IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF TEXAS

AMERICAN ASSOCIATION OF ANCILLARY BENEFITS,

Plaintiff,

v.

XAVIER BECERRA, *in his official capacity, as Secretary of the United States Department of Health and Human Services*; JULIE A. SU, *in her official capacity, as Acting Secretary Department of Labor*; and JANET YELLEN, *in her official capacity, as Secretary of the Treasury*,

Defendants.

Case No. 4:24-cv-783-SDJ

AMICUS BRIEF OF THE FOUNDATION FOR GOVERNMENT ACCOUNTABILITY IN SUPPORT OF PLAINTIFF'S OPPOSITION TO DEFENDANT'S CROSS-MOTION FOR SUMMARY JUDGMENT

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TABLE OF CONTENTS

TABLE OF CONTENTS ii
TABLE OF AUTHORITIES iii
INTEREST OF AMICUS CURIAE 1
INTRODUCTION 1
ARGUMENT 3
I. STLDI plans play an essential role in the insurance market alongside the ACA 3
A. STLDI plans provide uninsured Americans with valuable coverage. 4
B. STLDI plans support the ACA's goal of expanding coverage. 7
C. STLDI coverage is far better than the alternative of no insurance. 10
II. The restriction of STLDI plans is a major question, and Congress did not clearly authorize the Departments to decide it. 13
CONCLUSION 15
CERTIFICATE OF SERVICE 17

TABLE OF AUTHORITIES

CASES

Ala. Ass'n of Realtors v. HHS,
594 U.S. 758 (2021) 13, 14, 15

Azar v. Gresham,
141 S. Ct. 1043 (2021) 1

Biden v. Nebraska,
143 S. Ct. 2355 (2023) 15

Loper Bright Enterprises v. Raimondo,
603 U.S. 369 (2024) 1, 3

Luna Perez v. Sturgis Pub. Schs.,
598 U.S. 142 (2023) 2

Sackett v. EPA,
598 U.S. 651 (2023) 14

U.S. Dep't of Treasury v. Fabe,
508 U.S. 491 (1993) 5

Util. Air Regul. Grp. v. EPA,
573 U.S. 302 (2014) 13

West Virginia v. EPA,
597 U.S. 697 (2022) 13, 14, 15

STATUTES

15 U.S.C. §1012 5

42 U.S.C. §18091 .... 7, 8

42 U.S.C. §300gg-91 4

Pub. L. No. 104-191, 110 Stat. 1936 (Aug. 21, 1996) 4

Pub. L. No. 111-148, 124 Stat. 119 (Mar. 23, 2010) 5

REGULATIONS

62 Fed. Reg. 16894 (Apr. 8, 1997) 5

89 Fed. Reg. 23338 (Apr. 3, 2024) 4, 9, 10, 15

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(Jan. 6, 2025), bit.ly/4h4GKw4 .... 10, 11

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Jennifer Tolbert et al., *The Uninsured Population and Health Coverage*, KFF (May 28, 2024), bit.ly/3WeK5Rf 11, 12

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Letter from Sens. Baldwin et al. (Feb. 14, 2022), bit.ly/4h5fgXa 15

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S.J.Res.63 (2018), bit.ly/40flZai........ 15

U.S. Census Bureau, *Most Populous Cities*, perma.cc/5DY3-V9H4........ 8

INTEREST OF AMICUS CURIAE[1]

The Foundation for Government Accountability (FGA) is a 501(c)(3) nonprofit organization that helps millions achieve the American Dream by improving welfare, workforce, and healthcare at the state and federal levels. Launched in 2011, FGA promotes policy reforms that seek to free individuals from the trap of government dependence, restore dignity and self-sufficiency, and empower individuals to take control of their futures.

Since its founding, FGA has helped achieve more than 1,000 reforms impacting policies in 42 states as well as 30 federal reforms. FGA supports its mission by conducting innovative research, deploying outreach and education initiatives, equipping policy makers with the information they need to achieve meaningful reforms, and by appearing as amicus curiae before state and federal courts, including the U.S. Supreme Court in *Azar v. Gresham*, 141 S. Ct. 1043 (2021) and *Loper Bright Enterprises v. Raimondo*, 603 U.S. 369 (2024).

The Departments' rule restricting access to short-term limited duration insurance plans undermines an essential tool for providing health insurance to uninsured Americans. This case thus directly implicates FGA's core mission of helping individuals live healthy, independent, and fulfilling lives while promoting limited, constitutional government and a free market.

