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

BRIEF OF *AMICI CURIAE* AMERICAN MEDICAL ASSOCIATION, AMERICAN COLLEGE OF PHYSICIANS, AMERICAN OSTEOPATHIC ASSOCIATION, AMERICAN ACADEMY OF FAMILY PHYSICIANS, AMERICAN ACADEMY OF PEDIATRICS, AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS, THE HIV MEDICINE ASSOCIATION AND MEDICAL SOCIETY OF THE DISTRICT OF COLUMBIA IN SUPPORT OF PLAINTIFFS' MOTION FOR SUMMARY JUDGMENT

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CORPORATE DISCLOSURE STATEMENT

Amici curiae are non-profit organizations. They have no parent corporations and do not issue stock.

INTEREST OF *AMICI CURIAE*[1]

The American Medical Association (AMA) is the largest professional association of physicians, residents, and medical students in the United States. Additionally, through state and specialty medical societies and other physician groups seated in its House of Delegates, substantially all US physicians, residents and medical students are represented in the AMA's policy making process. The objectives of the AMA are to promote the science and art of medicine and the betterment of public health. AMA members practice and reside in all states and in the District of Columbia.

The American College of Physicians (ACP) is a national organization of internists. With 154,000 members, it is the largest medical-specialty organization and second-largest physician group in the United States. Its mission is to enhance the quality and effectiveness of health care by fostering excellence and professionalism in the practice of medicine.

The American Osteopathic Association represents 137,000 osteopathic physicians and medical students. Its objectives include promoting public health and access to health care.

The American Academy of Family Physicians, the national association of family doctors, is one of the largest national medical organizations, with 131,400 members from all 50 states, the District of Columbia, Guam, Puerto Rico, the Virgin Islands, and the Uniformed Services of the United States. The AAFP seeks to improve the health of patients, families, and communities by advocating for the health of the public, including by preserving and promoting quality cost-effective health care.

[1] In accordance with Local Civil Rule 7(o)(5) and Federal Rule of Appellate Procedure 29(a)(4)(E), *amici* certify that (1) this brief was authored entirely by counsel for *amici curiae* and not by counsel for any party, in whole or in part; (2) no party or counsel for any party contributed money to fund preparing or submitting this brief; and (3) apart from *amici curiae* and their counsel, no other person contributed money to fund preparing or submitting this brief.

The American Academy of Pediatrics (AAP) is an organization of 67,000 pediatricians committed to protecting the well-being of America's children, including by engaging in broad and continuous efforts to prevent harm to the health of infants, children, adolescents, and young adults caused by a lack of access to health coverage and care.

The American College of Obstetricians and Gynecologists (ACOG), is the specialty's premier professional membership organization dedicated to the improvement of women's health. With more than 58,000 members representing more than 90% of board certified ob-gyns in the United States, ACOG is dedicated to the advancement of women's health care, including advancing the core value of access for all women to high quality safe health care. ACOG has a long and strong history of supporting access to health care for all women.

The HIV Medicine Association (HIVMA) represents over 5,000 physicians, scientists, and other healthcare professionals who provide HIV prevention, care, and treatment in all states and in the District of Columbia. Its purpose is to represent the interests of HIV health care providers and researchers and their patients by promoting access to quality HIV care and by advocating for policies that ensure a comprehensive and humane response to the HIV pandemic.

The Medical Society of the District of Columbia (MSDC) is a state medical society with representation in the AMA House of Delegates. With over 2,500 members, MSDC is the largest medical organization representing metropolitan Washington physicians in the District.[2]

Amici all share a commitment to increasing access to the best and most affordable healthcare coverage for their members' patients. The Affordable Care Act was an important step

[2] The AMA and MSDC join this brief on their own behalves and as representatives of the Litigation Center of the American Medical Association and the State Medical Societies. The Litigation Center is a coalition among the AMA and the medical societies of each state, whose purpose is to represent the viewpoint of organized medicine in the courts.

towards achieving these goals. The 2018 Short Term Limited Duration Insurance (STLDI) Rule undermines the Act's vital reforms in ways that harm physicians, patients, and the healthcare system as a whole.

