ORAL ARGUMENT NOT YET SCHEDULED

No. 19-5212

In the United States Court of Appeals For the District of Columbia Circuit

ASSOCIATION FOR COMMUNITY AFFILIATED PLANS, ET AL.,

Appellants,

v.

UNITED STATES DEPARTMENT OF TREASURY, ET AL.,

Appellees.

On Appeal from the U.S. District Court
for the District of Columbia
Case No. 18-2133 (Leon, J.)

BRIEF FOR THE APPELLANTS

Karen W. Lin**
MAYER BROWN LLP
1221 Avenue of the Americas
New York, NY 10020-11001
(212) 262-1910

Andrew J. Pincus
Charles A. Rothfeld
Ankur Mandhania*
MAYER BROWN LLP
1999 K Street, N.W.
Washington, D.C. 20006-1101
(202) 263-3000

CERTIFICATE AS TO PARTIES, RULINGS, AND RELATED CASES

1. ***Parties and Amici.*** The plaintiffs-appellants in this case are: Association for Community Affiliated Plans; National Alliance on Mental Illness; Mental Health America; American Psychiatric Association; AIDS United; the National Partnership for Women and Families; and Little Lobbyists, LLC.

The defendants-appellees are: U.S. Department of Treasury; U.S. Department of Labor; U.S. Department of Health and Human Services; Alex M. Azar II, in his official capacity as Secretary of the Department of Health and Human Services; Patrick Pizzella, in his official capacity as Acting Secretary of the Department of Labor; Steven Mnuchin, in his official capacity as Secretary of the Department of Treasury; and the United States of America.

The following *amici* filed briefs in the district court in support of plaintiffs: AARP; AARP Foundation; American Academy of Family Physicians; American Academy of Pediatrics; American Academy of Obstetricians and Gynecologists; American College of Physicians; American Medical Association; American Osteopathic Association; HIV

Medicine Association; Medical Society of the District of Columbia; American Cancer Society; American Cancer Society Action Network; American Heart Association; American Lung Association; Cystic Fibrosis Foundation; Epilepsy Foundation; Hemophilia Federation of America; Leukemia & Lymphoma Society; March of Dimes Foundation; National Coalition for Cancer Survivorship; and the National Multiple Sclerosis Society.

2. ***Rulings Under Review.*** The ruling under review is the Order and Memorandum Opinion of the U.S. District Court for the District of Columbia (Leon, J.), filed July 19, 2019, in *Association for Community Affiliated Plans v. United States Department of Treasury*, No. 18-2133, granting defendants-appellees' motion for summary judgment and denying plaintiffs'-appellees' motion for summary judgment, reproduced at JA556-595. The memorandum decision is reported at 392 F. Supp. 3d 22 (D.D.C. 2019).

3. ***Related Cases.*** There are no related cases, and this case has not previously been before this Court or any court other than the U.S. District Court for the District of Columbia.

RULE 26.1 CORPORATE DISCLOSURE STATEMENT

Pursuant to Federal Rule of Appellate Procedure 26.1 and this Court's Circuit Rule 26.1, plaintiffs-appellants hereby state as follows:

1. Plaintiff-appellant Association for Community Affiliated Plans (ACAP) is an association of nonprofit and community-based insurers that provide coverage to low-income persons and persons with significant health care needs, including providing qualified health coverage to individuals through Affordable Care Act (ACA) marketplaces and that will be adversely affected if the regulation challenged in this case is upheld. No publicly held corporation has a 10% or greater ownership interest in ACAP and it does not include members that have issued shares or debt securities to the public.

2. Plaintiff-appellant the National Alliance on Mental Illness (NAMI) represents individuals affected by mental illness, who will face higher health insurance costs if the regulation challenged in this case is upheld and premiums for ACA marketplace plans therefore increase. No publicly held corporation has a 10% or greater ownership interest in NAMI and it does not include members that have issued shares or debt securities to the public.

3. Plaintiff-appellant Mental Health America (MHA) is a community-based nonprofit dedicated to addressing the needs of those living with mental illness and to promoting the overall mental health of all Americans; these people will lose access to health insurance coverage if the regulation challenged in this case is upheld. No publicly held corporation has a 10% or greater ownership interest in MHA and it does not include members that have issued shares or debt securities to the public.

4. Plaintiff-appellant American Psychiatric Association (APA) is the largest association of psychiatrists in the world; the medical services provided by its members are excluded from many insurance plans authorized by the regulation challenged in this case, which therefore will put doctors put in the position of discontinuing treatment (which may be ethically and legally impermissible) or providing treatment without compensation. No publicly held corporation has a 10% or greater ownership interest in APA and it does not include members that have issued shares or debt securities to the public.

5. Plaintiff-appellant AIDS United represents individuals with HIV and health care providers who treat those individuals; the

challenged regulation will lead to increased health insurance premiums for these individuals and more uncompensated care for their health care providers. No publicly held corporation has a 10% or greater ownership interest in AIDS United and it does not include members that have issued shares or debt securities to the public.

6. Plaintiff-appellant the National Partnership for Women & Families (NPWF) represents the interests of women by promoting fairness in the workplace; reproductive health and rights; access to quality, affordable health care; and policies that help women and men meet the dual demands of work and family. The regulation challenged here promotes health insurance plans that engage in pricing discrimination against women, exclude coverage for essential women's health services, and deny coverage based on pre-existing conditions. No publicly held corporation has a 10% or greater ownership interest in NPWF and it does not include members that have issued shares or debt securities to the public.

7. Plaintiff-appellant Little Lobbyists, LLC, is a group of families with children with serious health conditions, who will see the health insurance premiums of its families increase significantly if the

challenged regulation is upheld. No publicly held corporation has a 10% or greater ownership interest in Little Lobbyists and it does not include members that have issued shares or debt securities to the public.

TABLE OF CONTENTS

Page

TABLE OF CONTENTS
(continued)

Page

TABLE OF CONTENTS
(continued)

Page

TABLE OF AUTHORITIES

Page(s)

Cases

* *Authorities upon which we chiefly rely are marked with asterisks.*

TABLE OF AUTHORITIES
(continued)

Page(s)

* *Authorities upon which we chiefly rely are marked with asterisks.*

TABLE OF AUTHORITIES
(continued)

Page(s)

Statutes, Rules, and Regulations

* *Authorities upon which we chiefly rely are marked with asterisks.*

TABLE OF AUTHORITIES
(continued)

Page(s)

* *Authorities upon which we chiefly rely are marked with asterisks.*

TABLE OF AUTHORITIES
(continued)

Page(s)

* *Authorities upon which we chiefly rely are marked with asterisks.*

TABLE OF AUTHORITIES
(continued)

Page(s)

* *Authorities upon which we chiefly rely are marked with asterisks.*

TABLE OF AUTHORITIES
(continued)

Page(s)

Legislative Materials

* *Authorities upon which we chiefly rely are marked with asterisks.*

TABLE OF AUTHORITIES
(continued)

Page(s)

Miscellaneous

* *Authorities upon which we chiefly rely are marked with asterisks.*

TABLE OF AUTHORITIES
(continued)

Page(s)

* *Authorities upon which we chiefly rely are marked with asterisks.*

GLOSSARY

ACA	**Patient Protection and Affordable Care Act**
HIPAA	**Health Insurance Affordability and Accountability Act**
STLDI	**Short-term, limited-duration insurance**

.

.

JURISDICTIONAL STATEMENT

The district court had jurisdiction pursuant to 28 U.S.C. § 1331. This Court has jurisdiction under 28 U.S.C. § 1291. The district court's order entering summary judgment was entered on July 19, 2019, and appellants' Notice of Appeal was timely filed on July 29, 2019.

STATEMENT OF ISSUES

1. Whether the STLDI Rule is invalid because it conflicts with the text, structure, and purpose of the ACA.
2. Whether the STLDI Rule is invalid because it is inconsistent with the statutory term "short-term, limited duration insurance."
3. Whether the STLDI Rule is arbitrary and capricious.

STATUTE AND REGULATIONS INVOLVED

42 U.S.C. § 300gg-91(b)(5) provides:

> The 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

26 C.F.R. § 54.9801-2, 29 C.F.R. § 2590.701-2, and 45 C.F.R. § 144.103 provide:

Short-term, limited-duration insurance means health insurance coverage provided pursuant to a contract with an insurer that:

(1) Has an expiration date specified in the contract that is less than 12 months after the original effective date of the contract and, taking into account renewals or extensions, has a duration of no longer than 36 months in total;

(2) With respect to policies having a coverage date start before January 1, 2019, displays prominently in the contract and in any application materials provided in connection with enrollment in such coverage in at least 14 point type the language in the following notice 1, excluding the heading "Notice 1," with any additional information required by applicable state law:

Notice 1:

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 for an open enrollment period to get other health insurance coverage. Also, this coverage is not "minimum essential coverage." If you don't have minimum

essential coverage for any month in 2018, you may have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

(3) With respect to policies having a coverage start date on or after January 1, 2019, displays prominently in the contract and in any application material provided in connection with enrollment in such coverage in at least 14 point type the language in the following Notice 2, excluding the heading "Notice 2," with any additional information required by applicable state law:

Notice 2:

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 also might 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 for an open enrollment period to get other health insurance coverage.

(4) If a court holds the 36-month maximum duration provision set forth in paragraph (1) of this definition or its applicability to any person or circumstance invalid, the remaining provisions

and their applicability to other people or circumstances shall continue in effect.

STATEMENT

A. Introduction

In the Patient Protection and Affordable Care Act (ACA), Public Law No. 111-148, 124 Stat. 119 (2010), Congress sought to expand health insurance coverage, bolster health insurance markets, and ensure that health insurance policies offer real protection to policyholders. To do that, Congress used a specific health insurance model.

The ACA mandates that policies sold on the individual market—where individuals purchase insurance for themselves and their families (in contrast to employer-provided insurance)—comply with "guaranteed issue" and "community rating" requirements, which respectively (1) bar insurers from denying coverage to any person because of his or her preexisting conditions or health history; and (2) preclude insurers from charging higher premiums based on health history, gender, and many other criteria. The ACA also requires that health insurance policies offer a set of "essential" benefits to covered individuals, ensuring that health insurance is meaningfully protective.

