IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

CITY OF CHICAGO,

Plaintiff,

v.

ALEX M. AZAR, II, in his official capacity as Secretary of the United States Department of Health and Human Services, *et al.*,

Defendants.

Case No. 20-cv-1566-TJK

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

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King v. Burwell,
759 F.3d 358 (4th Cir. 2014) 9

Nat'l Fed'n of Indep. Bus. v. Sebelius,
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Statutes, Legislative Materials, and Administrative Materials

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26 U.S.C. § 4980H 7

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42 U.S.C. § 1396a(a)(10)(A)(i)(VIII) 7

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42 U.S.C. § 18031(d)(4)(E) 10

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42 U.S.C. § 18031(d)(4)(K) 10

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42 U.S.C. § 18031(i)(3)(B) 10

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42 U.S.C. § 18041(c)(1) 9

42 U.S.C. § 18071 9

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42 U.S.C. § 18082 9

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Rule II.8(b), Rules of the U.S. House of Representatives, 116th Cong. (2019)
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H. Rep. No. 111-299, pt. 1 (2009) 4, 5

H. Rep. No. 111-299, pt. 3 (2009) 4, 5, 6

Congressional Oversight Hearing on the Impact of the Administration's Policies Affecting the Affordable Care Act: Testimony Submitted to the H. Appropriations Subcomm. on Labor, Health, & Human Servs. (Feb. 6, 2019), https://perma.cc/H46S-QUVU 17

Legislative Hearing "Examining Threats to Workers with Preexisting Conditions Before the H. Educ. & Labor Comm. (Feb. 6, 2019), https://perma.cc/9YLK-A6LB 18

42 C.F.R. § 423.38(c)(8)(ii) 11

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45 C.F.R. § 155.420(d)(9) 3, 11

Exchange and Insurance Market Standards for 2015 and Beyond, 79 Fed. Reg. 15,808 (Mar. 21, 2014) 16

Extension of Certain Timeframes for Employee Benefit Plans, Participants, and Beneficiaries Affected by the COVID-19 Outbreak, 85 Fed. Reg. 26,351 (May 4, 2020) 14

HHS Notice of Benefit and Payment Parameters for 2019, 83 Fed. Reg. 16,930 (Apr. 17, 2018) 15, 16

HHS Notice of Benefit and Payment Parameters for 2017, 80 Fed. Reg. 75,488 (Dec. 2, 2015) 16

Market Stabilization, 82 Fed. Reg. 18,346 (Apr. 18, 2017) 17

Proclamation 9994, Declaring a National Emergency Concerning the Novel Coronavirus Disease (COVID-19) Outbreak, 85 Fed. Reg. 15,337 (Mar. 13, 2020) 14

Short-Term, Limited-Duration Insurance, 83 Fed. Reg. 38,212 (Aug. 3, 2018) 16, 17

Other Authorities

American Academy of Actuaries*, An Evaluation of the Individual Health Insurance Market and Implications of Potential Changes* (Jan. 2017), https://perma.cc/LX4R-A5SG 9

Adam Cancryn et al.*, How Trump Surprised His Own Team by Ruling Out Obamacare,* Politico (Apr. 3, 2020), https://perma.cc/Q76W-ULN4 15

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://perma.cc/QB6H-K3J6 4

Determination that a Public Health Emergency Exists, Pub. Health Emergency (Jan. 31, 2020), https://perma.cc/7ZJV-KKN7 14

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. (Mar. 30, 2011), https://perma.cc/7RZP-5H48 7

Charles Gaba, *UPDATE: 1.8 - 2.4 Million More Americans Would Likely #GetCovered if HealthCare.Gov Launched #COVID19 SEP*, ACASignups.net: Charles Gaba's Blog (Apr. 14, 2020), https://perma.cc/YD4R-TTEZ 14

Charles Gaba & Emily Gee, *How Trump's Policies Have Hurt ACA Marketplace Enrollment*, Ctr. for Am. Progress (Apr. 16, 2020), https://perma.cc/SFN6-ZFHT 18

Rachel Garfield et al., *Eligibility for ACA Health Coverage Following Job Loss*, Kaiser Fam. Found. (May 13, 2020), https://perma.cc/Q638-LVE4 12

Kate Heyer et al., RAND Corp., *Assessing the Role of State and Local Public Health in Outreach and Enrollment for Expanded Coverage: A Case Study on Boston and Massachusetts* (2016) (eBook) 18

