ORAL ARGUMENT NOT YET SCHEDULED

No. 19-5212

IN THE UNITED STATES COURT OF APPEALS
FOR THE DISTRICT OF COLUMBIA

ASSOCIATION FOR COMMUNITY AFFILITATED PLANS, *et al.*,
Appellants,

v.

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

On Appeal from a Final Judgment of the United States District Court for the District of Columbia
(Honorable Richard J. Leon)

BRIEF OF AMICI CURIAE AARP AND AARP FOUNDATION IN SUPPORT OF APPELLANTS

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November 12, 2019

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CERTIFICATE AS TO PARTIES, RULINGS, AND RELATED CASES

A. Parties and Amici

All parties, intervenors, and amici are listed in the Certificates as to Parties, Rulings Under Review, and Related Cases filed in this Court on July 31 and August 30, 2019.

B. Rulings Under Review

References to the rulings at issue appear in the Certificates as to Parties, Rulings Under Review, and Related Cases filed in this Court on July 31 and August 30, 2019.

C. Related Cases

Amici are not aware of any cases related to this appeal.

CORPORATE DISCLOSURE STATEMENT

Pursuant to Rule 29(a)(4)(A) of the Federal Rules of Appellate Procedure, amici curiae AARP and AARP Foundation submit the following corporate disclosure statement:

The Internal Revenue Service has determined that AARP is organized and operated exclusively for the promotion of social welfare pursuant to Section 501(c)(4) of the Internal Revenue Code and is exempt from income tax. The Internal Revenue Service has determined that AARP Foundation is organized and operated exclusively for charitable purposes pursuant to Section 501(c)(3) of the Internal Revenue Code and is exempt from income tax. AARP and AARP Foundation are also organized and operated as nonprofit corporations under the District of Columbia Nonprofit Corporation Act.

Other legal entities related to AARP and AARP Foundation include AARP Services, Inc., and Legal Counsel for the Elderly. Neither AARP nor AARP Foundation has a parent corporation, nor has either issued shares or securities.

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GLOSSARY

ACA	Patient Protection and Affordable Care Act
STLDI	Short-Term, Limited-Duration Insurance

STATUTES AND REGULATIONS AT ISSUE

Pertinent statutes, regulations and administrative materials are reproduced in the Brief for Appellants.

STATEMENT OF INTEREST

AARP is the nation's largest nonprofit, nonpartisan organization dedicated to empowering Americans 50 and older to choose how they live as they age. With nearly 38 million members and offices in every state, the District of Columbia, Puerto Rico, and the U.S. Virgin Islands, AARP works to strengthen communities and advocate for what matters most to families, with a focus on health security, financial stability, and personal fulfillment. AARP's charitable affiliate, AARP Foundation, works to end senior poverty by helping vulnerable older adults build economic opportunity and social connectedness. Among other things, AARP and AARP Foundation fight for access to quality healthcare across the country and frequently appear as friends of the court on issues affecting older Americans, including challenges to the Patient Protection and Affordable Care Act ("ACA"). *See, e.g.*, Brief of AARP, et al., *Texas v. United States of America,* No. 19-10011 (5th Cir. April 1, 2019); Brief of AARP, et al., *King v. Burwell*, No. 14-114 (U.S. Jan. 28, 2015); Brief of AARP, et al., *NFIB v. Sebelius*, Nos. 11-393 & 11-400 (U.S. Jan. 27, 2012).[1]

[1] AARP and AARP Foundation file this amicus brief pursuant to Rule 29 of the Circuit Rules of the United States Court of Appeals for the District of Columbia Circuit. Counsel for AARP and AARP Foundation authored this brief in whole. No party, party's counsel, or any other person other than the amici, its members, or counsel contributed money intended to fund preparing or submitting this brief.

SUMMARY OF THE ARGUMENT

This court should reverse the district court's decision granting summary judgment and set aside the August 2018 rule concerning Short-Term, Limited-Duration Insurance ("STLDI"). The rule redefined "short-term, limited duration" insurance as insurance available for 12 months or less, renewable for up to three years. 83 Fed. Reg. 38,212, 38,214-15 (August 3, 2018). If the rule is left undisturbed, the harm it is causing our healthcare system will continue to be felt acutely by pre-Medicare older adults.

Since the STLDI rule was proposed, AARP and other commenters have expressed concern that proliferation of STLDI policies would increase availability of plans that can deny coverage entirely or charge exorbitant premiums based on a person's age, health, or preexisting conditions. These plans will damage the individual market by siphoning younger, healthier individuals away from the ACA individual markets, making healthcare more expensive for those who remain; and result in the proliferation of confusing and deceptive marketing practices. Comment of AARP, April 23, 2018.[2] In addition to the rule's direct contravention of the ACA, it is also legally flawed because the 36-month duration limit is

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Counsel for both Parties have consented to Amici filing this brief.

[2] https://www.aarp.org/content/dam/aarp/politics/advocacy/2018/04/aarp-comment-short-term-health-plans-042318.pdf.

arbitrary. The Departments did not meaningfully address these concerns in the final rule, and the district court incorrectly concluded that the STLDI rule is permissible under the Administrative Procedure Act ("APA"). *Ass'n for Community Affiliated Plans v. United States Dep't of Treasury*, 392 F. Supp. 3d 22 (D.D.C. 2019) (hereinafter "*STLDI* Case").

Simply put, the definition of "short-term, limited duration insurance" is not reasonable when considered in the context of the interlocking reforms Congress enacted under the ACA, including the guaranteed issue, community rating, essential health benefits, and single risk pool provisions. With this rule in place, the nation will return to a pre-ACA health coverage landscape—an untenable situation for those who do not have access to coverage through their employer or publically funded programs like Medicare and Medicaid. The rule is designed to circumvent the structure of consumer protections created by Congress when it passed the ACA. Continued expansion of STLDI is especially threatening to older adults, who will face more expensive healthcare costs, or worse, lose access to the healthcare services they need.

