**No. 15-5310**

# In The United States Court of Appeals
**FOR THE DISTRICT OF COLUMBIA CIRCUIT**

CENTRAL UNITED LIFE INSURANCE CO., ET AL.,
PLAINTIFFS-APPELLEES,

v.

SYLVIA BURWELL, SECRETARY, ET AL.,
DEFENDANTS-APPELLANTS.

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

## BRIEF OF THE STATES OF WISCONSIN, ARKANSAS, GEORGIA, LOUISIANA, MICHIGAN, NEBRASKA, OKLAHOMA, SOUTH CAROLINA, TEXAS, UTAH, AND WEST VIRGINIA AS *AMICI CURIAE* SUPPORTING PLAINTIFFS-APPELLEES AND AFFIRMANCE

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## IDENTITY AND INTEREST OF *AMICI CURIAE*

The *amici curiae* are the States of Wisconsin, Arkansas, Georgia, Louisiana, Michigan, Nebraska, Oklahoma, South Carolina, Texas, Utah, and West Virginia ("States"), who file this brief under Federal Rule of Appellate Procedure 29(a).

The States have a sovereign right to regulate the sale of insurance within their borders, including the sale of standalone fixed-indemnity insurance. Through the Fixed-Indemnity Rule, Defendants-Appellants Sylvia Burwell and the Department of Health and Human Services (collectively "HHS"), have undermined the States' insurance marketplaces while also harming their citizens. *See* 79 Fed. Reg. 30,240 (May 27, 2014) (the "Fixed-Indemnity Rule" or the "Rule"). Specifically, the Rule deprives the States of their sovereign authority to permit fixed-indemnity coverage as a meaningful, well-regulated option for those citizens who have chosen not to purchase certain forms of health insurance. *See Nat. Fed. of Indep. Bus. v. Sebelius*, 132 S. Ct. 2566, 2601 (2012) ("The Federal Government does not have the power to order people to buy health insurance.").

As the States argue in this brief, the Rule is unlawful because, among other problems, it undermines the States' sovereign authority without clear congressional authorization, and arbitrarily harms the States and their citizens while providing no meaningful benefit to the public.

## STATEMENT

### I. The States Have A Congressionally Recognized, Sovereign Right To Regulate The Sale Of Insurance Within Their Borders

For over 150 years, the States have exercised "the unquestioned power to regulate insurance companies and the method of conducting that kind of business." 19 John A. Appleman & Jean Appleman, *Insurance Law and Practice* § 10321 (1982).

While the States engaged in intermittent insurance regulation in the late 18th and early 19th centuries, robust state regulation began after 1850. *See generally* Michael D. Rose, *State Regulation of Property and Casualty Insurance Rates*, 28 Ohio St. L.J. 669, 677 (1967).[1] For example, in 1858, Wisconsin enacted a comprehensive set of insurance

[1] The States' regulation after 1850 was in response to the "increased complexity of insurance" with the aim of improving "informed judgment[s]" by consumers. John G. Day, *Economic Regulation of Insurance in the United States* 9 (1970).

laws, 1858 Wis. Laws ch. 72, regulating and permitting companies to "make insurance upon the health or lives of individuals, and all and every insurance appertaining thereto, or connected with health or life risks." *Id.* § 1. These laws set forth the basics of insurance law, including financial, organizational, and annual-disclosure requirements. *Id.* §§ 5–8, 10, 13. Wisconsin also created liability for insurance companies and penalties for violations of the insurance laws. *Id.* §§ 22–24. In 1871, Wisconsin established a Commissioner of Insurance. *See* 1871 Wis. Laws ch. 72, § 32.[2]

The Supreme Court confirmed the States' primacy in the area of insurance in 1868, holding that "[i]ssuing a policy of insurance is not a transaction of commerce" for purposes of the Commerce Clause. *Paul v. Virginia,* 75 U.S. 168, 183 (1868). As a result of this case and its subsequent interpretation, "no federal regulation of the insurance industry was enacted during the next seventy-five years." Alan M. Anderson, *Insurance and Antitrust Law: The McCarran-Ferguson Act and Beyond*, 25 Wm. & Mary L. Rev. 81, 84 (1983).