The ACA exempts from these requirements "short-term, limited duration insurance" (STLDI), a narrow category traditionally intended (as its name indicates) to permit the sale of temporary policies to people who need coverage to fill a gap between annual insurance plans.

In the regulation challenged here (the STLDI Rule or Rule), however, the Departments determined that, although standard insurance policies last for a year, an insurance plan qualifies as "short-term, limited duration" when it lasts for ***any period up to a year*** and may be extended up to ***36 months***. They did so with the express goal of creating a health insurance market that operates as an alternative to the one created by the ACA and that effectively excludes people with pre-existing conditions.

By drawing healthier people out of ACA-compliant plans, the Rule will increase the costs and undermine the stability of the market established by the ACA. And it will produce a system in which many people end up with insurance that is wholly inadequate for their needs—the very system that Congress sought to displace by enacting the ACA. That is why the entities most knowledgeable about the Nation's health care system—among them the leading associations of

physicians (including the American Medical Association), of patients (including the American Cancer Society), and of health-care consumers (including the AARP)—appeared in this case below as *amici* to forcefully contest the Rule's validity.

This Rule is indefensible as a matter of law. Its construction of the statutory language may fairly be characterized as Orwellian: "short term, limited duration" insurance is not a term that describes (or that Congress plausibly would have used to describe) a form of primary insurance that operates in practice ***exactly*** like a standard annual insurance policy as to length and renewability. And the Departments promulgated the Rule for the express purpose of creating a separate system of individual health insurance to substitute for, and undermine, the plan adopted by Congress. But "[d]isagreeing with Congress's expressly codified policy choices isn't a luxury administrative agencies enjoy." *Central United Life Ins. Co. v. Burwell*, 827 F.3d 70, 73 (D.C. Cir. 2016). This Court should hold the Rule invalid.

B. Statement of facts

1. Regulation of individual health insurance coverage under HIPAA.

The legislative background relevant here begins in 1996, when Congress enacted the Health Insurance Portability and Accountability Act (HIPAA), Public Law 104-191, 110 Stat. 1936 (1996), an insurance reform statute that, among other things, established limited federal standards for "individual health insurance coverage" and mandated that such coverage provide for guaranteed plan renewability. Under that requirement, an insurer must offer continued insurance to a currently insured individual whose plan is expiring, even if that individual suffered adverse health consequences during the plan term. *Id.* § 111, 110 Stat. at 1979, 1982.

HIPAA exempted STLDI plans from that requirement, stating that "'individual health insurance coverage' … does not include short-term limited duration insurance." *Id.* § 102, 110 Stat. at 1973 (codified at 42 U.S.C. § 300gg-91). Renewability logically would not apply to such plans, which "traditionally [had been] sold to consumers who are trying

to fill coverage gaps for a few months."[1] *See* JA384 (Comment of Timothy Stozfus Jost) (STLDI was used "as a gap filler, purchased by people who, for example, were between jobs or school terms").[2]

The Departments then had to define what constituted an STLDI plan for HIPAA purposes. To do so, they adopted an interim final rule in 1997 that defined "short-term limited-duration coverage" to mean health insurance coverage that expired "within 12 months of the date the [insurance] contract becomes effective." Interim Rules for Health Ins. Portability for Grp. Health Plans, 62 Fed. Reg. 16,894, 16,958 (Apr. 8, 1997). The final rule adopted in 2004 contained the same language. Final Regulations for Health Coverage Portability for Grp. Health Plans

---

[1] Anna Wilde Mathews, *Sales of Short-Term Health Policies Surge*, The Wall Street Journal (Apr. 10, 2016), http://www.wsj.com/articles/sales-of-short-term-health-policies-surge-1460328539, cited at Excepted Benefits; Lifetime and Annual Limits; and Short-Term, Limited-Duration Insurance, 81 Fed. Reg. 75,316, 75,318 n.16 (Oct. 31, 2016).

[2] Prof. Jost is an authoritative source on this subject; he is the author of the HIPAA and ACA sections of the most widely used book for teaching health care law in American law schools, served as an appointed consumer representative to the National Association of Insurance Commissioners, and is an elected member of the National Academy of Medicine. JA381.

and Grp. Health Ins. Issuers Under HIPAA Titles I & IV, 69 Fed. Reg. 78,720, 78,748 (Dec. 30, 2004).

As commenters noted during the 2018 rulemaking challenged here, the Departments' decision in 1997 to interpret "short-term" as permitting a 364-day, 23-hour contract was likely arbitrary and capricious. JA381 (Jost Comment). Nothing in the 1997 preamble to the interim final rule or in the final 2004 rule defended this element of the Departments' definition, and ***no*** comments addressed this aspect of the 1997 or 2004 rule. But because "so little turned on this" (JA385 (Jost Comment))—at the time, STLDI was used only for interim, transitory coverage—this aspect of the Departments' definition went unchallenged.

2. Congress's enactment of the ACA to address discrimination in and promote accessibility to health insurance.

Prior to the enactment of the ACA, many individuals faced substantial discrimination in (or were effectively priced out of) the insurance market. *See* H.R. Rep. No. 111-299, tit. 3, pt. 1. In most States, insurance companies could discriminate in premiums or coverage against individuals based on pre-existing conditions, claims

history, health status, age, gender, occupation, and other factors. That risk segmentation both made health insurance unavailable to many Americans as a practical matter (because individuals with greater health needs faced unaffordable premiums) and led to wide and unsustainable fluctuations in costs for individuals. *See, e.g.*, Cong. Research Serv., *Private Health Insurance Provisions in Senate-Passed H.R. 3590, The Patient Protection and Affordable Care Act* 5 (Jan. 29, 2010).

Congress responded to these problems by enacting the ACA. Insofar as is relevant here, the ACA had two central goals:

First, the ACA "adopt[ed] a series of interlocking reforms designed to expand coverage in the individual health insurance market." *King v. Burwell*, 135 S. Ct. 2480, 2585 (2015). To this end, it established a "guaranteed issue" requirement, mandating that each insurer offering coverage in the individual and group markets in a State "accept every employer and individual in the State that applies for such coverage," prohibiting the prior practice of refusing coverage to individuals with a pre-existing conditions. 42 U.S.C. § 300gg-1(a). An insurer in the

individual or group market therefore may not limit or deny coverage based on the covered parties' health history. *Id.* § 300gg-3.

The ACA also includes a "community rating" provision that limits premium discrimination in the individual and small group health insurance markets. 42 U.S.C. § 300gg. Under this provision, factors such as health status, claims history, race, gender, sexual orientation, geography (except for rating areas established by the State), occupation, and many others may not be considered by insurers in setting rates. *See id.*

Congress regarded guaranteed issue and community rating as central to the ACA and essential to the operation of well-functioning insurance markets. These requirements make all enrollees in the individual market "members of a single risk pool" (42 U.S.C. § 18032(c)), ensuring that risk pools include both the healthy and the sick. To ensure that an adequate number of persons are in this risk pool, Congress (1) provided refundable tax credits to assist the purchase of insurance by individuals with defined household incomes and

(2) required that individuals who did not have qualified health insurance must pay a tax penalty. *See King*, 135 S. Ct. at 2487.[3]

This guarantee of coverage carried with it the risk of adverse selection—that individuals would wait to purchase insurance until they needed health care, which would produce a risk pool skewed toward individuals with high medical costs and therefore increase insurance premiums. Congress enacted several measures to guard against that possibility. In particular, the ACA instructs the Secretary of HHS to provide open enrollment periods for purchasing ACA-compliant plans, so as to encourage individuals to sign up for insurance at the beginning of the year rather than wait to do so until a medical condition arises. 42 U.S.C. § 18031(c)(6)(B). Congress also recognized that some people might miss the open enrollment period through no fault of their own,

[3] Although Congress modified the ACA in 2017 by reducing to zero the tax penalty imposed on individuals for failure to purchase ACA-compliant insurance (*see* Budget Fiscal Year, 2018, Pub. L. No. 115-97, § 11081, 131 Stat. 2054, 2092 (2017)), it did so only after being informed by the Congressional Budget Office that a mandate penalty was ***not*** essential to operation of the statute. Before Congress acted, the CBO reported that if the 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." CBO, *Repealing the Individual Health Insurance Mandate: An Updated Estimate* 1 (Nov. 2017).

and accordingly instructed the Secretary to provide for special enrollment periods to ensure that the Act's promise of guaranteed coverage remains available for these individuals. *Id.* § 18031(c)(6)(C). The Secretary responded by providing a special enrollment period for persons who lose minimum essential coverage mid-year. 45 C.F.R. § 155.420(d)(1).

Second, the ACA established minimum substantive standards ensuring that policies purchased in the individual insurance market will in fact provide meaningful coverage, so as to eliminate the documented and widespread abuses that prompted the Act's enactment. Congress thus required that all individual and small group plans provide a "comprehensive" package of "essential health benefits." 42 U.S.C. § 300gg-6(a). This package includes ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health services, substance use services, prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services and chronic disease management, and pediatric services (including oral and vision care). 42 U.S.C. § 18022(a). The ACA also extended mental health parity to the individual insurance

market, ensuring coverage of mental health and substance use disorder treatment comparable to that for physical health care. In addition, the ACA bans lifetime and annual dollar limits on insurance benefits, and includes other financial protections for enrollees, such as limitations on cost-sharing requirements. *See id.* § 18022(a), (c) (limitations on cost-sharing); *id.* § 18022(d) (minimum actuarial value).

3. The Departments' amendment of their STLDI regulation to harmonize it with the ACA.

In enacting the ACA's reforms, Congress had to specify the category of insurance plans to which the new requirements applied. It did so by cross-referencing HIPAA's definition of "individual health insurance coverage" and defining plans that complied with the ACA's requirements as "qualified health plans."[4] That cross-reference had the effect of exempting STLDI (which had been excluded from the HIPAA definition of individual health insurance) from all the ACA's requirements. So far as we have been able to determine, the language and legislative history of the ACA made ***no*** reference either to STLDI in general or to STLDI's exclusion from ACA requirements in particular.

