EXHIBIT 1

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MARYLAND

CITY OF COLUMBUS, *et al.*,

Plaintiffs,

v.

DONALD J. TRUMP, *et al.*,

Defendants.

Case No.
Civil Action No. 1:18-cv-02364

BRIEF OF AMICUS CURIAE HENRY J. AARON IN SUPPORT OF PLAINTIFFS' OPPOSITION TO DEFENDANTS' MOTION TO DISMISS

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INTEREST OF AMICUS CURIAE

Henry J. Aaron is the Bruce and Virginia MacLaury Senior Fellow in the Economic Studies Program at the Brookings Institution. He is a scholar of health care economics and policy and is the author of many books and articles on health insurance and health care policy. He holds a Ph.D. in economics from Harvard University and previously taught at the University of Maryland from 1967 through 1989, except for 1977-1978 when he served as Assistant Secretary for Planning and Evaluation at the Department of Health, Education, and Welfare. He currently serves as a member and vice-chair of the District of Columbia Health Benefits Exchange, which oversees the administration of many of the Affordable Care Act (ACA) reforms for residents of Washington, D.C., and is also a member and former chair of the Social Security Advisory Board. He has studied the effects on health care coverage of the ACA, submitted an amicus brief on the workings of the ACA to the Supreme Court in *King v. Burwell,* No. 14-114 (U.S. Jan. 28, 2015), and also submitted a declaration about the effects of the ACA in *Texas v. United States*, No. 4:18-cv-00167-O (N.D. Tex.).

ARGUMENT

A. The Extraordinary Success Of The Affordable Care Act In Increasing Coverage Has Turned On Encouraging Consumers To Enroll In ACA-Compliant Plans

This amicus brief focuses on two types of regulatory actions by the Trump Administration: (1) efforts to encourage participation in two kinds of health care plans that do not have to comply with certain fundamental requirements for such plans under the ACA, and (2) actions with the apparent purpose and likely effect of discouraging consumers from enrolling in ACA-compliant plans. As this brief explains, those actions are fundamentally antithetical to the design of the ACA, which is intended to expand and improve health care coverage across the nation by encouraging broad participation in ACA-compliant plans, thereby addressing the

problem of adverse selection that previously drove up health care costs and has bedeviled previous efforts at health care reform.

As amicus has explained in detail elsewhere,[1] the ACA is a comprehensive law that has improved the quality and affordability of health care and health insurance. The ACA helped lower the number of people without health insurance by an estimated 20.0 million people from October 2013 to early 2016, a drop of 43 percent in the uninsured rate.[2] This increase in coverage included an estimated 3 million African-Americans, 4 million people of Hispanic origin, and 8.9 million white non-elderly adults.[3] An estimated 6.1 million young adults and 1.2 million children gained coverage between 2010 and early 2016.[4] Many studies have found that access to health care has improved since the ACA was enacted, especially among low-income people. For example, from the fall of 2013 to the spring of 2017, the share of non-elderly adults without a regular source of care fell from 30 percent to 24.7 percent; the share that did not receive a routine checkup in the last 12 months fell from nearly 40 percent to 34 percent.[5] A review of the literature in 2017 found evidence that significant improvements in access to health

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[1] *See* Decl. of Henry J. Aaron, Ph.D., in Support of Mot. to Intervene of California, et al., *Texas v. United States*, No. 4:18-cv-00167-O (N.D. Tex.), ECF No. 15-1 (filed Apr. 9, 2018).

[2] Namrata Uberoi, Kenneth Finegold & Emily Gee, *Health Insurance Coverage and the Affordable Care Act, 2010-2016*, at 2 (HHS ASPE Issue Brief, Mar. 3, 2016), https://aspe.hhs.gov/system/files/pdf/187551/ACA2010-2016.pdf.

[3] *Id.* at 3.

[4] *Id.* at 5; Executive Office of the President, Council of Economic Advisers, *2017 Economic Report of the President*, Chapter 4: Reforming the Health Care System, at 213 (U.S. Government Publishing Office, Jan. 2017), https://obamawhitehouse.archives.gov/sites/default/files/docs/chapter_4-reforming_health_care_system_2017.pdf.

