JOSEPH H. HUNT
Assistant Attorney General
DAVID L. ANDERSON
United States Attorney
DAVID M. MORRELL
Deputy Assistant Attorney General
ERIC B. BECKENHAUER
Assistant Branch Director
BRADLEY P. HUMPHREYS
CORMAC EARLY
Trial Attorneys
Federal Programs Branch
U.S. Department of Justice, Civil Division
1100 L Street, NW
Washington, DC 20005
Tel.: (202) 305-0878
Fax: (202) 616-8460
Email: Bradley.Humphreys@usdoj.gov
Counsel for Defendants

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF CALIFORNIA

STATE OF CALIFORNIA, *et al.*, Plaintiffs, v. U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, *et al.*, Defendants.	Case No.: 3:20-cv-00682-LB **DEFENDANTS' OPPOSITION TO PLAINTIFFS' MOTION FOR SUMMARY JUDGMENT, AND NOTICE AND CROSS-MOTION FOR SUMMARY JUDGMENT, WITH MEMORANDUM OF POINTS AND AUTHORITIES** Date: June 11, 2020 Time: 9:30 AM Judge: Hon. Laurel Beeler Courtroom: Courtroom B, 15th Floor Trial: None

NOTICE OF MOTION AND MOTION

Notice is hereby given that, on June 11, 2020, before the Honorable Laurel Beeler, in Courtroom B of the 15th floor of the San Francisco Courthouse, Defendants will appear on this motion for the Court to enter summary judgment for Defendants on all claims asserted by Plaintiffs.

Defendants move pursuant to Rule 56 of the Federal Rules of Civil Procedure and seek an order entering final judgment for Defendants on all claims asserted in this action. The basis for this motion is set forth more fully in the accompanying Memorandum of Points and Authorities.

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MEMORANDUM OF POINTS AND AUTHORITIES

INTRODUCTION

In Section 1303(b)(2)(B) of the Affordable Care Act (ACA), Congress instructed that issuers of qualified health plans (QHPs) must "collect . . . a separate payment" from enrollees for the value of coverage of certain abortion services, if the issuer chooses to offer such coverage in its plans, and segregate payments received from enrollees for coverage of those abortion services from payments received for coverage of all other services. To better align issuer billing with the statutory requirements of Section 1303(b)(2)(B) and to enable compliance with the statute, the U.S. Department of Health and Human Services (HHS) promulgated the challenged regulation, which requires issuers of QHPs to bill enrollees separately for the coverage of any of these abortion services and for coverage of all other services, and to instruct enrollees to pay the separate bill in a separate transaction. *See* 84 Fed. Reg. 71,674 (Dec. 27, 2019) (Rule). None of Plaintiffs' challenges to this Rule has merit.

As an initial matter, HHS's interpretation of Section 1303(b)(2)(B) is well within Congress's broad grant of statutory authority to the agency. It comports with common sense to provide a separate bill to elicit a separate payment for a particular good or service, and HHS reasonably interpreted Congress's separate payment and segregation provisions to require as much. Plaintiffs argue that another paragraph of Section 1303 restricts when issuers may send "notices" to enrollees, and what information may be contained in them. But HHS reasonably interpreted the term "notice" not to include a bill for the payment of premiums for insurance coverage, particularly given Congress's express requirement in Section 1303(b)(2) that issuers "collect . . . separate payments" from enrollees for certain abortion services. Notably, if Plaintiffs were correct that a "notice" includes a bill, then HHS's prior policy of allowing issuers to itemize the portion of premiums attributable to abortion services would also be invalid.

Plaintiffs also challenge an enforcement policy HHS announced in the preamble to the Rule, but that policy is entirely compatible with this interpretation and unreviewable in any event. It is black-letter law that an agency's exercise of its enforcement authority is left to its discretion,

absent restrictions imposed on that discretion by Congress. Here, HHS announced its intent to exercise its enforcement discretion when issuers decide not to terminate coverage for enrollees who do not make the separate payment for coverage of certain abortion services and effectively opt out of that coverage by not making a separate payment for it. Congress imposed no restrictions on this exercise of discretion, and HHS's announcement regarding its enforcement discretion is therefore unreviewable.

Plaintiffs' claims that the Rule violates other provisions of the ACA, specifically Section 1554 and Section 1557, fail too. The Rule does not create any "unreasonable barriers" or otherwise "impede access to care" within the meaning of Section 1554; accepting Plaintiffs' contrary argument would effectively paralyze HHS, preventing it from ever promulgating a regulation that could even arguably have an adverse impact, no matter how indirect, on the availability of health care services. The Rule similarly does not implicate Section 1557, because Plaintiffs cannot show that the agency intentionally discriminated on the basis of sex.

Plaintiffs also cannot prevail on their remaining Administrative Procedure Act (APA) claims. They cannot show that the Rule is arbitrary and capricious. Plaintiffs offer a host of policy objections to the Rule, but HHS reasonably considered all relevant factors and took appropriate measures to mitigate the Rule's costs when it implemented Congress's decision to require collection of separate payments. At bottom, Plaintiffs argue that the Rule imposes unnecessary burdens on enrollees—but Plaintiffs' real complaint is with Congress, which imposed the separate payment collection and segregation requirements. While Plaintiffs also assert that HHS failed to follow the APA's notice-and-comment procedures because it did not announce its intention to exercise its enforcement discretion in the proposed rule, that announcement is a general statement of policy, for which notice and comment is not required.

Plaintiffs' Tenth Amendment claim is likewise meritless. The Rule does not attempt to directly regulate States as sovereigns, and any incidental costs the Rule's direct regulation of QHP issuers may impose on States that choose to operate their own Exchanges do not amount to a Tenth Amendment violation.

Finally, although Defendants believe they are entitled to summary judgment on Plaintiffs' claims, if the Court were to disagree and grant summary judgment for Plaintiffs, any relief should be limited to the named Plaintiffs consistent with the demands of Article III and longstanding equitable principles.

LEGAL AND FACTUAL BACKGROUND

A. Relevant Federal Statutes

Since 1976, Congress has included language, commonly known as the Hyde Amendment, in the annual appropriations bill for HHS and certain other agencies. *See, e.g.*, Department of Defense and Labor, Health and Human Services, and Education Appropriations Act, 2019, and Continuing Appropriations Act, 2019, Pub. L. No. 115-245, §§ 506-07, 132 Stat. 2981, 3118. The Hyde Amendment precludes the use of federal funds to pay for abortion services except in the case of rape, incest, or where the life of the mother is endangered by continuation of a pregnancy. *See Harris v. McRae*, 448 U.S. 297, 300-04 (1980).

In Section 1303 of the ACA, Congress enacted certain requirements related to abortion coverage in plans offered through Exchanges, known as QHPs, that cover abortion services for which public funding is prohibited under the Hyde Amendment—referred to as "non-Hyde abortion services." Subject to state law, QHP issuers may choose to provide coverage for non-Hyde abortion services. 42 U.S.C. § 18023(b).

Section 1303 imposes specific obligations on any issuer that chooses to issue a QHP that covers non-Hyde abortion services. The QHP issuer may not use federal premium tax credits or federal cost-sharing reductions to pay for such coverage. *Id.* § 18023(b)(2)(A). It must collect from each plan enrollee, without regard to the enrollee's age, sex, or family status, a "separate payment" for the portion of the premium that pays for coverage of non-Hyde abortion services equal to the actuarial value of that coverage but no less than $1 per enrollee, per month. *Id.* § 18023(b)(2)(B), (D). It must also collect a "separate payment" for the portion of the premium paid directly by the enrollee for services other than non-Hyde abortion services. *Id.* § 18023(b)(2)(B). The QHP issuer must deposit these separate payments into "separate allocation accounts." *Id.* These payments must

be segregated such that the payments in the separate allocation account for non-Hyde abortion coverage can be used only to pay for non-Hyde abortion services, and the payments in the separate allocation account for coverage of all other services can be used only to pay for those services. *Id.* § 18023(b)(2)(C).

Among other requirements, Section 1303 also outlines specific notice restrictions that issuers of QHPs that provide coverage of non-Hyde abortion services must follow. Those QHPs "shall provide a notice" of such coverage "to enrollees, only as part of the summary of benefits and coverage explanation, at the time of enrollment." *Id.* § 18023(b)(3)(A). Furthermore, that notice, as well as "any advertising used by the issuer with respect to the plan, any information provided by the Exchange, and any other information specified by the Secretary shall provide information only with respect to the total amount of the combined payments for [non-Hyde abortion services] and other services covered by the plan." *Id.* § 18023(b)(3)(B).

B. Prior Rulemaking and Guidance

In 2012, HHS promulgated a regulation implementing Section 1303 at 45 C.F.R. § 156.280. *See* 77 Fed. Reg. 18,310 (Mar. 27, 2012). In February 2015, HHS published guidance regarding, among other things, acceptable billing and premium collection methods for the portion of the consumer's total premium attributable to non-Hyde abortion services. *See* 80 Fed. Reg. 10,750 (Feb. 27, 2015) ("2016 Payment Notice"). HHS stated in the 2016 Payment Notice that the issuer could satisfy the separate-payment requirement in one of several ways, including by sending enrollees a single monthly invoice; a bill that separately itemizes the premium amount for non-Hyde abortion services; or—as HHS now requires in the challenged regulation—by "sending a separate monthly bill for th[ose] services." *Id.* at 10,840.

In October 2017, HHS released a bulletin that discussed the statutory requirements for separate payment, as well as this previous guidance with respect to the separate payment requirement. *See* CMS Bulletin Addressing Enforcement of Section 1303 of the Patient Protection and Affordable Care Act (Oct. 6, 2017) (CMS Bulletin), https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Section-1303-Bulletin-10-6-2017-FINAL-508.pdf. That

bulletin reflected the guidance for complying with Section 1303 contained in the 2016 Payment Notice, including that issuers may separately itemize payments for coverage of non-Hyde abortion services. HHS also indicated that it was "in the process of evaluating whether there are additional steps that we should take to ensure compliance with the requirements of section 1303 and its implementing regulations, including reevaluating the guidance issued in 80 Fed. Reg. 10750, 10840-41." CMS Bulletin at 3.