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

After the ACA's enactment, however, some insurers began using STLDI in novel ways to circumvent the ACA's requirements. Because STLDI plans are not subject to the ACA provisions, such plans may refuse coverage based on an individual's pre-existing health conditions; may discriminate in setting premiums; may omit essential health benefits that must be provided by ACA-compliant plans; and need not adhere to the ACA's bar on annual or lifetime benefits caps and limits on patients' out-of-pocket expenses. The Departments began considering this issue in 2014, the first year for which ACA-compliant plans were available. *See* Excepted Benefits; Lifetime and Annual Limits; and Short-Term, Limited-Duration Insurance, 81 Fed. Reg. 75316, 75318 & n.16 (Oct. 31, 2016). That process culminated in a 2016 final regulation, in which the Departments concluded that, to qualify as an STLDI plan, "coverage must be less than three months in duration, including any period for which the policy may be renewed." *Id.* at 75,318.

The Departments provided detailed, reasoned explanations for this definition in the 2016 rulemaking. They explained that STLDI plans historically had been "designed to fill temporary gaps in coverage when an individual is transitioning from one plan or coverage to

another plan or coverage." 81 Fed. Reg. at 75,317. But, the Departments continued, such plans now were being purchased by some individuals "as their primary form of health coverage," even though these plans did not provide "the protections of the Affordable Care Act" and thus "may not provide meaningful health coverage." *Id.* at 75,317-18. Moreover, the pricing of STLDI plans based on the insured's health history would allow these plans to target "healthier individuals," thereby "adversely impacting the risk pool for Affordable Care Act-compliant coverage." *Id.* at 75,318. Accordingly, the Departments determined that a definition tied to STLDI's original meaning was necessary to "improve the Affordable Care Act's single risk pool" and keep premiums for all participants in the individual health market at an affordable level. *Id.*

4. Congress's continued support for the ACA and promulgation of the STLDI Rule.

Congress has repeatedly considered, and rejected, proposals to repeal the ACA. It declined to adopt numerous proposals to repeal the statute altogether,[5] and declined to repeal or modify the ACA's

[5] *See* American Health Care Act of 2017, H.R. 1628 (2017); Better Care Reconciliation Act of 2017, S. Amend. 270 (July 25, 2017); Obamacare

protections for individuals with pre-existing conditions and its prohibition against discrimination in setting health insurance premiums.[6]

Immediately upon taking office, President Trump had "issued an Executive Order stating his Administration's policy 'to seek the prompt repeal of the [ACA].'" JA561. After the ACA repeal efforts failed, President Trump signed Executive Order 13813 on October 12, 2017, seeking to encourage expanded access to STLDI plans specifically because such plans are exempt from the "insurance mandates and regulations included in title I of the [ACA]"; the Order sought to make STLDI plans an "alternative" to ACA-compliant health care for consumers in the individual insurance marketplaces.[7] The proposed STLDI Rule, issued on February 21, 2018—which permitted STLDI plans to last for up to a year and to be renewed three times—was the

---

Repeal Reconciliation Act of 2017, S. Amend. 271 (July 25, 2017); Healthcare Freedom Act of 2017, S. Amend. 667 (July 26, 2017).

[6] Budget Fiscal Year 2018, 131 Stat. at 2092.

[7] Exec. Order No. 13813, Promoting Healthcare Choice and Competition Across the United States, 82 Fed. Reg. 48,385, 48,385 (Oct. 12, 2017).

Departments' response to the President's directive. Short-Term, Limited-Duration Insurance, 83 Fed. Reg. 7437 (Feb. 21, 2018).

The Departments received approximately 12,000 comments on their proposed rule. "[M]ore than 98%—or 335 of 340—of the healthcare groups that commented on the proposal to loosen restrictions on short term health plans criticized it, in many cases warning that the rule could gravely hurt sick patients," while "[n]ot a single group representing patients, physicians, nurses or hospitals voiced support" for the proposal.[8] The Departments themselves acknowledged that "[m]ost commenters ... stated that [STLDI] plans are not meant to take the place of comprehensive health insurance coverage" and that "most comments suggested not extending the maximum duration beyond the current less-than-3-month maximum." Short-Term, Limited-Duration Insurance, 83 Fed. Reg. 38,212, 38,217 (Aug. 3, 2018). Nevertheless, the Departments "finaliz[ed] the proposed rule with some modifications" on August 3, 2018. *Id.* at 38,214.

---

[8] 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.

"Under this final rule, short-term, limited-duration insurance means health coverage provided pursuant to a contract with an issuer that has an expiration date specified in the contract that is less than 12 months after the original effective date of the contract and, taking into account renewals or extensions, has a duration of no longer than 36 months in total." 83 Fed. Reg. at 38214-15. The Departments also clarified that "[n]othing in this final rule precludes the purchase of separate insurance contracts that run consecutively, so long as each individual contract is separate and can last no longer than 36 months." *Id.* at 38,220.

The final rule thus permits the purchase of STLDI coverage that is just short of a year in length, may be renewed or extended so that it remains in effect for up to three years, and—through the use of consecutive contracts—may be structured so that, as a practical matter, it has ***no*** mandated stopping point.

As the district court recognized (at JA567-70), the change in definition was intended to develop an alternative STLDI health insurance market that would compete with ACA-compliant plans as a means of offering primary insurance coverage: the avowed purpose of

the Rule is to provide "an additional choice for many consumers that exists side-by-side with individual market coverage." 83 Fed. Reg. at 38,218; *accord*, *e.g. id.* (purpose of Rule is "to expand more affordable coverage options to consumers who desire and need them, [and] to help individuals avoid paying for benefits provided in individual health insurance coverage that they believe are not worth the cost"); Julia Limitone, *Affordable Health Care is Here: HHS Sec. Alex Azar*, Fox Bus. (Aug. 2, 2018) (quoting HHS Secretary Alex Azar: "What we are doing is bringing cheap and more affordable options to individuals who are trapped under the Affordable Care Act."), goo.gl/kRgEiy; Press Release, U.S. Dep't of Health and Human Servs., Trump Administration Delivers on Promise of More Affordable Health Insurance Options (Aug. 1, 2018), goo.gl/PCtqf7 (statement of Secretary Azar that STLDI Rule provides "a much more affordable option for millions of the forgotten men and women left out by the current system").[9]

[9] In this respect, the Rule implemented the goal expressly articulated by President Trump: the administration—unable to obtain repeal of the ACA—has set out "doing it, piece by piece, [the ACA] is just being wiped out." Peter Sullivan, *Trump: ObamaCare Being Wiped Out 'Piece By Piece,'* The Hill (Feb. 23, 2018), goo.gl/jq3rnf.

The Departments themselves acknowledged that the Rule will make "relatively young, relatively healthy individuals in the middle-class and upper middle-class" "more likely to purchase short-term, limited-duration insurance," so "the proportion of healthier individuals in the [ACA-compliant individual market] ... will decrease." 83 Fed. Reg. at 38,235. This conclusion is widely shared, including by the American Academy of Actuaries: "Because of medical underwriting at issue, STLD is expected to attract healthier individuals with a lower premium and could put upward pressure on ACA rates as healthier enrollees leave the ACA pool." JA371 (Comment of American Academy of Actuaries).

According to the Departments' own initial estimates, which a number of commenters noted were unduly optimistic, "premiums for unsubsidized enrollees in the Exchanges will increase by 5 percent" as a result of this change. 83 Fed. Reg. at 38,235. The Departments projected that the Rule will cause enrollment in ACA-complaint plans to decrease by 1.3 million by 2028. *Id.* at 38,236. Another model, which accounted for several under-counting errors in the Departments' estimates, calculates that the Rule will lead ACA enrollment to decrease

by 8.2-15.0%, as premiums increase by 2.2-6.6% in the near term.[10] The President's Council of Economic Advisers more recently projected that well over one million enrollees will shift from ACA-compliant to STLDI coverage by ***2021***. Council of Economic Advisers, *Deregulating Health Insurance Markets: Value to Market Participants* 24 (Feb. 2019).

5. Continuing STLDI plan deficiencies.

Commenters also noted the risks that STLDI plans pose for consumers—risks that already have come to pass.

For example, commenters warned that STLDI plans are frequently marketed as providing ACA-compliant or equivalent coverage, thereby deceiving consumers into thinking that these plans offer more coverage than they actually do. JA427 (Comment of Families USA). One study conducted after the Rule's promulgation confirms that this is the case, finding that "consumers shopping online for health insurance, including those using search terms such as 'Obamacare plans' or 'ACA enroll,' will most often be taken to websites and brokers selling STLDI or other non-ACA compliant products." Sabrina Corlette et al., The Urban Institute, *The Marketing of Short-Term Health Plans*

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

2 (Jan. 31, 2019), https://rwjf.ws/2Sybdv2.

Indeed, at least 15 States have already warned consumers about the misleading advertising and exclusion-riddled nature of STLD plans. *See* Dania Palanker, JoAnn Volk, and Maanasa Kona, *Seeing Fraud and Misleading Marketing, States Warn Consumers About Alternative Health Insurance Products*, Commonwealth Fund (Oct. 30, 2019), https://doi.org/10.26099/c32n-5998. But the States have acknowledged that their best efforts will not prevent harm to consumers because they "lack comprehensive data about which insurers actively market STLDI to their residents," "generally lack the authority and/or capacity to engage in preemptive regulatory oversight that would prevent deceptive marketing tactics before they occur," and often cannot enforce their marketing standards retroactively "because little of the purchase transaction is documented in writing." Corlette*, supra*, at 2. As a result, these consumers will be exposed to the very abuses against that the ACA was designed to prevent, including coverage exclusions, after-the-fact rescissions, and unexpected annual and lifetime benefit caps.

