T BE IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

ASSOCIATION FOR COMMUNITY AFFILIATED PLANS, *et al.*

Plaintiffs,

v.

UNITED STATES DEPARTMENT OF TREASURY, *et al.*,

Defendants.

Civil Action No. 18-2133

PLAINTIFFS' MEMORANDUM OF LAW IN SUPPORT OF THEIR MOTION FOR A PRELIMINARY INJUNCTION

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TABLE OF CONTENTS

TABLE OF AUTHORITIES

Statutes

Other Authorities

INTRODUCTION

In this case, federal agencies (the Departments[1]) disregarded all of the constraints that should circumscribe administrative action. They issued a rule that has the express purpose and manifest effect of undermining a law enacted by Congress—and that rests on judgments directly contrary to the congressional policy that is embodied in the text and structure of that law. To reach this conclusion, the agencies distorted the plain statutory language; took no account of the expressly stated congressional goals; ignored, without meaningful explanation, the position taken just two years ago by these same agencies on the identical question; and disregarded, also without any legitimate justification, myriad informed comments that objected to the change in agency policy. Because this lawless rule will cause immediate disruption in the Nation's health insurance market, injuring all participants in that market (including plaintiffs) and leaving many individuals with inadequate—or no—health insurance, this Court should issue a preliminary injunction suspending the rule.

In the Patient Protection and Affordable Care Act (ACA), 124 Stat. 119, Congress sought to expand health insurance coverage, bolster health insurance markets, and ensure that health insurance policies offer real protection to policyholders. To do so, the ACA mandates that most policies sold on the individual market—where individuals purchase insurance for themselves and their families (as opposed to employer-provided insurance)—comply with "guaranteed issue" and "community rating" requirements, which respectively (1) bar insurers from denying coverage to any person because of his or her preexisting conditions or health history and (2) preclude insurers from charging higher premiums based on health history, gender, and (with some limits) age. The ACA also requires that health insurance policies offer a set of "essential" protections to covered individuals. As written, the ACA exempts from these requirements "short-

[1] These are the Departments of the Treasury, Health and Human Services, and Labor.

term, limited duration insurance" (STLDI), a narrow exception intended (as the language suggests) to permit the sale of temporary policies to people who are between annual insurance plans.

In the regulation challenged here (the STLDI Rule), however, the responsible agencies determined that a "short-term, limited duration" plan may last for ***364 days*** and may be extended up to ***36 months***. They did so for the express purpose of allowing the sale of health insurance policies that are not subject to the ACA's guaranteed issue, community rating, and essential benefits provisions, and therefore are cheaper than ACA-compliant plans. The Rule will create an alternative health insurance market from which people with pre-existing conditions are effectively barred; by luring healthier people out of ACA-compliant plans, it also will increase the costs and undermine the stability of the market established by the ACA. And it will produce a system in which many people end up with insurance that is wholly inadequate for their needs. Congress enacted the ACA to preclude just these results.

This Rule, issued as a matter of administrative fiat, oversteps the agencies' role and is indefensible as a matter of law: "Disagreeing with Congress's expressly codified policy choices isn't a luxury administrative agencies enjoy." *Central United Life Ins. Co. v. Burwell*, 827 F.3d 70, 73 (D.C. Cir. 2016). The Rule will impose irreparable injury on plaintiffs, entities whose members sell ACA-compliant insurance, provide health care services, and purchase insurance and use health care services, as well as on the broader public. This Court should issue an injunction suspending the Rule's effectiveness pending a final decision on the merits.

STATEMENT

1. In 1997, Congress enacted HIPAA, Public Law 104-191, 110 Stat. 1936, an insurance reform statute that, among other things, established limited federal standards for "individual health insurance coverage" and mandated that such coverage provide for guaranteed

renewability. Under this requirement, an insurer must offer continued insurance to a current insured individual whose plan is expiring, even if that individual utilized the insurance or suffered adverse health consequences during the plan term. *Id.* § 111, 110 Stat. 1979, 1982. But Congress in HIPAA exempted STLDI plans from that requirement. *Id.* § 102, 110 Stat. 1973 (codified at 42 U.S.C. § 300gg-91). The Departments then had to define what constituted an STLDI plan for HIPAA purposes.

Accordingly, the Departments adopted an interim final rule in 1997. That interim rule defined "short-term limited duration coverage" 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."[2] The final rule adopted in 2004 contained the same language.[3]

As several commenters noted during the 2018 rulemaking challenged here, the Departments' decision in 1997 to interpret "short-term" as permitting a 364-day contract was likely arbitrary and capricious.[4] Indeed, nothing in the 1997 preamble to the interim final rule defended this element of the Departments' definition, suggesting that the Departments did not give close consideration to this provision. But because HIPAA did not impose substantial requirements on the content of individual or group insurance plans, the federal classification of a plan as STLDI—rather than as continuing or long-term insurance—made no significant practical difference. Accordingly, this aspect of the Departments' definition went unchallenged.

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[2] *Interim Rules for Health Insurance Portability for Group Health Plans*, 62 Fed. Reg. 16,894, 16,958 (Apr. 8, 1997).

[3] *Final Regulations for Health Coverage Portability for Group Health Plans and Group Health Insurance Issuers Under HIPAA Titles I & IV*, 69 Fed. Reg. 78,720 (Dec. 30, 2004).

[4] *See, e.g.*, Comment of Timothy Stoltzfus Jost, Apr. 20, 2018.

2. During this period, and prior to the enactment of the ACA, many individuals faced substantial discrimination in (or were effectively priced out of) the insurance market.[5] In most states, insurance companies could discriminate in premiums or coverage against individuals based on pre-existing conditions, claims history, health status, age, gender, occupation, and other factors. That risk segmentation both made health insurance unavailable to many Americans as a practical matter (because individuals with the risk of higher health costs faced huge health insurance premiums) and led to wide and unsustainable fluctuations in costs for individuals.[6]

Congress responded to these problems by enacting the ACA, which it intended "to increase the number of Americans covered by health insurance and decrease the cost of health care." *National Fed'n of Indep. Bus. v. Sebelius*, 132 S. Ct. 2566, 2580 (2012) ("*NFIB*"). Insofar as is relevant here, the ACA had two central goals:

First, the ACA "adopt[ed] a series of interlocking reforms designed to expand coverage in the individual health insurance market." *King v. Burwell*, 135 S. Ct. 2480, 2585 (2015). To this end, it established a "guaranteed issue" requirement, mandating that each insurer offering coverage in the individual and group markets in a State "accept every employer and individual in the State that applies for such coverage," thus prohibiting the prior practice of refusing coverage to individuals with a history of health problems or a chronic disease condition.[7] An insurer in the individual or group market therefore may not limit or deny coverage based on the covered parties' pre-existing conditions.[8]

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5 H.R. Rep. No. 111-299, tit. 3, pt. 1.

6 *See, e.g.*, Cong. Research Serv., *Private Health Insurance Provisions in Senate-Passed H.R. 3590, The Patient Protection and Affordable Care Act* 5 (Jan. 29, 2010).

7 42 U.S.C. § 300gg-1(a).

8 *Id.* § 300gg-3.

The ACA also includes a "community rating" provision that limits premium discrimination in the individual and small group health insurance markets. This provision forbids variations in premiums except those based on enumerated factors, while limiting the rate variation permitted under those factors.[9] Thus, tobacco use is a permissible factor, "except that such rate shall not vary by more than 1.5 to 1"; so is age, "except that such rate shall not vary by more than 3 to 1 for adults"; and geography may be considered only in the context of rating areas established by the State.[10] Factors such as health status, claims history, race, gender, sexual orientation, geography (except for rating areas established by the State), occupation, and many others may not be considered by insurers in setting rates.[11] These provisions ensure that discriminatory pricing practices no longer unduly affect certain purchasers in the individual insurance market, as had been commonplace prior to the ACA's enactment.

Congress regarded guaranteed issue and community rating as essential to the operation of well-functioning insurance markets. These requirements make all enrollees in the individual market "members of a single risk pool"[12]; this requirement satisfies the ACA's core mission of making insurance affordable for all by spreading risk across all enrollees, ensuring that risk pools include both the healthy and the sick. To further expand the number of persons in this risk pool, Congress (1) provided refundable tax credits to assist the purchase of insurance by individuals with defined household incomes and (2) required that individuals who did not have qualified health insurance must pay a tax penalty. *See King*, 135 S. Ct. at 2487. Congress subsequently

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9 *Id.* § 300gg.

10 *Id.*

11 *See id.*

12 *Id.* § 18032(c).

reduced that penalty to zero (*see* Pub. L. 115-97 § 11081, 131 Stat. 2054, 2092 (2017)), but did not alter the ACA's other provisions.

This guarantee of coverage carried with it the risk of adverse selection—that individuals would wait to purchase insurance until they needed health care, which would produce a risk pool skewed toward individuals with high medical costs and therefore increase insurance premiums. Congress enacted several measures to guard against that possibility. In particular, the ACA instructs the Secretary of HHS to provide open enrollment periods for purchasing ACA-compliant plans, so as to encourage individuals to sign up for insurance at the beginning of the year rather than wait to do so until a medical condition arises. 42 U.S.C. § 18031(c)(6)(B). Congress also recognized that some people might miss the open enrollment period through no fault of their own, and accordingly instructed the Secretary to provide for special enrollment periods to ensure that the Act's promise of guaranteed coverage remains available for these individuals. *Id.* § 18031(c)(6)(C). The Secretary responded by providing a special enrollment period for persons who lose minimum essential coverage mid-year. 45 C.F.R. § 155.420(d)(1).

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

ensuring coverage of mental health and substance use disorder treatment comparable to that for physical health care. In addition, the ACA bans lifetime and annual dollar limits on insurance benefits, and includes other financial protections for enrollees, such as limitations on cost-sharing requirements.[13]

3. In enacting the ACA's reforms, Congress had to specify the category of insurance plans to which the new requirements applied. It did so by cross-referencing HIPAA's definition of "individual health insurance coverage" and defining plans that complied with the ACA's requirements as "qualified health plans."[14]

After the ACA's enactment, the Departments realized that they would need to revisit their prior rulemakings under HIPAA to reconcile their implementation of that statute with the ACA's comprehensive reforms of the insurance market. This effort included a reconsideration of the 1997 definition of "short-term, limited-duration," which had served one purpose under HIPAA but now had very different implications for the individual insurance market under the ACA.

