IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MARYLAND

CITY OF COLUMBUS, *et al.,* *Plaintiffs*, v. DONALD J. TRUMP, *et al.,* *Defendants*.	Civil Action No. 1:18-cv-02364-DKC

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

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INTRODUCTION

Plaintiffs fail to establish that the challenged portions of a final rule, 83 Fed. Reg. 16930 (Apr. 17, 2018) (the "2019 Rule"), are contrary to law or arbitrary and capricious under the Administrative Procedure Act ("APA"). Rather, the adjustments that Defendants made in this rule—an annual process that the Department of Health and Human Services ("HHS") undertakes to refine its programs and respond to any new developments pursuant to its rulemaking authority under the Patient Protection and Affordable Care Act ("ACA") and the Public Health Service Act ("PHS Act")—fully comply with all statutory requirements while minimizing unnecessary burdens. Although Plaintiffs repeatedly express their disagreement with HHS's policy choices, HHS engaged in reasoned decisionmaking when promulgating these adjustments, consistent with its obligation under *Motor Vehicle Mfrs. Ass'n v. State Farm Mut. Auto. Ins. Co.* ("*State Farm*"), 463 U.S. 29 (1983), to examine "the relevant data," articulate "a satisfactory explanation" for its decisions, and demonstrate "a rational connection between the facts found and the choice made." *Id.* at 45 (internal quotation omitted). Plaintiffs fail to show otherwise. Defendants therefore should be granted judgment as a matter of law on all claims.

ARGUMENT

I. THE COURT SHOULD GRANT JUDGMENT IN DEFENDANTS' FAVOR ON ALL CLAIMS

As demonstrated in Defendants' opening brief and as further discussed below, Defendants are entitled to judgment as a matter of law with respect to each of the nine aspects of the 2019 Rule at issue. The decisions that Plaintiffs challenge as contrary to law should be upheld under *Chevron, U.S.A., Inc. v. NRDC, Inc.* ("*Chevron*"), 467 U.S. 837 (1984), because they do not violate Congress's unambiguously expressed intent, and thus do not implicate *Chevron* step one, but instead reflect HHS's permissible interpretation of applicable authority under *Chevron* step two. *See PhRMA v. FTC*, 790 F.3d 198, 204 (D.C. Cir. 2015). Each of the challenged portions of the 2019 Rule also withstands arbitrary

and capricious review under the APA because the administrative record[1] demonstrates HHS's reasoned decisionmaking consistent with *State Farm*.

A. The 2019 Rule's removal of the direct notification requirement for advance payments of premium tax credits should be upheld. [Am. Compl. ¶ 282(a)]

1. HHS's Removal of the Direct Notification Requirement Is Not Contrary to Law

Plaintiffs first challenge the 2019 Rule's removal of a prior amendment to 45 C.F.R. § 155.305(f)(4), which had required Exchanges to send notifications to taxpayers that contained taxpayer-specific information and thus required special handling. The mandatory direct notices, added in 2016, related to health plan enrollees' eligibility for advance payments of premium tax credits. These advance payments are applied to an enrollee's health insurance premium during the plan year, before the federal income tax return for that year is filed. From the beginning, the governing regulation has made clear that enrollees are ineligible for future advance payments if their past advance payments were not reconciled with the premium tax credits claimed on the relevant taxpayers' federal income tax returns. 45 C.F.R. § 155.305(f)(4). The direct notices were supposed to inform taxpayers of a specific past failure to reconcile on behalf of an enrollee in their household. But as discussed in Defendants' opening brief, HHS's experience implementing the 2016 requirement led it to conclude in the 2019 Rule that, due to the additional burdens associated with handling material containing individualized tax information, direct notices should not be mandatory for State Exchanges. Def. Cross-S.J. Mem. ("Def. Mem.") [ECF 118-1] at 10-11 (citing 83 Fed. Reg. at 16982). Thus, while Federal Exchanges continue to provide direct notices to taxpayers, and State Exchanges are

[1] Although Plaintiffs' opening brief extensively cited the Declaration of Christen Young, among other materials, in support of their claims, Plaintiffs concede in their opposition brief that the extra-record material that they have submitted is not properly part of the administrative record and should not be considered by the Court in connection with the merits of Plaintiffs' APA claims. Pl. Cross-S.J. Opp. ("Pl. Opp.") [ECF 121] at 3 n.1. The Court should similarly disregard the extra-record material cited throughout the submissions of proposed amici.

encouraged to do the same where feasible, HHS removed the requirement. 83 Fed. Reg. 16982-83.

In their Amended Complaint, Plaintiffs assert that the 2019 Rule's revision of § 155.305(f)(4) conflicts with the "express statutory language" of an Internal Revenue Code provision, 26 U.S.C. § 36B. *See* Am. Compl. ¶ 54. But as explained in Defendants' opening brief, this claim fails at the outset because Plaintiffs rely on language in § 36B that addresses eligibility for the *tax credits themselves*, not eligibility for the *advance payments* made on behalf of enrollees toward premium costs during a plan year. Def. Mem. at 12. Indeed, to the extent § 36B addresses advance payments, it requires taxpayers to reduce the amount of any tax credit claimed on their federal income tax return by any advance payment received, 26 U.S.C. § 36B(f), and makes clear that the Secretary of the Treasury should coordinate with HHS regarding this reconciliation requirement, *id.* § 36B(g)(1) There is no conceivable conflict between HHS's regulation and § 36B, so as to support Plaintiffs' claim at *Chevron* step one. *See PhRMA*, 790 F.3d at 207 (at *Chevron* step one, plaintiff "must show that the statute [at issue] unambiguously forecloses the [agency's] interpretation" (internal quotation omitted)).

Unlike the tax credits, eligibility for advance payments is governed not by § 36B but by an entirely separate statute, 42 U.S.C. § 18082. But the Amended Complaint fails to assert any conflict between the 2019 Rule's revision of 45 C.F.R. § 155.305(f)(4) and § 18082. In their opposition, Plaintiffs essentially concede that § 36B is inapplicable here but argue that the Court should construe their claim as asserting a conflict with § 18082 even though the Amended Complaint fails to set forth any such claim. *See* Pl. Opp. at 3-4.[2] Plaintiffs, however, may not amend their Amended Complaint through briefing. *Mylan Labs., Inc. v. Akzo, N.V.*, 770 F. Supp. 1053, 1068 (D. Md. 1991) ("it is

[2] Despite their concession, Plaintiffs continue to conflate the tax credits themselves with advance payments when they suggest that the ACA "does not allow an individual's failure to reconcile previous receipt of tax credits to be used as a basis for denying *tax credits* in the future." Pl. Opp. at 3 (emphasis added). As Defendants have explained, § 155.305(f) does not identify a basis for denying premium tax credits. Def. Mem. at 12. Any enrollees who are eligible for tax credits pursuant to § 36B may claim such credits on their federal income tax returns without regard to § 155.305(f). Rather, § 155.305(f) addresses when an enrollee may receive an *advance payment*.

axiomatic that the complaint may not be amended by the briefs in opposition to a motion to dismiss."); *Cape Hatteras Access Pres. All. v. Jewell*, 28 F. Supp. 3d 537, 552 (E.D.N.C. 2014) (arguments raised "for the first time in [plaintiff's] motion for summary judgment" are waived).

Plaintiffs seek to rely on *Jones v. Koons Auto., Inc.,* 752 F. Supp. 2d 670, 683 (D. Md. 2010), for the notion that a complaint need not "name-check every statute." *See* Pl. Opp. at 4. But that case involved a situation where the complaint clearly set forth the substance of the plaintiff's claim even though the citation was missing. *See Jones*, 752 F. Supp. 2d at 683 (pointing out that the complaint "states (if rather clumsily) what [statutory] requirements [the defendant] allegedly violated").

Here, in contrast, the Amended Complaint cannot be read to assert a conflict between § 155.305(f) and § 18082 because it plainly asserts a conflict with the express language of an entirely *different* statute, § 36B. *See* Am. Compl. ¶ 54 (addressing "[t]he statute's plain terms," where the "statute" at issue—quoted at length in that paragraph of the Amended Complaint—is indisputably § 36B). Nor can Plaintiffs plausibly rely on general references to the ACA elsewhere in the Amended Complaint. *See* Pl. Opp. at 4 (citing Am. Compl. ¶¶ 50, 56, 282). A general reference to the ACA—which spans nearly a thousand pages—in paragraphs unrelated to the 2019 Rule's removal of mandatory direct notifications could not possibly put Defendants on notice that Plaintiffs intended to assert a violation of § 18082. *Cf. McCann v. Quality Loan Serv. Corp.*, 729 F. Supp. 2d 1238, 1242 (W.D. Wash. 2010) (rejecting plaintiffs' attempt to assert a claim under the Truth in Lending Act ("TILA") when the relevant portion of the complaint neither cited nor otherwise invoked the TILA). Plaintiffs' challenge to the 2019 Rule's revision of § 155.305(f) as contrary to law should be rejected for this reason alone.

Plaintiffs' claim also should be rejected because, to the extent their argument can be understood at all, they fail to show that HHS's decision in the 2019 Rule to remove the direct notice requirement reflects an impermissible interpretation of § 18082. Plaintiffs purport to rely on canons

of statutory construction while making no attempt to identify the statutory language supposedly being construed. Plaintiffs' argument is all the more confusing because it is at times unclear which "statute" they intend to reference. For example, they invoke the rule that "taxing statutes are strictly construed against the government." Pl. Opp. at 5. But Plaintiffs had earlier conceded that § 155.305 was promulgated pursuant to § 18082, not § 36B, and § 18082 is not a "taxing statute."

