[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, NATIONAL ALLIANCE ON MENTAL ILLNESS, MENTAL HEALTH AMERICA, AMERICAN PSYCHIATRIC ASSOCIATION, AIDS UNITED, NATIONAL PARTNERSHIP FOR WOMEN & FAMILIES, and LITTLE LOBBYISTS, LLC,

Plaintiffs-Appellants,

v.

U.S. DEPARTMENT OF THE TREASURY; U.S. DEPARTMENT OF LABOR; U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES; ALEX M. AZAR II, in his official capacity as Secretary of Health and Human Services; EUGENE SCALIA, in his official capacity as Secretary of Labor; STEVEN T. MNUCHIN, in his official capacity as Secretary of the Treasury; and the UNITED STATES OF AMERICA,

Defendants-Appellees.

On Appeal from the United States District Court
for the District of Columbia

BRIEF FOR APPELLEES

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CERTIFICATE AS TO PARTIES, RULINGS, AND RELATED CASES

Under D.C. Circuit Rule 28(a)(1), the undersigned counsel certifies as follows:

A. Parties and Amici

Plaintiffs-appellants are the Association for Community Affiliated Plans, the National Alliance on Mental Illness, Mental Health America, the American Psychiatric Association, AIDS United, the National Partnership for Women & Families, and The Little Lobbyists, LLC.

Defendants-appellees are the U.S. Department of the Treasury; the U.S. Department of Labor; the U.S. Department of Health and Human Services; Alex M. Azar II, in his official capacity as Secretary of Health and Human Services; Eugene Scalia, in his official capacity as Secretary of Labor; Steven T. Mnuchin, in his official capacity as Secretary of the Treasury; and the United States of America.

Amici before the district court and this Court include the American Cancer Society, American Cancer Society Cancer Action Network, American Heart Association, American Lung Association, Cystic Fibrosis Foundation, Epilepsy Foundation, Global Healthy Living Foundation, Hemophilia Federation of America, Judge David L. Bazelon Center for Mental Health Law, Leukemia & Lymphoma Society, March of Dimes, National Coalition for Cancer Survivorship, National Multiple Sclerosis Society, AARP, AARP Foundation, American Medical Association, American College of Physicians, American Academy of Family Physicians, American Academy of Pediatrics, American College of Obstetricians and Gynecologists, and Medical Society of the District of

Columbia. The American Osteopathic Association and the HIV Medicine Association were amici before the district court. The U.S. House of Representatives is amicus before this Court.

B. Ruling Under Review

The ruling under review is a memorandum opinion and order denying plaintiffs' motion for summary judgment and granting defendants' motion for summary judgment, issued by Judge Richard J. Leon on July 19, 2019 (Dkt. Nos. 57, 58; JA556-596). The opinion is published at 392 F. Supp. 3d 22.

C. Related Cases

This case has not previously been before this Court or any court other than the district court. Defendants' counsel are unaware of any related cases currently pending in this Court or any other court.

/s/ Daniel Winik
Daniel Winik

TABLE OF CONTENTS

Page

TABLE OF AUTHORITIES iii

GLOSSARY ix

STATEMENT OF THE ISSUE 1

PERTINENT STATUTES AND REGULATIONS 1

STATEMENT 1

A. Statutory Background 1

1. HIPAA 1

2. The ACA 2

B. Regulatory Background 6

1. The 1997 and 2004 rules defining short-term limited duration insurance 6

2. The 2016 rule restricting the availability of short-term limited duration insurance 7

3. The 2018 rule largely restoring the longstanding definition of short-term limited duration insurance 11

C. Proceedings Below 17

SUMMARY OF ARGUMENT 19

STANDARD OF REVIEW 21

ARGUMENT 22

I. THE ACA DOES NOT FORECLOSE THE CHALLENGED RULE 22

A. In Enacting The ACA, Congress Implicitly Approved Essentially The Same Rule The Departments Have Now Restored............................22

B. The Challenged Rule Is Consistent With The ACA's Structure And Purposes 27

1. The ACA creates opportunity and incentives for consumers to choose comprehensive coverage, rather than limiting consumers' options 27

2. The Departments reasonably concluded that the challenged rule will not destabilize the Exchanges 32

II. THE LONGSTANDING DEFINITION OF SHORT-TERM LIMITED DURATION INSURANCE WAS CONSISTENT WITH HIPAA 36

III. THE DEPARTMENTS REASONABLY EXPLAINED THEIR DECISION TO RESTORE THE LONGSTANDING DEFINITION OF SHORT-TERM LIMITED DURATION INSURANCE 41

CONCLUSION 46

CERTIFICATE OF COMPLIANCE

ADDENDUM

TABLE OF AUTHORITIES

Cases: **Page(s)**

Albany Engineering Corp. v. FERC,
548 F.3d 1071 (D.C. Cir. 2008) 29

AFL-CIO v. Brock,
835 F.2d 912 (D.C. Cir. 1987) 25

Altman v. SEC,
666 F.3d 1322 (D.C. Cir. 2011) 24

Association for Community Affiliated Plans v. U.S. Department of Treasury,
392 F. Supp. 3d 22 (D.D.C. 2019) 17, 18, 19, 23, 29, 35, 37, 40

Biestek v. Berryhill,
139 S. Ct. 1148 (2019) 22

Central United Life Insurance Co. v. Burwell,
827 F.3d 70 (D.C. Cir. 2016) 3, 8, 30-31, 31

Commodity Futures Trading Commission v. Schor,
478 U.S. 833 (1986) 24

Grunewald v. Jarvis,
776 F.3d 893 (D.C. Cir. 2015) 21

Home Care Association v. Weil,
799 F.3d 1084 (D.C. Cir. 2015) 22

King v. Burwell,
135 S. Ct. 2480 (2015) 2, 3, 4, 6, 32, 34

Kucana v. Holder,
558 U.S. 233 (2010) 32

Michigan v. EPA,
268 F.3d 1075 (D.C. Cir. 2001) 22, 38

National Cable & Telecommunications Association v. FCC,
567 F.3d 659 (D.C. Cir. 2009) 22

NFIB v. Sebelius,
567 U.S. 519 (2012) 4, 29

Public Citizen, Inc. v. HHS,
332 F.3d 654 (D.C. Cir. 2003) 25

Rural Cellular Assocciation v. FCC,
588 F.3d 1095 (D.C. Cir. 2009) 22

Solid Waste Agency of Northern Cook County v. U.S. Army Corps of Engineers,
531 U.S. 159 (2001) 24

Texas v. United States,
340 F. Supp. 3d 579 (N.D. Tex. 2018) 3
945 F.3d 355 (5th Cir. 2019) 3

U.S. Association of Reptile Keepers, Inc. v. Zinke,
852 F.3d 1131 (D.C. Cir. 2017) 27

United States v. Mead Corp.,
533 U.S. 218 (2001) 22

Whitman v. American Trucking Associations,
531 U.S. 457 (2001) 26

Federal Statutes:

Health Care and Education Reconciliation Act of 2010,
Pub. L. No. 111-152, 124 Stat. 1029 2

Health Insurance Portability and Accountability Act of 1996 (HIPAA),
Pub. L. No. 104-191, 110 Stat. 1936 1
§ 102(a) 2, 6, 23
§ 111(a) 1, 2

Patient Protection and Affordable Care Act (ACA),
Pub. L. No. 111-148, 124 Stat. 119 (2010) 2

Tax Cuts and Jobs Act of 2017,
Pub. L. No. 115-97, § 11081, 131 Stat. 2054 3

26 U.S.C. § 36B(b)(2)(B)(i) 4

26 U.S.C. § 1222(1) 39

26 U.S.C. § 1222(2) 39

26 U.S.C. § 1283(a)(1)(A) 39

26 U.S.C. § 5000A 3, 28

26 U.S.C. § 5000A(e)(1) 5

26 U.S.C. § 5000A(e)(4)(A) 39

26 U.S.C. § 5000A(e)(5) 5

42 U.S.C. § 300gg 28

42 U.S.C. § 300gg-1 28

42 U.S.C. § 300gg-6(a) 31

42 U.S.C. § 300gg-11 31

42 U.S.C. § 300gg-15(a) 9, 41

42 U.S.C. § 300gg-18(c) 9, 41

42 U.S.C. § 300gg-21(b) 30

42 U.S.C. § 300gg-21(c) 30

42 U.S.C. § 300gg-63 .... 2, 30

42 U.S.C. § 300gg-91(b)(5) 1, 2, 2-3, 6, 23, 26, 27

42 U.S.C. § 300gg-91(c) 2

42 U.S.C. § 300gg-91(c)(3)(B) 30

42 U.S.C. § 18011 5

42 U.S.C. § 18021(a)(1)(B) 4

42 U.S.C. § 18031(d)(2)(B)(i) 4

42 U.S.C. § 18032 .... 5, 30

42 U.S.C. § 18032(c)(1) 30

42 U.S.C. § 18032(d)(1) 30

42 U.S.C. § 18032(d)(1)(A) 5

42 U.S.C. § 18032(d)(3)(A) 5, 30

42 U.S.C. § 18041(a)(2) 9, 41

State Statutes:

Ariz. Rev. Stat. § 20-1384(C)(2) 46

Cal. Ins. Code § 10123.61(a) 46

Haw. Rev. Stat. § 431:10A-605(a) 46

Ind. Code § 27-1-37.3-5(b)(6) 46

Kan. Stat. § 40-2,193(a)(2) 16

Md. Code, Ins. § 15-1301(s) 46

N.H. Rev. Stat. § 415:5(III) 16

Okla. Stat. tit. 36, § 4419(A) 46

Regulations:

5 C.F.R. § 316.401 39

45 C.F.R. § 144.103 13

62 Fed. Reg. 16,894 (Apr. 8, 1997) 7

69 Fed. Reg. 78,720 (Dec. 30, 2004) 7

81 Fed. Reg. 75,316 (Oct. 31, 2016) 8, 9, 10, 41, 44

83 Fed. Reg. 7437 (Feb. 21, 2018) 11

83 Fed. Reg. 38,212 (Aug. 3, 2018) 11, 13, 14, 15, 16, 17, 33 34, 36, 37, 42, 43, 44, 45

S.D. Admin. R. 20:06:40:02 23

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Legislative Materials:

H.R. Rep. No. 104-736 (1996) 38

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GLOSSARY

ACA	Patient Protection and Affordable Care Act
ACAP	Association for Community Affiliated Plans
CBO	Congressional Budget Office
COBRA	Consolidated Omnibus Budget Reconciliation Act of 1985
ERISA	Employee Retirement Income Security Act of 1974
HIPAA	Health Insurance Portability and Accountability Act of 1996
NAIC	National Association of Insurance Commissioners
NAIFA	National Association of Insurance and Financial Advisors
STLDI	Short-term limited duration insurance

STATEMENT OF THE ISSUE

When Congress enacted the Patient Protection and Affordable Care Act (ACA) in 2010, it retained a longstanding statutory provision that excludes "short-term limited duration insurance" from the federal requirements applicable to "individual health insurance coverage." 42 U.S.C. § 300gg-91(b)(5). The rule at issue here restored essentially the same definition of "short-term limited duration insurance" as was in effect from 1997 through 2016. The question presented is whether the district court correctly rejected plaintiffs' contention that the restored definition is contrary to law and arbitrary and capricious.