C. The Challenged Rule

On November 9, 2018, HHS proposed the Rule challenged here. *See* 83 Fed. Reg. 56,015 (Nov. 9, 2018) (NPRM). HHS explained in the NPRM that it "believes that some of the methods for billing and collection of the separate payment for non-Hyde abortion services . . . do not adequately reflect what we see as Congressional intent that the QHP issuer bill separately for two distinct (that is, 'separate') payments." *Id*. at 56,022. Although HHS recognized that itemizing the amounts that go toward non-Hyde abortion services "arguably identifies two 'separate' amounts for two separate purposes," HHS explained that "the [ACA] contemplates issuers billing for two separate 'payments' of these two amounts (for example, two different checks or two different transactions), consistent with the requirement on issuers in section 1303(b)(2)(B)(i) of the [ACA] to collect two separate payments." *Id*.

On December 27, 2019, after considering public comments, HHS published the Rule, largely adopting the proposals in the NPRM. *See* 84 Fed. Reg. 71,674. The Rule modifies 45 C.F.R. § 156.280 to require QHP issuers, beginning on or before the first billing cycle following June 27, 2020, to send monthly bills to each QHP policy holder for each of the separate amounts either by sending separate paper bills, which may be in the same envelope or mailing, or by sending separate bills electronically, which must be in separate emails or electronic communications. *See id.* (45 C.F.R. § 156.280(e)(2)(ii)(A)). QHP issuers also must instruct the policy holder to pay each of the separate amounts through a separate transaction. *See id.* (45 C.F.R. § 156.280(e)(2)(ii)(B)).

In addition to finalizing these regulatory modifications, HHS explained in the Rule's preamble that it intends to exercise its enforcement discretion in two scenarios, in response to

comments received on the NPRM. First, to address the risk of terminations related to enrollees' inadvertent failure to pay the separately billed amount for coverage of non-Hyde abortion services, HHS explained that it "intend[s] to propose further rulemaking to change our regulations including, for example, our regulations governing termination for non-payment of premiums." *Id.* at 71,686. HHS further explained that, in the meantime, until it "can finalize a separate rulemaking," HHS will "exercise enforcement discretion as an interim step." *Id.* Specifically, HHS stated that it "will not take enforcement action against a QHP issuer that adopts and implements a policy, applied uniformly to all its QHP enrollees, under which an issuer does not place an enrollee into a grace period and does not terminate QHP coverage based solely on the policy holder's failure to pay the separate payment for coverage of non-Hyde abortion services." *Id.* HHS announced that this enforcement posture will take effect upon the implementation date of the separate billing requirements—*i.e.*, June 27, 2020. *Id.*

Second, HHS also recognized that the enforcement posture described above would not address the separate concern, expressed by some commenters, that the lack of transparency under the prior billing requirements contributed to unknowing purchases of QHPs that include coverage of non-Hyde abortion services by consumers who object to purchasing such coverage. *See id.* HHS announced that, "[u]ntil we are able to address these concerns through future rulemaking or other appropriate action, we also will not take enforcement action against QHP issuers that modify the benefits of a plan either at the time of enrollment or during a plan year to effectively allow enrollees to opt out of coverage of non-Hyde abortion services by not paying the separate bill for such services." *Id.* HHS further recognized that "a QHP issuer's ability to make changes to its QHPs to implement a policy holder's opt out would be subject to applicable state law," but "encourage[d] states and State Exchanges to take an enforcement approach consistent with the one [HHS] intend[s] to take." *Id.*

D. This Litigation

Plaintiffs filed this case on January 30, 2020. *See* ECF No. 1. In their amended complaint, Plaintiffs allege that the Rule violates the APA because it exceeds Defendants' statutory authority

under Section 1303 (Count One), and that it is contrary to Section 1554 and Section 1557 (Count Two). *See* ECF No. 25. They further allege that the Rule is arbitrary and capricious (Count Three), that Defendants did not follow the APA's procedural requirements (Count Four), and that the Rule violates the Tenth Amendment (Count Five). *See id.*

The Court granted the parties' stipulated request to enter a briefing schedule on March 25, 2020, ECF No. 35, and Plaintiffs filed their motion for summary judgment on March 30, 2020, *see* Pls.' Notice of Mot. & Mot. for Summ. J., with Mem. of Points and Authorities, ECF No. 36 (Pls.' Mot.). Defendants now oppose Plaintiffs' motion and cross-move for summary judgment.

ARGUMENT

Defendants move for summary judgment under Rule 56 of the Federal Rules of Civil Procedure. Summary judgment is appropriate if "there is no genuine dispute as to any material fact and the movant is entitled to judgment as a matter of law." Fed. R. Civ. P. 56(a). For APA claims, "the district judge sits as an appellate tribunal" to resolve issues at summary judgment. *Am. Bioscience, Inc. v. Thompson*, 269 F.3d 1077, 1083 (D.C. Cir. 2001).[1]

I. THE RULE IS FULLY CONSISTENT WITH AND ADVANCES THE PURPOSES OF THE ACA

Plaintiffs cannot prevail on their statutory claims under the deferential framework set out in *Chevron U.S.A., Inc. v. NRDC*, 467 U.S. 837 (1984). It is a fundamental principle of administrative law that, unless a statute directly answers the precise question at issue, "a court may not substitute its own construction of a statutory provision for a reasonable interpretation made by the administrator of an agency." *Id*. at 844. The *Chevron* framework is based on the presumption "'that Congress, when it left ambiguity in a statute' administered by an agency, 'understood that

[1] Because this is an APA case, the Court should reject Plaintiffs' improper attempt to create a new record for the purposes of this litigation by submitting declarations and other materials. The APA provides that, "[i]n making the [] determinations [regarding the lawfulness of agency action], the court shall review the whole record," 5 U.S.C. § 706, and the Supreme Court has long held that the whole record is limited to "the full administrative record that was before the Secretary at the time he made his decision," *Citizens to Pres. Overton Park, Inc. v. Volpe*, 401 U.S. 402, 420 (1971); *see also Friends of the Earth v. Hintz*, 800 F.2d 822, 829 (9th Cir. 1986) (holding that the district court properly limited review to the administrative record).

the ambiguity would be resolved, first and foremost, by the agency, and desired the agency (rather than the courts) to possess whatever degree of discretion the ambiguity allows.'" *City of Arlington v. FCC*, 569 U.S. 290, 296 (2013) (citation omitted).

Section 1321(a) of the ACA expressly delegates authority to the Secretary to "issue regulations setting standards for meeting the requirements under this title," namely Title I of the ACA—which includes Section 1303, Section 1554, and Section 1557—"with respect to (A) the establishment and operation of Exchanges . . . (B) the offering of qualified health plans through such Exchanges . . . and (D) such other requirements as the Secretary determines appropriate." 42 U.S.C. § 18041(a)(1). Such a delegation of rulemaking authority demonstrates that "Congress would expect the agency to be able to speak with the force of law when it addresses ambiguity in the statute or fills a space in the enacted law," *United States v. Mead Corp.*, 533 U.S. 218, 229 (2001), and requires reviewing courts to analyze the agency's interpretation under the familiar two-step *Chevron* framework, *Chevron*, 467 U.S. at 842-45.

At *Chevron*'s first step, the Court "must determine whether Congress has provided an answer to the precise question at issue." *Medina Tovar v. Zuchowski*, 950 F.3d 581, 587 (9th Cir. 2020) (citing *Chevron*, 467 U.S. at 842-43). If "the court determines Congress has not *directly addressed the precise question at issue*," the Court must go on to decide "whether the agency's answer is based on a permissible construction of the statute," and must defer to the agency if it is. *Id.* (quoting *Chevron*, 467 U.S. at 843) (internal quotation marks omitted).

A. HHS Acted Well Within Its Statutory Authority and Reasonably Interpreted Section 1303 to Require Separate Billing

Plaintiffs first claim that the Rule is invalid because it allegedly interprets Section 1303 "in a manner that far exceeds Congressional intent." Pls.' Mot. at 34. This argument is a clear attempt to supplant their preferred reading of Section 1303 for the agency's.

The separate billing requirement at issue here reflects the agency's interpretation of Section 1303(b)(2)(B), in which Congress specified that, in the case of a QHP that provides coverage for non-Hyde abortion services, "the issuer of the plan shall collect from each enrollee in the plan . . .

a *separate payment* for each of" the portion of the premium reflecting the actuarial value of covering non-Hyde abortion services and the portion of the premium attributable to coverage for all other services. 42 U.S.C. § 18023(b)(2)(B)(i) (emphasis added). Congress further provided that the issuer "shall deposit all such separate payments into separate allocation accounts." *Id.* § 18023(b)(2)(B). In its proposed rulemaking on this subject, HHS explained that, rather than authorize "simply itemizing these two components of a single total billed amount," as previous guidance had allowed, these statutory provisions appeared to "contemplate[] issuers billing for two separate 'payments' of these two amounts (for example, two different checks or two different transactions)." 83 Fed. Reg. at 56,022; *see also* 84 Fed. Reg. at 71,685 (adhering to this interpretation). That interpretation is reasonable and well within the authority granted to the agency. Indeed, as then-Senator Ben Nelson—who proposed the relevant statutory language, sometimes known as the Nelson Amendment—explained at the time, under this legislative "compromise," "if you are receiving Federal assistance to buy insurance, and if that plan has any [non-Hyde] abortion coverage, the insurance company must bill you separately, and you must pay separately." Cong. Rec. S14134 (Dec. 24, 2009) (statement of Sen. Nelson).

Plaintiffs cherry pick the statutory language in an attempt to show that the Rule misinterprets it, arguing that "Section 1303 is concerned solely with effectuating the provision of abortion coverage while ensuring the segregation of federal funds." Pls.' Mot. at 34. Yet, Plaintiffs ignore that Section 1303(b)(2)(B)(i) specifically requires issuers to "collect from each enrollee in the plan . . . a separate *payment*" for coverage of non-Hyde abortion services, and to segregate payments for coverage of non-Hyde abortion services into a separate allocation account. 42 U.S.C. § 18023(b)(2)(B)(i) (emphasis added). Agencies "are bound, not only by the ultimate purposes Congress has selected, but by the means it has deemed appropriate, and prescribed, for the pursuit of those purposes." *MCI Telecomms. Corp. v. AT&T Co.*, 512 U.S. 218, 231 n.4 (1994). As explained in the preamble to the Rule, HHS promulgated the Rule in part because "consumers are more likely to make a separate payment for the non-Hyde abortion coverage when they receive a separate bill for such amount," 84 Fed. Reg. at 71,693, better aligning with the statutory separate-

payment requirement. Requiring QHP issuers to bill separately for coverage of non-Hyde abortion services also makes it more likely that issuers will comply with the additional requirement in Section 1303(b)(2)(B)(ii) that they maintain separate allocation accounts to keep payments for coverage of non-Hyde abortion service segregated from payments for coverage of all other services. *See* 42 U.S.C. § 18023(b)(2)(B)(ii). Far from exceeding HHS's statutory authority, the Rule furthers Section 1303's purpose and is a straightforward application of HHS's power to "set[] standards for meeting the requirements under [Section 1303]." 42 U.S.C. § 18041(a)(1).

