UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF TEXAS
SHERMAN DIVISION

AMERICAN ASSOCIATION OF ANCILLARY BENEFITS, *et al.*, *Plaintiffs,* v. XAVIER BECERRA, in his official capacity as Secretary of the United States Department of Health and Human Services, *et al.*, *Defendants.*	Case No. 4:24-cv-783-SDJ

BRIEF OF THE ASSOCIATION FOR COMMUNITY AFFILIATED PLANS AS *AMICUS CURIAE* IN SUPPORT OF DEFENDANTS

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INTEREST OF *AMICUS CURIAE*

The 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 healthcare needs. ACAP provides qualified health coverage to individuals through the Affordable Care Act (ACA) marketplaces. ACAP's members will be adversely affected if Plaintiffs succeed in their challenge to the 2024 Rule because their customers could be deceived into buying skimpy insurance that does not provide sufficiently protective coverage. In addition, the potential diversion of individuals from the ACA marketplace likely would result in higher premiums for the ACA-compliant insurance that ACAP's members provide. Indeed, detailed studies found that those adverse effects followed from the 2018 Rule. *Amicus* submits this brief to explain the harm that resulted from the 2018 Rule—harm that will be prevented by the 2024 Rule.

INTRODUCTION

This case concerns the validity of the federal regulation governing the availability of short term limited duration health insurance (STLDI). Historically, STLDI has not been used as comprehensive health insurance. Instead, as its name suggests, STLDI has been understood to be a temporary, time-limited form of insurance for individuals who have a brief lapse in comprehensive coverage, usually because they are between jobs. For that reason, STLDI plans are exempt from the consumer protections that federal law applies to comprehensive health insurance plans, such as the proscription against denying individuals coverage based on a preexisting condition. Thus, although STLDI "can be purchased at a fraction of the cost" of comprehensive insurance plans, "you get what you pay for. STLDI plans offer skimpier coverage and higher deductibles." *Ass'n for Cmty. Affiliated Plans v. U.S. Dep't of the Treasury ("ACAP")*, 966 F.3d 782, 786 (D.C. Cir. 2020).

As the United States explains, STLDI has been an element of the insurance market since 1997, when the Departments of Health and Human Services, Labor, and Treasury (the Departments) first promulgated regulations that defined STLDI by reference to the specific maximum time frame over which an individual could be covered by an STLDI plan. *See* Defs.' Cross-Mot. for Summ. J. and Resp. in Opp'n to Pls.' Mot. for Summ. J. at 1, ECF No. 37 ("Cross-Mot.").

But STLDI took on a much more prominent role after the enactment of the ACA, as certain insurers sought to circumvent the ACA's mandated protections by marketing STLDI as an alternative, and much skimpier, form of insurance. The Departments responded by issuing Rules—first in 2016, then in 2018, and again in 2024—refining the definition of STLDI. *See* Excepted Benefits; Lifetime and Annual Limits; and Short-Term, Limited-Duration Insurance, 81 Fed. Reg. 75316 (Oct. 31, 2016); Short-Term, Limited Duration Insurance, 83 Fed. Reg. 38212 (Aug. 3, 2018); and Short-Term, Limited Duration Insurance and Independent, Noncoordinated Excepted Benefits Coverage, 89 Fed. Reg. 23338 (Apr. 3, 2024).

Plaintiffs challenge the validity of the 2024 Rule, which revised the definition of STLDI set forth in the 2018 Rule by providing that individuals may be covered by that form of insurance only for a maximum initial term of three months, and for a total duration of four months. In contrast, the 2018 Rule defined STLDI as coverage with a contract term of less than one year and a maximum duration of three years.

The 2024 Rule falls squarely within the Departments' statutory authority. And it is essential to protect consumers and ensure lower health care costs for tens of millions of Americans. As this brief explains, the 2018 Rule resulted in widespread consumer deception—with individuals buying insurance that they believed would provide comprehensive coverage, only to find that insurance

wasn't available when it was needed. And purchases of this skimpy insurance increased the cost of ACA marketplace insurance for all Americans.

Finally, it is possible that the incoming administration may seek to alter the United States' position in this litigation. This brief explains that the Court should not permit the Government to effect a de facto rescission of the 2024 Rule by simply acquiescing to Plaintiffs' claims in this case. Instead—if the Government does change its litigation position and wishes to replace the 2024 Rule—the Court should stay this action so that the Departments may engage in the ordinary notice-and-comment rulemaking required by the Administrative Procedure Act.

