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' OPPOSITION TO DEFENDANTS' MOTION FOR SUMMARY JUDGMENT

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INTRODUCTION

The government's two summary judgment arguments are mutually inconsistent. The government argues first that plaintiffs (including insurers) have no standing because they cannot show that they will be adversely affected by the STLDI Rule, and it then argues on the merits that it should prevail because (among other things) STLDI plans permissibly offer consumers alternatives to the ACA-compliant plans that plaintiffs sell. Both of these propositions cannot be right. In fact, both are wrong.

Although the government's standing arguments are incorrect for several reasons, one of those flaws is obvious and itself requires rejection of the government's standing claim: the insurer plaintiffs certainly may proceed under the doctrine of competitor standing. Under that doctrine—which has been endorsed and applied repeatedly by the D.C. Circuit—an increase in competition stemming from regulatory activity *per se* creates standing to challenge the responsible regulation. This case is a textbook example of such standing: the STLDI Rule not only will in fact prompt, ***but was designed for the express purpose of encouraging and facilitating***, new competition for plaintiffs' ACA-compliant plans.

As for the government's merits argument, we show in our opening brief and confirm in the argument below that the STLDI Rule departs from the language, structure, and express purpose of the ACA. For that reason, the Nation's leading physician, patient, and healthcare consumer associations all have filed again in this case, as they did at the preliminary injunction stage, to challenge the Rule's legality. As the American Medical Association (AMA) and other physician groups explain, "[t]he Rule is devastating to the health, well-being, and pocketbooks of millions of Americans"; "[o]ne need 'not express any opinion on the wisdom of the Affordable Care Act' to recognize that the 2018 STLDI Rule sabotages the ACA's crucial reforms." AMA Br. 5-6 (quoting *Nat'l Fed'n of Indep. Bus. v. Sebelius*, 567 U.S. 519, 588 (2012)). Whatever one

thinks of the ACA, it is not the role of administrative agencies to rewrite the statute, or to read it off the books. This Court should hold the STLDI Rule invalid.

I. PLAINTIFFS HAVE STANDING.

The government first attacks plaintiffs' standing to bring this lawsuit, spending page after page attempting to explain why the harms to businesses, doctors, and consumers caused by the STLDI Rule are too "speculative" or "conjectural" to support this Court's jurisdiction. *See* Defs.' Br. 11-26. We demonstrate below that this is not the case. But the most striking thing about the government's standing arguments is how little time the Departments spend even trying to rebut plaintiffs' ***primary*** standing contention: that ACAP's member insurers are authorized to sue under the competitor standing doctrine. *See id.* at 21-22 (devoting two pages to competitor standing in the government's 15-page insurer standing section). That choice is revealing, because if the competitor standing doctrine applies—which it does—all the government's protestations about attenuation of harm and chains of causation are completely beside the point. On examination, it is plain why the government seeks to avoid that subject: it has nothing to say.

A. ACAP has standing on behalf of its members.

As the government recognizes, ACAP has associational standing on behalf of its member insurers if "at least one of its members would have standing to sue in [its] own right." *E.g. Ctr. for Biological Diversity v. EPA*, 861 F.3d 174, 182 (D.C. Cir. 2017).[1] Here, Community Health Choice (CHC) and ACAP's other members providing ACA-compliant individual coverage easily satisfy Article III's requirements of injury-in-fact, causation, and redressability. *See, e.g.*, *Lujan v. Defs. of Wildlife*, 504 U.S. 555, 560-61 (1992).

[1] The government does not dispute that the other two requirements for associational standing are met here. *See Ctr. for Biological Diversity*, 861 F.3d at 182 (requiring that "the interest [the organization] seeks to protect is germane to its purpose" and that "neither the claim asserted nor the relief requested requires the member to participate in the lawsuit") (quotation marks omitted).

1. ACAP's members have standing under the competitor standing doctrine.

The government cannot dispute that under "[t]he doctrine of competitor standing . . . [,] 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) (quoting *La. Energy & Power Auth. v. FERC*, 141 F.3d 364, 367 (D.C. Cir. 1998)); *see also, e.g.*, *Associated Gas Distribs. v. FERC*, 899 F.2d 1250, 1258 (D.C. Cir. 1990) ("Those who must compete with allegedly illegal commercial transactions have Article III standing to challenge a regulatory order authorizing the transactions.").

Competitor standing obviates the need to prove the specific mechanism by which a plaintiff will be harmed: the doctrine recognizes that, although "[t]he form of [] injury may vary[,] . . . increased competition almost surely injures a seller in one form or another." *Sherley*, 610 F.3d at 72. In other words, the doctrine holds that an increase in competition is ***itself*** a cognizable injury, quite apart from any decreased sales that may result. *See Wash. All. of Tech. Workers v. DHS*, 892 F.3d 332, 341 (D.C. Cir. 2018) (the fact that the challenged "regulations allow increased competition against" the plaintiffs "is a concrete injury-in-fact") (quotation marks omitted); *see also id.* (the relevant "injury . . . is exposure to competition rather than lost sales, per se") (quotation marks omitted).

The government's arguments about alleged uncertainty caused by the presence of independent economic actors are therefore completely irrelevant to the competitor standing analysis. The ***only*** question for competitor standing purposes is whether the STLDI Rule will result in "an actual or imminent increase in competition, which increase ***we recognize*** will almost certainly cause an injury in fact." *Sherley*, 610 F.3d at 73 (emphasis added). It is not plaintiffs' burden to show that causation; the competitor standing doctrine presumes it.[2] *Id.*; *see also, e.g.*, *Mendoza v. Perez*, 754 F.3d 1002, 1011 (D.C. Cir. 2014) ("The competitor standing

[2] The government can suggest otherwise only by omitting the critical language from its quotation of *Sherley*. *See* Defs.' Br. 22 (omitting "we recognize").

doctrine *recognizes* [that] parties suffer constitutional injury in fact when agencies . . . allow increased competition.") (emphasis added) (quotation marks omitted); *Sherley*, 610 F.3d at 72 (acknowledging the "'basic law of economics' that increased competition leads to actual injury") (quoting *New World Radio, Inc. v. FCC*, 294 F.3d 164, 172 (D.C. Cir. 2002)).

Thus, the D.C. Circuit has repeatedly upheld competitor standing in the face of contentions that the actions of third-party market participants somehow break the causal chain. *See Wash. All. of Tech. Workers*, 892 F.3d at 341 (rejecting as "inconsistent with the competitor standing doctrine" the argument that "[plaintiff]'s injury is not caused by the DHS because employers . . . independently decide whether [plaintiff's] members are hired"); *Honeywell Int'l Inc. v. EPA*, 374 F.3d 1363, 1370 (D.C. Cir. 2004) ("There is not much to this chain-of-speculation objection; it is well established that parties suffer cognizable injury under Article III when an agency lifts regulatory restrictions on their competitors or otherwise allows increased competition.") (alterations incorporated) (quotation marks omitted); *see also Bristol-Myers Squibb Co. v. Shalala*, 91 F.3d 1493, 1499 (D.C. Cir. 1996) (similar). This Court should do the same.

