[ORAL ARGUMENT NOT SCHEDULED]
No. 19-5212

IN THE UNITED STATES COURT OF APPEALS
FOR THE DISTRICT OF COLUMBIA CIRCUIT

Association for Community Affiliated Plans, *et al.*,
Plaintiffs-Appellants,
v.
United States Department of the Treasury, *et al.*,
Defendants-Appellees.

On Appeal from the United States District Court for the
District of Columbia (No. 18-cv-02133-RJL) (Hon. Richard J. Leon)

BRIEF *AMICUS CURIAE* OF U.S. HOUSE OF REPRESENTATIVES IN SUPPORT OF APPELLANTS

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STATEMENT REGARDING CONSENT TO FILE

Pursuant to D.C. Circuit Rule 29(b), undersigned counsel for *amicus curiae* U.S. House of Representatives represents that both parties have been sent notice of the filing of this brief and have consented to the filing.[1]

Amicus U.S. House of Representatives[2] has a strong interest in the effective implementation of the Patient Protection and Affordable Care Act (Affordable Care Act or the Act) and in ensuring that the millions of Americans who have benefited from its reforms and protections continue to do so. In 2010, the House passed the Affordable Care Act after significant study into the problems with then-existing health insurance markets. The House is thus particularly well suited to explain to the Court why Congress enacted this landmark legislation and how it has helped ensure that all Americans, including those with preexisting conditions, have access to quality, affordable health insurance. During the 116th Congress, the House has held multiple

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[1] Pursuant to Fed. R. App. P. 29(a), *amicus curiae* states that no counsel for a party authored this brief in whole or in part, and no person other than *amicus curiae* or its counsel made a monetary contribution to its preparation or submission.

[2] The Bipartisan Legal Advisory Group (BLAG) of the United States House of Representatives has authorized the filing of an *amicus* brief in this matter. The BLAG comprises the Honorable Nancy Pelosi, Speaker of the House, the Honorable Steny H. Hoyer, Majority Leader, the Honorable James E. Clyburn, Majority Whip, the Honorable Kevin McCarthy, Republican Leader, and the Honorable Steve Scalise, Republican Whip, and "speaks for, and articulates the institutional position of, the House in all litigation matters." Rules of the U.S. House of Representatives (116th Cong.), Rule II.8(b), https://perma.cc/M25F-496H. The Republican Leader and Republican Whip dissented.

hearings on actions taken by President Trump and his Administration that threaten to undermine the benefits and protections provided by the Act, and thus *amicus* also has unique knowledge about, and a strong interest in, the question whether the short-term limited duration insurance plans at issue in this case undermine the plan that Congress put in place when it passed the Affordable Care Act. As *amicus* knows, they do.

CERTIFICATE AS TO PARTIES, RULINGS, AND RELATED CASES

I. PARTIES AND AMICI

Except for *amicus* U.S. House of Representatives and any other *amici* who had not yet entered an appearance in this case as of the filing of the Brief for Appellants, all parties, intervenors, and *amici* appearing before the district court and in this Court are listed in the Brief for Appellants.

II. RULINGS UNDER REVIEW

Reference to the ruling under review appears in the Brief for Appellants.

III. RELATED CASES

Reference to any related cases pending before this Court appears in the Brief for Appellants.

/s/ Douglas N. Letter
Douglas N. Letter

November 12, 2019

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GLOSSARY

ACA	The Patient Protection and Affordable Care Act
STLDI	Short-Term, Limited Duration Insurance

STATUTES AND REGULATIONS

The pertinent statutes and regulations are set forth in the addendum to Appellants' Brief filed with this Court on November 4, 2019.

INTEREST OF *AMICUS CURIAE*

Amicus curiae is the United States House of Representatives (the House), which has a strong interest in the effective implementation of the Patient Protection and Affordable Care Act (Affordable Care Act, ACA, or the Act)[1] and in ensuring that the millions of Americans who have benefited from its reforms and protections continue to do so. In 2010, the House passed the Affordable Care Act after studying the problems with then-existing health insurance markets, and the House is thus particularly well suited to explain to the Court why Congress enacted this landmark legislation and how the Act has helped ensure that all Americans, including those with preexisting conditions, have access to quality, affordable health insurance. During the 116th Congress, the House has held multiple hearings on actions taken by President Trump and his Administration that threaten to undermine the benefits and protections provided by the Act, and thus *amicus* also has unique knowledge about, and a strong interest in, the question whether the Administration's rule expanding access to short-term, limited-duration insurance plans is consistent with the plan that Congress put in place when it passed the Affordable Care Act.