Katie Keith, *CMS Could Do More in Light of the Coronavirus Crisis*, Health Aff. (Mar. 25, 2020), https://perma.cc/N6KW-HQ6S 13

Letter from Sen. Christopher S. Murphy, et al., to Alex M. Azar II, HHS Sec'y (Apr. 7, 2020), https://perma.cc/X6RT-PLZC 13

Susannah Luthi, *Trump Rejects Obamacare Special Enrollment Period Amid Pandemic*, Politico (Mar. 31, 2020), https://perma.cc/58C6-Q377 15

Memorandum from Medicare Enrollment & Appeals Group Director Jerry Mulcahy to All Medicare Advantage Organizations, Part D Sponsors, and Medicare-Medicaid Plans (May 5, 2020), https://perma.cc/SE3U-CAYQ 15

Adrian Garcia Mosqueira & Benjamin D. Sommers, *Better Outreach Critical to ACA Enrollment, Particularly for Latinos*, Commonwealth Fund (Jan. 14, 2016), https://perma.cc/SD7X-RVZB 16

Paul R. Shafer et al., *Television Advertising and Health Insurance Marketplace Consumer Engagement in Kentucky: A Natural Experiment*, 20 J. Med. Internet Res. *1 (2018) 17

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 Aff. 1010 (2015) 18

Special Enrollment Periods for Complex Issues, Healthcare.gov, https://perma.cc/9KMD-JZSJ 11

Jennifer Tolbert et al., Kaiser Fam. Found., *Connecting Consumers to Coverage: Lessons Learned from Assisters for Successful Outreach and Enrollment* (2014), https://perma.cc/AD48-NFES....................16

Namrata Uberio et al., U.S. Dep't of Health & Human Servs., *Health Insurance Coverage and the Affordable Care Act, 2010-2016* (Mar. 3, 2016), https://perma.cc/9N44-6ERZ 11, 12

U.S. Gov't Accountability Office, GAO-18-565, *Health Insurance Exchanges: HHS Should Enhance Its Oversight of Open Enrollment Performance* (July 24, 2018) 18

Lydia Wheeler, *Newly Unemployed Scramble to Enroll in Obamacare in Time*, Bloomberg Law (Apr. 10, 2020), https://perma.cc/VV4P-J2S4 13

INTEREST OF *AMICUS CURIAE*[1]

Amicus curiae the United States House of Representatives[2] has a strong institutional interest in the effective implementation of the Patient Protection and Affordable Care Act. 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, how it has helped ensure that all Americans have access to quality, affordable health insurance, and why the Trump Administration's decision not to open a special enrollment period during the COVID-19 pandemic is inconsistent with the plan that Congress put in place when it passed the Affordable Care Act.

INTRODUCTION

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

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[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." Rule II.8(b), Rules of the U.S. House of Representatives, 116th Cong. (2019) https://perma.cc/J2SG-ZNDP. The Republican Leader and Republican Whip dissented.

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) that enable individuals who do not receive health insurance through their employer or through Medicaid to 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.

The Affordable Care Act has been remarkably successful in achieving that goal, and the Act's reforms have proven especially critical during the current COVID-19 pandemic. "COVID–19 [is] a novel severe acute respiratory illness that has killed . . . more than 100,000

nationwide. At this time, there is no known cure, no effective treatment, and no vaccine." *S. Bay United Pentecostal Church v. Newsom*, 140 S. Ct. 1613, 1613 (2020) (mem.) (Roberts, C.J., concurring in denial of application for injunctive relief). For individuals who contract the virus, access to quality, affordable coverage is necessary to ensure that they receive adequate care for any virus-related complications. At the same time, the pandemic has led to a severe economic downturn that has resulted in millions of Americans losing their jobs—and often losing their employer-provided health insurance coverage. The Affordable Care Act allows such individuals to remain insured either through Medicaid or, as relevant to this case, by purchasing insurance on the individual Exchanges. Specifically, the Act provides for "special enrollment periods" during which individuals may purchase insurance on the Exchanges outside of the annual open enrollment period following certain triggering events—like job loss. 42 U.S.C. § 18031(c)(6). Critically, the Act also requires the Department of Health and Human Services (HHS) to open a special enrollment period for all consumers under certain "exceptional circumstances" as HHS may provide. *Id*. § 1395w-101(b)(3)(C); *see id.* § 18031(c)(6)(C). HHS regulations implementing that statutory provision reiterate that special enrollment periods must be opened during "exceptional circumstances." 45 C.F.R. § 155.420(d)(9).