RELEVANT FACTUAL BACKGROUND

I. BEFORE THE ACA, INDIVIDUAL ACCESS TO HEALTHCARE WAS LIMITED AND PROHIBITIVELY EXPENSIVE FOR OLDER ADULTS.

Before the ACA was enacted, significant barriers prevented older Americans from obtaining affordable insurance coverage, resulting in poor health outcomes and financial instability. Most uninsured pre-Medicare adults (aged 50 – 64) who did not have access to affordable employer-sponsored insurance could not afford private insurance on the individual market, and did not qualify for publicly funded insurance programs. *See* Kaiser Comm'n on Medicaid & the Uninsured, *Key Facts about the Uninsured Population*, 2 (Sept. 2013).[3] This situation resulted in serious negative economic and health consequences for these individuals, their families, and the nation.

Many pre-Medicare adults without employer-sponsored coverage could not afford adequate insurance policies on the private individual market. In 2007, 61% of pre-Medicare adults who tried to purchase health insurance on the private market found it very difficult or impossible to afford. *See* Sara Collins et al., *Realizing Health Reform's Potential: Adults Ages 50-64 and the Affordable Care*

[3] https://kaiserfamilyfoundation.files.wordpress.com/2013/09/8488-key-facts-about-the-uninsured-population.pdf.

Act of 2010, The Commonwealth Fund, 5, Ex. 4 (Dec. 14, 2010).[4] Pre-Medicare adults paid high health insurance premiums and out-of-pocket medical expenses because insurers were allowed to deny coverage or offer sparse benefit packages to people with preexisting conditions, charged higher premiums based on age alone, or offered policies with very high cost sharing. Elizabeth Abbott et al., *Implementing the Affordable Care Act's Insurance Reforms: Consumer Recommendations for Regulators and Lawmakers*, at 10 (Aug. 2012); [5] Lynn Nonnemaker, *Beyond Age Rating: Spreading Risk in Health Insurance Markets*, AARP Pub. Policy Inst., 3, Tbl. 1 (Oct. 2009)[6] [hereinafter Lynn Nonemaker, *Beyond Age Rating*].

Those who had preexisting conditions or were otherwise unable to purchase health insurance on the individual market were often forced to turn to state-run high risk pools to obtain coverage that, even if available, were limited and very expensive. Lynda Flowers et al., *Experience Has Taught Us That High-Risk Pools*

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[4] https://www.commonwealthfund.org/publications/issue-briefs/2010/dec/realizing-health-reforms-potential-adults-ages-50-64-and.

[5] http://www.naic.org/documents/committees_conliaison_1208_consumer_recs_aca.pdf.

[6] https://assets.aarp.org/rgcenter/ppi/health-care/i35-age-rating.pdf.

Do Not Serve Consumers Well, AARP Pub. Policy Inst. (March 2017).[7] [hereinafter Lynda Flowers et al., *Experience Has Taught Us]*. For example, states charged people with preexisting conditions up to 200 percent of rates charged in the individual market. *Id.* The state-run high risk pools presented other barriers like waiting periods of up to 12 months for coverage related to preexisting conditions, high annual deductibles, low coverage limits, lifetime limits on services, and limits on prescription drug and behavioral health services. *Id.* These circumstances caused many pre-Medicare older adults to delay or forego care, resulting in, predictably, adverse health outcomes.[8] *Id.*

Older adults without health insurance suffer both physical and financial harm. As uninsured adults age, they are more likely to experience chronic health conditions, resulting in worse health outcomes and increased mortality. Between 2001 and 2010, the prevalence of multiple chronic conditions for adults ages 45 to

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[7] https://www.aarp.org/content/dam/aarp/ppi/2017-01/experience-has-taught-us-that-high-risk-pools-do-not-serve-consumers-well.pdf.

[8] As the ACA health exchanges were ramping up and anti-discrimination protections were put in place, a similar, temporary federally-run high-risk pool was implemented to cover people with preexisting conditions. Lynda Flowers et al., *Experience Has Taught Us*. This program, called the Preexisting Condition Insurance Program ("PCIP"), was also permitted to charge pre-Medicare older adults more in premiums, for example, amounting to as much as $12,264 for a 50-year-old person in 2011. *Id.*

64 skyrocketed. Brian W. Ward et al., *Prevalence of Multiple Chronic Conditions among US Adults: Estimates from the National Health Interview Survey, 2010*, Centers for Disease Control and Prevention, Vol. 10, 5 (Apr. 25, 2013).[9] The lack of adequate, affordable health insurance also profoundly affected the financial stability of adults and, in turn, the national economy—causing individuals to incur medical care costs that depleted retirement savings, contributed to debt, and even led to bankruptcy. *See, e.g.*, Karen Pollitz et al., *Medical Debt Among People With Health Insurance*, Kaiser Family Found., 12 (Jan. 2014).[10]

II. THE ACA INCREASED OLDER ADULTS' ACCESS TO AFFORDABLE HEALTHCARE.

The ACA addressed many of the barriers described above. Among other things, the ACA prohibited discrimination based on preexisting conditions (42 U.S.C. § 300gg-4), instituted a limit on how much more insurers could charge people based solely on their age, (42 U.S.C. § 300gg(a)(1)(A)(iii); 45 C.F.R. § 147.102(a)(1)(iii)), and established individual marketplaces in each state where consumers can purchase health insurance that meets ACA requirements (42 U.S.C. § 18031). Since the ACA was signed, approximately19 million people have gained

[9] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3652717/pdf/PCD-10-E65.pdf.

