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 (RJL)

DEFENDANTS' OPPOSITION TO PLAINTIFFS' MOTION FOR SUMMARY JUDGMENT

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INTRODUCTION

Plaintiffs concede in their Motion for Summary Judgment, ECF No. 39-1, that Congress enacted the Health Insurance Portability and Accountability Act ("HIPAA") and the Patient Protection and Affordable Care Act ("ACA") to *increase* access to health insurance coverage. Pls.' Mot. at 4, 17, 19, 30. Yet they contend that, in the face of skyrocketing premiums and dwindling choices that have made it more difficult for millions of Americans to purchase ACA-compliant insurance, and despite Congress's recognition of that reality by zeroing out the tax penalty for those who do not maintain minimum essential health coverage, the Departments of Labor, the Treasury, and Health and Human Services (the "Departments") must *further restrict* coverage options by severely limiting short-term limited duration insurance plans ("STLDI"). In Plaintiffs' view, the ACA limits STLDI coverage to less than three months even though that limitation was not in place when the ACA was passed and even if that limitation means that consumers who cannot afford or are unable to obtain ACA-compliant insurance must go without insurance altogether. Plaintiffs are wrong, and the Court should reject their claims.

First, Plaintiffs do not even attempt to meet their burden to establish standing. Instead, they address this jurisdictional prerequisite in a single footnote and argue, without any evidentiary support, that their insurer members who sell ACA-compliant plans will suffer competitive harm as a result of the STLDI Rule. Accordingly, Plaintiffs have abandoned their claims of standing on behalf of health care providers and consumers. As for their theory of insurer standing, Plaintiffs have not demonstrated that any specific insurer has actually experienced an increase in competition in the relevant market as a result of the STLDI Rule, or that in the absence of the STLDI Rule, consumers that otherwise would have purchased STLDI plans would consider their insurer members' ACA-compliant products as a reasonable and viable alternative. Indeed, Plaintiffs simply assume that any hypothetical increase in competition in any specific market is redressable by the invalidation of the STLDI rule. But that assumption is invalid because any alleged harm hinges on the independent decisions of numerous third parties who are not before this Court,

including state legislators and regulators who have already taken actions that will affect the impact of the STLDI Rule in their unique markets, as well as consumers and insurers.

Plaintiffs' claims also fail on the merits. The Departments clearly had the authority to issue the STLDI Rule, and the Rule is not contrary to HIPAA or the ACA, because Congress itself chose to exempt STLDI from the individual market reforms under HIPAA. And when enacting the ACA, Congress chose to retain that exemption, which had long been interpreted by the Departments to apply to plans with a term of less than 12 months, just as the challenged STLDI Rule does. Thus, even as Congress intended the ACA to create single risk pools for certain plans and to implement various reforms, it also recognized the functions STLDI serves and intended STLDI to continue to serve those functions. Plaintiffs seek to overcome this evidence of congressional intent by speculating that the Rule will have an "extraordinary" effect on the market structure created by the ACA. In fact, the Departments have determined that the Rule will have only a modest impact on ACA-regulated markets because, among other things, a significant majority (87 percent in 2018) of Exchange enrollees receive subsidies that generally insulate them from premium increases and disincentivize them to leave the ACA Exchanges. As to the remaining 13 percent of Exchange enrollees, some will choose not to leave the Exchanges for any number of reasons, including to take advantage of consumer protections that apply to qualified health plans sold on an Exchange. Unsurprisingly then, ACA Exchange enrollment has remained relatively stable in 2019.

Nor is the Rule arbitrary and capricious. The Departments fully explained their decision to restore their longstanding approach to STLDI after their short-lived experiment—restricting STLDI coverage to less than three months under the 2016 Rule—failed to stem declining enrollment and spiking premiums in the ACA markets. And contrary to Plaintiffs' contention that the STLDI Rule will cause coverage gaps, the STLDI Rule will in fact *prevent* such gaps by allowing individuals to purchase STLDI policies that reasonably can be expected to cover the range of circumstances in which they may need temporary coverage.

STATUTORY AND REGULATORY BACKGROUND

A comprehensive discussion of the statutory and regulatory background is set forth in the Departments' Memorandum of Law in Support of Motion for Summary Judgement, ECF No. 40-1 ("Defs.' Mot."), at 4-10.[1] The Departments add here that, in response to the STLDI Proposed Rule, they received supportive comments not only from the NAIC and many states, but also from numerous consumers and other interested parties, who noted that many consumers had already left the ACA-regulated insurance markets or were unable to afford ACA-compliant insurance because of high premiums. *See, e.g.*, A.R.181538; A.R.181546; A.R.181552; A.R.181563; A.R.181612; A.R.181614; A.R.181631; A.R.181650-51; A.R.181652; A.R.181666; A.R.181669; A.R.181682-83; A.R.181693; A.R.181712; A.R.181743; A.R.181745; A.R.181780; A.R.181790; A.R.181804; A.R.181806; A.R.182196; A.R.182197; A.R.182202-03; A.R.182209; A.R.182213; A.R.182215; A.R.182216; A.R.182217; A.R.182227; A.R.182417; A.R.183706; A.R.193642-43; A.R.197269-73 (comments of individual consumers, elected representatives, and insurance brokers); *see also, e.g.*, A.R.183018-20; A.R.194929-31; A.R.195224-26; A.R.196272-76; A.R.196341-51; A.R.197598-197614 (comments of groups and entities).

The Departments also note that, in finalizing the STLDI Rule, they considered at length the concern voiced by some commenters that the proposed STLDI Rule "would weaken the single risk pools and destabilize the individual market by syphoning young, healthy individuals to the short-term, limited-duration insurance market, leaving only those with higher expected health costs and those receiving subsidies in the individual market." STLDI Rule, 83 Fed. Reg. 38,212, 38,235 (Aug. 3, 2018). The Departments observed that other commenters disputed this view, "express[ing] confidence that the rule would *not* adversely impact the single risk pools" because the STLDI "market has been in existence for over three decades" and is a "niche within the broader

[1] To avoid redundancy, the Departments incorporate by reference that memorandum of law and focus here on points that are not already addressed in that memorandum or are worthy of emphasis or additional explanation. Terms defined in that memorandum have the same meaning in this opposition brief.

private health insurance market." *Id. (*emphasis added). The Departments also explained that, while the STLDI Rule could lead some younger, healthier individuals to purchase STLDI policies rather than ACA-regulated plans, the number of those enrollees was expected to be limited by the market-stabilizing effect of the subsidies, which would provide incentives for "healthy lower-income individuals [to] remain in individual market plans[,] . . . limiting the extent of adverse selection." *Id.* at 38,235-36. The Departments' economic analysis therefore projected that Exchange enrollment would decline by only approximately 200,000 enrollees (or approximately 2 percent) nationwide in 2019 and by approximately 600,000 enrollees (or approximately 5 percent) nationwide by 2028. *Id.* at 38,236. When the effects on off-Exchange enrollment were also considered, the aggregate projected impact was slightly larger (roughly 500,000 enrollees in 2019 and 1.3 million by 2028, constituting declines of roughly 3 percent and 9 percent respectively), but even this combined impact was not expected to be disturb the stability of the individual market. *Id.* at 28,236-39 (assessing various economic analyses and concluding that "the studies, in sum[,] suggest that the rule . . . will likely only result in a small average increase to premiums in the individual and group markets").

