IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

ASSOCIATION FOR COMMUNITY AFFILIATED PLANS, *et al.*

Plaintiffs,

v.

UNITED STATES DEPARTMENT OF TREASURY, *et al.*,

Defendants.

Civil Action No. 18-2133

PLAINTIFFS' MOTION FOR A PRELIMINARY INJUNCTION

Pursuant to Fed. R. Civ. P. 65(a) and Local Rule 65.1, Plaintiffs Association for Community Affiliated Plans, National Alliance on Mental Illness, Mental Health America, American Psychiatric Association, AIDS United, The National Partnership for Women & Families, and Little Lobbyists, LLC respectfully request that this Court issue a preliminary injunction suspending the effectiveness of the regulation on Short-Term, Limited-Duration Insurance promulgated by the defendant agencies (the "Departments") on August 3, 2018 (*see* 83 Fed. Reg. 38,212 (Aug. 3, 2018) (the "STLDI Rule")), pending resolution of this lawsuit. Plaintiffs further request, pursuant to Local Rule 65.1, a hearing on their motion at the Court's earliest possible convenience and as soon as possible after the filing of plaintiffs' reply brief on October 22.

As set forth in greater detail in the accompanying memorandum in support of this motion, plaintiffs have a substantial likelihood of succeeding on the merits of their claim, and a

preliminary injunction is necessary to prevent irreparable harm to them, is in the public interest, and will not prejudice the Departments. The STLDI Rule—in which the Departments determined that a "short-term, limited-duration" health insurance plan (which does not comply with the requirements imposed by Congress in the Affordable Care Act (ACA) on health insurance plans sold in the individual market) may last for 364 days and may be extended up to three years—is "arbitrary, capricious, an abuse discretion, or otherwise not in accordance with law" in violation of the Administrative Procedure Act. *See* 5 U.S.C. § 706(2)(A). The STLDI Rule directly undermines the policies and judgments codified by Congress in the text and structure of the ACA. To achieve this unlawful result, the Departments ignored the plain meaning of the statutory language they purport to interpret. They likewise disregarded without sufficient justification expressly stated congressional goals, the contrary position they took just two years ago on the identical questions, and the myriad informed comments that objected to the change in agency policy.

Absent immediate relief, the disruption to the nationwide health insurance market brought about by the STLDI Rule will cause plaintiffs—who are health care insurers who sell ACA-compliant insurance, health care providers who provide health care services and rely on patients' insurance benefits, and consumers who purchase insurance and use health care services—to suffer irreparable harm. It will also injure the health care system as a whole and leave many individuals with inadequate or no health insurance. In contrast, a delay in the STLDI Rule coming into effect will not injure the government or other interested parties.

To prevent the serious and irreparable harms that would be caused by the unlawful STLDI, plaintiffs respectfully request that the Court grant their motion and suspend the

effectiveness of the STLDI Rule. Plaintiffs' counsel conferred with opposing counsel about this Motion. Defendants' counsel opposes the Motion.

Dated: September 28, 2018

Respectfully submitted,

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PLAINTIFFS' MEMORANDUM OF LAW IN SUPPORT OF THEIR MOTION FOR A PRELIMINARY INJUNCTION

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September 28, 2018

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INTRODUCTION

In this case, federal agencies (the Departments[1]) disregarded all of the constraints that should circumscribe administrative action. They issued a rule that has the express purpose and manifest effect of undermining a law enacted by Congress—and that rests on judgments directly contrary to the congressional policy that is embodied in the text and structure of that law. To reach this conclusion, the agencies distorted the plain statutory language; took no account of the expressly stated congressional goals; ignored, without meaningful explanation, the position taken just two years ago by these same agencies on the identical question; and disregarded, also without any legitimate justification, myriad informed comments that objected to the change in agency policy. Because this lawless rule will cause immediate disruption in the Nation's health insurance market, injuring all participants in that market (including plaintiffs) and leaving many individuals with inadequate—or no—health insurance, this Court should issue a preliminary injunction suspending the rule.

In the Patient Protection and Affordable Care Act (ACA), 124 Stat. 119, Congress sought to expand health insurance coverage, bolster health insurance markets, and ensure that health insurance policies offer real protection to policyholders. To do so, the ACA mandates that most policies sold on the individual market—where individuals purchase insurance for themselves and their families (as opposed to employer-provided insurance)—comply with "guaranteed issue" and "community rating" requirements, which respectively (1) bar insurers from denying coverage to any person because of his or her preexisting conditions or health history and (2) preclude insurers from charging higher premiums based on health history, gender, and (with some limits) age. The ACA also requires that health insurance policies offer a set of "essential" protections to covered individuals. As written, the ACA exempts from these requirements "short-

[1] These are the Departments of the Treasury, Health and Human Services, and Labor.

term, limited duration insurance" (STLDI), a narrow exception intended (as the language suggests) to permit the sale of temporary policies to people who are between annual insurance plans.

In the regulation challenged here (the STLDI Rule), however, the responsible agencies determined that a "short-term, limited duration" plan may last for ***364 days*** and may be extended up to ***36 months***. They did so for the express purpose of allowing the sale of health insurance policies that are not subject to the ACA's guaranteed issue, community rating, and essential benefits provisions, and therefore are cheaper than ACA-compliant plans. The Rule will create an alternative health insurance market from which people with pre-existing conditions are effectively barred; by luring healthier people out of ACA-compliant plans, it also will increase the costs and undermine the stability of the market established by the ACA. And it will produce a system in which many people end up with insurance that is wholly inadequate for their needs. Congress enacted the ACA to preclude just these results.

This Rule, issued as a matter of administrative fiat, oversteps the agencies' role and is indefensible as a matter of law: "Disagreeing with Congress's expressly codified policy choices isn't a luxury administrative agencies enjoy." *Central United Life Ins. Co. v. Burwell*, 827 F.3d 70, 73 (D.C. Cir. 2016). The Rule will impose irreparable injury on plaintiffs, entities whose members sell ACA-compliant insurance, provide health care services, and purchase insurance and use health care services, as well as on the broader public. This Court should issue an injunction suspending the Rule's effectiveness pending a final decision on the merits.

STATEMENT

1. In 1997, Congress enacted HIPAA, Public Law 104-191, 110 Stat. 1936, an insurance reform statute that, among other things, established limited federal standards for "individual health insurance coverage" and mandated that such coverage provide for guaranteed

renewability. Under this requirement, an insurer must offer continued insurance to a current insured individual whose plan is expiring, even if that individual utilized the insurance or suffered adverse health consequences during the plan term. *Id.* § 111, 110 Stat. 1979, 1982. But Congress in HIPAA exempted STLDI plans from that requirement. *Id.* § 102, 110 Stat. 1973 (codified at 42 U.S.C. § 300gg-91). The Departments then had to define what constituted an STLDI plan for HIPAA purposes.

Accordingly, the Departments adopted an interim final rule in 1997. That interim rule defined "short-term limited duration coverage" to mean "health insurance coverage provided under a contract with an issuer that has an expiration date specified in the contract (taking into account any extensions that may be elected by the policyholder without the issuer's consent) that is within 12 months of the date the contract becomes effective."[2] The final rule adopted in 2004 contained the same language.[3]

As several commenters noted during the 2018 rulemaking challenged here, the Departments' decision in 1997 to interpret "short-term" as permitting a 364-day contract was likely arbitrary and capricious.[4] Indeed, nothing in the 1997 preamble to the interim final rule defended this element of the Departments' definition, suggesting that the Departments did not give close consideration to this provision. But because HIPAA did not impose substantial requirements on the content of individual or group insurance plans, the federal classification of a plan as STLDI—rather than as continuing or long-term insurance—made no significant practical difference. Accordingly, this aspect of the Departments' definition went unchallenged.

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[2] *Interim Rules for Health Insurance Portability for Group Health Plans*, 62 Fed. Reg. 16,894, 16,958 (Apr. 8, 1997).

[3] *Final Regulations for Health Coverage Portability for Group Health Plans and Group Health Insurance Issuers Under HIPAA Titles I & IV*, 69 Fed. Reg. 78,720 (Dec. 30, 2004).

[4] *See, e.g.*, Comment of Timothy Stoltzfus Jost, Apr. 20, 2018.

2. During this period, and prior to the enactment of the ACA, many individuals faced substantial discrimination in (or were effectively priced out of) the insurance market.[5] In most states, insurance companies could discriminate in premiums or coverage against individuals based on pre-existing conditions, claims history, health status, age, gender, occupation, and other factors. That risk segmentation both made health insurance unavailable to many Americans as a practical matter (because individuals with the risk of higher health costs faced huge health insurance premiums) and led to wide and unsustainable fluctuations in costs for individuals.[6]

Congress responded to these problems by enacting the ACA, which it intended "to increase the number of Americans covered by health insurance and decrease the cost of health care." *National Fed'n of Indep. Bus. v. Sebelius*, 132 S. Ct. 2566, 2580 (2012) ("*NFIB*"). Insofar as is relevant here, the ACA had two central goals:

First, the ACA "adopt[ed] a series of interlocking reforms designed to expand coverage in the individual health insurance market." *King v. Burwell*, 135 S. Ct. 2480, 2585 (2015). To this end, it established a "guaranteed issue" requirement, mandating that each insurer offering coverage in the individual and group markets in a State "accept every employer and individual in the State that applies for such coverage," thus prohibiting the prior practice of refusing coverage to individuals with a history of health problems or a chronic disease condition.[7] An insurer in the individual or group market therefore may not limit or deny coverage based on the covered parties' pre-existing conditions.[8]

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5 H.R. Rep. No. 111-299, tit. 3, pt. 1.

6 *See, e.g.*, Cong. Research Serv., *Private Health Insurance Provisions in Senate-Passed H.R. 3590, The Patient Protection and Affordable Care Act* 5 (Jan. 29, 2010).

7 42 U.S.C. § 300gg-1(a).

8 *Id.* § 300gg-3.

The ACA also includes a "community rating" provision that limits premium discrimination in the individual and small group health insurance markets. This provision forbids variations in premiums except those based on enumerated factors, while limiting the rate variation permitted under those factors.[9] Thus, tobacco use is a permissible factor, "except that such rate shall not vary by more than 1.5 to 1"; so is age, "except that such rate shall not vary by more than 3 to 1 for adults"; and geography may be considered only in the context of rating areas established by the State.[10] Factors such as health status, claims history, race, gender, sexual orientation, geography (except for rating areas established by the State), occupation, and many others may not be considered by insurers in setting rates.[11] These provisions ensure that discriminatory pricing practices no longer unduly affect certain purchasers in the individual insurance market, as had been commonplace prior to the ACA's enactment.

Congress regarded guaranteed issue and community rating as essential to the operation of well-functioning insurance markets. These requirements make all enrollees in the individual market "members of a single risk pool"[12]; this requirement satisfies the ACA's core mission of making insurance affordable for all by spreading risk across all enrollees, ensuring that risk pools include both the healthy and the sick. To further expand the number of persons in this risk pool, Congress (1) provided refundable tax credits to assist the purchase of insurance by individuals with defined household incomes and (2) required that individuals who did not have qualified health insurance must pay a tax penalty. *See King*, 135 S. Ct. at 2487. Congress subsequently

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9 *Id.* § 300gg.

10 *Id.*

11 *See id.*

12 *Id.* § 18032(c).

reduced that penalty to zero (*see* Pub. L. 115-97 § 11081, 131 Stat. 2054, 2092 (2017)), but did not alter the ACA's other provisions.

This guarantee of coverage carried with it the risk of adverse selection—that individuals would wait to purchase insurance until they needed health care, which would produce a risk pool skewed toward individuals with high medical costs and therefore increase insurance premiums. Congress enacted several measures to guard against that possibility. In particular, the ACA instructs the Secretary of HHS to provide open enrollment periods for purchasing ACA-compliant plans, so as to encourage individuals to sign up for insurance at the beginning of the year rather than wait to do so until a medical condition arises. 42 U.S.C. § 18031(c)(6)(B). Congress also recognized that some people might miss the open enrollment period through no fault of their own, and accordingly instructed the Secretary to provide for special enrollment periods to ensure that the Act's promise of guaranteed coverage remains available for these individuals. *Id.* § 18031(c)(6)(C). The Secretary responded by providing a special enrollment period for persons who lose minimum essential coverage mid-year. 45 C.F.R. § 155.420(d)(1).

Second, the ACA established minimum substantive standards to eliminate abuses and ensure that policies purchased in the individual insurance market will in fact provide meaningful coverage. Congress thus required that all individual and small group plans provide a "comprehensive" package of "essential health benefits." 42 U.S.C. § 300gg-6(a). This package includes ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health services, substance use services, prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services and chronic disease management, and pediatric services (including oral and vision care). 42 U.S.C. § 300gg-6(a). The ACA also extended mental health parity to the individual insurance market,

ensuring coverage of mental health and substance use disorder treatment comparable to that for physical health care. In addition, the ACA bans lifetime and annual dollar limits on insurance benefits, and includes other financial protections for enrollees, such as limitations on cost-sharing requirements.[13]

3. In enacting the ACA's reforms, Congress had to specify the category of insurance plans to which the new requirements applied. It did so by cross-referencing HIPAA's definition of "individual health insurance coverage" and defining plans that complied with the ACA's requirements as "qualified health plans."[14]

After the ACA's enactment, the Departments realized that they would need to revisit their prior rulemakings under HIPAA to reconcile their implementation of that statute with the ACA's comprehensive reforms of the insurance market. This effort included a reconsideration of the 1997 definition of "short-term, limited-duration," which had served one purpose under HIPAA but now had very different implications for the individual insurance market under the ACA.

Unlike ACA-compliant plans, STLDI plans are exempt from the HIPAA requirement that insurance plans be guaranteed renewable; an STLDI provider may decline to continue covering an insured individual when the insurance term ends. STLDI plans also are not subject to the ACA provisions that prohibit insurers from refusing coverage based on an individual's pre-existing health conditions and from setting premiums based on an individual's health history, gender, or (outside specified parameters) age. STLDI plans likewise may omit essential health benefits that must be provided by ACA-compliant individual health insurance plans, and need not adhere to the ACA's limits on patients' out-of-pocket expenses. Thus, STLDI plans may omit essential

[13] See 42 U.S.C. § 18022(a), (c) (limitations on cost-sharing); *id.* § 18022(d) (minimum actuarial value).

[14] Qualified health plans must comply with additional requirements as well; we use that term here for convenience.

health benefits and engage in other business practices that are forbidden to ACA-compliant individual health insurance plans.

The Departments began considering this issue in 2014, the first year for which ACA-compliant plans were available, after it became apparent that some insurers would use STLDI plans to circumvent the ACA reforms. That process culminated in a 2016 final regulation, in which the Departments concluded that, to qualify as an STLDI plan, "coverage must be less than three months in duration, including any period for which the policy may be renewed."[15]

The Departments provided detailed, reasoned explanations for this definition in the 2016 rulemaking. They explained that STLDI plans were being purchased by some individuals "as their primary form of health coverage," even though these plans did not provide "the protections of the Affordable Care Act" and thus "may not provide meaningful health coverage."[16] Moreover, the pricing of STLDI plans based on the insured's health history would allow these plans to target "healthier individuals," thereby "adversely impacting the risk pool for Affordable Care Act-compliant coverage."[17] Thus, the Departments determined that a tailored interpretation of STLDI was necessary to "improve the Affordable Care Act's single risk pool" and keep premiums for all participants in the individual health market at an affordable level.[18]

4. Although Congress modified the ACA after the statute's enactment by reducing to zero the tax imposed on individuals for failure to purchase ACA-compliant insurance, it repeatedly

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15 81 Fed. Reg. at 75,318.

16 *Id.* at 75,317-18.

17 *Id.* at 75,318.

18 *Id.*

rejected proposals to repeal the statute altogether[19] and declined to repeal or modify the ACA's protections for individuals with pre-existing conditions and its prohibition against discrimination in setting health insurance premiums.[20]

Soon after these ACA repeal efforts failed, President Trump signed Executive Order 13813 on October 12, 2017,[21] directing expanded access to STLDI plans specifically because such plans are exempt from the "insurance mandates and regulations included in title I of the [ACA]"; the Order sought to make STLDI plans an "alternative" to ACA-compliant health care for consumers in the individual insurance marketplaces.[22] The proposed STLDI Rule, issued on February 21, 2018, was the Departments' response to the President's directive.[23]

The Departments received approximately 12,000 comments on their proposed rule.[24] One analysis found that "more than 98%—or 335 of 340—of the healthcare groups that commented on the proposal to loosen restrictions on short-term health plans criticized it, in many cases warning that the rule could gravely hurt sick patients," while "[n]ot a single group representing patients, physicians, nurses or hospitals voiced support" for the proposal.[25] Nevertheless, and

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[19] *See* American Health Care Act of 2017, H.R. 1628 (2017); Better Care Reconciliation Act of 2017, S. Amend. 270 (July 25, 2017); Obamacare Repeal Reconciliation Act of 2017, S. Amend. 271 (July 25, 2017); Healthcare Freedom Act of 2017, S. Amend. 667 (July 26, 2017).

[20] Budget Fiscal Year 2018, 131 Stat. 2054, 2092 (Dec. 22, 2017).

[21] Exec. Order No. 13813, Presidential Executive Order Promoting Healthcare Choice and Competition Across the United States (Oct. 12, 2017), perma.cc/VM65-EXTU.

[22] *Id.*

[23] *Short-Term, Limited-Duration Insurance*, 83 Fed. Reg. 7437 (Feb. 21, 2018).

[24] *Short-Term, Limited-Duration Insurance*, 83 Fed. Reg. 38,212 (Aug. 3, 2018). Though the complete set of comments is not publicly available, 9,205 of them have been published at goo.gl/2P8wnL.

[25] Noam N. Levey, *Trump's New Insurance Rules are Panned by Nearly Every Healthcare Group that Submitted Formal Comments*, L.A. Times, May 30, 2018.

notwithstanding many other objections, the Departments "finalized the proposed rule with some modifications" on August 3, 2018.[26]

The Departments explained that "[u]nder this final rule, short-term, limited-duration insurance means health coverage provided pursuant to a contract with an issuer that has an expiration date specified in the contract that is less than 12 months after the original effective date of the contract and, taking into account renewals or extensions, has a duration of no longer than 36 months in total."[27] The Departments also clarified that "[n]othing in this final rule precludes the purchase of separate insurance contracts that run consecutively, so long as each individual contract is separate and can last no longer than 36 months."[28] Consequently, the final rule permits the purchase of STLDI coverage that, as a practical mater, has ***no*** mandated stopping point. The Departments provided no reasoned explanation and identified no changed circumstances (whether factual or legal) justifying this deviation from their contrary conclusions in the 2016 STLDI rulemaking, which had taken place less than 2 years earlier.

The consequences of the final rule are addressed in detail below. Certain effects are not debatable: The Departments themselves acknowledged that the rule will make "relatively young, relatively healthy individuals in the middle-class and upper middle-class" "more likely to purchase short-term, limited-duration insurance," so "the proportion of healthier individuals in the [ACA-compliant individual market] . . . will decrease."[29] This conclusion is widely shared, including by the American Academy of Actuaries: "Because of medical underwriting at issue,

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[26] 83 Fed. Reg. at 38,214.

[27] *Id.* at 38214-15.

[28] *Id.* at 38220.

[29] *Id.* at 28235.

STLD is expected to attract healthier individuals with a lower premium and could put upward pressure on ACA rates as healthier enrollees leave the ACA pool."[30]

According to the Departments' own initial estimates, which a number of commenters noted were unduly optimistic, "premiums for unsubsidized enrollees in the Exchanges will increase by 5 percent" as a result of this change.[31] Another model, which accounted for several under-counting errors in the Departments' estimates, estimates that ACA enrollment will decrease by 8.2-15.0% and that premiums will increase by 2.2-6.6% in the near term.[32]

5. Plaintiffs are associations of insurers, health care providers, and entities that assist and advocate for individuals who have medical conditions or otherwise use medical services. All participated in the 2018 rulemaking proceeding and/or believe strongly that the STLDI Rule both will injure them directly and is incompatible with their shared purpose of ensuring access to adequate, affordable health care for all Americans. They filed the complaint in this suit on September 14, 2018, contending that the STLDI Rule is (1) inconsistent with the ACA's terms structure, and manifest purpose, and (2) is arbitrary and capricious is several respects. Each plaintiff and its members and/or the individuals and groups that it represents will suffer significant and irreparable harm from the STLDI rule.

ARGUMENT

On the eve of open enrollment for 2019 ACA-compliant insurance, the Departments have promulgated the STLDI Rule, which—if it remains in effect for this open enrollment period—will upend the individual market for health insurance and harm millions of people. This Court

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[30] Comment of American Academy of Actuaries, Apr. 6, 2018, at 5.

[31] 83 Fed. Reg. at 28235.

[32] Wakely Consulting Group, *Effects of Short-Term Limited Duration Plans on the ACA-Compliant Individual Market,* perma.cc/T8RE-4F37.

should preliminarily enjoin the Rule to prevent this drastic change from going forward while this challenge to the Rule's legality is being resolved. A preliminary injunction is warranted where the movant makes a "clear showing that four factors, taken together, warrant relief: likely success on the merits, likely irreparable harm in the absence of preliminary relief, a balance of the equities in its favor, and accord with the public interest." *League of Women Voters of U.S. v. Newby*, 838 F. 3d 1, 6 (D.C. Cir. 2016). Each element of this test is satisfied here.

I. PLAINTIFFS ARE LIKELY TO SUCCEED ON THE MERITS OF THEIR CLAIMS.

Under the Administrative Procedure Act, courts must "hold unlawful and set aside agency action" that is "arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law." 5 U.S.C. § 706(2)(A). Here, the STLDI Rule should be vacated under the APA because it is unlawful for at least four reasons: (1) the Departments exceeded their authority by promulgating a rule that undermines the individual health insurance market structure established by Congress in the text and structure of the ACA; (2) the Departments' interpretation of "short term" is contrary to HIPAA and the ACA; (3) the Departments' interpretation of "limited duration" is contrary to HIPAA and the ACA; and (4) the STLDI Rule is arbitrary and capricious for lack of reasoned explanation. Given the Departments' disregard of the statutory text and clear congressional policy, plaintiffs are likely to prevail on these arguments.

A. The Departments Lack Authority To Issue The STLDI Rule, Which Conflicts With Congress's Legislative Judgments Embodied In The ACA.

The power of federal agencies to issue rules is granted by Congress: "an agency literally has no power to act . . . unless and until Congress confers power upon it." *La. Pub. Serv. Comm'n v. FCC*, 476 U.S. 355, 375 (1986); *see also City of Arlington, Tex. v. FCC*, 569 U.S. 290, 297 (2013) ("Both [agencies'] power to act and how they are to act is authoritatively

prescribed by Congress."). In short, "[a]gencies may act only when and how Congress lets them." *Central United Life*, 827 F.3d at 73.

Necessarily, then, agencies may not issue rules that conflict with statutes that Congress has enacted. "A reviewing court must reject administrative constructions of [a] statute . . . that are inconsistent with the statutory mandate or that frustrate the policy that Congress sought to implement." *Wash. Hosp. Ctr. v. Bowen*, 795 F.2d 139, 144 (D.C. Cir. 1986) (alterations in original) (internal quotation marks omitted); *see, e.g., Chem. Mfrs. Ass'n v. Nat. Res. Def. Council, Inc.*, 470 U.S. 116, 125 (1985) ("[I]f Congress has clearly expressed an intent contrary to that of the Agency, our duty is to enforce the will of Congress."); *Chevron, U.S.A., Inc. v. Nat. Res. Def. Council, Inc.*, 467 U.S. 837, 843 n.9 (1984) ("The judiciary is the final authority on issues of statutory construction and must reject administrative constructions which are contrary to clear congressional intent.").

Congress exercised its legislative power in the ACA to structure the individual health insurance market in a manner that it determined would improve access to health care. The Departments' power and discretion to act are constrained by that statutory judgment. Because the STLDI Rule contravenes and undercuts Congress's judgments, embodied in the text and structure of the ACA, the Rule is both contrary to law and arbitrary and capricious.

1. The STLDI Rule Exceeds The Departments' Authority Because It Violates The ACA.

The authority asserted by the Departments in promulgating the STLDI Rule is astounding in its breadth: They claim the power to create a new form of primary health insurance that is exempt from all of the ACA's central requirements, so as to vastly expand the number of individuals who purchase insurance that lacks the characteristics that Congress regarded as "essential." *See* 83 Fed. Reg. 38,212. They would do this by expanding the ability of individuals

to purchase insurance coverage that does not meet the requirements of the ACA—namely, short-term limited duration insurance. 83 Fed. Reg. at 38,214.

But Congress did not grant the Departments this authority. When reviewing an agency's construction of the statute that it administers, courts must first determine "whether Congress has directly spoken to the precise question at issue. If the intent of Congress is clear, that is the end of the matter." *Chevron*, 467 U.S. at 842-43. To determine whether Congress has spoken on a question, courts employ "traditional tools of statutory construction" (*id.* at 843 n.9)—including "all pertinent interpretive principles." *Carter v. Welles-Bowen Realty, Inc.*, 736 F.3d 722, 731 (6th Cir. 2013) (Sutton, J., concurring). And "[i]f an interpretive principle resolves a statutory doubt in one direction, an agency may not reasonably resolve it in the opposite direction." *Id.*

One such principle is that courts "expect Congress to speak clearly if it wishes to assign to an agency decisions of vast 'economic and political significance.'" *King*, 135 S.Ct. at 2489; *Util. Air Regulatory Grp. v. EPA*, 134 S. Ct. 2427, 2444. The STLDI Rule will have just such an enormous impact on the structure and economics of the individual insurance market and the millions of people who obtain health insurance through it—subjects that have been the center of heated political debates for decades. *See, e.g, Timeline: History of Health Reform in the U.S.*, Kaiser Family Foundation (2011), perma.cc/539M-4QFY.

