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IN THE UNITED STATES DISTRICT COURT

FOR THE NORTHERN DISTRICT OF CALIFORNIA

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

Plaintiffs,

v.

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

Defendants.

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

PLAINTIFFS' NOTICE OF MOTION AND MOTION FOR SUMMARY JUDGMENT, WITH MEMORANDUM OF POINTS AND AUTHORITIES

Date:	June 11, 2020
Time:	9:30 AM
Courtroom:	Courtroom 5, 15th Floor
Judge:	Magistrate Judge Laurel Beeler
Action Filed:	January 30, 2020

TO THE COURT, ALL PARTIES, AND THEIR ATTORNEYS OF RECORD:

PLEASE TAKE NOTICE that on June 11, 2020 at 9:30 a.m. in Courtroom B located at 450 Golden Gate Avenue, San Francisco, CA, 94102, Plaintiffs the State of California, State of New York, State of Colorado, District of Columbia, State of Maine, State of Maryland, State of Oregon, and State of Vermont, pursuant to Federal Rule of Civil Procedure 56(a), will and hereby do move for summary judgment on each of the causes of action set forth in their Amended Complaint because the Rule, "Patient Protection and Affordable Care Act: Exchange Program Integrity," 84 Fed. Reg. 71,674 (December 27, 2019) (to be codified at 45 C.F.R. pt. 155, 156), violates the Administrative Procedure Act and the United States Constitution.

This motion is based on this notice, the Memorandum of Points and Authorities, the concurrently filed appendix of evidence, all records, documents, and papers in the Court's file, and any written and oral argument presented at the hearing in this matter.

STATEMENT OF RELIEF REQUESTED

Summary judgment is appropriate, and the States are entitled to judgment as a matter of law because there is no genuine issue of disputed material fact. Therefore, the States respectfully request this Court enter summary judgment in their favor as to all claims, declare the Rule invalid under the APA, and immediately set aside the Rule to prevent its enforcement. Alternatively, the States request the Court enter judgment as to those claims the Court sees as fit for resolution at this time.

Dated: March 30, 2020

Respectfully Submitted,

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MEMORANDUM OF POINTS AND AUTHORITIES

INTRODUCTION

Plaintiffs the States of California, New York, Colorado, Maine, Maryland, Oregon, and Vermont, and the District of Columbia (collectively, the States) challenge Defendants' adoption of a new billion-dollar federal regulation that requires health insurance carriers (issuers) to collect insurance premiums in an unprecedented and prohibitively expensive manner. Under the Final Rule, every consumer (policy holder) will receive two separate bills and must make two separate payments for their health insurance premiums: (1) a payment of at least $1 for abortion coverage *alone*; and (2) a payment for the *rest* of their health coverage benefits. This new mandate is not only confusing to health plan policy holders and may result in loss of coverage, but the astronomical costs of $900 million far exceeds any purported benefits.

The Rule undermines the States' sovereignty over the regulation of healthcare. The Rule disproportionately impacts states, including Plaintiff States, that either mandate abortion coverage, or allow the provision of abortion coverage in a qualified health plan on the individual market. These outcomes conflict with the Affordable Care Act, through which Congress intended to decrease healthcare costs and increase access to healthcare coverage.

The Rule violates the Administrative Procedure Act and should be vacated. First, the Rule exemplifies arbitrary and capricious agency rulemaking because HHS makes unsubstantiated conclusions that contradict the evidence in the administrative record. Second, the Rule is contrary to law; it conflicts with the statutory text of the ACA, imposes barriers to care, and conflicts with safeguards intended to ensure parity in healthcare. Third, the Rule exceeds the statutory authority vested in HHS under the ACA. Fourth, the Rule is procedurally invalid because it imposes new requirements not contained in the proposed rule, depriving the States and the public the opportunity to comment. Lastly, the Rule unconstitutionally undermines the States' sovereign laws relating to the regulation of public health, including women's reproductive freedom. Allowing the States to continue the smooth operation of their respective state Exchanges and regulatory oversight of their individual markets serves the public interest. The

States therefore respectfully request this Court enter summary judgment in their favor as to all claims, declare the Rule invalid and immediately vacate it, thus protecting consumers, state healthcare markets, and the States' fiscs and their sovereignty.