INTRODUCTION

Congress chose to authorize short-term limited duration insurance as an affordable alternative to federally regulated health insurance. But the Departments of HHS, Labor, and

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1 This brief was not authored in whole or in part by counsel for any party and no person or entity other than amicus curiae or its counsel has made a monetary contribution to the brief's preparation or submission. All parties were notified of and consented to this brief.

Treasury are dissatisfied with that choice. They believe that STLDI plans are incompatible with the Affordable Care Act, even though the ACA expressly authorizes them. So the Departments have decided that the ACA must be rewritten by severely restricting STLDI plans to prevent Americans from choosing them. This is a familiar script of agency hubris and overreach.

The Departments' rule restricting access to STLDI plans is based on two flawed assumptions. The first is that STLDI plans undermine ACA coverage by allowing some individuals to exit the ACA risk pool. But Congress didn't think so, and for good reason. STLDI plans give individuals who want or need an alternative to ACA coverage the option to obtain affordable short-term insurance. Thus, while STLDI plans may reduce the size of the ACA risk pool, they pursue the ACA's goal of expanding insurance coverage. For those who can't afford ACA plans, STLDI plans are far better than being uninsured. And for some people who can afford ACA plans, STLDI plans provide better coverage. Thus, Congress's decision to protect STLDI plans is a classic legislative trade-off that pursues multiple policy objectives rather than pursuing one objective "'at all costs.'" *Luna Perez v. Sturgis Pub. Schs.*, 598 U.S. 142, 150 (2023).

Even assuming that STLDI plans are in tension with the ACA, and that Congress made a mistake in deciding to protect them, the agencies wrongly assume that they have the statutory authority to fix that mistake. Whether STLDI plans can be severely restricted to increase the size of the ACA risk pool is a major political and economic question that Congress chose not to answer in the ACA. Thus, according to the default rule for insurance regulation under the McCarran-Ferguson Act, Congress left that question to be answered by the State governments.

Congress never authorized the Departments to decide that issue. All Congress did was leave the term "short-term limited duration insurance" undefined. This silence is not a green light for the Departments to decide whether Americans should have access to STLDI plans.

With the demise of *Chevron*, the era of such unauthorized agency policymaking is over. *See Loper Bright*, 603 U.S. at 412-13. This Court should say so, deny the Departments' cross-motion for summary judgment, and grant the plaintiff's motion for summary judgment.

ARGUMENT

I. STLDI plans play an essential role in the insurance market alongside the ACA.

The Department's first mistaken premise is that STLDI plans undermine the ACA. But STLDI plans provide valuable health insurance at an affordable price, promoting the ACA's goal of expanding coverage. For decades, STLDI plans have played an essential role in the healthcare market by offering Americans an affordable alternative to federally regulated health insurance.

Today, after the passage of the Affordable Care Act, access to STLDI plans has become even more important. The ACA promised Americans "increased options and lower costs," but "the opposite has happened over the last several years." Greg George & Nicholas Horton, *Short-Term Plans: Affordable Options for America's Uninsured* at 3 (Jan. 24, 2019), bit.ly/4gKi5gB. "Premiums have skyrocketed, leaving Americans paying more and more out of pocket with limited choices," and "[i]ndividuals who have not been priced out of the market altogether are left with few affordable options." *Id.* The result is that tens of millions of Americans are now uninsured. *See id.* at 3-4. For some of the uninsured, STLDI plans are a temporary stopgap until they can afford to obtain ACA coverage and rejoin the risk pool. For others, STLDI plans provide objectively superior coverage to ACA plans. In either case, STLDI plans offer

millions of Americans the choice of affordable insurance coverage, which is one of the central goals of the Affordable Care Act.

Despite the benefits of STLDI plans, the Departments' rule severely restricts access to them by capping their total duration (with extensions and renewals) at 4 months—down from 36 months—and by prohibiting "a renewal or extension … by the same issuer to the same policyholder within [a] 12-month period." 89 Fed. Reg. 23338, 23352 (Apr. 3, 2024). These restrictions "will deliver a crippling blow" to STLDI plans. FGA Comments at 2 (Sept. 1, 2023), bit.ly/4a9rIDj. The Departments' goal is to maximize the ACA risk pool, *see* 89 Fed. Reg. at 23351-52, but restricting STLDI plans will come at great cost. The rule will not only force some individuals on STLDI plans to obtain inferior ACA coverage, but more importantly, it will deprive millions of uninsured Americans—who cannot afford *any* ACA coverage—of an alternative form of coverage. This is "unreasonable, unlawful, and cruel." CATO Institute Comments at 1 (Sept. 12, 2024), bit.ly/4j1NCMC.

