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UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF CALIFORNIA

STATE OF CALIFORNIA, *et al.*, Plaintiffs, v. U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, *et al.*, Defendants.	Case No.: 3:20-cv-00682-LB **DEFENDANTS' REPLY IN SUPPORT OF CROSS-MOTION FOR SUMMARY JUDGMENT** Date: June 18, 2020 Time: 9:30 AM Judge: Hon. Laurel Beeler Courtroom: Courtroom B, 15th Floor Trial: None

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INTRODUCTION

This case is, at bottom, a disagreement over the best interpretation of an ambiguous provision of the Affordable Care Act ("ACA"). Clearly, if it were up to Plaintiffs, they would not require issuers of qualified health plans ("QHPs") to separately bill enrollees for coverage of non-Hyde abortion services. But Plaintiffs' strong disagreement over HHS's interpretive choice does not make the Rule unlawful. For the reasons explained in Defendants' opening brief and below, HHS's interpretation of Section 1303 fits well within the statutory language and is supported by the available legislative history. Plaintiffs' attempt to demonstrate that the Rule conflicts with Section 1554 and Section 1557 of the ACA also fails.

Nor can Plaintiffs succeed on their challenge to HHS's statement in the Rule's preamble that it does not currently intend to bring enforcement actions against QHP issuers in certain circumstances—which Plaintiffs refer to as the "opt-out policy." The agency's exercise of its enforcement discretion is unreviewable as a matter of black-letter law, and, in any event, Plaintiffs cannot show that HHS's current enforcement posture is unlawful. Plaintiffs' procedural APA claim also lacks merit, because the "opt-out policy" is a general statement of enforcement policy, not a legislative rule that requires notice-and-comment rulemaking.

Plaintiffs' argument that the Rule is arbitrary and capricious likewise fails because Plaintiffs refuse to acknowledge the effect of Congress's policy choice to require the collection of separate payments on HHS's implementation of that instruction. Thus, while Plaintiffs attack the Rule's costs and its implementation timeline, they fail to account for the benefits of improved statutory compliance. The Rule's preamble, however, fully explained HHS's reasoning and shows that HHS considered all of the relevant factors. That is all the APA requires.

Finally, Plaintiffs offer no real response to the uniform precedents demonstrating that the Rule does not offend the Tenth Amendment. Instead, Plaintiffs attempt to constructively amend their complaint to raise a distinct argument under Section 1303's preemption clause. This Court should not permit Plaintiffs to change course at this stage; in any case, Plaintiffs' preemption argument is meritless.

ARGUMENT

I. THE RULE IS CONSISTENT WITH THE ACA.

Plaintiffs fail to show that the challenged Rule conflicts with the ACA. Congress's express and broad delegation of rulemaking authority to HHS in Section 1321(a) of the ACA 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. *See* Defs.' Opp'n to Pls.' Mot. for Summ. J. & Notice and Cross-Motion for Summ. J., with Mem. of P. & A. at 7-8, ECF No. 43 ("Defs.' Mem."). Plaintiffs' arguments that the statute forecloses HHS's interpretation lack merit.

A. The Rule Does Not Violate Section 1303.

1. The Rule Is Permissible Under Section 1303(b)(2)(B).

Plaintiffs' front-line statutory argument is that HHS is not entitled to *Chevron* deference because, they claim, Section 1303 *unambiguously* forecloses HHS's interpretation set forth in the Rule. *See* Pls.' Opp'n to Defs.' Mot. for Summ. J. & Reply in Supp. of Pls.' Mot. for Summ. J. at 14-15, ECF No. 44 ("Pls.' Opp'n"). They argue that the Rule is impermissible because Section 1303(b)(2)(B)(i) says that issuers "shall collect . . . *a separate payment*" rather than "shall *separately collect* payments." Pls.' Opp'n at 14. But the "separate payment" language in Section 1303(b)(2)(B) requires collection of a separate payment specifically for the value of coverage for non-Hyde abortion services, 42 U.S.C. § 18023(b)(2)(B)(i), rather than a single payment for coverage of all services, and separate bills are the most natural way to accomplish that end.

As HHS explained in the NPRM, the requirement that issuers "shall collect . . . a separate payment" for coverage of non-Hyde abortion services, along with the requirement that QHP issuers "shall deposit all such separate payments into separate allocation accounts," 42 U.S.C. § 18023(b)(2)(B)(ii), "contemplates issuers billing for two separate 'payments' of these two amounts (for example, two different checks for two different transactions)." 83 Fed. Reg. 56,015, 56,022 (Nov. 9, 2018). Plaintiffs clearly disagree with that interpretation, but they cannot show

that it is foreclosed by the statute. In fact, the Rule furthers the purpose of Section 1303(b)(2)(B) by requiring issuers to provide separate bills for coverage of non-Hyde abortion services.

Although Plaintiffs assert that "Congress was not concerned with consumers separately paying two portions of their health insurance premium through individually different transactions," Pls.' Opp'n at 14, the statutory text suggests just the opposite—for example, by requiring "a separate deposit" for premiums for coverage of non-Hyde abortion services paid through employee payroll deposits. *See* 42 U.S.C. § 18023(b)(2)(B)(ii). So too does the relevant legislative history, cited in Defendants' opening brief. *See* Defs.' Mem. at 9. As then-Senator Ben Nelson, who proposed the relevant statutory language, explained, "if you are receiving Federal assistance to buy insurance, and if that plan has any [non-Hyde] abortion coverage, the insurance company must bill you separately, and you must pay separately." Cong. Rec. S14134 (Dec. 24, 2009) (statement of Sen. Nelson). Plaintiffs conspicuously ignore that legislative history in their attempt to supplant what Congress actually did in Section 1303(b)(2)(b) with their preferred policy outcome.