BACKGROUND AND STATEMENT OF FACTS

I. THE AFFORDABLE CARE ACT AND ABORTION COVERAGE

A. The ACA's Reformation of the Healthcare System

In 2010, Congress enacted the Affordable Care Act seeking to "increase the number of Americans covered by health insurance and decrease the cost of health care." *Nat'l Fed'n of Indep. Bus. v. Sebelius*, 567 U.S. 519, 538 (2012); 42 U.S.C § 18091(2)(C), (F) & (G). To ensure individuals had access to and maintained insurance coverage, Congress strengthened consumer protections for private coverage in the individual market. The ACA, among other things, , improved and expanded coverage by instituting consumer protections such as imposing annual limits on out-of-pocket expenses and prevented discrimination on the basis of preexisting conditions.

The ACA also enacted Sections 1554 and 1557, which aimed to create, facilitate, and safeguard parity in healthcare. Section 1554 prohibits the Secretary of HHS from promulgating any regulation that creates unreasonable barriers to an individuals' ability to obtain appropriate medical care; impedes timely access to health care services; or limits the availability of health care treatment for the full duration of a patient's medical needs. 42 U.S.C. § 18114. Section 1557 prohibits a broad range of health programs or activities—including the health insurance Exchanges—from "exclud[ing] [individuals] from participation in, be[ing] denied the benefits of, or be[ing] subjected to discrimination" on the basis of any classification listed under federal civil rights statutes, including sex, race, color, or national origin. 42 U.S.C. § 18116.

Most relevant to the Final Rule, Congress increased Americans' access to affordable, quality healthcare through two key reforms: (1) the creation of effective state health insurance Exchanges that allow consumers "to compare and purchase [private] insurance plans," and (2) the provision of federal subsidies to eligible individuals to help lower their cost of coverage. *King v. Burwell*, 135 S. Ct. 2480, 2485-87 (2015); 42 U.S.C. § 1396w–3(b)(1)(B)–(C); §§ 18031, 18041.

1. State Health Exchanges

The ACA requires that every state establish a "health insurance Exchange." 42 U.S.C. § 18031(b), (d). Exchanges are marketplaces in which consumers and small businesses can shop for and purchase health insurance coverage. The ACA gave states the flexibility to decide whether to develop and host their own Exchanges, or let HHS establish and run Exchanges for them. *See id.* § 18041. States have since implemented various platforms, including exclusively state-based Exchanges, federally facilitated Exchanges, and hybrid options such as Exchanges run by HHS in conjunction with the state or state-based Exchanges that use the federal platform.[1]

States are required to annually certify or recertify health plans sold on their Exchanges as "qualified health plans." 42 U.S.C. § 18031(c)(1). To be certified, health plans must provide all the essential health benefits required under the ACA, as well as any benefit mandated by state law or included in the state's benchmark plan, such as abortion coverage. *Id.* § 18031(d)(3)(B)(i); *see e.g.* 45 C.F.R. § 155.200(d). Consumers who purchase qualified health plans through the Exchange are entitled to coverage of the essential health benefits of the policy for the entire duration of the plan year. Plan years are maintained by "open enrollment" periods established by the State in state-based Exchanges, typically extending from fall to winter, during which consumers can shop for health plans in advance of the plan year. 45 C.F.R. § 155.410. Outside of open enrollment, plan changes and new enrollments are only possible for people who experience a qualifying event.[2]

The ACA gave states operational discretion to design their platforms to meet their unique health priorities, including the ability to expand their own open enrollment periods or mandate additional essential health benefits required or allowed by state laws. As a result, Plaintiff States

[1] In Plaintiff States, California New York, Colorado, the District of Columbia, Maryland, and Vermont, operate state-based exchanges (SBEs), while Oregon operates a state-based exchange on the federal platform (SBE-FP), and Maine operates a federally facilitated exchange (FFE). The States represent the diversity contemplated by the ACA, which authorized significant state flexibility in the operation of the States' health insurance markets.

[2] *Id.* § 155.420. A qualifying event is a change in a policy holder's situation (getting married, having a baby, or losing health coverage) that can make one eligible for a Special Enrollment Period, allowing policy holders to enroll in health insurance outside the yearly Open Enrollment Period.

all require or allow coverage for abortion services as a covered health benefit that qualified health plans participating in their respective Exchange offer.

2. Federal Subsidies

To enable widespread access to health insurance coverage, the ACA established federal subsidies. The ACA provided federal advance premium tax credits and cost-sharing subsidies for qualifying individuals to offset the costs to consumers. 42 U.S.C. § 18071. These subsidies presented another incentive for the public to secure insurance coverage and removed another significant barrier to care—the high costs of premiums and out-of-pocket costs.