There is also evidence that the ACA resulted in lower insurance premiums. For example, in New York State, where guaranteed issue and community rating requirements were in place prior to enactment of the ACA, implementing the full suite of Affordable Care Act reforms caused premiums to drop by about 50%. Roni Caryn Rabin & Reed Abelson, *Health Plan Cost for New Yorkers Set to Fall 50%*, N.Y. Times (July 16, 2013), https://www.nytimes.com/2013/07/17/health/health-plan-cost-for-new-yorkers-set-to-fall-50.html.

[5] Sharon K. Long et al., *Sustained Gains In Coverage, Access, And Affordability Under The ACA: A 2017 Update*, 36(9) Health Aff. 1656, 1658 (2017), https://www.healthaffairs.org/doi/10.1377/hlthaff.2017.0798.

insurance were associated with increased use of health care. Those gains included increased use of outpatient care, greater rates of having a usual source of care or personal physician, increased use of preventive services, increased prescription drug use and adherence, improved access to surgical care,[6] and more timely cancer treatment.[7] Racial and ethnic disparities in access to care fell following the expansion of coverage.[8]

Before the ACA's enactment, insurers could lawfully lower risks associated with offering health insurance by denying coverage for preexisting conditions, capping annual and lifetime benefits they would pay out under a plan, and excluding from plans various important benefits and treatments.[9] In part because of such strategies, many Americans were exposed to serious risks even when insured: According to the Commonwealth Fund, nearly 20 percent of adults under age 65 lacked health insurance in 2012, and another 16 percent were underinsured.[10]

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[6] Benjamin D. Sommers, Atul A. Gawande, & Katherine Baicker, *Health Insurance Coverage and Health: What the Recent Evidence Tells Us*, 377(6) New Eng. J. Med. 586 (2017), http://www.nejm.org/doi/full/10.1056/NEJMsb1706645.

[7] *See, e.g.*, Laurie McGinley, *ACA Linked to Reduced Racial Disparities, Earlier Diagnosis and Treatment in Cancer Care*, Wash. Post (June 2, 2019), https://www.washingtonpost.com/health/2019/06/02/aca-linked-reduced-racial-disparities-earlier-diagnosis-treatment-cancer-care.

[8] Jie Chen et al., *Racial and Ethnic Disparities in Health Care Access and Utilization under the Affordable Care Act*, 52(2) Med. Care 140 (2016), https://www.ncbi.nlm.nih.gov/pubmed/26595227; Benjamin D. Sommers et al., *Changes in Self-Reported Insurance Coverage, Access to Care, and Health Under the Affordable Care Act*, 314(4) JAMA 366 (2015), https://jamanetwork.com/journals/jama/fullarticle/2411283.

[9] Gary Claxton, Larry Levitt, & Karen Pollitz, *Pre-ACA Market Practices Provide Lessons for ACA Replacement Approaches*, (Henry J. Kaiser Family Foundation, Feb 16, 2017), https://www.kff.org/health-costs/issue-brief/pre-aca-market-practices-provide-lessons-for-aca-replacement-approaches/.

[10] Sara R. Collins, Herman K. Bhupal, & Michelle M. Doty, *Health Insurance Coverage Eight Years After the ACA*, Commonwealth Fund (Feb. 7, 2019), https://www.commonwealthfund.org/publications/issue-briefs/2019/feb/health-insurance-coverage-eight-years-after-aca. The study defines "underinsured" individuals as adults who were insured all year but experienced one of the following: out-of-pocket costs, excluding premiums, equaled 10% or more of income; out-of-pocket costs, excluding premiums, equaled 5% or more of income if low-income (<200% of poverty); or deductibles equaled 5% or more of income. *Id.*

The ACA's consumer protections addressed several common obstacles to obtaining affordable, meaningful health insurance. Subject to narrow exceptions discussed below, the ACA requires all health plans to cover preexisting conditions. It also prohibits insurers from denying claims based on preexisting conditions or varying premiums based on the insured's health status.[11] In addition, the ACA prohibits caps on annual and lifetime benefits, a provision that protects those who require costly treatment.[12] The ACA also requires insurance plans to cover a set of "Essential Health Benefits," including (1) ambulatory patient services, (2) emergency services, (3) hospitalization, (4) maternity and newborn care, (5) mental health and substance use disorders, including behavioral health treatment, (6) prescription drug coverage, (7) rehabilitative and habilitative services and devices, (8) laboratory services, (9) preventive and wellness services and chronic disease management, and (10) pediatric services, including oral and vision care. [13] Before the ACA's enactment, insurers frequently had omitted such services from plans, but the ACA required that compliant health insurance policies plans provide those important benefits.[14]