ARGUMENT

I. THE 2024 RULE FALLS WELL WITHIN THE DEPARTMENTS' STATUTORY AUTHORITY.

Congress did not provide a definition of STLDI. But the text and structure of the relevant statutes make clear that the 2024 Rule properly implements the governing statutes.

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, 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. Cross-Mot. at 18; *see, e.g.*, *Definition of Health Insurance Terms*, Bureau of Labor Statistics, perma.cc/T3MF-SFBU (noting that a benefit period is "usually a year"). A "short-term" insurance plan, then, is one that involves a "relatively short period of time" as compared to one year.

At the same time, "limited" means "[r]estricted in size, amount, or extent." *Limited*, Oxford English Dictionary, perma.cc/P9ZB-LVJH. A contract that may be renewed multiple times does

not fit within that definition; indeed, understanding "limited duration" to restrict renewal is what distinguishes the meaning of that term from the meaning of "short term." 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.[1]

Consequently, given the plain meaning of both "short term" and "limited duration," STLDI must mean a "term" considerably shorter than one year that lasts for a very limited total duration. *See* Cross-Mot. at 18. The time periods set forth in the 2024 Rule—three months, renewable for one additional month—therefore follow directly from the statutory text. In contrast, the interpretation offered by the 2018 Rule departed from that text; "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. The 2024 Rule also is consistent with the ACA's structure, using terms that are "'reasonably related' to the statutory provisions governing comprehensive coverage and distinguishing STLDI from individual health insurance coverage." *Id*. at 15.

The 2024 Rule therefore is a reasonable exercise of the Departments' statutory authority. As the Government notes, "the 2024 Rule gives independent meaning to the textual description of STLDI by interpreting 'short term' to relate to the initial STLDI contract term and 'limited duration' to relate to the STLDI contract's total duration." Cross-Mot. at 18. The Rule thus follows directly from the plain statutory terms. *Id*. at 17-19. Moreover, as the Government describes (*id*.

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[1] *See, e.g.*, Minn. Stat. § 62A.65; N.H. Rev. Stat. § 415:5(III); Mich. Comp. Laws § 500.2213b(9); Nev. Admin. Code § 689A.434 (1997); 28 Tex. Admin. Code § 3.3002 (1997); S.D. Admin. R. 20:06:39:32 (2003).

at 20, 29-35), and as we explain further below, the 2024 Rule was necessary and appropriate to effectuate the statutory purposes.

II. THE 2024 RULE IS A REASONABLE EXERCISE OF THE DEPARTMENTS' AUTHORITY THAT PROTECTS CONSUMERS AND LOWERS THE COST OF HEALTH INSURANCE FOR TENS OF MILLIONS OF AMERICANS.

A. The ACA Provides Health Care Guarantees That Congress Regarded As Essential

In appreciating the propriety of the 2024 Rule, it is helpful to begin with the goals of the ACA. Prior to enactment of the ACA, many individuals faced substantial discrimination in (or were effectively priced out of) the medical insurance market, leaving them with inadequate health insurance or no insurance at all. *See* H.R. Rep. No. 111-299, tit. 3, pt. 1. In most States, insurance companies could discriminate against individuals based on pre-existing conditions, health status, gender, and many other factors. That risk segmentation made health insurance unavailable to many Americans as a practical matter. The existence of these pre-ACA problems has been widely documented.

Congress responded to these concerns by enacting the ACA. Two of the statute's sets of provisions are of central importance here:

First, the ACA "adopt[ed] a series of interlocking reforms designed to expand coverage in the individual health insurance market." *King v. Burwell*, 576 U.S. 473, 478-79 (2015). To this end, Congress established a "guaranteed issuance" requirement that prohibits refusing coverage to individuals with pre-existing conditions. 42 U.S.C. §§ 300gg-1(a), 300gg-3. Within specified limits, the ACA also mandated use of "community rating," which prohibits premium discrimination on the basis of factors such as health status, claims history, and gender. 42 U.S.C. § 300gg. And Congress required that issuers treat all enrollees in the individual health insurance market as "members of a single risk pool." 42 U.S.C. § 18032(c).

Congress regarded this latter reform as central to the ACA and necessary to make insurance available for all. It ensures that the risk pool includes both the healthy and the sick, which is essential if coverage for persons with pre-existing conditions is to be available and affordable. Otherwise, younger and healthier people will purchase cheap and limited policies, while those with pre-existing conditions will be segregated in their own prohibitively expensive plans.

