ORAL ARGUMENT SCHEDULED FOR MARCH 20, 2020

No. 19-5212

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

ASSOCIATION FOR COMMUNITY AFFILIATED PLANS, ET AL.,

Appellants,

v.

UNITED STATES DEPARTMENT OF TREASURY, ET AL.,

Appellees.

On Appeal from the U.S. District Court
for the District of Columbia
Case No. 18-2133 (Leon, J.)

REPLY BRIEF FOR THE APPELLANTS

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SUMMARY OF ARGUMENT

A. Congress did not ratify the 1997 Rule when it enacted the ACA. The Supreme Court and this Court repeatedly have held that ratification by re-enactment should be found only when, at a minimum, there is reason to believe that Congress was aware of the prior regulation. Here, the government does not, and could not, contend that Congress was aware of the 1997 Rule when it enacted the ACA: that rule was of distinctly limited importance, and neither the 1997 rule nor STLDI itself was mentioned during consideration of the ACA.

B. The STLDI Rule is inconsistent with the text and purpose of the ACA. Congress intended that all purchasers of primary insurance in the individual market would be in a single risk pool, an outcome that the STLDI Rule would frustrate. There is no evidence Congress intended that either STLDI or other products exempted from HIPAA's definition of individual health insurance coverage, such as excepted benefits, would be marketed as primary health insurance in competition with ACA-compliant plans; at the time of the ACA's enactment, those products were not used as comprehensive insurance. Conversely, there

is every reason to believe that Congress intended all forms of primary health insurance to offer benefits deemed "essential" in the ACA.

C. The STLDI Rule departs from the plain meaning of the words "short-term" and "limited-duration." The government makes no attempt to show how a term that is virtually as long as the standard term could reasonably be characterized as "short-term." Nor does it explain how "limited-duration," when used in conjunction with "short-term," could mean anything other than nonrenewable.

D. The STLDI Rule is arbitrary and capricious. It takes no account of the policy of the ACA, the statute it was promulgated to govern. The government does not show that the Departments offered a reasoned explanation for displacing the 2016 Rule, the purposes of which they ignore or misstate. And the Departments still have not responded to comments showing that the STLDI Rule will create dangerous gaps in insurance coverage.

ARGUMENT

In the Departments' telling, Congress enacted the ACA to establish two parallel health insurance systems in the individual market. The first serves people who choose to obtain ACA-compliant

plans, which must provide the health benefits that Congress found to be "essential"; accept people with pre-existing conditions; avoid discrimination in their premiums; and offer a range of other protections that guard against the abuses Congress found to have been rampant in the pre-ACA health insurance market.

The parallel system, the Departments continue, is available to all people who dislike the ACA—although, as a practical matter, this system excludes people with pre-existing conditions or who cannot pay the discriminatorily high premiums charged to many groups of consumers by non-ACA-compliant plans. Insurance obtained through this shadow system typically will not provide the benefits found by Congress to be "essential," and will instead feature all the abuses that Congress condemned when it enacted the ACA, while weakening ACA-compliant plans by drawing young and healthy subscribers out of those plans.

Although the Departments represent that Congress intended this alternative insurance system to serve as many as 14 million people (*see* U.S. Br. 5, 29), the system is nowhere expressly mentioned in the text or history of the ACA. Instead, the Departments say, Congress

accomplished this far-reaching result *sotto voce*, through the ACA's incorporation by reference of HIPAA's definition of "individual health insurance coverage," which excludes STLDI. The Departments assert that by taking this step, Congress meant STLDI to be the vehicle through which millions of people would obtain their non-ACA-compliant primary insurance coverage—even though, as the Departments expressly acknowledged when promulgating the STLDI Rule, STLDI was used at the time of the ACA's enactment only as a form of transitional coverage.

This account of the ACA's purpose is head-scratchingly wrong. In Justice Scalia's famous terminology, a rule affecting the availability and price of health insurance that is crucial to the well-being of millions of people is a paradigmatic elephant; a bare cross-reference to an obscure definitional provision in a decades-old statute is the quintessential mousehole. Try as they might, the Departments cannot cram their elephant into the mousehole provided by Congress. For that reason—and because the Departments also take no account of the statutory language, while failing to defend their defective rulemaking process—the STLDI Rule should be set aside.

I. The ACA did not ratify the 1997 rule.

The Departments begin by stating that the "clearest evidence" supporting the STLDI Rule is Congress's asserted ratification of the 1997 Rule's STLDI definition when it enacted the ACA. U.S Br. 22. But the declaration that this is the Departments' "clearest evidence" is a concession of weakness. As we showed in our opening brief (at 47-49), the Departments' ratification argument repeatedly has been rejected by the Supreme Court and this Court. The Departments' contrary contentions are wrong.