[10] https://kaiserfamilyfoundation.files.wordpress.com/2014/01/8537-medical-debt-among-people-with-health-insurance.pdf.

health insurance coverage. Ricardo Alonso-Zaldivar, *U.S. Clings to Health Coverage Gains Despite Turmoil*, AP News (May 23, 2018).[11] The impact that accessing affordable healthcare has had on pre-Medicare older adults, both in terms of health outcomes and financial stability, is tremendous. *See, e.g.*, Laura Skopec et al., *Monitoring the Impact of Health Reform on Americans Ages 50-64: Access to Health Care Improved during Early ACA Marketplace Implementation*, Urban Inst. and AARP Pub. Policy Inst., 2 (Jan. 2016)[12]; Laura Skopec et al., *Monitoring the Impact of Health Reform on Americans Ages 50-64: Fewer Americans Have Difficulty Paying Family Medical Bills after Early ACA Marketplace Implementation*, Urban Inst. and AARP Pub. Policy Inst. (Jan. 2016)[13] ("Between December 2013 and March 2015, the number of 50- to 64-year-olds reporting difficulty paying family medical bills or unmet health needs due to cost dropped."); Laura Skopec et al., *Monitoring the Impact of Health Reform on Americans Ages 50-64: Uninsured Rate Dropped by Nearly Half between*

[11] https://www.aarp.org/health/health-insurance/info-2018/health-insurance-coverage-steady.html.

[12] https://www.aarp.org/content/dam/aarp/ppi/2015/access-to-health-care-improved-during-early-aca-%20marketplace-implementation.PDF.

[13] https://www.aarp.org/content/dam/aarp/ppi/2015/fewer-americans-ages-50-64-have%20-difficulty-paying-family-medical-bills-after-early-aca-marketplace%20Implementation.PDF.

December 2013 and March 2015, Urban Inst. and AARP Pub. Policy Inst. (Oct. 2015)[14] (finding "the uninsured rate for people ages 50 to 64 fell by 47.4 percent…").

In the context of the ACA-regulated markets, the role of STLDI was expected to be far more limited than in the past. 81 Fed. Reg. 75,316, 75,317 (Oct. 31, 2016) (noting that because of the ACA's guaranteed issue and special enrollment provisions STLDI was no longer "an important means for individuals to obtain health coverage"). Nevertheless, prior to 2016 and despite the individual mandate and other provisions in place designed to encourage individuals to participate in the ACA exchanges, insurers marketed STLDI plans to individuals as an alternative to primary health insurance coverage, often circumventing the 12-month coverage limitation. *Id.*; *see also* Anna Wilde Mathews, *Sales of Short-Term Health Policies Surge*, Wall Street Journal, April 10, 2016.[15] The number of people enrolled in STLDI plans more than doubled from 2013 to 2014, and by the end of December 2016, the National Association of Insurance Commissioners (NAIC) estimated that 160,000 people were covered by STLDI policies, although some

[14] https://www.aarp.org/content/dam/aarp/ppi/2015/uninsured-rate-dropped-by-nearly-half-between-december-2013-march-2015.pdf.

[15] https://www.wsj.com/articles/sales-of-short-term-health-policies-surge-1460328539.

reports suggested this number was far greater. Kevin Lucia et al., *State Regulation of Coverage Options Outside of the Affordable Care Act: Limiting the Risk to the Individual Market*, The Commonwealth Fund, 2 (March 2018)[16] [hereinafter Kevin Lucia et al., *Limiting the Risk*].

At that time, the Departments expressed concern about this practice, particularly its adverse impact on the risk pool for ACA-compliant coverage, making it more difficult to keep premiums affordable and stable. 81 Fed. Reg. 75,317-18 (Oct. 31, 2016). To protect consumers, the Departments issued new regulations in 2016 that redefined "short-term, limited-duration insurance" as nonrenewable plans lasting no more than 3 months. *Id*. This change was consistent with both the more limited role that STLDI plans historically played before the ACA and the ACA's goal of pooling individuals with varying levels of risk in the individual ACA-compliant market.

[16] https://www.commonwealthfund.org/sites/default/files/documents/___media_files_ publications_fund_report_2018_mar_lucia_state_regulation_alternative_coverage_options_rev. pdf.

ARGUMENT

I. THE STLDI RULE IS CONTRARY TO THE CLEAR PROVISIONS OF THE ACA CONGRESS DESIGNED TO ENSURE THAT ALL AMERICANS, AND OLDER ADULTS IN PARTICULAR, HAVE ACCESS TO QUALITY, AFFORDABLE HEALTHCARE.

As described above, the ACA changed the landscape of our national healthcare system and addressed many longstanding discrimination practices. *See also* Br. of Appellants at 9-14. Of critical importance to older Americans are the provisions of the ACA that prevent insurance providers from denying coverage or setting insurance premiums based on preexisting conditions ("guaranteed issue" requirement) and from charging pre-Medicare older adults on the individual market more than three times the rate of an individual age 21 and older ("age rating" requirement). 42 U.S.C. § 300gg(a)(1)(A)(iii). These provisions ensure adults ages 50 to 64 have access to affordable health insurance coverage. STLDI is exempt from the ACA's requirements, including those concerning guaranteed issue and age rating. Br. of Appellants at 14-16. Accordingly, issuers of such policies can turn back the clock and engage in the discriminatory practices that caused pre-Medicare adults to forego needed medical treatment or take on significant medical debt prior to enactment of the ACA.