INTRODUCTION

Amici curiae include the foremost physician groups in the United States. They collectively represent nearly a million physicians and other healthcare professionals. Although *amici* represent a variety of different specialties, all share the goal of improving healthcare in the United States. A key part of this mission is providing as many of their members' patients as possible with affordable, meaningful health coverage. As courts have recognized again and again, this is the same goal as underpins the Affordable Care Act itself.[3]

The 2018 Short-Term, Limited Duration Insurance (STLDI) Rule is antithetical to this shared goal. The Rule is devastating to the health, well-being, and pocketbooks of millions of Americans—and disproportionately so for women, children, and the chronically ill. To understand why, this Court need look no further than the comments Defendants received during the rulemaking process. Approximately 12,000 commenters submitted responses to the proposed rule. Remarkably "[n]ot a single group representing patients, physicians, nurses or hospitals voiced support" for the proposal.[4] *Amicus* American Medical Association's comment perfectly captures the uniform opposition by those who know healthcare the best:

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[3] *E.g.*, *Cutler v. U.S. Dep't of Health and Human Servs.*, 797 F.3d 1173, 1175 (D.C. Cir. 2015) ("Congress enacted the Affordable Care Act in 2010 in an effort to 'increase the number of Americans covered by health insurance and decrease the cost of health care.'" (quoting *National Federation of Independent Business* v. *Sebelius*, 567 U.S. 519, 538-539 (2012)); *Seven-Sky v. Holder*, 661 F.3d 1, 4 (D.C. Cir. 2011) ("Suffice it to say that the Affordable Care Act sought to reform our nation's health insurance and health care delivery markets with the aims of improving access to those markets and reducing health care costs and uncompensated care.").

[4] 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. See Protect Our Care, *The People Who Know Health Care The Best Say Short-Term Plans Are The Worst* (Apr. 23, 2018), https://www.protectourcare.org/substandard-inadequate-health-insurance-coverage-those-who-know-best-react-to-the-trump-administrations-short-term-proposal/ ("Yesterday marked the deadline for comments to be submitted on the Trump Administration's proposed short-term scam insurance. A wide variety of health care experts – including doctors, insurance exchange operators,

> [T]he coverage gains of the past decade should be maintained. Central to this principle is ensuring meaningful coverage, assisting individuals with low-incomes or unusually high medical costs in obtaining health insurance coverage and meeting cost-sharing obligations, and ensuring the continuation of essential health benefit (EHB) categories and their associated protections against annual and lifetime limits and out-of-pocket expenses. Affordability is also critical, as is stabilizing and strengthening the individual health insurance market, maintaining key insurance market reforms under current law, and expanding choice of health insurance coverage to best meet individual needs. The proposed rule fails to comply with these important principles, and in fact, would reverse progress that has been made in expanding meaningful coverage to millions of previously uninsured Americans.[5]

Amici respectfully ask this Court to bear these principles in mind as it evaluates this case. More important, it asks this Court to bear these consequences in mind. One need "not express any opinion on the wisdom of the Affordable Care Act" to recognize that the 2018 STLDI Rule sabotages the ACA's crucial reforms. *National Federation of Independent Business*, 567 U.S. at 588. That alone demonstrates why plaintiffs should prevail in their motion. The information below, drawn from *amici*'s vast expert medical experience, makes clear that plaintiffs are correct that the STDLI rule is invalid, arbitrary, and capricious. Their motion for summary judgment should be granted.

ARGUMENT

I. THE 2018 STLDI RULE SABOTAGES THE AFFORDABLE CARE ACT'S PATIENT PROTECTIONS

A. The Affordable Care Act Included Consumer Protection Provisions to Improve the Quality of Health Care Coverage Accessible to Americans

Prior to passage of the ACA, millions of Americans struggled to obtain adequate health coverage. Approximately 30% of Americans lacked meaningful health care coverage. Almost

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insurance companies, analysts, and more than 100 patient groups – continue to make clear their strong opposition to the Administration's proposal.")

[5] American Medical Association, Comment Letter on Notice of Proposed Rulemaking, Short-Term, Limited Duration Insurance (CMS-9924-P) (April 23, 2018) at 1-2, https://www.regulations.gov/document?D=CMS-2018-0015-8708.

18% of Americans were completely uninsured. [6] Nearly 12% were underinsured (that is, spent a high share of their income on medical care despite having insurance).[7]

One cause of this problem was the ways that insurance companies managed the risk of high payouts. Some individuals, especially those with serious health conditions, were priced out of new insurance plans because of the high costs that could be expected to treat their conditions. If they lost their coverage for any reason, they could have difficulty obtaining new coverage. Insurance policies also routinely included provisions limiting liability under the policy for costs that could be linked to a condition predating the policy.[8] Insurers also employed other techniques that increased costs and limited coverage for those with pre-existing conditions, which at any given time is approximately 27% of non-elderly adults.[9] These techniques included:

- ***Rate-ups***, by which those with pre-existing conditions were charged premiums higher than those in perfect health;
- ***Exclusion riders***, by which coverage for treatment of specific conditions—or body parts or systems affected by those conditions—were excluded from the policy;
- ***Increased deductibles***, by which those with pre-existing conditions received plans with higher deductibles than completely healthy people, either for all covered benefits or benefits specific to their particular pre-existing condition; and

[6] Niraj Chokshi, *Historians Take Note: What America Looked Like Before Obamacare*, Washington Post, March 26, 2014, https://www.washingtonpost.com/blogs/govbeat/wp/2014/03/26/historians-take-note-what-america-looked-like-before-obamacare/.