Neither of the cases Plaintiffs rely on—*California v. U.S. Department of Health and Human Services*, 941 F.3d 410 (9th Cir. 2019), *cert. filed* (2020) (No. 19-1038), and *MCI Telecommunications Corp. v. AT&T*, 512 U.S. 218 (1994)—supports their claim that HHS lacked statutory authority to promulgate the Rule. In *California*, the Ninth Circuit examined an allegedly "limited delegation" of authority in the ACA providing that certain health plans and insurance issuers "'shall, at a minimum provide coverage for and shall not impose any cost sharing requirements for . . . with respect to women, such additional preventive care and screenings as provided for in the comprehensive guidelines supported by'" the Health Resources Services Administration (HRSA), 941 F.3d at 424-25 (quoting 42 U.S.C. § 300gg-13(a)(4)). The court concluded that the agencies improperly exempted certain entities from the requirement to cover services included in the HRSA guidelines. Relying on the mandatory "shall" language in the statute, the Ninth Circuit concluded that Congress's allegedly "limited delegation" did not "delegate to HRSA or any other agency the discretion to exempt *who must meet the obligation.*" *Id.* at 425. Here, there is no such allegedly "limited delegation" to HHS. *See* 42 U.S.C. § 18041(a). Nor is there any language in Section 1303 that could fairly be read to prohibit HHS from requiring issuers to bill separately for non-Hyde abortion services. If anything, as HHS explained in the preamble, the requirement for a separate bill furthers the congressional instruction that issuers "collect . . . separate payments" for those services. *See, e.g.*, 84 Fed. Reg. at 71,693.

MCI Telecommunications Corp. is similarly inapposite. Plaintiffs cite that case for the proposition that "an agency's interpretation of a statute is not entitled to deference when it goes

beyond the meaning that the statute can bear." Pls.' Mot. at 35 (quoting *MCI Telecomms. Corp.*, 512 U.S. at 229). Yet there, the Supreme Court addressed the Federal Communications Commission's implementation of "a fundamental revision of the statute, changing it from a [statutorily mandated] scheme of rate regulation in long-distance common-carrier communications to a scheme of rate regulation only where effective competition does not exist." *MCI Telecomm. Corp.*, 512 U.S. at 231-32. The Court struck down the challenged regulation because it "effectively . . . introduc[ed] a whole new regime of regulation (or of free-market competition), which may well be a better regime but is not the one that Congress established." *Id.* at 234. Here, of course, the Rule's requirement that issuers send an additional bill to enrollees cannot seriously be construed as a "fundamental revision" of the ACA, or even of Section 1303—particularly given Congress's explicit instruction that issuers should collect "separate payment[s]" from enrollees for non-Hyde abortion services and maintain those payments in separate allocation accounts.

B. The Rule Does Not Violate Section 1303(b)(3)'s Notice Provision

Left without any valid basis to object to HHS's interpretation of Section 1303(b)(2)(B), Plaintiffs make the extraordinary argument that—despite Section 1303(b)(2)(B)'s requirement that issuers "collect from each enrollee . . . a separate payment" for premiums for coverage of non-Hyde abortion services, 42 U.S.C. § 18023(b)(2)(B)(i)—issuers are not, in fact, allowed to indicate on any bill sent to enrollees the amount of the premium attributable to such services because of another provision in Section 1303 setting out "[r]ules relating to notice." Pls.' Mot. at 27-28 (citing 42 U.S.C. § 18023(b)(3)(A), (B)). They argue that—because issuers are required to provide "a notice to enrollees" of coverage of non-Hyde abortion services "only as part of the summary of benefits and coverage explanation, at the time of enrollment," 42 U.S.C. § 18023(b)(3)(A), and because that "notice" and other enumerated types of communications "shall provide information only with respect to the total amount of the combined payments," *id.* § 18023(b)(3)(B)—issuers may not provide separate bills for coverage of non-Hyde abortion services, as doing so would give additional "notice" to enrollees. *See* Pls.' Mot. at 27-28.

Plaintiffs' argument cannot survive scrutiny. To begin, Plaintiffs do not make a *Chevron* step-two argument (*i.e.*, that HHS's interpretation, although authorized by the statutory text, is unreasonable). Instead, they rely only on the "plain language" of Section 1303. *See* Pls.' Mot. at 27 ("The plain meaning of the statute states that notice of abortion coverage must be provided only at the time of enrollment."). Thus, for Plaintiffs to prevail, the Court would need to accept that Congress *unambiguously* intended Section 1303(b)(3)(A) and (B) to include bills sent to enrollees. But Congress provided no such clear statement, even though it easily could have done so.

Congress did not define "notice" or the other terms in Section 1303(b)(3). If anything, by requiring that a notice may be provided "only as part of the summary of benefits and coverage explanation, at the time of enrollment," the text of Section 1303(b)(3)(A) suggests that a "notice" does not mean a monthly bill or invoice, but, rather, a communication that explains to enrollees the details of the QHP coverage at the time of enrollment. 42 U.S.C. § 18023(b)(3)(A). Similarly, Section 1303(b)(3)(B) pertains only to "the notice described [in Section 1303(b)(3)(A)], any advertising used by the issuer with respect to the plan, any information provided by the Exchange, and any other information specified by the Secretary." *Id.* § 18023(b)(3)(B). Again, Congress easily could have specified that Section 1303(b)(3)(B) includes bills or invoices for payment—as opposed to "advertising," for example—but it did not. And the fact that Congress left it to HHS to determine what "other information" is encompassed in the limitations under Section 1303(b)(3)(A) and (B)—which HHS concluded does not include a bill or invoice, *see* 84 Fed. Reg. at 71,693—further suggests that Congress conferred discretion on the agency, and that the Court should defer to the HHS's interpretation of the statute. As HHS explained, "any insight the policy holder gains from the separate bill for coverage of non-Hyde abortion services about the QHP's coverage [of those services] is incidental to the primary purpose of the bill, which is to help ensure separate payment by the policy holder, and separate QHP issuer collection on this portion of the policy holder's premium." 84 Fed. Reg. at 71,694.

Plaintiffs' interpretation of Section 1303(b)(3) to include invoices is at odds with the rest of Section 1303 and, indeed, common sense. Plaintiffs would have the Court believe that, in

Section 1303(b)(2)(B), Congress explicitly required issuers to collect separate payments for non-Hyde abortion services from enrollees, but then, in Section 1303(b)(3), unambiguously forbade them from sending bills for those services to enrollees to elicit such payments. Nothing in the statute requires Plaintiffs' far-fetched conclusion.

Moreover, Plaintiffs' argument proves far too much. As HHS explained in the preamble to the Rule, accepting the position that a "notice" includes bills for payment would mean that HHS's pre-Rule interpretation, which allowed issuers to send enrollees bills containing a separate line item for the premium amount for non-Hyde abortion services, or a separate bill, also violated Section 1303(b)(3). *See* 84 Fed. Reg. at 71,694. But Plaintiffs do not challenge HHS's prior interpretation of Section 1303, and in fact seek to have the Court reimpose that interpretation by vacating the Rule.

Given that the terms in Section 1303(b)(3) are not defined, and that Congress did not specify the method a QHP issuer must use to comply with the separate payment requirement under Section 1303(b)(2)(B), the statute is ambiguous, and HHS was entitled to fill the space left by that ambiguity through the Rule. Plaintiffs therefore cannot prevail on their argument that the Rule violates the notice provisions in Section 1303(b)(3).

C. Section 1303 Does Not Prohibit HHS from Exercising Its Enforcement Discretion

Plaintiffs also argue that HHS violated Section 1303 by announcing in the Rule's preamble that it will not take enforcement action against QHP issuers that modify the benefits of a plan to effectively allow enrollees to opt out of coverage of non-Hyde abortion services by not paying the separate bill for coverage of those services. *See* Pls.' Mot. at 28-29; *see also* 84 Fed. Reg. at 71,686. Plaintiffs are incorrect.

First, HHS's decision whether to take enforcement action is an unreviewable exercise of agency discretion under *Heckler v. Chaney*, 470 U.S. 821 (1985). In *Chaney*, the Supreme Court held that an agency's decision not to exercise its enforcement discretion, or to exercise it in a particular way, is presumed to be "immune from judicial review under § 701(a)(2)" of the APA.

470 U.S. at 832; *see also Sierra Club v. Whitman*, 268 F.3d 898, 902-03 (9th Cir. 2001). "The Supreme Court explained in [*Chaney*] that the APA does not usually provide a right to judicial review of an agency's failure to enforce statutory provisions entrusted to agency supervision." *Coker v. Sullivan*, 902 F.2d 84, 88 (D.C. Cir. 1990). This is so because an "agency's decision not to prosecute or enforce, whether through civil or criminal process, is a decision generally committed to an agency's absolute discretion." *Chaney*, 470 U.S. at 831.

The presumption of agency discretion can be overcome if Congress indicates that enforcement is not discretionary. *See Sierra Club*, 268 F.3d at 902; *Ass'n of Irritated Residents v. EPA*, 494 F.3d 1027, 1032 (D.C. Cir. 2007). But Congress has provided no such indication here. The relevant statutory enforcement provision, 42 U.S.C. § 300gg-22,[2] does not contain "guidelines for the agency to follow in exercising its enforcement powers," *Chaney*, 470 U.S. at 833, so as to make HHS's enforcement decisions reviewable. Section 300gg-22 provides grants of general enforcement authority to States and to HHS over certain matters, but, crucially, is silent about how they are to exercise that authority. The statute gives States the primary enforcement authority. *See* 42 U.S.C. § 300gg-22(a)(1). HHS, in turn, has secondary enforcement authority to enforce a provision if the State advises HHS that it does not have authority to enforce the provision, or if the State fails to substantially enforce a provision, *see id*. § 300gg-22(a)(2); 45 C.F.R. § 150.203. But even when HHS's enforcement authority is triggered, the statute says little about the manner in which HHS is to exercise that authority.

