IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MARYLAND

PLANNED PARENTHOOD OF MARYLAND, INC., *et al.* *Plaintiffs,* v. ALEX M. AZAR II, Secretary of the United States Department of Health and Human Services in his official capacity, *Defendants*.	Case No. 1:20-cv-00361-CCB

MOTION FOR SUMMARY JUDGMENT

Pursuant to Rule 56 of the Federal Rules of Civil Procedure, Defendants move for summary judgment in their favor on all of Plaintiffs' claims. Included with this motion are Defendants' memorandum of law and a proposed order.

Dated: May 5, 2020

Respectfully submitted,

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CERTIFICATE OF SERVICE

I hereby certify that on this 5th day of May 2020, a copy of the foregoing was filed electronically and was thus served on all counsel of record.

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DEFENDANTS' OPPOSITION TO PLAINTIFFS' MOTION FOR SUMMARY JUDGMENT AND MEMORANDUM IN SUPPORT OF DEFENDANTS' CROSS-MOTION FOR SUMMARY JUDGMENT

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INTRODUCTION

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

As an initial matter, HHS's interpretation of Section 1303(b)(2)(B) is well within Congress's broad grant of statutory authority to the agency, and is fully consistent with—and, indeed, furthers—the requirements of that specific provision. It comports with common sense to provide a separate bill to elicit a separate payment for a particular good or service, and HHS reasonably interpreted Congress's separate payment and segregation of funds provisions to require as much. Plaintiffs do not contend otherwise, and their attempts to manufacture conflicts with other portions of the statute fail at each turn.

Plaintiffs principally take aim at an enforcement policy—which they refer to as the "Opt-Out Policy"—that HHS announced in the preamble to the Rule. That announcement does not change any substantive legal requirements on issuers. It merely reflects HHS's intent to exercise its enforcement discretion when issuers modify the benefits of a plan to allow enrollees to opt out

of non-Hyde abortion services coverage by not making a separate payment for it, subject to "appropriate measures to distinguish between a policy holder's inadvertent non-payment of the separate bill for non-Hyde abortion services and a policy holder's intentional nonpayment of the separate bill." *Id.* at 71,687. HHS's announcement does not conflict with Section 1303(b)(2)(B)(i)'s requirement that issuers "collect from each enrollee" the portion of premiums attributable to coverage for certain abortion services. More fundamentally for the purposes of this litigation, Plaintiffs lack standing to challenge HHS's announcement of how it intends to exercise its enforcement discretion, because they have not shown any injury flowing from it. Plaintiffs also cannot prevail because it is black-letter law that an agency's exercise of its enforcement authority is left to its discretion, absent restrictions imposed on that discretion by Congress. Congress imposed no restrictions on HHS's exercise of discretion, and therefore Plaintiffs' challenge to the so-called "Opt-Out Policy" is meritless.

Plaintiffs next argue that the Rule conflicts with another paragraph of Section 1303, which restricts when issuers may send "notices" to enrollees, and what information may be contained in them. But HHS reasonably interpreted that provision not to include bills for the payment of premiums, particularly given Congress's express requirement in Section 1303(b)(2)(B) that issuers "collect . . . separate payments" from enrollees for certain abortion services. Notably, if Plaintiffs were correct that a "notice" includes a bill, then HHS's prior policy of allowing issuers to itemize the portion of premiums attributable to abortion services would also be invalid, and it is unclear how an issuer could, in fact, collect the separate payments that Congress intended for these services.

Plaintiffs' claim that the Rule violates Section 1554 of the ACA fails too. The Rule does not create any "unreasonable barriers" or otherwise "impede[] timely access to care" within the

meaning of Section 1554; accepting Plaintiffs' contrary argument would effectively paralyze HHS, preventing it from ever promulgating a regulation that could even arguably have an adverse impact, no matter how indirect, on the availability of health care services.

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

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

FACTUAL AND LEGAL BACKGROUND

A. Relevant Federal Statutes

Since 1976, Congress has included language, commonly known as the Hyde Amendment, in the annual appropriations bill for HHS and certain other agencies. *See, e.g.*, Department of Defense and Labor, Health and Human Services, and Education Appropriations Act, 2019, and Continuing Appropriations Act, 2019, Pub. L. No. 115-245, §§ 506-07, 132 Stat. 2981, 3118. The Hyde Amendment precludes the use of federal funds to pay for abortion services except in the case

of rape, incest, or where the life of the mother is endangered by continuation of a pregnancy. *See Harris v. McRae*, 448 U.S. 297, 300-04 (1980).

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

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

Among other requirements, Section 1303 also outlines specific notice restrictions that issuers of QHPs that provide coverage of non-Hyde abortion services must follow. Those QHPs "shall provide a notice" of such coverage "to enrollees, only as part of the summary of benefits

and coverage explanation, at the time of enrollment." *Id.* § 18023(b)(3)(A). Furthermore, that notice, as well as "any advertising used by the issuer with respect to the plan, any information provided by the Exchange, and any other information specified by the Secretary shall provide information only with respect to the total amount of the combined payments for [non-Hyde abortion services] and other services covered by the plan." *Id.* § 18023(b)(3)(B).

B. Prior Rulemaking and Guidance

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

In October 2017, HHS released a bulletin that discussed the statutory requirements for separate payment. *See* CMS Bulletin Addressing Enforcement of Section 1303 of the Patient Protection and Affordable Care Act (Oct. 6, 2017) (CMS Bulletin), https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Section-1303-Bulletin-10-6-2017-FINAL-508.pdf. That bulletin reflected the guidance for complying with Section 1303 contained in the 2016 Payment Notice, including that issuers may separately itemize payments for coverage of non-Hyde abortion services. HHS also indicated that it was "in the process of evaluating whether there are additional steps that we should take to ensure compliance with the requirements of section 1303

and its implementing regulations, including reevaluating the guidance issued in 80 Fed. Reg. 10750, 10840-41." CMS Bulletin at 3.

C. The Challenged Rule

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

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

In addition to finalizing these regulatory modifications, HHS explained in the Rule's preamble that it intends to exercise its enforcement discretion in two scenarios, in response to comments received on the NPRM. First, to address the risk of terminations related to enrollees'

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

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

D. This Litigation

Plaintiffs filed this case on February 11, 2020. *See* ECF No. 1. Plaintiffs claim that the Rule violates the APA because it allegedly violates certain provisions of the ACA (Count One). *See id.* ¶¶ 82-89. They further allege that the Rule is arbitrary and capricious (Count Two) and that Defendants did not follow the APA's procedural requirements (Count Three). *See id.* ¶¶ 90-110.

The Court granted the parties' joint motion to enter a briefing schedule on February 26, 2020, ECF No. 27, and Plaintiffs filed their motion for summary judgment on March 2, 2020, *see* Mem. in Support of Pls.' Mot. for Summ. J., ECF No. 29-1 (Pls.' Mem.). The Court entered a revised briefing schedule on April 15, 2020. *See* ECF No. 35. Pursuant to that revised schedule, Defendants now oppose Plaintiffs' motion and cross-move for summary judgment.

ARGUMENT

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

[1] Because this is an APA case, the Court should reject Plaintiffs' improper attempt to create a new record for the purposes of this litigation by submitting declarations and other materials. The APA provides that, "[i]n making the [] determinations [regarding the lawfulness of agency action], the court shall review the whole record," 5 U.S.C. § 706, and the Supreme Court has long held that the whole record is limited to "the full administrative record that was before the Secretary at the time he made his decision," *Citizens to Pres. Overton Park, Inc. v. Volpe*, 401 U.S. 402, 420 (1971); *see also, e.g.*, *Nat'l Fed. Of the Blind v. U.S Abilityone Comm'n*, 421 F. Supp. 3d 102, 114 (D. Md. 2019) ("The function of the district court is to determine whether or not as a matter of law the evidence in the administrative record permitted the agency to make the decision it did." (quotation and alteration omitted)).