Plaintiffs also now insist that they do not challenge the underlying requirement in § 155.305(f), in effect since 2012, that those seeking advance payments must have reconciled prior advance payments on their federal income tax returns. *See* Pl. Opp. at 4 ("the focus of Plaintiffs' challenge is not the failure-to-reconcile requirement"). Plaintiffs here essentially acknowledge that their Amended Complaint—which plainly limits the scope of any APA challenge to the 2019 Rule—could not possibly be construed to raise such a challenge. Nevertheless, Plaintiffs continue to advance a convoluted theory that the 2019 Rule's removal of mandatory direct notices was impermissible *because*, in their view, the failure-to-reconcile requirement is itself impermissible, which they suggest somehow (though they fail to explain the basis for their theory) leads to heightened due process requirements, requiring direct notices. *See* Pl. Opp. at 5.

But as Defendants have explained, the Amended Complaint asserts no due process violation in connection with their "contrary to law" claim, *see* Am. Compl. ¶ 54, and Plaintiffs concede that they "do not bring a standalone due process claim." Pl. Opp. at 5. Their suggestion that hypothetical due process concerns should play a role in the Court's analysis here also ignores that, in a facial challenge like this one, Plaintiffs would have to "establish that no set of circumstances exist under which the [regulation] would be valid." *Earthworks v. U.S. Dep't of the Interior*, No. CV 09-1972, 2020 WL 6270751, at *7 (D.D.C. Oct. 26, 2020) (quoting *Reno v. Flores*, 507 U.S. 292, 301 (1993)). Plaintiffs make no attempt to meet this "heavy burden," *id.* (quoting *Rust v. Sullivan*, 500 U.S. 173, 183 (1991)), nor could they, given HHS's experience that approximately 60 percent of households with Federal Exchange

enrollees that did not receive direct notices nevertheless received notice allowing them to successfully correct their failure to reconcile. 2019 Proposed rule, 82 Fed. Reg. 51052, 51086 (Nov. 2, 2017).

Moreover, even under Plaintiffs' theory that the 2012 promulgation is somehow relevant to their challenge, Plaintiffs are wrong to assume that HHS was prohibited in 2012—whether by § 18082 or § 36B—from restricting advance payments to those who failed to meet the reconciliation requirement in prior years. If anything, the two statutes, read together, delegate authority to HHS and the IRS to "coordinat[e]" the tax credit with "the program for advance payment of the credit" as they deem appropriate. 26 U.S.C. § 36B(g)(1); *see* 42 U.S.C. § 18082(a) (directing HHS, "in consultation with the Secretary of the Treasury," to "establish a program" for determining advance payments). Congress thus "explicitly left a gap for [HHS] to fill," *Chevron*, 467 U.S. at 843-44, and HHS reasonably did so by requiring reconciliation as one of the eligibility criteria for advance payments. *See* 83 Fed. Reg. at 16984 ("HHS is committed to ensuring consumers eligible for [advance payments] maintain that important benefit; however, we also believe that ensuring consumers are not receiving [advance payments] improperly is necessary for program integrity."); *cf. Fairfax Hosp. Ass'n, Inc. v. Califano*, 585 F.2d 602, 606 (4th Cir. 1978) (recognizing HHS's authority to establish prophylactic rules in programs it administers to "protect against . . . potential abuse[]").

Turning back to the 2019 Rule, similar reasoning applies. Again, neither § 18082 nor § 36B requires HHS to include a mandatory direct notification requirement in its advance payment regulation, which was why the original 2012 regulation contained no such requirement. After adding the requirement in 2016, HHS permissibly decided to remove it based on experience gained in its implementation. In reaching this decision, HHS took into account the burdens involved in providing direct notices but also considered that Exchanges able to do so could continue providing direct notices; and that taxpayers would continue to receive combined notices, could appeal any adverse determination, could regain eligibility for advance payments by correcting the failure to reconcile, and

ultimately would continue to be eligible for the premium tax credit when filing their federal income tax return for that year. *See* 83 Fed. Reg. at 16983. HHS thus reasonably encouraged Exchanges to provide direct notices while acknowledging that the burdens involved may make direct notices infeasible for some Exchanges. HHS's interpretation of § 18082 as allowing its removal of mandatory direct notices is reasonable. *See PETA v. U .S. Dep't of Agric.*, 861 F.3d 502, 507 (4th Cir. 2017); *see also Earthworks*, 2020 WL 6270751, at *15 (where agency "carefully explained its decision to reverse course," its "change of heart" did not "deprive it of *Chevron* deference"). This interpretation is also "rationally related to the goals of" the ACA, *PhRMA*, 790 F.3d at 208, because it is aimed at ensuring eligible enrollees, who have complied with reconciliation requirements, receive advance payments while also taking care not to impose excessive burdens on State Exchanges, which play an important role in the health insurance marketplaces created by the ACA. If the Court reaches the issue, it should thus uphold this aspect of the 2019 Rule under *Chevron* step two.

In the end, Plaintiffs fail to offer any coherent argument that the 2019 Rule's removal of mandatory direct notices is contrary to law. The Court therefore should reject Plaintiffs' contrary-to-law challenge to this aspect of the 2019 Rule.

2. HHS's Removal of the Direct Notification Requirement Is Not Arbitrary or Capricious

The Court should likewise reject Plaintiffs' arbitrary-and-capricious challenge to this provision. *See PhRMA*, 790 F.3d at 204 (recognizing *Chevron* step two analysis often "overlaps" with arbitrary and capricious review). As discussed in Defendants' opening brief, HHS took into account the competing concerns that Plaintiffs identify and did not summarily dismiss them as Plaintiffs suggest. *See* Def. Mem. at 15-16. The situation here is a far cry from that in *Casa De Maryland v. U.S. Dep't of Homeland Sec.*, 924 F.3d 684 (4th Cir. 2019), *cert. denied*, No. 18-1469, 2020 WL 3492650 (U.S. June 29, 2020), cited by Plaintiffs. There, the court concluded that the agency's stated reason for rescinding DACA—that it was unlawful—failed to identify any law that had been violated and also failed to explain its

inconsistency with a prior opinion by the Department of Justice's Office of Legal Counsel. *Id.* at 704-05. The court also held that the agency failed to take into account the "reliance interests" of "[h]undreds of thousands of people [who] had structured their lives on the availability of deferred action" during the five years it had been in effect. *Id.* at 705.

None of the bases for the court's decision in *Casa De Maryland* are present here. Indeed, although Plaintiffs make much of HHS's prior statement, in support of its imposition of mandatory direct notices in 2016, that such notices were "essential," HHS did not act unreasonably by reevaluating its conclusion, particularly in light of the intervening experience of both Federal and State Exchanges when implementing or attempting to implement the requirement. *FCC v. Fox Television Stations, Inc.,* 556 U.S. 502, 515 (2009); *see also Overdevest Nurseries, L.P. v. Scalia*, 454 F. Supp. 3d 46, 59–61 (D.D.C. 2020) (upholding agency's revision of prior rule because the agency "sufficiently acknowledged the changes and offered a reasoned explanation for them" (internal quotation omitted)).

. The 2019 Rule explains that the inclusion of protected tax information in direct notices imposed burdens because such notices require special handling. 83 Fed. Reg. at 16982-84. Indeed, at least one State Exchange identified extensive operational changes that would be necessary in order to implement the requirement. *See id.* at 16984. Plaintiffs do not contest HHS's description of what is required to protect taxpayer information, but they suggest that it does not qualify as "adequate support" because HHS referenced a "workaround"—in the form of printed notices sent through contractors able to handle individual tax information in a secure manner—that Federal Exchanges were able to implement. Pl. Opp. at 7-8 (citing 83 Fed. Reg. at 16984 n.45).

But HHS explained that not all State Exchanges are able to take this approach due to their "limited print contracting options." *See* 83 Fed. Reg. at 16983-84. Moreover, even for Federal Exchanges, this workaround has drawbacks in that it fails to follow standard notice processes, such as using a household contact's preferred mode of communication and making notices available in

consumers' online accounts. *Id.* at 16984 n.45. Yet in order to provide direct notices electronically, Federal Exchanges would have to change their "notice generation and storage infrastructure" so that they could "segregate and secure" individual tax information, and they would also have to make significant changes to their "entire account creation framework." *See id.* at 16984. Although Plaintiffs question whether State Exchanges that are not already able to send direct notices would face similar difficulties, Pl. Opp. at 7-8, their speculation is no basis to overturn HHS's conclusion, particularly when one State Exchange confirmed those difficulties, 83 Fed. Reg. at 16984. *Cf. Pub. Citizen, Inc.* v. FAA, 988 F.2d 183, 197 (D.C. Cir. 1993) (agency need not respond to speculative comments). The administrative record thus provides ample support for the fact that direct notices require burdensome special handling. The fact that Federal Exchanges are able to—and do—provide direct notices, or that some State Exchanges may as well, does not mean that every State Exchange has the resources to do the same.

Plaintiffs also point to HHS's statement that 60 percent of those who received only combined notices, and not direct notices, had successfully taken action to correct a failure to reconcile. *See* Pl. Opp. at 6. HHS cited this number as showing that combined notices do provide notice allowing for corrective action. *See* 82 Fed. Reg. at 51086. In response to comments asserting that "a success rate of 60 percent" was not "sufficient," HHS agreed that there was "room for improvement" but indicated its expectation that the success rate would likely improve, despite its removal of mandatory direct notices, because consumers' familiarity with the requirement to reconcile would increase over time. 83 Fed. Reg. at 16983. HHS also pointed to the appeals process as a further avenue through which consumers might continue receiving advance payments and ultimately correct their failure to reconcile. *See id.* HHS thus provided a reasoned response sufficient to satisfy the APA. *See Pub. Citizen*, 988 F.2d at 197 ("[T]he agency's response to public comments need only enable us to see what major issues of policy were ventilated . . . and why the agency reacted to them as it did." (internal quotation omitted)).