A. STLDI plans provide uninsured Americans with valuable coverage.

For years Congress has sought to give Americans choices when purchasing health insurance. In 1996, Congress expanded federal regulation of health insurance through HIPAA, "limit[ing] the circumstances in which consumers who changed jobs could be denied coverage later based on preexisting conditions." Cross-MSJ at 4. But Congress also recognized the need for consumer choice and affordable alternatives, so it created an exception to these HIPAA rules for "short-term limited duration insurance." Pub. L. No. 104-191, §102, 110 Stat. 1936 (Aug. 21, 1996), *codified at* 42 U.S.C. §300gg-91(b)(5). Congress did not define "short-term limited duration insurance." *See id.* By staying silent on what qualifies as a STLDI plan,

Congress left the matter to be decided by the State governments under the McCarran-Ferguson Act. *See, e.g.*, *U.S. Dep't of Treasury v. Fabe*, 508 U.S. 491, 500-02 (1993); 15 U.S.C. §1012. Despite the lack of Congressional authorization for federal agencies to regulate STLDI plans, the Departments issued a rule that defined STLDI plans as "health insurance coverage … that has an expiration date specified in the contract (taking into account any extensions …) that is within 12 months of the date the contract becomes effective." 62 Fed. Reg. 16894, 16958 (Apr. 8, 1997).

In following years, Congress has enacted many other federal statutes regulating health insurance, but as in HIPAA, Congress repeatedly exempted STLDI plans. *See* CATO Institute Comments, *supra* at 2. In 2010, when Congress enacted sweeping new federal requirements for health insurance under the ACA, Congress once again exempted STLDI plans. *See* Pub. L. No. 111-148, §1001, 124 Stat. 119 (Mar. 23, 2010). STLDI plans are thus exempt from ACA rules "that prohibit medical underwriting, pre-existing condition exclusions, and lifetime and annual limits, and that require minimum coverage standards." Karen Pollitz et al., *Understanding Short-Term Limited Duration Health Insurance*, KFF (Apr. 23, 2018), bit.ly/40x1xlF.

Because STLDI plans are not subject to the full panoply of federal regulations, "short-term policies, not surprisingly, cost less than ACA-compliant major medical health insurance policies." *Id.* "Data … shows that short-term plans are significantly less expensive than plans sold in the individual market," with one analysis showing that they are "nearly 60 percent less expensive on average." George & Horton, *supra* at 6. "Other analyses have produced similar findings, with some finding short-term plans to be up to 80 percent less expensive than the lowest-cost bronze plan in the individual market on average, and up to 93 percent less

expensive in some states." *Id.* The price differential is staggering. One commenter described the "real life example [of] 'Maria,'" a woman who in 2023 had a choice between the cheapest ACA bronze plan at $4,821/year or an STLDI plan as low as $1,100/year, with customized coverage targeted to her specific medical needs. CATO Institute Comments, *supra* at 9.

STLDI plans have other advantages as well. "Short-term plans can be purchased at any time, unlike other plans available on the individual market which restrict enrollment to open enrollment periods or following a life-changing event," and "[c]overage usually begins within a few days compared to other medical coverage that can take several weeks to begin." George & Horton, *supra* at 5. By contrast, ACA plans may be purchased "only during narrow 'open' or 'special' enrollment periods," and "[e]ven then, there can be a lag of up to two months before Obamacare coverage takes effect." Michael F. Cannon, *Biden Short-Term Health Plans Rule Creates Gaps in Coverage*, CATO Institute (Mar. 14, 2024), bit.ly/4h3GGg4. STLDI plans "can [also] offer more customized choices." George & Horton, *supra* at 5.