PERTINENT STATUTES AND REGULATIONS

Pertinent statutes and regulations are reproduced in the addendum to this brief.

STATEMENT

A. Statutory Background

1. HIPAA

In 1996, Congress enacted the Health Insurance Portability and Accountability Act (HIPAA), Pub. L. No. 104-191, 110 Stat. 1936. As relevant here, HIPAA amended the Public Health Service Act to establish new federal requirements for "individual health insurance coverage."[1] *Id.* § 111(a), 110 Stat. at 1978-1987. It provided that "the

[1] HIPAA also amended parallel provisions of the Internal Revenue Code and the Employee Retirement Income Security Act of 1974 (ERISA). For simplicity, we refer to the Public Health Service Act amendments and implementing regulations.

term 'individual health insurance coverage' means health insurance coverage offered to individuals in the individual market, but does not include short-term limited duration insurance," sometimes referred to as STLDI. *Id.* § 102(a), 110 Stat. at 1973 (codified at 42 U.S.C. § 300gg-91(b)(5)). As a result of that exclusion, short-term limited duration insurance plans were not subject to the requirements that HIPAA established for individual health insurance coverage, such as guaranteed renewability. Instead, such plans would continue to be regulated by the States. HIPAA similarly provided that the new federal requirements for individual market plans would not apply to various forms of "excepted benefits," including "fixed indemnity insurance." *Id.* § 111(a), 110 Stat. at 1987 (exemption for individual market "excepted benefits") (codified at 42 U.S.C. § 300gg-63); *id.* § 102(a), 110 Stat. at 1973-1974 (defining "excepted benefits") (codified at 42 U.S.C. § 300gg-91(c)).

2. The ACA

In 2010, Congress enacted the Patient Protection and Affordable Care Act (ACA), Pub. L. No. 111-148, 124 Stat. 119, "to expand coverage in the individual health insurance market." *King v. Burwell*, 135 S. Ct. 2480, 2485 (2015).[2] Congress left in place HIPAA's exclusion of "short-term limited duration insurance" from the category of "individual health insurance coverage" subject to certain regulations. 42 U.S.C. § 300gg-

[2] The ACA was subsequently amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029.

91(b)(5). Congress likewise "left intact and incorporated the [preexisting] rules regarding excepted benefits." *Central United Life Ins. Co. v. Burwell*, 827 F.3d 70, 72 (D.C. Cir. 2016).

Instead of prohibiting these and other forms of limited health coverage, which are relatively inexpensive, the ACA gave individuals strong incentives to purchase comprehensive health coverage and ensured that they would have the opportunity to do so. It generally prohibited issuers of comprehensive coverage from denying coverage or charging higher premiums based on an individual's health status, through the "guaranteed issue and community rating" requirements. *King*, 135 S. Ct. at 2486. As enacted, it required most individuals to maintain "minimum essential coverage" or else pay a tax penalty. 26 U.S.C. § 5000A; *see King*, 135 S. Ct. at 2486.[3] And for individuals without access to minimum essential coverage through their employers or a government program (like Medicare or Medicaid), the ACA established state-by-state Exchanges offering the opportunity to purchase individual coverage. *King*, 135 S. Ct. at 2487. The ACA also required that plans offered through an Exchange provide specified "essential health

[3] The Tax Cuts and Jobs Act of 2017 reduced the amount of the ACA's tax penalty to $0 effective January 1, 2019. Pub. L. No. 115-97, § 11081, 131 Stat 2054, 2092. In December 2018, a district court entered a declaratory judgment that the elimination of the tax penalty rendered unconstitutional the requirement to maintain minimum essential coverage, and further ruled that this requirement is not severable from the rest of the ACA. *Texas v. United States*, 340 F. Supp. 3d 579 (N.D. Tex. 2018). The Fifth Circuit affirmed as to the minimum-essential-coverage requirement but remanded for further analysis of severability. *Texas v. United States*, 945 F.3d 355 (5th Cir. 2019), *pets. for cert. docketed*, Nos. 19-840 (filed Jan. 3, 2020) and 19-841 (filed Jan. 3, 2020).

benefits," 42 U.S.C. § 18021(a)(1)(B); *see id.* § 18031(d)(2)(B)(i), and provided billions of dollars of refundable tax credits each year to help qualifying individuals pay for insurance purchased through an Exchange, *King*, 135 S. Ct. at 2487-2489.

The overwhelming majority of people who buy individual coverage on the Exchanges do so using tax credits, which the ACA made available only for qualified health plans purchased through an Exchange. *King*, 135 S. Ct. at 2489, 2493. In 2014, approximately 87 percent of people who bought insurance on an Exchange did so with tax credits, *id.* at 2493, and that figure has remained stable over time, *see* JA91 (Wu Decl. ¶ 6) (same percentage for 2018). The amount of the credit is pegged not just to the consumer's household income but to the premium charged by a benchmark plan available on the Exchange, 26 U.S.C. § 36B(b)(2)(B)(i), so that if the benchmark premium increases, the subsidy increases by a corresponding amount. That mechanism insulates consumers who are eligible for subsidies from the effect of the premium increase.

Notwithstanding the ACA's incentives to obtain minimum essential coverage, Congress anticipated that many people would not do so. When the ACA was enacted, the Congressional Budget Office (CBO) estimated that four million people would choose to pay the tax penalty rather than obtain minimum essential coverage. *NFIB v. Sebelius*, 567 U.S. 519, 568 (2012) (citing CBO, *Payments of Penalties for Being Uninsured Under the Patient Protection and Affordable Care Act* at 1 (Apr. 30, 2010), https://go.usa.gov/xpv5d). Congress also exempted several categories of individuals from the tax penalty, including those who could not afford ACA-compliant coverage and those for

whom obtaining such coverage would pose a hardship.[4] 26 U.S.C. § 5000A(e)(1), (5). The CBO projected that those provisions would exempt more than 14 million people from the tax penalty. CBO, *Payments of Penalties for Being Uninsured Under the Patient Protection and Affordable Care Act* at 1.

Rather than risk leaving millions of people uninsured, the ACA maintained HIPAA's provisions allowing consumers to purchase short-term limited duration insurance and excepted benefits, as described above. In addition, in a provision designed to foster "[c]onsumer choice," 42 U.S.C. § 18032, Congress disavowed any intent to restrict the markets for off-Exchange individual plans, which are not subject to all of the same requirements as plans offered on the Exchanges. The consumer choice provision specifies that "[n]othing in this title shall be construed to prohibit" an insurer "from offering outside of an Exchange a health plan to a qualified individual," *id.*, or "to restrict the choice of a qualified individual to enroll or not to enroll in a qualified health plan or to participate in an Exchange," *id.* § 18032(d)(1)(A), (3)(A).

[4] This brief uses "ACA-compliant" as shorthand for coverage that complies with the requirements applicable to individual market plans, as distinct from the requirements applicable to short-term limited duration insurance or excepted benefits. The term does not include "grandfathered" plans, in effect at the time of the ACA's enactment, which are exempted from certain ACA requirements by 42 U.S.C. § 18011. Nor does it include certain plans in effect as of October 1, 2013, for which the Centers for Medicare & Medicaid Services has announced a policy not to enforce some ACA requirements. *See* Letter from Gary Cohen, Dir., Center for Consumer Information and Insurance Oversight, to Insurance Commissioners (Nov. 14, 2013), https://go.usa.gov/xdacs; *see also* Memo from Randy Pate, Dir., Center for Consumer Information and Insurance Oversight (Mar. 25, 2019) (extending this non-enforcement policy through 2020), https://go.usa.gov/xdacz.

The availability of relatively inexpensive coverage options became especially important to low-income adults as a result of the Supreme Court's ruling in *NFIB*, which effectively made the ACA's Medicaid expansion optional for each State (rather than mandatory as Congress had specified in the ACA). Because Congress had assumed that certain low-income adults would be covered by expanded state Medicaid programs, the ACA's tax credits are not available to individuals with household income below the federal poverty level. *King*, 135 S. Ct. at 2487. As a consequence, millions of low-income adults are eligible neither for Medicaid nor for the tax credits they would need to afford an Exchange plan. *See* Kaiser Family Foundation, *The Coverage Gap: Uninsured Poor Adults in States that Do Not Expand Medicaid* at 3, 5 (Mar. 21, 2019) (nationally, nearly 2.5 million low-income adults fall into this coverage gap).[5]

B. Regulatory Background

1. The 1997 and 2004 rules defining short-term limited duration insurance

As explained above, HIPAA excluded "short-term limited duration insurance" from the requirements applicable to "individual health insurance coverage." HIPAA § 102(a), 110 Stat. at 1973 (codified at 42 U.S.C. § 300gg-91(b)(5)). But Congress did not define "short-term limited duration insurance." In 1997, the Departments with

[5] http://files.kff.org/attachment/Issue-Brief-The-Coverage-Gap-Uninsured-Poor-Adults-in-States-that-Do-Not-Expand-Medicaid.

responsibility for implementing HIPAA issued an interim final rule that (as relevant here) defined that phrase.[6]

The 1997 rule defined short-term limited duration insurance to mean "health insurance coverage provided under a contract with an issuer that has an expiration date specified in the contract (taking into account any extensions that may be elected by the policyholder without the issuer's consent) that is within 12 months of the date the contract becomes effective." 62 Fed. Reg. 16,894, 16,958 (Apr. 8, 1997). In other words, to qualify as short-term limited duration insurance under HIPAA, the coverage contract (1) had to expire within a year of its effective date and (2) could not be renewed or extended past that point unless the insurer agreed. Although the renewability of the contract was not guaranteed, the rule did not limit renewal with an insurer's consent.