The Departments do not, and cannot, identify any clear and specific congressional grant of authority to unilaterally restructure the nationwide individual insurance markets and determine whether and how much insurance individuals should purchase; they rely instead only on their authority to define undefined statutory terms based on a generalized "necessary and appropriate" clause in the Public Health Services Act. *See* 83 Fed. Reg. at 32,215. But it is implausible that Congress intended to delegate such sweeping and contentious authority to the Departments

through a vague and generalized "necessary and appropriate" provision and a single undefined statutory term: As the Supreme Court has put it, Congress "does not, one might say, hide elephants in mouseholes." *Whitman v. Am. Trucking Ass'ns, Inc.*, 531 U.S. 457, 468 (2001).

Indeed, far from authorizing the Departments to take such a drastic step, Congress in the ACA spoke to the very questions that the Departments now claim to be addressing, making clear that the Departments may not establish STLDI as an alternative to ACA-compliant insurance. In interpreting statutes to determine whether Congress has spoken directly on a question, the Supreme Court has admonished that it is important to respect the "fundamental canon of statutory construction that the words of a statute must be read in their context and with a view to their place in the overall statutory scheme." *FDA v. Brown & Williamson Tobacco Corp.*, 529 U.S. 120, 133 (2000). "In determining whether Congress has specifically addressed the question at issue, the court should not confine itself to examining a particular statutory provision in isolation. Rather, it must place the provision in context, interpreting the statute to create a symmetrical and coherent regulatory scheme." *Id.* at 121; *see also Bell Atl. Tel. Cos. v. FCC*, 131 F.3d 1044, 1048 (D.C. Cir. 1997) (looking to "the history, structure, and underlying policy purpose of the statute").

This is particularly important in a statute like the ACA, where the major provisions are "interdependent" and expressly note that they work "together with the other provisions of [the] Act." *See NFIB*, 567 U.S. at 696 (Scalia, J., dissenting); *see also* 42 U.S.C. § 18091(2)(C) (working "together" to "add millions of new consumers to the health insurance market"); *id.* § 18091(2)(E) (working "together" to "significantly reduce" the economic cost of the "poorer health and shorter lifespan of the uninsured"); *id.* § 18091(2)(F) (working "together" to "lower health insurance premiums"); *id.* § 18091(2)(G) (working "together" to "improve financial

security for families"); *id.* § 18091(2)(I) (working "together" to minimize "adverse selection and broaden the health insurance risk pool to include healthy individuals"); *id.* § 18091(2)(J) (working "together" to "significantly reduce administrative costs and lower health insurance premiums").

And here, the statutory scheme created by the Affordable Care Act unambiguously precludes precisely what the Departments seek to do through the STLDI Rule. In the ACA, Congress enacted a comprehensive system for "expand[ing] more affordable coverage options to consumers who desire and need them" and "reduc[ing] the number of uninsured individuals" (83 Fed. Reg. at 38,218)—the purported goals of the STLDI Rule. But Congress determined that the way to accomplish these ends is through the requirements of guaranteed issue and community rating (*see* 42 U.S.C. 300gg-1, 300gg-3, 300gg-4(a); §§ 300gg(a)(1), 300gg-4(b)), assuring that all health insurance consumers would be "members of a *single* risk pool." 42 U.S.C. § 18032(c). It specifically prohibited insurers from refusing coverage to individuals with preexisting conditions, and from setting premiums based on individuals' health history, gender, and other factors. The STLDI Rule, by contrast, attempts to make STLDI plans—which are exempt from all of these requirements—substitutes for ACA-compliant plans. The Rule thus adopts the approach that Congress specifically rejected.

Congress also addressed whether the federal government should "help individuals avoid paying for benefits provided in individual health insurance coverage that they believe are not worth the cost" (83 Fed. Reg. at 38,218)—another asserted goal of the STLDI Rule. Congress unambiguously answered ***no***, codifying in the ACA its judgment that all individuals should receive coverage for certain essential health benefits in order to assure access to necessary health

care. *See* 42 U.S.C. §§ 300gg-6(a), 18022(b). Again, the STLDI Rule implements a policy that Congress specifically rejected in the text of the ACA.

"Ambiguity … 'is a creature not of definitional possibilities but of statutory context.' *Brown v. Gardner*, 513 U.S. 115, 118 (1994). [And] [s]een in its proper context, [the Departments' Rule] clearly misreads the [ACA]." *Central United Life*, 827 F.3d at 74. Because the STLDI Rule thus violates the ACA, it should be set aside as contrary to law.

2. The STLDI Rule Advances An Unreasonable Interpretation Of "Short Term Limited Duration Coverage."

Moreover, even assuming *arguendo* that the Departments possessed some discretion in determining the types of primary health insurance that should be available to consumers in the individual market, the Departments did not reasonably exercise that discretion in promulgating the STLDI Rule. At step two of the *Chevron* inquiry, courts "must reject administrative construction of [a] statute . . . . that frustrate[s] the policy that Congress sought to implement." *Shays v. Fed. Election Comm'n*, 528 F.3d 914, 919 (D.C. Cir. 2008); *see also Util. Air Regulatory Grp.*, 134 S. Ct. at 2442 ("[A]n agency interpretation that is 'inconsisten[t] with the design and structure of the statute as a whole' does not merit deference." (quoting *Univ. of Tex. Sw. Med. Ctr. v. Nassar*, 133 S. Ct. 2517, 2529 (2013))). And here, it is unquestionable that both the purpose and the effect of the STLDI Rule is to frustrate Congress's policy as embodied in the text and structure of the ACA. Accordingly, it is an impermissible exercise of discretion by the Departments.

The purpose of the STLDI Rule is clear: The Departments acknowledge that the Rule was promulgated pursuant to the directive in Executive Order 13813, with the goal of changing the structure of the individual insurance market established by the ACA. *See* 83 Fed. Reg. 38,212; *see also* Julia Limitone, *Affordable Health Care Is Here: HHS Sec. Alex Azar*, Fox Bus.

(Aug. 2, 2018) (quoting HHS Secretary Alex Azar: "What we are doing is bringing cheap and more affordable options to individuals who are trapped under the Affordable Care Act.").

And the STLDI Rule would in fact do what it is designed to do, frustrating the purposes and policies of the ACA. As explained above, Congress enacted the ACA to make affordable coverage widely available. There were potentially many ways of achieving this goal, but the policy chosen by Congress in the ACA was to couple a prohibition on insurers denying coverage and charging individuals higher premiums based on their medical history (42 U.S.C. §§ 300gg(a)(1), 300gg-1, 300gg-3, 300gg-4(a), 300gg-4(b)) with subsidies and tax incentives to assist individuals in purchasing insurance. 26 U.S.C. §§ 36B, 5000A. For this reform to work, Congress deemed it "essential" to minimize adverse selection and "broaden the health insurance pool to include healthy individuals," placing all covered individuals in a single insurance pool. 42 U.S.C. § 18091(l); *see also supra* at pages 4-6 (describing essential health benefits and open and special enrollment period requirements).

But the Departments ***concede*** that the STLDI Rule frustrates these policies—in particular, the congressional intent to "broaden the health insurance pool to include healthy individuals" (42 U.S.C. § 18091(l)) and to create a "single risk pool" in the individual market (*id.* § 10832). The Departments acknowledge that the Rule intends to make STLDI "an additional ... option that may be available to [individuals]." 83 Fed. Reg. 38,218. This is a recognition that the Rule will "lead to adverse selection," with "relatively young, relatively healthy individuals in the middle-class and upper middle-class" "more likely to purchase short-term, limited duration insurance," so "the proportion of healthier individuals in the individual market Exchanges will decrease." *Id.* at 38,235. The Departments further recognize that this adverse selection will in turn cause "premiums for unsubsidized enrollees in the Exchanges [to] increase by 5 percent" (an

estimate which, as discussed above, is unreasonably optimistic). *Id.* These rising costs will, in turn, encourage more people to defer purchasing coverage until they are ill, which will put further upward pressure on premium costs, until insurers must either "significantly increase premiums" or simply exit the market, resulting in a self-perpetuating death spiral. *Sebelius*, 567 U..S. at 548. Again, the Departments admit this: The Rule may result in "fewer issuers . . . offer[ing] plans in the individual market." 83 Fed. Reg. 38,233. As a result, many Americans will be unable to obtain the coverage they need to treat their medical conditions. An interpretation of the ACA that undermines and destabilizes the marketplace and protections put into place by Congress in the ACA simply cannot qualify as reasonable.

3. The STLDI Rule Is Arbitrary and Capricious Because It Rests On Judgments Rejected By Congress In The ACA.

Finally, in addition to being contrary to law, the Rule is arbitrary and capricious because the Departments "'relied on factors which Congress has not intended [them] to consider.'" *Safari Club Int'l v. Zinke*, 878 F.3d 316, 325 (D.C. Cir. 2017) (quoting *State Farm*, 463 U.S. at 43). As explained above, the ACA is premised on the notion that all plans in the individual market will be part of a "single risk pool," consisting of plans that offer a set of essential health benefits and to which individuals are assured access through the guaranteed-issue and community-rating provisions. Rather than seeking to implement that statutory scheme, however, the Departments have openly declared their intent to develop a parallel market, outside the ACA's single risk pool, in which coverage is not assured and essential benefits are not guaranteed. *See* 83 Fed. Reg. at 38,216 ("this regulatory action is necessary and appropriate to remove federal barriers that inhibit consumer access to additional, more affordable coverage options"); *id.* at 38,218 ("the availability of short-term limited-duration insurance provides an additional choice for many consumers that exists side-by-side with individual market coverage").

The Departments may now disagree with the statutory scheme that Congress created, but they are "not free to substitute new goals in place of the statutory objectives without explaining how these actions are consistent with [their] authority under the statute." *Indep. U.S. Tanker Owners Comm. v. Dole*, 809 F.2d 847, 854 (D.C. Cir. 1987).

The Departments compounded their error by "'fail[ing] to consider an important aspect of the problem'" that Congress tasked them to address. *Sierra Club*, 878 F.3d at 325 (quoting *State Farm*, 463 U.S. at 43). As discussed above, Congress's goal in enacting Title I of the ACA was to create an individual insurance market through the enactment of several inter-related measures that would work "together" to "lower health insurance premiums," 42 U.S.C. § 18091(2)(F), and minimize "adverse selection and broaden the health insurance risk pool to include healthy individuals." *Id*. § 18091(2)(I).

The Departments disregarded these statutory goals. As the Departments themselves acknowledged, the STLDI rule will not assist in achieving the statutory purposes, but instead will shrink the health insurance risk pool and increase health insurance premiums for ACA-compliant plans. 83 Fed. Reg. at 38,217. By the Departments' own estimate, the STLDI Rule will cause enrollment in individual market plans to decrease by 1.3 million, and premiums for such plans to increase by 5%, by 2028. 83 Fed. Reg. at 38,236. This likely is a drastic understatement of the Rule's real effect; as discussed above, independent experts estimate that ACA enrollment will decrease by 8.2-15%. *See* page 11, *supra*; *see also* Urban Institute, *Updated: The Potential Impact of Short-Term Limited-Duration Policies on Insurance Coverage, Premiums, and Federal Spending*, 2 (Mar. 2018). Even the Departments' own estimate, however, shows that they not only disregarded Congress's declared goals to lower premiums and broaden the risk pool in the individual insurance market, but that they directly chose to flout Congress' design by

undermining the individual insurance market so as to create a parallel, "side-by-side" market that would operate outside the ACA.

In sum, the Rule's purpose and effect of subverting the individual health insurance system that Congress enacted in the ACA renders the Rule contrary to law and arbitrary and capricious.

B. The Departments' Interpretation Of "Short Term" To Include Plans That Are 99.97% As Long As Standard Insurance Plans Is Contrary To Law.

Against this background, it is unsurprising that the Departments' efforts to shoehorn their inconsistent policy goals into the term "short-term limited duration insurance" as used in HIPAA and the ACA also is contrary to the plain meaning of the statutory text. As noted above, it is a "fundamental canon of statutory construction that the words of a statute must be read in their context and with a view to their place in the overall statutory scheme." *Brown & Williamson Tobacco Corp.*, 529 U.S. at 133; *see also Beecham v. United States*, 511 U.S. 368, 372 (1994) ("The plain meaning that [courts] seek to discern is the plain meaning of the whole statute, not of isolated sentences."). "A statutory provision that may seem ambiguous in isolation is often clarified by the remainder of the statutory scheme . . . because only one of the permissible meanings produces a substantive effect that is compatible with the rest of the law." *Util. Air*, 134 S. Ct. at 2442 (quotation marks and ellipsis omitted). Here, the text, purpose, and context of Congress's use of the term "short term limited duration insurance" all demonstrate that "short term" does not mean a period that is virtually equivalent to the term of a standard annual health insurance plan. Accordingly, the Department's interpretation of that term must be set aside as contrary to law. *See, e.g., Am. Fed'n of Labor & Congress of Indus. Orgs. v. Fed. Election Comm'n*, 177 F. Supp. 2d 48, 55 (D.D.C. 2001); *Am. Bankers Ass'n v. Nat'l Credit Union Admin.*, 271 F.3d 262, 267 (D.C. Cir. 2001).

1. The Departments' Interpretation Of "Short Term" Is Contrary To The Statutory Text.

The plain meaning of the term "short-term" is unambiguous: it means "occurring over or involving a relatively short period of time." *Short-term*, Merriam-Webster Dictionary, perma.cc/4ZCF-QPLQ. As that definition makes clear, the term is relative. And here, the relevant benchmark is the length of a standard health insurance plan: one year. *See, e.g.,* 42 U.S.C. 13031 (requiring American Health Benefit Exchanges to provide for "annual open enrollment periods"); *Definition of Health Insurance Terms*, Bureau of Labor Statistics, perma.cc/T3MF-SFBU (noting that a benefit period is "usually a year"); *Glossary of Health Insurance Terms*, Med. Mut., perma.cc/H4WX-VCPR (defining "benefit period" and explaining that "[i]t is often one calendar year for health insurance plans"); *Plan Year*, HealthCare.gov, perma.cc/CV6L-QQAU (defining "plan year" as a "12-month period of benefits coverage under a group health plan").

A "short-term" insurance plan, then, is one that involves a "relatively short period of time" as compared to one year. And a term just a day short of one year—*i.e.* more than 99.97% of the length of a standard term of health insurance—cannot in any meaningful sense of the word be considered "relatively short."

2. The Departments' Interpretation Is Contrary To The Congressional Purpose And Statutory Context Of HIPAA.

Congress's purpose in defining "individual health insurance coverage" to exclude "short-term limited duration insurance," as well those terms' place within the overall HIPAA and ACA schemes, confirm that "short term" means what it says—and does not mean anything close to a year.

a. Congress enacted HIPAA to increase access to and portability of health insurance coverage for individuals and their families so that they could retain their health insurance when they changed or lost their jobs. *See, e.g.,* S. Rep. No. 104-156, at 1 (HIPAA was intended to

"mak[e] it easier for people who change jobs or lose their jobs to maintain adequate coverage"). In particular, Congress was concerned with the large number of Americans who were "at risk of becoming uninsured or subject to preexisting condition exclusions under the current system because they change jobs, lose jobs, or work for employers who change insurance policies." *See id.* at 4. Congress was also concerned with the increasing costs faced by high-risk, high-cost individuals caused by "increasing segmentation of the private insurance market" and "reduc[tion of] the pool of firms seeking coverage . . . in the community-rated market." *Id.* These problems were aggravated in the individual market because "[m]ost individual insurance policies impose pre-existing condition exclusions or limitations; individuals with chronic health conditions may be entirely denied coverage." H.R. Rep. No. 104-496, at 71 (1996); *see also* S. Rep. No. 104-156, at 7.

Accordingly, HIPAA was "designed to curtail the most common abuses in the current system by requiring health plans to compete based on quality, price, service, and efficiency, instead of refusing to offer coverage to those who are in poor health and who need coverage the most." S. Rep. No. 104-156, at 13. With respect to the individual market, Congress sought to ensure that individuals who previously had insurance through a group health insurance plan could maintain adequate coverage if they lost, left, or changed their jobs. *Id.* at 2, 4. It did this by (1) prohibiting issuers that offer health insurance coverage in the individual market from declining to offer such coverage, deny enrollment to, or impose any preexisting condition exclusion to someone who previously had 18 months of continuous health coverage under a group health plan (subject to certain limitations) (Pub. L. 104-191, § 111, 110 Stat. 1979); and (2) requiring such issuers to renew individual health insurance coverage at the option of the individual, *id.*, 110 Stat. 1982. These requirements apply to issuers offering "individual health

insurance coverage," which Congress defined to mean *all* "health insurance coverage offered to individuals in the individual market" *except* for "short-term limited duration insurance." *Id.* § 102, 110 Stat. 1973 (codified at 42 U.S.C. § 300gg-91).

As the overall statutory context and legislative background make clear, Congress's purpose was to protect individuals with preexisting conditions and other high risk factors. Such individuals who lost their group health insurance would be able to obtain coverage (including coverage for those pre-existing conditions) in the individual market. And once an individual had coverage in the individual market, they would be able to renew and keep that insurance, even if their health condition worsened, new conditions developed, or new risk factors emerged.

When "short term" is interpreted in accordance with its plain meaning, the exception for "short-term limited duration coverage" is consistent with HIPAA's purposes. The market in which people typically obtained health insurance still would be regulated to protect people with preexisting conditions. Those regulations would not apply to STLDI plans, types of insurance that were not intended to serve people in an ongoing fashion and where the ability to obtain coverage or maintain that coverage into the future need not be regulated by Congress.

But interpreting "short term" to include virtual equivalents of a standard, annual insurance plan (as the Departments have in the STLDI Rule) frustrates this purpose. It creates a new market segment where individuals with pre-existing conditions are entirely unprotected. These individuals may not be able to access such coverage, and they may lose such coverage once they have it if their health changes or new conditions emerge—the exact problems that Congress sought to remedy in enacting HIPAA.

b. Even if Congress had left open under HIPAA whether "short-term" could encompass plans that are one day shorter than standard annual plans, it unquestionably foreclosed such an

interpretation through the enactment of the ACA. For one thing, the text of the ACA removes any doubt that "short-term," as used in "short-term limited duration coverage," has a meaning consistent with its plain meaning—*i.e.*, a period that is relatively shorter than the typical 12-month standard insurance plans. In the ACA, Congress referred to a "short coverage gap[]," which would be exempt from the ACA's penalty for failure to maintain minimum essential coverage. 26 U.S.C. § 5000A(e)(4). And Congress expressly defined a "short coverage gap[]" as a "period of less than 3 months." *Id.* § 5000A(e)(4)(A).

Congress surely intended that definition of "short"—as meaning a "period of less than 3 months"—to apply to the same word as used in the phrase "short-term limited duration coverage" (as incorporated by reference in the ACA). "A standard principle of statutory construction provides that identical words and phrases within the same statute should normally be given the same meaning." *Powerex Corp. v. Relian Energy Servs., Inc.*, 551 U.S. 224, 232 (2007). This canon applies with special force here given the common policy judgment underlying the "short coverage gaps" and "short-term limited duration coverage" provisions and the fact that the two provisions complement each other. By exempting from the ACA's penalty "short coverage gaps" of less than three months, Congress expressed its judgment that individuals should not have coverage that falls outside the minimum essential coverage requirements for longer than three months. Construing "short-term limited duration coverage," which does ***not*** have to comply with the minimum essential coverage requirements, as including plans that are much longer than three months is irreconcilable that congressional judgment. *See also* 42 U.S.C. § 300gg-7 (providing that "[a] group health plan and a health insurance issuer offering group health insurance coverage shall not apply any waiting period . . . that exceeds 90 days").

In contrast, there is ***no*** indication that Congress regarded "short term" plans as suitable for satisfying individuals' primary and permanent health insurance needs—a reading, as noted above, that would run counter to the ACA's central goals. It is hardly likely that Congress would have used the phrase "short-term" as a counter-intuitive mechanism for circumventing the ACA's principal objective.

C. Interpreting "Limited Duration" To Encompass Plans That Can Be Renewed For A Total Of 36 Months Is Contrary To Law.

The Department's interpretation of "limited duration" to permit insurance plan renewals of up to three years—with the possibility that, at the time of purchase, these contracts could be stacked on end to give them an even longer effective life—is likewise contrary to law. The plain meaning of the statutory text is that short term limited duration insurance is a one-time, non-renewable coverage option. "Limited" means "[r]estricted in size, amount, or extent." *Limited*, Oxford English Dictionary, perma.cc/P9ZB-LVJH. A contract that may be automatically renewed is, by definition, not restricted to its original term; thus, the STLDI Rule departs from the plain meaning of the statutory language. This conclusion is bolstered by the fact that the States that have legislated on the topic of STLDI plans refer to such coverage as non-renewable, or renewable only for a very short period."[33]

A contrary interpretation, would also run afoul of Congress's specification that short term limited duration insurance be "short term." It does not make sense to believe that Congress would limit the term of individual plans to a period relatively shorter than a year (say, 3 months),

[33] *See, e.g.*, 1994 Minn. Laws 556; 1995 N.H. S.B. 30; 1995 Or. S.B. 152; 1995 Ind. S.B. 576; 1995 Mo. S.B. 27; 1995 Tenn. H.B. 1213; 1996 Fla. S.B. 910; 1996 Va. H.B. 1026; 1998 Mich. S.B. 1007; Nev. Admin. Code § 689A.434 (1997); 28 Tex. Admin. Code § 3.3002 (1997); 1998 Colo. H.B. 1053; 2002 Cal. H.B. 424; 2002 Ga. H.B. 1100; 2002 Utah S.B. 122; S.D. Admin. R. 20:06:39:32 (2003); 2009 Wis. S.B. 27; 2013 Kan. H.B. 2107.

but allow these plans to be renewed repeatedly so that their effective duration is that of full-time, conventional (renewable) annual plans.

And such an interpretation of limited duration would be inconsistent with Congress's intent for the same reasons that doom the Departments' interpretation of "short-term." Permitting individuals to extend or renew short term limited duration insurance for up to three years further dismantles barriers to healthy individuals leaving the ACA-compliant individual coverage market and purchasing STLDI instead. As explained above (*supra* at page 20), this will have the impermissible effect of undermining Congress's policy to create a single risk pool that enables all individuals to obtain to affordable, quality health insurance.

D. The STLDI Rule Is Arbitrary And Capricious.

Finally, the STLDI Rule is arbitrary and capricious. In reviewing the action of the Departments, this Court must engage in a "thorough, probing, in-depth review" (*Citizens to Preserve Overton Park, Inc. v. Volpe*, 401 U.S. 402, 415 (1971)) to determine whether the agencies have "examine[d] the relevant data and articulate[d] a satisfactory explanation for its action . . . ." *Motor Vehicle Mfrs. Ass'n v. State Farm Mut. Ins. Co.*, 463 U.S. 29, 43 (1983). An agency rule is arbitrary and capricious if "the agency has relied on factors which Congress has not intended it to consider, entirely failed to consider an important aspect of the problem, offered an explanation for its decision that runs counter to the evidence before the agency, or is so implausible that it could not be ascribed to a difference in view or the product of agency expertise." *Id.*; *see also Michigan v. EPA*, 135 S. Ct. 2699, 2706 (2015). Where an agency changes its existing policy, it must "show that there are good reasons for the new policy" and that it took into account any "serious reliance interests" the previous policy engendered. *Encino Motorcars, LLC v. Navarro*, 136 S. Ct. 2117, 2126 (2016).

Here, the Departments' decisionmaking process was riddled with deficiencies, for all of these reasons.

1. In promulgating the Rule, the Departments departed from prior, well-reasoned interpretations of "short-term limited duration insurance"—including over two decades of settled law regarding the meaning of "limited duration. And they did so without providing the required reasoned explanation.

Since the 1990s, the Departments have interpreted "limited duration" plans to be limited to the maximum permissible *initial* plan term. *See* 62 Fed. Reg. 16,894 (Apr. 8, 1997). In 2016, the Departments reaffirmed that the maximum period of coverage for short-term limited duration insurance may not be enlarged through extensions. They felt the need to do this in light of evidence, detailed in the rulemaking, that "short-term, limited duration [insurance] is being sold in situations other than those that the exception from the definition of individual health insurance coverage was initially intended to address." 81 Fed. Reg. 75,316, 75,317 (Oct. 31, 2016); *see id.* at 75,317-18 & n.16. Specifically, "individuals [were] purchasing this coverage as their primary form of health coverage," and "some insurers [were] providing renewals of the coverage that extend the duration beyond 12 months." *Id.* 75,318. This, the Departments explained, resulted in individuals not receiving meaningful health coverage (as intended by the ACA) and "adversely impact[ed] the risk pool for Affordable Care Act-compliant coverage" because STLDI policies could discriminate based on health status and target healthier individuals. *Id.* 75,317-18.

In the new STLDI Rule, the Departments do not dispute any of the facts underlying their previous analysis and conclusion. To the contrary, they ***confirm*** them. *See, e.g.,* 83 Fed. Reg. at 38,231, 38,233-36. The Departments now simply claim that it is desirable to make STLDI "an additional choice for many consumers that exists side-by-side with individual market coverage."

Id. at 38,218; *see also id.* at 38,222, 38,228, 38,229. But as explained above, making STLDI plans an attractive option for individuals' primary insurance is inconsistent with the ACA and therefore not a permissible basis for justifying the Rule. Moreover, the Departments fail to even acknowledge that they had previously concluded that this outcome was incompatible with the ACA. 81 Fed. Reg. at 75,317-18. Such a disregard for that previous conclusion is arbitrary and capricious. *FCC v. Fox Television Stations, Inc.*, 556 U.S. 502, 515 (2009).