Far from displacing HHS's "power to discriminate among issues or cases it will pursue," *Chaney*, 470 U.S. at 833, Section 300gg-22 merely provides that "any" applicable health insurance issuer or group health plan that is a non-Federal governmental plan and that fails to meet an applicable provision "is subject to a civil money penalty"; defines the entity liable for such a

[2] This provision of the Public Health Service Act directly applies only to the enforcement of requirements set forth in Title XXVII of that Act. Section 1303 of the ACA is not codified in the Public Health Service Act. However, under Section 1321(c) of the ACA, the enforcement provisions in 42 U.S.C. § 300gg-22 are made applicable to certain ACA requirements not codified in the Public Health Service Act, such as those in Section 1303. *See* 42 U.S.C. § 18041(c).

penalty; and sets forth certain conditions on the amount of penalty that can be imposed, among other things. 42 U.S.C. §§ 300gg-22(b)(2)(A)-(C). Notably, Congress has not specified when or how HHS is to exercise its general enforcement authority when it is responsible for enforcing the applicable federal requirements, or otherwise prioritized HHS's enforcement efforts. *See Chaney*, 470 U.S. at 834. This absence of enforcement guidance in Section 300gg-22 "by itself is fatal" to Plaintiffs' claims. *Balt. Gas & Elec. Co. v. FERC*, 252 F.3d 456, 461 (D.C. Cir. 2001).

Plaintiffs may argue, incorrectly, that the statutory phrase "the Secretary shall enforce such provision (or provisions)," 42 U.S.C. § 300gg-22(a)(2), should be read as a mandatory command that eliminates HHS's discretion as to the timing and manner of enforcement. That would not be a proper reading of the statute. As an initial matter, the statutory phrase "shall enforce" in the context of Section 300gg-22's dual state-federal enforcement scheme serves to designate where general enforcement authority lies (*i.e.*, with a state or with HHS) as to a particular state and particular statutory provision(s). It does not speak to the manner in which this authority is to be exercised. *See, e.g.*, *Sutton v. Earles*, 26 F.3d 903, 909 (9th Cir. 1994) (interpreting the phrase "[t]he regulations in this section shall be enforced by the Commanding Officer" as "simply a designation of the officer *who* will exercise enforcement authority, rather than as a mandate requiring that officer to perform specific enforcement actions"); *see also West Virginia ex rel. Morrisey v. U.S. Dep't of Health & Human Servs.*, 827 F.3d 81, 83-84 (D.C. Cir. 2016) (rejecting on jurisdictional grounds a challenge to HHS's "transitional policy" under which the agency declined to enforce certain provisions of the ACA, leaving to the States the choice to enforce or not to enforce those provisions).

Indeed, it would be unnatural to read Section 300gg-22(a)(2) as governing the timing or manner of enforcement by HHS. The logic of such a reading would suggest that HHS must pursue *every* issuer that fails to comply with any applicable statutory requirement, even though "[a]n agency generally cannot act against each technical violation of the statute that it is charged with enforcing," *Chaney*, 470 U.S. at 831; *see NRDC v. FDA*, 760 F.3d 151, 171 (2d Cir. 2014) ("It is rare that agencies lack discretion to choose their own enforcement priorities."). There is "no

indication in case law or legislative history that such was Congress' intention." *Chaney*, 470 U.S. at 835.[3]

Even putting aside that the enforcement discretion announced in the Rule is unreviewable, Plaintiffs' argument also fails because it is based on an incorrect statement of what Section 1303 requires, and what the Rule actually does. Plaintiffs state that Section 1303(b)(2)(B)(i) "requires that policy holders *pay* the issuer for the abortion coverage in their qualified health plan," thereby suggesting that HHS cannot exercise its discretion not to bring an enforcement action against issuers who decide to modify QHPs to allow enrollees to opt out of paying for coverage for non-Hyde abortion services. Pls.' Mot. at 28 (emphasis added). In fact, Section 1303(b)(2)(B)(i) says that issuers "*shall collect* from each enrollee . . . a separate payment" for non-Hyde abortion services covered under the QHP. To the degree issuers modify the benefits of a QHP to allow enrollees to opt out of coverage for non-Hyde abortion services, Section 1303(b)(2)(B)(i) is not implicated, because enrollees would no longer receive coverage for those services after the QHP is modified.

Plaintiffs also suggest, somewhat obliquely, that the Rule is invalid because "HHS has no authority to allow policy holders to opt out of state-required benefits included in its benchmark plan or voluntarily offered in [QHPs]," Pls.' Mot. at 29, and that HHS's exercise of its enforcement authority will "interfere in a state's certification of qualified health plan benefits that include abortion, " *id.* at 29. But, of course, the statement in the preamble regarding HHS's exercise of its enforcement authority does not change any substantive law. It is merely an intention—subject to agency discretion—not to enforce certain requirements on QHPs if modified by issuers.[4] HHS was

[3] Nor can Plaintiffs find any discretion-withdrawing guidelines elsewhere. HHS's regulations interpreting and implementing § 300gg-22, found at 45 C.F.R. Part 150, expressly preserve the agency's enforcement discretion. *See, e.g.*, 45 C.F.R. § 150.203 ("CMS enforces PHS Act requirements to the extent warranted (*as determined by CMS*) . . . ." (emphasis added)); *see also Harmon Cove Condo. Ass'n, Inc. v. Marsh*, 815 F.2d 949, 953 n.4 (3d Cir. 1987) (noting that the agency's regulations authorized discretionary enforcement action).

[4] Plaintiffs raise the same challenge to HHS's exercise of its enforcement discretion, repackaged as an excess of statutory authority claim. *See* Pls.' Mot. at 36. As discussed herein, however, HHS's exercise of its enforcement discretion is unreviewable. HHS also clearly has

explicit in the preamble that the changes finalized by the Rule "do not preempt state law regarding coverage of non-Hyde abortion services or otherwise attempt to coerce states into changing these laws or to deny QHP issuers the ability to offer plans on the Exchanges that provide coverage of non-Hyde abortion services." 84 Fed. Reg. at 71,694. Moreover, even though HHS has indicated how it intends to exercise its enforcement discretion, States remain the primary enforcers of the Section 1303's requirements, and—despite HHS's encouragement to take an enforcement approach consistent with HHS's, *id*. at 71,686—nothing in the Rule limits States from exercising their independent enforcement authority. States still have the ability, under the ACA, to set their own benchmarks to include coverage for abortion services and enforce any other relevant State law, contrary to Plaintiffs' claim. *See* Pls.' Mot. at 36; *see also* 45 C.F.R. § 156.111(a)-(b); 84 Fed. Reg. at 71,686 ("[A] QHP issuer's ability to make changes to its QHPs to implement a policy holder's opt out would be subject to applicable state law.").

D. The Rule Is Consistent with Section 1554

Plaintiffs' Section 1554 claim fares no better. That provision states,

> Notwithstanding any other provision of [the Affordable Care] Act, the Secretary of Health and Human Services shall not promulgate any regulation that—
>
> (1) creates any unreasonable barriers to the ability of individuals to obtain appropriate medical care;
>
> (2) impedes timely access to health care services;
>
> (3) interferes with communications regarding a full range of treatment options between the patient and the provider;
>
> (4) restricts the ability of health care providers to provide full disclosure of all relevant information to patients making health care decisions;
>
> (5) violates the principles of informed consent and the ethical standards of health care professionals; or
>
> (6) limits the availability of health care treatment for the full duration of a patient's medical needs.

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statutory authority to decide whether to bring an enforcement action, *see* 42 U.S.C. § 300gg-22, which is all that the so-called "opt-out policy" reflects.

42 U.S.C. § 18114. Plaintiffs argue that, by requiring issuers to bill separately for non-Hyde abortion services, and because that requirement may impose additional costs on issuers and/or lead to potential enrollment or coverage changes, the Rule "creates[] an[] unreasonable barrier[]" to obtaining care, "impedes timely access to health care services," and "limits the availability of health care treatment," allegedly in violation of Section 1554. *See* Pls.' Mot. at 29-31.

Plaintiffs' claim is meritless. In Section 1303(b)(2)(B), Congress specifically instructed QHP issuers to "collect from each enrollee . . . a separate payment" for non-Hyde abortion services and to maintain those payments in separate allocation accounts. 42 U.S.C. § 18023(b)(B). And in the Rule, in order to give better effect to those statutory provisions, HHS reasonably interpreted Section 1303(b)(2)(B) to mean that QHP issuers should send separate bills to policy holders for the portion of the premium attributable to coverage for such services. Doing so does not create an "unreasonable barrier" to obtaining, "impede" access to, or "limit the availability" of any type of health care. Indeed, the Rule does not speak directly to the provision of health care at all, only the manner in which issuers of QHPs bill for certain services.

Accordingly, Plaintiffs rely on potential second- and third-order effects of the Rule, such as additional burdens on issuers that could lead them to modify the coverage they elect to offer. But as the en banc Ninth Circuit recently explained, Section 1554 is only "meant to prevent *direct* government interference with health care"; in other words, "[t]he most natural reading of § 1554 is that Congress intended to ensure that HHS, in implementing the broad authority provided by the ACA, does not improperly *impose regulatory burdens on doctors and patients*." *California by & through Becerra v. Azar*, 950 F.3d 1067, 1094 (9th Cir. 2020) (en banc) (emphases added). Nothing in the en banc Ninth Circuit's recent construction of Section 1554 suggests this provision sweeps as broadly as Plaintiffs imagine.

Indeed, it is worth pausing to appreciate the scope of Plaintiffs' argument. If the Court were to accept Plaintiffs' interpretation of Section 1554, HHS would be barred from adopting essentially

any regulation that could even potentially raise health care costs or indirectly lead to a reduction in coverage, no matter how speculative the chain of contingencies, because, on Plaintiffs' reading, doing so would impose "unreasonable burdens" or costs on enrollees or health care providers. For example, under Plaintiffs' logic, HHS could not impose any administrative burdens on issuers to document how they are complying with Section 1303(b)(2)(B)'s mandate, because the additional burden might, through some chain of events, result in additional costs and therefore result in some enrollees leaving the plan. Nor, in Plaintiffs' view, could HHS ever adopt a regulation declining to provide Medicare coverage for a particular procedure, *see, e.g.*, *Heckler v. Ringer*, 466 U.S. 602, 607 (1984), as that would purportedly "impede access to health care services" (and perhaps erect an "unreasonable barrier[] to the ability of individuals to obtain appropriate medical care" as well), 42 U.S.C. § 18114(1)-(2). Plaintiffs' reasoning, if accepted, would effectively halt HHS from making even minor changes to programs any time a provider or patient arguably was adversely affected.