Unlike ACA-compliant plans, STLDI plans are exempt from the HIPAA requirement that insurance plans be guaranteed renewable; an STLDI provider may decline to continue covering an insured individual when the insurance term ends. STLDI plans also are not subject to the ACA provisions that prohibit insurers from refusing coverage based on an individual's pre-existing health conditions and from setting premiums based on an individual's health history, gender, or (outside specified parameters) age. STLDI plans likewise may omit essential health benefits that must be provided by ACA-compliant individual health insurance plans, and need not adhere to the ACA's limits on patients' out-of-pocket expenses. Thus, STLDI plans may omit essential

[13] See 42 U.S.C. § 18022(a), (c) (limitations on cost-sharing); *id.* § 18022(d) (minimum actuarial value).

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

health benefits and engage in other business practices that are forbidden to ACA-compliant individual health insurance plans.

The Departments began considering this issue in 2014, the first year for which ACA-compliant plans were available, after it became apparent that some insurers would use STLDI plans to circumvent the ACA reforms. That process culminated in a 2016 final regulation, in which the Departments concluded that, to qualify as an STLDI plan, "coverage must be less than three months in duration, including any period for which the policy may be renewed."[15]

The Departments provided detailed, reasoned explanations for this definition in the 2016 rulemaking. They explained that STLDI plans were being purchased by some individuals "as their primary form of health coverage," even though these plans did not provide "the protections of the Affordable Care Act" and thus "may not provide meaningful health coverage."[16] Moreover, the pricing of STLDI plans based on the insured's health history would allow these plans to target "healthier individuals," thereby "adversely impacting the risk pool for Affordable Care Act-compliant coverage."[17] Thus, the Departments determined that a tailored interpretation of STLDI was necessary to "improve the Affordable Care Act's single risk pool" and keep premiums for all participants in the individual health market at an affordable level.[18]

4. Although Congress modified the ACA after the statute's enactment by reducing to zero the tax imposed on individuals for failure to purchase ACA-compliant insurance, it repeatedly

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15 81 Fed. Reg. at 75,318.

16 *Id.* at 75,317-18.

17 *Id.* at 75,318.

18 *Id.*

rejected proposals to repeal the statute altogether[19] and declined to repeal or modify the ACA's protections for individuals with pre-existing conditions and its prohibition against discrimination in setting health insurance premiums.[20]

Soon after these ACA repeal efforts failed, President Trump signed Executive Order 13813 on October 12, 2017,[21] directing expanded access to STLDI plans specifically because such plans are exempt from the "insurance mandates and regulations included in title I of the [ACA]"; the Order sought to make STLDI plans an "alternative" to ACA-compliant health care for consumers in the individual insurance marketplaces.[22] The proposed STLDI Rule, issued on February 21, 2018, was the Departments' response to the President's directive.[23]

The Departments received approximately 12,000 comments on their proposed rule.[24] One analysis found that "more than 98%—or 335 of 340—of the healthcare groups that commented on the proposal to loosen restrictions on short-term health plans criticized it, in many cases warning that the rule could gravely hurt sick patients," while "[n]ot a single group representing patients, physicians, nurses or hospitals voiced support" for the proposal.[25] Nevertheless, and

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[19] *See* American Health Care Act of 2017, H.R. 1628 (2017); Better Care Reconciliation Act of 2017, S. Amend. 270 (July 25, 2017); Obamacare Repeal Reconciliation Act of 2017, S. Amend. 271 (July 25, 2017); Healthcare Freedom Act of 2017, S. Amend. 667 (July 26, 2017).

[20] Budget Fiscal Year 2018, 131 Stat. 2054, 2092 (Dec. 22, 2017).

[21] Exec. Order No. 13813, Presidential Executive Order Promoting Healthcare Choice and Competition Across the United States (Oct. 12, 2017), perma.cc/VM65-EXTU.

[22] *Id.*

[23] *Short-Term, Limited-Duration Insurance*, 83 Fed. Reg. 7437 (Feb. 21, 2018).

[24] *Short-Term, Limited-Duration Insurance*, 83 Fed. Reg. 38,212 (Aug. 3, 2018). Though the complete set of comments is not publicly available, 9,205 of them have been published at goo.gl/2P8wnL.

[25] Noam N. Levey, *Trump's New Insurance Rules are Panned by Nearly Every Healthcare Group that Submitted Formal Comments*, L.A. Times, May 30, 2018.

notwithstanding many other objections, the Departments "finalized the proposed rule with some modifications" on August 3, 2018.[26]

The Departments explained that "[u]nder this final rule, short-term, limited-duration insurance means health coverage provided pursuant to a contract with an issuer that has an expiration date specified in the contract that is less than 12 months after the original effective date of the contract and, taking into account renewals or extensions, has a duration of no longer than 36 months in total."[27] The Departments also clarified that "[n]othing in this final rule precludes the purchase of separate insurance contracts that run consecutively, so long as each individual contract is separate and can last no longer than 36 months."[28] Consequently, the final rule permits the purchase of STLDI coverage that, as a practical mater, has ***no*** mandated stopping point. The Departments provided no reasoned explanation and identified no changed circumstances (whether factual or legal) justifying this deviation from their contrary conclusions in the 2016 STLDI rulemaking, which had taken place less than 2 years earlier.

The consequences of the final rule are addressed in detail below. Certain effects are not debatable: The Departments themselves acknowledged that the rule will make "relatively young, relatively healthy individuals in the middle-class and upper middle-class" "more likely to purchase short-term, limited-duration insurance," so "the proportion of healthier individuals in the [ACA-compliant individual market] . . . will decrease."[29] This conclusion is widely shared, including by the American Academy of Actuaries: "Because of medical underwriting at issue,

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[26] 83 Fed. Reg. at 38,214.

[27] *Id.* at 38214-15.

[28] *Id.* at 38220.

[29] *Id.* at 28235.

STLD is expected to attract healthier individuals with a lower premium and could put upward pressure on ACA rates as healthier enrollees leave the ACA pool."[30]

According to the Departments' own initial estimates, which a number of commenters noted were unduly optimistic, "premiums for unsubsidized enrollees in the Exchanges will increase by 5 percent" as a result of this change.[31] Another model, which accounted for several under-counting errors in the Departments' estimates, estimates that ACA enrollment will decrease by 8.2-15.0% and that premiums will increase by 2.2-6.6% in the near term.[32]

5. Plaintiffs are associations of insurers, health care providers, and entities that assist and advocate for individuals who have medical conditions or otherwise use medical services. All participated in the 2018 rulemaking proceeding and/or believe strongly that the STLDI Rule both will injure them directly and is incompatible with their shared purpose of ensuring access to adequate, affordable health care for all Americans. They filed the complaint in this suit on September 14, 2018, contending that the STLDI Rule is (1) inconsistent with the ACA's terms structure, and manifest purpose, and (2) is arbitrary and capricious is several respects. Each plaintiff and its members and/or the individuals and groups that it represents will suffer significant and irreparable harm from the STLDI rule.

ARGUMENT

On the eve of open enrollment for 2019 ACA-compliant insurance, the Departments have promulgated the STLDI Rule, which—if it remains in effect for this open enrollment period—will upend the individual market for health insurance and harm millions of people. This Court

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[30] Comment of American Academy of Actuaries, Apr. 6, 2018, at 5.

[31] 83 Fed. Reg. at 28235.

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

should preliminarily enjoin the Rule to prevent this drastic change from going forward while this challenge to the Rule's legality is being resolved. A preliminary injunction is warranted where the movant makes a "clear showing that four factors, taken together, warrant relief: likely success on the merits, likely irreparable harm in the absence of preliminary relief, a balance of the equities in its favor, and accord with the public interest." *League of Women Voters of U.S. v. Newby*, 838 F. 3d 1, 6 (D.C. Cir. 2016). Each element of this test is satisfied here.

I. PLAINTIFFS ARE LIKELY TO SUCCEED ON THE MERITS OF THEIR CLAIMS.

Under the Administrative Procedure Act, courts must "hold unlawful and set aside agency action" that is "arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law." 5 U.S.C. § 706(2)(A). Here, the STLDI Rule should be vacated under the APA because it is unlawful for at least four reasons: (1) the Departments exceeded their authority by promulgating a rule that undermines the individual health insurance market structure established by Congress in the text and structure of the ACA; (2) the Departments' interpretation of "short term" is contrary to HIPAA and the ACA; (3) the Departments' interpretation of "limited duration" is contrary to HIPAA and the ACA; and (4) the STLDI Rule is arbitrary and capricious for lack of reasoned explanation. Given the Departments' disregard of the statutory text and clear congressional policy, plaintiffs are likely to prevail on these arguments.

A. The Departments Lack Authority To Issue The STLDI Rule, Which Conflicts With Congress's Legislative Judgments Embodied In The ACA.

The power of federal agencies to issue rules is granted by Congress: "an agency literally has no power to act . . . unless and until Congress confers power upon it." *La. Pub. Serv. Comm'n v. FCC*, 476 U.S. 355, 375 (1986); *see also City of Arlington, Tex. v. FCC*, 569 U.S. 290, 297 (2013) ("Both [agencies'] power to act and how they are to act is authoritatively

prescribed by Congress."). In short, "[a]gencies may act only when and how Congress lets them." *Central United Life*, 827 F.3d at 73.

Necessarily, then, agencies may not issue rules that conflict with statutes that Congress has enacted. "A reviewing court must reject administrative constructions of [a] statute . . . that are inconsistent with the statutory mandate or that frustrate the policy that Congress sought to implement." *Wash. Hosp. Ctr. v. Bowen*, 795 F.2d 139, 144 (D.C. Cir. 1986) (alterations in original) (internal quotation marks omitted); *see, e.g., Chem. Mfrs. Ass'n v. Nat. Res. Def. Council, Inc.*, 470 U.S. 116, 125 (1985) ("[I]f Congress has clearly expressed an intent contrary to that of the Agency, our duty is to enforce the will of Congress."); *Chevron, U.S.A., Inc. v. Nat. Res. Def. Council, Inc.*, 467 U.S. 837, 843 n.9 (1984) ("The judiciary is the final authority on issues of statutory construction and must reject administrative constructions which are contrary to clear congressional intent.").