[1] The Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010), *as amended*, Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029.

INTRODUCTION

In 2010, Congress passed the Affordable Care Act, a landmark law that sought to achieve "near-universal coverage," 42 U.S.C. § 18091(2)(D), by making quality, affordable health insurance available to all Americans. Congress passed the Act in response to serious problems affecting America's insurance and health care systems. Many employers failed to offer coverage to their employees, and only a limited number of individuals were eligible for government health insurance programs like Medicaid. Moreover, those who could not obtain coverage through their employer or Medicaid were forced to try their luck in the individual market. That market was plagued with sky-high prices, care that was not comprehensive, and discriminatory practices that prevented millions of Americans from obtaining coverage. As a result, one-seventh of the American population lacked health insurance, and millions more lacked coverage that addressed all their medical needs.

In response to these systemic flaws, Congress passed the Affordable Care Act "to increase the number of Americans covered by health insurance and decrease the cost of health care." *Nat'l Fed'n of Indep. Bus. v. Sebelius* (*NFIB*), 567 U.S. 519, 538 (2012) (opinion of Roberts, C.J.). To achieve that end, the law includes a number of provisions designed to expand access to quality health insurance to as many Americans as possible.

First, the Act allows states to expand eligibility for Medicaid. Prior to the Affordable Care Act, only certain categories of people, such as low-income children,

elderly people, and pregnant women were eligible; after the Act, states that have participated in the Medicaid expansion can now provide coverage for all individuals earning up to 133 percent of the federal poverty line. Second, the Act created a system of American Health Benefit Exchanges (Exchanges) so that individuals who do not receive health insurance through their employer or through Medicaid can purchase health insurance in the individual marketplace, and the Act provides tax credits to subsidize the cost of insurance for many lower- and middle-income individuals. Third, the Act prevents insurers from discriminating because of an individual's preexisting conditions and includes a number of other protections designed to ensure that insurers offer comprehensive care to a wide swath of consumers. Among those protections is the Act's requirement that insurance sold on ACA exchanges cover "essential health benefits"—core benefits that ensure quality coverage.

These various provisions of the Act were all designed with one primary goal in mind: to reduce the number of Americans who do not have access to quality, affordable coverage. This Administration's new rule governing short-term, limited duration insurance (STLDI) plans undermines this goal. *See* Short-Term, Limited-Duration Insurance, 83 Fed. Reg. 38,212 (Aug. 3, 2018) (the 2018 Rule). STLDI plans are a type of health insurance designed to fill temporary gaps in coverage—for example, when individuals are between jobs. Importantly, however, these plans are not required to comply with key ACA protections, like the prohibition on

discrimination based on preexisting conditions and the requirement that policies cover essential health benefits. Notwithstanding those significant shortcomings in STLDI plans, the 2018 Rule allows consumers to purchase STLDI plans that last just short of an entire year—the length of most comprehensive health insurance policies—and that can be renewed for up to three years. *Id.* at 38,214-15.

This Rule undermines Congress's goal of ensuring that all Americans have access to quality, affordable insurance. To start, the Affordable Care Act was enacted to place consumers in the individual market into unified risk pools so that insurers cover a pool of patients robust enough to enable them to provide coverage on a nondiscriminatory basis without charging patients untenable premiums. The 2018 Rule, however, encourages consumers who might otherwise purchase comprehensive insurance on the Exchanges to buy STLDI plans outside the Exchanges, removing them from the unified risk pools that are so important to the Act's reforms, which aim to keep coverage affordable for all consumers.

To make matters worse, some insurers are attempting to steer consumers into less-protective STLDI plans without explaining how they differ from comprehensive insurance, leaving many consumers unaware that their STLDI plans do not offer the robust benefits and protections provided by plans sold on the Exchanges. In short, by destabilizing the individual marketplaces and confusing consumers into purchasing care that is not comprehensive, the 2018 Rule undermines Congress's plan and harms

the millions of Americans who depend on the Act to access quality, affordable health insurance.