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

Plaintiffs cannot prevail on their statutory claims under the deferential framework set out in *Chevron U.S.A., Inc. v. NRDC*, 467 U.S. 837 (1984). It is a fundamental principle of administrative law that, unless a statute directly answers the precise question at issue, "a court may not substitute its own construction of a statutory provision for a reasonable interpretation made by the administrator of an agency." *Id*. at 844. The *Chevron* framework is based on the presumption "'that Congress, when it left ambiguity in a statute' administered by an agency, 'understood that the ambiguity would be resolved, first and foremost, by the agency, and desired the agency (rather than the courts) to possess whatever degree of discretion the ambiguity allows.'" *City of Arlington v. FCC*, 569 U.S. 290, 296 (2013) (citation omitted).

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

At *Chevron*'s first step, the Court must determine "whether Congress has directly spoken to the precise question at issue." *Nat'l Elec. Mfrs. Ass'n v. U.S. Dep't of Energy*, 654 F.3d 496, 504 (4th Cir. 2011) (citing *Chevron*, 467 U.S. at 842-43). If the answer is yes, the court must give

effect to Congress's intent. If the answer is no—that is, if the statute is ambiguous—"the question for the court is whether the agency's answer is based on a permissible construction of the statute." *Id.* at 843.

Plaintiffs' statutory claims each fail under the deferential *Chevron* framework. The separate billing requirement at issue reflects the agency's interpretation of Section 1303(b)(2)(B), in which Congress specified that, in the case of a QHP that provides coverage for non-Hyde abortion services, "the issuer of the plan shall . . . collect from each enrollee in the plan . . . a *separate payment* for each of" the portion of the premium reflecting the actuarial value of covering non-Hyde abortion services and the portion of the premium attributable to coverage for all other services. 42 U.S.C. § 18023(b)(2)(B)(i) (emphasis added). Congress further provided that the issuer "shall deposit all such separate payments into separate allocation accounts." *Id.* § 18023(b)(2)(B)(ii). In its proposed rulemaking on this subject, HHS explained that, rather than authorize "simply itemizing these two components of a single total billed amount," as previous guidance had allowed, these statutory provisions appeared to "contemplate[] issuers billing for two separate 'payments' of these two amounts (for example, two different checks or two different transactions)." 83 Fed. Reg. at 56,022; *see also* 84 Fed. Reg. at 71,685 (adhering to this interpretation). That interpretation is reasonable and furthers the congressional intent behind Section 1303(b)(2)(B). Indeed, as then-Senator Ben Nelson—who proposed the relevant statutory language, sometimes known as the Nelson Amendment—explained at the time, under this legislative "compromise," "if you are receiving Federal assistance to buy insurance, and if that plan has any [non-Hyde] abortion coverage, the insurance company must bill you separately, and you must pay separately." Cong. Rec. S14134 (Dec. 24, 2009) (statement of Sen. Nelson).

Based on the plain language of Section 1303(b)(2)(B) and the relevant legislative history, it is no surprise that Plaintiffs do not even attempt to argue that the promulgated regulations are not a permissible interpretation of that provision. Rather, Plaintiffs' only option is to attempt to manufacture a conflict based on (1) HHS's announcement of its intent to exercise its enforcement discretion (the so-called "Opt-Out Policy"); (2) a separate provision in Section 1303 related to what types of "notice" issuers may provide to enrollees; and (3) Section 1554, which restricts HHS from imposing direct regulatory burdens on doctors and patients. As discussed below, none of Plaintiffs' statutory claims has merit.

A. Plaintiffs' Challenge to the So-Called "Opt-Out Policy" Fails Because They Lack Standing to Challenge It and Because It Is An Unreviewable Exercise of HHS's Enforcement Discretion

Plaintiffs argue that HHS violated Section 1303(b)(2)(B)(i) by announcing in the Rule's preamble that it does not plan to take enforcement action against QHP issuers that modify the benefits of a plan to effectively allow enrollees to opt out of coverage of non-Hyde abortion services by not paying the separate bill for coverage of those services. *See* Pls.' Mem. at 34-35; *see also* 84 Fed. Reg. at 71,686. Plaintiffs reason that, because Section 1303(b)(2)(B)(i) states that QHP issuers "shall [ ] collect from each enrollee" separate payments for coverage of non-Hyde abortion services, 42 U.S.C. § 18023(b)(2)(B)(i), HHS may not exercise its discretion regarding whether or not to take enforcement action if an issuer does not collect payments as required by the statute.

Plaintiffs' argument fails at the outset because they lack standing to challenge HHS's intended exercise of enforcement discretion. Article III standing is a threshold jurisdictional requirement. *See Central Wesleyan College v. W.R. Grace & Co.*, 6 F.3d 177, 188 (4th Cir. 1993). "In order to have standing, a plaintiff must demonstrate some actual or threatened injury as a result of the putatively illegal conduct of the named defendant, and must show that the injury can be

fairly traced to the challenged action and that the injury is likely to be redressed by a favorable decision." *Herlihy v. Ply-Gem Industries, Inc*., 752 F. Supp. 1282, 1290 (D. Md. 1990); *see also Gladstone, Realtors v. Village of Bellwood*, 441 U.S. 91, 99 (1979). A plaintiff has the burden to demonstrate standing for each claim it seeks to press. *See DaimlerChrysler Corp. v. Cuno*, 547 U.S. 332, 352 (2006).

Here, Plaintiffs fail to show that the so-called "Opt-Out Policy" harms them in any way. HHS has merely announced that it does not currently intend to bring enforcement actions *against issuers* who may choose to modify the benefits of a plan in certain circumstances. That announcement does not change any substantive legal requirements on issuers, and it creates no burdens or costs on Plaintiffs—none of whom are issuers. Nor does HHS's announcement prevent states, such as Maryland, from exercising their own primary enforcement authority to ensure compliance with the requirements of Section 1303. *See* 42 U.S.C. § 300gg-22(a)(1). Plaintiffs therefore point to no "distinct and palpable" harm that both (1) affects them "in a personal and individual way" and (2) is "actual or imminent, not conjectural or hypothetical." *Lujan v. Defenders of Wildlife*, 504 U.S. 555, 560 & n.1 (1992).

Even putting Plaintiffs' lack of injury aside—which by itself is fatal to their challenge to the "Opt-Out Policy"—Plaintiffs also cannot prevail because HHS's decision whether to take enforcement action is an unreviewable exercise of agency discretion under *Heckler v. Chaney*, 470 U.S. 821 (1985). In *Chaney*, the Supreme Court held that an agency's decision not to exercise its enforcement discretion, or to exercise it in a particular way, is presumed to be "immune from judicial review under § 701(a)(2)" of the APA. 470 U.S. at 832; *see also Sierra Club v. Whitman*, 268 F.3d 898, 902-03 (9th Cir. 2001). "The Supreme Court explained in [*Chaney*] that the APA does not usually provide a right to judicial review of an agency's failure to enforce statutory

provisions entrusted to agency supervision." *Coker v. Sullivan*, 902 F.2d 84, 88 (D.C. Cir. 1990). This is so because an "agency's decision not to prosecute or enforce, whether through civil or criminal process, is a decision generally committed to an agency's absolute discretion." *Chaney*, 470 U.S. at 831.