6. Procedural history.

Plaintiffs are associations of insurers, health care providers, and entities that assist and advocate for individuals who have medical conditions or otherwise use medical services. All believe that the STLDI

Rule is incompatible with their shared purpose of ensuring access to adequate, affordable health care for all Americans. They instituted this action on September 14, 2018, contending that the STLDI Rule is (1) inconsistent with the ACA's language, structure, and manifest purpose; and (2) is arbitrary and capricious in several respects. Plaintiffs and the government both moved for summary judgment.

In the ruling now on appeal, the district court began by rejecting the government's argument that plaintiffs lack standing. JA565-70. The court held that the insurer plaintiffs have standing under the "competitor standing doctrine," noting that "the 'entire purpose' of the 2018 Rule 'is to promote competition' for individual insurance which will 'inevitably come at the expense of' market competitors, like the insurer plaintiffs, who sell ACA-compliant plans." JA566-67. The court therefore found it unnecessary to consider the standing of the remaining plaintiffs. JA566.

But the court ruled for the government on the merits. It first held that the STLDI Rule does not "implicate[] a question of deep economic and political significance that is central to the statutory scheme," and therefore that the power to issue the Rule is within the Departments'

presumptive authority. JA572 (citations and internal quotation marks omitted); *see* JA573-81. Applying the analysis of *Chevron, U.S.A., Inc. v. Natural Resources Defense Council, Inc.*, 467 U.S. 837 (1984), the court next held that nothing in the ACA's language or policy unambiguously forecloses the Departments' interpretation (JA581-88) and that a renewable plan of insurance that runs for up to a year is consistent with the ordinary meaning of "short-term, limited duration insurance." JA588-91.

The court also found the Rule consistent with the ACA's policy because, in its view, Congress "did ***not*** intend for the law to apply to all species of individual health insurance." JA593. Finally, in a brief footnote, the court rejected plaintiffs' argument that the Rule is arbitrary and capricious, opining that the Departments provided a reasoned basis for their departure from the 2016 Rule and adequately addressed significant objections raised by comments submitted during the 2018 rulemaking. JA594-95 & n.16.

SUMMARY OF ARGUMENT

A. The STLDI Rule is irreconcilable with the structure and policy of the ACA. It is central to Congress's plan that virtually all persons in

the individual health insurance market be included in a single risk pool. And it was a key congressional goal that all persons in that market both receive specified "essential" insurance protections and are shielded against the pernicious effects of benefits caps.

The Rule's purpose and effect—made clear by its text—will frustrate both of these congressional goals. It is designed to draw younger and healthier individuals out of ACA-compliant plans—and therefore out of the ACA single risk pool—with the inevitable result that premiums on ACA-compliant plans will increase. And it will cause millions of people who purchase skimpy STLDI plans to lose both the health insurance benefits that Congress labeled "essential" and the crucial protection of bars on caps to annual and lifetime benefits.

The Departments lack the authority to issue a regulation that so directly undercuts the statute they are purporting to enforce. And it is particularly apparent that Congress did not authorize the Departments to take such a radical step through the backhanded cross-reference in the ACA of an obscure definition in another statute; as Justice Scalia famously wrote for the Supreme Court, Congress does not hide elephants in mouseholes.

B. The Rule also is inconsistent with the plain meaning of the statutory terms "short-term" and "limited duration." A standard term of insurance is one year long. That being so, no one who uses words in the ordinary way would describe an insurance plan that lasts for 364 days and 23 hours as a "short-term" plan; in ordinary usage, a brief filed in this Court that has 12,999 words (rather than the permissible 13,000) is not a "short brief."

Ued in combination with "short-term" and in light of its history, "limited duration" means nonrenewable; again, no reasonable user of language would characterize a plan that may be renewed three times for up to 36 months as a "limited duration" plan. Had Congress really meant to authorize the creation of a new form of long-lasting, primary health insurance, it surely would not have called it "short-term, limited duration insurance."

C. The Rule is arbitrary and capricious. The Departments made no attempt to explain what was wrong with the rule they had adopted just two years earlier that limited STLDI to a nonrenewable three-month term; the concerns identified in 2016 with adverse selection and denial of essential health benefits were just as salient in 2018 as in

2016. And the Departments simply disregarded comments noting that the Rule would cause gaps in health insurance, as people who use STLDI as their primary form of insurance lose their STLDI coverage but (because they had not been in an ACA-compliant plan) are not eligible to participate in an ACA special enrollment period.

STANDARD OF REVIEW

On appeal from a district court's ruling on a challenge to agency action, this Court "review[s] the district court's grant of summary judgment de novo, 'applying the same standards as those that govern the district court's determination.'" (citation omitted). *Alpharma Inc. v. Leavitt*, 460 F.3d 1, 6 (D.C. Cir. 2006).

ARGUMENT

The government's defense of the Rule rests on two central propositions. The first is that Congress—through the incorporation by reference into the ACA of a definition from another statute—meant to authorize the Departments to promulgate a rule that allows ***anyone*** in the individual health insurance market to purchase, as their continuing, primary form of insurance, a policy that does not comply with ACA requirements; that pulls consumers out of the ACA single-risk pool; that effectively excludes people with pre-existing conditions;

that omits benefits characterized by Congress as "essential"; and that will leave many consumers saddled with ruinous medical debt. The second is that Congress used the phrase "short-term, limited duration insurance" to authorize a new form of primary health insurance that operates, in practice, ***just*** like standard insurance.

The Red Queen could believe many impossible things before breakfast, but this Court should not. Congress customarily does not—without a word of explanation—authorize agencies to subvert the key goals of major statutes. Congress typically does not use ordinary words to mean the opposite of what they plainly say. And federal agencies may not adopt regulations that have the purpose and effect of undermining a statutory regime, based on agency preferences that are directly contrary to the congressional judgments embodied in statute—and that Congress itself repeatedly has declined to enact.

Under the Administrative Procedure Act, courts must "hold unlawful and set aside agency action" that is "arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law." 5 U.S.C. § 706(2)(A). Here, the STLDI Rule is unlawful for at least three reasons: (1) the Departments exceeded their authority by promulgating a rule

that departs from the individual health insurance market structure established by Congress in the text and structure of the ACA; (2) the Departments' interpretation of "short term" and "limited duration" is contrary to the plain meaning of the statutory text; and (3) the STLDI Rule is arbitrary and capricious because the Departments adopted a rule that is expressly designed to overturn Congress's determinations embodied in the ACA, failed to offer a reasoned explanation for their departure from the 2016 Rule, and did not provide a meaningful response to critical comments on the Rule. The STLDI Rule should be set aside.

I. The STLDI Rule is invalid as not in accordance with law.

It is fundamental that federal agencies may not issue rules that conflict with the statutes that the agencies are purporting to apply: Courts "must reject administrative construction of [a] statute .... that frustrate[s] the policy that Congress sought to implement." *Shays v. Fed. Election Comm'n*, 528 F.3d 914, 919 (D.C. Cir. 2008).[11] In assessing

[11] *See also*, *e.g.*, *Util. Air Regulatory Grp. v. E.P.A.*, 573 U.S. 302, 321 (2014) ("[A]n agency interpretation that is 'inconsisten[t] with the design and structure of the statute as a whole' does not merit deference." (citation omitted)); *Chem. Mfrs. Ass'n v. Nat. Res. Def.*

the consistency of a regulation with the statute it interprets, a court "first exhausts the traditional tools of statutory construction to determine whether a congressional act admits of plain meaning. If, in light of its text, legislative history, structure, and purpose, a statute is found to be plain in its meaning, then Congress has expressed its intention as to the question, and deference is not appropriate." *Arizona Public Service Co. v. E.P.A.*, 211 F.3d 1280, 1287 (D.C. Cir. 2000).

In the ACA, Congress structured the individual health insurance market in the particular manner that it determined would improve access to health care. The Departments' power and discretion to act are constrained by that statutory determination. Because the STLDI Rule contravenes Congress's judgment, embodied in the text and structure of the ACA, the Rule is contrary to law.[12]

Council, Inc., 470 U.S. 116, 125 (1985) ("[I]f Congress has clearly expressed an intent contrary to that of the Agency, our duty is to enforce the will of Congress.")ok; *Chevron*, 467 U.S. at 843 n.9 ("The judiciary is the final authority on issues of statutory construction and must reject administrative constructions which are contrary to clear congressional intent.").

[12] In its analysis, the district court concluded that "*Chevron*'s deferential framework" applies here because the 2018 Rule does not involve a "question of [such] deep economic and political significance" "that Congress would not have conferred [the authority to promulgate

A. The STLDI Rule departs from the requirements imposed by Congress to govern the individual insurance market.

To begin with, Congress in the ACA spoke to the very questions that the Departments now claim to be addressing, making clear that the Departments may not establish STLDI as a generally available alternative to ACA-compliant insurance. This reality is fatal to the government's defense of the Rule.

---

the Rule on the Departments] without so stating." JA571, 572 & n.7 (citations and internal quotation marks omitted). The court rested that determination on its conclusions that (1) Congress left it to the Departments to define "an *entire category* of individual health insurance" (that is, STLDI) (JA575; and (2) in the court's view, the data do not show that the STLDI Rule "is, in fact, causing any meaningful number of individuals to leave the Exchange markets and purchase STLDI plans." JA578. The district court was wrong on both of these points. As we show in text, there is literally ***no*** evidence that Congress meant to confer upon the Departments the authority create of an entirely new form of primary health insurance. And the government itself projects that millions of people will leave ACA-compliant plans for STLDI (*see* pages 21-22, *supra*); it could hardly be otherwise, as the STLDI Rule was promulgated specifically to have that effect. *See, e.g., King*, 135 S. Ct. at 2489 (*Chevron* does not apply to analysis of regulation "affecting the health insurance for millions of people"). In our view, however, whether the interpretive rule of *King* or of *Chevron* applies makes no difference to the outcome of this case. As we have noted, deference to the agency is not warranted when the "statute is found to be plain in its meaning," and the Court should find the meaning of the ACA to be plain here.

When reviewing an agency's construction of the statute that it administers, courts must first determine "whether Congress has directly spoken to the precise question at issue. If the intent of Congress is clear, that is the end of the matter." *Chevron*, 467 U.S. at 842-43. That principle resolves this case. Here, the statutory scheme created by the ACA unambiguously precludes precisely what the Departments seek to do.

