N0. 19-5212

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

ASSOCIATION FOR COMMUNITY AFFILIATED PLANS, et al.,
Plaintiffs-Appellants

v.

U.S DEPARTMENT OF THE TREASURY,ET AL.,
Defendants-Appellees

On Appeal from the United States District Court
For the District of Columbia

BRIEF AMICUS CURIAE OF THE BUCKEYE INSTITUTE, CATO INSTITUTE, AND MICHAEL F. CANNON IN SUPPORT OF DEFENDANTS-APPELLEES

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COMBINED CERTIFICATES

Certificate as to Parties, Rulings, and Related Cases

Pursuant to Circuit Rule 28(a)(1), counsel for *amici* certifies as follows: Except for the Buckeye Institute, Cato Institute, and Michael F. Cannon, all parties, intervenors, and amici that have appeared in this Court are listed in the Brief for Appellees. The ruling at issue and related cases also appear in the brief for Appellees.

Certificate of Counsel under Circuit Rules 29(c)(4) and 29(c)(5)

The Buckeye Institute was founded in 1989 and is an independent research and educational institution—a think tank—whose mission is to advance free-market public policy in the states. The staff at the Buckeye Institute accomplishes the organization's mission by performing timely and reliable research on key issues, compiling and synthesizing data, formulating free-market policies, marketing those public policy solutions for implementation in Ohio and replication across the country, and filing *amicus* briefs with the courts.

The Cato Institute was established in 1977 as a nonpartisan public policy research foundation dedicated to advancing the principles of individual liberty, free markets, and limited government. Toward those

ends, Cato publishes books and studies, conducts conferences, and issues the annual *Cato Supreme Court Review*.

Michael F. Cannon is a nationally recognized health policy scholar who has done extensive work on the Patient Protection and Affordable Care Act (ACA), its legislative history, and health insurance markets.

Amici seek to show this Court that the district court ruled correctly and how the maximum term of short-term, limited duration insurance impacts the consumers of health care.

Corporate Disclosure Statement

Pursuant to Federal Rule of Appellate Procedure 26.1, Buckeye and Cato each certify that they have no corporate parent, and that no publicly held company has an ownership interest of 10% or more in either of them. All parties have consented to the filing of this brief.

/s/ Robert Alt
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STATEMENT OF AMICI INTEREST[1]

The Buckeye Institute (Buckeye) was founded in 1989 and is an independent research and educational institution—a think tank—whose mission is to advance free-market public policy in the states. The staff at the Buckeye Institute accomplishes the organization's mission by performing timely and reliable research on key issues, compiling and synthesizing data, formulating free-market policies, and marketing those public policy solutions for implementation in Ohio and replication across the country. The Buckeye Institute is located directly across from the Ohio Statehouse on Capitol Square in Columbus, where it assists executive and legislative branch policymakers by providing ideas, research, and data to enable the lawmakers' effectiveness in advocating free-market public policy solutions.

The Cato Institute (Cato) was established in 1977 as a nonpartisan public policy research foundation dedicated to advancing the principles

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[1] All parties consented to the filing of this brief.

Counsel for *amici* certify that no counsel for any party authored this brief in whole or in part and that no person other than *amici* made any contribution intended to fund the preparation or submission of this brief.

of individual liberty, free markets, and limited government. Cato's Robert A. Levy Center for Constitutional Studies was established to restore the principles of limited constitutional government that are the foundation of liberty. Toward those ends, Cato publishes books and studies, conducts conferences and forums, and produces the annual *Cato Supreme Court Review*.

The work of both Buckeye and Cato addresses health care policy. For its part, Buckeye seeks to increase coverage, quality, and affordability by supporting customers and competition among providers. Buckeye's priorities include promoting the removal of restrictions that block the ability of providers to offer care thereby increasing the supply of health care providers. Cato, similarly, seeks to restore individual liberty by expanding the range of health care decisions individuals can make and by reducing the number government makes.