[2] In 1855, Massachusetts created the first full-time Commissioner of Insurance, followed by New York in 1866, and New Hampshire in 1869. Day, *supra* note 1, at 10.

Within a few decades, the States had filled this role as primary and exclusive insurance regulators. "By 1900, thirteen states had separate insurance departments; by 1918 the number had increased to thirty-six." David G. Stebing, *Insurance Regulation in Alaska: Healthy Exercise of A State Prerogative*, 10 Alaska L. Rev. 279, 287 (1993).

The Supreme Court reexamined *Paul* in 1944 and held that the business of insurance was not "wholly beyond the regulatory power of Congress under the Commerce Clause." *United States. v. Se. Underwriters Ass'n*, 322 U.S. 533, 553 (1944). The Supreme Court's holding "precipitated widespread controversy and dismay. Chaos was freely predicted." Anderson, *supra*, at 85 (quoting *New York Insurance Dep't, The Open Competition Rating Law: A Statement of Principles and Procedures* 71, in 111 *Annual Report of the Superintendent of Insurance to the New York Legislature* 355 (1969)).

Congress promptly responded by enacting the McCarran-Ferguson Act, ch. 20, 59 Stat. 33 (1945) (codified as amended at 15 U.S.C. §§ 1011–15), which reconfirmed the States' traditional role as primary regulators of insurance, notwithstanding the change in the Supreme Court's Commerce Clause jurisprudence. In the Act, Congress declared

that the "*continued* regulation and taxation by the several States of the business of insurance is in the public interest, and that silence on the part of the Congress shall not be construed to impose any barrier to the regulation or taxation of such business by the several States." 15 U.S.C. § 1101 (emphasis added). The Act recognized the States' sovereign authority to regulate insurance, except where Congress enacts legislation that "specifically relates to the business of insurance." 15 U.S.C. § 1012(b).[3]

After the McCarran-Ferguson Act, the States' regulation of insurance continued as it had before *Southeastern Underwriters*. Like most other States, by the 1950s and 1960s Wisconsin had promulgated insurance laws and regulations that continue to be in full force and effect today. *See, e.g.,* Wis. Admin. Code § Ins 3.13 (first enacted in 1958); Ark. Code § 23-85-101 *et seq.* (first enacted in 1947); Tex. Ins. Code § 1201.001 *et seq.* (first enacted in 1955); Ga. Code § 33-29-1,

[3] When Congress enacted the Employee Retirement Income Security Act of 1974 ("ERISA")—which was widely understood as a major federal intrusion into an area traditionally regulated by the States—Congress included a saving clause that reserved the States' powers over insurance, consistent with the McCarran-Ferguson Act. *See* 29 U.S.C. § 1144(b)(2)(A); *see generally Metro. Life Ins. Co. v. Mass.*, 471 U.S. 724, 732–33 (1985).

*et seq*. (first enacted in 1960); and Ga. Comp. R. & Regs. 120-2-12-.01, *et seq*. (first enacted in 1965).

## II. Fixed-Indemnity Insurance, Including Standalone Fixed-Indemnity Insurance, Plays A Critical Role For Consumers In The States' Insurance Marketplace

Fixed-indemnity policies pay a policyholder a fixed amount of money upon the occurrence of an event. 79 Fed. Reg. at 30,253. For example, a fixed-indemnity policy may pay a policyholder $100 for each day in a hospital or $50 for each doctor visit. *Id.* Benefits could also be triggered when a policyholder undergoes a surgical procedure, diagnostic test, or a wellness screening, or when the policyholder purchases prescription drugs. JA 127–29. There are no deductibles, co-payments, or co-insurance requirements. Rule Comments, ID CMS-2014-0036-0124, at 5 (April 21, 2014). The dollar amount of the benefit is predetermined at a fixed number, regardless of the cost of the underlying expense. *Id.* at 5–6. Furthermore, there are no network limitations: those with fixed-indemnity insurance may receive care from any provider without having their benefits reduced. *Id.* at 6. And with one exception (California), no other state requires a fixed-indemnity policyholder to have major medical coverage. *Id.* at 6–7.