[7] *Id.*

[8] Gary Claxton, et al., *Pre-existing Conditions and Medical Underwriting in the Individual Insurance Market Prior to the ACA*, Henry J. Kaiser Family Foundation (Dec. 12, 2016), https://www.kff.org/health-reform/issue-brief/pre-existing-conditions-and-medical-underwriting-in-the-individual-insurance-market-prior-to-the-aca/.

[9] Gary Claxton, Larry Levitt, & Karen Pollitz, *Pre-ACA Market Practices Provide Lessons for ACA Replacement Approaches*, Henry J. Kaiser Family Foundation (Feb 16, 2017), https://www.kff.org/health-costs/issue-brief/pre-aca-market-practices-provide-lessons-for-aca-replacement-approaches/.

- ***Modified benefits***, by which those with pre-existing conditions had certain benefits (for example, prescription drug benefits) limited or excluded from their policies.[10]

Physicians and patients ultimately paid for these limitations. Instead of obtaining preventative care and routine examinations, "many individuals would wait to purchase health insurance until they needed care." 42 U.S.C. § 18091(2)(I). But at that point, they often sought expensive emergency treatment.[11] This resulted in much sicker patients and much higher costs than if medical problems had been addressed earlier. *See generally* 42 U.S.C. § 18091(2)(E) ("The economy loses up to $207,000,000,000 a year because of the poorer health and shorter lifespan of the uninsured. By significantly reducing the number of the uninsured, the requirement, together with the other provisions of this Act, will significantly reduce this economic cost.").

If patients' poorer health outcomes were not bad enough, the increased cost of care meant that they were left with significant medical debt. *Id*. § 18091(2)(E)-(G) ("62 percent of all personal bankruptcies are caused in part by medical expenses."); *see* Allen St. John, *How the Affordable Care Act Drove Down Personal Bankruptcy: Expanded health insurance helped cut the number of filings by half*, Consumer Reports (May 2, 2017), https://www.consumerreports.org/personal-bankruptcy/how-the-aca-drove-down-personal-bankruptcy/. This medical debt could financially cripple the patients and leave their caregivers facing their own losses. And inability to afford high medical costs was not confined to a small percentage of indigent Americans: a 2016 survey by the Federal Reserve found that approximately 46% of Americans did not have enough money to cover a $400 emergency expense, meaning they would have to pay such expense by credit card

[10] Gary Claxton, et al., *supra* note 8.

[11] *See, e.g.*, Ted MacKinney, et al., *Does Providing Care for Uninsured Patients Decrease Emergency Room Visits and Hospitalizations?*, US National Library of Medicine, National Institutes of Health (March 11, 2013), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4818592/.

and face debt from the credit card company, borrow from friends and family, or leave the bill unpaid.[12]

In response to the staggering numbers of uninsured and underinsured Americans and the exploding health care costs throughout the system, Congress passed the ACA in 2010.[13] The ACA implemented a number of reforms to help more Americans obtain affordable, meaningful health coverage, including, as relevant here, (a) requiring insurance plans to cover pre-existing conditions and to provide a basic set of services called Essential Health Benefits; and (b) preventing insurance plans from establishing caps on annual benefits.[14]

Each of these protections provided a crucial check on the historic problems of underinsurance and skyrocketing medical expenses. By requiring plans to cover pre-existing conditions, a major factor leading to the denial of claims and refusal to provide affordable coverage was eliminated. And by precluding caps on annual benefits, consumers were spared the financial devastation that came with a serious or chronic condition requiring particularly expensive treatment.

Similarly, the "Essential Health Benefits" of the ACA required all plans to provide patients with coverage for certain types of common, basic care that was nonetheless frequently excluded from individual insurance plans before the ACA was enacted. The ACA's Essential Health Benefits include: (1) ambulatory patient services; (2) emergency services; (3) hospitalization; (4)

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[12] Ylan Q. Mui, *The Shocking Number of Americans Who Can't Cover a $400 Expense*, Washington Post, May 25, 2016, https://www.washingtonpost.com/news/wonk/wp/2016/05/25/the-shocking-number-of-americans-who-cant-cover-a-400-expense/?utm_term=.2f6208458f41.

[13] *See National Federation of Independent Business*, 567 U.S. 538.

