**IN THE UNITED STATES DISTRICT COURT**
**FOR THE DISTRICT OF MARYLAND**

| | |
|---|---|
| CITY OF COLUMBUS, et al.,<br><br>*Plaintiffs*,<br><br>v.<br><br>DONALD J. TRUMP, in his official capacity as President of the United States of America, et al.,<br><br>*Defendants*. | No. 1:18-cv-02364-DKC |

**MOTION OF YOUNG INVINCIBLES FOR LEAVE TO FILE BRIEF AS *AMICUS CURIAE* IN SUPPORT OF PLAINTIFFS' MOTION FOR SUMMARY JUDGMENT**

Pursuant to this Court's Standing Order No. 2018-07, Young Invincibles respectfully requests that the Court grant it leave to file the attached brief as *amicus curiae* in support of Plaintiffs' Motion for Summary Judgment (ECF No. 108). Both Plaintiffs and Defendants have consented to filing of this brief. No party's counsel drafted any portion of the brief, and neither a party nor its counsel contributed money to fund its preparation or submission.

Young Invincibles is a national nonprofit organization dedicated to elevating the young adult voice in the political process and advancing economic opportunity for young adults (ages 18-34). Since its founding, Young Invincibles has become the leading national organization dedicated to expanding young adult health coverage. Focusing on both federal and state policy, Young Invincibles has developed a network of thousands of young people nationwide who continue to fight to ensure all young people have access to comprehensive, affordable, health coverage.

This Court has allowed "[t]he aid of amici curiae … at the trial level where they provide helpful analysis of the law, they have a special interest in the subject matter of the suit, or existing counsel is in need of assistance." *Doyle v. Hogan*, No. CV DKC 19-0190, 2019 WL 3500924, at *4 (D. Md. Aug. 1, 2019) (citing *Bryant v. Better Bus. Bureau of Greater Maryland, Inc.*, 923 F. Supp. 720, 728 (D. Md. 1996)). As described above and in the attached brief, the proposed *amicus* have a substantial interest in this litigation and offer the Court the attached brief to aid its understanding of the detrimental consequences of Defendants' actions on the ability of the public to access quality health coverage.

For the foregoing reasons, Young Invincibles respectfully requests leave to file the accompanying brief as *amicus curiae* in support of Plaintiffs' Motion for Summary Judgment. A proposed order is attached.

Dated: October 26, 2020

Respectfully submitted,

/s/ *Jennifer C. Guest*
Joel McElvain (*pro hac vice* pending)
Jennifer C. Guest, Bar #20494
Ahsin Azim (*pro hac vice* pending)
KING & SPALDING LLP
1700 Pennsylvania Avenue, N.W.
Suite 200
Washington, D.C. 20006
202.626.9260 (phone)
202.626.3737 (fax)
jguest@kslaw.com

Counsel for *Amicus Curiae*

**IN THE UNITED STATES DISTRICT COURT**
**FOR THE DISTRICT OF MARYLAND**

| | |
|---|---|
| CITY OF COLUMBUS, et al.,<br><br>*Plaintiffs*,<br><br>v.<br><br>DONALD J. TRUMP, in his official capacity as President of the United States of America, et al.,<br><br>*Defendants*. | No. 1:18-cv-02364-DKC |

**BRIEF OF AMICUS CURIAE YOUNG INVINCIBLES IN SUPPORT OF PLAINTIFFS' MOTION FOR SUMMARY JUDGMENT**

Joel McElvain (*pro hac vice* pending)
Jennifer C. Guest, Bar #20494
Ahsin Azim (*pro hac vice* pending)
KING & SPALDING LLP
1700 Pennsylvania Avenue, N.W.
Suite 200
Washington, D.C. 20006
202.626.9260 (phone)
202.626.3737 (fax)
jguest@kslaw.com

Counsel for *Amicus Curiae*

# TABLE OF CONTENTS

# TABLE OF AUTHORITIES

**Page(s)**

**CASES**

U.S. Supreme Court



Circuit Court



**STATUTES AND REGULATIONS**

**OTHER AUTHORITIES**

## INTEREST OF AMICUS CURIAE

Young Invincibles is a national nonprofit organization dedicated to elevating the young adult voice in the political process and advancing economic opportunity for young adults (ages 18-34). Since the organization's founding by young people fighting for young adult values in health care reform, Young Invincibles has become the leading national organization dedicated to expanding young adult health coverage. Focusing on both federal and state policy, Young Invincibles has developed a network of thousands of young people nationwide who fight to ensure all young people have access to comprehensive, affordable, health coverage.