The government cannot escape the competitor standing doctrine by baldly asserting that "STLDI plans and ACA-compliant plans are in different product markets." Defs.' Br. 22. No decision requires a court to define or artificially constrain the relevant market for competitor standing purposes; the question is simply whether the plaintiffs will face increased competition. In arguing otherwise, the government seizes on language from a decision that, far from redefining the elements of competitor standing, simply denied the doctrine's applicability to "Sheriff Arpaio's theory that more immigrants mean more crime," which was "not sufficiently analogous to the basic laws of economics for our competitor standing cases to apply." *Arpaio v. Obama*, 797 F.3d 11, 23 (D.C. Cir. 2015). In claiming to have discovered a previously unknown element to the competitor standing doctrine in *Arpaio*'s dicta, the government thus "makes the mistake of reading an opinion . . . like a statute." *United States v. Stitt*, 860 F.3d 854, 878 (6th

Cir. 2017) (en banc) (Sutton, J., dissenting), *majority opinion rev'd*, 139 S. Ct. 399 (2018). Nor does the government explain why—even under its reading—the relevant "market" should be defined in a way that makes no economic sense ("the Texas Exchange for ACA-compliant plans," Defs.' Br. 22), rather than, for example, as the overall "market" for individuals purchasing health insurance in Texas, when consumers are in fact free to choose between Exchange coverage and non-Exchange STLDI plans anywhere in the State. In any event, the precedents are clear: "[r]egardless how we have phrased the standard in any particular case, . . . the basic requirement common to all our cases is that the complainant show an actual or imminent increase in competition." *Sherley*, 610 F.3d at 73; *see also Wash. All. of Tech. Workers*, 892 F.3d at 339 (same).

Such an increase in competition is abundantly clear here. To begin, the government cannot plausibly deny that CHC and ACAP's other member insurers will face increased competition as a result of the STLDI Rule—because ***the avowed purpose*** of the Rule is to provide a (previously illegal) alternative to ACA-compliant coverage. The STLDI Rule itself declared that STLDI would be "an additional choice for many consumers that exists side-by-side with individual market coverage, with the end result that individuals are provided with more choices." *Short-Term, Limited-Duration Insurance*, 83 Fed. Reg. 38,212, 38,218 (Aug. 3, 2018); *see also id.* at 38,227 ("This final rule aims to increase insurance options for individuals unable or unwilling to purchase available individual market plans."). And the Executive Order that directed defendants to issue the Rule announced that STLDI is "*an appealing and affordable alternative* to government-run exchanges for many people without coverage available to them through their workplaces." Exec. Order No. 13,813, § 1(b)(ii), 82 Fed. Reg. 48,385, 48,385 (Oct. 17, 2017) (entitled "Promoting Healthcare Choice *and Competition* Across the United States") (emphases added). HHS Secretary Alex Azar has repeatedly emphasized the same thing. *See, e.g.*, Alex M. Azar II, *Obamacare Forgot About You. But Trump Didn't*, Wash. Post (Aug. 15, 2018), goo.gl/rUQv43 ("Expanding short-term insurance is just part of President Trump's larger

agenda to improve health-care choice *and competition* for Americans.") (emphasis added); Twitter post by "Secretary Alex Azar," @SecAzar (Aug. 1, 2018), perma.cc/9NWP-DRMH (stating, in a post about STLDI, that "[o]ur efforts are focused on introducing new choices and competition to the insurance market").

It is therefore hard to take the government seriously when it asserts that STLDI plans "do not directly compete with QHPs, thus rendering inapplicable the competitor standing doctrine here," on the basis that short-term plans "are not reasonable substitutes for ACA-compl[ia]nt plans." Defs.' Br. 22. Of course, plaintiffs do not believe that STLDI plans are ***adequate*** substitutes for ACA-compliant insurance. *See id.* (citing Compl. ¶ 5). But that does not say anything about whether they are substitutes in the economic sense, meaning that consumers may choose one over the other based on their relative prices.[3] In fact, that is precisely what the government intends for STLDI plans. *See* Twitter post by "Secretary Alex Azar," @SecAzar (Aug. 17, 2018), perma.cc/8EZ5-AYWT ("Who could benefit from a short-term, limited duration health plan? [You could,] [i]f your ACA coverage is too expensive.").

What is more, since the STLDI Rule went into effect, ACAP's members are now ***in fact*** subject to competition from STLDI providers operating in their areas. A search of the online health insurance marketplace eHealth reveals that there are 53 different 12-month STLDI plans available to a 30-year-old nonsmoking male in Houston, Texas, which is the area served by CHC. *See* Lyons-Berg Decl. ¶ 4 & Ex. A. Twelve-month STLDI plans are also available in the areas served by at least three other ACAP member insurers. *See id.* ¶¶ 5-7 & Exs. B-D.[4] And at

[3] Specifically, two goods are substitutes if they have a positive cross elasticity of demand.

[4] Dayton, Ohio is served by the Marketplace plans of ACAP member CareSource. *See* CareSource, *Ohio: Marketplace* (captured Mar. 15, 2019), perma.cc/LDK9-9JX3 (service area includes Montgomery County, Ohio, which contains Dayton). Racine, Wisconsin is served by the Marketplace plans of ACAP member Children's Community Health Plan. *See* Children's Cmty. Health Plan, *Service Area—Together* (captured Mar. 15, 2019), perma.cc/B6AZ-QK3G (service area includes Racine County, Wisconsin, which contains the city of Racine). Pittsburgh, Pennsylvania is served by the Marketplace plans of ACAP member UPMC. *See* UPMC, *UPMC*

least one ACAP member insurer operates a Marketplace plan in an area where 36-month renewals are not only permitted by law,[5] but are in fact currently being offered. *See id.* ¶ 8 & Ex. E. It is thus certainly not the case that the STLDI Rule is "at most, the first step in the direction of future competition." Defs.' Br. 22 (quoting *New World Radio*, 294 F.3d at 172). The competition has already begun. ACAP's member insurers have "show[n] an *actual* . . . increase in competition," which equates to injury-in-fact under the competitor standing doctrine. *Sherley*, 610 F.3d at 73 (emphasis added).

Finally, causation and redressability are easily established in competitor standing cases. *See Sherley*, 610 F.3d at 72 ("[I]t is clear the alleged injury is traceable to the [challenged regulatory action] and redressable by the court."); *Honeywell Int'l*, 374 F.3d at 1369; *Wash. All. of Tech. Workers*, 892 F.3d at 341. Because the relevant injury is increased competition from market entrants who were previously barred by regulation, that injury is self-evidently caused by the relaxing of those regulations. *Id.* Similarly, the injury is redressable because if the challenegd rule is set aside, the previously barred competitors will be barred once again, ending the unlawful competition. *Id.* That is exactly the case here: if the Court sets aside the STLDI Rule, ACAP's member insurers will no longer face unlawful competition from 364-day STLDI plans. Causation

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Health Plan for Individuals and Families 2019, at 13, 15 (2019), goo.gl/49Sjnj (service area includes Allegheny County, Pennsylvania, which contains Pittsburgh). *See generally* ACAP, *Our Plans* (captured Mar. 15, 2019), perma.cc/W3K8-JXG6 (listing CareSource, Children's Community Health Plan, and UPMC as ACAP members offering Marketplace plans).

