ORAL ARGUMENT SET 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.)

BRIEF OF *AMICI CURIAE* STATE OF IDAHO, GOVERNOR OF IDAHO BRAD LITTLE, BLUE CROSS OF IDAHO, AND SELECTHEALTH INC. IN SUPPORT OF APPELLEES AND IN SUPPORT OF AFFIRMANCE

LAWRENCE G. WASDEN
ATTORNEY GENERAL
BRIAN KANE
Assistant Chief Deputy
MEGAN A. LARRONDO
Counsel of Record
Deputy Attorneys General
P.O. Box 83720
Boise, ID 83720-0010
Tel.: (208) 334-2400
megan.larrondo@ag.idaho.gov

Counsel for State of Idaho and Governor Brad Little

ANTHONY F. SHELLEY
Miller & Chevalier Chartered
900 16th St. NW
Washington, DC 20006
Tel.: (202) 626-5800
ashelley@milchev.com

Counsel for Blue Cross of Idaho and SelectHealth, Inc.

CERTIFICATE AS TO PARTIES, RULINGS, AND RELATED CASES

Under D.C. Circuit Rule 28(a)(1), the undersigned counsel certifies as follows:

A. Parties and *Amici*

Except for *amici* the State of Idaho, Governor of Idaho Brad Little, Blue Cross of Idaho and SelectHealth Inc. and any other amici who had not yet entered an appearance in this case as of the filing of the Brief for Appellees, all parties, intervenors and *amici* appearing before the district court and in this Court are listed in the Brief for Appellees.

B. Rulings under Review

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

C. Related Cases

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

Dated: January 28, 2020

/s/ Megan Larrondo
Megan Larrondo

RULE 26.1 CORPORATE DISCLOSURE STATEMENT

Pursuant to Federal Rule of Appellate Procedure 26.1 and this Court's Circuit Rule 26.1, *amici* Blue Cross of Idaho and SelectHealth, Inc. hereby state as follows:

Amicus Blue Cross of Idaho states that it is not publicly traded and has no parent company. Blue Cross of Idaho does not have stock, and therefore no publicly traded company owns more than 10% of its stock.

Amicus SelectHealth, Inc. states that it is a wholly owned subsidiary of Intermountain Healthcare, Inc. Intermountain Healthcare, Inc. is a Utah not-for-profit corporation that is not publicly traded and has no parent company. SelectHealth, Inc. does not have stock and therefore no publicly traded company owns more than 10% of its stock.

Dated: January 28, 2020

/s/ Anthony F. Shelley (per email consent)
Anthony F. Shelley

TABLE OF CONTENTS

TABLE OF AUTHORITIES

Cases: **Page(s)**

Federal Statutes:

State Statutes:

Federal Regulations:

State Regulations:

Other Authorities

GLOSSARY OF ABBREVIATIONS

ACA	Patient Protection and Affordable Care Act
ESTP	Enhanced Short-Term Plans
HIPAA	Health Insurance Portability and Accountability Act of 1996

PERTINENT STATUTES AND REGULATIONS

Except for the statutes and regulations reproduced in the addendum, all applicable statutes and regulations are contained in the Brief for Appellants and the Brief for Appellees.

IDENTITY AND INTEREST OF *AMICI*[1]

The State of Idaho and its Governor have an interest in this matter due to the State's constitutional responsibility over the health and welfare of its citizens and the State's role as the primary regulator of health insurance. The State of Idaho, through its Governor, Legislature, and Department of Insurance, have enacted laws that allow for the sale of "traditional" short-term, limited duration insurance and of enhanced short-term plans ("ESTPs") to address the problem of affordability and accessibility of health insurance.

Governor Brad Little is the current Governor of the State of Idaho. The supreme executive power of the State is vested in the Governor, and he is responsible for ensuring that the laws are faithfully executed in the state.

Blue Cross of Idaho is a not-for-profit mutual insurance company based in Idaho with over 570,000 members. It is an independent licensee of the Blue Cross and Blue Shield Association. The company is focused on providing Idahoans access to high-quality healthcare at the lowest possible cost. Blue Cross of Idaho

[1] Per Federal Rule of Appellate Procedure 29(a)(2), all parties have consented to the filing of this *amicus curiae* brief as to those *amici* for whom consent is required; and, per Federal Rule of Appellate Procedure 29(a)(4)(E), *amici* Governor Brad Little, Blue Cross of Idaho, and SelectHealth certify that (1) this brief was authored entirely by counsel for *amici* and not by counsel for any party, in whole or in part; (2) no party or counsel for any party contributed money to fund the preparation or submission of this brief; and (3) apart from *amici* and their counsel, no other person contributed money to fund the preparation or submission of this brief.

sells ESTPs in accordance with Idaho law.

SelectHealth, Inc. ("SelectHealth") is a not-for-profit health insurance company serving more than 910,000 members in Utah, Idaho, and Nevada. SelectHealth provides insurance to individuals, small employers, large employers, and government program beneficiaries, as well as third-party administrator services to self-funded groups. SelectHealth is committed to offering superior service and providing access to high quality care. SelectHealth sells ESTPs in accordance with Idaho law.

Amici share a commitment to ensuring that affordable, quality health insurance is available to Idahoans.

SUMMARY OF ARGUMENT

The district court was correct to refuse to take as fact Appellants' calamitous predictions about what States would do with the flexibility restored to them by the final rule on Short-Term, Limited Duration Insurance, 83 Fed. Reg. 38,212 (Aug. 3, 2018) (codified at 26 C.F.R. § 54; 29 C.F.R. § 2590; and 45 C.F.R. §§ 144, 146, 148) ("2018 Rule"), promulgated by the Departments of Labor, Treasury and Health and Human Services ("Departments"). Appellants assumed that, within the space Congress twice retained for them, States would *only* regulate short-term, limited duration insurance in a way that would necessarily siphon

healthy people out of Qualified Health Plans[2] made available pursuant to the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 ("ACA") and hamstring Congress's goals in enacting the ACA.[3]

Appellants did not wait to see what States would do with the space to govern that the 2018 Rule restored to them. They filed their underlying lawsuit, which was essentially a facial challenge to the 2018 Rule, two weeks *before* the 2018 Rule took effect.[4] Subsequent developments demonstrate the district court was correct to uphold the 2018 Rule.