In 2004, the Departments issued a final rule that included a substantively identical definition of short-term limited duration insurance. 69 Fed. Reg. 78,720, 78,783 (Dec. 30, 2004).

2. The 2016 rule restricting the availability of short-term limited duration insurance

After the Exchanges became operational in 2014, premiums began to rise, and the Departments took steps to restrict coverage options other than ACA-compliant

[6] The rule was jointly issued by three Departments because HIPAA amended parallel provisions of the Internal Revenue Code, ERISA, and the Public Health Service Act, which are administered by the Departments of the Treasury, Labor, and Health and Human Services, respectively.

individual plans with the goal of shoring up the markets for such plans. One such rule, promulgated by the Department of Health and Human Services, was the subject of this Court's decision in *Central United*, 827 F.3d 70. That rule "effectively eliminated stand-alone fixed indemnity plans" by providing that fixed indemnity insurance would not qualify as an excepted benefit in the individual market (and thus as exempt from the ACA's individual market requirements) unless sold to individuals who already had minimum essential coverage. *Id.* at 73 (emphasis omitted). This Court vacated the rule, emphasizing that "[d]espite the ACA's sweeping reforms to the health insurance market, it left intact and incorporated the [preexisting] rules regarding excepted benefits." *Id.* at 72. The Court concluded that the Department "lacked authority to demand more of fixed indemnity providers than Congress required." *Id.* at 75.

The Departments took a similar approach in a 2016 rule that restricted the availability of short-term limited duration insurance. The rule provided that, effective for policy years beginning on or after January 1, 2017, no plan would qualify as short-term limited duration insurance under HIPAA unless it had "an expiration date specified in the contract (taking into account any extensions that may be elected by the policyholder with or without the issuer's consent) that is less than 3 months after the original effective date of the contract." 81 Fed. Reg. 75,316, 75,326 (Oct. 31, 2016).[7] The 2016 rule thus

[7] The 2016 rule also required that short-term limited duration insurance include a specified disclaimer. 81 Fed. Reg. at 75,326.

altered the longstanding definition of short-term limited duration insurance by reducing the maximum contract term from less than 12 months to less than three months and by prohibiting renewals even with the insurer's consent. The Departments indicated that they believed the change was warranted because, "[i]n some instances, individuals [were] purchasing [short-term limited duration insurance] coverage as their primary form of health coverage," and "some issuers [were] providing renewals of the coverage that extend the duration beyond 12 months." *Id.* at 75,317. The Departments feared that healthier individuals would purchase short-term limited duration plans and thus "adversely impact[] the risk pool for Affordable Care Act-compliant coverage." *Id.* at 75,318.

The National Association of Insurance Commissioners (NAIC)—which the Departments often consult on matters of insurance regulation, *see*, *e.g.*, 42 U.S.C. §§ 300gg-15(a), 300gg-18(c), 18041(a)(2)—opposed the 2016 rule. The NAIC emphasized that "[s]hort term, limited duration insurance has long been defined as a policy of less than 12 months both by the states and [by] the federal government," and warned that the change "could harm some consumers, limit consumer options, and have little positive impact on the risk pools in the long run." NAIC Comment on 2016 Proposed Rule at 1-2 (Aug. 9, 2016).[8] The NAIC explained that "if an individual misses the open enrollment period and applies for short-term, limited duration coverage in February, a 3-

[8] https://www.naic.org/documents/government_relations_160809_hhs_reg_short_term_dur_plans.pdf.

month policy would not provide coverage until the next policy year." *Id.* at 1. The NAIC further stressed that "there are instances when consumers simply cannot afford, even with the subsidies, an insurance plan with minimum essential coverage," and urged that those consumers' options "should not be limited to either paying for coverage they cannot afford or exposing themselves to the risk of losing their coverage after three months if they become sick." *Id.* at 2. The NAIC cautioned that, "[i]f the concern is that healthy individuals will stay out of the general pool by buying short-term, limited duration coverage," the proposed rule would not "stop that." *Id.* at 1. "If consumers are healthy," the NAIC explained, they could "continue buying a new policy every three months." *Id.* at 1-2. "Only those who become unhealthy" and thus could not obtain a new policy would "be unable to afford care," which would not be "good for the risk pools in the long run." *Id.* at 2. The NAIC argued that, "[i]nstead of redefining short-term, limited duration plans," the Departments should focus on "educating consumers and ensuring that they are aware of the limitations of these and other excepted benefit plans," instead of "redefining short-term, limited duration plans." *Id.*

The Departments acknowledged such concerns but nonetheless finalized the proposed changes without modification. 81 Fed. Reg. at 75,318. No party sought judicial review of the 2016 rule, and no court passed on its validity.

3. The 2018 rule largely restoring the longstanding definition of short-term limited duration insurance

Market conditions on the Exchanges continued to deteriorate after the 2016 rule took effect. Between 2016 and 2017, average premiums for individual market plans rose by 21 percent, while the Exchange enrollment of unsubsidized consumers—*i.e.*, consumers who bore the full cost of increased premiums—fell by 20 percent. 83 Fed. Reg. 38,212, 38,214 (Aug. 3, 2018). In June 2017, the Department of Health and Human Services published a request for information on changes that could be made to increase affordable coverage options for individuals. *Id.* at 38,213. In response, various commenters "stated that shortening the permitted length of short-term, limited-duration insurance policies had deprived individuals of affordable coverage options." *Id.* Given "the increased costs of [ACA]-compliant" coverage, a commenter explained, "many financially-stressed individuals" faced "a choice between short-term, limited-duration insurance coverage and going without any coverage at all." *Id.*

The Departments therefore proposed to restore the maximum contract term (less than 12 months) that had governed short-term limited duration insurance between 1997 and 2016. 83 Fed. Reg. 7437, 7446 (Feb. 21, 2018). The Departments also proposed to expand the requirement that insurers disclose the potential limitations of short-term limited duration plans so as to prevent consumer confusion and deception, *id.*, and solicited comments on the conditions under which insurers should be allowed to renew or continue such plans beyond 12 months, *id.* at 7440.

The NAIC supported the Departments' proposal, explaining that "[r]eturning the Federal definition to 'less than 12 months' … is consistent not only with longstanding federal law but also with how [short-term limited duration insurance] has been long defined by most states." NAIC Comment on 2018 Proposed Rule at 1 (Apr. 23, 2018) (JA484), https://go.usa.gov/xpvyF. The National Association of Insurance and Financial Advisors (NAIFA) likewise offered its support, explaining that short-term limited duration insurance is an important option for consumers who need coverage beyond a 90-day period, including those who fall within the Medicaid coverage gap. NAIFA Comment on 2018 Proposed Rule at 2 (Apr. 18, 2018) (JA376), https://go.usa.gov/xpvyM. NAIFA explained that short-term limited duration insurance can provide "necessary stop-gap coverage while consumers shop for a more comprehensive health plan," such as if they lose a job. *Id.*; *see also, e.g.*, Galen Institute Comment on 2018 Proposed Rule at 7 (Apr. 23, 2018) (JA469) (noting that "[d]uring the most recent recession, [the] average [duration of unemployment] at one point reached … more than three times the 90-day limitation" imposed by the 2016 rule), https://go.usa.gov/xpvyt. Many commenters also supported the expanded disclosure requirement as a means to prevent consumer confusion or deception. The NAIC, for example, wrote that "educating consumers and ensuring that they are aware of the limitations of these plans is paramount." NAIC Comment on 2018 Proposed Rule at 1 (JA484).

Other commenters opposed the proposed rule. Plaintiff ACAP, for instance, argued that short-term limited duration coverage "should not be marketed as an alternative to ACA-compliant coverage, as it simply is not a meaningful alternative." ACAP Comment on 2018 Proposed Rule at 3 (Apr. 20, 2018) (JA391), https://go.usa.gov/xdqQt. ACAP expressed concern that the proposed regulation would "have a deleterious impact on the individual market single risk pool." *Id.* It submitted a report by the Wakely Consulting Group, which estimated that the proposed rule would lead "1.07 to 1.95 million" people to "drop ACA-compliant coverage" for short-term limited duration plans over a period of "4 to 5 years"—a prospect that the consultants believed would "result in a 2.2 to 6.6 percent increase in premiums in the ACA-compliant market." *Id.* at 5 (JA393).

After reviewing the comments, the Departments issued a final rule in 2018 that largely reinstated the definition of short-term limited duration insurance that had been in effect from 1997 to 2016. The 2018 rule provides that "short-term limited duration insurance" means coverage provided under a contract that has "an expiration date specified in the contract that is less than 12 months after the original effective date of the contract and, taking into account renewals or extensions, has a duration of no longer than 36 months in total." 83 Fed. Reg. at 38,243 (amending 45 C.F.R. § 144.103). That definition is somewhat more restrictive than the one that applied between 1997 and 2016, in that it limits the total duration of such plans—including all renewals—to three years. The 2018 rule further requires that short-term limited duration plans carry the

following notice, "display[ed] prominently" and "in at least 14 point type," together "with any additional information required by applicable state law":

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

Id.[9]

The Departments explained why they were reverting to the longstanding definition of short-term limited duration insurance and departing from the 2016 rule's modified definition. They observed that, "although the [2016 rule] was intended to boost enrollment in individual health insurance coverage," the rule "did not succeed in that regard." 83 Fed. Reg. at 38,214. "Rather, average monthly enrollment in individual market plans decreased by 10 percent between 2016 and 2017, while premiums increased by 21 percent." *Id.* In the same period, as noted above, average monthly enrollment in Exchange plans for individuals without subsidies fell by 1.3 million, or 20 percent. *Id.* The Departments therefore "determined that the expansion of additional

[9] The required notice differed for plans with a start date before January 1, 2019, when the tax penalty for failing to maintain minimum essential coverage was reduced to $0. Such plans were also required to inform consumers that the plans did not qualify as minimum essential coverage. 83 Fed. Reg. at 38,243.

coverage options such as short-term, limited-duration insurance is necessary, as premiums have escalated and affordable choices in the individual market have dwindled." *Id.*

The Departments acknowledged that fostering the availability of short-term limited duration insurance "could have an impact on the risk pools for individual health insurance coverage, and could therefore raise premiums for individual health insurance coverage." 83 Fed. Reg. at 38,217. They projected, however, that any such effect would be modest. They explained that because subsidies "are available only for" ACA-compliant "plans offered on Exchanges," it is "likely that healthy lower-income individuals will remain in [ACA-compliant] plans even if they place a relatively low value on [ACA-compliant] coverage because the individual subsidized premium is so low, limiting the extent of adverse selection." *Id.* at 38,235-236.

