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UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF WASHINGTON

STATE OF WASHINGTON,

Plaintiff,

v.

ALEX M. AZAR II, in his official capacity as Secretary of the United States Department of Health and Human Services; UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES; SEEMA VERMA, in her official capacity as Administrator of the Centers for Medicare and Medicaid Services; and CENTERS FOR MEDICARE AND MEDICAID SERVICES,

Defendants.

NO. 2:20-CV-00047

PLAINTIFF STATE OF WASHINGTON'S REPLY IN SUPPORT OF ITS MOTION FOR PARTIAL SUMMARY JUDGMENT ON NON-PREEMPTION

NOTED FOR: April 9, 2020
Without Oral Argument
(*See* ECF No. 12)

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I. INTRODUCTION

The Double-Billing Rule, which HHS promulgated under its limited authority to interpret the ACA, cannot preempt Washington's Single-Invoice statute as a matter of law. The ACA's text is dispositive: Section 1303 allows, but does not mandate, separate billing, and Congress left states free to legislate on that issue. *Chevron* deference does not apply to HHS's statutory interpretation proffered during the course of this litigation. Even if *Chevron* did apply, HHS's argument that it can preempt Washington law via rulemaking fails the first step of that analysis because Congress's contrary intent is embedded in the statute itself. HHS's *post hoc* interpretation of Section 1303 violates the ACA's text and structure, controlling case law, HHS's own prior guidance, and even HHS's own Double-Billing Rule, which does *not* purport to preempt state law. In attempting to regulate contrary to the Single-Invoice Statute, HHS exceeds its limited interpretive authority. The Court should vacate the Rule or, at least, declare it invalid in the State of Washington.[1]

II. ARGUMENT

A. Congress's Express Intent Not to Preempt State Law Is Dispositive, and HHS's Contrary Interpretation Is Not Entitled to Any Deference

The outcome of this case is dictated by clear statutory language expressing Congress's intent *not* to preempt state law like the Single-Invoice Statute, which

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[1] HHS's "cross-motion" is a transparent attempt to obtain additional unnecessary briefing. *See* ECF No. 5 at 2 (2.b–2.e).

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does not conflict with Section 1303. Mot. at 9–15, 19–20. HHS takes the remarkable position that, despite multiple express disclaimers of preemption Congress included in Sections 1303 and 1321, HHS has authority to "interpret" Section 1303 to preempt the Single-Invoice Statute and, moreover, that this Court owes deference to its interpretation. Yet HHS's *Chevron*-based analysis rests on the demonstrably wrong premise that Section 1303 is "ambiguous" and that HHS's interpretation of preemptive effect is "permissible." These arguments have no merit whatsoever.

While HHS does not say so, its claim to *Chevron* deference is grounded on the general proposition "that a statute's ambiguity constitutes an implicit delegation from Congress to the agency to fill in the statutory gaps." *Smith v. Berryhill*, 139 S. Ct. 1765, 1778 (2019). But HHS fails to show any statutory ambiguity and disregards Congress's *explicit* statements of non-preemption. This is erroneous. *See King v. Burwell*, 135 S. Ct. 2480, 2489 (2015) ("If the statutory language is plain, [the court] must enforce it according to its terms."); *Util. Air Regulatory Grp. v. EPA*, 573 U.S. 302, 328 (2014) ("an agency may not rewrite clear statutory terms . . ."). Without a statutory ambiguity, there is no *Chevron* step two analysis.

HHS skips over this central issue, explained throughout the State's Motion. Section 1303 is unambiguous and an agency's reinterpretation of statutory language cannot override a clear statutory non-preemption provision. Mot. at 9–20. That is the teaching of *Oregon v. Ashcroft*, in which the Ninth Circuit refused to afford *Chevron* deference to the Attorney General's preemptive reinterpretation that "cannot be squared with the CSA's non-preemption clause." 368 F.3d 1118, 1126 (9th Cir.

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2004), *aff'd sub nom. Gonzales v. Oregon*, 546 U.S. 243 (2006). HHS fails to distinguish that closely analogous case. *See* Opp. at 2, 9 (citing *Gonzales*).

