IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MARYLAND

CITY OF COLUMBUS, *et al.*, Plaintiffs, v. DONALD J. TRUMP, *et al.*, Defendants.	Civil Action No. 1:18-cv-02364-DKC

MOTION FOR LEAVE TO FILE BRIEF OF THE SHRIVER CENTER ON POVERTY LAW, PLANNED PARENTHOOD FEDERATION OF AMERICA, THE NATIONAL HEALTH LAW PROGRAM, THE ASIAN & PACIFIC ISLANDER AMERICAN HEALTH FORUM, THE ASSOCIATION OF ASIAN PACIFIC COMMUNITY HEALTH ORGANIZATIONS, AND FAMILIES USA AS AMICI CURIAE SUPPORTING PLAINTIFFS' MOTION FOR SUMMARY JUDGMENT

The Shriver Center on Poverty Law ("Shriver Center"), Planned Parenthood Federation of America ("PPFA"), the National Health Law Program ("NHeLP"), the Asian & Pacific Islander American Health Forum ("APIAHF"), the Association of Asian Pacific Community Health Organizations ("AAPCHO"), and Families USA (collectively, "Amici")[1] hereby move for leave to file an amicus curiae brief in support of Plaintiffs' Motion for Summary Judgment. 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. Both Plaintiffs and Defendants have consented to the filing of this brief. A copy of the proposed amicus brief is attached as Exhibit 1, and a proposed Order is attached as Exhibit 2. Amici request that the brief be deemed filed on the date of this motion, October 26, 2020.

[1] Amici are non-profit organizations, with no parent corporations, and they do not issue stock.

Under Standing Order 2018-07, the filing of an amicus brief is authorized with leave of the court. This court has explained that the filing of an amicus brief may be permitted where (1) amici provide helpful analysis of the law, (2) the amici have a special interest in the subject matter, or (3) existing counsel is in need of assistance. *See Bryant v. Better Bus. Bureau*, 923 F. Supp. 720, 728 (D. Md. 1996). As described in more detail below, Amici have a special and compelling interest in the subject matter, particularly in regard to the various avenues through which the Patient Protection and Affordable Care Act ("ACA") has helped women, low-income Americans, members of historically marginalized racial and ethnic groups, and others, in their efforts to obtain quality coverage.

The Shriver Center is a national non-profit focused on building a future free from racism and poverty, and it works to make equal justice and opportunity a reality. One of the Shriver Center's particular focuses is on ending racial disparities in access to, and quality of, health care. To that end, the Shriver Center aims to remove barriers to access for disadvantaged groups and to make health care more affordable. The Shriver Center filed comments in the rulemaking that produced the 2019 Rule, which is the principal subject of this litigation.

Founded over 100 years ago, Planned Parenthood is the oldest and largest provider of reproductive health care in the United States. Its mission is to provide comprehensive reproductive health care services and related educational programs, and to advocate for public policies to ensure access to health services. In particular, Planned Parenthood affiliates provide high-quality reproductive health care to individuals and communities facing serious barriers to obtaining such care—especially individuals with low incomes, individuals located in rural and other medically underserved areas, and communities of color. PPFA has long focused on ensuring that implementation of the ACA provides consumers throughout the nation with access

to quality, affordable health care. PPFA filed comments in the rulemaking that produced the 2019 Rule.

NHeLP is a national non-profit that protects and advances health rights of low-income and underserved individuals and families. NHeLP strives to give a voice to low-income individuals and families in federal and state policy-making, promote the rights of patients in emerging managed-care healthcare systems, and advocate for a healthcare system that will ensure all people have access to quality and comprehensive health care. NHeLP filed comments in the rulemaking that produced the 2019 Rule.

APIAHF is a national non-profit established in 1986 that works toward health equity and health justice for all communities, but is especially focused on doing so for Asian American and Native Hawaiian and Pacific Islander communities. APIAHF supports local Asian American and Native Hawaiian and Pacific Islander communities so that they may have an influence on local, state, and national policy. APIAHF filed comments in the rulemaking that produced the 2019 Rule.

AAPCHO is dedicated to promoting advocacy, collaboration, and leadership that improves health care access and outcomes for Asian American and Native Hawaiian and Pacific Islander communities within the United States and its territories. AAPCHO provides policy analysis, education, and training opportunities to community-based organizations and primary care providers serving underserved populations throughout the United States. AAPCHO filed comments in the rulemaking that produced the 2019 Rule.