*Amicus* has an interest in promoting comprehensive, affordable health coverage. It is critically important to enroll the young adult population on the Affordable Care Act's Exchanges, both because their enrollment helps to ensure marketplace stability and because young adults need coverage when they face unexpected health issues. For this reason, *amicus* objects to the Department of Health and Human Services' Notice of Benefit and Payment Parameters for 2019, which instituted a number of policies that reduce the affordability of coverage in plans on the Exchanges, degrade the quality of that coverage, and promote the marketing of plans that offer inferior coverage.

## ARGUMENT

Since its enactment, the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010) (the "ACA," or the "Act"), has provided millions of Americans with affordable, high-quality health insurance. The Act achieves this goal, in part, by establishing health care Exchanges, through which Americans may purchase affordable, comprehensive health coverage, and may obtain the assistance of non-profit navigators in selecting an appropriate plan. Since the current Administration took office in 2017, however, the Department of Health and

Human Services ("HHS") has "implemented many policies that distort the Act's requirements and undermine the Act's purposes." Pls.' Mem. in Supp. of Mot. for S.J., ECF No. 108-1, at 1. A case in point is the Administration's first annual rulemaking governing the operation of the ACA's Exchanges. In its Notice of Benefit and Payment Parameters for 2019, 83 Fed. Reg. 16,930 (Apr. 17, 2018) (the "Payment Rule"), HHS set forth rules that (1) deprive individuals of subsidies needed for the purchase of insurance on the ACA's Exchanges, (2) diminish the quality of the coverage provided by plans on the Exchanges, and (3) impede consumers from gaining the assistance of disinterested, non-profit Navigators in evaluating their health coverage options. Each of these polices is in direct conflict with the purpose of the ACA and should be set aside.

## I. The Payment Rule Deprives Individuals of Subsidies Needed for the Purchase of Insurance.

### A. The Payment Rule Fails to Give Individuals Adequate Notice of the Reasons They Have Been Declared Ineligible for Subsidies.

The ACA offers subsidies to enrollees through the health insurance exchanges, which reduce both monthly premiums and out-of-pocket costs for comprehensive health coverage. In particular, the Act provides a premium tax credit, which reduce enrollees' monthly payments for insurance coverage. 26 U.S.C. § 36B. The tax credits may be claimed on an advance basis to cover the cost of coverage obtained through the health insurance Exchanges. *See* 42 U.S.C. § 18082. The advance premium tax credit ("APTC") payments must be reconciled on a taxpayer's income tax return. Accordingly, if the relevant tax filer does not complete his or her return, or otherwise fails to reconcile advance payments, then that individual, and potentially also his or her spouse and dependents, would lose eligibility to claim APTC payments in future years.

In its Notice of Benefit and Payment Parameters for 2018, HHS implemented "targeted and detailed messaging to tax filers that highlights specific requirement to file an income tax return

and reconcile APTC paid on their behalf—and the potential adverse impact on APTC eligibility for future coverage years," finding that this messaging was "*essential*." 81 Fed. Reg. 94,054, 94,124 (Dec. 22, 2016) (emphasis added). This direct notification requirement, set forth at 45 C.F.R. § 155.305(f)(4), was put in place to "explain to the consumer how to correct the problem and regain APTC eligibility, and to provide timetables for action, and to provide this information within the bounds of IRS privacy rules, which limit the disclosure of Federal tax information." *Id.*

The Payment Rule, however, removed this "essential" direct notification requirement. 83 Fed. Reg. at 16,982. HHS sought to justify this about-face by noting that the direct notices contained federal tax information, which required special handling, and thus increased the burden on the Exchanges. *Id.* at 16,982–83. HHS provided that federally-run Exchanges would continue to provide direct notices, but encouraged state-operated Exchanges only to do so "where feasible." *Id.* at 16,983–84.