ARGUMENT

THE AFFORDABLE CARE ACT WAS DESIGNED TO EXPAND ACCESS TO QUALITY, AFFORDABLE HEALTH INSURANCE, AND THE NEW RULE REGARDING STLDI PLANS SIGNIFICANTLY UNDERMINES THAT GOAL.

A. The Affordable Care Act Responded to Serious Problems in America's Health Care System That Had Left Millions Without Quality, Affordable Insurance.

Congress passed the Affordable Care Act in response to serious problems plaguing America's health care system. *See* H. Rep. No. 111-299, Pt. 3, at 55 (2009) ("The U.S. health care system is on an unsustainable course."). In 2007, "more than 45.7 million people were uninsured … , representing more than one-seventh of the population." H. Rep. No. 111-299, Pt. 1, at 320 (2009). A number of different factors contributed to this uninsured rate.

First, while most large employers offered their employees health insurance benefits, "[l]ess than half of all small employers (less than 50 employees) offer[ed] health insurance coverage to their employees." *Id.* at 322. Indeed, there was "no federal requirement that employers offer health insurance coverage to employees or their families." H. Rep. No. 111-299, Pt. 3, at 134.

Second, at the time the Affordable Care Act was passed, health care costs were skyrocketing, making it difficult for most Americans to purchase their own insurance

in the individual market. "Between 1999 and 2008, health insurance premiums more than doubled as wages largely stagnated." *Id.* at 55-56 (citing testimony of Jacob Hacker).[2] On top of that, the United States "spen[t] substantially more than other developed countries on health care, both per capita and as a share of GDP." H. Rep. No. 111-299, Pt. 1, at 320. This dramatic increase in health care costs affected employers—who "face[d] a growing challenge paying for health benefits while managing labor costs to succeed in a competitive market," *id.*—and federal and state budgets—"both directly, through spending on Medicare, Medicaid, and other programs, and indirectly, through tax expenditures for health insurance and expenses," *id.* at 320-21.

Third, millions of Americans who were not provided insurance benefits by their employers and could not afford or were denied coverage in the individual market were also ineligible for insurance through government programs like Medicaid. Indeed, at the time, Medicaid offered federal funding to States only "to assist pregnant women, children, needy families, the blind, the elderly, and the disabled in obtaining medical care." *NFIB*, 567 U.S. at 541 (citing 42 U.S.C. § 1396a(a)(10)).

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[2] *See* David Blumenthal & Sara Collins, *Where Both the ACA and AHCA Fall Short, and What the Health Insurance Market Really Needs*, Harv. Bus. Rev. (Mar. 21, 2017), https://perma.cc/23U5-3987 ("premiums for ... policies [in the individual market] were increasing more than 10% a year, on average, while the policies themselves had major deficiencies").

Finally, insurance companies in many States were permitted to discriminate against individuals when deciding whether to issue insurance policies. Most notably, it was commonplace for companies to refuse to insure patients with preexisting conditions. Because "'20 percent of the population account[ed] for 80 percent of health spending'" in 2009, "health insurers—particularly in the individual market— … adopted discriminatory, but not illegal, practices to cherry-pick healthy people and to weed out those who [we]re not as healthy." H. Rep. No. 111-299, Pt. 3, at 92 (quoting testimony of Karen Pollitz). Such practices included: "denying health coverage based on pre-existing conditions or medical history, even minor ones; charging higher, and often unaffordable, rates based on one's health; excluding pre-existing medical conditions from coverage; charging different premiums based on gender; and rescinding policies after claims [we]re made based on an assertion that an insured's original application was incomplete." *Id.* Similarly, before Congress passed the Affordable Care Act, insurance companies often considered conditions usually experienced by women, including pregnancy, a previous Caesarean section, or a history of having survived domestic abuse, to be "pre-existing conditions" that could preclude coverage.[3]

[3] *See, e.g., What Women Want: Equal Health Care for Equal Premiums*: *Hearing before the S. Comm. on Health, Education, Labor and Pensions*, 111th Cong. 3 (2009) (testimony of Marcia D. Greenberger, Co-President, National Women's Law Center), https://perma.cc/3K6E-NY9L.

As a result of these practices, "many uninsured Americans—ranging from 9 million to 12.6 million—voluntarily sought health coverage in the individual market but were denied coverage, charged a higher premium, or offered only limited coverage that excludes a preexisting condition." *Fla. ex rel. Atty. Gen. v. U.S. Dep't of Health & Human Servs.*, 648 F.3d 1235, 1245 (11th Cir. 2011), *aff'd in part, rev'd in part by NFIB*, 567 U.S. 519. Congress found that "[d]iscrimination based on health, gender and other factors has severe economic consequences for those who have been unable to find affordable health coverage and for those who have coverage, but are under-insured." H. Rep. No. 111-299, Pt. 3, at 92.