B. Section 1303

Consistent with federal statutory restrictions (such as the Hyde Amendment), the ACA also established mechanisms to ensure that federal funds are not used to pay for abortion care. The Hyde Amendment, enacted through an annual appropriations bill, prohibits the use of federal funds appropriated to HHS to pay for abortion care. *See* 42 C.F.R. §§ 441.202, 441.203, and 441.206.[3] The Hyde Amendment does not apply to private dollars, including private health insurance nor does it restrict state funds from being provided for abortion coverage otherwise. As a result, the ACA carefully imposed special rules in Section 1303 to govern the use of federal subsidies for the purchase of qualified health plans that offered abortion coverage.

Section 1303 provides that qualified health plan issuers may not use federal Exchange subsidies in the form of tax credits or cost-sharing subsidies to pay for otherwise legal abortion services (for which federal funding is prohibited). 42 U.S.C. § 18023(b)(2)(A). Thus, if a qualified health plan includes coverage of abortion services, issuers must charge all policy holders at least one dollar ($1) per month for the premium attributable to abortion services, which must then be deposited and maintained in a separate account. *Id.* §18023(b)(2)(D)(ii)(III). The remainder of the insurance premium not related to abortion services must be deposited and maintained in a different account. *Id.* §§ 18023(b)(2)(B)(i)-(ii) and (b)(2)(C). Further, issuers are

[3] Exemptions apply in certain limited circumstances, in cases where pregnancies are the result of rape, incest, or when the pregnancy threatens the life of the pregnant person. *See* 42 C.F.R. §§ 441.202, 441.203, and 441.206.

required to provide notice to policy holders of the qualified health plan's inclusion of abortion coverage, "*only* as part of the summary of benefits and coverage explanation, at the time of enrollment, of such coverage." *Id.* § 18023(b)(3)(A) (emphasis added). The statute assigns state health insurance commissioners the task of ensuring that issuers of qualified health plans comply with requirements to segregate funds. *Id.* § 18023(b)(2)(E).

Section 1303 implements three key objectives. First, it maintains a state's flexibility to allow or prohibit coverage of abortion services to be sold through their respective Exchanges, 42 U.S.C. § 18023(a)(1). Second, it establishes that, unless otherwise prohibited by state law, participating issuers may elect to cover abortion services in qualified health plans for the entire benefit-year. For qualified health plans that cover abortion, it establishes separate accounting requirements to ensure federal funds are segregated from a policy holder's out-of-pocket funds for abortion coverage. *Id.* § 18023(b). Third, Section 1303 establishes that nothing in the ACA preempts the application of state laws regarding "the prohibition of (or requirement of) coverage, funding, or procedural requirements on abortions…." *Id.* § 18023 (c).

Since Section 1303's enactment almost a decade ago, states have imposed separate accounting and transparency requirements for coverage of abortion services provided by qualified health plans sold through the individual health insurance Exchanges. *See* Patient Protection and Affordable Care Act, Pub. L. 111-148, § 1303, 124 Stat. 119, 896; 42 U.S.C. § 18023 (2019); *see also* Executive Order No. 13535, 75 Fed. Reg. 15,599 (Mar. 29, 2010) ("maintaining current Hyde restrictions on abortion services and extending those restrictions to the newly created health insurance Exchanges").

C. Previous Rulemaking Implementing Section 1303

In 2014, amid the ongoing development of the ACA Exchanges, the United States Government Accountability Office (GAO) issued a report, which identified inconsistencies regarding the implementation of Section 1303. The GAO report found that, in an examination of eighteen issuers in ten states where qualified health plans covered abortion, two failed to collect the statutory minimum of $1 per enrollee per month, four failed to include notices of abortion

coverage, and most did not collect payments by sending a bill itemizing the separate payments or by sending separate bills for the coverage.

In response, HHS proposed and finalized a rule in 2015, which established that issuers could satisfy Section 1303 in a number of ways, including:

(1) sending a single monthly bill that separately itemizes the premium amount for abortion services;

(2) sending a separate monthly bill for abortion services; or

(3) sending a notice at or soon after the time of enrollment that the monthly bill will include a separate charge for abortion coverage and specify the charge.

