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, *et al.*, *Defendants*.	No. 1:20-cv-361-CCB

DEFENDANTS' REPLY IN SUPPORT OF
CROSS-MOTION FOR SUMMARY JUDGMENT

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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, issuers of qualified health plans ("QHPs") would not have to separately bill enrollees for coverage of non-Hyde abortion services. But Plaintiffs' strong disagreement with 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' argument that the Rule is arbitrary and capricious therefore fails. 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.

Nor can Plaintiffs succeed on their statutory arguments. HHS stated in the Rule's preamble that it does not currently intend to bring enforcement actions against QHP issuers in certain circumstances. While Plaintiffs refer to this statement as the "Opt-Out Policy," it is an unreviewable exercise of enforcement discretion that they lack standing to challenge. In any event, Plaintiffs cannot show that HHS's current enforcement posture is unlawful, or that notice-and-comment rulemaking was required before announcing it. Plaintiffs' attempt to demonstrate that the Rule conflicts with Section 1303(b)(3) and Section 1554 of the ACA also lacks merit.

The Court should grant summary judgment in Defendants' favor.

ARGUMENT

I. THE RULE IS NOT ARBITRARY AND CAPRICIOUS.

A. The Rule Better Aligns HHS's Regulations with the Statute.

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. 71,674, 71,684 (Dec. 27, 2019). Although itemizing components in a single bill "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.

Despite ample opportunity, Plaintiffs have never directly disputed HHS's interpretation of Section 1303. They never argue that "separate" cannot be read to mean "distinct," or that HHS was required to conclude that a single payment transaction can contain multiple "separate" payments. Instead, Plaintiffs advance three oblique attacks on HHS's interpretation.

First, they argue that Section 1303(b)(3)'s notice provision and Section 1554 of the ACA preclude HHS's position. Those arguments rely on incorrect readings of the statute, as explained in more detail below. *See* Part II.B, *infra*.

Second, Plaintiffs note that they read Defendants' opening brief to treat the terms "separate payments" and "separate transactions" as distinct. Opp'n to Defs.' Cross-Mot. for Summ. J. & Reply in Supp. of Pls.' Mot. for Summ. J. at 5, ECF No. 42 ("Pls.' Opp'n"). That argument misreads both the Rule and Defendants' opening brief, which explain that separately itemized components of a single payment transaction might be understood as "separate" for certain purposes, but that Section 1303 is best read to call for fully separate transactions. 84 Fed. Reg. at 71,684. In other words, the Rule clarifies that even though the terms may not be identical in some contexts, they are the same for purposes of Section 1303.

Third, Plaintiffs claim that the Rule is at odds with what one comment described as the "ordinary commercial practice" of "[a]dministratively separating funds received through one payment transaction" for "bundled" coverage for distinct insurance policies, such as for life and health insurance. Pls.' Opp'n at 5-6. At most, however, that comment suggests that a different interpretation of Section 1303 may have been *permissible*, but Plaintiffs do not even attempt to argue that Congress *required* the collection of "separate" payments in a single transaction. *Cf.*, *e.g.*, *ViroPharma, Inc. v. Hamburg*, 898 F. Supp. 2d 1, 19 (D.D.C. 2012) (rejecting the argument that a statutory term's "common usage in industry transforms it into a clear term"). In any case, even if bundled payments for distinct insurance policies qualify as "separate" payments, that has no bearing on the relevant question whether a single premium payment must be understood to pay "separately" for each type of coverage offered within a single insurance policy. Perhaps unsurprisingly, Plaintiffs point to nothing in the record suggesting, for example, that a standard auto insurance premium payment is commonly understood to pay separately for collision coverage and property damage coverage.

Plaintiffs thus cannot meet their burden under *Chevron* to show that the Rule's interpretation of the term "separate payment" is impermissible. They nevertheless claim that HHS may not invoke *Chevron* deference unless it concedes that its interpretation of Section 1303, and thus the decision to impose the costs of the Rule, was "wholly within its discretion." Pls.' Opp'n at 1; *id.* at 5 n.2. As Defendants have already explained, that argument fundamentally misunderstands *Chevron* deference, which is a tool for judicial review rather than for agency rulemaking. Under *Chevron*, *the reviewing court* must first determine whether the statutory language is ambiguous, and if so whether the agency's interpretation is permissible. *See Chevron, U.S.A., Inc. v. Nat. Res. Def. Council, Inc.*, 467 U.S. 837, 844 (1984). Nothing requires an agency to proceed in the same fashion, as Plaintiffs expressly concede. Pls.' Opp'n at 7. It is thus perfectly acceptable for an agency to identify what it believes to be the best interpretation of the statute at hand, as HHS did, without needing to make a "discretionary" policy decision among the available permissible interpretations. The sole case that Plaintiffs cite to the contrary is not remotely on point: *Shipbuilders Council of America v. U.S. Coast Guard*, 578 F.3d 234, 243 (4th Cir. 2009), simply involved the exception to "*Auer* deference" for an agency's interpretation of a regulation "when an agency interprets a rule that parrots the statutory text." *Kisor v. Wilkie*, 139 S. Ct. 2400, 2417 n.5 (2019); *see Shipbuilders Council*, 578 F.3d at 243 (holding that the regulation did "little more than restate the terms of the statute itself" (quoting *Gonzales v. Oregon*, 546 U.S. 243, 257 (2006)).

