**ORAL ARGUMENT NOT YET SCHEDULED**

*In the United States Court of Appeals*
*For the District of Columbia Circuit*

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**NO. 19-5212**

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ASSOCIATION FOR COMMUNITY AFFILIATED PLANS, ET AL.,
Appellants,

v.

UNITED STATES DEPARTMENT OF THE TREASURY, ET AL.

Appellees.

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**ON APPEAL FROM THE U.S. DISTRICT COURT**
**FOR THE DISTRICT OF COLUMBIA**
**CASE NO. 18-2133 (LEON, J.)**

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# BRIEF OF *AMICI CURIAE* PENNSYLVANIA INSURANCE DEPARTMENT AND WISCONSIN OFFICE OF THE COMMISSIONER OF INSURANCE, IN SUPPORT OF APPELLANTS AND IN SUPPORT OF THEIR PETITION FOR *EN BANC* RECONSIDERATION

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## CERTIFICATE AS TO PARTIES, RULINGS, AND RELATED CASES

Pursuant to D.C. Circuit Rule 28(a)(1), the undersigned counsel certified as follows:

### A. Parties and *Amici*

Except for *amici* Pennsylvania Insurance Department and the Wisconsin Office of the Commissioner of Insurance, any other *amici* who had not yet entered an appearance in this case as of filing of the Brief of Appellees, all parties, intervenors, and *amici* appearing before the District Court and in this Court are listed in the Brief for Appellees.

### B. Rulings under Review

Reference to the ruling under review appears in the Brief for Appellees.

### C. Related Cases

Reference to any related cases pending before this Court appears in the Brief for Appellees.

/s/ Robert A. Reiley

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## STATUTES AND CODES



## FEDERAL REGISTER

The Pennsylvania Insurance Department, led by Insurance Commissioner Jessica K. Altman (the "Department" or the "Pennsylvania Department"), joined by the Wisconsin Office of the Commissioner of Insurance (the "Wisconsin Office"), respectfully submit this *amici curiae* brief in support of the petition of the Association for Community Affiliated Plans for *en banc* reconsideration before the District of Columbia Circuit Court of Appeals ("Petition for Reconsideration").

## STATEMENT OF INTEREST OF *AMICI CURIAE*

*Amici* are charged with administering the laws regulating the business of insurance in their respective states. As the primary regulators of commercial health insurance policies sold in their states, *amici* are tasked with protecting consumers by ensuring that, when they shop for health insurance coverage, they are not subject to misrepresentations or misleading or deceptive marketing, that any limitations to the policies are clear, and that, if a consumer chooses to purchase a policy, the policy is administered and claims adjudicated properly.

## SUMMARY OF ARGUMENT

The 2018 Rule, by expanding access to "long-term" short-term limited duration insurance (STLDI), challenges the Department's ability to carry out its regulatory functions of ensuring that health insurance consumers in Pennsylvania are protected and that insurers can compete in a stable, predictable market. Short-Term Limited-Duration Insurance, 83 Fed. Reg. 38212 (Aug. 3, 2018) (2018 Rule).

By extending the duration and renewability of STLDI in the 2018 Rule, the United States Department of Health and Human Services (HHS) has made STLDI look and act like a viable alternative to purchasing comprehensive, major medical insurance. However, the Affordable Care Act (ACA) changed the landscape: "long-term" STLDI is no longer needed in the post-ACA construct of the health insurance market as all Americans are now guaranteed the ability to purchase ACA coverage. Allowing "long-term" STLDI as a year-round option for healthier individuals will result in higher premiums for ACA coverage and will destabilize the market for comprehensive coverage.

Additionally, STLDI also harms the consumers who purchase it, providing few benefits, and less coverage than expected, yet without clearly disclosing those limitations. Moreover, once health care services are used, STLDI insurers use post-claim underwriting and other improper claims practices to prevent payment.

Therefore, the 2018 Rule has a deleterious effect on the consumers in the individual market and runs counter to the purpose and construct of the ACA. The Department and the Wisconsin Office, which agrees with and adopts the Department's arguments, urge this Court to rehear this matter *en banc* and invalidate the 2018 rule.

