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IN THE UNITED STATES DISTRICT COURT

FOR THE NORTHERN DISTRICT OF CALIFORNIA

STATE OF CALIFORNIA, STATE OF NEW YORK, STATE OF COLORADO, DISTRICT OF COLUMBIA, STATE OF MAINE, STATE OF MARYLAND, STATE OF OREGON, and **THE STATE OF VERMONT,**

Plaintiffs,

v.

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES; ALEX M. AZAR, II, in his official capacity as Secretary of Health and Human Services; **THE CENTERS FOR MEDICARE & MEDICAID SERVICES; SEEMA VERMA,** in her official capacity as Administrator of Centers for Medicare & Medicaid Services,

Defendants.

Case No. 3:20-cv-00682-LB

PLAINTIFFS' OPPOSITION TO DEFENDANTS' MOTION FOR SUMMARY JUDGMENT AND REPLY IN SUPPORT OF PLAINTIFFS' MOTION FOR SUMMARY JUDGMENT

Date: June 11, 2020
Time: 9:30 am
Dept: Courtroom B, 15th Floor
Judge: Magistrate Judge Laurel Beeler
Trial Date: None
Action Filed: January 30, 2020

TABLE OF CONTENTS

TABLE OF CONTENTS
(continued)

Page

TABLE OF AUTHORITIES

Page

CASES

TABLE OF AUTHORITIES
(continued)

Page

TABLE OF AUTHORITIES
(continued)

Page

STATUTES

TABLE OF AUTHORITIES
(continued)

Page

CONSTITUTIONAL PROVISIONS

OTHER AUTHORITIES

INTRODUCTION

Defendants the U.S. Department of Health and Human Services (HHS), Secretary Alex M. Azar II, the Centers for Medicare & Medicaid Services (CMS), and Administrator Seema Verma (collectively Defendants or HHS) rest their argument on circular reasoning and the erroneous premise that the ACA's Section 1303 is ambiguous and thus their interpretation is entitled to deference under *Chevron, U.S.A., Inc. v. Natural Res. Def. Council*, 467 U.S. 837, 842-45 (1984). That cannot be so. Section 1303 is clear—it does not mandate billing through separate transactions, it *requires* carriers (issuers) to segregate the payment collected, placing amounts into separate accounts, and *prohibits* any billing that separates the cost of abortion coverage from the total health premium. As the States show, HHS cannot delegate to itself the authority beyond that of Section 1303's text. Such usurpation of Congressional power undermines the States' sovereignty over the regulation of healthcare, disproportionately impacting states, including Plaintiff States, that either mandate abortion coverage, or allow the provision of abortion coverage in a qualified health plan on the individual market. These outcomes run afoul ACA's objectives, through which Congress intended to decrease healthcare costs, expand healthcare coverage, and maintain its neutrality regarding abortion care.

Furthermore, HHS's Rule is arbitrary and capricious agency action and is owed no deference. It imposes exorbitant costs with no benefit. The Rule change fails to meet the requirements of *Encino Motorcars, LLC v. Navarro*, 136 S. Ct. 2117, 2127 (2016), because HHS offers no persuasive explanation for its abrupt change of course. HHS also fails to acknowledge that one of the ACA's principal objectives was to expand healthcare coverage by reducing private health insurance costs, not stifle it through an onerous regulation that risks consumer coverage and imposes unnecessary costs on states.

Because the Rule violates the APA and the Tenth Amendment, this Court should grant the States' motion for summary judgment and vacate the Rule entirely. HHS requests that any relief granted should be limited to the named Plaintiffs. Defs. Mot. for Summ. J. and Opp'n (hereinafter Defs. Opp'n) at 37. But vacatur of an invalid rule is required by the APA. The Ninth

Circuit has described vacatur as the standard remedy in an APA case, and HHS provides no reason to depart from the statutorily prescribed norm.

ARGUMENT

I. THE RULE IS ARBITRARY AND CAPRICIOUS

A. HHS's Justification Is Unsatisfactory, Unpersuasive, and Unsubstantiated

1. HHS's Position that Requiring Separate Transactions "*Better Aligns*" with Section 1303 is Not an Adequate Explanation

HHS claims that its new interpretation of Section 1303 "better aligns" with "a policy choice made by Congress." Defs. Opp'n at 24. This justification continues to be unpersuasive and insufficient. Agency action must be "the product of reasoned decisionmaking." *Motor Vehicle Mfrs. Ass'n of U.S., Inc. v. State Farm Mut. Auto. Ins.*, 463 U.S. 29, 52 (1983). And while an agency may revoke prior policy, its action must be "supported by the record and reasonably explained." *Id.* at 51-52. "One aspect of that explanation would be a justification for rescinding the regulation before engaging in a search for further evidence." *Id.* at 52. Beyond quoting the statute's requirement to "collect…a separate payment," HHS does not—and cannot—point to anything that explains *why* or *how* the administrative record supports its new interpretation.

To survive arbitrary-and-capricious review, HHS asserts it "need only 'analyze or explain why the statute *should be interpreted*' as the agency proposes." Defs. Opp'n at 24 (emphasis added) (citing *Encino Motorcars*, 136 S. Ct. at 2127). The Rule's preamble, HHS claims, sufficiently explained its belief that the prior rule did "not adequately reflect Congress' intent." Defs. Opp'n at 24 (citing 84 Fed. Reg. 71,674 at 71,684 (Dec. 27, 2019)). HHS states "it was obliged to determine *how* to require collection of separate payments in distinct transactions, rather than whether to do so at all." *Id.* (emphasis in original). But such a bare-bones re-statement of HHS's position—that it believes separate transactions to be a better interpretation of Congress' intent—cannot also be the explanation for why Section 1303 *should be interpreted* that way. Such circular logic is precisely the sort of reasoning that *Encino Motorcars* held was an insufficient "good reason" for a new policy. 136 S. Ct. at 2127.

In *Encino Motorcars*, the Supreme Court considered the Department of Labor's re-interpretation of the Fair Labor Standards Act's overtime requirements. 136 S. Ct. 2117. The Court found that the "Department said almost nothing" to explain the basis for the new policy, except that it "believes that [its] interpretation is reasonable and sets forth the appropriate approach." *Id.* Even after recognizing that the Department had previously implemented a comparable statutory interpretation and there were corresponding congressional amendments to the Act, the Court held the agency's reversal "fell short of the agency's duty to explain *why* it deemed it necessary to overrule its previous position." *Id.* at 2126 (emphasis added).

The Supreme Court also found the public's reliance on the Department's prior position significant to its analysis. *Id.* Here, issuers, states, and consumers have come to rely on the HHS's prior position—a position that mirrors standard health insurance industry practice—to furnish a single bill for all enrollees which includes all benefits integrated in the policy and a single transaction is used to pay that bill in full (while the separate payments for the abortion coverage are segregated by the issuer upon receipt). Indeed, as the Supreme Court acknowledged in *Encino Motorcars*, even if the new policy was a previously permissible regulatory scheme, the agency is *still* required to explain why the statute should now be interpreted as the agency proposes. 136 S. Ct. 2117. HHS fails this threshold requirement. HHS does not, identify anything in the record that explains why it sought to change course or why the statute should now be interpreted to require billing through separate transactions. Whatever reasons HHS has for asserting "that it was obliged to determine *how* to require collection of separate payments in distinct transactions," neither the Rule, nor the record sufficiently explains those reasons. Defs. Opp'n at 24 (emphasis in original). HHS cannot, without justification, arbitrarily decide to change regulations that carry the force of law, only Congress can do that. *Encino Motorcars*, 136 S. Ct. 2117 (finding that where the agency has failed to provide even a minimal level of analysis, its action is arbitrary and capricious and cannot carry the force of law).

2. The Use of Separate Transactions to Promote Compliance is Implausible

According to HHS, requiring separate billing transactions is its statutory obligation. HHS argues that the States "miss the mark" in claiming the agency lacked good reasons for promulgating the Rule because any objections to its interpretation "should be taken up with Congress." Defs. Mot. at 25. HHS essentially takes the remarkable position that the Rule "is not subject to arbitrary and capricious review" because Section 1303 *mandates* the "distinct requirement of a separate payment" which delegates to HHS the authority to issue the Rule as a matter of course—without any judicial review. *Id.* at 25-26.

As a threshold matter, HHS undercuts its own argument because it takes both the position that Section 1303 is unambiguous, such that the "separate payment" statutory language *mandates* its new requirement of separate transactions, *id.*, while its principal argument is that Section 1303 is ambiguous and HHS is entitled to *Chevron* deference, Defs. Opp'n at 8 (citing *Chevron, U.S.A., Inc. v. Natural Res. Def. Council*, 467 U.S. 837, 842-45 (1984)). These are contradictory positions, and both are wrong. *See, infra*, *Section II* (discussing that the Rule is also an impermissible and unreasonable statutory construction).