In arguing to the contrary, Plaintiffs essentially contend that HHS should have given more weight to commenters that agreed with Plaintiffs' preferred approach while disregarding dissenting comments. But that is not what the APA requires, nor would it be prudent for HHS to ignore the concerns of State Exchanges when it relies on their participation to provide effective insurance markets. Moreover, rather than reversing its prior view that direct notices were important, HHS continued in the 2019 Rule to emphasize that direct notices are a good idea when feasible. Thus, HHS explained that Federal Exchanges would continue to provide direct notices and that State Exchanges were encouraged to do so as well. 83 Fed. Reg. at 16983-84.

In sum, Plaintiffs are wrong in suggesting that HHS gave no explanation for its decision. HHS did give an explanation, and that explanation demonstrates that HHS considered the relevant factors and came to a reasonable conclusion. Plaintiffs' disagreement with HHS's decision is no basis to hold the decision arbitrary or capricious. Defendants should be granted summary judgment on this claim.

B. The 2019 Rule's extension of HHS's 2018 approach to network adequacy for qualified health plans offered in Federal Exchanges should be upheld. [Am. Compl. ¶ 282(b)]

1. HHS's Network Adequacy Approach Is Not Contrary to Law

Plaintiffs' second APA claim alleges that the 2019 Rule is contrary to 42 U.S.C. § 18031(c)(1) and (d)(4)(A). Am. Compl. ¶ 60. Section 18031(c)(1) requires HHS to "establish criteria" by which health plans would be deemed to "ensure a sufficient choice of providers." As described in Defendants' opening brief, HHS plainly has complied with this obligation by promulgating 45 C.F.R. § 156.230—a regulation that sets forth the network adequacy criteria that a qualified health plan must satisfy. Def. Mem. at 17-28. Plaintiffs' challenge regarding that requirement thus fails at the outset, and Plaintiffs in their opposition abandon any argument that HHS has violated § 18031(c)(1).

Instead, Plaintiffs now focus solely on § 18031(d)(4)(A), which provides that an Exchange must, consistent with HHS's network adequacy criteria, "implement procedures" for the certification

of qualified health plans. 42 U.S.C. § 18031(d)(4)(A). But Plaintiffs' claim on that ground fails as well. As explained in Defendants' opening brief, the 2019 Rule extended a process originally adopted in the Market Stabilization Rule, by which Federal Exchanges would rely on State determinations of network adequacy (provided that the State's network adequacy review process was itself adequate), conduct their own evaluation, or rely on the determinations of accrediting entities. Def. Mem. at 17 (citing 83 Fed. Reg. at 17025). By adopting and extending this process, HHS has complied with the requirement in § 18031(d)(4)(A), with respect to Federal Exchanges.

Plaintiffs' contrary theory relies on the notion that the word "implement" in § 18031(d)(4)(A) imposes an obligation on Federal Exchanges *not* to rely on States' determinations. *See* Pl. Opp. at 9. However, under *Chevron* step one, Plaintiffs fail to establish that the statutory language unambiguously precludes a Federal Exchange from adopting and implementing a process that relies on State determinations where States have an adequate process to determine a plan's compliance with the criteria set forth in § 156.230. Indeed, Congress had envisioned that most Exchanges would be run by States in the first place. *See King v. Burwell*, 576 U.S. 473, 483 (2015) (citing 42 U.S.C. § 18031(b)(1)); 42 U.S.C. § 18041(c)(1) (providing for HHS to establish and operate Federal Exchanges only in States that have not established their own Exchanges). Thus, Congress's focus in § 18031(d)(4)(A) was on ensuring that the procedures implemented by an Exchange be "consistent" with HHS's guidelines, not on whether an Exchange performs the actual review for compliance with network adequacy guidelines itself. Indeed, if Congress had deemed it crucial for Exchanges to perform their own network adequacy reviews, that requirement could have been expressly set forth in the statute, but Congress imposed no such requirement, nor did it adopt a different requirement specific to Federal Exchanges. The process that HHS established pursuant to § 18031(d)(4)(A) reflects a permissible reading of the statute and should thus be upheld under *Chevron* step two.

Plaintiffs' continued reliance on *U.S. Telecom Ass'n v. FCC*, 359 F.3d 554 (D.C. Cir. 2004), is

misplaced. Unlike the rule at issue in that case, the 2019 Rule does not delegate to States the ability to create exceptions to the network adequacy criteria set forth by HHS. Rather, any procedure implemented by an Exchange—whether a Federal Exchange or a State Exchange—must conform to the criteria that HHS set forth in § 156.230. Moreover, Plaintiffs ignore that § 18031(d)(4)(A) cannot be read as a congressional delegation of authority to a "federal officer or agency," *U.S. Telecom Ass'n*, 359 F.3d at 565, in the first place. The provision is not specifically aimed at HHS at all and is a far cry from the grant of "broad discretion" to the FCC "to permit or forbid certain activities" at issue in *U.S. Telecom*, *see id.* at 567. Rather, § 18031(d)(4)(A) simply requires both State and Federal Exchanges to follow a process designed to ensure that qualified health plans comply with HHS criteria. The process extended in the 2019 Rule satisfies that obligation and is not contrary to law.

2. HHS's Network Adequacy Approach Is Not Arbitrary or Capricious

Nor is the 2019 Rule's approach to network adequacy arbitrary or capricious. Here again, Plaintiffs appear to focus exclusively on the process that Federal Exchanges would follow in accord with § 18031(d)(4)(A).[3] And as with their first claim, addressed *supra* Part I.A.2, Plaintiffs again rely on the notion that HHS should have followed recommendations of some commenters rather than others, and should not have accorded weight to comments provided by "health insurers or insurer trade associations." *See* Pl. Opp. at 12. But HHS was required to consider all significant comments that were submitted, *City of Portland v. EPA*, 507 F.3d 706, 713 (D.C. Cir.2007), and it was entitled to take into account the views of a variety of stakeholders, including plan issuers who may choose to withdraw from participation in Exchanges altogether if continued participation is too burdensome. *See* 83 Fed.

[3] Plaintiffs make a single, vague reference to a lack of "'strong federal minimum standards' for network adequacy," Pl. Opp. at 10, but they fail to allege any specific weaknesses in the criteria set forth in § 155.230, or to argue that the 2019 Rule is arbitrary or capricious on that basis. Nor could they succeed in any such challenge given that those criteria were promulgated before the 2019 Rule. Rather, Plaintiffs continue to focus on the process by which Federal Exchanges rely on network adequacy determinations made by States or accrediting entities.

Reg. at 16930 ("Over time, issuer exits and increasing insurance premiums have threatened the stability of the individual and small group Exchanges in many geographic areas."). The notion that HHS "prioritized expanding state and issuer flexibility at the expense of ensuring adequate coverage," Pl. Opp. at 12, is a false dichotomy because Exchanges require issuer participation in order to function at all. HHS's role is to evaluate the competing interests at stake in light of the larger purpose to ensure well-functioning Exchanges, not to prioritize one set of stakeholders over another.

The cases that Plaintiffs cite only underscore the reasonableness of HHS's decision. The court in *PhRMA* rejected the plaintiff's APA challenge, holding that the agency's "cumulative experience . . . was a valid basis for its decision" to depart from past practice and promulgate a rule focused specifically on the pharmaceutical industry, and that certain submissions the agency had relied upon did not qualify as the type of "technical studies and data" that commenters might need to review. *PhRMA*, 790 F.3d at 211-12. Like that case, this is not a situation where HHS failed to consider a statutorily-required factor or provided no response whatsoever to comments. Rather, HHS explained in the 2019 Rule that the network adequacy approach that it was adopting had already been in effect during the 2018 benefit year. 83 Fed. Reg. at 17025. HHS further explained that it had "relied on State and accrediting entities" for such reviews in the past and was aware that States typically "have requirements in place that specifically address access to adequate networks." *See id.*[4]; *see also Nat'l Tour Brokers Ass'n v. ICC*, 671 F.2d 528, 533 (D.C. Cir. 1982) (concluding agency had adequately supported its decision based on its own past experience). Plaintiffs point to nothing in the record suggesting that issuers' network adequacy was adversely affected by HHS's approach during the previous year. Rather, many commenters acknowledged that States already provide oversight of network adequacy and that

[4] In contrast, HHS decided *not* to expand the role of States in regard to "the review of service area; accreditation; [or] compliance review" because it concluded, "[b]ased on comments received," that "States presently lack resources, including staffing resources, to conduct these reviews." *Id.* at 17026. Although Plaintiffs cherry-pick nine discrete aspects of the 2019 Rule for their challenge, HHS's reasoned decisionmaking is apparent throughout the 2019 Rule.

requiring additional federal review would be "duplicative." 83 Fed. Reg. at 17025; *see* Def. Mem.at 20-21 (citing supportive comments).

Although other commenters questioned the adequacy of States' and accrediting entities' review, HHS explained that Federal Exchanges would only rely on State review processes that *were* adequate. *See* 83 Fed. Reg. at 17025 (indicating HHS would "rely on the States' reviews in States in which a [Federal Exchange] is operating, provided the State has a sufficient network adequacy review process"). Plaintiffs thus miss the mark when they fault HHS for failing to "explain *why* . . . state review processes are adequate and what facts support that view." Pl. Opp. at 11. Rather than relying on a blanket pronouncement that State review processes are always adequate, as Plaintiffs imply, HHS instead made the adequacy of State review processes a prerequisite for Federal Exchanges' reliance on those processes, requiring that States have "the authority to enforce standards that are at least equal to the 'reasonable access standard' defined in § 156.230 and means to assess issuer network adequacy." *See* 83 Fed. Reg. at 17025. HHS also indicated that it would "continue to monitor enrollee complaints for access concerns." *Id.* The results of such monitoring could be incorporated in a future year's rulemaking if HHS determines that further adjustments are warranted. For purposes of the 2019 Rule, it is not arbitrary or capricious for HHS to attempt to minimize duplicative reviews in order to reduce unnecessary burdens on issuers, which would in turn "help stabilize the markets." *See id.* The Court therefore should grant judgment on this issue in Defendants' favor.