Buckeye and Cato also file amicus briefs in cases that implicate their foundational purposes. In this case, they support the August 1, 2018 final rule issued by the Departments of Health and Human Services, Labor and Treasury expanding the availability of short-term, limited

duration health insurance coverage because it vindicates their foundational principles of free markets and individual liberty.

Amicus Michael F. Cannon is a nationally recognized health policy scholar who has done extensive work on the Patient Protection and Affordable Care Act, its legislative history, and health insurance markets. He has filed numerous *amicus curiae* briefs in litigation involving the ACA. Cannon also filed extensive comments on the February 21, 2018 proposed rule, "Short-Term, Limited Duration Insurance." The Departments repeatedly cited Cannon's comments in the August 1, 2018 final rule.

SUMMARY OF THE ARGUMENT

Congress has allowed short-term, limited duration insurance (STLDI) to be exempt from the statutory requirements applicable to other federally recognized individual health insurance plans. While Congress has known of and provided for such insurance, it has never defined the term or duration of STLDI. That left a gap that the administrative agencies have filled, and, since 1997, with limited exception, federal regulations have consistently defined STLDI as having, among other things, an expiration date that is "within 12 months

of the date the contract becomes effective." See 29 C.F.R. § 2590-701-1 (2019). Nothing in the Health Insurance Portability and Accountability Act (HIPAA) or the Affordable Care Act (ACA) compels setting aside this consistent regulatory practice. See 29 C.F.R. § 2590.701-2 (2019).

The sole exception occurred between December 30, 2016 and 2018, when the Departments limited the maximum term to less than three months. See 81 Fed. Reg. 75,316, 75,317 (Oct. 31, 2016). In 2018, the Departments reversed that limitation and reverted to the prior rule after the President pointed to the term limits on STLDI as one area "where current regulations limit choice and competition" and targeted them for change. 82 Fed. Reg. 48,385 (Oct. 12, 2017).

As the district court observed, "[I]t is not my role to interfere with or disrupt the balance struck by policymakers" in this case. *Ass'n for Associated Community Plans v. Dep't of the Treasury*, 392 F. Supp. 3d 22, 45 (D.D.C. 2019). It shouldn't be the role of this Court either. Limiting the term of STLDI as the Association Appellants desire doesn't just "limit choice and competition." It threatens to inflict real harm on real people, as the experience of Arizona resident Jeanne Balvin typifies. As the National Association of Insurance Commissioners explained in 2016, the

cramped three-month limit then proposed and later adopted stripped health insurance coverage from consumers after they fell ill, leaving them with a period of up to a year during which they faced expensive medical bills with no health insurance coverage. If the longstanding policy of the 12-month term is once again abandoned in favor of a shorter 3-month term, the experience of Jeanne Balvin will befall many more sick Americans.

ARGUMENT

The district court properly concluded that the Departments acted within the scope of their statutory authority in reinstating the 12-month term for STLDI. *Amici* will then show how the remedy sought by the Association Appellants injures STLDI enrollees who fall ill. Finally, they will point to the way in which competitor standing, which is the basis for the Association Appellants' claim, illustrates the true nature of this case.

I. The district court correctly rejected the contention that either HIPAA or the ACA requires a particular term for STLDI.

When Congress enacted the Health Insurance Portability and Accountability Act (HIPAA), in 1996, it defined "individual health insurance coverage" so as not to include STLDI. See 42 U.S.C. § 300gg-91(b)(5) ("The term 'individual health insurance coverage' means health

insurance offered to individuals in the individual market, but does not include short-term limited duration insurance."). Beyond exempting STLDI from other HIPAA statutory requirements, Congress did not define either "short-term" or "limited duration." Thus, it fell to the responsible federal departments to define the terms, which they did to include health insurance coverage with an expiration date "that is within 12 months of the date the contract becomes effective." See 62 Fed. Reg. 16,894, 16958 (Apr. 8, 1977) ("the 1997 rule").[2]

There the regulatory definition stayed until 2016. Even though Congress enacted the Patient Protection and Affordable Care Act in 2010 (ACA), which added requirements to "individual health insurance coverage," it left in place HIPAA's exemption of STLDI from such regulatory requirements. 42 U.S.C. § 300gg-91(b)(5). Again, Congress chose not to define either "short-term" or "limited duration."