Congress exercised its legislative power in the ACA to structure the individual health insurance market in a manner that it determined would improve access to health care. The Departments' power and discretion to act are constrained by that statutory judgment. Because the STLDI Rule contravenes and undercuts Congress's judgments, embodied in the text and structure of the ACA, the Rule is both contrary to law and arbitrary and capricious.

1. The STLDI Rule Exceeds The Departments' Authority Because It Violates The ACA.

The authority asserted by the Departments in promulgating the STLDI Rule is astounding in its breadth: They claim the power to create a new form of primary health insurance that is exempt from all of the ACA's central requirements, so as to vastly expand the number of individuals who purchase insurance that lacks the characteristics that Congress regarded as "essential." *See* 83 Fed. Reg. 38,212. They would do this by expanding the ability of individuals

to purchase insurance coverage that does not meet the requirements of the ACA—namely, short-term limited duration insurance. 83 Fed. Reg. at 38,214.

But Congress did not grant the Departments this authority. When reviewing an agency's construction of the statute that it administers, courts must first determine "whether Congress has directly spoken to the precise question at issue. If the intent of Congress is clear, that is the end of the matter." *Chevron*, 467 U.S. at 842-43. To determine whether Congress has spoken on a question, courts employ "traditional tools of statutory construction" (*id.* at 843 n.9)—including "all pertinent interpretive principles." *Carter v. Welles-Bowen Realty, Inc.*, 736 F.3d 722, 731 (6th Cir. 2013) (Sutton, J., concurring). And "[i]f an interpretive principle resolves a statutory doubt in one direction, an agency may not reasonably resolve it in the opposite direction." *Id.*

One such principle is that courts "expect Congress to speak clearly if it wishes to assign to an agency decisions of vast 'economic and political significance.'" *King*, 135 S.Ct. at 2489; *Util. Air Regulatory Grp. v. EPA*, 134 S. Ct. 2427, 2444. The STLDI Rule will have just such an enormous impact on the structure and economics of the individual insurance market and the millions of people who obtain health insurance through it—subjects that have been the center of heated political debates for decades. *See, e.g, Timeline: History of Health Reform in the U.S.*, Kaiser Family Foundation (2011), perma.cc/539M-4QFY.

The Departments do not, and cannot, identify any clear and specific congressional grant of authority to unilaterally restructure the nationwide individual insurance markets and determine whether and how much insurance individuals should purchase; they rely instead only on their authority to define undefined statutory terms based on a generalized "necessary and appropriate" clause in the Public Health Services Act. *See* 83 Fed. Reg. at 32,215. But it is implausible that Congress intended to delegate such sweeping and contentious authority to the Departments

through a vague and generalized "necessary and appropriate" provision and a single undefined statutory term: As the Supreme Court has put it, Congress "does not, one might say, hide elephants in mouseholes." *Whitman v. Am. Trucking Ass'ns, Inc.*, 531 U.S. 457, 468 (2001).

Indeed, far from authorizing the Departments to take such a drastic step, Congress in the ACA spoke to the very questions that the Departments now claim to be addressing, making clear that the Departments may not establish STLDI as an alternative to ACA-compliant insurance. In interpreting statutes to determine whether Congress has spoken directly on a question, the Supreme Court has admonished that it is important to respect the "fundamental canon of statutory construction that the words of a statute must be read in their context and with a view to their place in the overall statutory scheme." *FDA v. Brown & Williamson Tobacco Corp.*, 529 U.S. 120, 133 (2000). "In determining whether Congress has specifically addressed the question at issue, the court should not confine itself to examining a particular statutory provision in isolation. Rather, it must place the provision in context, interpreting the statute to create a symmetrical and coherent regulatory scheme." *Id.* at 121; *see also Bell Atl. Tel. Cos. v. FCC*, 131 F.3d 1044, 1048 (D.C. Cir. 1997) (looking to "the history, structure, and underlying policy purpose of the statute").

This is particularly important in a statute like the ACA, where the major provisions are "interdependent" and expressly note that they work "together with the other provisions of [the] Act." *See NFIB*, 567 U.S. at 696 (Scalia, J., dissenting); *see also* 42 U.S.C. § 18091(2)(C) (working "together" to "add millions of new consumers to the health insurance market"); *id.* § 18091(2)(E) (working "together" to "significantly reduce" the economic cost of the "poorer health and shorter lifespan of the uninsured"); *id.* § 18091(2)(F) (working "together" to "lower health insurance premiums"); *id.* § 18091(2)(G) (working "together" to "improve financial

security for families"); *id.* § 18091(2)(I) (working "together" to minimize "adverse selection and broaden the health insurance risk pool to include healthy individuals"); *id.* § 18091(2)(J) (working "together" to "significantly reduce administrative costs and lower health insurance premiums").

And here, the statutory scheme created by the Affordable Care Act unambiguously precludes precisely what the Departments seek to do through the STLDI Rule. In the ACA, Congress enacted a comprehensive system for "expand[ing] more affordable coverage options to consumers who desire and need them" and "reduc[ing] the number of uninsured individuals" (83 Fed. Reg. at 38,218)—the purported goals of the STLDI Rule. But Congress determined that the way to accomplish these ends is through the requirements of guaranteed issue and community rating (*see* 42 U.S.C. 300gg-1, 300gg-3, 300gg-4(a); §§ 300gg(a)(1), 300gg-4(b)), assuring that all health insurance consumers would be "members of a *single* risk pool." 42 U.S.C. § 18032(c). It specifically prohibited insurers from refusing coverage to individuals with preexisting conditions, and from setting premiums based on individuals' health history, gender, and other factors. The STLDI Rule, by contrast, attempts to make STLDI plans—which are exempt from all of these requirements—substitutes for ACA-compliant plans. The Rule thus adopts the approach that Congress specifically rejected.

Congress also addressed whether the federal government should "help individuals avoid paying for benefits provided in individual health insurance coverage that they believe are not worth the cost" (83 Fed. Reg. at 38,218)—another asserted goal of the STLDI Rule. Congress unambiguously answered ***no***, codifying in the ACA its judgment that all individuals should receive coverage for certain essential health benefits in order to assure access to necessary health

care. *See* 42 U.S.C. §§ 300gg-6(a), 18022(b). Again, the STLDI Rule implements a policy that Congress specifically rejected in the text of the ACA.

"Ambiguity … 'is a creature not of definitional possibilities but of statutory context.' *Brown v. Gardner*, 513 U.S. 115, 118 (1994). [And] [s]een in its proper context, [the Departments' Rule] clearly misreads the [ACA]." *Central United Life*, 827 F.3d at 74. Because the STLDI Rule thus violates the ACA, it should be set aside as contrary to law.

2. The STLDI Rule Advances An Unreasonable Interpretation Of "Short Term Limited Duration Coverage."

Moreover, even assuming *arguendo* that the Departments possessed some discretion in determining the types of primary health insurance that should be available to consumers in the individual market, the Departments did not reasonably exercise that discretion in promulgating the STLDI Rule. At step two of the *Chevron* inquiry, courts "must reject administrative construction of [a] statute . . . . that frustrate[s] the policy that Congress sought to implement." *Shays v. Fed. Election Comm'n*, 528 F.3d 914, 919 (D.C. Cir. 2008); *see also Util. Air Regulatory Grp.*, 134 S. Ct. at 2442 ("[A]n agency interpretation that is 'inconsisten[t] with the design and structure of the statute as a whole' does not merit deference." (quoting *Univ. of Tex. Sw. Med. Ctr. v. Nassar*, 133 S. Ct. 2517, 2529 (2013))). And here, it is unquestionable that both the purpose and the effect of the STLDI Rule is to frustrate Congress's policy as embodied in the text and structure of the ACA. Accordingly, it is an impermissible exercise of discretion by the Departments.

The purpose of the STLDI Rule is clear: The Departments acknowledge that the Rule was promulgated pursuant to the directive in Executive Order 13813, with the goal of changing the structure of the individual insurance market established by the ACA. *See* 83 Fed. Reg. 38,212; *see also* Julia Limitone, *Affordable Health Care Is Here: HHS Sec. Alex Azar*, Fox Bus.

(Aug. 2, 2018) (quoting HHS Secretary Alex Azar: "What we are doing is bringing cheap and more affordable options to individuals who are trapped under the Affordable Care Act.").

And the STLDI Rule would in fact do what it is designed to do, frustrating the purposes and policies of the ACA. As explained above, Congress enacted the ACA to make affordable coverage widely available. There were potentially many ways of achieving this goal, but the policy chosen by Congress in the ACA was to couple a prohibition on insurers denying coverage and charging individuals higher premiums based on their medical history (42 U.S.C. §§ 300gg(a)(1), 300gg-1, 300gg-3, 300gg-4(a), 300gg-4(b)) with subsidies and tax incentives to assist individuals in purchasing insurance. 26 U.S.C. §§ 36B, 5000A. For this reform to work, Congress deemed it "essential" to minimize adverse selection and "broaden the health insurance pool to include healthy individuals," placing all covered individuals in a single insurance pool. 42 U.S.C. § 18091(l); *see also supra* at pages 4-6 (describing essential health benefits and open and special enrollment period requirements).

