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.)

PETITION FOR REHEARING AND REHEARING EN BANC

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FRAP 35 STATEMENT

This case presents a question of exceptional importance: whether Congress authorized regulatory agencies to allow the creation of a new form of primary health insurance that is exempt from all of the protections mandated by the Patient Protection and Affordable Care Act (ACA), Public Law No. 111-148, 124 Stat. 119 (2010).

Congress enacted the ACA to address long-standing deficiencies in the market for individual health insurance, among them the denial of insurance to people with pre-existing conditions and the widespread marketing of insurance that was wholly inadequate for the purchasers' needs. Congress accomplished that goal by (among other things) guaranteeing the availability of coverage for those with pre-existing conditions, barring price discrimination in premiums, and mandating that all health insurance policies offer "essential" benefits. As a key part of this structure, Congress required that issuers include all individual market policies in a single risk pool; this reform prevented market segmentation that otherwise would make coverage unaffordable for persons with an adverse health history.

In the regulation at issue here (the Rule or STLDI Rule), however, the Departments of Treasury, Health and Human Services, and Labor (the Departments) provided that a specialized form of health coverage known as short-term, limited-duration insurance (STLDI)—which is not subject to the ACA's requirements—could be marketed in competition with ACA-compliant plans as a form of primary health insurance. Although STLDI previously had been used only as transitional coverage for people between primary insurance plans, the Departments' Rule allows STLDI to last for up to a year and to be renewed up to three times, making it function exactly like ordinary, primary insurance.

The Departments promulgated this Rule expressly to allow for the development of an alternative form of primary insurance that would be marketed in competition with ACA-compliant coverage, but that would provide none of the protections mandated by the ACA. A divided panel of this Court upheld that regulation. *Ass'n for Community Affiliated Plans v. U.S. Dep't of the Treasur*y, 966 F.3d 782 (D.C. Cir. 2020) (Addendum 1).

This decision is wrong, disregarding the ACA's language, structure, and manifest policy. It departs from this Court's

understanding that a regulation is inherently arbitrary and capricious if it contravenes the congressional goal. *See*, *e.g.*, *Gresham v. Azar*, 950 F.3d 93 (D.C. Cir. 2020). It also is inconsistent with the Supreme Court's explanation of Congress's intent regarding the ACA's operation. *See King v. Burwell*, 576 U.S. 473 (2015).

And the holding is of enormous practical importance: It threatens to leave millions of people with health insurance that Congress regarded as inadequate, to increase insurance premiums for millions more, and to undermine the stability of the markets created by the ACA. That is why the entities most knowledgeable about the Nation's health care system—among them the leading associations of physicians (including the American Medical Association), of patients (including the National American Cancer Society), and of health-care consumers (including AARP), as well as the U.S. House of Representatives—appeared in this case as *amici* to forcefully contest the Rule's validity.

As Judge Rogers concluded in dissent, "[i]t is difficult to imagine a starker conflict between a statutory scheme and a rule that purports to administer it." Add. 24. Further review by the en banc Court is warranted.

STATEMENT

1. Prior to enactment of the ACA, many individuals faced substantial discrimination in (or were effectively priced out of) the medical insurance market, leaving them with inadequate health insurance or no insurance at all. *See* H.R. Rep. No. 111-299, tit. 3, pt. 1. In most States, insurance companies could discriminate against individuals based on pre-existing conditions, health status, gender, and many other factors. That risk segmentation made health insurance unavailable to many Americans as a practical matter. *See* Add. 18-19 (Rogers, J., dissenting). The existence of these widely documented pre-ACA problems is not in dispute.

Congress responded to these concerns by enacting the ACA. Two of the statute's sets of provisions are of central importance here:

First, the ACA "adopt[ed] a series of interlocking reforms designed to expand coverage in the individual health insurance market." *King*, 576 U.S. at 478. To this end, Congress established a "guaranteed issue" requirement that prohibits refusing coverage to individuals with pre-existing conditions. 42 U.S.C. §§ 300gg-1(a), 300gg-3. Within specified limits, the ACA also mandated use of "community rating," which

prohibits premium discrimination on the basis of factors such as health status, claims history, and gender. 42 U.S.C. § 300gg. And Congress required that issuers treat all enrollees in the individual health insurance market as "members of a single risk pool." 42 U.S.C. § 18032(c).