A. Before the ACA, Older Americans Experienced Ubiquitous Discrimination Based on Age and Health Status.

At least 40% of people ages 50 to 64 have what could be characterized by an insurance carrier as a preexisting condition. Claire Noel-Miller et al., *In Health Reform, Stakes are High for Older Americans with Preexisting Health Conditions*, AARP Pub. Policy Inst. (March 2017).[17] The likelihood of having a pre-existing condition increases with age: up to 84 percent of those ages 55 to 64—31 million individuals—have at least one pre-existing condition. Dep't of Health and Human Servs., Office of the Assistant Secretary for Planning and Evaluation, *Health Insurance Coverage for Americans with Pre-Existing Conditions: The Impact of the Affordable Care Act* (Jan. 5, 2017).[18] Prior to the ACA, insurers routinely denied coverage to applicants with a wide variety of prior health problems that pre-Medicare adults tend to experience more often, such as heart disease, stroke, rheumatoid arthritis, chronic headaches, kidney stones, and angina. *See* Gary Claxton et al., *Preexisting Conditions and Medical Underwriting in the Individual Insurance Market Prior to the ACA*, The Kaiser Family Foundation (Dec. 12, 2016) [hereinafter Gary Claxton, et al., *Preexisting Conditions and Medical*

[17] https://www.aarp.org/content/dam/aarp/ppi/2017-01/ACA-Protects-Millions-of-Older-Adults-with-Preexisting-Health-Conditions-PPI-AARP.pdf.

[18] https://aspe.hhs.gov/system/files/pdf/255396/Pre-ExistingConditions.pdf

Underwriting]. [19] Insurers who did not deny coverage outright would often limit benefits or charge excessive premiums based on an individual's health status. H.R. Rep. No. 111-443, pt. 2, at 981 (2010).

Insurers also frequently charged people ages 50 to 64 exorbitant rates – five or six times, or even as much as 11 times greater than their younger counterparts – solely based on their age. *See* Karen Pollitz et al., *How Accessible is Individual Health Insurance for Consumers in Less-Than-Perfect Health?*, Georgetown Univ. Inst. For Healthcare Research and Policy and Kaiser Family Foundation, (June 6, 2001).[20] Insurers used an applicant's age when setting premium rates, commonly referred to as "age rating," because, they argued, health status declines with age, leading to more insurance claims. *See* NAIC & the Ctr. for Ins. and Policy Research, *Health Insurance Rate Regulation.*[21] This practice placed the cost of health insurance disproportionately on the oldest individuals in the market, and, thus, put insurance out of reach for many in the pre-Medicare age group. "For

[19] https://www.kff.org/health-reform/issue-brief/pre-existing-conditions-and-medical-underwriting-in-the-individual-insurance-market-prior-to-the-aca/.

[20] https://www.kff.org/wp-content/uploads/2013/01/how-accessible-is-individual-health-insurance-for-consumer-in-less-than-perfect-health-report.pdf

[21] http://www.naic.org/documents/topics_health_insurance_rate_ regulation_brief.pdf.

many older adults and older families, the higher out-of-pocket costs that come with greater medical use in older age, combined with high premiums due to steep age rating [], would lead to a high burden of total healthcare costs relative to income." Linda J. Blumberg et al., *Age Rating Under Comprehensive Healthcare Reform: Implications for Coverage, Costs, and Household Financial Burdens*, Urban Inst., at 8 (Oct. 2009).[22]

B. Under the STLDI Rule, Older Adults Will Be Left With Fewer and More Expensive Healthcare Coverage Options in The Individual Market.

Because STLDI is not subject to the ACA's consumer protection provisions, the Departments' promise of "increased consumer choice," 83 Fed. Reg. at 38,214, is especially disingenuous for pre-Medicare older adults. Those with preexisting conditions might not be able to obtain a STLDI policy at all. For those without preexisting conditions who are able to obtain a STLDI policy, the coverage will likely be expensive because there will be no protections against or limits on age rating in how premiums are set. *See* Gary Claxton et al., *Pre-existing Conditions and Medical Underwriting*.[23] The lack of essential health benefits means coverage

[22] https://www.urban.org/sites/default/files/publication/30701/411970-Age-Rating-Under-Comprehensive-Health-Care-Reform-.PDF.

[23] https://www.kff.org/health-reform/issue-brief/pre-existing-conditions-and-medical-underwriting-in-the-individual-insurance-market-prior-to-the-aca/.

will also be inadequate, leaving people with many unmet medical needs because of the myriad of conditions STLDI policies often exclude. *Id.*

Moreover, individuals who buy into STLDI plans may not know what protections exist – or are lacking—in their plan. Even if these individuals initially secure a STLDI policy, they may be subject to post-claim underwriting or rescission – a practice prohibited under the ACA – that can result in abrupt cancellation of coverage. For example, before the ACA, one retiree, several months after purchasing a series of 6-month short-term insurance policies, went to the doctor regarding a lump that had been behind her ear for about a year. Peter Harbage M.P.P. and Hilary Haycock, *Primer on Post-Claims Underwriting*, Robert Wood Johnson Foundation, at 3-4 (citing Julie Appleby, *People left holding the bag when policies revoked*, USA Today, December 13, 2007)).[24] The lump was diagnosed as cancer, and her insurer canceled her policy on the basis that the lump was preexisting. *Id.* The insurer said, "an ordinarily prudent person would seek diagnosis or treatment when a lump initially presents itself[,]" which, according to the insurer in this example, was prior to the purchase of her policy. *Id.* Without restrictions on such practices, pre-Medicare older adults are vulnerable to the

[24] https://harbageconsulting.com/wp-content/uploads/2016/08/Primer-on-Post-Claims-Underwriting.pdf.

discriminatory and even predatory practices of insurers, who are not required to make paying for medical care a priority.