Families USA is a national, non-partisan, non-profit organization that has represented the interests of health care consumers and promoted health care reform in the United States for more than 35 years. Families USA fought for passage of the ACA and sponsored studies that helped

shape it. Having long represented the interests of health-care consumers, Families USA offers a valuable perspective on how the statute is operating and how it has unequivocally and substantially improved access to health care.

Respectfully submitted,

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October 26, 2020

CERTIFICATE OF SERVICE

I hereby certify that on October 26, 2020, the foregoing document was filed with the Clerk of the Court, using the CM/ECF system, causing it to be served on all counsel of record.

Dated: October 26, 2020

/s/ Russell P. Hanser
Russell P. Hanser

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

BRIEF OF AMICI CURIAE

SHRIVER CENTER ON POVERTY LAW,
PLANNED PARENTHOOD FEDERATION OF AMERICA,
NATIONAL HEALTH LAW PROGRAM,
ASIAN & PACIFIC ISLANDER AMERICAN HEALTH FORUM,
ASSOCIATION OF ASIAN PACIFIC COMMUNITY HEALTH ORGANIZATIONS,
AND FAMILIES USA

IN SUPPORT OF
PLAINTIFFS' MOTION FOR SUMMARY JUDGMENT

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INTERESTS OF AMICI

The Shriver Center on Poverty Law ("Shriver Center"), Planned Parenthood Federation of America ("PPFA"), the National Health Law Program ("NHeLP"), the Asian & Pacific Islander American Health Forum ("APIAHF"), the Association of Asian Pacific Community Health Organizations ("AAPCHO"), and Families USA (collectively, "Amici") submit this brief to assist the court in understanding the unique challenges faced by women, low-income and other economically vulnerable Americans, and members of Black, Indigenous, and People of Color ("BIPOC") communities, among others, in their efforts to obtain quality health-care coverage. As detailed herein, before the Patient Protection and Affordable Care Act ("ACA") passed, these groups faced especially daunting barriers to obtaining health-care coverage, and accordingly had significantly higher uninured rates than other Americans. The ACA changed that, expanding coverage and narrowing the gap. Upon assuming office, though, the Trump Administration initiated a multi-front assault on the law, which – as Plaintiffs have made clear – included but was not limited to adoption of the 2019 Rule. That assault has had its intended effect, reversing the trend toward expanded coverage and leaving many of the people whose interests Amici work to defend once again uninsured. Each of the individual Amici filed comments opposing aspects of the proposed 2019 Rule, but the Department of Health and Human Services ("HHS") paid no heed to their concerns. Amici therefore have a direct and substantial interest in seeing this Court declare the 2019 Rule arbitrary, capricious, and otherwise unlawful.

ARGUMENT

Like many millions of Americans, the groups whose interests Amici represent benefited dramatically from the passage and implementation of the ACA. In particular, the ACA's creation of health-care exchanges enabling Americans to easily identify and compare plans that were appropriate to their needs, safe in the knowledge that the listed plans satisfied basic criteria

set out in the Act, enabled millions of Americans to secure appropriate coverage, often for the first time. When HHS proposed to modify or eliminate features that were critical to the exchanges' success, Amici commented, explaining why the contemplated changes would harm Americans generally and marginalized groups in particular. HHS largely ignored these concerns, in many cases simply adopting modifications that parroted its proposal. As Amici predicted, and contrary to HHS's rosy predictions, these changes have harmed those who had been most helped by the exchanges in the first place. The 2019 Rule is arbitrary and capricious and otherwise unlawful. For these reasons, the Court should grant Plaintiffs' Motion for Summary Judgment.

I. SYSTEMICALLY MARGINALIZED GROUPS FACE PARTICULARLY DAUNTING CHALLENGES IN OBTAINING ADEQUATE HEALTH-CARE COVERAGE.

As Amici made clear during the rulemaking, marginalized groups – including women, children, BIPOC, economically vulnerable Americans, and others – face special challenges in obtaining adequate health-care coverage. These challenges include structural racism and sexism in the provision of medical care and access to insurance, affordability of care, low English proficiency, and limited access to the technologies needed to research and select coverage online. For example, PPFA explained to HHS that "[t]he majority of Planned Parenthood patients have incomes at or below 150 percent of the Federal Poverty Level (FPL)." AR3007. Many of these patients are eligible to purchase coverage through a qualified health plan on an exchange. More than half of all people who purchase private coverage on an exchange are women. *E.g.*, ASPE, *Health Insurance Marketplaces 2016 Open Enrollment Period: Final Enrollment Report*, at 12 tbl.4 (March 2016), https://aspe.hhs.gov/system/files/pdf/187866/Finalenrollment2016.pdf. But "[w]omen, in particular, have reported difficulty finding plans that provide them sufficient access to the health care providers they need." AR3009.