Congress regarded this latter reform as central to the ACA and necessary to make insurance available for all. It ensures that the risk pool includes both the healthy and the sick, which is essential if coverage for persons with pre-existing conditions is to be available and affordable. Otherwise, younger and healthier people will purchase cheap and limited policies, while those with pre-existing conditions will be segregated in their own prohibitively expensive plans.

Second, the ACA established minimum substantive standards ensuring that policies purchased in the individual insurance market will in fact provide meaningful coverage, so as to eliminate the widespread abuses that prompted the Act's enactment. Congress thus required that all individual plans provide a "comprehensive" package of what it labeled "essential health benefits." 42 U.S.C. § 300gg-6(a). This package includes, among many other protections, such things as

emergency services, hospitalization, maternity and newborn care, mental health services, substance abuse services, and prescription drug coverage. *Id*, § 18022(a). In addition, the ACA bans lifetime and annual dollar limits on insurance benefits. *See id.* § 18022(a), (c).

2. In enacting the ACA's reforms, Congress had to specify the category of insurance plans to which the new requirements apply. It did so by cross-referencing the definition of "individual health insurance coverage" (the category of health insurance generally understood at that time to be the individual market) that was used in the Health Insurance Portability and Accountability Act (HIPAA), Public Law 104-191, 110 Stat. 1936 (1996), a statute that established limited renewability rules for such coverage. That cross-reference had the effect of exempting STLDI—which had been excluded from the HIPAA definition of individual health insurance, so as not to be included in the renewability rules applicable to primary coverage—from all the ACA's requirements. But there is no evidence that Congress had STLDI's exclusion from the HIPAA definition of "individual health insurance" in mind when it enacted the ACA; neither the statutory text nor the legislative history of the ACA makes ***any*** express reference to STLDI.

As the Departments themselves recognize, at the time that Congress enacted the ACA, STLDI was used exclusively as a form of transitional insurance by people between comprehensive plans, and not as a primary form of insurance coverage. *See* Add. 20 (Rogers, J., dissenting) (citing regulatory explanation). During that pre-ACA period, the Departments had defined STLDI as coverage that could last for up to a year and be renewed with the issuer's consent. *See* Add. 3 (majority opinion).

After the ACA's enactment, however, some insurers began using STLDI to circumvent the ACA's requirements, selling STLDI—for the first time—as a form of comprehensive, primary coverage. *See* Add. 20 (Rogers, J., dissenting) (citing regulatory materials). Because STLDI plans are not subject to the ACA's provisions, such plans may refuse coverage based on an individual's pre-existing health conditions; may discriminate based on health status and gender in setting premiums; and may omit essential health benefits that must be provided by ACA-compliant plans. In 2016, the Departments, concerned that sale of STLDI as primary insurance would undercut the ACA market and leave purchasers with inadequate protection, responded to this development

by requiring that an STLDI plan last no longer than three months. *Id.* (citing regulation).

Subsequently, the new administration urged Congress to repeal the ACA. When Congress repeatedly declined to do so, the Departments proposed the STLDI Rule so as to authorize a new form of primary insurance that departs from the ACA's requirements. Although commenters overwhelmingly opposed the proposal and healthcare groups were almost unanimous in their objections,[1] the Departments adopted the final Rule in August 2018. 83 Fed. Reg. at 38,214. In doing so, the Departments expressly explained that they intended this change to create an alternative means of obtaining primary insurance "that exists side-by-side with [ACA] individual market coverage." 83 Fed. Reg. at 38,218.