In 2014, fixed-indemnity policies were considered one of the "fastest-growing components of the employer benefits market," for reasons including the fact that they help cover "out-of-pocket expenses that can reach thousands of dollars" for employees who have employer-offered plans or even plans under the Affordable Care Act ("ACA"). Jay Hancock, *Health insurance industry markets supplemental policies to cover medical costs*, Wash. Post, Feb. 5, 2014, http://wpo.st/3l7E1. In Wisconsin alone—where insurance companies started selling fixed-indemnity insurance policies in 1892—nearly 60 insurance companies have sold over 57,000 fixed-indemnity policies that are currently in effect. In Arkansas, fixed-indemnity insurance has been sold since at least 1959, and today over 100 insurance companies sell within the category of disability-income policies, which includes fixed-indemnity insurance.

In many cases, fixed-indemnity insurance is a supplement to major medical insurance. *See* Rule Comments, ID CMS-2014-0036-0097, at 3 (April 21, 2014). When an individual owns fixed-indemnity insurance alongside major medical insurance, fixed-indemnity can serve as a hedge against deductibles or co-pays.

Rule Comments, ID CMS-2014-0036-0209, at 3 (April 21, 2014). Fixed-indemnity insurance can also be used as income replacement during an illness or hospitalization, or triggered in the event of a specific illness, like cancer. *See* JA 43.

At the same time, fixed-indemnity insurance can be an extremely valuable standalone product for those *without* major medical insurance. JA 150–51. In fact, many individuals purchase standalone fixed-indemnity insurance precisely because they cannot afford major medical insurance. JA 151. Even after the ACA, medical coverage is still "not economically feasible" for millions of Americans, including for those who qualify for a "hardship exemption" under Medicaid; additionally, millions more cannot afford major medical insurance because they fall into a "Medicaid Gap" where they do not qualify for Medicaid *or* the ACA subsidies. Rule Comments, ID CMS-2014-0036-0097, at 3 (April 22, 2014); *accord* Rachel Garfield & Anthony Damico, *The Coverage Gap: Uninsured Poor Adults in States that Do Not Expand Medicaid—An Update*, Kaiser Family Foundation

(Jan. 21, 2016).[4] The Government Accountability Office estimates that roughly 14 million Americans either do not qualify for Medicaid, or the ACA subsidies, or both. *See* GAO Report, *Private Health Insurance,* 27–28 (March 2015), http://www.gao.gov/assets/670/669165.pdf.

Standalone fixed-indemnity insurance is also a viable option for Americans who can afford major medical insurance, but have simply declined to purchase such insurance. These individuals include those who are temporarily uninsured because of a job change or a missed open-enrollment period, JA 32, and those who choose to remain uninsured because of cost savings derived from purchasing fixed-indemnity insurance and paying the ACA penalty. JA 37, 151.

In all, an estimated 2 to 4 million Americans own standalone fixed-indemnity policies without major medical coverage. Rule Comments, ID CMS-2014-0036-0097, at 3 (April 22, 2014). These millions of uninsured Americans often choose to mitigate their risks by purchasing standalone fixed-indemnity insurance. *Id.* at 4.