The reality facing the vast majority of States, including Idaho, cannot be ignored. People who do not qualify for premium tax credits (also known as subsidies) are being priced out of Qualified Health Plans. They are being forced to go without health insurance or to use lower-priced, but often inadequate, replacements.[5] The 2018 Rule restores to the States the flexibility to innovate ways to draw these individuals back into health insurance markets, stabilize their

---

[2] *Amici* use the term "Qualified Health Plans" to refer to all ACA-compliant individual health insurance coverage, whether or not certified by an Exchange, with the understanding that the term of art "qualified health plan" includes most, but not all, ACA-compliant individual health insurance coverage. *See* 42 U.S.C. § 18021(a)(1) (defining a "qualified health plan" for the purposes of the ACA).
[3] JA44-50; Br. for the Appellants at 26.
[4] JA10; JA563; JA113.
[5] John C. Goodman, Opinion, *Alternatives to Obamacare*, FORBES (Jan. 30, 2019, 7:57 AM), https://www.forbes.com/sites/johngoodman/2019/01/30/alternatives-to-obamacare/#644a3e4961ff (accessed Jan. 21, 2020).

markets for Qualified Health Plans, and ensure that their citizens have access to meaningful and affordable coverage.

Idaho has used the space restored to it by the 2018 Rule to ensure meaningful consumer choice for Idahoans seeking health insurance by allowing the sale of "traditional" short-term limited duration insurance and of enhanced short-term plans ("ESTPs"), a variant of short-term, limited duration insurance. Idaho's actions are intended to draw healthy people who are being priced out of Qualified Health Plans back into the market, to make quality coverage available, and to stabilize the entire market in a way that meets Idaho's unique needs.

Idaho's experience demonstrates that the 2018 Rule is consistent with Congressional intent. The district court's order dismissing Appellants' challenge to the 2018 Rule should be affirmed.

IDAHO'S EXPERIENCE

Idaho's experience is illustrative of the problems facing many States in the Nation and supports the Departments' findings underlying the 2018 Rule. As with the majority of States, Idaho has seen an overall decrease in enrollment in Qualified Health Plans.[6] Between 2015 and 2018, Idaho saw a 14 percent decrease

[6] Idaho Dep't of Ins., Health Insurance Survey Report at 4-5, 7 (Compiled Sept. 22, 2017, Rev. Nov. 1, 2017) ("2017 IDOI Report") https://doi.idaho.gov/DisplayPDF?id=16HealthInsuranceSurvey&cat=Company; Idaho Dep't of Ins., Health Insurance Survey Report at 4-5, 8-9 (Compiled Aug.

in enrollment.[7] As Idaho's population grew during this same period, this represented a 19 percent decrease in the percentage of Idaho's population enrolled in Qualified Health Plans.[8]

During the same period, premiums for Qualified Health Plans rose dramatically. From 2015 to 2018, premiums in Idaho for Qualified Health Plans increased by 70 percent.[9]

For Idahoans who qualify for subsidies under the ACA, the rise in premiums has been sufficiently offset by the associated increase in subsidies to keep those individuals enrolled in Qualified Health Plans.[10] For this population, Idaho has

---

10, 2019) ("2019 IDOI Report") https://doi.idaho.gov/DisplayPDF?id=18HealthInsuranceSurvey&cat=Company. These Idaho Department of Insurance reports use the term "ACA-Compliant" to identify individual health insurance coverage that is compliant with the ACA.

[7] 2017 IDOI Report, *supra*, at 4; 2019 IDOI Report, *supra*, at 4. Comprehensive data reflecting trends in health insurance in Idaho in 2019 is not yet available.

[8] 2017 IDOI Report, *supra*, at 4; 2019 IDOI Report, *supra*, at 4, 13.

[9] KFF's State Health Facts, Data Source: Healthcare.gov, state rate review websites, state plan finder tools and CMS analysis of rate changes in the benchmark silver plan (Oct. 2019), "Marketplace Average Benchmark Premiums," available at: https://www.kff.org/health-reform/state-indicator/marketplace-average-benchmark-premiums/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D (accessed Jan. 21, 2020).

[10] The ACA provides premium tax credits to help low and middle income individuals (individuals with household incomes between 100 and 400 percent of the federal poverty line) afford the cost of insurance purchased through the Exchanges. *See King v. Burwell*, 135 S. Ct. 2480, 2487 (2015). "Exchanges" are locations in each state where people can shop for Qualified Health Plans. 42 U.S.C. § 18031(b)(1). The Exchanges provide advance payments of premium tax

seen a small increase in average monthly enrollment in subsidized Qualified Health Plans.[11]

However, Idaho has seen a dramatic decrease in the percentage of Idahoans enrolled on its Exchange who do not qualify for subsidies. Between 2015 and 2018, average monthly enrollment in Qualified Health Plans decreased by 38 percent for those who did not qualify for subsidies.[12]

This reality has created a new gap of Idahoans priced out of health insurance. In addition to the individuals identified by Appellees, this gap comprises middle-income Idahoans (incomes of $48,560 or more for an individual and $100,400 for a family of four in 2019) who are not eligible for subsidies due to income and, therefore, often cannot afford Qualified Health Plans.[13] Older adults

---

credits directly to an eligible individual's insurer, lowering the net cost of insurance to the individual. *See* 42 U.S.C. §§ 18081-18082.

[11] CENTERS FOR MEDICARE & MEDICAID SERVICES, TRENDS IN SUBSIDIZED AND UNSUBSIDIZED ENROLLMENT ("CMS Enrollment Trends") at 8 (Aug. 12, 2019), https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/Trends-Subsidized-Unsubsidized-Enrollment-BY17-18.pdf

[12] *Id*.

[13] Rachel Fehr, et al., *How Affordable are 2019 ACA Premiums for Middle-Income People?*, KAISER FAMILY FOUNDATION (Mar. 5, 2019), https://www.kff.org/health-reform/issue-brief/how-affordable-are-2019-aca-premiums-for-middle-income-people/ (accessed Jan. 21, 2020); Steve Findlay, *Health Costs Bear Down On Families Who Don't Qualify for ACA Subsidies*, KAISER HEALTH NEWS (Dec. 14, 2018, 7:00 AM), https://www.npr.org/sections/health-shots/2018/12/14/674791999/health-costs-bear-down-on-families-who-dont-qualify-for-aca-subsidies (accessed Jan. 21, 2020).

with incomes just above the subsidy cut-off in rural areas, of which Idaho has many, have been hit particularly hard.[14]

This new coverage gap also contains those who fall into the so-called "family glitch," which exists because subsidies are not available to an individual worker and his or her family members to purchase Qualified Health Plans when they can enroll in "affordable" job-based health insurance.[15] But the affordability of job-based health insurance is determined by the cost of the *worker's* coverage instead of the often significantly higher cost of coverage for the worker's family members.[16] Thus, for example, health insurance can be unaffordable for the spouses of middle income workers, such as teachers, because the cost of enrolling on their spouse's plan is unaffordable and they do not qualify for subsidies to purchase a Qualified Health Plan.[17]

---

[14] Fehr, et al., *supra* note 13.
[15] 26 C.F.R. § 1.36B-2(c)(3)(v)(A)(2); Cara M. Passaro, *Using the State Innovation Waiver to Fill Obamacare's Coverage Gaps in Connecticut*, 16 Conn. Pub. Int. L.J. 299, 308-09 n.71, 314 (2017) (citations omitted).
[16] *Id.* at 314.
[17] Nancy Metcalf, *When It's Too Expensive to Add Your Family to Your Health Plan: Blame the Unnecessary 'Family Glitch'*, CONSUMER REPORTS (Dec. 3, 2014), https://www.consumerreports.org/cro/news/2014/12/when-it-s-too-expensive-to-add-your-family-to-your-health-plan/index.htm.