First, the Departments declare that Congress's failure to revise a regulation when it revisits the statute that gave rise to that regulation is "'persuasive evidence that the interpretation is the one intended by Congress.'" U.S. Br. 24 (quoting *Altman v. SEC*, 666 F.3d 1322, 1326 (D.C. Cir. 2011)). But so far as we have been able to determine, courts have applied that principle to uphold a regulation only when there is evidence that Congress was aware of the administrative construction. That was the case in *Altman*, the Departments' only authority on this point, where Congress expressly incorporated the terms of the pre-existing regulation into the ratifying statute. *See id.* at 1326. The

government identifies no decision finding ratification absent evidence of such awareness.

Second, the Departments attempt to distinguish the decisions we cite as involving ratification claims resting on "[f]ailed legislative proposals." U.S. Br. 24. That accurately describes one of the cases we note, *Solid Waste Agency of Northern Cook County v. United States Army Corps of Engineers*, 531 U.S. 159, 169-70 (2001), although the Supreme Court there used unqualified language in urging "extreme care" in application of the ratification doctrine. The other decisions we cited are materially identical to this case, where the Supreme Court rejected the government's "reenactment argument" because "the record of congressional discussion preceding reenactment makes no reference to the … regulation, and there is no other evidence to suggest Congress was even aware of the [agency's] interpretive position. 'In such circumstances we consider the … reenactment to be without significance.'" *Brown v. Gardner*, 513 U.S. 115, 121 (1994) (ellipsis added by the Court) (citation omitted). *See* Opening Br. 48 & n.18. That, of course, is precisely the situation in this case. The government fails to cite, let alone attempt to distinguish, these decisions.

Third, the Departments see no need for "hard evidence" that Congress was aware of the 1997 Rule when it enacted the ACA so long as there is "'reason to assume[] congressional familiarity with the administrative interpretation at issue.'" U.S. Br. 25. But here, as we showed in our opening brief (at 9, 48-49), there is every reason to assume that Congress had ***no*** familiarity with the 1997 Rule, which (1) addressed an obscure element of the health insurance market; (2) was of such ***un***importance that the Departments offered no explanation for the Rule when issuing it either in proposed form in 1997 or final form in 2004; (3) received no public comments at either time; and (4) so far as we (and, evidently, the government) is aware, was not mentioned at any point by anyone during the lengthy process leading to the ACA's enactment. If ever there were a case in which legislative ratification would be an insupportable fiction, this is it.[1]

[1] The Departments maintain that Congress must have been aware of the 1997 Rule because that Rule would, in our telling, frustrate the ACA's central reforms; therefore, the Departments continue, "[i]t defies reason for plaintiffs to suggest in the same breath that the definition was too inconsequential for Congress to ignore." U.S. Br. 25. This contention, however, is circular. Congress ignored the 1997 Rule when it enacted the ACA precisely because, in the years preceding the ACA's enactment, the rule ***was*** so inconsequential that Congress did not have

Fourth, the Departments see a distinction between an agency's argument that its approach has been mandated by Congress and an assertion that "Congress approved the interpretation as permissible," evidently meaning to contend that evidence of congressional awareness of the assertedly ratified rule is necessary in the first, but not the second, of these situations. U.S. Br. 25. But this distinction makes no sense: if Congress cannot be deemed to have enacted a standard that it did not know existed, it surely also cannot be deemed to have given that standard some less formal sort of approval. "[B]ecause the rationale of [this] canon must be, either that those in charge of the amendment are familiar with existing rulings, or that they meant to incorporate them, … the government's [ratification] argument has little weight absent some evidence of (or reason to assume) congressional familiarity with the administrative interpretation at issue." *Public Citizen Inc. v. HHS*, 332 F.3d 654, 669 (D.C. Cir. 2003) (citation omitted). *See also Brown*, 513 U.S. at 121; *AFL-CIO v. Brock*, 835 F.2d 912, 915 (D.C. Cir. 1987).

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it in mind. It was only post-enactment, when insurers began marketing STLDI so as to evade the ACA's requirements, that the 1997 definition became significant.

Finally, even if the Departments' ratification arguments otherwise had force, "[t]here is an obvious trump to the reenactment argument, … in the rule that 'where the law is plain, subsequent reenactment does not constitute an adoption of a previous administrative construction.'" *Brown*, 513 U.S. at 121 (citation omitted). As we showed in our opening brief, and next explain, the text and policy of the ACA plainly require rejection of the STLDI Rule.