In lieu of these direct notices, HHS reverted to a prior policy of "indirect notice," under which enrollees would receive a notice that only hinted at the possibility that a defect in a tax filing was the reason that the enrollee had been found to be ineligible for APTCs. This form of notice, however, had proven to be ineffective; only 60 percent of tax filers receiving such a notice took appropriate action to file a tax return to reconcile their APTC payment. *Id.* at 16,983. The Payment Rule, then, effectively assumes that the remaining 40 percent of individuals are not eligible for APTCs. Nowhere does the rule explain the logic of this assumption. This is a hallmark of arbitrary and capricious rulemaking. *See Motor Vehicle Mfrs. Ass'n of U.S. v. State Farm Mut. Auto. Ins. Co.*, 463 U.S. 29, 43 (1983) ("[T]he agency must examine the relevant data and articulate a satisfactory explanation for its action including a rational connection between the facts found and the choice made.") (internal quotation marks and citations omitted). It is far more logical to

conclude that many of these individuals simply did not receive adequate notice of the corrective action they needed to take.

### B. The Payment Rule Imposes Pointless Verification Requirements on Lower-Income Individuals who Claim Subsidies.

APTC payments are available for individuals with incomes from 100 to 400 percent of the federal poverty level. *See* 45 C.F.R. § 155.320. Before the Payment Rule, HHS generally required the Exchanges to accept a consumer's attestation to his or her projected annual household income when that attestation reflected a higher income than what was indicated in data from the Internal Revenue Service and Social Security Administration. The Payment Rule revoked that policy, and now the agency requires an individual to locate and submit additional documentation if electronic sources indicate that the applicant's income is below the federal poverty level. 83 Fed. Reg. at 16,985.

This requirement creates a burden for lower-income persons, whose income may be highly variable from year to year, and who may face difficulty in locating documentation of their income. As of 2017, approximately 8.4 million U.S. households (including 14.1 million adults and 6.4 million children) were *unbanked*, meaning that no one in the household has a bank account.[1] An additional 24.2 million households (composed of 48.9 million adults and 15.4 million children) were *underbanked*, meaning that the household has an account at an insured institution but also obtains financial services outside of the banking system. *Id.* For this significant portion of American households that are unbanked or underbanked, income verification is exceptionally difficult, all the more so when minor changes in income, such as the addition of a few extra shifts at work, could push an individual above or below 100% of the federal poverty level. Young adult

[1] Federal Deposit Ins. Corp., *2017 FDIC National Survey of Unbanked and Underbanked Households*, 1 (2017), www.fdic.gov/analysis/household-survey/2017/2017report.pdf.

populations are particularly at risk, as they experience income fluctuations more often and may lack adequate income documentation.

HHS did not even attempt to grapple with the practical difficulties its changes created for these households. It instead asserted that this rule was needed as a "program integrity check" to protect against individuals who falsely overstate their income to qualify for APTCs. 83 Fed. Reg. at 16,986. At the same time, the agency acknowledged that "it does not have firm data" that any such pattern of false claims exists. *Id.* HHS, in other words, imposed a severe—and, in some cases, unsurmountable—burden on lower-income individuals' eligibility for subsidized health coverage, based on nothing more than its speculation that some persons may intentionally be misreporting their income. And the agency's guesswork on this score is particularly misplaced for individuals in the vast majority of states that have accepted the ACA's expansion of the Medicaid program, given that these persons could likely gain coverage on favorable terms if they reported income within Medicaid's eligibility limits. It is arbitrary and capricious, then, for the agency to base its denial of subsidies on nothing more than its "conclusory or unsupported suppositions." *NetCoalition v. SEC*, 615 F.3d 525, 539 (D.C. Cir. 2010).

## II. The Payment Rule Diminishes the Quality of Coverage Provided by Plans on the Exchanges.

### A. The Payment Rule Undermines Standards Designed to Ensure Network Adequacy.

Exchanges are required to review plan offerings for network adequacy to ensure that they provide meaningful coverage. *See* 42 U.S.C. § 18031(c)(1)(B). The Payment Rule, however, declared that federally-run Exchanges would no longer perform this mandatory function but would instead rely on a state's finding of network adequacy if the Federal Exchange determined that the State has a "sufficient" network adequacy review process. 83 Fed. Reg. at 17,025.