In the ACA, Congress enacted a comprehensive system for "expand[ing] more affordable coverage options to consumers who desire and need them" and "reduc[ing] the number of uninsured individuals" (83 Fed. Reg. at 38,218)—the purported goals of the STLDI Rule. It sought to accomplish these goals in two ways.

First, through the requirements of guaranteed issue and community rating. *See* 42 U.S.C. §§ 300gg-1, 300gg-3, 300gg-4(a); §§ 300gg(a)(1), 300gg-4(b). To ensure that insurance in the individual market remains affordable, Congress required that health insurance consumers in the individual market be "members of a ***singl****e* risk pool." 42 U.S.C. § 18032(c) (emphasis added). Congress "designed the Act" this way because its overriding concern was "to avoid" "creat[ing] . . . 'death

spirals'" in the insurance market (*King*, 135 S. Ct. at 2494), which would develop if younger and healthier consumers left ACA-compliant plans for those that did not comply with the guaranteed-issue and community-rating requirements.

Congress's unequivocal goal was preventing that result. It designed the ACA to "minimize . . . adverse selection and broaden the health insurance risk pool to include healthy individuals," which would "lower health insurance premiums" and create "effective health insurance markets" that contain "improved health insurance products" and expand access to quality affordable health care for all. 42 U.S.C. § 18091(2)(I). Moreover, Congress made it clear that this result was the purpose of the entire Act, not just a single provision. *E.g.*, *id.* § 18061 (requiring states to establish "applicable reinsurance entities," "the purpose of which is to help stabilize premiums . . . when the risk of adverse selection related to new rating rules and market changes is greatest"); *id.* § 18032(c) (requiring "[a] health insurance issuer [to] consider all enrollees ... to be members of a single risk pool" in the individual and small group markets).

This is particularly important in a statute like the ACA, where the major provisions are "interdependent" and expressly note that they work "together with the other provisions of [the] Act." *See Nat'l Fed'n of Indep. Bus. v. Sibelius*, 567 U.S. 519, 696 (2012) (Scalia, J., dissenting); *see also* 42 U.S.C. § 18091(2)(C) (working "together" to "add millions of new consumers to the health insurance market"); *id.* § 18091(2)(E) (working "together" to "significantly reduce" the economic cost of the "poorer health and shorter lifespan of the uninsured"); *id.* § 18091(2)(F) (working "together" to "lower health insurance premiums"); *id.* § 18091(2)(G) (working "together" to "improve financial security for families"); *id.* § 18091(2)(I) (working "together" to minimize "adverse selection and broaden the health insurance risk pool to include healthy individuals"); *id.* § 18091(2)(J) (working "together" to "significantly reduce administrative costs and lower health insurance premiums").

Given that goal, the ACA's "statutory scheme compels [courts] to reject [an] interpretation [of the ACA if the interpretation] would destabilize the individual insurance market . . . and likely create the very 'death spirals' that Congress designed the Act to avoid." *King*, 135

S. Ct. at 2492-93. In *King*, the Court rejected as "implausible" an interpretation of the Act that would undermine its "guaranteed issue and community rating requirements." *Id.* at 2494.

The STLDI Rule has the same effect. As the Departments have not only admitted, but celebrated (*supra* 19-22), the Rule's purpose is to segment the insurance market by providing an alternative to ACA-compliant plans for healthy individuals. This is—literally—the definition of adverse selection. The Rule's result is therefore directly contrary to the ACA's express goal.

Second, Congress addressed whether the government should "help individuals avoid paying for benefits provided in individual health insurance coverage that they believe are not worth the cost" (83 Fed. Reg. at 38,218)—another asserted goal of the STLDI Rule. And Congress unambiguously answered ***no***, codifying in the ACA its judgment that ***all*** individuals should receive coverage for certain essential health benefits so as to assure access to necessary health care. *See* 42 U.S.C. §§ 300gg-6(a), 18022(b). There is no doubt that Congress regarded such benefits as a crucial element of the reformed insurance

market; after all, it labeled them "essential" in the statutory text.[13] And here again, the STLDI Rule, which will vastly expand the use of what Congress expressly declared to be ***inadequate*** insurance products, implements a policy that Congress specifically rejected in the language of the ACA.

Congress likewise considered whether the government should let individuals gamble on cheaper health care that offered inadequate protections and had paltry coverage limits. Again, it unambiguously answered ***no***. *See* 42 U.S.C. §§ 300gg-11 (prohibiting insurers from imposing "lifetime [and with a limited pre-2014 exception, annual] limits on the dollar value of benefits for any participant or beneficiary"). A primary motivation of the ACA was ending the tragedy of patients whose financial ailments compounded their medical ones, once they became ill and quickly hit their coverage limits. The legislative record

---

[13] *See also* S. Rep. No. 111-89, at 9 (2009) ("The purpose of [the bill] would be to ensure that ***all Americans*** have access to affordable and essential health benefits coverage."); 156 Cong. Rec. H1865 (daily ed. Mar. 21, 2010) (statement of Rep. Doggett) ("With this reform, ***every insured American*** gets valuable consumer protections."); 155 Cong. Rec. S13375 (daily ed. Dec. 17, 2009) (statement of Rep. Johnson) (stating that the act "will provide the security of ***meaningful***, affordable health care coverage ***for all***") (emphases added).

repeatedly confirms that the ACA's purpose was to prevent ***any*** American from suffering that fate.[14] Again, the STLDI Rule thwarts Congress's intent on this point.

B. Congress would have spoken more clearly had it intended to give the Departments the authority to create an alternative form of primary insurance.

The conflict between the Rule and Congress's intent is confirmed by the extraordinary nature of the change that the Departments would effect through the STLDI Rule. To determine whether Congress has spoken to a question, courts employ "traditional tools of statutory construction" (*Chevron*, 467 U.S. at 843 n.9)—including "all pertinent interpretive principles." *Carter v. Welles-Bowen Realty, Inc.*, 736 F.3d

---

[14] *See, e.g.*, 156 Cong. Rec. H1913 (daily ed. Mar. 21, 2010) (statement of Rep. Israel) (noting that the ACA "guarantee[s] a standard benefit package for ***all Americans*** with an annual cap on out-of-pocket spending. ***No family*** should go bankrupt because of medical expenses") (emphasis added); 155 Cong. Rec. H12867 (daily ed. Nov. 7, 2009) (statement of Rep. Miller) ("Let me be specific about what our reforms will mean for the American people: ... An annual cap on out-of-pocket expenses ... and [a] ban on lifetime caps on what insurance companies will pay"); *id.* at H12866 (statement of Rep. Wu) ("The bill will set a yearly limit on how much you can be charged for out-of-pocket expenses because ***no one*** should go broke because you get sick.") (emphasis added); *id.* at H12605 (statement of Rep. Slaughter) ("With this bill we can end the constant worry by people who ... reach [their] lifetime cap on insurance.").

722, 731 (6th Cir. 2013) (Sutton, J., concurring). "If an interpretive principle resolves a statutory doubt in one direction, an agency may not reasonably resolve it in the opposite direction." *Id.*

One such principle is that courts "expect Congress to speak clearly if it wishes to assign to an agency decisions of vast 'economic and political significance.'" *King*, 135 S. Ct. at 2489; *Util. Air Regulatory Grp. v. EPA*, 573 U.S. at 326.

Here, that is just what the Departments would accomplish with the STLDI Rule. They purport to create a new form of primary health insurance that is exempt from all of the ACA's central requirements—with the express purpose of drawing "millions" of people out of what Congress intended to be a single market, while also vastly expanding the number of individuals who purchase insurance that lacks the characteristics Congress regarded as "essential." *See* pages 19-22, *supra.* Whether or not the Rule makes ACA-compliant coverage unaffordable for many people, it certainly will have an enormous impact on the structure of the individual insurance market and the innumerable people who obtain health insurance through it—in a manner directly contrary to Congress's determinations embodied in the

ACA. *See, e.g, Timeline: History of Health Reform in the U.S.*, Kaiser Family Foundation (2011), perma.cc/539M-4QFY.

But the Departments do not, and cannot, identify any clear and specific congressional grant of authority to unilaterally restructure the nationwide individual insurance market and determine whether and how much insurance individuals should be permitted to purchase. The Departments rely instead only on a generalized "necessary and appropriate" clause that appears, not in the ACA, but in the Public Health Services Act. *See* 83 Fed. Reg. at 38,216. It surely is implausible to suggest that Congress intended to delegate such sweeping and contentious authority to the Departments through a vague and generalized "necessary and appropriate" provision and a single undefined statutory term. As the Supreme Court has put it, Congress "does not, one might say, hide elephants in mouseholes." *Whitman v. Am. Trucking Ass'ns, Inc.*, 531 U.S. 457, 468 (2001).[15]

[15] We address above the district court's view that a rule that was designed to (and will in fact) affect the health insurance of millions of people is not a regulatory elephant, and that a statutory definition borrowed by cross-reference from a prior law without explanation or comment is not a statutory mousehole. *See* note 12, *supra*; JA573-77.

The Departments have taken this step because they disagree with the statutory scheme that Congress created, openly declaring their intent to develop a parallel market, outside the ACA's single risk pool, in which coverage is not assured and essential benefits are not guaranteed. But they are "not free to substitute new goals in place of the statutory objectives without explaining how these actions are consistent with [their] authority under the statute." *Indep. U.S. Tanker Owners Comm. v. Dole*, 809 F.2d 847, 854 (D.C. Cir. 1987). For the reasons we have explained, the Departments have failed to do that here.

C. The Departments' defenses of the rule are unavailing.

Against this background, the government presented, and the district court accepted, several defenses of the Rule. None has merit.