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

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

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

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

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

Indeed, it would be unnatural to read Section 300gg-22(a)(2) as governing the timing or manner of enforcement by HHS. The logic of such a reading would suggest that HHS must pursue

every issuer that fails to comply with any applicable statutory requirement, even though "[a]n agency generally cannot act against each technical violation of the statute that it is charged with enforcing," *Chaney*, 470 U.S. at 831; *see NRDC v. FDA*, 760 F.3d 151, 171 (2d Cir. 2014) ("It is rare that agencies lack discretion to choose their own enforcement priorities."). There is "no indication in case law or legislative history that such was Congress' intention." *Chaney*, 470 U.S. at 835.[3]

Nor is this case like *Casa de Maryland v. U.S. Department of Homeland Security*, 924 F.3d 684 (4th Cir. 2019), where the Fourth Circuit reviewed a challenge to the governments' rescission of the Deferred Action for Childhood Arrivals (DACA) policy. *See id*. at 698-701. Here, HHS has stated its present intent to exercise its enforcement discretion when issuers modify the benefits of a plan to allow enrollees to opt out of non-Hyde abortion services coverage by not making a separate payment for it. 84 Fed. Reg. at 71,686. Unlike in *Casa de Maryland*, the agency did not do so based on a "direct interpretation[] of the commands of the substantive statute." 924 F.3d at 698. Rather, HHS announced its intention based on the concern expressed by some commenters regarding a lack of transparency. *See* 84 Fed. Reg. at 71,786. HHS's statement of its current enforcement posture is also subject to QHP issuers taking "appropriate measures to distinguish between a policy holder's inadvertent non-payment of the separate bill for non-Hyde abortion services and a policy holder's intentional nonpayment of the separate bill." *Id.* at 71,687. Those

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

are the sorts of "mingled assessments of fact, policy, and law that drive an individual enforcement decision" and therefore distinguish this case from *Casa de Maryland*, 924 F.3d at 699.

At bottom, Plaintiffs' argument fails because it is based on an incorrect statement of what the agency did in announcing its intent regarding prospective enforcement. Contrary to Plaintiffs' assertion, HHS's statement in the Rule's preamble does not "bind[] the government." *See* Pls.' Mem. at 34. HHS is free to change its intended enforcement posture at its discretion. HHS's explanation of its current intent also does not change any substantive law, and therefore cannot create a conflict with Section 1303(b)(2)(B)(i). The obligation that issuers "collect from each enrollee" the portion of the premium attributable to coverage for non-Hyde abortion services remains undisturbed. *See* 42 U.S.C. § 18023(b)(2)(B)(i). The agency has merely stated an intention—subject to agency discretion—not to bring an enforcement action regarding certain requirements on QHPs if modified by issuers. Plaintiffs' claims—in addition to being unreviewable—lack any substantive basis in law.

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

Plaintiffs also make the extraordinary argument that—despite Section 1303(b)(2)(B)'s requirement that issuers "collect from each enrollee . . . a separate payment" for premiums for coverage of non-Hyde abortion services, 42 U.S.C. § 18023(b)(2)(B)(i)—issuers are not, in fact, allowed to indicate on any bill sent to enrollees the amount of the premium attributable to such services because of another provision in Section 1303 setting out "rules relating to notice." Pls.' Mem. at 35-37 (citing 42 U.S.C. § 18023(b)(3)(A), (B)). They argue that—because issuers are required to provide "a notice to enrollees" of coverage of non-Hyde abortion services "only as part of the summary of benefits and coverage explanation, at the time of enrollment," 42 U.S.C. § 18023(b)(3)(A), and because that "notice" and other enumerated types of communications "shall provide information only with respect to the total amount of the combined payments," *id.*

§ 18023(b)(3)(B)—issuers may not provide separate bills for coverage of non-Hyde abortion services, as doing so would give additional "notice" to enrollees. *See* Pls.' Mem. at 35-37.

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

Plaintiffs' interpretation of Section 1303(b)(3) to include invoices is at odds with the rest of Section 1303 and, indeed, common sense. Plaintiffs would have the Court believe that, in Section 1303(b)(2)(B), Congress explicitly required issuers to collect separate payments for non-

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

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

Plaintiffs attempt to salvage their atextual reading of Section 1303(b)(3) by quoting selectively from HHS's response to certain comments in the preamble. They claim that, because HHS pointed to increased transparency for enrollees as a benefit of the Rule, HHS somehow confirmed that a separate bill is, in fact, a "notice" within the meaning of Section 1303(b)(3). Pls.' Mem. at 36-37 (citing 84 Fed. Reg. at 71,695). As HHS explained, however, the primary purpose of requiring issuers to bill separately for coverage of non-Hyde abortion services is "to help ensure separate payment by the policy holder, and separate QHP issuer collection of this portion of the policy holder's premium." In other words, the Rule furthers the congressional intent behind Section 1303(b)(2)(B). That the Rule incidentally increases transparency does not transform a "bill" into a "notice" within the meaning of Section 1303(b)(3)(A).

Given that the terms in Section 1303(b)(3) are not defined, and that Congress did not specify the method a QHP issuer must use to comply with the separate payment requirement under Section 1303(b)(2)(B), the statute is ambiguous, and HHS was entitled to fill the space left by that

ambiguity through the Rule. Plaintiffs therefore cannot prevail on their argument that the Rule violates the notice provisions in Section 1303(b)(3).

C. The Rule Is Consistent with Section 1554

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

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

42 U.S.C. § 18114. Plaintiffs argue that, by requiring issuers to bill separately for non-Hyde abortion services, and because that requirement may impose additional costs on issuers and/or lead to potential enrollment or coverage changes, the Rule "undermines access to care," allegedly in violation of Section 1554. *See* Pls.' Mem. at 33-34 (citing 42 U.S.C. § 18114(1)-(3)).

Plaintiffs' claim is meritless. In Section 1303(b)(2)(B), Congress specifically instructed QHP issuers to "collect from each enrollee . . . a separate payment" for non-Hyde abortion services and to maintain those payments in separate allocation accounts. 42 U.S.C. § 18023(b)(B). And in the Rule, in order to give better effect to those statutory provisions, HHS reasonably interpreted Section 1303(b)(2)(B) to mean that QHP issuers should send separate bills to policy holders for

the portion of the premium attributable to coverage for such services. Doing so does not create an "unreasonable barrier" to obtaining, "impede" access to, or "limit the availability" of any type of health care. *See id.* § 18114. Indeed, the Rule does not speak directly to the provision of health care at all, only the manner in which issuers of QHPs bill for certain services.

Accordingly, Plaintiffs rely on potential second- and third-order effects of the Rule, such as additional burdens on issuers that could lead them to modify the coverage they elect to offer. *See* Pls.' Mem. at 32-33. But as the en banc Ninth Circuit recently explained, Section 1554 is only "meant to prevent *direct* government interference with health care"; in other words, "[t]he most natural reading of § 1554 is that Congress intended to ensure that HHS, in implementing the broad authority provided by the ACA, does not improperly *impose regulatory burdens on doctors and patients*." *California by & through Becerra v. Azar*, 950 F.3d 1067, 1094 (9th Cir. 2020) (en banc) (emphases added). Nothing the en banc Ninth Circuit's recent construction of Section 1554 suggests this provision sweeps as broadly as Plaintiffs imagine.