But the Departments ***concede*** that the STLDI Rule frustrates these policies—in particular, the congressional intent to "broaden the health insurance pool to include healthy individuals" (42 U.S.C. § 18091(l)) and to create a "single risk pool" in the individual market (*id.* § 10832). The Departments acknowledge that the Rule intends to make STLDI "an additional ... option that may be available to [individuals]." 83 Fed. Reg. 38,218. This is a recognition that the Rule will "lead to adverse selection," with "relatively young, relatively healthy individuals in the middle-class and upper middle-class" "more likely to purchase short-term, limited duration insurance," so "the proportion of healthier individuals in the individual market Exchanges will decrease." *Id.* at 38,235. The Departments further recognize that this adverse selection will in turn cause "premiums for unsubsidized enrollees in the Exchanges [to] increase by 5 percent" (an

estimate which, as discussed above, is unreasonably optimistic). *Id.* These rising costs will, in turn, encourage more people to defer purchasing coverage until they are ill, which will put further upward pressure on premium costs, until insurers must either "significantly increase premiums" or simply exit the market, resulting in a self-perpetuating death spiral. *Sebelius*, 567 U..S. at 548. Again, the Departments admit this: The Rule may result in "fewer issuers . . . offer[ing] plans in the individual market." 83 Fed. Reg. 38,233. As a result, many Americans will be unable to obtain the coverage they need to treat their medical conditions. An interpretation of the ACA that undermines and destabilizes the marketplace and protections put into place by Congress in the ACA simply cannot qualify as reasonable.

3. The STLDI Rule Is Arbitrary and Capricious Because It Rests On Judgments Rejected By Congress In The ACA.

Finally, in addition to being contrary to law, the Rule is arbitrary and capricious because the Departments "'relied on factors which Congress has not intended [them] to consider.'" *Safari Club Int'l v. Zinke*, 878 F.3d 316, 325 (D.C. Cir. 2017) (quoting *State Farm*, 463 U.S. at 43). As explained above, the ACA is premised on the notion that all plans in the individual market will be part of a "single risk pool," consisting of plans that offer a set of essential health benefits and to which individuals are assured access through the guaranteed-issue and community-rating provisions. Rather than seeking to implement that statutory scheme, however, the Departments have openly declared their intent to develop a parallel market, outside the ACA's single risk pool, in which coverage is not assured and essential benefits are not guaranteed. *See* 83 Fed. Reg. at 38,216 ("this regulatory action is necessary and appropriate to remove federal barriers that inhibit consumer access to additional, more affordable coverage options"); *id.* at 38,218 ("the availability of short-term limited-duration insurance provides an additional choice for many consumers that exists side-by-side with individual market coverage").

The Departments may now disagree with the statutory scheme that Congress created, but they are "not free to substitute new goals in place of the statutory objectives without explaining how these actions are consistent with [their] authority under the statute." *Indep. U.S. Tanker Owners Comm. v. Dole*, 809 F.2d 847, 854 (D.C. Cir. 1987).

The Departments compounded their error by "'fail[ing] to consider an important aspect of the problem'" that Congress tasked them to address. *Sierra Club*, 878 F.3d at 325 (quoting *State Farm*, 463 U.S. at 43). As discussed above, Congress's goal in enacting Title I of the ACA was to create an individual insurance market through the enactment of several inter-related measures that would work "together" to "lower health insurance premiums," 42 U.S.C. § 18091(2)(F), and minimize "adverse selection and broaden the health insurance risk pool to include healthy individuals." *Id*. § 18091(2)(I).

The Departments disregarded these statutory goals. As the Departments themselves acknowledged, the STLDI rule will not assist in achieving the statutory purposes, but instead will shrink the health insurance risk pool and increase health insurance premiums for ACA-compliant plans. 83 Fed. Reg. at 38,217. By the Departments' own estimate, the STLDI Rule will cause enrollment in individual market plans to decrease by 1.3 million, and premiums for such plans to increase by 5%, by 2028. 83 Fed. Reg. at 38,236. This likely is a drastic understatement of the Rule's real effect; as discussed above, independent experts estimate that ACA enrollment will decrease by 8.2-15%. *See* page 11, *supra*; *see also* Urban Institute, *Updated: The Potential Impact of Short-Term Limited-Duration Policies on Insurance Coverage, Premiums, and Federal Spending*, 2 (Mar. 2018). Even the Departments' own estimate, however, shows that they not only disregarded Congress's declared goals to lower premiums and broaden the risk pool in the individual insurance market, but that they directly chose to flout Congress' design by

undermining the individual insurance market so as to create a parallel, "side-by-side" market that would operate outside the ACA.

In sum, the Rule's purpose and effect of subverting the individual health insurance system that Congress enacted in the ACA renders the Rule contrary to law and arbitrary and capricious.

B. The Departments' Interpretation Of "Short Term" To Include Plans That Are 99.97% As Long As Standard Insurance Plans Is Contrary To Law.

Against this background, it is unsurprising that the Departments' efforts to shoehorn their inconsistent policy goals into the term "short-term limited duration insurance" as used in HIPAA and the ACA also is contrary to the plain meaning of the statutory text. As noted above, it is a "fundamental canon of statutory construction that the words of a statute must be read in their context and with a view to their place in the overall statutory scheme." *Brown & Williamson Tobacco Corp.*, 529 U.S. at 133; *see also Beecham v. United States*, 511 U.S. 368, 372 (1994) ("The plain meaning that [courts] seek to discern is the plain meaning of the whole statute, not of isolated sentences."). "A statutory provision that may seem ambiguous in isolation is often clarified by the remainder of the statutory scheme . . . because only one of the permissible meanings produces a substantive effect that is compatible with the rest of the law." *Util. Air*, 134 S. Ct. at 2442 (quotation marks and ellipsis omitted). Here, the text, purpose, and context of Congress's use of the term "short term limited duration insurance" all demonstrate that "short term" does not mean a period that is virtually equivalent to the term of a standard annual health insurance plan. Accordingly, the Department's interpretation of that term must be set aside as contrary to law. *See, e.g., Am. Fed'n of Labor & Congress of Indus. Orgs. v. Fed. Election Comm'n*, 177 F. Supp. 2d 48, 55 (D.D.C. 2001); *Am. Bankers Ass'n v. Nat'l Credit Union Admin.*, 271 F.3d 262, 267 (D.C. Cir. 2001).

1. The Departments' Interpretation Of "Short Term" Is Contrary To The Statutory Text.

The plain meaning of the term "short-term" is unambiguous: it means "occurring over or involving a relatively short period of time." *Short-term*, Merriam-Webster Dictionary, perma.cc/4ZCF-QPLQ. As that definition makes clear, the term is relative. And here, the relevant benchmark is the length of a standard health insurance plan: one year. *See, e.g.,* 42 U.S.C. 13031 (requiring American Health Benefit Exchanges to provide for "annual open enrollment periods"); *Definition of Health Insurance Terms*, Bureau of Labor Statistics, perma.cc/T3MF-SFBU (noting that a benefit period is "usually a year"); *Glossary of Health Insurance Terms*, Med. Mut., perma.cc/H4WX-VCPR (defining "benefit period" and explaining that "[i]t is often one calendar year for health insurance plans"); *Plan Year*, HealthCare.gov, perma.cc/CV6L-QQAU (defining "plan year" as a "12-month period of benefits coverage under a group health plan").

A "short-term" insurance plan, then, is one that involves a "relatively short period of time" as compared to one year. And a term just a day short of one year—*i.e.* more than 99.97% of the length of a standard term of health insurance—cannot in any meaningful sense of the word be considered "relatively short."

2. The Departments' Interpretation Is Contrary To The Congressional Purpose And Statutory Context Of HIPAA.

Congress's purpose in defining "individual health insurance coverage" to exclude "short-term limited duration insurance," as well those terms' place within the overall HIPAA and ACA schemes, confirm that "short term" means what it says—and does not mean anything close to a year.

a. Congress enacted HIPAA to increase access to and portability of health insurance coverage for individuals and their families so that they could retain their health insurance when they changed or lost their jobs. *See, e.g.,* S. Rep. No. 104-156, at 1 (HIPAA was intended to

"mak[e] it easier for people who change jobs or lose their jobs to maintain adequate coverage"). In particular, Congress was concerned with the large number of Americans who were "at risk of becoming uninsured or subject to preexisting condition exclusions under the current system because they change jobs, lose jobs, or work for employers who change insurance policies." *See id.* at 4. Congress was also concerned with the increasing costs faced by high-risk, high-cost individuals caused by "increasing segmentation of the private insurance market" and "reduc[tion of] the pool of firms seeking coverage . . . in the community-rated market." *Id.* These problems were aggravated in the individual market because "[m]ost individual insurance policies impose pre-existing condition exclusions or limitations; individuals with chronic health conditions may be entirely denied coverage." H.R. Rep. No. 104-496, at 71 (1996); *see also* S. Rep. No. 104-156, at 7.

Accordingly, HIPAA was "designed to curtail the most common abuses in the current system by requiring health plans to compete based on quality, price, service, and efficiency, instead of refusing to offer coverage to those who are in poor health and who need coverage the most." S. Rep. No. 104-156, at 13. With respect to the individual market, Congress sought to ensure that individuals who previously had insurance through a group health insurance plan could maintain adequate coverage if they lost, left, or changed their jobs. *Id.* at 2, 4. It did this by (1) prohibiting issuers that offer health insurance coverage in the individual market from declining to offer such coverage, deny enrollment to, or impose any preexisting condition exclusion to someone who previously had 18 months of continuous health coverage under a group health plan (subject to certain limitations) (Pub. L. 104-191, § 111, 110 Stat. 1979); and (2) requiring such issuers to renew individual health insurance coverage at the option of the individual, *id.*, 110 Stat. 1982. These requirements apply to issuers offering "individual health

insurance coverage," which Congress defined to mean *all* "health insurance coverage offered to individuals in the individual market" *except* for "short-term limited duration insurance." *Id.* § 102, 110 Stat. 1973 (codified at 42 U.S.C. § 300gg-91).

As the overall statutory context and legislative background make clear, Congress's purpose was to protect individuals with preexisting conditions and other high risk factors. Such individuals who lost their group health insurance would be able to obtain coverage (including coverage for those pre-existing conditions) in the individual market. And once an individual had coverage in the individual market, they would be able to renew and keep that insurance, even if their health condition worsened, new conditions developed, or new risk factors emerged.