Nor are the other bases cited for the new interpretation of "limited duration" "good reasons for the new policy." *Id.* The Departments attempted to justify their new interpretation by pointing to the fact that Congress did not address STLDI plans in the ACA. 83 Fed. Reg. at 38,220. But that is hardly a basis for disregarding the Departments' own prior contrary conclusion, which of course post-dated enactment of the ACA.

The Departments also noted that COBRA coverage (which requires certain group health plans to extend coverage to individuals who would otherwise lose that coverage) can last up to 36 months in some circumstances. 83 Fed. Reg. at 38,221. But COBRA coverage is not expressly constrained to be of "limited duration." In any event, that coverage complies with the ACA's requirements and keeps the covered individual in the group coverage risk pool, whereas STLDIs do not. Accordingly, extended COBRA coverage does not pose the same threats to Congress's policies as do STLDI plans.

2. The Departments' departure from their 2016 Rule is flawed for an additional reason. As noted above, the ACA mandates an open enrollment period for individuals who lose minimum essential coverage mid-year. But an STLDI plan qualifies neither as minimum essential coverage nor as a plan in the individual insurance market. 26 C.F.R. § 1.5000A-2(d)(1). As a consequence, an individual who enrolls in ACA-compliant coverage and must change plans

will be guaranteed a seamless continuation of coverage; an individual who enrolls in an STLDI plan will not, running the risk of losing his or her eligibility to enroll in full coverage even if he or she later develops an illness or condition that requires costly treatment.

This risk is minimized, however, if STLDI plans are limited to three months or less. Under HHS's regulations, the special enrollment period for the loss of minimum essential coverage lasts for 60 days, and new coverage will begin the month after enrollment. 45 C.F.R. § 155.420(b)(2)(iv), (c)(1). A short-term plan of up to three months, then, may cover an individual's gap during this time between the termination of coverage under one ACA-compliant plan and the beginning of coverage under another.

It was, in part, for this reason that the Departments acted in their 2016 rule to limit STLDI plans to a period of no longer than three months. At that time, the Departments explained that "[s]hort-term, limited duration insurance allows for coverage to fill temporary coverage gaps when an individual transitions between sources of primary coverage." 81 Fed. Reg. at 75,316, 75,318 (Oct. 31, 2016). In contrast, "for longer gaps in coverage, guaranteed availability of coverage and special enrollment period requirements in the individual health insurance market under the Affordable Care Act ensure that individuals can purchase individual market coverage through or outside of the Exchange that is minimum essential coverage and includes the consumer protections of the Affordable Care Act." *Id.*

The new STLDI Rule threatens to upset this balance by permitting "short-term" plans to last for longer than three months. Enrollees in these plans will lose their eligibility for enrollment in ACA-compliant plans after the special enrollment period for a gap in comprehensive coverage expires. This runs contrary to Congress's central purpose in providing special enrollment periods for Exchange plans, which, as even HHS itself has recently acknowledged, was to provide a

safeguard to preserve the ACA's promise of guaranteed coverage: "In the individual market, … special enrollment periods are intended, in part, to promote continuous enrollment in health coverage during the benefit year by allowing those who were previously enrolled in coverage to obtain new coverage without a lapse or gap in coverage." 82 Fed. Reg. 18,346, 18,355 (Apr. 18, 2017).

A number of commenters noted this concern during the rulemaking proceedings. As one commenter, Community Catalyst, described the issue:

> Moreover, consumers could be left with uncovered bills and/or find themselves "uninsurable." Because insurers can deny a new contract if the enrollee becomes sick or injured during the coverage term, consumers may believe they can extend or renew coverage until rejected by the issuer. If their short-term plan ends before marketplace open enrollment, their loss of coverage would not qualify for a special enrollment period, leaving a consumer to wait until the next annual open enrollment period to select a new plan. This will lead to a gap in coverage for many consumers.

Comment of Community Catalyst, p. 4. *See also* Comment of Young Invincible, p. 7; Comment of Centene Corporation, p. 2; Comment of U.S. PIRG, p. 2.

In promulgating the STLDI Rule, the Departments acknowledged the submission of these comments, *see* 83 Fed. Reg. at 38,217, but they provided no response beyond that acknowledgement and no indication why they believed it appropriate to encourage a market for STLDI plans when the inevitable result would be that many individuals would be locked out of access to needed comprehensive coverage. This is the hallmark of arbitrary decisionmaking, for two reasons.

First, the Departments failed even to acknowledge, let alone grapple with, this important aspect of their own decision making the last time they confronted this topic in 2016. By failing to "provide an adequate explanation for [their] departure from" their own recent analysis of the

issue, the Departments fell short of the APA's requirements. *Dillmon v. Nat'l Transp. Safety Bd.*, 588 F.3d 1085, 1089--90 (D.C. Cir. 2009). *See also Fox Television Stations*, 556 U.S. at 515.

Second, the Departments' failure to meaningfully engage with commenters who raised this issue was arbitrary. Although an agency "need not address every comment" made during the notice and comment period, "it must respond in a reasoned manner to those that raise significant problems." *City of Waukesha v. EPA*, 320 F.3d 228, 257 (D.C. Cir. 2003) (quoting *Reytblatt v. Nuclear Regulatory Comm'n*, 105 F.3d 715, 722 (D.C. Cir. 1997)). Significant comments are those "which, if true, raise points relevant to the agency's decision and which, if adopted, would require a change in an agency's proposed rule." *City of Portland v. EPA*, 507 F.3d 706, 715 (D.C. Cir. 2007). Under this standard, Community Catalyst and others plainly raised significant comments, as they present powerful grounds for the Departments not to depart from the prior rule limiting short-term plans to three months. The Departments, however, simply "refused to engage with" the commenters' concerns, *Delaware Dep't of Nat. Res. & Envtl. Control v. EPA*, 785 F.3d 1, 15 (D.C. Cir. 2015), and so acted arbitrarily.

* * * *

For all of these reasons, the STLDI Rule was an abuse of administrative authority: "the [Departments'] rule was an act of amendment, not interpretation. Accordingly, [the Departments] ha[ve] no colorable claim to *Chevron* deference." *Central United Life*, 827 F.3d at 74. In this setting, plaintiffs are likely to succeed on the merits of their challenge.

II. PLAINTIFFS AND THEIR MEMBERS WILL SUFFER IRREPARABLE HARM ABSENT AN INJUNCTION.

The second requirement for a preliminary injunction, "'likely irreparable harm in the absence of preliminary relief," *League of Women Voters of U.S. v. Newby*, 838 F.3d 1, 6 (D.C. Cir. 2016) (quotation omitted), is also met here. To satisfy this factor, "the harm must be 'certain

and great,' 'actual and not theoretical,' 'and so imminen[t] that there is a clear and present need for equitable relief to prevent irreparable harm.'" *Id.* at 7--8 (quoting *Chaplaincy of Full Gospel Churches v. England*, 454 F.3d 290, 297 (D.C. Cir. 2006)). But "[a]s a preliminary injunction requires only a ***likelihood*** of irreparable injury, Damocles's sword does not have to actually fall on [plaintiffs] before the court will issue an injunction." *Id.* at 8-9 (emphasis added) (internal citation omitted). Finally, the harm must also be "beyond remediation." *Id.* at 8 (internal quotation marks omitted).

Plaintiffs, who perform discrete roles and have varying interests in the healthcare system, satisfy these requirements in several independent ways. We address each in turn.

A. Insurer Plaintiffs

First, Plaintiff ACAP's member insurers[34] will be irreparably injured as newly legalized longer STLDI plans siphon off their policyholders, and potential new customers, during the upcoming ACA open enrollment period. ACAP's members are not-for-profit safety net health plans serving low-income communities; many of ACAP's members offer ACA-compliant insurance plans. Murray Decl. ¶ 3. For example, Community Health Choice, Inc., one of ACAP's members, currently serves approximately 110,000 Houston-area customers through its ACA-compliant plans. *Id.* ¶ 11; Janda Decl. ¶ 6.

If the STLDI Rule goes into effect on October 2, many of those customers will leave their current plans during open enrollment in favor of an STLDI plan. The Wakely Consulting Group, a leading actuarial firm, projects that the STLDI Rule will cause between 1 million and 1.9 million people to leave ACA-compliant individual enrollment plans in the near term (four to five years). Murray Decl. Ex. B, at 2. Estimates from other studies range as high as 4.3 million

[34] As a membership organization with associational standing, ACAP may assert irreparable harm on behalf of its members in seeking a preliminary injunction. *See, e.g.*, *AARP v. EEOC*, 226 F. Supp. 3d 7, 23 (D.D.C. 2016) (noting association plaintiff's "burden to demonstrate that its members will suffer irreparable harm from" the challenged agency action).

STLDI enrollees in 2019 alone.[35] Even the government estimates that enrollment in ACA-compliant plans will decrease by 200,000 people in 2019, and that enrollment will be down by 1.3 million by 2028. 83 Fed. Reg. at 38,236. Moreover, because ACAP's members serve low-income communities, its plans will likely be hit harder than average by defections of price-conscious consumers. Murray Decl. ¶ 8. Community Health Choice alone expects to lose up to 10,000 current members from its Marketplace plans if the STLDI rule takes effect, corresponding to a loss of $50 million to $100 million in revenue. Janda Decl. ¶ 11.

This competitive harm to ACAP members' business constitutes irreparable injury justifying issuance of a preliminary injunction. As the D.C. Circuit has explained, "economic actors suffer an injury in fact when agencies lift regulatory restrictions on their competitors or otherwise allow increased competition against them." *Sherley v. Sebelius*, 610 F.3d 69, 72 (D.C. Cir. 2010) (internal quotation marks omitted; alterations adopted). Here, even the agencies agree that their rule will cause hundreds of thousands of people to leave ACA-compliant plans (83 Fed. Reg. at 38,236); they therefore cannot be heard to argue that competitive harm to ACAP members is not sufficiently "certain," or "actual [rather than] theoretical." *League of Women Voters*, 838 F.3d at 8. And that harm is self-evidently "great" where one ACAP member alone stands to lose between $50 million and $100 million in revenue. Janda Decl. ¶ 11.

Importantly, the ACAP plaintiffs' harm need not satisfy the higher standard of magnitude sometimes required to find that ***recoverable*** economic loss is irreparable. *See, e.g.*, *Wisc. Gas Co. v. FERC*, 758 F.2d 669, 674 (D.C. Cir. 1985) ("Recoverable monetary loss may constitute irreparable harm only where the loss threatens the very existence of the movant's business."). This is because ACAP members' loss in the absence of an injunction will be *un*recoverable. As this Court has explained:

[E]ven if the claimed economic injury did not threaten plaintiff's viability, it is

[35] Comment of the National Partnership for Women & Families, at 6 (April 23, 2018), goo.gl/krFSzd.

> still irreparable because plaintiffs cannot recover money damages against FDA. Where a plaintiff cannot recover damages from an agency because the agency has sovereign immunity, "any loss of income suffered by [the] plaintiff is irreparable *per se*."

Smoking Everywhere, Inc. v. FDA, 680 F. Supp. 2d 62, 77 n.19 (D.D.C. 2010) (Leon, J.), *aff'd sub nom. Sottera, Inc. v. FDA*, 627 F.3d 891 (D.C. Cir. 2010) (quoting *Feinerman v. Bernardi*, 558 F. Supp. 2d 36, 51 (D.D.C. 2008)). Just so here: Although ACAP members' losses will be directly attributable to the STLDI Rule, they will have no ability to recoup those losses from the government once the rule takes effect. *See id.* (noting that "[a]bsent a waiver, sovereign immunity shields the federal government and its agencies . . . from suit," and that the APA "waives sovereign immunity for federal agencies but only in actions 'seeking relief other than money damages'") (quoting 5 U.S.C. § 702). For the same reasons, the harm to ACAP members' businesses is "beyond remediation." *League of Women Voters*, 838 F.3d at 8 (internal quotation marks omitted).

Finally, that the open enrollment period for 2019 is only weeks away renders harm "so imminen[t] that there is a clear and present need for equitable relief." *League of Women Voters*, 838 F.3d at 8 (quotation omitted). Absent a qualifying life event for a particular individual, open enrollment is the only opportunity each year for customers to consider their health insurance options and select a plan for the year ahead. *See* 45 C.F.R. § 155.410(a)(2). Once open enrollment takes place and thousands of current ACA-compliant plan customers have been locked into contracts with STLDI providers, there will be no way to un-ring that bell; those customers will be gone for the 2019 plan year at the very least. Open enrollment begins on November 1, 2018 and ends on December 15, 2018, for the federal marketplace. A preliminary injunction is therefore critical to preserve the insurance markets as they were before the issuance of the STLDI Rule. *See Aamer v. Obama*, 742 F.3d 1023, 1043 (D.C. Cir. 2014) ("The primary purpose of a preliminary injunction is to preserve the object of the controversy in its then existing condition—to preserve the status quo.") (internal quotation marks omitted).

B. Provider Plaintiffs

Next, several of the plaintiffs are organizations whose members provide healthcare services, including to individuals with ACA-compliant insurance coverage, and who will therefore be injured by the STLDI Rule.

The American Psychiatric Association (APA), for example, is the national professional association for psychiatrists, medical doctors who specialize in the treatment of mental health and substance use disorders. STLDI plans frequently do not cover mental health services, and most do not cover substance abuse treatment.[36] Individuals who purchase those plans and subsequently need such services, something that happens with considerable frequency to young people, will find themselves unable to pay for them—putting psychiatrists in the position of either refusing service or providing uncompensated care. Brandt Decl. ¶ 6; Kolodner Decl. ¶ 12.

In addition, as healthy patients are diverted from ACA-compliant plans, the cost for those plans will rise. This will certainly lead to an increase in premiums that many patients of APA's members will not be able to afford. When existing patients lose coverage and can no longer pay for their care the physician is ethically obligated to continue to provide essential treatment until the patent is transitioned to another provider. Kolodner Decl.¶ 5. But lower-cost STLDI plans will not provide the level of coverage needed for treatment of many mental health and/or substance use disorder patients, meaning that there will be no provider to whom the patient can transition. Kolodner Decl. ¶ 12. Moreover, as costs to ACA plan issuers increase because the patient population is less healthy, plans will institute cost-reduction practices, including prior authorization requirements for basic services, more frequent auditing, and more stringent medical necessity standards. Kolodner Decl. ¶ 14. Such measures increase the amount of uncompensated time the psychiatrist must spend on each patient to ensure their care is covered,

[36] Karen Pollitz et al., *Issue Brief: Understanding Short-Term Limited Duration Health Insurance*, Kaiser Family Foundation (Apr. 23, 2018), perma.cc/2K7N-4XWA; *see also, e.g.*, Kimball Decl. ¶ 6.

thereby reducing the amount of time the psychiatrist has to see other patients, further straining access to an already underserved specialty, and reducing the income of the providers. *Id.*

When similar measures were imposed in the past, psychiatrists could not afford the income loss, and many psychiatrists opted out of insurance plans altogether, choosing instead to operate on a cash-only basis. *Id.* The STLDI Rule will likely put psychiatrists to the same choice: significant reductions in income due to uninsured patients and increased uncompensated administrative time for insured patients, or movement to a cash-only operation. *Id.* But many of APA members' current patients on Marketplace plans would be unable to pay out of pocket for treatment. And critically, the profession's ethical rules would likely require a psychiatrist who stops accepting insurance to continue treating his or her current patients (despite the fact that they are unable to pay) until they can be transitioned to a new doctor—a task that will grow increasingly difficult as more and more psychiatrists make the same move to cash-only practices. *Id.*

Thus, psychiatrists will be concretely, monetarily injured by the STLDI Rule no matter which choice they make. And like those of the insurers discussed above, the losses to these psychiatrists will be beyond remediation, and therefore constitute irrevocable harm.

Similarly, organizations that provide healthcare services to patients with pre-existing conditions—like the member organizations of plaintiff AIDS United (*See* Milan Decl. ¶ 9)—will be forced to provide increased uncompensated care as a result of the STLDI Rule. These populations by definition will be excluded from STLDI plans; individuals with HIV/AIDS are exactly the kind of patients who insurers will discriminate against or exclude, given the chance. *Id.* ¶¶ 5-6. HIV/AIDS patients will therefore be left behind in Marketplace plans facing the full brunt of the rise in premiums; many individuals will be unable to pay those premiums, and will drop their coverage entirely. Their healthcare providers will either have to continue treating them for free, or to refuse treatment. Either way, those providers are harmed, and are left with no remedy at law for their injury.

Finally, organizations like plaintiff Mental Health America (MHA)'s affiliates, which provide rehabilitation, socialization, and housing services to individuals with mental illness (another pre-existing condition), will be harmed programmatically by the STLDI Rule. *See* Howard Decl. ¶ 8. In this sense, "[a]n organization is harmed if the actions taken by the defendant have perceptibly impaired the organization's programs," and "the defendant's actions directly conflict with the organization's mission." *League of Women Voters*, 838 F.3d at 8 (internal quotation marks omitted; alterations incorporated).

As individuals with mental illness are priced out of increasingly expensive ACA-compliant Marketplace plans and their conditions are therefore left untreated, more and more people will come to need the rehabilitation, housing, and other services offered by MHA associate organizations. With limited budgets, MHA associates will be forced to either divert resources from other efforts to fund expansions of these programs or let these individuals' needs go unmet, in contravention of MHA's mission. Howard Decl. ¶¶ 3, 8. Their programs will thus be "perceptibly impaired." *League of Women Voters*, 838 F.3d at 8; *cf. People for the Ethical Treatment of Animals v. USDA*, 797 F.3d 1087, 1093 (D.C. Cir. 2015) ("[A] 'concrete and demonstrable injury to [an] organization's activities—with the consequent drain on the organization's resources—constitutes far more than simply a setback to the organization's abstract social interests' and thus suffices for standing.") (quoting *Havens Realty Corp. v. Coleman*, 455 U.S. 363, 379 (1982)). Again, absent an injunction, there is no remedy for these harms.

C. Consumer Plaintiffs

Finally, the STLDI Rule will also cause harm to plaintiffs representing consumers of healthcare. For example, some of AIDS United's members are organizations of individuals living with HIV/AIDS. Milan Decl. ¶ 8. The harm that will befall these individuals is by now familiar: They will be left behind in Marketplace plans that provide the benefits and protections that the ACA guarantees with no choice but to pay the increasing premiums—estimated at 2.2% to 6.6%

(*see* Murray Decl. Ex. B at 2)—because cheaper STLDI plans with pre-existing condition bars will not accept them. *See, e.g.*, Milan Decl. ¶¶ 5-6. The resulting economic loss constitutes irreparable harm, as these individuals will lack a remedy at law. *Smoking Everywhere*, 680 F. Supp. 2d at 77 n.19. What is more, some people will likely be unable to afford the increase at all, and will be forced to forgo lifesaving treatment—surely an irreparable injury.

The families represented by plaintiff Little Lobbyists—families with children who have complex pre-existing conditions—face the same irreparable harms. *See* Hung Decl. ¶¶ 5-9. So do the individuals with mental illness represented by plaintiff National Alliance on Mental Health. *See* Kimball Decl. ¶¶ 6-8. Indeed, individuals with mental illness are doubly at risk, because serious mental illness most often shows its first signs during adolescence or early adulthood—and young, otherwise healthy people are exactly those who are most likely to leave Marketplace coverage for STLDI plans. *Id.* ¶ 6; Kolodner Decl. ¶ 5; Fassler Decl. ¶ 5. Thus, an outwardly healthy young adult could easily sign up for an STLDI plan, not knowing that he or she will be diagnosed with mental illness—which the STLDI plan either does not cover or covers with a low dollar cap—in the next 364 days. Such a situation is likely to lead to serious harm, as early intervention and consistent treatment are key to successful mental health outcomes. Fassler Decl. ¶ 5; Kimball Decl. ¶ 7; Howard Decl. ¶ 3. Similarly, the women for whom the National Partnership for Women and Families advocates may purchase STLDI plans and find themselves without coverage for maternity care when they get pregnant. The lack of coverage for prenatal care, labor and delivery, and postpartum care for pregnant women and newborns could lead to significant consequences for both the health and economic wellbeing of women and their families. Like insurers and service providers, therefore, disadvantaged patient populations are certain to suffer irreparable injury absent a preliminary injunction.

III. THE BALANCE OF EQUITIES AND THE PUBLIC INTEREST STRONGLY FAVOR AN INJUNCTION.

The remaining two factors for the issuance of a preliminary injunction—"a balance of the

equities in its favor, and accord with the public interest" (*League of Women Voters*, 838 F.3d at 6 (internal quotation marks omitted))—also weigh heavily in favor of relief here. The balance-of-equities factor requires courts to "balance the competing claims of injury and . . . consider the effect on each party of the granting or withholding of the requested relief." *Aracely, R. v. Nielsen*, 319 F. Supp. 3d 110, 156 (D.D.C. 2018) (quoting *Winter v. Nat. Res. Def. Council, Inc.*, 555 U.S. 7, 24 (2008)). Harm to interested third parties is also included in this calculation. *See League of Women Voters*, 838 F.3d at 12. Moreover, the balance of the equities and the public interest "merge into one factor when the government is the non-movant." *Aracely, R.*, 319 F. Supp. 3d at 156; *see also, e.g.*; *Pursuing Am.'s Greatness v. FEC*, 831 F.3d 500, 511 (D.C. Cir. 2016) ("[T]he government's interest *is* the public interest.") (citing *Nken v. Holder*, 556 U.S. 418, 435 (2009)).

As we have demonstrated, the harms to plaintiffs in the absence of a preliminary injunction will be severe. But the harm to the public interest will be even greater.

A. Individual Consumers Will Be Injured If The STLDI Rule Goes Into Effect.

To begin, countless consumers are likely to be deceived into purchasing STLDI plans, thinking that these plans offer more coverage than they actually do. STLDI and other ACA-noncompliant plans are frequently marketed as providing ACA-compliant or equivalent coverage—indeed, the Insurance Commissioners of multiple States have had to issue press releases warning consumers about such conduct.[37] As reported in comments submitted in

[37] *See, e.g.*, *Wyoming residents asked to be vigilant against health insurance callers*, KGWN News (Mar. 30, 2016) ("Wyoming Insurance Commissioner Tom Glause warns Wyoming consumers not to fall prey to high-pressure telemarketers selling short-term or limited benefit health insurance products that are not compliant with the Affordable Care Act (ACA), despite some company promises."), goo.gl/nj3RMT; Press Release, Iowa Ins. Div., *Consumer Alert: Final Tips as ACA Open Enrollment Period Ends December 15* (Dec. 12, 2017), goo.gl/XMnEic; Press Release, Pa. Ins. Dep't, *Acting Insurance Commissioner Alerts Consumers of Individual Health Plans Not Compliant with Affordable Care Act* (Nov. 8, 2017), perma.cc/E85K-B6U6; Press Release, Alaska Dep't of Commerce, Cmty. & Econ. Dev., *The Division of Insurance*

response to the Proposed Rule, sales agents will flat-out "contact an individual and tell them that the plan complies with the ACA when it does not."[38] In fact, HHS ***itself*** **—**including HHS Secretary Alex Azar—are touting the availability of STDI plans. Consumers would be forgiven for thinking that an STLDI plan is an adequate substitute for comprehensive coverage when the United States government agency whose mission it is "to enhance and protect the health and well-being of all Americans"[39] is telling them directly that STLDI "might be right" for them.

As a result, these consumers will be exposed to the exact range of abuses against which the ACA was designed to protect, including coverage exclusions, rescissions, and annual and lifetime benefit caps. Benefit caps mean that an STLDI consumer who experiences an accident or unexpected serious illness can end up paying thousands of dollars out of pocket—which is one thing if that consumer consciously chose to take that gamble, but quite another if the consumer expected to purchase a product comparable to comprehensive insurance.

Coverage exclusions are problematic for a similar reason: STLDI plans frequently do not cover services that healthy individuals may find that they need only after purchasing the plan. To take the most obvious example, one study found that ***no*** available STLDI plans cover maternity care.[40] But an entire nine-month pregnancy fits easily within a 364-day STLDI term, and consumers covered only by STLDI would therefore be looking at a choice between spending

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Cautions Alaskans that Short-Term Health Insurance is not ACA Compliant (Dec. 15, 2015), perma.cc/EKG5-KYGZ.

[38] Comment of Families USA, at 2 (Apr. 23, 2018), goo.gl/cmqcQA; *see also, e.g.*, Reed Abelson, *Without Obamacare Mandate, 'You Open the Floodgates' for Skimpy Health Plans*, N.Y. Times (Nov. 30, 2017), https://goo.gl/pCcqoG ("[S]ome brokers are deliberately promoting [STLDI] policies without pointing out that they do not meet the same levels of coverage of A.C.A. plans, said Scott Flanders, the chief executive of eHealth. 'They're selling the hell out of it,' he said.").

[39] *About HHS*, U.S. Dep't of Health & Human Servs., perma.cc/8ELQ-UPUG.

[40] Karen Pollitz et al., *Issue Brief: Understanding Short-Term Limited Duration Health Insurance*, Kaiser Family Foundation (Apr. 23, 2018), perma.cc/GX37-G7A6.

thousands of dollars out of pocket[41] or forgoing needed care. There are over six million pregnancies in the United States each year.[42]

Rescissions—retroactive cancellations of coverage—are likewise prohibited for Marketplace plans, but not for STLDI plans. One comment on the Proposed Rule reflects the story of an Illinois woman who suffered extreme vaginal bleeding, losing half her blood and requiring an emergency hysterectomy and a five-day hospital stay. Her short-term insurance provider refused to pay a cent of the resulting medical bills—which amounted to tens of thousands of dollars—claiming that her regular menstrual cycle constituted a pre-existing condition.[43] Similarly, a San Diego man had a heart attack and required a $900,000 triple-bypass surgery, but his STLDI plan refused to pay for it, arguing that he failed to disclose pre-existing medical conditions ***for which he had not been diagnosed***.[44] Exposing more people to such conduct is not in the public interest.