Plaintiffs separately argue that the Rule may not receive *Chevron* deference because, they claim, it did not adequately explain how it interpreted Section 1303. Specifically, Plaintiffs fault the Rule for failing to rely on "public comment[s]" to support its interpretation, and for the lack of "government investigations and reports" or "data, studies or other references" showing that the

previous interpretation did not serve what Plaintiffs claim is "Section 1303's purpose of ensuring that federal funds do not pay for non-Hyde abortion services." Pls.' Opp'n at 6, 9.

Those arguments misunderstand HHS's burden under the APA. 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 "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). This requirement is met "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 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.

The fault in the agency's position in that decision was not the substance of its statutory interpretation, which "several public comments supported." *Id.* at 2127. Instead, it was that "the Department did not explain what (if anything) it found persuasive in those comments beyond the few statements above." *Id.* To rule in the agency's favor, the Court would thus have needed "to speculate on reasons that might have supported [the] agency's decision," when "the agency in fact gave almost no reasons at all." *Id.*

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 Telecommunicationss, Inc. v. Metrophones Telecommunications, 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.

In short, an agency's burden under *Encino Motorcars* is merely to provide sufficient reasoning for the reviewing court to discern why the agency chose the interpretation it did. That inquiry does not turn on the merits of the agency's interpretation; instead, it determines the appropriate standard for the court's subsequent review of the interpretation on the merits. If the court cannot tell why an agency picked the interpretation it did, then it must interpret the statute without affording deference to the agency. *Encino Motorcars*, 136 S. Ct. at 2127 (the statute "must be construed without placing controlling weight on the Department's . . . regulation"). Even in such a case, the consequence of the agency's insufficient reasoning is to preclude judicial deference to the agency, not to set aside the regulation as arbitrary and capricious. But if the court *can* discern the agency's path, and the other conditions for *Chevron* deference apply—none of which Plaintiffs contest in this case—then the regulation receives *Chevron* deference.

The Rule's interpretation of Section 1303 easily clears the bar of adequately explaining HHS's reasoning. 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.

Plaintiffs' arguments to the contrary are misguided. The point of *Encino Motorcars* was not that an agency can justify its statutory interpretation only by relying on public comments, but

rather that it must provide *some* reason sufficient for the court to understand why it chose the interpretation it did. *Encino Motorcars*, 136 S. Ct. at 2127. If the agency fails to do so, then the existence of potential reasons, whether in public comments or any other form, does not suffice. *Id.* But here, the Court is not left guessing, because HHS clearly explained that it interpreted "separate" to mean "distinct."

Plaintiffs also fault HHS for not relying on "investigations and reports" showing that the previous interpretation did not adequately ensure that federal funds are not used to pay for non-Hyde abortion services, citing *Rust v. Sullivan*, 500 U.S. 173, 187 (1991). Pls.' Opp'n at 9-10. That argument misreads *Rust*. In that case, the Supreme Court upheld an HHS regulation reinterpreting an ambiguous statutory provision, and held that the agency provided sufficient reasoned analysis to explain its decision. *Rust*, 500 U.S. at 187. Part of that reasoning was that "the new regulations are more in keeping with the original intent of the statute." *Id.* The Court also noted other justifications HHS had advanced for the new regulation, including studies showing that the prior policy "failed to implement properly the statute," and considerations of "client experience" and "shift[s] in attitude." *Id.* But the Court did not hold that each of those components of the agency's reasoning was *necessary* to its holding, and it has since expressly held that there is no requirement for an agency to show that a prior policy has somehow "failed" before an agency can change course. *See FCC v. Fox TV Stations, Inc.*, 556 U.S. 502, 515 (2009) ("[I]t 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."). And *Long Island Care at Home* and *Encino Motorcars* confirm that statutory compliance alone is a sufficient "good reason" to change policy. *Long Island Care at Home*, 551 U.S. at 175; *Encino Motorcars*, 136 S. Ct. at 2127.

Moreover, as Defendants have already explained and Plaintiffs do not contest, the "separate payment" mandate is a distinct statutory requirement from Section 1303's restrictions on the use of federal funds. *See* Defs.' Opp'n to Pls.' Mot. for Summ. J. & Mem. in Supp. of Defs.' Cross-Mot. for Summ. J. at 28, ECF No. 35-1 ("Defs.' Mem."). 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 the ACA as a whole.

Plaintiffs simply ignore the Rule's express reasoning from the text of the statute, claiming that the *only* indicia of Congressional intent HHS can point to is the statement of Senator Nelson, who proposed the relevant statutory language. Pls.' Opp'n at 2, 6-7. That argument is a red herring. As the Rule explains, and as Plaintiffs have never challenged, the Rule's core interpretive step is to read the term "separate" to mean "distinct." 84 Fed. Reg. at 71,684. Senator Nelson's statement *confirms* that interpretation, but contrary to Plaintiffs' supposition, it is not *the reason* for the Rule.

Plaintiffs' final argument on the meaning of Section 1303 is the somewhat confusing contention that the Rule's analysis of costs tacitly concedes that "separate payments" need not be made in "separate transactions." According to Plaintiffs, if "HHS [were] correct about Section 1303's mandate," it would not have needed to analyze "costs to issuers related to their acceptance and reconciliation of those separate transactions." Pls.' Opp'n at 12. The Rule, however, is clear that its statutory interpretation drives its analysis of costs, not the other way around.

B. The Rule Properly Accounts for Costs.

As Defendants explained in their opening brief, whether and to what extent an agency may consider costs in promulgating regulations depends on what the relevant statute requires. Section

109 of the Clean Air Act, for example, "unambiguously bars cost considerations." *Whitman v. Am. Trucking Ass'n*, 531 U.S. 457, 471 (2001). Even where the statute requires an agency to weigh the costs of regulation, it is enough for the agency to pay "at least some attention to cost" unless the statute expressly requires a more formal analysis. *Michigan v. EPA*, 135 S. Ct. 2699, 2707 (2015).

