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*.	Case No. 1:18-cv-02364-DKC

BRIEF OF U.S. HOUSE OF REPRESENTATIVES AS *AMICUS CURIAE* IN SUPPORT OF PLAINTIFFS

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INTEREST OF *AMICUS CURIAE*[1]

Amicus curiae is the United States House of Representatives ("the House"),[2] which has a strong institutional interest in the effective implementation of the Patient Protection and Affordable Care Act ("the Affordable Care Act" or "the Act") and ensuring that the millions of Americans who have benefited from its reforms and protections continue to do so. In 2010, the House passed the Affordable Care Act after significant study into the problems with then-existing health insurance markets, and the House is thus particularly well suited to explain to the Court why Congress enacted this landmark legislation and how it has helped ensure that all Americans, including those with preexisting conditions, have access to quality, affordable health insurance. During the 116th Congress, the House has held multiple hearings on actions taken by President Trump and his Administration that threaten to undermine the benefits and protections provided by the Act, and thus *amicus* also has unique knowledge about, and a strong interest in, the question whether the Trump Administration's actions are consistent with the plan that Congress put in place when it passed the Affordable Care Act.

INTRODUCTION

In 2010, Congress passed the Affordable Care Act, a landmark law that sought to achieve "near-universal coverage," 42 U.S.C. § 18091(2)(D), by making quality, affordable health

[1] No person or entity other than *amicus* and its counsel assisted in or made a monetary contribution to the preparation or submission of this brief.

[2] The Bipartisan Legal Advisory Group (BLAG) of the United States House of Representatives has authorized the filing of an *amicus* brief in this matter. The BLAG comprises the Honorable Nancy Pelosi, Speaker of the House, the Honorable Steny H. Hoyer, Majority Leader, the Honorable James E. Clyburn, Majority Whip, the Honorable Kevin McCarthy, Republican Leader, and the Honorable Steve Scalise, Republican Whip, and "speaks for, and articulates the institutional position of, the House in all litigation matters." Rules of the U.S. House of Representatives (116th Cong.), Rule II.8(b), *available at* https://tinyurl.com/HouseRules116thCong. The Republican Leader and Republican Whip dissented.

insurance available to all Americans. When Congress passed the Affordable Care Act, it was responding to serious problems affecting America's insurance and health care systems. Many employers failed to offer coverage to their employees, and only a limited number of individuals were eligible for government health insurance programs like Medicaid. Moreover, those who could not obtain coverage through their employer or Medicaid were forced to try their luck in the individual marketplace. That marketplace was plagued with sky-high prices, care that was not comprehensive, and discriminatory practices that prevented millions of Americans from obtaining coverage. As a result, one-seventh of the American population lacked health insurance.

In response to these systemic flaws, Congress passed the Affordable Care Act "to increase the number of Americans covered by health insurance and decrease the cost of health care." *Nat'l Fed'n of Indep. Bus. v. Sebelius* (*NFIB*), 567 U.S. 519, 538 (2012) (opinion of Roberts, C.J.). The law thus includes a number of provisions designed to expand access to health insurance to as many Americans as possible. First, it expands Medicaid to all low-income individuals. Second, it prevents insurers from discriminating on the basis of preexisting conditions, and includes a number of other protections designed to ensure that insurers offer comprehensive care to a wide swath of consumers. Third, it creates a system of American Health Benefit Exchanges ("Exchanges") whereby individuals who do not receive health insurance through their employer or through Medicaid can easily compare and purchase health insurance in the individual marketplace, and it provides tax credits to subsidize the cost of insurance for many lower- and middle-income individuals. Finally, the Act includes many provisions designed to assist individuals with obtaining coverage on the Exchanges. These various provisions were all designed with one primary goal in mind: to reduce the number of Americans who do not have access to quality, affordable coverage.