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[1] "[M]ore than 98%—or 335 of 340—of the healthcare groups that commented on the proposal to loosen restrictions on short term health plans criticized it, in many cases warning that the rule could gravely hurt sick patients," while "[n]ot a single group representing patients, physicians, nurses or hospitals voiced support" for the proposal. Noam N. Levey, *Trump's New Insurance Rules are Panned by Nearly Every Healthcare Group that Submitted Formal Comments*, L.A. Times, May 30, 2018. The Departments themselves acknowledged that "most comments suggested not extending the maximum duration beyond the [then-]current less-than-3-month maximum." Short-Term, Limited-Duration Insurance, 83 Fed. Reg. 38,212, 38,217 (Aug. 3, 2018).

3. Plaintiffs brought this suit under the Administrative Procedure Act to challenge the legality of the Rule. The district court rejected the challenge, and a divided panel of this Court affirmed.

Insofar as is relevant here, the majority rested its decision to uphold the Rule on two central points. ***First***, the majority noted that the regulatory definition of STLDI in place when Congress enacted the ACA was similar to that in the current Rule, finding that history to be "powerful evidence that the modern STLDI Rule is consistent with the ACA. After all, '[w]here Congress adopts a new law incorporating sections of a prior law, Congress normally can be presumed to have had knowledge of the interpretation given to the incorporated law, at least insofar as it effects the new statute.'" Add. 11 (citation omitted).

Second, the majority opined that Congress meant to authorize the use of alternative forms of primary insurance by people who preferred to avoid ACA-compliant coverage, reasoning that the ACA did not "relentlessly pursu[e] one goal: maximizing the number of individuals with comprehensive health insurance." Add. 13. Although the majority acknowledged the Departments' predictions that the Rule

would lead to premium increases for ACA-compliant plans, it discounted the significance of that impact as "relatively small." Add. 14.

Judge Rogers dissented. As she explained, "[t]he ACA not only sought to expand access to affordable health insurance, but it did so in a particular manner. Congress deemed certain health benefits essential, prohibited discrimination against individuals with preexisting conditions, and ensured that healthier and less healthy individuals would share a single risk pool." Add. 21-22. And, she continued, "[t]he Rule departs from the ACA's structure in several significant ways, recreating the problems that existed in the American health insurance market before the statute's enactment and that the statute was designed to solve." Add. 22.

In particular, Judge Rogers noted that "the Rule promotes the use of STLDI plans to circumvent the coverage requirements that Congress deemed essential." Add. 22. "But Congress expressly decided not to allow consumers to purchase plans offering less than minimum 'essential health benefits' as their primary form of coverage." *Id.*

In addition, Judge Rogers observed, the Rule "fractures the 'single risk pool' that Congress deemed critical to the success of the ACA." Add. 23. As she explained:

> [T]he Rule draws younger, healthier consumers out of the market for ACA-compliant coverage, with the predicted result of higher premiums for those who remain in the risk pool. It therefore directly undermines a central purpose of the ACA's "major reforms," namely to "minimize … adverse selection and broaden the health insurance risk pool to include healthy individuals, which will lower health insurance premiums."

Add. 23-24. (quoting *King*, 576 U.S. at 493) (ellipsis in original).

REASONS FOR GRANTING THE PETTION

The panel's decision approved a regulation that will frustrate central elements of the ACA. The Departments designed the Rule to draw younger and healthier individuals out of ACA-compliant plans and therefore out of the ACA single risk pool, which inevitably will increase the costs and undermine the stability of the market established by the ACA. At the same time, the Rule will cause millions of people who purchase skimpy STLDI plans to lose the health insurance benefits that Congress labeled "essential," with disastrous

medical and financial consequences for countless individuals. There is no doubt that will happen; as we show below, it ***already*** is happening.

The panel erred in upholding this Rule. Its decision misunderstood the ACA. And its analysis departed both from this Court's settled principles governing the review of regulations and the Supreme Court's particular understanding of the ACA's operation. Especially because these errors involve the operation of an enormously important statute, in a manner that will affect the health care available to millions of people, the en banc Court should grant review.

A. The STLDI Rule is inconsistent with the ACA.

As Judge Rogers demonstrated, Congress in the ACA sought to expand access to health insurance "in a particular manner." Add. 21. It was central to Congress's plan that virtually all persons in the individual health insurance market be included in a single risk pool; and it was a key congressional goal that all persons in that market receive specified "essential" insurance protections. "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*, 950 F.3d at 101 (citation omitted). The Departments failed to do that here.