Similarly, NHeLP cited particular difficulties faced by BIPOC in obtaining health care:

> Nonelderly Asians, Hispanics, Blacks, and American Indians and Alaska Natives face increased barriers to accessing care compared to Whites and have lower utilization of care. For example, the preterm birth rate for Black women is 24% – higher than for any other women. Black women experience higher rates of certain chronic conditions such as diabetes, hypertension, and sexually transmitted infections, which can result in poor birth outcomes if these conditions [] remain unidentified or unmanaged before women become pregnant. In 2015, the infant mortality rates were 5.0% for Hispanic, 8.3% for American Indian/Native Alaskans, 11.3% for Non-Hispanic Black, compared to 4.9% for non-Hispanic Whites.

AR1300 (footnote omitted).

Language barriers, Amici explained, pose special challenges for individuals seeking health care and coverage. APIAHF explained that persons who are immigrants, who have limited proficiency in English, and who have low health literacy face special difficulties in applying for and effectively utilizing health coverage and care, AR2584, while AAPCHO addressed the needs of "consumers who are limited English proficient (LEP), immigrant or with low levels of health literacy," for whom "applying for and effectively utilizing health coverage and care [was] already difficult," AR1817. Indeed, the record showed that nearly one in three Asian Americans and nearly one in ten Native Hawaiian and Pacific Islander speaks English less than "very well," creating barriers to enrollment in health insurance *E.g.*, AR1820; AR2587.

The record further revealed that economically vulnerable Americans face multiple barriers to consistent, high-quality insurance and medical care. APAIHF underscored the difficulties faced by those experiencing "frequent changes in employment status, housing and household makeup," AR2591, while Families USA highlighted the challenges faced by those with fluctuating incomes near the poverty line, hourly workers, and the self-employed. AR2738.

II. AMICI DEMONSTRATED THAT PROPOSED RULE AMENDMENTS WOULD IMPOSE UNWARRANTED HARMS ON MARGINALIZED GROUPS.

When HHS issued its proposed rule in 2018, Amici recognized that many of the modifications contemplated would disproportionately harm the groups whose interests they work to protect. Accordingly, Amici participated in the rulemaking proceeding, laying out the many ways in which the new rule, if adopted, would impact women, low-income and economically vulnerable Americans, members of racial and ethnic minorities, and other marginalized groups. Amici detailed problems with virtually all of the modifications highlighted by Plaintiffs in this case, but here, for brevity's sake, will focus on just four.

a. Navigator Program Modifications

Amici uniformly opposed proposed modifications to the Navigator program. As Plaintiffs have explained, the ACA requires exchanges to provide grants to health-care "Navigators," organizations that work to help enroll individuals in qualified health-care plans. With respect to Navigators, HHS proposed to eliminate (1) the requirement that there be at least two Navigators per exchange; (2) the requirement that Navigators maintain physical presence in the exchange; and (3) the requirement that at least one Navigator in an exchange be a community-based, consumer-focused nonprofit. Amici (and others) showed that each of these modifications would wreak havoc on at-risk populations.

As an initial matter, Amici showed that the Navigator program played a critical role in increasing enrollment by members of marginalized groups. As PPFA noted:

> According to [HHS's] own website, "navigators play a vital role in helping consumers prepare electronic and paper applications to establish eligibility and enroll in coverage through the Marketplaces and potentially qualify for an insurance affordability program. They also provide outreach and education to raise awareness about the Marketplace, and refer consumers to health insurance ombudsman and consumer assistance programs when necessary."