Over the last two years, the Trump Administration has repeatedly taken steps to undermine Congress's goal of expanding coverage. For instance, the Centers for Medicare and Medicaid Services recently promulgated a Rule that ends the requirement that Exchanges provide "standardized options," which make it easier for consumers to compare plans and more likely that they will purchase insurance. *See* Notice of Benefit and Payment Parameters for 2019, 83 Fed. Reg. 16,930, 16,974-75 (Apr. 17, 2018). That same Rule also ends the requirement that Navigators—entities that assist individuals with signing up for insurance—have a physical presence in the area they serve, seriously undermining their effectiveness. The Administration has also taken steps designed to reduce enrollment on the Exchanges. The Administration has, among many other things, shortened the open enrollment period, drastically reduced funding for advertisements to educate consumers about the Exchanges, cut funding for Navigators, and failed to set numeric enrollment targets. Through all of these actions, the Administration has undermined the Affordable Care Act, and it has harmed the millions of Americans who depend on the Act to access quality, affordable health insurance.

ARGUMENT

THE AFFORDABLE CARE ACT WAS DESIGNED TO EXPAND HEALTH CARE BENEFITS AND PROTECTIONS, YET THE TRUMP ADMINISTRATION HAS MADE SIGNIFICANT EFFORTS TO UNDERMINE THAT GOAL.

A. The Affordable Care Act Responded to Serious Problems in America's Health Care System That Had Left Millions Without Quality, Affordable Insurance.

Congress passed the Affordable Care Act in response to serious problems plaguing America's health care system. *See* H.R. Rep. No. 111-299, Pt. 3, at 55 (2009) ("The U.S. health care system is on an unsustainable course."). In 2007, "more than 45.7 million people were uninsured . . . , representing more than one-seventh of the population." H.R. Rep. No. 111-299, Pt. 1, at 320 (2009). This uninsured rate was caused by a number of different factors. First, while

almost all large employers offered their employees health insurance benefits, "[l]ess than half of all small employers (less than 50 employees) offer[ed] health insurance coverage to their employees." *Id.* at 322. Indeed, there was "no federal requirement that employers offer health insurance coverage to employees or their families." H.R. Rep. No. 111-299, Pt. 3, at 134.

Second, at the time the Affordable Care Act was passed, health care costs were skyrocketing, making it difficult for most Americans to purchase their own insurance in the individual marketplace. "Between 1999 and 2008, health insurance premiums more than doubled as wages largely stagnated." *Id.* at 55-56 (citing testimony of Jacob Hacker).[3] On top of that, the United States "spen[t] substantially more than other developed countries on health care, both per capita and as a share of GDP." H.R. Rep. No. 111-299, Pt. 1, at 320. This dramatic increase in health care costs affected employers—who "face[d] a growing challenge paying for health benefits while managing labor costs to succeed in a competitive market," *id.*—and federal and state budgets—"both directly, through spending on Medicare, Medicaid, and other programs, and indirectly, through tax expenditures for health insurance and expenses," *id.* at 320-21.

Third, insurance companies in many States were permitted to discriminate against individuals with preexisting conditions. Because "'20 percent of the population account[ed] for 80 percent of health spending'" in 2009, "health insurers—particularly in the individual market— . . . adopted discriminatory, but not illegal, practices to cherry-pick healthy people and to weed out those who [we]re not as healthy." H.R. Rep. No. 111-299, Pt. 3, at 92 (quoting testimony of Karen Pollitz). Such practices included: "denying health coverage based on pre-

[3] *See* David Blumenthal & Sara Collins, *Where Both the ACA and AHCA Fall Short, and What the Health Insurance Market Really Needs*, Harv. Bus. Rev. (Mar. 21, 2017), https://hbr.org/2017/03/where-both-the-aca-and-ahca-fall-short-and-what-the-health-insurance-market-really-needs ("premiums for . . . policies [in the individual market] were increasing more than 10% a year, on average, while the policies themselves had major deficiencies").