Plaintiffs also flip the *Chevron* framework on its head when they say that the "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." Pls.' Opp'n at 15. HHS has never asserted that the Section 1303 "*mandate*[*s*]" its interpretation. *Id*. Although HHS believes that the Rule better aligns issuer practice with the statutory separate-payment requirement, the appropriate question under *Chevron* is whether the Rule's requirement that QHP issuers bill separately is *permissible*, not whether Section 1303 *requires* HHS's interpretation. Certainly nothing in Section 1303(b)(2)(B) unambiguously prohibits HHS's interpretation, and therefore HHS is entitled to deference under *Chevron*.

2. The Rule Does Not Violate Section 1303(b)(3)'s Notice Provisions.

Plaintiffs' arguments based on Section 1303(b)(3) also fail. The parties' core dispute is whether the term "notice," as used in Section 1303(b)(3)(A) and Section 1303(b)(3)(B), includes a bill or invoice for insurance coverage. However, as Defendants have explained, and as Plaintiffs concede, the term "notice" is not defined in the ACA. *See* Defs.' Mem. at 12; Pls.' Opp'n at 16.

And nothing in the statute forecloses HHS's interpretation that a "notice" does not include a monthly bill. To the contrary, Section 1303(b)(3)(A) instructs issuers to provide a "notice" but "only as part of the summary of benefits and coverage explanation, at the time of enrollment," 42 U.S.C. § 18023(b)(3)(A). This text strongly suggests that "notice" refers to information issuers send to enrollees to explain the extent of their coverage, not a monthly bill or invoice for payment, *see* Defs.' Mem. at 12. The fact that Plaintiffs are forced to rely on what they call "accepted industry practice" and "common sense business practice," and even sixteenth-century French etymology, Pls.' Opp'n at 16-17, only shows that the statute is open to agency interpretation.

Moreover, as HHS explained in the preamble to the Rule, the requirement in Section 1303(b)(2)(B)(i) that issuers "collect . . . a separate payment" for coverage of non-Hyde abortion services further suggests that a "notice" should not include a bill or invoice, in order to harmonize Section 1303(b)(3) with Section 1303(b)(2)(B). *See* 84 Fed. Reg. 71,674, 71,694 (Dec. 27, 2019). Plaintiffs, of course, disagree that Section 1303(b)(2)(B) permits the issuance of separate bills or invoices, but they are incorrect for the reasons discussed above. *See* Part I.A.1, *supra*. And, as with their argument regarding Section 1303(b)(2)(B), Plaintiffs' reading of Section 1303(b)(3) is squarely at odds with the available legislative history, which Plaintiffs do not address, and which indicates that "the insurance company must bill [ ] separately" for non-Hyde abortion coverage. Cong. Rec. S14134 (Dec. 24, 2009) (statement of Sen. Nelson).

Plaintiffs are thus forced to rely on the language in the heading to Section 1303(b)(3)(B), "Rules relating to payments," Pls.' Opp'n at 15-16, to argue that the limitations on notices also apply to monthly bills. *Id.* at 15-16. But there is no dispute over whether Section 1303(b)(3)(B) relates to "payments"; it specifies that certain types of information—*i.e.*, "[t]he 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"—shall provide payment "information only with respect to the total amount of the combined payments for [non-Hyde abortion services] and other services covered by the plan." 42 U.S.C. § 18023(b)(3)(B). There is nothing in Section 1303(b)(3)(B), or any other provision of the ACA,

however, that suggests that the "notice" referenced there includes a bill or invoice, so Plaintiffs' argument is unpersuasive.

Notably, Plaintiffs appear to concede that their interpretation would not only make the current Rule invalid but also mean that HHS's pre-Rule interpretation violated Section 1303(b)(3) because it allowed issuers to send enrollees a either single bill separately itemizing the premium amount for non-Hyde abortion services or a separate bill just for those services. *See* Defs.' Mem. at 13. Their only response is that HHS's prior regulations "are not at issue before this Court." Pls.' Opp'n at 16. But by asking the Court to vacate the current Rule, Plaintiffs are necessarily seeking to reimpose HHS's prior interpretation, even though the prior regime would also be unlawful under their theory of the statutes.

3. The Rule Does Not "Fundamentally Revise[] Congress' Intent."

Plaintiffs' final argument with respect to Section 1303 is that the HHS's interpretation is so fundamentally at odds with the statute that HHS lacked authority to promulgate the Rule. *See* Pls.' Opp'n at 25-26. Plaintiffs double-down on *MCI Telecommunications Corp. v. AT&T*, 512 U.S. 218 (1994) (*MCI Telecom*), to suggest that the Rule represents the same sort of "whole new regime of regulation" as in that case. *See* Pls.' Opp'n at 25; *MCI Telecom*, 512 U.S. at 234. Plaintiffs' argument finds no support in any fair reading of *MCI Telecom*, where the Supreme Court addressed the FCC's effort to fundamentally alter a decades-old regime for regulating an entire industry—attempting to move from rate-regulation to free-market competition—through a provision in the Communications Act of 1934 allowing the agency to "modify any requirement" in the relevant statutory section. *See id.* at 224-25. Here, the Rule's changes represent nothing near the sort of tectonic shift in the healthcare industry, or even with respect to healthcare coverage provided through ACA Exchanges, that would make this case comparable to *MCI Telecom.* Rather, the Rule reasonably requires QHP issuers to send a separate bill for coverage of one particular type of service based on HHS's common sense conclusion that requiring separate bills advances the statute's requirement that issuers "collect . . . a separate payment" for coverage of services and "deposit all such separate payments into separate allocation accounts." *See* 84 Fed. Reg. at 71,695;

42 U.S.C. § 18023(b)(2)(B); *see also* 80 Fed. Reg. 10,750, 10,840 (Feb. 27, 2015) (identifying sending a bill that separately itemizes the premium amount for coverage of non-Hyde abortion services as an option to satisfy the requirements of Section 1303(b)(2)(B)).