II. The STLDI Rule departs from the language and purpose of the ACA.

When the Departments turn to the merits of the Rule, they offer a counter-factual account of the ACA's language and purpose. As we have noted (at 2-4, *supra*), the Departments' story is that Congress sought to make ACA-compliant insurance available to persons who want it, but simultaneously allowed all who dislike the ACA to opt out of its provisions by purchasing skimpy primary insurance that carries none of the ACA's protections. For several reasons, this contention is wrong.

A. The ACA places all purchasers of primary insurance in a single risk pool.

To begin, the Departments misstate the ACA's purpose, as reflected in the statute's plain language. The ACA's theory is that virtually all people seeking health insurance in the individual market

should be in a single risk pool. Op. Br. 32-38. Congress could not have been clearer about the universality of this requirement:

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

42 U.S.C. § 18032(c) (emphasis added). Congress believed this structure essential to prevent adverse selection and keep health coverage affordable. *See* Opening Br. 10-13.

In response, the Departments declare that Section 18032 fosters "consumer choice," emphasizing that "[t]he provision disavows any intent to restrict the markets for off-Exchange insurance plans, which are not subject to all of the same requirements as plans offered on the Exchanges." U.S. Br. 30 (citing 42 U.S.C. § 18032(d)(1)). But this is a non sequitur: although off-Exchange plans are not subject to certain technical requirements certifying "qualified" plans for sale on

Exchanges,[2] ***all*** plans authorized by the ACA, including off-Exchange plans, must meet the ACA's individual market requirements and, under Section 18032(c)(1), must make all enrollees in all plans part of the single risk pool. Perhaps this is why the Departments did not rely on Section 18032(d) before the district court, which in turn did not cite the provision.[3]

B. Congress did not intend to allow the sale of alternative forms of comprehensive coverage in competition with ACA-compliant plans.

1. The Departments also maintain, "more broadly," that "Congress preserved less expensive coverage options for consumers" because it expected "that millions of people would be either unwilling to purchase or unable to afford ACA-compliant coverage." U.S. Br. 29-30; *see id.* at 5. There is, however, ***no*** evidence that Congress used the HIPAA

[2] The additional requirements are set out in 42 U.S.C. § 18031(c)(1) and include, for example, accreditation requirements and requirements that "qualified health plans" contract with essential community providers.

[3] The Departments get no further in quoting Section 18032(d)(3)(A), which "preserves 'the choice of a qualified individual to enroll *or not to enroll* in a qualified health plan or to participate in an Exchange.'" U.S. Br. 30. Section 18032(d)(3)(A) simply says that anyone eligible to enroll in a qualified plan may choose to purchase an ACA-compliant plan off an Exchange, rather than a qualified plan certified for sale on an Exchange.

definition of "individual health insurance coverage" in the ACA to establish STLDI as a comprehensive, alternative coverage option for people who, for whatever reason, dislike the ACA; the government points to no such evidence.

On the face of it, "preserv[ing] less expensive coverage options" could not have been the intent of Congress, which would have known that coverage without consumer protections is not the answer to the lack-of-insurance problem posited by the Departments. Such plans, notably including STLDI, would be wholly unavailable as a practical matter to the millions of the Departments' hypothesized uninsured who need health insurance the ***most*** and who the ACA was specifically designed to protect—those with pre-existing conditions and persons charged discriminatorily high premiums (women of child-bearing age, the elderly, and persons with a history of illness, among many others). All of these people would be denied coverage outright, or priced out of this alternative market, just as they had been excluded from such plans prior to enactment of the ACA. *See* Opening Br. 9-10.

The Departments' contention that Congress expected HIPAA's exceptions from the definition of "individual health insurance coverage"

to serve as a gateway for non-ACA-compliant primary coverage (*see* U.S. Br. 30) is flawed for an additional reason: Those exceptions—including STLDI—***never*** had been treated as primary health insurance before the ACA's enactment. *See* Opening Br. 7-8. The Departments do not contend otherwise. It therefore is hardly likely that Congress cross-referenced HIPAA's definition into the ACA so that these previously peripheral forms of coverage would become the basis for a new system of comprehensive insurance covering millions of people.

In this regard, the evolving nature of Departments' argument is telling. Before the district court, the Departments also contended that Congress's preservation of alternatives to ACA-compliant coverage showed that Congress did not expect all insured to be in ACA-compliant plans. To support this contention, the Departments pointed to grandfathered pre-ACA plans and student plans, which the district court relied upon. *See* Opening Br. 44-45. As we show in our opening brief (44-47), however, this contention was plainly wrong: student plans are generally subject to ACA requirements; grandfathered plans also are subject to key ACA requirements and were exempted from others so as to ease the healthcare industry into full ACA compliance.