80 Fed. Reg. 10,750, at 10,840 (Feb. 27, 2015).

In addition, the 2015 rule clarified that Section 1303 does not require an issuer to separately identify the premium for abortion services on the monthly bill to comply with the separate payment requirement. *Id.* And to further minimize the burden on issuers and consumers, the rule affirmed that consumers may pay—in a single transaction—both the premium payment for abortion services and the separate payment for all other services with issuers depositing the two separate payments on the backend into the issuers' corresponding separate accounts. *Id.* In October 2017, the Centers for Medicare & Medicaid Services' (CMS) Center for Consumer Information and Insurance Oversight issued a bulletin confirming that these same alternatives comply with the segregated funding requirements of Section 1303.[4]

II. HHS'S CHANGES TO ABORTION COVERAGE RULES

A. The Proposed Rule

In 2018, HHS issued a notice of proposed rulemaking (NPRM) to require issuers of qualified health plans that include abortion coverage to send—and consumers to pay—two entirely separate bills every month for payment of the health insurance premium. One bill would comprise the premium amount attributable to abortion services (for at least $1) in a completely

[4] Centers for Medicare and Medicaid Services, *CMS Bulletin Addressing Enforcement of Section 1303 of the Patient Protection and Affordable Care Act* (Oct. 06, 2017), https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Section-1303-Bulletin-10-6-2017-FINAL-508.pdf.

separate transaction, to the extent of requiring separate envelopes and stamps, or separate emails and electronic payment links, and a second bill would comprise the premium amount attributable to the remaining covered services. 83 Fed. Reg. 56,015, 56,030-031 (Nov. 09, 2018). HHS estimated that this new requirement would impose one-time costs of about $63,000 and ongoing costs of over $1.6 million annually for all impacted issuers. *Id.* at 56,025-026. In addition, HHS estimated the rule would impose costs of over $30 million for policy holders to comply with these proposals. *Id.* at 56,028. The agency's sole justification for this costly and unprecedented mandate is that HHS *believes* that these new changes now "better align" with the separate payments provision in Section 1303 of the ACA, despite several comments to the contrary. 83 Fed. Reg. 56,022.

HHS received nearly 75,000 public comments in response to the NPRM. While some commenters supported the finalization of the rule, an overwhelming majority of the submitted comments opposed the rule. Commenters representing state-based Exchanges, state regulating bodies, participating issuers, consumer advocacy groups, including medical experts, all raised significant issues with the improper, onerous, and unnecessary requirements of the NPRM.

Of primary significance were the serious concerns raised by numerous Exchanges that the proposal could result in considerable consumer confusion and, consequently, the potential loss of insurance coverage. *See* Covered California, AR 078652; New York State of Health (NYSoH) Comment, AR 81027; Connect for Health Colorado, AR 81099-81100; Connecticut's Access Health CT, AR 81070; District of Columbia Health Benefit Exchange Authority (DC HBX) Comment, AR 80936- 80937; Silver State Health Insurance Exchange Comment, AR 76518. These comments explained that, even with outreach and education campaigns, most consumers will not understand why they are receiving two separate bills, or that they must remit payments separately. *See* Silver State Health Insurance Exchange Comment, AR 76518.

Additionally, commenters described the likelihood that the rule would cause consumers to erroneously fail to complete initial enrollment in a healthcare plan. Upon initial enrollment, a consumer must make the first month's premium payment in full. This is known as a "binder" payment. Without making this payment in full, coverage cannot be initiated. Because the

proposed rule would require a new and unprecedent payment scheme where a policy holder must make one payment of at least $1, and a separate payment of the balance of the premium, some consumers would likely fail to make the binder payment in full, and thus fail to initiate coverage at all. *See* Access Health CT Comment, AR 81071; Attorneys General (AG) Multistate Comment, AR 78737; Blue Cross Blue Shield Association (BCBSA) Comment, AR 80264-80265; American Health Insurance Plans (AHIP) Comment, AR 80215.

Numerous physician and professional medical associations expressed their concerns that policy holders who fail to pay the abortion-related portion of the premium would be left without health coverage, because they generally "will have 90 days from the date of the missed payment to reconcile their balance or risk termination of benefits." *See* the American Academy of Family Physicians (AAFP), American Academy of Pediatrics (AAP), American College of Obstetricians and Gynecologists (ACOG), American College of Physicians (ACP), American Medical Association (AMA), and the American Psychiatric Association (APA) Group Comment (hereinafter Physicians Group Comment), AR 80953. Commenters underscored that the onerous billing and payment requirements and the resultant risk of coverage termination would hurt vulnerable communities most, including those living in rural areas lacking reliable access to the internet, living with a disability, and who are members of the LGBTQ community. *See* National Family Planning & Reproductive Health Association (NFPRHA) Comment, AR 81302; National Latina Institute for Reproductive Health (NLIRH) Comment, AR 79077; The National LGBTQ Task Force Comment, AR 79733. Vulnerable groups already face disparities in access to healthcare. The Rule's changes create additional barriers that will "exacerbate these disproportionate burdens," particularly because its complexity will further confuse those "with lower health insurance literacy." Jacobs Institute of Women's Health Comment, AR 81081.