The ACA gave consumers incentives to buy comprehensive health insurance coverage and provided for health insurance exchanges to help

[2] The 1997 regulation was promulgated as an interim final rule. See 62 Fed. Reg. 16,894, 16,958 (Apr. 8, 1997 In 2004, a final rule containing a substantially identical definition was issued. 69 Fed. Reg. 78,720, 78,783 (Dec. 30, 2004).

those who could not obtain coverage through their employers or a federal program like Medicare or Medicaid. Notwithstanding the promise of "affordable care," health insurance premiums rose, and the regulators sought to shore up the market for ACA-compliant health insurance plans. In particular, the regulators shortened the allowable duration of STLDI from 12 months to three. 81 Fed. Reg. 75,316 (Oct. 31, 2016) ("the 2016 rule"). They saw STLDI as "an important means for individuals to obtain health coverage when transitioning from one job to another (and from one group health plan to another) or when faced with other similar situations." 81 Fed. Reg. at 75,317. But regulators were concerned that "[i]n some instances, individuals [were] purchasing [short-term, limited duration insurance] coverage as their primary form of health coverage," and renewals sometimes extended their coverage beyond 12 months. *Id.* They suggested that, because of limitations in some policies, STLDI "may not provide meaningful health coverage." 81 Fed. Reg. at 75, 318. In addition, "because these policies can be medically underwritten based on health status, healthier individuals may be targeted for this type of coverage, thus adversely impacting the risk pool for Affordable Care Act-compliant coverage." *Id.*

In October 2017, the president pointed to problems in the performance of the health insurance industry that followed the implementation of ACA. 82 Fed. Reg. 48,385 (Oct. 12, 2017). He identified STLDI as one area "where current regulations limit choice and competition" and targeted it for change. *Id.* He noted that, because STLDI is exempt from the ACA's "onerous and expensive mandates and regulations," it represented "an appealing and affordable alternative to government-run exchanges for many people without coverage available to them through their workplaces." *Id.* The problems stemmed from the then-current regulation's capping the duration of STLDI coverage at three months and "preventing any extensions selected by the policy-holder beyond three months of total coverage." *Id.*

In 2018, after a notice-and-comment period, the Departments issued a final rule that returned the allowable expiration date for STLDI to less than 12 months. 45 C.F.R. § 144.103 (2019) ("the 2018 rule"). That rule also limits the duration of coverage to "less than 36 months in total." *Id.* In addition, policies that started after January 1, 2019, must carry a notice in 14-point type warning consumers of certain potential risks:

> This coverage is not required to comply with certain federal market requirements for health insurance, principally those

> contained in the Affordable Care Act. Be sure to check your policy carefully to make sure you are aware of any exclusions or limitations regarding coverage of preexisting conditions or health benefits (such as hospitalization, emergency services, maternity care, preventive care, prescription drugs, and mental and substance use disorder services). Your policy might also have lifetime and/or annual dollar limits on health benefits. *If this coverage expires or you lose eligibility for this coverage, you might have to wait until an open enrollment period to get other health insurance coverage.* Also, this coverage is not "minimum essential coverage." If you don't have minimum essential coverage for any month in 2018, you may have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month. *Id* (italics added).

In particular, the italicized portion warns consumers of an important restriction on *ACA* coverage. For most of the year, the ACA generally prohibits customers from enrolling in ACA coverage, leaving those who fail to enroll during a brief window to wait until January 1 of the following year for coverage. 42 U.S.C. § 300gg–1(b); 42 U.S.C. § 18031(c)(6); 45 C.F.R. § 155.410 (e) (2017).