[4] Available at http://kff.org/health-reform/issue-brief/the-coverage-gap-uninsured-poor-adults-in-states-that-do-not-expand-medicaid-an-update/

Fixed-indemnity insurance is a rational choice for these individuals because it provides "meaningful access to the healthcare system." *Id.* Harvard economists have noted that in some circumstances, fixed-indemnity insurance is the "*optimal* insurance policy"; such a policy is "efficient" and the "simplest health insurance policy" because it pays a "fixed amount of money for a particular condition when an individual is sick." 1 *Handbook of Health Economics*, ch. 11, at 575 (2000), http://hks.harvard.edu/fs/rzeckhau/CZ2000.pdf (emphasis added). These uninsured individuals may use standalone fixed-indemnity insurance to cover the costs of doctor visits, diagnostic tests, wellness screenings, surgeries, prescription drugs, emergency room trips, or hospital stays. JA 127–28. They may also use fixed-indemnity insurance as a cash-replacement benefit in the event of an injury or illness that requires the insured to miss days of work. Rule Comments, ID CMS 2014-0036-0097, at 3–4 (April 22, 2014).

## III. Congress Has Specifically Provided That The States, Not The Federal Government, Regulate Fixed-Indemnity Insurance

In 1996, Congress enacted the Health Insurance Portability and Accountability Act ("HIPAA"), Pub. L. No. 104-191, 110 Stat. 1936

(codified as amended in scattered sections of 18, 26, 29, and 42 U.S.C. (2010)), which specifically confirmed the States' role as exclusive regulators of fixed-indemnity insurance, consistent with the McCarran-Ferguson Act.[5] As HIPAA explained: "[t]he requirements of this part" (HIPAA's individual insurance market rules and corresponding HHS regulations) "shall not apply to any health insurance coverage in relation to its provision of excepted benefits." 42 U.S.C. § 300gg-63(a). "Excepted benefits" are defined as including "[h]ospital indemnity and other fixed indemnity insurance." 42 U.S.C. § 300gg-91(c)(3)(B).[6] This means that federal law does not apply to fixed-indemnity insurance, which is treated as an "excepted benefit[ ]."

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[5] As a technical matter, HIPAA amended the Public Service Health Act of 1944. Pub. L. No. 78-410, 58 Stat. 682 (1944), *amended by* Pub. L. No. 104-191, 110 Stat. 1936 (1996). *Amici* refer to HIPAA, rather than the Public Service Health Act, given that HIPAA is the statute that first included the terms "excepted benefits" and "fixed indemnity insurance." Before HIPAA, the Public Service Health Act—with a few exceptions—applied to federal programs, services, benefits, and agencies.

[6] Other notable examples of "excepted benefits" include "disability income insurance," 42 U.S.C. § 300gg-91(c)(1)(A), "liability insurance," *id.* § 300gg-91(c)(1)(C), "automobile medical payment insurance," *id.* § 300gg-91(c)(1)(E), and "limited scope dental or vision benefits," *id.* § 300gg-91(c)(2)(A).

In its first regulations interpreting HIPAA after its enactment, HHS confirmed that federal law did not apply to "[c]overage only for a specified disease or illness (for example, cancer policies), or hospital indemnity or other fixed indemnity insurance (for example, $100/day) if the policies meet the requirements of 45 C.F.R. 146.145(b)(4)(ii)(B) and (b)(4)(ii)(C) regarding noncoordination of benefits." 62 Fed. Reg. 16,985, 17,004 (April 8, 1997). HHS reconfirmed this position in 2004: "To be hospital indemnity or other fixed indemnity insurance" and therefore not regulated by federal law, "the insurance must pay a fixed dollar amount per day (or per other period) of hospitalization or illness (for example, $100/day) regardless of the amount of expenses incurred." 69 Fed. Reg. 78,720, 78,762 (Dec. 30, 2004) (group market regulation).

In 2010, Congress enacted the Affordable Care Act and in doing so displaced, to some extent, state regulation of the health-insurance market. Pub. L. 111-148, 124 Stat. 119 (codified as amended in scattered sections of 21, 25, 26, 29, and 42 U.S.C. (2010)). Critically for this case, however, Congress specifically declined to displace State regulation of fixed-indemnity insurance. Congress chose to regulate only "health insurance coverage," 42 U.S.C. §§ 18021(b)(1)(A), 18022,

which does not include "excepted benefits" like fixed-indemnity insurance. *See* 42 U.S.C. § 18021(b)(2); *see generally* Appellees' Br. 2–3, 7–8. Indeed, as late as January 24, 2013, HHS understood that fixed-indemnity insurance was an "excepted benefit" and could continue to be issued as a standalone product. *See* Dep'ts of Labor, Health and Human Servs., & Treasury, *FAQs about Affordable Care Act Implementation Part XI* (Jan. 24, 2013), http://www.dol.gov/ebsa/faqs/faq-aca11.html; *see also* Rule Comment, ID CMS-2014-0036-0097, at 2 (April 22, 2014).