Amici for the Departments argue that STLDI plans are not legally "*required*" to cover "prescription drugs, mental health care, preventative care, and other benefits deemed essential under the ACA." Brief of Amici Curiae The Leukemia & Lymphoma Society et al., Dkt. 48 at 4-5, 12, 18 (Dec. 20, 2024) (emphasis added); *see* Brief of Amicus Curiae The Association for Community Affiliated Plans, Dkt. 50 at 6 (Dec. 23, 2024). But STLDI plans frequently cover such care; the difference is that STLDI plans can be customized to the patient's needs to avoid paying for unnecessary coverage. *See* CATO Institute Comments, *supra* at 6-7; *see also* Pollitz, *supra* at Table 2. "A 2019 study by health policy expert Chris Pope of the Manhattan Institute found … STLDI plans that cover all the ACA's essential health benefits are widely available,

with the sole exception of maternity services." Paragon Health Institute et al. Comments at 5 (Sept. 13, 2023), bit.ly/4h4jqyC.

At times STLDI plans are *more* comprehensive than ACA coverage. According to data from the Kaiser Family Foundation, "STLDI plans in major cities have … annual out-of-pocket limits … as low as $1,000," and "[i]n most markets, STLDI plans offer up to $5 million of lifetime coverage." CATO Institute Comments, *supra* at 4-6. Moreover, "[s]hort-term plans typically have much broader networks than ACA individual market plans do." Paragon Health Institute et al. Comments, *supra* at 5. And "[h]ospitals and doctors are more likely to participate in short-term plans because they tend to offer better payment rates than ACA plans do." *Id.*

The superiority of some STLDI plans to ACA plans is at least partly due to the ACA's "community-rating price controls." CATO Institute Comments, *supra* at 13. These regulations "mak[e] coverage less comprehensive by effectively penalizing issuers unless they 'avoid enrolling people who are in worse health' by designing plans to be 'unattractive to people with expensive health conditions.'" *Id.* "Rather than guarantee comprehensive coverage, these provisions create a race to the bottom by ceaselessly penalizing any ACA plan that is more comprehensive than its competitors." *Id.* at 14. Tragically, "the centerpiece of the ACA's regulatory scheme is actively eroding coverage for all enrollees," and this trend cannot be reversed by eliminating STLDI plans. *Id.* Thus, for many people, STLDI plans are the only alternative to the ACA's self-inflicted reductions in coverage. *See id.* at 13-14.

B. STLDI plans support the ACA's goal of expanding coverage.

One of the ACA's primary goals is to "achiev[e] near-universal coverage by building upon and strengthening the private employer-based health insurance system." 42 U.S.C.

§18091(2)(D). As discussed, the ACA has not yet achieved this goal, partly because of the high cost of ACA plans that have priced tens of millions of Americans out of the ACA market. *See* George & Horton, *supra* at 4. As of last year, 7.7 percent of the U.S. population—*26 million* people—are still uninsured, and this population is expected to "rise over the course of the next decade …[to] 8.9 percent in 2034," which is estimated to be *32 million* uninsured. Jessica Hale et al., *Health Insurance Coverage Projections For The US Population And Sources Of Coverage, By Age, 2024-34*, Health Affairs (June 18, 2024), bit.ly/3BS6ddv. To put these numbers in perspective, the uninsured population is larger than the population of the ten largest American cities *combined*, including New York, Los Angeles, and Chicago, which together have a population of about 25 million. U.S. Census Bureau, *Most Populous Cities*, perma.cc/5DY3-V9H4.

There are many reasons for this widespread lack of insurance, but the biggest reason by far is that the uninsured cannot afford ACA coverage. Jennifer Tolbert et al., *Key Facts About the Uninsured Population*, KFF (Dec. 18, 2024), bit.ly/4fMCd0x. "In 2023, 63% of uninsured adults ages 18-64 said that they were uninsured because the cost of coverage was too high." *Id.* "Many uninsured people do not have access to coverage through a job, and some people … remain ineligible for financial assistance for coverage." *Id.* "In some cases, even with subsidies, Marketplace coverage may not be affordable." *Id.* "According to a 2018 survey by eHealth, only one in four individuals shopping for health insurance are willing to spend more than $200 per month," but "[f]ederal data show[ed] that nearly half of all federal exchange enrollees have no access to any plans that cost less than $400 per month." George & Horton, *supra* at 4. Without STLDI plans, millions of these individuals will continue to have no options.

STLDI plans give them a chance—perhaps the only chance—to get coverage. STLDI plans thus fulfill a primary purpose of the ACA.