The first effect of the 2018 rule is to return the allowable term of STLDI to less than 12 months, which has been the rule since 1997 with only a limited interruption. In addition, it empowers consumers to make their own decisions, fostering competition in the health insurance industry. The regulatory warning helps consumers to evaluate the likely benefits

and potential risks of STLDI. As discussed below, it also highlights a limitation on ACA coverage that STLDI helps to ameliorate.

A. Neither HIPAA nor the ACA require the re-imposition of the cramped and restrictive 2016 three-month rule.

It is hard to imagine why a rule that has been in place for the better part of 23 years now should be invalid. Cf. *Ass'n for Community Affiliated Plans*, 392 F. Supp. 3d at 33 ("Plaintiffs thus do not, and could not, contend that the Departments exceeded their congressionally delegated power when they defined STLDI in 1997 and 2004 or, more to their liking, in 2016.") More to the point, while the proponents of the three-month rule wanted to shore up the risk pool for ACA-compliant coverage, the proponents of the 2018 rule sought to clear away places in which "current regulations limit [consumer] choice and competition [in the market]." 82 Fed. Reg. 48,385. The courts are neither constitutionally tasked nor equipped to choose between the competing policies, and the Administrative Procedure Act does not require a different result.

The district court unsurprisingly concluded, "There is . . . no serious question that Congress delegated to the Departments the ability to define STLDI when it enacted HIPAA in 1996." 392 F. Supp. 2d at 33. It further explained, "The ACA's passage did not alter this status quo. In fact, the

ACA—which in some ways constituted a sea change to the provision of individual health insurance in the United States—retained *untouched* HIPAA's exception of STLDI from individual market insurance regulations." *Id.* (emphasis in original). Rather, "the 2010 Congress was presumptively aware of the Departments' longstanding interpretation when it passed the ACA." *Id.* at 34.

Moreover, the 12-month term works with HIPAA, not against it. The district court noted that the definition aided in extending HIPAA's protections so that holders of STLDI coverage could claim it as all or part of the unbroken "creditable coverage" required to obtain certain protections HIPAA provides. As it explained, the HIPAA statutory framework "makes it difficult to construe HIPAA . . . to *permit* unrenewable STLDI plans of less than three months but *preclude* STLDI plans of less than 12 months that are renewable for up to 36 months, given that the latter plans would better enable individuals to maintain unbroken 'creditable coverage' and access the law's protections." *Id.* at 41 (emphasis in original).

The 1997 Rule, and by implication, the 2018 Rule limiting the term of STLDI to less than 12 months, fit with HIPAA in another way. As the

district court observed, "[U]nder HIPAA's scheme, that would have (1) helped individuals more easily maintain an uninterrupted period of prior 'creditable coverage' to become eligible for the law's protections (and avoid the 'significant break in coverage' that could negate eligibility), and (2) in some cases, reduced the period during which a new issuer could refuse benefits to a participant relating to preexisting conditions." *Ass'n for Community Affiliated Plans*, 392 F. Supp. 3d at 44.

Likewise, the district court correctly rejected the Association Appellant's contention that the ACA requires the reinstatement of the 2016 three-month rule. As the Supreme Court observed, the ACA was "designed to expand coverage in the individual health insurance market." *King v. Burwell*, 135 S. Ct. 2480, 2484 (2015); see also *NFIB v. Sebelius*, 567 U.S. 519, 538 (2012) (ACA aimed to "increase the number of Americans covered by health insurance and decrease the cost of health care."). The district court noted that "the 2010 Congress's use of a tax penalty to incentivize individuals to purchase coverage within three months of a coverage lapse does not dictate the characteristics of the short-term coverage options that the 1996 Congress intended to be available to individuals who face such a lapse." *Ass'n for Community*

Affiliated Plans, 392 F. Supp. 3d at 41. Put differently, the Association Appellants want the courts "to interpret a word in accordance with the meaning given to the same word used fourteen years later by a different Congress in a different statute contained in a different title of the U.S. Code." *Id.* at 42.