Before this Court, the Departments have changed course, abandoning any reliance on the grandfathered or student plans that were a central part of their district court argument. Instead, they offer a new theory to show that Congress intended to permit development of an alternative system of primary health care in the individual market, emphasizing the exemptions from HIPAA's "individual health insurance coverage" definition. They focus particularly on "'excepted benefits' such as 'fixed indemnity insurance.'" U.S. Br. 30.

But this new focus on excepted benefits, which the government conspicuously fails to define or describe, is no more helpful to its contention. Excepted benefits, which are defined in the Public Health Service Act (PHSA), 42 U.S.C. § 201, include benefits "that are generally not health coverage" (such as automobile insurance and workers' compensation); vision and dental benefits, and long-term and nursing home care; supplemental benefits like Medigap; and benefits for a specified disease (like cancer-only policies), as well as fixed indemnity insurance.[4] *See* 81 Fed. Reg. 75,316, 75,319 (Oct. 31, 2016).

[4] Fixed indemnity policies "pay out a fixed amount of cash upon the occurrence of a particular medical event," such as a hospital visit or

These benefits either are not health insurance at all or offer limited protections that do not provide comprehensive insurance. The Departments point to no evidence that Congress intended, or would have anticipated, that excepted benefits, any more than STLDI, would serve as the foundation for an alternative regime of primary health insurance that would be marketed in competition with ACA-compliant plans.

In arguing to the contrary, the government places considerable weight on *Central United Life Insurance v. Burwell*, which invalidated an HHS rule providing that excepted benefits could be offered only to individuals who also have ACA minimum essential coverage. U.S. Br. 3, 8, 30-31. But the government's reliance on a decision ***invalidating*** a regulation is misplaced. In *Central United*, the challenged regulation read an element into the definition of excepted benefits that does not appear in the PHSA, and therefore "HHS's rule proposed to 'amend' the PHSA itself." 827 F.3d at 73. Further, the ACA expressly "endorses the PHSA's definition" of excepted benefits. *Id.* at 74. Accordingly, the

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purchase of prescription drugs, "which the policyholder is then free to use however she chooses." *Central United Life Ins. v. Burwell*, 827 F.3d 70, 72 (D.C. Cir. 2016).

Court invalidated the regulation because, "[w]here the text is as clear as it is here, 'that is the end of the matter.'" *Id.* (citation omitted).

Central United actually refutes the government's position in every particular. Although the ACA expressly endorses the PHSA definition of excepted benefits, it says nothing about STLDI. HHS in *Central United* did not defend its regulation as necessary to advance the purpose of the ACA (*see* 827 F.3d at 74; 79 Fed. Reg. 30,240, 30,253-57 (May 27, 2014))[5]; here, the STLDI Regulation undermines the ACA's structure and purpose. The Court found the regulation challenged in *Central United* to be irreconcilable with the statutory language; here, the STLDI Rule is inconsistent with the ACA's text. *See* pages 21-27 *infra*; Opening Br. 50-57. Moreover, we contend, as did the plaintiff in *Central United*, that the governing statutory terms should be read as they are written. The key lesson of *Central United* is this: a regulation must be set aside when the agency "color[s] outside the lines of its authority." 827 F.3d at 72.

[5] The government points to no evidence in support of its assertion that HHS adopted the excepted-benefits rule challenged in *Central United* "with the goal of shoring up the markets for" ACA-compliant plans. U.S. Br. 7-8.

2. For similar reasons, the Departments are wrong to insist that the ACA requirements that health plans offer specified "essential" benefits and include additional related protections are irrelevant because Congress "preserv[ed] … the [HIPAA] exceptions" for STLDI and excepted benefits. U.S. Br. 31. As we noted in our opening brief (at 36-38), it is hardly likely that Congress intended some insured Americans to go without protections deemed "essential" in the ACA's text. (The Departments carefully avoid quoting the statute's "minimum essential benefits" language, instead saying vaguely that the ACA requires issuers "to provide certain specified benefits.")

Moreover, the legislative background shows unequivocally that Congress intended all insured Americans to benefit from these protections. *See* Opening Br. 37-38 & nn.13, 14. And as we showed in our opening brief (at 9-10)—and as the *amicus* briefs filed in this Court by the American Medical Association (and other leading groups of medical professionals), the American Lung Association (and other leading patient advocacy groups), AARP, and the House of Representatives all forcefully confirm—these ACA provisions are directly responsive to serious abuses that plagued the health insurance

marketplace at the time of the ACA's enactment but that would be permitted again by the Rule. It is most improbable that Congress intended to leave the millions of people in the Departments' shadow market subject to those abuses.