Plaintiffs also fail to show that the Rule is invalid because it "discounts the unambiguous congressional intent behind the ACA." Pls.' Opp'n at 25. If anything, as discussed above, the Rule *furthers* congressional intent in light of (1) the requirement in Section 1303(b)(2) that issuers collect separate payments for coverage of non-Hyde abortion services, which is reinforced with respect to payments made through payroll deductions; and (2) then-Senator Nelson's statement in the relevant legislative history that insurance companies must bill separately for abortion coverage. *See* Part I.A.1, *supra*. The Court should also reject Plaintiffs' bald assertion that the Rule "is [ ] an impermissible interpretation of Section 1303 because it could effectively foreclose abortion coverage in private insurance in many states." Pls.' Opp'n at 26. The Rule does not regulate abortion coverage in any way, much less foreclose it; nor, as HHS stated explicitly, does it preempt State laws *requiring* coverage of non-Hyde abortion services on ACA Exchanges, *see* 84 Fed. Reg. at 71,694. Plaintiffs' remaining discussion regarding Congress's rejection of certain legislation that would have imposed restrictions related to coverage of abortions services is *a propos* of nothing. *See* Pls.' Opp'n at 26. It should go without saying that the Rule does not impose any additional *legislative* requirements. The Rule merely interprets an existing, ambiguous statute, which HHS is charged with implementing, in the way the agency believes best advances congressional intent. For all the reasons above, the Court should reject Plaintiffs' arguments based on Section 1303.

B. Plaintiffs' Challenge to HHS's Exercise of Its Enforcement Discretion Fails.

1. The So-Called "Opt-Out Policy" Is Unreviewable and Lawful.

The Court should likewise reject Plaintiffs' argument that the so-called "opt-out policy" is reviewable. In an attempt to avoid the strong presumption that enforcement decisions are discretionary and therefore unreviewable, *see Heckler v. Chaney*, 470 U.S. 821 (1985), Plaintiffs claim at several points that HHS has "codified" its current enforcement posture "through a

regulation" or "in a published regulation." Pls.' Opp'n at 18. That is incorrect. Although HHS's statement regarding its enforcement discretion appears in the Federal Register, it does not modify the regulatory text in the Code of Federal Regulations. *Compare* 84 Fed. Reg. at 71,686 (describing HHS's current posture), with *id.* at 71,710 (providing the modified text to 45 C.F.R. § 156.280). HHS's statement regarding its enforcement discretion also does not bind the agency, or anyone else, and Plaintiffs do not even attempt to argue that Congress directed HHS as to when or how to exercise its enforcement discretion, such that an exception to the presumption in *Chaney* might apply. Plaintiffs therefore cannot succeed on their challenge to the so-called "opt-out policy." *See* Defs.' Mem. at 14-16.

Even assuming the Court could somehow review HHS's current intent regarding its enforcement discretion, Plaintiffs' merits arguments also fail. Plaintiffs again appear to suggest that HHS's exercise of its enforcement discretion somehow changes substantive law—for example, "to allow for the alteration of the coverage terms of a qualified health plan during the plan year," or "to allow issuers to eliminate a health benefit for all enrollees in the plan." Pls.' Opp'n at 19. The "opt-out policy" does no such thing. As HHS acknowledged in the preamble, the requirements of Section 1303 remain in effect, even if HHS does not currently intend to exercise its secondary enforcement authority in certain situations. *See* 84 Fed. Reg. at 71,686. Indeed, for any violations, QHP issuers are subject to enforcement actions by States, which remain the primary enforcers of those requirements. *See* 42 U.S.C. § 300gg-22(a)(1); 84 Fed. Reg. at 71,692 ("As is the case with many provisions in the [ACA], states are generally the entities primarily responsible for implementing and enforcing the provisions in Section 1303 . . . related to individual market QHP coverage of non-Hyde abortion services."). Plaintiffs are therefore incorrect that "HHS's position . . . renders Section 1303 null," even as to the narrow circumstances in which HHS has indicated it intends to exercise its enforcement discretion. Pls.' Opp'n at 19.[1]

[1] For the same reasons, Plaintiffs' argument that HHS's exercise of its enforcement discretion somehow "Interferes with State Authority" fares no better. Pls.' Opp'n at 26-27. Plaintiffs claim that the so-called "opt-out policy" "abrogates authority that is specifically designed for the States." *Id.* at 27. Not so. As discussed above, States retain their primary enforcement authority regarding the requirements of Section 1303, and nothing in the Rule interferes with

2. Plaintiffs' Procedural APA Claim Lacks Merit.

As Defendants explained at length in their opening brief, the so-called "opt-out policy" is a general statement of policy regarding how the agency currently intends to exercise its enforcement discretion going forward. *See* Defs.' Mem. at 32-34. An agency's announcement of how and when it will pursue (or forbear from) enforcement is a quintessential use of general policy statements, to which the APA's procedural requirements do not apply. *See Clarian Health West, LLC v. Hargan*, 878 F.3d 346, 358-59 (D.C. Cir. 2017). Plaintiffs make no effort to address Defendants' arguments, or to explain why HHS needed to submit its statement regarding the exercise of its enforcement discretion to notice-and-comment rulemaking. Rather, Plaintiffs state in a single conclusory clause that "[t]he Rule's opt-out policy is a legislative rule not immune from judicial review." *See* Pls.' Opp'n at 27.[2] Plaintiffs' procedural APA claim therefore fails.