[5] *See Strengthening Our Health Care System: Legislation to Reverse ACA Sabotage and Ensure Pre-Existing Conditions Protections: Hearing on H.R. 986, H.R. 987, H.R. 1010, and H.R. 1143 before the Subcomm. on Health of the H. Comm. on Energy & Commerce*, 115th Cong. (2019) (written testimony of Jessica K. Altman, Commissioner, Pennsylvania Insurance Department), perma.cc/JG6V-GXCM ("Pennsylvania state law does not currently contain restrictions on STLDI."); *accord Short-Term Health Insurance in Pennsylvania*, HealthInsurance.org (Oct. 1, 2018), perma.cc/BKK5-MJ7S.

In this regard, the government is incorrect in asserting that Texas law caps renewals at 12 months. *See* Def. Br. 13 (citing 28 Tex. Admin. Code § 3.3002(18)). The Texas statute capping STLDI plans at 12 months includes within that limit only "extensions that may be elected by the insured *without* the insurer's consent." 28 Tex. Admin Code § 3.3002(18) (emphasis added).

and redressability are satisfied, and ACAP has competitor standing through its members.

2. ACAP's members also have standing independent of the competitor standing doctrine.

As demonstrated in plaintiffs' preliminary injunction briefing, ACAP members are also suffering an injury-in-fact apart from the competitor standing doctrine, in the form of harm to their business interests as their customers are drawn away to STLDI plans. 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. Importantly, those numbers are net of the effect of "zeroing out" the individual mandate penalty (*cf.* Defs.' Br. 18-19); taking the $0 mandate penalty as a baseline, the STLDI Rule will cause an ***additional*** 1 to 1.9 million people to drop their ACA-compliant insurance, resulting in an ***additional*** premium increase of 2.2% to 6.6% for those remaining in ACA-compliant plans. *See* Murray Decl. Ex. B, at 15-17. Even the government estimated that enrollment in ACA-compliant plans would decrease by up to 500,000 people in 2019 and will be down by 1.3 million by 2028. 83 Fed. Reg. at 38,236.[6]

Moreover, CHC alone stands to lose up to 10,000 customers from the legalization of long-term STLDI plans, and other ACAP members are similarly situated. Janda Decl ¶ 11; Murray Decl. ¶ 11. The government points to the ACA subsidies available to some of CHC's over 100,000 consumers, suggesting that such customers have no incentive to switch to STLDI. Defs.' Br. 14. But more than 14,000 of CHC's Marketplace enrollees in 2018 received ***zero*** advance premium tax credits, and CHC provided ACA-compliant insurance to more than 8,600 additional consumers who bought their plans outside an Exchange—and who are therefore

[6] The government complains that these numbers are nationwide, rather than tailored to ACAP's member insurers. Defs.' Br. 15. But it provides no reason to think that the economic forces resulting in nationwide trends would ***not*** apply in the States where ACAP's members operate.

ineligible to receive subsidies.[7] Murray Suppl. Decl. ¶ 5 & tbl. 2. Many of ACAP's other members have even higher percentages of unsubsidized consumers. *Id.* Because these customers bear the entire brunt of their insurance premiums, they are especially likely to be lured away by facially cheaper STLDI products.[8]

The government's primary response is to contend that standing is somehow precluded because the mechanism of plaintiffs' injury involves the actions of third-party economic actors. *See* Defs.' Br. 13. But it is settled that "mere indirectness of causation is no barrier to standing, and thus, an injury worked on one party by another through a third party intermediary may suffice." *Tel. & Data Sys., Inc. v. FCC*, 19 F.3d 42, 47 (D.C. Cir. 1994) (quoting *Nat'l Wildlife Fed'n v. Hodel*, 839 F.2d 694, 705 (D.C. Cir. 1988)). That is, in assessing standing, "[w]e are concerned . . . not with the *length* of the chain of causation, but [with] the *plausibility* of each of the links that comprise the chain." *Hodel*, 839 F.2d at 705 (emphasis added) (quoting *Autolog Corp. v. Regan*, 731 F.2d 25, 31 (D.C. Cir. 1984)).

Thus, the D.C. Circuit has had no trouble crediting standing theories that assume that independent economic actors will act as predicted by economic principles. *See, e.g.*, *Osborn v. Visa Inc.*, 797 F.3d 1057, 1065 (D.C. Cir. 2015) (finding standing based on "certain economic assumptions about supply and demand," including that "consumers . . . are price conscious"); *Airlines for Am. v. TSA*, 780 F.3d 409, 410-11 (D.C. Cir. 2015) (finding standing based on a chain of causation that assumes consumers will respond to market forces); *Fund for Animals, Inc. v. Norton*, 322 F.3d 728, 733 (D.C. Cir. 2003) (Mongolian government would suffer injury-in-fact from prohibition on importing Mongolian sheep trophies into the United States, because "some hunters will not travel to Mongolia to hunt" the sheep, resulting in a loss of tourist revenue); *Autolog*, 731 F.2d at 31 (endorsing union's standing theory that unidentified third-

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[7] *See* 26 C.F.R. § 1.36B-2(a).

[8] This is to say nothing of the consumers who receive some subsidies, but not enough to offset the difference in price between an ACAP member plan and a much cheaper STLDI plan.

party shipping firms, which would presumably employ union members, would "move in to meet [] heavy demand" if the agency stopped a foreign firm from meeting that demand). Indeed, the D.C. Circuit has explicitly distinguished "allegations of future injury that are firmly rooted in the basic laws of economics"—which are sufficiently concrete to support standing—from speculative allegations of future injury. *Arpaio*, 797 F.3d at 23 (quoting *United Transp. Union v. ICC*, 891 F.2d 908, 912 n.7 (D.C. Cir. 1989)).

Just so here: ACAP members' injury relies on the certainty that some consumers will respond as intended to the price differential between ACA-compliant insurance and the significantly cheaper short-term plans authorized by the STLDI Rule. Their standing is thus "firmly rooted in the basic laws of economics." *Arpaio*, 797 F.3d at 23; *cf. Animal Legal Def. Fund v. Glickman*, 154 F.3d 426, 441 (D.C. Cir. 1998) ("[O]ne narrow proposition at least is clear: injurious private conduct is fairly traceable to the administrative action contested in the suit if that action authorized the conduct or established its legality.") (quoting *Tel. & Data Sys.*, 19 F.3d at 47). This is not "'an extended chain of contingencies'" (Defs.' Br. 13); it simply presumes that some consumers will follow the price curve and will take advantage of what the HHS Secretary has described as "a much more affordable option for millions of the forgotten men and women left out by the current system." U.S. Dep't of Health & Human Servs., *Trump Administration Delivers on Promise of More Affordable Health Insurance Options* (Aug. 1, 2018), perma.cc/PU75-DK7K.