Plaintiffs' reading of Section 1554 defies common sense and cannot be what Congress intended. It is a basic principle of statutory interpretation that Congress "does not alter the fundamental details of a regulatory scheme in vague terms or ancillary provisions—it does not, one might say, hide elephants in mouseholes." *Whitman v. Am. Trucking Ass'ns*, 531 U.S. 457, 468 (2001). Plaintiffs would have this Court believe that Congress effectively prevented HHS from promulgating any regulations with respect to Section 1303—and indeed, with respect to any other statute HHS administers (or, at a minimum, any provision in the ACA)—that impose any burdens, no matter how indirectly, on patients or providers, and that it did so without any meaningful legislative history so indicating. The Court should reject Plaintiffs' untenable position.

Other principles point in the same direction. "[I]t is a commonplace of statutory construction that the specific governs the general . . . ." *Morales v. Trans World Airlines, Inc.*, 504 U.S. 374, 384 (1992). "The general/specific canon is perhaps most frequently applied to statutes

in which a general permission or prohibition is contradicted by a specific prohibition or permission." *Id*. Under such circumstances, "[t]o eliminate the contradiction, the specific provision is construed as an exception to the general one." *RadLAX Gateway Hotel, LLC v. Amalgamated Bank*, 566 U.S. 639, 645 (2012). Here, even if Section 1554 could possibly be interpreted as Plaintiffs suggest, Section 1303(b)(2)(B) applies much more narrowly to the question of how issuers collect and maintain payments from enrollees for coverage, which is distinct from the direct provision of health care services or communications between provider and patient. The Court should decline to interpret Section 1554, the much more general statute, so as to override HHS's eminently reasonable interpretation of the more specific requirements under Section 1303(b)(2)(B).

E. The Rule Is Consistent with Section 1557

Plaintiffs also claim that the Rule is inconsistent with Section 1557 of the ACA. *See* Pls.' Mot. at 31-33. That provision provides, as relevant here, that

> [A]n individual shall not, on the ground prohibited under . . . title IX of the Education Amendments of 1972 (20 U.S.C. 1681 et seq.) . . . be excluded from participation in, be denied the benefits of, or be subjected to discrimination under, any health program or activity, any part of which is receiving Federal financial assistance . . . .

42 U.S.C. § 18116(a). Plaintiffs argue that the Rule is invalid because it allegedly discriminates "on the basis of sex," as that phrase has been interpreted under Title IX. Pls.' Mot. at 31-33.

Plaintiffs' claim has no merit. Plaintiffs acknowledge that, in order to succeed, they must provide "*proof* of an *intentional* discriminatory act." *Id.* at 32 (emphasis added); *see also, e.g.*, *Cannon v. Univ. of Chicago*, 648 F.2d 1104, 1109 (7th Cir. 1981) (adopting the standard that a violation of Title IX "requires an intentional discriminatory act and that disparate impact alone is not sufficient to establish a violation"). Here, Plaintiffs offer no proof of intentional discrimination, because there is none. The Rule does not discriminate against women within the meaning of Title IX; it merely requires QHP issuers to provide a separate bill for coverage of non-Hyde abortion services, consistent with the "[s]pecial rules" Congress established with respect to coverage for those services in QHPs offered on an Exchange. 42 U.S.C. § 18023.

The reasons for the Rule are clear, and do not—contrary to Plaintiffs' claim—reflect an intent to discriminate against women. Specifically, HHS concluded that "some of the methods for billing and collection of the separate payment for coverage of non-Hyde abortion services described as permissible in the preamble to the 2016 Payment Notice do not adequately reflect Congress's intent." 84 Fed. Reg. at 71,684. HHS further explained its view that "the statute contemplates issuers billing separately for coverage of non-Hyde abortion services, consistent with Congress's intent that issuers collect separate payments for such services." *Id.* at 71,685. While Plaintiffs reject HHS's interpretation as "frivolous," *see* Pls.' Mot. at 33, it is clearly permissible under Section 1303 for the reasons discussed in the preamble and above.

Plaintiffs' tortured attempt to infer discriminatory intent conflicts with black-letter law. Specifically, Plaintiffs claim that because only women access abortion services, and because the Rule will impose additional costs on issuers who offer coverage for non-Hyde abortion services, which may in turn increase the cost of such coverage, HHS must have intentionally discriminated against women because of their sex. *Id.* at 32-33. But even the direct "disfavoring of abortion . . . is not *ipso facto sex* discrimination." *Bray v. Alexandria Women's Health Clinic*, 506 U.S. 263, 273 (1993); *cf. Geduldig v. Aiello*, 417 U.S. 484, 497 n.20 (1974) ("While it is true that only women can become pregnant it does not follow that every legislative classification concerning pregnancy is a sex-based classification."). And here, HHS explained its neutral and non-discriminatory reasons for the interpretive change in the Rule's preamble, as discussed above. That explanation is entitled to a presumption of regularity and, "in the absence of clear evidence to the contrary, courts presume that [public officials] have properly discharged their official duties." *United States v. Chem. Found.*, 272 U.S. 1, 14-15 (1926).

Plaintiffs' attempt to infer discriminatory intent from possible indirect effects on women, because only women access abortion services, is at bottom a disparate impact theory, which is not available under Title IX, as Plaintiffs themselves acknowledge. *See* Pls.' Mot. at 32. Accepting that theory would also mean that HHS could never issue regulations that have any impact on the availability or cost of abortion services, because doing so would arguably affect women more than

men. And, indeed, Plaintiffs' theory would have the same implications for coverage of services like mammograms, prostate exams, or any others that may be sex-specific. The Court should reject this boundless theory and enter judgment in Defendants' favor on Plaintiffs' Section 1554 claim.

II. THE RULE IS NOT ARBITRARY AND CAPRICIOUS

Plaintiffs argue that the Rule is arbitrary and capricious because HHS allegedly ignored the costs of requiring separate premium payments for coverage of non-Hyde abortion services, and failed to articulate offsetting benefits. Pls.' Mot. at 16-26. But Plaintiffs largely aim at the wrong target: it was Congress, not HHS, that decided to require collection of "a separate payment" for coverage of non-Hyde abortion services. HHS merely implemented that directive in the Rule at issue here. In doing so, HHS fully explained the Rule's costs and benefits, and properly considered the concerns raised during the public comment period.

The APA requires a reviewing court to "hold unlawful and set aside agency action . . . found to be . . . arbitrary [or] capricious." 5 U.S.C. § 706(2)(A). "The scope of review" for a challenge to agency action under that standard "is narrow and a court is not to substitute its judgment for that of the agency." *Motor Vehicles Mfrs. Ass'n of U.S., Inc. v. State Farm Mut. Auto. Ins. Co.*, 463 U.S. 29, 43 (1983). The ultimate question is whether the agency acted "within the bounds of reasoned decisionmaking." *Balt. Gas & Elec. Co. v. Nat. Res. Def. Council*, 462 U.S. 87, 105 (1983). Agency action can fail this test if the agency (1) "relied on factors which Congress has not intended it to consider"; (2) "entirely failed to consider an important aspect of the problem"; (3) "offered an explanation for its decision that runs counter to the evidence before the agency"; or (4) offered an explanation "so implausible that it could not be ascribed to a difference in view or the product of agency expertise." *State Farm*, 463 U.S. at 43.

The reviewing court may not "second-guess[] the [agency's] weighing of risks and benefits and penaliz[e] [it] for departing from the . . . inferences and assumptions" of others, *Dep't of Commerce v. New York*, 139 S. Ct. 2551, 2571 (2019), or "ask whether a regulatory decision is the best one possible or even whether it is better than the alternatives," *FERC v. Elec. Power Supply Ass'n*, 136 S. Ct. 760, 782 (2016). Agency action that "changes prior policy" is not subject to a

heightened standard of review; "it suffices that the new policy is permissible under the statute, that there are good reasons for it, and that the agency *believes* it to be better, which the conscious change of course adequately indicates." *FCC v. Fox*, 556 U.S. 502, 514, 515 (2009).

The APA requires agencies to base their decisions "on consideration of the relevant factors," *State Farm*, 463 U.S. at 42, but it does not require them to "conduct a formal cost-benefit analysis in which each advantage and disadvantage is assigned a monetary value," *Michigan v. EPA*, 135 S. Ct. 2699, 2711 (2015), or assess the relevant factors in quantitative terms, *Ranchers Cattlemen Action Legal Fund v. USDA*, 415 F.3d 1078, 1096-97 (9th Cir. 2005). An agency thus "may justify its policy choice by explaining why that policy 'is more consistent with statutory language' than alternative policies." *Encino Motorcars, LLC v. Navarro*, 136 S. Ct. 2117, 2127 (2016) (quoting *Long Island Care at Home, Ltd. v. Coke*, 551 U.S. 158, 175 (2007)).

A. Requiring Separate Billing as a Means of Collecting Separate Payments Is Not Arbitrary or Capricious

1. The Rule Implements the Statutory Separate-Payment Requirement

Plaintiffs acknowledge that HHS promulgated the Rule to "'better align'" the regulations with its new interpretation of Section 1303," but nevertheless claim that HHS acted "without *any* good reasons for the new policy" and failed to "examine relevant data or articulate a satisfactory explanation, beyond its belief that this is a better policy." Pls.' Mot. 16. They go on to complain that "HHS fails to identify any evidence indicating that the current regulations have resulted in noncompliance with Section 1303," and that "[t]he agency did not quantify *any* benefit resulting from the Rule." *Id.* at 16, 20. Plaintiffs then shift gears to claim that HHS is instead attempting to "rely on the Rule's stated purpose of helping alleviate consumer confusion." *Id.* at 18.

The common thread running through that volley of sometimes contradictory arguments is the premise that "Section 1303 is concerned solely with effectuating the provision of abortion coverage while ensuring the segregation of federal funds." *Id.* at 34. From Plaintiffs' perspective, HHS could have chosen not to require collection of separate bills at all, and its decision to press ahead with requiring separate bills demanded justification with quantitative data that doing so

would improve compliance with the segregation of federal funds. Evidence that implementing the Section 1303's requirement with separate bills calling for separate transactions would reduce confusion for some enrollees, however, must be excluded from consideration, Plaintiffs say, because that benefit was not adequately flagged in the notice of proposed rulemaking, and is not an express statutory objective. *Id.* at 18-19. And fidelity to the statutory text, in Plaintiffs' view, could not justify departing from previous guidance because Congress, allegedly, had "acquiesce[d] to the prior scheme." *Id.* at 19.