C. The Rule Does Not Violate Section 1554.

Plaintiffs argue that the Rule violates Section 1554 because "a foundational aspect of healthcare access in this country is insurance coverage," and they claim that "imposing requirements that *implicate* continued coverage for healthcare consumers or the loss of a critical health benefit [ ] constitute a 'direct interference with certain health care activities.'" *See* Pls.' Opp'n at 21-22 (emphasis added). Plaintiffs' argument is unmoored from the text of Section 1554 and is at odds with the Ninth Circuit's interpretation of that provision.

The Rule here does not impose anything like a "direct government interference with health care." *California v. Azar*, 950 F.3d 1067, 1094 (9th Cir. 2020) (en banc). As the Ninth Circuit has explained, "[t]he most natural reading of § 1554 is that Congress intended to ensure HHS, in implementing the broad authority provided by the ACA, does not improperly *impose regulatory burdens on doctors and patients.*" *Id*. The Rule creates no such regulatory burden. The Rule applies

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States' ability in that respect. HHS has merely explained its current intention not to take separate enforcement actions in some circumstances. Plaintiffs' argument that HHS's exercise of its own discretion "abrogates" States' independent authority is nonsensical.

[2] Moreover, the case Plaintiffs cite for that proposition, *Hall v. EPA*, 273 F.3d 1146 (9th Cir. 2001), does not address the distinction between legislative rules and general statements of policy.

only to QHP issuers—not doctors or patients—and requires them to provide a separate bill to enrollees for coverage of non-Hyde abortion services. *See* 84 Fed. Reg. at 71,710 (42 C.F.R. § 156.280). To accept Plaintiffs' argument that the Rule nevertheless violates Section 1554 because it could hypothetically lead to a reduction in health insurance coverage, one must ignore any meaningful distinction between "direct" interference and indirect consequences.

Plaintiffs' argument also fails because it lacks a limiting principle, as Defendants have explained. *See* Defs' Mem. at 18-20. Plaintiffs offer up a token acknowledgement that Section 1554 (obviously) does not prevent HHS from imposing administrative burdens on issuers, for things like documenting their compliance with the law. But Plaintiffs do not explain *why* such burdens would not violate Section 1554 under their interpretation of that provision. Indeed, as Plaintiffs interpret Section 1554, any regulation that could "implicate continued coverage" by increasing issuers' administrative costs and, perhaps, indirectly affect coverage decisions would be a "direct interference with certain health care activities" and therefore impermissible. Pls.' Opp'n at 21-22. That cannot be what Congress intended in Section 1554, and, indeed, that is not how the Ninth Circuit has interpreted the provision. *See California*, 950 F.3d at 1094.

D. The Rule Does Not Violate Section 1557.

The Court should also reject Plaintiffs' Section 1557 claim out of hand. As Plaintiffs previously stated, but now appear to ignore, in order to show a violation of Section 1557, which incorporates Title IX of the Education Amendments of 1972, *see* 42 U.S.C. § 18116(a), they must provide "*proof* of an *intentional* discriminatory act." Pls.' Notice of Mot. & Mot. for Summ. J. with Mem. of P. & A. at 32, ECF No. 36 ("Pls.' Mot.") (emphasis added); *see also* Defs.' Mem. at 20-21. Plaintiffs provide no such proof, because there is none. There is no question that HHS provided neutral and non-discriminatory reasons for its interpretive changes implemented in the Rule. *See* 84 Fed. Reg. at 71,694; Pls.' Opp'n at 22.

Plaintiffs' submission—in short, that "the intention to discriminate is evident in the logic of HHS's provisions" because "only women" access abortions, Pls.' Opp'n at 22—comes nowhere close to meeting their burden. As the Supreme Court held in *Bray v. Alexandria Women's Health*

Clinic, 506 U.S. 263 (1993), the fact that only women can become pregnant does not mean that even the direct disfavoring of abortion is "*ipso facto* sex discrimination." Defs.' Mem. at 21 (quoting *Bray*, 506 U.S. at 273). The potential disparate *impact* on women does not prove that HHS promulgated the Rule "*because of*" any potential "adverse effects upon an identifiable group." *Bray*, 506 U.S. at 272, 274 (concluding that preventing abortion "is not the stuff out of which . . . invidiously discriminatory animus is created"). Plaintiffs offer no reason to question the Rule's stated purpose—*i.e.*, to "achiev[e] better alignment with the statutory requirement for issuers to collect a separate payment for coverage of non-Hyde abortion services," *see* 84 Fed. Reg. at 71,695—and HHS's explanation is entitled to a presumption of regularity "in the absence of clear evidence to the contrary," *United States v. Chem. Found.*, 272 U.S. 1, 14-15 (1926).

II. THE RULE IS NOT ARBITRARY AND CAPRICIOUS.

As Defendants explained in their opening brief, HHS's reason for adopting the Rule was both clear and straightforward: "Congress intended that QHP issuers collect two distinct (that is, 'separate') payments, one for coverage of non-Hyde abortion services, and one for coverage of all other services covered under the policy, rather than 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." 84 Fed. Reg. at 71,684. Although itemizing components in a single bill, HHS explained, "arguably identifies two 'separate' amounts for two separate purposes," *id.* at 71,693, when Congress required issuers to "collect . . . a separate payment" for the portion of the premium representing the actuarial value of covering non-Hyde abortion services and for the remainder of the premium, 42 U.S.C. § 18023(b)(2)(B)(i), it intended for the payments to be "separate" in the sense of taking place in distinct transactions, *id.* at 71,684. In short, "separate" payments means "distinct" payment transactions, not just separately itemized components of a single transaction.