Fundamental to the success of the ACA is enrollment of as many people as possible in ACA-compliant plans. Health insurance, like all insurance, operates on the principle of risk pooling: Individuals who are currently relatively healthy and younger pool with others, in

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[11] *See* 42 U.S.C. § 300gg-4(b) (prohibiting insurers from setting premiums based on health status); 42 U.S.C. § 300gg-1 (requiring insurers to issue coverage to every individual); 42 U.S.C. § 300gg-3 (prohibiting insurers from issuing plans with pre-existing condition exclusions.).

[12] *See* 42 U.S.C. § 300gg-11 (prohibiting insurers from imposing both annual and lifetime limits on the dollar value of benefits).

[13] *See* 46 U.S.C. § 18022 (defining "essential health benefits" as including "at least [these ten enumerated] general categories and the items and services covered within the categories").

[14] Amy Jeter & Craig Palosky, *Analysis: Before ACA Benefits Rules, Care for Maternity, Mental Health, Substance Abuse Most Often Uncovered by Non-Group Health Plans* (Henry J. Kaiser Family Foundation, June 14, 2017), https://www.kff.org/health-reform/press-release/analysis-before-aca-benefits-rules-care-for-maternity-mental-health-substance-abuse-most-often-uncovered-by-non-group-health-plans/.

recognition of the fact that people who are young and healthy today will age and experience increasing illness in the future. Efforts to broaden health care coverage and achieve balanced pools have always confronted the issue of adverse selection: Younger and healthier individuals have a natural desire to form separate groups or to buy relatively skimpy policies, whereas older and less healthy individuals generally prefer more comprehensive policies. The ACA deploys numerous strategies to counteract adverse selection, including premium subsidies that make insurance more affordable for those with low incomes, prohibitions on insurance policies that do not comply with the ACA's fundamental coverage requirements, and extensive efforts to promote and facilitate broad enrollment in ACA-compliant plans.

This brief addresses recent regulatory actions by the Trump Administration that tend to undermine the latter two objectives. As explained below, those measures encourage enrollment in non-compliant plans or obstruct enrollment in compliant plans. Those actions will divert enrollment from ACA-compliant plans in a manner antithetical to Congress's intent in enacting the ACA. Those measures will increase the cost of ACA-compliant insurance. They will cause consumers either to forgo health care or to seek uncompensated care, much of it from jurisdictions like the plaintiffs, which support health care providers of last resort. In short, the measures described here clash fundamentally with congressional intent as expressed in the ACA.

B. The Expansion Of Short-Term, Limited-Duration Insurance Policies And Association Health Plans Will Increase The Cost Of ACA-Compliant Plans And Force Uninsured And Under-Insured Individuals To Seek Uncompensated Care

For consumers to benefit fully from the ACA's promise, it is essential that they broadly participate in ACA-compliant plans. That broad participation will make health plans accessible at affordable prices. However, recent actions by the Trump Administration have significantly expanded two types of plans—Short-Term, Limited-Duration Insurance ("STLDI") policies and

Association Health Plans ("AHPs")—that are not subject to many of the ACA's requirements. By promoting those plans, which will divert consumers from ACA-compliant plans, the Administration's actions are likely to drive up the cost of ACA-compliant insurance and to force underinsured individuals to seek uncompensated care.