When "short term" is interpreted in accordance with its plain meaning, the exception for "short-term limited duration coverage" is consistent with HIPAA's purposes. The market in which people typically obtained health insurance still would be regulated to protect people with preexisting conditions. Those regulations would not apply to STLDI plans, types of insurance that were not intended to serve people in an ongoing fashion and where the ability to obtain coverage or maintain that coverage into the future need not be regulated by Congress.

But interpreting "short term" to include virtual equivalents of a standard, annual insurance plan (as the Departments have in the STLDI Rule) frustrates this purpose. It creates a new market segment where individuals with pre-existing conditions are entirely unprotected. These individuals may not be able to access such coverage, and they may lose such coverage once they have it if their health changes or new conditions emerge—the exact problems that Congress sought to remedy in enacting HIPAA.

b. Even if Congress had left open under HIPAA whether "short-term" could encompass plans that are one day shorter than standard annual plans, it unquestionably foreclosed such an

interpretation through the enactment of the ACA. For one thing, the text of the ACA removes any doubt that "short-term," as used in "short-term limited duration coverage," has a meaning consistent with its plain meaning—*i.e.*, a period that is relatively shorter than the typical 12-month standard insurance plans. In the ACA, Congress referred to a "short coverage gap[]," which would be exempt from the ACA's penalty for failure to maintain minimum essential coverage. 26 U.S.C. § 5000A(e)(4). And Congress expressly defined a "short coverage gap[]" as a "period of less than 3 months." *Id.* § 5000A(e)(4)(A).

Congress surely intended that definition of "short"—as meaning a "period of less than 3 months"—to apply to the same word as used in the phrase "short-term limited duration coverage" (as incorporated by reference in the ACA). "A standard principle of statutory construction provides that identical words and phrases within the same statute should normally be given the same meaning." *Powerex Corp. v. Relian Energy Servs., Inc.*, 551 U.S. 224, 232 (2007). This canon applies with special force here given the common policy judgment underlying the "short coverage gaps" and "short-term limited duration coverage" provisions and the fact that the two provisions complement each other. By exempting from the ACA's penalty "short coverage gaps" of less than three months, Congress expressed its judgment that individuals should not have coverage that falls outside the minimum essential coverage requirements for longer than three months. Construing "short-term limited duration coverage," which does ***not*** have to comply with the minimum essential coverage requirements, as including plans that are much longer than three months is irreconcilable that congressional judgment. *See also* 42 U.S.C. § 300gg-7 (providing that "[a] group health plan and a health insurance issuer offering group health insurance coverage shall not apply any waiting period . . . that exceeds 90 days").

In contrast, there is ***no*** indication that Congress regarded "short term" plans as suitable for satisfying individuals' primary and permanent health insurance needs—a reading, as noted above, that would run counter to the ACA's central goals. It is hardly likely that Congress would have used the phrase "short-term" as a counter-intuitive mechanism for circumventing the ACA's principal objective.

C. Interpreting "Limited Duration" To Encompass Plans That Can Be Renewed For A Total Of 36 Months Is Contrary To Law.

The Department's interpretation of "limited duration" to permit insurance plan renewals of up to three years—with the possibility that, at the time of purchase, these contracts could be stacked on end to give them an even longer effective life—is likewise contrary to law. The plain meaning of the statutory text is that short term limited duration insurance is a one-time, non-renewable coverage option. "Limited" means "[r]estricted in size, amount, or extent." *Limited*, Oxford English Dictionary, perma.cc/P9ZB-LVJH. A contract that may be automatically renewed is, by definition, not restricted to its original term; thus, the STLDI Rule departs from the plain meaning of the statutory language. This conclusion is bolstered by the fact that the States that have legislated on the topic of STLDI plans refer to such coverage as non-renewable, or renewable only for a very short period."[33]

A contrary interpretation, would also run afoul of Congress's specification that short term limited duration insurance be "short term." It does not make sense to believe that Congress would limit the term of individual plans to a period relatively shorter than a year (say, 3 months),

[33] *See, e.g.*, 1994 Minn. Laws 556; 1995 N.H. S.B. 30; 1995 Or. S.B. 152; 1995 Ind. S.B. 576; 1995 Mo. S.B. 27; 1995 Tenn. H.B. 1213; 1996 Fla. S.B. 910; 1996 Va. H.B. 1026; 1998 Mich. S.B. 1007; Nev. Admin. Code § 689A.434 (1997); 28 Tex. Admin. Code § 3.3002 (1997); 1998 Colo. H.B. 1053; 2002 Cal. H.B. 424; 2002 Ga. H.B. 1100; 2002 Utah S.B. 122; S.D. Admin. R. 20:06:39:32 (2003); 2009 Wis. S.B. 27; 2013 Kan. H.B. 2107.

but allow these plans to be renewed repeatedly so that their effective duration is that of full-time, conventional (renewable) annual plans.

And such an interpretation of limited duration would be inconsistent with Congress's intent for the same reasons that doom the Departments' interpretation of "short-term." Permitting individuals to extend or renew short term limited duration insurance for up to three years further dismantles barriers to healthy individuals leaving the ACA-compliant individual coverage market and purchasing STLDI instead. As explained above (*supra* at page 20), this will have the impermissible effect of undermining Congress's policy to create a single risk pool that enables all individuals to obtain to affordable, quality health insurance.

D. The STLDI Rule Is Arbitrary And Capricious.

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

Here, the Departments' decisionmaking process was riddled with deficiencies, for all of these reasons.

1. In promulgating the Rule, the Departments departed from prior, well-reasoned interpretations of "short-term limited duration insurance"—including over two decades of settled law regarding the meaning of "limited duration. And they did so without providing the required reasoned explanation.

Since the 1990s, the Departments have interpreted "limited duration" plans to be limited to the maximum permissible *initial* plan term. *See* 62 Fed. Reg. 16,894 (Apr. 8, 1997). In 2016, the Departments reaffirmed that the maximum period of coverage for short-term limited duration insurance may not be enlarged through extensions. They felt the need to do this in light of evidence, detailed in the rulemaking, that "short-term, limited duration [insurance] is being sold in situations other than those that the exception from the definition of individual health insurance coverage was initially intended to address." 81 Fed. Reg. 75,316, 75,317 (Oct. 31, 2016); *see id.* at 75,317-18 & n.16. Specifically, "individuals [were] purchasing this coverage as their primary form of health coverage," and "some insurers [were] providing renewals of the coverage that extend the duration beyond 12 months." *Id.* 75,318. This, the Departments explained, resulted in individuals not receiving meaningful health coverage (as intended by the ACA) and "adversely impact[ed] the risk pool for Affordable Care Act-compliant coverage" because STLDI policies could discriminate based on health status and target healthier individuals. *Id.* 75,317-18.

In the new STLDI Rule, the Departments do not dispute any of the facts underlying their previous analysis and conclusion. To the contrary, they ***confirm*** them. *See, e.g.,* 83 Fed. Reg. at 38,231, 38,233-36. The Departments now simply claim that it is desirable to make STLDI "an additional choice for many consumers that exists side-by-side with individual market coverage."

Id. at 38,218; *see also id.* at 38,222, 38,228, 38,229. But as explained above, making STLDI plans an attractive option for individuals' primary insurance is inconsistent with the ACA and therefore not a permissible basis for justifying the Rule. Moreover, the Departments fail to even acknowledge that they had previously concluded that this outcome was incompatible with the ACA. 81 Fed. Reg. at 75,317-18. Such a disregard for that previous conclusion is arbitrary and capricious. *FCC v. Fox Television Stations, Inc.*, 556 U.S. 502, 515 (2009).

Nor are the other bases cited for the new interpretation of "limited duration" "good reasons for the new policy." *Id.* The Departments attempted to justify their new interpretation by pointing to the fact that Congress did not address STLDI plans in the ACA. 83 Fed. Reg. at 38,220. But that is hardly a basis for disregarding the Departments' own prior contrary conclusion, which of course post-dated enactment of the ACA.

The Departments also noted that COBRA coverage (which requires certain group health plans to extend coverage to individuals who would otherwise lose that coverage) can last up to 36 months in some circumstances. 83 Fed. Reg. at 38,221. But COBRA coverage is not expressly constrained to be of "limited duration." In any event, that coverage complies with the ACA's requirements and keeps the covered individual in the group coverage risk pool, whereas STLDIs do not. Accordingly, extended COBRA coverage does not pose the same threats to Congress's policies as do STLDI plans.

2. The Departments' departure from their 2016 Rule is flawed for an additional reason. As noted above, the ACA mandates an open enrollment period for individuals who lose minimum essential coverage mid-year. But an STLDI plan qualifies neither as minimum essential coverage nor as a plan in the individual insurance market. 26 C.F.R. § 1.5000A-2(d)(1). As a consequence, an individual who enrolls in ACA-compliant coverage and must change plans

will be guaranteed a seamless continuation of coverage; an individual who enrolls in an STLDI plan will not, running the risk of losing his or her eligibility to enroll in full coverage even if he or she later develops an illness or condition that requires costly treatment.

This risk is minimized, however, if STLDI plans are limited to three months or less. Under HHS's regulations, the special enrollment period for the loss of minimum essential coverage lasts for 60 days, and new coverage will begin the month after enrollment. 45 C.F.R. § 155.420(b)(2)(iv), (c)(1). A short-term plan of up to three months, then, may cover an individual's gap during this time between the termination of coverage under one ACA-compliant plan and the beginning of coverage under another.

It was, in part, for this reason that the Departments acted in their 2016 rule to limit STLDI plans to a period of no longer than three months. At that time, the Departments explained that "[s]hort-term, limited duration insurance allows for coverage to fill temporary coverage gaps when an individual transitions between sources of primary coverage." 81 Fed. Reg. at 75,316, 75,318 (Oct. 31, 2016). In contrast, "for longer gaps in coverage, guaranteed availability of coverage and special enrollment period requirements in the individual health insurance market under the Affordable Care Act ensure that individuals can purchase individual market coverage through or outside of the Exchange that is minimum essential coverage and includes the consumer protections of the Affordable Care Act." *Id.*

The new STLDI Rule threatens to upset this balance by permitting "short-term" plans to last for longer than three months. Enrollees in these plans will lose their eligibility for enrollment in ACA-compliant plans after the special enrollment period for a gap in comprehensive coverage expires. This runs contrary to Congress's central purpose in providing special enrollment periods for Exchange plans, which, as even HHS itself has recently acknowledged, was to provide a

safeguard to preserve the ACA's promise of guaranteed coverage: "In the individual market, … special enrollment periods are intended, in part, to promote continuous enrollment in health coverage during the benefit year by allowing those who were previously enrolled in coverage to obtain new coverage without a lapse or gap in coverage." 82 Fed. Reg. 18,346, 18,355 (Apr. 18, 2017).