Returning to pre-ACA age rating practices will also harm pre-Medicare older adults. An AARP research report conducted by Milliman estimated that changing the ACA age rating limit from 3:1 to 5:1 in the individual markets would significantly increase premiums for pre-Medicare older adults. Jane Sung et al., *Impact of Changing The Age Rating Limit for Health Insurance Premiums*¸ AARP Pub. Policy Inst. (Feb. 2017).[25] Even while maintaining the other protections the ACA provides, increasing the age rating limits within the structure of the ACA would increase premiums by 22 percent for adults age 60 plus, and by 13 percent for adults ages 50 to 60. *Id.* at 1. Without any age rating limitation, and without any of the ACA's other consumer protections, STLDI plans will not provide an affordable option for many pre-Medicare older adults, who will be left paying out of pocket to secure medical treatment excluded from their STLDI plan or forced to forego critical care.

C. Expansion of STLDI Has Created Confusion In The Individual Insurance Market.

As appellants point out (Br. for Appellants at 22-23), the risks to consumers associated with expansion of STLDI that commenters, including AARP, warned of

[25] https://www.aarp.org/content/dam/aarp/ppi/2017-01/Final_Spotlight_Age_Rating_Feb7.pdf.

have been realized across the country. The rule leaves regulation of STLDI almost entirely to the states. 83 Fed. Reg. at 38,219. The minimal disclosure language contained in the final rule states that each individual consumer is responsible for reviewing their STLDI policy in detail to determine what conditions are covered and what exclusions may apply. Leaving consumers to fend for themselves with only this limited information has increased confusion and created an environment that is ripe for deceptive marketing of STLDI plans and fraud against consumers, especially those who are older. Indeed, an Urban Institute report indicates the regulators in several states "acknowledged that many consumers would likely be confused about the differences between short-term plans and ACA-compliance coverage." Sabrina Corlette et al., *The Marketing of Short-Term Health Plans: An Assessment of Industry Practices and State Regulatory Responses*, Urban Institute (Jan. 2019).[26]

Older adults are likely to be especially susceptible to this confusion, as many already have a difficult time navigating increasingly complex healthcare options. A recently published AARP survey reveals that almost two-thirds of pre-Medicare older adults (ages 60 to 64) were unable to answer a majority of four basic

[26] https://www.urban.org/sites/default/files/publication/99708/moni_stldi_final.pdf.

questions about the program. Kent Allen, *Many Older Adults Can't Answer Basics on Medicare*, AARP, (Sept. 18, 2018).[27] Even in the Medicare context, where the government has worked diligently to simplify enrollment processes, making coverage choices involves complex decision-making. Dena Bunis, *How to Choose a Medicare Plan*, AARP Bulletin, (Oct. 2017).[28]

Expanding the availability and duration of STLDI policies promises to complicate matters further. The deputy commissioner of the California Department of Insurance has said "[p]eople don't realize these products don't cover much of anything," and "[i]f they end up needing significant care, they probably won't be able to afford the share of the costs they have to pay." Nancy Metcalf, *Is 'Short-Term' Health Insurance a Good Deal?*, Consumer Reports, (Dec. 22, 2017)[29] Individuals are even less likely to be able to make fully informed choices in light of the history of brokers "using tactics rife with fraud" to induce consumers to purchase these plans. Reed Abelson, *Without Obamacare Mandate, 'You Open the*

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[27] https://www.aarp.org/health/health-insurance/info-2018/most-adults-cant-answer-medicare-questions.html?intcmp=HEA-HI-FEED.

[28] https://www.aarp.org/health/medicare-insurance/info-2017/choosing-medicare-plan.html? intcmp=AE-HEA-HI-COV-R1-C1-ART-CRGTHM2017.

[29] https://www.consumerreports.org/health-insurance/is-short-term-health-insurance-a-good-deal/.

Floodgates' for Skimpy Health Plans, New York Times, Nov. 30, 2017 [hereinafter "Reed Abelson, *Floodgates*"] (citing study by online broker eHealth).[30] Indeed, a marketing scan performed after implementation of the STLDI rule shows that consumers are likely to have difficulty obtaining the information necessary to make informed insurance purchases. Corlette, *supra*.

STLDI brokers are notorious for their aggressive and misleading marketing practices, and both individual consumers and state regulators have begun to file lawsuits to curb unlawful practices. Reed Abelson, *Floodgates.*[31] In the past two years, Pennsylvania regulators took legal action against seven agents for misrepresenting STLDI plans. *Id.* In Montana, the state auditor recommended disciplining a group of STLDI brokers who used "misinformation and deception" to market STLDI plans to consumers, when it was found that many buyers did not know their plans were not ACA-compliant and did not cover preexisting conditions. Metcalf, *Is 'Short-Term' Health Insurance a Good Deal*?.[32] In their

[30] https://www.nytimes.com/2017/11/30/health/health-insurance-obamacare-mandate.html.

[31] https://www.nytimes.com/2017/11/30/health/health-insurance-obamacare-mandate.html.

[32] https://www.consumerreports.org/health-insurance/is-short-term-health-insurance-a-good-deal/.

comment to the STLDI proposed rule, NAIC and the Center for Insurance Policy Research ("CIPR") requested that implementation of the rule be delayed until 2020, so that states could "modify existing laws and regulations to protect consumers and state markets." Comment of NAIC and CIPR, April 23, 2018.[33] Significantly, many states' regulators lack the authority to reject or require modifications to STLDI policies before they are sold. Corlette, *supra.* In addition, in many states, insurers who offer short term plans are not required to annually refile their plans or rates with the state unless there is a "material" change to the benefit design or formula by which rates are set (unlike ACA-compliant plans, which must be refiled annually). *Id.*

II. THE STLDI RULE UNDERMINES THE ACA'S SINGLE RISK POOL PROVISION, SIGNIFICANTLY LIMITING HEALTHCARE CHOICES FOR MANY INDIVIDUALS AS THEY AGE.