The medical professionals' comments explained that consumers whose coverage is terminated for non-payment outside of the annual open enrollment period and are not eligible to re-enroll for lack of a qualifying event will be subject to gaps in coverage. Such gaps in coverage are "particularly concerning for women of reproductive age who may experience an unintended pregnancy during this gap." American College of Obstetricians and Gynecologists (ACOG)

Comment, AR 81311; *see also* AG Multistate Comment, AR 78738-78739. Moreover, ACOG cautioned that interference with access to coverage harms the patient-physician relationship because "limiting access to comprehensive women's health coverage in the Exchanges…impedes a patient's ability to make the best medical decision for herself and her family." *Id.*

Commenters also drew attention to the specific danger that the NPRM poses to women's access to abortion, explaining that "[r]egulations designed to erode access to abortion undermine the health and safety of women" and "jeopardiz[e] women's ability to make their own healthcare[-]related decisions." New Voices for Reproductive Justice & Women's Law Project Comment, AR 80521. Further, "although women can technically purchase supplemental abortion coverage, such policies are practically nonexistent, thereby leaving women with no abortion coverage." *Id*. Lack of access to abortion has long term health consequences for women. *See also* Asian & Pacific Islander American Health Forum (APIAHF) Comment, AR 70985 (discussing health harms, "women who are denied access to an abortion have been found to suffer adverse physical and mental health consequences."); The American Public Health Association (APHA) Comment, AR 81295 ("women denied abortions are more likely to experience eclampsia, death, and other serious medical complications during the end of pregnancy"); Equality North Carolina Comment, AR 80375 (individuals "assigned female at birth have the same need for sexual and reproductive health services").

Consumer advocacy groups also explained to HHS that the current method for segregating funds aligns with industry practices and was endorsed by the National Association of Insurance Commissioners. Center on Budget and Policy Priorities Comment, AR 81218; *see also* AHIP Comment, AR 80207; Western Center for Law and Poverty (WCLP) Comment, AR 81334-81335; California Pan-Ethnic Health Network (CPEHN) Comment, AR 80489; Planned Parenthood Federation of America (PPFA) Comment, AR 79777; California Department of Insurance (CDI) Comment, AR 072862. Accepted insurance practices already allow payments for different types of coverage within the same instrument and transaction. Moreover, bundled coverage—such as life and disability insurance or home and car insurance—is commonplace

because it allows enrollees to pay for multiple policies in one transaction with the same instrument. AHIP Comment, AR 80207; WCLP Comment, AR 81335.

Not only is requiring separate transactions difficult and costly but sending two bills will harm consumers. Commenters stated that consumers wary of financial deception will suspect that the bill for a nominal amount is a "scam" and will be aggravated by the additional paperwork and process. PPFA Comment, AR 79778; BCBSA Comment, AR 80263-80264. Based on a survey undertaken on behalf of issuers, AHIP explained that the majority of Americans who buy their own insurance opposed the changes; 95 percent think healthcare administration should be made simpler and 89 percent agree that making two separate monthly payments for their premium would be a burden. AHIP Comment, AR 80206-80207.

Issuer groups and individual carriers also provided an exhaustive list of the operational problems with these changes, "suggest[ing] a striking gap in the understanding of the implementation costs and challenges of the rule." Blue Shield of California (BSC) Comment, AR 81321 (raising significant operational burdens, potentially up to $7 million in annual costs); *see also* AHIP Comment, AR 80207-80208; Association of Community Affiliated Plan Comment, AR 81166 (discussing that medium-sized health plans, of about 70,000 enrollees, determined that CMS underestimated the costs on issuers by 2,666 times for the first year alone). Issuers and trade associations emphasized that such a costly revamp of their billing systems would require anywhere from 12-18 months, and up to two years to operationalize these stricter guidelines. *See* BSC Comment, AR 81321; BCBSA Comment, AR 80264; AHIP Comment, AR 80212.