B. The STLDI Rule Will Injure The Health Care System As A Whole.

Moreover, the STLDI Rule puts at risk the stability of the entire individual insurance market established by the ACA. As explained above (at pages 18-21), skewing the risk pool for ACA-compliant insurance by drawing away healthy consumers will increase premiums for those plans, leading to a new wave of flight by the next-healthiest tier of consumers (as well as those who simply cannot afford the increase). This cyclical adverse selection mechanism may ultimately threaten the survival of the ACA's marketplaces themselves.

Even in the short term, though, the departure of healthy individuals from ACA-compliant plans is sure to raise premiums for those left behind. Healthy people pay their premiums but do

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[41] One study found that for even an uncomplicated pregnancy, commercial insurers paid over $18,000 on average for childbirth and newborn care. *The Cost of Having a Baby in the United States*, Truven Health Analytics (Jan. 2013), perma.cc/L3DY-LLDV.

[42] Sally C. Curtin et al., *NCHS Data Brief: Pregnancy Rates for U.S. Women Continue to Drop*, Nat'l Ctr. for Health Statistics (Dec. 2013), perma.cc/X2FJ-QU3N.

[43] Comment of EverThrive Illinois, at 2 (Apr. 23, 2018), goo.gl/j21Noe.

[44] *See* Abelson, *supra* n. 38.

not require much care, so they are profitable customers for insurance companies. If they leave ACA-compliant plans in large numbers, there is no doubt that premiums have to rise to pay for the care of the sicker people remaining in the risk pool.

Those participants in ACA-compliant plans ineligible for premium tax credits will have to bear the increased costs themselves. This injury alone—to millions of Americans[45]—demonstrates that the STLDI Rule will harm the public interest. Moreover, some of those customers will not be able to cover the increases, and will lose coverage altogether, opening themselves up to financial ruin from large medical bills or—worse—illness or even death due to lack of treatment.

And for the purchasers of ACA-compliant insurance who ***are*** eligible for premium tax credits under the ACA, the American taxpayer will foot the increased bill. This will be no small cost: By the government's admission, the STLDI Rule will increase the cost to the government of premium tax credits—which are paid for with every American's tax dollars—by $28.2 ***billion***. 38 Fed. Reg. at 38,236.

As discussed above, all of these harms are closely linked to the upcoming open enrollment period, which starts November 1, 2018. Open enrollment is generally the only time that existing consumers are able to shop around or switch plans; it is also the only time that currently uninsured individuals may purchase ACA-compliant plans. 45 C.F.R. § 155.410(a)(2).[46] Thus, if STLDI plans are available during open enrollment—as the Final Rule would allow—all the harms described above would be locked in for plan year 2019. Failure to enter a preliminary injunction before November 1 (and certainly, before open enrollment closes

[45] 11.8 million people signed up for ACA-compliant coverage during the 2018 open enrollment period. *See* Ctrs. for Medicare & Medicaid Servs., *Health Insurance Exchanges 2018 Open Enrollment Period Final Report* (Apr. 3, 2018), perma.cc/D6Z6-ECRD.

[46] Firms planning to offer STLDI plans obviously know this; it has been reported that "the companies that sell [STLDI plans] are already gearing up to use the six-week open enrollment period . . . as a focal point for their own, often aggressive marketing efforts." Sarah Lueck, *Key Flaws of Short-Term Health Plans Pose Risks to Consumers*, Center for Policy & Budget Priorities (Sept. 20, 2018), perma.cc/5LAG-UK2D.

in December) therefore "would in fact upend the status quo." *Sherley v. Sebelius*, 644 F.3d 388, 398 (D.C. Cir. 2011); *see also, e.g.*, *Tyndale House Publishers, Inc. v. Sebelius*, 904 F. Supp. 2d 106, 130 (D.D.C. 2012) ("Because any of these consequences would result in a change in the *status quo*, the Court finds that the balance of equities tips in favor of [a preliminary injunction].") (internal citation omitted).

C. Enjoining Implementation Of The STLDI Rule Will Not Injure The Government.

On the other side of the ledger, a preliminary injunction will cause no harm to the government. The equities therefore favor plaintiffs, since "[w]here an injunction will 'not substantially injure other interested parties,' the balance of equities tips in the movant's favor." *Jacinto-Castanon de Nolasco v. ICE*, 319 F. Supp. 3d 491, 503 (D.D.C. 2018) (quoting *League of Women Voters*, 838 F.3d at 12).

First, the government has "no public interest in the perpetuation of unlawful agency action." *League of Women Voters*, 838 F.3d at 12. "To the contrary, there is a substantial public interest in having governmental agencies abide by the federal laws that govern their existence and operations." *Id.* (internal quotation marks omitted); *see also, e.g.*, *Damus v. Nielsen*, 313 F. Supp. 3d 317, 342 (D.D.C. 2018) ("As courts in this district have recognized, 'The public interest is served when administrative agencies comply with their obligations under the APA.'") (quoting *Northern Mariana Islands v. United States*, 686 F. Supp. 2d 7, 21 (D.D.C. 2009)). Because the STLDI Rule is contrary to the law and is arbitrary and capricious, enjoining it is in the public interest.

Second, the ***only*** effect on the government of a preliminary injunction would be to delay the STLDI Rule coming into effect. Apart from all the harms the rule would cause, even its ***proponents*** argued to the agencies that it should not take effect until 2020. Writing in support of the Proposed Rule, the National Association of Insurance Commissioners—a non-partisan group representing the chief insurance regulators of all 50 States, the District of Columbia, and all

federal territories—stated:

> [S]tates are concerned about the timing of this rule, and some states may want to modify existing laws and regulations to protect consumers and state markets. Therefore, we recommend that the final regulation allow states, if they so choose, to begin enforcing the new rules in 2020, thus giving them time to review their rules and seek statutory or regulatory changes to facilitate a smooth transition.[47]

The States' approach appropriately reflects the basic intuition that the STLDI Rule is a major policy shift in an extremely complicated area, and that rushing into such a change would not be in the public interest ***even if*** the rule were otherwise beneficial.

In short, a preliminary injunction would protect plaintiffs, consumers, and the public interest. The government can show no countervailing harm from injunctive relief, other than a delay in implementing its preferred policy. Plaintiffs have therefore "demonstrated that the balance of the equities tips in their favor," *League of Women Voters*, 838 F.3d at 12, and an injunction should issue.

CONCLUSION

The Court should grant Plaintiffs' Motion for a Preliminary Injunction.

[47] Comment of the National Association of Insurance Commissioners, at 2 (Apr. 23, 2018), goo.gl/BmVDFw.

Respectfully submitted,

Dated: September 28, 2018

/s/ *Andrew J. Pincus*

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IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

ASSOCIATION FOR COMMUNITY AFFILIATED PLANS, et al., *Plaintiffs*, v. UNITED STATES DEPARTMENT OF TREASURY, et al., *Defendants*.	Civil Action No. 18-cv-2133

DECLARATION OF HARRY A. BRANDT, MD

I, Harry A. Brandt, MD, declare and state as follows:

1. I am a board-certified psychiatrist practicing in Maryland and specializing in the treatment of eating disorders. I received my medical degree from the University of Maryland School of Medicine in 1983. I am the Co-Director of The Center for Eating Disorders at Sheppard Pratt, Chief of Psychiatry at University of Maryland-St. Joseph Medical Center, and a Distinguished Fellow of the American Psychiatric Association (APA), where I have been an elected member of the Assembly, President of the Maryland District Branch and a member for 33 years.

2. Eating disorders are serious illnesses which are usually accompanied by other serious mental and physical illnesses. Patients with eating disorders have a very high death rate from starvation or medical comorbidities, and the highest suicide rates of all psychiatric

illnesses. Treatment is often long term and it is not unusual to have patients in treatment for ten years or more with periodic exacerbations and remissions. Regular appointments are critical to my patients' success.

3. I participate in insurance plans and in insurance plans sold in the Affordable Care Act (ACA) marketplace. Many of my patients have individual insurance policies and have been able to acquire them because of the Affordable Care Act's prohibition of discrimination against persons with preexisting conditions and requirement that mental health be covered and covered in parity with all other medical care.

4. The rates I charge are comparable to the rates of other psychiatrists in my area. After passage of the ACA, there was a significant increase in the number of patients who were able to receive life changing treatment because they were able to finally obtain health insurance coverage. Prior to the ACA, many of these patients fell into a "grey zone" where their income level was too high for federal and state assistance, but too low to afford the level of insurance needed to treat their illnesses. While my patients may be able to afford cheaper short-term limited duration plans, these plans will not cover my services.

5. The number of persons receiving quality treatment for eating disorders will decline if ACA marketplace plans are no longer available at a reasonable cost.

6. If healthier individuals leave the exchange markets in favor of short-term plans, the cost of insurance under the ACA will render it unattainable for many of my patients. If these patients purchase short-term limited duration plans that exclude pre-existing conditions and/or charge significantly higher rates for those patients, they will not be able to find a psychiatrist to whom they can transition their care. Many will be unable to afford care again, and the reality for them is that they will be back in the "grey zone" where insurance is not attainable for them. In

that case, ethics rules require that I continue providing essential health care for patients who cannot afford to pay without charge, which is not economically feasible for a sustained period, and the patients will only be able to obtain emergency care in an emergency room. They will not have access to the consistent care needed for their recovery. Given the seriousness of their illness, continued coverage under the ACA may be a life or death situation for these patients.

I declare under penalty of perjury that the foregoing is true and correct to the best of my knowledge and belief.

Executed on September 26th, 2018 at Towson, MD

Harry A. Brandt, MD

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

ASSOCIATION FOR COMMUNITY AFFILIATED PLANS, et al., *Plaintiffs*, v. UNITED STATES DEPARTMENT OF TREASURY, et al., *Defendants*.	Civil Action No. 18-cv-2133

DECLARATION OF DAVID A. FASSLER, MD

I, David A. Fassler, MD, declare and state as follows:

1. I am a board-certified child and adolescent psychiatrist practicing in Burlington, Vermont. I graduated from the Yale University School of Medicine, completed my adult psychiatry residency at the University of Vermont and my child and adolescent psychiatry fellowship at Cambridge Hospital, Harvard University. I am a clinical professor of psychiatry at the University of Vermont and a Distinguished Fellow of the American Psychiatric Association (APA) where I have been an active member for 33 years, served as chair of the Council on Children, Adolescents and Families, and as Treasurer of the Board of Trustees. I am the founder and Clinical Director of Otter Creek Associates, an interdisciplinary group practice providing comprehensive mental health and substance use treatment services for children, adolescents and families. We have over 100 affiliated clinicians who provide care to approximately 5,000 patients per year through 8 offices in Vermont.

2. A significant number of our patients are insured by plans purchased through the Affordable Care Act (ACA) marketplace (ACA Plans).

3. A substantial portion of Otter Creek's patient population are children and adolescents. There is a regional and national shortage of psychiatrists for this population.

4. After passage of the ACA, there was a significant increase in the number of patients who were able to access treatment because they were able to obtain health insurance coverage. Many of our current patients (both children and adults) have individual insurance policies and have been able to acquire them because the Affordable Care Act prohibits discrimination against people with preexisting conditions and because of the requirement that treatment for mental health and substance use disorders be covered and covered at parity with all other medical care.

5. Insurance coverage which allows access to comprehensive treatment for mental health and substance use disorders is of critical importance -- especially for children and adolescents. Many serious mental illnesses, such as bipolar disorder and schizophrenia, do not present until late adolescence or early adulthood, but the first indicators of such disorders are often present in children and teens. Early detection and treatment improves outcomes and reduces the risk of lasting emotional difficulties.

6. If young and healthier individuals leave the exchange markets in favor of short-term plans, the cost of insurance under the ACA will render it unattainable for many of our patients. Many will be unable to afford care again or will be transitioned to short term plans that do not cover mental illness or that charge unreasonable rates for coverage of preexisting conditions. Although psychiatrists and other mental health professionals in my practice will

continue providing care to the extent possible, many of these patients will eventually experience difficulty accessing appropriate ongoing treatment.

I declare under penalty of perjury that the foregoing is true and correct to the best of my knowledge and belief.

Executed on September 27th, 2018 at Burlington, Vermont.

David A. Fassler, MD

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

ASSOCIATION FOR COMMUNITY AFFILIATED PLANS, et al., *Plaintiffs*, v. UNITED STATES DEPARTMENT OF TREASURY, et al., *Defendants*.	Civil Action No. 18-cv-2133

DECLARATION OF PAUL GIONFRIDDO

I, Paul Gionfriddo, hereby declare as follows:

1. I have personal knowledge of the following facts, and if called as a witness I could and would testify competently as to their truth.

2. I am the President and CEO of Mental Health America (MHA). In that capacity, I am familiar with MHA's operations.

3. MHA is the nation's leading community-based nonprofit dedicated to addressing the needs of those living with mental illness and to promoting the overall mental health of all Americans. Its work is driven by its commitment to promote mental health as a critical part of overall wellness, including prevention services for all, early identification and intervention for those at risk, integrated care, services, and support for those who need it, with recovery as the goal. Much of the organization's current work is guided by the Before Stage 4 philosophy—that mental health conditions should be treated long before they reach the most critical points in the disease process.

4. MHA affiliates—that is, local organizations for whom MHA is the national association—provide public education, information and referral, support groups, and rehabilitation services, as well as socialization and housing services to those confronting mental health problems and their loved ones.

5. MHA believes that expanding the use of STLDI will harm disproportionately individuals living with mental health issues, because: (1) STLDI is not a realistic option for people with chronic behavioral health concerns, since STLDI plans are not required to—and often do not—cover mental health and substance abuse treatment services; and (2) the siphoning of younger, healthier individuals from ACA risk pools will increase plan premiums and decrease the number of plans participating in the marketplace.

6. We are also concerned that insurance issuers and brokers will favor these plans over marketplace coverage because brokers can receive higher commissions and issuers can achieve profits that are not counted under the ACA's 80-percent medical loss ratio requirement.

7. The STLDI Rule would make it more challenging for people that choose STLDI plans to access comprehensive services for mental health and substance use disorders when they need those services.

8. The Rule will therefore obstruct MHA's goal of promoting the overall mental health of all Americans, and will likely lead to more individuals requiring the support groups and rehabilitation, socialization, and housing services provided by MHA affiliates. This will require those affiliates, in turn, to divert more and more of their limited resources to those services, or else leave those needs unaddressed.

9. MHA submitted comments in response to the Proposed STLDI Rule. A true and correct copy of those comments is attached as Exhibit A.

I declare under penalty of perjury that the foregoing is true and correct to the best of my knowledge and belief. Executed on September 28, 2018, at Middletown, CT.

Paul Gionfriddo

Exhibit A

April 9, 2018

The Honorable Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8010
7500 Security Boulevard
Baltimore, MD 21244-8010

RE: Proposed Rule, Short-Term, Limited-Duration Insurance
CMS-9924-P

Dear Administrator Verma:

Mental Health America (MHA) appreciates the opportunity to respond to the Proposed Rule entitled "Short-Term, Limited-Duration Insurances" promulgated by the Internal Revenue Service, the Department of Labor, Employee Benefits Security Administration, and the Centers for Medicare & Medicaid Services' (Proposed Rule).

MHA, founded in 1909, is the nation's leading community-based nonprofit dedicated to addressing the needs of those living with mental illness and to promoting the overall mental health of all Americans. Our work is driven by our commitment to promote mental health as a critical part of overall wellness, including prevention services for all, early identification and intervention for those at risk, integrated care, services, and supports for those who need it, with recovery as the goal.

We write to oppose the policy contained in the Proposed Rule. We strongly urge the Administration to prioritize its efforts on healthcare affordability and access so that people who truly need care for mental health and substance use disorders can continue to receive it. The Affordable Care Act (ACA), while not perfect, has offered a lifeline to individuals with mental health conditions and their families. The Proposed Rule offers no counterbalance to the recognized risks it imposes on marketplace stability, and no meaningful alternative for individuals relying on ACA plan coverage.

The Proposed Rule's only mention of individuals with costly medical conditions was to acknowledge that short-term plan enrollees who develop a chronic condition would switch to marketplace coverage. This underscores our belief that individuals with chronic mental health and substance use disorders will be disproportionately impacted by this proposed policy because:

- Short-term health coverage is not a realistic option for people with chronic behavioral health concerns as these plans do not have to cover mental health and substance use treatment services and,
- The anticipated syphoning of younger, healthier individuals from the ACA risk pools will increase plan premiums and decrease the number of plans participating in the marketplace.

The Proposed Rule indicates that short-term health insurance offers lower premiums for reduced benefits and patient protections that will likely attract younger, healthier individuals. It is unlikely that individuals with certain mental health and substance use disorders would be able to meet medical underwriting standards to obtain this type of coverage and, if coverage is available, it would be associated with a higher premium. These plans have additional shortcomings that make enrollment of little value to individuals with mental health and substance use conditions, including:

- Short-term insurance plans generally exclude coverage for preexisting medical conditions;
- These plans do not have to cover essential health benefits, and most do not offer coverage for prescription medications.
- Issuers would be allowed to rescind or decline coverage;
- Deductibles and cost-sharing obligations are often far more onerous than those contained in ACA plans; and
- Lifetime and annual caps can be applied to limit coverage.

We are also concerned that insurance issuers and brokers will favor these plans over marketplace coverage because brokers can receive higher commissions and issuers can achieve profits that are not counted under the ACA's 80 percent medical loss ratio requirement.

This Proposed Rule would damage already-fragile insurance marketplaces essentially transforming them to high risk pools, and would make it more challenging for people that choose these plans to access comprehensive services for mental health and substance use disorders when they need them.

Once again, MHA appreciates the opportunity to submit comments on the Proposed Rule and looks forward to seeing the Administration reconsider changing the rule defining short term plans. Please do not hesitate to contact Caren Howard, Advocacy Manager at choward@mentalhealthamerica.net if you or your staff would like to discuss these issues in greater detail.

Best Regards,

Caren Howard
Advocacy Manager
Mental Health America
500 Montgomery Street
Suite 820
Alexandria, VA 22314
Telephone: (703) 797-2585
Email: choward@mentalhealthamerica.net
www.mentalhealthamerica.ne

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

ASSOCIATION FOR COMMUNITY AFFILIATED PLANS, et al., *Plaintiffs*, v. UNITED STATES DEPARTMENT OF TREASURY, et al., *Defendants*.	Civil Action No. 18-cv-2133

DECLARATION OF ELENA HUNG

I, Elena Hung, hereby declare as follows:

1. I have personal knowledge of the following facts, and if called as a witness I could and would testify competently as to their truth.

2. I am the President and co-founder of Little Lobbyists, LLC. In that capacity, I am familiar with the full scope of Little Lobbyists' operations. I have led Little Lobbyists since its inception in 2017.

3. Little Lobbyists is an organization of families who have medically complex children requiring significant medical care. Its mission is to advocate on behalf of the millions of such children across the country to ensure that their stories are heard and their access to quality health care is protected.

4. Little Lobbyists submitted comments to the government in response to the proposed STLDI Rule. Attached as Exhibit A is a true and correct copy of Little Lobbyists' comments.

5. As explained in Little Lobbyists' comments, the families it represents are not likely to be eligible for STLDI plans because their children's medical conditions are preexisting conditions, which means they likely will not satisfy the medical underwriting conditions associated with STLDI plans.

6. In addition, the children of these families often require extensive, and expensive, medical care. As such, they may be practically excluded from STLDI plans, which are exempt from the Affordable Care Act's prohibition of annual and lifetime caps on medical care, even if those plans are willing to approve a family's application.

7. The families whose interests Little Lobbyists represents are often not able to know about and anticipate their family's medical needs, through no fault of their own. For example, a couple who purchases an STLDI plan may then find themselves expecting a child during the year-long STLDI plan term; if that child is born prematurely, they may require medical care costing into the millions of dollars. In such circumstances, the Affordable Care Act's assurance that insurance providers cannot deny coverage because their bills have reached a certain amount may be all that makes it affordable for them to obtain the care necessary to keep their child alive. If these families instead have STLDI coverage, they will face devastating emotional trauma in addition to financial ruin.

8. In addition to the families who are harmed because they purchase STLDI insurance, families which choose to maintain their current insurance will be harmed by the STLDI Rule. The STLDI Rule allows insurers to cherry-pick healthy individuals away from the individual insurance market, worsening the risk pool for individuals who remain in the ACA-compliant insurance markets. As a result, insurers will raise premiums for those who remain on

the insurance market, forcing them to choose between being harmed by losing their medical coverage or being harmed by paying increased premiums.

9. Many families on whose behalf Little Lobbyists advocates are not eligible for premium tax credits, meaning they will bear the full burden of the premium cost increases. Some will likely be unable to afford the increased costs, will lose coverage, and will be unable to access needed medical care.

I declare under penalty of perjury that the foregoing is true and correct to the best of my knowledge and belief. Executed on September 28, 2018, at Silver Spring, MD.

/s/ Elena Hung
Elena Hung

Exhibit A

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Your Voice in Federal Decision-Making

MD

The is a Comment on the **Centers for Medicare Medicaid Services** (CMS) Proposed Rule: **Short-Term, Limited-Duration Insurance CMS-9924-P**

For related information, **Open Docket Folder**

Comment

Little Lobbyists is an organization of families with one thing in common: we all have medically complex children requiring significant medical care. Our mission is to advocate on behalf of the millions of such children across the country to ensure that their stories are heard and their access to quality health care is protected.

America badly needs changes to health care laws and regulations that expand access to care and decrease costs; however, these changes must not come at the expense of necessary care and financial protections for vulnerable children and their families. Unfortunately, that is just what the proposed rule would do. By allowing short term insurance plans for up to a year in length that would not contain basic protections provided by the Affordable Care Act including the prohibition on discrimination against individuals with preexisting conditions and the prohibition of annual caps on medical care children with complex medical needs across the country, and their families, will be harmed in multiple ways.

As is the case with many medical conditions, parents of children with complex medical needs are frequently not in the position to know about and anticipate the care their children will need, through no fault of their own. For such families, the protections afforded by the Affordable Care Act are literally life-saving. Children born prematurely, or with other complex medical needs, often require extended hospital stays with medical care billed into the millions of dollars. The need for comprehensive medical care frequently continues long after they are finally discharged home. The protections in the Affordable Care Act ensure that insurance providers cannot deny coverage for medical care because their medical bills reach a certain threshold. It ensures that they have access to lifesaving prescription drugs. It ensures that the preexisting conditions these children are born with will not prevent their ability to access care into the future.

The short-term insurance plans proposed in this rule eviscerates those protections. Families purchasing such plans for health coverage, whose children subsequently encounter medical difficulties, will soon find these insurance plans to be worthless failing to cover the specific, life-saving care their child needs, and taking coverage away completely if care becomes too expensive. On top of the trauma and stress that comes with a sick child, these families will face financial ruin as well. While our focus is on medically complex children, this outcome is no less true for

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any individual who encounters unforeseen medical complications, be it through sickness or an accident.

The damage would not be limited to those families buying short-term plans created by this proposed rule. For those families that remain in ACA-compliant plans to ensure they receive the care their child needs, the cost of insurance premiums would increase, leading to financial hardship realities that the proposed rule explicitly concedes. Once again, children and families who are most in need of care and financial protection will be the most negatively affected.

As we stated at the outset, Americas health insurance system needs fixing. Access to care must be expanded so that all Americans can receive the care they require, and the cost of this care must be controlled so that financial hardship and bankruptcy due to medical care is reduced to a terrible relic of bygone days. There are ways of meeting this vital goal. Americans demand it. Unfortunately, this proposed rule, which provides a path to less comprehensive care and higher medical costs for our nations most vulnerable, is a harmful leap backwards.

On behalf of the millions of children with complex medical needs and their families, we ask that the proposed rule be rescinded and replaced by one that truly sets access to comprehensive and affordable health care for all Americans as its cornerstone.

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

ASSOCIATION FOR COMMUNITY AFFILIATED PLANS, et al., *Plaintiffs*, v. UNITED STATES DEPARTMENT OF TREASURY, et al., *Defendants*.	Civil Action No. 18-cv-2133

DECLARATION OF KENNETH JANDA

I, Kenneth Janda, hereby declare as follows:

1. I have personal knowledge of the following facts, and if called as a witness I could and would testify competently as to their truth.

2. I am the President and Chief Executive Officer of Community Health Choice, Inc. (Community). In that capacity, I am familiar with the full scope of Community's operations. I have held this position since 2009, and have worked at Community since 2008.

3. Community is a local, not-for-profit provider of health insurance coverage. Community's mission is to improve the health and well-being of under-served residents of Southeast Texas by opening doors to coordinate, high-quality, affordable health care and health-related social services.

4. Community was created in 1997 by the Harris County Hospital District as a separate, not-for-profit organization. Community serves Medicaid and Children's Health

Insurance Program (CHIP) recipients, and has also offered ACA-compliant plans on the federally facilitated health insurance marketplace (the Marketplace) since 2014.

5. Community offers 7 Marketplace plans for 2018: 2 Bronze plans, 3 Silver plans, and 2 Gold plans. An eighth plan (a Lean Silver plan) will be offered in 2019.

6. Community currently serves approximately 110,000 members through its Marketplace plans. This is in addition to approximately 290,000 Medicaid/CHIP members, and approximately 7,000 State of Texas employees served through an HMO option.