Meanwhile, the States have diligently exercised their sovereign authority to regulate fixed-indemnity insurance. For example, Wisconsin's fixed-indemnity regulations, which first appeared in the 1950s and 1960s,[7] focus on disclosure and fair solicitation. These regulations require, for example, certain fixed-indemnity policy provisions and disclosures regarding cancellation and benefits,

[7] In its annual report, the Wisconsin Insurance Commissioner explained that fixed-indemnity insurance "had become such an important type of insurance by 1957 and so many policies were being submitted to the Department for approval that it became necessary to establish minimum requirements for policy form approval and to outline a suggested procedure for submitting such forms for review and approval by the Department." Paul J. Rogan, *Report of Commissioner*, 20 (Wis. Ins. Comm'r. 1958).

Wis. Admin. Code § Ins 3.13(2)(c), a ten-day free look period with a right to return, *id.* § Ins 3.13(2)(j), a specific form of applications, *id.* § Ins 3.13(4), minimum requirements for claim reserves, *id.* § Ins 3.17, detailed standards for the solicitation of policies and prohibiting deceptive practices, *id.* §§ Ins 3.27, 3.28, 3.29, 3.31, and a disclosure that "THIS IS A LIMITED POLICY – READ IT CAREFULLY" diagonally across the front and back of the policy in at least 18-point type, *id.* § Ins 3.13(2)(h). Insurers that violate these rules are subject to enforcement actions by the Commissioner of Insurance. Wis. Admin. Code § Ins 5.08.

Other States employ similar regulations that have been on the books for decades. For example, West Virginia prohibits certain policy provisions (such as certain preexisting condition limitations) and imposes minimum standards for benefits, including mandatory minimum dollar amounts paid in specific situations. W. Va. Code R. § 114-12-1, *et seq.* West Virginia likewise requires certain disclosures, W. Va. Code R. § 114-12-6, including disclosing that a policy providing benefits for specified illnesses only, such as cancer or particular accidents, must clearly and conspicuously state in prominent type on

the limited policy: "Caution: This is a limited benefits policy. Read it carefully with the Outline of Coverage." W. Va. Code R. § 114-12-6.12.

Arkansas also imposes regulations upon the sale of fixed-indemnity insurance, including, by way of example, certain mandatory policy provisions, grace periods, reinstatement options, claims procedures, and prohibitions against reduction of benefits due to other insurance contracts. *See* Ark. Code § 12-85-101, *et seq*. Like other States, Arkansas also mandates disclosures. For example, for hospital-confinement indemnity policies in particular, Arkansas requires a warning to policyholders to "READ YOUR POLICY CAREFULLY" and that "[s]uch policies do not provide any benefits other than the fixed daily indemnity for hospital confinement (nursing home confinement or intensive care) . . . ." Ark. Code R. § 054.00.18-8. Georgia similarly requires disclosure for fixed-indemnity policies, such as "THIS IS A LIMITED POLICY" or "THIS IS A CANCER ONLY POLICY," and requires very specific explanations of benefits when advertising includes "descriptive words which might imply 'full coverage' for all expenses normally related to hospitalization or medical care." Ga. Comp. R. & Regs. 120-2-12-.05(3) and (4).

