] K.Pollitz, J. Tolbert and M. Diaz, *Data Note: Further Reductions in Navigator Funding for Federal Marketplace States,* Kaiser Family Foundation (Sept 24, 2018), https://www.kff.org/health-reform/issue-brief/data-note-further-reductions-in-navigator-funding-for-federal-marketplace-states/.

requirement that each marketplace have at least two navigator entities, one of which was supposed to be a community and consumer-focused nonprofit group, and the requirement that a navigator be physically present in the area that it serves. 83 Fed. Reg. 16,930, 16,979 (Apr. 17, 2018). As a result, four states were left with no navigators at all, and nine additional states had no navigators in large parts of their state.[26]

These declines in assistance particularly impede enrollment by people who lack the confidence to apply for insurance on their own, or have limited understanding of the marketplace or their plan choices. The cuts have a disproportionate impact on low income populations: enrollment by consumers with incomes under 200% of poverty fell by 7.6% in 2018.[27] Requests for assistance often are related to help with translation, help with the website, lack of internet service, or Medicaid-related questions. [28] Moreover, assisters were much more likely to serve populations that needed help for those latter reasons than were brokers.[29]

In 2017-2018, new enrollments declined by 489,638 in states using the federal marketplaces, which were the subject of navigator cuts. In three of the states that lost all or most navigator funding, New Hampshire, Montana and Texas, enrollment declined 10, 14, and 18 percent respectively from 2016 to 2018.[30] From December 2017 to December 2018, Medicaid and CHIP

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[26] *See* Map 2: https://www.kff.org/health-reform/issue-brief/data-note-further-reductions-in-navigator-funding-for-federal-marketplace-states/.

[27] K.Pollitz, et al, *Data Note*, op cit.

[28] K. Pollitz, J. Tolbert, and A. Semanskee, *2016 Survey of Health Insurance Marketplace Assister Programs and Brokers*, Kaiser Family Foundation (June 8, 2016), https://www.kff.org/health-reform/report/2016-survey-of-health-insurance-marketplace-assister-programs-and-brokers/.

[29] *Id.*

[30] Calculation from Health Insurance marketplace Open Enrollment Report for 2016, Office of the Assistant Secretary for Planning and Evaluation, Department of Human Services, and Marketplace Open Enrollment Public Use Files for 2019, as cited in Kaiser Family Foundation, Marketplace Enrollment (2014-2019), https://www.kff.org/health-reform/state-indicator/marketplace-enrollment/.

enrollment also declined by 1.6 million enrollees.[31] States with large declines in Medicaid enrollment had experienced cuts in in-person marketplace assistance ranging from 83 percent to 87 percent.[32] Since assisters and marketplace websites screen applicants for Medicaid and refer those eligible to Medicaid, declines in marketplace assistance and outreach are likely to have an effect on Medicaid enrollment.

B. The Administration Is Taking Steps to Deter Consumers from Enrolling in Quality Health Insurance Plans as Envisioned by the ACA.

1. Administrative actions to promote the sale of non-ACA compliant short-term limited duration health insurance undermine ACA protections and leave consumers at great financial risk when they become sick.

Short-term limited duration health insurance (STLDI), historically used to provide stop-gap coverage, is exempt from Federal market requirements. 83 Fed. Reg. 38,212, 38,213 (Aug. 3, 2018).[33] Thus, it can exclude coverage for preexisting conditions, charge a higher rate based on an individual's health history and health status, exclude benefits such as prescription drugs, maternity care, mental health services and substance use disorder services, include a dollar cap on services and not limit consumer out-of-pocket expenses. When the Obama Administration issued a regulation limiting STLDI to fewer than 3 months, it noted that such policies target healthier individuals for coverage, thus adversely impacting the risk pool for ACA compliant coverage. 81 Fed. Reg. 75,316 (Oct. 31, 2016).