C. The 2019 Rule's removal of the requirement that HHS provide advance approval of third-party auditors for entities participating in direct enrollment is not arbitrary or capricious. [Am. Compl. ¶ 282(c)]

The Court should also reject Plaintiffs' third claim, which addresses the 2019 Rule's removal of a requirement that HHS provide advance approval of third-party auditors that conduct operational readiness reviews for entities participating in direct enrollment. *See* Def. Mem. at 22-23. Plaintiffs' challenge here is based on speculation that, absent HHS's advance approval of third-party auditors,

agents and brokers will engage in "unscrupulous" behavior by "channel[ing] [consumers] away from ACA-compliant plans." Pl. Opp. at 13. But as explained in Defendants' opening brief, HHS in fact expanded operational readiness review requirements to include issuers as well as agents and brokers; it set forth "HHS-defined specifications and requirements" that auditors must follow; and it took steps to ensure that such auditors would be "subject to HHS oversight" through audits or other evaluations conducted by HHS or its designee. 83 Fed. Reg. at 16981. HHS thus responded to concerns of commenters by emphasizing its commitment to such continuing oversight while explaining that the 2019 Rule's approach would reduce regulatory burdens on agents, brokers, and issuers, as well as auditors; and reduce duplicative HHS oversight. *Id.* at 16981-82.

Although Plaintiffs attempt to analogize the situation here to that in *Friends of Back Bay v. U.S. Army Corps of Engineers*, 681 F.3d 581, 587-88 (4th Cir. 2012), that case is in no way similar to this one. The court in that case was evaluating an agency's conclusion pursuant to the National Environmental Policy Act ("NEPA") that no environmental impact statement was required before approving a permit to construct a boat ramp. The agency's decision relied, in part, on a preexisting "no-wake zone" in the area where the ramp was to be built. *Id.* at 588. But the court concluded that this reliance was not reasonable because the zone was "entirely unenforced." *Id.* The agency's finding of no significant impact, premised on the no-wake zone, therefore was arbitrary and capricious. *Id.* at 589.

Plaintiffs point to no parallel HHS finding here, based on a flawed premise and made pursuant to statutorily required procedures like those set forth in NEPA. To the extent Plaintiffs mean to analogize third-party auditors who have not received advance HHS approval to an "entirely unenforced" no-wake zone, the analogy fails. Such auditors still must comply with HHS-issued standards and continue to be subject to ongoing HHS oversight, as are agents, brokers, and issuers themselves. 83 Fed. Reg. at 16982. Plaintiffs thus fail to identify any legitimate basis for invalidating HHS's decision on this point. Indeed, Plaintiffs' argument relies on a number of unsubstantiated

inferences, including the notion that third-party auditors who have not received advance HHS approval will not comply with HHS's standards, and that the brokers and agents who are reviewed by those auditors will be more likely to engage in fraudulent behavior. Such speculation fails to show that this aspect of the 2019 Rule is arbitrary or capricious. *Am. Whitewater v. Tidwell*, 770 F.3d 1108, 1116 (4th Cir. 2014). The Court should enter judgment on this issue in Defendants' favor.

D. The 2019 Rule's cessation of the practice of designating "Simple Choice" plans is not arbitrary or capricious. [Am. Compl. ¶ 282(d)]

The Court should also uphold HHS's decision in the 2019 Rule to discontinue Simple Choice plans. As discussed in Defendants' opening brief, HHS set forth a reasoned explanation for its decision to stop designating plans as "Simple Choice" and to stop giving such plans preference when displaying plan options on Exchange websites. Def. Mem. at 25-28. Specifically, HHS determined that because it had designed the Simple Choice plans to be as similar as possible to the most popular qualified health plans in the Federal Exchanges, plans with similar characteristics, but lacking the "Simple Choice" designation, would remain available and that the market would benefit from removal of the Simple Choice designation in a number of ways. 83 Fed. Reg. at 16974-75. For one thing, consumers would not choose Simple Choice plans based solely on those plans' preferential display even though other plans would better meet the consumers' needs. *See id.* In addition, issuers would be encouraged to develop innovative plan alternatives. *See id.* HHS deemed both results particularly important "given the stresses faced by the individual market." *Id.* at 16974.

Contrary to Plaintiffs' assertion, HHS squarely addressed comments suggesting that overall enrollment in Exchange plans would be harmed by the removal of Simple Choice plans. In response to concerns that this step would make it more difficult for some consumers to choose a plan, HHS noted that HealthCare.gov has developed tools that "enable most consumers to make plan selections" and that HHS "continue[s] to explore strategies to make shopping on HealthCare.gov as easy as possible, and to better support consumers in choosing coverage that is best for them." *Id.* at 16975.

Moreover, HHS recognized the value of enrolling in "coverage that is best for" a particular consumer and thus agreed with comments that removing Simple Choice plans would "mitigate[e] the risk" that consumers choose those plans only because of their preferential display. *See id.*

HHS's response was reasonable. While consumer enrollment is undoubtedly a key purpose of the ACA, that does not mean HHS is precluded from taking steps that might temporarily lead to lower enrollments for purposes of ensuring stronger markets in the long term. *Cf. Henson v. Santander Consumer USA Inc.*, 137 S. Ct. 1718, 1725 (2017) (rejecting plaintiffs' speculation regarding Congress's intent based solely on statute's ostensible "primary objective"). After all, as HHS recognized in the 2019 Rule, the purpose of fostering innovative plan designs is to create new plans that consumers will enroll in, and issuers certainly have market incentives to design their plans in a manner that will attract consumer enrollment. *See* 83 Fed. Reg. at 16974-75 (discussing HHS's goal to "encourage free market principles in the individual market," and assessing issuers' incentives based on consumer demand). Plaintiffs thus are simply wrong when they claim that HHS was unconcerned with overall enrollment. HHS did not discount enrollment as a concern but recognized that enrollment is inextricably intertwined with the overall health of the individual market. Ultimately, HHS made a policy judgment that the market would be better served by discontinuing Simple Choice plans and instead encouraging issuers to develop innovative plan designs. HHS need not establish that its earlier decision to include Simple Choice plans was incorrect. Rather, it need only provide a "reasoned explanation for discounting the importance of the facts that it . . . previously relied upon." *U.S. Sugar Corp. v. EPA*, 830 F.3d 579, 626 (D.C. Cir. 2016). It has done so here.

Plaintiffs point to HHS's prior conclusion, when adopting Simple Choice plans, that Simple Choice plans would not "hamper innovation or limit choice," nor would they "steer consumers" to unsuitable plans. Pl. Opp. at 16-17 (quoting 81 Fed. Reg. 12204, 12292 (Mar. 8, 2016)). The concerns expressed about Simple Choice plans during the 2019 rulemaking, however, followed a number of

years in which Simple Choice plans had actually been in place. It was reasonable for HHS to accord those concerns greater weight when they were based on issuers' actual experience with Simple Choice plans. In promulgating the 2019 Rule, HHS also emphasized a greater interest in fostering innovation due to existing stresses in the individual market. 83 Fed. Reg. at 16974.

Finally, Plaintiffs double down on their reliance on *United Steel v. Mine Safety & Health Administration*, 25 F.3d 1279 (D.C. Cir. 2019). But that case is inapposite for the reasons explained in Defendants' opening brief. Def. Mem. at 27. Despite Plaintiffs' suggestion to the contrary, Congress's general goals in enacting the ACA are not the same as the express statutory prohibition at issue in *United Steel*. Here, Congress vested broad authority over many aspects of the ACA's implementation in HHS, and such delegation encompasses the authority to establish or discontinue Simple Choice plans. HHS therefore was entitled to discontinue Simple Choice plans as long as it provided a reasoned explanation for doing so. *Encino Motorcars, LLC v. Navarro*, 136 S. Ct. 2117, 2125 (2016) ("Agencies are free to change their existing policies as long as they provide a reasoned explanation for the change."). Because the 2019 Rule satisfies that standard, the Court should grant judgment on this issue to Defendants.

E. The 2019 Rule's modification of standards for Navigator certification should be upheld. [Am. Compl. ¶ 282(e)]

1. HHS's New Navigator Selection Standards Are Not Contrary to Law

Plaintiffs fail to establish that the 2019 Rule's modification of Navigator selection standards in 45 C.F.R. § 155.210(c)(2) and (e)(7) is contrary to law. As explained in Defendants' opening brief, the standards that the Secretary must establish pursuant to 42 U.S.C. § 18031(i)(4)(A), in regard to Navigators, are independent of Exchanges' obligations in selecting Navigators under 42 U.S.C. § 18031(i)(1)-(2) or Navigators' own statutory duties under 42 U.S.C. § 18031(i)(3)(A)-(E). The focus of the § 18031(i)(4) standards is to ensure that any Navigators selected by an Exchange are "qualified, and licensed if appropriate," to carry out Navigator activities and to avoid conflicts of interest. 42

U.S.C. § 18031(i)(4)(A). Congress did not direct the Secretary to incorporate Navigators' specific obligations under § 18031(i)(3)(A)-(E) into the § 18031(i)(4)(A) standards. Nevertheless, to the extent HHS was required to include Navigators' statutory duties among its own standards for Navigators, it has done so. *See* 45 C.F.R. § 155.210(c)(1)(i) (requiring that Navigators "[b]e capable of carrying out at least those duties described in" § 155.210(e), which incorporates all of the Navigator duties set forth in § 18031(i)(3)). The relevant subsections incorporating those obligations, 45 C.F.R. § 155.210(c)(1) and (e)(1)-(5), were unchanged by the 2019 Rule.