A global health pandemic of the type the nation now faces is plainly the type of "exceptional circumstance[]" in which a special enrollment period is required. Indeed, recognizing how critical it is that individuals be able to acquire health insurance during the pandemic, all but one of the states that run their own Exchanges have opened special enrollment periods that allow eligible consumers to purchase health insurance in the individual marketplace. The Trump Administration, however, has chosen not to open a special enrollment period in the more than thirty states that rely on the Federal Government to operate their Exchanges. And it

has offered no sufficient reason for its failure to do so. By failing to create a special enrollment period at a time when consumers need quality, affordable health insurance the most, the Administration is undermining Congress's plan in passing the Affordable Care Act.

ARGUMENT

THE AFFORDABLE CARE ACT WAS DESIGNED TO EXPAND THE AVAILABILITY OF AFFORDABLE HEALTH INSURANCE, AND THE TRUMP ADMINISTRATION'S UNREASONED DECISION NOT TO OPEN A SPECIAL ENROLLMENT PERIOD DURING THE COVID-19 PANDEMIC UNDERMINES CONGRESS'S PLAN.

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

Congress passed the Affordable Care Act in response to serious problems plaguing America's health care system. *See* H. 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. Rep. No. 111-299, pt. 1, at 320 (2009). A number of different factors contributed to this uninsured rate. 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. 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

[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://perma.cc/QB6H-K3J6 ("premiums for . . . policies [in the individual market] were

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. 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. Rep. No. 111-299, pt. 3, at 92 (quoting testimony of Karen Pollitz). Such practices included: "denying health coverage based on pre-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 sub nom. NFIB*, 567 U.S. 519. Congress found that "[d]iscrimination based

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increasing more than 10% a year, on average, while the policies themselves had major deficiencies").

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. 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. 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)).

Importantly, Congress found that one consequence of being uninsured or underinsured was that it made it "more likely that a person will not receive adequate medical care," because "[i]ndividuals without insurance often go without or delay care, and the care they do receive is likely to be lower quality than the care received by insured individuals." H. Rep. No. 111-299, pt. 3, at 83. Indeed, at the time the ACA passed, "[a]n estimated 18,000 to 22,000 Americans die[d] each year because they d[id] not have health coverage." *Id.* Moreover, "increases in the numbers of uninsured people . . . create[d] additional uncompensated care costs, which include[d] costs incurred by hospitals and physicians for the charity care they provide[d] to the uninsured as well as bad debt such as unpaid bills." *Id.* at 85. Such increases also burdened federal and state governments, which "use tax revenues to pay health care providers for a portion of these [uncompensated] costs." *Id.*

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, 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"). The Affordable Care Act does so in a number of respects.

First, it provides funding to States to expand Medicaid coverage to all individuals earning up to 133 percent of the federal poverty level. *See* 42 U.S.C. § 1396a(a)(10)(A)(i)(VIII). The Congressional Budget Office estimated that this expansion provided coverage to millions of Americans.[4]

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." *Id*. § 300gg-6(a) ("A health insurance issuer that offers health insurance

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[4] *See* Cong. Budget Office, *CBO's Analysis of the Major Health Care Legislation Enacted in Mar. 2010* 22-23 (Mar. 30, 2011), https://perma.cc/7RZP-5H48 (prepared statement of Douglas Elmendorf, Director, Cong. Budget Office).

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, 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).

Fourth, 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).[5] 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) ("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."), *aff'd*, 135 S. Ct. 2480. 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 Exchanges and tax credits are 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,"[6] the Act includes a number of different provisions to facilitate enrollment. For example, the Act requires Exchanges to "provide for the operation of a toll-free telephone

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[5] As of 2019, 13 States operate State Exchanges, 32 States rely principally on the Federal Government to run their Exchanges, and 6 States have a hybrid Exchange of some sort. Compl. ¶ 30.

[6] American Academy of Actuaries, *An Evaluation of the Individual Health Insurance Market and Implications of Potential Changes* 1 (Jan. 2017), https://perma.cc/LX4R-A5SG.

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 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). Exchanges are also 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).