A number of commenters noted this concern during the rulemaking proceedings. As one commenter, Community Catalyst, described the issue:

> Moreover, consumers could be left with uncovered bills and/or find themselves "uninsurable." Because insurers can deny a new contract if the enrollee becomes sick or injured during the coverage term, consumers may believe they can extend or renew coverage until rejected by the issuer. If their short-term plan ends before marketplace open enrollment, their loss of coverage would not qualify for a special enrollment period, leaving a consumer to wait until the next annual open enrollment period to select a new plan. This will lead to a gap in coverage for many consumers.

Comment of Community Catalyst, p. 4. *See also* Comment of Young Invincible, p. 7; Comment of Centene Corporation, p. 2; Comment of U.S. PIRG, p. 2.

In promulgating the STLDI Rule, the Departments acknowledged the submission of these comments, *see* 83 Fed. Reg. at 38,217, but they provided no response beyond that acknowledgement and no indication why they believed it appropriate to encourage a market for STLDI plans when the inevitable result would be that many individuals would be locked out of access to needed comprehensive coverage. This is the hallmark of arbitrary decisionmaking, for two reasons.

First, the Departments failed even to acknowledge, let alone grapple with, this important aspect of their own decision making the last time they confronted this topic in 2016. By failing to "provide an adequate explanation for [their] departure from" their own recent analysis of the

issue, the Departments fell short of the APA's requirements. *Dillmon v. Nat'l Transp. Safety Bd.*, 588 F.3d 1085, 1089--90 (D.C. Cir. 2009). *See also Fox Television Stations*, 556 U.S. at 515.

Second, the Departments' failure to meaningfully engage with commenters who raised this issue was arbitrary. Although an agency "need not address every comment" made during the notice and comment period, "it must respond in a reasoned manner to those that raise significant problems." *City of Waukesha v. EPA*, 320 F.3d 228, 257 (D.C. Cir. 2003) (quoting *Reytblatt v. Nuclear Regulatory Comm'n*, 105 F.3d 715, 722 (D.C. Cir. 1997)). Significant comments are those "which, if true, raise points relevant to the agency's decision and which, if adopted, would require a change in an agency's proposed rule." *City of Portland v. EPA*, 507 F.3d 706, 715 (D.C. Cir. 2007). Under this standard, Community Catalyst and others plainly raised significant comments, as they present powerful grounds for the Departments not to depart from the prior rule limiting short-term plans to three months. The Departments, however, simply "refused to engage with" the commenters' concerns, *Delaware Dep't of Nat. Res. & Envtl. Control v. EPA*, 785 F.3d 1, 15 (D.C. Cir. 2015), and so acted arbitrarily.

* * * *

For all of these reasons, the STLDI Rule was an abuse of administrative authority: "the [Departments'] rule was an act of amendment, not interpretation. Accordingly, [the Departments] ha[ve] no colorable claim to *Chevron* deference." *Central United Life*, 827 F.3d at 74. In this setting, plaintiffs are likely to succeed on the merits of their challenge.

II. PLAINTIFFS AND THEIR MEMBERS WILL SUFFER IRREPARABLE HARM ABSENT AN INJUNCTION.

The second requirement for a preliminary injunction, "'likely irreparable harm in the absence of preliminary relief," *League of Women Voters of U.S. v. Newby*, 838 F.3d 1, 6 (D.C. Cir. 2016) (quotation omitted), is also met here. To satisfy this factor, "the harm must be 'certain

and great,' 'actual and not theoretical,' 'and so imminen[t] that there is a clear and present need for equitable relief to prevent irreparable harm.'" *Id.* at 7--8 (quoting *Chaplaincy of Full Gospel Churches v. England*, 454 F.3d 290, 297 (D.C. Cir. 2006)). But "[a]s a preliminary injunction requires only a ***likelihood*** of irreparable injury, Damocles's sword does not have to actually fall on [plaintiffs] before the court will issue an injunction." *Id.* at 8-9 (emphasis added) (internal citation omitted). Finally, the harm must also be "beyond remediation." *Id.* at 8 (internal quotation marks omitted).

Plaintiffs, who perform discrete roles and have varying interests in the healthcare system, satisfy these requirements in several independent ways. We address each in turn.

A. Insurer Plaintiffs

First, Plaintiff ACAP's member insurers[34] will be irreparably injured as newly legalized longer STLDI plans siphon off their policyholders, and potential new customers, during the upcoming ACA open enrollment period. ACAP's members are not-for-profit safety net health plans serving low-income communities; many of ACAP's members offer ACA-compliant insurance plans. Murray Decl. ¶ 3. For example, Community Health Choice, Inc., one of ACAP's members, currently serves approximately 110,000 Houston-area customers through its ACA-compliant plans. *Id.* ¶ 11; Janda Decl. ¶ 6.

If the STLDI Rule goes into effect on October 2, many of those customers will leave their current plans during open enrollment in favor of an STLDI plan. The Wakely Consulting Group, a leading actuarial firm, projects that the STLDI Rule will cause between 1 million and 1.9 million people to leave ACA-compliant individual enrollment plans in the near term (four to five years). Murray Decl. Ex. B, at 2. Estimates from other studies range as high as 4.3 million

[34] As a membership organization with associational standing, ACAP may assert irreparable harm on behalf of its members in seeking a preliminary injunction. *See, e.g.*, *AARP v. EEOC*, 226 F. Supp. 3d 7, 23 (D.D.C. 2016) (noting association plaintiff's "burden to demonstrate that its members will suffer irreparable harm from" the challenged agency action).

STLDI enrollees in 2019 alone.[35] Even the government estimates that enrollment in ACA-compliant plans will decrease by 200,000 people in 2019, and that enrollment will be down by 1.3 million by 2028. 83 Fed. Reg. at 38,236. Moreover, because ACAP's members serve low-income communities, its plans will likely be hit harder than average by defections of price-conscious consumers. Murray Decl. ¶ 8. Community Health Choice alone expects to lose up to 10,000 current members from its Marketplace plans if the STLDI rule takes effect, corresponding to a loss of $50 million to $100 million in revenue. Janda Decl. ¶ 11.

This competitive harm to ACAP members' business constitutes irreparable injury justifying issuance of a preliminary injunction. As the D.C. Circuit has explained, "economic actors suffer an injury in fact when agencies lift regulatory restrictions on their competitors or otherwise allow increased competition against them." *Sherley v. Sebelius*, 610 F.3d 69, 72 (D.C. Cir. 2010) (internal quotation marks omitted; alterations adopted). Here, even the agencies agree that their rule will cause hundreds of thousands of people to leave ACA-compliant plans (83 Fed. Reg. at 38,236); they therefore cannot be heard to argue that competitive harm to ACAP members is not sufficiently "certain," or "actual [rather than] theoretical." *League of Women Voters*, 838 F.3d at 8. And that harm is self-evidently "great" where one ACAP member alone stands to lose between $50 million and $100 million in revenue. Janda Decl. ¶ 11.

Importantly, the ACAP plaintiffs' harm need not satisfy the higher standard of magnitude sometimes required to find that ***recoverable*** economic loss is irreparable. *See, e.g.*, *Wisc. Gas Co. v. FERC*, 758 F.2d 669, 674 (D.C. Cir. 1985) ("Recoverable monetary loss may constitute irreparable harm only where the loss threatens the very existence of the movant's business."). This is because ACAP members' loss in the absence of an injunction will be *un*recoverable. As this Court has explained:

[E]ven if the claimed economic injury did not threaten plaintiff's viability, it is

[35] Comment of the National Partnership for Women & Families, at 6 (April 23, 2018), goo.gl/krFSzd.

> still irreparable because plaintiffs cannot recover money damages against FDA. Where a plaintiff cannot recover damages from an agency because the agency has sovereign immunity, "any loss of income suffered by [the] plaintiff is irreparable *per se*."

Smoking Everywhere, Inc. v. FDA, 680 F. Supp. 2d 62, 77 n.19 (D.D.C. 2010) (Leon, J.), *aff'd sub nom. Sottera, Inc. v. FDA*, 627 F.3d 891 (D.C. Cir. 2010) (quoting *Feinerman v. Bernardi*, 558 F. Supp. 2d 36, 51 (D.D.C. 2008)). Just so here: Although ACAP members' losses will be directly attributable to the STLDI Rule, they will have no ability to recoup those losses from the government once the rule takes effect. *See id.* (noting that "[a]bsent a waiver, sovereign immunity shields the federal government and its agencies . . . from suit," and that the APA "waives sovereign immunity for federal agencies but only in actions 'seeking relief other than money damages'") (quoting 5 U.S.C. § 702). For the same reasons, the harm to ACAP members' businesses is "beyond remediation." *League of Women Voters*, 838 F.3d at 8 (internal quotation marks omitted).

Finally, that the open enrollment period for 2019 is only weeks away renders harm "so imminen[t] that there is a clear and present need for equitable relief." *League of Women Voters*, 838 F.3d at 8 (quotation omitted). Absent a qualifying life event for a particular individual, open enrollment is the only opportunity each year for customers to consider their health insurance options and select a plan for the year ahead. *See* 45 C.F.R. § 155.410(a)(2). Once open enrollment takes place and thousands of current ACA-compliant plan customers have been locked into contracts with STLDI providers, there will be no way to un-ring that bell; those customers will be gone for the 2019 plan year at the very least. Open enrollment begins on November 1, 2018 and ends on December 15, 2018, for the federal marketplace. A preliminary injunction is therefore critical to preserve the insurance markets as they were before the issuance of the STLDI Rule. *See Aamer v. Obama*, 742 F.3d 1023, 1043 (D.C. Cir. 2014) ("The primary purpose of a preliminary injunction is to preserve the object of the controversy in its then existing condition—to preserve the status quo.") (internal quotation marks omitted).