STLDI policies were originally designed to provide health insurance for brief periods during which consumers experienced a gap in standard coverage—for example, because they were between jobs.[15] Under the ACA, STLDI policies are not required to cover preexisting conditions, may impose caps on annual and lifetime benefits, and need not comply with the essential health benefits requirements.[16] Insurers offering STLDI policies have taken advantage of those exceptions. A recent study of available STLDI plans found that 43 percent failed to cover mental health services, 62 percent did not cover substance abuse treatment, 71 percent did not cover outpatient prescription drugs, and *none* covered maternity care.[17] Moreover, *all* of the plans in the study excluded coverage for preexisting conditions, the coverage of which was a prime objective of the ACA. Many capped annual benefits for certain services and treatments, which Congress sought to prevent through enactment of the ACA.[18] The ACA did not altogether prohibit STLDI plans, but STLDI plans were never intended as a replacement for long-term coverage. Until 2018, the maximum term of such policies was three months, and plans could not be renewed.[19]

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[15] *See* Short-Term, Limited-Duration Insurance, 83 Fed. Reg. 38,212, 38,213 (Aug. 3, 2018).

[16] *Id.*

[17] Karen Pollitz et al., *Understanding Short-Term Limited Duration Health Insurance* (Henry J. Kaiser Family Foundation, Apr. 23, 2018), https://www.kff.org/health-reform/issue-brief/understanding-short-term-limited-duration-health-insurance/.

[18] *Id.*

[19] Excepted Benefits; Lifetime and Annual Limits; and Short-Term, Limited-Duration Insurance, 81 Fed. Reg. 75,316, 75,318 (Oct. 31, 2016).

AHPs serve a purpose different from STLDI policies—namely, to permit single plans to cover closely linked businesses so that each can offer coverage similar to that offered by other companies. AHPs offered to a bona fide employee association are not subject to the ACA's Essential Health Benefits requirements and may vary rates according to factors that individual and small-group plans are prohibited from considering, including age, gender, industry, and geography.[20] Under longstanding federal law, to be eligible for this treatment, participating employers must represent a "bona fide single employer group," and under prior administrations that was a difficult hurdle to clear. All member employers were required to participate in the same trade or business and to operate effectively as a single employer. Those requirements curtailed the formation of AHPs primarily as a way to avoid the ACA's consumer protections.

The Trump Administration has dramatically broadened the potential use of STLDI policies and AHPs as substitutes for ACA-compliant coverage. These steps are contrary to the ACA's goal of providing broad access to meaningful and affordable health insurance coverage. In August 2018, the Departments of the Treasury, Labor, and Health and Human Services finalized a regulation that increased the maximum STLDI plan term from three months to 364 days (just one day less than the duration of plans subject to ACA requirements) and allowed such plans to be extended for up to 36 months. The rule also permits the purchase of multiple consecutive plans. These new regulations, in combination, enable insurers to market STLDI policies for effectively unlimited periods.[21] In June 2018, the Department of Labor finalized a rule expanding access to AHPs in several ways, including by allowing unrelated employers to

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[20] Sabrina Corlette, Josh Hammerquist, & Pete Nakahata, *New Rules to Expand Association Health Plans*, Actuary Mag. (May 2018), https://theactuarymagazine.org/new-rules-to-expand-association-health-plans/.

[21] *See* Short-Term, Limited-Duration Insurance, 83 Fed. Reg. 38,212, 38,216-20 (Aug. 3, 2018).

join "associations" formed primarily for the purpose of offering insurance and permitting associations to include employers that are not in the same line of business, but instead merely reside in the same geographic area.[22]

These measures will have a significant and adverse impact on enrollment in ACA-compliant coverage. One recent study showed that removing limitations on the duration and renewability of STLDI policies will result in an additional *2.6 million* people without coverage providing essential health benefits required by the ACA.[23] The Congressional Budget Office has projected that the new rules regarding AHPs will lead *4 million* additional individuals to enroll in such plans, 90 percent of whom otherwise would have opted for ACA-compliant coverage.[24]

This widespread replacement of ACA-compliant insurance with the more limited coverage provided by STLDI policies and AHPs will have detrimental effects on both consumers and health care providers. Consumers who opt for cheaper non-compliant plans often do so under the mistaken belief that those policies offer the same range of benefits as ACA-compliant plans.[25] Faced with unexpected gaps in (or denials of) coverage, consumers may face financial ruin or be forced either to forgo care or to obtain free treatment and services from state and local providers, who have often served as the provider of last resort. For example, in 2009 state and

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[22] *See* Definition of "Employer" Under Section 3(5) of ERISA—Association Health Plans, 83 Fed. Reg. 28,912, 28,914 (June 21, 2018).