Finally, in addition to an annual open enrollment period during which any eligible consumer can purchase health insurance, the Act provides that the Secretary of Health and Human Services "shall require an exchange to provide for special enrollment periods specified in section 9801 of Title 26 and other special enrollment periods under circumstances similar to such periods under part D of title XVIII of the Social Security Act," commonly referred to as Medicare Part D, which provides coverage for prescription drugs. *Id.* § 18031(c)(6)(C). Section 9801 of Title 26 requires, among other things, that group health plans permit employees to enroll for coverage if they lose "eligibility for [prior] coverage (including as a result of legal separation, divorce, death, termination of employment, or reduction in the number of hours of employment)." 26 U.S.C. § 9801(f)(1)(C)(ii). The statute governing Medicare Part D requires HHS to open special enrollment periods for prescription drug coverage in "[e]xceptional circumstances," 42 U.S.C. § 1395w-101(b)(3)(C), and the implementing regulations for that

provision also require special enrollment periods in a variety of circumstances, including during "exceptional circumstances as [the Centers for Medicare and Medicaid Services] may provide," 42 C.F.R. § 423.38(c)(8)(ii).

Consistent with the requirements for group health plans, the Department of Health and Human Services has promulgated regulations that require Exchanges to provide special enrollment periods for 60 days after certain "triggering events"—like losing coverage or gaining a dependent. *See* 45 C.F.R. § 155.420. And consistent with Medicare Part D, the HHS regulations provide that "the Exchange must allow a qualified individual . . . to enroll in or change from one [quality health plan] to another if" the qualified individual "demonstrates to the Exchange, in accordance with guidelines issued by HHS, that the individual meets other exceptional circumstances as the Exchange may provide." *Id.* § 155.420(d)(9). Examples of exceptional circumstances include "[a] natural disaster, such as an earthquake, massive flooding, or hurricane," which prevents individuals from enrolling. *Special Enrollment Periods for Complex Issues*, Healthcare.gov, https://perma.cc/9KMD-JZSJ. These special enrollment periods play a critical role in fulfilling Congress's goal of expanding coverage because they ensure that consumers will be able to purchase health insurance on the Exchanges when they need it the most.

Through all of these reforms, 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 people had purchased plans on the state and federal Exchanges established by the Affordable Care Act. Namrata Uberio et al., U.S. Dep't of Health & Human Servs., *Health Insurance Coverage and the Affordable Care Act, 2010-2016*, at 8 (2016), https://perma.cc/9N44-6ERZ. And approximately 14.5 million more people began

receiving comprehensive benefits through Medicaid and the Children's Health Insurance Program. *Id.* Overall, there has been a net gain of more than 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 Refusal to Implement a Special Enrollment Period During the COVID-19 Pandemic Undermines the Affordable Care Act.

Even though it is critically important that people be able to obtain health insurance in the midst of this global health crisis, and even though the Affordable Care Act and its implementing regulations specifically require the HHS Secretary to set up special enrollment periods in the face of "exceptional circumstances," this Administration has failed to implement a special enrollment period during the COVID-19 pandemic to ensure that people who do not currently have health insurance are able to obtain it. This decision undermines Congress's plan in passing the Affordable Care Act and is part and parcel of this Administration's long-running effort to undermine that law.

1. The Administration's refusal to implement a Special Enrollment Period during the COVID-19 pandemic undermines the Exchanges. According to one estimate, "nearly 27 million people could potentially lose [employer-sponsored insurance] and become uninsured following job loss" as a result of the pandemic. Rachel Garfield et al., *Eligibility for ACA Health Coverage Following Job Loss*, Kaiser Fam. Found. (May 13, 2020), https://perma.cc/Q638-LVE4.

Uninsured individuals are less likely to seek care and are more likely to face significant barriers to testing for COVID-19. *See* Compl. ¶ 74. Although some individuals who lose coverage might be eligible for a special enrollment period based on individualized triggering events, proving eligibility often involves a time-consuming process of documentation within a short timeframe that many consumers might find difficult to accomplish during the pandemic.

See Lydia Wheeler, *Newly Unemployed Scramble to Enroll in Obamacare in Time*, Bloomberg Law (Apr. 10, 2020), https://perma.cc/VV4P-J2S4. Indeed, with most employers shutting down in-person operations, and with libraries and other government buildings closed, even printing the documents necessary to prove eligibility for existing special enrollment periods might be nearly impossible for many consumers. Moreover, existing special enrollment periods would not cover "individuals who never had insurance coverage as part of their employment; individuals who had atypical employment circumstances . . . ; or individuals who simply wish to obtain insurance coverage in response to a once-in-a-generation pandemic." Compl. ¶ 89. Finally, "announcing an emergency [special enrollment period (SEP)] would help raise awareness of the availability of coverage through HealthCare.gov among important groups, including for those who might already be eligible for an SEP but unaware of their options." Katie Keith, *CMS Could Do More in Light of the Coronavirus Crisis*, Health Aff. (Mar. 25, 2020), https://perma.cc/N6KW-HQ6S.