## ARGUMENT

### I. STLDI Negatively Impacts the Individual Health Insurance Market.

#### A. The Individual Market Healthcare Landscape Before the ACA.

Prior to the ACA, individuals were only able to purchase health insurance if they were healthy, or if they purchased coverage for everything except what ailed them, or if they paid substantial premium. With the Health Insurance Portability and Accountability Act of 1996, group-based coverage was required to be "guaranteed available" and "guaranteed renewable." 42 U.S.C. §§ 300gg *et seq.* (HIPAA). HIPAA did provide that certain individuals leaving group-based coverage – if they had "creditable coverage," i.e., coverage for a long enough period that the individual did not have unknown (to the insurer) pent-up health needs that would need immediate care – were guaranteed the right to purchase individual coverage on a go-forward basis. 42 U.S.C. § 300gg-41. In Pennsylvania, this coverage was provided through an "alternative mechanism." 40

P.S. §§ 981-1 *et seq*. That HIPAA alternative mechanism, along with a second type of "conversion" coverage also available to Pennsylvanians coming off of group coverage, was very expensive: the premiums were approximately 120% of the group coverage premium.[1]

In that pre-ACA environment, where an individual did not have group coverage, was not eligible for continuation coverage, and was not healthy enough or wealthy enough to purchase comprehensive coverage on their own, STLDI was at least an option to cover at least some of their health care needs.

However, STLDI was underwritten: an insurer could choose to offer a policy to a person if they appeared healthy and not likely to need care; could refuse to offer a policy to a person who had, or was likely to have, a health condition that might require the insurer to pay out claims; or could choose to cover only a person for everything except their pre-existing condition. Therefore, even if they were offered coverage, a person with pre-existing conditions would likely have found that STLDI was not attractive because of the exclusions and limitations included in the policy. At the same time, because STLDI was quite attractive to those who were healthier and did not expect to need to use the coverage, an increase in STLDI plans in the market drove up costs for those who expected to need care.

[1] COBRA coverage was, and still is, also available for an individual leaving employer-based coverage, but it was, and still is, temporary. *See* 29 U.S.C. §§ 1161 *et seq*.

Thus, individuals with pre-existing conditions – for example, over 25% of Pennsylvanians – by being ineligible for and priced out of the STLDI market, were only able to purchase health insurance that was more expensive, if available at all.

**B. The ACA Significantly Changed the Landscape.**

The ACA brought a seismic shift in the ability of individuals to have comprehensive health insurance. By 2014, an individual was guaranteed the ability to purchase and renew comprehensive health insurance. No longer did a person have to hope they had no pre-existing conditions or hope that they retained their group coverage long enough to qualify for the alternative mechanism if they left the group.

Instead, with passage of the ACA, provisions of law introduced by HIPAA were amended so that the individual market, like the group market, was made "guaranteed issue" and "guaranteed renewable." All individuals were now able to purchase comprehensive health insurance, without underwriting. Additionally, the price of the coverage was now based on the rate for everyone in the "community," with only limited variations not including a person's health. 42 U.S.C. § 300gg.

The only limitation to purchasing coverage under the ACA is one of timing: it is available for purchase only during an open enrollment period or limited special enrollment periods. Outside of those times, STLDI remains an option. And if a

person changes employment but there is a waiting period before the person (or dependents) can access the new employer-based coverage, STLDI remains an option. But for those limited circumstances, STLDI is no longer needed as the lifeline that it was pre-ACA.

It was into this changed landscape that HHS promulgated the 2016 Rule: Excepted Benefits; Lifetime and Annual Limits; and Short-Term, Limited-Duration Insurance, 81 Fed. Reg. 75316 (October 31, 2016) (2016 Rule). No longer was STLDI one of the very few options available to someone desperate to have some measure of health insurance; everyone has the option to purchase comprehensive coverage on a guaranteed basis. No longer may an individual be denied coverage outright or denied coverage for everything except what ails them. No longer may an individual be charged substantially higher premiums on account of their pre-existing health conditions.

**C. STLDI's Effect on the Individual Market.**

By interjecting STLDI that is effectively neither "short-term" nor "limited-duration", the 2018 Rule violates the construct of the ACA, pushing the individual market towards an unsustainable future. If the healthiest individuals are lured into purchasing STLDI because of lower premium costs, and the unhealthiest individuals are excluded from making that choice due to their pre-existing

conditions, ACA-compliant coverage risks becoming an *ad hoc* high-risk pool. This means premium costs will rise. While many people that purchase coverage on their own are eligible for financial assistance through the ACA, about one in five are not. It is that population, and particularly the segment of that population with preexisting conditions, that expanding access to STLDI purports to help, but that in fact may be most harmed by the resulting market segmentation and higher prices.