Plaintiffs mistake the simplicity of HHS's interpretation for a lack of explanation and accuse HHS of circular reasoning. *See* Pls.' Opp'n at 2. But their argument misunderstands both the Rule's reasoning and the legal principles that govern this Court's review. It is neither "a bare-bones restatement of HHS's position" nor "circular logic," *id.*, to interpret the phrase "separate

payment" to mean "distinct payment transaction." Had Plaintiffs chosen to, they could have attempted to argue that "separate" does not mean "distinct" or that a single payment transaction can contain two "separate" payments. They have conspicuously failed to do so. But Plaintiffs' litigation decision not to *contest* the central interpretive step underpinning the Rule does not mean that HHS failed to *explain* that step. A circular argument assumes its own conclusion; a circular justification for the Rule would thus be something like "Section 1303 requires distinct payment transactions because it requires distinct payment transactions." HHS's actual reasoning, in contrast, is that Section 1303 requires distinct payment transactions because it requires separate payments, and the term "separate payment" should be interpreted to mean "distinct payment transaction." 84 Fed. Reg. at 71,684. Interpreting "separate" to mean "distinct" is so clearly justified that Plaintiffs apparently have failed to notice that it is, in fact, an interpretation. But an argument is not circular merely because it is both simple and strong (and, in this case, uncontested).

Most of Plaintiffs' argument that the Rule is arbitrary and capricious relies on overlooking the Rule's careful reasoning. Despite Plaintiffs' rhetoric, HHS does not claim the power to "without justification, arbitrarily decide to change regulations that carry the force of law." Pls.' Opp'n at 3. Instead, HHS claims the power to reconsider its regulations and bring them more in line with the statutes they interpret through a process, like this one, that complies with the APA. Nor does HHS claim that the Rule "is not subject to arbitrary and capricious review." *Id.* at 4. HHS merely argues that the *statutory text* requiring a "separate payment" is not subject to arbitrary and capricious review. Remarkably, Plaintiffs disagree. They assert, without citing any authority, that "[e]ven assuming that HHS's Rule is a permissible statutory interpretation, such an excessively expensive policy change . . . is not a *reasonable* agency decision." Pls.' Opp'n at 9-10. In other words, even if Congress did intend to require separate transactions, Plaintiffs assert that HHS could not reasonably carry out that decision. Plaintiffs offer no support for that contention.

To justify a regulation as a matter of statutory interpretation rather than policy discretion, an agency need only explain that the regulation "'is more consistent with statutory language' than alternative policies," and it must "analyze or explain why the statute should be interpreted" as the

agency proposes. *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)). "The agency need provide only a 'minimal level of analysis' to avoid its action being deemed arbitrary and capricious." *City of Los Angeles v. Barr*, 929 F.3d 1163, 1181 (9th Cir. 2019) (quoting *Encino Motorcars*, 136 S. Ct. at 2125). The agency satisfies this requirement "when the agency's explanation is clear enough that its path may reasonably be discerned." *Encino Motorcars*, 136 S. Ct. at 2125 (quotation omitted).

Encino Motorcars and the cases it relies on illustrate the boundary between adequate and inadequate explanations. In *Encino Motorcars*, the Department of Labor attempted to justify a regulation interpreting an amendment to the Fair Labor Standards Act not to apply to certain automobile dealership employees. *Encino Motorcars*, 136 S. Ct. at 2121. The agency's justification for that conclusion, in its entirety, was that "the statute does not include such positions and the Department recognizes that there are circumstances under which the requirements for the [provision] would not be met," and that it "believes that this interpretation is reasonable" and "sets forth the appropriate approach." *Id.* at 2127. As the Supreme Court understood it, the agency's argument really was circular: the statute did not include the employees at issue, according to the agency, because it "does not include such positions." *Id.* That argument failed to provide even the "minimal level of analysis" necessary to survive arbitrary and capricious review. *Id.* at 2125.

But the Supreme Court was careful to note that it did not hold that agencies may not rely on their interpretation of statutory text in making regulations: "an agency may justify its policy choice by explaining why that policy 'is more consistent with statutory language' than alternative policies." *Id.* at 2127 (quoting *Long Island Care at Home*, 551 U.S. at 175). The case the Court cited for that holding, in turn, involved a statutory provision exempting any employee "employed in domestic service employment to provide companionship services" from the Fair Labor Standards Act's minimum wage and maximum hours rules. *Long Island Care at Home*, 551 U.S. at 162 (quoting 29 U.S.C. § 213(a)(15)). The Department of Labor interpreted that provision to apply to workers employed by third-party employers or agencies. *Id.* at 175. The agency's explanation for its interpretation, in its entirety, was that it had "'concluded that these exemptions

can be available to such third party employers' because that interpretation is 'more consistent' with statutory language that refers to '"any employee" engaged "in" the enumerated services' and with 'prior practices concerning other similarly worded exemptions.'" *Id.* (quoting 40 Fed. Reg. 7404, 7405 (Feb. 20, 1975)). The Supreme Court deemed that a "reasonable, albeit brief, explanation." *Id.* And the case the Supreme Court cited for that conclusion, *Global Crossing Telecomms., Inc. v. Metrophones Telecomms., Inc.*, 550 U.S. 45 (2007), held that an agency had adequately justified a determination when its "opinion simply state[d]" its conclusion, but the "context and cross-referenced opinions" made the agency's "rationale obvious." *Global Crossing*, 550 U.S. at 63-64.