There are two problems with HHS's assertion that Section 1303 mandates separate transactions. First, even if the Rule were a permissible construction of the statute, which it is not, the APA requires an administrative agency to justify its actions and substantiate its explanation in the record. *State Farm*, 463 U.S. 29 at 51-52. Instead, HHS only provides circular reasoning. Second, accepting HHS's new position would require this Court to find that all issuers and states subject to Section 1303 have been noncompliant since its enactment. Such a conclusion would be unreasonable given that HHS's previous guidance allowed for single itemized billing, and even the Rule ratifies this practice.

a. HHS's Justification for the Rule is Circular and Unwarranted

HHS insists that the Court's review should be limited to whether HHS "justified the use of separate bills to promote compliance" with its new statutory interpretation that Section 1303 mandates billing through separate transactions. Defs. Opp'n at 25. Such flawed reasoning puts

the cart before the horse. When an agency departs from a prior regulatory scheme, "good reasons" must be the driving force for the new policy, the new rule cannot also be the reason. *See, e.g., Encino Motorcars*, 136 S. Ct. at 2126. Moreover, HHS's argument would require the Court to assume that there is a need to "promote compliance." However, HHS does not identify anything in the record indicating noncompliance is either likely or occurring. To the contrary, the record amply demonstrates that segregation of payments was fully compliant with Section 1303 already. *See* American Public Health Association Comment, AR 80207; Covered California Comment, AR 078651; California Department of Insurance Comment, AR 072862; Center on Budget and Policy Priorities Comment, AR 81218.

Moreover, while HHS states that the Rule "makes it more likely that issuers will comply with the additional requirement in Section 1303(b)(2)(B)(ii) that [issuers] maintain separate allocation accounts to keep payments for [abortion] coverage… segregated from payments for coverage of all other services," HHS fails to explain *how* this would result. Defs. Opp'n at 10. Requiring billing through separate transactions does nothing to affect what happens to the payment once it is collected. And the Rule does not in itself guarantee that payments are deposited in the correct account nor does it implicate at all from which account abortion services are paid. In fact, by requiring separate transactions, the Rule makes it *less* likely that separate payments will be collected because of consumer confusion and error. This is especially so, after requiring only one transaction in the normal course, and having "consumers [become] accustomed to receiving and paying bills in total amounts, even when the bill includes charges for a variety of items." *See* Pls. Mot. for Summ. J. (hereinafter Pls. Mot.) at 20; *see also* Pls. Compl. ¶ 116, ECF No.1.[1] Finally, as explained in the States' motion, Pls. Mot. at 25, the Rule itself requires insurers to accept separate payments in one transaction.

[1] HHS contradicts itself on this very point. HHS indicated in the proposed rule that sending two separate bills will reduce consumer confusion because "consumers may inadvertently miss or discard a second paper bill included in a single envelope," 83 Fed. Reg. 56015, at 56023 (Nov. 09, 2018), only to later claim in the final Rule, that it "believe[s] policy holders are more likely to make a separate payment…when they receive a separate bill for such amount, and that receiving the separate bill in a separate communication further bolsters that likelihood." 84 Fed. Reg. 71,685.

Fundamentally, HHS misidentifies and misconstrues the purpose of Section 1303. Section 1303 ensures that issuers maintain federal funds separate from those used to pay for abortion services. HHS misunderstands the States' position in suggesting the opening brief "assumes away" Section 1303's call for a "separate payment." Defs. Mot. at 25-26. The States do not make such assumption—they specifically acknowledge that the statute calls for a "separate payment" attributable to abortion coverage. In fact, the States contextualized the argument by explaining that "Congress' use of the 'separate payment' in the text of the statute is intended to make clear that the funds must be segregated by the issuer upon receipt." Pls. Mot. at 35. The States' position is explicit; "requiring two separate transactions is not a permissible application of the statute" because "the import of Section 1303 is [about] how federal funds are separately maintained and how they are ultimately *spent*," not the method by which funds are collected. *Id.* at 34-35 (emphasis in original).

b. HHS's Logic Supports the Current Single-Billing Scheme

HHS's justification for requiring issuers to accept single payment transactions while also claiming the statute "mandates" separate transactions, is unpersuasive. *See* Defs. Opp'n at 27, 29-30. Indeed, HHS's justifications demonstrate that the Rule's separate transaction requirement is structurally flawed because it fails to achieve HHS's purported goal. HHS claims that its decision to not reject a single payment transaction under the Rule is not irrational because Section 1303 does not require a policy to be terminated when consumers pay in a single transaction. Defs. Opp'n at 29. Nor do the States believe that this would be a reasonable construction. Congress would not have created an arbitrary scheme where consumers could inadvertently lose coverage from missing a $1 payment. Indeed, this proves the States' point—a separate transactions requirement is not a reasonable reading of Section 1303.

HHS relies on *Rodriguez v. United States* to justify its choice, arguing that HHS need not impose rigid consequences to prove that the Rule is rational since "no legislation pursues its purposes at all costs." *Id.* at 29 (modifications omitted) (citing *Rodriguez*, 480 U.S. 522, 525-26 (1987)). In *Rodriguez*, the Supreme Court held that courts cannot rely on the broad purposes of a statute, where the statutory language "is sufficiently clear in its context and not at odds with the

legislative history." *Rodriguez v. United States*, 480 U.S. 522, 526 (1987). The Supreme Court reasoned that, while statutory construction allows consideration of the purpose and the legislative history of a statute, "[d]eciding what competing values will or will not be sacrificed to the achievement of a particular objective is the very essence of legislative choice—and it frustrates rather than effectuates legislative intent simplistically to assume that *whatever* furthers the statute's primary objective must be the law." *Id.* at 525–26 (emphasis in original). Under *Rodriguez*, where the statute is clear, courts are bound by its plain language.

HHS's simple declaration of a court's authority to review agency action does not assist HHS here. Indeed, HHS's contradictory positions undercut its own reliance on *Rodriguez*. First, HHS insists it was obliged to issue the Rule, requiring issuers to send separate bills and enrollees to make separate payments, because it believes Section 1303 *mandates* such separate transactions, Defs. Opp'n at 24. At the same time, HHS concedes that "Section 1303 speaks to []issuers, requiring them to 'collect…a separate payment'; it does not separately address enrollees at all." *Id.* at 29. This concession vitiates HHS's assertion that the plain statutory text of Section 1303 mandate's the Rule's requirement that consumers must also send separate payments in separate transactions. HHS cannot have it both ways.

Second, HHS admits that Section 1303 does not "dictate any particular penalty for issuers that fail to collect a separate payment"… or "enrollees who cause that failure by remitting a single payment for the entire premium." *Id.* HHS claims that because Section 1303 is "silent" on penalties, it has "discretion to determine that []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." *Id.* (emphasis added). But this is at odds with HHS's position that it has *no discretion* since the plain statutory text of Section 1303 "mandates" the new Rule's requirements for billing through separate transactions, such that issuers *do not satisfy* their statutory obligation by adhering to the current regulatory scheme. *Id.* To the contrary, Section 1303's lack of any such penalty is further evidence that the statute *does not* mandate a separate billing requirement. HHS's arguments demonstrate that

making both payments in a single transaction is logical and a common-sense billing practice that preserves health insurance coverage. Yet again, HHS tries to have it both ways.

In the end, consumers and issuers are led back to the current regulatory scheme, which allows consumers to make single transactions of the separate payments and maintains Section 1303's primary obligation that issuers deposit the payments in separate accounts. As stated previously, the Rule "adds financial and administrative burdens on issuers and consumers without necessarily achieving a different result." Pls. Mot. at 26.

3. The Rule is Not Supported by the Administrative Record

The Rule's separate billing requirement is unsupported by the record and therefore arbitrary. *State Farm*, 463 U.S. at 43 (requiring a "rational connection between the facts found and the choice made"). The record extensively documents the Rule's harm and supports the States' assertions that such costly agency decisions, in resources and health risks, is unreasonable.