Plaintiffs make no argument that any statutory provision required *any* consideration of costs in this case, let alone the particular dollars-and-cents quantification they propose. Instead, they attempt to circumvent the relevant precedents by asserting that "costs and benefits are an 'important aspect of the problem'" that an agency must consider regardless of the statutory context. Pls.' Opp'n at 12-13 (quoting *Motor Vehicles Mfrs. Ass'n v. State Farm Mut. Auto Ins. Co.*, 463 U.S. 29, 43 (1983). That argument turns *Michigan v. EPA* on its head. That case held that the EPA was obliged to consider costs because the relevant statute—which directed the EPA to regulate power plant emissions "if [it] finds such regulation is appropriate and necessary," 42 U.S.C. § 7412(n)(1)(A)—when "read fairly and in context" "requires at least some attention to cost." *Michigan*, 135 S. Ct. at 2706, 2707, 2709. If it were proper to consider costs for *every* regulation, the Court's statutory analysis would have been entirely superfluous. Yet the Supreme Court acknowledged that even the statutory language at issue in that case, requiring regulations to be "appropriate and necessary," "does not encompass cost" in all settings. *Id.*; *see, e.g.*, *Nicopure Labs, LLC v. FDA*, 266 F. Supp. 3d 360 (D.D.C. 2017) ("[P]laintiffs can point to no [statutory] source for a requirement that costs be taken into account when the deeming power is exercised, and *Michigan v EPA* is distinguishable."), *aff'd*, 944 F.3d 267 (D.C. Cir. 2019). *Michigan* thus affirms that the role of cost considerations in agency rulemaking turns on the particular statutory context. Plaintiffs make no such argument here.

Having assumed without support that *Michigan* applies in this case, Plaintiffs go on to misapply its requirement of "at least some attention to cost." *Michigan*, 135 S. Ct. at 2707. Plaintiffs do not contest that the Rule did indeed pay extensive attention to cost. Instead, they allege that the Rule's consideration of costs is "littered with errors and inconsistencies." Pls.' Opp'n at 11. But Plaintiffs do not identify *any* "error" in the Rule's analysis, and point to only one alleged "inconsistency." Specifically, Plaintiffs complain that HHS produced a quantitative estimate of the cost to issuers of accepting payment through separate transactions, but did not quantify the "moderately higher" burden to consumers who pay their premiums in separate transactions. Pls.' Opp'n at 13 (quoting 84 Fed. Reg. at 71,706). Notably, Plaintiffs do not argue that the Rule's qualitative assessment of the costs to consumers was itself irrational.

Plaintiffs cannot show that quantifying one cost but qualitatively assessing a related cost renders a rule arbitrary and capricious. To begin with, they do not contest that HHS had no obligation to quantify any of the Rule's costs. *See* Defs.' Mem. at 31. Nor do they point to any authority holding that if an agency quantifies one cost it must quantify them all. The one case Plaintiffs cite concerns "unexplained inconsistency" in an agency's statutory interpretation, and has no relevance to assessing an agency's empirical methodology. *Jimenez-Cedillo v. Sessions*, 885 F.3d 292, 298 (4th Cir. 2018). Finally, Plaintiffs make no attempt to show that quantitatively, rather than qualitatively, estimating the cost to consumers would have made a meaningful difference here. As Defendants already explained, agencies must respond to comments in rulemaking to the extent that, "if adopted, [they] would require a change in the agency's proposed rule." *Home Box Office, Inc. v. FCC*, 567 F.2d 9, 35 n.58 (D.C. Cir. 1977); *State of S.C. ex rel. Tindal v. Block*, 717 F.2d 874, 886 (4th Cir. 1983). Plaintiffs offer no serious response to that point.

See Pls.' Opp'n at 11. If an agency need not respond to a comment *at all*, it follows that it need not respond in any particular manner, so long as its response is rational, as it was here.

For the first time in their opposition and reply, Plaintiffs argue that it was arbitrary for the Rule to impose the costs of separate *billing* even if the statute requires separate *transactions*. Pls.' Opp'n at 12. But Plaintiffs ignore the Rule's explanation for requiring separate bills: "We also believe policy holders are more likely to make a separate payment for coverage of non-Hyde abortion services when they receive a separate bill for such amount, and that receiving the separate bill in a separate communication further bolsters that likelihood." 84 Fed. Reg. at 71,685. The justification for separate billing is thus the same as that for requiring separate transactions, namely, better alignment with Congressional intent. Moreover, Plaintiffs point to nothing in the record to support their apparently novel contention that HHS should have permitted issuers to send a single bill instructing enrollees to pay in separate transactions.

Despite professing to accept that the APA does not require HHS to quantify costs and benefits, and that not all costs are amenable to quantification, Plaintiffs continue to insist that better alignment with Congressional intent is merely "some vague notion" that offers "no discernible benefit." Pls.' Opp'n at 10, 12. Such rhetoric aside, Plaintiffs offer no real response to the Supreme Court's clear holding that an agency may fully justify a regulation by explaining that it "'is more consistent with statutory language' than alternative policies." *Encino Motorcars*, 136 S. Ct. at 2127 (quoting *Long Island Care at Home*, 551 U.S. at 175). The Rule does exactly that, and the APA requires nothing more.