1. Congress did not seek to encourage use of insurance that fails to offer the protections mandated by the ACA.

The district court was incorrect in opining that "[t]here is no indication that the ACA is structurally incompatible with the STLDI exemption" because "lawmakers were not rigidly pursuing the ACA-

compliant market at all costs." JA586 n.13, 594; JA580-81[16] In fact, Congress's plan was to create a single, ACA-compliant individual market: It is essential to the operation of the ACA that virtually all purchasers of insurance in the individual market participate in a single risk pool. On the face of it, a regulation that is intended to create an alternative individual insurance market for non-ACA compliant plans available to anyone—except, of course, those who are priced out of the alternative market because they have a pre-existing condition or are subject to price discrimination—is therefore fundamentally incompatible with the ACA.

The district court's suggestion that Congress's principal concern was expanding the use of ***any*** kind of health insurance, rather than only ACA-compliant plans (JA581), is quite wrong. Congress could have

[16] The district court indicated that Congress "sought to foster a robust ACA-compliant market" through "the individual mandate and tax penalty," and that the zeroing out of the penalty therefore somehow changes the legal significance of ACA provisions that Congress did ***not*** change. JA594. But that is not so. Even while reducing the tax penalty to zero, Congress repeatedly declined to repeal the ACA or others of the Act's provisions; reduced the tax penalty only after being assured that health insurance markets would remain stable; and nowhere suggested that it would be permissible for the Departments to encourage creation of an alternative insurance regime that would sell policies lacking "essential" benefits and draw people out of ACA-compliant plans.

allowed the sale of skimpy plans that omit essential medical services, or that impose low annual or lifetime caps on benefit payments. But that is precisely what Congress rejected in the ACA. It required ACA-compliant plans to offer essential services—and it labeled those health benefits "essential"—for a reason: prior to the ACA, plans that omitted such benefits or imposed coverage caps both led consumers to suffer "the financial devastation that came with a serious or chronic condition requiring particularly expensive treatment," and denied consumers treatments that "are crucial for patient health, and in some cases life-saving." AMA District Court *amicus* Br. (AMA DC Br.) 9, 14, Dkt. No. 55. Congress did not want the ACA to replicate that regime; it enacted the ACA specifically to supplant it. Yet, as we show above (at 22-23) and as the medical *amici* confirmed (AMA DC Br. 12-21), STLDI plans often have the very deficiencies that Congress sought to eliminate. Far from furthering the ACA's goals, the STLDI Rule would directly undermine the congressional objective.

Congress was quite clear about this. It meant the ACA to "standardize benefits to force insurance companies to compete on price and quality ***and not their ability to select the healthiest***

individuals and ensures that ***every*** policy offered in the individual and small group market provides meaningful coverage for essential services." S. Rep. No. 111-89, at 4 (2009) (emphasis added). Thus, the ACA's purpose was "to ensure that all Americans have access to affordable and essential health benefits coverage (1) by requiring that ***all*** new health benefits plans offered to individuals and employers in the individual and small group market are qualified health plans (QHPs) that meet the insurance rating reforms and essential health benefits coverage requirements[.]" *Id.* at 9 (emphasis added). Yet the Rule allows the new expanded STLDI plans to create a market for individual insurance that ***does*** compete on the "ability to select the healthiest individuals" and ***does not*** offer essential benefits.

2. The Rule cannot be justified by Congress's authorization of student and grandfathered plans.

The district court also thought that the Departments' vast expansion of STLDI policies is consistent with the ACA because "Congress exempted multiple forms of individual health insurance from the ACA's reforms and the State-specific risk pools," pointing specifically to student and grandfathered plans. JA593-94 & n.15. But

the exemptions identified by the district court are not really ACA exceptions at all.

Student plans are exempted from the ACA requirements that make no sense in a university context. For example, the governing regulation limits guaranteed renewability by permitting a student plan to cease coverage when the covered individual ***ceases being a student*** (45 C.F.R. § 147.145(b)(iii)), allows the student plan to adjust the coverage period to less than a year (permitting it to match the academic year) (*id.* § 147.145(b)(ii)), and so on. Notably, the preamble to the interim student plan regulation makes clear that the regulation does ***not*** permit student plans to avoid providing "important protections of the PHS Act and the Affordable Care Act that apply to individual health insurance coverage," making student plans "generally subject to the individual market requirements" of those laws. *Student Health Insurance Coverage*, 76 Fed. Reg. 7767, 7770 (Feb. 11, 2011).

As for grandfathered plans, they were not subjected to the entirety of ACA requirements so as to "***ease the transition of the healthcare industry*** into the reforms established by the Affordable Care Act." Interim Final Rules for Group Health Plans and Health Insurance

Coverage Relating to Status as a Grandfathered Health Plan Under the Patient Protection and Affordable Care Act, 75 Fed. Reg. 34,538, 34,541 (June 17, 2010) (emphasis added).[17] For that reason, the Departments promulgated regulations that imposed some ACA requirements on such plans immediately, and then laid out steps that insurers had to take to maintain grandfather status. *Id.* They also implemented a number of provisions, such as restrictions on cost-sharing, designed to nudge insurers toward un-grandfathering their plans. 75 Fed. Reg. at 34,549-50. And in any event, grandfathered plans are still subject to a number of ACA requirements, including (among others) the medical loss ratio requirements, elimination of pre-existing condition requirements, and the ban on lifetime coverage caps (and, starting in 2014, the ban on annual coverage limits). *See* Grandfathered Health Insurance Plans, https://www.healthcare.gov/health-care-law-protections/grandfathered-plans/; Soc'y for Human Res. Mgmt., *FAQs About Grandfathered Health Plans* (Aug. 26, 2013), perma.cc/3X6R-GFFC (summarizing rules).

---

[17] *See also* Final Rules for Grandfathered Plans, Preexisting Condition Exclusions, Lifetime and Annual Limits, Rescissions, Dependent Coverage, Appeals, and Patient Protections Under the Affordable Care Act, 80 Fed. Reg. 72,192, 72,193 (Nov. 18, 2015) (finalizing interim final rules "without substantial change").

Thus, the treatment of grandfathered plans and student plans under the ACA is entirely consistent with Congress's intent to minimize, as far as possible, the number of Americans purchasing individual market coverage who are outside the single ACA risk pool and who lack essential health benefit coverage. And they certainly are not support for an approach that, like the STLDI Rule, would allow ***any*** healthy person to buy, at will, coverage that does not comply with the ACA.

3. Congress did not ratify the STLDI definition adopted by rule in 1997.

The district court also erred in concluding that Congress should be deemed to have ratified the 1997 Rule's STLDI definition when it incorporated into the ACA, by reference, HIPAA's definition of individual health insurance. JA573-74. "Although [the Supreme Court has] recognized congressional acquiescence to administrative interpretations of a statute in some situations, [it has] done so with extreme care." *See Solid Waste Agency of N. Cook Cty. v. U.S. Army Corps of Eng'rs*, 531 U.S. 159, 169 (2001). In particular, both the Supreme Court and this Court have explained that the legislative reenactment doctrine "requires a showing of both congressional

awareness and 'express congressional approval of an administrative interpretation if it is to be viewed as statutorily mandated.'" *Gen Am. Transp. Corp. v. I.C.C.*, 872 F.2d 1048, 1053 (D.C. Cir. 1989) (quoting *AFL-CIO v. Brock*, 835 F.2d 912, 915 (D.C. Cir. 1987)).[18] That standard requires rejection of the government's ratification argument.

In this case, there is no evidence that Congress was even aware of the Departments' interpretation of HIPAA's STLDI language when it enacted the ACA, let alone that it approved of the Departments' gloss. That likely is because, as we demonstrate above (at 9), the STLDI definition as it related to HIPAA was of very limited importance, was

[18] *See also, e.g.*, *Brown v. Gardner*, 513 U.S. 115, 121 (1994) (finding no reenactment because "the record of congressional discussion preceding reenactment makes no reference to the VA regulation, and there is no other evidence to suggest that Congress was even aware of the VA's interpretive position"); *Demarest v. Manspeaker*, 498 U.S. 184, 190 (1991) (refusing to apply legislative reenactment doctrine because "[t]here is no indication that Congress was aware of the administrative construction … at the time it revised the statute"); *United States v. Calamaro*, 354 U.S. 351, 359 (1957) (same); *Cape Cod Hosp. v. Sebelius*, 630 F.3d 203, 214 (D.C. Cir. 2011) (ratification canon "has little relevance" where Congress did not reenact the specific section at issue); *Pub. Citizen, Inc. v. HHS*, 332 F.3d 654, 668, 669 (D.C. Cir. 2003) (ratification canon is of "little assistance" where Congress did not amend statutory language at issue; "the government's [ratification] argument has little weight absent some evidence (or reason to assume) congressional familiarity with the administrative interpretation at issue.").

not discussed by the Departments in the promulgation of the HIPAA STLDI rule, was the subject of ***no*** public comments at that time, and (as STLDI was understood to be a transitional form of insurance), would not have been regarded as relevant to the ACA. The ratification doctrine therefore has no application here.[19]

And, of course, the ratification canon in any event cannot overcome the plain meaning of the statute. *U.S. Ass'n of Reptile Keepers, Inc. v. Zinke*, 852 F.3d 1131, 1141 (D.C. Cir. 2017). "Where the law is plain, subsequent reenactment does not constitute an adoption of a previous administrative construction." *Demarest*, 498 U.S. at 190; *accord, Brown v. Gardner*, 513 U.S. at 121. For all the reasons already discussed, that is the case here.

---

[19] This is particularly the case given the fact that in December 2016—after the Departments issued the 2016 rule limiting STLDI to no more than three months—Congress further amended Section 300gg-91, without addressing the STLDI definition or disturbing the specific provision that defines the term "individual health insurance coverage." 21st Century Cures Act, Pub. L. No. 114-255, div. C, tit. 18, § 18001(c)(1), 130 Stat. 1033, 1344 (2016). Under the logic of the government's own ratification argument, then, it would be at least as accurate, if not more so, to claim that Congress ratified the ***three-month*** limit on short-term plans.

