[PUBLISH]

In the United States Court of Appeals

For the Eleventh Circuit

No. 21-13116

FEDERAL TRADE COMMISSION,

Plaintiff-Appellee,

versus

SIMPLE HEALTH PLANS LLC,
a Florida Limited Liability Company, et al.,

Defendants,

STEVEN J. DORFMAN,
individually and as an officer, member or manager of Simple Health Plans LLC, Health Benefits One LLC, Health Center Management LLC, Innovative Customer Care LLC, Simple

Insurance Leads LLC, and Senior Benefits One LLC,

Defendant-Appellant.

Appeal from the United States District Court
for the Southern District of Florida
D.C. Docket No. 0:18-cv-62593-DPG

Before WILLIAM PRYOR, Chief Judge, JILL PRYOR, and GRANT, Circuit Judges.

GRANT, Circuit Judge:

The Federal Trade Commission alleges that Steven J. Dorfman and his six companies engaged in unfair or deceptive business practices in violation of § 5(a) of the Federal Trade Commission Act and the Telemarketing Sales Rule. 15 U.S.C. § 45(a); 16 C.F.R. Part 310. Relying on its authority under § 13(b) of the FTC Act, the Commission obtained a preliminary injunction that included an asset freeze and the imposition of a receiver. Dorfman now argues that the preliminary injunction must be dissolved because a recent Supreme Court decision undermines the Commission's § 13(b) authority. *See AMG Cap. Mgmt., LLC v. FTC*, 141 S. Ct. 1341, 1344 (2021).

He is right that the decision limits the Commission's § 13(b) authority, but wrong about what that means here. The Commission's updated complaint also invokes § 19 against Dorfman, and that provision authorizes the asset freeze and receivership. We therefore affirm the order denying Dorfman's emergency motion to dissolve the preliminary injunction.

I.

A.

For over four years—starting in 2013 and continuing until the Commission began this action in October 2018—Dorfman and the companies under his control engaged in a "bait and switch" scheme to sell underinclusive health insurance plans to unwitting consumers.[1] The technical term for these plans is "limited indemnity plans and medical discount memberships." But as the district court put it, they are more like grocery store savers cards than health insurance. They allow consumers to purchase medical services at pre-negotiated discount rates, but the consumer retains the risk of catastrophic medical bills. And if that risk becomes a reality? The plans are "practically worthless."

[1] Because Dorfman does not challenge the district court's findings of fact, we draw our recitation of the facts from the facts as they existed at the preliminary injunction stage. The parties have engaged in substantial discovery since the preliminary injunction was entered, and at summary judgment specific facts may be different. The facts recited here are for the purposes of this appeal only.

The Commission says that Dorfman led consumers to believe they were purchasing comprehensive insurance plans that would shift the risk of catastrophic bills to insurers and cover "a large portion of the expense for doctor's visits, emergency room visits, hospital stays, laboratory services, and prescription medicine." Dorfman's companies also wrongly assured consumers that the plans they purchased would allow them to avoid the Affordable Care Act's tax penalty for non-compliant plans.

The alleged misrepresentations did not end there. According to the Commission, the companies falsely represented that they were experts on, and providers of, government-sponsored health insurance policies. On their websites, they claimed—again, falsely—that they were affiliated with the AARP and the Blue Cross Blue Shield Association. The companies' lead generation tactics were also less than straightforward. For example, when consumers searched Google for "Obama Care Insurance" the top results included "obamacarequotes.org." This website—which was designed to give the impression that it offered comprehensive health insurance—prompted consumers to provide their contact information. A salesperson would then initiate contact, following a script that Dorfman himself "wrote, reviewed, and approved." Like the websites, these scripts contained misrepresentations designed to push consumers into Dorfman's inferior plans.

Only after payment was collected was it (sometimes) revealed to consumers that they had purchased limited benefit

plans. At the end of their calls, consumers were transferred to a new salesperson to hear a series of densely worded and difficult-to-comprehend disclosures. But before this "verification process," consumers were warned not to ask any questions and were told by their initial sales representative that only some of the information they were about to hear would apply to them—a caveat designed to suggest that anything inconsistent with the salesperson's earlier representations did not apply. Verification scripts also varied depending on whether the call was being recorded. If it was, the sales reps were directed to give honest answers to consumers' questions. But if it was not, they were instructed to continue to mislead consumers into believing that they had purchased comprehensive health insurance.

The Commission alleges that these sales were as profitable as they were dishonest: Dorfman and his companies received over $180 million in commissions from the plans. Their customers, meanwhile, were stuck with surprise medical bills. In one example cited by the district court, a consumer was led to believe that his copays would be limited to $50 and his out-of-pocket expenses capped at $2,000. But by the time he passed away (about four months after purchasing his plan) he had incurred around $300,000 in uncovered medical bills. This was only one example—extensive evidence detailed other injuries Dorfman's scheme inflicted on consumers.

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