Finally, the statutory landscape has changed in a way that favors longer-term STLDI. As the district court pointed out the congressional repeal of the individual mandate penalty means that "relatively healthy Exchange enrollees are no longer choosing between paying ACA-compliant plan premiums or a fine." *Ass'n for Community Affiliated Plans*, 392 F. Supp. 3d at 38. Instead, "[t]heir choice now is between paying ACA plan premiums and going uninsured altogether." *Id.* The district court then explained, "By modestly (re)expanding the utility of less expensive STLDI plans, the Rule aims to minimize the harm and expense that would result from these individuals opting to forego health insurance in the face of rising premiums." *Id.*

II. The Association Appellants' desired remedy would throw patients with expensive medical needs out of their health plans and deny coverage to those with preexisting conditions.

Plaintiffs challenge the 2018 rule as arbitrary and capricious. They urge this Court to reinstate the 2016 rule limiting STLDI plans to less than three months.

The effect of this remedy would be to throw patients with expensive medical needs out of their health plans and to leave them with no coverage for up to 12 months. It would subject patients with expensive medical needs to cancelled coverage, medical underwriting, denial of coverage, coverage gaps, expensive medical bills, potential denial of care, and potential bankruptcy.

State insurance regulators opposed the 2016 rule for this very reason. The National Association of Insurance Commissioners (NAIC) called the three-month limit "arbitrary" and explained it would strip coverage from patients with expensive medical needs, leaving them with no coverage for up to one year. The NAIC pointed to one way in which the "arbitrary" 3-month rule could harm consumers:

> [I]f an individual misses the open enrollment period and applies for short-term, limited duration coverage in February, a 3-month policy would not provide coverage [that lasts] until the next policy year (which will start on January 1).

> The only option would be to buy another short-term policy at the end of the three months, but since the short-term health plans nearly always exclude pre-existing conditions, if the person develops a new condition while covered under the first policy, the condition would be denied as a preexisting condition under the next short-term policy. In other words, only the healthy consumers would have coverage options available to them; unhealthy consumers would not.

See National Ass'n of Insurance Commissioners, Comment on Proposed Rule (Aug. 9, 2016), at 1-2, available at https://www.naic.org/documents/government_relations_160809_hhs_reg_short_term_dur_plans.pdf. In other words, a three-month limit on STLDI plans requires insurers to cancel coverage after enrollees fall ill but before they can obtain other coverage.

That exact fate befell Arizona resident Jeanne Balvin. Donna Rosato, *Short-Term Health Insurance Isn't as Cheap as You Think*, Consumer Reports (Oct. 2, 2018), available at consumerreports.org/health-insurance/short-term-health-insurance-isnt-as-cheap-as-you-think. In 2017, at age 61, Balvin purchased an STLDI plan, which provided her coverage as good or better than ACA coverage at a fraction of the cost. Her premium was "$274 per month, one-third of what an ACA plan would cost her." *Id.* When Balvin underwent emergency surgery and hospitalization for diverticulitis in

June 2017, her STLDI plan covered the cost minus a $2,500 deductible. *Id.* An ACA plan would have forced Balvin to pay substantially more in premiums, substantially more out of pocket, or both. At the time, for applicants Balvin's age, the lowest-cost ACA plans posted an average monthly premium of $744 and an average deductible of $6,092. Kev Coleman, *Aging Consumers without Subsidies Hit Hardest by 2017 Obamacare Premium & Deductible Spikes,* Health Pocket (Oct. 26, 2016), available at healthpocket.com/healthcare-research/infostat/2017-obamacare-premiums-deductibles#.Xih-cGhKiM8; see also Joann Weiner, Older Women Bear the Brunt of Higher Insurance Costs under Obamacare, Washington Post (Jun. 24, 2014),available at washingtonpost.com/blogs/she-the-people/wp/2014/06/24/older-women-bear-the-brunt-of-higher-insurance-costs-under-obamacare/ ("Women age 55 to 64 will face a huge spike in cost when they go out to buy individual insurance on the federal exchange. These women bear the brunt of the increased premiums and out of pocket expenses after the Affordable Care Act.").