These projected effects of the STLDI Rule are modest. By way of comparison, the Congressional Budget Office ("CBO") estimated that repealing the individual mandate would cause *5 million* enrollees to drop ACA-compliant nongroup market coverage in the next three years—an impact that is almost four times the Departments' projected impact of the STLDI Rule over the next decade yet still was not expected to impact the overall stability of the nongroup market.[2] *See* CBO, Repealing the Individual Health Insurance Mandate: An Updated Estimate, at 3 Table 2, (Nov. 2017) ("CBO 2017 Report") A.R.122598 (projecting a loss of 5 million enrollees in nongroup coverage by 2021 if the individual mandate were repealed or the tax penalty reduced

[2] Congress ultimately chose not to repeal the individual mandate but instead reduced to $0 the tax penalty for failing to comply with that mandate. *See* Defs.' Mot. at 5. CBO projected that the impact of such a reduction would be similar to repealing the mandate altogether. CBO 2017 Report, at 1, A.R.122596.

to $0); *id.* at 1 (projecting that "[n]ongroup insurance markets would continue to be stable in almost all areas of the country throughout the coming decade" if the individual mandate were repealed or the tax penalty reduced to $0); *see also* Pls.' Mot. at 9 n.22 (citing same). In a later report analyzing the combined effects of Congress's decision to reduce the individual mandate tax penalty to $0, the STLDI Rule, and many other factors potentially affecting the insurance markets, CBO again explained that it expected the nongroup markets to remain stable over the next decade because "subsidies—combined with the rules requiring insurers to offer coverage for preexisting medical conditions, the relative ease of comparison shopping in the marketplaces, and the effects of other requirements—are anticipated to produce sufficient demand for nongroup insurance, including among people with low health care expenditures[.]" CBO, *Federal Subsidies for Health Insurance Coverage for People Under Age 65: 2018 to 2028*, (May 23, 2018) ("CBO 2018 Report"), at 6; A.R.122610.

These projections of market stability have thus far been borne out. As the Departments have noted, enrollment in the nongroup insurance markets in states for which 2019 data is available declined by less than 400,000 nationwide, a figure that reflects a wide range of factors beyond the STLDI Rule, including any impact of Congress's decision in the Tax Cuts and Jobs Act ("TCJA") to reduce the individual mandate tax penalty to $0, the nationwide decrease in unemployment, current and expected Medicaid expansion in some states, the behaviors of insurers, state legislators, and state regulators in specific markets, and the increased availability of Association Health Plans, among others. Defs.' Mot. at 18-20.

ARGUMENT

I. Plaintiffs Have Not Established Standing Under the Competitive Standing Doctrine or Any Other Theory.

Plaintiffs bear the burden of demonstrating the "irreducible constitutional minimum" of standing—a concrete and certainly-impending injury-in-fact, traceability, and redressability—for each of their claims. *See* Defs' Mot. at 11-12. To meet that burden at the summary judgment

phase, they "must support each element of [their] claim to standing by affidavit or other evidence[.]" *Sierra Club v. EPA*, 292 F.3d 895, 899 (D.C. Cir. 2002) (citations omitted).

Plaintiffs fail to do so. They have made only one passing reference in a footnote to their insurer members' alleged competitive injury, effectively conceding that their consumer and provider members lack standing. Pls.' Mot. at 17 n.51 (stating that, in a multi-plaintiff case, it is enough that only one plaintiff has standing). But even as to their insurer members, Plaintiffs have made no attempt to present any evidence that any of them is "losing and will continue to lose subscribers to STLDI plans authorized by the Rule." *Id.* That failure is itself reason to deny their motion because a plaintiff must produce evidence of standing "*at the first appropriate point* in the review proceeding"—here, their motion for summary judgment—so that the defendant is not "left to flail at the unknown in an attempt to prove the negative." *Sierra Club,* 292 F.3d at 900-01 (emphasis added).

Even if the Court were to consider affidavits submitted with Plaintiffs' now-withdrawn motion for a preliminary injunction—affidavits upon which Plaintiffs appear no longer to rely—those affidavits do not satisfy Article III's stringent standards. They simply contain now-outdated speculation that a certain insurer-member, Texas-based Community Health Choice, Inc. ("CHC") could lose "as many as" 10,000 enrollees to STLDI plans without any explanation of how that projection was reached or even any reference to specific STLDI plans being sold in the same geographical regions in which CHC operates. PI Janda Decl. ¶ 11, ECF No. 10-6. The affidavits also provide no evidence that CHC or any other insurer member *actually did* lose enrollees now that the STLDI Rule has been in effect for more than six months and insurers have been allowed to begin selling STLDI products as permitted by the Rule and any applicable state-level regulation. Nor do the affidavits provide any evidence that such a loss, if it occurred, is traceable to competition from STLDI products as opposed to myriad other factors affecting insurance markets at the national, state, and local levels, including but not limited to the TCJA's reduction of the individual mandate penalty to $0. Indeed, the TCJA eliminates a significant disincentive for individuals to go without ACA-compliant coverage and may be a particularly relevant factor for

people who do not receive subsidies and must absorb high premium costs. *See* Defs.' Mot. at 17-20; *see also, e.g.*, A.R.181693 (commenter who "left the insurance market altogether" after seeing ACA-market premiums increase to over $2200 per month); A.R.181804 (commenter who "dropped ACA plan i[n] 2015" due to skyrocketing premiums); A.R.181806 ("As a licensed insurance agent I can tell you, this would not adversely affect the ACA at all, since those individuals wouldn't purchase an ACA [plan] due to high costs anyway!"); A.R.186199 (commenter who dropped ACA-compliant coverage because "[p]aying over $1400.00 a month was unacceptable to me").

To the extent Plaintiffs seek to rely on the economic estimates discussed in the STLDI Rule, *see* Pls.' Mot. at 13 n.35, the estimates similarly are insufficient to satisfy Plaintiffs' burden. As the Departments have shown, those broad-brush estimates of the nationwide effects of the STLDI Rule do not suggest that the Rule will have any impact on a particular insurer (much less the member insurers of the Plaintiffs in this action), nor do such projections satisfy Article III's rigorous requirement that a plaintiff show a harm that has either already occurred or is "certainly impending." *Clapper v. Amnesty Int'l USA*, 568 U.S. 398, 409 (2013); Defs.' Mot. at 20-22. That is especially true given the wide variation among states in their regulatory approaches to STLDI, *see* Defs.' Mot. at 17-18, as well as demographic differences across states and regions that necessarily will affect STLDI offerings and uptake of those offerings in different geographical markets. For example, in the state of Texas, where CHC is located, state law prohibits extensions or renewals of an STLDI plan beyond one year, even though the STLDI Rule permits renewals up to 36 months. *See* 28 Tex. Admin. Code § 3.3002(18). This, of course, also means that Plaintiffs have not shown that any insurer member will be impacted by the renewal provision of the STLDI Rule.

Although Plaintiffs insist that they have standing as a matter of law, noting in a conclusory fashion that their insurer members "may proceed under the doctrine of competitor standing," Pls.' Mot. at 17 n.51, that too is insufficient to meet Plaintiffs' burden to establish standing. *Cf. CTS Corp. v. EPA*, 759 F.3d 52, 64 (D.C. Cir. 2014) ("A footnote is no place to make a substantive legal

argument[.]"); *Hutchins v. District of Columbia,* 188 F.3d 531, 539-540 n.3 (D.C. Cir. 1999) (a court "need not consider cursory arguments made only in a footnote"). As Defendants have fully demonstrated in their motion for summary judgment, Plaintiffs' insurer members do not have competitor standing in this case. To invoke that doctrine, Plaintiffs must demonstrate that the government lifted a "regulatory restriction on a '*direct and current competitor*'" or took regulatory action that predictably "enlarges the pool of competitors . . . *in the same market*" as one of their insurer members. *Arpaio v. Obama*, 797 F.3d 11, 23 (D.C. Cir. 2015) (emphasis added, citation omitted); *accord New World Radio, Inc. v. FCC*, 294 F.3d 164, 170 (D.C. Cir. 2002). STLDI plans and ACA-compliant plans are not "direct and current competitors" given the many differences between the two product-types, including that STLDI policies are not guaranteed renewable or available, generally do not offer comprehensive benefits or protections for pre-existing conditions, are time-limited, and cannot be purchased with ACA subsidies. *See* Defs.' Mot. at 22.