The Rule's explanation of its interpretation of Section 1303 is markedly superior to any of the agency explanations discussed in those cases. In contrast to *Encino Motorcars*, the Rule does not assume its conclusion but rather explains that its interpretation of "separate payments" as "distinct payments" means that payments in a single transaction are not sufficiently "separate" to satisfy the statute, even if itemized as separate charges. 84 Fed. Reg. at 71,684. And unlike *Long Island Care at Home*, the Rule does not rely on unstated assumptions about the meaning of statutory terms, such as the word "any." *Long Island Care at Home*, 551 U.S. at 175. Instead, the Rule clearly states its interpretation of the relevant statutory language. 84 Fed. Reg. at 71,694.

That is all the APA requires. Plaintiffs fault the Rule for not pointing to factual evidence to support its interpretation, Pls.' Opp'n at 2, and for failing to explain why "separate" should be interpreted as "distinct" *as of December 27, 2019*, *id.* at 3 ("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."). But "[a]gencies are free to change their existing policies as long as they provide a reasoned explanation for the change." *Encino Motorcars*, 126 S. Ct. at 2125. On a question of statutory interpretation, it is unsurprising that an agency's "reasoned explanation" would turn on "the traditional tools of statutory interpretation," namely "text, structure, history, and purpose," *Joffe v. Google, Inc.*, 746 F.3d 920, 935-36 (9th Cir. 2013), rather than facts in the administrative record.

Plaintiffs assert that HHS "undercuts its own argument" and takes "contradictory positions" because it justifies the Rule as the *best* interpretation of Section 1303 but argues for deference to its position as a *permissible* interpretation. Pls.' Opp'n at 4. There is no contradiction in arguing that an agency's interpretation is correct even without deference, but that the agency is owed deference to the extent that there is ambiguity. Such arguments are common in administrative litigation. *See, e.g.*, *Envtl. Def. Ctr., Inc. v. U.S. EPA*, 344 F.3d 832, 868 n. 49 (9th Cir. 2003) ("Even if the statute were ambiguous, we would defer to EPA's reasonable interpretation."). But analyzing the statute for ambiguity and permissible readings under *Chevron* is a tool for judicial review. Rather than compare the available "permissible" interpretations on their policy merits, HHS simply explained its understanding of the *correct* interpretation of the statute.

Plaintiffs' error here is telling. When a court reviews an agency's interpretation of a statute under *Chevron*, "[w]hether [it] might consider one reading superior to the other is irrelevant for purposes of judicial review," because "[i]t is axiomatic that 'a court may not substitute its own construction of a statutory provision for a reasonable interpretation made by the administrator of the agency.'" *Quang Van Han v. Bowen*, 882 F.2d 1453, 1457 (9th Cir. 1989) (quoting *Chevron, U.S.A., Inc. v. Nat. Res. Def. Council*, 467 U.S. 837, 844 (1984)). Plaintiffs presume that an agency is required to take the same approach—as long as more than one interpretation is *permissible* under *Chevron*, in Plaintiffs' view, an agency may not prefer one over another except on the basis of policy considerations. *See* Pls.' Opp'n at 4 ("[E]ven if the Rule were a permissible construction of the statute . . . the APA requires an administrative agency to justify its actions and substantiate its explanation in the record."). Plaintiffs thus mistake the Rule's explanation that HHS interprets Section 1303 to mandate separate transactions for a claim that "Section 1303 is unambiguous." *Id.* In Plaintiffs' view, if the prior guidance permitting a single transaction were also "permissible" for *Chevron* purposes, then HHS would have no basis to require separate transactions as a matter of statutory interpretation and could only justify its choice in terms of policy costs and benefits relative to single transactions. That is not the law. An agency may justify a regulation by explaining that it "is more consistent with statutory language"—there is no obligation to show that the

agency's reading is the only possible interpretation, or that the agency's interpretation is also superior as a matter of policy. *Encino Motorcars*, 136 S. Ct. at 2127. Balancing fidelity to statutory text with practical consequences involves precisely the sort of "value-laden decisionmaking and the weighing of incommensurables" entrusted to federal agencies. *Dep't of Commerce v. New York*, 139 S. Ct. 2551, 2571 (2019); *see also Rust v. Sullivan*, 500 U.S. 173, 187 (1991) (even when a statute was "ambiguous," the 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").

Plaintiffs' insistence that HHS "simply disregards the high costs" of the Rule thus rests on a category error. Pls.' Opp'n at 9. HHS does not dispute that requiring separate transactions is more costly than permitting a single transaction, and it likewise acknowledges that its implementation timeline is more costly than a slower alternative. But those costs are simply incommensurable with the benefit of statutory compliance; it makes little sense, for example, to protest that expedited implementation "increases costs for issuers by *50 percent*," Pls.' Opp'n at 10, as if there were some way for this Court to determine that achieving statutory compliance by a given time is instead worth only a 25 percent increase in costs.