HHS disputes that it ignored the exorbitantly high cost of implementing the Rule because it made efforts to minimize them. However, this cannot be attributed to HHS's reasoned decision-making. Any effort to "minimize" costs came only after thousands of commenters pointed out the wholly inadequate cost-benefit analysis of HHS's notice of proposed rulemaking. *See* Pls. Mot. at 10, 19. HHS's carelessness in grossly underestimating costs in the Proposed Rule cannot save the final Rule. *See* Pls. Mot. at 19-21. Indeed, HHS's final analysis reflected unreasonable costs *even after* the agency modified the Proposed Rule's provisions. Even though withdrawing the requirement for separate envelopes with separate postage from the final Rule saved issuers an estimated $15.6 to $31.2 million annually, the Rule's requirement for billing through separate transactions still costs consumers, states, and issuers upwards of one billion dollars. *See* 84 Fed. Reg. 71,697; 83 Fed. Reg. 56,015 at 56,030-31; Pls. Mot. at 20.

And it is unclear what exactly HHS assumes the Rule *will* save. While HHS walked back its too rosy preliminary analysis to more accurately reflect the Rule's true costs, it is a feigned attempt at the transparency and accountability required by the APA. It simply cannot be sufficient that an agency may notice a rule that proposes so expensive a regulatory change that any slight modifications to the rule's final iteration of its cost-benefit analysis automatically

makes the regulatory decision more reasonable. Indeed, "[w]hen the agency reexamines its findings…it must also reconsider its judgment of the *reasonableness* of the monetary and other costs associated" with the promulgating the regulatory change. *State Farm*, 463 U.S. at 55 (emphasis added). Here, HHS "should bear in mind [what] Congress intended" as the "preeminent factor" of the law in question. *Id*.

HHS has acted arbitrarily and capriciously because it does not meaningful address *why* separate billing is so problematic and contrary to congressional intent. First, contrary to one of the cornerstones of the ACA—to expand and minimize the costs of providing health insurance coverage—the Rule's egregious implementation and on-going costs does precisely the opposite, it makes coverage more expensive and subject to loss over a $1 charge. Second, the ACA also sought to reduce unnecessary regulatory barriers that impede access to care. 42 U.S.C. § 18114. And Section 1303 represented a compromise between these two goals. Although it prohibited the use of federal Exchange subsidies, to pay for abortion coverage and services, it allowed the use of subsidies to offset health insurance costs, thereby making care more accessible. Pls. Mot. at 4.

Instead, HHS states that "the costs of the Rule are inherent in any method of requiring separate payments." Defs. Opp'n at 26. This unresponsive disregard for the concerns of the public advocates, state agencies, Exchanges, and industry groups is capricious agency action. *See* Pls. Mot. at 7-11. HHS ignores the personal administrative expense for consumers, stating that costs are unavoidable in any method of collecting separate payments. Defs. Opp'n at 26. HHS similarly disregards the high costs associated with the risk of loss of coverage under the Rule, and merely nods to the concerns raised by commenters but does not meaningfully grapple with the problems of policy termination, increased out-of-pocket costs, and barriers to healthcare. Pls. Mot. at 23-25; *see also Gresham v. Azar*, 950 F.3d 93, 103 (D.C. Cir. 2020) ("[n]odding to concerns raised by commenters only to dismiss them in a conclusory manner is not a hallmark of reasoned decisionmaking.").

Even assuming that HHS's Rule is a permissible statutory interpretation, such an excessively expensive policy change, coupled with its significant and potentially irreversible harms—to women's reproductive health, uninsured rates, uncompensated care costs, or the public

health fiscs—is not a *reasonable* agency decision. The Rule's unreasonableness is reinforced by HHS's inability to show any real need for the change or dispute or any noncompliance with Section 1303. Pls. Mot. at 14-17. HHS is not only in search of a problem where none exists, but its reckless rule change creates many.

B. HHS's Decision to Implement the Rule Mid-Plan Year is Arbitrary

Requiring that the Rule be implemented during the middle of a plan year is an arbitrary decision. HHS's sole justification is that it is reasonable to expect prompt compliance with a regulation. Defs. Opp'n at 30. But this rests on the premise that it was reasonable for HHS to conclude that—in spite of the excessive implementation costs—six months is sufficient time for issuers, Exchanges, and state regulators to comply with the Rule in the first place. Rather than provide a justification supported by evidence in the record, tailored to the particulars of this situation, HHS sidesteps. The Rule presupposes a reason for implementation during the plan year—a reason that HHS never provides. However, based on the record of anticipated harms, mid-year implementation is unreasonable when issuers and states are at their busiest, negotiating health plan changes, new contracts, and preparing for their open enrollment periods. HHS states that it will accommodate "entities that work in good faith to achieve compliance" and cannot do so "for reasons beyond their control." *Id.* It is unclear exactly what constitutes "good faith compliance" sufficient for HHS to grant States compliance extensions; HHS has provided no guidance. An agency cannot excuse an arbitrary timeline by vaguely claiming it will accommodate noncompliance. *State Farm*, 463 U.S. at 43 (agency must establish a "rational connection between the facts found and the choice made."). Absent a reason that justifies urgency, mandating mid-year implementation is unreasonable.

Further, this "accommodation" does not justify or relieve the increase in expense caused by the unnecessary mid-plan effective date of June 27, 2020. HHS admits that its expedited implementation increases costs for issuers by *50 percent*. 84 Fed. Reg. 71,697. This incredible burden will similarly be borne by the States that will engage resources to set in motion regulatory processes and technical system changes. For the States, these costs drain significant and finite resources, in time and money, and are an obstacle to any "good faith" compliance efforts which

may grant a state an extension. *See e.g.*, Defs. Opp'n at 31. HHS wants the Court to believe that enforcement, though burdensome and costly, will be imposed with leniency. *See* Defs. Opp'n at 30. But such high costs demonstrate that delayed enforcement is either illusory, or not "reasonable mitigation." HHS argues that it fully considered the costs of the implementation timeline and decided that the need for prompt statutory compliance justified the costs. Defs. Opp'n at 31. HHS has never shown that statutory compliance was lacking. To the contrary, the evidence before the agency demonstrated that insurers are in full compliance with Section 1303.

And HHS's conclusion that, "[it] believe[s] six months is sufficient…to implement the administrative and operational changes to billing processes necessary to comply," 84 Fed. Reg. 71,689, is unsupported by the record and arbitrary. In *Gresham v. Azar*, the court held that HHS's conclusory statements failed to consider a key aspect of the problem—loss of coverage—resulting in an arbitrary agency decision. *Gresham v. Azar*, 950 F.3d 93, 103-104 (D.C. Cir. 2020). The court suggested that the agency's decision to overlook the Medicaid statute's primary purpose, to provide health care coverage, compounded its arbitrariness. *Id.* Here, HHS disputes the application of *Gresham*, arguing that administrative costs are unrelated to Section 1303's objective. Defs. Opp'n at 31. However, the purpose of Section 1303 was to facilitate the expansion of access to health insurance for eligible individuals. In fact, Section 1303, 42 U.S.C. § 18023, is couched under the law's Subchapter III, entitled "Available Coverage Choices for All Americans." Overlooking the costs for mid-year plan implementation ignores the risk that issuers may drop abortion coverage from qualified health plans, or that inadvertent coverage terminations will leave consumers without coverage. The choice is patently arbitrary.

C. Implementing the Rule During the COVID-19 Pandemic Is Irresponsible

While the States acknowledge that the 2019 novel coronavirus (COVID-19)'s pandemic burdens were not before HHS during creation of the Rule, HHS's insistence on implementation of the Rule during a pandemic is arbitrary, capricious, and irresponsible. This public health emergency requires a concerted effort by the States' health departments and other agencies to focus on broadening the delivery of public health services, guaranteeing the public is insured, and addressing the concomitant harms of this unprecedented pandemic. In raising the serious

concerns and the additional impediments it places on implementation, as well as the forthcoming increase in premiums resulting from expenses deployed to combating the pandemic, the States aim to provide situational context for the Court.

While HHS declares that the agency "will formally delay the Rule's implementation date well in advance of June 27, 2020," Defs. Opp'n at 32, HHS has only just this week informed Exchanges and issuers of the forthcoming change. *See* 45 C.F.R. Part 156, RIN 0938-AU32 (posted for public inspection May 1, 2020, to be published on May 08, 2020).[2] And HHS's delay of the Rule's effective date by a mere 60 days in light of COVID-19 is insufficient, and demonstrates the agency's unrealistic expectations, or—more alarming—its failure to understand all that is required to implement such a significant regulatory change.