Finally, eligibility for subsidies is calculated based on the individual's income in the year coverage is provided.[18] This structure can push individuals and families with unpredictable annual incomes, such as small business owners or those in agriculture, out of Qualified Health Plans because they are forced to gamble that their income for the upcoming year will qualify them for a subsidy.[19] This unpredictability has real costs: if a family's income in the upcoming year is higher than estimated, it could be forced to repay some or all of the tax credit the next year, even if it cannot afford to do so.[20] This uncertainty can cause people to forgo buying Qualified Health Plans, particularly now that the tax penalty for not having health insurance has been reduced to $0.[21]

---

[18] 26 U.S.C. § 36B(b)(2)(B)(ii) (basing the premium tax credit calculation in part on "the taxpayer's household income for the taxable year").

[19] Tara Straw, *Threat of Tax Credit Repayment Would Reduce Coverage, Put Many Families at Financial Risk*, CENTER ON BUDGET & POLICY PRIORITIES (Nov. 14, 2017), https://www.cbpp.org/sites/default/files/atoms/files/11-14-17health.pdf (accessed Jan. 21, 2020).

[20] 26 U.S.C. § 36B(f)(2); *Explaining Health Care Reform: Questions About Health Insurance Subsidies*, KAISER FAMILY FOUNDATION (Jan. 16, 2020), https://www.kff.org/health-reform/issue-brief/explaining-health-care-reform-questions-about-health/ (accessed Jan. 21, 2020). If the taxpayer has a household income of less than 400 percent of the poverty line for the size of the family, repayment of excess tax credit is capped. 26 U.S.C. § 36B(f)(2)(B)(i). There is no cap if the household income is estimated to be less than 400 percent of the poverty line and the individual ends up with income for the taxable year exceeding 400 percent of the poverty line. *Id.*

[21] *See* 26 U.S.C. § 5000A, as amended by the Tax Cuts and Jobs Act, Pub. L. No. 115-97, § 11081, 131 Stat. 2054, 2092 (2017).

Idaho's experience is not unique. The vast majority of States are experiencing these same affordability issues.[22] Nationally, marketplace enrollment among subsidized Qualified Health Plan enrollees rose from 8.7 million in 2015 to 9.2 million in 2018 as premiums have risen.[23] However, the number of unsubsidized enrollees in Qualified Health Plans has fallen in this same period from 6.4 million to 3.9 million.[24]

Notably, Idaho has seen the number of people enrolled in non-insurance alternatives increase. For example, from 2017 to 2018, the estimated number of Idahoans enrolled in health-care sharing ministries increased by an estimated 53 percent to about 24,282 lives.[25] Health-care sharing ministries are exempt from the ACA's patient protection requirements, as well as from Idaho's laws governing insurance, and have been the subject of numerous consumer complaints.[26]

---

[22] JA115 ("[A]verage monthly enrollment in individual market plans decreased by 10 percent between 2016 and 2017, while premiums increased by 21 percent."); *see also* CMS Enrollment Trends, *supra* note 11, at 3; Rachel Fehr, et al., *Data Note: Changes in Enrollment in the Individual Health Insurance Market Through Early 2019*, KAISER FAMILY FOUNDATION (Aug. 21, 2019), https://www.kff.org/private-insurance/issue-brief/data-note-changes-in-enrollment-in-the-individual-health-insurance-market-through-early-2019/ (accessed Jan. 21, 2019).

[23] Fehr, et al., *supra* note 22.

[24] *Id.*

[25] IDOI 2019 Report, *supra* note 6, at 14. This data was gathered by voluntary survey of select health-care sharing ministries and likely under-estimates the number of Idahoans participating in health-care sharing ministries.

[26] *See* 26 U.S.C. § 5000A(d)(2)(B); Idaho Code Ann. § 41-121(1) (West 2019); JoNel Aleccia, *'Sham' Sharing Ministries Test Faith Of Patients And Insurance*

Against this backdrop, Idaho has exercised the flexibility that Congress retained for it within the Health Insurance Portability and Accountability Act, Pub. L. No. 104-191, 110 Stat. 1936, in 1996 ("HIPAA") and the ACA, and that the Departments restored to it by the 2018 Rule, to increase the accessibility and availability of health insurance to consumers. Idaho allows the sale of two short-term, limited duration health insurance options: (1) nonrenewable "traditional" short-term, limited duration health insurance with policies lasting six months or less[27] and (2) ESTPs. ESTPs are individual health benefit plans that have an initial term of less than 12 months, are renewable for up to 36 months, and provide most of the protections required by the ACA.[28] Neither option could have existed under the rule the 2018 Rule replaced. Idaho has made options for quality health insurance affordable and accessible to individuals priced out of Qualified Health Plans in a way that coexists with the ACA market.

Multiple carriers offer nonrenewable "traditional" short-term, limited duration plans in Idaho.[29] The Idaho Department of Insurance has approved five

---

Regulators, KAISER HEALTH NEWS (May 17, 2019) (https://khn.org/news/sham-sharing-ministries-test-faith-of-patients-and-insurance-regulators/) (accessed Jan. 21, 2020).

[27] *See* IDAPA 18.04.16.010.03 (West 2019).

[28] *See* Idaho Code Ann. § 41-5214 (West 2019); IDAPA 18.04.16 (West 2019).

[29] Louise Norris, *Short-term health insurance in Idaho*, Healthinsurance.org (Dec. 14, 2019), https://www.healthinsurance.org/idaho-short-term-health-insurance/ (accessed Jan. 21, 2020).

ESTPs, offered by two different carriers, which are currently being sold in Idaho.[30]

If the 2018 Rule is struck down, Idaho and other States will be denied the space they need to innovate solutions to the indisputable problem of health insurance affordability. This would be the antithesis of the intent of the federal health insurance laws.

ARGUMENT

A. The 2018 Rule follows Congress's intent to retain significant roles for the States and is consistent with the States' constitutional responsibilities for the health and safety of their residents.