## IV. The Fixed-Indemnity Rule Prohibits Standalone Fixed-Indemnity Insurance

Just a few months after HHS confirmed that fixed-indemnity insurance remained under State, not federal, regulatory authority, HHS claimed the authority to regulate certain types of fixed-indemnity insurance. *See* 79 Fed. Reg. at 30,341. As relevant here, the Rule added a new requirement that in order to buy fixed-indemnity insurance, the purchasers must "attest, in their application, that they have other health coverage that is minimum essential coverage [under the ACA]." *Id.* at 30,257; 45 C.F.R. § 148.220(b)(4)(i). In short, the Rule prohibits the sale of standalone fixed-indemnity insurance. If a customer does not already have minimum essential coverage under the ACA, then fixed-indemnity insurance will be recast as "health insurance coverage" under the ACA, and subject to the entirety of the ACA's requirements, which fixed-indemnity insurance is not designed to satisfy. *See, e.g.,* 42 U.S.C. § 18022.

## ARGUMENT

### I. The Fixed-Indemnity Rule Is Illegal Because It Intrudes Upon The States' Sovereign Authority To Regulate Insurance Without Clear Congressional Authorization

Appellees cogently explain why the Rule is contrary to federal statute. *See* Appellees' Br. 19–33. In this brief, the States support and expand upon one important aspect of that statutory analysis: the Rule is unlawful because it intrudes upon the States' sovereign right to regulate their own insurance markets, without the requisite "clear and manifest" congressional authorization to do so. *See* Appellees' Br. 29 n.7 (quoting *Gregory v. Ashcroft*, 501 U.S. 452, 461 (1991)).

A. It is a "well-established principle that it is incumbent upon the federal courts to be certain of Congress' intent before finding that federal law overrides the usual constitutional balance of federal and state powers." *Bond v. United States*, 134 S. Ct. 2077, 2089 (2014) (citation omitted). "This principle applies when Congress intends to preempt the historic powers of the States or when it legislates in traditionally sensitive areas that affect the federal balance." *Raygor v. Regents of Univ. of Minn.*, 534 U.S. 533, 543 (2001) (citation omitted).

When a federal agency seeks to intrude upon areas traditionally regulated by the States, the agency must point to "clear and manifest" congressional authorization for such actions. *Gregory*, 501 U.S. at 460–61 (citation omitted). The Supreme Court has explained that if "Congress intends to alter the usual constitutional balance between the States and the Federal Government, it must make its intention to do so unmistakably clear in the language of the statute." *Id.* at 460 (citation omitted). "In traditionally sensitive areas, such as legislation affecting the federal balance, the requirement of clear statement assures that the legislature has in fact faced, and intended to bring into issue, the critical matters involved in the judicial decision." *Id.* at 461 (citation omitted).

B. History and congressional action confirm that regulation of insurance is a core state sovereign function, such that federal agency intrusion would require a clear statement from Congress.

As described above, robust state regulation of the American insurance industry started in the mid-19th Century. *See supra* pp. 2–3. For more than seventy-five years after the Supreme Court's decision in *Paul,* "it was generally assumed" that the States were the primary *and*

*exclusive* regulators of insurance in this country. Spencer L. Kimball & Ronald N. Boyce, *The Adequacy of State Insurance Rate Regulation: The McCarran-Ferguson Act in Historical Perspective*, 56 Mich. L. Rev. 545, 553 (1958).

After *Southeastern Underwriters*, held that insurance could be subject to federal regulation under the Commerce Clause, Congress responded swiftly by declaring in the McCarran-Ferguson Act that the States retain their traditional and primary role in regulating insurance. *See* 15 U.S.C. § 1012. Since that Act, the Supreme Court has confirmed the States' traditional role in regulating the "substantive terms of insurance contracts." *Metro. Life Ins. Co. v. Mass.*, 471 U.S. 724, 742 & n.19 (1985) (collecting cases). The States have "full power to prescribe the forms of contract" as well as the "terms of protection of the insured." *Hoopeston Canning Co. v. Cullen*, 318 U.S. 313, 321 (1943). More recently, the Supreme Court explained that McCarran-Fergusson "restore[d] the supremacy of the States in the realm of insurance regulation." *U.S. Dep't of Treasury v. Fabe*, 508 U.S. 491, 499–500 (1993).