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[31] Preliminary enrollment data provided to the Centers for Medicare & Medicaid Services by state Medicaid agencies is available online at: https://www.medicaid.gov/medicaid/program-information/medicaid-and-chip-enrollment-data/monthly-reports/index.html, cited in E. Ruff and E. Fishman, *The Return of Churn: State Paperwork Barriers Caused More Than 1.5 Million Low-Income People to Lose Their Medicaid Coverage in 2018*, Families USA (April 2019), https://familiesusa.org/sites/default/files/product_documents/Return_of_Churn_Analysis.pdf.

[32] Percentage cuts in navigator funding for TN, WY, UT, and OH, Pollitz et al, 2018 op cit.

[33] Bernadette Fernandez et al., *Background Information on Health Coverage Options Addressed in Executive Order 13813* at i-ii, Congressional Research Services (Jun. 6, 2018), https://fas.org.sgp/crs/misc/R45216.pdf.

Unfortunately, the Trump Administration expanded the sale of STLDI for periods up to 12 months, which can be extended to last for up to 36 months. 83 Fed. Reg. 38,212 (Aug. 3, 2018). In comments to the 2018 proposed rule, *amici* Families USA and Community Catalyst explained that, because the people attracted to short-term limited duration insurance are likely healthier people not in search of comprehensive benefits or coverage of pre-existing conditions, the sales of short term plans destabilize the individual market by pulling healthier individuals away and thus raising prices for people wanting and needing comprehensive insurance. *Amici* also explained that people who buy short-term plans would be left unprotected in cases of serious illness.[34] Families USA described a case in which a man was billed $211,690 for heart surgery because his STLDI, which excluded preexisting conditions, determined that he had one because of his father's medical history, even though he had never been diagnosed with the disease. Even after intervention by the D.C. Office of the Health Care Ombudsman, which pushed the plan to pay part of this bill, the patient remained liable for $199,910 because the plan had set "maximum payable benefits" that fell far short of typical costs.[35] Short-term plans commonly exclude coverage of mental health and substance use disorder services.[36] As of April 2018, no plans sold

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[34] Families USA, Comments on Short-Term Limited Duration Insurance Proposed Rule (Apr. 23, 2018), https://www.regulations.gov/document?D=CMS-2018-0015-8801; Community Catalyst, Comments on Short-Term Limited Duration Insurance Proposed Rule (Apr. 23, 2018), https://www.regulations.gov/document?D=CMS-2018-0015-8855.

[35] Families USA, *Comments on Short-Term Limited-Duration Insurance Proposed Rule* (Apr. 23, 2018), https://www.regulations.gov/document?D=CMS-2018-0015-8801.

[36] Families USA, Mental Health America, National Council for Behavioral Health, National Alliance on Mental Illness, *Short-Term Plans Do Not Cover Life-Saving Mental Health and Substance Use Treatment* (Aug. 1, 2018), https://familiesusa.org/sites/default/files/product_documents/STP-and-Mental-Health_Factsheet_0.pdf; Karen Pollitz, M. L., *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/.

by two large online brokers covered maternity care and 71 percent of STLDI's did not cover prescription drugs.[37]

Researchers at Georgetown University found that subsequent to the new rule, consumers shopping online for health insurance, including those using search terms such as "ACA enroll" will most often be directed to websites and brokers selling short term plans and other non-ACA compliant products and that such websites and brokers often fail to provide consumers with the information necessary to inform their purchase.[38] Consumer testing revealed that when consumers were shown the marketing brochure for a popular six-month short-term plan, few could initially understand the concept of a short-term plan; they assumed that it would offer the same coverage and benefits as typical health plans. They also struggled to understand what could be considered a pre-existing condition and the plan's cost implications.[39]

The FTC is challenging short term plans on the grounds that they mislead consumers into thinking they are buying comprehensive policies that would cover pre-existing conditions even though they fail to cover routine medical expenses and leave consumers with uncovered medical bills.[40] In December 2018, the Florida Sun Sentinel reported that "nearly 37,000 consumers

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[37] Karen Pollitz, M. L., *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/

[38] S. Corlette, K. Lucia, D. Palanker, and O. Hoppe, *The Marketing of Short-Term Health Plans: An Assessment of Industry Practices and State Regulatory Responses,* Robert Wood Johnson Foundation and Urban Institute (Jan. 31, 2019), https://www.rwjf.org/en/library/research/2019/01/the-marketing-of-short-term-health-plans.html.