For 2019, the Departments estimated that an additional 600,000 people would enroll in short-term limited duration insurance, while Exchange enrollment would decrease by 200,000 and enrollment in off-Exchange plans would decrease by 300,000.[10] 83 Fed. Reg. at 38,236. They thus projected that 100,000 of the 600,000 new enrollees in short-term limited duration coverage would be people "who were previously uninsured." *Id.* The Departments expected that premiums for unsubsidized enrollees in Exchange plans would increase by 1 percent. *Id.* at 38,236. Extending the projections to 2028, the Departments estimated that enrollment in short-term limited duration

[10] As noted below (at 30), off-Exchange individual plans are not subject to all of the same requirements as plans eligible for the Exchanges.

plans would increase by 1.4 million (while enrollment in individual market plans would decrease by 1.3 million) and that unsubsidized premiums for Exchange plans would increase by 5 percent. *Id.* The Departments concluded that "the critical need for coverage options that are more affordable than individual health insurance coverage, combined with the general need for more coverage options and choice, substantially outweigh the estimated impact on individual health insurance premiums." *Id.* at 38,217.

Furthermore, the Departments noted that States retain an important regulatory role under the rule. For example, "States remain free to adopt a definition [of short-term limited duration insurance] with a shorter maximum initial contract term or shorter maximum duration." 83 Fed. Reg. at 38,216. States also "are free to regulate such coverage in every other respect," such as through consumer-protection laws that prevent plan issuers from engaging in "deceptive marketing practices." *Id.* at 38,219. And States may "impose additional requirements with respect to the language in the consumer notice," such as a requirement that the notice be offered in languages appropriate to each State's demographics. *Id.*; *see id.* at 38,224. Various States have adopted requirements for short-term limited duration insurance plans that supplement those imposed by the 2018 rule. *See, e.g.*, Kan. Stat. § 40-2,193(a)(2) (limiting plans to one renewal); N.H. Rev. Stat. § 415:5(III) (limiting plans to six months); *see also infra* pp. 45-46 (discussing state laws adopted since the 2018 rule).

The 2018 rule took effect for policies sold on or after October 2, 2018, sixty days after the rule's publication in the Federal Register. 83 Fed. Reg. at 38,226. It has been in effect continuously since then.

C. Proceedings Below

Plaintiffs brought this challenge to the 2018 rule under the Administrative Procedure Act, alleging that the rule is contrary to law and arbitrary and capricious. JA10-59 (complaint).[11] The lead plaintiff—the Association for Community Affiliated Plans (ACAP), a trade association of health plans—alleged that its members would lose customers as a result of the 2018 rule. JA25 ¶ 23. ACAP identified only one insurer who would allegedly suffer harm: Community Health Choice Inc., which sells insurance to primarily low-income individuals in Texas. JA25-26 ¶¶ 24-26. The complaint alleged that some of Community's customers would switch to short-term limited duration plans as a result of the 2018 rule and that the rule would make it more difficult for Community to compete for additional customers. JA26-27 ¶¶ 26-29.

On cross-motions for summary judgment, the district court upheld the 2018 rule. *Association for Cmty. Affiliated Plans v. U.S. Dep't of Treasury* (*ACAP*), 392 F. Supp. 3d 22 (D.D.C. 2019). The court concluded that ACAP could challenge the 2018 rule under the competitor standing doctrine, *id.* at 30-33, but it rejected the challenge on the merits,

[11] Plaintiffs also alleged a failure to engage in adequate notice-and-comment rulemaking, but they later abandoned that claim.

id. at 33-45. The court explained that there is "no serious question that Congress delegated to the Departments the authority to define STLDI when it enacted HIPAA in 1996," because HIPAA "defined 'individual health-insurance coverage' to exclude STLDI but made no attempt to dictate the characteristics that mark such plans." *Id.* at 33. The court rejected plaintiffs' contention that, when Congress enacted the ACA, it eliminated the Departments' discretion to define short-term limited duration insurance. *Id.* On the contrary, the court explained, "the ACA—which in so many ways constituted a sea change to the provision of individual health insurance coverage in the United States—retained *untouched* HIPAA's exception of STLDI from individual market insurance regulations." *Id.*

The court also rejected plaintiffs' assertion that the restored definition would destabilize the Exchanges. 392 F. Supp. 3d at 36. The court explained that most enrollees in Exchange plans have little incentive to switch to short-term limited duration plans, because the tax credits that 87 percent of Exchange enrollees use to buy insurance are not available for such plans. *Id.* Even for unsubsidized enrollees, the court noted, premiums for Exchange plans were projected to increase by only 1 percent in 2019 and 5 percent by 2028—increases unlikely to persuade many enrollees to accept the risks associated with short-term limited duration insurance plans. *Id.* The court noted that, in fact, premiums for Exchange plans fell by 1.5 percent overall in 2019. *Id.*

More generally, the court rejected plaintiffs' contention that Congress intended to foster the markets for ACA-compliant coverage by eliminating other coverage options. 392 F. Supp. 2d at 44-45. The court explained that although Congress ensured all consumers would have the opportunity and the incentive to acquire ACA-compliant coverage, it did not eliminate preexisting exemptions for other forms of coverage. *Id.* at 45. "In other words," the court reasoned, "lawmakers were not rigidly pursuing the ACA-compliant market at all costs," including "at the risk of individuals going without insurance altogether." *Id.*

SUMMARY OF ARGUMENT

I. In enacting the ACA, Congress incorporated HIPAA's definition of "individual health insurance coverage," and with it the exclusion of "short-term limited duration insurance" from that category of regulated plans. The challenged rule adopts virtually the same definition of short-term limited duration insurance that had been in place for more than a decade when Congress enacted the ACA. Yet even as Congress comprehensively rewrote the laws governing individual health insurance, it declined to eliminate HIPAA's exclusion of short-term limited duration plans from the category of individual health insurance coverage or to modify the Departments' longstanding definition. That is powerful evidence that Congress approved the longstanding agency interpretation as permissible, rather than foreclosing it as plaintiffs suggest.

In arguing that the longstanding definition is nonetheless inconsistent with the ACA, plaintiffs misunderstand the ACA's structure and purposes. They insist that Congress meant for all otherwise-uninsured consumers to purchase ACA-compliant plans on the Exchanges. But Congress anticipated that millions of people would be unable or unwilling to purchase ACA-compliant plans, and it accordingly chose to preserve other coverage options, including short-term limited duration insurance. Congress fostered the market for ACA-compliant plans by ensuring that consumers would have the opportunity to purchase such plans and by offering strong tax incentives for them to do so, not by eliminating other coverage options at the risk of leaving millions uninsured.

Plaintiffs claim that the challenged rule will destabilize the Exchanges because of the risk that some healthy consumers may choose to purchase short-term limited duration plans rather than ACA-compliant plans. But plaintiffs ignore an important way in which the ACA mitigates that risk: generous tax subsidies, which are available only for ACA-compliant plans. As the district court recognized, the subsidies—available to the overwhelming majority of Exchange consumers—dramatically reduce the risk that such consumers will choose short-term limited duration plans over ACA-compliant plans. That expectation is consistent with the projections in the rulemaking record, including those submitted by plaintiff ACAP itself. And it has been borne out since the rule took effect more than a year ago.

II. Plaintiffs are equally wrong to contend that the longstanding definition of short-term limited duration insurance was inconsistent with HIPAA. Even assuming Congress intended for short-term limited duration insurance to be used in transitional contexts, there is no basis to believe that Congress expected transitional gaps (such as periods of unemployment) would be limited to a few months. To the contrary, Congress recognized in the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) that the need for transitional coverage could last for several years. The less-than-12-month definition also advanced HIPAA's historical objectives by making it easier for consumers to qualify for HIPAA's protections.

III. Finally, the challenged rule is neither arbitrary nor capricious. The Departments had a sound basis for reverting to their longstanding definition of short-term limited duration insurance, and they reasonably explained their choice to do so.

STANDARD OF REVIEW

On appeal from a district court's grant of summary judgment in an APA action, this Court reviews "*de novo*, applying the Administrative Procedure Act standard that requires [courts] to set aside agency action that is arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law." *Grunewald v. Jarvis*, 776 F.3d 893, 898 (D.C. Cir. 2015) (quotation marks omitted). "[W]hen Congress has explicitly or impliedly left a gap for an agency to fill, there is a delegation of authority to the agency to give meaning to a specific provision of the statute by regulation, 'and any ensuing regulation is binding in the courts unless procedurally defective, arbitrary and capricious in

substance, or manifestly contrary to the statute.'" *Michigan v. EPA*, 268 F.3d 1075, 1082 (D.C. Cir. 2001) (quoting *United States v. Mead Corp.*, 533 U.S. 218, 227 (2001)). An agency's decision is not arbitrary and capricious if it rests on a "'reasoned explanation'" and is supported by substantial evidence in the administrative record. *Home Care Ass'n v. Weil*, 799 F.3d 1084, 1094, 1096 (D.C. Cir. 2015). The "threshold for such evidentiary sufficiency is not high," *Biestek v. Berryhill*, 139 S. Ct. 1148, 1154 (2019), and "[t]he 'arbitrary and capricious' standard is particularly deferential in matters implicating predictive judgments," *Rural Cellular Ass'n v. FCC*, 588 F.3d 1095, 1105 (D.C. Cir. 2009).

ARGUMENT

I. THE ACA DOES NOT FORECLOSE THE CHALLENGED RULE

Plaintiffs contend (at 33) that "the statutory scheme created by the ACA unambiguously precludes" the challenged rule. That is incorrect. Nothing in the ACA is inconsistent with the challenged rule—much less "unambiguously" so, as would be necessary to deprive the Departments of their longstanding discretion to fill the statutory gap created by HIPAA, *National Cable & Telecomms. Ass'n v. FCC*, 567 F.3d 659, 663 (D.C. Cir. 2009). Nor does the ACA render the challenged rule unreasonable. The rule is therefore entitled to deference. *Michigan v. EPA*, 268 F.3d 1075, 1082 (D.C. Cir. 2001).

A. In Enacting The ACA, Congress Implicitly Approved Essentially The Same Rule The Departments Have Now Restored

The clearest evidence that the challenged rule is consistent with the ACA is that Congress implicitly approved a virtually identical rule when it enacted the ACA.