1. Congress intended all consumers to receive essential health benefits.

A key reform enacted by the ACA was the determination that ***all*** individuals should receive certain essential health benefits so as to assure access to necessary health care. *See* 42 U.S.C. §§ 300gg-6(a), 18022(b). Congress regarded these protections, along with the prohibition of annual and dollar limits on benefit payments (42 U.S.C. §§ 300gg-11), as a crucial element of the reformed insurance market; after all, Congress labeled these protections "essential benefits" in the statutory text. The STLDI Rule, which will vastly expand the use of what Congress thought to be ***inadequate*** insurance products, thus invites re-creation of a health-care regime that Congress specifically rejected in the language of the ACA.

The Rule certainly will have that effect. As the *amicus* briefs filed in this Court by the American Medical Association, National American Cancer Society, AARP, and the House of Representatives all demonstrate in detail, the ACA essential-benefits 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' new, alternative market subject to the very abuses that led Congress to enact the ACA in the first place.

2. Congress wanted all plan enrollees to be in a single risk pool.

In addition, as Judge Rogers also explained, the Rule "fractures the 'single risk pool' that Congress deemed critical to the success of the ACA." Add. 23. As reflected in the statute's plain language, the ACA's design requires inclusion in a single risk pool of virtually all people seeking health insurance in the individual market. 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 … to be members of a single risk pool." 42 U.S.C. § 18032(c) (emphasis added). Congress determined this structure—which places the healthy and the ill in a single pool—to be essential in keeping health coverage affordable, avoiding adverse selection and preventing runaway premiums for those with pre-existing conditions.

Congress "designed the Act" this way because its overriding concern was "to avoid" "creat[ing] . . . 'death spirals'" in the insurance market (*King*, 576 U.S. at 492) that could develop if younger and healthier consumers left ACA-compliant plans for cheaper ones that did not accept persons with health problems. The Supreme Court therefore rejected as "implausible" an interpretation of the Act that would undermine the "guaranteed issue and community rating requirements." *Id.* at 494-95. But that is the precise, unavoidable effect of the Rule. And it surely is implausible to think that Congress, having demanded that that all of an issuer's plans in the individual market participate in one risk pool, then allowed issuers effectively to opt out of that requirement at will simply by labeling their primary-coverage plans "STLDI."

3. The panel's rationales for upholding the Rule are flawed.

The panel's decision nevertheless to uphold the Rule rests on a misunderstanding both of the ACA and of controlling legal principles articulated by this Court and the Supreme Court.

First, the panel found support for its holding in its observation that the Rule mirrors the regulatory definition of STLDI that existed

when Congress enacted the ACA, on the view that Congress is presumed to have ratified the prior regulation. 966 F.3d at 790. But when addressing the significance of prior regulatory provisions, both the Supreme Court and this Court have explained that, where "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," "'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 Public Citizen Inc. v. HHS*, 332 F.3d 654, 669 (D.C. Cir. 2003).

Here, where STLDI was not mentioned at all in the text or history of the ACA, it is an obvious fiction to suggest that Congress had the prior STLDI regulation in mind when it enacted the ACA.[2] And, as Judge Rogers added, "there was no reason for Congress to expect that

[2] The panel's contrary suggestion (Add. 11-12) simply disregards this reality. Indeed, STLDI was such a small part of the pre-ACA insurance market that the Departments received ***no*** comments on their pre-ACA STLDI regulation (as opposed to ***12,000*** mostly hostile comments on the Rule). If ever there were a case in which it distorts actual congressional intent to presume familiarity with a pre-enactment regulation, this is it.

consumers would begin purchasing STLDI plans as their primary form of health insurance, considering that when Congress enacted the ACA, STLDI was simply a product used to fill gaps in coverage." Add. 24.

Second, the panel reasoned that Congress did not "relentlessly" pursue the goal of maximizing the number of people with ACA-compliant coverage, instead permitting individuals who were unhappy with the ACA to opt out of the statute and obtain slimmed-down coverage as an alternative. Add. 13-14. But this analysis is wrong, for two reasons.