existing conditions or medical history, even minor ones; charging higher, and often unaffordable, rates based on one's health; excluding pre-existing medical conditions from coverage; charging different premiums based on gender; and rescinding policies after claims [we]re made based on an assertion that an insured's original application was incomplete." *Id.* As a result of these practices, "many uninsured Americans—ranging from 9 million to 12.6 million—voluntarily sought health coverage in the individual market but were denied coverage, charged a higher premium, or offered only limited coverage that excludes a preexisting condition." *Fla. ex rel. Atty. Gen. v. U.S. Dep't of Health & Human Servs.*, 648 F.3d 1235, 1245 (11th Cir. 2011), *aff'd in part, rev'd in part by NFIB*, 567 U.S. 519. Congress found that "[d]iscrimination based on health, gender and other factors has severe economic consequences for those who have been unable to find affordable health coverage and for those who have coverage, but are under-insured." H.R. Rep. No. 111-299, Pt. 3, at 92.

Finally, millions of Americans who were not provided insurance benefits by their employers and could not afford or were denied coverage in the individual market were also ineligible for insurance through government programs like Medicaid. Indeed, at the time, Medicaid offered federal funding to States only "to assist pregnant women, children, needy families, the blind, the elderly, and the disabled in obtaining medical care." *NFIB*, 567 U.S. at 541 (citing 42 U.S.C. § 1396a(a)(10)).

B. Congress Passed the Affordable Care Act To Expand Access to Quality, Affordable Health Insurance, and the Act's Reforms Have Been Remarkably Successful.

In light of these serious and systemic problems that had resulted in millions of Americans who could not access quality, affordable health insurance, Congress passed the Affordable Care Act "to expand coverage" while keeping health care costs in check. *King v. Burwell*, 135 S. Ct. 2480, 2485 (2015); *see NFIB*, 567 U.S. at 538 ("The Act aims to increase the number of Americans

covered by health insurance and decrease the cost of health care."); 42 U.S.C. § 18091(2)(D) (the Act aims to achieve "near-universal coverage"). It does so in three primary ways. First, the Act expands Medicaid to provide funding to States to provide coverage to all individuals earning up to 133% of the federal poverty level. *See id*. § 1396a(a)(10)(A)(i)(VIII). This expansion was estimated to provide coverage to millions of Americans. *See CBO's Analysis of the Major Health Care Legislation Enacted in Mar. 2010 Before the H. Subcomm. on Health of the Comm. on Energy & Com*., 112th Cong. 22-23 (Mar. 30, 2011) (statement of Douglas Elmendorf, Director, Cong. Budget Office).

Second, the Act includes various market reforms designed to expand access to insurance coverage. For instance, the Act requires large employers to offer insurance to their employees or pay a penalty, 26 U.S.C. § 4980H; to automatically enroll new and current employees of large employers in an employer-sponsored plan unless an employee opts out, 29 U.S.C. § 218a; and to offer adequate health insurance plans, 26 U.S.C. § 4980H(a). The Act also includes numerous other important provisions that, for example, prohibit insurers from imposing lifetime dollar limits on the value of coverage, 42 U.S.C. § 300gg-11; prohibit insurers from rescinding coverage except in the case of fraud, *id.* § 300gg-12; require individual and group health plans to cover preventive services without cost sharing, *id.* § 300gg-13; and allow children to stay on their parents' health insurance until age 26, *id.* § 300gg-14.

The Act further addresses the inadequacy of benefits in the individual and small group markets by expressly providing that insurance offered in those markets must include "essential health benefits." 42 U.S.C. § 300gg-6(a) ("A health insurance issuer that offers health insurance coverage in the individual or small group market shall ensure that such coverage includes the essential health benefits package required under section 18022(a) of this title."). While the law

gave the Secretary of Health and Human Services authority to define what those "essential health benefits" would be, the law specified that "such benefits shall include at least the following general categories": ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance abuse disorder services, prescription drugs, rehabilitative and habilitative services, laboratory services, preventive and wellness services and chronic disease management, and pediatric services, including oral and vision care. *Id.* § 18022(b)(1). All of these reforms were designed to allow more Americans access to comprehensive insurance coverage.