C. The Rule's Implementation Date is not Arbitrary or Capricious.

As Defendants explained in their opening brief, HHS consciously determined that the goal of achieving better alignment with Congressional intent justified a six-month implementation

timeline, even accounting for the increased costs of that timeline relative to waiting until the start of a new plan-year. *See* 84 Fed. Reg. at 71,689. In doing so, the agency gave extensive consideration to the burdens that compliance would impose on issuers. *Id.* at 71,697.

Plaintiffs' ultimate argument against the Rule's implementation date is that "the purported 'benefit' of statutory alignment does not justify this cost." Pls.' Opp'n at 16. But all Plaintiffs mean by that is that the Rule does not *achieve* better statutory compliance because, they allege, it misinterprets the statute. *Id.* That argument is incorrect, for the reasons discussed in Defendants' opening brief and below. Plaintiffs do not—and could not—argue that statutory compliance *in general* cannot justify the costs of prompt implementation of the Rule. As with the overall benefit of improving statutory compliance, the benefit of doing so promptly is non-quantifiable and incommensurable with the monetary costs the Rule outlines. It is thus a matter of "value-laden decisionmaking and the weighing of incommensurables" entrusted to agency discretion. *Dep't of Commerce v. New York*, 139 S. Ct. 2551, 2571 (2019).

Plaintiffs cannot show that the implementation date is arbitrary and capricious simply because it imposes costs. They are thus left to argue that the implementation date is impossible. Plaintiffs' only argument on that count is to point to a single sentence in a single comment on the Proposed Rule, which they misquote. As Defendants already explained, Defs.' Mem. at 34-35, America's Health Insurance Plans ("AHIP") surveyed 18 QHPs, only ten of which are subject to the Rule, about the time it would take to comply with the Rule. AR 080215. Specifically, AHIP's comment states that "we asked issuers how long it would take to implement the necessary changes to support separate billing and payments." *Id.* Plaintiffs extrapolate from that lone sentence that "issuers and their representatives identified the time period 'necessary' to comply, not just necessary to avoid increased costs." Pls.' Opp'n at 15. But the survey did not make that

distinction—it asked only "how long it would take to implement the necessary changes," not for the shortest possible implementation timeline regardless of cost. AR 080215. Plaintiffs thus point to no basis in the record to conclude that any issuer claimed that compliance within six months would not even be possible.

The other comments Plaintiffs cite confirm the point. The National Association of Insurance Commissioners, for example, noted that implementation in the middle of a plan-year would increase consumer confusion and impose "a substantial burden" on issuers. AR 079065. But aside from claiming that *immediate* implementation (rather than the six-month timeline the Final Rule settled on) would leave "no time for issuers, exchanges, or regulators to educate consumers on the new billing process," that comment does not suggest that compliance within six months would not be possible. *Id.* Plaintiffs likewise cite Connect for Health Colorado's comment, but that points only to a wish for time to develop "consumer education materials." AR 081101.

In the absence of any record evidence that issuers cannot comply with the Rule within six months, Plaintiffs instead point to comments they claim "exhaustively detail[] the many steps required to implement the rule." Pls.' Opp'n at 15. But merely detailing the steps needed to achieve compliance is not relevant to the implementation timeline, because those comments do not say how long it will take to implement any of those steps. *See* AHIP Comment, AR 080221-23; Blue Cross Blue Shield Association Comment, AR 080264-65. Those details thus add nothing to the bare-bones time estimates in those comments, which, as Defendants have already explained, do not even address whether compliance within six months is *possible*. *See* Defs.' Mem. at 35. Simply put, there was no "specific, contradictory evidence" in the record on the relevant issue. Plaintiffs thus attempt to shift the burden, claiming that no comments support the conclusion that the six-month timeline "would be reasonable." Pls.' Opp'n at 15. Even if true, that argument would be

beside the point, because HHS fully considered the steps necessary for issuers to achieve compliance and settled on an implementation date that allows sufficient time to complete those steps. Plaintiffs notably do not contend that HHS failed to consider any particular activity that issuers would need to undertake to achieve compliance. In any case, Plaintiffs are simply wrong that "*no* issuer" indicated that six months would be sufficient. Pls.' Opp'n at 15. In fact, two of AHIP's survey respondents answered that implementation would take six months, and four more said twelve months. AR 080221. Notably, the survey did not allow for any answer shorter than six months, or for any answer in between six and twelve months. *Id.*

In light of the record evidence, Plaintiffs cannot establish that compliance within six months would be impossible for issuers. Instead, the record confirms that compliance on that timeline would be achievable, despite its costs. And Plaintiffs have offered this Court no basis on which to conclude that prompt statutory compliance does not justify that cost.

D. The Rule Properly Considered the Impact of the So-Called "Opt-Out Policy"

As Defendants explained in their opening brief, *see* Defs.' Mem. at 36-37, the so-called "Opt-Out Policy" was part of a suite of modifications to the proposed rule to reduce the costs of compliance, with the overall financial impact being to "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 coverage for non-payment of miniscule amounts." 84 Fed. Reg. at 71,705.

Plaintiffs insist, without citing any authority, that HHS was obligated to consider the financial impact of the "Opt-Out Policy" in isolation, and to assess that impact with reference only to the status quo ante rather than to the proposed rule it was intended to modify. Pls.' Opp'n at 17. But they conspicuously fail to contest the Rule's assessment of the financial impact of the policy

in the relevant context, which is to make issuers less likely to drop coverage of non-Hyde abortion services in states that permit them to do so.