AR3010, *quoting* CMS.gov, *In-Person Assistance in the Health Insurance Marketplaces*, https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces/assistance. PPFA noted that Navigator programs and other assistance programs helped over five million consumers enroll in coverage during the ACA's third open enrollment period. *Id.* Moreover, Navigators were likely to significantly increase enrollment: "According to a Commonwealth Fund survey, lack of awareness about the Marketplace, difficulty selecting plans during the enrollment process, and lack of assistance in selecting plans are among the top reasons that people do not enroll in Marketplace coverage." *Id*. A 2015 study confirmed the importance of Navigators, concluding that "[t]he strongest predictor of completing the application process was receiving help with enrollment from a navigator or application assister, which increased the probability of obtaining coverage by nearly 10 percentage points." Somers, Maylone, Nguyen, Blendon, and Epstein, *The Impact Of State Policies On ACA Applications And Enrollment Among Low-Income Adults In Arkansas, Kentucky, And Texas*, 34 HEALTH AFFAIRS 1010, 1015 (2016), https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.2015.0215. In short, as Amici demonstrated, more Americans would be insured if they had assistance in becoming aware of the Marketplace, selecting plans, and (where available) obtaining financial assistance – exactly the functions served by Navigators.

Amici next explained at length why the elimination of the "two Navigators per state" requirement would be especially harmful to groups with unique needs. This requirement "ensures that a state can have a general entity and one more tailored to specific needs within a state, whether that includes a focus on young adults, limited English proficient individuals, or other targeted populations." AR3355; AR1289. As AAPCHO cautioned, "[f]ewer navigators would likely mean fewer resources going to each state for in-person assistance, hurting the

populations that rely on help for enrollment and follow-up." AR1820. Moreover, elimination of the two-per-state requirement "would greatly reduce the likelihood that entities with relationships with specific populations in a state will receive navigator funding," particularly because the record revealed that Navigators beyond the first in the exchange often "target[] different populations that are hard to reach or require specialized enrollment assistance." AR1820.

Amici also detailed the adverse consequences that would arise from elimination of the "physical presence" requirement.

> First, face-to-face assistance is often critical to obtain the trust of applicants and to help walk them through the various components of application, plan selection, resolving data matching inconsistencies, and perhaps assisting with appeals. Further, entities with a physical presence will better know their communities and be better able to serve them because they likely interact with the target populations on an ongoing basis and are able to build relationships that transcend the application process…. In particular, individuals with low health literacy (in addition to low literacy in general), low internet proficiency and who live in rural areas may face additional challenges in enrolling and rely on assisters [including Navigators] to help complete enrollment.

AR3356; AR1290. Families USA noted that "[o]n average, it takes 90 minutes to help consumers enroll for the first time and 60 minutes to help renew[] consumers," and that physically present Navigators are best situated to "explain[] basic health insurance concepts" and help the enrollee "upload[] documents to prove eligibility, enter[] information in an application, and view[] detailed plan information…." AR2736. AAPCHO and APIAHF agreed, noting that, "[f]or many [Asian Americans, Native Hawaiians, and Pacific Islanders], only in-person assistance provides the tools needed to enroll" for a plan. AR1820; AR2587. In particular, "Consumers with low-levels of technology utilization depend upon in-person assistance for quality enrollment." AR1822; AR2588. These groups supplied a study showing that "[a]mong

consumers who attempted to enroll during the first three months of open enrollment, those who reported having in-person assistance were roughly twice as likely to successfully enroll in a health plan as those who attempted to enroll online without any help." Enroll America, *In-Person Assistance Maximizes Enrollment Success* (Mar. 2014), http://champsonline.org/assets/files/ToolsProducts/OEResources/In-Person-Assistance-Success.pdf (assessing ACA's first open enrollment period) (cited at AR2587).

Amici further challenged any removal of the requirement that at least one Navigator in each exchange be a community-based, consumer-facing nonprofit. In Families USA's words, "[c]ommunity-based nonprofits are the most likely to have relationships with and experience serving lower income and uninsured consumers who qualify for the marketplace and need help with enrollment, have relationships in minority and limited English proficient communities, and have incentives to serve complex households with multiple streams of income." AR2736. APAIHF highlighted the ways in which Navigators from within the community are "uniquely qualified to understand the needs of its population," and reported that "[n]onprofit navigator groups typically have expertise in one or more communities, like veterans or [low English proficiency] populations, as well as a trusted name with many community members" – "competencies that non-community groups lack." AR2588. Shriver Center and NHeLP agreed, noting that community and consumer-based entities are "best suited to address the[] needs" of individuals requiring a navigator's assistance. AR1289-AR1290; AR3355-AR3356. As PPFA explained, Navigators are known and trusted by the communities they serve – they "often have the deepest relationships with the community, and customers may be more likely to [be comfortable] sharing their health and financial information" with them, "which facilitates enrollment." AR3010.