[39] Kleimann Communication Group, *Report on Testing Consumer Understanding of a Short-Term Health Insurance Plan.* Atlanta: Georgians for a Healthy Future on behalf of consumer representatives to the National Association of Insurance Commissioners (Mar. 15, 2019), https://healthyfuturega.org/wp-content/uploads/2019/04/Consumer-Testing-Report_NAIC-Consumer-Reps.pdf.

[40] https://www.ftc.gov/system/files/documents/cases/simple_health_ca11_ftc_response_to_stay_motion_3-27-19.pdf.

continued to pay $6.3 million in monthly premiums for insurance plans the FTC says are nearly worthless."[41] The Pennsylvania Insurance Commissioner recently testified about a consumer who was left with a bill of over $16,000 with her short term limited duration plan when the enrollee suffered an injury at work which landed her in the hospital's intensive care unit. She was left with this large bill because her plan's maximum benefit for various services fell far short of charges, and because she had a hefty deductible and coinsurance.[42]

The Trump Administration's rule is increasing the sale of short-term plans. EHealth told investors in October that it saw an 18 percent jump in enrollment in short-term plans in 2018.[43] These plans not only leave individuals without adequate coverage (which is completely counter to the purposes of the ACA), but because they target healthier individuals, they adversely impact the risk pool for ACA compliant coverage, causing the price of those plans to rise.

2. The Trump Administration issued rules that expand the use of Association Health Plans (AHPs) which not only undermine consumer protections but also put individuals at risk of purchasing fraudulent and insolvent health plans.

Prior to the ACA, Association Health Plans (AHPs) had been sold to associations of large employers, associations of small employers, and associations that included self-employed people.[44] Many AHPs, however, became insolvent or were used by scam operators to defraud consumers of millions of dollars. For example, "between 2000 and 2002, 144 such operations

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[41] R. Hurtibise, South Florida Sun Sentinel, *37,000 victims still paying $6.3 million monthly for 'scam' health insurance* (Dec. 28, 2018), https://www.sun-sentinel.com/business/fl-bz-simple-health-37k-victims-paying-6-million-a-month-20181227-story.html.

[42] Jessica Altman, Testimony Before the House Energy and Commerce Committee Subcommittee on Health (Feb. 13, 2019), https://energycommerce.house.gov/sites/democrats.energycommerce.house.gov/files/documents/Testimony-Altman-ACA%20Leg%20Hearing-021319.pdf.

[43] Applebee, op cit.

[44] Mila Kofman, J.D, *Association Health Plans: Loss of State Oversight Means Regulatory Vacuum and More Fraud*, Georgetown University (2005), https://hpi.georgetown.edu/ahp/.

left over 200,000 policyholders with over $252 million in medical bills and without health insurance," forcing some victims into bankruptcy and leaving some with "lifelong physical conditions as a result of delayed or foregone medical care."[45]

The ACA addressed the problems associated with AHPs in several ways: it requires registration, allows for federal cease and desist orders in cases of fraud, and provides for confidential communication among states and the federal government regarding investigation and enforcement.[46] In 2011 guidance, the Obama Administration determined that, in most cases, the size of the individual employer participating in an association, and not the size of the association, determines whether an employer's coverage is subject to small group, large group, or individual health insurance market rules; hence, health insurance policies sold thorough an association to individuals must comply with the ACA's individual market protections, while associations marketed to small employers must comply with small-group coverage rules.[47]

The Trump Administration drastically loosen federal regulation in an effort to allow more associations of small employees to obtain health coverage in the large group market, which lacks many consumer protections associated with individual and small group coverage. 83 Fed. Reg. 28,912 (Jun. 21, 2018). The Administration did so by loosening the longstanding test under which associations were treated as *bona fide* associations that could claim to be a large employer. The rule allows "working owners" (self-employed people) to purchase insurance coverage through associations that would not be subject to the ACAs benefit requirements for individuals

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[45] *Id.*

[46] US District Court for the District of Columbia Opinion, State of New York v U.S. Department of Labor, et al, Civil Action 18-1747 (Mar. 28, 2019), https://ecf.dcd.uscourts.gov/cgi-bin/show_public_doc?2018cv1747-79.