Because STLDI plans cater to a different market of consumers than do ACA-regulated plans—and because Plaintiffs provide no evidence to support their theory of standing—it is purely speculative whether, in the absence of the STLDI Rule, STLDI consumers would shop for coverage in the ACA-regulated markets, as opposed to dropping insurance altogether, continuing to purchase STLDI in 3-month increments, or making other arrangements altogether. *Id.*; *see also, e.g.*, A.R.181693 (commenter who "left the insurance market altogether [before the STLDI Rule took effect] and [joined] a health sharing ministry" after seeing ACA-market premiums increase to over $2200 per month); A.R.186199 (commenter who dropped coverage in 2018 and joined a health care sharing ministry because "[p]aying over $1400.00 a month was unacceptable to me . . . . Many of my friends have done the same thing[.]"); A.R.196313 ("26,000 Iowans left the Marketplace in 2018" due to high costs). Plaintiffs therefore fail to demonstrate that the STLDI Rule—as opposed to some other factor, such as unaffordable premiums—is the substantial source of any loss of enrollment by any insurer member (which is itself a speculative proposition) or that the Court can redress that harm through a decision in Plaintiffs' favor.

Plaintiffs' cited cases are inapposite. In each, the plaintiffs presented actual evidence of

direct and current competition impacted by the agency's decision. In *Sherley v. Sebelius*, 610 F.3d 69, 74 (D.C. Cir. 2010), the D.C. Circuit found competitor standing based upon evidence that the plaintiff researchers were competing directly against new grant applicants for the same specific grants, which the court emphasized "intensified the competition for a share in a *fixed* amount of [grant] money." (emphasis added). And, in *Washington Alliance of Technology Workers v. DHS*, 892 F.3d 332, 341 (D.C. Cir. 2018), the D.C. Circuit found competitor standing only after emphasizing that the plaintiff job applicants competed against student visa holders for the very *same* positions in the *same* sector of the labor market, including for specific job opportunities at Microsoft. In contrast, Plaintiffs do not show that their insurer members compete with any STLDI issuers for the same "fixed" share of consumers, much less for the same consumers.

II. Plaintiffs' Claims Fail on their Merits.[3]

A. The STLDI Rule Is Comfortably Within the Departments' Authority.

Plaintiffs' claims also fail on the merits. Plaintiffs first contend that the Departments lacked authority to promulgate the STLDI Rule because the Rule "unilaterally restructure[s] the nationwide individual insurance market" and conflicts with policy judgments embodied in the ACA. Pls.' Mot. at 19, 23. They are wrong. An alleged conflict with policy judgments does not equate to the absence of authority to resolve ambiguity in a statute, and in any event, there is no such conflict. It was Congress—not the Departments—that exempted STLDI plans from the federal insurance market reforms. Congress did so under HIPAA in 1996 by defining the phrase

[3] Plaintiffs cite numerous newspaper articles, a Twitter post, and other extra-record materials throughout their Statement of Facts section, many of which post-date the promulgation of the STLDI Rule. *See* Pls.' Mot. at 12 and notes 29, 33, 39, 40, 43, 44, 45, 46, 47, 50. The Court should not consider such materials in connection with its review on the merits, as judicial review under the APA is based solely on the administrative record. Defs.' Mot. at 10-11*; see also, e.g.*, *Camp v. Pitts*, 411 U.S. 138, 143 (1973) (where there is a "contemporaneous explanation" for an agency decision, the validity of that decision "must . . . stand or fall on the propriety of that" explanation); *In re Subpoena Duces Tecum Served on the Office of the Comptroller of the Currency*, 156 F.3d 1279, 1279-80 (D.C. Cir. 1998) ("the reasonableness of the agency's action is judged in accordance with its stated reasons.").

"individual health insurance coverage" in section 2791 of the PHS Act to exclude STLDI, while delegating to the Departments the authority to define the meaning of that phrase. *See* Defs.' Mot. at 27-28; 42 U.S.C. §§ 300gg-91(d)(5), 300gg-92. And Congress made the same judgment in 2010 when, after the Departments had long defined STLDI as a policy of less than twelve months, Congress retained the STLDI exemption in the ACA without disturbing the Departments' longstanding regulatory approach. *See generally* ACA, title I (overhauling Part A of title XXVII of the PHS Act, 42 U.S.C. § 300gg *et seq.*, without modifying definition of "individual health insurance coverage" or STLDI). As a matter of law, these circumstances provide persuasive evidence that Congress did not intend to require the Departments to change their longstanding definition of STLDI. *See* Defs.' Mot. at 27-28; *see also, e.g.*, *Commodity Futures Trading Comm'n v. Schor*, 478 U.S. 833, 846 (1986) ("[W]hen Congress revisits a statute giving rise to a longstanding administrative interpretation without pertinent change, the congressional failure to revise or repeal the agency's interpretation is *persuasive evidence* that the interpretation is the one intended by Congress." (emphasis added, citation omitted)); *Altman v. SEC*, 666 F.3d 1322, 1326 (D.C. Cir. 2011) (same); *Wash. All. of Tech. Workers v. DHS*, 156 F. Supp. 3d 123, 141 (D.D.C. 2015) (under the "legislative reenactment doctrine," Congress "'is presumed to be aware of an administrative or judicial interpretation of a statute and to adopt that interpretation when it reenacts [statutory language] without change'" (citation omitted)), *vacated on other grounds*, 650 F. App'x 13 (D.C. Cir. 2016).

Plaintiffs seek to avoid this legal presumption. First, they assert that "the government's argument would itself require partial invalidation of the STLDI Rule because the pre-ACA STLDI definition did not permit ***any*** renewal of STLDI plans." Pls.' Mot. at 33 (emphasis in original). This is incorrect. The 1997 and 2004 Rules permitted unlimited renewal or extension of an STLDI plan so long as the issuer consented to such extensions. *See* 1997 Rule, 62 Fed. Reg. 16,894, 16,928 (Apr. 8, 1997) (defining STLDI as a policy of less than twelve months "taking into account

any extensions that may be elected by the policyholder *without the issuer's consent*" (emphasis added)); 2004 Rule, 69 Fed. Reg. 78,720 (Dec. 30, 2004) (same).[4]

Plaintiffs also are wrong to contend that the Defendants may not rely on this persuasive evidence of congressional intent because "the Departments did not invoke this . . . canon [of legislative reenactment] in their rulemaking" and therefore "may not shore up their work now by presenting it for the first time in briefing." Pls.' Mot. at 34. The rule of *SEC v. Chenery Corp.*, 318 U.S. 80, 87 (1943), which limits a court's review of an agency's decisionmaking to the rationale relied upon during the rulemaking proceeding, extends only to "*factual* determination[s] or . . . *policy judgment[s]* that [the agency] alone is authorized to make." *Shea v. Dir., Office of Workers' Comp. Programs*, 929 F.2d 736, 739 n.4 (D.C. Cir. 1991) (emphasis added); *see also Canonsburg Gen. Hosp. v. Burwell*, 807 F.3d 295, 304-05 (D.C. Cir. 2015). Here, the Departments do not point to the legislative reenactment doctrine as a policy justification for the Rule; rather, the doctrine is identified in this case merely as one of many reasons why Plaintiffs' legal argument about the Departments' authority is incorrect as a matter of law. Because that legal issue does not raise any "issue of fact, policy, or agency expertise," the "court can (and should) affirm [the Departments' decision] on [that] legal ground[.]" *Canonsburg Gen. Hosp.*, 807 F.3d at 305.