7. The consolidated financials of Community Health Choice, Inc., and Community Health Choice Texas, Inc.—two separate entities operated by common management and board of directors—reflect approximately $1.5 billion in revenue in 2017; projected revenue for 2018 is $1.7 billion.

8. Community is a safety net health plan, focused on serving low-income populations. We believe most of our members were previously uninsured, many have pre-existing conditions, and few can afford large deductibles. Short-Term, Limited Duration Insurance (STLDI) products are not reasonable alternatives for the vast majority of Community members.

9. Many Community members lack sophisticated knowledge of health insurance products; for example many do not appreciate the risks involved in buying a Bronze plan when eligible for cost-sharing reductions under a Silver plan. Many also lack the understanding to appreciate the risks of STLDI plans with medical underwriting, high deductibles, and significant limits on covered services.

10. Approximately 30,000–40,000 of Community's Marketplace members are eligible for limited or no subsidies. These individuals are therefore vulnerable to being lured into purchasing STLDI plans with lower monthly premiums but potentially devastating coverage limits

and high deductibles. We also worry that 10,000 or more of Community's highly subsidized members may be confused by a low-cost STLDI plan, and therefore may make a switch despite their eligibility for subsidies under their current Marketplace plans.

11. Community therefore estimates a loss of as many as 10,000 current Marketplace members if the STLDI Rule goes into effect. This corresponds to a loss of $50 million to $100 million in revenue, depending on the age and premium of those who leave.

12. We expect that this exodus of (primarily younger and healthier) members will likely result in a sicker risk pool, which will require us to add a 5–10% morbidity adjustment to our rates each year for 3–5 years. The resulting long-term increase of 20–50% will cause significant harm to those who remain insured. Because Community primarily serves low-income individuals, we expect that some of our members will be unable to afford the increase in premiums, and will be forced to drop their coverage.

13. In addition, the availability of STLDI plans marketed as lower-cost alternatives to ACA-compliant Marketplace plans will harm Community's ability to enroll new members from the approximately 2 million uninsured Texans.

14. Community submitted its applications for its 2019 Marketplace plans to be certified as Qualified Health Plans by the Centers for Medicare and Medicaid Services (CMS) prior to the June 20, 2018 deadline set by CMS. As such, we could not fully anticipate that the STLDI Rule (which was promulgated on August 3, 2018, with an effective date of October 2, 2018) would allow formerly illegal STLDI plans to compete for customers in the open enrollment period for 2019, which runs from November 1, 2018 to December 15, 2018.

15. Agents and brokers have assisted in connecting Community with approximately 40% of its members. We believe that agents and brokers may receive higher commissions for

STLDI plans than for Marketplace plans. We also believe that agents and brokers are preparing to show STLDI products to our members during the upcoming open enrollment period.

16. Community is an affiliate of the Harris Health System, the provider of last resort in the Houston area, and closely collaborates with all other safety net providers including the Federally Qualified Health Centers in the Houston area. Because STLDI plans are not required to provide minimum essential coverage, and have historically engaged in frequent rescissions of coverage, an increase in STLDI enrollment will result in an increase of uncompensated care for these providers—that is, care that is provided but for which the provider is not reimbursed.

I declare under penalty of perjury that the foregoing is true and correct to the best of my knowledge and belief. Executed on September 28, 2018, at 4:19 p.m.

Kenneth Janda

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

ASSOCIATION FOR COMMUNITY AFFILIATED PLANS, et al., *Plaintiffs*, v. UNITED STATES DEPARTMENT OF TREASURY, et al., *Defendants*.	Civil Action No. 18-cv-2133

DECLARATION OF ANGELA KIMBALL

I, Angela Kimball, hereby declare as follows:

1. I have personal knowledge of the following facts, and if called as a witness I could and would testify competently as to their truth.

2. I am the National Director of Advocacy and Public Policy at the National Alliance on Mental Illness (NAMI). In that capacity, I am familiar with NAMI's operations. I previously served as NAMI's Director of State Advocacy.

3. NAMI is the nation's largest organization representing people living with mental illness and their families and is dedicated to building better lives for the millions of Americans affected by mental illness. NAMI is organized as an alliance of local affiliates, state organizations, and members.

4. NAMI's activities on behalf of individuals affected by mental illness fall into several categories. For one, NAMI advocates for effective prevention, diagnosis, treatment, support, research and recovery that improves the quality of life of persons who are affected by

mental illness. NAMI organizes peer-led education programs and support groups designed to provide outstanding free education, skills training, and support for people with mental health conditions and families. NAMI also operates a HelpLine, primarily staffed by volunteers, to answer questions about mental health conditions, symptoms, treatment options, and to provide referrals to services and supports for individuals and family members with mental health concerns.

5. NAMI believes that the STLDI Rule will have a dramatic impact on access to health and mental health care for people with mental illness.

6. First, STLDI plans are not required to—and frequently do not—cover mental health and substance abuse care, as well as prescription drug coverage. Even when these areas are covered, they are often subject to extreme restrictions. A person who purchases an STLDI plan and then requires mental health care is therefore certain to experience shock and hardship. STLDI plans can even retroactively rescind coverage entirely if they determine there were pre-symptomatic indications of a pre-existing condition. All this is especially troubling because research shows that the first symptoms of serious mental illness typically strike in youth and early adulthood—precisely the age group considered the most likely to purchase STLDI plans.

7. Research also shows that early intervention for mental health conditions is key to successful outcomes. If individuals on STLDI plans develop mental health issues, waiting for the next open enrollment period is no substitute for prompt and thorough mental health care.

8. Second, individuals who already have a mental health condition will be unable to purchase STLDI plans because of pre-existing condition rules or exorbitant medically-underwritten premiums. In addition, they will face rising premiums in Marketplace plans caused by the exit of younger, healthier consumers.

9. NAMI submitted comments in response to the Proposed STLDI Rule. Attached as Exhibit A is a true and correct copy of those comments.

I declare under penalty of perjury that the foregoing is true and correct to the best of my knowledge and belief. Executed on September 28, 2018, at Arlington, Virginia.

Angela Kimball

Exhibit A

April 23, 2018

The Honorable R. Alexander Acosta
Secretary
Department of Labor
200 Constitution Avenue, NW
Washington, DC 20210

The Honorable Alex Azar
Secretary
Department of Health and Human Services
200 Independence Avenue, SW
Washington, D.C. 20201

The Honorable David Kautter
Acting Commissioner, Internal Revenue Service
Department of the Treasury
1111 Constitution Avenue, NW
Washington, DC 20224

Attention: CMS-9924-P

Dear Secretary Acosta, Secretary Azar, and Commissioner Kautter:

On behalf of the National Alliance on Mental Illness (NAMI), I am pleased to offer comments on the proposed rule entitled "Short-Term, Limited-Duration (STLD) Insurance." As the nation's largest organization representing people living with mental illness and their families, NAMI appreciates the opportunity to comment on this rule.

At the outset, NAMI would like to express significant concerns regarding provisions in the rule that would loosen previously established constraints for enrollment in STLD plans and the impact it will have on the health and financial well-being of enrollees, particularly people living with mental illness or other serious or chronic health conditions. This rule, if finalized, is certain to have a dramatic impact on access to health and mental health care for people with mental illness, as well as long-lasting implications for the stability of the individual and small group health insurance market in states across the country.

The President's Executive Order 13813 proclaimed that "it shall be the policy of the executive branch…to facilitate…the development and operation of a healthcare system that provides high-quality care at affordable prices for the American people." NAMI has serious concerns that this proposed rule will provide neither high-quality health care nor care at affordable prices. Therefore, NAMI urges CMS to carefully consider the implications of the proposed rule on individuals' health and well-being, including Americans living with mental illness. Redefining STLD plans, as proposed in this rule, would take away comprehensive health benefits and patient protections, increase health care costs on individuals and the healthcare system, and put greater strain on the individual health insurance market. For this reason,

NAMI urges CMS to not finalize this rule and, instead, retain the previous durational constraints on STLD plans.

STLD Plans Lack Critical Patient Protections and Health Benefits

NAMI has significant concerns about the impact that the proposed rule will have on consumers, and specifically on people with mental illness. STLD plans are not required to adhere to important standards, including coverage of the ten essential health benefit (EHB) categories, guaranteed issue, age and gender rating, prohibitions on discrimination against people with pre-existing conditions, annual out-of-pocket maximums, prohibitions on annual and lifetime coverage limits, and many other critical patient and consumer protections. Without such protections, STLD plans will expose enrollees to a variety of harmful practices by plan sponsors. Despite the intention of the Executive Order to expand consumer choice, STLD plans would actually restrict access to health care coverage.

Access to a comprehensive set of essential health benefits (EHBs) ensures that people living with mental illness can get the prescription medications and mental health treatment they depend on to maintain quality of life. Because they do not have to cover EHBs, plans sold as STLDs will fall far short of what enrollees expect of health insurance coverage. Enrollees are certain to experience shock and hardship as a result of severely restricted access or the complete exclusion of critical coverage such as prescription drugs and mental health services. This is particularly troubling for NAMI as first symptoms of serious mental illness typically strike in youth and early adulthood, the very age group considered most likely to purchase STLD plans.

Further, even if the plan indicates it covers a certain essential benefit, the breadth of that service can fall far short of what individual patients need, as STLD plans will be able to impose artificially low restrictions on the number of visits or on prescription medications. Plans would also be able to avoid existing regulations that require their formularies to cover at least the same number of drugs in each state's benchmark plan, consider newly approved medications, utilize Pharmacy and Therapeutics Committees for formulary review, or follow prevailing treatment guidelines. Failing to cover basic benefits that a reasonable enrollee would expect to receive will leave consumers paying monthly premiums for substandard coverage, without any guarantee of access to needed health care.

Further, it is important to note that under STLD plans, enrollees could be subject to lifetime dollar limits or dollar limits on certain benefits such as mental health care – a practice that was specifically barred in the Affordable Care Act (ACA) and the Mental Health Parity and Addiction Equity Act (MHPAEA). Imposing annual and lifetime dollar limits would place an undue burden on individuals who have a mental health condition or experience a mental health crisis while being covered by a short-term plan.

Before the passage of the ACA, people living with mental illness were subject to insurer discrimination based on pre-existing conditions. They could be refused coverage or charged more because of a diagnosis of a mental health condition. In the absence of federal protections, STLD plans will be allowed to again discriminate based on health status. Not only can STLD plans "cherry pick" beneficiaries by choosing not to cover a person based on a pre-existing condition, such as a mental illness, if a person is diagnosed while covered, the plan can conduct a rigorous review of their medical history to retroactively assess whether or not there was evidence of medical advice or pre-symptomatic indications to determine if a condition was pre-existing in order to rescind coverage.

The proposed rule states that STLDs would be required to be sold with a disclaimer stating that the plan does not qualify as health coverage, or minimum essential coverage, and does not satisfy the coverage requirements of the ACA. Unfortunately, STLDs still offer the illusion of coverage and will likely offer

lower monthly premiums than ACA-compliant plans. This problem could be exacerbated by unscrupulous, aggressive and deceptive marketing methods.

Finally, under these plans, a beneficiary could find that their payments made toward the deductible do not count toward the maximum out-of-pocket costs and could experience high cost-sharing on preventive services and high costs for uncovered service or treatment costs. Medical bills had been a leading cause of personal bankruptcy before health care coverage expanded under the ACA. Finalization of this proposed rule could mean returning to a time when consumers have to choose between financial ruin and seeking health care.

Therefore, NAMI strongly urges CMS to consider the health and financial implications for consumers and require short-term plans to comply with ACA consumer protections.

Proposed Rule Undermines Consumer Choice and Stability of Health Insurance Market

The proposed policy changes for STLD plans in the rule will impact not just people who will experience restricted benefits when they suddenly need them, but the stability of the Marketplace and the greater healthcare system. As recognized in the proposed rule, "individuals who are likely to purchase short-term, limited-duration insurance are likely to be relatively young or healthy," which means that STLD plans will undoubtedly deplete the ACA-compliant market of younger, healthier individuals. This will leave traditional, ACA-compliant plans with a higher-risk pool of individuals, including people with mental illness, who are more care-dependent, while STLD plans will have a healthier, lower-risk pool. As a result, premiums would likely skyrocket for those in traditional health plans as insurers attempt to counter the higher costs of providing care when younger, healthier individuals are no longer a part of their risk pool.

The additional stress on already-fragile individual markets across the country will mean insurers will be less incentivized to participate in the ACA Marketplace as they weigh the risk of covering a pool of individuals who are more care-dependent and, therefore, have higher medical claims. Once STLD plans proliferate, it will create even more pressure on insurers to pull out of the ACA market and leave consumers with fewer choices. This is in direct conflict with the Administration's intention of providing more choice.

Proposed Rule Definition of "Short Term" is a Misnomer

The proposed rule would extend enrollment in STLD plans to 364 days, well beyond the previously restricted three-month duration maximum and would allow beneficiaries to renew their contract. STLDs were intended to be purposely limited, serving primarily as a stop-gap measure for insurance coverage in times of transition. They were never designed to support comprehensive access to health care. By relaxing duration restrictions, people may opt to utilize these plans as an alternative to ACA-compliant health plans, not knowing the risk they take on because these plans do not meet minimum essential coverage and utilize substandard health benefit design.

Furthermore, the proposed rule outlines changes to existing regulations allowing STLD plans to renew a person's coverage. Renewability does not protect a person against being charged a higher premium after receiving a diagnosis of a mental health condition. Because health status is not static, STLD plans are simply not a viable option for health insurance for people with previously diagnosed conditions, or even healthy individuals at the point at which coverage is initiated.

Therefore, NAMI recommends that CMS retain the "short term" nature of these plans and not allow them to continue beyond a duration of three months.

Issuers Should Not Be Allowed to Renew STLD Plans

The proposed rule seeks comment on whether and how to allow issuers to renew or extend short-term coverage beyond 12 months. It also seeks comment on a proposed streamlined application process that would expedite plan renewals or extensions. NAMI opposes allowing STLD plans to renew or extend coverage. Allowing for renewal only encourages longer enrollment in these plans and further undermines the stability of the individual market.

Instead, NAMI recommends that CCIIO support policies that encourage consumers to use STLD policies as they were intended – not as a long-term coverage option, but only to fill in short gaps in loss of coverage. Easing the reapplication process is in direct conflict with the entire purpose of a STLD policy and does nothing to protect people from pre-existing condition exclusions based on health conditions that began during the previous coverage period. Additionally, renewability does nothing to prevent insurers from engaging in medical underwriting and increasing premiums or denying claims for enrollees that incur high costs. Policies requiring renewability or streamlined application would therefore yield the same result; namely, enrollees with chronic or serious medical conditions like mental illness being denied coverage or being priced out of the short-term market.

Therefore, NAMI believes that renewability of plans should be reserved for health insurance plans that meet the definition of minimum essential coverage (MEC) and therefore we recommend that CMS not allow the renewability of STLD plans.

Conclusion

NAMI appreciates the opportunity to offer comments on this proposed rule. Given the history of discrimination and inadequate coverage in STLD plans, we are concerned that the proposed rule does not move us toward a health care system that provides high-quality care at affordable prices for Americans, including the millions who live with mental illness. NAMI urges CMS to withdraw this proposed rule and focus on efforts to stabilize the insurance market and lower premiums. We encourage CMS to retain the existing restrictions on STLD plans, including restoration of the three-month limitation on coverage and limits on renewability.

Sincerely,

Angela Kimball
National Director, Advocacy & Public Policy

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

ASSOCIATION FOR COMMUNITY AFFILIATED PLANS, et al., *Plaintiffs*, v. UNITED STATES DEPARTMENT OF TREASURY, et al., *Defendants*.	Civil Action No. 18-cv-2133

DECLARATION OF GEORGE KOLODNER, MD

I, George Kolodner, MD, declare and state as follows:

1. I am board certified in psychiatry and in addiction psychiatry. I received my medical degree from the University of Rochester in 1967. I currently practice at Kolmac Outpatient Recovery Centers in Maryland and the District of Columbia.

2. I am a Distinguished Life Fellow and member of the American Psychiatric Association (APA) and have been a member for 45 years. I served on the APA Council on Addiction Psychiatry from 1996 to 1999 and the Committee on Treatment of Addicted Patients from to 1999-2008 acting as its Vice-Chair from 2005 to 2008.

3. In my practice, my patients all have substance use disorders and often have co-occurring medical and mental health conditions.

4. Psychiatry differs from some other medical subspecialties in that establishing a relationship of trust with the patient over time is essential to developing an accurate diagnosis. Additionally, psychiatric medications are titrated over time with patients and are frequently

adjusted depending upon the patient's response and tolerance. It is important to the patient's welfare to carefully follow the patient over time to ensure that the treatment plan is working and can be adjusted as necessary. As such, regular appointments are critical to my ability to successfully treat my patients.

5. In addition, the ethical rules to which psychiatrists are bound require that the psychiatrist not terminate a relationship with a patient unless and until the patient is safely working with another provider. During that transition, the psychiatrist must provide bridge care to ensure the stability of the patient.

6. Almost all my patients pay for my services with the assistance of insurance. I participate in insurance plans sold in the Affordable Care Act marketplace. Many of my patients have individual insurance policies and have been able to acquire them because of the Affordable Care Act's prohibition of discrimination against persons with preexisting conditions and requirement that mental health be covered and covered in parity with all other medical care.

7. My services are priced at approximately the same level as other psychiatrists in my area.

8. Prior to the ACA, some of these patients could not afford individual coverage because their pre-existing mental health or substance use disorder disqualified them from insurance coverage or because the cost of coverage was out of reach because it was based upon their health status. Without coverage, they did not seek treatment; if they did seek treatment it was not at a level that would allow them to establish a stable recovery from their substance use disorders. Further, necessary medications were often not included in the list of medicines that they could afford, making it difficult if not impossible for my patients to access the medications

they needed to manage their illnesses. The ACA has allowed them access to care which in many instances is life-saving, and in most cases at least life-improving.

9. According to the National Institutes of Mental Health, a component of the United States Department of Health and Human Services, 18.3% of adults live with a mental illness, with the highest rate of prevalence of mental illness being among young adults aged 18-25.[1] 4.2% of adults have a serious mental illness, with the highest rate of prevalence of serious mental illness again being among young adults aged 18-25.[2] 49.5% of adolescents have a mental disorder and 22% of those individuals are severely impaired by it.[3]

10. Data produced by SAMSHA indicates that of those with a mental illness, only 42.9% receive treatment.[4]

11. Because many patients rely on ACA marketplace plans to pay for their mental health/substance use disorder treatment, the number of persons receiving quality treatment for mental health and/or substance use disorders will decline if ACA marketplace plans are no longer available at a reasonable cost.

12. Some of my patients who are driven out of the ACA marketplace may be able to obtain cheaper, less comprehensive insurance which will not cover the cost of my services. As these are driven out of the ACA market, I will have to transfer their care to another psychiatrist in their new insurance plan. Moreover, if these patients purchase a short-term, limited-duration insurance plan that excludes patients with preexisting conditions and/or can charge higher rates for patients with preexisting conditions, they will not be able to find another psychiatrist to

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[1] https://www.nimh.nih.gov/health/statistics/mental-illness.shtml#part_154910
[2] *Id.*
[3] *Id.*
[4] https://www.samhsa.gov/data/sites/default/files/DistrictOfColumbia_BHBarometer_Volume_4.pdf

whom to transition. In that case, I and other APA members will be obligated by our professional ethical code of conduct to continue to provide essential treatment even though the patient cannot pay for their care.

13. As more and more patients are priced out of the ACA market, my ability to practice medicine and to treat people regardless of their personal income level will decline. My patient base will dwindle.

14. As a doctor who contracts with insurance plans, I am aware of the steps that plans take to decrease costs. As healthy individuals leave the ACA market, it will be more expensive for the plans to cover care for the high-cost users left in the marketplace. This increases insurance rates for consumers but also causes plans to change utilization management practices to reduce costs. In my experience, these practices include adopting administrative hurdles such as requiring prior authorizations for basic medications and procedures, more frequently auditing medical records and bills, and making more stringent medical necessity standards, all of which will require physicians to donate significantly more uncompensated time to ensuring that their patients get the treatment they require. When these measures were instituted in the past, many psychiatrists elected not to participate in insurance plans and to operate on a cash only basis. Similar (and more extensive) cost reduction methods are likely to result from diversion of the healthiest patients away from ACA plans, leaving me and other APA members with the choice of significant reductions in income or leaving the plan altogether in favor of cash-only practices. Many APA members may not be able to afford the reduction in income, and will thus opt out of insurance plans. When they do so they will need to transition their patients who cannot pay in full for treatment to other psychiatrists, but the number of psychiatrists willing to take on these

patients (and accept payment from insurers) will have decreased. The net result will be fewer psychiatrists available for middle and lower income people in need of psychiatric care.

15. Young, apparently healthy people are likely to opt into short term limited duration plans believing that they are and will continue to be healthy. However, the highest rate of prevalence of severe mental illness is among young adults and symptoms often do not show until late teens and early twenties.

16. Thus, a significant portion of those who purchase STLDI plans may find themselves lacking the ability to afford mental health treatment that they need. For example, some of these young people may attempt suicide as a result of a mental health crisis, causing themselves immense suffering and burdening overcrowded emergency rooms with trying to save their lives.

I declare under penalty of perjury that the foregoing is true and correct to the best of my knowledge and belief.

Executed on September 27, 2018, at Washington, D.C.

George Kolodner, MD

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

ASSOCIATION FOR COMMUNITY AFFILIATED PLANS, et al., *Plaintiffs*, v. UNITED STATES DEPARTMENT OF TREASURY, et al., *Defendants*.	Civil Action No. 18-cv-2133

DECLARATION OF JESSE MILAN, JR., JD

I, Jesse Milan, Jr., hereby declare as follows:

1. I have personal knowledge of the following facts, and if called as a witness I could and would testify competently as to their truth.

2. I am the President & CEO of AIDS United. In that capacity, I am familiar with the full scope of AIDS United's operations. I have led AIDS United since 2016.

3. AIDS United is an organization whose mission is to end the HIV/AIDS epidemic in the United States. Its Public Policy Counsel of 49 HIV/AIDS service organizations and national and regional coalitions is the largest and longest-running community-based HIV/AIDS domestic policy coalition in the country. AIDS United additionally represents more than 200 grantee and sub-grantee AIDS Service Organizations who serve people living with HIV/AIDS throughout the United States.

4. AIDS United is a member of the HIV Health Care Access Working Group, a coalition of over 100 national and community-based HIV service organizations representing HIV

medical providers, public health professionals, advocates, and people living with HIV who are all committed to ensuring access to critical HIV- and hepatitis C-related health care and support services. AIDS United was a signatory to the Working Group's comments in response to the proposed STLDI Rule. Attached as Exhibit A is a true and correct copy of the Working Group's comments.

5. STLDI insurers generally do not accept individuals living with HIV. In one recent study, researchers submitted applications for coverage to 38 different STLDI plans on behalf of an applicant with HIV. All 38 applications were rejected.[1] By contrast, ACA-compliant plans are not permitted to discriminate on the basis of preexisting conditions, so they provide a key source of coverage for individuals living with HIV/AIDS.

6. In addition, individuals living with HIV/AIDS often require extensive, and expensive, medical care. As such, they would be practically excluded from STLDI plans, which are exempt from the Affordable Care Act's prohibition of annual and lifetime caps on medical care, even if those plans were willing to approve the application of an individual living with HIV/AIDS.

7. HIV/AIDS treatment is expensive, so individuals living with HIV/AIDS often rely on their health insurance to obtain the treatment they need to save their lives and maintain their quality of health.

8. Some AIDS United members are associations of individuals living with HIV/AIDS. When the cost of insurance for these individuals is increased, those members are forced to either

[1] Dawson, Lindsey and Jennifer Kates, "Short-Term Limited Duration Plans and HIV," Issue Brief, Kaiser Family Foundation, http://files.kff.org/attachment/Short-Term-Limited-Duration-Plans-and-HIV p.3 (June 2018).

pay higher provider costs, seek alternative and uncertain sources of funding to provide healthcare, or—if treatment is no longer affordable—cease providing necessary care. In any of these situations, those members are injured, and other AIDS United members who work to obtain treatment for such individuals must divert resources to finding replacement care for these individuals that could otherwise be used on their other advocacy and public health efforts.

9. Other AIDS United members are organizations that provide treatment to individuals living with HIV/AIDS. When individuals are not able to afford treatment, these AIDS United members must provide for treatment by diverting other scarce financial resources such as grant funding, be forced to decline to treat these individuals, or must treat them for free without compensation. These members of AIDS United will be harmed in all these circumstances because they will not able to obtain necessary and appropriate compensation for their services to people living with HIV.

10. The STLDI Rule allows insurers to cherry-pick healthy individuals away from the individual insurance market, worsening the risk pool for individuals who remain in the ACA-compliant insurance markets. As a result, insurers will raise premiums for the individuals who comprise the membership of AIDS United's members and must remain on the ACA marketplace. These individuals will be forced to choose between being harmed by losing their medical coverage or being harmed by paying increased premiums. Many members of AIDS United organizations are not eligible for premium tax credits, meaning they will bear the full burden of the premium cost increases.

I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct to the best of my knowledge and belief. Executed on September 28, 2018, at Moorea, French Polynesia.