Instead, Plaintiffs now clarify that they believe that permitting opt-outs will "directly increase issuer or consumer costs" because issuers will forgo premium payments for non-Hyde services from those who pursue an opt-out. Pls.' Opp'n at 16-17. But the Rule fully addresses that concern as well: As it explains, "the actuarial value of the non-Hyde abortion coverage under QHPs generally may be less than the minimum $1 per enrollee, per month" that issuers must charge under the statute. 84 Fed. Reg. at 71,690. The amounts involved—and therefore their financial impact on issuers—are thus, in the Rule's words, "miniscule." *Id.* at 71,705. That analysis is more than sufficient for this Court to discern the Rule's reasoning on the financial impact of the "Opt-Out Policy," namely, that the loss of "miniscule" payments will have correspondingly miniscule impacts. In any case, even if it were an error for HHS not to expressly state that the loss of miniscule payments will have miniscule financial impacts, it is inconceivable that any such error prejudiced Plaintiffs, and they make no argument to the contrary. *See, e.g.*, *Friends of Iwo Jima v. Nat'l Capital Planning Comm'n*, 176 F.3d 768, 774 (4th Cir. 1999) (harmless error doctrine applies to APA claims); *see also* 5 U.S.C. § 706 ("[D]ue account shall be taken of the rule of prejudicial error").

II. PLAINTIFFS' STATUTORY ARGUMENTS ARE MERITLESS.

A. Plaintiffs' Challenge to the "Opt-Out Policy" Fails.

1. Plaintiffs Cannot Prevail on the Merits of Their Challenge to HHS's Exercise of Its Enforcement Discretion, Which Is Non-Justiciable in Any Event.

Plaintiffs' challenge to the so-called "Opt-Out Policy" is without merit. Strikingly, Plaintiffs' reply focuses almost exclusively on whether they have standing to challenge HHS's exercise of its enforcement discretion and whether HHS's current enforcement posture is

reviewable—with hardly any discussion of *why*, in Plaintiffs' view, the "Opt-Out Policy" is unlawful. Indeed, Plaintiffs' only explanation of their merits argument is to say that "Congress's use of the word 'shall' in [Section 1303] imposes a 'discretionless obligation' *on issuers* to collect an abortion-related premium in plans that offer abortion coverage," and Plaintiffs state that the "Final Rule's Opt-Out Policy is contrary to this statutory mandate and therefore invalid." Pls.' Opp'n at 21 (emphasis added).

Plaintiffs' argument is based on a fundamental misconception of the "Opt-Out Policy," which is merely an explanation in the Rule's preamble regarding how the agency currently intends to exercise its enforcement discretion. *See* 84 Fed. Reg. at 71,686. HHS's current enforcement posture has no effect whatsoever on any substantive law. *See* Defs.' Mem. at 16. The requirement in Section 1303(b)(2)(B)(i) that issuers "shall . . . collect from each enrollee" the portion of the premium attributable to coverage for non-Hyde abortion services, 42 U.S.C. § 18023(b)(2)(B)(i), remains in full effect. And issuers that do not abide by Section 1303(b)(2)(B)(i)'s requirements, or any other requirement in Section 1303, are subject to enforcement action by State regulators, who Congress designated as 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.").

Although Plaintiffs attempt to fault HHS for "not explain[ing] how a state could continue to exercise 'enforcement authority to ensure compliance with the requirements of Section 1303,'" Pls.' Opp'n at 22, the States' authority to do so is clear in the ACA. *See* 42 U.S.C. § 300gg-22(a)(1) (giving States the authority to "require that health insurance issuers that sell, renew, or offer health insurance coverage in the State in the individual or group market meet the requirements of [Part A,

which includes Section 1303] with respect to such issuers," subject to certain inapplicable exceptions). Indeed, the ACA generally limits HHS's enforcement authority to a secondary role; the agency may enforce Section 1303 only in the event "of a determination by the Secretary that a State has failed to enforce a provision (or provisions) . . . with respect to health insurance issuers in the State." *Id.* § 300gg-22(a)(2). The so-called "Opt-Out Policy" does nothing to interfere with States' primary enforcement role—or to prevent HHS from bringing its own enforcement action if the agency were to change its current enforcement posture—and therefore does not undermine Section 1303, as Plaintiffs would have the Court believe.

At bottom, Plaintiffs cannot succeed on their claim that the "Opt-Out Policy" violates Section 1303(b)(2)(B)(i) because issuers still are required to collect separate payments for non-Hyde abortion services. Despite Plaintiffs' attempt to obscure it, that fact also demonstrates why Plaintiffs lack standing, and why the "Opt-Out Policy" is an unreviewable exercise of HHS's enforcement discretion.

Regarding standing, Plaintiffs cannot show any injury-in-fact that is fairly traceable to HHS's current enforcement posture. Plaintiffs claim that—as a result of HHS's decision not to exercise its secondary enforcement authority to ensure compliance with Section 1303(b)(2)(B)(i) in certain narrow circumstances, *see* 84 Fed. Reg. at 71,686—the overall "pool of enrollees contributing funds toward abortion-related services" will be reduced, which Plaintiffs claim will "force[] enrollees who continue to pay the abortion-related premium to shoulder the burden of opt-outs," Pls.' Opp'n at 22. But that sort of hypothetical outcome cannot confer standing, and Plaintiffs do not cite any case to suggest their specific alleged injuries meet the requirements of Article III. *See id.* at 21-22.