Plaintiffs next contend that Defendants' argument "is flawed on its own terms" because "'overwhelming evidence of acquiescence'" or "ratification" is necessary to "replace the plain text and original understanding of a statute with an amended agency interpretation." Pls.' Mot. at 34-36. But the premise of this argument is flawed because the Departments have not replaced the "plain text" or "original understanding" of the phrase "short-term limited duration insurance" under HIPAA. Again, HIPAA did not define the term. Rather, HIPAA left the definition to the Departments to supply, which they did by defining STLDI as policies that expire less than 12

[4] Of course, even if the Departments' 1997 and 2004 Rules had not permitted renewal, that fact would not "require partial invalidation of the STLDI Rule," as Plaintiffs suggest; it would simply mean that the *presumption* of validity under the legislative reenactment doctrine does not apply as to that aspect of the STLDI Rule.

months after their original effective date, subject to renewals or extensions with an issuer's consent. *Compare Solid Waste Agency of N. Cook Cty. v. U.S. Army Corps of Engineers*, 531 U.S. 159, 167 (2001) (rejecting extension of statutory phrase "navigable waters" to include an "abandoned gravel pit"). If anything, the understanding of STLDI at the time of the ACA's enactment was that it had a term of less-than-twelve months and could be renewed so long as the issuer agreed. Nor do the Departments contend that Congress's retention of the STLDI exemption in the ACA *requires* their present approach; it is simply persuasive evidence that the Departments' current approach is consistent with congressional intent. Therefore, Plaintiffs' reliance on *General Am. Transportation Corp. v. ICC*, 872 F.2d 1048 (D.C. Cir. 1989) is inapposite. *See id.* at 1053 (holding only that, even though *agency's prior interpretation was reasonable*, court could not conclude that Congress "'statutorily *mandated*'" that approach simply by amending other portions of the Act without amending provision at issue (citation omitted)).

Plaintiffs also assert that, "because Congress did not amend the specific statutory language at issue here, there is no basis for inferring that Congress had the [1997 and 2004] agency interpretation in mind when it enacted the ACA" in 2010. Pls.' Mot. at 35. Plaintiffs are wrong. First, for the legislative reenactment doctrine to apply, Congress need not have amended the specific *subsection* of section 2791 of the PHS Act in which the phrases "individual health insurance coverage" and STLDI appear. The point of the doctrine is that Congress's *failure* to amend specific statutory language, while revising or revisiting surrounding provisions, is evidence that Congress was familiar with and approved of an existing interpretation of the unamended provision. *See, e.g.*, *Young v. Cmty. Nutrition Inst.*, 476 U.S. 974, 983 (1986) (Congress's failure, despite adding a new statutory provision adjacent to the one at issue, "to change the scheme under which the [agency] operated is significant, for a 'congressional failure to revise or repeal the agency's interpretation is *persuasive evidence* that the interpretation is the one intended by Congress.'" (citations omitted, emphasis added); *Sebelius v. Auburn Reg'l Med. Ctr.*, 568 U.S. 145, 159 (2013) (Congress's amendment of same general statutory provision without amending specific

subsection at issue was again "persuasive evidence" that Congress approved of agency's approach).

Here, although Congress did not change the definition of "individual health insurance coverage" in section 2791 of the PHS Act, it did amend section 2791 when enacting the ACA, as well as both before and after the ACA, while the Departments' longstanding less-than-one-year framework for STLDI was in effect. *See, e.g.*, ACA § 1562 (amending and adding various definitional provisions under section 2791(d)(20)-(21) of the PHS Act), *codified at* 42 U.S.C. § 300gg-91(d)(20)-(21), (e). Specifically, Congress made clear in the ACA that, "[u]nless *specifically provided for otherwise*, the definitions contained in section 2791 of the Public Health Service Act (42 U.S.C. 300gg–91) shall apply with respect to [] title [I]" of the ACA, which established the insurance market reforms at issue in this lawsuit. ACA § 1551, *codified at* 42 U.S.C. § 18111 (emphasis added). The ACA also further cross-referenced definitions under section 2791 of the PHS Act. *See* ACA § 1301(b)(2)-(3). Moreover, Congress amended section 2791 on two other occasions—once in 2008 and again in 2015—each time leaving untouched the Departments' approach to STLDI. *See* Pub. L. 110-233, Title I, § 102(a)(4), 122 Stat. 881 (May 21, 2008); Pub. L. No. 114-60, § 2(b), 129 Stat. 543 (Oct. 7, 2015). These legislative actions leave no doubt that Congress was familiar with and intended to retain the exclusion for STLDI from the definition of "individual health insurance coverage" and to extend that exclusion, as then defined by the Departments, to the ACA's insurance market reforms.

Plaintiffs also invoke *Public Citizen, Inc. v. U.S. Dep't of Health & Human Servs.*, 332 F.3d 654, 668-69 (D.C. Cir. 2003), in which the D.C. Circuit found the legislative reenactment doctrine inapplicable because Congress made only "isolated amendments" to the statutory scheme, "no formal regulation addressed the [agency's interpretation]," and for "much of the relevant period . . . the agency took the *opposite* view from that which it maintains on this appeal." *Id*. at 668-69. *Public Citizen* actually confirms the applicability of the legislative reenactment doctrine here: the ACA was not an "isolated amendment" to the PHS Act but a comprehensive overhaul of federal health insurance regulation. *Compare id.* at 668; *compare also Alexander v. Sandoval*, 532 U.S.

275, 292 (2001) (legislative reenactment doctrine inapplicable "*when . . . Congress ha[d] not comprehensively revised a statutory scheme*" (emphasis added)). And unlike in *Public Citizen*, the Departments had promulgated formal regulations adopting their approach to STLDI more than a decade before Congress enacted the ACA. Accordingly, Congress's decision not to disturb the Departments' regulatory definition is compelling evidence that Congress approved of that approach. *See, e.g.*, *Creekstone Farms Premium Beef, LLC v. Dep't of Agric.*, 539 F.3d 492, 500 (D.C. Cir. 2008) ("Because section 102.5(d) was already in effect when the Congress amended VSTA in 1985, it had the opportunity to alter the regulation but did not do so. . . . the Congress's 1985 decision to leave section 102.5(d) undisturbed is 'persuasive evidence' that it is consistent with congressional intent."); *Doris Day Animal League v. Veneman*, 315 F.3d 297, 300 (D.C. Cir. 2003) (applying legislative reenactment doctrine in similar circumstances because it "fits this case perfectly"). While this doctrine may not have obligated the Departments to maintain their existing interpretation, it certainly *permits* them to do so as a reasonable exercise of their discretion to define an undefined term.

Plaintiffs also fault the Departments for "cit[ing] no evidence from the legislative debates surrounding the ACA . . . indicating that Congress was even aware of the definition of a 'short-term limited duration' plan that the Departments had applied" under HIPAA. Pls.' Mot. at 34-35. But Congress "can be *presumed* to have had knowledge of the interpretation given to [STLDI], at least insofar as it affect[ed]" the ACA. *Gordon v. U.S. Capitol Police*, 778 F.3d 158, 165 (D.C. Cir. 2015) (emphasis added). It is Plaintiffs who must produce evidence of a contrary legislative intent, which they fail to do. In any event, the absence of legislative history here is unsurprising because as the Supreme Court has recognized, "Congress wrote key parts of the [ACA] behind closed doors, rather than through 'the traditional legislative process[.]' . . . [a]nd Congress passed much of the Act using a complicated budgetary procedure known as 'reconciliation,' which limited opportunities for debate and amendment[.]" *King v. Burwell*, 135 S. Ct. 2480, 2492 (2015) (citation omitted).

Finally, citing *King v. Burwell*, Plaintiffs characterize the STLDI Rule as a decision "of vast 'economic and political significance,'" Pls.' Mot. at 22-23, in an attempt to avoid the *Chevron* framework generally and Congress's specific delegation to the Departments to define ambiguous terms. *See* 42 U.S.C. § 300gg-92 (delegating to the Departments authority to "promulgate such regulations as may be necessary or appropriate to carry out" the market reforms of HIPAA and the ACA). Plaintiffs' attempt is unavailing. Defining an ambiguous and statutorily undefined phrase like "short-term limited duration insurance" is precisely the type of undertaking that Congress routinely delegates to administrative agencies. Congress is therefore presumed to have understood that the ambiguity in the phrase "short-term limited duration" would "be resolved, first and foremost, by the agency, and desired the agency (rather than the courts) to possess whatever degree of discretion the ambiguity allows.'" *City of Arlington v. FCC*, 569 U.S. 290, 296 (2013).