b. Elimination of Standardized Options

Amici also emphasized that the elimination of standardized options would badly impair many individuals' ability to select the plans best suited for them. As AAPCHO and APIAHF explained, standardized options are especially important for groups likely to face challenges in understanding and contrasting available plans. "Many consumers have low health literacy and find it difficult to understand the difference between cost sharing structures, particularly those purchasing insurance for the first time." AR1818; AR2585. These groups cited a Kaiser Family Foundation survey finding that one in four consumers were not able to identify key health insurance terms, but young voters, the uninsured, and people with high school education or less were especially likely to score low, answering between 0 and 4 out of 10 questions correctly. Mira Norton, Liz Hamel & Mollyann Brodie, Kaiser Family Found., *Assessing Americans' Familiarity With Health Insurance Terms and Concepts* (Nov. 11, 2014), https://www.kff.org/health-reform/poll-finding/assessing-americans-familiarity-with-health-insurance-terms-and-concepts/ (cited at AR2585 n.3). These are the populations who would be most affected by elimination of the Simple Choice plans, as they benefit from the clear demarcation and consistent explanation that allows them to compare plans. The offering of standardized plans with easily compared terms was therefore central to fulfilling the ACA's goals: Such plans enabled "[m]eaningful consumer choice" by "provid[ing] upfront information," were "typically more affordable," and "facilitate[d] shoppers' comparison of benefits and … help[ed] them make informed enrollment decisions." AR3008. Absent standardized plans, Amici warned, "consumers frequently choose plans based only on premiums – without a clear understanding of additional out-of-pocket costs they might experience, as well as the benefits covered under the plan." *Id*.

Amici focused particularly on the importance of the "apples-to-apples" comparison made possible by standardized options. "Standardized options, also known as Simple Choice plans, are displayed differently on the Marketplace to ease plan comparison for Marketplace shoppers – essentially creating an apples-to-apples comparison that supports the decision-making process for consumers." AR3008. *See also* AR1276; AR2735; AR3455 ("Having standardized options assists customers in making informed choices. When plans share a common benefits structure, including tiering and cost sharing, consumers can make apples-to-apples comparisons of plans and benefits.").

Amici further explained that the presence of standardized options reduced consumers' out-of-pocket costs and therefore improved care. Families USA noted that such options "encourage plans to offer many outpatient services on a pre-deductible basis, improving access to services that prevent disease from worsening" and that, "[b]efore [standardized-option] plans were available, surveys showed that adults with non-group coverage often went without needed outpatient care due to its costs." AR2735.

c. Addition of Excessive Income-Verification Measures

Amici showed that proposals to require additional income-verification measures would also harm the groups whose interests they champion, given that members of these groups often lack access to or familiarity with the materials necessary to meet the criteria that the 2019 Rule implemented. In fact, many of the benefits that average- or high-income Americans might take for granted when documenting their income (*e.g.*, to obtain mortgages or compute tax obligations) are not available to those needing to prove their income for ACA purposes. Low-income Americans "may have fluctuating income due to shift work, seasonal work, time off needed for child/elder care, or a host of other reasons," or "may have changed jobs" during the relevant period. AR1293; AR3359. Some applicants may "simply be unable to find the time to

verify their income, such as those in cash-based industries who work erratic hours." AR1824. *See also* AR2738. And whereas many Americans can simply log onto their bank's website to download statements demonstrating their cash flow, the record showed that 43.8 percent of households with highly variable income "were un- or underbanked, meaning they likely would face significant challenges in verifying their income." *Id*. (citing Fed. Deposit Ins. Corp., 2015 FDIC National Survey of Unbanked and Underbanked Households at 18 figs. 3.4 & 3.5 (Oct. 2015), https://www.economicinclusion.gov/surveys/2015household/documents/2015_FDIC_Unbanked_HH_Survey_Report.pdf).

Amici showed as well that even the most able and diligent enrollee may be thwarted by defects in the systems used to verify registrants' incomes.

> We have seen that data verification systems, including systems for verifying income, citizenship and identify, all have serious flaws and can tie consumers up trying to produce the required documentation. For example, while 26 million Americans lack a credit history, including 30 percent of consumers in low-income neighborhoods, healthcare.gov relies on credit score providers in part to verify income.