Another key component of the ACA-regulated markets, designed to work in conjunction with the guaranteed issue and age rating provisions described *supra*, is that insurers in each state are required to consider all enrollees in all health plans as part of a single risk pool when setting premiums. 42 U.S.C. § 18032(c); 45 C.F.R. § 156.80. The purpose of the single risk pool is to "prevent issuers from segregating enrollees into separate rating pools based on health status[,]" thus

[33] https://www.naic.org/documents/index_health_reform_section_180423_comments_limited_ duration_nprm.pdf.

spreading healthcare costs among all exchange enrollees. *See* Final Rule, Patient Protection and Affordable Care Act; Health Insurance Market Rules; Rate Review, 78 Fed. Reg. 13,406, 13,422 (Feb. 27, 2013). Under this structure, the costs of insuring those with the greatest healthcare needs are offset by the profits from premiums paid by those who do not currently have high medical needs. *Id.* When the risk pool is diverse in terms of both age and anticipated medical needs, insurers can offer coverage with more predictable and stable premiums to everyone, including pre-Medicare older adults with preexisting conditions who would otherwise be unable to access coverage. *See* Kevin Lucia et al., *Limiting the Risk.*[34]

As appellants point out, the district court recognized that the STLDI rule was designed to create an alternative insurance market that would compete with ACA-compliant plans; to provide "an additional choice for many consumers that exists side-by-side with individual market coverage." Br. of Appellants at 19-20 (citations omitted). In addition, the Departments affirmed the findings originally contained in the 2016 rule that STLDI plans will generally draw healthier consumers who are currently enrolled in an ACA-compliant plan out of the individual markets. *See* 83 Fed. Reg. at 38,235. The STLDI rule, combined with

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[34] https://www.commonwealthfund.org/sites/default/files/documents/___media_files_ publications_fund_report_2018_mar_lucia_state_regulation_alternative_coverage_options_rev. pdf.

other changes, including the reduction of the individual mandate tax penalty to zero dollars and recent guidance expanding the scope of state waivers under section 1332 of the ACA,[35] will adversely impact risk allocation in the ACA marketplaces. Linda J. Blumberg et al., Urban Inst., *Updated Estimates of the Potential Impact of Short-Term Limited-Duration Policies* (Aug. 2018)[36] [hereinafter "Blumberg et al., "*Updated Impact of STLDI*"].This will resurrect the challenges older adults faced in the pre-ACA healthcare system.

A. The Departments Know Healthy Adults Will Enroll in STLDI Plans, Fragmenting the Risk Allocation for ACA-Compliant Plans and Undermining the ACA.

STLDI plans are likely to siphon away people who have not yet experienced health conditions that require more comprehensive ACA-compliant coverage. This is primarily because of the perception of immediate cost savings. For example, in 2016 a short-term policy averaged $109 per month for an individual, as compared to $378 for an ACA-compliant plan. Reed Abelson, *Floodgates* (citing study by online broker eHealth).[37] But in this case, you get what you pay for; STLDI plans

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[35] State Relief and Empowerment Waivers, 83 Fed. Reg. 53,575 (Oct. 24, 2018), https://go.usa.gov/xPz5Z.

[36] https://www.urban.org/sites/default/files/publication/98903/2001951_updated-estimates-of-the-potential-impact-of-stld-policies_0.pdf.

[37] https://www.nytimes.com/2017/11/30/health/health-insurance-obamacare-mandate.html.

have lower premiums because they offer little protection, often have high deductibles and contain caps on coverage, and leave consumers to foot most of the bill in an emergency. For example, a September 2019 news article profiled Marisia and David Diaz, ages 56 and 49, who were left with bills totaling $244,447.91 after David suffered a heart attack. Zeke Faux et al., *Health Insurance That Doesn't Cover the Bills Has Flooded the Market Under Trump*, Bloomberg Businessweek, (Sept. 17, 2019).[38] They learned their policy did not cover preexisting conditions, had a high deductible, limited physician visits, and placed caps on hospital coverage, emergency room visits, and surgery costs. *Id.* The Departments anticipated in the final rule that pre-Medicare adults like the Diazes and younger adults who do not have current health conditions may envision that these STLDI are better for them. 83 Fed. Reg. at 38,235.

The Departments expect up to 1.6 million people to buy short-term policies over the next four years, and they anticipate that in 2019 alone, between 100,000 and 200,000 people previously enrolled in individual market coverage will purchase STLDI policies instead. *See* 83 Fed. Reg. at 38,236. The Urban Institute

[38] https://www.bloomberg.com/news/features/2019-09-17/under-trump-health-insurance-with-less-coverage-floods-market?utm_campaign=KHN%3A%20First%20Edition&utm_source=hs_email&utm_medium=email&utm_content=76980149&_hsenc=p2ANqtz--was5njFFogOoxrFeIpw9Uf7HrJdzO3yDymf5TapdWcpLDywp6FfyUPnB2mL4SySsj-fwdA3pSyAEcgHziRA0CndrQ-Q&_hsmi=76980149.

estimates that introduction of expanded short-term, limited-duration policies, combined with the removal of the tax penalty, will increase the number of people without minimum essential health coverage by 2.6 million in 2019 – bringing that number up to 36.9 million people total. Blumberg et al., *Updated Impact of STLDI*.[39] Of those people, 32.5 million will be completely uninsured, and 4.3 million will enroll in expanded short-term, limited-duration plans—a far higher estimate than the Departments suggest. *Id*.