The cases on which Plaintiffs rely do not suggest otherwise; indeed, they involved agency decisions of an entirely different order of magnitude than the STLDI Rule at issue here. Unlike the "extraordinary" interpretative issue in *King*, which would have negated two of the ACA's "three major reforms" in the majority of states, "destabilize[d] the individual insurance market," and "create[d] the very 'death spirals' that Congress designed the Act to avoid," 135 S. Ct. at 2493, the STLDI Rule is projected to affect only roughly 5 percent of Exchange enrollment over the next decade. *See supra* at 4. Multiple governmental projections have concluded that the STLDI Rule will not disrupt the stability of the Exchanges or the nongroup market, *id.* at 4-5, and Exchange enrollment has, *in fact*, remained relatively stable in 2019, *id* at 5. These facts refute Plaintiffs' speculation that the STLDI Rule will "destroy" the ACA-compliant markets. Likewise, given that the STLDI Rule has simply *loosened* federal regulatory restrictions in a manner consistent with the Departments' approach for nearly two decades, Plaintiffs' other cited cases are inapposite. *Compare Utility Air Regulatory Group v. EPA*, 573 U.S. 302, 324 (2014) (hesitating to apply *Chevron* where EPA's interpretation "would bring about an *enormous and transformative expansion* in [its] regulatory authority" (emphasis added)); *FDA v. Brown & Williamson Tobacco Corp.*, 529 U.S. 120, 159 (2000) (same where FDA claimed new authority to regulate the tobacco

industry, contrary to its longstanding position and Congress's decision to regulate the industry directly). And where, as here, the Departments' "general rulemaking authority is clear," courts do not subject "*every* agency rule . . . to a *de novo* judicial determination of whether *the particular issue* was committed to agency discretion" because such "ad hoc judgment[s] regarding congressional intent . . . would render the binding effect of agency rules unpredictable" and result in "chaos." *City of Arlington*, 569 U.S. at 306-07. The framework of *Chevron* therefore applies.[5]

B. The STLDI Rule Is Not Contrary to Law Under *Chevron* Step One.

1. The STLDI Rule is Consistent With the Statutory Text.

Under the first step of the *Chevron* framework, the Court must determine whether Congress has spoken "*directly* . . . to the *precise* question at issue." *Chevron U.S.A. Inc. v. Nat. Res. Def. Council, Inc.*, 467 U.S. 837, 842-43 (1984) (emphasis added). In answering that question, the Court should "begin with the text of the statute[.]" *Nat'l Petrochemical & Refiners Ass'n v. EPA*, 630 F.3d 145, 152 (D.C. Cir. 2010) (citations omitted).

The text of HIPAA makes plain that Congress has not "directly" spoken to the maximum term or duration of STLDI. It provides only that "[t]he term 'individual health insurance coverage' means health insurance coverage offered to individuals in the individual market, but does not include short-term limited duration insurance." Pub. L. No. 104-191 § 102(a), *codified at* 42 U.S.C.A. § 300gg-91(b)(5). Congress's decision not to set a specific time period for STLDI is significant because Congress knows how to specify maximum periods of time when it desires to do so. In surrounding provisions of HIPAA, Congress provided, for example, that group plans could exclude coverage for a pre-existing condition if care for the condition was provided within a "*6–month period* ending on the enrollment date" and the exclusion "extend[ed] for a period of *not more than 12 months* (or *18 months* in the case of a late enrollee)" as adjusted by other factors.

[5] As part of their argument that the Departments lacked authority to issue the STLDI Rule, Plaintiffs also contend that "the statutory scheme created by the ACA unambiguously precludes" the Rule, Pls.' Mot. at 20-22, and that the Rule is unreasonable because it "frustrate[s] the policy that Congress sought to implement," *id.* at 24. Because these arguments are, in essence, arguments under *Chevron* step 1 and 2, Defendants address them in that context below.

HIPAA, Pub. L. No. 104-191, § 102(a) (emphasis added). In the ACA, Congress enacted similarly specific provisions, such as those governing persons who "ha[ve] not been covered under creditable coverage . . . during [a specific] *6–month period,*" Pub. L. No. 111-148 § 1101(d)(2), and "waiting period[s] . . . that exceed[] *90 days*." *Id.* § 1201 (emphasis added); *see also, e.g., id.* § 1412(c)(2)(B) (setting "a *3–month* grace period for nonpayment of premiums") (emphasis added). Yet rather than using similarly specific temporal language to define STLDI, Congress left it to the Departments to define the term. *See, e.g.*, *ViroPharma, Inc. v. Hamburg*, 898 F. Supp. 2d 1, 18 (D.D.C. 2012) (finding statutory phrase ambiguous where it was not defined and "nothing about 'the specific context in which [the phrase] is used' or 'the broader context of the statute as a whole' is likely to compel the conclusion that the phrase has a definite meaning" (citation omitted)).

Plaintiffs contend that, notwithstanding Congress's failure to use specific temporal language to define STLDI, the word "short" in STLDI must be read as a period of less than three months because, in section 1501 of the ACA (codified at 26 U.S.C. § 5000A(e)), Congress referred to a "short coverage gap" as a "period of less than 3 months." Pls.' Mot. at 32. The Departments have explained why this position would lead to absurd results as a factual matter; namely, the purpose of STLDI is to bridge gaps in more comprehensive coverage, and such gaps are likely to extend 3 months or longer, especially considering that insurance markets generally have only annual open enrollment periods. *See* Defs.' Mot. at 36-37. Plaintiffs' reliance on section 1501 of the ACA is also wrong as a legal matter. The term "STLDI" was first used in *HIPAA,* more than a decade before Congress used the phrase "short coverage gap" in the ACA. It is implausible to suggest that Congress, in 1996, intended the word "short" in STLDI to have the same meaning as the word "short" in a phrase that was not adopted until 2010. *Cf. ViroPharma, Inc.*, 898 F. Supp. 2d at 18 (finding exact same statutory phrase to have different meaning in different portions of the statute based, in part, on different chronology).

Moreover, simply because both "short-term limited duration insurance" and "short coverage gap" contain the word "short" does not mean that the word has the same meaning in both

phrases. The D.C. Circuit has instructed that "a statute's terms 'should be read in context, the statute's place in the overall statutory scheme should be considered, and the problem Congress sought to solve should be taken into account.'" *Id.* at 19 (citing *PDK Labs. Inc. v. DEA*, 362 F.3d 786, 796 (D.C. Cir. 2004)); *cf. Abbott Labs. v. Young*, 920 F.2d 984, 987 (D.C. Cir. 1990) ("it is not impermissible under *Chevron* for an agency to interpret an imprecise term differently in two separate sections of a statute which have different purposes"). Here, the term "short" modifies different words ("insurance" versus a "coverage gap"). The different provisions addressing STLDI and "short coverage gaps" appear in different statutes (HIPAA versus the ACA) and are codified in different titles of the United States Code (title 42 versus title 26). Unsurprisingly, they also have very different purposes. A "short coverage gap" defines one of many circumstances in which an individual was exempted from the individual mandate tax penalty prior to the TCJA's reduction of that penalty to $0; STLDI describes a type of insurance that is excluded from the ACA's insurance market reforms and is intended to offer consumers a coverage option when other coverage is unavailable, unaffordable, or infeasible to obtain. Plaintiffs offer no reason to conclude that Congress required the word "short" to mean the same thing in STLDI as it does in "short coverage gap" given the very different purposes of these statutory provisions. This is particularly true given that Congress clearly recognized in section 1501 of the ACA (the provision in which the phrase "short coverage gap" is used) many circumstances in which a person's inability to obtain ACA-compliant coverage could extend beyond three months. *See* Defs.' Mot. at 36-37; 26 U.S.C. § 5000A(e).