It is worth pausing to appreciate the scope of that argument. If the Court were to accept Plaintiffs' interpretation of Section 1554, HHS would be barred from adopting essentially *any* regulation that could even *potentially* raise health care costs or indirectly lead to a reduction in coverage, no matter how speculative the chain of contingencies, because, on Plaintiffs' reading, doing so would impose "unreasonable burdens" or costs on enrollees or health care providers. For example, under Plaintiffs' logic, HHS could not impose any administrative burdens on issuers to document how they are complying with Section 1303(b)(2)(B)'s mandate, because the additional burden might, through some chain of events, result in additional costs and therefore result in some enrollees leaving the plan. Nor, in Plaintiffs' view, could HHS ever adopt a regulation declining to provide Medicare coverage for a particular procedure, *see, e.g.*, *Heckler v. Ringer*, 466 U.S.

602, 607 (1984), as that would purportedly "impede access to health care services" (and perhaps erect an "unreasonable barrier[] to the ability of individuals to obtain appropriate medical care" as well), 42 U.S.C. § 18114(1)-(2). Plaintiffs' reasoning, if accepted, would effectively halt HHS from making even minor changes to programs any time a provider or patient arguably was adversely affected.

Plaintiffs' reading of Section 1554 defies common sense and cannot be what Congress intended. It is a basic principle of statutory interpretation that Congress "does not alter the fundamental details of a regulatory scheme in vague terms or ancillary provisions—it does not, one might say, hide elephants in mouseholes." *Whitman v. Am. Trucking Ass'ns*, 531 U.S. 457, 468 (2001). Plaintiffs would have this Court believe that Congress, through generalized language buried in the ACA's "Miscellaneous Provisions," Pub. Law 111-148, 124 State. 119, 258 (2010), effectively prevented HHS from promulgating any regulations with respect to Section 1303—and indeed, with respect to any other statute HHS administers (or, at a minimum, any provision in the ACA)—that impose any burdens, no matter how indirectly, on patients or providers, and that it did so without any meaningful legislative history so indicating. The Court should reject Plaintiffs' untenable position.

Other principles point in the same direction. "[I]t is a commonplace of statutory construction that the specific governs the general . . . ." *Morales v. Trans World Airlines, Inc.*, 504 U.S. 374, 384 (1992). "The general/specific canon is perhaps most frequently applied to statutes in which a general permission or prohibition is contradicted by a specific prohibition or permission." *Id*. Under such circumstances, "[t]o eliminate the contradiction, the specific provision is construed as an exception to the general one." *RadLAX Gateway Hotel, LLC v. Amalgamated Bank*, 566 U.S. 639, 645 (2012). Here, even if Section 1554 could possibly be interpreted as

Plaintiffs suggest, Section 1303(b)(2)(B) applies much more narrowly to the question of how issuers collect and maintain payments from enrollees for coverage, which is distinct from the direct provision of health care services or communications between provider and patient. The Court should decline to interpret Section 1554, the much more general statute, so as to override HHS's eminently reasonable interpretation of the more specific requirements under Section 1303(b)(2)(B).

II. THE RULE IS NOT ARBITRARY AND CAPRICIOUS

Plaintiffs argue that the Rule is arbitrary and capricious because HHS allegedly ignored the costs of requiring separate premium payments for coverage of non-Hyde abortion services and failed to articulate offsetting benefits, chose an implementation date that Plaintiffs claim is not feasible, and failed to consider the financial impact of the "Opt-Out Policy." Pls.' Mem. at 21-32. Each argument fails. Congress, not HHS, decided to require collection of "a separate payment" for coverage of non-Hyde abortion services. HHS merely implemented that directive in the Rule at issue here. In doing so, HHS fully explained the rationale for its decision, thoroughly described the Rule's costs and benefits, and properly considered the concerns raised during the public comment period. HHS also fully justified the need for prompt compliance with the statute, and nothing in the record supports Plaintiffs' contention that compliance with the Rule's implementation date is not possible. Finally, HHS properly considered the effects of the so-called "Opt-Out Policy" and explained that it would help preserve access to non-Hyde abortion services for those who want such coverage by making it less likely that issuers would drop coverage of such services from their plans altogether.

The APA requires a reviewing court to "hold unlawful and set aside agency action . . . found to be . . . arbitrary [or] capricious." 5 U.S.C. § 706(2)(A). "The scope of review" for a

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

The reviewing court may not "second-guess[] the [agency's] weighing of risks and benefits and penaliz[e] [it] for departing from the . . . inferences and assumptions" of others, *Dep't of Commerce v. New York*, 139 S. Ct. 2551, 2571 (2019), or "ask whether a regulatory decision is the best one possible or even whether it is better than the alternatives," *FERC v. Elec. Power Supply Ass'n*, 136 S. Ct. 760, 782 (2016). Agency action that "changes prior policy" is not subject to a heightened standard of review; "it suffices that the new policy is permissible under the statute, that there are good reasons for it, and that the agency *believes* it to be better, which the conscious change of course adequately indicates." *FCC v. Fox TV Stations, Inc.*, 556 U.S. 502, 514, 515 (2009).

The APA requires agencies to base their decisions "on consideration of the relevant factors," *State Farm*, 463 U.S. at 42, but it does not require them to "conduct a formal cost-benefit analysis in which each advantage and disadvantage is assigned a monetary value," *Michigan v. EPA*, 135 S. Ct. 2699, 2711 (2015), or assess the relevant factors in quantitative terms, *Ranchers Cattlemen Action Legal Fund v. USDA*, 415 F.3d 1078, 1096-97 (9th Cir. 2005). An agency thus

"may justify its policy choice by explaining why that policy 'is more consistent with statutory language' than alternative policies." *Encino Motorcars, LLC v. Navarro*, 136 S. Ct. 2117, 2127 (2016) (quoting *Long Island Care at Home, Ltd. v. Coke*, 551 U.S. 158, 175 (2007)).

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

1. The Rule Better Aligns the Regulations With the Statutory Separate-Payment Requirement

Plaintiffs acknowledge that HHS promulgated the Rule to achieve "better alignment between the regulations and Section 1303[]," but argue that it is "wholly illogical" to pursue more faithful implementation of the statute in the face of the Rule's "costs, including increased premiums, terminations of coverage, consumer confusion, and expenditure of time." Pls.' Mem. at 22. Plaintiffs notably fail to challenge HHS's conclusion that "separate payment[s]" require separate transactions, and that requiring separate bills better aligns the regulations with Congress's intent to require separate transactions. Nevertheless, they offer three reasons why HHS should have consciously disregarded its interpretation of Section 1303. First, in their view, HHS could have interpreted Section 1303 to allow for single rather than separate transactions, and thus avoided the Rule's costs; second, Plaintiffs claim that the Rule does not advance what they view as Section 1303's overall statutory purpose of prohibiting "the *use* of federal dollars for abortion care," *id.* at 23; and third, the Rule does not comport with their view of the overall purpose of the ACA to increase health insurance coverage and decrease health care costs. None of those considerations would justify HHS in ignoring the specific statutory mandate in Section 1303.