Third, the Act includes reforms that ensure that no American is denied the ability to purchase health insurance. The Act prevents discrimination on the basis of preexisting conditions by including a guaranteed-issue provision prohibiting insurers from denying coverage to any individual because of a medical condition or their medical history, *see id.* §§ 300gg-1, 300gg-3, 300gg-4, and a community-rating provision prohibiting insurers from charging higher premiums because of an individual's preexisting medical conditions, *id*. §§ 300gg(a), 300gg-4(b).

Finally, for individuals who are not eligible for Medicaid and do not receive insurance from their employer, the Act provides for the creation of Exchanges through which individuals can purchase health insurance for themselves and their families. The Act "requires the creation of an 'Exchange' in each State where people can shop for insurance, usually online." *King*, 135 S. Ct. at 2487 (citing 42 U.S.C. § 18031(b)(1)). Generally, States were tasked with setting up these Exchanges, *see* 42 U.S.C. § 18031(b)(1), but if a State declined to do so, the Secretary of Health and Human Services was required to "establish and operate such Exchange within the State." *Id.*

§ 18041(c)(1).[4] The Act then "s[ought] to make insurance more affordable by giving refundable tax credits to individuals with household incomes between 100 percent and 400 percent of the federal poverty line." *King*, 135 S. Ct. at 2487 (citing 26 U.S.C. § 36B). "Individuals who meet the Act's requirements may purchase insurance with the tax credits, which are provided in advance directly to the individual's insurer." *Id.* (citing 42 U.S.C. §§ 18081, 18082); *see King v. Burwell*, 759 F.3d 358, 364 (4th Cir. 2014), *aff'd by King*, 135 S. Ct. 2480 ("The Exchanges facilitate this process by advancing an individual's eligible tax credit dollars directly to health insurance providers as a means of reducing the upfront cost of plans to consumers."). The Act also requires insurers to reduce certain cost-sharing expenses—like deductibles and co-payments—for lower income individuals, and requires the Department of Health and Human Services to reimburse insurers for these cost-sharing reductions. *See* 42 U.S.C. § 18071.

The existence of the Exchanges and tax credits for purchasing insurance is critical to Congress's goal of expanding coverage: the Exchanges allow individuals to explore different insurance plans for themselves and their families and to purchase insurance online, while the tax credits make this coverage affordable for lower income Americans who are ineligible for Medicaid. Moreover, because the Exchanges work most effectively when "[i]ndividual enrollment" is sufficiently high, and there is a "balanced risk pool,"[5] the Act included a number of different provisions to facilitate enrollment. For example, the Act requires Exchanges to "provide for the operation of a toll-free telephone hotline to respond to requests for assistance," 42 U.S.C. § 18031(d)(4)(B), and "an Internet website through which enrollees and prospective enrollees of

[4] As of 2018, 12 States operate State Exchanges, 28 States rely on the federal government to run their Exchanges, and 11 States have a hybrid Exchange of some sort. Am. Compl. 14, ¶ 38.

[5] American Academy of Actuaries, *An Evaluation of the Individual Health Insurance Market and Implications of Potential Changes* 1 (Jan. 2017), https://www.actuary.org/files/publications/Acad_eval_indiv_mkt_ 011817.pdf.

qualified health plans may obtain standardized comparative information on such plans," *id.* § 18031(d)(4)(C), and to "utilize a standardized format for presenting health benefits plan options," *id.* § 18031(d)(4)(E), including "assign[ing] a rating to each qualified health plan offered through [an] Exchange," *id.* § 18031(d)(4)(D).