B. Provider Plaintiffs

Next, several of the plaintiffs are organizations whose members provide healthcare services, including to individuals with ACA-compliant insurance coverage, and who will therefore be injured by the STLDI Rule.

The American Psychiatric Association (APA), for example, is the national professional association for psychiatrists, medical doctors who specialize in the treatment of mental health and substance use disorders. STLDI plans frequently do not cover mental health services, and most do not cover substance abuse treatment.[36] Individuals who purchase those plans and subsequently need such services, something that happens with considerable frequency to young people, will find themselves unable to pay for them—putting psychiatrists in the position of either refusing service or providing uncompensated care. Brandt Decl. ¶ 6; Kolodner Decl. ¶ 12.

In addition, as healthy patients are diverted from ACA-compliant plans, the cost for those plans will rise. This will certainly lead to an increase in premiums that many patients of APA's members will not be able to afford. When existing patients lose coverage and can no longer pay for their care the physician is ethically obligated to continue to provide essential treatment until the patent is transitioned to another provider. Kolodner Decl.¶ 5. But lower-cost STLDI plans will not provide the level of coverage needed for treatment of many mental health and/or substance use disorder patients, meaning that there will be no provider to whom the patient can transition. Kolodner Decl. ¶ 12. Moreover, as costs to ACA plan issuers increase because the patient population is less healthy, plans will institute cost-reduction practices, including prior authorization requirements for basic services, more frequent auditing, and more stringent medical necessity standards. Kolodner Decl. ¶ 14. Such measures increase the amount of uncompensated time the psychiatrist must spend on each patient to ensure their care is covered,

[36] Karen Pollitz et al., *Issue Brief: Understanding Short-Term Limited Duration Health Insurance*, Kaiser Family Foundation (Apr. 23, 2018), perma.cc/2K7N-4XWA; *see also, e.g.*, Kimball Decl. ¶ 6.

thereby reducing the amount of time the psychiatrist has to see other patients, further straining access to an already underserved specialty, and reducing the income of the providers. *Id.*

When similar measures were imposed in the past, psychiatrists could not afford the income loss, and many psychiatrists opted out of insurance plans altogether, choosing instead to operate on a cash-only basis. *Id.* The STLDI Rule will likely put psychiatrists to the same choice: significant reductions in income due to uninsured patients and increased uncompensated administrative time for insured patients, or movement to a cash-only operation. *Id.* But many of APA members' current patients on Marketplace plans would be unable to pay out of pocket for treatment. And critically, the profession's ethical rules would likely require a psychiatrist who stops accepting insurance to continue treating his or her current patients (despite the fact that they are unable to pay) until they can be transitioned to a new doctor—a task that will grow increasingly difficult as more and more psychiatrists make the same move to cash-only practices. *Id.*

Thus, psychiatrists will be concretely, monetarily injured by the STLDI Rule no matter which choice they make. And like those of the insurers discussed above, the losses to these psychiatrists will be beyond remediation, and therefore constitute irrevocable harm.

Similarly, organizations that provide healthcare services to patients with pre-existing conditions—like the member organizations of plaintiff AIDS United (*See* Milan Decl. ¶ 9)—will be forced to provide increased uncompensated care as a result of the STLDI Rule. These populations by definition will be excluded from STLDI plans; individuals with HIV/AIDS are exactly the kind of patients who insurers will discriminate against or exclude, given the chance. *Id.* ¶¶ 5-6. HIV/AIDS patients will therefore be left behind in Marketplace plans facing the full brunt of the rise in premiums; many individuals will be unable to pay those premiums, and will drop their coverage entirely. Their healthcare providers will either have to continue treating them for free, or to refuse treatment. Either way, those providers are harmed, and are left with no remedy at law for their injury.

Finally, organizations like plaintiff Mental Health America (MHA)'s affiliates, which provide rehabilitation, socialization, and housing services to individuals with mental illness (another pre-existing condition), will be harmed programmatically by the STLDI Rule. *See* Howard Decl. ¶ 8. In this sense, "[a]n organization is harmed if the actions taken by the defendant have perceptibly impaired the organization's programs," and "the defendant's actions directly conflict with the organization's mission." *League of Women Voters*, 838 F.3d at 8 (internal quotation marks omitted; alterations incorporated).

As individuals with mental illness are priced out of increasingly expensive ACA-compliant Marketplace plans and their conditions are therefore left untreated, more and more people will come to need the rehabilitation, housing, and other services offered by MHA associate organizations. With limited budgets, MHA associates will be forced to either divert resources from other efforts to fund expansions of these programs or let these individuals' needs go unmet, in contravention of MHA's mission. Howard Decl. ¶¶ 3, 8. Their programs will thus be "perceptibly impaired." *League of Women Voters*, 838 F.3d at 8; *cf. People for the Ethical Treatment of Animals v. USDA*, 797 F.3d 1087, 1093 (D.C. Cir. 2015) ("[A] 'concrete and demonstrable injury to [an] organization's activities—with the consequent drain on the organization's resources—constitutes far more than simply a setback to the organization's abstract social interests' and thus suffices for standing.") (quoting *Havens Realty Corp. v. Coleman*, 455 U.S. 363, 379 (1982)). Again, absent an injunction, there is no remedy for these harms.

C. Consumer Plaintiffs

Finally, the STLDI Rule will also cause harm to plaintiffs representing consumers of healthcare. For example, some of AIDS United's members are organizations of individuals living with HIV/AIDS. Milan Decl. ¶ 8. The harm that will befall these individuals is by now familiar: They will be left behind in Marketplace plans that provide the benefits and protections that the ACA guarantees with no choice but to pay the increasing premiums—estimated at 2.2% to 6.6%

(*see* Murray Decl. Ex. B at 2)—because cheaper STLDI plans with pre-existing condition bars will not accept them. *See, e.g.*, Milan Decl. ¶¶ 5-6. The resulting economic loss constitutes irreparable harm, as these individuals will lack a remedy at law. *Smoking Everywhere*, 680 F. Supp. 2d at 77 n.19. What is more, some people will likely be unable to afford the increase at all, and will be forced to forgo lifesaving treatment—surely an irreparable injury.

The families represented by plaintiff Little Lobbyists—families with children who have complex pre-existing conditions—face the same irreparable harms. *See* Hung Decl. ¶¶ 5-9. So do the individuals with mental illness represented by plaintiff National Alliance on Mental Health. *See* Kimball Decl. ¶¶ 6-8. Indeed, individuals with mental illness are doubly at risk, because serious mental illness most often shows its first signs during adolescence or early adulthood—and young, otherwise healthy people are exactly those who are most likely to leave Marketplace coverage for STLDI plans. *Id.* ¶ 6; Kolodner Decl. ¶ 5; Fassler Decl. ¶ 5. Thus, an outwardly healthy young adult could easily sign up for an STLDI plan, not knowing that he or she will be diagnosed with mental illness—which the STLDI plan either does not cover or covers with a low dollar cap—in the next 364 days. Such a situation is likely to lead to serious harm, as early intervention and consistent treatment are key to successful mental health outcomes. Fassler Decl. ¶ 5; Kimball Decl. ¶ 7; Howard Decl. ¶ 3. Similarly, the women for whom the National Partnership for Women and Families advocates may purchase STLDI plans and find themselves without coverage for maternity care when they get pregnant. The lack of coverage for prenatal care, labor and delivery, and postpartum care for pregnant women and newborns could lead to significant consequences for both the health and economic wellbeing of women and their families. Like insurers and service providers, therefore, disadvantaged patient populations are certain to suffer irreparable injury absent a preliminary injunction.

III. THE BALANCE OF EQUITIES AND THE PUBLIC INTEREST STRONGLY FAVOR AN INJUNCTION.

The remaining two factors for the issuance of a preliminary injunction—"a balance of the

equities in its favor, and accord with the public interest" (*League of Women Voters*, 838 F.3d at 6 (internal quotation marks omitted))—also weigh heavily in favor of relief here. The balance-of-equities factor requires courts to "balance the competing claims of injury and . . . consider the effect on each party of the granting or withholding of the requested relief." *Aracely, R. v. Nielsen*, 319 F. Supp. 3d 110, 156 (D.D.C. 2018) (quoting *Winter v. Nat. Res. Def. Council, Inc.*, 555 U.S. 7, 24 (2008)). Harm to interested third parties is also included in this calculation. *See League of Women Voters*, 838 F.3d at 12. Moreover, the balance of the equities and the public interest "merge into one factor when the government is the non-movant." *Aracely, R.*, 319 F. Supp. 3d at 156; *see also, e.g.*; *Pursuing Am.'s Greatness v. FEC*, 831 F.3d 500, 511 (D.C. Cir. 2016) ("[T]he government's interest *is* the public interest.") (citing *Nken v. Holder*, 556 U.S. 418, 435 (2009)).

As we have demonstrated, the harms to plaintiffs in the absence of a preliminary injunction will be severe. But the harm to the public interest will be even greater.

A. Individual Consumers Will Be Injured If The STLDI Rule Goes Into Effect.

To begin, countless consumers are likely to be deceived into purchasing STLDI plans, thinking that these plans offer more coverage than they actually do. STLDI and other ACA-noncompliant plans are frequently marketed as providing ACA-compliant or equivalent coverage—indeed, the Insurance Commissioners of multiple States have had to issue press releases warning consumers about such conduct.[37] As reported in comments submitted in

[37] *See, e.g.*, *Wyoming residents asked to be vigilant against health insurance callers*, KGWN News (Mar. 30, 2016) ("Wyoming Insurance Commissioner Tom Glause warns Wyoming consumers not to fall prey to high-pressure telemarketers selling short-term or limited benefit health insurance products that are not compliant with the Affordable Care Act (ACA), despite some company promises."), goo.gl/nj3RMT; Press Release, Iowa Ins. Div., *Consumer Alert: Final Tips as ACA Open Enrollment Period Ends December 15* (Dec. 12, 2017), goo.gl/XMnEic; Press Release, Pa. Ins. Dep't, *Acting Insurance Commissioner Alerts Consumers of Individual Health Plans Not Compliant with Affordable Care Act* (Nov. 8, 2017), perma.cc/E85K-B6U6; Press Release, Alaska Dep't of Commerce, Cmty. & Econ. Dev., *The Division of Insurance*

response to the Proposed Rule, sales agents will flat-out "contact an individual and tell them that the plan complies with the ACA when it does not."[38] In fact, HHS ***itself*** **—**including HHS Secretary Alex Azar—are touting the availability of STDI plans. Consumers would be forgiven for thinking that an STLDI plan is an adequate substitute for comprehensive coverage when the United States government agency whose mission it is "to enhance and protect the health and well-being of all Americans"[39] is telling them directly that STLDI "might be right" for them.