In short, a blanket special enrollment period at this unprecedented time is critical to ensure that all consumers without coverage are able, consistent with Congress's plan, to purchase affordable health insurance on the Exchanges at a time when having quality, affordable insurance is more important than ever. *See* Letter from Sen. Christopher S. Murphy, et al., to Alex M. Azar II, HHS Sec'y (Apr. 7, 2020), https://perma.cc/X6RT-PLZC ("Opening up the ACA marketplace would provide an easy pathway to coverage for those who under previous circumstances may have decided to forego health insurance or purchase a substandard, junk insurance plan, but now in a global pandemic are in vital need of comprehensive coverage to protect themselves, their families, and our broader community."). Understanding that reality, 12 out of the 13 *state* Exchanges announced special enrollment periods for all consumers during the pandemic, a move that has been projected to lead to 237,000 people purchasing health insurance.

See Charles Gaba, *UPDATE: 1.8 - 2.4 Million More Americans Would Likely #GetCovered if HealthCare.Gov Launched #COVID19 SEP*, ACASignups.net: Charles Gaba's Blog (Apr. 14, 2020), https://perma.cc/YD4R-TTEZ. Moreover, the President himself has declared a national emergency, *Proclamation 9994, Declaring a National Emergency Concerning the Novel Coronavirus Disease (COVID-19) Outbreak*, 85 Fed. Reg. 15,337, 15,337 (Mar. 13, 2020), and the HHS Secretary has formally declared that a "public health emergency exists," *Determination that a Public Health Emergency Exists*, Pub. Health Emergency (Jan. 31, 2020), https://perma.cc/7ZJV-KKN7. Despite all this, however, this Administration has chosen not to open a special enrollment period for federal Exchanges, even though there can be no question that the pandemic constitutes an exceptional circumstance.

The Administration has taken other actions to ensure that Americans are able to access insurance and health care during this pandemic, which further calls into question the decision not to open a special enrollment period. For instance, the Internal Revenue Service and the Employee Benefits Security Administration extended deadlines for enrolling in group health plans and COBRA continuation coverage until 60 days after the end of the pandemic, citing the need to "take steps to minimize the possibility of individuals losing benefits because of a failure to comply with certain pre-established timeframes." *Extension of Certain Timeframes for Employee Benefit Plans, Participants, and Beneficiaries Affected by the COVID-19 Outbreak*, 85 Fed. Reg. 26,351, 26,352 (May 4, 2020). Similarly, the Centers for Medicare and Medicaid Services (CMS) has announced that it would interpret "the exceptional conditions Special Enrollment Period (SEP)" for Medicare Advantage and Medicare Part D to apply to "beneficiaries who were eligible for—but unable to make—an election because they were affected by the COVID-19 pandemic." Memorandum from Jerry Mulcahy, Medicare Enrollment

& Appeals Group Dir., to All Medicare Advantage Organizations, Part D Sponsors, and Medicare-Medicaid Plans (May 5, 2020), https://perma.cc/SE3U-CAYQ.

Despite taking appropriate action in other areas, however, the Administration has not opened a special enrollment period for federal Exchanges, and it has offered no sufficient reason for its failure to do so. To the contrary, public reporting suggests that the decision may have been political. Until March, officials at the Centers for Medicare and Medicaid Services had planned to announce a special enrollment period. *See, e.g.*, Susannah Luthi, *Trump Rejects Obamacare Special Enrollment Period Amid Pandemic*, Politico (Mar. 31, 2020), https://perma.cc/58C6-Q377. However, it has been reported that the President in the end refused to allow a special enrollment period for "purely ideological" reasons: his desire to undermine the Affordable Care Act. Adam Cancryn et al., *How Trump Surprised His Own Team by Ruling Out Obamacare*, Politico (Apr. 3, 2020), https://perma.cc/Q76W-ULN4. The decision "shocked the health care industry, triggered widespread criticism and prompted a scramble within the administration to find a new way to care for the growing population left exposed to the pandemic." *Id.*

2. The Administration's refusal to open a special enrollment period during this pandemic is just another example in a long list of efforts to thwart the Exchanges. For instance, in 2018, CMS promulgated a final rule that makes it harder for individuals to purchase insurance on the Exchanges. *See HHS Notice of Benefit and Payment Parameters for 2019*, 83 Fed. Reg. 16,930 (Apr. 17, 2018). The rule discontinued 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).