Second, the ACA established minimum substantive standards for health insurance, ensuring that policies purchased in the individual insurance market will in fact provide meaningful coverage and eliminating the widespread abuses that prompted the Act's enactment. Congress thus required that all individual plans provide a "comprehensive" package of what it labeled "essential health benefits." 42 U.S.C. § 300gg-6(a). This package includes, among many other necessary protections, such things as emergency services, hospitalization, maternity and newborn care, mental health services, substance abuse services, and prescription drug coverage. *Id.* § 18022(a). In addition, the ACA bans lifetime and annual dollar limits on insurance benefits. *See id.* § 18022(a), (c).

As noted above, however, after enactment of the ACA, certain insurers began marketing STLDI as a form of long-term comprehensive insurance that fell outside all of these ACA guarantees. The Departments accordingly promulgated the 2016 Rule, imposing time limits on the availability of STLDI to prevent that frustration of the statutory mandate. In the 2018 Rule, the Departments again revised the definition of STLDI, this time allowing it to last for up to one year with the possibility of three annual renewals. 83 Fed. Reg. at 38227. But again, certain insurers took advantage of that Rule to sell inadequate insurance, in a manner that was misleading and undermined ACA marketplaces. *See* 89 Fed. Reg. at 23365-66.

B. The 2018 Rule Had Detrimental Effects on Individuals Deceived Into Buying STLDI Plans They Thought Were Comprehensive Health Insurance Plans

Against this background, the 2024 Rule was a response to the tragic practical consequences of the greatly expanded availability of long-term STLDI under the 2018 Rule.

Due to STLDI's cheaper cost, deceptive marketing practices employed by many STLDI providers, and the "significant disparities in health insurance literacy among certain underserved racial and ethnic groups and people with incomes below the [federal poverty line]," after the 2018 Rule's promulgation many individuals began enrolling in STLDI rather than comprehensive plans. 89 Fed. Reg. at 23350. This result was substantially attributable to "[a]ggressive, deceptive marketing practices," which "are an ongoing challenge for consumers shopping for coverage." 89 Fed. Reg. at 23356. Secret "shopper studies" have detailed "ongoing practices by sellers of STLDI that do not inform consumers of eligibility for less expensive Exchange plans or that provide misleading information about STLDI with limited benefits." *Id.*; *see* Rachel Schwab & JoAnn Volk, *The Perfect Storm: Misleading Marketing of Limited Benefit Products Continues as Millions Losing Medicaid Search for New Coverage* (Aug. 28, 2023), Center on Health Insurance Reforms, https://chirblog.org/the-perfect-storm-misleading-marketing-of-limited-benefit-products-continues-as-millions-losing-medicaid-search-for-new-coverage; U.S. Gov't Accountability Off., GAO-20-634R, *Private Health Coverage: Results of Covert Testing for Selected Offerings*, (2020), https://www.gao.gov/products/gao-20-634r. For example, the Departments found extensive evidence of salespeople neglecting to tell consumers that they may be eligible for subsidized ACA plans, asserting that an individual's health needs would be covered by an STLDI plan despite plan documents contradicting these assertions, or misstating an STLDI plan's coverage of certain preexisting conditions. The Departments also noted examples of marketing materials with images of activities for which coverage of associated injuries are excluded, marketing materials with logos

of well-known issuers that are not affiliated with the STLDI being sold, or websites selling STLDI that misleadingly include the words "Obamacare" or "ACA." 89 Fed. Reg. at 23366.

And "[d]eceptive marketing practices can have devastating financial implications for consumers who purchased STLDI without fully understanding its limitations and later encounter unexpected and expensive medical events that are not covered by their insurance." 89 Fed. Reg. at 23356; *see, e.g.*, Jenny Deam, *He Bought Health Insurance for Emergencies. Then He Fell Into a $33,601 Trap*, ProPublica (May 8, 2021), https://www.propublica.org/article/junk-insurance. The reasons are obvious, and undeniable. A 2020 report found that over 60 percent of the STLDI policies surveyed had a maximum out-of-pocket limit greater than the $7,900 limit that was permitted for self-only comprehensive coverage in 2019, and 15 percent had limits in excess of $15,000; and as is typical for STLDI, these limits apply only to the coverage period, which in some cases was only 6 months, compared to the annual limits required under the ACA for comprehensive coverage. Gabriela Dieguez & Dane Hansen, *The Impact of Short-term Limited-duration Policy Expansion on Patients and the ACA Individual Market* (2020), https://www.milliman.com/en/insight/the-impact-of-short-term-limited-duration-policy-expansion-on-patients-and-the-aca-individual-market. Moreover, because STLDI is typically subject to medical underwriting and is not guaranteed renewable, consumers enrolled in STLDI in lieu of comprehensive coverage may be unable to renew their STLDI policy at the end of the coverage period—particularly if they have had a health event and utilized their STLDI coverage. These consumers therefore face the risk of being uninsured until they are eligible to purchase comprehensive coverage in the individual market during an open enrollment or when a special enrollment period occurs. 89 Fed. Reg. 23348-49.