Both in HIPAA and in the ACA itself, Congress confirmed that the States' primacy over insurance extends to fixed-indemnity insurance. In HIPAA, Congress specifically classified fixed-indemnity insurance as an "excepted benefit[ ]," which is not subject to federal regulation. *See* 42 U.S.C. § 300gg-91(c)(3)(B); *accord* 69 Fed. Reg. 78,720, 78,762. And in the ACA—which displaced some state regulation of insurance—Congress specifically excluded from federal regulation "excepted benefits" like fixed-indemnity insurance. 42 U.S.C. § 18021(b)(2); *see also* Dep'ts of Labor, Health and Human Servs., & Treasury, *FAQs about Affordable Care Act Implementation Part XI* (Jan. 24, 2013), http://www.dol.gov/ebsa/faqs/faq-aca11.html.

C. The Rule violates the States' traditional, sovereign right to regulate insurance, including fixed-indemnity insurance. Only California currently requires fixed-indemnity policies to be sold only to individuals with major medical insurance. *See supra* p. 6. Under the Rule, however, HHS has forbidden all of the States from making the contrary policy choice, which the vast majority of States have concluded better serves their citizens' needs. The Rule thus undermines the States' policies of providing a vibrant, diversified insurance market for

their citizens. The Rule both "preempt[s] the historic powers of the States" and imposes federal regulation "in traditionally sensitive areas that affect the federal balance." *Raygor*, 534 U.S. at 543 (citation omitted). Accordingly, the Rule could be lawful only if it satisfied the clear statement rule that the Supreme Court set forth in *Gregory*, *Raygor*, and *Bond*.

HHS does not argue that Congress provided a clear statement authorizing the agency to outlaw standalone fixed-indemnity insurance. If Congress made anything "unmistakably clear in the language of the statute," *Gregory*, 501 U.S. at 460, it is that fixed-indemnity insurance is *not* subject to federal regulation. *See supra* pp. 10–12. At the very minimum, because HHS can make no argument that Congress "unmistakably" permitted the Rule, the Rule is unlawful.

## II. The Rule Is Arbitrary And Capricious Because It Damages The States And Their Citizens While Providing No Meaningful Benefits

A regulation is "arbitrary" or "capricious" under the APA, 5 U.S.C. § 706, when the agency fails to "articulate a satisfactory explanation for its action including a rational connection between the facts found and the choice made." *Motor Vehicle Mfrs. Ass'n. v. State Farm Mut. Auto.*

*Ins. Co.*, 463 U.S. 29, 43 (1983) (citation omitted). The Rule violates this basic requirement because it damages the States and their citizens without providing any meaningful benefits to consumers.

A. By eliminating standalone fixed-indemnity plans from the States' insurance marketplace, the Rule causes serious harm to the States and their citizens.

The States' citizens purchase standalone fixed-indemnity insurance for a variety of important personal reasons and family circumstances. As explained, *supra* pp. 5–10, these fixed-indemnity customers may be some of the millions of uninsured Americans who cannot afford major medical insurance, are between jobs, missed an open enrollment period, or simply choose to remain without major medical insurance. Fixed-indemnity insurance may be the right choice for some of these individuals; in fact, fixed-indemnity may be an optimal choice for some individuals. Whatever the reasons for lack of insurance or the personal situations of these uninsured Americans, the States have a critical interest in ensuring that these citizens have access to meaningful healthcare choices. By banning standalone

fixed-indemnity plans, the Rule seriously undermines that sovereign interest.

B. HHS's primary justification for the Rule—that people are being "misled" or that there is "confusion about these policies"—is made without any record support, Appellants' Br. 21; 79 Fed. Reg. at 30,256, and thus cannot possibly outweigh the harms to the sovereign States and their citizens described above. *See also* Appellees' Br. 40–41.