Even if Section 1303 were somehow ambiguous, *Chevron* deference is particularly inappropriate where, as here, "Congress has not authorized" HHS to preempt state law. *Wyeth v. Levine*, 555 U.S. 555, 576–77 (2009) (no deference to claim of preemption in FDA rule's preamble where Congress did not authorize preemption by regulation, proposed rule had disclaimed preemption, and preemption was at odds with Congress's purposes and "FDA's own longstanding position"); *see also Gonzales*, 546 U.S. at 258 (*Chevron* deference "is not accorded merely because the statute is ambiguous and an administrative official is involved"; "the rule must be promulgated pursuant to authority Congress has delegated to the official"). Here, Congress authorized HHS to enforce Section 1303's provisions, not to promulgate preemptive rules—rather, Congress expressly forbade this in Section 1303(c)(1).

Moreover, the Double-Billing Rule itself does not purport to interpret the non-preemption provisions in Sections 1303 or 1321. Indeed, HHS had no reason to address them, since the Rule disclaims any preemption of state law. Mot. at 18–19. As such, HHS is improperly seeking judicial deference to an expedient litigation position rather than a procedurally proper agency determination. *Chevron* does not apply at all to "procedurally defective" agency actions, *Encino Motorcars, LLC v. Navarro*, 136 S. Ct. 2117, 2125 (2016), such as a *post hoc* "agency litigating position." *Price v. Stevedoring Servs. of Am., Inc.*, 697 F.3d 820, 830 (9th Cir. 2012); *Alaska v. Fed. Subsistence Bd.*, 544 F.3d 1089, 1095 (9th Cir. 2008) ("We do not

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afford *Chevron* or *Skidmore* deference to litigation positions unmoored from any official agency interpretation"); *accord Bowen v. Georgetown Univ. Hosp.*, 488 U.S. 204, 212–213 (1988); *U.S. v. Mead Corp.*, 533 U.S. 218, 228 (2001) (interpretations "advanced for the first time in a litigation brief" are treated with "near indifference"); *cf. Kisor v. Wilkie*, 139 S. Ct. 2400, 2417–18 (2019) ("[A] court may not defer to a new interpretation . . . that creates 'unfair surprise' to regulated parties" such as "when an agency substitutes one view of a rule for another.").

Nor does *Chevron* apply to "an agency's *conclusion* that state law is pre-empted"; courts "perform[] [their] own conflict determination, relying on the substance of state and federal law and not on agency proclamations of pre-emption."[2] *Wyeth*, 555 U.S. at 576; *see also Lusnak v. Bank of Am., N.A.*, 883 F.3d 1185 (9th Cir.), *cert. denied*, 139 S. Ct. 567 (2018) (no deference to agency

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[2] HHS's cases addressing the "presumption against preemption" (Opp. at 2, 10–12) are inapposite: all concern agency interpretations of the scope of statutory *preemption* provisions, not regulations propounded in violation of *non*-preemption provisions. *See Smiley v. Citibank (S.D.), N.A.*, 517 U.S. 735 (1996) (addressing presumption against preemption and agency interpretation of express preemption provision); *Cuomo v. Clearing House Ass'n, L.L.C.*, 557 U.S. 519, 525 (2009) (analyzing agency interpretation of express preemption provision); *Coventry Health Care of Mo., Inc. v. Nevils*, 137 S. Ct. 1190 n.3, 1198 (2017) (interpreting express preemption provision without deciding whether *Chevron* deference was owed).

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regulation interpreting scope of National Banking Act preemption given Congress's express intent: "state consumer financial law is preempted *only if* it 'prevents or significantly interferes with the exercise by the national bank of its powers'"); *Solberg v. Victim Servs., Inc.*, 415 F. Supp. 3d 935, 955 (N.D. Cal. 2019) (cited in Mot. at 15); *cf. Smiley*, 517 U.S. at 744 (assuming that "*whether* a statute is pre-emptive" must be "decided *de novo* by the courts," not by agencies).

To the extent *Chevron* applies at all, the analysis can be concluded here. No deference is owed to HHS's statutory interpretations, offered for the first time in litigation and contrary to the plain language of the very statute it purports to interpret.