Under either the 1997 rule or the 2018 rule, Balvin's STLDI plan could have lasted 12 months, providing her continuous coverage until she

became eligible for coverage in an ACA-compliant plan on January 1, 2018. Because Balvin's STLDI plan was subject to the 2016 rule, however, it expired after three months.

Even though Balvin immediately purchased a new three-month STLDI plan from the same issuer, the three-month limit had already done its damage. The necessity of having to reapply for coverage subjected Balvin to medical underwriting *after* she developed an expensive illness.

Within one month of purchasing the new three-month STLDI plan from the same issuer, Balvin wound up back in the hospital twice more—once for an abdominal infection and again for a blood clot. Since the 2016 rule had forced Balvin's insurer to terminate her initial STLDI plan after her first hospitalization, however, the same insurer that provided Balvin with excellent coverage for that hospitalization notified her that her second and third hospitalizations stemmed from "preexisting condition[s] related to the diverticulitis and wouldn't be covered under the terms of the [new] contract." Rosato.

Again, under either the 1997 rule or the 2018 rule that is currently in effect, Balvin could have purchased a 12-month STLDI plan that

covered all three hospitalizations and provided her continuous coverage at least until she could enroll in an ACA plan. Her diverticulitis would have remained an insured condition. Instead, the 2016 rule threw Balvin out of her (superior) coverage; turned her *insured* condition into an *uninsured* and *uninsurable* preexisting condition; left her with no coverage for her diverticulitis; and saddled her with $97,000 in unpaid medical bills. Rosato.

To be clear, plaintiffs are requesting as a *remedy* the very rule that threw Balvin out of her health plan and left her with $97,000 in unpaid medical bills. Plaintiffs are asking the court not to offer but to *deny* consumers like Balvin the opportunity to purchase affordable, continuous coverage; to require insurers not to maintain but to *terminate* coverage for sick enrollees; to relieve those insurers of any obligation to pay for those enrollees' ongoing medical needs; to expose STLDI enrollees to medical underwriting *after* the enrollees develop expensive illnesses; and to subject countless patients with expensive medical needs to the same fate as Balvin—cancelled coverage, medical underwriting, denial of coverage, coverage gaps, potential denial of medical care, expensive medical bills, and potential bankruptcy.

Indeed, plaintiffs urge this Court to move in a direction that is completely opposite from the direction in which Congress has consistently moved. Congress has *never* enacted or sought any restrictions on short-term plans of the type plaintiffs seek. When Congress enacted the ACA, it left consumers the choice of enrolling in short-term plans under the rules that existed at the time. Congress has *never* given any indication it wished to restrict the ability to purchase short-term plans or alter the rules that had been in place since 1996. Congress has *never*, in any health-insurance market, sought to expose sick patients to medical underwriting, as plaintiffs seek. On the contrary, at every turn, Congress has sought to shield sick patients from medical underwriting.[3] Plaintiffs are asking the court to turn back the clock by exposing patients to medical underwriting after they fall ill.

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[3] Since 1996, Congress has mandated that all issuers of health insurance in the individual or group market "must renew or continue in force such coverage at the option of the plan sponsor or the individual." 42 U.S.C. §300gg–2 (2014), https://www.gpo.gov/fdsys/pkg/USCODE-2016-title42/html/USCODE-2016-title42-chap6A-subchapXXV-partAsubpartI-sec300gg-2.htm. (Many issuers in the individual market offered stronger consumer protections than the law required, including renewal guarantees that protected enrollees from underwriting after initial enrollment.) The ACA prohibited medical underwriting in the individual market.