[23] Linda J. Blumberg, Matthew Buettgens, & Robin Wang, *Updated: The Potential Impact of Short-Term Limited-Duration Policies on Insurance Coverage, Premiums, and Federal Spending* 2 (Urban Institute, March 2018), https://www.urban.org/sites/default/files/publication/96781/2001727_updated_finalized.pdf.

[24] Congressional Budget Office, *Federal Subsidies for Health Insurance Coverage for People Under Age 65: 2018 to 2028*, at 10 (May 23, 2018), https://www.cbo.gov/system/files/2018-06/53826-healthinsurancecoverage.pdf.

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

local entities accounted for 15 percent of mental health spending.[26] That figure was expected to decline following the passage of the ACA, given that law's requirement that private health insurance plans include coverage for mental health treatment.[27] But the expanded availability of AHPs and STLDI plans as a replacement for ACA-compliant coverage means that many more consumers will purchase insurance that is exempt from the law's mental health services requirement. Consumers with mental health issues who encounter this unexpected gap in coverage are likely to resort to services offered by state and local governments.

Expanded enrollment in AHPs and STLDI plans will also generate the adverse selection problem that Congress sought to avoid in enacting the ACA. AHPs and STLDI plans are often nominally less expensive than ACA-compliant plans, and they typically attract younger, healthier individuals who are less likely to base decisions on the specific limitations in non-ACA-compliant plans. This exodus of healthy individuals from the small-group and individual markets for ACA-compliant insurance means that those who remain in those markets will on average be less healthy and have higher health care costs, which will in turn lead to higher premiums for those consumers. According to the Congressional Budget Office, the net effect of shifts by healthy individuals to AHPs and STLDI plans will be a 2 to 3 percent premium increase for plans that meet the ACA's Essential Health Benefits requirements and other protections.[28]

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[26] Pew Charitable Trusts & John D. and Catherine T. MacArthur Foundation, *Mental Health and the Role of the States* 4 (June 2015), https://www.pewtrusts.org/~/media/assets/2015/06/mentalhealthandroleofstatesreport.pdf.

[27] *Id.*

[28] Congressional Budget Office, *Federal Subsidies for Health Insurance Coverage for People Under Age 65: 2018 to 2028*, at 10 (May 23, 2018), https://www.cbo.gov/system/files/2018-06/53826-healthinsurancecoverage.pdf.

C. Increased Barriers To Enrollment Will Drive Up The Cost Of ACA-Compliant Plans And Force More Consumers To Seek Uncompensated Care

In addition to adding new consumer protections to most types of health insurance plans, the ACA includes various measures designed to promote broad enrollment in plans that include these protections. For example, the law requires each state to have an "exchange," or health insurance marketplace, through which consumers can compare and enroll in ACA-compliant plans.[29] Each exchange is established and operated by either the state it services or the federal government.[30] As of 2018, twelve states and the District of Columbia operated their own "state-based" exchanges, and other states relied on the federal government to run their exchanges using HealthCare.gov, either as a "federally-facilitated" exchange or as the enrollment platform for the state's exchange.[31] During an exchange's annual "open enrollment" period, individuals not eligible for Medicare or Medicaid can compare and enroll in affordable, quality insurance plans, independent of their employment.[32] Consumers who obtain health insurance through an exchange will often be eligible for subsidies to reduce the cost of their insurance plans: the ACA makes advance premium tax credits available to individuals whose income is between 100-400 percent of the federal poverty line.[33]

To promote awareness of the exchanges and assist consumers during open enrollment, the ACA created the Navigator program.[34] ACA Navigators in each state receive grants from the

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[29] 42 U.S.C. § 18031(b)(1).

[30] *See* 42 U.S.C. §§ 18031(b)(1), 18041(c)(1).

[31] Kaiser Family Foundation, *State Health Insurance Marketplace Types, 2018* (last accessed June 6, 2019), https://www.kff.org/health-reform/state-indicator/state-health-insurance-marketplace-types/.

[32] 42 U.S.C. § 18031(c)(6).

[33] 26 U.S.C. § 36B; 42 U.S.C. §§ 18081, 18082.