One of the district court's central findings—that the STLDI rule does not threaten the stability of the individual markets—is undermined by the facts. The district court supported this determination by relying on a statement in the rule that says subsidies—amounts provided by the government to individuals who made between 100% and 400% of the federal poverty level to cover the cost of insurance premiums—cannot be used to purchase *STLDI*. 392 F. Supp. 3d at 36 (citing 83 Fed. Reg at 38,235-36). Therefore, the district court reasoned, individuals who receive subsidies have no incentive to exit the exchanges and purchase STLDI plans. *Id.* This conclusion ignores the fact that just two months after issuing the STLDI rule, the Departments issued guidance related to section 1332 of the ACA

[39] https://www.urban.org/sites/default/files/publication/98903/2001951_updated-estimates-of-the-potential-impact-of-stld-policies_0.pdf.

that expressly contemplates states utilizing such a waiver to expand access to STLDI. State Relief and Empowerment Waivers, 83 Fed. Reg. 53575 (Oct. 24, 2018).[40] Although the Departments have yet to approve such a waiver, at least one state has released a draft waiver application that would allow for subsidization of plans that offer a more limited set of essential health benefits. *See* The Office of the Governor, Georgia Draft1332 Waiver Application (Nov. 4, 2019).[41] Nevertheless, after issuing the STLDI rule, the Departments effectively paved the way for states to waive many of the ACA's provisions, including in ways that would allow utilization of subsidies for STLDI premiums.

Pulling that many people from the ACA-compliant individual market defies Congressional intent and jeopardizes the financial viability of ACA-compliant plans. *See* Kevin Lucia et al., *Limiting the Risk* at 2; *see also* Dena Bunis, *Short-Term Insurance Plans Are a Bad Idea*, AARP (March 21, 2018) [hereinafter "Busis *STIPlans are a Bad Idea"]*.[42] Adverse selection is inevitable because

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[40] https://go.usa.gov/xPz5Z.

[41] https://gov.georgia.gov/document/document/georgia1332draftwaiver 11042019pdf/download. The draft Georgia waiver application indicates that issuers will be required to stay in the single risk pool, maintain protections for people with preexisting conditions, and may not medically underwrite. *Id.* at 18.

[42] https://www.aarp.org/politics-society/advocacy/info-2018/congress-reject-junk-health-insurance-plans-fd.html.

individuals with higher average healthcare expenses will continue to enroll in ACA-complaint plans. Blumberg et al., *Impact of STLDI*.[43] Meanwhile, healthy individuals currently enrolled in comprehensive coverage (as opposed to individuals who are currently uninsured), will be drawn to STLDI. The Congressional Budget Office (CBO) and Joint Committee on Taxation (JCT) expect that "lower premiums are more likely to attract people [] who already purchase coverage than they are to convince a person [] to purchase coverage for the first time." Congressional Budget Office (Jan. 2019), *How CBO and JCT Analyzed Coverage Effects of New Rules for Association Health Plans and Short-Term Plans* [hereinafter "CBO *Analyzed Coverage Effect of New Rules"]*.[44] The Departments acknowledge this result in the supplementary information to the final rule, noting that the rule "could lead to further worsening of the risk pool by keeping healthy individuals out of the individual market for longer periods of time…." 83 Fed. Reg. at 38,235.

[43] https://www.urban.org/sites/default/files/stld_draft_0226_original_0.pdf.

[44] https://www.cbo.gov/system/files?file=2019-01/54915-New_Rules_for_AHPs_STPs.pdf.

B. Risk Pool Fragmentation Will Increase Premiums For Pre-Medicare Older Adults Remaining On ACA-Compliant Plans.

Implementation of the STLDI Rule will cause premiums to rise for those remaining in the ACA-regulated individual health insurance market who do not qualify for a subsidy or tax credit. AARP's Public Policy Institute anticipates that the SLTDI rule combined with the zeroing out of the individual mandate penalty will lead to higher annual premiums than they otherwise would for 60-year-olds purchasing silver level coverage on an ACA marketplace. Jane Sung et al., *Warning: Short-Term Plans = Higher Premiums for Older Adults* AARP Pub. Policy Inst., (March 21, 2018)[45]; see *also* Bunis, *STIPlans Bad Idea*.[46]

The CBO and JCT estimate that premiums will rise by roughly 3 percent as a result of the STLDI rule and the final rule concerning association health plans (83 Fed. Reg. 28912 (June 21, 2018)). Congressional Budget Office, *How CBO and JCT Analyzed Coverage Effects of New Rules for Association Health Plans and Short-Term Plans* (Jan. 2019).[47] Other estimates that take into consideration

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[45] https://blog.aarp.org/2018/03/21/warning-short-term-health-plans-higher-premiums-for-older-adults/.

[46] https://www.aarp.org/politics-society/advocacy/info-2018/congress-reject-junk-health-insurance-plans-fd.html.

[47] https://www.cbo.gov/system/files?file=2019-01/54915-New_Rules_for_AHPs_STPs.pdf.

the zeroing out of the individual mandate tax penalty estimate far higher premium increases for individual ACA-complaint plans– 18.3 percent on average – in the 43 states (including the District of Columbia) that do not prohibit or limit short-term plans. Blumberg et al., *Updated Impact of STLDI*.[48] The district court dismissed the significance of such an increase, 392 F. Supp. 3d at 36, but returning to circumstances where older adults are priced out of the insurance market is a dangerous proposition and huge step backwards for the nation.

III. THE RULE PLACES NO MEANINGFUL LIMIT ON THE DURATION OF SHORT-TERM INSURANCE AND PROVIDES INSTRUCTIONS ON HOW TO EXTEND STLDI PLANS WELL BEYOND 36-MONTHS WITHOUT THREAT OF FEDERAL ENFORCEMENT, DEMONSTRATING THE DEPARTMENTS' INTENT TO UNDERMINE THE ACA.