Plaintiffs also suggest that even if Congress did not impose a *specific* cap on the length of STLDI, the phrases "short-term" and "limited duration" cannot be construed to cover plans that are one day shorter than standard insurance plans and are renewable for up to 36 months. Pls.' Mot. at 28-29, 36. But they do not explain why that is so, nor do they suggest how the Court is to evaluate what length *would* be permissible. Plaintiffs' arguments also ignore a fundamental distinction between a STLDI plan and a standard nongroup insurance plan: the latter is guaranteed renewable, and thus the coverage frequently will extend for many years at the option of the

enrollee. In other words, when compared to a standard policy—which is generally at least one year but may be renewed for many years—an initial STLDI policy term of less than one year is relatively "short," and a maximum duration of 36-months is relatively "limited." *See* Defs.' Mot. at 30-32 (rebutting Plaintiffs' plain text challenge to the STLDI Rule).

Plaintiffs also argue that the Departments' definition of "limited duration" to encompass renewals of up to 36 months "run[s] afoul of Congress's specification that 'short term, limited duration' insurance be 'short term'"; according to Plaintiffs, Congress would not have "limit[ed] the term of individual plans to a period relatively shorter than a year (say, three months), but allow these plans to be renewed repeatedly so that their effective duration is that of full-time, conventional (renewable) annual plans." Pls.' Mot. at 37. But the standard duration of coverage in a conventional plan is not limited to only 36 months, given the requirement under HIPAA and the ACA that such plans generally be guaranteed renewable in perpetuity. Moreover, Plaintiffs are conflating the terms "short-term" and "limited duration," contrary to the interpretive canon that "disfavors rendering one or more statutory words or phrases redundant." 83 Fed. Reg. at 38,220; *see also* Defs.' Mot. at 40-41. For these reasons and the many others set forth in Defendants' Motion, Plaintiffs' plain text arguments should be rejected.

2. The STLDI Rule Is Consistent with the Statutory Scheme Under Both HIPAA and the ACA.

Unable to show that Congress directly addressed the permissible term or duration of STLDI, or that the STLDI Rule is inconsistent with the plain statutory text, Plaintiffs seek to rely primarily on the ACA's purpose and structure to rebut the presumption that Congress approved of the Departments' long-standing approach by leaving it untouched in the ACA. *See* Pls.' Mot. at 20-21, 30-32, 37. Plaintiffs' invocation of statutory purpose and structure fails on its own terms. Although the Court may consider congressional purpose and the statutory structure in its *Chevron* step one analysis, "[r]eliance on context and structure in statutory interpretation is a 'subtle business, calling for great wariness lest what professes to be mere rendering . . . and attempted interpretation of legislation becomes legislation itself.'" *King*, 135 S. Ct. at 2495-96. Thus, the

structure and context are relevant only insofar as they unambiguously demonstrate that Congress "*directly* addressed" the "*precise* question" of how long STLDI can last. In this case, they do not so demonstrate.

First, although Plaintiffs focus at length on the ACA, the most relevant statutory context for discerning congressional intent regarding the meaning of STLDI is *HIPAA*—where the phrase appeared—not the ACA, where it did not. As the Departments have shown, nothing about HIPAA's statutory structure or purpose is inconsistent with permitting STLDI policies of less than one year. *See* Defs.' Mot. at 33-34. To the contrary, because Congress allowed STLDI coverage to count toward the periods of "creditable coverage" required to take advantage of HIPAA's guaranteed availability and preexisting condition protections, *see* 42 U.S.C. § 300gg-3(c)(1)(B); HIPAA §§ 701(a)(3), 2701(a)(3), 2741(a), (b)(1), a longer STLDI term clearly would help further HIPAA's purpose in providing those protections. *See* Defs.' Mot. at 34.[6]

Plaintiffs' arguments to the contrary make little sense. Plaintiffs argue that allowing up to 364 days of STLDI coverage would have frustrated HIPAA's protections for preexisting conditions, Pls.' Mot. at 31, but that is not so. HIPAA generally limited the period in which a new insurer could exclude coverage of preexisting conditions to 12 months "reduced by the aggregate of the periods of creditable coverage [without a significant break in that coverage] . . . as of the enrollment date." HIPAA § 2701(a)(2)-(3) & (c)(2)(A) (applicable to new group coverage); *id.* § 2741(a)(1)(B) (applicable to new individual market coverage for individuals that met "creditable coverage" requirement and other criteria). Because STLDI counted as "creditable coverage," a longer period of STLDI would have *helped* an individual maintain the continuous period of creditable coverage necessary to take advantage of HIPAA's pre-existing condition protections.

[6] Plaintiffs are incorrect that the creditable coverage requirement demanded "18 months of continuous health coverage under a group health plan[.]" Pls.' Mot. at 30. That requirement could be met with any form of "[h]ealth insurance coverage," including STLDI and multiple other forms of coverage. The group health plan had only to be the *latest* coverage in the period of at least 18 months of continuous creditable coverage for the consumer to be considered an "eligible individual" for purposes of the HIPAA individual market guaranteed availability protections. *See* HIPAA § 2741(b)(1)(A); 42 U.S.C. § 300gg-3(c)(1); Defs.' Mot. at 34.

Similarly, a longer period of STLDI would have reduced the period in which the individual's new insurer could exclude coverage for pre-existing conditions. In contrast, under Plaintiffs' "less-than-three month and not renewable" interpretation, an individual might *not* be able to take advantage of those protections if she purchased an STLDI policy and later developed a condition that rendered her unable to purchase another STLDI policy or individual market coverage. That person—through no fault of her own—might incur a significant break in creditable coverage that would cause her to be ineligible to benefit from HIPAA's preexisting condition protections. Plaintiffs provide no reason to conclude that Congress intended to subject individuals to that risk under HIPAA.

Nor do Plaintiffs offer any cogent explanation for their assertion that the "plain and historic" meaning of STLDI was as "relatively brief, gap-filling coverage for people between annual plans" that are subject to "HIPAA's access and portability guarantees[.]" Pls.' Mot. at 31. Plaintiffs appear to believe that HIPAA's guaranteed availability of individual market coverage would have extended to those who acquired a less-than-three month STLDI policy after losing other coverage but not to those who acquired a longer STLDI policy. In fact, HIPAA's guaranteed availability of individual market coverage was only available to individuals with 18 months of creditable coverage whose "most recent prior creditable coverage was under a group health plan, governmental plan, or church plan." HIPAA § 2741(b)(1)(A), *codified at* 42 U.S.C. § 300gg-41(b)(1)(A). Thus, that guarantee would not have applied to an individual whose most recent coverage was under an STLDI policy, regardless of whether that plan was less than 3 months, less than 12 months, or some other length. However, to the extent an individual *was* transitioning directly out of a group, governmental, or church plan, the length of any prior period of STLDI would have mattered, especially if the group, governmental or church coverage had lasted for less than 18 months. In that event, just as with HIPAA's preexisting condition protections, a longer permissible term of STLDI prior to such group, governmental, or church coverage would have helped the person obtain the requisite period of creditable coverage necessary to take advantage of HIPAA's guarantee of individual market coverage, whereas a more limited term would have put

that individual at risk of a break in creditable coverage that could have precluded her from utilizing those protections.

To the extent Plaintiffs mean simply to suggest that a person transitioning directly from group coverage into new group or individual market coverage might have chosen to use STLDI to bridge any waiting period before the new coverage took effect, that argument also fails to demonstrate any conflict between the STLDI Rule and HIPAA. The mere fact that a less-than-3 month STLDI policy may have been useful in certain circumstances under HIPAA does not mean that those were the only scenarios in which they were useful. *See also* Defs.' Mot. at 37. Nor does it mean that a longer period of STLDI would have frustrated HIPAA's objectives. Plaintiffs therefore have not shown any incongruity between STLDI plans of up to 364 days and the protections established under HIPAA, which is likely why the Departments' long-standing approach went unchallenged for the nearly two decades in which it was in effect.