The 2018 Rule therefore undermines the individual health insurance market, making STLDI available and superficially attractive to consumers. But STLDI that is neither "short-term" nor "limited-duration," and which is both underwritten and less than comprehensive, harms the individual market.

## II. STLDI Harms Individual Consumers.

### A. STLDI Policies Have Significant Benefit Limitations.

STLDI also exposes the individuals who purchase it to substantial harm. STLDI looks affordable because it has a low monthly premium. But that affordability will likely be illusory: those who need health care will encounter exclusions and limitations on the coverage.

First, STLDI can exclude benefits through medical underwriting. A person's pre-existing health conditions can be excised from the coverage (or

subject to exorbitant premiums). For example, the Department received a complaint from a consumer who had stressed her extensive orthopedic history and requested an ACA-compliant plan but was sold a policy that denied payment for her orthopedic surgery.

Second, STLDI plans do not have to cover essential health benefits: typical STLDI policies do not cover maternity care, prescription drugs, mental health care, preventive care, and substance use disorder services. *See* https://www.kff.org/health-reform/issue-brief/understanding-short-term-limited-duration-health-insurance/ (accessed August 17, 2020) (of the STLDI plans sold in Philadelphia subject to an April 2018 study, only 57% of the plans included mental health benefits, 33% covered substance use disorder treatment, 33% covered prescription drugs and *none* covered maternity).

Third, STLDI plans may impose lifetime and annual limits. They are also not subject to cost-sharing limits, even requiring cost-sharing in excess of $20,000, compared to the ACA cap on cost-sharing of $8,150 in 2020. *See* Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2020, 84 Fed. Reg. 17454, 17541 (April 25, 2019). In addition, STLDI plans may impose arbitrarily low per-benefit monetary caps. For example, the Department assisted a consumer who was held for overnight observation in an

emergency room, incurring charges of over $13,000, but whose STLDI policy had an emergency room maximum of only $250.

Finally, STLDI plans are not subject to other ACA requirements, such as minimum medical loss ratios. While ACA-compliant individual policies are required to pay out at least 80% of premium revenue for claims and medical expenses, the average loss ratio for the majority of the individual market STLDI policies sold nationally in 2018 was far less. Indeed, the three insurers who together sold 80% of all STLDI in the market had loss ratios of 37%, 58%, and 36%, respectively. National Association of Insurance Commissioners, Accident and Health Policy Experience Report for 2018, available at https://www.naic.org/prod_serv/AHP-LR-19.pdf (accessed August 20, 2020). This means that for most enrollees in STLDI, most of their premium dollars were not used to pay claims, but were used by the insurers for other purposes, including profit.

**B. STLDI Policies Have Inadequate Consumer Disclosures.**

A significant piece of an insurance product is its consumer disclosures, whether in marketing materials or in the policy language itself. While the 2018 Rule requires STLDI to include a brief notice encouraging consumers to check their policies carefully, that requirement has limited effect when not coupled with access to such things as provider directories, formularies, and summaries of

benefits and coverage – all of which are required by the ACA for comprehensive insurance, but none of which are required of STLDI. *See, e.g.*, 42 U.S.C. § 300gg-15, 45 C.F.R. §§ 147.200, 156.122, 156.230.

Given the lack of access to such fundamental documents, many consumers purchase STLDI without fully understanding the product's limitations. Some of this is due to producers (agents or brokers) promoting high-commission STLDI products: the Department has assisted consumers who specifically ask producers for ACA-compliant coverage, but are sold STLDI with significant coverage limitations. But it is also due to the lack of clear representations, or outright misrepresentations, of a policy's limitations, so that the consumer does not understand the extent of the benefit limitations included in a policy until after the consumer needs health care and tries to access coverage. Deceptive marketing is a significant concern.[2] This lack of consumer disclosure prompted the Department to develop a brochure that highlights the differences between STLDI and comprehensive coverage, assisting a consumer to clearly see the distinction and ask the right questions before making a purchase of a plan that they later regret.

[2] Consumers shopping online for health insurance, using search terms such as "Obamacare plans" or "ACA enroll," were most often directed to sources selling STLDI or other non-ACA compliant products. Corlette S, Lucia K, Palanker D, and Hoppe O, The Marketing of Short-Term Health Plans, January 31, 2019, at: https://www.rwjf.org/en/library/research/2019/01/the-marketing-of-short-term-health-plans.html (accessed August 17, 2020).