The United States Constitution gives the States, not the Federal government, responsibility over "the facets of governing that touch on citizens' daily lives," such as health insurance.[31] The States have historically had "primacy" in "regulation of matters of health and safety."[32] "The Framers thus ensured that powers which 'in the ordinary course of affairs, concern the lives, liberties, and properties of the people' were held by governments more local and more

---

[30] Press Release, Enhanced Short-term Plans Available for Idaho Families in 2020 (Dec. 17, 2019), available at: https://gov.idaho.gov/pressrelease/enhanced-short-term-plans-available-for-idaho-families-in-2020/; *see also* Blue Cross of Idaho, https://shoppers.bcidaho.com/individual-and-family/access-plans.page (accessed Jan. 21, 2020); SelectHealth, Enhanced Short-Term Plans (Idaho 2020), https://selecthealth.org/linkapi/public/api/v1/AgentResources/GetFile?id=270

[31] *Nat'l Fed'n of Indep. Bus. v. Sebelius*, 567 U.S. 519, 536 (2012).

[32] *CTS Corp. v. Waldburger*, 573 U.S. 1, 19 (2014) (quoting *Medtronic, Inc. v. Lohr*, 518 U.S. 470, 485 (1996)).

accountable than a distant federal bureaucracy."[33]

With both the HIPAA and the ACA, Congress recognized this constitutional imperative, preserving room for the States to continue to exercise their fundamental constitutional role of protecting the general health and safety of their citizens, more broadly, and regulating health insurance, more specifically. When Congress enacted HIPAA in 1996, and excluded "short-term limited duration insurance" from the definition of "individual health coverage," it created a scheme that left significant roles for the States in achieving its purpose of, among other things, "improv[ing] portability and continuity of health insurance coverage in the group and individual markets."[34] And "the ACA left HIPAA's federal-state relationship largely intact."[35] Instead of creating a federal system to address its concerns about health care, "Congress chose" with the ACA "to preserve a central role for…state governments."[36]

The ACA is clear about this. It contains a clause that "disclaim[s] any ACA

[33] *Nat'l Fed'n of Indep. Bus.*, 567 U.S. at 536 (quoting THE FEDERALIST NO. 45, at 293 (James Madison)).
[34] H.R. REP. NO. 104-496, at 1, *reprinted in* 1996 U.S.C.C.A.N. 1865, 1865.
[35] EMPLOYER'S GUIDE TO THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT ¶ 230 (David Slaughter, ed. 2019), 2005 WL 4171609.
[36] *Nat'l Fed'n of Indep. Bus.*, 567 U.S. at 599 (Ginsburg, J., with Sotomayor, Breyer and Kagan, JJ., concurring in part, concurring in the judgment in part, and dissenting in part).

preemption over the entire field of health insurance."[37] This mirrors the provision in HIPAA allowing States to adopt and enforce laws and regulations affording greater consumer protections than the federal scheme.[38]

The ACA also allows the States to exercise discretion in other areas, including:

- to "elect" to establish and operate their own Exchanges;[39]
- to create a Basic Health Plan for low income individuals not eligible for Medicaid;[40]
- to seek approval for significant changes to their individual marketplaces through Section 1332 State innovation waivers;[41] and

[37] *Conway v. United States*, 145 Fed. Cl. 514, 522 (2019) (petition for cert. docketed) (citing *St. Louis Effort for AIDS v. Huff*, 782 F.3d 1016, 1022 (8th Cir. 2015) ("This preemption clause is a narrow one, and only those state laws that 'hinder or impede' the implementation of the ACA run afoul of the Supremacy Clause."); and then citing *UnitedHealthcare of N.Y., Inc. v. Vullo*, 323 F. Supp. 3d 470, 481 (S.D.N.Y. 2018) (holding that the ACA does not preempt the field of health insurance), *appeal argued*, No. 18-2583 (2d Cir. Feb. 8, 2019)); Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 1321(d), 124 Stat. 119, 187 (2010) (codified at 42 U.S.C. § 18041(d)) ("No Interference with State Regulatory Authority—Nothing in this title shall be construed to preempt any State law that does not prevent the application of the provisions of this title.").
[38] Pub. L. No. 104-191, § 2723(a), 110 Stat. 1936, 1971-72 (1996) (codified at 42 U.S.C. § 300gg–23(a)); *id.*, § 2762(a), 110 Stat. at 1987 (codified at 42 U.S.C. § 300gg–62(a)).
[39] 42 U.S.C. §§ 18031 and 18041; *King*, 135 S. Ct. at 2489.
[40] 42 U.S.C. § 18051.
[41] 42 U.S.C. § 18052.

- to exercise primary enforcement authority over health insurance issuers to ensure compliance with the ACA's reforms.[42]

The 2018 Rule is consistent with Congress's demonstrated intent to leave space for the States to exercise discretion to meet the needs of their particular populations. It "provide[s] more flexibility to states to pursue innovative solutions to meet their market-specific needs."[43]

In contrast, Appellants' rigid interpretation of the terms "short-term" and "limited duration" is inconsistent with both statutory language and Congressional intent. Appellants' interpretation would remove essentially all discretion and flexibility from the States, which is particularly troublesome in an area that Congress expressly carved out from Federal regulation.

HIPAA and the ACA left room for the States to exercise their constitutional responsibilities and to work out implementing details to suit the needs of their unique populations. The 2018 Rule ensures that, in the arena of short-term, limited duration insurance, the States can do just that.

B. States are using the space restored to them by the 2018 Rule to address health insurance quality and affordability for their populations.

As the Departments anticipated, States are taking a variety of approaches,

---

[42] CENTERS FOR MEDICARE & MEDICAID SERVICES, THE CENTER FOR CONSUMER INFORMATION & INSURANCE OVERSIGHT, https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Market-Reforms/compliance (accessed Jan. 21, 2020).

[43] JA128; *see also* JA130.

consistent with their constitutional responsibilities, in the space retained for them by HIPAA, the ACA, and the 2018 Rule to experiment with regulations on short-term, limited duration health insurance in accordance with each State's considered judgment.

A few States have enacted or continued bans on the sale of all short-term, limited duration insurance.[44] Several limit the term and duration of short-term, limited duration plans to less than that allowed by the 2018 Rule.[45] Some have adopted the outermost limits allowed by the 2018 Rule as the permissible term and duration.[46] Some impose requirements on the benefits that must be covered by such plans.[47] Some require insurers offering short-term, limited duration plans to

---

[44] *See, e.g.*, Cal. Ins. Code § 10123.61 (West 2019); N.Y. State Dep't of Financial Servs., Ins. Circular Letter No. 7 (Jun. 21, 2018), available at: https://www.dfs.ny.gov/insurance/circltr/2018/cl2018_07.htm (accessed Jan. 21, 2020).

[45] *See, e.g.*, D.C. Code Ann. § 31-3303.13d(d), (e) (West 2019); Haw. Rev. Stat. Ann. § 431:10A-605(a) (West 2018); IDAPA 18.04.16.010.03 ("traditional" short-term, limited duration insurance only); 215 Ill. Comp. Stat. Ann. 190/10(c) (West 2018); Me. Rev. Stat. Ann. tit. 24-A, § 2849-B(8) (West 2019); Md. Code Ann., Ins. § 15-1301(s) (West 2018); N.D. Cent. Code Ann. § 26.1-36-49(1) (West 2019); N.D. Admin. Code 45-06-16-01(2) (West 2019); Vt. Stat. Ann. tit. 8, § 4084a(c) (West 2018); Wash. Admin. Code § 284-43-8000(3), (5) (West 2020).