Regardless, HHS failed to take a formal position on its reasonable mitigation efforts in an official action in any reasonable amount of time. As recently as April 7, Plaintiff States California, New York, Colorado, Maryland, Oregon, Vermont, and the District of Columbia wrote a letter to HHS's Secretary demanding he halt implementation of the Rule to allow the States' insurance and healthcare agencies to prioritize mission-critical work during this pandemic, and yet HHS has failed to even respond to the letter.[3],[4]

In any event, delayed implementation of the Rule by a mere 60 days, Defs. Opp'n at 32, is hardly sufficient to accommodate the now seven weeks' long COVID-19 national emergency, which is expected to continue in the fall,[5] and further shows that the implementation date can be delayed and is thus arbitrarily assigned; there is no urgency for implementation.

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[2] Available at https://s3.amazonaws.com/public-inspection.federalregister.gov/2020-09608.pdf.

[3] Available at https://www.oag.ca.gov/system/files/attachments/press-docs/4.7.2020%20-%20Letter%20to%20HHS%20re%20Section%201303%20_%20COVID-19.pdf; *See* https://www.whitehouse.gov/wp-content/uploads/2020/03/M-20-16.pdf.

[4] Notably, CMS delayed portions of its Interoperability and Patient Access final rule in light of COVID-19, https://www.cms.gov/Regulations-and-Guidance/Guidance/Interoperability/index; and the Food and Drug Administration recently requested and obtained court approval to delay its requirement to conduct a premarket review of certain e-cigarette, cigar and other deemed new tobacco products by 120 days, "solely as a result of the pandemic and these exceptional and unforeseen circumstances," available at https://tinyurl.com/Court-Grants-FDA-Exten-COVID19.

[5] *See* https://www.whitehouse.gov/presidential-actions/proclamation-declaring-national-emergency-concerning-novel-coronavirus-disease-covid-19-outbreak/ (March 13, 2020

(continued…)

D. An Arbitrary Rule Is Unlawful and Not Entitled to *Chevron* Deference

As discussed, the Rule is a product of arbitrary and capricious agency action because it is not "reasoned decisionmaking." *State Farm*, 463 U.S. at 52. Rulemaking requires that agencies "examine the relevant data and articulate a satisfactory explanation for its action including a rational connection between the facts found and the choice made." *Id.* at 43. When an agency departs from prior policy, as HHS has done here, it must "show that there are good reasons for the new policy." *Encino Motorcars*, 136 S. Ct. at 2126. Failure to satisfy these threshold requirements makes a regulation arbitrary and capricious, and such unlawful regulations receive no *Chevron* deference. *Id.*; *see also Altera Corp. & Subsidiaries v. Comm'r of Internal Revenue*, 941 F.3d 1200, 1210 (9th Cir. 2019) ("Chevron deference is not warranted where the regulation is 'procedurally defective'"); *Gomez-Sanchez v. Sessions*, 892 F.3d 985, 995 (9th Cir. 2018) (same).

Here, HHS's statutory interpretation imposes a statutory construction inapposite with prior regulations.[6] Pls. Mot. at 6. HHS fails to provide a satisfactory explanation for the Rule's promulgation and that *good reasons* exist for its new interpretation—*Chevron* deference is thus not applicable. Besides, the *Chevron* deference demanded by HHS undermines the judiciary's ability to perform its democratic function on the other branches. *See Baldwin v. United States*, 140 S. Ct. 690, 692 (2020) (Thomas, J., dissenting from denial of cert) ("When the Executive is free to dictate the outcome of cases through erroneous interpretations, the courts cannot check the Executive by applying the correct interpretation of the law.").

II. THE RULE IS CONTRARY TO THE ACA

The Rule is contrary to the text and purpose of the ACA, which sought to expand coverage in the individual health insurance market by instituting key insurance reforms. Specifically, the Rule is in direct contravention of Section 1303, because it breaches the statute's prohibition on

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declaration of a national emergency); *see* https://www.washingtonpost.com/health/2020/04/21/coronavirus-secondwave-cdcdirector/.

[6] *See* 2015 prior guidance, 80 Fed. Reg. 10,750 at 10,840 (Feb. 27, 2015); *also* 2017 CMS bulleting confirming the alternatives. Centers for Medicare and Medicaid Services, *CMS Bulletin Addressing Enforcement of Section 1303 of the Patient Protection and Affordable Care Act* (Oct. 06, 2017), https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Section-1303-Bulletin-10-6-2017-FINAL-508.pdf.

specifying and separating abortion coverage from total health premiums, it exceeds the statue's limitation on notice, and impermissibly allows issuers to abdicate from their statutory duty to collect payment for abortion coverage. In addition, the Rule violates Sections 1554 and 1557, which aim to facilitate and safeguard parity in healthcare, because the Rule imposes unnecessary barriers to care, both access to health insurance generally, and specifically women's access to abortion. Generally, when analyzing the legality of agency action, courts apply the two-step *Chevron* framework. *Chevron,* 467 U.S. at 842-45. Under *Chevron*, courts consider whether the statute is ambiguous and, if so, whether the agency's interpretation is reasonable, or permissible under the statute. *Id*. at 842-43. The framework rests on ambiguity constituting an implicit delegation of authority from Congress to the agency, allowing it to fill in the gaps. *F.D.A. v. Brown & Williamson Tobacco Corp.*, 529 U.S. 120, 159 (2000). But that analysis is unnecessary here, where the statutory language is plain and unambiguous, the inquiry ends and courts must enforce the statute according to the statutory terms. *Chevron*, 467 U.S. at 842.

A. The Rule is Contrary to the Plain Language of Section 1303

1. Section 1303 Requires Issuers to Collect Separate Payments, Not the Separate Collection of Payments

The text of Section 1303 is unambiguous and must be read as enacted by Congress. The statute plainly states that issuers "shall *collect…a separate* payment" for abortion coverage, not the inverse, i.e. that issuers shall *separately collect* payments. § 18023(b)(2)(B)(i). The order of words matters because, contrary to HHS's position, Congress was not concerned with consumers separately paying two portions of their health insurance premium through individually different transactions, but rather that the separate amounts required by Section 1303 be appropriately accounted for. The States are not "cherry-picking statutory language," but reading the plain language of the text. *See BP Am. Prod. Co. v. Burton*, 549 U.S. 84, 91 (2006) ("Statutory terms are generally interpreted in accordance with their ordinary meaning."). HHS's interpretation, on the other hand, Defs. Opp'n at 9, would result in the Court reading words into the statute. HHS asks that the Court construe the statute to require separate collections, not separate payments. The States further note that Section 1303 requires a collection from "each enrollee"—a portion of

the statute that HHS elides completely. § 18023(b)(2)(B)(i). HHS's separate payment interpretation would seem to require separate transactions from each enrollee, yet it does not. In short, it is HHS that cherry-picks the statue, and this Court need go no further than the plain language of the statute to conclude that Congress did not *unambiguously mandate* separate billing transactions in Section 1303. *Chevron*, 467 U.S. at 842-43; States' Mot. at 14-17.

2. The Rule is Contrary to Section 1303's "Rules Relating to Notice"

a. Abortion Cannot be Separated from the Total Health Premium

HHS's Rule further violates the requirement that notice regarding payments provide information only with respect to the total amount of the combined payments. HHS responds that Section 1303 does not speak to *bills* sent to enrollees, because it is under the title "Rules relating to notice" subsection, § 1303(b)(3). Still, its companion provision, § 1303(b)(3)(B), limits how billing can be conducted. Section 1303(b)(3)(B) is titled, "Rules relating to *payments*" and reads:

> The notice described in subparagraph (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 *shall provide information only with respect to the total amount of the combined payments* for services *described in paragraph (1)(B)(i)* and other services covered by the plan.

§ 18023(b)(3)(B) (emphasis added).

This subsection *unambiguously* refers to the payments required to be collected under § 18023(b)(2)(B)(i). The text plainly identifies "payments for services described in paragraph (1)(B)(i)"—which addresses "abortions for which public funding is prohibited." *Id.* This means that bills regarding "abortion for which public funding is prohibited" can only bill "the *total amount* of the combined payments." *Id.* Here, Congress has spoken to the "precise question at issue," *Chevron*, 467 U.S. at 842-43, and made clear its intent to prohibit the separation of abortion cost from the total health premium. Not only is this explicitly stated in the text of Section 1303, but it also follows common sense; a bill is a notice to consumers, notifying them of a charge required to be paid. *See also* Pls. Mot. at 27.

While Congress did not specify the method of complying with Section 1303, it was explicit about what it intended to *prohibit.* HHS struggles and fails to reconcile § 1303(b)(2)(B),

requiring the collection of separate payments, and § 1303(b)(3)(B), prohibiting the separation of coverage costs. In its view, it would be irrational for Congress to require issuers to conduct billing in separate transactions, and at the same time forbid them, under the notice subsections, from sending bills that separate the costs to collect such payments. Defs. Opp'n at 12. However, that only underscores the States' position: the text of Section 1303 is intended to direct issuers to segregate the funds for abortion coverage on the back end, once premiums are collected.