As a result, these consumers will be exposed to the exact range of abuses against which the ACA was designed to protect, including coverage exclusions, rescissions, and annual and lifetime benefit caps. Benefit caps mean that an STLDI consumer who experiences an accident or unexpected serious illness can end up paying thousands of dollars out of pocket—which is one thing if that consumer consciously chose to take that gamble, but quite another if the consumer expected to purchase a product comparable to comprehensive insurance.

Coverage exclusions are problematic for a similar reason: STLDI plans frequently do not cover services that healthy individuals may find that they need only after purchasing the plan. To take the most obvious example, one study found that ***no*** available STLDI plans cover maternity care.[40] But an entire nine-month pregnancy fits easily within a 364-day STLDI term, and consumers covered only by STLDI would therefore be looking at a choice between spending

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Cautions Alaskans that Short-Term Health Insurance is not ACA Compliant (Dec. 15, 2015), perma.cc/EKG5-KYGZ.

[38] Comment of Families USA, at 2 (Apr. 23, 2018), goo.gl/cmqcQA; *see also, e.g.*, Reed Abelson, *Without Obamacare Mandate, 'You Open the Floodgates' for Skimpy Health Plans*, N.Y. Times (Nov. 30, 2017), https://goo.gl/pCcqoG ("[S]ome brokers are deliberately promoting [STLDI] policies without pointing out that they do not meet the same levels of coverage of A.C.A. plans, said Scott Flanders, the chief executive of eHealth. 'They're selling the hell out of it,' he said.").

[39] *About HHS*, U.S. Dep't of Health & Human Servs., perma.cc/8ELQ-UPUG.

[40] Karen Pollitz et al., *Issue Brief: Understanding Short-Term Limited Duration Health Insurance*, Kaiser Family Foundation (Apr. 23, 2018), perma.cc/GX37-G7A6.

thousands of dollars out of pocket[41] or forgoing needed care. There are over six million pregnancies in the United States each year.[42]

Rescissions—retroactive cancellations of coverage—are likewise prohibited for Marketplace plans, but not for STLDI plans. One comment on the Proposed Rule reflects the story of an Illinois woman who suffered extreme vaginal bleeding, losing half her blood and requiring an emergency hysterectomy and a five-day hospital stay. Her short-term insurance provider refused to pay a cent of the resulting medical bills—which amounted to tens of thousands of dollars—claiming that her regular menstrual cycle constituted a pre-existing condition.[43] Similarly, a San Diego man had a heart attack and required a $900,000 triple-bypass surgery, but his STLDI plan refused to pay for it, arguing that he failed to disclose pre-existing medical conditions ***for which he had not been diagnosed***.[44] Exposing more people to such conduct is not in the public interest.

B. The STLDI Rule Will Injure The Health Care System As A Whole.

Moreover, the STLDI Rule puts at risk the stability of the entire individual insurance market established by the ACA. As explained above (at pages 18-21), skewing the risk pool for ACA-compliant insurance by drawing away healthy consumers will increase premiums for those plans, leading to a new wave of flight by the next-healthiest tier of consumers (as well as those who simply cannot afford the increase). This cyclical adverse selection mechanism may ultimately threaten the survival of the ACA's marketplaces themselves.

Even in the short term, though, the departure of healthy individuals from ACA-compliant plans is sure to raise premiums for those left behind. Healthy people pay their premiums but do

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[41] One study found that for even an uncomplicated pregnancy, commercial insurers paid over $18,000 on average for childbirth and newborn care. *The Cost of Having a Baby in the United States*, Truven Health Analytics (Jan. 2013), perma.cc/L3DY-LLDV.

[42] Sally C. Curtin et al., *NCHS Data Brief: Pregnancy Rates for U.S. Women Continue to Drop*, Nat'l Ctr. for Health Statistics (Dec. 2013), perma.cc/X2FJ-QU3N.

[43] Comment of EverThrive Illinois, at 2 (Apr. 23, 2018), goo.gl/j21Noe.

[44] *See* Abelson, *supra* n. 38.

not require much care, so they are profitable customers for insurance companies. If they leave ACA-compliant plans in large numbers, there is no doubt that premiums have to rise to pay for the care of the sicker people remaining in the risk pool.

Those participants in ACA-compliant plans ineligible for premium tax credits will have to bear the increased costs themselves. This injury alone—to millions of Americans[45]—demonstrates that the STLDI Rule will harm the public interest. Moreover, some of those customers will not be able to cover the increases, and will lose coverage altogether, opening themselves up to financial ruin from large medical bills or—worse—illness or even death due to lack of treatment.

And for the purchasers of ACA-compliant insurance who ***are*** eligible for premium tax credits under the ACA, the American taxpayer will foot the increased bill. This will be no small cost: By the government's admission, the STLDI Rule will increase the cost to the government of premium tax credits—which are paid for with every American's tax dollars—by $28.2 ***billion***. 38 Fed. Reg. at 38,236.

As discussed above, all of these harms are closely linked to the upcoming open enrollment period, which starts November 1, 2018. Open enrollment is generally the only time that existing consumers are able to shop around or switch plans; it is also the only time that currently uninsured individuals may purchase ACA-compliant plans. 45 C.F.R. § 155.410(a)(2).[46] Thus, if STLDI plans are available during open enrollment—as the Final Rule would allow—all the harms described above would be locked in for plan year 2019. Failure to enter a preliminary injunction before November 1 (and certainly, before open enrollment closes

[45] 11.8 million people signed up for ACA-compliant coverage during the 2018 open enrollment period. *See* Ctrs. for Medicare & Medicaid Servs., *Health Insurance Exchanges 2018 Open Enrollment Period Final Report* (Apr. 3, 2018), perma.cc/D6Z6-ECRD.

[46] Firms planning to offer STLDI plans obviously know this; it has been reported that "the companies that sell [STLDI plans] are already gearing up to use the six-week open enrollment period . . . as a focal point for their own, often aggressive marketing efforts." Sarah Lueck, *Key Flaws of Short-Term Health Plans Pose Risks to Consumers*, Center for Policy & Budget Priorities (Sept. 20, 2018), perma.cc/5LAG-UK2D.

in December) therefore "would in fact upend the status quo." *Sherley v. Sebelius*, 644 F.3d 388, 398 (D.C. Cir. 2011); *see also, e.g.*, *Tyndale House Publishers, Inc. v. Sebelius*, 904 F. Supp. 2d 106, 130 (D.D.C. 2012) ("Because any of these consequences would result in a change in the *status quo*, the Court finds that the balance of equities tips in favor of [a preliminary injunction].") (internal citation omitted).

C. Enjoining Implementation Of The STLDI Rule Will Not Injure The Government.

On the other side of the ledger, a preliminary injunction will cause no harm to the government. The equities therefore favor plaintiffs, since "[w]here an injunction will 'not substantially injure other interested parties,' the balance of equities tips in the movant's favor." *Jacinto-Castanon de Nolasco v. ICE*, 319 F. Supp. 3d 491, 503 (D.D.C. 2018) (quoting *League of Women Voters*, 838 F.3d at 12).

First, the government has "no public interest in the perpetuation of unlawful agency action." *League of Women Voters*, 838 F.3d at 12. "To the contrary, there is a substantial public interest in having governmental agencies abide by the federal laws that govern their existence and operations." *Id.* (internal quotation marks omitted); *see also, e.g.*, *Damus v. Nielsen*, 313 F. Supp. 3d 317, 342 (D.D.C. 2018) ("As courts in this district have recognized, 'The public interest is served when administrative agencies comply with their obligations under the APA.'") (quoting *Northern Mariana Islands v. United States*, 686 F. Supp. 2d 7, 21 (D.D.C. 2009)). Because the STLDI Rule is contrary to the law and is arbitrary and capricious, enjoining it is in the public interest.

Second, the ***only*** effect on the government of a preliminary injunction would be to delay the STLDI Rule coming into effect. Apart from all the harms the rule would cause, even its ***proponents*** argued to the agencies that it should not take effect until 2020. Writing in support of the Proposed Rule, the National Association of Insurance Commissioners—a non-partisan group representing the chief insurance regulators of all 50 States, the District of Columbia, and all

federal territories—stated:

> [S]tates are concerned about the timing of this rule, and some states may want to modify existing laws and regulations to protect consumers and state markets. Therefore, we recommend that the final regulation allow states, if they so choose, to begin enforcing the new rules in 2020, thus giving them time to review their rules and seek statutory or regulatory changes to facilitate a smooth transition.[47]

The States' approach appropriately reflects the basic intuition that the STLDI Rule is a major policy shift in an extremely complicated area, and that rushing into such a change would not be in the public interest ***even if*** the rule were otherwise beneficial.

In short, a preliminary injunction would protect plaintiffs, consumers, and the public interest. The government can show no countervailing harm from injunctive relief, other than a delay in implementing its preferred policy. Plaintiffs have therefore "demonstrated that the balance of the equities tips in their favor," *League of Women Voters*, 838 F.3d at 12, and an injunction should issue.

CONCLUSION

The Court should grant Plaintiffs' Motion for a Preliminary Injunction.

[47] Comment of the National Association of Insurance Commissioners, at 2 (Apr. 23, 2018), goo.gl/BmVDFw.

Respectfully submitted,

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