C. The STLDI Rule will undermine the ACA by encouraging adverse selection.

The Departments also insist that the STLDI Rule "will not destabilize the Exchanges." U.S. Br. 32. Even if that were so, it would not save the Rule. Whatever the Rule's empirical effect, Congress directed that all of an issuer's enrollees in the individual market be in a single risk pool and that all receive the ACA's essential benefits and other protections; even if the ACA survives the Rule's impact, the Rule nevertheless is inconsistent with the ACA's express requirements.

In any event, it is plain from the government's own data that the Rule does precisely what Congress feared when it sought to avoid adverse selection. Although the Departments' brief disregards this element of the Rule's impact, the President's Council of Economic Advisors estimates that the Rule will draw well over a million enrollees out of ACA-compliant plans by the end of next year; the Departments themselves projected a decline of that magnitude by later in the decade.

See Opening Br. 21-22. The Departments recognize that such departures will cause premiums in ACA-compliant plans to increase by 5 percent, an amount that likely is understated. *Id.* at 21. For persons living on the edge, the purported beneficiaries of the STLDI Rule, such a price increase for an expensive product is far from trivial.

The Departments nevertheless insist that this impact is immaterial because tax subsidies "make many individual market participants effectively immune to premium increases" (U.S. Br. 32), asserting that 87 percent of people "who bought Exchange plans did so with tax credits." *Id.* at 34. But the Departments' use of this statistic is misleading. It disregards insureds who purchase coverage off an Exchange. And even as to on-Exchange purchasers, it includes in its 87 percent calculation the many individuals who receive partial subsidies, which may cover only a very small fraction of a policy's cost and leave the insured sensitive to price.[6] The Departments offer no sense of how many people fall into this category.

[6] For example, in Harris County, Texas, a consumer with earnings at 300 percent of the federal poverty level ($37,470) who purchases the second-lowest "silver" plan (the benchmark upon which subsidies are based) for $319/month would receive a subsidy of $13.62/month—

The Departments also are simply wrong in asserting that "Plaintiffs offer no reason to conclude that customers of ACAP's member insurers will abandon highly subsidized comprehensive plans in favor of short-term limited duration insurance." U.S. Br. 35. In fact, ACAP member Community Health Choice saw enrollment in ACA-compliant plans decline by more than 11 percent from 2018 to 2019; and every one of ACAP's member companies operating in States where 12-month STLDI plans are legal suffered a decline in enrollment from 2018 to 2019, while every one of its members operating in States that ban or restrict 12-month STLDI plans saw an enrollment increase. *See* Decl. Of Heather J. Foster (JA8). A recent, comprehensive review found this effect nationwide, with prices up and enrollment down for ACA-compliant plans in States that permit year-long STLDI. Dane Hansen & Gabriela Dieguez, *The Impact of Short-Term Limited-Duration Policy Expansion on Patients and the ACA Individual Market* 15-19 (Feb.

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leaving the consumer to pay $305.38/month. And all but one other plan would cost more. Center for Consumer Information & Insurance Oversight, *2020 QHP Choice and Premiums in HealthCare.gov States – Appendix Tables (XSLX)*, https://www.cms.gov/CCIIO/Resources/Data-Resources/QHP-Choice-Premiums (tab "Avg. SLCSP Prem. 27yo-County").

2020), https://www.lls.org/sites/default/files/National/USA/Pdf/STLD-Impact-Report-Final-Public.pdf. That is just what one would expect from the increased availability of cheap "junk" plans.

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At bottom, the government's argument reduces to the assertion that Congress's "primary" goal—concededly, "the desire to maximize comprehensive coverage"—was not its "'sole object,'" and that Congress did not intend the ACA "to force an all-or-nothing choice on Americans otherwise lacking comprehensive health insurance." U.S. Br. 29, 31. But Congress's goal very plainly was to place the largest possible number of people in high quality, ACA-compliant insurance; the STLDI Rule's avowed purpose of allowing anyone to opt out of the ACA at will, resulting in millions of people purchasing "junk" plans, is flatly inconsistent with that purpose. "The Supreme Court and this court have consistently reminded agencies that they are 'bound, not only by the ultimate purposes Congress has selected, but by the means it has deemed appropriate, and prescribed, for the pursuit of those purposes.'" *Gresham v. Azar*, 2020 WL 741278 (D.C. Cir. Feb. 14, 2020), at *5

(citation omitted). And here, Congress chose to expand health insurance coverage by directing consumers into ACA-compliant plans.