The Defendants incorrectly contend that *amicus* Young Invincibles supported this proposal. Defs.' Mem. in Opp'n to Pls.' Mot. for S.J. ECF No. 118-1, at 30. Quite the contrary: Young Invincibles declared that it could support this change only if "strong minimum federal network adequacy standards that are at least as protective as the current ACA standards" were maintained.[2] HHS has not fulfilled this condition; it has not maintained federal standards that would guarantee that plans provide coverage for a robust network of providers. And the states have not been able to pick up the slack; a 2014 Survey on state insurance standards prepared for the National Association of Insurance Commissioners revealed that the vast majority of states failed to enforce network adequacy standards.[3] Fewer than half the states even have established metrics to evaluate whether marketplace plans provide adequate networks.[4] Federal review of network adequacy, then, continues to be necessary to ensure that consumers are actually able to use the coverage they purchase in a meaningful way.

**B. The Payment Rule Eliminates Standardized Options for Exchange Plans.**

In order to help guide individuals through the complex process of purchasing insurance, HHS had provided for standardized options for plans on the Exchanges—that is, the Exchanges

---

[2] Administrative Record, ECF No. 114-2, at 365 (Young Invincibles comment letter).

[3] Christine Barber, et al., *Ensuring Consumers' Access to Care: Network Adequacy State Insurance Survey Findings and Recommendations for Regulatory Reforms in a Changing Insurance Market*, HEALTH MGMT. ASSOC. 2 (2014), naic.org/documents/committees_conliaison_network_adequacy_report.pdf; *see also* Mark A. Hall et al., *A Better Approach to Regulating Provider Network Adequacy*, BROOKINGS INST. 7 (2017) ("Once regulators approve an insurer's network adequacy plan, typically they then leave it to insurers to self-monitor their own compliance. Rather than conducting routine audits or requiring periodic reports of actual compliance, state regulators usually rely on consumer complaints to highlight situations that might require investigation."), www.brookings.edu/wp-content/uploads/2017/09/regulatory-options-for-provider-network-adequacy.pdf.

[4] Justin Giovannelli et al., *Implementing the Affordable Care Act: State Regulation of Marketplace Plan Provider Networks*, COMMONWEALTH FUND (May 5, 2015), www.commonwealthfund.org/publications/issue-briefs/2015/may/implementing-affordable-care-act-state-regulation-marketplace (in 2014, "[t]wenty-one states had qualitative standards to assess the adequacy of plans' provider networks").

would display plans with a specified cost-sharing structure to allow for comparison shopping. This procedure "simplif[ied] the consumer plan selection process," 81 Fed. Reg. 12,204, 12,289 (Mar. 8, 2016), "encouraged issuers to offer [standardized] plans," 83 Fed. Reg. at 16,974, and allowed for "differential display of these plans on HealthCare.gov," *id*. The Payment Rule eliminated the display of standardized options altogether, ostensibly to encourage "innovations" in plan offerings. *Id.* There is no logic to this new policy. Insurers have always been free to offer "innovative" plan designs on the Exchanges. The standardized options display simply allowed consumers to evaluate what sort of value they would be getting from these alternatives.

As *amicus* Young Invincibles explained in its comments letter, the standardized options display has proven to be especially valuable for newer consumers who are not used to buying insurance.[5] Young adults in particular have lower levels of health insurance literacy compared to older adults, are less likely to be familiar with health insurance concepts, and therefore have a harder time comparing plans.[6] These newer consumers are especially prone to confusion from modified displays that have effect of promoting superficially appealing, but inferior, forms of coverage, such as high-deductible health plans. Moreover, the removal of a display of standardized options could only make the plan selection process more complicated for consumers, which inevitably will discourage enrollment.