The government's contrary argument is especially ill-taken because the government itself both predicts and intends that many consumers will make the switch to STLDI plans. *See, e.g.*, 83 Fed. Reg. at 38,236. The government's arguments, which amount to "'minimiz[ing] the importance and impact of [its] own decision' in order to defeat standing," therefore are "more than 'somewhat curious.'" *Fla. Audubon Soc'y v. Bentsen*, 94 F.3d 658, 681 (D.C. Cir. 1996) (en banc) (Rogers, J., dissenting) (quoting *Sec. Indus. Ass'n v. Clarke*, 885 F.2d 1034, 1041 (2d Cir. 1989)); *see also id.* ("Moreover, this is not a case where a plaintiff has seized on a possible

incidental side-effect of a government action; rather, [the injurious effect] was one of the Secretary's stated purposes in proposing [the regulation].").

Finally, the government points to preliminary data from the 2019 open enrollment season showing that Exchange enrollment declined by 3.8% (or roughly 332,000 individuals) from 2018, and it contends that this somehow detracts from plaintiffs' case. Defs.' Br. 16-17; *see* Wu Decl. ¶ 20. In fact, this is actually a ***larger*** decline than the government predicted in the Rule itself. *See* 83 Fed. Reg. at 38,236 (predicting a decrease in Exchange enrollment for 200,000 subscribers in 2019). Moreover, the fact that (1) actuaries predicted a decline in enrollment, (2) those actuaries attributed part of that decline specifically to the STLDI Rule, and (3) a decline in enrollment was in fact observed shows not only that ACAP members were harmed, but that those harms are fairly traceable to the Rule and redressable by this Court. After all, "[i]njury-in-fact is not Mount Everest." *Canadian Lumber Trade All. v. United States*, 517 F.3d 1319, 1333 (Fed. Cir. 2008) (quoting *Danvers Motor Co. v. Ford Motor Co.*, 432 F.3d 286, 294 (3d Cir. 2005)). ACAP has standing even disregarding the competitor standing doctrine.

B. The provider and consumer plaintiffs also have standing.

Although it is axiomatic that in a multi-plaintiff case only "one plaintiff must have standing to seek each form of relief requested" (*Town of Chester v. Laroe Estates, Inc.*, 137 S. Ct. 1645, 1651 (2017)), the provider and consumer plaintiffs also have standing for similar reasons. Just as with ACAP's members, the government's objections to the standing of the provider and consumer plaintiffs rest primarily on the proposition that causal chains involving third parties are too speculative to support standing. *See* Defs.' Br. 23, 25. As explained above (at 9-10), they are not. The D.C. Circuit has consistently blessed standing arguments that rely at least as heavily on the "basic laws of economics" as do plaintiffs' injuries here. *Arpaio*, 797 F.3d at 23; *see, e.g.*, *Osborn*, 797 F.3d at 1065; *Fund for Animals*, 322 F.3d at 733. This Court should

do the same.[9]

i. Provider plaintiffs

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.[10] 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. *Id.* ¶ 12. Moreover, as costs to ACA plan issuers increase because the patient

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[9] *American Freedom Law Center v. Obama*, 821 F.3d 44 (D.C. Cir. 2016), cited repeatedly by the government, does not suggest otherwise. The plaintiffs there "made no concrete allegations, nor provided any specific evidence, establishing that the cost of their health insurance plan is likely to increase in the future." *Id.* at 50. Among other distinctions, here the government itself has predicted that its rule will cause ACA-compliant plan premiums to rise. *See* 83 Fed. Reg. at 38,236.

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

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. *Id.* ¶ 14. Such measures increase the amount of uncompensated time the psychiatrist must spend on each patient to ensure their care is covered, 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.*

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. *See 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 refuse treatment. Either way, those providers are harmed.

Finally, organizations like plaintiff Mental Health America's (MHA) affiliates, which provide rehabilitation, socialization, and housing services to individuals with mental illness (another pre-existing condition), will be injured 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 v. Newby*, 838 F.3d 1, 8 (D.C. Cir. 2016) (alterations incorporated) (quotation marks omitted); *see Nat'l Treasury Emps. Union v. United States*, 101 F.3d 1423, 1430 (D.C. Cir. 1996).

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; *accord 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)).

ii. Consumer plaintiffs

Finally, the STLDI Rule will also harm the plaintiffs who represent 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 prohibitions will not accept them. *See, e.g.*, Milan Decl. ¶¶ 5-6. What is more, some people will likely be unable to afford the increase at all and will be forced to forgo lifesaving treatment.

The families represented by plaintiff Little Lobbyists—families with children who have complex pre-existing conditions—face the same injuries. *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. ¶ 15; Fassler Decl. ¶ 5; *see* 83 Fed. Reg. at 38,236. 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—all of which can occur within the same 364 day window—for pregnant women and newborns could lead to significant adverse consequences for both the health and economic well-being of women and their families. Like insurers and service providers, therefore, disadvantaged patient populations are injured by the STLDI Rule.

II. THE STLDI RULE IS INVALID.

On the merits, the government essentially premises its defense of the STLDI Rule on four propositions: (1) that Congress did ***not*** intend the ACA to create a comprehensive system for the regulation of individual health insurance that places most purchasers in a single risk pool and assures those purchasers essential health benefits; (2) that the STLDI Rule rests on a reasonable reading of the ACA's statutory terms; (3) that the Departments offered a reasonable explanation for their departure from the 2016 Rule; and (4) that the STLDI Rule takes a reasonable approach to addressing the problem of transitory gaps in health insurance coverage. The government's defense rests on all four premises; if even one is incorrect, summary judgment for plaintiffs is proper. As it happens, all of these propositions are wrong.

A. The STLDI Rule conflicts with Congress's legislative judgments.

1. The government does not, and could not, deny that the STLDI Rule is designed allow for the development of an alternative system of primary health insurance that "millions" of

consumers will use in place of ACA-compliant plans.[11] The government's central contention therefore must be that Congress in the ACA did not have a "single-minded" focus on placing most consumers of individual health insurance in a single risk pool (Defs.' Br. 32; *see id*. at 32-33, 35) and on assuring that most consumers receive what Congress labeled "essential" health benefits. Instead, the government insists that a regime that leads to an increase in ***any*** form of insurance coverage—including coverage that omits what Congress itself deemed to be essential benefits, that excludes (or terminates) people with pre-existing conditions, and that includes onerous annual and lifetime caps on benefits—is consistent with the congressional intent underlying the ACA. *See id*. at 39. From these starting points, the government concludes that Congress authorized the Departments to allow for the unlimited sale of primary health insurance options that do not comply with ACA requirements, that will draw numerous consumers out of the ACA single risk pool, and that will leave many consumers with insurance coverage that Congress, when it enacted the ACA, expressly regarded as inadequate.