B. Congress Passed the Affordable Care Act To Expand Access to Quality, Affordable Health Insurance, and the Act's Reforms Have Been Remarkably Successful.

In light of these serious and systemic problems that resulted in millions of Americans being without access to quality, affordable health insurance, Congress passed the Affordable Care Act "to expand coverage" while keeping health care costs in check. *King v. Burwell*, 135 S. Ct. 2480, 2485 (2015); *see NFIB*, 567 U.S. at 538 ("The Act aims to increase the number of Americans covered by health insurance and decrease the cost of health care."); 42 U.S.C. § 18091(2)(D) (the Act aims to achieve "near-universal coverage"). The Affordable Care Act does so in three primary ways. First, it provides funding to States to expand Medicaid coverage to all individuals earning up to 133 percent of the federal poverty level. *See* 42 U.S.C.

§ 1396a(a)(10)(A)(i)(VIII). The Congressional Budget Office estimated that this expansion provided coverage to millions of Americans.[4]

Second, for individuals who are not eligible for Medicaid and do not receive insurance from their employer, the Act provides for the creation of Exchanges through which individuals can purchase health insurance for themselves and their families. *See King*, 135 S. Ct. at 2487. The Act then "seeks to make insurance more affordable by giving refundable tax credits to individuals with household incomes between 100 percent and 400 percent of the federal poverty line." *Id.* (citing 26 U.S.C. § 36B). "Individuals who meet the Act's requirements may purchase insurance with the tax credits, which are provided in advance directly to the individual's insurer." *Id.* (citing 42 U.S.C. §§ 18081, 18082).

Because the Exchanges work most effectively when "[i]ndividual enrollment" is sufficiently high, and there is a "balanced risk pool,"[5] the Act included a number of different provisions to facilitate enrollment in this single risk pool. For example, the Act requires Exchanges to "provide for the operation of a toll-free telephone hotline to respond to requests for assistance," 42 U.S.C. § 18031(d)(4)(B), to create "an

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[4] *See CBO's Analysis of the Major Health Care Legislation Enacted in Mar. 2010 Before the H. Subcomm. on Health of the Comm. on Energy & Com.*, 112th Cong. 22-23 (Mar. 30, 2011) (statement of Douglas Elmendorf, Director, Cong. Budget Office), https://perma.cc/7RZP-5H48.

[5] American Academy of Actuaries, *An Evaluation of the Individual Health Insurance Market and Implications of Potential Changes* 1 (Jan. 2017), https://perma.cc/2CUL-2PW2; *see* Blumenthal & Collins, *supra* note 2.

Internet website through which enrollees and prospective enrollees of qualified health plans may obtain standardized comparative information on such plans," *id.* § 18031(d)(4)(C), and to "utilize a standardized format for presenting health benefits plan options," *id.* § 18031(d)(4)(E), including "assign[ing] a rating to each qualified health plan offered through [an] Exchange," *id.* § 18031(d)(4)(D).

Third, the Act includes various market reforms designed to expand access to insurance coverage. For instance, the Act requires large employers to offer insurance to their employees or pay a penalty, 26 U.S.C. § 4980H; to automatically enroll new and current employees of large employers in an employer-sponsored plan unless an employee opts out, 29 U.S.C. § 218a; and to offer adequate health insurance plans, 26 U.S.C. § 4980H(a). The Act also includes numerous other important provisions that, for example, prohibit insurers from imposing lifetime dollar limits on the value of coverage, 42 U.S.C. § 300gg-11; prohibit insurers from rescinding coverage except in the case of fraud, *id.* § 300gg-12; require individual and group health plans to cover preventive services without cost sharing, *id.* § 300gg-13; and allow children to stay on their parents' health insurance until age 26, *id.* § 300gg-14.

The Act further addresses the inadequacy of benefits in the individual and small group markets by expressly providing that insurance offered in those markets must include "essential health benefits." 42 U.S.C. § 300gg-6(a) ("A health insurance issuer that offers health insurance coverage in the individual or small group market shall

ensure that such coverage includes the essential health benefits package required under section 18022(a) of this title.").