HHS never responded to Young Invincibles' comment, a failure that it has tried to justify by asserting that it "was not obligated to refute every supposed benefit of standardized options where its policy choice favored innovation over those benefits. …. Comments that raise points

[5] Administrative Record, ECF No. 114-2, at 365–66 (comment letter of Young Invincibles).
[6] Sharon Long et al., *Low ACA Knowledge and Health Literacy Hinder Young Adult Marketplace Enrollment*, HEALTH AFFAIRS BLOG, (Feb. 12, 2014), www.healthaffairs.org/do/10.1377/hblog20140212.037152/full/.

that are not relevant to the agency's decision do not require a response." Defs.' Mem. in Opp'n to Pls.' Mot. for S.J., ECF No. 118-1, at 37 (internal citations and quotation marks omitted). Comments that *are* relevant *do* require a response, however, and the Young Invincibles letter plainly fell into this latter category. Many consumers are unfamiliar with basic features of health insurance. The Kaiser Family Foundation has found that one fourth of consumers could not identify key health insurance terms, disproportionately so among younger people (43 percent), uninsured people (47 percent), and those with a high school education or less (45 percent).[7] What is more, absent a display of standardized options, insurers could easily promote plans with benefit designs that discriminate on the basis of health status, cherry-picking lower-cost individuals and discouraging enrollment by higher-cost individuals, thereby undermining the ACA's guarantee of affordable coverage for those with pre-existing conditions.[8] These were both "important aspects of the problem," *Dep't of Homeland Sec. v. Regents of Univ. of California*, 140 S. Ct. 1891, 1910 (2020), that HHS was required to consider in evaluating how plan options would be displayed on the Exchanges.

**C. The Payment Rule Encourages Unreasonable Rate Increases.**

The ACA requires the Secretary, in conjunction with States, to establish a process for the annual review of unreasonable premium increases for health insurance coverage. 42 U.S.C. § 300gg-94(a)(1). Insurers are required to submit a justification for any rate increases above a certain threshold. *See* 45 C.F.R. §§ 154.101. The Payment Rule undermines the effectiveness of

[7] Mira Norton et al, *Assessing Americans' Familiarity With Health Insurance Terms and Concepts*, KAISER FAMILY FOUND. (Nov 11, 2014), www.kff.org/health-reform/poll-finding/assessing-americans-familiarity-with-health-insurance-terms-and-concepts/.

[8] *See* Douglas Jacobs, *CMS' Standardized Plan Option Could Reduce Discrimination*, HEALTH AFFAIRS BLOG (Jan. 6, 2016), http://www.healthaffairs.org/do/10.1377/hblog20160106.052546/full/.

these rate reviews by raising the threshold for review from a 10-percent increase to a 15-percent increase, 83 Fed. Reg. at 16,972–73, and by exempting student health plans from this process, 83 Fed. Reg. at 16,972.

*Threshold for Rate Review*. HHS asserts that, "since the inception of the review threshold, only one filing with this determination [of unreasonableness] has fallen between the 10 to 15 percent range," 83 Fed. Reg. at 16,973, and that this history demonstrates that insurers necessarily have good reason when they raise their rates by as much as 15 percent annually. This simply does not follow. Under the same logic, one could just as readily conclude that because one is dry, there is no need for an umbrella. It is far more likely that, because insurers knew that their rates would be reviewed, they proposed rate increases that they knew they could justify.

And where insurers could not provide that justification, consumers benefitted. For example, for the 2018 plan year in Oregon—when insurers were required to justify rate increases of more than 10 percent—Moda's proposed rate increase of 13.1 percent was reduced to a 9.2 percent increase as a result of the rate review process. Consumers in Oregon saved tens of millions of dollars as a result of this review, but would not have done so if the Payment Rule had already been in effect.[9]

HHS suggested in the Payment Rule that insurers also reasoned that rate increases of up to 15 percent would be presumptively reasonable, given large spikes in the cost of Exchange plans for the 2018 year. This ignores the fact that the jump in premiums that year was a temporary, one-year phenomenon that was driven by the Administration's own efforts to undermine the operation of the ACA. Premiums shot up that year as a result of the Administration's termination of cost-

[9] *See* 2018 Final Rate Decisions, OR DEPT. OF CONS. & BUS. SERVS. (2018), dfr.oregon.gov/healthrates/Documents/2018-fnl-rates.pdf.

sharing subsidies and its efforts to create uncertainty over the continuing viability of the ACA's shared responsibility payments for those who lack insurance.[10] The 2018 premium increases also largely made up for insurers' earlier underpricing and would have been less than 10 percent in a stable policy environment.[11] Since then, the growth rate for health spending has averaged 5.4 percent per year.[12] A central premise of the agency's decision to raise the threshold for rate reviews, then, is simply incorrect.