This contention, however, takes no account of the manifest intent of the Congress that enacted the ACA. As we showed in our opening brief (at 20-22), Congress expressly sought to place virtually all individual health insurance consumers in a single risk pool and assure that they receive essential health benefits. This structure makes possible the guaranteed issue requirement that permits people with pre-existing conditions to obtain insurance coverage, avoiding the

[11] The government states that "the Departments have not claimed the unilateral authority to create a new form of primary insurance by restoring a definition that has existed since 1997." Defs.' Br. 29. If they mean by this that STLDI has been marketed since 1997 as a form of primary insurance, they are wrong; such marketing did not begin until after enactment of the ACA, as the Departments themselves acknowledged when issuing the 2016 Rule. *See* Pls. Opening Br. 8-9. They carefully do not, and could not, deny that they intend the Rule to allow the marketing of STLDI insurance as an alternative to ACA-compliant plans.

"death spiral" that otherwise would occur as healthier and younger consumers left the risk pool, purchasing ACA-compliant coverage only after they become sick. *See* Pls. Opening Br. 5-7.

There is no doubt that this is the model Congress meant to put in place when it enacted the ACA. By doing so, Congress responded directly and expressly to the failures that previously had plagued the health insurance system, including a structure that simply excluded individuals with pre-existing conditions, made health insurance prohibitively expensive for others, and left many people who did have insurance with woefully inadequate coverage. *See* AMA Br. 6-10. There also is no doubt, as we showed in our opening brief (at 12-13) and as the medical *amici* confirm (*see* AMA Br. 12-21), that the STLDI Rule will undermine the ACA's goals and policies, drawing millions of consumers out of ACA-compliant plans (thus undermining the stability of individual insurance markets and driving up premiums) and leaving many of those consumers with health insurance coverage that is wholly unsuited to their needs. As the medical *amici* explain: the STLDI Rule will "mov[e] the health insurance market back to the days where Americans had no or inadequate insurance," with "serious adverse consequences for physicians and the patients in their care" as patients lose "essential benefits [that] are crucial for patient health, and in some cases life-saving." *Id.* at 10, 12, 14. The government has literally nothing to say about these key motivators and indicia of congressional intent.

2. As evidence that Congress nevertheless intended to permit the development of widely used alternatives to ACA-compliant plans, the government points to "Congress's exclusion, in varying degrees, of several health coverage options from the ACA's market reforms, all of which might draw some younger, healthier people out of the single risk pool." Defs.' Br. 35. The government focuses in particular on "grandfathered" plans that existed prior to the ACA and on

student health insurance plans, as well as STLDI plans. *Id*. But Congress's creation of these narrow ACA exceptions demonstrates the ***flaw*** in the government's argument.

As we show in our opening brief (at 27-28), these exceptions are narrow, self-limiting, and (in the case of grandfathered plans for individuals) inevitably diminishing. None creates a mechanism that any consumer in the market for individual health insurance—let alone the millions of people that the Departments imagine will purchase STLDI plans—could use to opt out of ACA-compliant coverage. Consequently, that Congress believed it necessary to allow these limited, targeted exceptions strongly suggests that the creation by administrative fiat of a general, alternative market for primary insurance is inconsistent with the congressional intent.

And on closer examination, the ACA exceptions identified by the government are not really ACA exceptions at all, at least as the government uses that concept. Thus, student plans are exempted from the ACA requirements that make no sense in a university context. For example, the governing regulation limits guaranteed renewability by permitting a student plan to cease coverage when the covered individual ***ceases being a student*** (45 C.F.R. § 147.145(b)(iii)), allows the student plan to adjust the coverage period to less than a year (permitting it to match the academic year) (*id.* § 147.145(b)(ii)), and so on. Notably, the preamble to the interim student plan regulation makes clear that the regulation does ***not*** permit student plans to avoid providing "important protections of the PHS Act and the Affordable Care Act that apply to individual health insurance coverage," making student plans "generally subject to the individual market requirements" of those laws. *Student Health Insurance Coverage,* 76 Fed. Reg. 7767, 7770 (Feb. 11, 2011). Indeed, the importance of providing such protections to students is ***why*** the Departments clarified in that preamble that student health insurance is ***not*** STLDI. *Id.*; *see also Student Health Insurance Coverage,* 77 Fed. Reg. 16,453, 16,455 (Mar. 21, 2012) (final rule

explaining that "the short-term limited duration model does not apply to coverage that a student could have through the same health insurance issuer for one or more years during the course of his or her undergraduate or graduate education").

As for grandfathered plans, they were not subjected to the entirety of ACA requirements so as to "*ease the transition of the healthcare industry* into the reforms established by the Affordable Care Act." *Interim Final Rules for Group Health Plans and Health Insurance Coverage Relating to Status as a Grandfathered Health Plan Under the Patient Protection and Affordable Care Act*, 75 Fed. Reg. 34,538, 34,541 (June 17, 2010) (emphasis added); *see also Final Rules for Grandfathered Plans, Preexisting Condition Exclusions, Lifetime and Annual Limits, Rescissions, Dependent Coverage, Appeals, and Patient Protections Under the Affordable Care Act*, 80 Fed. Reg. 72,192, 72,193 (Nov. 18, 2015) (finalizing interim final rules "without substantial change"). For that reason, the Departments promulgated regulations that imposed some ACA requirements on such plans immediately, and then laid out steps that insurers had to take to maintain grandfather status. *Id.* They also implemented a number of provisions, such as restrictions on cost-sharing, designed to nudge insurers toward un-grandfathering their plans. 75 Fed. Reg. at 34,549-50.

And in any event, grandfathered plans are still subject to a number of ACA requirements, including (among others) the medical loss ratio requirements, elimination of pre-existing condition requirements, and the ban on lifetime coverage caps (and, starting in 2014, the ban on annual coverage limits). *See* https://www.healthcare.gov/health-care-law-protections/grandfathered-plans/; Soc'y for Human Res. Mgmt., *FAQs About Grandfathered Health Plans* (Aug. 26, 2013), perma.cc/3X6R-GFFC (summarizing rules). Thus, the treatment of grandfathered plans and student plans under the ACA is entirely consistent with Congress's

intent to minimize, as far as possible, the number of Americans who are outside the single ACA risk pool and who lack essential health benefit coverage; they are not support for the Departments' new "any insurance will do" approach to the market and do not suggest that Congress approved the creation of alternative forms of primary health insurance.

The government nevertheless maintains that "[t]hese exemptions . . . refute any notion that Congress's concerns about adverse selection and market segmentation were so strong as to wholly foreclose alternatives to ACA-compliant insurance in all circumstances." Defs.' Br. 35. But the STLDI Rule turns on its head the goal of "wholly" avoiding the foreclosure of recourse to non-ACA-compliant plans in "all circumstances"; it allows ***any*** consumer to purchase primary insurance that is not ACA-compliant in ***any*** circumstance—except, of course, for consumers with pre-existing conditions, who will be barred as a practical matter from obtaining STLDI coverage. The market segmentation and diluted insurance protections that will follow from this regime run directly contrary to the goal of the ACA. In contrast, properly used as they were prior to the ACA as a way of obtaining a narrow form of transitional coverage for people between primary insurance plans, STLDI plans are (like student and grandfathered plans) narrow and self-limiting.