III. Competitor standing is little more than calling on the courts to facilitate rent-seeking.

It merits judicial notice that Appellants are asking the court to harm patients like Jeanne Balvin because doing so would improve Appellants' competitive position in the marketplace.

Appellants have frankly stated their motivation for challenging the 2018 rule, and requesting this particular relief, is that their revenues will suffer under the 2018 rule, while reinstating the 2016 rule would preserve their revenues. The lead Appellant represents insurers that sell the very sort of ACA-compliant plans Jeanne Balvin found unaffordable. Motion for Preliminary Injunction, Doc. 10 Appellants allege those member-insurers "will be injured directly by the [2018 rule's] authorization of competing insurance products that will be priced lower than [their] policies" because those member-insurers "will … lose customers to competing companies offering STDLI policies." Complaint, at 16, ¶ 23. Appellants allege the 2018 rule will lead uninsured consumers to choose STLDI plans rather than ACA plans and "many of those [member-insurers' existing] customers will leave their current plans … in favor of an STLDI plan." Plaintiffs' Memorandum of Law in Support of Motion for Preliminary Injunction, Doc. 10-1 at 33 "[One

member-insurer] alone expects to lose up to 10,000 current members from its Marketplace plans if the STLDI rule takes effect, corresponding to a loss of $50 million to $100 million in revenue." *Id.* at 34. Appellants' standing claim presumes that their desired remedy—reversion to the 2016 rule—would redress these injuries.

The harms that befell Balvin—the harms the NAIC foretold—are therefore not unintended consequences of Appellants' desire to reinstate the three-month limit. They are *intended* consequences. Appellants seek to subject STLDI plans to that limit *because* doing so would mean less protection for consumers who choose their competitors' products. Appellants hope that by exposing consumers who choose their competitors' products and then fall ill to some combination of cancelled coverage, medical underwriting, denial of coverage, coverage gaps, potential denial of medical care, expensive medical bills, and potential bankruptcy, Appellants can drive consumers away from their competitors' products and toward their own products.

The Association Appellants' reliance on competitor standing thus reveals this case to be little more than an attempt at rent-seeking. "People are said to seek rents when they try to obtain benefits for

themselves through the political arena. They typically do so by . . . getting a special regulation that hampers their competitors."[4] The three-month rule favors the Association Appellants at the expense of STLDI carriers and STLDI enrollees like Jeanne Balvin, whom it would expose to considerable risk.

The Association Appellants may sincerely believe their member-insurers' ACA-compliant health plans offer superior coverage to STLDI plans. The place to test that belief is not in the courts, but in the market. If the Association Appellants are losing customers to STLDI plans, the proper course of action is for them to make their coverage offerings better. It is not to punish consumers who find their products unattractive.

CONCLUSION

For the foregoing reasons and those in the Brief of Appellees, this Court should affirm the judgment of the court below.

[4] David R. Henderson, *Rent Seeking*, Concise Encyclopedia of Economics, (May 31, 2010). (available at econlib.org/library/Enc/RentSeeking.html).

Respectfully submitted,

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CERTIFICATE OF COMPLIANCE

This brief complies with the type volume limit of Federal Rule of Appellate Procedure 32(a)(7)(B) because it contains 4,249 words. This brief also complies with the typeface and type-style requirements of Federal Rule of Appellate Procedure 32(a)(5)-(6) because it was prepared using Microsoft Word 2016 in 14-point Century, a proportionally spaced typeface.

/s/ Robert Alt
Robert Alt

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 D.C. Circuit by using the appellate CM/ECF system on January 28, 2020. Participants in the case who are registered CM/ECF users will be served by the CM/ECF system.

Executed this 28th day of January, 2020.

/s/ Robert Alt
Robert Alt