[14] *See, e.g.*, 46 U.S.C. § 18022; *Lifetime & Annual Limits*, U.S. Department of Health & Human Services, https://www.hhs.gov/healthcare/about-the-aca/benefit-limits/index.html; *Pre-Existing Conditions*, U.S. Department of Health & Human Services, https://www.hhs.gov/healthcare/about-the-aca/pre-existing-conditions/index.html.

maternity and newborn care; (5) mental health and substance use disorder services including behavioral health treatment; (6) prescription drugs; (7) rehabilitative and habilitative services and devices; (8) laboratory services; (9) preventive and wellness services and chronic disease management; and (10) pediatric services, including oral and vision care.[15]

Before the ACA, many of these essential services were not covered by a significant percentage of health insurance plans. For example, 75% of non-group health plans did not cover delivery and inpatient maternity care.[16] Similarly, 45% did not cover substance abuse disorder services and 38% did not cover mental health services.[17] Nearly 20% had some limitation on coverage of prescription medications.[18] Under the ACA, however, individual long-term insurance plans are all required to cover these services, providing meaningful coverage to those who did not have it before.

B. The 2018 STLDI Rule Undermines the Consumer Protection Provisions in the Affordable Care Act, Leaving Patients Vulnerable to Worse Health Outcomes and/or Financial Ruin

The 2018 STLDI Rule undermines the ACA's vital patient reforms, moving the health insurance market back to the days where Americans had no or inadequate insurance. By doing so, it will lead to worse health outcomes and increased medical costs.

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[15] 42 U.S.C. § 18022(b)(1); *see also Information on Essential Health Benefits (EHB) Benchmark Plans*, Centers for Medicare & Medicaid Services, https://www.cms.gov/cciio/resources/data-resources/ehb.html.

[16] Amy Jeter & Craig Palosky, *Analysis: Before ACA Benefits Rules, Care for Maternity, Mental Health, Substance Abuse Most Often Uncovered by Non-Group Health Plans*, Henry J. Kaiser Family Foundation (June 14, 2017), https://www.kff.org/health-reform/press-release/analysis-before-aca-benefits-rules-care-for-maternity-mental-health-substance-abuse-most-often-uncovered-by-non-group-health-plans/.

[17] *Id.*

[18] *Id.*

STLDI plans predate the ACA.[19] They were originally intended to provide coverage for brief periods in which a consumer had a gap in standard coverage, such as a short gap between jobs.[20] Unlike other insurance plans, moreover, there was no requirement that they be renewable at the policyholder's option.[21]

The prevalence of STLDI plans increased after passage of the ACA because STLDI plans are not subject to the ACA's consumer protection requirements to cover pre-existing conditions, provide Essential Health Benefits, and abolish caps on annual benefits.[22] At the same time, regulations were enacted limiting STLDI plans to a total of less than three months, including any renewals, so they could not be used as substitutes for ACA-compliant insurance. These regulations ensure that STLDI plans would only be used for the gap-filling for which they were originally designed—especially because those plans lacked the basic protective features that the ACA sought to promote.[23]

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[19] *See, e.g.*, Interim Rules for Health Insurance Portability for Group Health Plans, 62 Fed. Reg. 16894, 16928 (April 8, 1997) (defining short-term, limited-duration insurance).

[20] Short-Term, Limited-Duration Insurance, 83 Fed. Reg. 38212-01, 38,213 (Aug. 3, 2018).

[21] *See id.*

[22] *Id.*

[23] Excepted Benefits; Lifetime and Annual Limits; and Short-Term, Limited-Duration Insurance, 81 Fed. Reg, 75316-01, 75318 (Oct. 31, 2016) ("Before enactment of the Affordable Care Act, short-term, limited-duration insurance was an important means for individuals to obtain health coverage when transitioning from one job to another (and from one group health plan to another) or when faced with other similar situations. However, with guaranteed availability of coverage and special enrollment period requirements in the individual health insurance market under the Affordable Care Act, individuals can purchase coverage with the protections of the Affordable Care Act to fill in the gaps in coverage.… Because short-term, limited-duration insurance is exempt from certain consumer protections, the Departments are concerned that these policies may have significant limitations, such as lifetime and annual dollar limits on essential health benefits (EHB) and pre-existing condition exclusions, and therefore may not provide meaningful health coverage. Further, because these policies can be medically underwritten based on health status, healthier individuals may be targeted for this type of coverage, thus adversely impacting the risk pool for Affordable Care Act-compliant coverage. To address the issue of short-term, limited-duration insurance being sold as a type of primary coverage, the Departments proposed regulations