1. At the time of the ACA's enactment, HIPAA had excluded "short-term limited duration insurance" from the federal standards for "individual health insurance coverage" for more than a decade. HIPAA § 102(a), 110 Stat. at 1973 (codified at 42 U.S.C. § 300gg-91(b)(5)). And for nearly all of that time, the Departments had defined the scope of the exclusion in almost exactly the way they have now defined it. That definition was "far from an outlier." *Association for Cmty. Affiliated Plans v. U.S. Dep't of Treasury* (*ACAP*), 392 F. Supp. 3d 22, 43 (D.D.C. 2019). To the contrary, the National Association of Insurance Commissioners (NAIC)—an association of the chief insurance regulators in the fifty states and the District of Columbia—explained before the Departments modified the definition in 2016 that "[s]hort term, limited duration insurance ha[d] long been defined as a policy of less than 12 months … by the states" as well as by the Departments. NAIC Comment on 2016 Proposed Rule at 1; *see, e.g.*, S.D. Admin. R. 20:06:40:02; 28 Tex. Admin. Code § 3.3002(b)(18); *see also* NAIC Comment on 2018 Proposed Rule at 1 (JA484).

Even as the ACA comprehensively revised the law governing health insurance, Congress did not redefine the category of plans subject to federal regulation. It simply incorporated by reference the definitions already codified in the Public Health Service Act, including HIPAA's definition of "individual health insurance coverage" and the exclusion of "short-term limited duration insurance" from that category. 42 U.S.C. § 300gg-91(b)(5).

"'It is well established that when Congress revisits a statute giving rise to a longstanding administrative interpretation without pertinent change, the congressional failure to revise or repeal the agency's interpretation is persuasive evidence that the interpretation is the one intended by Congress.'" *Altman v. SEC*, 666 F.3d 1322, 1326 (D.C. Cir. 2011) (quoting *Commodity Futures Trading Comm'n v. Schor*, 478 U.S. 833, 846 (1986); some quotation marks omitted). By incorporating HIPAA's definition of "individual health insurance coverage" without modifying the Departments' longstanding interpretation of that provision, Congress implicitly approved the Departments' interpretation as permissible.

2. Plaintiffs argue that although the Supreme Court has "'recognized congressional acquiescence to administrative interpretations of a statute in some situations, [it has] done so with extreme care.'" Br. 47 (quoting *Solid Waste Agency of N. Cook Cty. v. U.S. Army Corps of Eng'rs*, 531 U.S. 159, 169 (2001)). But none of the asserted reasons for caution applies here.

In the case plaintiffs quote, the Supreme Court warned against reliance on "[f]ailed legislative proposals," which "are a particularly dangerous ground on which to rest an interpretation of a prior statute." *Solid Waste Agency*, 531 U.S. at 169-170 (quotation marks omitted). But this is not a case, like *Solid Waste Agency*, where Congress's acquiescence in an agency interpretation stems simply from its "failure to pass legislation that would have overturned" the interpretation, *id.* at 169. Rather, as acknowledged

by Professor Jost—whose views plaintiffs regard (at 8 n.2) as "authoritative"—Congress "*adopted*" HIPAA's "preexisting insurance definitions" in defining the scope of the ACA's comprehensive reforms. JA381 (emphasis added).

Plaintiffs further claim (at 48) that "there is no evidence that Congress was even aware of the Departments' interpretation of HIPAA's STLDI language when it enacted the ACA." But there is no need for hard evidence; it suffices if there is "reason to assume[] congressional familiarity with the administrative interpretation at issue." *Public Citizen, Inc. v. HHS*, 332 F.3d 654, 669 (D.C. Cir. 2003). And if ever there were reason to assume Congress's familiarity with an agency interpretation, it is here, where plaintiffs insist (at 25-26) that the Departments' longstanding definition was "irreconcilable with the structure and policy of the ACA" and could "frustrate" the ACA's central reforms. It defies reason for plaintiffs to suggest in the same breath that the definition was too inconsequential for Congress to notice.

Plaintiffs contend (at 47-48) that courts have required "express congressional approval of an administrative interpretation if it is to be viewed as statutorily mandated" (quotation marks omitted). But the Departments are not suggesting that their interpretation should be viewed as statutorily mandated—only that Congress approved the interpretation as permissible and certainly cannot be said to have *foreclosed* it. *Cf. AFL-CIO v. Brock*, 835 F.2d 912, 916 (D.C. Cir. 1987) (distinguishing between Congress's "'approval'" of an agency's interpretation and its mandating that interpretation).

3. Even leaving aside the doctrine of acquiescence, there is no plausible argument that the ACA—which did not amend HIPAA's exclusion of "short-term limited duration insurance," 42 U.S.C. § 300gg-91(b)(5)—nonetheless foreclosed the Departments' longstanding definition of that statutory term. For more than a decade before the ACA, the Departments unquestionably had authority to fill the gap that Congress had created when HIPAA excluded "short-term limited duration insurance" from various requirements without defining that term. The Departments reasonably filled that gap with the longstanding definition, which served HIPAA's objectives for the reasons discussed below (at 38).

It is difficult to understand how plaintiffs can claim (at 38-41) that Congress would have needed to speak more clearly to give the Departments the authority to define short-term limited duration insurance. The exemption that Congress enacted in HIPAA and maintained in the ACA is no "mousehole[]," *Whitman v. American Trucking Ass'ns*, 531 U.S. 457, 468 (2001); it creates an entire category of insurance not subject to certain federal regulations and leaves the Departments to define that category. Nor is the challenged rule an "elephant[]," *id.*, for the reasons discussed below. Substantial evidence in the rulemaking record—including a study that plaintiff ACAP commissioned—predicted that the 2018 rule would have only a modest effect on premiums for Exchange plans, and that prediction has been borne out since the rule took effect.

B. The Challenged Rule Is Consistent With The ACA's Structure And Purposes

The 2018 rule interprets language enacted by HIPAA, not the ACA—and, as discussed above, Congress implicitly approved the Departments' longstanding interpretation of HIPAA when it enacted the ACA. The rule's consistency with the structure and purposes of the ACA is therefore relevant only to the extent the ACA can be regarded as having implicitly amended HIPAA's exclusion of "short-term limited duration insurance" from the category of "individual health insurance coverage," 42 U.S.C. § 300gg-91(b)(5). And courts "will not understand Congress to have amended an act by implication unless there is a 'positive repugnancy' between the provisions of the preexisting and newly enacted statutes, as well as language manifesting Congress's 'considered determination' of the ostensible change." *U.S. Ass'n of Reptile Keepers, Inc. v. Zinke*, 852 F.3d 1131, 1141 (D.C. Cir. 2017). Plaintiffs have shown nothing like that.

At any rate, the challenged rule is entirely consistent with the ACA's structure and purposes. Plaintiffs' contrary arguments fundamentally misunderstand the ACA.

1. The ACA creates opportunity and incentives for consumers to choose comprehensive coverage, rather than limiting consumers' options

Plaintiffs' central argument is that the challenged rule contravenes the ACA because it fosters an alternative to ACA-compliant plans. There is no doubt that the ACA sought to foster robust markets for the comprehensive health coverage sold on the

Exchanges, but it did so by guaranteeing the availability of comprehensive plans, offering consumers tax subsidies for purchasing them, and imposing a tax penalty on most consumers lacking ACA-compliant coverage. It did not extinguish other coverage options for consumers, at the risk of forcing millions of people to go uninsured.

Plaintiffs and their amici devote considerable attention to the ACA's guaranteed-issue and community-rating provisions—provisions meant to ensure that Americans have access to plans offering comprehensive health insurance, by preventing insurers from denying coverage or charging higher premiums on the basis of consumers' medical history or certain other factors. *See* 42 U.S.C. §§ 300gg, 300gg-1; *supra* p. 3. But the challenged rule in no way diminishes the effect of those provisions. Consumers who wish to purchase ACA-compliant plans have the same opportunity to do so as before the challenged rule took effect.

Plaintiffs insist (at 42) that the challenged rule nonetheless violates the spirit of the ACA because "Congress's plan was to create a single, ACA-compliant individual market." They claim that, by fostering the availability of short-term limited duration insurance, the challenged rule undermines Congress's vision of a unitary market. In reality, however, Congress had no such vision. Congress expected that millions of uninsured people would be unable or unwilling to purchase ACA-compliant coverage on the Exchanges, and it explicitly preserved other coverage options.

a. Even when the ACA imposed a tax penalty on non-exempted individuals who failed to maintain "minimum essential coverage," 26 U.S.C. § 5000A—a penalty

now reduced to zero, *see supra* p. 3 n.3—Congress set the penalty fairly low, making it economically rational for some Americans to pay the penalty rather than purchasing insurance. *See NFIB v. Sebelius*, 567 U.S. 519, 566 (2012) (amount of the penalty would "be far less than the price of insurance" for "most Americans" and could "never be more"). At the time the ACA was enacted, the Congressional Budget Office (CBO) estimated that about four million people would pay the tax penalty in 2016 rather than obtain ACA-compliant coverage. CBO, *Payments of Penalties for Being Uninsured Under the Patient Protection and Affordable Care Act* at 1. And the CBO projected that more than 14 million people would be exempt from the tax penalty, either because ACA-compliant coverage would be unaffordable or because they would fall within another of the statutory exemptions. *Id.*

Given the expectation that millions of people would be either unwilling to purchase or unable to afford ACA-compliant coverage, it is unsurprising that Congress preserved less expensive coverage options for consumers. As the district court noted, "lawmakers were not rigidly pursuing the ACA-compliant market … at the risk of individuals going without insurance altogether." 392 F. Supp. 3d at 45. Plaintiffs commit "an interpretative error of long standing" in treating the ACA's "primary or precipitating object"—that is, the desire to maximize comprehensive insurance coverage—"as its sole object." *Albany Eng'g Corp. v. FERC*, 548 F.3d 1071, 1076 (D.C. Cir. 2008).

b. Congress's desire to preserve other coverage options is not just implicit in Congress's expectation that millions of people would require such options; it is explicit in the statute itself.

Plaintiffs rely throughout their brief on 42 U.S.C. § 18032(c)(1), which states that "[a] health insurance issuer shall consider all enrollees in all health plans (other than grandfathered health plans) offered by such issuer in the individual market, including those enrollees who do not enroll in such plans through the Exchange, to be members of a single risk pool." From that provision, plaintiffs infer (at 42) that "Congress's plan was to create a single, ACA-compliant individual market." As an initial matter, plaintiffs ignore the rest of the provision, which fosters "[c]onsumer choice." 42 U.S.C. § 18032. The provision disavows any intent to restrict the markets for off-Exchange insurance plans, which are not subject to all of the same requirements as plans offered on the Exchanges. *Id.* § 18032(d)(1). And it explicitly preserves "the choice of a qualified individual to enroll *or not to enroll* in a qualified health plan or to participate in an Exchange." *Id.* § 18032(d)(3)(A) (emphasis added).