While the law gave the Secretary of Health and Human Services the authority to define what those "essential health benefits" would be, the law specified that "such benefits shall include at least the following general categories": ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance abuse disorder services, prescription drugs, rehabilitative and habilitative services, laboratory services, preventive and wellness services and chronic disease management, and pediatric services, including oral and vision care. *Id.* § 18022(b)(1). All of these reforms were designed to allow more Americans access to comprehensive insurance coverage, as many insurance plans did not offer such robust coverage at the time the Affordable Care Act was passed.

Finally, the Act includes reforms that ensure that no American is denied the ability to purchase health insurance. The Act prevents discrimination on the basis of preexisting conditions by including a guaranteed-issue provision prohibiting insurers from denying coverage to any individual because of a medical condition or their medical history, *see id.* §§ 300gg-1, 300gg-3, 300gg-4, and a community-rating provision prohibiting insurers from charging higher premiums because of an individual's preexisting medical conditions, *id.* §§ 300gg(a), 300gg-4(b). Individual and small group health plans are specifically precluded from charging certain patients

higher premiums because of their gender. *Id.*[6] These reforms are designed to fulfill Congress's goal of expanding coverage and ensuring that the coverage that individuals receive meets a baseline standard of comprehensiveness at a reasonable cost.

The Affordable Care Act has been wildly successful in ameliorating the immense public health problem caused by having so many Americans without adequate health insurance. As of 2016, approximately 12.7 million more people had purchased plans in the individual market through the state and federal Exchanges than before the Affordable Care Act was passed. Namrata Uberio et al., *Health Insurance Coverage and the Affordable Care Act, 2010-2016* at 8, Dep't of Health & Human Servs. (Mar. 3, 2016), https://perma.cc/86HF-CH2M. Approximately 14.5 million more people began receiving comprehensive benefits through Medicaid and the Children's Health Insurance Program. *Id.* Overall, as of 2016, there had been a net gain of 20 million Americans with health insurance coverage. *Id.* This gain spans many generational, ethnic, and racial groups, and has particularly benefited women, younger people, and Black and Hispanic individuals. *Id.* at 2.

[6] *See also* Centers for Medicare & Medicaid Services, *Information on Essential Health Benefits (EHB) Benchmark Plans*, https://perma.cc/VZ7R-62L7; National Women's Law Center, *Turning to Fairness: Insurance Discrimination Against Women Today and the Affordable Care Act* 4 (Mar. 2012), https://perma.cc/4EZA-XVQU.

C. The Administration's Change to the Rule Governing STLDI Plans Undermines the Affordable Care Act.

Despite the success of the Affordable Care Act, the President and his Administration have taken various actions to undermine the Act and thwart its achievement of the important public health goal of "near-universal coverage." 42 U.S.C. § 18091(2)(D). The 2018 Rule is a prime example of an action this Administration has taken that undermines the Affordable Care Act.

As the Administration itself has explained, STLDI plans are "a type of health insurance coverage that was designed to fill temporary gaps in coverage when an individual is transitioning from one plan or coverage to another form of coverage," such as when an individual is "between jobs."[7] Importantly, because STLDI plans are intended to be temporary,[8] they do not fall within the definition of "individual health insurance coverage," 42 U.S.C. § 300gg-91(b)(5), and thus need not comply with certain important Affordable Care Act protections—most prominently the requirement that insurers cover essential health benefits and the prohibition on

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[7] CMS.gov, *Fact Sheet: Short-Term, Limited-Duration Insurance Proposed Rule* (Feb. 20, 2018), https://perma.cc/4KUR-E3VV.

[8] *See, e.g.*, Excepted Benefits; Lifetime and Annual Limits; and Short-Term, Limited-Duration Insurance, 81 Fed. Reg. 75,316, 75,318 n.22 (Oct. 31, 2016) (the "2016 Rule") (shortening the allowable term for STLDI plans to three months, "consistent with the exemption from the individual shared responsibility provision for gaps in coverage of less than three months").

discrimination based on preexisting conditions.[9] Despite these serious shortcomings in the coverage offered by STLDI plans, the Administration promulgated a new rule, which allows these plans to last up to just short of one year—the length of most comprehensive insurance policies—with up to two renewals that can extend the length of an STLDI plan to three years. *See* 83 Fed. Reg. at 38,214-15. The 2018 Rule reversed the 2016 Rule, which had limited STLDI plans to three months in duration, including renewal periods. *See* 81 Fed. Reg. at 75,318 n.22.