Plaintiffs misinterpret this argument to mean that when HHS does take account of costs to permit less than perfect statutory compliance—as it does by prohibiting termination of coverage for enrollees who submit their full premium payment in a single transaction—it thereby concedes that it could abandon the separate payment requirement altogether on the basis of cost. Pls.' Opp'n at 6-7 ("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."). But as Defendants already explained, there is ample statutory basis to refrain from imposing draconian costs on enrollees who fail to facilitate compliance with a statutory mandate that applies to *issuers*, particularly when the statute does not specify any penalty for non-compliance. Defs.' Mem. at 26-27. HHS exercised its discretion over "value-laden decisionmaking and the weighing of incommensurables," *Dep't of Commerce*, 139 S. Ct. at 2571, to determine that

issuers adequately comply with the separate payment transaction mandate by sending separate bills, instructing enrollees to pay those bills in separate transactions, and depositing payments into separate allocation accounts, even if some enrollees fail to remit payments in separate transactions. That does not in any way imply that HHS could have exercised the same discretion to permit issuers to simply ignore the separate payment transaction mandate. And even if HHS did have such broad discretion, Plaintiffs can point to nothing that would *require* it to exercise that discretion as Plaintiffs prefer or that would subject the exercise of that discretion to cost-benefit analysis. *See, e.g.*, *Whitman v. Am. Trucking Ass'ns*, 531 U.S. 457, 465 (2001) (extent to which an agency may or must consider costs in promulgating regulations depends on "what authority the statute confers."). All the APA requires is an explanation of the agency's statutory interpretation that is sufficiently clear so that a reviewing court may "reasonably discern[]" the agency's explanation of why the statute should be interpreted as it proposes. *Encino Motorcars*, 136 S. Ct. at 2125, 2127.

Plaintiffs attempt to undercut HHS's interest in achieving statutory compliance by reading the "separate payment" requirement out of the statute and treating "segregation of payments" as the only requirement in Section 1303. Pls.' Opp'n at 5. In their view, "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.'" *Id.* at 6. But fund segregation is a distinct statutory requirement. *See* 42 U.S.C. § 18023(b)(2)(C). Plaintiffs simply ignore the Supreme Court's admonition that 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 Telecom*, 512 U.S. at 231 n.4.

Turning to the administrative record, Plaintiffs make the extraordinary claim that the modifications to the Final Rule to minimize its costs relative to the Proposed Rule "cannot be attributed to HHS's reasoned decision-making" because those modifications came in response to comments on the Proposed Rule. Pls.' Opp'n at 8. Plaintiffs offer no authority for their apparent contention that responding to comments is not reasoned decision-making; indeed, it is the whole point of notice-and-comment rulemaking. Instead, Plaintiffs imply, without any basis in the record,

that HHS acted in bad faith when it responded to comments in what Plaintiffs describe as "a feigned attempt at the transparency and accountability required by the APA." *Id.* But as the Rule and Defendants' opening brief explain at length, HHS acted on its understanding of congressional intent, and the question before it was thus not whether to require separate transactions, but instead how to do so. Defs.' Mem. at 25. It was not bad faith or a "feigned attempt" at transparency for HHS to consider costs at the relevant margin.

Finally, Plaintiffs take issue with the Rule's implementation timeline. Plaintiffs again misstate HHS's burden on this issue, demanding a justification "supported by evidence in the record, tailored to the particulars of this situation." Pls.' Opp'n at 10. To the extent Plaintiffs seek evidence that compliance on the Rule's timeline is *possible*, the Rule more than suffices, providing a detailed account of the "burden to complete the one-time technical build to implement the necessary changes," the tasks and worker-hours required, and the costs of doing so. 84 Fed. Reg. at 71,697. But as already explained, there is no formula to resolve the question whether prompt statutory compliance is worth that cost. That is a matter of "value-laden decisionmaking and the weighing of incommensurables" of the kind that Congress left to HHS's discretion. *Dep't of Commerce*, 139 S. Ct. at 2571. Plaintiffs claim that Section 1303's location in "Subchapter III" of the ACA shows that its purpose "was to facilitate the expansion of access to health insurance for eligible individuals," which they imply provides a basis to deem the Rule's implementation timeline "unnecessary" and "unreasonable" because it increases administrative costs. Pls.' Opp'n at 10-11. But it strains credulity to think that Congress did not anticipate that Section 1303's restrictions on the use of federal funds would impose administrative costs, and the kinds of general statements of purpose that Plaintiffs gesture toward "cannot override [a statute's] operative language." *Sturgeon v. Frost*, 139 S. Ct. 1066, 1086 (2019). The Rule's extensive discussion of the costs of its implementation timeline did not somehow "overlook" an important aspect of the problem. Pls.' Opp'n at 11.

For the first time in their reply brief, Plaintiffs argue that the prospect of enforcement discretion for issuers that attempt in good faith to achieve timely compliance renders the

implementation date arbitrary because "HHS has provided no guidance" on how that discretion will be implemented. Pls.' Opp'n at 10. That argument simply ignores the Rule's explanation that "[e]vidence of such good faith efforts might include records showing that planning for compliance . . . was begun within a reasonable time following the publication of the final rule, but events outside the . . . issuer's control caused implementation delays." 84 Fed. Reg. at 71,690.

Plaintiffs also take issue with HHS's decision to delay the Rule's implementation by 60 days in light of the COVID-19 public health emergency, claiming that it did not come soon enough or extend the deadline long enough. *See* Pls.' Opp'n at 11-12. Plaintiffs complain that HHS "failed to take a formal position on its reasonable mitigation efforts in an official action in any reasonable amount of time," citing an April 7 letter from various Plaintiffs to the Secretary of HHS. Pls.' Opp'n at 12. But Plaintiffs have acknowledged that they knew of the forthcoming delay as early as March 26, *see* Pls.' Mot. at 22 n.8, and they point to no actual consequences of the allegedly "unreasonable" delay in formally announcing the postponement. Likewise, Plaintiffs complain that "a mere 60 days" is "hardly sufficient" in light of the COVID-19 emergency, but they disregard HHS's acknowledgement that the duration of the emergency is uncertain, as is its impact on particular issuers, and that enforcement discretion may be appropriate until as late as six months after the end of the public health emergency. 85 Fed. Reg. at 27, 550, 27,600 (May 8, 2020). And Plaintiffs' suggestion that the Rule's implementation timeline is somehow "arbitrary" because it has been delayed in the face of a global pandemic is entirely without merit. Pls.' Opp'n at 12.