As the States made clear, the statute requires separate payments, but it *does not* require that these be made through separate transactions. Pls. Mot. at 34-35. Under this reading, Section 1303's provisions operate seamlessly: Congress required issuers to collect a separate amount for abortion coverage but required that bills sent to collect payment of the benefits only identify the total amount of the premium. HHS concedes the previous rules do not violate Section 1303, 84 Fed. Reg. 71,694, and they allow issuers either to send separate bills or single bills indicating that an amount to cover segregated services are also included. Defs. Opp'n at 13. The States note that the 2015 regulations are not at issue before this Court. It is the States' construction that comports with both the requirement for payments, § 1303(b)(2)(B), and the total amount limitation, § 1303(b)(3)(B), because whether in separate bills or in single bills, the language separately identifying coverage of abortion services simply indicates it is required by federal law or regulation. This comports with industry practice, where consumers purchase a *package* of medical benefits set at a fixed premium rate, which ensures health coverage markets work efficiently and are affordable for all. *See* Pls. Mot. at 20-21; AHIP Comment, AR 80207.

b. Abortion Must be Part of the Summary of Benefits Notice

The Rule is similarly contrary to the statute's notice limitation, because although HHS disagrees, "bills or invoices" *are* notices to consumers. Defs. Opp'n at 12. Defendants argue that because Section 1303 does not define notice, HHS has the authority to define it under § 1303(b)(3)(B) ("any other information specified by the Secretary"). *Id.* This has no merit.

While Section 1303 does not define the word *notice*, it need not—it is accepted industry practice (and common sense business practice) that bills or invoices serve as notices to consumers about what services they have agreed to pay for, what is owed, or what labor has been performed.

The term "invoice" itself stems from sixteenth-century old-French related to the word "envois," or "envoyer," similar to an envoy, and which literally means "message."[7] *Pacific Coast Federation of Fishermen's Associations v. Glaser*, 945 F.3d 1076, 1084 (9th Cir. 2019) (statutory construction uses the "ordinary, contemporary, and common meaning" of the text).

Moreover, HHS does not refute the plain language of the statute. Section § 1303(b)(3), titled "Rules relating to notice," contains a specific provision, § 1303(b)(3)(A), that clearly limits "Notice" given and reads as follows:

> A qualified health plan that provides for coverage of the services described in paragraph (1)(B)(i) shall provide a notice to enrollees, *only as part of the summary of benefits and coverage explanation*, at the time of enrollment, of such coverage.

§ 18023(b)(3)(A) (emphasis added).

This subsection requires that any such notice be provided only as part of the *coverage explanation,* which is typically at the time of enrollment. Similar to § 1303(b)(3)(B), this subsection limits HHS's ability to isolate the explanation of abortion coverage, (1)(B)(i), from the explanation of the entire package of benefits included in the health policy. Again, the text is plain and requires notice of benefits to be presented as a *summary* of the coverage. In other words, the discussion of health benefits in the policy must be comprehensive and complete, and not separate out abortion coverage from the packaged benefits. *See BP Am. Prod. Co.,* 549 U.S. at 91 ("Statutory terms are generally interpreted in accordance with their ordinary meaning.").

As discussed above, sending separate bills (an option made available under HHS's initial rulemaking of 2015) that do not distinctly dissociate coverage amounts are permissible under Section 1303. However, as currently promulgated, HHS's separate billing requirement under this Rule is contrary to law because it requires issuers to provide notice of abortion coverage in a manner not permitted by the statute. The Rule itself requires issuers to isolate abortion coverage, by "instruct[ing] policy holders to pay" their coverage benefits individually, not as a comprehensive benefits package. § 156.280(e)(2)(B); 84 Fed. Reg. at 71,711.

[7] "Invoice." *Merriam-Webster.com Dictionary*, Merriam-Webster, https://www.merriam-webster.com/dictionary/invoice. Accessed 28 Apr. 2020.

3. HHS's Opt-Out Policy Violates Section 1303's Mandate that Issuers Provide the Coverage Offered and Collect the Premium for Cost of Abortion Coverage When Included in the Plan

HHS argues that its decision to include the new opt-out policy in the Rule is foreclosed from judicial review under *Heckler v. Chaney*, 470 U.S. 821 (1985). HHS is incorrect. HHS does not have the authority to codify a nonenforcement policy through a regulation.

In *Chaney*, the plaintiffs sued the Food & Drug Administration to enforce a statute. *Chaney* concerns the Executive branch's discretion to exercise its enforcement powers over individual legal violations, based on the particular factual circumstances surrounding each violation. *See Chaney*, 470 U.S. at 831–33. The Supreme Court reasoned that agency action is committed to agency discretion by law, where a statute is so broadly drawn that a court would have no meaningful standard against which to judge the agency's exercise of discretion, and the decision is presumptively non-reviewable. *Id.* at 821 (citing § 701(a)(2)).

But *Chaney* does not stand for the proposition that nonenforcement decisions are unreviewable when agencies promulgate nonenforcement policies in a published regulation. *See Chaney*, 470 U.S. at 839 ("the Court properly does not decide today that nonenforcement decisions are unreviewable in cases where… an agency engages in a pattern of nonenforcement of clear statutory language") (Brennan, J., concurring). Rather, *Chaney* held that "Congress did not set agencies free to disregard legislative direction in the statutory scheme that the agency administers," *id.* at 833, and that it was not addressing reviewability of an agency decision to "'consciously and expressly adopt[] a general policy' that is so extreme as to amount to an abdication of its statutory responsibilities," *id.* at 833 n.4.

As this Court has the authority to review all aspects of the Rule, including the procedures used to promulgate it, the Court should find the opt-out policy invalid, both procedurally and substantively. First, the States were denied the opportunity to comment on the policy because the agency did not include it in the Proposed Rule. Nor is the opt-out policy a logical outgrowth of the Proposed Rule. The States address this more fully below. *See Section IV.A-B*. HHS tacitly concedes this by laying out its only defense—lack of judicial reviewability.

Second, substantively, the opt-out policy is not a valid use of the agency's regulatory authority. HHS does not have the authority to use its enforcement discretion to allow for the alteration of the coverage terms of a qualified health plan during the plan year. Congress authorized HHS to enforce Section 1303's provisions, not to promulgate rules contrary to its express purpose. By its express terms, Section 1303 provides states the right to elect to include or prohibit abortion coverage in qualified health plans. 42 U.S.C. § 18023(a). Once that determination is made and a health plan is issued, the coverage terms are effective for the plan year. And in states that require the inclusion of such coverage, Section 1303 expressly does not interfere. 42 U.S.C. § 18023(c)(1). Accordingly, Section 1303 requires that policyholders pay the issuer for the abortion coverage included in the qualified health plan. § 18023(b)(2)(B)(i) ("the issuer of the plan *shall* collect from each enrollee").

Therefore, if abortion is a covered benefit under the terms of the health plan, issuers must, under Section 1303, collect payment for that coverage benefit. *See Serv. Employees Int'l Union v. United States*, 598 F.3d 1110, 1113 (9th Cir. 2010) ("This language does not confer on the agency discretion to decide… [t]he word 'shall' is ordinarily [t]he language of command." (internal quotations omitted)). While HHS can, and has in this Rule, exercised enforcement discretion against issuers who do not place a policyholder in a grace period and do not terminate coverage based solely on the policyholder's failure to make payments for abortion coverage in separate transactions, *see* 84 Fed. Reg. 71,686, HHS has no authority under the guise of "enforcement discretion" to allow issuers to eliminate a health benefit for all enrollees in the plan.

Extraordinarily, HHS's position to the contrary renders Section 1303 null. Defs. Opp'n at 16. HHS inaccurately maintains that, once the policyholder elects not to pay the separate $1 amount for abortion coverage and the issuer eliminates such coverage from the specific health insurance policy's benefits package, the requirement to collect the payment under (b)(2)(B)(i) is no longer implicated. *Id*. This argument is meritless.