Critically, HHS's "confusion" argument ignores the States' traditional role as competent regulators of insurance, which already have in place regulations to avoid consumer confusion with regard to these products. For example, in Wisconsin, an individual who purchases fixed-indemnity insurance is greeted with a disclaimer reading, "THIS IS A LIMITED POLICY – READ IT CAREFULLY" diagonally across the front and back of the policy in at least 18-point type. Wis. Admin. Code § Ins 3.13(2)(h). Other specific disclosures apply to fixed-indemnity policies that may apply only to a specific disease or injury. *See, e.g., id.* at § Ins 3.27(9)(zb) ("THIS IS A CANCER ONLY POLICY"). Wisconsin's regulations further seek to "safeguard[ ]"

all "prospective purchasers . . . by providing such persons with clear and unambiguous statements, explanations, advertisements and written proposals concerning the policies offered to them." *Id.* at § Ins 3.27(1). Wisconsin prohibits deceptive advertisements that "exaggerate a benefit or minimize cost by overstatement, understatement or incompleteness," *id.* at § Ins 3.27(9), requires specific disclosures for all "exceptions, reductions and limitations . . . affecting the basic provisions of the policy," *id.* at § Ins 3.27(10), and even grants the right of any customer to return a fixed-indemnity policy within ten days for a full refund, *id.* at § Ins 3.13(2)(j).

Similarly, West Virginia requires certain disclosures, W. Va. Code R. § 114-12-6, including that a policy providing benefits for specified illnesses only, such as cancer or for specified accidents, must clearly and conspicuously state in prominent type on the limited policy: "Caution: This is a limited benefits policy. Read it carefully with the Outline of Coverage." W. Va. Code R. § 114-12-6.12. And Arkansas, for example, requires hospital-indemnity policies to state, "READ YOUR POLICY CAREFULLY" and "[s]uch policies do not provide any benefits other than the fixed daily indemnity for hospital confinement (nursing home

confinement or intensive care) . . . ." Ark. Code R. § 054.00.18-8. Likewise, Georgia requires disclosure for fixed-indemnity policies, such as "THIS IS A LIMITED POLICY" or "THIS IS A CANCER ONLY POLICY," and requires very specific explanations of benefits when advertising of policies might include "descriptive words which might imply 'full coverage' for all expenses normally related to hospitalization or medical care." Ga. Comp. R. & Regs. 120-2-12-.05(3) and (4).

In making this "confusion" argument the lynchpin of the Rule, HHS did not even consider whether these state-level regulations already addressed any "confusion" concerns HHS may have in this area.

* * * *

The States, as the primary regulators of insurance in America for 150 years, have a sovereign right to ensure that their citizens have meaningful insurance options. One such choice that the vast majority of States have decided to permit is standalone fixed-indemnity insurance, which the States have concluded can serve consumers' needs. HHS has no authority to deprive the States of their historic, sovereign authority to permit the sale of this form of insurance.

## CONCLUSION

The judgment of the District Court should be affirmed.

Dated: February 29, 2016

Respectfully submitted,

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## CERTIFICATE OF COMPLIANCE

Pursuant to Federal Rule of Appellate Procedure 32(a)(7)(C), I certify the following:

This brief complies with the type-volume limitation of Federal Rule of Appellate Procedure 32(a)(7)(B) because this brief contains 4,617 words, excluding the parts of the brief exempted by Federal Rule of Appellate Procedure 32(a)(7)(B)(iii) and Circuit Rule 32(e)(1).

This brief complies with the typeface requirements of Federal Rule of Appellate Procedure 32(a)(5) and the type style requirements of Federal Rule of Appellate Procedure 32(a)(6) because this brief has been prepared in a proportionately spaced typeface using the 2007 version of Microsoft Word in 14-point Century Schoolbook font.

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## CERTIFICATE OF SERVICE

I hereby certify that on this 29th day of February 2016, I filed the foregoing Brief with the Clerk of the Court using the CM/ECF System, which will send notice of such filing to all registered CM/ECF users.

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