Rather than changing Navigators' statutory duties, the 2019 Rule removed two prior *regulatory* requirements relating to Exchanges' selection of Navigators. *See* 83 Fed. Reg. at 16979–80 (removing a two-Navigator-per-Exchange requirement in § 155.210(c)(2) and a physical presence requirement in § 155.210(e)(7)). Neither of those requirements was imposed by the statutory provisions governing Exchanges' selection of Navigators. *See* 42 U.S.C. § 18031(i)(1)-(2). Plaintiffs argue that § 18031(i)(4)(A) imposes a mandatory obligation on HHS to *ensure* "that Exchanges select Navigators that can perform their statutory functions," Pl. Opp. at 18, implicitly suggesting that in some cases Navigators can only perform their statutory functions if an Exchange selects more than one Navigator or if the selected Navigator has a physical presence in the Exchange service area. But the language of § 18031(i)(4)(A) refers to "standards . . . to ensure" that a Navigator is "qualified," in a general sense, not to ensure that any particular Navigator will meet the needs of any particular Exchange. Under *Chevron* step one, Plaintiffs thus fail to show that HHS has violated an unambiguous statutory requirement. *PhRMA*, 790 F.3d at 207. Their challenge also fails under *Chevron* step two because the 2019 Rule's revision represents a permissible interpretation of the relevant statutory requirements.

The structure of the ACA does not suggest that Congress intended to adopt a one-size-fits-all approach to Navigators. Instead, Congress allowed Exchanges to choose their own Navigators as long as the Navigators meet HHS's general qualification standards and the eligibility criteria of

§ 18031(i)(2). 42 U.S.C. § 18031(i)(1) (imposing obligation to establish Navigator program on Exchanges). But each Exchange must determine whether any particular Navigator or group of Navigators, even if generally qualified, will meet the specific needs of that Exchange, including whether the Navigator has sufficiently demonstrated that it has existing relationships in the community or could readily establish such relationships. *Id.* § 18031(i)(2). The 2019 Rule's amendment of § 155.210 simply provides Exchanges with greater flexibility in that selection process without affecting any statutory obligations. *See* 83 Fed. Reg. at 16979 (amendments are intended to give Exchanges "flexibility to award funding to the number and type of entities that will be most effective for the specific Exchange"). Plaintiffs' contrary-to-law challenge to the 2019 Rule's removal of regulatory requirements that were not imposed by statute therefore fails as a matter of law.

2. HHS's New Navigator Selection Standards Are Not Arbitrary or Capricious

Plaintiffs also fail to show that the 2019 Rule's amendment of Navigator selection requirements is arbitrary or capricious. As Defendants have explained, HHS reasonably adopted the amendments in order to give Exchanges greater flexibility in selecting Navigators that would best meet their needs. Def. Mem. at 31. Exchanges that wish to select more than one Navigator, or a Navigator with a preexisting physical presence in the Exchange location, are free to do so. However, if they determine that having a single Navigator will meet the needs of their community, they may select a single Navigator.

Plaintiffs' assertion that HHS has "eliminate[ed] a minimum floor for Navigator programs" and instead has given "complete discretion to Exchanges," Pl. Opp. at 19, misses the mark and fails to demonstrate that this aspect of the 2019 Rule is arbitrary or capricious. The prior two-Navigator and physical presence regulatory requirements are not properly characterized as a "floor." Rather, they are characteristics that, in some instances, may contribute to a Navigator's ability to establish relationships with the relevant employers and potential enrollees in a community—a statutory

requirement that Navigators still must meet, 42 U.S.C. § 18031(i)(2)(A); 45 C.F.R. § 155.210(c)(1)(ii)—or to an Exchange's ability to select the best Navigator or Navigators for its needs. However, HHS reasonably concluded that Exchanges are best-positioned to determine how much weight to give physical presence when selecting Navigators, as well as how many Navigators are needed. 83 Fed. Reg. at 16979-80. Any Exchange that wishes to select two Navigators or to select Navigators with an established physical presence in its area may still do so.

Plaintiffs assert that the 2019 Rule is internally inconsistent because the 2019 Proposed Rule stated that "entities with a physical presence and strong relationships in their [Federal Exchange] service areas *tend to* deliver the most effective outreach and enrollment results," 82 Fed. Reg. at 51084 (emphasis added). Pl. Opp. at 20. Plaintiffs misunderstand HHS's statement. The fact that HHS recognized that physical presence *often* adds to Navigators' effectiveness is not equivalent to a finding that physical presence is always necessary, nor is it inconsistent with HHS's determination that "each Exchange is best suited to determining the weight to give a physical presence in the Exchange service area" as long as the selection process is consistent with statutory requirements. 83 Fed. Reg. at 16979-80. Again, an Exchange that concludes that an entity with a physical presence in its service area *will* better serve its population can act on that conclusion by selecting that entity to serve as a Navigator.

Moreover, although, as Plaintiffs point out, some commenters disagreed with HHS's proposal to remove the two regulatory requirements, other commenters supported the proposal. 83 Fed. Reg. at 16980. HHS acknowledged and addressed negative comments but emphasized that its changes would give each Exchange greater flexibility to "ensure that its service area can be assisted by the entity or entities that best fits the needs of its population." *Id.* at 16981. Plaintiffs fail to identify any relevant factors that HHS failed to consider, or significant comments that HHS failed to address. Instead, Plaintiffs attempt to apply a recent decision in another court, *Dist. of Columbia v. U.S. Dep't of Agric.*, 444 F. Supp. 3d 1 (D.D.C. 2020). Pl. Opp. at 21. But that case is inapposite. The court in *Dist.*

of Columbia held that the Department of Agriculture had failed to address the "[v]oluminous evidence" submitted by commenters to show that "general unemployment rates alone cannot measure whether an area has 'a sufficient number of jobs'" to meet the statutory standard for imposing a work requirement on food stamps. *Id.* at 22. Here, Plaintiffs point to no similar voluminous evidence—or any evidence at all to support their assertion that providing Exchanges with greater flexibility is "inappropriate," *see* Pl. Opp. at 21, or will prevent Navigators from performing their statutory duties. Rather, they simply disagree with HHS's policy choice to give Exchanges flexibility rather than imposing specific requirements not set forth by statute. This disagreement provides no basis to second-guess HHS's decision. *Am. Whitewater*, 770 F.3d at 1116. Rather, because HHS's decision reflects reasoned decisionmaking and is neither arbitrary nor capricious, the Court should grant judgment to Defendants on this issue.

F. The 2019 Rule's modifications to the Small Business Health Options Program should be upheld. [Am. Compl. ¶ 282(f)]

1. HHS's Amendment of SHOP Standards Is Not Contrary to Law

Plaintiffs fail to establish that the 2019 Rule's modifications to the Small Business Health Options Program ("SHOP") standards are contrary to law. As discussed in Defendants' opening brief, HHS removed some regulatory burdens on SHOPs in light of the low issuer participation in SHOPs and low consumer enrollments in qualified health plans through SHOPs. Def. Mem. at 33-34. None of the removed burdens are mandated by statute. Rather, HHS had originally imposed these requirements pursuant to its general authority under the ACA to promulgate "standards" for meeting the ACA's statutory requirements, including those relating to the "establishment and operation" of SHOPs. 42 U.S.C. § 18041(a)(1)(A). This is not a situation in which Congress has "directly spoken to the precise question at issue," so as to implicate *Chevron* step one. *City of Arlington v. FCC*, 569 U.S. 290, 296 (2013) (quoting *Chevron*, 467 U.S. at 842). Rather, the statutory provisions governing SHOPs require States to establish a SHOP "that is designed to assist" small business employers "in facilitating

the enrollment of their employees in qualified health plans offered in the small group market." 42 U.S.C. § 18031(b)(1)(B). In the 2019 Rule, HHS determined that SHOPs could continue to perform their statutorily-required functions if the prior regulatory requirements of providing employee eligibility, premium aggregation, and online enrollment functionality were removed. 83 Fed. Reg. at 16996. In particular, HHS determined that SHOPs could still "assist" small business employers in "facilitating the enrollment of their employees" by certifying plans for sale through a SHOP, by providing plan information on a website, by providing a premium calculator that generates estimated prices of available plans, and by staffing a call center to answer SHOP-related questions. *Id.* at 16997.

Plaintiffs argue that such actions do not "facilitate" enrollment within the meaning of § 18031(b)(1)(B). However, Plaintiffs concede that the term "facilitate" broadly means "to make easier." Pl. Opp. at 22. Although Plaintiffs suggest that directing employers to a private insurer or broker would not be helpful, HHS concluded that the actions taken by a SHOP operating in a "leaner" fashion, including the actions listed above, such as answering questions through a call center, would still provide assistance to small business employers. 83 Fed. Reg. at 16997; *cf. id.* at 16999 (pointing out that the ACA does not require SHOPs "to *process* the enrollment of qualified employees" (emphasis added) but only requires them to "assist qualified employers in facilitating employees' enrollment"). HHS's interpretation of the term "facilitate" is permissible and therefore should be upheld under *Chevron* step two. *CASA de Maryland, Inc. v. Trump*, 971 F.3d 220, 250 (4th Cir. 2020).