III. The Departments misconstrue the phrases "short-term" and "limited duration."

As might be expected, given the Rule's departure from the ACA's language and purpose, the Rule also departs from the particular statutory terms it purports to interpret.

A. Plans that last almost as long as standard plans are not "short term."

The Departments make no serious attempt to show that the STLDI Rule's definition of "short term" is consistent with the statutory text. They do not deny that "short" is a relative word, so that "short term" means "lasting a relatively short period of time"; in ordinary usage, a "term" can be "short" only in relation to some other period. Opening Br. 51. So far as short-term insurance is concerned, the Departments do not point to any period of comparison other than the standard term of insurance—and they do not deny that one year ***is*** the standard insurance term. Nor do they defend the district court's farfetched holding (or their own argument below) that ***any*** period short

of the standard one-year term—even if it is just one hour short of a year—reasonably could be characterized as a "short-term" plan.[7]

Rather than address the actual language of HIPAA and the ACA, the Departments defend their reading of "short-term" by mentioning other statutes that address transitional insurance coverage—noting that COBRA temporary continuation coverage could last for up to 36 months—and by pointing to circumstances where certain individuals might have benefited under HIPAA's coverage guarantee from STLDI that lasts for a year. U.S. Br. 37-38. But the short answer to these arguments is that Congress simply did not write the STLDI provision in those terms. In the controlling clause, Congress does not mention the "temporary," "transitional," or "continuation" plans invoked by the Departments (*see* U.S. Br. 37); it refers instead to "short term" plans, a phrase that in ordinary usage excludes plans that are materially similar in length to standard plans. Indeed, under the Departments' reasoning and analogy to COBRA, a plan that "last[s] several years" or

[7] The government does note that "short-term" can mean up to one year in other contexts, such as "short-term capital gain." U.S. Br. 39. But that is immaterial: what is relatively "short-" or "long-term" varies with the relative context. A short-term mortgage could last ten years; a long-term quarantine could last for a month.

"up to 36 months"—three times ***longer*** than the standard insurance plan—could qualify as "short term" insurance. U.S. Br. 37. That approach might fairly be described as nonsensical.

Moreover, as we explained in our opening brief (at 54-55), our reading of "short term" is confirmed by Congress's use of the word "short" in the ACA's "short coverage gap" provision to mean three months. The Departments' only response is its observation that the 1996 Congress that enacted HIPAA did not anticipate the enactment of the ACA fourteen years later. U.S. Br. 39. Obviously, however, that is not our contention.

Instead, as we also explained in our opening brief (at 55 n.21), the Departments promulgated the STLDI Rule expressly to affect application of the ACA. *See,* e.g., 83 Fed. Reg. 38,212, 38,213-14, 38,215-16. That being so, the language giving rise to the Rule may not be interpreted in a manner inconsistent with the intent of the Congress that enacted the ACA. And if the plain language of HIPAA's STLDI exemption somehow were thought to authorize the STLDI Rule, this is, for the reasons explained above, a case where there is a "positive repugnancy" between HIPAA's STLDI language and the ACA, such that

the ACA impliedly amended that element of HIPAA. *U.S. Ass'n of Reptile Keepers, Inc. v. Zinke*, 852 F.3d 1131, 1141 (D.C. Cir. 2017).

2. In addition, the Departments' arguments from COBRA and from HIPAA policy regarding the meaning of "short term" are wrong on their own terms. In the particular context of the ACA, the Departments thought that COBRA justified permitting STLDI coverage to last for a lengthy period because, "[s]imilar to COBRA, short-term, limited duration insurance also serves as temporary coverage for individuals transitioning between other types of coverage." 83 Fed. Reg. at 38,221. But this argument is internally inconsistent; the whole point of the STLDI Rule is to create a new form of primary coverage that is ***not*** transitory. And as explained by *amicus* AARP (at Br. 29 n.49), COBRA coverage must comply with the ACA's requirements and therefore implies nothing about the appropriate period for a "junk" plan.

As for HIPAA policy, the Departments note that the statute provided guaranteed availability of insurance for individuals who previously had "creditable coverage," adding that, because HIPAA treated STLDI as creditable coverage, a longer definition of STLDI would make it easier to benefit from HIPAA's protections. U.S. Br. 38.