The 2018 Rule undermines Congress's goals in passing the ACA for at least two reasons. First, the proliferation of STLDI plans that last as long as comprehensive insurance policies diverts consumers away from insurance plans on the Exchanges—plans that offer comprehensive coverage and cannot discriminate against consumers with preexisting conditions. This diversion dilutes the risk pools in Act-compliant plans on those Exchanges, raising premiums and destabilizing those markets.

Second, insurers can use deceptive marketing practices and other tactics to encourage consumers to purchase STLDI plans despite those plans not meeting the Act's otherwise stringent consumer protections. In that way, consumers can be misled into thinking that they have purchased insurance that complies with the Act's

[9] *See, e.g.*, Karen Pollitz et al., *Issue Brief: Understanding Short-Term Limited Duration Health Insurance*, Kaiser Family Foundation (Apr. 23, 2018), https://perma.cc/GX37-G7A6 (finding that not a single available STLDI plan covered maternity care).

protections when they purchase STLDI plans, even though those plans discriminate on the basis of preexisting conditions and do not cover essential health needs. In both of these ways, the 2018 Rule undermines what Congress sought to accomplish when it passed the Affordable Care Act, set up the Exchanges, and established important consumer protections for the health insurance market.

1. The 2018 Rule undermines Congress's plan to create a single risk pool in the individual marketplace.

A key aspect of the Affordable Care Act's market reforms was to consolidate patients in the individual market into single risk pools. *See* 42 U.S.C. § 18032(c)(1)-(2) (requiring health insurance issuers in the individual and small group markets to "consider all enrollees in all health plans (other than grandfathered health plans) offered by such issuer … to be members of a single risk pool"). This means that insurers in the individual and small-group markets provide coverage to a broad base of both healthy and sick individuals, spreading costs among a larger number of consumers and lowering health insurance premiums overall. Congress found that "broaden[ing] the health insurance risk pool to include healthy individuals" would support Congress's goal of providing access to "improved health insurance products that are guaranteed issue and do not exclude coverage of pre-existing conditions." *Id.* § 18091(2)(I). Put differently, maintaining a balanced single risk pool would help achieve the Act's goals of eliminating discriminatory pricing and policies, and providing robust, comprehensive healthcare to all who want it. *See Seven-Sky v. Holder*,

661 F.3d 1, 4 (D.C. Cir. 2011) ("[T]he Affordable Care Act sought to reform our nation's health insurance and health care delivery markets with the aims of improving access to those markets and reducing health care costs and uncompensated care.").

Despite Congress's aim, the 2018 Rule permits consumers to purchase years-long STLDI plans rather than plans that include the protections the Act requires, leaving them outside of the risk pools that are so important to the functioning of the individual marketplace. The district court dismissed this fear, suggesting that "any potential negative impact from the 2018 Rule [is] minimal." J.A. 580. But multiple studies have concluded that the Rule will result in consumers leaving Act-compliant plans to purchase STLDI plans, and will do so in numbers significant enough to dilute risk pools and drive increases in premiums. For instance, "[u]sing a sophisticated microsimulation model," the Urban Institute projected that in states that do not restrict the length of STLDI plans, their availability would produce "about a 19 percent reduction in the ACA-compliant market … leading to an 8 percent increase in premiums."[10] Similarly, the Center for Health and Economy projected increased

[10] Mark Hall, The Brookings Institution, *Stabilizing and Strengthening the Individual Health Insurance Market: A View from Ten States* 44 (July 2018), https://perma.cc/288H-D6QZ.

premiums of 5 to 9 percent in the Affordable Care Act marketplace, reducing enrollment in those comprehensive plans by approximately 800,000 people.[11]

In short, by siphoning consumers from the individual and small-group markets, the 2018 Rule undermines Congress's plan that consumers join single risk pools to distribute the costs of providing comprehensive health care coverage among a broad swath of healthy and sick individuals. The Rule, therefore, will drive up premiums and reduce access to quality, affordable insurance—directly contrary to Congress's plan in passing the Act.

2. The 2018 Rule undercuts Congress's goal of ensuring the quality of health insurance available in the individual marketplace.