3. The government is equally incorrect when it purports to find support in the proposition that the ACA was designed to expand insurance coverage and then continues: "[t]o the extent Plaintiffs believe that affordability and choice can only be pursued through initiatives that facilitate *ACA-compliant* coverage, . . . there is no support in the ACA for that belief." Defs.' Br. 39; *see also id*. at 1 (STLDI Rule "complements the ACA's goals of increasing affordability, availability, and continuity of health insurance coverage"). In fact, that is ***just*** what Congress intended. One obvious way for Congress to increase "affordability" (at least for people without pre-existing conditions) would have been to allow the sale of skimpy plans that omit essential

medical services, or that impose low annual or lifetime caps on benefit payments. But that is precisely what Congress chose to avoid in the ACA. Congress instead required ACA-compliant plans to offer essential services—and Congress labeled those health benefits "essential"—for a reason: prior to the ACA, plans that omitted these benefits or imposed coverage caps both led consumers to suffer "the financial devastation that came with a serious or chronic condition requiring particularly expensive treatment" and denied them treatments that "are crucial for patient health, and in some cases life-saving." AMA Br. 9, 14. Congress did not want the ACA to replicate that regime; it enacted the ACA specifically to supplant it. Yet, as we showed in our opening brief (at 13-16) and as the medical *amici* confirm (AMA Br. 12-21), STLDI plans often have the very deficiencies that Congress sought to eliminate. Far from furthering the ACA's goals, the STLDI Rule would directly undermine the congressional objective.[12]

4. Finally, the government maintains that Congress should be presumed to have ratified the definition of STLDI promulgated by the Departments in 1997, and made final in 2004 in connection with HIPAA, as encompassing plans of just less than 12 months (taking account of extensions that could be elected without the issuer's consent). Defs.' Br. 27-28, 35. But as we show in our opening brief (at 33-36), that is not so. As Judge Silberman has written for the D.C. Circuit, the ratification doctrine "requires a showing of both congressional awareness and ***express*** congressional approval of an administrative interpretation if it is to be viewed as statutorily mandated." *Gen. Am. Transp. Corp. v. ICC*, 872 F.2d 1048, 1053 (D.C. Cir. 1989) (emphasis added) (quotation marks omitted).

[12] The government's reliance (Defs.' Br. 39) on *Central United Life Insurance Co. v. Burwell*, 827 F.3d 70 (D.C. Cir. 2016), is misplaced. There, the court explained simply that HHS may not consider the goal of limiting adverse selection to the exclusion of all else, so as to ***eliminate*** a type of coverage specifically provided for in the Public Health Services Act. *Id.* at 73. This holding has no bearing here, where the Departments did not consider the ACA's statutory goals ***at all*** and where no one is advocating eliminating STLDI.

Here, however, there is ***no*** evidence that Congress was aware of and intended to incorporate the pre-ACA HIPAA regulation, thus exempting 364-day plans from the ACA's reforms. In fact, as we noted in our opening brief, there is no "indication [that] Congress considered th[at] interpretation" ***at all.*** *Koszola v. FDIC*, 393 F.3d 1294, 1299 (D.C. Cir. 2005). To the contrary, there is no reason to believe that Congress was even aware of the definition of "short-term, limited-duration" that the Departments had applied in the quite different context of HIPAA's continuing coverage rules (a definition of such limited importance that it elicited no discussion by the Departments and no comments from the public during the HIPAA rulemaking), let alone that Congress approved of that definition. And there is no reason that Congress would have devoted any attention to the regulatory history of STLDI, given the extremely limited role that everyone—including the Departments—agree such plans played prior to enactment of the ACA. *See* Pls.' Opening Br. 3, 8.

The point is confirmed by Congress's failure to amend the statutory language containing the "short-term, limited duration" language, which makes it even less likely that Congress had either the prior STLDI definition or the HIPAA regulation in mind when it enacted the ACA. *See* Pls.' Opening Br. 35-36 (citing cases). That, perhaps, is why the Departments failed to rely on ratification during their 2018 STLDI rulemaking—a failure that itself precludes their reliance on that rationale now. *See id*. at 34 (citing *Nat'l Fuel Gas Supply Corp. v. FERC*, 468 F.3d 831, 839 (D.C. Cir. 2006)).

B. The STLDI Rule is inconsistent with the ACA's language.

1. Separately, we also showed in our opening brief that, because the standard length of a health insurance plan is one year—and because, under the plain meaning of "short-term," a "short-term plan" is one that is short ***relative to a standard plan***—a short-term plan in this context must be one that is meaningfully shorter than a year. Pls.' Opening Br. 28-29. The

government agrees that "short-term" is a relative phrase, and it also appears to agree that a standard insurance plan is one year long. Defs.' Br. 30. But it insists that, because a plan that is 364.99 days long "is shorter than the length of that standard plan," is it "'relatively short'"—making an STLDI plan that is anything up to one year long a "short-term" plan. *Id*. With respect, however, this reading tortures the language. Consider this ordinary usage: if five out of a gang of bank robbers receive 40-year terms of imprisonment and the sixth member of the gang is sentenced to 39.5 years in prison, the sixth robber may have received a "relatively shorter" term than the other five. Surely, however, no one would describe a 39.5-year sentence as a "short term of imprisonment." So too, here: a plan of insurance can be characterized as short-term only if it is meaningfully shorter than the standard term. No one who uses language in the usual sense would refer to a plan of insurance that is barely short of a year long to be a "short-term plan."

For similar reasons, the government gets no further in noting that "short-term," when combined with ***other*** activities or services (like investments, gains, or loans), may refer to a period of up to a year. Defs.' Br. 31. Investments, loans, and gains—unlike terms of insurance—have no standard length, and often involve terms of multiple years. Accordingly, that "short-term" might reasonably refer to a year when used in connection with those activities or services says nothing about whether such a usage is reasonable when applied in connection with an insurance policy. Two feet is a "short neck" when that phrase is used in connection with a giraffe; it is a very long neck when used in connection with a turtle.[13]

[13] The government finds support in state-law definitions of "short-term" insurance that mirror the Departments' approach. Defs.' Br. 31. But these definitions generally (like the two specifically cited by the government, in South Dakota and Texas) simply ***followed*** the 1997 Rule's definitions, in time and in substance, having been promulgated at a time when STLDI was not used as a primary form of insurance. They add nothing to the government's analysis.

The comparison drawn from the statute at hand is far more useful: as noted in our opening brief, Congress expressly defined a "short" coverage gap in the ACA as a gap that lasts less than three months. As we showed in our opening brief, Congress's use of the same word—"short"—in both of these phrases ("short coverage gap" and "short-term, limited-duration") presumptively should be understood to mean that Congress intended that word to receive the same meaning as it is used in both phrases. Pls.' Opening Br. 32-33. Anticipating this point, the government argues that the word "short" means different things in the two provisions because "[t]he two terms arise in different contexts serving different purposes." Defs.' Br. 36. But that is not so; in fact, the provisions serve closely related and complementary purposes. A short coverage gap is one that was exempt from the ACA penalty for failure to maintain minimum essential coverage; exempting such a gap from the ACA penalty protected individuals who were between ACA-compliant plans. And STLDI plans, intended to provide transitional coverage to such people, likewise do not have to comply with ACA minimum essential coverage requirements. In the short coverage gap provision, Congress showed that it regarded three months as the maximum period that was appropriate for such ACA non-compliant plans—which also, as we have explained, is the period during which individuals may be unable to obtain ACA-compliant coverage. Pls.' Opening Br. 32-33.