Jesse Milan, Jr., JD

Exhibit A

April 23, 2018

Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8010
Baltimore, MD 21244

Attention: CMS-9924-P

To Whom It May Concern:

We are writing on behalf of the HIV Health Care Access Working Group (HHCAWG) – a coalition of over 100 national and community-based HIV service organizations representing HIV medical providers, public health professionals, advocates, and people living with HIV who are all committed to ensuring access to critical HIV- and hepatitis C-related health care and support services. We appreciate the opportunity to provide comments to the proposed rule, *Short-Term, Limited-Duration Insurance*, issued by the Departments of Health and Human Services, Labor, and Treasury ("the Departments"). Standards and protections governing individual and small group private insurance markets must ensure access to comprehensive and affordable coverage for people living with HIV, hepatitis C (HCV), and other chronic conditions. We are concerned that the proposal to expand coverage under short-term, limited duration plans will harm vulnerable populations, and we urge HHS to consider the recommendations and comments detailed below.

Coverage Lasting up to 364 Days Is Not Short-Term

Prior to 2016, some short-term, limited duration plans covered individuals for periods up to or exceeding 12 months. The Departments took regulatory action in 2016 to limit short-term plan duration to under three months because they found that plans were being sold in situations other than those the rules were intended to address.[1] Short-term, limited duration plans are intended as temporary coverage for individuals facing short gaps in insurance—for example, in between jobs—and are not a substitute for long-term coverage. However, consumers were purchasing these plans as a primary form of health coverage for periods up to or exceeding one year. The Departments expressed concerns that short-term, limited duration plans were not "meaningful health coverage"[2] due to limitations such as annual and lifetime benefit limits and

[1] Excepted Benefits; Lifetime and Annual Limits; and Short-Term, Limited-Duration Insurance, 81 Fed. Reg 75,316, 75,317-18 (Oct. 31, 2016).
[2] *Id*.

pre-existing condition exclusions, and therefore imposed a plan duration of under three months in order to protect consumers from financial harm. In keeping with the purpose of short-term coverage, we urge the Departments to maintain the current federal standard to ensure this coverage is actually short-term.

The Rule Would Weaken Important Consumer Protection and Benefits Standards, and Would Restore Pre-ACA Practices That Harmed People with High Health Needs

The proposal to change current rules by allowing issuers to sell short-term plans with a maximum coverage period of less than 12 months would jeopardize important consumer protections. The proposal would allow plans that bypass important Affordable Care Act (ACA) protections, such as essential health benefits (EHBs), rating restrictions, guaranteed issue, the federal medical loss ratio, and the pre-existing condition exclusion prohibition, to be marketed to consumers as a long-term alternative to ACA-compliant coverage. This proposed rule would especially harm people living with HIV, HCV, and other chronic conditions, particularly given the ways that issuers have historically designed short-term, limited duration plans to explicitly discriminate against these populations.

Short-term plans have historically engaged in post-claims underwriting in order to rescind coverage or deny claims for services that may be associated with a pre-existing condition. One analysis of popular short-term plans found that issuers have denied claims for enrollees who experienced symptoms within the prior five years "that would cause a reasonable person to seek diagnosis, care, or treatment," even if the person never received care—for example, because they were uninsured or underinsured.[3] We are concerned that this broad discretion for issuers to deny claims may lead to financial hardship for consumers who purchase short-term plans and later learn that they have an untreated medical condition. Consumers who develop chronic conditions after they enroll in short-term coverage are also unprotected under the proposed rule, which does nothing to strengthen coverage standards under short-term plans or restrict issuer discretion to rescind coverage based on post-claims underwriting.

Short-term plans also often exclude important EHBs such as prescription drug coverage, mental health, and substance use, and it is not always apparent to consumers which benefits are covered and which are excluded. A recent report from the Kaiser Family Foundation examining existing short-term plans found that 71% do not cover prescription drugs, a key EHB for people living with HIV, HCV, and other chronic conditions.[4] Furthermore, short-term plans have historically placed annual and lifetime limits on coverage, including condition-specific caps for chronic illnesses, and tend to have higher consumer cost sharing without annual out-of-pocket maximum caps. Consumers may not know the limits of their plan until after they develop a medical condition or otherwise require a higher level of services. Since health status is not

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[3] Dania Palanker, Kevin Lucia, and Emily Curran, *New Executive Order: Expanding Access to Short-Term Health Plans Is Bad for Consumers and the Individual Market*, THE COMMONWEALTH FUND (Oct. 11, 2017), http://www.commonwealthfund.org/publications/blog/2017/aug/short-term-health-plans.

[4] Karen Pollitz et al., *Understanding Short-Term Limited Duration Health Insurance*, KAISER FAMILY FOUND. (Apr. 23, 2018), https://www.kff.org/health-reform/issue-brief/understanding-short-term-limited-duration-health-insurance/.

static, enrolling in a deficient plan can be devastating for someone diagnosed with HIV, HCV, or another serious medical condition after enrolling in a short-term plan.

Expanding the Short-Term Market Will Increase Fraud and Other Deceptive Practices

Short-term plans also have a long history of fraud and misrepresentation. Insurance brokers have historically engaged in deceptive sales tactics, leading consumers to purchase short-term coverage because it was falsely represented as being ACA-compliant. Consumers only learned that this was not true after their claims were denied, leaving patients and providers with substantial unpaid claims. Expanding the short-term market could lead to increased consumer confusion about coverage and substantial risk for fraudulent practices to market sub-par plans as ACA-compliant plans. We appreciate the Departments' proposal to revise the required notices that must appear in insurance contracts and application materials, specifically the addition of language clarifying that "short-term, limited duration" plans are not considered minimum essential coverage and that consumers who lose such coverage must wait until the next Open Enrollment to enroll in an ACA-compliant plan. However, we do not feel that this revised notice is sufficient to warn consumers of the value of excluded services or the financial risks associated with such plans. This lack of notice can be especially harmful to people living with HIV and HCV, for whom ACA protections such as EHBs, limits on rescission, and bans on lifetime or annual limits are crucial.

Issuers Should Not Be Allowed to Renew Short-Term Plans

The Departments seek comment on their proposal to allow issuers to renew or extend short-term coverage beyond 12 months, as well as on a proposed streamlined application process that would expedite plan renewals or extensions. We do not believe that the ability to renew or extend coverage is sufficient to make short-term plans a consumer-friendly product. This only encourages longer enrollment in these plans and further undermines the stability of the individual market. We strongly urge the Departments to support policies that encourage consumers to use short-term plans as they were intended, not as a long-term coverage option, but as an option to fill short gaps in coverage. Streamlining the reapplication process is in direct conflict with the entire purpose of a short-term plan, and it does not protect consumers from medical underwriting or pre-existing condition exclusions based on health conditions that began during the prior coverage period.[5] Additionally, federal legislative proposals that would make short-term plans renewable would similarly fail to protect consumers with health conditions. Renewability does not prevent insurers from engaging in medical underwriting and increasing premiums or denying claims for consumers who incur high costs—for example, people living with HIV, HCV, and other chronic conditions.[6] Policies requiring renewability or streamlined application would therefore yield the same result: consumers with health conditions would be denied coverage or priced out of the short-term market and would have

[5] AM. ACAD. OF ACTUARIES, COMMENTS RE: CMS-9924-P—SHORT-TERM, LIMITED DURATION INSURANCE 4-5 (APR. 6, 2018), http://www.actuary.org/files/publications/STLD_Comment%20Letter_040618.pdf.

[6] *Id*.

no choice but to enroll in ACA-compliant plans, leading to higher costs in the ACA-compliant market.

The Rule Would Make Comprehensive ACA-Compliant Coverage More Expensive

Current rules limiting contract length of short-term, limited duration plans to no more than three months are in place to prevent insurers from siphoning healthy enrollees from the individual market. The Departments took regulatory action in 2016 to limit short-term plan duration to under three months based on findings that these plans adversely impacted the risk pool for ACA-compliant coverage.[7] The justification for reversing these rules now, just two years later, is not evinced in the record. In fact, the Departments acknowledge that the proposed rule could weaken states' individual market single risk pools, increase costs to consumers and issuers, and reduce consumer choice by causing issuers to exit the individual market, but do not propose policies that would mitigate these consequences.

If the proposed rule were finalized in its current form, short-term plans could essentially function as long-term coverage that bypasses important ACA protections. These plans would be competing in the same market as ACA-compliant individual plans, but would be subject to different rules. Issuers could structure eligibility rules, benefit designs, and marketing practices in ways that encourage enrollment by healthier individuals while discouraging less healthy individuals, thus enabling issuers to charge lower-than-average premiums. Additionally, short-term plans are medically underwritten, meaning that individuals with pre-existing conditions or known health risks can be denied coverage or charged higher premiums. This would create an uneven playing field and lead to adverse selection because short-term plans could siphon healthy individuals from the ACA-compliant plans and leave the individual market with higher risk enrollees. Since short-term plans would not be part of the single risk pool and the risk adjustment program, there would be no transfer of funds from short-term plans to the ACA-compliant market to reflect the difference in risk between these segments.[8] People that want comprehensive coverage in the individual market could find their options dwindling or that the premiums are unaffordable. This is especially harmful to people living with HIV, HCV, and other chronic conditions who may not be able to find affordable individual coverage that is adequate to meet their health needs.

The Department predicts that the proposed rule would result in 100,000 to 200,000 young and healthy individuals leaving the ACA-compliant market and purchase short-term plans. However, we believe that plan enrollment in these short-term plans would likely be much higher. Researchers predict that as many as 4.3 million individuals would enroll in expanded short-term plans if the proposed rule is finalized in its current form.[9] Additionally, research shows that the combined effect of the proposed rule and the elimination of the individual shared responsibility

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[7] Excepted Benefits; Lifetime and Annual Limits; and Short-Term, Limited-Duration Insurance, 81 Fed. Reg at 75,318.

[8] AM. ACAD. OF ACTUARIES, *supra* note 5, at 2.

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

payment would increase ACA-compliant individual insurance premiums by 18.3 percent on average.[10] We are concerned that the Departments' predictions are too conservative, and that the proposed rule could result in a mass exodus of healthy individuals from the ACA-compliant market that is likely to leave people with pre-existing conditions like HIV and HCV without viable coverage options.[11]

The Departments Should Focus on Ways to Stabilize the Market

We share the Departments' stated concern that policy interventions are necessary to stabilize the individual market, particularly for individuals not eligible for federal subsidies. We believe that a federal reinsurance program is the best way to stabilize the market. Instead of policies that segment the market, we urge the Departments to focus on policies that shore up the individual market, protecting people living with and at risk for HIV, HCV, and other conditions. In addition to an adequate reinsurance program, we also support increased investment in outreach, education, and enrollment to ensure robust participation by both healthy and sick individuals in the ACA's Marketplaces. We welcome the opportunity to work with the Departments on these efforts.

Thank you for the opportunity to comment this proposed rule. We urge HHS to continue its commitment to ensure that people living with HIV, HCV, and other chronic and complex conditions have access to quality, affordable healthcare coverage. Please contact Amy Killelea with the National Alliance of State and Territorial AIDS Directors at akillelea@nastad.org, Andrea Weddle at aweddle@hivma.org with the HIV Medicine Association, or Robert Greenwald at rgreenwa@law.harvard.edu with the Center for Health Law and Policy Innovation if we can be of assistance.

Respectfully submitted by:

ADAP Educational Initiative | AIDS Alabama | AIDS Action Baltimore | AIDS Alliance for Women, Infants, Children, Youth & Families | AIDS Foundation of Chicago | AIDS Research Consortium of Atlanta | AIDS United | American Academy of HIV Medicine | APLA Health | AIDS Resource Center of Wisconsin | Communities Advocating Emergency AIDS Relief (CAEAR) | Community Access National Network (CANN) | Georgia AIDS Coalition | Harm Reduction Coalition | HealthHIV | HIV Medicine Association| Housing Works | Human Rights Campaign | Legal Council for Health Justice | Michigan Positive Action Coalition | Minnesota AIDS Project | National Alliance of State and Territorial AIDS Directors | National Latino AIDS Action Network | NMAC | Positive Women's Network - USA| Project Inform | Rocky Mountain CARES | San Francisco AIDS Foundation | SisterLove | Southern AIDS Coalition | Southern HIV/AIDS Strategy Initiative | The AIDS Institute | Treatment Access Expansion Project

[10] *Id*.

[11] *See, e.g.*, AM. ACAD. OF ACTUARIES, *supra* note 5, at 5 (predicting that enrollment in short-term plans will likely exceed the Departments' projections).

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

ASSOCIATION FOR COMMUNITY AFFILIATED PLANS, et al., *Plaintiffs*, v. UNITED STATES DEPARTMENT OF TREASURY, et al., *Defendants*.	Civil Action No. 18-cv-2133

DECLARATION OF MARGARET A. MURRAY

I, Margaret A. Murray, hereby declare as follows:

1. I have personal knowledge of the following facts, and if called as a witness I could and would testify competently as to their truth.

2. I am the Chief Executive Officer of The Association for Community Affiliated Plans (ACAP). In that capacity, I am familiar with the full scope of ACAP's operations. I have led ACAP since its inception in 2001.

3. ACAP is a national trade association of 62 not-for-profit and community-based Safety Net Health Plans (SNHPs) located in 29 states. Our member plans provide coverage to more than 20 million individuals, including over 700,000 Marketplace enrollees in ACA-compliant Qualified Health Plans. Sixteen of ACAP's SNHP members offer Qualified Health Plans or a Basic Health Plan option on the Marketplaces in 2018.

4. ACAP's mission is to strengthen not-for-profit Safety Net Health Plans in their work to improve the health of lower-income and vulnerable populations. ACAP's vision is to

improve the health and well-being of lower-income and vulnerable populations and the communities in which they live.

5. ACAP submitted comments to the government in response to the proposed STLDI Rule. Attached as Exhibit A is a true and correct copy of ACAP's comments. As part of the comment process, ACAP engaged an actuarial firm, Wakely Consulting Group (Wakely), to analyze the impact of the proposed STLDI Rule. Attached as Exhibit B is a true and correct copy of the report prepared by Wakely, which was also submitted as an attachment to ACAP's comments.

6. The Wakely report states that "the difference in benefits and premiums between the plans that comply with ACA regulations and STLDI plans would effectively create separate risk pools and risk segmentation. . . . Given the regulatory flexibility, STLDI plans would attract healthier enrollees, removing them from the ACA-compliant risk pool, increasing risk selection, and further increasing premiums, continuing the downward spiral. Over time the difference between the two risk pools would increase and escalate the instability and uncertainty in the ACA-compliant individual market."

7. Wakely's analysis estimates that in the near term (four to five years) the STLDI Rule will result in 1,070,000 to 1,948,000 individuals leaving ACA-compliant individual enrollment plans, leading to a 2.2% to 6.6% increase in average premiums in those ACA-compliant plans.

8. ACAP members are particularly at risk of having their customers attracted away by lower-cost STLDI plans that are not required to comply with ACA regulations, since ACAP members by definition primarily serve low-income communities, where individuals are uniquely sensitive to price and may be less sophisticated about the exact details of various health insurance

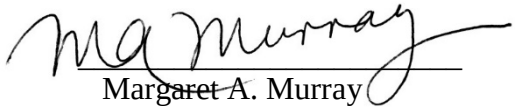
products. With the increased morbidity of ACAP members' risk pools, resulting increases in premiums, and low-income customers therefore being priced out of the market, ACAP members would face a downward spiral and even the risk of bankruptcy.

9. An important facet of this problem for ACAP members is consumer confusion. Because health literacy is low throughout America—and particularly in the lower-income communities served by ACAP members—it will be difficult for ACAP members to explain to consumers why they should purchase ACA compliant plans when STLDI plans carry a lower sticker price; that is, that the real costs of STLDI plans take effect only when a patient gets sick or has an accident and needs care. The STLDI Rule's requirement that STLDI contracts and applications contain a disclaimer that "[t]his coverage is not required to comply with certain federal market requirements for health insurance" is insufficient to put customers on notice of this distinction. The resulting customer confusion will result in a loss of business for ACAP members, as consumers are drawn in by lower up-front premiums of ACA-noncompliant STLDI plans.

10. The timing of the STLDI rule also harms ACAP members. The deadline for ACAP members to submit their applications to have plans included in the Marketplaces for 2019 was June 20, 2018. But the STLDI Final Rule was not promulgated until August 3, 2018, after ACAP members' 2019 plans were required to be finalized. ACAP members invested substantially in putting together the details of those plans, without the knowledge that formerly illegal STLDI plans would be available during the November-December 2018 open enrollment period. The effective date of the STLDI Rule—October 2, 2018—therefore upsets the settled expectations of ACAP members and harms them by putting them at a competitive disadvantage in an open enrollment season that is only weeks away.

11. I have read the declaration of Kenneth Janda, President and CEO of Community Health Choice, Inc. (Community) in this case. Community is one of ACAP's 62 member organizations. Fifteen of ACAP's other member organizations are similarly situated to Community in that they provide Marketplace coverage to low-income individuals, many of whom lack sophisticated knowledge of health insurance products and are therefore vulnerable to being lured away from Marketplace plans by STLDI products, if the STLDI Rule goes into effect. These ACAP members will therefore face similar harms to those attested to by Mr. Janda.

I declare under penalty of perjury that the foregoing is true and correct to the best of my knowledge and belief. Executed on September 28, 2018, at 3:58pm.



Margaret A. Murray

Exhibit A

ACAP
Association for Community Affiliated Plans

1155 15th Street, N.W., Suite 600 | Washington, DC 20005
Tel. 202.204.7508 | Fax 202.204.7517 | www.communityplans.net
John Lovelace, Chairman | Margaret A. Murray, Chief Executive Officer

April 20, 2018

David J. Kautter, Acting Commissioner
Internal Revenue Service
Department of the Treasury

Preston Rutledge, Assistant Secretary
Employee Benefits Security Administration
Department of Labor

Randy Pate, Deputy Administrator and Director
Center for Consumer Information and Insurance Oversight
Centers for Medicare & Medicaid Services
Department of Health & Human Services

Submitted electronically via: www.regulations.gov

RE: CMS-9924-P

Dear Acting Commissioner Kautter, Assistant Secretary Rutledge, and Deputy Administrator and Director Pate:

The Association for Community Affiliated Plans (ACAP) respectfully submits comments regarding the proposed rule on *Short-Term, Limited-Duration Insurance.*

ACAP is an association of 61 not-for-profit and community-based Safety Net Health Plans (SNHPs) located in 29 states. Our member plans provide coverage to more than 20 million individuals enrolled in Medicaid, the Children's Health Insurance Program (CHIP) and Medicare Special Needs Plans for dually-eligible individuals, including over 700,000 Marketplace enrollees. Nationally, Safety Net Health Plans serve almost half of all Medicaid managed care enrollees. Sixteen of ACAP's Safety Net Health Plan members offer qualified health plans (QHPs) or a Basic Health Plan option in the Marketplaces in 2018.

Summary of ACAP's Comments

ACAP has chosen to respond to the impact the proposed Short-Term, Limited-Duration Insurance rule that are particularly relevant to both Safety Net Health Plans (SNHPs) and the consumers they serve. Specifically, our comments are focused so as to ensure business stability

for SNHPs and to not place undue burden or harm on consumers, in particular the low-income and vulnerable populations that are traditionally served by SNHPs.

ACAP would also like to emphasize that the comments herein support SNHPs in their efforts to serve their communities, which they are generally well-acquainted to by way of their experience serving Medicaid enrollees. We believe there is a careful balance that must be struck in order to support issuers in the Marketplace while at the same time not instituting policies that would have a deleterious impact on consumers.

ACAP previously commented in support of the previous Administration's proposed rule to limit short-term, limited duration insurance (STLDI) to three months or less. Our comments on this proposed regulation are in the same vein, as we believe STLDI coverage should be used as it was originally intended—to fill short-term, temporary gaps in coverage—and not as an alternative to meaningful individual health insurance coverage. ACAP encourages the Administration not to finalize this rule and has a number of specific comments addressed herein. In particular, we wish to draw attention to the following recommendations from our comments:

- **Duration:** ACAP objects to the Departments' proposal to permit STLDI coverage for up to 364 days and urges the Departments to ensure that short-term coverage is truly short-term. ACAP urges the Departments to establish that the policy term for any STLDI plan must end by December 31 of that calendar year.
- **Renewability:** ACAP objects to the Departments' proposal to change the language surrounding extensions "with or without the issuer's consent" to simply "without the issuer's consent." Specifically, ACAP objects to any renewals of STLDI coverage, much less a streamlined renewal process.
- **Impact:** ACAP rejects the Departments' estimates of the impact of the proposed rule and instead wishes to submit for the record a full actuarial analysis produced by the Wakely Consulting Group, which is included as Appendix A herein.
- **Disclosure Statement:** ACAP appreciates the Departments' proposal to require a continued disclosure statement on all contract and application materials. We urge the Departments to also require a disclosure statement on marketing materials and to change the wording of the proposed disclosure statement to make it clear that STLDI coverage does not comply with the federally-mandated ACA requirements.
- **Effective Date:** ACAP urges the Departments not to institute an effective date for the proposal prior to January 1, 2020.

Expanded Comments

As the Administration notes in its proposed regulation, STLDI coverage "is not individual health insurance coverage." We believe that for this reason, among others, STLDI coverage should not be marketed as an alternative to ACA-compliant coverage, as it simply is not a meaningful alternative. Additionally, the proposed regulation, especially when combined with recent other regulations recently finalized by this Administration, will have a deleterious impact on the individual market single risk pool – thus impacting the business stability for SNHPs offering individual market products.

First and foremost, STLDI plans do not represent meaningful coverage as they may rate based on age, gender, and health status, and deny selected benefits to individuals based on their health status or cost. Such plans also tend to have extraordinarily high deductibles (often well above the ACA-compliant maximum), no annual or lifetime limits for consumers; further, they are not required to follow medical loss ratio (MLR) requirements, and regularly engage in rescissions. The confluence of these factors means that they are focused primarily on profits rather than providing needed care to enrollees. Such skimpy benefit packages will undoubtedly lead to an increase in uncompensated care to boot. STLDI plans offered in recent years have had a medical loss ratio below 50% and/or deductibles of $20,000 for each three months of coverage. Historically, issuers offering such coverage have been notoriously unscrupulous—often rescinding coverage as soon as individuals file substantial claims. This issue continues to remain pervasive, as evidenced earlier this month by a recent $5 million, multi-state settlement by one such STLDI issuer in response to its business practices.[1]

For these reasons, we object to expanding access to STLDI coverage in its entirety. We respond to the specific issues raised in the regulation, with expanded detail, below.

COVERAGE DURATION

The Departments request feedback on the appropriate length of short-term, limited duration insurance. While the Departments have proposed up to 364 days, we believe that is, by definition, not "short-term." We supported previous efforts to limit such coverage to 3 months or less and would argue that is a reasonable timeframe for such coverage—and certainly no longer than 6 months.

Additionally, while there is an argument to be made regarding the need for STLDI coverage as an option for consumers outside the annual open enrollment period or who do not have access to

[1] http://www.insurance.ca.gov/0400-news/0100-press-releases/2018/upload/nr036HCCLifeSettlement.pdf

ACA-compliant coverage through a special enrollment period, such options should not go beyond the end of the calendar year so that consumers will have the full set of coverage options that are available during open enrollment For this reason, we encourage the Departments to require, as part of the final rule, that regardless of duration, any such STLDI coverage must end by December 31st of a given year, in order to better align consumers with the individual market open enrollment period so that they have a full plethora of coverage options to choose from.

ACAP objects to the Departments' proposal to permit STLDI coverage for up to 364 days and urges the Departments to ensure that short-term coverage is truly short-term. Additionally, regardless of when such a policy is effectuated, ACAP urges the Departments to establish that the policy term for any STLDI plan must end by December 31 of that calendar year. STLDI coverage is meant to fill temporary gaps in coverage and as such should not be viewed as an alternative to comprehensive, meaningful health insurance coverage.

RENEWABILITY

The Departments also request comment on under what conditions issuers should be permitted to continue STLDI coverage for consumers for 12 months or longer. Again, by definition, we argue that issuers should not be permitted to renew STLDI coverage, as it immediately ceases to be of "limited duration."

The proposed regulation's considerations surrounding renewability are twofold. The proposed language would effectively permit extensions of coverage of 12 months and beyond *with* the issuer's consent. It seeks information on the conditions under which issuers should be permitted to allow coverage for 12 months or longer and whether there should be an expedited or streamlined reapplication process. We urge the Departments to reject both of these options. By permitting coverage to be extended based on the issuer's consent, the impact on the individual market risk pool will be even more striking, as issuers will choose to permit renewals for only the healthiest, least-risky, or least-expensive consumers. There is already a level of self-selection by young or healthy consumers enrolling in STLDI coverage, which the Departments recognize in the preamble, and permitting further extension of such coverage options will only serve to increase the adverse selection impact on the individual market. Additionally, as soon as there is a reapplication process for extended coverage beyond a year, STLDI plans will become QHP alternatives—again moving beyond their defined purpose of serving consumers needing to fill temporary gaps in coverage. Put simply, there should not be a reapplication process for STLDI coverage, much less a streamlined process.

ACAP objects to the Departments' proposal to change the language surrounding "extensions that may be elected by the policyholder with or without the issuer's consent" to simply "without

the issuer's consent." Specifically, ACAP objects to any renewals of STLDI coverage, much less a streamlined renewal process.

IMPACT

In response to the Departments' request for feedback on their take-up and premium estimates, ACAP asked an actuarial firm to model the impact of the proposed regulation. Please see Appendix A for the full report, produced by the Wakely Consulting Group.

Wakely states that "the difference in benefits and premiums between the plans that comply with ACA regulations and STLDI plans would effectively create separate risk pools and risk segmentation….Given the regulatory flexibility, STLDI plans would attract healthier enrollees, removing them from the ACA-compliant risk pool, increasing risk selection, and further increasing premiums, continuing the downward spiral. Over time the difference between the two risk pools would increase and escalate the instability and uncertainty in the ACA-compliant individual market."