When it passed the Affordable Care Act, Congress was not only concerned with making health insurance more available to all consumers, it was also concerned with fixing pervasive problems in the health insurance market, including underinsurance, discriminatory pricing, and plans that left consumers without coverage for certain essential needs. As Congress put it at the time, the Act was passed to respond to evidence of "significant shortfalls in the *quality* of care provided in the United States." H. Rep. No. 111-299, Pt. 1, at 323 (emphasis added).

[11] Hall, *supra* note 10, at 45 n.150 (citing Center for Health and Economy, *The Proposed Modifications to Short Term Limited Duration Insurance Plans* (June 26, 2018), https://perma.cc/E9WF-7YK5).

For that reason, as described above, Congress included several important consumer protections in the Affordable Care Act. For instance, insurers cannot charge individuals higher premiums due to their age, gender, health, or preexisting conditions. Congress also established a baseline set of essential health benefits that insurers must provide, including, for instance, prescription drugs, maternity care, hospitalization, and chronic disease management. In short, Congress sought to craft a law that would eliminate deceptive plans that provided only bare-bones coverage and put in their place a robust market of plans that would meet a certain threshold of quality and coverage.

The district court suggested that Congress was not concerned with the quality of coverage in the individual marketplaces, pointing to a provision in the Act that exempts "grandfathered plans" in place before the Affordable Care Act passed. J.A. 594 n.15 (citing 42 U.S.C. § 18011). Congress, however, granted those exceptions understanding that there would be "a 5-year grace period beginning [in the first year] for existing group health plans," after which those plans would be required to meet "the new federal health insurance standards." H. Rep. 111-299, Pt. 1 at 372. By contrast, the 2018 Rule permits STLDI plans to exist indefinitely, forever damaging the effectiveness of the Exchanges that provide comprehensive insurance policies. In support of the same point, the district court also pointed to the exclusion of student health insurance plans from the Act's requirements, J.A. 594 n.15, but that narrow exclusion does not suggest that Congress was unconcerned about the quality of

insurance policies in the individual marketplace, especially given that the Act requires insurers to provide coverage to individuals under age 26 through their parents' insurance plans.

The 2018 Rule subverts Congress's plan that all health insurance provide a certain threshold of coverage. Although most STLDI policies provide minimal coverage that fails to cover benefits for essential health needs, insurers are now permitted to market them as years-long alternatives to Act-compliant policies, while simultaneously denying coverage to individuals whom the Act was passed to protect. Indeed, the House Committee on Energy and Commerce has noted that "insurance companies that sell STLDI [plans] discriminate against individuals with pre-existing conditions and put consumers at significant financial risk."[12] In fact, as discussed at a House hearing, 70 percent of the difference in price between STLDI plans and Act-compliant plans is due to STLDI providers' ability to exclude consumers with preexisting conditions.[13] The pervasiveness of these plans that discriminate against individuals with preexisting conditions severely undercuts the Act's goal of ensuring

[12] Press Release, House Committee on Energy & Com., *E&C Launches Investigation Into Companies that Sell or Broker Junk Health Insurance Plans* (Mar. 13, 2019), https://perma.cc/44MA-WTZE.

[13] *Strengthening Our Health Care System: Legislation to Reverse ACA Sabotage and Ensure Pre-Existing Conditions Protections: Hearing Before the H. Comm. on Energy & Com.*, 116th Cong. (2019) at 58:20 (Testimony of Jessica K. Altman, Commissioner, Pennsylvania Insurance Department), https://perma.cc/4Q3Q-4VTA.

coverage for all "regardless of personal characteristics extraneous to the provision of high quality health care or related services." H. Rep. No. 111-299, Pt. 1, at 394.

On top of that, the Rule allows insurers to use marketing strategies for STLDI plans that obscure from consumers the fact that the years-long plans they are buying provide bare-bones coverage. For instance, marketing scans have revealed that "consumers shopping online for health insurance, including those using search terms such as 'Obamacare plans' or 'ACA enroll,' will most often be directed to websites and brokers selling STLDI or other non-ACA compliant products."[14] Indeed, before the 2019 open enrollment periods, an online search for the terms "Obamacare plans," "ACA enroll," "[c]heap health insurance," and "[s]hort-term health insurance" produced disturbing results: 99 percent of the Internet sites produced by that search were offering at least one plan that did not comply with the Affordable Care Act's requirements. Corlette et al., *supra* note 14, at 4, 6. Even during open enrollment, over 80 percent of the sites produced by that search were offering one or more plans that were not in compliance with the Act because they did not provide coverage that meets the Act's anti-discrimination and essential-health-benefits requirements. *Id.* at 6. As a recent study noted, "[t]hese websites and brokers often fail to provide consumers with the plan information necessary to inform their purchase." *Id.* at 8.