Moreover, Exchanges are required to "establish [a] Navigator program," *id.* § 18031(d)(4)(K), which by law awards grants to entities that "conduct public education activities to raise awareness of the availability of qualified health plans," *id.* § 18031(i)(3)(A), "distribute fair and impartial information" about enrollment and the availability of tax credits and cost-sharing reductions, *id.* § 18031(i)(3)(B), and "facilitate enrollment in qualified health plans," *id.* § 18031(i)(3)(C). The Secretary of Health and Human Services is tasked with "establish[ing] standards for navigators . . . , including provisions to ensure that any private or public entity that is selected as a navigator is qualified, and licensed if appropriate, to engage in the navigator activities." *Id.* § 18031(i)(4)(A).

These reforms are designed to fulfill Congress's goal of expanding coverage and ensuring that the coverage that individuals receive meets a baseline standard of comprehensiveness at a reasonable cost. Every provision—from the expansion of Medicaid to millions of Americans, to the establishment of Exchanges, to the creation of the Navigator system to assist individuals with obtaining coverage—was designed to fulfill that goal.

The Act has been wildly successful in ameliorating the immense public health problem caused by having so many Americans without adequate health insurance. As of 2016, approximately 12.7 million more people had purchased plans in the individual market through the state and federal Exchanges than before the Affordable Care Act was passed. Namrata Uberio et al., *Health Insurance Coverage and the Affordable Care Act, 2010-2016* at 8, Dep't of Health &

Human Servs. (Mar. 3, 2016), https://aspe.hhs.gov/system/files/pdf/187551/ACA2010-2016.pdf. And approximately 14.5 million more people began receiving comprehensive benefits through Medicaid and the Children's Health Insurance Program (CHIP). *Id.* Overall, there has been a net gain of 20 million Americans with health insurance coverage. *Id.* This gain spans many generational, ethnic, and racial groups, and has particularly benefited women, younger people, and Black and Hispanic individuals. *Id.* at 2.

C. The Administration's Various Actions Undermine the Affordable Care Act.

Despite the success of the Affordable Care Act, the President and his Administration have taken various actions to undermine the Act and thwart its achievement of the important public health goal of "near-universal coverage." 42 U.S.C. § 18091(2)(D). Those actions threaten to harm the millions of Americans who have benefited, and continue to benefit, from the Affordable Care Act's benefits and protections. Just a few examples suffice to show how the Administration has repeatedly sought to undermine the Act.

First, the Centers for Medicare and Medicaid Services (CMS) promulgated a final Rule that undermines the Exchanges. *See* Notice of Benefit and Payment Parameters for 2019, 83 Fed. Reg. 16,930 (Apr. 17, 2018). As discussed earlier, Congress created Exchanges to improve access to health insurance for individuals who cannot obtain it through an employer or through a government program like Medicaid. Indeed, the very purpose of the Exchanges was to make it easy for individuals who could not otherwise obtain insurance to purchase it on the individual market and thereby bring in a broad pool of consumers. Yet the CMS Rule makes it harder for individuals to purchase insurance on the Exchanges. For example, the Rule discontinues the requirement that Exchanges provide "standardized options" for health care plans, which help consumers understand the different levels of coverage and compare different plans within each level. *Id.* at 16,974-75. This change was promulgated despite the Department of Health and

Human Services' own prior findings that "[a]n excessive number of health plan options makes consumers less likely to make any plan selection, more likely to make a selection that does not match their health needs, and more likely to make a selection that leaves them less satisfied." HHS Notice of Benefit and Payment Parameters for 2017, 80 Fed. Reg. 75,488, 75,542 (Dec. 2, 2015) (proposed rule).

The Rule also eliminates the requirement that Navigators have physical presences in the areas they serve. *See* 83 Fed. Reg. at 16,979-81. This change reduces the effectiveness of the Navigator program. The physical-presence requirement was previously imposed "so that face-to-face assistance can be provided to applicants and enrollees." Exchange and Insurance Market Standards for 2015 and Beyond, 79 Fed. Reg. 15,808, 15,832 (Mar. 21, 2014). Indeed, numerous studies have found that in-person assistance can make a big difference in improving rates of enrollment.[6] Thus, as Plaintiffs allege, undoing these requirements would "dampen overall enrollment, especially among vulnerable populations, and thereby increase the rate of the uninsured." Am. Compl. 43, ¶ 79.