*See* https://www.insurance.pa.gov/Coverage/Documents/Health/Short%20Term%20Health%20Insurance%20Brochure_Website.pdf.

### C. STLDI May Be Subject to Post-Claims Underwriting and Improper Claims Practices.

One of the most concerning aspects of STLDI policies is the practice of post-claims underwriting, which often results in a denial of coverage or outright rescission of the policy. As STLDI policies often exclude coverage for pre-existing conditions, policyholders who make a claim may be investigated by the insurer to determine whether the recently diagnosed condition could be considered pre-existing. The Department has seen STLDI insurers deny claims rather than enabling policyholders to avail themselves of the coverage for which they paid and the benefits they should rightly expect to receive. Whether that is by combing through past medical records that may or may not relate to the condition for which the claim is made, or simply substituting its judgment and concluding that a condition "must have" manifested in such a way that an ordinary prudent individual would have previously sought medical advice and treatment, an STLDI insurer may use post-claims underwriting and improper claims practices to make it extraordinarily difficult for a consumer to access those benefits.

In a particularly poignant situation in light of the COVID-19 pandemic, the Department assisted a consumer who purchased five consecutive STLDI policies and was hospitalized for a virus during the final term. The insurer delayed payment and demanded three years of records to determine if the hospital admission in any way related to a pre-existing condition. Only after the involvement of the Department did the insurer make payment on the claims – for over $42,000. In another situation, an insurer misrepresented that certain providers were in-network. On charges of over $100,000, the insurer paid less than $400, and left the consumer to self-pay an "uninsured" charge of $57,000.

Finally, the appeal rights established by the ACA do not extend to STLDI. Consequently, following a denial of benefits, or a rescission of coverage, a person with an STLDI policy may find they have no opportunity to challenge their benefit denial or rescission.

## CONCLUSION

What the Pennsylvania Department and Wisconsin Office have seen, from their seats as the regulator of the health insurance market in their states, is that instead of providing more options at lower cost, STLDI has negative impacts for both those who purchase comprehensive coverage, as well as for those who purchase STLDI.

Without state legislation prohibiting or constraining STLDI in their states, *amici* are not able to completely prevent the deleterious impact of STLDI on the individual health insurance market in their states. The proliferation of STLDI, which draws healthy individuals away from ACA-compliant coverage to STLDI, means that insurers have to account for a less healthy population when calculating the rates for comprehensive ACA-compliant coverage.

For those who are able to purchase STLDI, *amici* are making concerted efforts to assure that advertising materials are clear, the marketing is not specious, and consumer disclosures and the policy itself properly explain the benefits covered, and, critically, the limitations of the coverage.

Invalidating the 2018 Rule will provide clarity for consumers, and promote an individual market that is more stable, with comprehensive coverage that is both more affordable and more available than oxymoronic "long-term" short-term limited duration insurance.

Respectfully submitted,

By: /s/ Robert A. Reiley

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Dated: September 8, 2020

## CERTIFICATE OF COMPLIANCE

This amicus brief complies with the type-volume limitation of Federal Rule of Appellate Procedure 35 and D.C. Circuit Rule 29(b)(4) because it contains 2598 words, excluding the parts of the brief exempted by Federal Rule of Appellate Procedure 32(f) and D.C. Circuit Rule 32(f).

This amicus brief complies with the typeface requirements of Rule 32(a)(5) and the type-style requirement of Rule 32(a)(6) because it was been prepared in a proportionately spaced typeface using Microsoft Word in Times New Roman 14-point type for text and footnotes.

/s/ Robert A. Reiley
Name

Dated: September 8, 2020

## F.R.A.P. RULE 29(a)(4)(E) STATEMENT

1. Counsel for Pennsylvania Insurance Department authored the foregoing Brief of *Amicus Curiae* in Support of Appellants and in Support of their Petition for Reconsideration.

2. Neither the Pennsylvania Insurance Department or the Wisconsin Office of the Commissioner of Insurance, nor their respective counsel, contributed money that was intended to fund preparing or submitting the foregoing Brief.

3. No person contributed money that was intended to fund preparing or submitting the foregoing Brief.

## CERTIFICATE OF SERVICE

I hereby certify that on September 8, 2020, I caused a true and correct copy of the foregoing to be served on all counsel of record through the Court's CM/ECF system.

/s/ Robert A. Reiley
Name

Dated: September 8, 2020