AR1824.

d. Elimination of Required Notification Regarding Tax Credit Ineligibility

For similar reasons, Amici showed, removal of the requirement that individuals be notified that they were being denied tax credits would harm the populations whose interests they represent. To begin with, as Amici made clear, the rationale provided by HHS for this proposed change did not withstand even the barest scrutiny. HHS stated that, under the then-governing approach, about 60 percent of households receiving notification took corrective action. HHS asserted that the approximately 40 percent of households receiving the notification that did *not* take action were likely *ineligible*. *See* 82 Fed. Reg. 51086 (Nov. 2, 2017). As Amici showed,

however, this was nonsense. First, it is irrational to eliminate a notice requirement when 60 percent of recipients took action after notification. Second, as for the 40 percent of households that did not take corrective action, HHS failed to consider that they might have failed to do so for reasons entirely unrelated to eligibility. Indeed, as Amici pointed out, "Given the insufficient clarity of the notices, it is probable and indeed likely, that the majority of the 40% failed to take action specifically because" the notices they received were inadequate. AR3358; AR1292.

In fact, Amici warned, elimination of the notification requirement would result in the exclusion of many deserving registrants. NHeLP and the Shriver Center, for example, observed that applicants eligible for tax credits by definition have incomes between 100% and 400% of the federal poverty line, and "many cannot afford the luxury of paying for a benefit until they can determine what next steps they need to take to maintain" their tax credits. AR1291-AR1292; AR3357. Similarly, AAPCHO explained that Asian Americans and Native Hawaiian/Pacific Islanders with low English proficiency "often miss notices because they are unable to read them[,] as notices are only provided in English and Spanish." AR1824. If the notification requirement were eliminated, AAPCHO warned, "even more consumers will fail to take action ahead of open enrollment to reconcile," placing "a further burden on groups performing enrollment work." AR1823.[1]

III. THE HARMS ABOUT WHICH AMICI WARNED HHS HAVE COME TO PASS SINCE THE 2019 RULE TOOK EFFECT.

Events since the 2019 Rule's adoption have borne out the concerns Amici raised before HHS. While the ACA initially succeeded in reducing the proportion of uninsured Americans,

[1] Moreover, the harms imposed by the elimination of this requirement were compounded by the modifications to the Navigator program, because Navigators would ordinarily be able to help enrollees facing reconciliation problems or other issues.

this figure has risen again during the current Administration, and particularly in the wake of the 2019 Rule's application.

The ACA, as initially implemented, had its intended effect: Enrollment increased, and costs declined. This was particularly true for members of the groups for whom Amici advocate. Prior to the ACA's enactment, people of color were significantly more likely to be uninsured than white people. In 2010 (the year the law passed), the uninsured rate for nonelderly white Americans was 13.1 percent, compared to 16.7 percent for Asian Americans, 17.9 percent for Native Hawaiians and Pacific Islanders, 19.9 percent for black Americans, 32.0 percent for American Indians and Alaskan Natives, and 32.6 percent for Hispanic Americans. Samantha Artiga, Kendal Orgera & Anthony Damico, *Changes in Health Coverage by Race and Ethnicity Since the ACA, 2010-2018*, Kaiser Family Found. (Mar. 5, 2020), https://www.kff.org/racial-equity-and-health-policy/issue-brief/changes-in-health-coverage-by-race-and-ethnicity-since-the-aca-2010-2018/. By 2017 these rates had fallen dramatically and across-the-board: nonelderly Hispanic Americans' uninsured rate had dropped from 32.6 percent to 18.9 percent, Black Americans' from 19.9 percent to 11.1 percent, Asian Americans' from 16.7 percent to 7.1 percent, Native Hawaiian and Pacific Islanders' from 17.9 percent to 10.6 percent, and White Americans' from 13.1 percent to 7.3 percent. *Id.* These changes not only improved coverage rates but narrowed the gap between White Americans and many racial and ethnic minorities. *Id.* ("Blacks, Asians, and American Indians and Alaska Natives … had larger percentage point increases in coverage compared to Whites…"). Uninsured rates for women nationwide dropped from 13.9 percent in 2010 to 7.7 percent in 2017, while men's uninsured rates dropped from 17.1 percent to 9.7 percent. State Health Compare, *Health Insurance Coverage Type*, http://statehealthcompare.shadac.org/table/30/health-insurance-coverage-type-by-

sex#1/5,4,1,10,86,9,8,6,44,45/24/59,60. While 28.4 percent of families with annual incomes under $25,000 were uninsured in 2010, that rate was almost halved, to 15.1 percent, by 2017; the figure fell by over one-third, from 16.5 percent to 10.9 percent, for families earning between $25,000 and $49,999 per year. *Id.*