But this reasoning, too, makes no sense in the ACA context. Prior to the ACA, employer-sponsored coverages typically had waiting periods of up to 12 months during which pre-existing conditions were not covered (*see* Pub. L. 104-191, § 101); HIPAA eliminated the waiting period for persons who had a sufficiently long period of creditable coverage, making a longer creditable coverage period desirable. But that is no longer so because the ACA limits the employer exclusion period to 90 days, perfectly matching three-month STLDI. This change makes the longer creditable coverage period immaterial—meaning that this policy cannot support the Departments' post-ACA reading.

B. A renewable plan is not one of "limited duration."

The Departments' reading of "limited duration" also is defective. They observe only that nothing in HIPAA ***expressly*** precludes renewal of STLDI. U.S. Br. 40. But they make no response to our demonstration that, even read in isolation, "limited duration" is most naturally understood to mean nonrenewable. Opening Br. 56-58.

And they wholly ignore the statutory context. HIPAA generally was designed to assure the renewability of health insurance plans but does not provide for renewability of STLDI, an omission suggesting that

Congress defined STLDI in terms that do not allow for renewability. *See* JA 384 (Jost comment). That explains Congress's combination of "short term" ***and*** "limited duration"; because "short term" limits the length of a plan, "limited duration" is "not redundant surplusage" only because it "refers specifically to the fact that short-term coverage was under HIPAA non-renewable." *Id.* at 384-85. Although we made this point in our opening brief (at 57), the Departments offer no response.

They also, finally, disregard the obvious peculiarity of their reading as it applies to the ACA. As we noted in our opening brief (at 50-51), had Congress wanted to authorize the development of a new form of primary insurance that is marketed in competition with ACA-compliant plans, it surely would not have labeled that product "short-term, limited-duration" insurance, as those phrases describe neither the reality nor the defining qualities of STLDI as contemplated by the Rule. But here, too, the Departments make no response.

IV. The STLDI Rule is arbitrary and capricious.

The Departments' defense against the arbitrary and capricious challenge is unavailing.

A. A regulation that departs from the congressional intent is arbitrary and capricious.

As we showed in our opening brief (at 59), a regulation that is inconsistent with the clear congressional policy that the agency purports to interpret is inherently arbitrary and capricious. *See Gresham*, 2020 WL 741278, at *5. For the reasons explained above and in our opening brief, the STLDI Rule is inconsistent with that intent and therefore invalid under the APA.

Although the Departments make no direct response to this point, they do contend that the ACA has no bearing on the proper interpretation of the phrase "short-term, limited-duration" insurance because that language appears only in HIPAA. U.S. Br. 27. But as we note in our Opening Br. (at 17-18), the STLDI Rule was promulgated for the express purpose of governing the ACA. If, as we submit, the STLDI Rule will frustrate the ACA's purpose, the Rule must be set aside under the APA because it is "agency action that 'entirely failed to consider an important aspect of the problem.'" *Gresham*, 2020 WL 741278, at *4.

B. The Departments failed to explain their departure from the 2016 Rule.

We also showed in our opening brief (at 59-63) that the Departments failed to explain their departure from the 2016 Rule. In

response, the Departments maintain that they properly justified the change by observing that the 2016 Rule had been intended to "boost enrollment" in ACA-compliant plans, but that it failed to do so. U.S. Br. 43-44. Addressing our observation that the 2016 rulemaking nowhere mentioned boosting plan enrollment (Opening Br. 61-62), the Departments now say that the promulgators of the STLDI Rule actually meant that the 2016 rule failed in its goal of stopping "a migration of 'healthier individuals' from ACA-compliant plans to short-term plans" and that "[t]he Departments changed course in 2018 because they found that the means chosen in the 2016 rule 'did not succeed in' mitigating that concern." U.S. Br. 44.

But this "post hoc rationalization[] of the [Departments'] decision" will not do. *Gresham*, 2020 WL 741278, at *5. There is an obvious difference between "boosting enrollment" and combating adverse selection, and the 2016 rule was directed only at the latter of these goals. And as to that goal, the 2016 rule was ***entirely*** successful, precluding the use of STLDI as an alternative to ACA-compliant plans and keeping STLDI offered as primary insurance from drawing subscribers out of ACA-compliant plans.

In addition, the Departments in 2016 limited the use of STLDI because such plans have "significant limitations, such as lifetime and annual dollar limits on essential health benefits (EHB) and pre-existing condition exclusions, and therefore may not provide meaningful health coverage." 81 Fed. Reg. at 75,317-18. The rulemaking in 2016 gave this consideration fully as much weight as the concern with adverse selection. But the 2018 rulemakers did not explain why this concern was no longer salient or was outweighed by other considerations (or, indeed, mention it at all), and the Departments do not address it in their brief to this Court.