Wakely provide three alternate estimates of the impact of the proposed regulation on the ACA-compliant market, all of which are at least four times higher than the Departments' stated estimate of 100,000—200,000 enrollees who will drop ACA-compliant coverage. First, Wakely notes that the Departments' estimate does not include plans purchased "off-Exchange." When the Departments' own estimates are applied to the off-Exchange market, Wakely found that the entire ACA-compliant individual market would actually decrease between 400,000—790,000 enrollees, resulting in a premium increase of 0.7 to 1.4% in 2019 alone.

Wakely then proceeds to use the experience of "transitional" plans to guide an estimate of the likelihood consumers will take up an ACA- compliant coverage alternative. Wakely notes that STLDI plans are not even as generous as transitional plans and so reduces the number of people enrolled by half to create a proxy for the potential STLDI market. In this case, Wakely estimates that 826,000 consumers are expected to leave the ACA-compliant market to purchase STLDI coverage.

And finally, Wakely estimates a longer-term impact, over the next 4 to 5 years, once issuers have had a chance to fully re-build underwriting capabilities and roll out STLDI products. Wakely used claims and metal level data to estimate which consumers are most likely to drop ACA-compliant coverage for STLDI. Their analysis found that 1.07 to 1.95 million enrollees are likely to switch coverage, which would also result in a 2.2 to 6.6 percent increase in premiums in the ACA-compliant market.

It is also worth noting that all of the estimates discussed above are *after* the impact of the zeroing of the individual mandate penalty is factored in. Yet we know that many of the consumers most likely to drop coverage after elimination of the mandate penalty are in fact the same consumers who are most likely to take up STLDI coverage as an "alternative" policy. Wakely also provides an estimate looking at the combined impact of the mandate penalty repeal and the STLDI proposal to show the overarching impact of those moving to STLDI coverage. Ultimately, Wakely found that with the combined impact of the repeal of the mandate and the STDLI proposal, when looking at all three scenarios modeled, 20.9 to 26.3 percent of the total individual market are likely to switch to STLDI coverage—resulting in total ACA-compliant market premium increases of 10.8 to 12.8 percent.

ACAP rejects the Departments' estimates of the impact of the proposed rule and instead wishes to submit for the record a full actuarial analysis produced by the Wakely Consulting Group, which is included as Appendix A herein.

DISCLOSURE

The Departments also solicit feedback on proposed changes to the disclosure statement required in all contract and application materials. We urge the Departments, first and foremost, to also require a disclosure statement to be included in marketing materials, so that consumers are aware that such plans are not ACA-compliant. Put simply, consumers deserve to know whether or not their health coverage is comprehensive and meaningful.

Unfortunately, we know that health literacy is low throughout America, and as such, it is important to ensure that consumers are easily able to determine what they are purchasing. We appreciate the Departments' recognition of this and their plan to continue a disclosure statement in contract and application materials. We believe a similar, shortened disclosure statement should be extended to marketing materials. Furthermore, we urge the Departments to make clear in the disclosure statement not just that STLDI coverage "is not required to comply" with the ACA requirements, but that it "does not comply." We believe a greater due-diligence is due to consumers than to simply tell them to read and understand their policy, especially as full policy documents for these plans may not accessible to consumers until after they have enrolled in said plan.

ACAP appreciates the Departments' proposal to require a continued disclosure statement on all contract and application materials. We urge the Departments to also require a disclosure statement on marketing materials and to change the wording of the proposed disclosure statement to make it clear that STLDI coverage does not comply with the federally-mandated ACA requirements.

EFFECTIVE DATE

Finally, ACAP wishes to respond to the proposed effective date. For multiple reasons, we object to the Departments' proposal to permit the sale of STLDI coverage within 60 days of finalizing the rule. First, given the destabilizing effect STLDI coverage will have on the ACA-compliant market, we believe it would be detrimental to QHP issuers whose rates will have long-since been set for that policy year—and will not have factored in the impact of the rule.

Additionally, as the Departments recognize, states also have the authority to regulate STLDI. However, given the infrequency with which some state legislatures meet, we believe it is important to give states adequate time to respond to the changes and that the proposal should not go into effect prior to 2020.

ACAP urges the Departments not to institute an effective date for the proposal prior to January 1, 2020.

Conclusion

The proposed regulation is certain to introduce a new level of instability to the individual market due to adverse selection, increased enrollee churn, and rising premium costs. According to research by Wakely, we also know that it is unsubsidized enrollees in need of comprehensive coverage who will be most harmed—not helped—by this proposal. While this proposal is ostensibly about improving access to coverage choices, for the unsubsidized consumers most in need of access to affordable coverage, this proposal will only serve to put comprehensive coverage out of reach. We urge the Departments not to finalize the proposed regulation.

ACAP thanks the IRS, EBSA, and CMS for their willingness to consider the aforementioned issues. If you have any additional questions or comments, please do not hesitate to contact Heather Foster (202-204-7508 or hfoster@communityplans.net).

Sincerely,

/s/

Margaret A. Murray
Chief Executive Office

Exhibit B

www.wakely.com

Wakely

Association for Community Affiliated Plans

Effects of Short-Term Limited Duration Plans on the ACA-Compliant Individual Market

Prepared by:
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Wakely

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Executive Summary

Wakely was retained by the Association for Community Affiliated Plans (ACAP) to conduct a qualitative and quantitative review of the effects of the recent short-term limited duration insurance (STLDI) proposed regulation on the ACA-compliant individual health insurance market.[1]

The Affordable Care Act (ACA) created an environment in which individuals could purchase coverage in the individual market (ACA-compliant individual market) without discrimination on the basis of health. Many of the additional provisions embedded in the ACA were designed to make the coverage more comprehensive or to enhance the stability of the ACA-compliant individual market. Recently, the Trump Administration has released a proposed regulation allowing individuals to enroll in STLDI plans for a longer time period than permitted by current regulation and also making it easier to renew coverage. Both of these proposed changes increase the availability and attractiveness of STLDI plans. The proposed regulation has the potential to increase market instability, market segmentation, and adverse selection in the ACA-compliant individual market because a substantial number of healthy members will likely migrate to STLDI plans.

This paper analyzed the proposed STLDI regulatory change and the potential effects it could have on the ACA-compliant individual market. We analyzed the impact using a variety of methodologies to develop a range of enrollment decreases and premiums increases within the ACA-compliant individual market. The scenarios were based on estimated impacts by the tri-agency departments[2], a comparison to ACA transitional enrollment[3], and 2016 ACA-compliant individual claims and membership data.

In the table below, Scenarios 1a, 1b, and 2 represent impacts in the first full year, 2019, of the proposed STLDI regulation. Scenarios 3a and 3b reflect total effects STLDI plans will have after an initial ramp up period (the "near term"), which we expect to occur after four to five years. In 2019, the proposed regulation to reduce limitations on STLDI plans is estimated to increase ACA-compliant individual market premiums by approximately 0.7% to 1.7% and decrease enrollment by approximately 2.7% to 6.4%, or between 396,000 to 826,000 people (Scenarios 1a, 1b, and 2). To compare, the Departments of Treasury, Labor, and Health and Human Services (known as the tri-agency departments), displayed in Scenarios 0a and 0b below, estimated the impact of the

[1] If this paper is distributed to outside parties, the paper should be distributed in its entirety. Anyone receiving this paper should retain their own experts in interpreting its contents. The opinions expressed in this paper are those of the authors and do not necessarily reflect those of Wakely. This paper is intended to discuss the impact of STLDI plans on the ACA-compliant individual market; other uses may be inappropriate.

[2] The proposed regulation was submitted by the Departments of Treasury, Labor, and Health and Human Services.

[3] Transitional plans, also known as grandmothered plans, are non-ACA compliant plans that existed in 2013 and allowed to continue into 2014. See https://www.cms.gov/CCIIO/Resources/Letters/Downloads/commissioner-letter-11-14-2013.PDF.

STLDI regulatory changes on the ACA-compliant individual market would decrease enrollment between 100,000 and 200,000 people, for on-Exchange only. Note that Wakely's estimates apply to the total on and off-Exchange market. After issuers have time to fully implement and market STLDI plans (i.e., near term) the impact is larger, with an estimated premium increase of 2.2% to 6.6% and enrollment decrease ranging from 8.2% to 15.0% (Scenarios 3a and 3b).

Note, that these estimates are based on a market in which there is no individual mandate penalty. The repeal of the mandate tax has further compounded the impact of the proposed STLDI regulation change as individuals are no longer required to pay this penalty when enrolled in a STLDI plan and because higher premiums in the ACA-compliant individual market will drive more individuals to drop coverage. Details regarding the enrollment and premium impacts due to the removal of this tax can be found in Table 2. Federal policy makers should consider the effects of this proposed regulation on consumers and market stability before finalizing, and state policy makers should consider options to address these potential issues if the proposed regulation is implemented.

Table 1 - Effects of Short-Term Limited Duration Plans on the ACA-Compliant Individual Market

Scenario	Scenario 0a	Scenario 0b	Scenario 1a	Scenario 1b	Scenario 2	Scenario 3a	Scenario 3b
Method	**Proposed Rule Low**	**Proposed Rule High**	**Proposed Rule Adjusted Low**	**Proposed Rule Adjusted High**	**Transitional Enrollment**	**Individual ACA Claims Cost Data Low**	**Individual ACA Claims Cost Data High**
Year of Impact	**2019**	**2019**	**2019**	**2019**	**2019**	**Near Term**	**Near Term**
Estimate Performed By?	Tri-Agency [4]	Tri-Agency [4]	Tri-Agency, Wakely Adjusted	Tri-Agency, Wakely Adjusted	Wakely	Wakely	Wakely
Off-Exchange Population Included?[1]	No	No	Yes	Yes	Yes	Yes	Yes
Increase in Premiums[2]	0.3%	0.6%	0.7%	1.4%	1.7%	2.2%	6.6%
Decrease in Enrollment	-1.0%	-2.1%	-2.7%	-5.4%	-6.4%	-8.2%	-15.0%
ACA-Compliant Individual Enrollment, Prior to Impact of STLDI Plans[3]	9,730,000	9,730,000	14,730,000	14,730,000	13,000,000	13,000,000	13,000,000
Reduction of Members	100,000	200,000	396,000	791,000	826,000	1,070,000	1,948,000
ACA-Compliant Individual Enrollment, After Impact of STLDI Plans[3]	9,630,000	9,530,000	14,334,000	13,939,000	12,174,000	11,930,000	11,052,000

[1] The population includes only on-Exchange ACA-compliant individual membership within the proposed rule (scenarios 0a and 0b) analyses. Both on and off-Exchange membership are included within the additional scenarios. Because the proposed rule analyses do not account for effects of the off-Exchange market, there will be downstream impacts to market premiums.
. All scenarios reflect the repeal of the individual mandate.
[2] Scenarios 1a - 3a assume that members who leave the ACA-compliant individual market for STLDI coverage cost 25% less on average compared to enrollees that remain in the ACA-compliant individual market. Scenario 3b assumes this differential is 38%.

[3] The baseline ACA-compliant individual market membership, prior to impacts due to the repeal of the individual mandate and STLDI plan regulation change, in scenarios 0 and 1 are based on higher on and off-Exchange estimates. These estimates align with CBO assumptions. Scenarios 2 and 3 rely on smaller on and off-Exchange baseline estimates. Refer to the quantitative section "Scenario 2 – Transitional Enrollment as Guide (2019 Impact)" for further explanation.
[4]See note above regarding the Departments of Treasury, Labor, and Health and Human Services (known as the tri-agency departments) proposed rule. Further detail is described within the quantitative section of the report.

Introduction

On October 12th, 2017, President Trump signed an executive order instructing the Federal government to promulgate regulations that would, among other things, make it easier for individuals to receive coverage through STLDI plans. STLDI plans do not have to follow the ACA market reform rules that were instituted in 2014 to protect consumers. These rules prevent insurance companies from denying coverage or charging more to individuals with pre-existing conditions and contain many requirements regarding benefit designs to maintain adequate coverage. Since STLDI plans do not have to cover costly members with pre-existing conditions and also offer less generous benefits, the premiums are far lower than plans that follow the market reform rules (ACA-compliant plans).

A proposed regulation was released by the Trump administration on February 28th, 2018, which proposes to extend the maximum coverage period for STLDI plans from approximately 3 months to 364 days. Additionally, policyholders will be able to renew and reapply for STLDI coverage much more easily than before, and can potentially extend coverage beyond the proposed 364 day maximum limit. In turn, STLDI plans will become more attractive for certain individuals and enrollment in such plans is expected to increase.

If the proposed regulation change is implemented, a portion of lower cost members are expected to migrate from the ACA-compliant individual market to STLDI plans. Consequently, the ACA-compliant individual market risk pool would contain a greater proportion of sick people (this effect is also known as adverse selection). This impact to the ACA-compliant individual market is further worsened due to the repeal of the individual mandate, which will be in effect beginning in 2019, creating more adverse selection through additional individuals choosing to migrate to a STLDI plan or remain uninsured. As adverse selection increases, premiums will also increase to cover the rising average claims costs. The higher premiums in turn make it less likely that healthy individuals will enroll and stay enrolled, which creates a loop of higher premiums, causing greater adverse selection, which, in turn, again leads to higher premiums. When this cycle continues unfettered it is called a 'death spiral,' which results in market collapse.

It is important to note that the concept of a death spiral is less applicable to subsidized enrollees given the current structure of premium subsidies (tax credits). Individuals eligible for premium tax credits are insulated from market premium increases as the amount of premium owed is a function of their income, not overall premium. Consequently, as premiums increase, subsidized individuals will not have their out-of-pocket costs increase. Therefore, this subsidy structure shelters some individuals from these large rate increases, making them more likely to remain in the ACA-

compliant individual Exchange market. Unsubsidized enrollees, however, directly bear the full brunt of premium increases. The dynamics of premium increases and worsening morbidity does directly affect them and their ability to afford health insurance. Significant adverse selection within the unsubsidized population may still impact issuer participation or lead to a death spiral.

Additionally, instability driven by the high churn of membership, rising claims costs, and uncertainty of market risk will deter some issuers from offering coverage, which has been witnessed in the ACA-compliant individual market in recent years. In the initial years of the ACA, 2014 and 2015, market forces (such as attempts to gain market share, uncertainty regarding the number of young and healthy individual entering the market, competitor positioning, etc.) drove premium rates very low, to an unsustainable level, in many states. As the markets corrected over the next few years (due to financial losses, instability in the market, and unexpected loss of risk corridor funding) numerous issuers exited the ACA-compliant individual market, leaving many consumers with one or few options. The issuers that remained charged higher premiums. Higher premiums increase the likelihood of unsubsidized enrollees choosing lower cost STLDI plans.

This is not to say that all enrollment in STLDI plans will come from the current ACA-compliant pool. It can also be expected that some individuals who are or will become uninsured (further exacerbated by the repeal of the individual mandate effective 2019) will also choose to purchase STLDI plans. The IRS reports that for the 2015 benefit year (2016 tax filing season) 6.5 million people paid the individual mandate penalty. Additionally, 12.7 million people claimed one or more health care coverage exemptions to avoid having to pay the mandate penalty.[4]

Due to data limitations, this analysis will focus on the impacts that the STLDI regulation change will have on the ACA-compliant individual market and the behavioral effects of those currently in the individual market. As discussed, the projected effects of STLDI plans are after accounting for the repeal of the individual mandate. The proposed STLDI plan regulation will also have effects, both direct and indirect, on other coverage cohorts, such as the uninsured.

Short-Term Limited Duration Insurance Plans: Differences from ACA-Compliant Plans

STLDI plans are designed to fill temporary coverage gaps. Historically, their benefits and cost-sharing differed from ACA-compliant plans in a number of key aspects. The Commonwealth Fund recently noted that STDLI plans do not have a ban on rating for or excluding coverage for pre-existing conditions, do not provide any of the ten essential health benefits[5] (e.g., prescription drug

[4] https://www.irs.gov/pub/newsroom/commissionerletteracafilingseason.pdf
[5] https://www.healthcare.gov/glossary/essential-health-benefits/

coverage), and do not have cost-sharing requirements.[6] Below is a listing of some specific differences between the two coverage options:

- Many STLDI plans have deductibles of $7,000 to $20,000 for three months of coverage, compared to ACA-compliant plans which are for a year of coverage and legally cannot exceed an amount preset by the Secretary (for example, deductibles for ACA-compliant individual plans were essentially capped at the maximum out of pocket amount of $7,150 in 2017).[7]

- The American Academy of Actuaries notes that many STLDI plans have coverage limits of $1 million while ACA-compliant plans do not have annual limits.[8]

- At the time of renewal or purchase, STLDI plans can exclude coverage for any condition developed in the prior coverage period. Individuals not only can be excluded due to illness when they initially purchase the coverage, but if re-occurring or chronic conditions occur while individuals have STLDI, then they would be unlikely to be covered again at the time of renewal. This is different from even pre-ACA individual market coverage, in which additional underwriting was not conducted at renewal.

- Additionally, ACA rating rules, such as age and gender restrictions, do not apply so these plans can charge higher premiums for individuals who have health conditions or can charge more based on a person's sex.

- STLDI plans do not have to follow Medical Loss Ratio[9] (MLR) restrictions so fewer premium dollars go to paying medical coverage and instead go to administration and profit. Historically, these ratios have been much lower in STLDI plans (for example the largest insurer of STLDI products in 2016 had a MLR below 50%, far below the 80% required MLR in the ACA-compliant individual market).[10]

- Individuals in STLDI plans would be at risk for rescission. Rescissions are retroactive cancellations of coverage, often occurring after individuals file claims due to medical necessity. While enrollees in ACA coverage cannot have their policy retroactively cancelled, enrollees in STLDI plans can. According to Georgetown University, reports

[6] http://www.commonwealthfund.org/publications/blog/2017/aug/short-term-health-plans
[7] Ibid.
[8] http://www.actuary.org/files/publications/Executive_Order_Academy_Comments_110717.pdf
[9] The ACA requires that all issuers spend at least 80% of premium revenues on medical costs.
[10] http://www.commonwealthfund.org/publications/blog/2017/aug/short-term-health-plans

suggest issuers offering STLDI plans have been aggressive at using rescissions to shift their liability onto consumers.[11]

The difference in benefits and premiums between the plans that comply with ACA regulations and STLDI plans would effectively create separate risk pools[12] and risk segmentation. As the American Academy of Actuaries notes, "Noncompliant plans would likely be structured to be attractive to low-cost enrollees through fewer required benefits, higher cost-sharing, and premiums that vary by health status".[13] Given the regulatory flexibility, STLDI plans would attract healthier enrollees, removing them from the ACA-compliant risk pool, increasing risk selection, and further increasing premiums, continuing the downward spiral. Over time the difference between the two risk pools would increase and escalate the instability and uncertainty in the ACA-compliant individual market.

Context: Changes Since 2014

Evolution of Regulations on STLDI plans

Following the full implementation of the ACA requirements in 2014, marketing of STLDI plans changed. In particular, they were marketed as alternatives to ACA coverage, with STLDI plans being renewed indefinitely (generally every three months). This allowed individuals to stay in STLDI plans if both the plan and consumer wished to extend coverage. The result was that enrollment in STLDI plans increased from 1.0 million to 1.5 million member months between 2013 and 2015.[14]

In the fall of 2016, the Obama Administration introduced rules to limit the duration individuals could stay enrolled in STLDI plans to no more than three months (including renewals). The rules also required that application materials include clear language stating that the coverage did not meet standards—known as minimum essential coverage—exempting individuals from the mandate penalty. The Administration noted that these plans could have limitations for consumers, for the above stated reasons, and they could produce adverse selection in the ACA risk pool. The Administration did not ban the sales of these products because "the individual shared responsibility provision…provides sufficient incentive to discourage consumer from purchasing multiple successive short-term, limited duration insurance policies".[15]

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[11] http://chirblog.org/state-options-to-respond-to-executive-order-on-short-term-plans/
[12] In the ACA-compliant market premiums are set in reference to a state's entire risk mix for all enrollees in ACA-compliant plans. A worsening ACA-compliant risk pool would affect all ACA-compliant premiums (excluding the effects of APTCs)
[13] ibid
[14] https://s3.amazonaws.com/public-inspection.federalregister.gov/2016-26162.pdf
[15] ibid

Individual Mandate in the ACA

The individual mandate ("shared responsibility provision") was designed to reduce risk selection. The requirement has a tax penalty for individuals that can afford insurance but choose not to purchase coverage. The result of the policy was that incentives exist for healthy individuals to enroll in ACA-compliant coverage, as individuals that enrolled only in STLDI plans for more than three months would still be required to pay the mandate penalty. Individuals that were uninsured for less than three months were exempt from the mandate penalty, and STLDI plans were meant to serve as a backstop for individuals who might need just a short-term policy to fill such a short gap. While some criticized the mandate penalty as being too small, it did still have effects on the ACA-compliant individual market. For coverage relating to the 2015 benefit year, approximately 6.6 million people paid about $3 billion in individual responsibility payments or about $457 per tax household.[16]

However, these incentives will change starting in 2019. In December of 2017, President Trump signed into law a bill that, among other things, would effectively repeal the individual mandate.[17] Repealing the mandate resulted in both direct and indirect effects that will serve to make the STLDI plans popular. First is that by repealing the mandate, the total cost to consumers of being covered by STLDI plans will be lower since individuals only have to pay the premiums and not both the premiums and the mandate penalty. In other words, repealing the mandate should increase enrollment in STLDI plans. Secondly, by repealing the mandate, ACA premiums will be higher due to an increase in adverse selection,[18] therefore increasing the premium differential between ACA-compliant plans and STLDI plans. The larger the premium difference between the two types of plans, the greater the popularity of STLDI plans, creating a continued cycle of adverse selection.

Implications of New Regulations

On February 28, 2018, the Trump administration released a proposed regulation which would relax current limitations on STLDI plans.[19] The regulation, among other things, proposes two key changes. The first amends regulations so that the maximum coverage period for STLDI plans is now 364 days. This is an increase of approximately 9 months relative to current regulations. The second key change makes it easier for policyholders to renew or reapply for coverage beyond the

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[16] https://www.irs.gov/pub/irs-soi/17sprbul.pdf
[17] https://www.vox.com/policy-and-politics/2017/11/14/16651698/obamacare-individual-mandate-republican-tax-bill. The penalty for the individual mandate was set at $0. For brevity will refer to this change as mandate repeal.
[18] https://www.cbo.gov/system/files/115th-congress-2017-2018/reports/53300-individualmandate.pdf
[19] https://www.federalregister.gov/documents/2018/02/21/2018-03208/short-term-limited-duration-insurance

364-day limit.[20] Both of these actions are designed to increase the availability and attractiveness of STLDI plans.

The most direct impact the regulation has is the likelihood of removing healthy and young individuals from the ACA-compliant individual market. The regulation itself notes that short-term limited duration insurance is likely to attract young or healthy individuals. The proposed regulation notes that removing healthy individuals from the ACA risk pool results in higher premiums for those without premium subsidies and higher Federal costs due to the increased subsidy levels as a result of the worsening risk pool and higher premiums.

Consumers who switch to STLDI plans may also be harmed. As the regulation notes "… consumers who switch to such policies (STLDI plans) from ACA-compliant plans would experience loss of access to some services and providers and an increase in out-of-pocket expenditures related to such excluded services…"[21] Additionally, consumers may be harmed as STLDI plans would still not be considered minimum essential coverage and so they would not be protected if their STLDI coverage were to lapse. For example, if an individual was diagnosed with a serious medical condition mid-year and therefore unable to afford the new higher premium at the time of renewal,[22] or experienced a coverage rescission, the person would be unable to get access to ACA coverage via a special enrollment period (SEP). While this does have the benefit of protecting the ACA risk pool, it could lead to individuals having spells of no coverage and higher levels of uncompensated care. And the ACA-compliant risk pool would still ultimately bear the expenses of delayed coverage once the consumer is finally able to enroll during open enrollment.

States do retain significant authority in regulating STLDI plans, which will affect the impact from state to state. According to the Urban Institute, eight states currently have regulations that would limit STLDI expansion.[23] These limitations mostly take the form of how long an individual can consecutively have coverage in a STLDI (e.g., a STLDI can only provide coverage for a maximum of three months and not be renewed). The proposed regulation would not preempt state law on STLDI plans, but it also does not require states to regulate STLDI plans.

In the proposed regulation, HHS provided an impact analysis of the effects of STLDI plans on the ACA-compliant individual market. They estimated that between 100,000 and 200,000 members would exit the Exchanges to take up coverage in STLDI plans in 2019, further increasing the morbidity of the ACA-compliant risk pool, premiums, and Federal expenditures via higher

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[20] https://www.healthaffairs.org/do/10.1377/hblog20180220.69087/full/
[21] https://www.federalregister.gov/documents/2018/02/21/2018-03208/short-term-limited-duration-insurance
[22] While not included in the analysis, there have been several Congressional proposals making renewal of STLDIs easier for consumers. If approved, this would directionally increase enrollment in these plans and premium increases in the ACA market.
[23] https://www.urban.org/sites/default/files/publication/96781/stld_draft_0226_finalized_0.pdf

premium subsidies (advanced premium tax credits – APTC). In the next section, we will examine potential effects of the proposed regulation on the ACA-compliant individual market.

Analysis of Proposed Regulations

Case Study: Tennessee

The unique case of Tennessee's individual market may provide a preview of the effects on the ACA-compliant individual market of offering non-ACA products. Due to a 1993 law, the state allows the Tennessee Farm Bureau to sell coverage to individuals. This coverage is not exclusively provided to farmers but is generally available to all Tennesseans and is similar to the type of plans that existed in the pre-ACA world. As a matter of state law, the coverage is not considered insurance. As a result, when the ACA's key provisions, such as guaranteed issue and not denying coverage based on pre-existing conditions, came into the effect, they did not apply to the Tennessee Farm Bureau plans. This allowed the Tennessee Farm Bureau to continue to sell new coverage options that compete against ACA-compliant plans.