All of that is wrong. "Better alignment" with the statutory text is not just one variable among many that HHS may balance or trade-off against other goals in the pursuit of "better policy"—it is what *defines* good policy for administrative agencies. *See* U.S. Const. art. 1 § 1 ("All legislative Powers herein granted shall be vested in a Congress of the United States."). It is a "core administrative-law principle that an agency may not rewrite clear statutory terms to suit its own sense of how the statute should operate." *Util. Air Regulatory Group v. EPA*, 573 U.S. 302, 328 (2014). To survive arbitrary-and-capricious review, an agency's decision to comply with what it views as a policy choice made by Congress need only "analyze or explain why the statute should be interpreted" as the agency proposes. *Encino Motorcars*, 136 S. Ct. at 2127.

HHS did just that in the Rule. It explained that "some of the methods for billing and collection of the separate payment for coverage of non-Hyde abortion services described as permissible in the preamble to the 2016 Payment Notice do not adequately reflect Congress's intent." 84 Fed. Reg. at 71,684. Instead, HHS explained that it "believe[d] Congress intended that QHP issuers collect two distinct (that is, 'separate') payments, one for the coverage of non-Hyde abortion services, and one for coverage of all other services covered under the policy." *Id.* In HHS's view, Congress did not intend that "simply itemizing these two components in a single bill, or notifying the enrollee that the monthly invoice or bill will include a separate charge for these services" would suffice. *Id.* HHS thus understood that it was obliged to determine *how* to require collection of separate payments in distinct transactions, rather than whether to do so at all.

Plaintiffs appear to share HHS's view, equating "separate payments" with separate transactions throughout their brief. *See, e.g.*, Pls.' Mot. at 1 ("Under the Final Rule," enrollees "must make two separate payments for their health insurance premiums."); *id.* at 7-8 ("the proposed rule would require a new and unprecedent[ed] payment scheme where a policy holder must make one payment of at least $1, and a separate payment of the balance of the premium"); *id.* at 29-30 ("The Rule creates barriers to healthcare because it requires policy holders to receive and make two separate payments for health coverage . . ."); *id.* at 34 (Section 1303 "does not authorize HHS to mandate separate bills and separate payments in separate transactions."); *id.* ("The Rule's requirement of separate billing and separate payment is outside the authority delegated to HHS under" Section 1303); *id.* at 37 ("The NPRM required separate bills and separate payments—mandating completely separate transactions—in order for a consumer to pay their insurance premium."). Of course, none of those statements would make sense if bundling all portions of the premium payment into a single transaction counted as making two "separate payments." And Plaintiffs make no textual argument that a single transaction can somehow count as two separate payments for purposes of Section 1303.

2. Plaintiffs' Arguments Against Requiring Separate Bills for Separate Payments are Meritless

The proper scope of this Court's review of whether the Rule constituted arbitrary and capricious agency action is thus not whether HHS justified requiring issuers to collect separate payments over not doing so—that choice was made in Congress, and is not subject to "arbitrary and capricious" review. It is instead whether HHS has justified the use of separate bills to promote compliance with that requirement. Much of Plaintiffs' argument is simply irrelevant to that inquiry.

To begin with, Plaintiffs' charge that HHS lacked "good reasons" for the Rule, Pls.' Mot. 16-19, misses the mark. As already demonstrated, that argument should be taken up with Congress. Their contention that HHS failed to show "noncompliance with Section 1303" depends on a reading of that section that HHS expressly rejected. *Id.* at 16. Likewise, the argument that HHS failed to show "any actual evidence of violation of Section 1303's segregation of funds

requirements" assumes away Section 1303's distinct requirement of "a separate payment." *Id.* at 18. And Plaintiffs' objection to HHS's projection that the Rule will reduce confusion for some enrollees confuses one *benefit* of the Rule, adduced in public comments, with the *purpose* of the Rule to comply with the statutory "separate payment" mandate, which the NPRM expressly articulated. *See* NPRM, 83 Fed. Reg. at 56,022. On the actual interpretive decisions HHS faced in promulgating the Rule, however, Plaintiffs' brief is silent—they make no argument that HHS lacked good reasons for implementing the separate-payment requirement in this particular manner, rather than some other way.

Likewise, Plaintiffs' claim that HHS allegedly ignored the "exorbitantly high costs" of the Rule, Pls.' Mot. at 19-22, and the "evidence . . . showing significant harms" from the Rule, *id.* at 23-25, again fails to distinguish between the costs of requiring separate payments *vel non* and the costs of doing so in the particular manner HHS chose in the Rule. Nevertheless, HHS gave full consideration to the costs and burdens the Rule would impose, and made reasonable efforts to minimize them. In particular, Plaintiffs argue that HHS did not adequately consider "the reasons to prefer single, or bundled billing, especially in the health insurance industry." *Id.* at 20. But as the comments Plaintiffs cite confirm, the costs of the Rule are inherent in any method of requiring separate payments. Consumers "are accustomed to receiving and paying bills in total amounts, even when the bill includes charges for a variety of items." *Id.* (quoting CDI Comment, AR 072862). Any method of requiring separate payments in separate transactions would thus pose some risk of consumer confusion. Likewise, the chance that enrollees might ultimately select out of plans that offer abortion services that they do not expect to use is inherent in any method of collecting separate premium payments for such coverage, *id.* at 20-21, and HHS expressly tailored its enforcement policies to mitigate that risk, *see* 84 Fed. Reg. at 71,687.

Similarly, Plaintiffs' argument about "the costs and personal administrative expense that will befall policy holders" turns on costs that would exist in any method of collecting separate payments, such as the costs of writing separate checks or sending multiple electronic payments. Pls.' Mot. at 23. Plaintiffs contend that it was unreasonable for HHS to "choose[] to proceed with

the Rule in spite of such concerns." *Id.* But HHS is not free to simply ignore a congressional mandate, and Plaintiffs do not argue that HHS chose unreasonably costly means of pursuing that mandate relative to other possible implementation methods.

The same is true for Plaintiffs' arguments about the risk of loss of coverage, and particularly loss of coverage for abortion services. Plaintiffs are simply wrong to claim that the Rule "ignored" those costs, *id.* at 24; to the contrary, HHS expressly "acknowledge[d] commenters' concerns that, even with fulsome outreach and education efforts to explain the billing scheme to the policy holder, consumer confusion could still lead to inadvertent coverage losses." 84 Fed. Reg. at 71,686. In light of that risk, HHS prohibited issuers from terminating coverage for enrollees who pay their full premium amount in a single payment. *Id.* It also expressed its intent to exercise enforcement discretion to allow QHP issuers to avoid placing enrollees into a grace period or terminating coverage "based solely on the policy holder's failure to pay the separate payment for coverage of non-Hyde abortion services." *Id.* Plaintiffs are again wrong to claim that HHS did not respond to commenter concerns about higher out-of-pockets costs for abortion services as a consequence of coverage loss except to "merely state[] that it considered" those comments. Pls.' Mot. at 25. In fact, HHS explained that the modifications it had made to the proposed Rule would reduce the costs it would impose on issuers of continuing to provide non-Hyde abortion coverage, and thereby reduce the likelihood that those seeking abortion care would face additional out-of-pocket costs. *See* 84 Fed. Reg. at 71,705. HHS went on to explain that it had taken the enforcement posture discussed above as a further means to mitigate the risk of coverage loss. *Id.*. And Plaintiffs misstate the record in quoting HHS's response to a different concern as its answer to the risk of coverage loss: HHS explained that the Rule did not place an unconstitutional condition on the right to access abortion because the burden of "understanding and paying" the separate bill for non-Hyde coverage would fall equally on all enrollees in plans offering such coverage whether or not they "actually do access coverage" for abortion services. *Id.* at 71,695. That response was wholly unrelated to the distinct issue of coverage loss.

Plaintiffs insist that "HHS did not adequately consider" the harms of loss of coverage. Pls.' Mot. 25. But HHS did consider those harms, and it modified the Rule and its enforcement posture as a result. It nevertheless concluded that complying with "a better interpretation" of the statute "justifies the costs." 84 Fed. Reg. at 71,695. Even if the Court might have weighed the relevant factors differently, the question before it on APA review is merely whether the agency's conclusion was the product of reasoned decisionmaking. The record is clear that it was.

Plaintiffs' claim that Congress "acquiesce[d]" to the 2016 guidance, Pls.' Mot. at 19, does not change the analysis. Plaintiffs cite no authority for their implicit argument that an agency may not change its interpretation of a statute it administers unless Congress changes the statute, and both the Supreme Court and the Ninth Circuit have repeatedly rejected the idea. *See, e.g.*, *Chevron*, 467 U.S. at 863-64 ("An initial agency interpretation is not instantly carved in stone. On the contrary, the agency, to engage in informed rulemaking, must consider varying interpretations and the wisdom of its policy on a continuing basis."); *Fox*, 556 U.S. at 515 (An agency may adopt a new interpretation if it "is permissible under the statute."); *accord, e.g.*, *California v. Azar*, 950 F.3d at 1096-97.

Finally, Plaintiffs also fault HHS's consideration of alternatives to the Rule, suggesting that HHS should instead have pursued "consumer education . . . to help remedy the perceived public confusion and transparency about abortion coverage that some commenters raise, and upon which HHS relies to justify the Rule *post hoc*." Pls.' Mot. at 26. This argument once again ignores the stated purpose of the Rule, which HHS rearticulated in explaining why it decided not to maintain its prior guidance: the Rule better complies "with the statutory requirements for collecting a separate payment." 84 Fed. Reg. at 71,708. Plaintiffs make no argument that "consumer education" alone could fulfill that purpose, and their proposal that HHS should pursue consumer education for a different purpose is beside the point.

In short, Plaintiffs' objections to the Rule are largely objections to the very concept of requiring separate payments, rather than to HHS's efforts to implement that requirement.

Regardless of the merits of those policy concerns, they offer no basis for either HHS or this Court to ignore a congressional mandate.