The 2019 Rule took direct aim at many of the consumer-focused features of the ACA that were most responsible for these changing circumstances. Innovations such as the Navigator program, for example, placed community engagement at the heart of the health-coverage ecosystem, bringing coverage to many previously uninsured individuals. As Amici warned, the rule modifications likely eroded the gains made by women, low-income and economically vulnerable Americans, racial and ethnic minorities, and other marginalized groups. According to the State Health Access Data Assistance Center ("SHADAC"), the uninsured rate across the United States *rose* from 8.9 percent in 2018 to 9.2 percent in 2019. SHADAC, *Uninsurance Rates for Illinois in 2018 and 2019*, https://www.shadac.org/sites/default/files/publications/1_year_ACS_2019/aff_s2701_IL_2018_2019.pdf. Census Bureau data show that "Hispanics experienced the largest change in uninsured rates among race and Hispanic origin groups, increasing from 17.9 percent in 2018 to 18.7 percent in 2019." Katherine Keisler-Starkey & Lisa N. Bunch, U.S. Census Bureau, *Health Insurance Coverage in the United States: 2019* (Sept. 2020), https://www.census.gov/content/dam/Census/library/publications/2020/demo/p60-271.pdf. Meanwhile, "the percentage of non-Hispanic Whites and Asians without health insurance coverage increased by 0.2 and 0.3 percentage points, respectively." *Id.* The proportion of uninsured children in the United States rose from 5.2 percent in 2018 to 5.7 percent in 2019, with particularly sharp increases for children who were poor (6.4 percent to 6.9 percent for those between 100 percent and 399 percent the poverty line and 6.6 percent to 7.4 percent for

those below the poverty line) or Hispanic (8.2 percent to 9.2 percent). *Id.* Between 2018 and 2019, the share of the population that was uninsured rose in 19 states, and fell in only one (Virginia, which implemented Medicaid expansion on January 1, 2019). SHADAC, *2019 ACS: Rising National Uninsured Rate Echoed Across 19 States; Virginia Only State to See Decrease* (Sept. 15, 2020), https://www.shadac.org/news/2019-acs-rising-national-uninsured-rate-echoed-across-19-states-virginia-only-state-see. Nationwide, there were 1.07 million more individuals without health insurance in 2019 than in 2018, reflecting almost double the increase from 2017-2018 (535,000 individuals). *Id.*

Thus, whereas the ACA as originally implemented increased insurance coverage significantly, the actions of the current Administration, and in particular the changes wrought by the 2019 Rule, have had the opposite effect, undercutting rather than advancing the ACA's core objective. This is precisely the outcome about which Amici warned HHS, and for which HHS declined to account in adopting the 2019 Rule. For this reason and others, the 2019 Rule was arbitrary, capricious, and otherwise unlawful.

CONCLUSION

For the foregoing reasons, the Court should grant Plaintiffs' motion for summary judgment, vacate the challenged provision of the 2019 Rule, and enter judgment for Plaintiffs.

Respectfully submitted,

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October 26, 2020

CERTIFICATE OF SERVICE

I hereby certify that on October 26, 2020, the foregoing document was filed with the Clerk of the Court, using the CM/ECF system, causing it to be served on all counsel of record.

Dated: October 26, 2020

/s/ Russell P. Hanser
Russell P. Hanser

EXHIBIT 2

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MARYLAND

CITY OF COLUMBUS, *et al.*, Plaintiffs, v. DONALD J. TRUMP, *et al.*, Defendants.	Civil Action No. 1:18-cv-02364-DKC

[PROPOSED] ORDER

Upon consideration of the Motion for Leave to File Brief of the Shriver Center on Poverty Law, Planned Parenthood Federation of America, the National Health Law Program, the Asian & Pacific Islander American Health Forum, the Association of Asian Pacific Community Health Organizations, and Families USA as Amici Curiae Supporting 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