The Tennessee Farm Bureau has been very successful at attracting and keeping healthy enrollees. According to one report, in 2017 they covered as many as 73,000 enrollees (this includes 50,000 "grandfathered plans" and 23,000 enrollees that have signed up since the ACA market reform rules went into effect).[24] To put these numbers into context, in 2017, approximately 200,000 members, on average, were enrolled on-Exchange for the first half of 2017.[25] While we do not yet have the average total ACA-compliant individual market enrollment for 2017, 73,000 Farm Bureau enrollees likely would represent approximately a quarter of the total "individual market" (Farm Bureau coverage plus ACA-compliant market) in 2016.[26]

A Society of Actuaries paper analyzed the risk mix in ACA plans in 2015[27] and found that, excluding Arkansas,[28] Tennessee's ACA-compliant individual market had the worst risk score (or relative measure of how costly individuals are in the ACA-compliant market) of any state in the country. Tennessee had an adjusted risk score of 2.80 while the national average was 2.31.[29] To further the instability within the ACA-compliant individual market, Tennessee also has

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[24] http://chirblog.org/whats-going-tennessee-one-possible-reason-affordable-care-act-challenges/
[25] https://downloads.cms.gov/files/effectuated-enrollment-snapshot-report-06-12-17.pdf
[26] Using the 2016 June 30th Report, Wakely estimated the size of the Tennessee's ACA individual market using billable member months. If one were to combine both the individual market and Farm bureau into a singular risk pool, the Farm Bureau's 73,000 enrollees would represent 26.7% of the total market
[27] https://www.soa.org/research-reports/2016/relative-risk-aca-market/
[28] Arkansas was excluded since its ACA risk pool includes Medicaid expansion beneficiaries.
[29] The SOA adjusted risk scores for differences in age and actuarial value to better differences between states due to health differences.

experienced large rate increases. All three of the major issuers increased rates in 2017 in excess of 40%.[30] Overall the second lowest cost silver plan increased 278% between 2014 and 2018.[31] This is the largest increase of any Healthcare.gov state. At the end of 2016 one issuer (United) exited the market and several issuers reduced their footprint. The situation was so dire the Insurance Commissioner characterized the Exchange market as "very near collapse."[32]

As can be seen in the Tennessee case study, allowing products that underwrite to directly compete with ACA products will increase risk selection in the ACA-compliant individual market. Healthier individuals migrated to the less expensive (underwritten) products which caused morbidity to increase in the ACA products, resulting in premium increases, issuer exits, and overall uncertainty in the market.

While illustrative of the overall dynamics of how non-ACA products may affect the ACA risk pool, the Tennessee experience may not be directly comparable in the short-term because of the Tennessee Farm Bureau's long history in the state, large pre-ACA enrollment, and significant advertising presence. The aforementioned dynamics of the Tennessee experience are largely qualitative in nature; in the next section, we will provide quantitative analyses on the potential effects STLDI might have on the ACA-compliant individual market.

Quantitative Analyses

The reintroduction of underwriting and rescissions at a larger scale are not immediate; for many issuers, it may take some time to implement (the proposed regulation estimates only 160,000 people are currently enrolled in STLDI plans). Furthermore, it may take time to market the products to individuals. To control for the fact that the effects of STLDI plans should grow over time, we have analyzed the effects of STLDI plans both in the short term (scenarios 1 and 2 below) and the near term (scenario 3 below).

Neither sets of analyses account for potential reduction in issuer participation and competition. As enrollment shrinks and morbidity increases, fewer issuers may be willing to provide coverage, which again may result in higher premiums. In the extreme case of a bare county (no ACA-compliant issuer coverage) the results would be catastrophic for enrollees in those areas. Consequently, these analyses can be considered to underestimate the impact as enrollment losses and premium increases could be higher if the resulting issuer behavior was accounted for.

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[30] https://www.healthinsurance.org/tennessee/
[31] https://aspe.hhs.gov/system/files/pdf/258456/Landscape_Master2018_1.pdf
[32] https://www.tennessean.com/story/money/industries/health-care/2016/08/23/insurers-get-approval-for-2017-obamacare-rates/89196762/?from=global&sessionKey=&autologin=

Scenarios 0 and 1 – Extension of Proposed Regulation Regulatory Impact Analysis (2019 Impact)

As part of the proposed regulation, the Departments of Treasury, Labor, and Health and Human Services (known as the tri-agency departments or simply tri-agency) estimated the impact of the STLDI regulatory changes on the ACA-compliant individual market. In particular, they estimated that between 100,000 and 200,000 people would leave the Exchanges and enroll in STLDI plans. This shift of young and/or healthy individuals to STLDI products was estimated to increase premiums in the ACA-compliant individual market 0.3% to 0.6%, on average nationwide. Note, these impacts are specific to year 2019. The tri-agency estimates are shown in Scenarios 0a and 0b in the table below.

However, there are a number of reasons to believe the tri-agencies' estimate may be understated. First, the tri-agencies' estimate that the relative morbidity of those that leave ACA coverage for STLDI plans compared to those that stay in ACA coverage is 75% (meaning those that are expected to leave cost 25% less on average compared to average enrollees that remain in the ACA-compliant individual market). Other estimates of the morbidity of individuals that leave the ACA-compliant individual market on a relative basis are lower.[33] For example, using CBO's analysis of the mandate repeal, Wakely estimated that CBO assumed a morbidity differential of individuals leaving due to the mandate repeal as approximately 62% (meaning those that are expected to leave cost 38% less on average compared to average enrollees that remain in the ACA-compliant individual market). In other words, individuals leaving the ACA-compliant risk pool could be healthier/less costly than what the tri-agency's rule assumed. The larger the difference in health status between those that leave the ACA-compliant risk pool versus those that stay results in larger premium increases in the ACA-compliant market. Second, and more important, the tri-agency's analysis does not include the ACA-compliant individual off-Exchange market. As part of the single risk pool, off-Exchange ACA enrollees should be included in the total impacts. Since off-Exchange ACA enrollees are all unsubsidized, they are directly affected by premium increases and, therefore, more likely to exit the ACA-compliant individual market for STLDI plans compared to the subsidized population.

For Wakely's modeling of scenario 1, we assumed a 75% morbidity differential to align with the Federal impact analysis.[34] Also, we adjusted the tri-agency's results to include the ACA-compliant individual off-Exchange market. To estimate what proportion of the off-Exchange membership would exit for STLDI coverage, we used the tri-agency's estimated percent of unsubsidized on-

[33] Https://obamawhitehouse.archives.gov/sites/default/files/page/files/201701_individual_health_insurance_market_cea_issue_brief.pdf

[34] While the morbidity difference is likely around 75%, it could be lower, a point that is explored later in the analysis. The larger the morbidity difference, the larger the premium impact.

Exchange enrollees that would migrate to STLDI plans. To estimate the size of the ACA-compliant individual off-Exchange market, we relied on the same CBO analysis that the tri-agencies relied on to estimate the effects of the mandate repeal.[35] Please note that the tri-agencies' analysis does not specifically state the methods and assumptions used to arrive at their estimated number of people who would transition to short-term duration plans. Nor was it indicated what difference in assumptions were used to develop the low and high scenario results.

By using the tri-agency's initial findings and adjusting for off-Exchange membership, we estimate that, after accounting for the removal of the individual mandate, the entire ACA-compliant individual market would further decrease by between 400,000 enrollees (scenario 1a) and 790,000 enrollees (scenario 1b). The high and low scenarios were also modeled in the tri-agency's report. This represents 2.7% to 5.4% of the total estimated ACA-compliant individual market in 2019 (based on membership after no individual mandate). Updating the membership component of the tri-agency analysis to include off-Exchange membership results in an estimated premium increase of 0.7 to 1.4% in 2019, significantly higher than the tri-agency's estimates.

Scenario 2 – Transitional Enrollment as Guide (2019 Impact)

To provide further sensitivity testing, Wakely used a second methodology to estimate the effects of STLDI plans on the ACA-compliant individual market in 2019. In this analysis, we varied our assumptions regarding the estimated size of the ACA-compliant individual market from the baseline in the tri-agency's analysis assumed in scenario 1. In 2017, the off-Exchange market decreased in size severely.[36] Consequently, we assumed the size of the off-Exchange market may be smaller than the CBO estimate relied on in scenario 1. The result was an overall baseline individual ACA-compliant enrollment of 15.0 million (both on and off-Exchange) compared to 18.1 million as assumed in scenario 1.

As discussed, scenario 1 aligned with CBO assumptions of both baseline enrollment (on and off-Exchange) and effects of the mandate. A smaller off-Exchange in the baseline could imply that the mandate repeal enrollment effects are correspondingly lower. To avoid biasing the analysis (i.e., smaller off-Exchange and larger mandate repeal effect), we used all of the key CBO projected inputs. If we aligned both the on and off-Exchange market size in scenario 1 with what

[35] Theoretically, off-Exchange enrollees would also be at risk for leaving the ACA risk pool due to the mandate repeal. However, since the tri-agency analysis included the full effect of the mandate repeal (3 million) on-Exchange it would be inappropriate to double count these losses off-Exchange as well.

[36] http://www.markfarrah.com/healthcare-business-strategy/A-Brief-Look-at-the-Turbulent-Individual-Health-Insurance-Market.aspx

was used for scenario 2, the expected premiums effects of STLDIs are 0.9% and 1.8%, respectively, higher than they otherwise would have been in scenario 1.

Given the smaller enrollment baseline, we used the Office of the Actuaries' estimated enrollment loss due to the mandate repeal (or 2 million), which is less than the CBO estimated enrollment loss.[37] Finally, we relied on the experience of transitional enrollment to estimate the demand for STLDI plans. In 2014, the Obama Administration allowed individuals that had 2013 (i.e., pre-ACA) coverage to continue enrollment in their current plans—often referred to as "grandmothered" plans and known as "transitional" plans for the purposes of this analysis. The Brookings Institute estimated that approximately 1.6 million people who had initially purchased non-ACA coverage before the mandate went into effect in 2014 maintained their non-ACA transitional coverage rather than choosing to be uninsured or purchase ACA-compliant coverage.[38]

While not a perfect proxy, STLDI plans do represent a non-ACA coverage alternative, similar to how transitional plans functioned as a non-ACA coverage option for many Americans in 2014. Furthermore, not every state allowed transitional plans to exist. States that intervened to protect the ACA-compliant individual market and disallow transitional plans may similarly map to states that will intervene to protect the ACA market from STLDI plans, which would decrease the STLDI market compared to the transitional plan market in 2014. One difference between transitional plans and STLDI plans that may impact take-up is that in STLDI plans, individuals would have to undergo underwriting at renewal; individuals in transitional plans did not undergo underwriting. Also, transitional plans are more generous than STLDI plans and so may attract a somewhat different population mix. Individuals that were enrolled in transitional policies in 2014 may have since dropped coverage and may not be enrolled in the ACA-compliant individual market— thus shifting from different coverage or uninsured status.

To account for the more stringent enrollment requirements for STLDI plans and differences compared to transitional plans, as detailed above, we reduced the number of people in transitional plans by 50% to create a proxy for the potential STLDI market. The results of this scenario estimate that 830,000 people out of 13 million total enrollees, representing 6.4% of enrollment, may exit the ACA-compliant individual market. We again assumed a 75% morbidity differential of enrollees migrating to STLDI plans from the ACA-compliant individual market. This would result in a premium increase of 1.7%. Although this scenario is intended to estimate the impact in 2019, there is some sensitivity in the potential STLDI market. In increasing the assumption that the potential STLDI market is approximately 50% of the transitional market, the STLDI market may begin to converge to a nearer term estimate. This assumes, similar to scenario 3, that it will take

[37]https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/ProjectionsMethodology.pdf
[38] https://www.brookings.edu/wp-content/uploads/2017/10/individualmarketprofitability.pdf

issuers longer to develop STLDI products compared to the pre-ACA products that had been in place for quite some time.

Scenario 3 – Individual ACA Claims Cost Analysis (Near Term Impact)

The final methodological approach we used was to examine health status and metal level in the ACA-compliant individual market as a proxy for an enrollee's propensity to shift from an ACA plan to a STLDI plan. This estimate should be considered a near term estimate, in four to five years, as the full impact of the proposed regulation is not immediate; it will take a few years for the full effect of STLDI plans to be felt on the ACA-compliant individual market. It will take time for issuers to develop STLDI products and (re)build the necessary operations to underwrite. In 2019, as illustrated in scenarios 1 and 2, not enough time has lapsed for issuers to have the operational capabilities to fully implement STLDI plans. Therefore, scenario 3 estimates are larger than the initial two.[39]

Wakely used a proprietary dataset of nationwide 2016 ACA-compliant individual market enrollees that consists of approximately 6.4 million members. We grouped individuals into one of three categories listed below to determine those who would be most likely at risk of switching from ACA-compliant coverage to STLDI coverage, referred to as the "at risk" group.

Category 1. Individuals enrolled in lower metal level plans. Lower metal levels were defined as catastrophic, bronze, and silver regular (no cost-sharing reduction variant) plans.

Category 2. Individuals who were unsubsidized.

Category 3. Individuals who had lower cost sharing (copay, deductible, coinsurance) spending levels. Lower spending levels were defined as less than the average cost of a STLDI plan premium as identified by the tri-agency's rule ($124 average monthly premiums in the fourth quarter of 2016). Since females would likely to be charged higher than males (due to the underwriting process in STLDI plans), different premium levels were assumed by gender.[40]

Based on the criteria defined above, we identified that approximately 36% of enrollees within the individual dataset fell into both Categories 1 and 3. Then, based on the 36% of enrollees, we estimated different propensities for shifting coverage from the ACA-compliant individual market to the STLDI market by also taking Category 2, the unsubsidized population, into account as

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[39] Please note that in reality the ACA-compliant individual market will experience large churn between STLDI plans as those that become unhealthy will shift to the ACA-compliant individual market and those who consider themselves healthy shift out.

[40] The ACA requires plans to conform to a particular level of actuarial value (i.e., metal levels). Wakely only used enrollees that were in catastrophic, bronze, or non-CSR silver plans. Individuals that selected these plans could be considered to have revealed preferences for lower premiums and less cost-sharing protection. Lower spending levels were identified as having less claims cost than an average STLDI plan as noted in the tri-agency regulation ($124).

subsidized members are much less likely to drop ACA-compliant individual market coverage. We adjusted the data as follows:

- Two scenarios, high and low, were modeled to produce a range of estimates.
- All individuals enrolled off-Exchange and members in catastrophic plans on-Exchange (unsubsidized, within Category 2) would be most likely to drop or shift coverage. In the low scenario, we assumed a majority of these members would dis-enroll from the ACA-compliant individual market. In the high scenario, we assumed 100%.
- Individuals enrolled on-Exchange in bronze and regular silver metal level plans are less likely to drop, since a larger portion of these members are likely to be eligible for subsidies. For these plans, in the low scenario, we assumed 80% of the unsubsidized members would dis-enroll from the ACA-compliant individual market and none of the subsidized enrollees would drop coverage. In the high scenario, we assumed 100% of the unsubsidized and a small portion of the subsidized members, based on the tri-agency's analysis in scenario 1b, would exit the ACA-compliant individual market.
- By accounting for all three categories listed above, the at risk group ranges from 20% to 26% of total market enrollees, based on the high and low scenarios. These percentages represent the proportion of members, based on the 2019 estimated ACA-compliant individual market membership prior to mandate repeal, that will leave due to combined impacts of the removal of the individual mandate and the proposed changes to the STLDI regulation.
- Applying the enrollment decrease percentages to the ACA-compliant market enrollment, pre-repeal mandate, would equate to approximately 3.0 to 3.9 million enrollees in high and low scenarios.

Because the identified at risk group would be largely the same population that would be at risk for becoming uninsured due to the effective individual mandate repeal, we reduced the potential pool of enrollees by the expected enrollment loss due to the mandate repeal, as estimated by CMS' Office of the Actuary, or 2.0 million enrollees.[41] This produced the proportion of enrollees that are estimated to shift into STLDI coverage. The initial at risk group includes members that may drop coverage due to the repeal of the individual mandate or may have disenrolled in 2017 or 2018. The data has not been adjusted from 2016; therefore, our estimates reflect higher bounds. This results in an estimated 1.0 to 1.9 million individuals who would ultimately be at risk for shifting from ACA-compliant individual plans to STLDI plans in the near term.

[41]https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/ProjectionsMethodology.pdf

It should be noted that in a world where mandate repeal has stronger effects, the marginal effect of STLDI plans may be less. This is because enrollees who are healthier are more likely to be uninsured. The extent to which mandate repeal has less of an effect, there is a larger pool of ACA individuals that may shift to STLDI plans.

In the high and low scenarios, the same post-mandate repeal enrollment baseline as assumed in scenario 2 was used (i.e., an ACA-compliant individual market of 13 million enrollees). The low scenario assumes that the relative morbidities of those that leave for STLDI plans compared to those that stay in ACA coverage is 75%, whereas the high scenario decreases the morbidity differential to 62%. It is possible that in the event of large enrollment decreases, the morbidity differential between those that stay and those that leave could be large. To account for the potential of more extreme morbidity differences we used a larger difference in health status in the high scenario. The final impact results in an enrollment decrease of 8.2% to 15.0% in the ACA-compliant individual market and a 2.2% to 6.6% increase in premiums. Again, these assumptions show a near term impact of four to five years. The table below includes enrollment for the ACA-compliant individual market (both on and off-Exchange) in total and for subsidized enrollees, premium impacts, and enrollment impacts. Enrollment levels are estimated prior to the repeal of the individual mandate. Then, enrollment and premium impacts are re-estimated based on the repeal of the individual mandate, and again after the proposed STLDI regulation change. Both the loss of the individual mandate and proliferation of STLDI plans would impact the unsubsidized market much more drastically than the subsidized market. The combined impact of both the repeal of the mandate and the easing restrictions on STLDI plans would result in premium increases of 20.5% to 26.3% higher than they otherwise would have been.

Table 2 - Effects of STLDI Proposed Regulation on ACA-Compliant Individual Market Risk Pool (Different Scenarios)

Scenario	Scenario 0a	Scenario 0b	Scenario 1a	Scenario 1b	Scenario 2	Scenario 3a	Scenario 3b
Method	**Proposed Rule Low**	**Proposed Rule High**	**Proposed Rule Adjusted Low**	**Proposed Rule Adjusted High**	**Transitional Enrollment**	**Individual ACA Claims Cost Data Low**	**Individual ACA Claims Cost Data High**
Year	**2019**	**2019**	**2019**	**2019**	**2019**	**Near Term**	**Near Term**
Estimate Performed By?	Tri-Agency[5]	Tri-Agency[5]	Tri-Agency, Wakely Adjusted	Tri-Agency, Wakely Adjusted	Wakely	Wakely	Wakely
Off-Exchange Population Included?[1]	No	No	Yes	Yes	Yes	Yes	Yes
Baseline, with enforcement of Individual Mandate							
Individual Total Enrollment[2]	13,130,000	13,130,000	18,130,000	18,130,000	15,000,000	15,000,000	15,000,000
Individual Subsidized Enrollment	8,459,000	8,459,000	8,459,000	8,459,000	8,459,000	8,459,000	8,459,000
Baseline, with removal of Individual Mandate							
Increase in Premiums	10.0%	10.0%	10.0%	10.0%	5.8%	5.8%	5.8%
Reduction of Members[3]	3,400,000	3,400,000	3,400,000	3,400,000	2,000,000	2,000,000	2,000,000

Scenario	Scenario 0a	Scenario 0b	Scenario 1a	Scenario 1b	Scenario 2	Scenario 3a	Scenario 3b
Method	**Proposed Rule Low**	**Proposed Rule High**	**Proposed Rule Adjusted Low**	**Proposed Rule Adjusted High**	**Transitional Enrollment**	**Individual ACA Claims Cost Data Low**	**Individual ACA Claims Cost Data High**
Individual Total Enrollment	9,730,000	9,730,000	14,730,000	14,730,000	13,000,000	13,000,000	13,000,000
Individual Subsidized Enrollment	8,122,000	8,122,000	8,122,000	8,122,000	8,122,000	8,122,000	8,122,000
Scenario, Impact of STLDI Plans							
Increase in Premiums[4]	0.3%	0.6%	0.7%	1.4%	1.7%	2.2%	6.6%
Reduction of Members	100,000	200,000	396,000	791,000	826,000	1,070,000	1,948,000
Decrease in Enrollment	-1.0%	-2.1%	-2.7%	-5.4%	-6.4%	-8.2%	-15.0%
Individual Total Enrollment	9,630,000	9,530,000	14,334,000	13,939,000	12,174,000	11,930,000	11,052,000
Individual Subsidized Enrollment	8,112,000	8,102,000	8,112,000	8,102,000	8,122,000	8,122,000	8,122,000
Total Impacts due to Removal of Individual Mandate and STLDI Plans							
Increase in Premiums	10.3%	10.6%	10.8%	11.6%	7.6%	8.2%	12.8%
Reduction of Members	3,500,000	3,600,000	3,796,000	4,191,000	2,826,000	3,070,000	3,948,000
Decrease in Enrollment	-26.7%	-27.4%	-20.9%	-23.1%	-18.8%	-20.5%	-26.3%

[1] The population includes only on-Exchange ACA-compliant individual membership within the proposed rule (scenarios 0a and 0b) analyses. Both on and off-Exchange membership are included within the additional scenarios. Because the proposed rule analyses do not account for effects of the off-Exchange market, there will be downstream impacts to market premiums.
[2] The baseline ACA-compliant individual market membership, prior to impacts due to the repeal of the individual mandate and STLDI plan regulation change, in scenarios 0 and 1 are based on higher on and off-Exchange estimates. These estimates align with CBO assumptions. Scenarios 2 and 3 rely on smaller on and off-Exchange baseline estimates. Refer to the quantitative section "Scenario 2 – Transitional Enrollment as Guide (2019 Impact)" for further explanation.
[3] The reduction in members due to the repeal of the individual mandate in scenarios 0 and 1 are based on CBO assumptions, as assumed within the proposed rule analyses. Scenarios 2 and 3 rely on a smaller reduction in members due to the repeal of the individual mandate, as assumed by the Office of the Actuaries'. Refer to the quantitative section "Scenario 2 – Transitional Enrollment as Guide (2019 Impact)" for further explanation.
[4] Scenarios 1a - 3a assume that members who leave the ACA-compliant individual market for STLDI coverage cost 25% less on average compared to enrollees that remain in the ACA-compliant individual market. Scenario 3b assumes this differential is 38%.
[5] See note above regarding the Departments of Treasury, Labor, and Health and Human Services (known as the tri-agency departments) proposed rule. Further detail is described within the quantitative section of the report.

Conclusion

In 2016, the Obama Administration enacted a regulation that limited enrollment in STLDI plans. Individuals were not allowed to enroll in STLDI plans for more than three consecutive months. This was done to prevent STLDI enrollment from harming the ACA-compliant risk pool and to limit consumer's exposure to underwriting, rescissions, annual limits, and other harmful policies that were in effect prior to the ACA in 2014. In February of 2018, the Trump Administration proposed to reverse the Obama era regulation to make it easier for individuals to stay enrolled in STLDI plans. While it would provide healthy individuals access to cheaper, less generous coverage, it would also increase premiums for individuals in the ACA risk pool. The effective repeal of the mandate starting in 2019 introduces additional uncertainty into the ACA risk pool and is expected to increase the morbidity of the risk pool.

The combination of removing restrictions on STLDI plans and repealing a mandate penalty for individuals that sign up for these plans should increase the attractiveness of STLDI plans to current ACA enrollees. Using a variety of scenarios, Wakely estimates that STLDI plans will have an adverse effect on the ACA individual market and that the effect will grow with time. The impact in 2019 is estimated to increase premiums 0.7% to 1.4% and decrease enrollment by 2.7% to 5.4% in the ACA-compliant individual market. In the near term, once the STLDI market has had a chance to expand, we estimate that premiums for ACA-compliant individual enrollees could be 2.2% to 6.6% higher and enrollment 8.2% to 15.0% lower. The STLDI regulation change combined with the repeal of the individual mandate will further exacerbate the impacts and increase premiums from 10.8% to 12.8% and decrease enrollment from 20.9% to 26.3% (based on 2019 and near term estimates).

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

ASSOCIATION FOR COMMUNITY AFFILIATED PLANS, *et al.* *Plaintiffs,* v. UNITED STATES DEPARTMENT OF TREASURY, *et al.*, *Defendants.*	Civil Action No. 18-2133

[PROPOSED] ORDER GRANTING
MOTION FOR PRELIMINARY INJUNCTION

Upon consideration of the plaintiffs' motion for a preliminary injunction the memoranda and declarations filed in support thereof and opposition thereto, and the arguments of the parties, it is hereby

ORDERED that plaintiffs' motion for a preliminary injunction is hereby GRANTED; and it is further

ORDERED that the defendants' new short-term limited-duration insurance rule set forth at 83 Fed. Reg. 38,212 is hereby enjoined. Defendants United States Department of Treasury, U.S. Department of Labor, U.S. Department of Health and Human Services, Alex M. Azar II, in his official capacity as Secretary of Health and Human Services, R. Alexander Acosta, in his official capacity as Secretary of Labor, Steven Mnuchin, in his official capacity as Secretary of

the Treasury, the United States of America, and their agents, are enjoined from implementing and enforcing the aforementioned rule, and the legal effectiveness of the rule is suspended.

Dated: _____

_____
Hon. Richard J. Leon
United States District Judge