II. The Departments' interpretation of the statutory language is inconsistent with its plain meaning.

Against this background—and applying simple common sense to the specific statutory language at issue—it is unsurprising that the Departments' efforts to shoehorn their policy goals into the phrase "short-term limited duration insurance" as used in the ACA also is contrary to the plain meaning of the statutory text. The STLDI Rule allows for the sale of policies that last just short of a year, that may be renewed so that they continue in effect for 36 months, and that may be "stacked" so that they remain in force indefinitely. Such STLDI policies are indistinguishable from standard polices to the naked eye, and surely will look like ordinary insurance to the typical consumer, so much so that the Departments found it necessary to require that such policies carry disclaimers declaring that they need not comply with the ACA. *See* 83 Fed. Reg. at 38,223.

Such policies are not, in any ordinary use of the words, "short-term, limited duration insurance." And surely, it is inconceivable that Congress, had it really set out to authorize the creation of a new form of primary insurance that serves as an alternative to ACA-compliant coverage, would have given that insurance the labels "short-term" and

"limited duration." The real difference between ACA-compliant and STLDI policies has nothing to do with their length; it involves their content. STLDI plans are not meaningfully shorter than ACA-compliant plans; but they are much skimpier.

A. The Departments' interpretation of "short-term" is insupportable.

1. The plain meaning of "short-term" insurance is a policy that is meaningfully shorter than the standard annual insurance term.

The plain meaning of the phrase "short term" is unambiguous: it means "occurring over or involving a relatively short period of time." *Short-term*, Merriam-Webster Dictionary, perma.cc/4ZCF-QPLQ. As that definition makes clear, and as the district court itself recognized (*see* JA590), something can be "short" only as it relates to the length of something else: A length of one foot is very short for the neck of a giraffe, but very long for the neck of a turtle. And here, the relevant benchmark is the length of a ***standard*** health insurance plan: one year. *See, e.g.,* 42 U.S.C. § 13031 (requiring American Health Benefit Exchanges to provide for "annual open enrollment periods"); *Definition of Health Insurance Terms*, Bureau of Labor Statistics, perma.cc/T3MF-SFBU (noting that a benefit period is "usually a year"); *Glossary of*

Health Insurance Terms, Med. Mut., perma.cc/H4WX-VCPR (defining "benefit period" and explaining that "[i]t is often one calendar year for health insurance plans"); *Plan Year*, HealthCare.gov, perma.cc/CV6L-QQAU (defining "plan year" as a "12-month period of benefits coverage under a group health plan"); JA381 (Jost Comment).

A "short-term" insurance plan, then, is one that involves a "relatively short period of time" as compared to one year. And a term that is just an hour short of one year—*i.e.* more than 99.9 per cent the length of a standard term of health insurance—cannot in any meaningful sense of the word be considered "short."

In nevertheless concluding that a 364-day, 23-hour plan is "short," the district court described as "wishful thinking" the suggestion that a "short-term" plan must be measured against the length of a standard annual insurance plan. JA583. But the government has not denied that a standard insurance plan lasts for a year (a claim that would, in any event, be belied by the annual open enrollment periods used in all ACA Exchanges, for federal employee insurance, and with which virtually all Americans who have employer-supplied insurance are familiar). The district court itself recognized that the statutory word "short"

necessarily means "'short' by comparison to another term." JA589. That being so, the only plausible comparative benchmark is the standard annual insurance term.

The district court also concluded that, even granting that a standard insurance term is one year, "a plan with an initial term of less than a year constitutes 'a relatively short period of time.'" JA590. But, with respect, that reasoning tortures customary usage. It would seem obvious that "[n]o one would call a 119-minute movie a short movie, compared to a 120-minute movie." JA384 (Jost Comment). This Court likely would not describe this brief—which has 12,997 words, rather than the maximum permissible 13,000, as a "short brief." And Congress surely would not have called a plan of insurance that is a minute short of the standard term (and that is intended to function like standard, primary insurance in all practical respects) a "short-term" plan.[20]

[20] The district court also pointed to state-law definitions of "short-term" insurance that mirror the Departments' approach. JA590 n.14. But these definitions generally (like the two specifically cited by the court, in South Dakota and Texas) simply ***followed*** the 1997 Rule's definitions, in time and in substance, having been promulgated when STLDI was not used as a primary form of insurance. They add no support to the court's analysis.

There is no ambiguity on this point. "Ambiguity … 'is a creature not of definitional possibilities but of statutory context.' *Brown v. Gardner*, 513 U.S. 115, 118 (1994). [And] [s]een in its proper context, [the STLDI Rule] clearly misreads the [ACA]." *Central United Life*, 827 F.3d at 74.

2. Short-term insurance as used in the ACA should receive the same length as the term "short coverage gap" as used in the same statute.

Moreover, other elements of the ACA's text confirm that "short," as used in "short-term plan," has a meaning consistent with its plain meaning—*i.e.*, a period that is relatively shorter than the typical 12-month standard insurance plan. Thus, in the ACA Congress provided that a "short coverage gap[]" was exempt from the ACA's penalty for failure to maintain minimum essential coverage, defining "short coverage gap[]" as a "period of less than 3 months." 42 U.S.C. § 5000A(e)(4)(A). Congress presumptively intended that definition of "short"—as meaning a "period of less than 3 months"—to apply to the interpretation of same word as used in the phrase "short-term" coverage (as incorporated in the ACA).

And this canon applies with special force here because the "short coverage gaps" and "short-term limited duration coverage" provisions complement one another: The "short coverage gap" provision and STLDI both address the length of time during which a person may go without ACA-compliant coverage. The first withholds a penalty during that time. And the second allows for transitional insurance during that period—which, as we explain below (at 64), is the length of time of a traditional waiting period for employer coverage. *See also* 42 U.S.C. § 300gg-7 (providing that "[a] group health plan and a health insurance issuer offering group health insurance coverage shall not apply any waiting period . . . that exceeds 90 days").[21]

---

[21] The District court questioned whether ACA, as opposed to HIPAA, "is relevant to the *Chevron* analysis at all, given that the statute does not reference STLDI but simply reenacts HIPAA's exemption of STLDI from individual market regulations." JA586 n.31. But the STLDI Rule is a regulation promulgated specifically to affect the operation of the ACA by allowing persons to obtain primary forms of insurance that do not satisfy ACA requirements. That being so, the language that the Departments purport to apply may not be interpreted in a manner that is "clearly inconsistent with the intent of [the] Congress" that enacted the ACA. *Mova Pharm. Corp. v. Shalala*, 140 F.3d 1060, 1067-69, 1070 (D.C. Cir. 1998). Indeed, that Congress used the same word in the ACA to apply both to short coverage gaps (which must be no longer than 90 days) and to STLDI bears on Congress's understanding in 2010 of the word as originally used in HIPAA.

B. Interpreting "limited duration" to encompass plans that may be renewed for a total of 36 months is contrary to law.

The Departments' interpretation of "limited duration" as permitting insurance plan renewals of up to three years—with the possibility that, at the time of purchase, these contracts could be stacked on end to give them an even longer effective life—is likewise contrary to law. The plain meaning of the statutory text is that short-term limited duration insurance is a one-time, ***non-renewable*** coverage option. "Limited" means "[r]estricted in size, amount, or extent." *Limited*, Oxford English Dictionary, perma.cc/P9ZB-LVJH. But a contract that may be automatically renewed numerous times and replicated so that it lasts indefinitely hardly fits within that formula. This conclusion is bolstered by the fact that States that have legislated on the topic of STLDI plans typically refer to such coverage as non-renewable or renewable only for a very short period.[22]

---

[22] *See, e.g.,* 1994 Minn. Laws 556; 1995 N.H. S.B. 30; 1995 Or. S.B. 152; 1995 Ind. S.B. 576; 1995 Mo. S.B. 27; 1995 Tenn. H.B. 1213; 1996 Fla. S.B. 910; 1996 Va. H.B. 1026; 1998 Mich. S.B. 1007; Nev. Admin. Code § 689A.434 (1997); 28 Tex. Admin. Code § 3.3002 (1997); 1998 Colo. H.B. 1053; 2002 Cal. H.B. 424; 2002 Ga. H.B. 1100; 2002 Utah S.B. 122;

And the point is confirmed by the history of the term. "The primary innovation of HIPAA in the individual market was guaranteed renewability. HIPAA provided that individual market coverage was guaranteed renewable, but that short-term coverage was not." JA384 (Jost Comment). In this context, "'[l]imited duration' in this [STLDI] definition is not redundant surplusage, but refers specifically to the fact that short-term coverage was under HIPAA non-renewable—non-renewability was its distinguishing characteristic." *Id.* at JA384-85.

And the reality is that there is no reason for the STLDI Rule's authorization of repeated renewability—especially when combined with a plan term that lasts for up to a year—unless the plan is designed to serve as an alternative form of primary health insurance that continues far into the future. Yet no reasonable person would characterize such a long-lasting policy as a "limited duration" plan.

III. The STLDI Rule is arbitrary and capricious.

The STLDI Rule also is arbitrary and capricious. In reviewing the action of the Departments, the Court engages in a "thorough, probing,

---

S.D. Admin. R. 20:06:39:32 (2003); 2009 Wis. S.B. 27; 2013 Kan. H.B. 2107.

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

Here, the Departments' decisionmaking process suffered from each of these deficiencies.

A. The Departments' disregard of Congress's policy judgments is arbitrary and capricious.

To begin with, the STLDI Rule is arbitrary and capricious because—although promulgated specifically in light of the ACA—it rests on policy determinations that Congress expressly rejected when it enacted that statute. The Departments dismissed the importance of the Rule's impact on the individual insurance market single-risk pool specified by the ACA; created an alternative insurance system that replicates the flaws that Congress meant to eliminate; and will lead to many people being denied benefits that Congress deemed "essential." On the face of it, the Departments therefore "relied on factors which Congress has not intended [them] to consider" and "entirely failed to consider an important aspect of the problem." A regulation that frustrates the congressional plan, and that was adopted with the intent of doing so, is the definition of arbitrary agency action.

B. The Departments failed to provide a reasoned explanation for their departure from the 2016 Rule.

In addition, in promulgating the STLDI Rule, the Departments departed from their prior, well-reasoned 2016 interpretation of "short-term limited duration insurance." And they did so without providing the required reasoned explanation or, indeed, any real explanation at all.