Because HHS purports to provide the ability for issuers to allow policyholders to opt out of the abortion coverage and *not enforce* the statute's requirement—as a matter of course—to collect the cost for that coverage, the Rule's opt-out policy constitutes an "abdication of its statutory

responsibilities." *NAACP. v. Sec'y. of HUD*, 817 F.2d 149, 158–59 (1st Cir. 1987) (holding that HUD's pattern of failing "affirmatively…to further" the Fair Housing Act was reviewable as an "abdication of [HUD's] statutory responsibilities") (quoting *Chaney*, 470 U.S. at 833 n.4)); *N. Ind. Pub. Serv. Co. v. FERC*, 782 F.2d 730, 745–46 (7th Cir. 1986) ("[W]e do not think that the Commission can essentially abandon its regulatory function…under the guise of unreviewable agency inaction."). As *Chaney* foretold, such a blanket nonenforcement contrary to clear statutory language is not unreviewable, 470 U.S. at 839—it is contrary to law.

4. The Rule is an Unreasonable Interpretation of Section 1303 and HHS Deserves No *Chevron* Deference

Even assuming that Section 1303 is ambiguous, the Rule is an unreasonable construction of the statute and is still not owed any *Chevron* deference. "Regardless of how serious the [purported] problem an administrative agency seeks to address, [], it may not exercise its authority 'in a manner that is inconsistent with the administrative structure that Congress enacted into law.'" *Brown & Williamson*, 529 U.S. at 125 (concluding that the FDA lacked authority to regulate certain tobacco products). Changing course from a previous regulatory scheme that afforded flexibility through a number of options for states and issuers comply, to a single method of compliance, is unreasonable. In addition, for all the reasons discussed in *Section I*, *supra*, the Rule is arbitrary and capricious and therefore unreasonable and invalid.

B. The Rule Violates Section 1554's Prohibition on Creating Barriers to Care

HHS maintains that in *California v. Azar*, the Ninth Circuit en banc panel found that Section 1554 is only meant to prevent "direct government interference with healthcare," namely by imposing "regulatory burdens on doctors and patients." Defs. Opp'n at 18; 950 F.3d 1067, 1094 (9th Cir. 2020). HHS argues that the Rule's separate billing requirements do not impose any barriers to care, since it does not directly address the provision of healthcare at all, "only the manner in which issuers bill certain services." Defs. Opp'n at 18. HHS is wrong.

The Rule not only impacts the manner in which issuers bill "certain services," the Rule changes the manner in which issuers bill for *health insurance*. HHS's choice in words is demonstrative of its failure to appreciate the foundational reformation of the ACA, and *why*

maintaining the state-and-federal balance was so critical. Section 1303 safeguarded the states' flexibility and sovereignty over its regulation of abortion care. As the Ninth Circuit found, the maintenance of state sovereignty over abortion was explicit, and Section 1303 "emphasized the ACA's neutrality regarding abortion issues." *California v. Azar*, 950 F.3d at 1095.

In "implementing the broad authority provided by the ACA" and its sweeping changes to come, preventing HHS from promulgating precisely this type of Rule was a hallmark of Section 1554 and Congressional intent. *Id.* at 1094 ("Congress showed its intent to ensure that certain interests of individuals and entities would be protected notwithstanding the broad scope of the ACA, and that such protections would supersede any other provision in the ACA 'in the event of a clash'") (internal citation omitted).

Moreover, a foundational aspect of healthcare access in this country is insurance coverage. As discussed in the States' motion, the ACA was enacted "to expand coverage in the individual health insurance market," and it adopted a series of reforms "primarily involving *insurance reform*." *Id.* at 1091 (citing *King v. Burwell*, 135 S. Ct. 2480, 2485-87 (2015), and *Nat'l Fed'n of Indep. Bus. v. Sebelius*, 567 U.S. 519, 538 (2012) (emphasis added)). It is unconscionable for HHS—the country's largest executive agency tasked with enforcing the landmark legislation that is the ACA—to suggest that insurance coverage "does not directly address" healthcare at all. It does. Expansion of health coverage was one of the ACA's principal goals.

HHS claims that accepting the States' position on Section 1554's applicability would render a series of regulations that "indirectly" lead to a reduction in coverage subject to Section 1554's purview. HHS overstates the States' argument and unreasonably simplifies the harms that flow from the Rule. The States are not arguing that "any regulation that could *potentially* raise health care costs or indirectly lead to a reduction in coverage…" is covered by Section 1554. Defs. Opp'n at 18-19. HHS *does* have the ability to impose requirements on issuers to document how they are complying with Section 1303(b)(2)(B), and currently already does. *See* § 18023(b)(2)(E) ("Ensuring compliance with segregation requirements," requires issuers to submit annual filings with respect to the "premium segregation plans"). But, imposing requirements that implicate continued coverage for healthcare consumers or the loss of a critical health benefit, constitutes a

"direct interference with certain health care activities," namely insurance coverage. *California v. Azar*, 950 F.3d at 1094. To be clear, HHS recognized that some patients will lose all their insurance coverage due to the Rule, incurring out-of-pocket costs and experiencing interruptions in their healthcare. 84 Fed. Reg. at 71,688. This interference with insurance coverage has a direct impact on doctors' ability to provide and charge for covered services, and patients' ability to obtain such services, either affordably or at all, resulting in harmful gaps in coverage. *See* Pls. Mot. at 8; ACOG Comment, AR 81311-81312; AG Multistate Comment, AR 78738-78739, 78745; NYSoH Comment, AR 81028; State of Washington Comment, AR 81040; APHA Comment, AR 81295-81296.

And, HHS itself has previously defined "health program or activity" as including "the provision or *administration* of health-related services or health-related *insurance coverage*."[8] *See* regulations implementing Section 1557 of the ACA, which prohibits discrimination on the basis of race, color, national origin, sex, age, or disability in certain health programs and activities, 81 Fed. Reg. 31376-31473 (May 18, 2016). Therefore, insurance coverage is not merely tangential to healthcare, it is part and parcel of the provision of health services. Because the Rule imposes such onerous requirements intended to create direct barriers to healthcare, HHS acted contrary to Section 1554. *See* Pls. Mot. at 24-25, 30 n.12.

C. The Rule is Contrary to Section 1557 Because the Rule Discriminates Against a Health Service Exclusively Sought by Women

HHS argues it does not discriminate against women, because it provided neutral and non-discriminatory reasons for the interpretive change in the Rule. Defs. Opp'n at 21. But HHS cannot claim ignorance to the discriminatory problem the Rule creates. First, HHS concedes that abortion services are sought exclusively by women. 84 Fed. Reg. 71,694 ("only women access [] abortion services.").[9] Second, HHS is aware of the serious health harms involved in its

[8] 81 Fed. Reg. 31376-31473 (May 18, 2016), "Nondiscrimination in Health Programs and Activities" Available at http://federalregister.gov/a/2016-11458. The proposed rule was published at 80 Fed. Reg. 54,172, at 54,174 (Sept. 8, 2015), http://www.gpo.gov/fdsys/pkg/FR-2015-09-08/pdf/2015-22043.pdf.

[9] Though the States' motion focuses on how the Rule targets women, the Rule also may affect (continued…)

rulemaking that are specific to women who will be unable to obtain time-sensitive abortion care. *See* Pls. Mot. at 23-25. In response to public comments, HHS states it understood that, "the combination of issuer burden and consumer confusion" could result in "reduction in the availability of [abortion] coverage…(either by issuers choosing to drop this coverage to avoid additional costs or by enrollees having their coverage terminated for failure to pay the second bill) thereby potentially increasing out-of-pocket costs for some women seeking those services." 84 Fed. Reg. 71, 694; *See* Pls. Mot. at 30. Despite the severe and adverse consequences to women, HHS decided to promulgate the final Rule.

Thus, the intention to discriminate is evident in the logic of HHS's provisions. If the Rule pressures issuers into eliminating abortion coverage from their plans, this result will deprive "only women" of an essential medical benefit—abortion services—that HHS acknowledges, "only women access." 84 Fed. Reg. 71,694.

HHS understood that in some states, like the several Plaintiff States, issuers are generally required to provide abortion coverage, such that an issuer's ability to even make use of the Rule's opt-out policy, is impossible. 84 Fed. Reg. at 71,686 ("We recognize 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."). Under the Rule, issuers are either forced to absorb the excessive costs of implementation or move their business to other states that allow (or even require) them to drop abortion coverage altogether. HHS's intention was clear in the preamble, that the opt-out policy "would result in the enrollees having a modified plan that does not cover…abortion services, meaning that they would no longer have an obligation to pay the required premium for such services." *Id.* To the extent state laws are frustrated, HHS said it "encourage[s] states and State Exchanges to take an enforcement approach that is consistent" with the Rule. *Id.*

As the Supreme Court held, discriminatory purpose, "implies more than intent as volition or intent as awareness of consequences" but it "implies that the decisionmaker…selected or reaffirmed a particular course of action at least in part 'because of,' not merely 'in spite of[]' its

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people who do not identify as women, including some gender non-confirming people and some transgender men.

adverse effects upon an identifiable group." *Bray v. Alexandria Women's Health Clinic*, 506 U.S. 263, 271-72 (1993) (citing *Pers. Adm'r of Massachusetts v. Feeney*, 442 U.S. 256, 279 (1979)).