First, Plaintiffs claim that the Rule "fails to explain what is better about an interpretation that imposes massive new costs, reduces flexibility . . . , and in some cases results in issuers using the very same compliance mechanisms they used under the earlier rules." Pls.' Mem. at 22. In Plaintiffs' view, the Rule "recognizes that the term 'separate payment' in Section 1303 is

ambiguous, and that the flexible compliance options permitted by previous HHS regulations and guidance were consistent with it" (although Plaintiffs conspicuously fail to offer any arguments of their own in support of that reading). *Id.* They thus argue that there is no additional benefit to being "more consistent with Section 1303's intent" that can outweigh the "new costs" and "reduce[d] flexibility" that the Rule will cause. *Id.*

That argument rests on mistaken premises. Regardless of whether the prior guidance was a permissible interpretation of Section 1303, HHS concluded that the *best* reading of Section 1303 was that it requires separate payments in separate transactions, and it implemented that Congressional directive in the Rule. Nothing requires agencies to treat all permissible readings of a statute as equally valid, or to choose among permissible interpretations based solely on policy concerns rather than fidelity to Congressional intent.

The Rule notes that "Section 1303 . . . do[es] not specify the method a QHP issuer must use to comply with the separate payment requirement," and it "recognize[s] . . . that the previous methods of itemizing or providing advance notice about the amounts noted as permissible in the preamble of the 2016 Payment Notice arguably identifies two 'separate' amounts for two separate purposes." 84 Fed. Reg. at 71, 693. But the Rule also explained that "Congress intended that QHP issuers collect two distinct (that is, 'separate') payments, one for the coverage of non-Hyde abortion services, and one for coverage of all other services covered under the policy." *Id.* at 71,684. In HHS's view, Congress did not intend that "simply itemizing these two components in a single bill, or notifying the enrollee that the monthly invoice or bill will include a separate charge for these services" would suffice. *Id.* The Rule thus explained that the prior guidance was *not* consistent with HHS's current understanding of Congressional intent, but it said nothing either

way about whether the prior guidance was nevertheless a permissible interpretation for purposes of a court conducting *Chevron* analysis.

That is because, contrary to Plaintiffs' unsupported assumption, agencies need not justify adherence to Congressional policy choices in terms of costs and benefits relative to other arguably permissible, but inferior, interpretations of the statute. "Better alignment" with the statutory text is not just one variable among many that HHS may balance or trade-off against other goals in the pursuit of "better policy"—it is what *defines* good policy for administrative agencies. *See* U.S. Const. art. 1 § 1 ("All legislative Powers herein granted shall be vested in a Congress of the United States."). It is a "core administrative-law principle that an agency may not rewrite clear statutory terms to suit its own sense of how the statute should operate." *Util. Air Regulatory Group v. EPA*, 573 U.S. 302, 328 (2014). And at the very least, the choice between fidelity to the best interpretation of statutory text and practical consequences involves the sort of "value-laden decisionmaking and the weighing of incommensurables" entrusted to federal agencies. *Dep't of Commerce*, 139 S. Ct. at 2571. As a result, it is never arbitrary and capricious for an agency to "justify its policy choice by explaining why that policy 'is more consistent with statutory language,'" so long as the agency "analyze[s] or explain[s] why the statute should be interpreted" as the agency proposes. *Encino Motorcars*, 136 S. Ct. at 2127 (quoting *Long Island Care at Home*, 551 U.S. at 175); *see also Rust v. Sullivan*, 500 U.S. 173, 187 (1991) (even when statute "ambiguous," HHS "Secretary amply justified his change of interpretation with a 'reasoned analysis'" based on his determination that "the new regulations are more in keeping with the original intent of the statute").

HHS did just that in the Rule. It explained that "some of the methods for billing and collection of the separate payment for coverage of non-Hyde abortion services described as

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

Plaintiffs suggest that the Rule concedes that separate payments need not mean separate transactions, because the Rule does not allow an issuer to refuse payment if an enrollee pays their premium in full in a single transaction. *See* Pls.' Mem. at 22. That argument is meritless. "[N]o legislation pursues its purposes at all costs," *Rodriguez v. United States*, 480 U.S. 522, 525-26 (1987), and nothing in Section 1303 stands in the way of HHS's conclusion that "potential loss of coverage would be an unreasonable result of an enrollee paying in full, but failing to adhere to the QHP issuer's requested payment procedure," 84 Fed. Reg. at 71,685.

Section 1303 speaks to QHP issuers, requiring them to "collect . . . a separate payment"; it does not separately address enrollees at all. 42 U.S.C. § 18023. Nor does it dictate any particular penalty for issuers that fail to collect a separate payment in any particular instance, still less so for enrollees who cause that failure by remitting a single payment for the entire premium. In light of that statutory silence, HHS acted well within its discretion to determine that QHP issuers may satisfy their obligation to collect separate payments by sending separate bills, instructing enrollees to pay those bills in separate transactions, and depositing payments into separate allocation accounts. Perhaps HHS could ensure even higher rates of compliance with the separate payment

requirement if it were to allow, or even instruct, issuers to "refuse the payment and initiate a grace period or terminate the policy holder's QHP coverage," 84 Fed. Reg. at 71,711, for paying the entire premium in one transaction, but Section 1303 does not require such harsh consequences. It was not arbitrary or capricious for HHS consider such costs in crafting the Rule.

Plaintiffs' second and third arguments are of a piece: that HHS failed to show "any evidence of issuer non-compliance with Section 1303's separate-accounting requirement," and that the Rule "does nothing to further [the] prohibition on the *use* of federal dollars for abortion care," Pls.' Mem. at 22-23; and that HHS "fails to reconcile the rule with the ACA's purpose 'to increase the number of Americans covered by health insurance and decrease the cost of health care,'" *id.* (quoting *Nat'l Fed'n of Indep. Bus. v. Sebelius*, 567 U.S. 519, 538 (2012)). Those arguments are simply an attempt to write the "separate payment" requirement out of Section 1303. Congress did not leave it up to HHS to decide how best to ensure that federal funds are not spent on non-Hyde abortion services; it specified the means to do so, through "separate payment[s]," "separate allocation accounts," and segregation of funds. 42 U.S.C. § 18023(b)(2). Agencies "are bound, not only by the ultimate purposes Congress has selected, but by the means it has deemed appropriate, and prescribed, for the pursuit of those purposes." *MCI Telecomms. Corp. v. AT&T Co.*, 512 U.S. 218, 231 n.4 (1994). HHS had no authority to ignore the specific separate payment mandate based on a general assessment of the overall purpose of Section 1303, or of the ACA as a whole.

Plaintiffs' final argument regarding the Rule's benefits is that HHS improperly attempted to justify it based on its projection that the Rule will reduce confusion for some enrollees. Pls.' Mem. 24-25. That argument confuses one incidental *benefit* of the Rule with its overall *justification* of improving statutory compliance. HHS did not attempt to justify its actions based on considerations of transparency: "the changes are primarily meant to better align the regulatory

requirements for QHP issuer billing of enrollee premiums with the statutory separate payment requirement in section 1303," but the Rule also "acknowledge[s] that the finalized policy regarding separate billing may increase transparency for policy holders who object on the basis of conscience to coverage of non-Hyde abortion services in their QHPs." 84 Fed. Reg. at 71,691. The Rule included that benefit in the "Regulatory Impact Analysis" portion of the preamble because "Executive Orders 12866 and 13563 direct agencies to assess *all* costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity), to the extent permitted by law." *Id.* at 71,700 (emphasis added). Unsurprisingly, Plaintiffs point to no authority suggesting that an agency "relie[s] on factors which Congress has not intended it to consider" whenever it conducts a routine Regulatory Impact Analysis. *See, e.g.*, *Air Transp. Ass'n of Am. v. FAA*, 169 F.3d 1, 8-9 (D.C. Cir. 1999) (agency's "analysis of expected benefits and costs" pursuant to Executive Order 12866 "is not subject to judicial review").