Plaintiffs otherwise fail to tie their arguments to any statutory directive at all. Although Plaintiffs repeatedly quote language not appearing in any relevant statute, such as the phrases "basic SHOP functionalities" and "essential to ensure that SHOPs will meet their statutory obligation," Pl. Opp. at 22, Plaintiffs identify no statutory violations. Plaintiffs' arguments that SHOPs should verify employee eligibility in addition to employer eligibility, and that SHOPs should continue to provide premium aggregation, are based on their policy disagreements rather than statutory text. *See, e.g.*, 83

Fed. Reg. at 16997 ("aggregation functions are not a function mandated by the []ACA and therefore may be altered or removed," and "SHOP-registered agents and brokers will be able to assist employers in performing these tasks"); *id.* at 17001 (recognizing that the ACA's SHOP provisions focus on small business employers and "do[] not have to be interpreted to require SHOPs to provide for employee enrollment functionality," so SHOPs do not need to determine employee eligibility). HHS is therefore entitled to judgment on Plaintiffs' "contrary-to-law" claim as to this amendment.

2. HHS's Amendment of SHOP Standards Is Not Arbitrary or Capricious

Nor are the 2019 Rule's changes to SHOP standards arbitrary or capricious. As explained in Defendants' opening brief, Plaintiffs' argument that HHS should have conducted an economic cost-benefit analysis is meritless. Def. Mem. at 37. Plaintiffs now acknowledge that no economic analysis was required, but they argue that HHS nevertheless failed to consider "the costs to the public" of its proposed changes to the SHOP standards. Pl. Opp. at 24. However, HHS extensively addressed the issues raised in comments, both in a general section on SHOP standards and in connection with the specific regulatory changes made in the 2019 Rule. 83 Fed. Reg. at 17000-04. Moreover, Plaintiffs do not dispute that participation in SHOPs has in fact been low. The 2019 Rule emphasized that this reality called for reducing regulatory burdens on SHOPs, and it addressed the situation by giving SHOPs the option "to operate in a leaner fashion." *Id.* at 16998-99.

Plaintiffs otherwise argue that the 2019 Rule's changes "could" make it more difficult for the relatively small number of employers that had used SHOPs in the past to access "fair and impartial information," provide a choice of plans, or meet minimum participation requirements. Pl. Opp. at 24. But HHS explained in the 2019 Rule that SHOPs' focus under the leaner option would be squarely on assisting employers, that employers "will be able to see the SHOP plans available, by coverage level and issuers, in their area using the plan comparison tool available on a SHOP website," 83 Fed. Reg. at 16997; that SHOPs choosing the leaner option "would still be required to provide an opportunity

for employers to offer employees a choice of plans," *id.* at 16999; that the calculation of minimum participation rates would be adjusted to help employers provide such choices, *id.* at 16999-17000; and that the premium calculator "would be where an employer or SHOP-registered agent or broker could go to see a complete listing of all [qualified health plans] available in a given area," *id.* at 17000. HHS also concluded that any impact on employers of removing premium aggregation functions would be "minimal," given the low use of SHOPs, *id.* at 16998, but that any resulting increased burden on employers would be "outweighed" by the ultimate benefits employers would receive by having SHOPs better able to carry out their leaner functions, and by not having to provide SHOPs with information that had previously been required, *id.* at 17001. Contrary to Plaintiffs' assertion, HHS's consideration of these issues was far from "dismissive and cursory," Pl. Opp. at 25. Rather, HHS fully engaged in the reasoned decisionmaking process that the APA requires. *Fox*, 556 U.S. at 515. The Court should enter judgment on this issue in Defendants' favor.

G. The 2019 Rule's modification of income verification requirements for advance payments of premium tax credits is not arbitrary or capricious. [Am. Compl. ¶ 282(g)]

The Court should also reject Plaintiffs' challenge to the program integrity measure that HHS adopted in the 2019 Rule, relating to advance payments of premium tax credits. As explained in Defendants' opening brief, HHS reasonably decided to require income verification for applicants asserting eligibility for advance payments of premium tax credits where information from the IRS or Social Security Administration indicated that their income was below 100 percent of FPL (making them potentially eligible for Medicaid but not for advance payments), but the applicants attested to projected annual income between 100 and 400 percent of FPL, and at least 10 percent greater than what the electronic sources indicated. 83 Fed. Reg. at 16985. In doing so, HHS addressed a loophole created by the fact that, in this circumstance, someone who was ineligible for advance payments based on the electronic sources could gain access to the payments by projecting a higher income amount. Def. Mem. at 39. The 10 percent threshold continued to provide some leeway for normal income

fluctuations.

Plaintiffs argue that Defendants dismissed concerns about the impact of this measure on low-income consumers "in a conclusory manner." Pl. Opp. at 26. But that argument grossly mischaracterizes the 2019 Rule. HHS not only acknowledged the concern that "households with lower income might experience higher relative levels of variance in their income from year-to-year," but described steps that HHS had taken to help such individuals verify their income, including its release of a consumer guide and worksheet, and indicated that HHS continued to "explor[e] strategies" to help individual with fluctuating income report their income accurately. 83 Fed. Reg. at 16986.[5] HHS also noted that the addition of this program integrity measure responded to concerns expressed in reports issued by the U.S. Government Accountability Office ("GAO") and HHS Office of Inspector General ("OIG"). *Id.* at 16986 & n.47.

Although Plaintiffs argue that HHS's responses to comments were inadequate, the import of their argument is that individuals at this income level are often simply unable to verify their income, so HHS should forego any attempt at all to require income verification. But HHS was not required to give up on a reasonable program integrity measure when the current insurance eligibility structure leaves a gap between where Medicaid coverage ends in some States and where eligibility for advance payments begins, and thus creates a loophole where fraud can occur. Plaintiffs acknowledge that that "there may theoretically be an incentive for consumers to inflate their income in non-Medicaid expansion states" but assert that no such incentive would exist in States that have chosen to expand Medicaid. Pl. Opp. at 28. To the extent they intend to suggest that HHS could have limited the

[5] Plaintiffs fault Defendants for failing to identify any strategies developed after the 2019 Rule was promulgated. Pl. Opp. at 27. But as Defendants emphasized in their opening brief, judicial review here is limited to the administrative record, reflecting material that was before the agency at the time of its decision, and upon which it relied in promulgating the 2019 Rule. *See Citizens to Pres. Overton Park, Inc. v. Volpe*, 401 U.S. 402, 420 (1971).

applicability of the program integrity measure to those States, they cite no comment raising such a suggestion in the administrative record, nor do they cite any authority for the notion that HHS was required to adopt the least restrictive possible measure, even if it means applying different requirements to different States. HHS reasonably decided to adopt a measure that would apply uniformly rather than creating a patchwork of different requirements applicable in different jurisdictions.

Nor was HHS required to show that fraud has already occurred. If that were the law, no agency could include program integrity measures in its original regulatory scheme, but would instead have to wait to add them until after it could verify fraud had occurred. The APA imposes no such restriction on agency action. *Cf. Rust*, 500 U.S. at 190 (upholding program integrity measures that the Secretary had included in Title X regulations, in part responding to "observations in [] GAO and OIG reports" about potential problems); *see also Fairfax Hosp. Ass'n, Inc.*, 585 F.2d at 606 (recognizing that, "[p]articularly in a program as complex as the Medicare program," HHS could rationally conclude that "a particular limitation or qualification would protect against . . . potential abuse[]" despite the "inherent imprecision of a prophylactic rule"). Plaintiffs fail to address *Rust*, *Fairfax Hospital*, or other cases such as *Stillwell v. Off. of Thrift Supervision*, 569 F.3d 514 (D.C. Cir. 2009), cited in Defendants' opening brief, recognizing that "agencies can, of course, adopt prophylactic rules to prevent potential problems before they arise." *Id.* at 519.

Moreover, Plaintiffs' argument that HHS's evaluation of whether to implement a program integrity measure does not require "technical scientific expertise," and therefore is not entitled to deference, Pl. Opp. at 27, is not well taken. Courts have repeatedly recognized that HHS is entitled to significant deference in regard to the complex regulatory health insurance schemes that it administers. *See Fairfax Hosp. Ass'n*, 585 F.2d at 606; *cf. Shands Jacksonville Med. Ctr., Inc. v. Azar*, 959 F.3d 1113, 1118 (D.C. Cir. 2020) (recognizing "heightened deference that courts are to accord the Secretary's

interpretation of a complex and highly technical regulatory program such as Medicare" (internal quotation omitted)). At the very least, the arbitrary and capricious standard of the APA itself requires such deference. *FERC v. Elec. Power Supply Ass'n*, 136 S. Ct. 760, 782 (2016), *as revised* (Jan. 28, 2016) ("A court is not to ask whether a regulatory decision is the best one possible or even whether it is better than the alternatives."). Here, the 2019 Rule's inclusion of a new program integrity requirement for a certain category of income reporting discrepancies is not arbitrary or capricious, and the Court should enter judgment on this issue in Defendants' favor.

H. The 2019 Rule's amendments to federal rate review requirements should be upheld. [Am. Compl. ¶ 282(h)]

1. HHS's Exemption of Student Health Insurance Coverage From Pre-Issuance Federal Rate Review Is Not Contrary To Law

The Court should also reject Plaintiffs' claim that HHS's decision in the 2019 Rule to exempt student health insurance coverage from pre-issuance federal rate review is contrary to law. As explained in Defendants' opening brief, the PHS Act directs the Secretary to "monitor premium increases of health insurance coverage offered through an Exchange and outside of an Exchange." 42 U.S.C. § 300gg-94(2)(A). The PHS Act also authorizes the Secretary to "promulgate such regulations as may be necessary or appropriate" to implement the Act's provisions. *Id.* § 300gg-92. Pursuant to that authority, the Secretary promulgated regulations setting forth procedures for HHS, in conjunction with States, to review health insurance issuers' proposed rate increases for the upcoming plan year, prior to issuance, in order to determine whether the increases are "unreasonable," 45 C.F.R. § 154.225. *See id.* §§ 154.101 to .301. From the beginning, HHS has not subjected large group market coverage to this pre-issuance federal rate review process because large employers are able to bargain effectively with issuers, thus obviating the risk that any rate increase would be unreasonable. *See* 2011 Rate Review Rule, 76 Fed. Reg. 29963, 29966 (May 23, 2011). In the 2019 Rule, HHS applied the same logic to student health insurance coverage because such coverage is negotiated by educational institutions,

which have a level of sophistication and bargaining power equivalent to that of large employers. 82 Fed. Reg. at 51078-79; 83 Fed. Reg. at 16972. This decision represents a permissible reading of statutory requirements because nothing in the PHS Act requires HHS to apply uniform pre-issuance rate review procedures to all types of health insurance coverage, nor does the Act specifically require HHS to apply such procedures to student health insurance coverage.