B. HHS's *Post Hoc* Interpretation of Section 1303's Non-Preemption Provision Is Completely Unpersuasive

HHS, in its opposition brief, urges for the first time a statutory interpretation that dramatically narrows the scope of Section 1303's non-preemption provision to accommodate the agency's preemptive Double-Billing Rule. Specifically, HHS asserts that Section 1303 only preserves state authority to determine "whether and on what terms to prohibit or require issuers on the Exchanges to cover and fund abortion services." Opp. at 16. This overly narrow and restrictive interpretation of Section 1303's non-preemption provision contradicts its text, structure, and purpose.

Section 1303 provides that "state laws regarding abortion"—namely, any state laws "regarding" abortion coverage, funding, or procedural requirements—remain in force, so long as they comport with that section's funding segregation requirements. 42 U.S.C. § 18023(c)(1). HHS's new theory is that Section 1303

"categorically" distinguishes between state laws concerning "payment collection and allocation" (which supposedly can be preempted) and "coverage, funding, or procedural requirements" (which are supposedly distinct, and exempt from preemption). Opp. at 16. HHS's rewriting of Section 1303 does not bear scrutiny.

There is no indication in the statute that Congress intended to categorically exempt state laws concerning "billing arrangements" for abortion coverage and funding from Section 1303's broad protection from preemption. *Contra* Opp. at 17. HHS does not dispute that the term "regarding" in the non-preemption provision has a broadening effect, not a narrowing one. *See* Opp. at 15 (acknowledging, without refuting, the substantiated textual argument in Mot. at 14). The subjects of the Single-Invoice Statute—billing plan enrollees and receiving premium payments for coverage—obviously relate to coverage and funding for health care services. Indeed, this relationship is inherent in Section 1303's own text and structure: the statute establishes "special rules relating to *coverage* of abortion services"—i.e., *funding* segregation requirements that implement restrictions on the use of federal funds. 42 U.S.C. § 18023(b) (emphasis added). Moreover, HHS itself addressed the obvious relationship between billing, funding, and coverage by acknowledging in the Rule's preamble that policyholders who fail to pay both monthly premium bills required by the Double-Billing Rule may suffer "loss of coverage." 84 Fed. Reg. 71,684, 71,709.

HHS's effort to establish a "categorical" distinction falls flat. The federal and state laws at issue *both* establish "coverage" and "funding" requirements. Thus, the correct reading of Section 1303(c)(1) is that it preserves state laws "regarding"

coverage and funding unless they conflict with the ACA.[3] *Cf. Gonzales*, 546 U.S. at 270–71 (there was "no question" that the CSA "set uniform national standards" in a specified area, but "given the structure and limitations of federalism" and the "structure and operation of the CSA," including its non-preemption provision, the statute did not otherwise preempt state law). Here, as in *Gonzales*, there is "only one area in which Congress set general, uniform standards" regarding abortion coverage and funding in the ACA: Section 1303's funding segregation requirements.

Finally, HHS's litigation position contradicts the Rule itself, which plainly states that it "does not . . . preempt state law." 84 Fed. Reg. at 71,709. HHS suggests that this statement is a "fragment" taken out of context or should simply be ignored for some reason, Opp. at 19, but the Rule's preemption disclaimer means just what it says. There is nothing "gotcha" about holding HHS to its word. *See Hillsborough County v. Automated Med. Labs. Inc.*, 471 U.S. 707, 718 (1985) ("[B]ecause agencies . . . can speak through a variety of means, including . . . preambles, . . . we can expect that they will make their intentions clear if they intend for their

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[3] Notably, HHS does not offer a new interpretation of Section 1321's general disclaimer of preemption; the parties agree it preserves state laws that do not "actually conflict with" the "mandates of the ACA" itself. Opp. at 14; *see* Mot. at 13–15. HHS's effort to evade Section 1321 depends upon its assertion that its reinterpretation of Section 1303's "separate payment" language is an "authoritative" construction. That sleight of hand is unavailing, as discussed both above and below.

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regulations to be exclusive.").[4] HHS seems to fault the State for not calling its attention to the Single-Invoice Statute enacted in May 2019, but ignores that the NPRM's comment period had closed by then. 83 Fed. Reg. 56,015 ("To be assured consideration, comments must be received . . . no later than 5 p.m. on January 8, 2019."). HHS had ample time after May to review state laws before broadly proclaiming in December that its Rule does not preempt any of them. For all of these reasons, the Court should reject HHS's new reading of Section 1303(c)(1).