The district court held that the rule's 36-month duration "limit" was "obviously consistent with the ordinary meaning of 'limited duration'" because "'the term during which [the coverage] exists or lasts' is 'circumscribed within definite limits' and 'restricted' to 36 months." Op. at 26 (alterations original). However, the plans' duration is, in fact, *not* circumscribed at all. The district court opinion all but acknowledges that when contrasting ACA exchange plan

[48] https://www.urban.org/sites/default/files/publication/98903/2001951_updated-estimates-of-the-potential-impact-of-stld-policies_0.pdf. Estimates are current as of this report's August 2018 publication. Additional states may have enacted legislation limiting STLDI plans since publication.

enrollment in states that "meaningfully restrict STLDI plan terms" with those that follow the current federal rule. Op. at 23. Indeed, the rule itself makes clear that the nominal 36-month duration limit is illusory—and intentionally so.[49] The rule explains how individuals can extend STLDI coverage indefinitely, and the Departments actively encourage doing so.

The rule details precisely how individuals and insurance providers may circumvent the 36-month limit without risk of federal agency intervention. 83 Fed. Reg. at 38,222. The rule describes multiple "mechanisms" to extend STLDI coverage. *Id.* First, individuals may purchase separate option contracts "or other instrument[s] under which the individual can, in advance, lock in a premium rate in the future." *Id.* Individuals may also "purchase a new, separate short-term, limited-

[49] Because the district court collapsed the *Chevron* Step II and "arbitrary and capricious" analyses, Op. at 33-34, it did not address whether the departments adequately explained its basis for selection 36 months as the theoretical duration-limit. Even if this limit really did cabin STLDI plans' duration, the Departments' explanation that 36-months is comparable to COBRA's duration limit is fatally flawed. COBRA coverage, unlike STLDI coverage, is comprehensive. *See* 42 U.S.C. §§ 300gg-300gg-9 (describing coverage, cost-sharing, and non-discrimination requirements for ACA-compliant plans, including group health insurance coverage like that provided by an employer). The period of time that is appropriate for offering access to more comprehensive, employer-based group health coverage under COBRA cannot be analogized to the period of time that is appropriate for allowing minimal, limited coverage that is not ACA-compliant to continue. COBRA is not substantively inadequate or discriminatory against pre-Medicare older adults and others with preexisting health conditions, and it is not a vehicle for destabilizing the individual markets by siphoning off younger, healthier individuals. Thus, transplanting one of COBRA's duration limits into the STLDI context is irrational.

duration insurance policy at a specified premium rate at a future date without re-underwriting[.]" *Id.* Under these circumstances, the Department suggests, "it may be possible for a consumer to maintain coverage under short-term, limited-duration insurance policies for extended periods of time." *Id.*

The rule goes on to explain that issuers are not prohibited from "offering a new short-term, limited-duration insurance policy to consumers who have previously purchased this type of coverage, or otherwise prevent consumers from stringing together coverage under separate policies offered by the same or different issuers, for total coverage periods that would exceed 36 months." *Id.* Finally, the rule specifies that "[t]he Departments are also significantly limited in their ability to take an enforcement action under [the relevant statutory provisions] with respect to such transactions involving products or instruments that are not health insurance coverage." *Id.*

Contrary to the district court's conclusion, this government guidebook on how to extend STLDI plans for beyond any reasonable sense of "short-term" is a glaring "indication that those charged with implementing the balance [of policy concerns] have failed to observe it." Op. at 38. Not only have the Departments declined to even attempt to place any limits on individuals' or issuers' ability to extend STLDI coverage indefinitely, but they have also set forth detailed instructions on how to craft such extensions with impunity. More than that, the

Departments have essentially disclaimed any authority to prevent individuals or issuers from taking advantage of loopholes. In short, the rule that purportedly sets limits on the term and duration of non-ACA-compliant individual insurance goes out of its way to make any such limits meaningless.

This loophole-instruction-manual evinces the Departments' intent to undermine the ACA-compliant market rather than supplementing or complementing it. Allowing STLDI plans to become permanent fixtures undermines the ACA-compliant market by creating a parallel STLDI market that will be in direct competition. A regulation that undercuts the purpose of the statute it purports to interpret is invalid because it is unreasonable, arbitrary, and capricious. *Northpoint Technology, Ltd. v. F.C.C.*, 412 F.3d 145, 151 (D.C. Cir. 2005) ("A 'reasonable' explanation of how an agency's interpretation serves the statute's objectives is the stuff of which a 'permissible' construction is made"); *AARP v. EEOC*, 267 F. Supp. 3d 14, 30 (2017) ("The purpose of a statute, and the way in which a proposed rule furthers the purposes of a statute, is critical to the *Chevron* step two analysis"). A regulation that *deliberately* subverts the statutory purpose also relies on impermissible factors—an independent reason for invalidating the rule. *Safari Club Int'l v. Zinke*, 878 F.3d 316, 325 (D.C. Cir. 2017) (citing *Motor Vehicle Mfrs. Ass'n v. State Farm Mut. Auto Ins. Co.*, 463 U.S. 29,

43 (1983)). Because this rule demonstrably sets out to undermine the statute it interprets it is arbitrary and capricious and should be vacated and set aside.

CONCLUSION

For these reasons, the district court's decision should be overturned.

Dated: November 12, 2019

Respectfully Submitted,

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CERTIFICATE OF COMPLIANCE

1. This document complies with the word limit of Fed. R. App. P. 32(a)(7) because, excluding parts of the document exempted by Fed. R. App. P. 32(f), this document contains 6,107 words.

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Date: November 12, 2019

/s/Kelly Bagby
Kelly Bagby

CERTIFICATE OF SERVICE

I hereby certify that on November 12, 2019 I electronically filed the foregoing Brief of Amici Curiae AARP and AARP Foundation in Support of Appellants with the Clerk of the Court for the United States Court of Appeals for the D.C. Circuit by using the CM/ECF system. I certify that all participants in the case are registered CM/ECF users and that service will be accomplished by the CM/ECF system.

Date: November 12, 2019

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