[14] Sabrina Corlette et al., *The Marketing of Short-Term Health Plans: An Assessment of Industry Practices and State Regulatory Responses* 2 (Jan. 2019), https://perma.cc/ZC3H-NRQR.

Furthermore, even when consumers specifically search for plans that provide them with the quality coverage Congress wanted to make available to all consumers in the Affordable Care Act, they are often directed to STLDI plans, with little information as to the differences. This can leave consumers thinking that they have robust, comprehensive insurance, when in fact their insurance might, for instance, leave them without coverage if they have a heart attack after a history of high blood pressure, or if they are hospitalized on a Friday or a Saturday instead of a less busy time of the week.[15] In fact, although websites directing consumers to certain insurance policies for purchase have often "touted the ACA's open enrollment period to entice consumers to purchase a policy, none directed consumers to healthcare.gov, the official government website where consumers can apply for premium subsidies and enroll in ACA-compliant coverage." Corlette et al., *supra* note 14, at 7. This disparity is exacerbated by the fact that providers have a strong financial incentive to steer consumers into STLDI plans; while Act-compliant plans require insurers to spend at least 80 cents of every dollar paid in premiums on care, there is no similar

[15] *See* Margot Sanger-Katz, *What To Know Before You Buy Short-Term Health Insurance*, N.Y. Times (Aug. 1, 2018), https://perma.cc/36E3-PLEP (describing limitations in STLDI plans); *see also* Michael Hiltzik, *Column: The Fine Print of Those Short-Term Health Plans Favored by Trump: Don't Get Sick on a Weekend*, L.A. Times (Apr. 26, 2018), https://perma.cc/DJ5R-Z5CN (describing an STLDI plan marketed in thirteen states by UnitedHealth's subsidiary, Golden Rule, which "won't cover hospital room, board or nursing services for patients admitted to a hospital on a Friday or Saturday, unless for an emergency or for necessary surgery the next day").

requirement for STLDI plans. Some of the leading insurers spend less than 50 cents per dollar from STLDI plans on actual care—more than doubling the amount of money available for administrative costs and profits as compared to Act-compliant plans. *Strengthening Our Health Care System*, *supra* note 13, at 2:06:20.

In sum, the 2018 Rule undermines Congress's aim in passing the Affordable Care Act by allowing insurers to offer years-long STLDI plans to patients as an alternative to Act-compliant policies, despite the fact that STLDI plans can offer coverage that is discriminatory and fails to provide essential health benefits. Not only do these plans circumvent the consumer protections Congress established when it passed the Affordable Care Act, they are often misleadingly marketed as comparable alternatives to robust, Act-compliant policies. Thousands of consumers are then left, knowingly or unknowingly, without comprehensive coverage when they need it—contrary to Congress's goal in passing the Affordable Care Act.

CONCLUSION

For the foregoing reasons, the judgment of the district court should be reversed.

Respectfully submitted,

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CERTIFICATE OF COMPLIANCE

I hereby certify that this brief complies with the type-volume limitation of Fed. R. App. P. 32(a)(7)(B) because it contains 5,181 words, excluding the parts of the brief exempted by Fed. R. App. P. 32(a)(7)(B)(iii).

I further certify that the attached *amicus* brief complies with the typeface requirements of Fed. R. App. P. 32(a)(5) and the type style requirements of Fed. R. App. P. 32(a)(6), because it has been prepared in a proportionally spaced typeface using Microsoft Word Professional Plus 2016 in Garamond, 14-point font, a proportionally-spaced typeface.

Executed this 12th day of November, 2019.

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CERTIFICATE OF SERVICE

I hereby certify that I electronically filed the foregoing with the Clerk of the Court for the United States Court of Appeals for the D.C. Circuit by using the appellate CM/ECF system on November 12, 2019.

I certify that all participants in the case are registered CM/ECF users and that service will be accomplished by the appellate CM/ECF system.

Executed this 12th day of November, 2019.

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