C. HHS's Interpretation of Section 1303's Unambiguous Funding Segregation Provisions Is Equally Unpersuasive

HHS next urges this Court to adopt a novel reading of Section 1303's funding segregation requirements that conflates a separate "payment" with a separate "bill," thus requiring double billing. Opp. at 6. This statutory interpretation, which is also contrary to what HHS said in its rulemaking, is irredeemably flawed. Section 1303 must be read to require funding segregation for abortion and non-abortion coverage, but otherwise not to preempt state laws "regarding" abortion coverage and funding.[5]

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[4] The State does not assert a claim for violation of Exec. Order 13132. *Contra* Opp. at 19. Rather, this directive illustrates HHS's radical departure from proper administrative procedure, which is actionable under the APA. 5 U.S.C. § 706(2)(D).

[5] The interpretation advanced in HHS's brief is *not* what HHS said in the Double-Billing Rule. In the Rule, HHS acknowledged that "Section 1303 of the PPACA . . . **do[es] not specify the method** a QHP issuer must use to comply with

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As HHS admits in the Rule, Section 1303 does not specify any particular method necessary to comply with the separate payment requirement. Separate bills are *one* acceptable method (if permitted by state law), but it does not follow that this is the *only* acceptable method, as HHS now argues. HHS long recognized that Congress declined to specify a single required method—which is not the same as an ambiguity. *See* Mot. at 4–5, 15 (discussing 2015 Rule). If Congress intended to make separate billing the *only* method of collecting a separate payment, it "would have employed apt language to clearly state this intent." *Bond v. United States*, 872 F.2d 898, 900 (9th Cir. 1989). Congress directly addressed issuer billing elsewhere in the ACA and knows how to distinguish between sending separate bills and segregating funds into separate accounts. *Compare, e.g.*, 42 U.S.C. § 18082 (issuer responsibilities for billing statement disclosures) *with* 42 U.S.C. § 18023(b)(2) (funding segregation). Section 1303 does not mention "bills" (or "invoices") *at all.* 42 U.S.C. § 18023. It merely requires issuers to "collect . . . a separate payment" and segregate the moneys into a separate account, without specifying any method for doing so.[6] 42 U.S.C. § 18023. HHS wrongly asserts that the State "does not directly

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the separate payment requirement . . . ." 84 Fed. Reg. at 71,683 (emphasis added).

[6] It is telling that the Double-Billing Rule does not require issuers to reject separate payments made via a single transaction—it requires only that the issuer "instruct" enrollees to pay in separate transactions. 84 Fed. Reg. at 71,685 ("QHP issuers that receive *combined enrollee premiums* in a single payment must treat the

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dispute" that Section 1303 "can reasonably be read to *require* sending separate bills." Opp. at 2, 8. The State vehemently disputes this atextual reading: Section 1303 may *allow* separate bills, but clearly does not *require* them. Mot. at 1, 4–5, 11, 15, 17–20.

In the Rule's preamble, HHS acknowledged public comments that separate billing is "against industry practice" and agreed that it creates a "risk" of "consumer confusion" and "inadvertent coverage losses." 84 Fed. Reg. at 71,684, 71,686. Washington's Single-Invoice Statute reflects the State's policy choices to avoid such draconian consequences. It comports with Section 1303 because it enables QHP issuers to "collect . . . a separate payment" to be segregated from other moneys, without confusing consumers or jeopardizing their coverage by sending a separate bill or demanding separate payment transactions. *See* Mot. at 6–7 & n.1, 15, 18, 19–20. It is not preempted by Section 1303.

III. CONCLUSION

For the reasons above and in the State's Motion, the Court should GRANT the State's Motion for Partial Summary Judgment on Counts I and II.

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portion of the premium attributable to coverage of non-Hyde abortion services as a *separate payment* . . . .") (emphasis added); *see also id.* at 71,693 (conceding that 2015 Rule's compliance options "arguably identifie[d] two 'separate' amounts for two separate purposes," consistent with statute's text).

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