To establish standing, an alleged injury "must have actually occurred or must occur imminently," and "hypothetical, speculative or other possible future injuries do not count in the standings calculus." *Whitmore v. Arkansas*, 495 U.S. 149, 155 (1990). Here, Plaintiffs' claimed injuries—*i.e.*, increased costs for insurance coverage of non-Hyde abortion services—are far from certain or imminent as a result of the "Opt-Out Policy."[1] As discussed above, HHS's current enforcement posture leaves the substantive requirements of Section 1303(b)(2)(B)(i) untouched. Thus, it is far from certain that any issuer—much less the specific issuers that offer coverage to any of the individual Plaintiffs in this case—will, in fact, make the independent decision to modify the benefits of any plan. Indeed, to the extent that a State disagrees with HHS's enforcement discretion, to do so would open those issuers up to potential State enforcement action for, among other things, violating Section 1303(b)(2)(B)(ii).

Furthermore, even if some issuers do decide to modify certain plans that cover non-Hyde abortion services, none of the Plaintiffs is regulated directly, and the Rule does not prevent them from obtaining non-Hyde abortion services. Thus, any modest increase in the cost of coverage that results from the Rule is not sufficient to confer Article III standing. *See, e.g.*, *Lane v. Holder*, 703 F.3d 668, 672-73 (4th Cir. 2012) (consumers merely "paying the end-line cost of an economic regulation" are not injured unless they are either (1) "directly regulated by the law being challenged" or (2) "prevented outright from obtaining" the regulated product).

Yet, even if the Court were to disagree on standing—and despite Plaintiffs' basic failure to show that the "Opt-Out Policy" is unlawful on the merits—they still could not prevail because

[1] Importantly, because Plaintiffs must establish standing with respect to each of their claims independently, *see DaimlerChrysler Corp. v. Cuno*, 547 U.S. 332, 352 (2006), Plaintiffs cannot support their claim for standing with respect to their challenge to the "Opt-Out Policy" by pointing to any increased costs to issuers or enrollees that result from Rule's requirement that issuers send separate bills for non-Hyde abortion services, which is a distinct issue.

HHS's decision regarding when and how to bring an enforcement action is a matter of unreviewable agency discretion. *See* Defs.' Mem. at 12-16. Plaintiffs' argument that HHS's current enforcement posture is reviewable rests on a tautology. They state the "the policy does not leave any discretion to agency officials to take enforcement action while the policy remains in place." Pls.' Opp'n at 26. Yet, HHS could change its "policy" at any time, simply by announcing a different position with respect to enforcement, because the "Opt-Out Policy" is not binding on the agency. *See* Defs.' Mem. at 38-40 (explaining that HHS's statement as to its enforcement discretion is a general statement of policy, not a legislative rule subject to notice-and-comment rulemaking). To accept Plaintiffs' argument that an agency's explanation of how it intends, for now, to exercise its enforcement powers is subject to judicial review would be inconsistent with the Supreme Court's holding in *Heckler v. Chaney*, 470 U.S. 821 (1985), that such decisions are "generally committed to an agency's absolute discretion." *See id.* at 831.

Plaintiffs' reliance on *Casa de Maryland v. U.S. Department of Homeland Security*, 924 F.3d 684 (4th Cir. 2019), *petition for cert. filed*, 2019 WL 2267223 (U.S. May 24, 2019) (No. 18-1469), to support their argument that the Court may direct how or when HHS may exercise its enforcement discretion, *see* Pls.' Opp'n at 25-26, is misplaced. Plaintiffs acknowledge, as they must, that the holding in *Casa de Maryland* was based on the Fourth Circuit's conclusion that the enforcement policy at issue in that case (the rescission of DACA) was "likely to be [a] direct interpretation[] of the commands of the substantive statute rather than the sort of mingled assessments of fact, policy, and law that drive an individual enforcement decision." *Id.* at 26 (quoting *Casa de Maryland*, 924 F.3d at 699). Here, unlike HHS's interpretation of Section 1303(b)(2)(B) to require issuers to provide separate bills to enrollees, the agency's exercise of its enforcement discretion does not rely on any construction of the statute.

Further, as Defendants explained in their opening brief, whether HHS will exercise is discretion is subject to an issuer taking "appropriate measures to distinguish between a policy holder's inadvertent non-payment of the separate for bill for non-Hyde abortion services and a policy holder's intentional nonpayment of the separate bill." *Id*. at 71,687; *see* Defs.' Mem. at 15. Thus, when deciding whether to forbear from enforcement, HHS must make an individualized assessment whether the issuer has met the specific criteria HHS described in the preamble—*e.g.*, whether a policy holder's opt out of coverage for non-Hyde abortion services is applied to all persons in the enrollment group under the policy. *See* 84 Fed. Reg. at 71,687. HHS's decision whether it will, in fact, forbear from enforcement with respect to any particular issuer is the sort of "mingled assessment[] of fact, policy, and law" that is unreviewable. *Casa de Maryland*, 924 F.3d at 699.