[34] 42 U.S.C. § 18031(d)(4)(K).

state's exchange to conduct public education activities, distribute enrollment information, and provide direct assistance to consumers seeking to obtain health insurance through the exchange.[35] Various types of entities can participate as Navigators, including trade and professional associations, non-profit organizations, and chambers of commerce.[36] In states where the federal government operates exchanges, the Department of Health and Human Services ("HHS") enters into cooperative agreements with Navigators to ensure they have funding to perform these functions.[37] HHS has itself also conducted advertising campaigns in accordance with regulations requiring all exchanges to "conduct outreach and education activities … to educate consumers about the Exchange and insurance affordability programs to encourage participation."[38]

By facilitating enrollment in health insurance plans, ACA exchanges promote the ACA's goal of broadening coverage while reducing adverse selection. Recent actions by the Trump Administration have undermined that objective, however, by making it more difficult for consumers to obtain insurance through these exchanges. In particular, the Administration has decimated the Navigator program in states with federally facilitated exchanges. In each of the past two years the Administration has drastically cut the funding HHS provides to Navigators in states with federally facilitated exchanges: from $63 million to $36 million in 2017 (a 50 percent

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[35] 42 U.S.C. § 18031(i)(1).

[36] 42 U.S.C. § 18031(i)(2).

[37] *See, e.g.*, HHS, *Cooperative Agreement to Support Navigators in Federally-facilitated and State Partnership Marketplaces*, Funding Opportunity No. CA-NAV-15-001 (Apr. 15, 2015), https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces/Downloads/Navigator_2015_FOA_FINAL_04_15_2015.pdf.

[38] 45 C.F.R. § 155.205(e).

cut), and from $36 million to just $10 million for 2018 (an additional 72 percent cut).[39] Those cuts erased funding entirely for several states (Iowa, Montana, and New Hampshire), and significant areas of other states (for example, Cleveland, Akron, Toledo, and Youngstown, Ohio) will be without Navigator service.[40]

Without access to Navigators, consumers who need assistance when shopping for and enrolling in a health care plan are more likely to go without insurance. For example, one recent study of factors contributing to enrollment found that "[t]he strongest predictor of completing the [insurance] application process was receiving help … from a [N]avigator or application assister."[41] Thus, it is no surprise that the Administration's dramatic cuts to Navigator funding for federally facilitated exchanges have been accompanied by declining enrollment among those most likely to require Navigator assistance. Enrollment by low-income consumers fell by nearly 8 percent in 2018, and nearly half a million fewer new consumers (those without prior experience enrolling through an exchange) enrolled in 2018 than did so in 2017.

The Administration has further discouraged enrollment through federal exchanges by significantly contracting the period during which consumers may select a health insurance plan or switch to a new plan. For both the 2016 and 2017 plan years, open enrollment lasted three months, from November 1 through January 31 of the following year. For the 2018 and 2019 plan years, in contrast, the Trump Administration cut the open enrollment period in half, setting

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[39] Karen Pollitz, Jennifer Tolbert, & Maria Diaz, *Data Note: Further Reductions in Navigator Funding for Federal Marketplace States* (Henry J. Kaiser Fam. Found., Sept. 24, 2018), https://www.kff.org/health-reform/issue-brief/data-note-further-reductions-in-navigator-funding-for-federal-marketplace-states/.

[40] *Id.*

[41] 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(6) Health Aff. 1010, 1015 (2015), https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.2015.0215.

it to run from November 1 until only December 15 each year. Moreover, significant cuts to advertising reduce the likelihood that consumers will hear about the shortened windows. Whereas the federal government spent more than $100 million to advertise the 2017 open enrollment period, for 2018 it spent just $10 million—a 90 percent reduction. Together with reduced Navigator funding, 2018's abbreviated and less publicized open enrollment period led to nearly 1 million fewer people using HealthCare.gov to select a health insurance plan than in 2016.[42]

Comparing results from federally facilitated exchanges to enrollment in state-run marketplaces further reveals the impact of the Administration's actions. States that in 2017 and 2018 operated their own exchanges were able to provide extended open enrollment periods and set their own budgets for Navigator funding and advertising. Those states as a whole saw enrollment remain steady or increase slightly during this period compared to 2016, whereas enrollment through federally facilitated exchanges declined 10 percent.[43] The state-run exchanges also showed other signs of stability relative to their federal counterparts, including smaller premium increases (43% vs. 75%) and fewer market exits by insurance carriers.[44]