3. HHS's Decision Not to Permit Termination of Coverage Solely as a Result of Failure to Make Separate Payments Was Not Irrational

Plaintiffs raise only one argument that squarely addresses HHS's interpretive decisions about how to implement the separate-payment requirement rather than whether to do so at all, claiming that "the Rule is arbitrary because it fails to require issuers to make policy holders *pay* the bill attributable to abortion coverage 'in a separate transaction from any payment [to] the policy'—its purported goal for implementing the new Rule." Pls.' Mot. 25-26 (citation omitted). Plaintiffs argue that the Rule's acknowledgment that "potential loss of coverage would be an unreasonable result of an enrollee paying in full, but failing to adhere to the QHP issuer's requested payment procedure" proves that the Rule is "irrational" because it does not require separate payments in all circumstances without regard to the damage that doing so may cause. *Id.* (citation omitted). That argument is meritless. "[N]o legislation pursues its purposes at all costs." *Rodriguez v. United States*, 480 U.S. 522, 525-26 (1987). That is particularly true here, where there is no statutory requirement for the extreme cost that Plaintiffs would have HHS impose on individuals to show that its effort to fulfill a congressional mandate are "rational." Section 1303 speaks to QHP issuers, requiring them to "collect . . . a separate payment"; it does not separately address enrollees at all. 42 U.S.C. § 18023. Nor does it dictate any particular penalty for issuers that fail to collect a separate payment in any particular instance, still less so for enrollees who cause that failure by remitting a single payment for the entire premium.

In light of that statutory silence, HHS acted well within its discretion to determine that QHP issuers may satisfy their obligation to collect separate payments by sending separate bills, instructing enrollees to pay those bills in separate transactions, and depositing payments into separate allocation accounts. Perhaps HHS could ensure even higher rates of compliance with the separate payment requirement if it were to allow, or even instruct, issuers to "refuse the payment and initiate a grace period or terminate the policy holder's QHP coverage," 84 Fed. Reg. at 71,711,

for paying the entire premium in one transaction, but Section 1303 does not require such harsh consequences. It was not arbitrary or capricious for HHS consider such costs in crafting the Rule.

B. HHS's Choice of Implementation Date was not Arbitrary or Capricious

Plaintiffs advance two related arguments against HHS's choices about how to implement the separate-payment mandate. First, they object to HHS's choice of implementation date. Second, they complain that HHS has not delayed that implementation date in light of the COVID-19 national health emergency. Neither objection has merit.

Plaintiffs fault HHS for setting an implementation date of six months after the effective date of the Rule—namely, June 27, 2020. As HHS acknowledged, that implementation date would require issuers to adjust their billing practices mid plan-year and would thus impose greater costs than delaying implementation until the start of a new plan-year. 84 Fed. Reg. at 71,697. As part of its response to those concerns, HHS explained that it would "consider extending enforcement discretion" to QHP issuers "that may face uncommon or unexpected impediments to timely compliance," but that it did not anticipate extending such discretion for more than one year after the publication of the Rule. *Id.* at 71,689-90. But Plaintiffs take that reasonable effort to mitigate the harms of unexpected obstacles to compliance as a concession that "full implementation is not required by HHS until plan year 2021" and that the "increased expenses caused by a six-month implementation period are wholly unnecessary." Pls.' Mot. at 21.

Neither point withstands scrutiny. *Every* exercise of enforcement discretion necessarily contemplates the possibility of less-than-full compliance with the regulation being enforced, but that does not mean that an agency may not rationally enforce the regulation *at all*. It is perfectly reasonable for an agency to conclude that prompt compliance with a statute is necessary, even if it would impose higher costs than delayed compliance, while still making allowances for regulated entities that work in good faith to achieve timely compliance but nevertheless fail for reasons beyond their control. That is precisely what HHS did in the Rule.

As HHS explained, and as Plaintiffs do not challenge, it projected that six months would provide sufficient time for issuers, Exchanges, and state regulators to comply with the Rule. 84

Fed. Reg. at 71,689-90. HHS acknowledged that the implementation date would entail "implementation challenges" and "added administrative costs," but it nevertheless explained that "a 6-month implementation timeline appropriately prioritizes the goals of improved statutory alignment with the additional time State Exchanges and issuers may need to implement this policy." *Id.* at 71,689. HHS thus considered the relevant factors and decided that the need for prompt compliance with the statute justified the additional costs of a six-month implementation window, with the possibility of enforcement discretion if extraordinary circumstances shifted the balance in particular cases. That is all that the APA requires.

The lone case Plaintiffs rely on, *Gresham v. Azar*, 950 F.3d 93 (D.C. Cir. 2020), is not to the contrary. In that case, the D.C. Circuit held that the Secretary had acted arbitrarily and capriciously in granting a waiver of certain Medicaid requirements to a state demonstration project. *Id.* at 103. The court held that the primary purpose of Medicaid is to provide health care coverage, and that the Secretary improperly dismissed comments raising concerns about loss of coverage by stating that the project would "increase healthy outcomes"—"an entirely different set of objectives than . . . the principal objective of Medicaid." *Id.* at 102, 103. In the court's view, the Secretary thus "entirely failed to consider an important aspect of the problem." *State Farm*, 463 U.S. at 43.

None of the factors supporting the court's holding in that case apply here. First, reducing administrative costs is not a statutory objective of Section 1303, let alone the primary one. Second, the Rule does expressly consider the costs of the implementation timeline. And third, it goes without saying that statutory compliance—the factor that HHS determined outweighed the costs of a six-month implementation period—is an objective of the statute.

Plaintiffs also argue that by "forcing the States' agencies to prioritize altering their billing processes in order to comply with the new Rule by June 27, 2020 . . . HHS necessarily detracts from the States' abilities to prioritize responding to the national crisis of COVID-19." Pls.' Mot. at 22. That argument is wrong both factually and doctrinally.

As a factual matter, and as Plaintiffs acknowledge in a footnote, HHS has informed Plaintiffs that it intends to delay the Rule's implementation date by 60 days in light of the COVID-

19 emergency. *See* Pls.' Mot. at 22 n. 8. HHS will formally delay the implementation date well in advance of June 27, 2020. Plaintiffs contend that that delay is "insufficient," *id.*, but they fail to substantiate that claim.

As a matter of law, moreover, Plaintiffs are wrong that an otherwise valid regulation can retroactively become arbitrary and capricious due to subsequent changed circumstances. As the Supreme Court has held, a claim that an agency acted arbitrarily or capriciously in failing to amend a rule in light of later developments such as a judicial decision provides "no basis for the court to set aside the agency's action prior to any application for relief addressed to the agency itself." *Auer v. Robbins*, 519 U.S. 452, 459 (1997).

III. HHS COMPLIED WITH THE APA'S PROCEDURAL REQUIREMENTS

Plaintiffs argue that HHS failed to comply with the APA's notice-and-comment requirements because it stated for the first time in the Rule's preamble that it will not take enforcement action against QHPs that modify the benefits of a plan to effectively allow enrollees to opt out of coverage for non-Hyde abortion services by not paying the separate bill for such services. *See* Pls.' Mot. at 37-38. Plaintiffs are incorrect. The APA generally requires an agency to follow notice-and-comment procedures before promulgating rules. 5 U.S.C. § 553(b), (c); *Perez v. Mortg. Bankers Ass'n*, 575 U.S. 92, 95-96 (2015). But the APA exempts "general statements of policy" from that requirement unless another statute provides otherwise, 5 U.S.C. § 553(b)(3)(A), and none does here. HHS's statement regarding how it will exercise its enforcement discretion, which Plaintiffs call the "opt-out policy," is exempt from the APA's notice-and-comment requirements because it is a general statement of policy.

General statements of policy "advise the public prospectively of the manner in which the agency proposes to exercise a discretionary power." *Chrysler Corp. v. Brown*, 441 U.S. 281, 302 n.31 (1979) (quoting Dep't of Justice, Attorney General's Manual on the APA 30 n.3 (1947)). They "serve a dual purpose": both to "inform[] the public concerning the agency's future plans and priorities for exercising its discretionary power," as well as to "'educate' and provide direction to the agency's personnel in the field, who are required to implement . . . policies and exercise . . .

discretionary power in specific cases." *Mada-Luna v. Fitzpatrick*, 813 F.2d 1006, 1013 (9th Cir. 1987). And a "general statement of policy," often "announces the course which the agency intends to follow in future adjudications." *Pac. Gas & Elec. Co. v. FPC*, 506 F.2d 33, 38 (D.C. Cir. 1974).

By contrast, legislative rules, which are subject to the APA's notice-and-comment requirements, have the force and effect of law, and thus create legally enforceable rights or obligations in regulated parties. *Perez*, 575 U.S. at 96; *Chrysler Corp. v. Brown*, 441 U.S. 281, 302-03 (1979). In other words, an "agency action that . . . would be the basis for an enforcement action for violations of those obligations or requirements—is a legislative rule." *Nat'l Mining Ass'n v. McCarthy*, 758 F.3d 243, 251 (D.C. Cir. 2014). The APA generally leaves to the agency the choice of which mode to employ. *See* 5 U.S.C. § 553(b). If an agency chooses to issue a statement of policy rather than a legislative rule, that choice has consequences: The agency's statements in the policy have "no binding effect on members of the public or on courts." 1 Richard J. Pierce, Jr., Administrative Law Treatise § 6.3, at 419 (5th ed. 2010).

A quintessential use of policy statements is for an agency to announce how and when it will pursue (or forbear from) enforcement, in the exercise of its discretion. *See Clarian Health West, LLC v. Hargan*, 878 F.3d 346, 358-59 (D.C. Cir. 2017) ("If the agency so chooses, it may forego notice-and-comment procedures and announce through a policy statement its intentions for future adjudications."). Such enforcement policies explain how the agency intends to exercise a power that is "generally committed to an agency's absolute discretion." *Chaney*, 470 U.S. at 831. Unlike legislative rules adopted after notice-and-comment, such enforcement policies do not establish or alter any legally enforceable rights or obligations of third-parties. And such policies can readily be changed, in response to changing circumstances and priorities.

Applying these principles, HHS's so-called "opt-out policy" can only be viewed as a general statement of policy, to which the APA's notice-and-comment procedures do not apply. *See* 5 U.S.C. § 553(b)(3)(A). HHS's statement regarding how it will exercise its enforcement discretion does not bind regulated parties or the courts in any way; it does not even "bind" HHS in any meaningful sense. Nor is it codified in the Code of Federal Regulations. HHS's statement

in the preamble reflects nothing more than guidance regarding how the agency currently intends to exercise its discretion going forward. Plaintiffs' notice-and-comment claim therefore fails.