[46] *See* Idaho Code Ann. § 41-5203(11) (West 2019) (ESTPs only); Okla. Stat. Ann. tit. 36, § 4419 (West 2019); Tex. Ins. Code Ann. § 1509.001 (West 2019).

[47] *See, e.g.*, 3 Colo. Code Regs. § 702-4:4-2-41 (West 2019); 18 Del. Admin. Code 1320-5.0 (West 2019); Ind. Code Ann. § 27-8-5.9-3 (West 2019); Iowa Admin. Code r. 191-36.6(514D) (West 2019); Wash. Admin. Code § 284-43-8000(1)(a) (West 2020).

cover preexisting conditions.[48] Some limit the marketing and sale of short-term limited duration plans during the open enrollment window for Qualified Health Plans.[49] One prohibits an insurer from enrolling or renewing an individual in a short-term, limited duration plan if the individual was eligible to purchase a Qualified Health Plan during the previous calendar year.[50] And some impose strict limits on the ability of insurers to rescind short-term limited duration policies, a practice often called "rescission" in which insurers retroactively cancel coverage.[51]

Idaho is experimenting with its own way of regulating short-term, limited duration health insurance within the space restored by the 2018 Rule by allowing the sale of nonrenewable "traditional" short-term, limited duration insurance and of ESTPs. Idaho is ensuring its citizens are given access to meaningful health insurance options in a way that complements Qualified Health Plans and meets the unique needs of its population. Idaho's experience supports affirmance of the district court's decision.

---

[48] *See*, *e.g.*, Conn. Gen. Stat. Ann. § 38a-476(b)(3) (West 2020); D.C. Code Ann. § 31-3303.13d(c) (West 2019); 4-3 Vt. Code R. § 61:8(D)(3) (West 2019).
[49] *See*, *e.g.*, Me. Rev. Stat. Ann. tit. 24-A, § 2849-B(8)(D) (West 2019); Wash. Admin. Code § 284-43-8000(4) (West 2020).
[50] Haw. Rev. Stat. Ann. § 431:10A-605(a) (West 2018).
[51] *See*, *e.g.*, 215 Ill. Comp. Stat. Ann. 190/10(d) (West 2018); Nev. Rev. Stat. Ann. § SB 481, § 8 (West 2020).

1. Idaho's actions are consistent with Congress's express intent to increase the number of Americans with health insurance and decrease the cost of health care.

Congress enacted the ACA with the aim of "increas[ing] the number of Americans covered by health insurance and decreas[ing] the cost of health care."[52] Idaho believes allowing the sale of both nonrenewable "traditional" short-term limited duration health insurance and ESTPs will give the portion of its population that is currently being priced out of unsubsidized Qualified Health Plans access to quality, affordable health insurance.[53] For the purposes of the following discussion, Idaho focuses on ESTPs as they are new to the market, but it believes that the availability of both types of short-term, limited duration insurance in Idaho achieves Congressional intent.

a. ESTPs are intended to increase the number of Idahoans with health insurance.

ESTPs are allowed to take an individual's health history into account in setting premiums, meaning pre-subsidy premiums can be up to 50 percent less than Qualified Health Plans and making them especially attractive to healthy people who cannot afford unsubsidized Qualified Health Plans.[54] State regulators

[52] *Nat'l Fed'n of Indep. Bus.*, 567 U.S. at 538.
[53] Press Release, *supra* note 30.
[54] *See* Idaho Code Ann. § 41-5206(1)(a) (West 2019); *see also* John Tozzi, *A Cheaper Alternative to Obamacare Is A Hit in Idaho*, BLOOMBERG (Jan. 10, 2020,

anticipated that most of the enrollment in ESTPs would come from people who were *not* currently enrolled in coverage through Idaho's Exchange.[55]

The sole fact that ESTPs are likely to increase the number of Idahoans with affordable quality health insurance demonstrates their consistency with Congressional intent. As Appellees argue and the district court correctly concluded, Congress did not intend that every American be enrolled in a Qualified Health Plan.[56]

b. ESTPs are designed to lower the cost of health care.

ESTPs are likely to decrease the cost of care by reducing premiums for Qualified Health Plans and encouraging competition amongst insurers on Idaho's Exchange.

Congress deemed it essential to the success of the reforms implemented by the ACA that the healthy and the young be drawn into the health insurance risk pools.[57] The premiums paid by that population help keep the premiums for the old and the sick manageable and help retain insurers in the market.[58] The importance

---

7:00 AM), https://www.bloomberg.com/news/articles/2020-01-10/obamacare-health-insurance-2020-cheaper-alt-plans-cover-less.

[55] Idaho Health Ins. Exchange dba Your Health Idaho, Marketplace Comm. Minutes at 8-9 (Sept. 3, 2019), available at: https://www.yourhealthidaho.org/wp-content/uploads/09-03-2019-DRAFT-Marketplace-Minutes-for-APPROVAL.pdf.

[56] JA593; Br. for the Appellees at 27-32.

[57] *Nat'l Fed'n of Indep. Bus.*, 567 U.S. at 548.

[58] *Id.*, 567 U.S. at 548, 556.

of enticing new enrollees with affordable plans is heightened given that the tax penalty intended to incentivize healthy individuals to purchase health insurance is now $0.[59]

As stated above, ESTPs are intended to draw healthy people into the health insurance market.[60] ESTPs impact premiums for Qualified Health Plans because Idaho requires that ESTPs "comprise a single risk pool" with all of a carrier's Qualified Health Plans.[61] Premiums for ESTPs and Qualified Health Plans are both linked to a carrier's "index rate."[62] Thus, Idaho's single risk pool requirement means that the "index rate" must reflect the combined medical costs of both the carrier's Qualified Health Plans and ESTPs. An infusion of healthy people on ESTPs could reduce premiums for all Idahoans in the individual insurance market.

Further, ESTPs encourage participation and competition in the Qualified

---

[59] *See* 26 U.S.C. § 5000A, as amended by the Tax Cuts and Jobs Act, Pub. L. No. 115-97, § 11081, 131 Stat. 2054, 2092 (2017).
[60] Tozzi, *supra* note 54.
[61] IDAPA 18.04.16.022.01.d (West 2019).
[62] *See* Idaho Code Ann. § 41-5203(14) (West 2019) ("'Index rate' means, as to a rating period for individuals with similar case characteristics, the arithmetic average of the applicable base premium rate and the corresponding highest premium rate."); Idaho Code Ann. § 41-5203(4) (West 2019) ("'Base premium rate' means, as to a rating period, the lowest premium charged or that could have been charged under a rating system by the individual carrier to individuals with similar case characteristics for health benefit plans with the same or similar coverage."); Idaho Code Ann. § 41-5206 (West 2019) (premiums may not deviate from the index rate by more than 50 percent).