The Administration has taken other regulatory actions designed to limit use of both the state and federal exchanges under the ACA. For example, whereas in prior years a consumer could receive subsidies by providing only an "attestation" of income between 100 and 400 percent of the federal poverty line, a new rule requires consumers to provide documentation of

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[42] *See* CMS, *Health Insurance Exchanges 2018 Open Enrollment Period Final Report* (Apr. 3, 2018), https://www.cms.gov/newsroom/fact-sheets/health-insurance-exchanges-2018-open-enrollment-period-final-report.

[43] Jane M. Zhu, Daniel Polsky, & Yuehan Zhang, *State-Based Marketplaces Outperform Federally-Facilitated Marketplaces* (U. Penn. Leonard Davis Inst. of Health Econ., Mar 21, 2018) https://ldi.upenn.edu/brief/state-based-marketplaces-outperform-federally-facilitated-marketplaces.

[44] *Id.*

their incomes in situations where "electronic data sources" indicate that income may in fact be less that 100 percent of the poverty line.[45] The Administration adopted this rule without any evidence consumers had been abusing the prior system by providing false "attestations,"[46] and despite various studies showing that increased paperwork burdens reduce enrollment in health insurance, particularly for the healthy individuals essential to maintaining stable insurance markets.[47]

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According to various studies, the number of uninsured Americans has increased significantly since President Trump took office—thereby reversing ACA's previous pattern of consistently expanding health insurance coverage.[48] Much of this decline likely results from new obstacles and reduced support for consumers seeking to obtain insurance through ACA exchanges, particularly exchanges operated by the federal government. Moreover, the recent expansion of AHPs and STLDI plans will only add to the already growing population of Americans who lack coverage that provides the Essential Health Benefits defined by the ACA.

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[45] *See* Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2019, 83 Fed. Reg. 16,930, 16,985-87 (Apr. 17, 2018).

[46] *Id.* at 16,986.

[47] *See, e.g.*, Stan Dorn, *Helping Special Enrollment Periods Work Under the Affordable Care Act* 5-6 (Urban Institute, June 2016), https://www.urban.org/sites/default/files/publication/81806/2000834-Helping-Special-Enrollment-Periods-Work-Under-the-Affordable-Care-Act.pdf; CMS, *Pre-Enrollment Verification for Special Enrollment Periods* (2016), https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/Pre-Enrollment-SEP-fact-sheet-FINAL.PDF.

[48] Although the timeframe and methodologies for these studies varied, each found a significant increase in the number of Americans without health insurance. For example, the Congressional Budget Office recently estimated that the number of uninsured Americans increased by 1.4 million between 2016 and 2018. *See* Congressional Budget Office, *Health Insurance Coverage for People Under Age 65: Definitions and Estimates for 2015 to 2018*, at 7 (Apr. 2019), https://www.cbo.gov/system/files/2019-04/55094-CoverageUnder65_0.pdf. Recent Gallup polling, meanwhile, places that figure at more than six million. *See* Dan Witters, *U.S. Uninsured Rate Rises to Four-Year High*, Gallup (Jan. 23, 2019), https://news.gallup.com/poll/246134/uninsured-rate-rises-four-year-high.aspx. Finally, analysis by the Census Bureau concluded that 400,000 more Americans lacked health insurance in 2017 than in 2016. *See* Edward R. Berchick, Emily Hood, & Jessica C. Barnett, *Health Insurance Coverage in the United States: 2017* (US Census Bureau, Sept. 12, 2018), https://www.census.gov/library/publications/2018/demo/p60-264.html.

By reducing the number of Americans without quality health insurance, the Trump Administration's actions will raise the cost of compliant insurance and force more consumers to seek uncompensated care from providers of last resort.

CONCLUSION

The challenged actions of the Trump Administration discussed in this brief are fundamentally antithetical to the design of the ACA, which is intended to expand and improve health care coverage across the nation by encouraging broad participation in ACA-compliant plans. They will have the effect of reducing coverage under the ACA and will increase the burden on state and local governments to provide health care.

Dated: June 7, 2019

Respectfully submitted,

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