IV. THE RULE DOES NOT VIOLATE THE TENTH AMENDMENT

Plaintiffs next erroneously assert that the Rule infringes on their "sovereign authority to enforce their own law," and thus violates the Tenth Amendment. Pls.' Mot. at 38. Specifically, Plaintiffs contend that the costs of complying with the Rule interfere with their State laws that "require or allow abortion coverage to be provided in qualified health plans." *Id.* Plaintiffs' argument is flatly inconsistent with precedent, and would, if accepted, imperil the very possibility of cooperative federalism.

As Plaintiffs acknowledge, the Tenth Amendment protects "the sovereignty reserved to the States." *New York v. United States*, 505 U.S. 144, 174 (1992). Congress's "legislative authority" thus operates "directly over individuals rather than over states." *Id.* at 165. But Plaintiffs cite no authority for their argument that the Tenth Amendment curtails the federal government's power to regulate individuals merely because doing so might indirectly increase costs to State governments.

The Rule plainly does not attempt to regulate States directly. Despite their suggestion that the Rule "deprive[s] the States their authority (pursuant to the ACA) to enact state laws that include abortion coverage as a protected benefit," Plaintiffs do not appear to seriously contend that the Rule restricts their sovereign power to legislate. Pls.' Mot. at 39. Instead, they complain that the Rule will drive up costs for States that both chose to manage their own Exchanges and either require or permit non-Hyde abortion coverage in QHPs, and that the ACA allows HHS to step in to enforce federal requirements directly against issuers if States substantially fail to enforce those requirements. *Id.* They also raise the prospect that a State might risk losing up to one percent of the federal funds it receives through HHS if it does not adequately comply with the Rule, citing a provision of the ACA that provides for such a penalty if a state engages in a "pattern of abuse" amounting to "serious misconduct" with respect to the financial integrity of the Exchanges. Pls.' Mot. at 15, 39 (citing 42 U.S.C. § 18033(a)).

The mere prospect of increased costs for State regulators does not amount to a Tenth Amendment violation. As the Supreme Court explained in *New York v. United States*, "[a] State whose citizens do not wish it to [comply with a statutory requirement] may devote its attention and its resources to issues its citizens deem more worthy; the choice remains at all times with the residents of the State, not with Congress." 505 U.S. at 174. There is no Tenth Amendment problem when "[t]he State need not expend any funds, or participate in any federal program, if local residents do not view such expenditures or participation as worthwhile." *Id.*

Nor does the prospect that HHS could step in to enforce its regulations if States substantially fail to do so encroach on the States' constitutional prerogatives, as the Supreme Court held in *Hodel v. Virginia Surface Mining & Reclamation Ass'n*, 452 U.S. 264 (1981). In that case, the Court considered the constitutionality of the Surface Mining Control and Reclamation Act. *Id.* at 268. States "wishing to assume permanent regulatory authority" over surface coal mining were required to submit to the Interior Secretary a "proposed permanent program" demonstrating compliance with federal regulations. *Id.* at 271. If a State declined, the Secretary would "develop and implement a federal permanent program" for that State, assuming the "full regulatory burden." *Id.* at 272, 288. Virginia argued that this program violated the Tenth Amendment because "the threat of federal usurpation of their regulatory roles coerces the States into enforcing the Surface Mining Act." *Id.* at 289. The Supreme Court flatly rejected the argument, explaining that a "wealth of precedent attests to congressional authority to displace or pre-empt state laws regulating private activity affecting interstate commerce when these laws conflict with federal law." *Id.* at 290 (citations omitted). Further, the Court stated, "it is clear that the Commerce Clause empowers Congress to prohibit all—and not just inconsistent—state regulation of such activities." *Id.* "Although such congressional enactments obviously curtail or prohibit the States' prerogatives to make legislative choices respecting subjects the States may consider important, the Supremacy Clause permits no other result." *Id.* The Court concluded: "Congress could constitutionally have enacted a statute prohibiting any state regulation of surface coal mining. We fail to see why the

Surface Mining Act should become constitutionally suspect simply because Congress chose to allow the States a regulatory role." *Id.*

Plaintiffs do not argue that Congress lacked the power to create the Exchanges. It therefore follows under controlling precedent that Congress, and HHS acting with its delegated regulatory power, can set the rules that govern the Exchanges. That includes the power to determine when HHS may step in to directly enforce federal standards in the face of a State's failure to do so. *See, e.g.*, *South Carolina v. Baker*, 485 U.S. 505, 514-15 (1988) ("That a State wishing to engage in certain activity must take administrative . . . action to comply with federal standards regulating that activity is a commonplace that presents no constitutional defect.").

That is the case here: the Exchanges are creatures of federal law, and the States may choose to manage their own Exchanges or not as they see fit. HHS's regulatory role does not offend the Tenth Amendment merely because the Exchanges allow for state participation. Were it otherwise, it would become practically impossible for Congress to impose *any* standards on State-run Exchanges, because States face costs in ensuring compliance no matter which particular regulation they enforce. Thus, if the Plaintiffs' Tenth Amendment argument were to prevail, the same reasoning would prevent any federal effort to require QHPs on State-run Exchanges to provide essential health benefits, or to refrain from discriminating on the basis of pre-existing health conditions or any other prohibited basis. All such requirements depend on States that choose to manage Exchanges expending funds to ensure compliance, and all would be subject to invalidation on Plaintiffs' theory.

Plaintiffs' invocation of the risk of losing funds if they somehow have an "inability to comply, or allow issuers to comply, with the Rule" is similarly misguided. Pls.' Mot. at 39. The provision they cite applies to patterns of serious financial misconduct in the management of Exchanges, *see* 42 U.S.C. § 18033(a)—which Plaintiffs do not seriously claim they risk violating—and HHS did not cite that provision as a possible enforcement mechanism if States fail to comply with the Rule. *See* 84 Fed. Reg. at 71,692. Instead, HHS cited that provision in an entirely separate provision of the Rule, dealing with "periodic data matching" requirements to

ensure that individuals do not simultaneously receive federal subsidies for QHPs on an Exchange and for coverage under another federal program such as income-based enrollment in Medicaid. *See* 84. Fed. Reg. 71,677-78. In that context, concerning the possibility of fraudulent claims for federal assistance, HHS raised the possibility of employing its statutory powers to penalize fraud on the Exchanges. Plaintiffs do not challenge that portion of the Rule, and the enforcement mechanisms appropriate in that distinct context are not relevant to their Tenth Amendment challenge.

V. ANY RELIEF SHOULD BE LIMITED ONLY TO THE NAMED PLAINTIFFS

Plaintiffs ask the Court to vacate the challenged Rule, presumably on a nationwide basis. *See* Pls.' Mot. at 40. For the reasons explained above, Plaintiffs' claims lack merit, and Plaintiffs are not entitled to relief. However, even if the Court were to agree with Plaintiffs on the merits of one or more of their claims, nationwide relief would be inappropriate. Article III and longstanding equitable principles require that relief "be no more burdensome to the defendant than necessary to provide complete relief to the plaintiffs." *Madsen v. Women's Health Ctr., Inc.*, 512 U.S. 753, 765 (1994); *see Gill v. Whitford*, 138 S. Ct. 1916, 1930-31, 1935 (2018). Here, nationwide relief is unnecessary to redress Plaintiffs' alleged injuries. To start, Plaintiffs' choice to bring a facial challenge does not justify nationwide relief. *See City & Cty. of San Francisco v. Trump*, 897 F.3d 1225, 1244-45 (9th Cir. 2018) (vacating nationwide scope of injunction in facial constitutional challenge to executive order). Nor does Plaintiffs' decision to bring APA claims necessitate a nationwide remedy. *See, e.g.*, *California v. Azar*, 911 F.3d 558, 582-84 (9th Cir. 2018) (vacating nationwide scope of injunction in facial challenge under the APA); *Los Angeles Haven Hospice, Inc. v. Sebelius*, 638 F.3d 644, 664-65 (9th Cir. 2011) (same). A court "do[es] not lightly assume that Congress has intended to depart from established principles" regarding equitable discretion, *Weinberger v. Romero-Barcelo*, 456 U.S. 305, 313 (1982), and the APA's general instruction that unlawful agency action "shall" be "set aside," 5 U.S.C. § 706(2), is insufficient to mandate such a departure. The Supreme Court therefore has confirmed that, even in an APA case, "equitable defenses may be interposed." *Abbott Labs. v. Gardner*, 387 U.S. 136, 155 (1967).

Accordingly, the Court should construe the "set aside" language in Section 706(2) as applying only to the named Plaintiffs, especially as no federal court had issued a nationwide injunction before Congress's enactment of the APA in 1946, nor would do so for more than fifteen years thereafter, *see Trump v. Hawaii*, 138 S. Ct. 2392, 2426 (2018) (Thomas, J., concurring). Nationwide relief would be particularly harmful here given that another district court, in Maryland, is currently considering similar challenges. And although a district court in the Eastern District of Washington recently declared the Rule invalid and without force in the State of Washington, *see Washington v. Azar*, No. 20-cv-00047-SAB, Order (E.D. Wash. Apr. 9, 2020), the government may still appeal that decision. If the government prevails in those other cases, either at the district court or on appeal, nationwide relief here would render those victories meaningless as a practical matter.

CONCLUSION

For the foregoing reasons, Defendants respectfully submit that the Court should deny Plaintiffs' motion for summary judgment and enter judgment in favor of Defendants.

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Respectfully submitted,

JOSEPH H. HUNT
Assistant Attorney General

DAVID L. ANDERSON
United States Attorney

DAVID M. MORRELL
Deputy Assistant Attorney General

ERIC B. BECKENHAUER
Assistant Branch Director

/s/ Bradley P. Humphreys
BRADLEY P. HUMPHREYS
CORMAC EARLY
Trial Attorneys
United States Department of Justice
Civil Division, Federal Programs Branch
1100 L Street, NW
Washington, DC 20005
Tel: (202) 305-0878

Fax: (202) 616-8460
Email: Bradley.Humphreys@usdoj.gov

Counsel for Defendants

CERTIFICATE OF SERVICE

I hereby certify that, on April 20, 2020, I electronically filed the foregoing document with the Clerk of the Court, using the CM/ECF system, which will send notification of such filing to the counsel of record in this matter who are registered on the CM/ECF system.

/s/ Bradley P. Humphreys
BRADLEY P. HUMPRHEYS