2. HHS Thoroughly Described the Rule's Costs

As Plaintiffs do not dispute, Section 1303's "separate payment" mandate is best read as a "separate transaction" requirement. The proper scope of this Court's review of whether the Rule constituted arbitrary and capricious agency action is thus not whether HHS has justified requiring issuers to collect separate payments in separate transactions over not doing so—that choice was made in Congress, and is not subject to "arbitrary and capricious" review. It is instead whether HHS has justified the use of separate bills to promote compliance with that requirement. *None* of Plaintiffs' arguments about the Rule's costs are relevant to that inquiry: Plaintiffs complain at length about the "massive costs" of the Rule, Pls.' Mem. at 25, but never distinguish between the

costs of requiring separate transactions *vel non* and the costs of doing so in the particular manner HHS chose in the Rule.

That failure resolves Plaintiffs' arguments that HHS did not sufficiently consider and respond to comments raising concerns over the Rule's costs: "whether [HHS] adequately responded these comments makes no difference because the Agency had no obligation to respond to them in the first place." *City of Portland, Oregon v. EPA*, 507 F.3d 706, 714 (D.C. Cir. 2007). As the Fourth Circuit has explained, "the Secretary is obligated to identify and comment on only the relevant and significant issues raised during the proceeding." *State of S.C. ex rel. Tindal v. Block*, 717 F.2d 874, 886 (4th Cir. 1983) (citing *Home Box Office, Inc. v. FCC*, 567 F.2d 9, 35 n.58 (D.C. Cir. 1977)). In so doing, the Court of Appeals adopted the D.C. Circuit's understanding of "significant" comments as those "which, if adopted, would require a change in an agency's proposed rule." *Home Box Office*, 567 F.2d at 35 n.58. Because HHS reasonably understood Congress to have mandated separate payments in separate transactions, it was not free to simply ignore that decision on the basis of cost, and comments that merely pointed out the costs of requiring separate transactions—as distinct from the costs of any given means of implementing that requirement relative to other options—were quite beside the point.

Nevertheless, contrary to Plaintiffs' assertions, HHS did fully consider and account for the costs of the Rule; it is simply not tenable to argue that the preamble's extensive discussion of costs so "entirely failed to consider" that aspect of the problem as to have strayed beyond the "bounds of reasoned decisionmaking." Plaintiffs thus largely abandon the familiar doctrinal rubric for determining whether agency action was arbitrary and capricious and instead frame their argument in terms of HHS's alleged failure to quantify the Rule's costs and benefits. *See, e.g.*, Pls.' Mem. at 25-26 ("HHS could not identify a *single* quantifiable benefit of the Final Rule"); *see also, e.g., id.*

at 26 ("HHS failed to quantify any time or other costs that consumers will incur . . . ."); *id.* at 27 ("[T]he only consumer costs quantified in the Final Rule relate to a consumer's time spent reading and understanding bills."); *id.* ("[I]t was fundamentally irrational for the agency to treat the costs of making two separate payment transactions as . . . unquantifiable."); *id.* at 28 ("HHS failed to quantify . . . other substantial costs to consumers"); *id.* at 29 ("HHS did not try to quantify these massive costs to consumers"). But Plaintiffs of course fail to cite *any* authority to justify this narrow fixation on quantified costs and benefits. Even where a statute calls for formal economic analysis—and this one does not—it is well understood that not all costs and benefits are amenable to quantification. *See, e.g.*, Office of Management and Budget, Circular A-4, at 26-27 ("some important benefits and costs (e.g., privacy protection) may be inherently too difficult to quantify or monetize given current data and methods"); *id*. at 4 ("intangible rationales do not need to be quantified"), https://www.whitehouse.gov/sites/whitehouse.gov/files/omb/circulars/A4/a-4.pdf. And where a statute requires less formal consideration of costs—which, again, is not the case here—it has been enough for the agency to pay "at least some attention to cost," *Michigan*, 135 S. Ct. at 2707, which the agency plainly did here. *See, e.g.*, *Nicopure Labs, LLC v. FDA*, 266 F. Supp. 3d 360, 403 (D.D.C. 2017) ("[E]ven if the agency was bound by the decision in *Michigan v. EPA* to pay 'some attention to cost,' that was done in this case." (citation omitted)), *aff'd*, 944 F.3d 267 (D.C. Cir. 2019).

Neither case Plaintiffs cite is to the contrary. In *Public Citizen v. Fed. Motor Carrier Safety Admin.*, 374 F.3d 1209 (D.C. Cir. 2004), the D.C. Circuit held that agency's explanation for dropping a proposed safety requirement from a final rule was "probably flawed" because the agency ignored "seemingly obvious" ways to estimate the costs and benefits. *Public Citizen*, 374 F.3d at 1222. There, however, the statute expressly provided that the agency "'shall consider the

costs and benefits of the requirement,'" *id*. at 1212 (quoting 49 U.S.C. § 31502(d)). Likewise, in *Business Roundtable v. SEC*, 647 F.3d 1144 (D.C. Cir. 2011), the court faulted an agency for failing "to estimate and quantify the costs it expected companies to incur," when it did not "claim that estimating those costs was not possible, for empirical evidence about [those costs] was readily available." *Id. at* 1150. But that case similarly turned on a "unique [statutory] obligation" on the agency "to assess the economic consequences of its rule." *Id.* at 1148, 1150 (citing 15 U.S.C. §§ 78c(f), 78w(a)(2), 80a-2(c)).

Here, in contrast, Plaintiffs point to no statutory obligation on HHS to assess the Rule's costs at all, much less in quantitative terms. Nor did HHS attempt to justify any regulatory choice that Plaintiffs challenge on the basis that it could not adequately assess costs and benefits. And further quantification of the specific costs Plaintiffs identify would not have improved HHS's decisionmaking because the Rule's primary benefit of improving statutory compliance is not quantifiable. Calculating a dollars and cents figure for the "increased costs incurred by enrollees who choose to make separate payments for coverage of non-Hyde abortion services" (per Plaintiffs, the Rule's "[m]ost egregious[]" failure to account for costs, Pls.' Mem. at 26) would reveal nothing pertinent to the decision to require separate transactions.

The same is true of Plaintiffs' complaint that HHS failed to quantify "the impact of premium increases and resulting enrollment reductions on the rule's estimated costs." Pls.' Mem. at 28. As Plaintiffs acknowledge, HHS did address those costs, "estimat[ing] that enrollment will be reduced in the impacted states very slightly as a result of the increase to premiums." 84 Fed. Reg. at 71,704. HHS also explained that those costs "are *necessary* to achieve better alignment of issuer billing with the statute." *Id.* (emphasis added). In each case—"the costs [to consumers] of making two separate payment transactions" and premium "increases [that] would reduce

enrollment," Pls.' Mem. at 27, 28—Plaintiffs point to no alternative means of requiring separate payment transactions that might have reduced those costs, which are a consequence of the separate transaction requirement, no matter how it may be implemented. It was not up to HHS—and it is not up to Plaintiffs or this Court—to determine whether those costs are worth bearing; Plaintiffs should take that argument to Congress.

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

Plaintiffs fault HHS for setting an implementation date of six months after publication of the Rule—namely, June 27, 2020.[4] As HHS acknowledged, that implementation date would require issuers to adjust their billing practices mid plan-year and would thus impose greater costs than delaying implementation until the start of a new plan-year. 84 Fed. Reg. at 71,697. As part of its response to those concerns, HHS explained that it would "consider extending enforcement discretion" to QHP issuers "that may face uncommon or unexpected impediments to timely compliance," but that it did not anticipate extending such discretion for more than one year after the publication of the Rule. *Id.* at 71,689-90. HHS acknowledged that the implementation date would entail "implementation challenges" and "added administrative costs," but it nevertheless explained that "a 6-month implementation timeline appropriately prioritizes the goals of improved statutory alignment with the additional time State Exchanges and issuers may need to implement this policy." *Id.* at 71,689.