Plaintiffs' contrary argument stems from their misunderstanding of 42 U.S.C. § 300gg-94 and HHS's implementing regulations. Plaintiffs focus on § 300gg-94(a)(2), which states that the rate review process established by the Secretary "shall require health insurance issuers to submit to the Secretary and the relevant State a justification for an unreasonable premium increase prior to the implementation of the increase," and to "post such information on their Internet websites." 42 U.S.C. § 300gg-94(a)(2). Plaintiffs argue that Congress's use of the phrase "health insurance issuers" here necessarily encompasses student health insurance plans and that such plans therefore must submit to the same rate review procedures as other types of health insurance. Pl. Opp. at 29.

But Plaintiffs ignore the key term in § 300gg-94(a)(2)—"unreasonable." This provision applies only to "unreasonable" premium increases. 42 U.S.C. § 300gg-94(a)(2). And the pre-issuance federal rate review process set forth in HHS's regulations is the process by which pre-issuance rate increases are reviewed to determine whether the increases are "unreasonable" in the first instance. *See, e.g.*, 45 C.F.R. § 154.101(b) ("This part . . . establishes the process by which it will be determined whether the rate increases are unreasonable rate increases as defined in this part."); *id.* § 154.102 (defining "[u]nreasonable rate increase"); *id.* § 154.205 (setting forth how HHS determines whether a rate increase is unreasonable).

HHS thus specifically implemented the requirement set forth in § 300gg-94(a)(2) in 45 C.F.R. § 154.230—a provision that necessarily applies only *after* HHS has determined that an issuer's rate increase is unreasonable and, in accord with § 300gg-94(a)(2), requires the issuer to submit a Final

Justification to HHS and to post the Final Justification on its website. 45 C.F.R. § 154.230(c). This regulatory framework shows that § 300gg-94(a)(2) has no bearing on HHS's determination that student health insurance coverage should be excluded from the pre-issuance federal rate review process because that process occurs before any requirement in § 300gg-94(a)(2) has been triggered.[6] No requirement in that statutory provision is conceivably implicated here. Nor does any other provision of the PHS Act require HHS to apply uniform pre-issuance federal rate review procedures to all health insurance coverage. Absent any such uniform requirement, Plaintiffs' continued focus on whether HHS could "exempt" student health insurance coverage from pre-issuance federal rate review is beside the point.

Plaintiffs otherwise cite a prior HHS statement that student health insurance coverage was subject to rate review, Pl. Opp. at 30 (citing Student Health Insurance Coverage, Final rule, 77 Fed. Reg. 16453, 16458 (Mar. 21, 2012)), which Defendants have already explained was simply an accurate description of the status quo at the time. *See* Def. Mem. at 47 n.5. Nothing in that description suggests that the 2019 Rule's exclusion of student health insurance coverage from pre-issuance rate review is contrary to law. Plaintiffs thus do not prevail at *Chevron* step one. Rather than speaking directly to the issue, the PHS Act delegates authority to the Secretary to promulgate any regulations deemed "necessary or appropriate" to carry out its provisions. 42 U.S.C.§ 300gg-92.

Plaintiffs fail to advance an argument that this aspect of the 2019 Rule is contrary to law under *Chevron* step two. However, any such argument would also fail because HHS's exclusion of student

[6] Although, under the 2019 Rule's revision, a rate increase in student health insurance coverage is not subject to automatic federal reviews of proposed rate increases, HHS may make an unreasonableness determination when reviewing a student health insurance plan's rates in a State that does not itself have an effective rate review program. *See* 83 Fed. Reg. at 16972 (HHS will continue to generally review such rates "[i]n States that do not have an Effective Rate Review Program," in order to "monitor the compliance of student health insurance coverage with applicable market rating reforms based on complaints and as part of targeted market conduct examinations"). In that event, the requirement in § 300gg-94(a)(2) would be triggered, and the plan would have to comply with 45 C.F.R. § 154.230(c).

health insurance coverage from pre-issuance federal rate review is permissible. As it previously concluded with respect to large group coverage, HHS recognized that rate increases that occur in these contexts will be the product of negotiation between the issuer and a sophisticated purchaser with bargaining leverage. 82 Fed. Reg. at 51078–79; 83 Fed. Reg. at 16972. It thus reasonably determined that student health insurance coverage should be treated like large group coverage insofar as the latter is excluded from pre-issuance federal rate review. Further, HHS's conclusion is consistent with its different treatment of student health insurance in other respects, such as by exempting it from the ACA's single risk pool rating requirements. *See* 45 C.F.R. § 147.145(b)(3). For these reasons, and as discussed further below in regard to Plaintiffs' arbitrary and capricious claim, HHS's decision should be upheld under *Chevron* step two.

2. HHS's Rate Review Changes Are Not Arbitrary or Capricious

Plaintiffs also fail to show that the 2019 Rule's exclusion of student health insurance coverage from pre-issuance federal rate review was arbitrary or capricious. As described above and in Defendants' opening brief, HHS's decision was reasonable in light of the strong similarities between student health insurance coverage and large group coverage, which HHS had already determined should be excluded from pre-issuance federal rate review. Def. Mem. at 48. Plaintiffs suggest that the fact that HHS originally subjected student health insurance coverage to pre-issuance rate review requires HHS to show that student health insurance coverage has changed in some way in order to now exclude it. Pl. Opp. at 31. But that is not the applicable standard under the APA. Rather, HHS's reasoned explanation is all that the APA requires. *Encino Motorcars, LLC*, 136 S. Ct. at 2125 ("Agencies are free to change their existing policies as long as they provide a reasoned explanation for the change.").

In this instance, moreover, HHS's prior inclusion of student health insurance coverage in pre-issuance federal rate review was not based on any "factual findings," so no such findings were

contradicted by the 2019 Rule. *Cf.* Pl. Opp. at 31 (quoting *Fox*, 556 U.S. at 515). Treating student health insurance coverage like other forms of individual coverage was the default until HHS considered the question in greater detail and determined that student health insurance coverage should be treated like large group coverage for purposes of pre-issuance federal rate review. Meanwhile, HHS made a number of other decisions that incrementally implemented its understanding that student health insurance coverage resembles large group coverage more than it does individual coverage in certain respects. *See* 77 Fed. Reg. at 16457 (excepting student health insurance coverage from guaranteed availability and guaranteed renewability requirements as generally applied in the individual market); Rate Review, Final rule, 78 Fed. Reg. 13406, 13424 (Feb. 27, 2013) (exempting student health insurance coverage from the ACA's single risk pool requirement due to the reality that student health insurance policies are "generally rated on a group basis," based on the college's or university's students enrolled in the plan);.2015 Payment Notice, 79 Fed. Reg. 13744, 13749, 13752 (Mar. 11, 2014) (exempting student health insurance coverage from requirement to establish open enrollment periods and coverage effective dates based on calendar policy year). The 2019 Rule simply represents another reasonable step in this progression. Indeed, HHS pointed out that its exemption of student health insurance coverage from single risk pool rating requirements made pre-issuance federal rate review even less relevant since single risk pool pricing was "the primary focus of the rate review program." 83 Fed. Reg. at 17056.

Plaintiffs otherwise rely on the notion that Defendants failed to respond to four comments that opposed the proposed change. Plaintiffs note that one of the comments cited studies that were done prior to the ACA, suggesting that those involved in negotiating student health insurance coverage may have conflicts of interest and that such plans had been profitable to insurers. Pl. Opp. at 31 (citing AR1945). But those studies had nothing to do with the potential impact of excluding student health insurance coverage from pre-issuance federal rate review. The commenter acknowledged that

"tremendous progress has been made to expand consumer protections for students and better regulate student health plans." AR1945 (Young Invincibles). The commenter then merely speculated that HHS's proposal "would scale back this progress." *Id.* But all other applicable requirements regarding student health insurance coverage remain in effect, and the commenter gave no indication that the "progress" it cited was in any way connected to the prior applicability of pre-issuance federal rate review requirements to such coverage. Although most comments on this proposal supported the elimination of pre-issuance federal rate review for student coverage, HHS responded to the few negative comments on this proposal by explaining that, in States where HHS is responsible for enforcement, it would "continue to monitor the compliance of student health insurance coverage with applicable market rating reforms based on complaints and as part of targeted market conduct examinations." 83 Fed. Reg. at 16972. In addition, HHS noted that States also generally maintain the flexibility to review student health rate increases of any size, along with any other aspect of student health insurance coverage. *Id.* HHS's decision was not arbitrary or capricious.