The 2018 STLDI Rule obliterates these limitations. Under the new regulation, the maximum period for STLDI plans has been expanded to any period of time under a year.[24] Thus, "short-term" plans can be for as long as 364 days, just one day less than ACA-compliant plans. It would be problematic enough if Defendants merely took these plans right up to the one-year line. But they go even further. Under the 2018 Rule, STLDI plans can be extended up to 36 months, and multiple 36-month plans can be purchased, essentially extending the plans permanently.[25]

As a result of these durational manipulations, STLDI plans can be offered that look like ACA-compliant plans and last long enough that an individual could use them for primary coverage. Looks, of course, can be deceiving. These extendable 364-day plans do not provide the full suite of coverage that Congress intended and they are fundamentally inconsistent with the ACA's many core reforms, including guaranteed issue, modified community rating, essential health benefit requirements, prohibitions on preexisting condition exclusions, annual and lifetime limit prohibitions, and other protections.

A proliferation of STLDI plans under the 2018 STLDI Rule will have serious adverse consequences for physicians and the patients in their care. Most starkly, one leading study showed that, as a result of the loosening of STLDI requirements, approximately "36.9 million people would be without minimum essential coverage, an increase of 9.0 million people over prior law and 2.6 million people over current law."[26] The same study found, moreover, that "[o]nce STLD plans

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to revise the definition of short-term, limited-duration insurance so that the coverage must be less than three months in duration, including any period for which the policy may be renewed.").

[24] 83 Fed. Reg. at 38216.

[25] *Id.* at 38220.

[26] Linda J. Blumberg et al., *Updated: The Potential Impact of Short-Term Limited-Duration Policies on Insurance Coverage, Premiums, and Federal Spending*, Urban Institute, 6 (March 14, 2018), https://www.urban.org/research/publication/updated-potential-impact-short-term-limited-duration-policies-insurance-coverage-premiums-and-federal-spending. The same study

are expanded, 8.5 million fewer people would have insurance compared with prior law, and 2.5 million fewer people would have insurance compared with current law in the 45 states that do not prohibit or limit STLD plan expansion."[27] These consequences carry enormous health risks for *amici*'s members' patients. It is well-established in the medical community that "[c]ompared with the insured, uninsured individuals have a higher prevalence of chronic medical illness, greater physical morbidity, and higher mortality."[28]

In particular, another recent study indicated that many STLDI policies currently on the market have significant coverage limitations:

- 43% of the plans studied do not cover mental health services;
- 62% do not cover services for substance abuse treatment (including both alcohol and other drugs),
- 71% do not cover outpatient prescription drugs, and
- *None* of the plans studied cover maternity care.[29]

The study also found that in seven states, no plan offered *any* of the four categories of benefits listed above.[30] Moreover, even when STDLI plans do cover the essential benefits discussed above,

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shows that this decreased coverage will not reduce federal health care spending. Quite the contrary: "With the expanded STLD policies in place, however, federal spending is estimated to be 9.3 percent or $33.3 billion higher than under prior law." *Id*. at 16.

[27] *Id*.

[28] Donna L Washington, *Charting the Path from Lack of Insurance to Poor Health Outcomes*, West J Med. 2001 Jul; 175(1): 23, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1071459/.

[29] Karen Pollitz, et al., *Understanding Short-Term Limited Duration Health Insurance*, Henry J. Kaiser Family Foundation (Apr. 23, 2018), https://www.kff.org/health-reform/issue-brief/understanding-short-term-limited-duration-health-insurance/. This is consistent with the pre-ACA marketplace, when 75% of individual market plans did not cover maternity care services. *See* American College of Obstetricians and Gynecologists, Comment Letter on Notice of Proposed Rulemaking, Short-Term, Limited Duration Insurance (CMS-9924-P) (Apr. 23, 2018) at 2.

[30] Karen Pollitz, et al., *supra* note 29.

they frequently contain limitations or exclusions that would not be permitted by the ACA. For example, 6 of the 7 plans studied that *did* offer prescription drug coverage applied a maximum dollar cap on the benefit.[31] And all of the plans reviewed in the study exclude coverage for pre-existing conditions.[32] The limited evidence since the promulgation of the new rule is consistent with *amici*'s expectation that the new plans would offer inadequate coverage. For example, one report indicates that most new STLDI plans offered in Louisiana "have caps or other limitations on coverage – for instance, some plans put a cap on ambulance rides or hospitalization."[33]

As *amici*'s physician members know well, and as Congress recognized, the essential benefits noted above are crucial for patient health, and in some cases life-saving. For example, 1 in 5 adult Americans has some form of mental illness.[34] One such mental health condition, depression, is the leading cause of disability worldwide. The overwhelming majority—90%—of suicides, which is the tenth leading cause of death for men in the United States, occur when the victim has an underlying mental illness.[35] Mental health treatment, an essential benefit not covered by many STLDI plans, can alleviate the symptoms of depression and prevent suicide.