The government also notes that Congress has since reduced the penalty for failure to obtain ACA-compliant coverage to zero, which, it contends, suggests that Congress "no longer believes it appropriate to penalize individuals for a coverage gap of any length." Defs.' Br. 36. But this observation is wholly beside the point. The government does not—and cannot—argue that the Congress acting in 2017 had any intent to change the meaning of the phrase "short-term" in the term "short-term, limited-duration insurance"; as a result, the Congress that enacted the

ACA is the Congress whose intent governs here. And that Congress, as we have explained, intended the word "short" to mean up to three months. In the absence of any intent by Congress in 2017 to alter that definition, Congress's intent from 2014—as expressed in the statute it enacted, which has not been amended in relevant part—continues to govern. Thus, it is true that, as we have explained (Pls.' Opening Br. 9 & n.22), the Congress that "zeroed out" the ACA penalty did not regard the penalty as essential to operation of the statute. But the fact that Congress in 2017 no longer regarded it as appropriate to penalize a failure to obtain ACA-compliant coverage says nothing about whether Congress (years earlier) adopted a definition of STLDI that would undermine the ACA's essential provisions.

2. The government gets no further in its defense of "limited duration" as a term that permits repeated plan renewals, in a structure that allows these three-year contracts to be stacked so that they continue, in the same form, in perpetuity. Essentially all it has to say in support of this reading is that a rule that permits up to 36 months of plan renewals literally "restrict[s]," and therefore limits, the period during which an STLDI plan may be in effect. Defs.' Br. 32. But a plan that is renewable for multi-year periods (and that effectively could continue forever if consumers purchase multiple versions of the same plan) is not of "limited duration" under any plausible reading. In fact, under the government's construction of the statutory text, a plan that is renewable 100 times for a total of 99 years would be of "limited duration" because it would, literally, have a time limit.[14] Respectfully, such a reading is nonsensical. The point is confirmed

[14] The government's argument at the preliminary injunction stage made that point expressly: it premised its reading of the statutory language on the argument that "[a] thirty-six-month cap on extensions and renewals quite literally 'restrict[s]' the 'time during which [an STLDI contract] exists or last[s].'" Defs.' P.I. Br. 32 (alterations in original). Perhaps recognizing that this argument (almost) "quite literally" would mean that "limited-duration" plans need have ***no*** limit on the period during which they could be extended, the government has tweaked the argument as expressed in its summary judgment brief; it now says that "[a] 36-month cap on coverage under

by the reality that there is no reason for this sort of long-term renewability unless the plan is designed to serve as a permanent, alternative form of primary health insurance; yet no reasonable person would characterize such a policy, which lasts three times as long as the standard length of an insurance plan, as a "limited-duration" plan.

The government also purports to find support for its reading in the combination of "short-term" and "limited-duration," contending that its approach offers a better understanding of both terms "'because, while an insurance policy's duration is (absent cancellation) never shorter than its term, a policy's term can be shorter than its duration (if the policy is renewed or extended).'" Defs.' Br. 41 (quoting 83 Fed. Reg. at 38,220). But plaintiffs' reading of the statute avoids redundancy just as well; restricting a policy's term to less than three months makes it "short-term," and requiring that it be non-renewable makes it of "limited duration." Thus, avoiding redundancy is no reason to accept the government's illogical, unlawful reading of the statute.

In fact, that Congress used the terms "short-term" and "limited-duration" in combination greatly ***strengthens*** the force of our position. As the government has recognized—indeed, as the Secretary of HHS has trumpeted—the whole point of the STLDI Rule is to create a mechanism by which consumers may obtain STLDI plans that they will use as long-lasting (that is, for one year, 36 months, or potentially far longer) forms of primary insurance, as a substitute for (year-long) ACA-compliant plans. Again, no reasonable person would describe plans with these characteristics as ones that are "short-term, limited-duration." And it is impossible to believe that Congress would have expected plans that it labeled "short-term" and of "limited duration" to be the means by which consumers may obtain their regular, continuing health insurance coverage.

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an STLDI plan '[r]estrict[s]' the 'time during which [an STLDI contract] exists or lasts' and therefore gives reasonable meaning to the phrase 'limited duration.'" Defs.' Br. 32 (alterations in original). But this formulation, too, would allow for 99 renewals, which also literally would "restrict[] the time during which an STLDI contract exists or lasts."

C. The STLDI Rule is arbitrary and capricious.

Finally, the government's argument that the STLDI Rule survives the "arbitrary and capricious" inquiry is flawed, for several reasons.

1. Defending the Departments' abandonment of the 2016 Rule, the government principally asserts that, "although the October 2016 final rule 'was intended to boost enrollment in individual health insurance coverage by reducing the maximum duration of coverage in short-term, limited-duration plans, it did not succeed in that regard.'" Defs.' Br. 40 (quoting 83 Fed. Reg. at 38,214). But as we showed in our opening brief (at 39-40), that was ***not*** the rationale for the 2016 Rule, which says ***nothing*** about boosting ACA-compliant plan enrollment. Instead, as we explained, the Departments in 2016 regarded it as crucial to prevent use of STLDI plans as a mechanism for evading the ACA because such plans provide inadequate coverage for consumers and threatened the stability of the risk pool for ACA-compliant coverage. For the reasons explained above, those concerns were as salient in 2018—and are as salient now—as they were in 2016.

In these circumstances, the Departments were, at a minimum, obligated to acknowledge and address the actual considerations that prompted the promulgation of the 2016 Rule. As the Supreme Court has explained:

> "In such cases it is not that further justification is demanded by the mere fact of policy change; but that a reasoned explanation is needed for disregarding facts and circumstances that underlay or were engendered by the prior policy." . . . It follows that an "[u]nexplained inconsistency" in agency policy is "a reason for holding an interpretation to be an arbitrary and capricious change from agency practice." . . . An arbitrary and capricious regulation of this sort is itself unlawful and receives no *Chevron* deference.

Encino Motorcars, LLC v. Navarro, 136 S. Ct. 2117, 2126 (2016) (citations omitted).