C. The rulemaking did not address the serious problem with coverage gaps.

The government engages in misdirection when it asserts that the Departments addressed comments that noted the problem of coverage gaps caused by the STLDI Rule. As we showed in our opening brief (at 63-67), those comments explained that, under the ACA and the 2016 Rule, coverage gaps always can be avoided because people who lose ACA-compliant coverage through no fault of their own will be able to obtain replacement ACA-compliant coverage within 90 days, a period

during which STLDI would be available. The Departments made just this point when promulgating the 2016 Rule. 81 Fed. Reg. at 75,318.

But the comments also noted that the STLDI Rule creates the possibility of coverage gaps by inviting people to use year-long STLDI as their primary insurance coverage. Because STLDI plans typically do not guarantee re-enrollment, people whose STLDI plans—purchased, in the Departments' view, as an ongoing form of primary insurance—terminate mid-year will be left with no insurance at all and no way of obtaining replacement insurance until the next general ACA open-enrollment period. This regime guarantees that many people will be left without insurance for extended periods.

In their brief to this Court, the Departments assert that the 2018 rulemaking reasoned that a three-month STLDI term would exacerbate coverage gaps because people who use STLDI as primary insurance would face re-underwriting every 90 days. U.S. Br. 44-45. But this reasoning is circular. Before promulgation of the STLDI rule, there was ***no*** coverage gap problem because consumers obtained primary insurance through ACA-compliant plans, which guaranteed them an opportunity to obtain replacement coverage within 90 days of plan

termination. The STLDI Rule therefore ***creates*** the coverage gap problem by making non-ACA-compliant STLDI a form of primary coverage.

Although comments to the 2018 Rule made this point, the Departments offered no response. That was impermissible. As Judge Sentelle recently wrote for the Court, addressing a proceeding conducted by one of the Departments here, "the Secretary's analysis of th[is] substantial and important problem is to note the concerns of others and dismiss those concerns in a handful of conclusory sentences. Nodding to concerns raised by commenters only to dismiss them in a conclusory manner is not a hallmark of reasoned decisionmaking." *Gresham*, 2020 WL 741278, at *7. Here, the Departments' performance was even worse: they offered ***no*** response at all to the comments raising this "substantial and important problem." That was arbitrary and capricious.

D. The STLDI Rule encourages the use of "junk" plans.

Finally, the Departments assert that there need be no concern about the proliferation of "junk" STLDI plans because consumers are warned about those plans' limitations and States are empowered to

address deficient plans. U.S. Br. 45-46. But experience has belied this assurance. Continued, extensive abuses in STLDI plans have been documented repeatedly; recent comprehensive studies confirm that STLDI replicates all of the deficiencies that plagued pre-ACA insurance, leaving many subscribers responsible for huge payments. Hansen & Dieguez, *supra*, at 9-11. *See*, *e.g.*, House Comm. on Energy & Commerce, *Hearing on Strengthening Our Health Care System: Legislation to Reverse ACA Sabotage and Ensure Pre-Existing Conditions Protections* (Feb. 13, 2019), https://tinyurl.com/rscuvsz; Opening Br. 22-23. And many States have themselves candidly recognized their inability to prevent consumers from being harmed by these practices. *See* Opening Br. 23. Once again, the Departments offer no response.

The Departments' *amici* Idaho and Louisiana do not cure this omission. Idaho emphasizes the availability in that State of "enhanced short-term plans," but such plans are sold in Idaho in competition with "traditional" STLDI. Idaho Br. 10-11. Louisiana notes the States' traditional role in regulating insurance (Br. 6)—but that was just as true prior to enactment of the ACA, when defects in the health-

insurance system prompted Congress to act on this exact issue. And although both States address concerns with consumers being priced out of the health-insurance market, Congress had that danger in mind and addressed it by seeking to keep the price of ACA-compliant coverage low through the avoidance of adverse selection—the very effect that is encouraged by the STLDI Rule.

CONCLUSION

The Court should reverse the decision of the district court.

Respectfully submitted,

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CERTIFICATE OF COMPLIANCE

This brief complies with the type-volume limitation of Federal Rules of Appellate Procedure 29(d) and 32(a)(7)(B) because it contains 6,495 words, excluding the parts of the brief exempted by Federal Rule of Appellate Procedure 32(a)(7)(B)(iii) and D.C. Circuit Rule 32(a)(1).

This 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 Century Schoolbook 14-point type for text and footnotes.

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CERTIFICATE OF FILING AND SERVICE

I hereby certify that on February 25, 2020, I filed the foregoing with the Clerk of the Court for the United States Court of Appeals for the District of Columbia Circuit by using the CM/ECF system which will serve all counsel of record.

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