Other essential health benefits are equally critical for *amici*'s patients. To take one example, studies have found that coverage gaps or caps on prescription drug coverage generally

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[31] *Id.*

[32] *Id.*

[33] Sam Karlin, *New Short-Term Health Products Hit Market in Louisiana After New Trump Admin Rule*, The Advocate, Oct. 2, 2018, https://www.theadvocate.com/baton_rouge/news/business/article_4a4a2bee-c67d-11e8-96e9-1b4a0292a1c0.html.

[34] National Alliance on Mental Illness, *Mental Health Facts In America*, https://www.nami.org/NAMI/media/NAMI-Media/Infographics/GeneralMHFacts.pdf.

[35] *Id.*; Hannah Nichols, *The Top 10 Leading Causes of Death in the United States*, Medical News Today, Feb. 23, 2017, https://www.medicalnewstoday.com/articles/282929.php.

lead to worse health outcomes.[36] Similarly, the CDC has described prenatal care as "essential," because it can help prevent low birth weight, which is the "single most important factor influencing neonatal mortality."[37] Prenatal care can help identify and eliminate life-threatening health complications caused by pregnancy.[38] And drug overdose—which "essential" substance abuse treatment helps avoid—is the leading cause of death among Americans under 50.[39] As any physician worth his or her salt knows, these services have been deemed "essential" for a reason—they are vital to a patient's general health and well-being.

The impact of policy exclusions common to STLDI are particularly devastating to our most vulnerable populations, including children and individuals in poor health, such as those with chronic conditions like HIV, mental illness, or substance abuse. They are also especially damaging to women. Because approximately half of pregnancies are unplanned,[40] women may choose to obtain STLDI insurance because they do not expect to require prenatal or maternity care, but then suddenly find themselves unexpectedly in need of such services. As a result, they could end up facing high medical bills and insufficient care both for themselves and their babies. Worse, if her STLDI coverage expires before the next open-enrollment period in the ACA exchanges, a pregnant

[36] Aaron S. Kesselheim, et al., *Prescription Drug Insurance Coverage and Patient Health Outcomes: A Systematic Review*, 105 Am. J Public Health e17 (Feb 2015), *available at* https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4318289/.

[37] Centers for Disease Control & Prevention, *Gateway to Health Communication & Social Marketing Practice: Pregnancy and Prenatal Care*, https://www.cdc.gov/healthcommunication/toolstemplates/entertainmented/tips/PregnancyPrenatalCare.html.

[38] National Institutes of Health, *What is Prenatal Care and Why Is It Important*, https://www.nichd.nih.gov/health/topics/pregnancy/conditioninfo/prenatal-care.

[39] Josh Katz, *Drug Deaths in America are Rising Faster than Ever*, New York Times, June 5, 2017, https://www.nytimes.com/interactive/2017/06/05/upshot/opioid-epidemic-drug-overdose-deaths-are-rising-faster-than-ever.html.

[40] American College of Obstetricians and Gynecologists, Comment Letter at 2, *supra* note 29.

woman could be left with no coverage at all, because the end of STLDI coverage does not trigger a special enrollment period—even if an individual becomes pregnant in the interim.[41]

A STLDI plan's meager menu of benefits presents little risk if the plan is truly confined to a short gap between periods when an individual would have more comprehensive insurance. But if this coverage is used as a *substitute* for ACA-compliant insurance, the results could be medically or financially catastrophic. Because issuers of STLDI plans can engage in post-claims underwriting, they can rescind coverage or deny claims for services that may be associated with a pre-existing condition. They also can terminate or refuse to renew coverage. If this loss of coverage occurs outside of an open-enrollment period, an STLDI policyholder would be unable to obtain ACA-compliant care and would be left without coverage entirely right as they are facing a health crisis—in other words, at the worst possible time for *amici*'s patients.[42]

The coverage limitations in STLDI plans can be particularly devastating for those who develop a new chronic condition after obtaining an STLDI plan. Health status is not static, and those who are initially healthy may be less likely to carefully investigate the limits of their coverage. And of course, most healthy people would not have reason to seek out insurance that covers a medical condition they have yet to develop. But these individuals will learn of the limits of their STLDI coverage, or lose coverage altogether, *after* they have developed a medical condition or require a higher level of services, potentially devastating them at their most vulnerable time. As STLDI plans frequently limit or exclude benefits like prescription drug benefits and can deny claims based on pre-existing conditions, STLDI plans can exclude coverage for the services

[41] *Id.*

[42] *E.g.*, Linda J. Blumberg et al. at 20, *supra* note 26 ("[S]ome people buying the narrower STLD polices will incur serious health problems once enrolled, and find that their plans do not meet their medical needs. This could lead to increases in unmet medical need and uncompensated care.").

that are most important to patients with chronic conditions. Annual caps on benefits would likewise harm those who are sickest and need insurance the most.