*Exclusion of student plans from rate reviews*. HHS chose to exclude student health plans from rate reviews, reasoning that this form of coverage is "more in line with large group pricing, in which experience rating and other factors can be used to determine rates." 83 Fed. Reg. at 16,972. Student plans, however, are dissimilar from large group plans in several important ways. Students enrolled at a particular college are presented with a limited range of options, and those options have historically been relatively meager, particularly in comparison to plans offered by large employers.[13] There is no reason, then, to assume that colleges and universities have a sufficient incentive to negotiate with insurers to protect students from rate increases.

The Defendants dismiss Young Invincibles' comment as "speculat[ive]," or "non-significant," and thus not worthy of a response in the rulemaking. Defs.' Opp'n to Pls.' Mot. for S.J., ECF No. 118-1, at 57. Far from speculative, the deficiencies in student plans are proven and

---

[10] Sabrina Corlette, *Proposed Premium Rates for 2018: What Do Early Insurance Company Filings Tell Us?*, CHIRBLOG (May 17, 2017), chirblog.org/proposed-premium-rates-for-2018-what-do-early-filings-tell-us/.

[11] Matthew Fielder, *Taking Stock of Insurer Financial Performance in the Individual Health Insurance Market through 2017*, BROOKINGS (Oct. 27, 2017), www.brookings.edu/research/taking-stock-of-insurer-financial-performance-in-the-individual-health-insurance-market-through-2017/.

[12] Sean P. Keehan, Office of the Actuary, CMS, *National Health Expenditure Projections, 2019–28: Expected Rebound In Prices Drives Rising Spending Growth* (Mar. 24, 2020), www.healthaffairs.org/doi/full/10.1377/hlthaff.2020.00094.

[13] Administrative Record, ECF No. 114-2, at 361-362 (comment letter of Young Invincibles).

well known. Prior to the enactment of the ACA, student health plans left many students with inadequate yet expensive coverage.[14] Although significant strides have been made, the Payment Rule would scale back this progress. Students have few, if any, choices in picking a student health plan once they select a school, because institutions typically offer students one or very few plan options. Without rate review, students could see their premiums skyrocket and insurers could be incentivized to generate higher profits on products requiring less transparency.

**D. The Payment Rule Allows Insurers to Charge More for Inferior Coverage.**

The Medical Loss Ratio ("MLR") provision in the ACA stops insurers from inflating premiums with excessive overhead by requiring them to spend at least 80 percent of their premium revenue on medical services or on activities that improve health quality. 42 U.S.C. § 300gg-18(b). This provision operates to guarantee that consumers receive real value for their premiums and is a critical piece of the ACA's consumer protections.[15] During the first year that the MLR was in effect, insurers paid out over a billion dollars in rebates to nearly 13 million individuals.[16] The Payment Rule undermines the effectiveness of the MLR provision, limiting the value that consumers will gain from insurance purchased on the Exchanges.

---

[14] *See* Press Release, Office of the Attorney General, *Attorney General Cuomo Finds College Students Nationwide May Be At Risk Due To Inferior Health Insurance Plans* (Apr. 8, 2010), ag.ny.gov/press-release/2010/attorney-general-cuomo-finds-college-students-nationwide-may-be-risk-due-inferior ("The Attorney General's investigation revealed that many school-sponsored student health plans have limitations and exclusions that put college students and their families at risk of facing catastrophic costs for medical care. Some plans have exclusions for pre-existing conditions, leaving many students with such conditions completely uncovered for any related treatments. Some plans require students with pre-existing conditions that are uncovered to purchase the plan at its full price. Many plans also have extremely low coverage limits.").

[15] Michael J. McCue, *The Federal Medical Loss Ratio Rule: Implications for Consumers in Year 3*, COMMONWEALTH FUND (Mar. 26, 2015), www.commonwealthfund.org/publications/issue-briefs/2015/mar/federal-medical-loss-ratio-rule-implications-consumers-year-3.