Plaintiffs next argue that, "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." Pls.' Mot. at 32. Plaintiffs face an insurmountable burden to demonstrate that Congress intended to amend the original understanding of STLDI under HIPAA notwithstanding its decision to leave that framework untouched under the ACA. Courts "will not understand Congress to have amended an act by implication unless there is a '*positive repugnancy*' between the provisions of the preexisting and newly enacted statutes, as well as language manifesting Congress's '*considered determination*' of the ostensible change." *U.S. Ass'n of Reptile Keepers, Inc. v. Zinke*, 852 F.3d 1131, 1141 (D.C. Cir. 2017) (emphasis added, citations omitted). Plaintiffs' efforts to show the former fall short, and they do not even attempt to show the latter.

Plaintiffs' theory that the STLDI Rule is repugnant to the ACA largely boils down to their contention that "Congress determined that the way to [expand insurance coverage] is through the requirements of guaranteed issue and community rating, assuring that all health insurance consumers would be members of a *single* risk pool." Pls.' Mot. at 20 (citation omitted). However,

Congress did not require "all health insurance consumers [to] be 'members of a single risk pool.'" Rather, Congress created separate single risk pools in each state for individual and small group plans, 42 U.S.C. § 18032(c), which make up a *fraction*—less than 5 percent—of the overall insurance market. Wu Decl. in Supp. of Defs.' Mot. ("Wu Decl.") ¶ 8, ECF No. 40-2; *see also* CBO 2018 Report at 4, Table 1; *id.* at 5, A.R.122609 ("Nongroup insurance covers a much smaller share of the population under age 65 than employment-based policies and Medicaid do.").

Moreover, while guaranteed issue, community rating, and single risk pool requirements for ACA-compliant individual market plans constituted *one* of the ways in which Congress sought to expand health insurance coverage for individuals not otherwise covered by group health plans (including self-insured plans) or government-sponsored coverage, Congress did not determine that they were the *only* way to expand coverage. Rather, Congress specifically sought to expand and preserve a diversity of coverage types, many of which have the effect of reducing the number of individuals in community-rated plans and the single risk pools. These include, for example, the Medicaid expansion and the creation of incentives for employers to expand offerings of group coverage. *See* ACA §§ 1421, 1511-13, 2001; *see also* Defs.' Mot. at 6-7, 35. Congress also generally allowed people to keep their pre-ACA individual insurance policies, even though those "grandfathered" plans were not required to employ community rating, offer essential health benefits, or participate in the single risk pools. *See* ACA § 1251. And Congress retained the exemption for STLDI. Congress evidently sought to balance its policy objective of facilitating a market for ACA-compliant plans against a competing desire to maintain consumers' flexibility and ensure access to a variety of health insurance coverage options. Nothing in the ACA mandates that the Departments prioritize the former objective over the latter.[7]

[7] Plaintiffs assert that alternatives to ACA-compliant individual coverage are "narrow and self-limiting," Pls.' Mot. at 27, but they are wrong. Taken together, these alternatives dwarf the ACA-compliant individual markets. *See* Defs.' Mot. at 6, 34-35; Wu Decl. ¶ 8; CBO 2018 Report at 4, Table 1.

Plaintiffs similarly rely on Congress's statements in 42 U.S.C. § 18091 that it hoped to "minimize . . . adverse selection and broaden the health insurance risk pool." Pls.' Mot. at 20-21. However, these statements were made in the context of discussing the "*individual responsibility requirement*." 42 U.S.C. § 18091(1) (emphasis added). Specifically, Congress stated that, "[i]n the absence of the *requirement*, some individuals would make an economic and financial decision to forego health insurance coverage," *id.* § 18091(2)(A), and that "[t]he *requirement* is essential to creating effective health insurance markets." *Id.* § 18091(2)(I) (emphasis added); *see also King*, 135 S. Ct. at 2486 ("In Congress's view, th[e] [*individual responsibility*] *requirement* was 'essential to creating effective health insurance markets.'" (emphasis added)); *id.* at 2487 ("Congress found that the guaranteed issue and community rating requirements would not work without the [*individual responsibility*] *requirement*." (emphasis added)). If anything, these statements suggest that Congress intended to address adverse selection through the *individual mandate* and the tax penalty—which the STLDI Rule does not affect—rather than by wholly foreclosing alternative coverage options for people who cannot obtain or afford ACA-compliant coverage. Congress has never suggested that the guaranteed issue and community rating requirements would not work unless *STLDI policies* were restricted to less than three months—a prerequisite to finding that Congress intended to amend the original understanding of STLDI under HIPAA by implication.

Plaintiffs also contend that Congress "unambiguously answered ***no***" to the question "whether the federal governments should 'help individuals avoid paying for benefits provided in individual health insurance coverage that they believe are not worth the cost,'" Pls.' Mot. at 21 (citations omitted). Yet as the Departments have explained, that contention cannot be squared with the TCJA, which reduced to zero the tax penalty for individuals who choose not to maintain minimum essential coverage, thereby reducing pressure for individuals to purchase insurance that they do not want or cannot afford. *See Maryland v. United States*, No. ELH-18-2849, 2019 WL 410424, at *8 (D. Md. Feb. 1, 2019) (quoting floor debate on the TCJA that "you will no longer be punished" if "you decide [an ACA] plan doesn't fit your family" (citing 163 Cong. Rec. S7672

(daily ed. Dec. 1, 2017)). Plaintiffs may not ask this Court to again increase that pressure by restricting STLDI options that Congress intended to exist. *Cf. Central United Life Ins. Co. v. Burwell*, 827 F.3d 70 (D.C. Cir. 2016) (holding that HHS exceeded its authority by unduly restricting non-ACA compliant coverage options that Congress intended to exist).[8]

In any event, Congress surely understood that its individual insurance market reforms, including guaranteed issue, community rating, essential health benefit requirements, and protections for preexisting conditions, are useless to those who cannot afford or are otherwise unable to obtain the ACA-compliant products that offer them. Thus, the relevant question is whether, once comprehensive coverage is out of reach for an individual, the Departments nevertheless should limit alternative coverage forms such as STLDI to three months without renewability, potentially forcing the individual to go without insurance altogether after three months. Congress did not impose that requirement. Instead, Congress expressly provided that HHS "shall not promulgate any regulation that creates any unreasonable barriers to the ability of individuals to obtain appropriate medical care." ACA § 1554, 42 U.S.C. § 18114. Plaintiffs' desired less-than-three month approach would create precisely such a barrier.

[8] Plaintiffs argue that Congress passed the TCJA "only after being informed by [CBO] that a mandate penalty was ***not*** essential to operation of the statute," which is Plaintiffs' characterization of CBO's finding that "if the mandate penalty were repealed (or the mandate eliminated altogether), '[n]ongroup insurance markets would continue to be stable in almost all areas of the country throughout the coming decade.'" Pls.' Mot. at 9 & n.22 (citation omitted). Plaintiffs appear to believe that CBO's finding bolsters their claim that Congress would not approve of the STLDI Rule. In fact, CBO essentially made the *same finding* about the STLDI Rule. *See* CBO 2018 Report at 2, A.R.122606 (projecting that even with *combined* impact of the STLDI Rule, the TCJA, a rule loosening restrictions on Association Health Plans, a lack of funding for certain ACA subsidies, and other factors, "[t]he nongroup health insurance market is stable in most areas of the country over the next decade"); *see also id.* at 10-11, A.R.122614-15 (discussing STLDI). Indeed, CBO estimated that the STLDI Rule would reduce enrollment in the nongroup insurance markets by roughly 650,000 people, *see* CBO 2019 Report at 8, which is far less than the 5 million people it projected could drop coverage as a result of the TCJA. CBO 2017 Report at 3, A.R.122598. Thus, under Plaintiffs' own logic, CBO's findings suggest that Congress would not be troubled by the STLDI Rule.