But more broadly, plaintiffs ignore that the provision is limited to individual market plans, 42 U.S.C. § 18032(c)(1), and Congress chose to preserve preexisting exemptions from requirements applicable to such plans. Those exemptions include not just the short-term limited duration provision at issue here, but also (for example) the exemption for "excepted benefits" such as "fixed indemnity insurance," 42 U.S.C. § 300gg-91(c)(3)(B). *See id.* §§ 300gg-21(b), (c), 300gg-63. In *Central United Life Insurance*

Co. v. Burwell, 827 F.3d 70 (D.C. Cir. 2016), this Court explained that the ACA had "left intact and incorporated" the preexisting "rules regarding excepted benefits," *id.* at 72, and for that reason the Court vacated a rule that "effectively eliminated stand-alone fixed indemnity plans" by providing that they would not qualify as excepted benefits in the individual market unless sold to individuals who already had minimum essential coverage, *id.* at 73 (emphasis omitted). Plaintiffs turn *Central United* on its head when they insist that the ACA nonetheless compelled the Departments to ensure that short-term limited duration plans cannot be sold as alternatives to ACA-compliant coverage.

For much the same reason, plaintiffs err in relying (at 36-37) on provisions requiring issuers to provide certain specified benefits, 42 U.S.C. § 300gg-6(a), and to eliminate lifetime or annual coverage limits, *id.* § 300gg-11. That argument assumes Congress intended for all consumers to be covered by plans satisfying each of the ACA's requirements, but it ignores Congress's preservation of the exceptions discussed above.

In sum, plaintiffs are wrong to suggest Congress intended to force an all-or-nothing choice on Americans otherwise lacking comprehensive health insurance, requiring them to purchase ACA-compliant plans on the Exchanges or else go without insurance altogether. Congress created tax incentives for consumers to acquire ACA-compliant plans, and it enacted the guaranteed-issue and community-rating provisions to ensure consumers would have the opportunity to acquire such plans. But Congress fully understood that not all consumers would be willing or able to obtain ACA-compliant insurance, and it declined to eliminate other forms of coverage, including

short-term limited duration insurance. "[N]o law pursues its purpose at all costs, and … the textual limitations upon a law's scope"—such as the exclusion of short-term limited duration plans from the category of individual health insurance coverage—"are no less a part of its purpose than its substantive authorizations." *Kucana v. Holder*, 558 U.S. 233, 252 (2010) (quotation marks omitted).

2. The Departments reasonably concluded that the challenged rule will not destabilize the Exchanges

Plaintiffs also suggest that the challenged rule may make healthy consumers more likely to purchase short-term limited duration plans instead of ACA-compliant plans—a phenomenon known as "adverse selection." In theory, that development could increase premiums for ACA-compliant plans and thus drive additional healthy consumers to seek other coverage options. At its extreme, that process could lead to a so-called "death spiral." *See King v. Burwell*, 135 S. Ct. 2480, 2485-2486 (2015) (discussing adverse selection and death spirals). But in proclaiming that the challenged rule will create death spirals, plaintiffs largely ignore the effects of tax subsidies that make many individual market participants effectively immune to premium increases.

a. Congress was acutely sensitive to adverse selection concerns in enacting the ACA. When the statute was under consideration, the CBO advised Congress that the guaranteed-issue and community-rating requirements would result in "adverse selection" that would "tend to increase premiums in the exchanges relative to nongroup premiums under current law." CBO, *An Analysis of Health Insurance Premiums Under the*

Patient Protection and Affordable Care Act at 19 (Nov. 30, 2009), https://go.usa.gov/xpfCH. The CBO concluded, however, that "other provisions of the proposal would tend to mitigate that adverse selection." *Id.* Most notably, it determined that there would be "an influx of enrollees with below-average spending for health care, who would purchase coverage because of the new subsidies to be provided and the individual mandate to be imposed." *Id.* at 6; *see also id.* at 19-20 (subsidies would cover roughly 80 percent of premiums for consumers with income less than twice the federal poverty level). The CBO further explained that the structure of the subsidies would mitigate adverse selection. Because subsidized consumers' premiums "would be determined on the basis of their income," the CBO observed, "higher premiums resulting from adverse selection would not translate into higher amounts paid by those enrollees." *Id.* at 20. Instead, "federal subsidy payments would have to rise to make up the difference." *Id.* The CBO informed Congress that the subsidies thus "would dampen the chances that a cycle of rising premiums and declining enrollment would ensue." *Id.*

In the challenged rule, the Departments hewed closely to Congress's judgment that tax subsidies for ACA-compliant plans would mitigate any effect of adverse selection. The Departments explained that although the restored definition of short-term limited duration insurance could cause some healthy individuals to choose such plans over ACA-compliant plans, any such effect would be modest because subsidies "are available only for" ACA-compliant "plans offered on Exchanges." 83 Fed. Reg. at 38,235-236. Given the subsidies, the Departments explained, it is "likely that healthy

lower-income individuals will remain in [ACA-compliant] plans even if they place a relatively low value on [ACA-compliant] coverage because the individual subsidized premium is so low." *Id.* And an overwhelming majority of Exchange consumers qualify for subsidies. *See King*, 135 S. Ct. at 2493 (in 2014, 87 percent of people who bought Exchange plans did so with tax credits); JA91 (Wu Decl. ¶ 6) (same for 2018).

b. The administrative record—including plaintiffs' own study—refutes their assertion (at 35) that the challenged rule will "destabilize the individual insurance market" and "create the very 'death spirals' that Congress designed the [ACA] to avoid."

A report by the Wakely Consulting Group, which ACAP commissioned and submitted with its comment on the 2018 proposed rule, *see* JA393, projected that the rule would increase premiums for ACA-compliant plans by 0.7 to 1.7 percent in 2019. Wakely Consulting Group, *Effects of Short-Term Limited Duration Plans on the ACA-Compliant Individual Market* at 1 (Wakely Report), https://go.usa.gov/xdqQt. After several years, the report projected, premiums would increase by 2.2 to 6.6 percent. *Id.* at 2; *see* JA393 ("4 to 5 years"); Pl. Br. 22 (citing this estimate). Those estimates were similar to the Departments' expectation that the 2018 rule would cause premiums to increase by 1 percent in 2019 and by 5 percent by 2028. 83 Fed. Reg. at 38,236. And the report acknowledged that such increases would be absorbed by increases in the subsidies available to the vast majority of Exchange consumers. *See* Wakely Report at 3 ("[T]he concept of a death spiral is less applicable to subsidized enrollees given the current structure of premium subsidies[.]"). Indeed, as the district court recognized,

modest premium increases are unlikely even to persuade many *unsubsidized* enrollees to accept the limited coverage afforded by short-term limited duration insurance. 392 F. Supp. 3d at 36.

The Departments' expectations about the modest effect of the rule have been borne out since the rule took effect more than a year ago. Premiums for benchmark Exchange plans fell by 1.5 percent in 2019. JA94-95 (Wu Decl. ¶ 18); *ACAP*, 392 F. Supp. 3d at 36. And the Centers for Medicare & Medicaid Services has recently announced that the premium for a benchmark Exchange plan will drop by 4 percent in 2020, relative to 2019. Press Release, Centers for Medicare & Medicaid Services (Oct. 22, 2019), https://go.usa.gov/xpxQf.

The effect of the 2018 rule on the customer base of ACAP's members should be especially slight. ACAP's members "provide coverage to low-income persons and persons with significant health care needs." Pl. Br. iii; *see* JA25 ¶ 24 (discussing named member Community Health Choice). For low-income persons, the comprehensive plans that ACAP's members sell on Exchanges are affordable because of the ACA's tax credits. Plaintiffs offer no reason to conclude that customers of ACAP's member insurers will abandon highly subsidized comprehensive plans in favor of short-term limited duration insurance, nor do they suggest that low-income persons who are ineligible for tax credits (such as those in the Medicaid coverage gap) can afford the full premiums that ACAP's members charge for the comprehensive plans they sell on Exchanges. Indeed, in Texas—home to Community Health Choice, the insurer member identified in

the complaint, JA25-27 ¶¶ 24-30—enrollment in Exchange plans *increased* between the 2018 open enrollment period (for 2019 plans) and the 2019 open enrollment period (for 2020 plans). *Compare* 2020 Federal Health Insurance Exchange Enrollment Period Final Weekly Enrollment Snapshot (Jan. 8, 2020), https://go.usa.gov/xphqf (1,116,293 enrollments for 2020) *with* Final Weekly Enrollment Snapshot for the 2019 Enrollment Period (Jan. 3, 2019), https://go.usa.gov/xphqA (1,087,240 enrollments for 2019).

Thus, plaintiffs' own submissions supported the Departments' determination that "the critical need for coverage options that are more affordable than individual health insurance coverage, combined with the general need for more coverage options and choice, substantially outweigh the estimated impact" of the 2018 rule "on individual health insurance premiums." 83 Fed. Reg. at 38,217.

II. THE LONGSTANDING DEFINITION OF SHORT-TERM LIMITED DURATION INSURANCE WAS CONSISTENT WITH HIPAA

As discussed above, Congress effectively approved the Departments' longstanding interpretation of the "short-term limited duration insurance" provision when it enacted the ACA. It is therefore irrelevant whether the interpretation might previously have been regarded as inconsistent with HIPAA. At any rate, the Departments' interpretation—which was issued in the immediate wake of HIPAA's enactment, and which provoked no challenge for two decades—is consistent with HIPAA's text and purposes even setting aside Congress's later approval.

A. Contrary to plaintiffs' contention, HIPAA's use of the phrase "short-term" did not foreclose the Departments' definition of short-term limited duration plans to include those with an initial term of less than 12 months.