Some of the Rule's changes are more subtle, but will nonetheless reduce the effectiveness of the Exchanges. For instance, the Rule permits Exchanges to deny tax credits *without notice* to individuals who do not reconcile the amount of credit they receive in advance with the amount that should be allowed on their tax returns. 83 Fed. Reg. at 16,982-85. This change could reduce enrollment because "[t]he unexpected loss of this assistance would likely cause many if not most

[6] *See, e.g.*, Adrian Garcia Mosqueira & Benjamin D. Sommers, *Better Outreach Critical to ACA Enrollment, Particularly for Latinos*, The Commonwealth Fund (Jan. 14, 2016), http://www.commonwealthfund.org/publications/blog/2016/jan/better-outreach-critical-to-aca-enrollment-particularly-for-latinos; Jennifer Tolbert et al., *Connecting Consumers to Coverage: Lessons Learned from Assisters for Successful Outreach and Enrollment* 2 (Sept. 19, 2014), http://files.kff.org/attachment/connecting-consumers-to-coverage-issue-brief.

individuals to drop coverage entirely, especially since they will not know why they lost it or how to remedy their loss." Am. Compl. 33, ¶ 56. Similarly, the Rule substantially scales back oversight of insurance brokers who assist individuals with signing up for insurance, despite evidence that these brokers were often "committing fraud, signing up individuals without their knowledge or consent, and using inaccurate calculators for [tax credit] eligibility." *Id.* at 37, ¶ 65. This change "will increase the likelihood that consumers receive inaccurate information, thus decreasing overall enrollment and leading to a rise in the rate of the uninsured." *Id.* at 38, ¶ 68.

This Administration has also taken other actions outside the Rule that undermine the law's purpose of achieving near-universal coverage. First, the Administration has reduced the open enrollment period on Exchanges—the period during which individuals can enroll in coverage—from 3 months to 1.5 months. Market Stabilization, 82 Fed. Reg. 18,346, 18,353-55 (Apr. 18, 2017); *see* 45 C.F.R. § 155.410(e) (2017). As studies have recognized, reducing the enrollment period will reduce the number of enrollees.[7]

Second, the Administration has drastically reduced funding for advertisements to educate consumers about the Exchanges and their insurance options. For instance, during open enrollment that began in November of 2017, the Administration spent only $10 million, 90% less than the previous year, on advertising. Am. Compl. 78, ¶ 147. However, Congressional hearings have made clear that advertising is critical to successfully enrolling a broad base of consumers. For instance, at a recent hearing, one witness testified that a multi-year study conducted by CMS itself

[7] *See, e.g.*, Paul R. Shafer et al., *Television Advertising and Health Insurance Marketplace Consumer Engagement in Kentucky: A Natural Experiment*, 20 J. Med. Internet Res. *1, *7 (2018) (finding that "shortening the open enrollment period from 90 to 45 days . . . could have further negative consequences [for ACA enrollment]," particularly as the new period is dominated by the Thanksgiving week, which sees "large drops in [enrollment] activity").

"demonstrated the causal relationship between advertising and enrollment."[8] And another testified that "insurers increased premiums due to the Trump Administration's decision to decrease spending on marketplace advertising and consumer assistance."[9] The research confirms this testimony.[10]

Third, the Administration has cut funding for Navigators to one-sixth the amount of funding previously provided. Am. Compl. 87, ¶ 165. These funding cuts resulted in many Navigator organizations declining their awards and withdrawing from the program. U.S. Gov't Accountability Office, GAO-18-565, Health Insurance Exchanges: HHS Should Enhance Its Oversight of Open Enrollment Performance 30 (July 2018) ("GAO Study"). As numerous studies have pointed out, however, Navigator programs and similar application assistance initiatives are central to encouraging enrollment for low-income adults, and their reduction will have detrimental effects on overall enrollment and equity.[11]