A characteristic example is that of Sam Bloechl. Mr. Bloechl, a then-32 year old landscape business owner from Lemont, Illinois, had been experiencing chronic back pain, so called his insurance broker to upgrade his insurance. He told the broker about prior visits to a chiropractor and was assured that, so long as there was no outstanding diagnosis, STLDI would be right for him—indeed, the broker said, Mr. Bloechl would be wasting his money if he bought a more expensive plan.

That was bad advice. One month after enrolling in the STLDI plan, Mr. Bloechl was diagnosed with stage IV T-Cell non-Hodgkin lymphoma. Although he began treatment immediately, and achieved remission six months into chemotherapy and radiation, his doctors told him that the disease would likely return if he did not get a bone marrow transplant. But as he began to prepare for the procedure, Mr. Bloechl got word that his STLDI plan had deemed his diagnosis a preexisting condition and, as a result, had denied him coverage for the needed transplant. The insurer likewise denied him coverage for the six months of treatment he had already received. Left without an option—because STLDI plans are exempt from the ACA's requirement that they cover individuals with preexisting conditions—Mr. Bloechl delayed getting the transplant and wound up buried beneath $800,000 of medical debt and on the verge of bankruptcy. None of this would have happened had STLDI not been offered as an alternative to comprehensive insurance. National Alliance on Mental Illness, *Under-Covered: How "Insurance-Like" Products Are Leaving Patients Exposed* 10 (2021), https://www.nami.org/wp-content/uploads/2023/08/Undercovered_Report_03252021-1.pdf.; *see* 89 Fed. Reg. at 23348.

Katrina Black's story is also illustrative, and typical. Ms. Black, a then-26-year-old third-year law student, had just accepted a job in a new city halfway across the country. After graduating in May, she and her husband moved to Texas, where Ms. Black was set to start working as an

attorney. But her new job would not start for five months and her student health insurance was about to expire. So Ms. Black went to healthcare.gov to purchase insurance.

When she did so, however, a pop-up appeared, asking for her phone number and zip code—and which, after she entered that information, ultimately led her out of the trusted marketplace without her even knowing. Ms. Black was then inundated with calls from brokers trying to sell her an insurance plan. When Ms. Black was given an inexpensive quote for a STLDI plan, she told the broker that she had endometriosis and needed continual treatment. The broker reassured her that her care would be covered; Ms. Black then enrolled. But as spring turned to summer, Ms. Black's STLDI provider informed her that the physical therapy sessions she had been attending three times a week every week would not be covered—and that, therefore, she was responsible for $6,000 in medical bills, all because her endometriosis was a preexisting condition for which the STLDI provider could legally deny her coverage. *Under-Covered*, *supra*, at 12.

These experiences are not atypical for those who purchase STLDI in the mistaken belief that it offers ACA-compliant comprehensive insurance. As noted above, and as the Preamble to the 2024 Rule demonstrates in detail, the Departments had learned about the use of "potentially deceptive or aggressive marketing of STLDI . . . to consumers who" lacked knowledge about those plans' "coverage limits." 89 Fed. Reg. at 23349-50. This was of particular concern to the Departments because "[c]onsumers who are unaware of the coverage limitations of these arrangements … can," as Mr. Bloechl's case shows, "face overwhelming medical costs if they require items and services that are not covered by the very limited group plan." *Id*. at 23350.

Moreover, these real-life experiences of Mr. Bloechl and Ms. Black under the 2018 Rule reflected harms felt by the broader public. One study conducted by the Government Accountability Office found that STLDI brokers were engaged in the systematic practice of "omit[ing] or

misrepresent[ing] information about the [STLDI] products they were selling." 89 Fed. Reg. at 23350 (citing *Private Health Coverage: Results of Covert Testing*, *supra*). For instance, "during a phone transaction," one broker "told the customer that they were purchasing a comprehensive health insurance plan, but instead sold the customer two" STLDI plans. *Id*. Although the customer told the broker repeatedly over the course of the conversation that they had diabetes and were seeking treatment for it, the application filled out by the broker on the customer's behalf said that they "had not been treated for or diagnosed with diabetes for the past five years." *Id*.