As a legal matter, Congress, by insisting that all plans be part of a single risk pool, ***did*** "relentlessly" seek to maximize the number of consumers in plans that provide adequate coverage (*i.e.*, "essential benefits"). And as a matter of fact, the Departments themselves recognized that "the vast majority of new enrollees in STLDI plans were expected to switch from existing [ACA-compliant] coverage." Add. 25 (Rogers, J., dissenting).

> The central issue, then, is not whether an STLDI plan is better than nothing, but whether such a policy is an appropriate substitute for a plan offering the comprehensive coverage and fair access that Congress deemed essential. Unless Congress amends the ACA's central provisions or

> repeals the statute, that decision is not left to the Departments or individual consumers.

Id.

It is no answer to observe, as did the panel, that the "exception for STLDI is baked into the statute itself" by virtue of the ACA's cross-reference to HIPAA's definition of "individual health insurance." Add. 11. The Departments promulgated the Rule specifically to affect administration of the ACA by making STLDI a product that competes with ACA-compliant plans; the Rule therefore must be consistent with Congress's goals for the ACA. As Judge Rogers explains, it is not.

Third, although the panel acknowledged that—by the Departments' own estimates—the Rule would lead to well over a million people leaving ACA-compliant plans before the end of the decade and would cause premium increases of 5% in those plans, the panel regarded these effects as consistent with the ACA's policy because they are "limited" and "relatively small." Add. 14; *see id.* at 24 (Rogers, J., dissenting). But this conclusion is dubious on its own terms; a price increase of 5% for an expensive product is significant for people living on the edge. And in any event, as Judge Rogers noted:

> By [the majority's] logic, the Executive Branch may incrementally chip away at a statute by promulgating rules that undermine the statutory scheme, so long as the effect of each regulatory action is sufficiently modest. When an agency prioritizes its own policy objectives over those that Congress enacted, as occurred here, this court necessarily must conclude that the agency's action was arbitrary and capricious.

Add. 25.

B. The panel's decision is one of exceptional practical importance

In upholding the Rule, the panel pointed to the Departments' post-promulgation factual submission, which the panel believed "confirms [that the Departments'] predictions [regarding the Rule's market effects] were reasonable"—and the panel also declined to find the Rule invalid "based on speculation about its potential, unrealized effects." Add. 14-15. But there is nothing speculative about the Rule's pernicious impact: the Rule ***is*** harming consumers and undermining the ACA, an effect so significant as to itself warrant en banc review.

First, the injury to consumers is widespread and serious. A recent, comprehensive review of STLDI coverage by the House Committee on Energy and Commerce found that STLDI plans "systematically discriminate against individuals with pre-existing

conditions, and against women"; "offer bare bones coverage, including major coverage limitations that are not always clear in marketing materials, making it difficult for consumers to know what they are buying"; "offer wholly inadequate protection against catastrophic medical costs"; "impose draconian coverage limitations even for illnesses, injuries, and conditions arising after a consumer purchases a policy;"; "on average, [use] less than half of the premium dollars collected from consumers … on medical care"; and "engage in heavy-handed back end tactics to avoid paying medical claims that do arise." U.S. House of Representatives, Committee on Energy and Commerce, *Shortchanged: How the Trump Administration's Expansion of Junk Short-Term Health Insurance Plans is Putting Americans at Risk*, at 3-4 (June 2020). STLDI therefore ***is*** replicating all of the deficiencies that plagued pre-ACA insurance.

Second, the Rule is undermining the ACA marketplaces. This effect is being felt 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. 2020), https://tinyurl.com/y3azjf78.

Experience thus confirms that the STLDI plans authorized by the Rule "leave enrollees without benefits that Congress deemed essential and disproportionately draw young, healthy individuals out of the 'single risk pool' that Congress deemed critical to the success of the ACA's statutory scheme." Add. 18 (Rogers, J., dissenting). The full Court should consider the validity of the Rule en banc.

CONCLUSION

The Court should grant panel rehearing or rehearing en banc.

Respectfully submitted,

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