The Rule does just that. It was issued to be effective in the middle of a plan year. It was issued despite significant risks for adverse health outcomes for women and massively expensive administrative hurdles. And it was issued without *any* justification supported by the record compelling its change in policy. HHS's decision is thus "unexplainable on grounds other than" its invidious discrimination against women's reproductive freedom. *Village of Arlington Heights v. Metropolitan Housing Development Corp.*, 429 U.S. 252, 266 (1977).

III. THE RULE IS AN IMPERMISSIBLE STATUTORY INTERPRETATION OF THE ACA

Even if HHS is entitled to deference—and it is not—the Rule still violates the APA because the agency's statutory interpretation is impermissible. The Rule exceeds its authority because is unreasonably ignores Congress' clear intent, embedded in Section 1303, to prohibit issuers from sending bills that separate the cost of abortion from the policy's total premium. In addition, the Rule is contrary to Congress' principal objectives in enacting the ACA, namely, to expand health coverage, minimize costs in the private health insurance market, and maintain state flexibility. When a statute is unambiguous as to a specific matter, and Congress' intent is clear, a court must "give effect to the unambiguously expressed intent of Congress." *Chevron*, 467 U.S. 842-43.

1. Section 1303 Provides a Limited Delegation of Authority

HHS's claim that Section 1303 has no language which limits its authority is meritless. Defs. Opp'n at 10. There are three ways in which the agency's authority is specifically curtailed in Section 1303. First, premiums are explicitly limited to billing that combines abortion coverage with the total health premium. § 18023(b)(3)(B). Second, HHS's authority to regulate is subject to state law limitations. § 18023(a)(3)(B). Third, HHS is prohibited from issuing regulations that preempt state law. § 18023(c)(1) (no effect "on State laws regarding the prohibition of (or requirement of) coverage, funding, or procedural requirements on abortions"); *see also State of Washington v. Azar et al.*, No. 2:20-cv-00047-SAB (E.D. Wash Apr. 09, 2020) (granting plaintiff's summary judgment motion on non-preemption).

2. The Rule Fundamentally Revises Congress' Intent in Section 1303

HHS dismisses the Supreme Court's considerations in *MCI Telecomm. Corp. v. AT&T* and rejects the States' argument that the separate abortion billing Rule represents a fundamental revision of the ACA, or even Section 1303. Defs. Opp'n at 11. But HHS's view continues to rest on the erroneous premise that Section 1303 mandates separate transactions.

Unsurprisingly, HHS fails to accept the import of *MCI Telecomm. Corp. v. AT&T*, 512 U.S. 218, 229 (1994). In holding that the FCC's wholesale dismantling of its rate regulation program was too sweeping to qualify as a "modification," the Supreme Court was informed by a structural reading of the statute's text. 512 U.S. 218, 229-231 (1994). In *MCI Telecomm.*, the statute contained a single exception that offered further indication that the authority alleged to be derived by the term to "modify" could not contemplate the FCC's fundamental changes. *Id.* The Court found that if the statute were indeed indifferent to the FCC's power to completely eliminate the tariff-filing requirement, then the only exception in the statue "strains out the gnat" of extending the waiting period for tariff revisions beyond a mere 120 days. *Id.*

Here, HHS similarly places too much focus on a minor issue and exaggerates the import of Section 1303(b)(2)(B)(i)'s instruction that issuers collect a "*separate* payment" for abortion coverage. HHS, in fact, bases its entire argument on its belief that "separate payment" inherently means billing through separate transactions. It does not. A review of the statute in its entirety and accounting for the restrictions of § 1303(b)(3) (such as limitations on notice and the prohibition on the separation of abortion cost from the total premium) confirms that Congress could not have intended the Rule's requirements.

Likewise, the Rule discounts the unambiguous congressional intent behind the ACA, and its many operative sections, ensuring the expansion of healthcare coverage and the reduction of barriers to care. Of import is Section 1303's significance in maintaining the status quo of state-level abortion regulation. *Cf. California by & through Becerra*, 950 F.3d at 1095; *see also State of Washington*, No. 2:20-cv-00047-SAB (E.D. Wash Apr. 09, 2020) Order at 10 ("Congress intended similar coordinated efforts with the States to achieve the [objectives] of the ACA.").

The Rule is also an impermissible interpretation of Section 1303 because it could effectively foreclose abortion coverage in private insurance in many states, contrary to congressional intent. In fact, Congress has repeatedly rejected legislation that would have amended Section 1303 to create a *de facto* ban on abortion coverage in the ACA Exchanges.[10] And where Congress desired to impose restrictions on abortion coverage, it has done so explicitly. For example, Congress required that any issuer offering multi-state plans that includes abortion coverage on state Exchanges must also offer a plan that does not include abortion services as "described in section 1303(b)(1)(B)(i)," ACA § 1334(a)(6). *United States v. Novak*, 476 F.3d 1041, 1071 (9th Cir. 2007) (("[f]ew principles of statutory construction are more compelling than the proposition that Congress does not intend sub silentio to enact statutory language that it has earlier discarded in favor of other language." (citation omitted)).

IV. HHS VIOLATED THE APA BY INTRODUCING THE RULE'S NEW OPT-OUT POLICY

A. The Opt-Out Policy Interferes with State Authority and Is Reviewable

HHS's claim of absolute discretion to enforce Section 1303 is incorrect. *See* Defs. Opp'n at 13-14. While some agency behavior is insulated from judicial review by Congressional design, the usual presumption in favor of review reflects deeply held notions about the courts' role in administrative law. 5 U.S.C. § 706. An agency's decision can be reviewed when its position is "plainly erroneous." *Robertson v. Methow Valley Citizens Council*, 490 U.S. 332, 359 (1989).

First, the Rule's opt-out policy—which provide issuers the discretion to give policyholders the ability to opt out of the abortion coverage by electing to nor pay the separate $1 amount for abortion coverage—is not merely a statement "issued by an agency to advise the

[10] *See* PPFA Comment, AR 079781 (*E.g.* Protect Life Act, H.R. 358/S.877, 112th Cong. (2011) (this bill would have amended Section 1303 to prohibit federal financial assistance, namely tax credits and cost-sharing reductions, from going to a plan that includes abortion coverage beyond the limited excepted instances); No Taxpayer Funding for Abortion and Abortion Insurance Full Disclosure Act of 2017, H.R. 7/S.184, 115th Cong. (2017) (this bill sought to amend the Internal Revenue Code and the ACA to prohibit QHPs from covering abortions). The 115th Congress, the outgoing Congress, also rejected the various iterations of the American Health Care Act and the Better Care Reconciliation Act, which would have prohibited federal financial assistance from being used to purchase a plan that includes abortion coverage. *See* H.R. 1628, the American Health Care Act of 2017 and Better Care Reconciliation Act of 2017).

public prospectively of the manner in which the agency proposed to exercise a discretionary power," Defs. Opp'n at 32 (quoting *Chrysler Corp. v. Brown*, 441 U.S. 281, 302 n.31 (1979)—there are significant consequences attached to the enforcement of the separate transaction requirements of HHS's Rule. *See Section II.A.4*, *supra* (discussing *Chaney*).

Second, Defendants' overreach into state laws and state enforcement *requires* judicial review. *W. Virginia ex rel. Morrisey v. United States Dep't of Health & Human Servs*., 827 F.3d 81, 82 (D.C. Cir. 2016); *see also* 42 U.S.C. § 300gg-22(a)(1). HHS consistently, yet mistakenly, claims to have enforcement authority over the requirements of any issuer. *See* Def. Opp. at 16-17. While § 300gg-22(a)(1) is silent regarding the federal government's enforcement, the federal government must still defer to state health insurance rules and requirements. Issuers must provide all the essential health benefits required under the ACA, as well as any benefit mandated by state law or included in the states' benchmarks. *See* 42 U.S.C. § 18031(d)(3)(B)(i); *see e.g.* 45 C.F.R. § 155.200(d). Moreover, Section 2(b) of the McCarran–Ferguson Act provides: "No Act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any State for the purpose of regulating the business of insurance…unless such Act specifically relates to the business of insurance." 15 U.S.C. § 1012(b); *U.S. Dep't of Treasury v. Fabe*, 508 U.S. 491, 500–01 (1993). HHS's impermissible "grant of discretion" to issuers allowing consumers to opt out of abortion coverage—a benefit required, included, or offered in health plans available in a State—has a profound impact on state substantive insurance laws. Allowing HHS to permit the alteration of the coverage benefits of a qualified health plan during the plan year, under the guise of its enforcement discretion, abrogates authority that is specifically designed for the states.