The district court's treatment of this issue, confined to a single sentence in a footnote, is incorrect.

The Departments in 2016 determined that the maximum period of coverage for "short-term limited duration" insurance should be three months. They did so in light of evidence, detailed in the rulemaking, that "short-term, limited duration insurance [was] being sold in situations other than those that the exception from the definition of individual health insurance coverage was initially intended to address." 81 Fed. Reg. at 75,317; *see id.* at 75,317-18 & n.16. Specifically, "individuals [were] purchasing this coverage as their primary form of health coverage," and "some insurers [were] providing renewals of the coverage that extend the duration beyond 12 months." *Id.* 75,318. This, the Departments explained, resulted in individuals not receiving essential health benefits (as mandated by the ACA) and "adversely impact[ed] the risk pool for Affordable Care Act-compliant coverage" because STLDI policies could discriminate based on health status and target healthier individuals. *Id.* 75,317-18.

In the new STLDI Rule, the Departments do not dispute ***any*** of the facts underlying their previous analysis and conclusion. To the

contrary, they ***confirm*** them. *See, e.g.,* 83 Fed. Reg. at 38,231, 38,233-36. The Departments now simply claim that it is desirable to make STLDI "an additional choice for many consumers that exists side-by-side with individual market coverage." *Id.* at 38,218; *see also id.* at 38,222, 38,228, 38,229. But the Departments' 2016 concerns were as salient in 2018—and are as salient now—as they were in 2016. Such a disregard for their previous reasoning is arbitrary and capricious. *FCC v. Fox Television Stations, Inc.*, 556 U.S. 502, 515 (2009).

In defending the Departments' change in position, the government argued and the district court held that "the departments clearly did provide a reasoned basis for departing from the 2016 Rule, including that the 2016 Rule was not successful in stabilizing the Exchanges." JA594 n.16; *see also* Gov. Preliminary Injunction Opp. 39, Dkt. 19 (2016 Rule had not succeeded in its goal of "boost[ing] enrollment in individual health insurance coverage").

But that was ***not*** the rationale for the 2016 Rule, which made no reference to "stabilizing the Exchanges" or "boost[ing] enrollment in individual health insurance coverage." Instead, the Departments explained at the time that the 2016 Rule was intended to address the

issue of "short-term, limited-duration insurance being sold as a type of primary coverage" instead of, as intended, "fill[ing] temporary coverage gaps when an individual transitions between sources of primary coverage." 81 Fed. Reg. at 75,318. And far from being unsuccessful, the 2016 Rule was ***completely*** effective in accomplishing this purpose: It prevented use of STLDI plans as a form of primary insurance.

In these circumstances, the Departments were, at a minimum, obligated to acknowledge and address the actual considerations that prompted the promulgation of the 2016 Rule:

> "In such cases it is not that further justification is demanded by the mere fact of policy change; but that a reasoned explanation is needed for disregarding facts and circumstances that underlay or were engendered by the prior policy." ... It follows that an "[u]nexplained inconsistency" in agency policy is "a reason for holding an interpretation to be an arbitrary and capricious change from agency practice."

Encino Motorcars, 136 S. Ct. at 2126 (citations omitted).

Even if the Departments had the statutory authority to decide that boosting enrollment in non-ACA compliant plans is a more important goal than maintaining the health insurance system established by Congress—and, of course, they do not—the Departments

would be required to identify that change and provide a reasoned explanation for it. *See, e.g., Int'l Union, United Mine Workers of Am. v. U.S. Dep't of Labor*, 358 F.3d 40, 44 (D.C. Cir. 2004) (Ginsburg, C.J.) (a "'change in agency priorities,' without explanation" is not sufficient under APA review because "it is merely a reiteration of the decision" to change the relevant rule). They failed to do that here.

C. The Departments failed to address comments explaining that the STLDI Rule will result in insurance coverage gaps for many consumers.

The Departments' departure from their 2016 Rule is flawed for an additional reason: They failed to consider the important problem of continuity of care for individuals who lose their coverage mid-year, a concern previously recognized by the Departments themselves and highlighted by numerous comments on the STLDI Rule. As noted above, the ACA mandates a special enrollment period for individuals who lose minimum essential coverage mid-year. But an STLDI plan does not qualify as minimum essential coverage and persons covered by such plans do not get to use special open enrollment. 26 C.F.R. § 1.5000A-2(d)(1). As a consequence, an individual who has ACA-compliant coverage and must change plans mid-year will be guaranteed a

seamless continuation of coverage; but an individual who uses STLDI as their primary insurance and loses coverage will remain without insurance protection until the next ACA general open enrollment period, which could be many months away.

This risk is minimized if STLDI plans are limited to three months, covering the gap between the termination of one ACA-compliant plan and the commencement of coverage under another: The ACA special enrollment period for the loss of minimum essential coverage lasts for 60 days, and new coverage will begin the month after enrollment. 45 C.F.R. § 155.420(b)(2)(iv), (c)(1). Thus, as the Departments explained in connection with the 2016 rule, "[s]hort-term, limited duration insurance allows for coverage to fill temporary coverage gaps when an individual transitions between sources of primary coverage." 81 Fed. Reg. at 75,318. In contrast, "for longer gaps in coverage, guaranteed availability of coverage and special enrollment period requirements in the individual health insurance market under the Affordable Care Act ensure that individuals can purchase individual market coverage through or outside of the Exchange that is minimum essential coverage and includes the consumer protections of the Affordable Care Act." *Id.*

During the STLDI rulemaking, a number of commenters specifically raised this concern about lengthy coverage gaps caused by the loss of STLDI that is used as a primary form of insurance. *See*, *e.g.*, JA449 (Community Catalyst); JA417 (Young Invincibles); JA396 (Centene Corporation); JA474 (U.S. PIRG). In promulgating the STLDI Rule, the Departments acknowledged the submission of these comments (*see* 83 Fed. Reg. at 38,217), but provided no response beyond that acknowledgement and no indication why they believed it appropriate to encourage a market for STLDI plans when the inevitable result would be to lock many individuals out of access to needed comprehensive coverage. This is the hallmark of arbitrary decisionmaking, for two reasons.

First, the Departments failed even to acknowledge, let alone grapple with, this important aspect of their own prior decision making. Again, by failing to "provide an adequate explanation for [their] departure from" their own analysis of the issue in 2016, the Departments fell short of the APA's requirements. *Dillmon v. Nat'l Transp. Safety Bd.*, 588 F.3d 1085, 1089-90 (D.C. Cir. 2009). *See also Fox Television Stations*, 556 U.S. at 515.

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

In reaching a contrary conclusion—again, in one sentence in a footnote—the district court opined that "the Departments expressly addressed coverage gaps and concluded that the 2018 Rule would provide greater gap protection to consumers than the 2016 Rule."

JA594-95 n.16 (citing 83 Fed. Reg. at 38,218). But that is incorrect. In fact, the cited page of the Federal Register notes that a person with a three-month STLDI policy might not be able to renew that policy if he or she had a pre-existing condition, a problem the Departments said could be avoided by permitting longer STLDI policies. But that observation has nothing to do with the problem of a person who uses STLDI as primary insurance and whose coverage, whatever its length, terminates—because it expires, because the covered party is retroactively found to have had a pre-existing condition, or for any other reason—and then is unable to obtain additional STLDI coverage because he or she has an adverse medical history. Such a person would then be uninsurable because he or she would not be eligible for the ACA's special open enrollment. The Departments simply disregarded this concern. And that, too, was arbitrary.

* * * *

Ultimately, the Departments' fundamental justification for the Rule appears to be that the ACA was badly conceived and that the Departments should be empowered to offer their own alternatives for persons who are dissatisfied with the ACA's requirements. The premise

of this contention is wrong; in fact, the ACA has expanded insurance coverage and reduced health care costs—which is why, as the *amicus* briefs filed below in this case demonstrate, doctors, patient groups, and consumers almost uniformly support the law and oppose the STLDI Rule. But however that may be, the decision whether the ACA should be replaced or modified is for Congress, not for agencies that are unhappy with the statute's operation. And Congress, although long aware of the complaints now offered by the Departments, repeatedly has refused to repeal the central ACA provisions that are threatened by the STLDI Rule.

For all of these reasons, the STLDI Rule is the very model of a regulation in which agencies have exceeded their legitimate authority. The Court should hold the Rule invalid.

CONCLUSION

The Court should reverse the decision of the district court.

Respectfully submitted,

/s/ Charles A. Rothfeld
Charles A. Rothfeld
Andrew J. Pincus
Ankur Mandhania*
MAYER BROWN LLP
1999 K Street, N.W.
Washington, D.C. 20006-1101
(202) 263-3000

Karen W. Lin**
MAYER BROWN LLP
1221 Avenue of the Americas
New York, NY 10020-11001
(212) 262-1910

Counsel for Appellants

November 4, 2019

* Member of the California Bar only. Not admitted in the District of Columbia. Practicing under the supervision of firm principals.

** Member of the New York Bar only. Not admitted in the District of Columbia. Practicing under the supervision of firm principals.

CERTIFICATE OF COMPLIANCE

This brief complies with the type-volume limitation of Federal Rules of Appellate Procedure 29(d) and 32(a)(7)(B) because it contains 12,997 words, excluding the parts of the brief exempted by Federal Rule of Appellate Procedure 32(a)(7)(B)(iii) and D.C. Circuit Rule 32(a)(1).

This brief complies with the typeface requirements of Rule 32(a)(5) and the type-style requirement of Rule 32(a)(6) because it was been prepared in a proportionately spaced typeface using Microsoft Word in Century Schoolbook 14-point type for text and footnotes.

/s/ *Charles A. Rothfeld*
Charles A. Rothfeld

Counsel for Appellants

CERTIFICATE OF FILING AND SERVICE

I hereby certify that on November 4, 2019, I filed the foregoing with the Clerk of the Court for the United States Court of Appeals for the District of Columbia Circuit by using the CM/ECF system which will serve all counsel of record.

/s/ *Charles A. Rothfeld*
Charles A. Rothfeld

Counsel for Appellants