2. Notice-and-Comment Rulemaking Was Not Required Regarding HHS's Announcement of Its Current Enforcement Posture.

As Defendants explained 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 37-40. 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 do not dispute the distinction between legislative rules and general statements of policy, nor do they dispute that the latter are not subject to notice-and-comment rulemaking. *See* Pls.' Opp'n at 30-31. Their primary rebuttal is that HHS's statement in the preamble does not leave the agency "free to exercise discretion." *Id.* at 31 (quoting *Clarian*, 878 F.3d at 357). But that is incorrect. Unlike the requirement for separate billing, the so-called "Opt-Out Policy" is not

codified in the Code of Federal Regulations, and the agency is free to take a different enforcement position at any time. *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). For that reason, this case is akin to *Clarian*, upon which Plaintiffs rely. In that case, HHS set forth in an instruction manual certain policies for how hospitals should be selected for reconciliation of certain Medicare payments. *Clarian*, 878 F.3d at 349. The D.C. Circuit rejected the plaintiffs' procedural APA claim because, "[p]ut simply, the Manual instructions 'merely explain how the agency will enforce a statute or regulation—in other words, how it will exercise its broad enforcement discretion.'" *Id.* at 358. The same is true here, and the fact that HHS chose to describe its current enforcement posture in the Federal Register in response to comments on the NPRM—as opposed to, for example, in a manual or on its website—changes nothing.

Nor does HHS's statement in the Rule's preamble regarding its current enforcement posture confer any third-party rights or obligations, as Plaintiffs suggest. *See* Pls.' Opp'n at 32. Plaintiffs point to a statement in the preamble that, in order for an issuer to avoid an enforcement action, "a policy holder's opt-out would have to be applied to all persons in the enrollment group under the policy." 84 Fed. Reg. at 71,687 (Pls.' Opp'n at 32 (quoting 84 Fed. Reg. at 71,687). But that requirement does not create any right or obligation for anyone—it merely describes the circumstances under which HHS currently intends to exercise its discretion. Because the so-called "Opt-Out Policy" merely "advise[s] the public prospectively of the manner in which the agency proposes to exercise a discretionary power," it is a general statement of policy for which notice-and-comment rulemaking was not required. *Chrysler Corp. v. Brown*, 441 U.S. 281, 302 n.31 (1979); *see also Casa de Maryland*, 924 F.3d at 702.

B. There Is No Conflict between the Rule and Section 1303's Notice Provisions.

Plaintiffs' objections to the notice provisions in Section 1303(b)(3) are a clear attempt to impose their preferred policy outcome in the face of an ambiguous statute. The parties' core dispute is whether the term "notice," as used in Section 1303(b)(3), includes a bill or invoice for insurance coverage. However, as Defendants have explained, and as Plaintiffs appear to concede, the term "notice" is not defined in the ACA. *See* Defs.' Mem. at 18; Pls.' Opp'n at 28. And nothing in the statute forecloses HHS's interpretation that a "notice" does not include a monthly bill. Plaintiffs point to different dictionary definitions of "notice," *see* Pls.' Opp'n at 28 (citing Merriam Webster Online and Black's Law Dictionary), but those sources do not shed light on whether the term, as used in Section 1303(b)(3), necessarily includes a monthly bill. Plaintiffs point out, for instance, that Merriam Webster defines notice to include "a written or printed announcement"—but that only begs the same interpretive question in dispute: an announcement of what? Even Plaintiffs' proffered definition does not suggest that a notice necessarily includes a bill for insurance coverage, as opposed to the announcement of coverage details that enrollees receive when they enroll in a plan.

Back to the actual text: 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 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 17-18. Indeed, and importantly, Plaintiffs themselves seem to concede the limited scope of Section 1303(b)(3). They state that, "*[e]xcept at the time of enrollment and in advertising*, Section 1303(b)(3) *does not* limit issuers' ability to tell consumers about the cost of abortion in their plans, should issuers choose to do so." Pls.' Opp'n at 29 (emphasis added). Whether Plaintiffs

realize it or not, that concession gives away the farm. Consistent with Defendants' interpretation of Section 1303(b)(3), Plaintiffs apparently agree that sending a monthly bill to enrollees specifically for the portion of their premiums attributable to coverage for non-Hyde abortion services—which is neither a statement at the time of enrollment nor advertising—does not run afoul of Section 1303(b)(3)'s limitation on what may be provided in a notice. And although Plaintiffs attempt to distinguish an issuer's decision to send a separate monthly bill for the cost of coverage for non-Hyde abortion services from HHS's decision to require issuers to do so, they fail to explain why that distinction has any relevance. Section 1303(b)(3), by its clear terms, applies only to QHPs, not to HHS. *See* 42 U.S.C. § 18023(b)(3).[2]

For the avoidance of doubt, even if Plaintiffs' concession were not fatal to their claim, HHS's interpretation is clearly *permissible*, particularly when read together with Section 1303(b)(2)(B), which requires issuers to "collect . . . separate payments" for coverage of non-Hyde abortion services; that they maintain separate accounts for those payments; and—much like what's required by the Rule—that there be "a separate deposit" of such payments paid through employee payroll deposits. 42 U.S.C. § 18023(b)(2). Otherwise, one would have to conclude that Congress *unambiguously* intended for HHS and/or issuers to effectively obscure from enrollees how they are billed and how their premiums are being applied. There is nothing in Section 1303(b)(3) that mandates such an illogical result. Indeed, Plaintiffs' argument that Section 1303(b)(3) prohibits

[2] Plaintiffs do state, somewhat obliquely, that Section 1303(b)(3)(B)'s reference to "other information specified by the Secretary" is "a limitation on the HHS's authority to require mandatory disclosure of the costs of abortion coverage beyond the disclosure specified in the statute itself." *See* Pls.' Opp'n at 28-29. But they do not explain why they believe that to be so, nor do they cite any authority to support the statement. *Id.* In any event, Plaintiffs are incorrect. As Defendants have explained, Congress's delegation to HHS to determine what information falls within Section 1303(b)(3)'s limitations only bolsters Defendants' interpretation of that provision. *See* Defs.' Mem. at 17.

the Rule is squarely at odds with the available legislative history, which Plaintiffs barely 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); *see also* Defs.' Mem. at 10.