[47] *See* CMS Insurance Standards Bulletin Series (September 1, 2011), https://www.cms.gov/CCIIO/Resources/Files/Downloads/association_coverage_9_1_2011.pdf.

or small groups, nor requirements to participate in the same risk pool with other individual insurers. 83 Fed. Reg. 614 (Jan. 5, 2018).

On March 28, 2019, the D.C. District Court struck down the final rule, explaining problems with all aspects of the rule and zeroing in on the rule's absurd treatment of "working owners" as employers who then would no longer receive the protections that apply to individual consumers under the ACA. The court noted that the final rule was "intended and designed to end run the requirements of the ACA but it does so only by ignoring the language and the purpose of both ERISA and the ACA." *New York* v. *United States Dep't of Labor*, 363 F. Supp. 3d 109 (D.D.C. 2019). Despite this court ruling, the Administration's guidance on the Department of Labor website still allows ASPs to be sold to "working owners without other employees (including sole-proprietors) and their families will be permitted to join AHPs." It says that "[t]he Department disagrees with the District Court's ruling and is considering all available options."

3. Together, the AHP and STLDI rules, if allowed to stand, will cause millions of people to lose health insurance protections they were provided under the ACA.

The Congressional Budget Office (CBO) and the Joint Committee on Taxation (JCT) predict that 3.1 million people who would otherwise have been insured in the small group market, and .9 million people who would otherwise have been insured in the nongroup market, will instead buy STLDI or AHPs as a result of these two new rules.[48] Thus, by the government's own estimates, 4 million people will lose important consumer protections and may be left without coverage for important services. CBO and JCT also predict that the rules will result in a 3 percent premium increase for people in compliant plans. [49]

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[48] Congressional Budget Office, *How CBO and JCT Analyzed Coverage Effect s of New Rules for Association Health Plans and Short-Term Plans* (Jan. 2019), https://www.cbo.gov/system/files/2019-01/54915-New_Rules_for_AHPs_STPs.pdf.

[49] *Id.*

4. Private web broker and insurance company websites exacerbate the problem of non-compliant plans.

Many people use websites other than the marketplace to enroll in marketplace plans and apply for ACA subsidies. This pathway is called direct enrollment in which insurance companies and brokers (including web-based brokers) use their own websites to help people enroll in marketplace plans and access subsidies. 81 Fed. Reg. 12,204, 12, 258 (Mar. 8, 2016).[50] Because direct enrollment entities are now permitted to offer a greater number of non-compliant plans on their websites (plans that are do not cover pre-existing conditions or cover essential health benefits) consumers are at even greater risk. Since insurers are not required to limit administrative expenses for these products as they would for ACA-compliant individual health insurance, they may pay higher broker commissions for the sale of non-compliant plans, and so direct enrollment entities have financial incentives to enroll consumers into the non-compliant plans.[51] In fact, some direct enrollment websites use screening tools that shift consumers to these non-compliant plans and away from the marketplace application process.[52]

CONCLUSION

The Trump Administration has taken steps that are contrary to the goals of the ACA and have started to move the county backwards. This Court should deny Defendants' Motion to Dismiss.

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[50] https://www.govinfo.gov/content/pkg/FR-2016-03-08/pdf/2016-04439.pdf.

[51] Kevin Lucia *et al.*, Urban Institute, *Views From the Market: Insurance Brokers' Perspectives on Changes to Individual Health Insurance*, (Aug. 2018), https://www.rwjf.org/content/dam/farm/reports/issue_briefs/2018/rwjf447745.

[52] Center on Budget and Policy Priorities,*"Direct Enrollment" in Marketplace Coverage Lacks Protections for Consumers, Exposes Them to Harm* (Mar. 15, 2019), https://www.cbpp.org/research/health/direct-enrollment-in-marketplace-coverage-lacks-protections-for-consumers-exposes. *See also*, https://www.urban.org/research/publication/marketing-short-term-health-plans-assessment-industry-practices-and-state-regulatory-responses/view/full_report.

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