According to the Departments and their *amici*, STLDI plans exacerbate the problem of high ACA premiums by drawing young, healthy individuals out of the ACA risk pool, causing ACA premiums to rise. Cross-MSJ at 9; Brief of Amici Curiae The Leukemia & Lymphoma Society et al., Dkt. 48 at 27; Brief of Amicus Curiae The Association for Community Affiliated Plans, Dkt. 50 at 11-12. But the reality is more nuanced. "The ACA individual market, regardless of metric, has performed better in states that fully permit STLDI." Paragon Health Institute, *Short-Term Health Plans, Long-Term Benefits* at 1 (Sept. 2023), bit.ly/3PxlRy5. "Between 2018 and 2023: 1) Exchange enrollment was up 62.7 percent in STLDI favorable states, more than 13 times greater than the 4.7 percent increase in STLDI unfavorable states; 2) The number of insurers selling exchange plans in STLDI favorable states increased 105 percent, more than three times the 31 percent increase in STLDI unfavorable states; and 3) Exchange plan premiums, particularly for benchmark plans and gold plans, decreased much more significantly in STLDI favorable states." *Id.*

There is no evidence that STLDI plans have destabilized ACA exchanges, and the Departments' own evidence shows no such thing. *See* 89 Fed. Reg. at 23351 n.116, 23402-03 (citing one study showing only a "0.5 percent [to] 2.0 percent" increase in premiums in 2020 attributed to expanded STLDI coverage). STLDI plans don't undermine the ACA; they expand coverage for those who need affordable options, working in tandem with the ACA and not at cross-purposes with it.

If anything, it is the Departments who are working at cross-purposes with the ACA by intentionally causing individuals who rely on STLDI plans to lose coverage. The Departments' rule "cancel[s] all new STLDI plans after four months" and "prohibit[s] renewals by prohibiting insurers to sell two STLDI plans to the same customer within a 12-month period." CATO Institute Comment, *supra* at 10; *see* 89 Fed. Reg. at 23352. The effect of this rule is that individuals who fall ill can no longer "use STLDI plans as [their] primary source of insurance." CATO Institute Comments, *supra* at 10. "Within four months of falling ill, the Departments' proposal [will] strip [them] of [their] current STLDI plan," which will "turn [their] otherwise *insured* medical condition into an uninsured *preexisting* condition" and "expose [them] to medical underwriting in that market." *Id.* The Departments' rule thus deprives these people of "any hope of enrolling in a subsequent STLDI plan" and forces them to be uninsured for "up to 12 months" before becoming eligible to enroll in an ACA plan. *Id.*

"These risks are not hypothetical" and "entirely foreseeable." *Id.* at 11. Indeed, these very harms "already befell STLDI enrollees from 2016 to 2018 after the Departments unwisely adopted a [similar] proposal." *Id.* But the Departments are quite blasé about how their rule will *increase* the ranks of the uninsured. While they "acknowledged the risk," they "concluded that the 2024 Rule's benefits outweighed that risk." Cross-MSJ at 32.

C. STLDI coverage is far better than the alternative of no insurance.

STLDI plans are not perfect, but they are far better than no insurance at all. Access to health insurance is essential to economic success. "People without medical insurance normally pay two to five times more for medical services than those with insurance coverage." AdventHealth, *How Much Does A Primary Care Visit Cost Without Insurance* (Jan. 6, 2025),

bit.ly/4h4GKw4. Due to these "unaffordable medical bills," "[m]ore than 6 in 10 (62%) uninsured adults report having health care debt compared to over 4 in 10 (44%) insured adults." Jennifer Tolbert et al., *The Uninsured Population and Health Coverage*, KFF (May 28, 2024), bit.ly/3WeK5Rf. This negatively impacts patients' financial situation, causing them to dip into savings, borrow money, and have trouble paying other living expenses. *Id.*

A lack of insurance also causes more insidious harms by encouraging patients to delay or forgo medical care. In 2023,

- 46.6% of uninsured adults and 27.4% of uninsured children did not see a healthcare professional, compared to 15.6% of adults and 3.7% of children with private insurance.
- 42.8% of the uninsured adults and 23.6% of uninsured children have no usual source of healthcare, compared to 11.2% of adults and 1.5% of children with private insurance.
- 24.7% of the uninsured adults and 9.7% of uninsured children postponed healthcare due to cost, compared to 6.2% of adults and 0.5% of children with private insurance.
- 22.6% of the uninsured adults and 9.5% of uninsured children went without healthcare due to cost, compared to 5.1% of adults and 0.7% of children with private insurance.
- 14% of the uninsured adults and 5.2% of uninsured children delayed or declined filling a prescription due to cost, compared to 5.9% of adults and 1.1% of children with private insurance.