[4] In light of the COVID-19 nationwide public health emergency, which emerged after Plaintiffs filed their motion, as well as litigation scheduling issues, HHS has delayed the implementation date of the Rule by 60 days, to August 27, 2020. *See* Medicare and Medicaid Programs, Basic Health Program, and Exchanges; Additional Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency and Delay of Certain Reporting Requirements for the Skilled Nursing Facility Quality Reporting Program, on display, May 1, 2020 https://s3.amazonaws.com/public-inspection.federalregister.gov/2020-09608.pdf (to be published in the Federal Register on May 8, 2020).

As Plaintiffs concede, HHS took account of the "burden to complete the one-time technical build to implement the necessary changes" that issuers would face, including "activities such as planning, assessment, budgeting, contracting, building and testing their systems; as well as one-time changes such as billing-related outreach and call center training." 84 Fed. Reg. at 71,697; *see also* Pls.' Mem. at 15, 25-27. HHS also provided specific estimates of the hours it would take business operations specialists, computer system analysts, computer programmers, computer and information system managers, and operations managers for each issuer to make the up-front changes necessary to comply with the Rule. *Id.* And HHS estimated the baseline hourly costs for each role, as well as the "additional costs such as higher contracting costs and overtime payments" that issuers would incur to implement the necessary changes within six months. *Id.* Plaintiffs do not challenge the accuracy of any of those calculations.

Nevertheless, Plaintiffs claim that HHS could not reasonably have determined that compliance within six months was possible, based on two isolated assertions from the Administrative Record. Pls.' Mem. at 29. First, the Blue Cross Blue Shield Association stated that "given the substantial investments that would be required to operationalize such stricter guidelines, most issuers would need up to two years for implementation." AR 080264. That comment provided no further substantiation for that estimate. *Id.* Second, America's Health Insurance Plans (AHIP) asserted that a survey of its members revealed that "[e]ighty-nine percent of respondent estimated that it would take at least 12 months to implement these changes while 67 percent responded that it would take at least 18 months." AR 080215. Notably, only nineteen health plans responded to the survey (and only 18 to the question about implementation time), and only ten of those members would actually be required to comply with the Rule; the remaining respondents "estimated the potential operations burden and timing if they were required to comply in the future." AR 080207.

The implementation time question allowed respondents to answer only in six-month increments, from "6 months" to "> 2 years." AR 080221. Only four respondents estimated that compliance would take more than eighteen months; eight estimated that compliance would take eighteen months; and six estimated that compliance would take twelve months or less. *Id.* AHIP's comment on the proposed rule did not offer any explanation of the basis for any of the respondents' estimates of the time needed for implementation. Needless to say, neither comment contradicts HHS's assumption that faster implementation would impose greater compliance costs on QHPs, and neither offers any basis to think that the QHPs nevertheless provided disinterested, objective estimates of the time needed for compliance. Likewise, neither comment commits to the position Plaintiffs take in their brief, that compliance on a faster than estimated timeline would be impossible, even with increased expenditure.

On these claims, Plaintiffs assert that HHS could not reasonably have concluded that compliance was even *possible* within six months (extendable up to twelve months for QHPs that attempt in good faith to achieve timely compliance). Pls.' Mem. at 30 ("HHS's unexplained conclusion that most issuers *could comply within six months* was at odds with 'specific, contradictory evidence' supplied by regulated entities and cannot be sustained.") (emphasis added, internal citation omitted). Far from being "clearly at variance with established facts," however, *id.*, HHS's implementation timeline is consistent with a substantial portion of the estimates offered in the comments, AR 080221, and supported with detailed unchallenged estimates of the time and costs needed to prepare QHPs' systems for compliance.

Plaintiffs also recapitulate their argument about the Rule's overall costs, complaining that HHS did not adequately justify the fifty-percent increase in implementation costs for the six-month timeline. Pls.' Mem. at 31. That argument fails for the same reason as before. HHS explained that

the timeline it chose "appropriately prioritizes the goals of improved statutory alignment." 84 Fed. Reg. at 71,689. That benefit cannot be quantified, which leaves Plaintiffs with no basis to claim that it cannot justify a fifty-percent increase (or any other particular amount) in administrative costs.

Finally, Plaintiffs' contention that HHS "did not seriously consider *any* implementation deadline longer than six months" is incorrect. Pls.' Mem. at 31. HHS expressly recognized that issuers might attempt in good faith to meet that deadline but nevertheless fail to achieve timely compliance, and concluded that enforcement discretion could appropriately deal with such situations for up to twelve months. Plaintiffs do not even attempt to offer any reason to prefer an extended deadline for all QHPs over a shorter deadline with the possibility of enforcement discretion beyond that deadline for those plans that can demonstrate the need for it, despite having made good faith compliance efforts.

C. HHS Appropriately Considered the Impacts of Allowing Enrollees to Opt Out of Coverage for Non-Hyde Abortion Services

Plaintiffs claim that HHS "failed to consider the financial impact" of allowing enrollees to opt out of coverage for non-Hyde abortion services "on plans and enrollees who seek to maintain abortion coverage." Pls.' Mem. at 31. Beyond claiming that there will be such an impact, however, Plaintiffs' argument is notably light on details, such as what they anticipate that impact would be or why it should affect HHS's exercise of enforcement discretion. Plaintiffs also ignore HHS's discussion of the reasoning behind its exercise of enforcement discretion, which appropriately addresses the likely impacts of that enforcement posture.

As the Rule notes, QHPs' ability to take advantage of HHS's enforcement discretion "would be subject to applicable state law." 84 Fed. Reg. at 71,686. Thus, the so-called "Opt-Out Policy" will apply only to issuers in a minority of states—*i.e.*, those considering whether to

"continue[] offering coverage of non-Hyde abortion services in states that do not require it" in light of the increased burden they may face to comply with the separate billing policy. *Id.* at 71,705. HHS announced the "Opt-Out Policy" enforcement posture as one of several components of its effort to "mitigate the risk of potential coverage loss" associated with the Rule. *Id.* At the same time, HHS also announced that it "will not take an enforcement action against a QHP issuer that adopts and implements a policy . . . applied uniformly to all its QHP enrollees, under which an issuer does not place an enrollee into a grace period and does not terminate QHP coverage based solely on the policy holder's failure to pay the separate payment for coverage of non-Hyde abortion services." *Id.*

Together with modifications to the proposed rule to reduce the costs of compliance with the Rule, HHS projected that this package of enforcement postures would "decreas[e] the likelihood that issuers will drop coverage of non-Hyde abortion services solely to avoid the burden associated with these changes or solely to avoid having to terminate enrollees coverage for non-payment of miniscule amounts." 84 Fed. Reg. at 71,705. In other words, the financial impact of the "Opt-Out Policy" is to reduce the cost to issuers of continuing to offer QHPs that cover non-Hyde abortion services relative to dropping those services from their plans altogether in states where that is possible. It thus helps to shore up the availability of non-Hyde abortion services for "plans and enrollees who seek to maintain abortion coverage." Pls.' Mem. at 31. Plaintiffs do not even acknowledge this projection, let alone contest it.