Health Plan market. "In order to offer an [ESTP], the carrier must also offer individual [Qualified Health Plans] through the Exchange in the same service area."[63] By incentivizing more Exchange participants with the chance to sell ESTPs, ESTPs increase choice and coverage options on the Exchange.

2. ESTPs offer patient protections consistent with Congress's intent of ensuring that Americans have access to quality health care.

While Congress never intended that all Americans be covered by insurance with the exact same consumer protections and requirements as those required for Qualified Health Plans,[64] the protections and requirements for ESTPs are substantially similar to those for Qualified Health Plans. And there can also be no doubt that, looking to the historical intent behind HIPAA, they help individuals maintain "creditable coverage." The dire warnings sounded by Appellants and their *amici* regarding shortcomings in patient protections in short-term, limited duration insurance fail to account for the requirements States can impose to meet the needs of their populations.[65]

---

[63] IDAPA 18.04.16.011.02 (West 2019).
[64] *See*, *e.g.*, 42 U.S.C. § 18011 (exempting pre-ACA "grandfathered health plans" from the ACA's reforms); 42 U.S.C. § 18118(c) (exempting student health insurance from the ACA's reforms).
[65] *See* IDAPA 18.04.16 (West 2019); *see also* Wash. Admin. Code § 284-43-8000 (West 2020); Iowa Admin. Code r. 191-36.6(514D)(11) (West 2019); 18 Del. Admin. Code 1320-5.0 (West 2019); Ind. Code Ann. § 27-8-5.9-3 (West 2019); 3 Colo. Code Regs. § 702-4:4-2-41 (West 2019); 215 Ill. Comp. Stat. Ann. 190/10(d) (West 2018); Nev. Rev. Stat. Ann. § SB 481, § 8 (West 2020).

An ESTP is defined as a "health benefit plan."[66] This subjects ESTPs to Idaho's provisions for renewable individual major medical coverage, including most of the provisions that apply to Qualified Health Plans, and imposes different requirements than those for "traditional" short-term, limited duration plans.[67]

Most notably, ESTPs contain protections for people with preexisting conditions; requirements that policies offer the "essential health benefits" mandated by the ACA; reasonable caps on annual benefits; limitations on the ability of carriers to engage in rescission; and protection for consumers upon a plan's end.

a. Preexisting Conditions

ESTPs are "guaranteed issue," meaning that the carrier cannot refuse to sell a policy to any individual who desires it, regardless of his or her health history.[68] Ensuring the availability of "guaranteed issue" plans was an important component of Congress's goal to increase the number of Americans with health insurance.[69]

ESTPs do differ from ACA plans in that premiums for ESTPs are affected

[66] *See* Idaho Code Ann. § 41-5203(11) (West 2019).
[67] *See*, *e.g.*, IDAPA 18.04.14.046 (West 2019).
[68] IDAPA 18.04.16.011.03 (West 2019).
[69] *Nat'l Fed'n of Indep. Bus.*, 567 U.S. at 597 (Ginsburg, J., with Sotomayor, Breyer and Kagan, JJ., concurring in part, concurring in the judgment in part, and dissenting in part.)

by an individual's health history.[70] However, as discussed above, regardless of health history, an individual's premium may not vary from the carrier's index rate by more than 50 percent.[71] And health history and claims cannot cause an individual's premium to increase by more than 15 percent for a new rating period.[72]

Depending on how enrollment is offered, ESTPs may impose a preexisting condition waiting period on new enrollees. If a carrier opts to offer an ESTP only during an annual open enrollment window, the carrier is prohibited from applying a preexisting condition waiting period.[73]

If a carrier opts to offer ESTPs year-round, the carrier may apply a 12 month preexisting condition waiting period while still providing all other plan benefits.[74] This waiting period helps carriers offer guaranteed issue plans given the reality of "adverse selection," described by Appellees (at 32-33).[75] If no preexisting

---

[70] *See* Idaho Code Ann. § 41-5206 (West 2019); 42 U.S.C. § 300gg(a)(1); IDAPA 18.04.16.022.01 (West 2019). Premium rates may not vary based on gender or on geographic rating areas beyond what is allowed by Qualified Health Plans. IDAPA 18.04.16.022.01(West 2019).
[71] Idaho Code Ann. § 41-5206(1)(a) (West 2019).
[72] Idaho Code Ann. § 41-5206(1)(b)(ii) (West 2019).
[73] IDAPA 18.04.16.020.01.b.i (West 2019).
[74] This waiting period may not extend any longer than 12 months from the effective date of coverage and is subject to waiver based on prior continuous insurance coverage. *See* Idaho Code Ann. § 41-5208(3) (West 2019); *and see* IDAPA 18.04.16.020.01.a.i (West 2019).
[75] *See King*, 135 S. Ct. at 2485.

condition waiting period applied, people could wait until they needed health care to sign up for ESTPs. The preexisting condition waiting period allows carriers to offer guaranteed ESTP enrollment year-round.

Qualified Health Plans address the problem of "adverse selection" with a *de facto* waiting period by limiting enrollment to specified windows.[76] ESTPs complement Qualified Health Plans by offering an insurance bridge between Qualified Health Plan enrollment periods.

b. Essential Health Benefits

ESTPs are required to provide the same essential health benefits that are provided by Qualified Health Plans, other than pediatric dental or vision benefits.[77] The restrictions on limitations on benefits for Idaho's Qualified Health Plans also apply to ESTPs.[78] Of the five ESTPs currently approved by the Idaho Department of Insurance, two have ACA Bronze level actuarial value and two have ACA Silver level actuarial value.[79]

---

[76] 42 U.S.C. § 18031(c)(6)(B) and (C); *Texas v. United States*, 945 F.3d 355, 418 (5th Cir. 2019), *as revised* (Dec. 20, 2019), *as revised* (Jan. 9, 2020) (King, J., dissenting) (petition for cert. filed).
[77] *See* IDAPA 18.04.16.030.03 (West 2019); IDAPA 18.04.16.010.01 (West 2019).
[78] *Id*.
[79] Idaho Dep't of Ins., Information about Idaho's Enhanced Short-Term Plans, at 5 https://doi.idaho.gov/consumer/Health/2020InformationaboutIdahosEnhancedShortTermPlans.pdf. (accessed Jan. 24, 2020).

c. Reasonable Caps on Benefits

The ACA prohibits caps on annual and lifetime benefits.[80] ESTPs, due to the fact that they are "short-term, limited duration" insurance, allow for annual limits of no less than one million dollars for each covered person.[81] This limit reflects the limited nature of short-term, limited duration insurance while still protecting consumers from nearly all catastrophic claims scenarios.