Plaintiffs are wrong to contend (at 51-52) that a "short-term" plan must be "meaningfully shorter than the standard annual insurance term" of one year. As the district court recognized, "[t]here is scant indication in HIPAA's text, structure, or purpose that Congress specifically intended for the Departments to define 'short-term' by reference to a one-year baseline." 392 F. Supp. 3d at 39. Even assuming (as Professor Jost claims) that short-term limited duration insurance was "widely marketed in 1996" as "a gap filler" for "people who, for example, were between jobs or school terms" (JA384), there is no basis to believe Congress assumed such gaps would be limited to a few months. To the contrary, as the Departments explained in issuing the 2018 rule, Congress recognized in the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) that a person's need for temporary coverage could easily last several years. 83 Fed. Reg. at 38,221. "COBRA requires certain group health plan sponsors to provide a temporary continuation coverage option for a minimum of 18, 29, or 36 months, depending on the nature of the qualifying event that triggers the temporary coverage period." *Id.* (noting also that the Federal Employees Health Benefits Program permits the temporary continuation of coverage for up to 36 months). Thus, when Congress enacted HIPAA, it understood that an individual's need for transitional insurance could well exceed several months.

Even if plaintiffs were correct that one year is the benchmark against which a "short-term" plan should be measured, the vagueness of the word "short-term" would make it impossible to say the Departments' construction is "'manifestly contrary to the statute,'" *Michigan*, 268 F.3d at 1082. That is particularly true because the Departments' less-than-12-month definition advances the purposes for which Congress enacted HIPAA. As Professor Jost explained, "HIPAA provided for 'guaranteed availability' of coverage (without preexisting condition exclusions) in the individual market for individuals who had lost group coverage," as long as they "had 'creditable coverage' for at least 18 months" and met certain other requirements. JA383. And HIPAA defined "creditable coverage" to include short-term limited duration insurance. *Id.*; *see also* H.R. Rep. No. 104-736 at 180 (1996) ("The conferees intend that creditable coverage includes short-term, limited coverage."). The less-than-12 month definition thus made it easier for individuals to satisfy the creditable-coverage requirement and benefit from HIPAA's protections. By contrast, plaintiffs' definition would have made it more difficult for consumers to satisfy the creditable-coverage requirement and benefit from HIPAA's protections using short-term limited duration plans.

It is unsurprising, given the powerful reasons to favor a less-than-12-month definition, that "most states" adopted the same definition of short-term limited duration insurance. NAIC Comment on 2018 Proposed Rule at 1 (JA484). To the extent the state definitions "*followed* the 1997 Rule's definitions," as plaintiffs suggest (at 53 n.20), that only underscores that States—which have independent authority to regulate short-

term limited duration insurance and to define it more restrictively than the federal government—saw the virtues of the federal definition. The less-than-12-month definition also resembles the definition of "short-term" in other contexts. *See, e.g.*, 26 U.S.C. § 1222(1), (2) (defining "short-term capital gain" and loss to include gains and losses from the sale of an asset "held for not more than 1 year"); *id.* § 1283(a)(1)(A) (similar, for "'short-term obligation'"); 5 C.F.R. § 316.401 (defining "a short-term position" for civil service purposes as "one that is not expected to last longer than 1 year").

Plaintiffs note (at 54-55) that an ACA provision made the tax penalty for failing to maintain minimum essential coverage inapplicable to "short coverage gaps," defined as a "period of less than 3 months," 26 U.S.C. § 5000A(e)(4)(A), and they argue that "short-term limited duration insurance" likewise must be limited to a period of less than three months. But it is implausible to suggest that the Congress that enacted HIPAA in 1996 meant for the word "short" to have the same meaning as in a distinct provision of a different statute enacted fourteen years later. Moreover, the provision on which plaintiffs rely underscores that when Congress wishes to define a statutory term by reference to a particular time period, it can easily do so.[12]

[12] Plaintiffs claim (at 55 n.21) that "Congress used the same word in the ACA to apply both to short coverage gaps … and to STLDI," but the ACA does not refer to short-term limited duration insurance at all.

B. The phrase "limited duration" likewise does not foreclose the Departments' definition of short-term limited duration insurance to include plans renewable for up to 36 months.

Plaintiffs are wrong to assert (at 56) that short-term limited duration insurance must refer to a "one-time, non-renewable coverage option" (emphasis omitted). They argue (at 57) that short-term limited duration plans must be nonrenewable by nature because HIPAA did not guarantee their renewability as it did for other plans, but that simply means insurers were not required to renew such plans. Nothing in HIPAA *precluded* the renewal of short-term limited duration plans. Indeed, the challenged rule is more restrictive in that regard than the longstanding definition that the Departments otherwise restored—a definition that placed no limit on renewals with the insurer's consent. *ACAP*, 392 F. Supp. 3d at 43 ("[F]rom 1997 to 2016 the Departments permitted *unlimited* issuer-consented renewals.").

Plaintiffs relatedly note (at 19) that the challenged rule does not prohibit consumers from purchasing a series of consecutive short-term plans. But the same was true under the 2016 rule that plaintiffs endorse, as well as under the longstanding definition restored by the 2018 rule. *See, e.g.*, Kaiser Family Foundation, *Understanding Short-Term Limited Duration Health Insurance* at 3 (Apr. 23, 2018) (under the 2016 rule, some consumers purchased "four-packs" of three-month STLDI plans as an alternative to

year-round ACA-compliant coverage).[13] In issuing the 2016 rule, the Departments explained that some commenters had urged them to "go further and prohibit issuers from offering short-term, limited-duration insurance to consumers who have previously purchased this type of coverage," in order "to prevent consumers from stringing together coverage under policies offered by the same or different issuers." 81 Fed. Reg. at 75,318. The Departments declined, concluding that such a restriction was "not warranted" and "would be difficult for State regulators to enforce, since prior coverage of a consumer would have to be tracked." *Id.*

III. THE DEPARTMENTS REASONABLY EXPLAINED THEIR DECISION TO RESTORE THE LONGSTANDING DEFINITION OF SHORT-TERM LIMITED DURATION INSURANCE

Plaintiffs also err in claiming that the challenged rule is arbitrary and capricious.

A. Plaintiffs are wrong to assert (at 59-63) that the Departments had no basis to restore the longstanding definition of short-term limited duration insurance and reject the revised definition that had been adopted in 2016.

1. In reverting to the original definition, the Departments reasonably responded to concerns raised about the less-than-three-month maximum term that had been imposed by the 2016 rule. As discussed above, the NAIC—which the Departments often consult on matters of insurance regulation, *see*, *e.g.*, 42 U.S.C. §§ 300gg-15(a), 300gg-18(c), 18041(a)(2)—opposed the less-than-three-month maximum term.

[13] http://files.kff.org/attachment/Issue-Brief-Understanding-Short-Term-Limited-Duration-Health-Insurance.

When it was first proposed in 2016, the NAIC warned that the less-than-three-month maximum term "could harm some consumers, limit consumer options, and have little positive impact on the risk pools in the long run." NAIC Comment on 2016 Proposed Rule at 2. "[I]f an individual misses the open enrollment period and applies for short-term, limited duration coverage in February," the NAIC explained, "a 3-month policy would not provide coverage until the next policy year." *Id.* at 1. The NAIC emphasized that "there are instances when consumers simply cannot afford, even with the subsidies, an insurance plan with minimum essential coverage." *Id.* at 2. And it argued that those consumers' options "should not be limited to either paying for coverage they cannot afford or exposing themselves to the risk of losing their coverage after three months if they become sick." *Id.*

In issuing the 2018 rule, the Departments explained that experience had borne out the concerns raised by the NAIC and other commenters. Between 2016 and 2017, average premiums for individual market plans rose by 21 percent, which (as a commenter noted) left "many financially-stressed individuals" with "a choice between short-term, limited-duration insurance coverage and going without any coverage at all." 83 Fed. Reg. at 38,213-214. The 2016 rule's restrictions on short-term limited duration coverage thus "deprived individuals of affordable coverage options." *Id.* at 38,213. That concern was particularly acute for low-income adults who fell within the Medicaid coverage gap—that is, those who were neither Medicaid-eligible (because their States did not expand their Medicaid programs) nor eligible for tax credits (because their

household income was below the federal poverty level). *See*, *e.g.*, NAIFA Comment on 2018 Proposed Rule at 2 (JA376) (raising this concern); *see also* Kaiser Family Foundation, *The Coverage Gap: Uninsured Poor Adults in States That Do Not Expand Medicaid* at 3, 5 (2.5 million low-income adults fall in the Medicaid coverage gap). Various commenters also urged that an individual's need for temporary coverage, such as after the loss of a job, often exceeds three months. *See, e.g.*, Galen Institute Comment on 2018 Proposed Rule at 7 (JA469); NAIFA Comment on 2018 Proposed Rule at 2 (JA376).

Plaintiffs do not acknowledge the concerns that motivated the Departments' decision to restore the longstanding definition, nor do they acknowledge the extent to which respected authorities voiced those concerns. For instance, plaintiffs emphasize (at 8 n.2) that Professor Jost, on whose comments they heavily rely, "served as an appointed consumer representative to the National Association of Insurance Commissioners," but they ignore the position taken by the NAIC itself, which opposed the 2016 rule and urged the Departments to restore the longstanding definition.

2. Plaintiffs are also incorrect to suggest (at 59-60) that the Departments provided no explanation for departing from the 2016 rule. The Departments explained that "although the [2016 rule] was intended to boost enrollment in individual health insurance coverage," the rule "did not succeed in that regard." 83 Fed. Reg. at 38,214.

Plaintiffs object (at 61-62) that "boost[ing] enrollment in individual health insurance coverage"—the objective at which the Departments said the 2016 rule had failed, 83 Fed. Reg. at 38,214—was not the actual objective of the 2016 rule. Rather, they say,

the 2016 rule was meant to address the perceived problem of short-term limited duration insurance "being sold as a type of primary coverage," 81 Fed. Reg. at 75,318, rather than filling transitional gaps. But limiting the use of short-term limited duration insurance as "primary coverage" was not an end in itself. It was simply the way in which the Departments hoped to address the concerns they expressed in the 2016 rule—particularly the concern that a migration of "healthier individuals" from ACA-compliant plans to short-term plans could "adversely impact[] the risk pool for [ACA]-compliant coverage." *Id.* at 75,317-318. The Departments changed course in 2018 because they found that the means chosen in the 2016 rule "did not succeed in" mitigating that concern and in fact created other concerns. 83 Fed. Reg. at 38,214.