But these risks apply to any users of STLDI plans who may get sick after obtaining this limited coverage. Just this week, *Consumer Reports* published the story of a retired Arizona woman who was hospitalized with an abdominal infection a few weeks after receiving emergency surgery for diverticulitis.[43] Her insurance company treated the abdominal infection as related to a pre-existing condition related to the diverticulitis and canceled her plan, ultimately leaving her with $97,000 in hospital bills.[44] This woman had more understanding than many who signed up for such plans. She had been aware that pre-existing conditions wouldn't be covered, but even she was in for a devastating surprise, as she had no idea that her STLDI plan could be canceled *retroactively*.[45]

Put simply, the risk that individuals will obtain STLDI coverage in lieu of ACA-compliant insurance is real. Defendants themselves acknowledged in rulemaking that they expected between 100,000 and 200,000 individuals previously enrolled in individual market coverage would purchase STLDI coverage after the 2018 STLDI rule took effect.[46] But independent studies have found that the numbers could be significantly higher.[47]

It is not surprising why individuals might purchase these plans: by offering far less coverage than ACA-compliant plans must, STLDI plans can charge significantly lower premiums.

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[43] Donna Rosato, *Short-Term Health Insurance Isn't As Cheap As You Think*, Consumer Reports, Oct. 2, 2018, https://www.consumerreports.org/health-insurance/short-term-health-insurance-isnt-as-cheap-as-you-think/.

[44] *Id.*

[45] *Id.*

[46] 83 Fed Reg at 38236.

[47] *See* American Medical Association, Comment Letter at 3, *supra* note 5.

These lower premiums are likely to be especially attractive to those who are struggling financially. Individuals may be induced by the lower premiums to purchase STLDI plans notwithstanding the more limited coverage because they do not understand the many additional limitations in the coverage that they will be obtaining or because they are healthy at the time they are purchasing the insurance and do not anticipate developing a condition that may require them to obtain services that are not covered.

The serious risk for consumer confusion caused by STLDI plans' potential exclusion of essential benefits is no fantasy; it was recognized to be a problem by Defendants themselves, and is addressed in the 2018 STLDI rule itself. The Rule requires contracts and application materials for STLDI plans to state that

> This coverage is not required to comply with certain federal market requirements for health insurance, principally those contained in the Affordable Care Act. Be sure to check your policy carefully to make sure you are aware of any exclusions or limitations regarding coverage of preexisting conditions or health benefits (such as hospitalization, emergency services, maternity care, preventive care, prescription drugs, and mental health and substance use disorder services). Your policy might also have lifetime and/or annual dollar limits on health benefits. If this coverage expires or you lose eligibility for this coverage, you might have to wait until an open enrollment period to get other health insurance coverage.[48]

But while this notice is clear recognition that the regulation creates a problem, it does little to solve it. It does not tell consumers what specific benefits their plan lacks that an ACA-compliant plan would require.[49] And unfortunately, health insurance is something most Americans simply do not understand. One study found just 9% of Americans showed an understanding of basic

[48] 83 Fed. Reg. at 38215.

[49] *Cf.* American Academy of Pediatrics, et al., Comment Letter on Notice of Proposed Rulemaking, Short-Term, Limited Duration Insurance (CMS-9924-P) (April 23, 2018), at 4 (proposing consumers of STLDI plans be required to sign an acknowledgement disclosing the precise benefits of an ACA plan their plan is not providing).

health insurance terms.[50] This is consistent with other research.[51] As a result, the prospect of confusion, or even downright misinformation is real. If the 2018 STLDI Rule is allowed to remain in effect, many purchasers of STLDI plans will do so without knowing that they are purchasing coverage with significant limitations, knowing what those limitations are, or intending to obtain such limited coverage. Whatever causes an individual to obtain such limited insurance, however, the expansion of STLDI policies risks doing real harm to the physical and financial health of those who purchase them.

II. THE 2018 STLDI RULE DESTABILIZES THE HEALTH INSURANCE MARKET, INCREASING HEALTH CARE COSTS FOR ALL AMERICANS

The negative effects of the 2018 STLDI Rule are not confined to those who purchase STLDI plans issued pursuant to that rule. Patients who *don't* purchase those plans also will be harmed. Because STLDI plans can offer far more limited benefits than ACA-compliant plans, the consumers most likely to purchase such plans in lieu of ACA-compliant plans are those who (at least at the time of purchase) are healthy. Healthy people also may be less likely to inquire into the specific limitations of STLDI plans because they do not have specific conditions about which they need to inquire, and are less likely to expect that they will need to use a significant amount of medical services.