B. The Opt-Out Policy is Not a Logical Outgrowth of the Proposed Rule

The Rule's opt-out policy is a legislative rule not immune from judicial review, and HHS's failure to provide notice-and-comment violates the APA because its alleged discretion to institute opt-out policies is not a logical outgrowth of the notice of proposed rulemaking. *Hall v. U.S. E.P.A.,* 273 F.3d 1146, 1163 (9th Cir. 2001).

HHS's proposed rule never suggested that health plans, which are subject to the purview of Section 1303, that provide abortion coverage, would be entirely left out of the statute's ambit by

an opt-out policy. *Marsh v. J. Alexander's LLC*, 905 F.3d 610, 639 (9th Cir. 2018). Further, HHS's changes are not "in character with the original scheme" of the proposed rule—it is a fundamental difference to delay enforcement of statutory standards—which supposes eventual compliance with the statute—and *eliminating* them altogether. *Center for Science in the Public Interest, et al., v. Sonny Perdue, et al.*, No. GJH-19-1004, 2020 WL 1849695, at *4 (D. Md. Apr. 13, 2020) (citing *Chocolate Mfrs. Ass'n of U.S. v. Block*, 755 F.2d 1098, 1105 (4th Cir. 1985)).

As discussed in its opening motion, the States could not reasonably have anticipated the final rulemaking would allow plans to eliminate the abortion benefit, one statutorily designated to be a part of the policy for the entire plan year. Pls. Mot. at 37; *Nat. Res. Def. Council, Inc. v. U.S. E.P.A.*, 863 F.2d 1420, 1429 (9th Cir. 1988).

V. THE RULE VIOLATES THE TENTH AMENDMENT

HHS argues that the Rule does not violate the Tenth Amendment because the Rule "does not attempt to regulate the State directly," and the States' increased costs alone are insufficient. Defs. Opp'n at 34-35. HHS claims that no problem exists when a "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.* (citing *New York v. United States*, 505 U.S. 144, 174 (1992)). HHS also argues that its threat to enforce its Rule if States substantially fail to do so does not implicate the Tenth Amendment. Defs. Opp'n at 35.

HHS's primary reliance on *Hodel v. Virginia Surface Mining & Reclamation Ass'n* is misplaced. Though in *Hodel*, the Court held that Congress has the authority to displace or pre-empt state laws regulating private activity affecting interstate commerce, 452 U.S. 264 (1981), Section 1303 explicitly includes a non-preemption section, § 18023(c)(1) ("No preemption of States laws regarding abortion"). Moreover, in a recent challenge to this Rule in the State of Washington, a district court affirmed this view, finding that, "by including the non-preemption sections in the ACA, it is clear Congress intended a similar coordinated effort with States to achieve the objections of the ACA, and as such, state laws that fulfill those objectives should not be preempted by subsequent agency action." *State of Washington v. Azar et al.*, No. 2:20-cv-00047-SAB (E.D. Wash Apr. 09, 2020), ECF No. 17, Order at 10.

In addition, HHS misstates the States' argument. At no point do the States assert that HHS lacks the authority to promulgate regulations concerning the operation of Exchanges. Defs. Opp'n at 36. However, regulation of qualified health plans that provide coverage of abortion services falls squarely within the ambit of state sovereignty over reproductive healthcare regulation is unambiguously preserved in the non-preemption provision of Section 1303. Such "regulation of health and safety matters is primarily, and historically, a matter of local concern." *Hillsborough Cty., Fla. v. Automated Med. Labs., Inc.*, 471 U.S. 707, 719 (1985). And federal courts must "be certain of Congress' intent before finding that federal law overrides the usual constitutional balance of federal and state powers," requiring a clear statement "before interpreting [a] statute's expansive language in a way that intrudes on the police power of the States." *Bond v. United States*, 572 U.S. 844, 858-860 (2014).

But the Rule lacks any basis in such a clear statement of Congressional intent: its sole function is to make it more burdensome and more confusing for women to pay for health plans that include legal abortion services, Pls. Mot. at 32-33, and frustrate the receipt of such coverage in states that require or allow it. *Cf.* Pls. Mot. at 38-39. The delivery of healthcare is foundational to a state's livelihood, and its public health policy priorities are uniquely reserved under the Tenth Amendment. This Court has found that "when a federal law interferes with a state's exercise of its sovereign 'power to create and enforce a legal code' [ ] it inflict[s] on the state…injury-in fact." *Cty. of Santa Clara v. Trump*, 250 F. Supp. 3d 497, 526 (N.D. Cal. 2017).

Unlike in *New York v. United States*, the States cannot reasonably divert its attention or resources from the provision of healthcare, including health coverage, more so when it pertains to coverage purchased and sold through the private health insurance market. 505 U.S. 144 (1992). In discussing the limits of Congress' power, the Supreme Court has underscored that the Constitution does not give the federal government the authority to require the States to regulate, instead the Constitution grants "the authority to regulate matters directly and to pre-empt contrary state regulation." *Id.* at 178. However, any such authority to regulate, here, is explicitly limited by Section 1303's non-preemption clause, which the ACA specifically intended to allow states to continue to function as sovereigns in the field of abortion regulation.

VI. THE RULE SHOULD BE VACATED AND SET ASIDE

HHS erroneously appeals to this Court's equitable powers, claiming that nationwide relief for the States is inappropriate. Defs. Opp'n at 37. But the States seek judgment as a matter of law, not a preliminary injunction. Pls. Mot. at 40. Vacatur is appropriate as it follows from the text of the APA itself. § 706(2). HHS offers no persuasive authority to the contrary.

Indeed, the Ninth Circuit has held that vacatur is the "standard remedy" when a court concludes that an agency's conduct was illegal under the APA. *See Stewardship Council v. E.P.A*, 806 F.3d 520, 532 (9th Cir. 2015). Thus, if a court determines that an agency's rule is "facially invalid, then the appropriate remedy under the APA is for the court to prohibit the rule's applicability in any and all circumstances, a ruling that unavoidably redounds to the benefit of parties 'not before the court.'" *Make the Road N.Y. v. McAleenan*, 405 F. Supp. 3d 1, 67 (D.D.C. 2019) (quoting *Lujan v. Nat'l Wildlife Fed'n*, 497 U.S. 871, 913 (1990) (Blackmun, J., dissenting)).

HHS cites general propositions of law limiting remedy to a plaintiff's particular injury. *See* Defs. Opp'n at 37. HHS's reliance on *Gill v. Whitford* is unhelpful because it does not discuss the APA or the scope of a vacatur, it involved an injunction on a state's gerrymandering efforts, not a challenge to a nationally applicable regulation. 38 S. Ct. 1916, 1930-31, 1935 (2018). Similarly, HHS incorrectly points to *California v. Azar* as an example, although in that case the Ninth Circuit was considering the appropriate scope of a preliminary injunction. 911 F.3d 558, 582–84 (9th Cir. 2018). For the same reasons, *Los Angeles Haven Hospice, Inc. v. Sebelius*, 638 F.3d 644 (9th Cir. 2011) (discussing an instatement of a nationwide injunction) and *Weinberger v. Romero-Barcelo*, 456 U.S. 305 (1982) have no bearing here.

The legal challenge before this Court concerns statutory arguments under the APA. If the Court finds for the States as a matter of law that HHS's actions violate the APA's requirements rendering the Rule invalid, the Rule must, therefore, be vacated and set aside.

CONCLUSION

The Court should grant summary judgment to the States, deny Defendants' cross-motion for summary judgment, and vacate the Rule in its entirety.

Dated: May 4, 2020

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CERTIFICATE OF SERVICE

Case Name: **State of California et al. v. U.S. Dep't of Health and Human Services et al.** No. **3:20-cv-00682-LB**

I hereby certify that on May 4, 2020, I electronically filed the following documents with the Clerk of the Court by using the CM/ECF system:

Plaintiffs' Opposition to Defendants' Motion for Summary Judgment and Reply in Support of Plaintiffs' Motion for Summary Judgment

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

I declare under penalty of perjury under the laws of the State of California the foregoing is true and correct and that this declaration was executed on May 4, 2020, at Oakland, California.

Brenda Ayon Verduzco	***/s/ Brenda Ayon Verduzco***
Declarant	Signature