Tolbert et al., *Key Facts*, *supra* at Figure 9.

Much of deferred and foregone healthcare is preventive care. *See, e.g.*, HHS Office of Disease Prevention & Health Promotion, *Health Care Access and Quality*, bit.ly/428exR5. A lack of early detection and treatment of illnesses can eventually lead to even higher medical bills—which the patient already cannot afford. *See, e.g.*, Dhruv Khullar, *As a Doctor, I See How a Lack of Health Insurance Worsens Illness and Suffering*, The Washington Post (Jan. 9, 2017),

bit.ly/3E0bn7G ("As doctors, we see such tragedies every day. We see how a lack of health insurance exacerbates illness and suffering.").

For example, "[u]ninsured patients are more likely to receive medical care only after [a] cancer has spread." *Id.* (citing Gary V. Walker et al., *Disparities in Stage at Diagnosis, Treatment, and Survival in Nonelderly Adult Patients With Cancer According to Insurance Status*, Journal of Clinical Oncology (Aug. 4, 2014), bit.ly/4fNQs4Z). And once the cancer has spread, "[t]hey're less likely to receive surgery and radiation, and are more likely to die." *Id.*; *see, e.g.*, Tolbert et al., *The Uninsured Population*, *supra*. One 2009 study found that "[n]early 45,000 annual deaths are associated with lack of health insurance," and that "uninsured, working-age Americans have a 40 percent higher risk of death than their privately insured counterparts, up from a 25 percent excess death rate found in 1993." *See* David Cecere, *New Study Finds 45,000 Deaths Annually Linked to Lack of Health Coverage*, The Harvard Gazette (Sept. 17, 2009), bit.ly/42373yF.

Behind these statistics is profound human suffering. Real people are devastated by preventative illnesses left untreated because of a lack of insurance. *See, e.g.*, Ricardo Nuila, *Here's the Story of One of the Millions of Texans Who Have No Medical Insurance*, Texas Monthly (Sept. 2023), bit.ly/4harqyk; Roseanna Garza, *No Insurance and a Catastrophic Illness: My Father's Story*, San Antonio Report (Feb. 17, 2020), bit.ly/3W9ACuM. Many of these tragedies could be prevented by STLDI insurance. *See, e.g.*, John Tozzi & Emma Ockerman, *What It's Like Living Without Health Insurance in America*, Bloomberg (Apr. 3, 2018), bit.ly/4fU4diT (describing an uninsured legal assistant who could not afford ACA "premiums that would have cost her around $250 to $300 per month"). The Departments' rule shows no regard for the suffering that could be avoided through access to STLDI plans.

II. The restriction of STLDI plans is a major question, and Congress did not clearly authorize the Departments to decide it.

Even if the Departments are correct that STLDI plans cannot coexist with ACA plans and must be severely restricted to protect the ACA risk pool, the Departments lack the authority to disrupt the statutory balance struck by Congress that allows these plans to coexist together. The ACA exempts STLDI plans and leaves the term "short-term limited duration insurance" undefined, thus putting State governments in charge of regulating STLDI plans under the McCarran-Ferguson Act. *See supra* 4-5. The Department's overthrow of this statutory balance has "vast economic and political significance," *Ala. Ass'n of Realtors v. HHS*, 594 U.S. 758, 764 (2021) (quotation marks omitted), "'significantly alter[s] the balance between federal and state power,'" *id.*, and concerns an "'earnest and profound debate across the country,'" *West Virginia v. EPA*, 597 U.S. 697, 732 (2022).

First, restricting alternatives to unaffordable ACA coverage has profound political and economic significance. Plaintiff has already noted the economic impact of the Departments' rule on the STLDI market. *See* MSJ at 28. But "the issues at stake are not merely financial." *Ala. Ass'n of Realtors*, 594 U.S. at 764. Restricting STLDI plans will deprive millions of uninsured Americans of the only affordable way for them to obtain coverage. *Cf. id.* at 765 (an eviction moratorium was a major question in part because it "put the applicants, along with millions of landlords across the country, at risk of irreparable harm"). This will continue to exacerbate the vast and costly problem of millions of Americans lacking health insurance.