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[8] *Congressional Oversight Hearing on the Impact of the Administration's Policies Affecting the Affordable Care Act Before the H. Appropriations Subcomm. on Labor, Health, & Human Servs.*, 116th Cong. (Feb. 6, 2019) (statement of Joshua Peck, co-founder, Get America Covered), https://docs.house.gov/meetings/AP/AP07/20190206/108858/HHRG-116-AP07-Wstate-PeckJ-20190206.pdf; *see id.* (noting that when the Trump Administration cut outreach and advertising during the final week of the 2016-17 open enrollment period, approximately 500,000 fewer people enrolled on the Exchanges).

[9] *Examining Threats to Workers with Preexisting Conditions Before the H. Educ. & Labor Comm.*, 116th Cong. (Feb. 6, 2019) (statement of Sabrina Corlette, Research Professor, Georgetown University's Center on Health Insurance Reforms), https://edlabor.house.gov/imo/media/doc/Testimony_Corlette0206192.pdf.

[10] *See, e.g.*, Sarah E. Gollust et al., *TV Advertising Volumes Were Associated with Insurance Marketplace Shopping and Enrollment in 2014*, 37 Health Affairs 956 (2018) (finding that the number of televised ads for health insurance, particularly those sponsored by the federal government, is positively correlated with rates of marketplace enrollment); Shafer et al., *supra*, at *1 (finding that weekly state-sponsored television advertising during the open enrollment period substantially increased enrollment and information-seeking behaviors).

[11] *See* Benjamin D. Sommers et al., *The Impact of State Policies on ACA Applications and Enrollment Among Low-Income Adults in Arkansas, Kentucky, and Texas*, 34 Health Affairs 1010,

And fourth, the Administration has failed to set numeric enrollment targets for 2018 and 2019. In prior years, the Department of Health and Human Services "used numeric targets to monitor enrollment progress during the open enrollment period and focus its resources on those consumers that it believed had a high potential to enroll in exchange coverage." GAO Study at 32. The Department failed to set such targets in 2018. *Id.* The Government Accountability Office found that "the lack of numeric enrollment targets for [the Department] to evaluate its performance with respect to the open enrollment period hamper[ed] the agency's ability to make informed decisions about its resources." *Id.* at 37.

In other words, in myriad ways, this Administration has tried to make it more difficult for individuals who need health insurance to access it through the Exchanges, even though Congress passed the Affordable Care Act to accomplish the opposite goal. When Congress passed the Affordable Care Act, it recognized that systemic problems in the health insurance markets meant that many Americans were denied critically important health insurance, and it passed the Affordable Care Act to put in place reforms to fix that. Among other things, Congress wanted to ensure that Americans who were not provided insurance by their employer or through a government program could easily go on an Exchange and purchase the best insurance option for themselves and their families. These Trump Administration actions undermine that goal.

1015, 1013 (2015) (finding that, for low-income adults, "[t]he strongest predictor of completing the application process was receiving help with enrollment from a navigator or application assister," as it increased enrollment "from 84.9 percent to 93.1 percent"); Kate Heyer et al., RAND Corp., Assessing the Role of State and Local Public Health in Outreach and Enrollment for Expander Coverage: A Case Study on Boston and Massachusetts 1, 4, 8 (2016) (eBook) (demonstrating that the navigator program was important for increasing enrollment in hard-to-reach and underserved communities).

CONCLUSION

For the foregoing reasons, the House submits this brief in support of Plaintiffs.

Dated: June 7, 2019

Respectfully submitted,
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CERTIFICATE OF SERVICE

I hereby certify that on June 7, 2019, the foregoing document was filed with the Clerk of the Court, using the CM/ECF system, causing it to be served on all counsel of record.

Dated: June 7, 2019

/s/ Brianne J. Gorod
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