d. Limitations on Rescission

Qualified Health Plans are prohibited from rescission unless the enrollee has engaged in fraud or made an intentional misrepresentation of material fact as prohibited by the terms of the plan or coverage.[82] Similarly, ESTPs may only be rescinded for fraud or material application misstatements.[83]

e. Renewability

ESTPs are guaranteed renewable *at the option of the enrollee* and the carrier is prohibited from requesting a new application or questions concerning the health or medical condition of the covered individual to effectuate the renewal.[84] Further, upon exhaustion of the policy's renewability due to duration or age, the

[80] *See* 42 U.S.C. § 300gg-11.
[81] *See* IDAPA 18.04.16.030.05.c (West 2019).
[82] 42 U.S.C. § 300gg-12.
[83] IDAPA 18.04.14.046.04 (West 2019).
[84] IDAPA 18.04.16.021.01 (West 2019); *see* Idaho Code Ann. § 41-5207(1) (West 2019).

policyholder must be allowed to enroll in the carrier's fully renewable coverage, including its Qualified Health Plans.[85]

Appellants' warnings about short-term, limited duration insurance are without merit. The 2018 Rule was right to restore the discretion that Congress left to the States to develop rules and requirements for short-term, limited duration insurance to fit the needs of their residents.

C. Idaho's experience shows that the district court was correct to decline to speculate that the 2018 Rule would destabilize the Exchanges.

The district court correctly determined that *Chevron* deference should be applied to the 2018 Rule. Idaho's experience demonstrates the district court was correct not to leap to the conclusion that allowing States to offer short-term, limited duration insurance consistent with the 2018 Rule would cause "a substantial exodus from the individual market Exchanges…that would threaten the ACA's structural core."[86] In fact, Idaho's experience shows the opposite to be the case.

While the price differential between unsubsidized Qualified Health Plans and ESTP offerings is notable, it is not so significant as to support the conclusion that ESTPs will cause a mass exodus from *unsubsidized* Qualified Health Plans.

---

[85] IDAPA 18.04.16.021.01.d (West 2019); *see* Idaho Code Ann. § 41-5207(1)(h) (West 2019).
[86] JA577.

Blue Cross of Idaho has reported the following comparison of premiums for its ESTP and Qualified Health Plan offerings:[87]

Scenario	Access Safeguard	ACA Bronze (unsubsidized)	Access Secure	ACA Silver (unsubsidized)
Single, 39, no conditions	$258	$331	$329	$491
Single, 42, high blood pressure with one prescription	$300	$348	$382	$516
Couple, 40, no conditions	$530	$670	$674	$995
Couple, 50, one spouse with high cholesterol and high blood pressure, one prescription	$759	$937	$966	$1,391

As this chart demonstrates, premiums for ESTPs simply cannot wildly undercut unsubsidized premiums for Qualified Health Plans.

The availability of ESTPs poses even less threat of drawing subsidized Qualified Health Plan enrollees out of that market. The Kaiser Family Foundation calculated that 4.2 million people nationwide in 2019 and 4.7 million people nationwide in 2020 were or are eligible to pay a $0 premium for a Bronze ACA plan due to the effect of subsidies.[88] Forty-one percent of Idaho's uninsured have

[87] Tozzi, *supra* note 54.
[88] Rachel Fehr, *How Many of the Uninsured Can Purchase a Marketplace Plan for Free in 2020?*, Kaiser Family Foundation (Dec. 10, 2019), https://www.kff.org/private-insurance/issue-brief/how-many-of-the-uninsured-can-purchase-a-marketplace-plan-for-free-in-2020/ (accessed Jan. 21, 2020).

access to a free Bronze ACA plan after subsidies in 2020.[89] The Kaiser Family Foundation has also concluded that "[s]ingle individuals with incomes below 250% of the poverty level can purchase [Silver ACA plans] with cost sharing reductions…for $20 to $215 per month after subsidies in 2020, on average, depending on the enrollees' income."[90]

Enrollment numbers confirm that ESTPs are not destabilizing Idaho's Qualified Health Plan markets. Blue Cross of Idaho has had about 1,500 members enroll in its ESTP offerings for policies that took effect January 1, 2020.[91] An additional 150 people have paid for coverage beginning in February 2020.[92] This is hardly a mass exodus. For each month of 2018, an average of 25,203 Idahoans enrolled in unsubsidized Qualified Health Plans and an average of 76,425 Idahoans enrolled in subsidized Qualified Health Plans.[93]

Time will tell how Idaho's options of nonrenewable "traditional" short-term,

---

[89] *Id.*

[90] *Id.* Cost-sharing reductions are a type of subsidy available under the ACA to income-eligible individuals enrolled on Silver Qualified Health Plans that reduce the out-of-pocket share of medical costs the insured must pay. 42 U.S.C. §§ 18022(c)(3), 18071(c); *California v. Trump*, 267 F. Supp. 3d 1119, 1123, 1134 (N.D. Cal. 2017).

[91] Tozzi, *supra* note 54. Idaho does not yet have data on the number of individuals enrolled in nonrenewable "traditional" short-term, limited duration insurance with a six month or less duration.

[92] *Id.*

[93] CMS Enrollment Trends, *supra* note 11, at 8.

limited duration insurance and ESTPs play out; just as time will tell how short-term, limited duration insurance plays out in States that impose different terms, durations, and conditions on such plans.

This is what the U.S. Constitution intended. The broad latitude of the States, necessary to address difficult problems and rapidly developing issues, has been likened to a laboratory of democracy.[94] Approaches that are ultimately successful in one State can be adopted by another as befits the needs of that State's population.

At this time, the facts simply do not show that the 2018 Rule is undermining the ACA, let alone "threatening [its] structural core."[95] The district court correctly held that the 2018 Rule is consistent with Congress's intent to allow States to experiment with solutions to the problem of the accessibility and affordability of quality health insurance.

CONCLUSION

The judgment of the district court should be affirmed.

---

[94] *See Ariz. State Legis. v. Ariz. Indep. Redistricting Comm'n*, 135 S. Ct. 2652, 2673 (2015) (citations omitted); *Oregon v. Ice*, 555 U.S. 160, 171 (2009) (citation omitted).

[95] JA577.

Dated: January 28, 2020

Respectfully submitted,

/s/ Megan A. Larrondo
LAWRENCE G. WASDEN
ATTORNEY GENERAL
BRIAN KANE
Assistant Chief Deputy
MEGAN A. LARRONDO
Counsel of Record
Deputy Attorneys General
P.O. Box 83720
Boise, ID 83720-0010
Tel.: (208) 334-2400
megan.larrondo@ag.idaho.gov

Counsel for State of Idaho and Governor Brad Little

/s/ Anthony F. Shelley (per email consent)
ANTHONY F. SHELLEY
Miller & Chevalier Chartered
900 16th St. NW
Washington, DC 20006
Tel.: (202) 626-5800
ashelley@milchev.com

Counsel for Blue Cross of Idaho and SelectHealth, Inc.