The exit of healthy people from ACA insurance markets, however, increases the costs of the more comprehensive plans. If healthy people exit the market for ACA-compliant insurance in

[50] Les Masterson. *United Health Survey: Most Americans Don't Understand Basic Health Plan Terms*, Healthcare Dive, Oct. 10, 2017, https://www.healthcaredive.com/news/unitedhealth-survey-most-americans-dont-understand-basic-health-plan-term/506895/.

[51] *See Policy Genius, 4 Basic Health Insurance Terms 96% of Americans Don't Understand*, https://www.policygenius.com/health-insurance/learn/health-insurance-literacy-survey/ ("PolicyGenius' survey of 2,000 American health insurance consumers found that 96% of Americans overestimate their understanding of health insurance concepts.").

order to obtain lower-premium STLDI plans, those who remain in the market for ACA-compliant plans will be on the whole less healthy, with higher average healthcare costs. As a result, the premiums for ACA-compliant plans will rise as fewer healthy people with lower healthcare costs remain in the risk pool to offset the higher costs of the less healthy people. There is no dispute that this will occur; the Defendants themselves acknowledge it.[52]

This increase in costs could be substantial. One study estimated that, if the STLDI rule went into effect, it would result in premiums increasing 18% on average in states that do not counteract the rule by prohibiting or limiting STLDI plans.[53] Another study estimated that premiums for those remaining in the individual market will increase by 6.6% as a result of the rule.[54] These premium hikes will disproportionately impact middle class families.[55]

Defendants justify their change in the hope that expansion of STLDI plans will increase consumer choice.[56] But the 2018 STLDI Rule does not do so in any meaningful way. One important tenet of ACA is to even the playing field on which health insurance plans can compete. By requiring all plans to provide a minimum set of services and play by the same rules designed to protect consumers and give them meaningful coverage, ACA sets the terms for competition:

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[52] *See* Short-Term, Limited-Duration Insurance, 83 FR 7437-01, 7443 (Feb. 21, 2018) ("Because short-term, limited-duration insurance policies can be priced in an actuarially fair manner, subject to State law, individuals who are likely to purchase such coverage are likely to be relatively young or healthy. Allowing such individuals to purchase policies that do not comply with PPACA, but with term lengths that may be similar to those of PPACA-compliant plans with 12-month terms, could potentially weaken States' individual market single risk pools. As a result, individual market issuers could experience higher than expected costs of care and suffer financial losses . . . .").

[53] *See* American Medical Association, Comment Letter at 3, *supra* note 5.

[54] *Id.*

[55] *Id*.

[56] *See* 83 Fed. Reg. at 38212 ("This action is being taken to lengthen the maximum duration of short-term, limited-duration insurance, which will provide more affordable consumer choices for health coverage.").

insurance plans can compete on services by offering more than the minimum consumer protections, or they can compete on price by reducing costs like overhead. They cannot compete on price by eliminating essential benefits and other consumer protections. In short, the 2018 STLDI Rule might increase consumer choices in the sense that more plans will be available; but it is a false choice because the new plans it offers are irreconcilable with the ACA and should not be offered at all.

Amici share Defendants' goal of supporting increased health plan choices. But the 2018 STLDI Rule will lead to a proliferation of inadequate health insurance policies, as well higher costs for those purchasing STLDI policies *and* those buying ACA-compliant policies. A desire for increased consumer choice cannot justify results so inimical to the ACA. "Congress passed the Affordable Care Act to improve health insurance markets, not to destroy them." *King v. Burwell*, 135 S. Ct. 2480, 2496 (2015). Defendants, like courts, must implement and "interpret the Act in a way that is consistent with the former, and avoids the latter." *Id.* The 2018 STLDI Rule does precisely the opposite. It should be invalidated.

CONCLUSION

For the reasons stated in Plaintiffs' brief, the Plaintiffs' motion for summary judgment should be granted.

Dated: March 1, 2019

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CERTIFICATE OF COMPLIANCE

I hereby certify that the foregoing complies with Local Civil Rule 7(o)(4) and does not exceed 25 pages.

Dated: March 1, 2019

/s/ Chad I. Golder
Chad I. Golder

CERTIFICATE OF SERVICE

I hereby certify that on March 1, 2019, I caused a true and correct copy of the foregoing to be served on all counsel of record through the Court's CM/ECF system.

Dated: March 1, 2019

/s/ Chad I. Golder
Chad I. Golder