The Departments' rule will also "bring about an enormous and transformative expansion in [the Departments'] regulatory authority." *Util. Air Regul. Grp. v. EPA*, 573 U.S. 302, 324 (2014). While Congress decided to maximize the covered population by giving

Americans a choice between ACA and STLDI plans, the Departments have decided to maximize the ACA risk pool through severe restrictions on STLDI plans that will cause more people to become uninsured. The political and economic significance of this decision cannot be overstated. If the Departments can rewrite Congress's statutory compromise between ACA and STLDI coverage, "[i]t is hard to see what measures … would [be] outside the [Departments'] reach." *Ala. Ass'n of Realtors*, 594 U.S. at 764-65.

Other factors point to the Departments' rule raising a major question. The rule will "'significantly alter the balance between federal and state power.'" *Id.* at 764; *see also, e.g.*, *Sackett v. EPA*, 598 U.S. 651, 679 (2023) ("'Congress [must] enact exceedingly clear language if it wishes to significantly alter the balance between federal and state power.'"). Because federal law does not define "short-term limited duration insurance," pursuant to the McCarran-Ferguson Act, State governments have been the primary regulators of STLDI coverage. *See supra* 4-5; *e.g.*, Louise Norris, *Finalized Federal Rule Reduces Total Duration of Short-Term Health Plans to 4 Months*, HealthInsurance.Org (Sept. 20, 2024), bit.ly/4hb7bk0. In most states, STLDI plans are permitted for durations ranging from six months to the maximum of 36 months under the prior rule. Norris, *supra*. The Departments' sweeping new rule overrides these laws with no express statutory authority, despite several States noting in comments how they carefully use STLDI plans to provide coverage for their citizens. *See, e.g.*, Alaska Comments (Sept. 11, 2023), bit.ly/3DQSK6c; Iowa Comments (Sept. 6, 2023), bit.ly/4aeehls.

The Departments' rule has also been "'the subject of an earnest and profound debate across the country.'" *West Virginia*, 597 U.S. at 732. For years there has been a contentious regulatory battle over STLDI coverage. Different administrations have restricted (in 2016),

then liberalized (in 2018), and restricted again (in 2024) Americans' access to STLDI plans, with each new proposal or request for comments drawing impassioned input from the public on both sides of the issue. *See, e.g.*, 89 Fed. Reg. at 23338-42. Even Congress has taken notice, with members of Congress writing to the Departments on the issue. *See, e.g.*, Letter from Sens. Baldwin et al. (Sept. 15, 2023), bit.ly/40iJq2K; Letter from Sens. Baldwin et al. (Feb. 14, 2022), bit.ly/4h5fgXa; Letter from Sens. Johnson et al. (June 8, 2017), bit.ly/40fv6rF. But Congress has "consistently rejected proposals" to eliminate STLDI plans. *West Virginia*, 597 U.S. at 731; *see* H.R. 711 (2023), bit.ly/3PuC8nd; S.J.Res.63 (2018), bit.ly/40flZai.

All these factors point to this issue being a major question. They show that "the basic and consequential tradeoffs inherent in" restricting access to STLDI plans "are ones that Congress would likely have intended for itself," *Biden v. Nebraska*, 143 S. Ct. 2355, 2375 (2023) (cleaned up), which makes the Department's "'claimed delegation … suspect,'" *West Virginia*, 597 U.S. at 732. Thus, to restrict access to STLDI plans, the Departments need clear statutory authorization. *See, e.g.*, *Biden*, 143 S. Ct. at 2374. But the Departments do not dispute that there is no clear statement here. *See* Cross-MSJ at 6. The only statutory basis for its rule is the term "short-term limited duration insurance," which the Department admits has no definition, and a generic grant of authority to enact rules "'necessary or appropriate to carry out'" statutory provisions. *Id.* These provisions are "a wafer-thin reed on which to rest such sweeping power" to restrict access to STLDI plans. *Ala. Ass'n of Realtors*, 594 U.S. at 765.

CONCLUSION

For these reasons, the Court should deny the Departments' cross-motion for summary judgment and grant the Plaintiff's motion for summary judgment.

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Respectfully submitted,

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CERTIFICATE OF SERVICE

I hereby certify that a true and correct copy of the foregoing has been served on counsel of record via the Court's electronic filing and service on January 17, 2025.

/s/ James Hasson