[16] Suzanne M. Kirchoff, *Medical Loss Ratio Requirements Under the Patient Protection and Affordable Care Act (ACA): Issues for Congress*, CONG. RES. SERV. 2 (Aug. 26, 2014), digital.library.unt.edu/ark:/67531/metadc462995/m1/1/high_res_d/R42735_2014Aug26.pdf.

HHS has historically permitted insurers to count "quality improvement activities"—that is, expenditures in addition to payments for medical services that improve health outcomes, such as patient-centered counseling—as a health care expenditure for purposes of the medical loss ratio. 45 C.F.R. § 158.150. But insurers could only claim expenditures that they actually did make. The Payment Rule replaces this requirement with a fiction. Insurers are now presumed to spend 0.8 percent of their premium revenues on quality improvement activities, whether they are able to provide documentation that they actually did so or not. HHS attempts to justify this change by asserting that insurers, in past years, had paid 0.7 to 0.8 percent of their revenues on quality improvement. 83 Fed. Reg. at 17,032. But, as even the agency acknowledges, this figure is only an average, and some insurers spend far less on quality improvement. *Id.* Moreover, there is no reason to assume that insurers will continue to spend the same amounts if they know they will now be credited for an expenditure even if they don't make it. The end result will be poorer health outcomes and a decrease in the value that consumers gain from the plans that they purchase.

## III. The Payment Rule Inhibits the Marketing of Exchange Plans.

### A. The Payment Rule Undermines Federal Oversight of Direct Enrollment Entities.

HHS has permitted the operation of "direct enrollment entities," that is, brokers who might steer consumers either to comprehensive health coverage available on the Exchanges or to other products, such as short-term health insurance plans that offer inferior coverage. These direct enrollment entities may earn commissions from the offerors of short-term plans that cap benefits

or that exclude critical benefits from coverage.[17] HHS, accordingly, has required that these entities be subject to an audit by an HHS-approved third party. *See* 83 Fed. Reg. at 16,981.

The Payment Rule removes this safeguard, and "instead permit[s] an agent, broker or issuer to select a third-party entity that meets HHS requirements to conduct an annual operational readiness review prior to participating in direct enrollment." *Id.* at 17,048. In other words, the rule allows the fox to choose who guards the henhouse. The conflict of interest that the rule creates is obvious and unjustifiable. HHS has failed entirely to justify its decision to permit this conflict of interest. It argues that its rule should survive simply because it *acknowledged* the danger of a conflict of interest, and that it intends to monitor the issue. Defs.' Opp'n to Pls.' Mot. for S.J., ECF No. 118-1, at 24. But merely "[n]odding to concerns raised by commenters only to dismiss them in a conclusory manner is not a hallmark of reasoned decisionmaking." *Gresham v. Azar*, 950 F.3d 93, 103 (D.C. Cir. 2020).

**B. The Payment Rule Inhibits the Operation of Navigators.**

The ACA requires every Exchange to establish a program under which grants are awarded to Navigators to educate the public on the availability of qualified health plans, to distribute fair information as to the availability of subsidies for the purchase of comprehensive coverage on the Exchanges, and to help consumers to enroll in qualified health plans. 42 U.S.C. § 18031(d)(4)(K), (i). Until the Payment Rule, each Exchange was required to have at least two Navigators, one of which needed to be a consumer-focused nonprofit group. 83 Fed. Reg. at 16,979.

[17] *See* JoAnn Volk, *State Options Blog Series: Streamlined, Direct Marketplace Enrollment Has Risks, Benefits, but Much Depends on State Oversight*, CHIRBLOG (Nov. 8, 2017), chirblog.org/state-options-streamlined-direct-marketplace-enrollment/.

The Administration has slashed funding for the Navigator program by about 84 percent.[18] As a result, the number of Navigator organizations dropped by more than one-half from 2018 to 2019. *Id.* The Payment Rule pours fuel on to the fire. Under the rule, it is now optional for Navigators to have an in-state presence, and there no longer needs to be at least two Navigators in a state, nor does one need to be a non-profit group. 83 Fed. Reg. at 16,979. Accordingly, the Payment Rule dramatically undermines the ACA's promise that disinterested third parties, without a profit motive, would be available to help consumer consider their health coverage options.