CERTIFICATE OF COMPLIANCE

1. This document complies with the word limit of Fed. R. App. P. 29(a)(5) and 32(a)(7) because, excluding the parts of the document exempted by Fed. R. App. P. 32(f) and Circuit Rule 32.1, this document contains 6,470 words, according to the word-processing program used to prepare it.
2. This document complies with the typeface requirements of Fed. R. App. P. 32(a)(5) and the type-style requirements of Fed. R. App. P. 32(a)(6) because it uses proportionately spaced 14-point Times New Roman typeface.

Dated: January 28, 2020

/s/ Megan A. Larrondo
MEGAN A. LARRONDO

ADDENDUM

TABLE OF CONTENTS

Idaho Code Ann. § 41-5203 (West 2019)

(11) "Enhanced short-term plan" means an individual health benefit plan that:

(a) Has an initial period of less than twelve (12) months and is renewable at the option of the individual for up to the number of months established by rules issued pursuant to section 41-5214, Idaho Code; and
(b) Otherwise meets the standards established by rules issued pursuant to section 41-5214, Idaho Code.

Idaho Code Ann. § 41-5214 (West 2019)

The director shall adopt reasonable rules to establish specific standards for enhanced short-term plans. The standards shall be in addition to and in accordance with applicable laws of this state, including this chapter. The standards:

(1) Shall include requirements for renewability that are consistent with federal law regarding short-term, limited duration insurance; and

(2) May include, but need not be limited to:
(a) A scope of covered benefits, which may be as broad as the scope of covered benefits required to be included in individual health benefit plans that are not deemed short-term, limited duration insurance under federal law;
(b) Restrictions on premium rate increases when an enhanced short-term plan ceases to be renewable and the individual policyholder reapplies for coverage from the same carrier; and
(c) Conversion of enhanced short-term plans into fully renewable coverage upon a finding by the director that the conversion complies with law and is in the best interests of the public.

IDAPA 18.04.16.010 (West 2019)

01. Benchmark Medical Plan. "Benchmark medical plan" means the health benefit plan identified by the U.S. Department of Health and Human Services to be applicable in establishing required benefit coverages by Qualified Health Plans within Idaho, excluding any supplements for pediatric dental or vision.

. . .

03. Nonrenewable Short-term Coverage. "Nonrenewable short-term coverage" means short-term, limited-duration insurance that is not renewable, has a duration of six (6) months or less in total, and does not meet the standards for an Enhanced Short-term Plan established by this rule.

. . .

07. Short-term, Limited-duration Insurance. "Short-term, limited-duration insurance" means health insurance coverage pursuant to a contract that has an expiration date specified in the contract that is less than twelve (12) months after the original effective date of the contract and, taking into account renewals or extensions, has a duration of no longer than thirty-six (36) months in total.

IDAPA 18.04.16.011 (West 2019)

. . .

02. Requirement to Offer Exchange Plans. In order to offer an enhanced short-term plan, the carrier must also offer individual QHPs through the Exchange in the same service area.

03. Guaranteed Issue. Enhanced short-term plans must be offered only on a guaranteed issue basis.

IDAPA 18.04.16.020 (West 2019)

. . .

01. Enhanced Short-term Plans. Carriers may choose one of the following two options for enrolling individuals in enhanced short-term plans.

a. Enrollment Throughout the Year. A carrier that opts to allow year-round enrollment in enhanced short-term plans must apply the following provisions:

i. A preexisting condition exclusion period, as defined at Subsection 010.04, may be applied, subject to Section 41-5208, Idaho Code.

. . .

b. Enrollment Through an Annual Open Enrollment Period. A carrier that opts to restrict enrollment in enhanced short-term plans to an annual open enrollment period must apply the following provisions:

i. No preexisting condition exclusion period may be applied.

. . .

IDAPA 18.04.16.021 (West 2019)

01. Enhanced Short-term Plans Renewals. The following provisions apply to the renewal of enhanced short-term plans:

a. A policy must be renewable at the option of the enrollee, consistent with the provisions provided in Section 41-5207, Idaho Code.
b. No new application or questions concerning the health or medical condition of the covered individuals may be requested to effectuate the renewal.
c. A policy must not be renewed if a renewal would extend the total duration of coverage under the policy beyond thirty-six (36) consecutive months.
d. Upon exhaustion of a policy's renewability due to duration or age, the policyholder shall be eligible for enrollment into fully renewable coverage, including all of the current carrier's QHPs, when an enhanced short-term policy has been in effect for at least eleven (11) months. The carrier shall provide timely notification to the policyholder of this eligibility along with the notification of any offer of reissuance.

IDAPA 18.04.16.022 (West 2019)

01. Enhanced Short-term Plans. The following provisions apply to the rates of enhanced short-term plans, in addition to any other requirements of Idaho Code or rules applicable to individual health benefit plans:

a. Unisex Rating. Premium rates may not vary according to gender.
b. Geographic Rating Areas. Geographic rating areas must be identical to those used for QHPs offered through the Exchange.
c. Medical Underwriting. Medical underwriting criteria may be used to ascertain the risk characteristics of an applicant, provided such criteria are limited to those found in the Universal Health Statement Addendum and available claims data.
d. Single Risk Pool. Enhanced short-term plans must comprise a single risk pool with all of a carrier's other actively marketed individual health benefit plans subject to Chapter 52, Title 41, Idaho Code. e. Rating Period. The rating period shall be on a calendar year basis, meaning the rates filed must apply to all enrollees uniformly during a given calendar year, and changes to premium rates must occur at the start of a new calendar year.

. . .

IDAPA 18.04.16.030 (West 2019)

. . .

03. Enhanced Short-term Plans Covered Benefits. Enhanced short-term plans must provide covered benefits consistent with the Idaho benchmark medical plan, including:

a. Outpatient services;
b. Emergency care;
c. Hospitalization;
d. Maternity and newborn care;
e. Mental health and substance abuse disorder services;
f. Prescription drugs;
g. Rehabilitation treatment;
h. Laboratory services; and
i. Preventive care.

05. Cost Sharing. A policy subject to this rule must meet the following cost sharing provisions:

. . .

c. The annual limit must not be less than one million dollars ($1,000,000) for each covered person.

CERTIFICATE OF SERVICE

I hereby certify that I electronically 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 on January 28, 2020.

I certify that all participants in the case are registered CM/ECF users and that service will be accomplished by the CM/ECF system.

Dated: January 28, 2020

/s/ Megan A. Larrondo
MEGAN A. LARRONDO