B. Plaintiffs also object (at 63-67) that the Departments did not address comments raising a concern that the 2018 rule might lead to coverage gaps. In reality, the Departments explained that a less-than-three-month maximum term would exacerbate—rather than mitigate—the problem of coverage gaps. 83 Fed. Reg. at 38,218. They explained that a less-than-three-month maximum term "would mean that every 3 months," people with short-term limited duration insurance "would be subject to re-underwriting if they did not have a renewal guarantee," might well see a "greatly increased" premium, might be denied a new policy "based on preexisting medical conditions," and "would not get credit" toward any deductible on a new plan "for money spent toward the deductible during the previous 3 months." *Id.* By contrast, under the

2018 rule, a consumer facing a coverage gap can potentially purchase a short-term limited duration insurance plan either for the length of the anticipated coverage gap or for long enough to reach the next open enrollment period, when the consumer can choose to purchase ACA-compliant coverage. Thus, the Departments explained, the need for continuous coverage is a reason that short-term limited duration insurance plans should *not* be limited to less than three months. *Id.*

C. Finally, plaintiffs note (at 22-23) that "commenters warned that STLDI plans are frequently marketed as providing ACA-compliant or equivalent coverage, thereby deceiving consumers into thinking that these plans offer more coverage than they actually do." The Departments shared the concern that "educating consumers and ensuring that they are aware of the limitations of these plans is paramount." NAIC Comment on 2018 Proposed Rule at 1 (JA484). That is why, as plaintiffs recognize (at 2-4), the 2018 rule requires that such plans include specified language disclosing their potential limitations, "prominently" and "in at least 14 point type," both "in the contract and in any application materials provided in connection with enrollment" (in addition to any other disclosures required by state law). 83 Fed. Reg. at 38,243. The Departments reasonably concluded that consumers informed by these notices "are in the best position to evaluate the tradeoffs between lower premiums and limitations of short-term, limited-duration insurance." *Id.* at 38,232.

Furthermore, States remain empowered to address concerns about short-term limited duration insurance that arise in their own markets. Indeed, after the 2018 rule

was issued, several States chose to limit the availability of short-term limited duration insurance. *See, e.g.*, Cal. Ins. Code § 10123.61(a) (prohibiting the sale of short-term limited duration insurance); Haw. Rev. Stat. § 431:10A-605(a) (prohibiting the sale of short-term limited duration insurance to persons eligible for Exchange coverage in the prior calendar year); Md. Code, Ins. § 15-1301(s) (restricting short-term limited duration plans to three months and barring renewals). Other states have lifted prior restrictions to allow short-term limited duration plans to the full extent permitted by the 2018 rule. *See, e.g.*, Ariz. Rev. Stat. § 20-1384(C)(2); Ind. Code § 27-1-37.3-5(b)(6); Okla. Stat. tit. 36, § 4419(A).

CONCLUSION

The district court's judgment should be affirmed.

Respectfully submitted,

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CERTIFICATE OF COMPLIANCE

This brief complies with the type-volume limit of Federal Rule of Appellate Procedure 32(a)(7)(B) because it contains 11,236 words. This brief also complies with the typeface and type-style requirements of Federal Rule of Appellate Procedure 32(a)(5)-(6) because it was prepared using Microsoft Word 2016 in 14-point Garamond, a proportionally spaced typeface.

/s/ Daniel Winik
Daniel Winik

ADDENDUM

TABLE OF CONTENTS

42 U.S.C. § 300gg-21(b), (c)........A1

42 U.S.C. § 300gg-63........A2

42 U.S.C. § 300gg-91(b), (c), (e)........A2

42 U.S.C. § 18032........A4

45 C.F.R. § 144.103........A5

42 U.S.C. § 300gg-21(b), (c)

§ 300gg-21. Exclusion of certain plans

…

(b) Exception for certain benefits

The requirements of subparts 1 and 2 shall not apply to any individual coverage or any group health plan (or group health insurance coverage) in relation to its provision of excepted benefits described in section 300gg-91(c)(1) of this title.

(c) Exception for certain benefits if certain conditions met

(1) Limited, excepted benefits

The requirements of subparts 1 and 2 shall not apply to any individual coverage or any group health plan (and group health insurance coverage offered in connection with a group health plan) in relation to its provision of excepted benefits described in section 300gg-91(c)(2) of this title if the benefits—

(A) are provided under a separate policy, certificate, or contract of insurance; or

(B) are otherwise not an integral part of the plan.

(2) Noncoordinated, excepted benefits

The requirements of subparts 1 and 2 shall not apply to any individual coverage or any group health plan (and group health insurance coverage offered in connection with a group health plan) in relation to its provision of excepted benefits described in section 300gg-91(c)(3) of this title if all of the following conditions are met:

(A) The benefits are provided under a separate policy, certificate, or contract of insurance.

(B) There is no coordination between the provision of such benefits and any exclusion of benefits under any group health plan maintained by the same plan sponsor.

(C) Such benefits are paid with respect to an event without regard to whether benefits are provided with respect to such an event under any group health plan maintained by the same plan sponsor or, with respect to individual coverage, under any health insurance coverage maintained by the same health insurance issuer.

(3) Supplemental excepted benefits

The requirements of this part shall not apply to any individual coverage or any group health plan (and group health insurance coverage) in relation to its provision of

excepted benefits described in section 300gg-91(c)(4) of this title if the benefits are provided under a separate policy, certificate, or contract of insurance.

…

42 U.S.C. § 300gg-63

§ 300gg-63. General exceptions

(a) Exception for certain benefits

The requirements of this part shall not apply to any health insurance coverage in relation to its provision of excepted benefits described in section 300gg-91(c)(1) of this title.

(b) Exception for certain benefits if certain conditions met

The requirements of this part shall not apply to any health insurance coverage in relation to its provision of excepted benefits described in paragraph (2), (3), or (4) of section 300gg-91(c) of this title if the benefits are provided under a separate policy, certificate, or contract of insurance.

42 U.S.C. § 300gg-91(b), (c), (e)

§ 300gg-91. Definitions

…

(b) Definitions relating to health insurance

(1) Health insurance coverage

The term "health insurance coverage" means benefits consisting of medical care (provided directly, through insurance or reimbursement, or otherwise and including items and services paid for as medical care) under any hospital or medical service policy or certificate, hospital or medical service plan contract, or health maintenance organization contract offered by a health insurance issuer.

(2) Health insurance issuer

The term "health insurance issuer" means an insurance company, insurance service, or insurance organization (including a health maintenance organization, as defined in paragraph (3)) which is licensed to engage in the business of insurance in a State and which is subject to State law which regulates insurance (within the meaning of section 514(b)(2) of the Employee Retirement Income Security Act of 1974. Such term does not include a group health plan.

…

(5) Individual health insurance coverage

The term "individual health insurance coverage" means health insurance coverage offered to individuals in the individual market, but does not include short-term limited duration insurance.

(c) Excepted benefits

For purposes of this subchapter, the term "excepted benefits" means benefits under one or more (or any combination thereof) of the following:

(1) Benefits not subject to requirements

(A) Coverage only for accident, or disability income insurance, or any combination thereof.

(B) Coverage issued as a supplement to liability insurance.

(C) Liability insurance, including general liability insurance and automobile liability insurance.

(D) Workers' compensation or similar insurance.

(E) Automobile medical payment insurance.

(F) Credit-only insurance.

(G) Coverage for on-site medical clinics.

(H) Other similar insurance coverage, specified in regulations, under which benefits for medical care are secondary or incidental to other insurance benefits.

(2) Benefits not subject to requirements if offered separately

(A) Limited scope dental or vision benefits.

(B) Benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof.

(C) Such other similar, limited benefits as are specified in regulations.

(3) Benefits not subject to requirements if offered as independent, noncoordinated benefits

(A) Coverage only for a specified disease or illness.

(B) Hospital indemnity or other fixed indemnity insurance.

(4) Benefits not subject to requirements if offered as separate insurance policy

Medicare supplemental health insurance (as defined under section 1395ss(g)(1) of this title), coverage supplemental to the coverage provided under chapter 55 of Title 10, and similar supplemental coverage provided to coverage under a group health plan.

…

(e) Definitions relating to markets and small employers

For purposes of this subchapter:

(1) Individual market

(A) In general

The term "individual market" means the market for health insurance coverage offered to individuals other than in connection with a group health plan.

…

42 U.S.C. § 18032

§ 18032. Consumer choice

(a) Choice

(1) Qualified individuals

A qualified individual may enroll in any qualified health plan available to such individual and for which such individual is eligible.

…

(c) Single risk pool

(1) Individual market

A health insurance issuer shall consider all enrollees in all health plans (other than grandfathered health plans) offered by such issuer in the individual market, including those enrollees who do not enroll in such plans through the Exchange, to be members of a single risk pool.

…

(d) Empowering consumer choice

(1) Continued operation of market outside Exchanges

Nothing in this title shall be construed to prohibit--

(A) a health insurance issuer from offering outside of an Exchange a health plan to a qualified individual or qualified employer; and

(B) a qualified individual from enrolling in, or a qualified employer from selecting for its employees, a health plan offered outside of an Exchange.

(2) Continued operation of State benefit requirements

Nothing in this title shall be construed to terminate, abridge, or limit the operation of any requirement under State law with respect to any policy or plan that is offered outside of an Exchange to offer benefits.

(3) Voluntary nature of an Exchange

(A) Choice to enroll or not to enroll

Nothing in this title shall be construed to restrict the choice of a qualified individual to enroll or not to enroll in a qualified health plan or to participate in an Exchange.

(B) Prohibition against compelled enrollment

Nothing in this title shall be construed to compel an individual to enroll in a qualified health plan or to participate in an Exchange.

(C) Individuals allowed to enroll in any plan

A qualified individual may enroll in any qualified health plan, except that in the case of a catastrophic plan described in section 18022(e) of this title, a qualified individual may enroll in the plan only if the individual is eligible to enroll in the plan under section 18022(e)(2) of this title.

…

45 C.F.R. § 144.103

§ 144.103 Definitions.

For purposes of parts 146 (group market), 147 (group and individual market), 148 (individual market), and 150 (enforcement) of this subchapter, the following definitions apply unless otherwise provided:

…

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

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

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

Notice 1:

This coverage is not required to comply with certain federal market requirements for health insurance, principally those contained in the Affordable Care Act. Be sure to check your policy carefully to make sure you are aware of any exclusions or limitations regarding coverage of preexisting conditions or health benefits (such as hospitalization, emergency services, maternity care, preventive care, prescription drugs, and mental health and substance use disorder services). Your policy might also have lifetime and/or annual dollar limits on health benefits. If this coverage expires or you lose eligibility for this coverage, you might have to wait until an open enrollment period to get other health insurance coverage. Also, this coverage is not "minimum essential coverage." If you don't have minimum essential coverage for any month in 2018, you may have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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

Notice 2:

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

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

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

…