III. PLAINTIFFS' NOTICE AND COMMENT CLAIM IS MERITLESS

Plaintiffs argue that HHS failed to comply with the APA's notice-and-comment requirements because it stated for the first time in the Rule's preamble that it does not plan to take enforcement action against QHPs that modify the benefits of a plan to effectively allow enrollees

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

"A directive that doesn't establish a 'binding norm' and leaves agency officials free to exercise their discretion qualifies as a general statement of policy." *Casa de Maryland*, 924 F.3d at 702 (citation omitted). Such general statements of policy "advise the public prospectively of the manner in which the agency proposes to exercise a discretionary power." *Chrysler Corp. v. Brown*, 441 U.S. 281, 302 n.31 (1979) (quoting Dep't of Justice, Attorney General's Manual on the APA 30 n.3 (1947)). And a "general statement of policy" often "announces the course which the agency intends to follow in future adjudications." *Pac. Gas & Elec. Co. v. FPC*, 506 F.2d 33, 38 (D.C. Cir. 1974).

By contrast, legislative rules, which are subject to the APA's notice-and-comment requirements, have the force and effect of law, and thus create legally enforceable rights or obligations in regulated parties. *Perez*, 575 U.S. at 96; *Chrysler*, 441 U.S. at 302-03. In other words, an "agency action that . . . would be the basis for an enforcement action for violations of those obligations or requirements—is a legislative rule." *Nat'l Mining Ass'n v. McCarthy*, 758 F.3d 243, 251 (D.C. Cir. 2014). The APA generally leaves to the agency the choice of which mode to employ. *See* 5 U.S.C. § 553(b). If an agency chooses to issue a statement of policy rather than

a legislative rule, that choice has consequences: The agency's statements in the policy have "no binding effect on members of the public or on courts." 1 Richard J. Pierce, Jr., Administrative Law Treatise § 6.3, at 419 (5th ed. 2010).

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

Applying these principles, HHS's so-called "Opt-Out Policy" can only be viewed as a general statement of policy, to which the APA's notice-and-comment procedures do not apply. *See* 5 U.S.C. § 553(b)(3)(A). HHS has created no "binding norm" that would apply to regulated parties or the courts in any way; it does not even "bind" HHS in any meaningful sense. *See Casa de Maryland*, 924 F.3d at 702 (holding that an agency memorandum did not create a "binding norm," and that notice-and-comment procedures were not required, because it did not "replace[ ] agency discretion with a new binding rule of substantive law" and did not "bind subsequent Secretaries who might disagree with [its] reasoning"). Nor does HHS's statement regarding how it plans to exercise its enforcement discretion affect the ability of states to exercise their primary enforcement authority. *See* 42 U.S.C. § 300gg-22(a)(1). It reflects nothing more than guidance regarding how

the agency currently intends to exercise its discretion with respect to its own, secondary enforcement authority going forward. Plaintiffs' notice-and-comment claim therefore fails.

IV. THE SCOPE OF ANY RELIEF SHOULD BE LIMITED

For the reasons discussed above, the Court should deny Plaintiffs' motion and enter judgment in favor of Defendants. But even if the Court were to disagree, in accordance with its constitutionally prescribed role, any relief should be limited to redressing the injuries of the parties before it. *See Gill v. Whitford*, 138 S. Ct. 1916, 1921, 1933-34 (2018).

Here, Plaintiffs fail to show that nationwide relief is necessary to redress their alleged injuries. The APA's general instruction that unlawful agency action "shall" be "set aside," 5 U.S.C. § 706(2), is insufficient to mandate such a departure. Indeed, the Fourth Circuit has rejected the argument that the APA requires a reviewing court to set aside a rule that it deems unlawful "for the entire country," finding instead that "[n]othing in the language of the APA requires [a court] to exercise such far-reaching power." *Virginia Soc'y for Human Life, Inc. v. FEC*, 263 F.3d 379, 394 (4th Cir. 2001), *overruled on other grounds by The Real Truth About Abortion, Inc. v. FEC*, 681 F.3d 544 (4th Cir. 2012). As the Fourth Circuit explained, "accepting [the] argument" that under the APA, the proper remedy "is an order setting aside the unconstitutional regulation for the entire country" "would result in the same harm as upholding the nationwide injunction." *Id*. at 393-94.

The Fourth Circuit's position is correct—and binding on this Court. Although the APA instructs that unlawful agency action "shall" be "set aside," 5 U.S.C. § 706(2), that section "does not deal with remedial orders at all," but simply "directs the court not to decide [a case] in accordance with [an unlawful] agency action." John Harrison, *Section 706 of the Administrative Procedure Act Does Not Call for Universal Injunctions or Other Universal Remedies*, Yale J. on

Reg. (Apr. 12, 2020), https://www.yalejreg.com/bulletin/section-706-of-the-administrative procedure-act-does-not-call-for-universal-injunctionsor-other-universal-remedies/. And to the extent Section 706 affects remedies, it does not authorize, let alone require, that the agency action be set aside, not just as applied to the plaintiff in a particular case, but to everyone. As another court in this District recently explained in considering this precise issue, "the APA does not require a reviewing court vacating a rule to do so on a nationwide basis," and "[t]here is no authority either in Fourth Circuit or Supreme Court jurisprudence that mandates such a finding." *Mayor & City Council of Baltimore v. Azar*, Civil Action No. RDB-19-1103, Mem. Op., 2020 WL 1873947, at *4 (D. Md. Apr. 15, 2020) (denying the plaintiff's motion for reconsideration to expand the effect of the Court's vacatur nationwide). Yet, even if the APA were ambiguous in this regard, it is axiomatic that equitable relief "does not follow from success on the merits as a matter of course" but rather is subject to "equitable discretion," *Winter v. NRDC, Inc.*, 555 U.S. 7, 32 (2008), and that a court "do[es] not lightly assume that Congress has intended to depart from established principles" regarding equitable discretion, *Weinberger v. Romero-Barcelo*, 456 U.S. 305, 313 (1982). The Supreme Court therefore has confirmed that, even in an APA case, "equitable defenses may be interposed." *Abbott Labs. v. Gardner*, 387 U.S. 136, 155 (1967).

Nationwide relief would be particularly harmful here given that another district court, in California, is currently considering a similar challenge. And although a district court in the Eastern District of Washington recently declared the Rule invalid and without force in the State of Washington based on State law not applicable here, *see Washington v. Azar*, No. 20-cv-00047-SAB, Order (E.D. Wash. Apr. 9, 2020), the government may still appeal that decision. If the government prevails in those other cases, either at the district court or on appeal, nationwide relief here would render those victories largely meaningless as a practical matter.

CONCLUSION

For the foregoing reasons, Defendants respectfully ask the Court to deny Plaintiffs' motion for summary judgment and grant Defendants' cross-motion for summary judgment.

Dated: May 5, 2020

Respectfully submitted,

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IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MARYLAND

PLANNED PARENTHOOD OF MARYLAND, INC., *et al.* *Plaintiffs,* v. ALEX M. AZAR II, Secretary of the United States Department of Health and Human Services in his official capacity, *Defendants*.	Case No. 1:20-cv-00361-CCB

[PROPOSED] ORDER

The Court, having considered Defendants' motion for summary judgment, Plaintiffs' opposition, and the entire record herein, orders as follows:

IT IS HEREBY ORDERED that Defendants' motion is GRANTED, and summary judgment is entered in Defendants' favor.

IT IS SO ORDERED.

Dated: _____

_____
Hon. Catherine C. Blake
United States District Judge