Plaintiffs also fail to show that the 2019 Rule's revision of the rate review threshold from 10 percent to 15 percent was arbitrary or capricious. Plaintiffs' arguments in regard to the threshold merely reflect their disagreement with HHS's policy decision. HHS explained its reasoning in detail and sufficiently responded to comments. 83 Fed. Reg. at 16972. The crux of Plaintiffs' argument appears to be that, even though HHS identified only one instance of an unreasonable rate increase in the range between 10 percent and 15 percent in the past, future increases in that range may more likely be unreasonable due to changed market conditions. Pl. Opp. at 33. But HHS explained its view that its change would not have a significant impact, and it was not required to address speculation about future market conditions, and their potential impact, in order for its current decision to be deemed reasonable. The Court should enter judgment on these issues in favor of Defendants.

I. The 2019 Rule's option to allow issuers to report quality improvement activity as a single fixed percentage should be upheld. [Am. Compl. ¶ 282(i)]

1. HHS's Provision of a Standardized QIA Expenditure Reporting Option Is Not Contrary to Law.

Plaintiffs' final challenge is equally ill-conceived. Here, HHS simplified an issuer reporting requirement by allowing issuers to report the amount spent on activities that improve health care quality ("QIA expenditures") as 0.8 percent of their earned premiums. 83 Fed. Reg. at 17032. HHS made this change based on audits and data analysis that it had conducted since 2011, which showed that on average issuers consistently made QIA expenditures of that amount. *See id.* Because there was so little variation in these amounts, over time or among issuers, and because these amounts represented a relatively small portion of overall expenditures, HHS decided to reduce the burden associated with tracking specific QIA expenditures by allowing issuers to report a QIA amount equal to 0.8 percent of their earned premiums. *Id.*

Plaintiffs argue that this change violates 42 U.S.C. § 300gg-18(a)(2), which requires issuers' reports to include amounts that their coverage "expends" on QIA. Pl. Opp. at 33. But nothing in the statute addresses *how* health insurance issuers are required to determine the amount of their QIA expenditures. *See* 42 U.S.C. § 300gg-18(a) (requiring submission of "a report concerning the ratio of the incurred loss (or incurred claims) plus the loss adjustment expense (or change in contract reserves) to earned premiums"). The 2019 Rule explained that issuers *do* consistently report, on average, expending 0.8 percent of their earned premiums on QIA. 83 Fed. Reg. at 17032. By removing issuers' burden to maintain records and provide a detailed calculation, HHS in no way changed the amount of QIA expenditures that issuers make—which is, on average, consistently 0.8 percent of earned premiums—nor did it change the fact that issuers will be reporting their QIA expenditures—an amount that is again on average 0.8 percent of earned premiums. HHS permissibly interpreted the statute to allow it to recognize that this particular factor in the calculation was essentially a constant,

and thus to allow issuers to treat it as such.

In opposing HHS's decision as contrary to law, Plaintiffs attempt to read into the statute a particular tracking and calculation methodology that is absent from the statutory text. Plaintiffs cite no authority that prevents HHS from recognizing that issuers consistently make QIA expenditures in the amount of 0.8 percent of earned premiums and revising its regulation to reflect that recognition. To the contrary, the statue authorizes the Secretary to promulgate regulations implementing this reporting requirement, *see* 42 U.S.C. § 300gg-18(b)(3), and the Secretary exercised that authority in the 2019 Rule. Plaintiffs thus fail to show that this aspect of the 2019 Rule is contrary to law.

2. HHS's Provision of a Standardized QIA Expenditure Reporting Option Is Not Arbitrary or Capricious.

.Nor do Plaintiffs establish that HHS's decision on this point is arbitrary or capricious. As discussed in Defendants' opening brief, HHS reasonably decided to replace a complex system of QIA expenditure itemization with a constant 0.8 percent figure, based on its determination that the latter amount was, in fact, what issuers, on average, had consistently reported spending on QIA. Def. Mem. at 53-54. HHS also took into account the fact that the QIA expenditure amount was a relatively small component of an issuer's overall costs. 83 Fed. Reg. at 17032.

In arguing that HHS's decisionmaking process was flawed, Plaintiffs again resort to questioning the evidentiary basis for HHS's action and nitpicking at HHS's responses to specific comments. But Plaintiffs do not genuinely contest the fact that the prior process for identifying, tracking, and reporting QIA expenditures *was* burdensome. *Cf. id.* (citing HHS's observations of burdens when conducting audits). Nor could they, as commenters have substantiated that was the case. *Id.* at 17033. Plaintiffs argue that HHS should have considered an alternative that would have involved revamping the itemization that was previously required. Pl. Opp. at 36. But as Defendants previously explained, Def. Mem. at 54, this alternative is insignificant because it would still impose some level of unnecessary burden, particularly given the consistent average 0.8 percent QIA

expenditure level that HHS had documented over a number of years, and the fact that QIA expenditures are only a small portion of an issuer's total expenses. *See State Farm*, 463 U.S. at 51 (agencies need not consider every conceivable alternative). Plaintiffs suggest that this explanation is a *post hoc* rationalization, Pl. Opp. at 36, but they confuse an agency's response to a significant alternative with a litigation defense explaining that a proposed alternative was not significant in the first place. Agencies are not required to explain *why* they deem an alternative insignificant. That issue only arises in litigation where, as here, a plaintiff raises a claim that requires the agency to defend its failure to address an insignificant alternative.

Plaintiffs otherwise fault HHS for disagreeing with comments regarding the impact of HHS's proposed change. But HHS did explain its rationale for reaching its decision, including the fact that its own review had led it to conclude that issuers who reported QIA expenses consistently reported, on average, a QIA expenditure of around 0.8 percent of earned premiums, and that the burdens of itemizing such expenditures that HHS had observed could be obviated by using that figure. 83 Fed. Reg. at 17032. HHS explained that there was no reason to expect that this change would reduce the amount issuers actually spend on QIA because incentives exist, outside the calculation process, to make such expenditures while the tweaks HHS added to the process, requiring issuers that opt to use the constant figure in one market to use it across the board, would remove any realistic possibility of gaming the system. *Id.* at 17033. Plaintiffs' attempt to rehash the same baseless arguments they made in their opening brief does nothing to establish that HHS's decision on this issue was arbitrary or capricious. The Court should grant judgment on this issue in Defendants' favor.

II. THE COURT SHOULD NOT SET ASIDE ANY ASPECT OF THE 2019 RULE ABSENT AN OPPORTUNITY FOR FURTHER BRIEFING ON AN APPROPRIATE REMEDY

Plaintiffs have attacked nine discrete aspects of the 2019 Rule, and HHS has demonstrated that it is entitled to summary judgment on every claim. But, in the unlikely event that the Court

concludes that some aspect of the rulemaking falls short, the Court should either remand to HHS without vacatur or provide an opportunity for the parties to briefly address appropriate remedies. Plaintiffs assert that Defendants have conceded that the appropriate remedy would be to set aside and vacate that portion of the 2019 Rule. Pl. Opp. at 1. However, "[i]t is well settled that "[a]n inadequately supported rule . . . need not necessarily be vacated." *Shands Jacksonville Med. Ctr., Inc.*, 959 F.3d at 1118 (quoting *Allied-Signal, Inc. v. U.S. Nuclear Regulatory Comm'n*, 988 F.2d 146, 150 (D.C. Cir. 1993) (citations omitted)). Rather, "[t]he Supreme Court has explained that '[i]f the record before the agency does not support the agency action, . . . the proper course, except in rare circumstances, is to remand to the agency for additional investigation or explanation.'" *Banner Health v. Price*, 867 F.3d 1323, 1356 (D.C. Cir. 2017) (quoting *Fla. Power & Light Co. v. Lorion*, 470 U.S. 729, 744 (1985)).

Here, for most grounds on which any adverse ruling could be based, HHS "may well be able to justify its decision[s]" on remand, and "it would be disruptive to vacate a rule that applies to other members of the regulated community" and to HHS's efforts to regulate health insurance markets in accord with the ACA and PHS Act. *Central & Sw. Servs., Inc. v. EPA*, 220 F.3d 683, 692 (5th Cir. 2000), *cert. denied*, 532 U.S. 1065 (2001); *cf. Sierra Club v. U.S. Corps of Eng'rs*, 909 F.3d 635, 655 (4th Cir. 2018) (recognizing that "the *Allied-Signal* remand-without-vacatur approach" may be "relevant in matters where agencies have 'inadequately supported rule[s]").

Plaintiffs' opening brief conceded that the appropriateness of vacatur largely depends on the basis for a court's ruling, as well as the disruptive consequences that vacatur might have. *See* Pl. Mem. [ECF 108] at 59-60. Given the number of claims and arguments that Plaintiffs have raised, it would be difficult to fully address these issues in the abstract, which would require discussing the appropriate remedy under every possible ruling that the Court might make. Moreover, bifurcated briefing is frequently ordered in similar circumstances. *See, e.g.*, *Am. Great Lakes Ports Ass'n v. Zukunft*, 296 F. Supp. 3d 27, 56 (D.D.C. 2017) (court "not inclined to decide the issue of remedy without additional

briefing from the parties now that the issues in the cross-motions have been resolved"); *Sierra Club v. U.S. Dep't of Agric., Rural Util. Serv.*, 841 F. Supp. 2d 349, 362 (D.D.C. 2012) (determining remand, not vacatur, was the appropriate remedy after court-ordered supplemental briefing about this issue). Thus, should the Court deny judgment to Defendants and grant judgment to Plaintiffs on any issue, it should allow further briefing to address the appropriate remedy in light of the Court's ruling.

CONCLUSION

For the reasons stated herein and in Defendants' opening brief, the Court therefore should deny Plaintiffs' motion for summary judgment and grant Defendants' cross-motion.

Dated: December 8, 2020

Respectfully submitted,

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CERTIFICATE OF SERVICE

The undersigned counsel certifies that on December 8, 2020, a true and accurate copy of the foregoing was electronically filed with the CM/ECF system, which will send a Notice of Electronic Filing to all counsel of record in this matter.

/s/ Kathryn L. Wyer
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