This same rule also eliminated the requirement that Navigators have physical presences in the areas they serve. *See* 83 Fed. Reg. at 16,979-81. This change reduced the effectiveness of the Navigator program. The requirement was previously imposed "so that face-to-face assistance would 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.[7]

The Administration has also sought to undermine the Affordable Care Act by diverting consumers, especially younger and healthier consumers, away from the Exchanges through its rule governing short-term, limited duration insurance (STLDI). *See Short-Term, Limited-Duration Insurance*, 83 Fed. Reg. 38,212 (Aug. 3, 2018). STLDI plans are a type of health insurance designed to fill temporary gaps in coverage, but these plans are not required to comply with key ACA protections, like the prohibition on discrimination based on preexisting conditions and the requirement that policies cover essential health benefits.

Notwithstanding those significant shortcomings, the Administration promulgated a rule that allows consumers to purchase STLDI plans that last just short of an entire year—the length

[7] *See, e.g.*, Adrian Garcia Mosqueira & Benjamin D. Sommers, *Better Outreach Critical to ACA Enrollment, Particularly for Latinos*, Commonwealth Fund (Jan. 14, 2016), https://perma.cc/SD7X-RVZB; Jennifer Tolbert et al., Kaiser Fam. Found., *Connecting Consumers to Coverage: Lessons Learned from Assisters for Successful Outreach and Enrollment* 2 (2014), https://perma.cc/AD48-NFES.

of most comprehensive health insurance policies—and that can be renewed for up to three years. *Id.* at 38,214-15. By encouraging consumers to buy STLDI plans outside the Exchanges, the rule undermines the Exchanges, which depend on unified risk pools so that insurers cover a pool of patients robust enough to enable the insurers to provide coverage on a nondiscriminatory basis without charging patients untenable premiums.

The Administration has also taken steps to reduce the number of people who sign up for health insurance on the Exchanges during open enrollment periods—the annual timeframe during which any qualified consumer can enroll in coverage. The Administration has reduced the length of the open enrollment period 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), which will reduce the number of enrollees.[8] The Administration has also drastically reduced funding for advertisements to educate consumers about the Exchanges and their insurance options. As Congressional hearings have made clear, advertising is critical to successfully enrolling a broad base of consumers,[9] which keeps costs low. Indeed, "insurers increased premiums due to the Trump Administration's decision to decrease spending on marketplace advertising and consumer

[8] *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").

[9] *Congressional Oversight Hearing on the Impact of the Administration's Policies Affecting the Affordable Care Act: Testimony Submitted to the H. Appropriations Subcomm. on Labor, Health, & Human Servs.* (Feb. 6, 2019), https://perma.cc/H46S-QUVU (prepared statement of Joshua Peck, Co-founder, Get America Covered); *see id.* at 5 (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).

assistance."[10] Moreover, the Administration has failed to set numeric enrollment targets for 2018 and 2019. The Government Accountability Office found that "the lack of numeric enrollment targets for HHS to evaluate its performance with respect to the open enrollment period hamper[ed] the agency's ability to make informed decisions about its resources." U.S. Gov't Accountability Office, GAO-18-565, *Health Insurance Exchanges: HHS Should Enhance Its Oversight of Open Enrollment Performance* 37 (July 24, 2018).

On top of that, the Administration has cut funding for Navigators that assist individuals with purchasing insurance on the Exchanges, which has resulted in many Navigator organizations declining their awards and withdrawing from the program. *Id.* at 30. As numerous studies have pointed out, 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] Overall, were it not for the Administration's myriad efforts to undermine the ACA, an estimated 1.26 million more people would have purchased health insurance on the Exchanges. *See* Charles Gaba & Emily Gee, *How Trump's Policies Have Hurt ACA Marketplace Enrollment*, Ctr. for Am. Progress (Apr. 16, 2020), https://perma.cc/SFN6-ZFHT.

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[10] *Legislative Hearing "Examining Threats to Workers with Preexisting Conditions," Before the H. Educ. & Labor Comm.* 11 (Feb. 6, 2019), https://perma.cc/9YLK-A6LB (prepared statement of Sabrina Corlette, Research Professor, Georgetown University's Center on Health Insurance Reforms).

[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 Aff. 1010, 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 Expanded 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).

* * *

This Administration's failure to open a special enrollment period during the COVID-19 pandemic is just another example of the 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 put in place reforms to fix that and ensure that Americans would have access to health insurance when they needed it most. 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. The Trump Administration's refusal to implement a special enrollment period in the midst of this pandemic plainly undermines that goal.

CONCLUSION

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

Respectfully submitted,

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