III. THE RULE DOES NOT VIOLATE THE TENTH AMENDMENT.

Plaintiffs have all but abandoned their argument that the Rule violates the Tenth Amendment in favor of their new argument that the Rule instead violates Section 1303's preemption provision. They repeat, without elaboration, their argument that "when a federal law interferes with a state's exercise of its sovereign 'power to create and enforce a legal code'" it inflicts an "injury-in-fact" sufficient to give the state standing. Pls.' Opp'n at 29 (quoting *Cty. of Santa Clara v. Trump*, 250 F. Supp. 3d 497, 526 (N.D. Cal. 2017)). Defendants do not dispute that

an alleged violation of the Tenth Amendment can suffice for standing. But Defendants are entitled to judgment on the merits because Plaintiffs have failed to demonstrate any such violation.

Plaintiffs note that "the Constitution does not give the federal government the authority to require states to regulate," Pls.' Opp'n at 29, but they point to nothing in the Rule that purports to do so, and they offer no response to the Supreme Court's holding in *Hodel v. Virginia Surface Mining & Reclamation Ass'n*, 452 U.S. 264 (1981), that cooperative federalism arrangements materially identical to the Exchanges do not violate the Tenth Amendment. *Id.* Similarly, Plaintiffs' only effort to distinguish *New York v. United States*, 505 U.S. 144 (1992), is the irrelevant assertion that "the States cannot reasonably divert its attention or resources from the provision of healthcare." Pls.' Opp'n at 29. But that case's holding turned on Congress's "authority to regulate private activity under the Commerce Clause," which Plaintiffs do not dispute extends to regulating the health insurance industry, not on Plaintiffs' apparent notion that regulating radioactive waste is sufficiently unimportant, compared to healthcare, to permit federal regulation. *New York*, 504 U.S. at 167. Taken at face value, moreover, Plaintiffs' argument would eliminate much of the ACA, which contains extensive federal regulation of "the provision of healthcare." Pls.' Opp'n at 29. In any case, the relevant question would not be whether a State can leave the entire field of healthcare provision to the federal government, but rather whether it can leave the management of its Exchange in federal hands without offending its sovereignty, which many States already do.

Rather than attempt to distinguish those precedents, Plaintiffs instead note that "Section 1303 explicitly includes a non-preemption section." Pls.' Opp'n at 28. Plaintiffs' Amended Complaint does not so much as mention Section 1303's preemption provision. *See generally* Am. Compl., ECF No. 25. "[S]ummary judgment is not a procedural second chance to flesh out inadequate pleadings," *Wasco Products, Inc. v. Southwall Techs. Inc.*, 435 F.3d 989, 992 (9th Cir. 2006), and Plaintiffs "may not effectively amend [their] [c]omplaint by raising a new theory . . . in [their] response to a motion for summary judgment," *La Asociacion de Trabajadores de Lake Forest v. City of Lake Forest*, 624 F.3d 1083, 1089 (9th Cir. 2010).

In any event, Section 1303's preemption clause is no more help to Plaintiffs than the Tenth Amendment. Plaintiffs do not argue that the Rule would preempt any specific State statute.[3] Plaintiffs assert that the preemption provision "unambiguously preserve[s]" "state sovereignty over reproductive healthcare regulation." Pls.' Opp'n at 29. But Section 1303 manifestly does not assign States the sole responsibility for regulating the collection of premium payments for plans on the Exchanges—as evidenced by Section 1303's own requirements in that area. Under Plaintiffs' argument, the preemption provision would render the "separate payment" requirement entirely redundant. And the same logic would eliminate the prohibition on the use of federal funds for non-Hyde abortion services—Section 1303's *raison d'être*—as that provision engages in "reproductive healthcare regulation" to at least the same extent as the Rule.

IV. ANY RELIEF SHOULD BE LIMITED TO THE NAMED PLAINTIFFS.

Finally, although the Rule is lawful for the reasons Defendants have explained, if the Court were to disagree, any relief must be limited to the specific Plaintiffs before the Court. Plaintiffs insist that nationwide relief is the "standard" remedy under the APA. Pls.' Opp'n at 30. But Plaintiffs' argument is meritless, given the Supreme Court's recent instruction to the contrary. In *Gill v. Whitford*, 138 S. Ct. 1916 (2018), the Court explained that any remedy "must be tailored to redress the plaintiff's particular injury." *Id.* at 1934. Vacating the Rule on a nationwide basis would go far beyond what is necessary to address Plaintiffs' particular alleged injury.

CONCLUSION

For the foregoing reasons, and for the reasons stated in Defendants' opening brief, the Court should deny Plaintiffs' motion for summary judgment and enter judgment in favor of Defendants.

Dated: June 2, 2020 Respectfully submitted,

[3] This case is therefore unlike *Washington v. Azar*, where the court concluded that the Rule conflicted with a specific Washington State statute requiring QHP issuers to issue a single invoice per month. *See Washington v. Azar*, No. 2:20-cv-00047 (E.D. Wash. Apr. 09, 2020), Order at 10, ECF No. 17.

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CERTIFICATE OF SERVICE

I hereby certify that, on June 2, 2020, I electronically filed the foregoing document with the Clerk of the Court, using the CM/ECF system, which will send notification of such filing to the counsel of record in this matter who are registered on the CM/ECF system.

/s/ Bradley P. Humphreys
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