C. The STLDI Rule Is Not Arbitrary and Capricious.[9]

Plaintiffs also fail to show that the STLDI Rule "is so implausible that it could not be ascribed to a difference in view or the product of agency expertise" or that the Departments "relied on factors which Congress has not intended [them] to consider, entirely failed to consider an important aspect of the problem, [or] offered an explanation for its decision that runs counter to the evidence before [them.]" *Motor Vehicle Mfrs. Ass'n v. State Farm*, 463 U.S. 29, 43 (1983).

1. The Departments Provided a Well-Reasoned Basis for Their Departure from the 2016 STLDI Rule.

Plaintiffs' contention that the Departments failed to explain why they were departing from the definition of STLDI in the 2016 STLDI Rule, Pls.' Mot. at 38-41, is meritless. As Defendants have explained, the Departments (1) acknowledged that they were deviating from their 2016 Rule, (2) explained that such deviation was warranted because the 2016 Rule had not succeeded in achieving its goal of stabilizing the markets or stemming declines in enrollment, (3) explained that their interpretation of STLDI as generally permitting renewal of STLDI coverage was consistent with the 1997 Rule, the 2004 Rule, and the 2016 Rule, and (4) explained that they were extending the allowable duration that could be achieved through such renewals beyond the maximum initial contract term in a manner that aligned with COBRA's protections for those transitioning out of group coverage. *See* Defs.' Mot. at 40-42. The STLDI Rule therefore amply meets the "minimal standards of rationality" required by the APA. *Troy Corp. v. Browner*, 120 F.3d 277, 283 (D.C. Cir. 1997).

Plaintiffs argue that the Departments' actions were nonetheless arbitrary and capricious, because the Departments did not rely on the precise policy goals that led them to promulgate the 2016 Rule. *See* Pls.' Mot. at 39-40. But there is no such requirement under the APA that the goals

[9] Plaintiffs have elected not to move for summary judgment on their allegations that the Departments failed to adequately consider regulatory alternatives, Compl. ¶¶ 120-21, failed to consider the effects of "permitting the sale of consecutive STLDI plans at a single time . . . in light of" the renewability provision, *id.* ¶ 121, and failed to satisfy notice and comment requirements, *id.* at 49 ¶ 87. They have, therefore, abandoned those claims.

for the initial policy be the same goals that drive the change. As the Supreme Court has emphasized, agencies are free to depart from prior policies so long as they provide a reasoned basis for doing so. *See, e.g.*, *Rust v. Sullivan*, 500 U.S. 173, 186 (1991) ("This Court has rejected the argument that an agency's interpretation is not entitled to deference because it represents a sharp break with prior interpretations." (citation omitted)). And agencies do not face any higher burden under the APA when departing from prior interpretations. *See FCC v. Fox Television Stations, Inc.*, 556 U.S. 502, 514 (2009). Rather, when agencies change policies, they "need not demonstrate to a court's satisfaction that the reasons for the new policy are *better* than the reasons for the old one." *Id.* at 515. "[I]t suffices that the new policy is permissible under the statute, that there are good reasons for it, and that the agency *believes* it to be better, which the conscious change of course adequately indicates." *Id.* The Departments' explanation in the preamble to the STLDI Rule easily clears that hurdle.

The cases Plaintiffs cite in no way bolster their argument that the Departments' departure from their prior interpretation was arbitrary and capricious. *See* Pls.' Mot. at 40, 43. In *Encino Motorcars v. Navarro*, 136 S. Ct. 2117 (2016), the agency's explanation was deficient because the agency "offered barely any explanation" at all. *Id.* at 2126. The Court acknowledged that a summary discussion of policy reasons underlying agency action often suffices, but—because of "*decades* of industry reliance on the Department's prior policy"—more explanation was required. *Id.* (emphasis added); *compare also Jicarilla Apache Nation v. U.S. Dep't of Interior*, 613 F.3d 1112, 1120 (D.C. Cir. 2010) (agency failed to justify change in policy where the agency did not even acknowledge prior, inconsistent precedent, "let alone explain why the agency chose to depart from it."). Here, the Departments provided a fulsome explanation for the change in policy, summarized above, and there was no similar decades-long interpretation that warranted additional explanation. To the contrary, the STLDI Rule largely *restored* the interpretation of STLDI that has existed since 1997 (except for the brief period following the 2016 STLDI Rule). *See* 69 Fed. Reg. at 78,748.

Plaintiffs also are wrong to assert that the Departments' change in policy with respect to renewability was arbitrary because it relied on an analogy to COBRA. Pls.' Mot. at 40-41. Plaintiffs' efforts to distinguish COBRA on the basis that "COBRA coverage complies with the ACA's requirements," Pls.' Mot. at 41, is misinformed. COBRA extends to a wide variety of coverage types, including "excepted benefits" which are not subject to the ACA's market reforms. *See* Defs.' Mot. at 6; 26 U.S.C. § 4980B(g)(2); 26 C.F.R. § 54.4980B-2, Q&A 1 and 4.

Finally, the STLDI Rule itself directly refutes Plaintiffs' insinuation that the "point of the STLDI Rule is to establish a form of primary coverage that is not transitory in any meaningful sense," Pls.' Opp'n at 40. *See* 83 Fed. Reg. at 38,221 ("short-term, limited-duration insurance . . . serves as temporary coverage for individuals transitioning between other types of coverage").

2. The Purported Harms that Plaintiffs Claim Will Result from the STLDI Rule Do Not Render It Unlawful.

Plaintiffs also rehash their claims that the STLDI Rule will harm consumers because it allegedly will cause coverage gaps and that the Departments failed to consider comments raising this concern. Pls.' Mot. at 41-44. As the Departments have explained, ensuring continuity of coverage is precisely why STLDI coverage should *not* be artificially constrained to three months, as Plaintiffs propose. Defs.' Mot. at 42-43. Because STLDI is not guaranteed renewable and its expiration does not trigger a special enrollment period ("SEP") in the individual market, a person requiring additional short-term coverage after the expiration of a less-than-three-month STLDI plan could be left without any coverage options. *Id.* at 42. The STLDI Rule avoids that outcome by allowing an individual to purchase STLDI for either the full duration of her expected coverage gap or at least long enough to take her to the next open enrollment period when she can purchase ACA-compliant coverage.

The STLDI Rule also addresses precisely the concerns that Plaintiffs fault the Departments for failing to consider, such as comments noting that a consumer could face a coverage gap if her short-term plan ends before marketplace open enrollment, and "that many individuals may be unable to obtain more comprehensive coverage at the end of the 3-month coverage period because

they may not qualify for a special enrollment period . . . ." 83 Fed. Reg. at 38,217. As the Departments explained, the STLDI Rule would provide *greater* protection from such coverage gaps than the 2016 STLDI Rule. *Id.* at 38,218 (explaining that limiting the initial contract term to a shorter duration would subject consumers to re-underwriting, new deductibles, higher premiums, and possible rejection of coverage). There is no merit to Plaintiffs' claim that the Departments refused to engage with commenters' concerns.

CONCLUSION

For the foregoing reasons, Plaintiffs' Motion for Summary Judgment should be denied.

Dated: March 15, 2019

Respectfully Submitted,

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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. 18-2133-RJL

[PROPOSED] ORDER

Upon consideration of the parties' cross motions for summary judgments, the parties' oppositions and replies, and the entire record herein, it is hereby ORDERED that Plaintiffs' motion is DENIED and Defendants' motion is GRANTED. Judgment is hereby entered in favor of Defendants.

Dated: _____

_____
Richard J. Leon
United States District Court Judge