Moreover, 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 either a single bill separately itemizing the premium amount for non-Hyde abortion services or a separate bill just for those services. *See* Defs.' Mem. at 18. Plaintiffs respond that they have "no obligation to defend [the prior interpretation and guidance] as valid in all respects." Pls.' Opp'n at 29. 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 statute.

C. The Rule Does Not Implicate Section 1554.

Plaintiffs double down in their reply on their extremely broad reading of Section 1554 to argue that HHS is prohibited from issuing regulations implementing its interpretation of Section 1303(b)(2)(B). *See* Pls.' Opp'n at 17-21. Plaintiffs' argument is unmoored from the text of Section 1554, is at odds with the interpretation of the only court of appeals to have considered the scope of that provision, and would lead to absurd results.

Section 1554, by its terms, applies only when there is an "unreasonable barrier" to obtaining, an "impedi[ment]" to access to, or a "limit[ation]" on the "availability of health care." *See* Defs.' Mem. at 19-20. As the Ninth Circuit recently 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.*" *California v.*

Azar, 950 F.3d 1067, 1094 (9th Cir. 2020) (en banc) (emphasis added). The Rule creates no such regulatory burden. It applies only to QHP issuers—not doctors or patients—and requires them only to provide a separate bill to enrollees for the portion of their premiums attributable to coverage of non-Hyde abortion services and to instruct enrollees to pay the separate bills through separate transactions. *See* 84 Fed. Reg. at 71,710 (42 C.F.R. § 156.280). There is nothing close to the sort of "direct government interference with health care" that could implicate Section 1554. *California*, 950 F.3d at 1094.

To accept Plaintiffs' contrary argument that the Rule nevertheless violates Section 1554 because it could hypothetically lead to a reduction in health insurance coverage because of increased costs, one must ignore any meaningful distinction between "direct interference" and indirect consequences recognized by the Ninth Circuit. Plaintiffs try to run from the holding in *California*, but their efforts to distinguish that case are unconvincing. While part of the Ninth Circuit's holding was that Section 1554 does not apply to federal grant programs, like Title X, Plaintiffs essentially ignore the portion of the court's decision that described Section 1554's proper scope—*i.e.*, to "direct interference" that imposes "burdens on doctors and patients." *Id.*

Plaintiffs' claim also lacks a limiting principle, as Defendants have explained. *See* Defs' Mem. at 20-22. Entirely absent from Plaintiffs' reply is any attempt to explain why their interpretation of Section 1554 would not prevent HHS from implementing *any* regulation that increases issuers' costs. *See* Pls.' Opp'n at 17-21. To the contrary, they point out that Section 1554 applies "[n]otwithstanding any other provision of this Act," 42 U.S.C. § 18114, and state that the "provision necessarily trumps all others, including Section 1303," Pls.' Opp'n at 19. Thus, to accept Plaintiffs' broad reading of Section 1554, the Court would need to conclude that the provision bars HHS from promulgating any regulation at all that effectuates any portion of the

ACA—no matter how closely it hews to Congress's intent—if doing so could even hypothetically increase the costs of insurance, or otherwise potentially make it more burdensome to receive any particular health care service, no matter how indirectly. That is a remarkable proposition and simply cannot be what Congress intended when enacting Section 1554. There is no reason to accept Plaintiffs' sweeping interpretation, because it finds no basis in the text of the statute. But even if there were any doubt, the Court should construe Section 1554 to avoid such absurd results. *See, e.g.*, *NLRB v. Wheeling Elec. Co.*, 444 F.2d 783, 787 (4th Cir. 1971) ("[S]tatutes are contextual as well as textual, and where a literal interpretation of a statutory provision would not accord with the intended purpose of the legislation, or produces an absurd result, courts must look beyond the plain words of the statute." (citations and internal quotation marks omitted)).

III. THE SCOPE OF ANY RELIEF SHOULD BE LIMITED.

Finally, although the Rule is lawful for the reasons Defendants have explained, if the Court were to disagree, any relief should be limited to the specific Plaintiffs before the Court. Plaintiffs insist that nationwide relief is the appropriate remedy under the APA. Pls.' Opp'n at 33-34. But Plaintiffs' argument is meritless, especially 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; *see also* Defs.' Mem. at 40-41.

With respect to Planned Parenthood of Maryland ("PPM"), Plaintiffs acknowledge that the Rule does not impose any regulatory burden on that entity. *See* Pls.' Opp'n at 35. And it is also not at all clear how PPM is plausibly injured by the Rule. Plaintiffs represent that they provide abortion services to individuals across the country. But nothing in the Rule interferes with the provision of abortion—it merely requires issuers to provide a separate bill for coverage of non-

Hyde abortion services, which those issuers are required to collect separate payment for under the ACA.

As to the Consumer Plaintiffs, any cognizable, non-speculative injury they could plausibly suffer would be remedied by an injunction preventing application of the Rule with respect to their insurance coverage. Yet, even assuming there were any doubt in that respect, the Court could decide whether broader relief is appropriate through consideration of Plaintiffs' motion for class certification. Defendants do not believe certification of Plaintiffs' proposed class is appropriate for reasons they will explain in their forthcoming opposition to Plaintiffs' class certification motion. However, the potential option of class certification—assuming Plaintiffs could meet the requirements of Rule 23(a)—further shows why vacatur is an inappropriate remedy here. That is particularly true given that a number of States have challenged the Rule in the Northern District of California, and vacatur would effectively render a government victory in that case 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.

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