Research has shown that more than 7 in 10 uninsured consumers prefer one-on-one help when enrolling in a plan.[19] In the third open enrollment period in 2016, almost half of all marketplace enrollees received assistance in-person, with 8 in 10 reporting they sought in-person help because they did not feel confident enrolling on their own.[20] In 2015, researchers found that even highly educated young adults have found "that their unfamiliarity with, or misunderstanding of, these [health insurance] terms made it difficult for them to make informed plan choices."[21]

---

[18] Katie Keith, *CMS To Maintain Navigator Funding At $10 Million For 2020, 2021*, HEALTH AFFAIRS (May 29, 2019), www.healthaffairs.org/do/10.1377/hblog20190529.659554/full/#:~:text=Since%20the%20Trump%20administration%20took,only%2039%20grantees%20for%202019.

[19] *Understanding the Uninsured Now*, ROBERT WOOD JOHNSON FOUND. (June 1, 2015), www.rwjf.org/en/library/research/2015/06/understanding-the-uninsured-now.html.

[20] Karen Pollitz et al., *2016 Survey of Health Insurance Marketplace Assister Programs and Brokers*, KAISER FAMILY FOUND. (June 8, 2016), www.kff.org/health-reform/report/2016-survey-of-health-insurance-marketplace-assister-programs-and-brokers/. Those who did seek in-person help were twice as likely to complete enrollment, and African Americans and Latinos were 43% more likely to seek in-person help than their white counterparts. *Id.*; *see also In-Person Assistance Maximizes Enrollment Success*, ENROLL AM. 1–2 (Mar. 2014), champsonline.org/assets/files/ToolsProducts/OEResources/In-Person-Assistance-Success.pdf.

[21] *Young adults find health insurance enrollment on HealthCare.gov challenging, according to study*, SCIENCEDAILY (June 16, 2015), www.sciencedaily.com/releases/2015/06/150616071718.htm; *see also* Charlene A. Wong et al., The Roles Of Assisters And Automated Decision Support Tools In Consumers' Marketplace Choices: Room For Improvement, HEALTHAFFAIRS (Mar. 2019), https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2018.05021.

This experience demonstrates the critical role played by local entities—such as food banks, HIV services organizations, United Way affiliates, and legal aid organizations—who have conducted in-person outreach, educated consumers, and assisted with enrollment since 2013.

HHS conceded this point in its Payment Rule: "Based on HHS's experience with Navigator programs in FFEs and other public programs, we believe entities with strong relationships in their FFE service areas tend to deliver the most effective outreach and enrollment results." 83 Fed. Reg. at 16,979–80. Yet the agency inexplicably chose to discard these local relationships and instead to promote the operation of outside entities, even though those entities might steer consumers away from the comprehensive and subsidized health coverage that is available on the Exchanges.

## CONCLUSION

The Payment Rule directly conflicts with the goals of the ACA. By issuing this rule, HHS has made it harder for individuals to gain the subsidies they need to purchase comprehensive health coverage; has diminished the quality of that coverage; and has undermined the ability of disinterested, non-profit Navigators to help consumers understand their health coverage options. For these reasons, this Court should grant Plaintiffs' Motion for Summary Judgment.

Dated: October 26, 2020

Respectfully submitted,

/s/ *Jennifer C. Guest*
Joel McElvain (*pro hac vice* pending)
Jennifer C. Guest, Bar #20494
Ahsin Azim (*pro hac vice* pending)
KING & SPALDING LLP
1700 Pennsylvania Avenue, N.W.
Suite 200
Washington, D.C. 20006
202.626.9260 (phone)
202.626.3737 (fax)
jguest@kslaw.com

Counsel for *Amicus Curiae*

**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*.

No. 1:18-cv-02364-DKC

**[PROPOSED] ORDER**

Upon consideration of the Motion of Young Invincibles for Leave to File Brief as *Amicus Curiae* in Support of Plaintiffs' Motion for Summary Judgment, it is hereby ORDERED that the Motion is GRANTED. The clerk is directed to file the brief on the docket in this matter.

**SO ORDERED.**

**Dated:** _____

_____
Judge Deborah K. Chasanow
UNITED STATES DISTRICT COURT JUDGE