In addition, the financial risk associated with incurring high levels of medical debt grows in tandem with the length an individual spends enrolled in an STLDI plan. In other words, the longer a person is enrolled in STLDI, the more likely it is that they will incur costs that are not covered and that will send them into debt. See 89 Fed. Reg. at 23348. That is "especially the case," the Preamble notes, "for consumers who encounter newly diagnosed conditions or have a significant medical event while enrolled in STLDI." Id. Indeed, even when STLDI covers claims, use of STLDI may lead to higher costs: according to one study cited in the Preamble, "the maximum out-of-pocket health care spending limit for STLDI was on average nearly three times that of comprehensive coverage in 2020." Id. (citing Dieguez & Hansen, *supra*).

C. The 2018 Rule Had Detrimental Effects On The Broader Insurance Marketplace

In addition to these concerns animating the Departments' revision of the 2018 Rule, that Rule also had distorting effects on the broader insurance marketplace. As already discussed, because the 2018 Rule permitted individuals to sign up for cheaper STLDI plans for longer periods of time, many healthy Americans who would otherwise have obtained comprehensive health insurance coverage under the ACA instead opted for an STLDI plan. As a practical matter, that meant these healthy individuals were drawn out of the ACA risk pools. And that, of course, had

the effect of "increas[ing] premiums" for everyone else "seeking to purchase individual health insurance coverage." 89 Fed. Reg. at 23351 (citing Dieguez & Hansen, *supra*). "For unsubsidized individuals, the[se] costs are borne directly by the consumer, and for subsidized individuals, the costs are borne largely by the Federal Government." *Id*.

But it need not be this way. Citing one study that looked at various policies adopted at the state level to restrict STLDI to shorter durations than permitted under the 2018 Rule, the Preamble to the 2024 Rule explains how "States that restricted or prohibited the sale of STLDI saw fewer consumers enroll in such insurance, were able to keep more healthy people in the individual health insurance coverage market risk pool, and saw a greater decline in average medical costs for enrollees in individual health insurance coverage." 89 Fed. Reg. at 23351 (citing Mark Hall & Michael McCue, *Short-Term Health Insurance and the ACA Market* (2020), Commonwealth Fund, https://www.commonwealthfund.org/blog/2022/short-term-health-insurance-and-aca-market).

Accordingly, this "new evidence" provided a compelling "additional basis for the Departments' conclusion that it [wa]s important to amend the Federal definition of STLDI." 89 Fed. Reg. at 23351.

III. IF THE NEW ADMINISTRATION DECIDES NOT TO DEFEND THE 2024 RULE, THE COURT SHOULD STAY THIS ACTION AND REQUIRE THE GOVERNMENT TO UTILIZE THE NOTICE-AND-COMMENT PROCESS TO RECONSIDER THE RULE.

Amicus recognizes that the incoming administration may take a different view with respect to the merits of this litigation. If that occurs, and the Government indicates that it no longer wishes to defend the 2024 Rule, the Government may not achieve a de facto rescission of the 2024 Rule and restoration of the 2018 Rule through a settlement in this case.

The United States is of course entitled to change its position in litigation with a change in Presidential administrations, but—as four Supreme Court Justices have explained—that does not

mean that resolution of litigation may be "leveraged . . . as a basis to immediately repeal [a] Rule, without using notice-and-comment procedures." *Arizona v. City & Cnty. of San Francisco*, 596 U.S. 763, 765–66 (2022) (Roberts, C.J., joined by Thomas, Alito, and Gorsuch, JJ., concurring) (citing 5 U. S. C. § 551(5)); *Perez v. Mortgage Bankers Ass'n*, 575 U.S. 92, 101 (2015)). Such an outcome would "allow[] the Government to circumvent the usual and important requirement, under the Administrative Procedure Act, that a regulation originally promulgated using notice and comment . . . may only be repealed through notice and comment." *Arizona*, 596 U.S. at 765.

Consequently, in the event the Government changes its position in this litigation, *Amicus* respectfully requests that the Court stay this action so that the Government may reconsider the 2024 Rule through the notice-and-comment process required by the Administrative Procedure Act. Alternatively, *Amicus* respectfully requests an opportunity to intervene in this litigation to defend the validity of the 2024 Rule.

CONCLUSION

This Court should deny Plaintiffs' Motion for Summary Judgment and grant Defendants' Cross-Motion for Summary Judgment. In the event that the United States abandons its defense of the 2024 Rule, *Amicus* requests an opportunity to intervene to defend the Rule.

Dated: December 20, 2024

Respectfully submitted,

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CERTIFICATE OF SERVICE

The undersigned hereby certifies that a true and correct copy of the foregoing document has been served on all counsel of record in accordance with the Federal Rules of Civil Procedure and this Court's CM/ECF filing system on December 20, 2024.

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