Perhaps boosting plan enrollment ***could*** be a reason for changing the rule—in other words, perhaps the Departments could decide that boosting enrollment in non-ACA compliant

plans that omit the protections regarded by Congress as essential is a more important policy goal than maintaining the risk pool and preserving the protections of essential health benefits—but to do so, the Departments would be required to identify that change and provide a reasoned explanation for it. *See, e.g., Int'l Union, United Mine Workers of Am. v. U.S. Dept. of Labor*, 358 F.3d 40, 44 (D.C. Cir. 2004) (Ginsburg, C.J.) (explaining that citing a "'change in agency priorities,' without explanation" is not sufficient under APA review because "it is merely a reiteration of the decision" to change the relevant rule). Here, the Departments have not even acknowledged a change in priority, let alone explained why such a shift is not arbitrary or capricious.[15]

2. The Departments attempt to justify their changed approach by contending that "STLDI coverage typically serves a transitory function," as does COBRA, "which establishes an analogous form of transitory coverage"; therefore, the Departments conclude, they appropriately looked to COBRA in allowing STLDI coverage under the ACA to last up to 36 months. Defs.' Br. 41. But there are two flaws in this argument. Most obviously, it is internally inconsistent: as

[15] The Departments maintain that the STLDI Rule did not amount to a change in policy because the 2016 Rule also allowed renewals (up to a ***total*** of three months) and "the 1997 Rule similarly permitted extensions." Defs.' Br. 40-41. This contention is silly. A rule that limited insurance policy length as extended to three ***months*** (and therefore necessarily precluded its use as a form of continuing, primary insurance) obviously is different in character from one that permits the policy to be kept in force for three ***years***. As for the 1997 Rule, it permitted renewal ***with the agreement of the issuer***, but it did not require that plans contain a unilateral option for the insured to renew coverage. The 2016 rule modified the 1997 approach to preclude any renewals over three months, ***with or without*** the issuer's consent. The new rule, however, extends the timeframe for renewal of plans ***without*** issuer consent (or unilaterally) to 36 months. This is a material change: giving people the unilateral option to renew permits them to plan on having STLDI as their coverage for much longer (up to 36 months) without undergoing medical underwriting. Thus, the adverse selection issues are much more pressing under the new rule than they were under the 1997 rule. (Any contract with a term can be "indefinitely renewed" through bilateral agreement. The ability to renew only if the counterparty agrees is not worth much, practically speaking; the ability to renew unilaterally is.)

we noted in our opening brief (at 40-41), the whole point of the STLDI Rule is to make STLDI plans "a realistic coverage option" (Defs.' Br. 1) by establishing them as a form of primary coverage that is ***not*** transitory in any meaningful sense. As conceptualized by the Departments in the STLDI Rule, then, STLDI is not at all analogous to COBRA coverage.

In addition, as explained in some detail by *amicus* AARP, COBRA coverage must comply with the ACA's requirements, making available comprehensive, employer-based group health coverage; COBRA therefore says nothing about the appropriate period for maintaining limited, non-ACA compliant individual coverage—coverage that may well be inadequate (because it lacks the ACA's essential protections) and that (unlike stopgap COBRA coverage) is likely to draw consumers out of the ACA risk pool on a continuing basis. *See* AARP Br. 20-22. Consequently, the maximum term of coverage under COBRA, which has co-existed with STLDI plans under both HIPAA and the ACA, always has been far longer than the maximum term permitted for STLDI—until the promulgation of the STLDI Rule.

3. We have explained that the STLDI Rule will make it impossible for people who lose their STLDI coverage mid-year to obtain health insurance; although individuals who lose ACA-compliant coverage mid-year will qualify for an ACA special open enrollment period and will be able to obtain replacement coverage within 90 days, consumers who use STLDI as their primary insurance and lose coverage mid-year will not qualify for ACA open enrollment and will be left without insurance protection. Additionally, any consumer who purchases STLDI coverage for a term of 364 days would miss the next open enrollment period, thinking they were covered; most consumers would not purchase a second (ACA-compliant) policy while their STLDI policy is still in effect unless they suddenly became sick and thus identified a gap in their STLDI coverage. This risk is minimized if STLDI is limited to three months, which will cover the gap

between the termination of one ACA-compliant plan and the commencement of coverage under another. Pls.' Opening Br. 41-42.

In nevertheless defending the reasonableness of the STLDI Rule, the government maintains that the new Rule will make coverage available to individuals who need transitional insurance protection for more than 90 days, which (it says) includes individuals who miss an open enrollment period, who lose coverage because of nonpayment, or who are exempted from obtaining ACA coverage because of hardship. Defs.' Br. 42; *see also id*. at 36-37.

But here, too, there is an obvious response to the government's contention: the STLDI Rule was not designed to address, and is not in fact responsive to, this purported problem—and this rationale is, in any event, inconsistent with the structure of the ACA. As the government (sometimes) acknowledges, STLDI is supposed to be transitional. For people in need of transitional coverage, a gap of more than three months almost always can be covered through purchase of a plan on an ACA Exchange because the event precipitating the loss of coverage typically will be a qualifying life event. *See* Pls.' Opening Br. 42. And for others (*e.g.*, those who lose their ACA-compliant coverage for nonpayment or simply miss ACA open enrollment), Congress wanted to create an incentive for individuals to enter ACA-compliant plans in a timely fashion; a central goal of the ACA is to get consumers into the single ACA risk pool ***before*** they are sick. Congress therefore wanted consumers to obtain ACA plans (and offered subsidies to help make that possible) rather than offer them a mechanism that allows them to stay out of such plans indefinitely.

In any event, even taking the government's claims at face value, the STLDI Rule simply is not targeted at the purported dangers the government addresses in its brief to this Court. STLDI plans are not limited to people who qualify for the ACA hardship exception or who miss

an ACA open enrollment period through no fault of their own. Instead, the overwhelming majority of individuals who take advantage of the new year-long (or multi-year) STLDI plans will be people who, contrary to Congress's intent, voluntarily opted out of the ACA (so as not to purchase what the government derisively labels "one-size-fits-all plans," Defs.' Br. 1), and instead chose slimmed-down STLDI plans as a cheaper, alternative form of primary insurance. If the Departments meant to address the limited categories of individuals it discusses now, the STLDI Rule is so poorly designed to accomplish that goal as to be arbitrary and capricious.

And there is an additional problem. As we note in our opening brief and as several commenters explained during the STLDI rulemaking (*see* Pls.' Opening Br. 42-43), the STLDI Rule creates a far more serious transitional concern of its own. STLDI plans do not guarantee re-enrollment and may retroactively deny treatment (through, for example, after-the-fact discovery of a pre-existing condition). Those plans also typically exclude people who have pre-existing conditions or otherwise present high risks. *See* Pls.' Opening Br. 12-13; AMA Br. 12-21. As a consequence, people whose STLDI plans—now purchased as an ongoing form of primary health insurance—terminate or are terminated mid-year will be left with no insurance at all and with no way of obtaining insurance until the next ACA annual open enrollment period, a regime that ***guarantees*** that many people will lack insurance for extended periods. As the government puts it, there is "nothing to suggest that Congress intended such an absurd outcome" through the marketing of plans that were designed to offer effective transitional coverage. Defs.' Br. 36-37. Certainly, the government offers nothing in support of that result or in response to the comments making this point—and that, in itself, makes the STLDI Rule arbitrary and capricious. *See* Pls.' Opening Br. 43-44 (citing cases).

CONCLUSION

The Court should deny defendants' Motion for Summary Judgment and grant plaintiffs' Motion.

Respectfully submitted,

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