State entities agreed and explained that the rule would significantly increase the regulatory and fiscal burdens on states, while encroaching on their sovereign ability to determine comprehensive health coverage. *See* AG Multistate Comment, AR 78734; State of Oregon, Department of Consumer and Business Services (DCBS) Comment, AR 76527; State of Washington Comment, AR 81038-81039; *see also* CPEHN Comment, AR 80490; Women's Law Center (NWLC) Comment, 79394. Commenters explained that Exchanges will face significant administrative costs and will need to invest in increased call center training and consumer assistance capacity in order to handle the expected increase in consumer queries, complaints, and

process terminations resulting from non-payments. Silver State Health Insurance Exchange Comment, AR 76518; *see also* Covered California Comment, AR 078652-078653; Access Health CT Comment, AR 81070- 81071; DC HBX, AR 80936- 80937; NYSoH Comment, AR 81029; Connect for Health Colorado Comment, AR 81101 (raised that "mid-year implementation" posed additional significant administrative complexities). Commenters stressed that "loss of coverage will also decrease the size of the risk pool and increase the cost of uncompensated care, which will drive medical costs and health insurance rates higher, further limiting access to coverage." State of Oregon, DCBS Comment, AR 76527; *see also* AG Multistate Comment, AR 78752 (the rule will interfere with gains in enrollment rates and the insurance risk pool); NYSoH Comment, AR 81028 (the rule will "reverse recent reductions in uncompensated care").

B. The Final Rule

On December 27, 2019, just shy of the close of several States' open enrollment periods for plan year 2020, HHS published the Rule, largely identical to the NPRM, and tasked issuers and states to prepare for implementation within six months. Patient Protection and Affordable Care Act; Exchange Program Integrity, 84 Fed. Reg. 71,674 (December 27, 2019) (to be codified at 45 C.F.R. pt. 155, 156).

The Rule changes the implementing regulations, 45 C.F.R. § 156.280, to require issuers to separately bill for the portion of the premium attributable to abortion services, at least $1, and to require consumers to pay the divided premium in separate transactions. 84 Fed. Reg at 71,710-711. Issuers can no longer send a single monthly bill that includes the costs for healthcare coverage and abortion coverage, even if the bill itemizes the separate amount for abortion services, nor can they notify policy holders as part of the summary of benefits and coverage explanation at the time of enrollment. *Id.* Instead, issuers must send two separate monthly bills, either by mail (now in an envelope containing two separate bills) or electronically (in two separate emails), to each policy subscriber. *Id.* And issuers must instruct consumers to pay each bill separately, either by separate paper checks or by two electronic transactions. *Id.*

Significantly, the Rule acknowledges that its initial cost-benefit analysis substantially underestimated the implementation costs. 84 Fed. Reg. 71,699. HHS further concedes that

implementing the Rule in only six months would cost each issuer an additional $4.1 million in higher contracting costs for system changes and overtime personnel payments. *Id.* HHS, therefore, estimates that one-time costs to bring all affected issuers (94 total) across the country into compliance and implement the necessary technical changes would require over 2.9 million hours of work and cost approximately $385 million for all issuers. *Id.* at 71,697. In addition, implementation would cost approximately $1.07 million per issuer annually (or about $100.2 million for all issuers). *Id*. at 71,698. The Rule estimates that on average, each state Exchange will incur one-time costs of $750,000, approximating $9 million for all twelve state-based Exchanges that permit the sale of qualified health plans offering abortion coverage, and ongoing costs of $2.4 million for 2020 alone. *Id.* at 71,705. The ongoing costs to the states would be approximately $36 million for plan years 2020 to 2024. *Id.* at 71,707. Moreover—accounting for only consumers' personal administrative burdens of understanding the separate billing requirements and not any costs for lost coverage—the Rule estimates that consumers will incur about $35.5 million in the first year alone. *Id.*

Despite the significant costs multiplied by the serious time limitations, the Rule requires the implementation of separate abortion billing requirements by June 27, 2020—after open enrollment for 2020 was finalized, in the middle of the plan year, and during the particularly busy months in which most issuers are calculating and negotiating changes for the following plan year. HHS simply states that, contrary to every statement of industry stakeholders and the States who must implement the Rule, HHS "believe[s] 6 months is sufficient…to implement the administrative and operational changes to billing processes necessary to comply" with the Rule. 84 Fed. Reg. at 71,689, 71,690; *Cf.* BSC Comment, AR 81321; AHIP Comment, AR 80212.

In a partial attempt to address the impact on consumers, the Rule prohibits issuers from initiating a grace period or terminating a policy holders' coverage if they fail to pay the premium bill separately and continue to make combined single payments in full. *Id.* at 71,711. And much like the former regulatory scheme, HHS explains that any issuer receiving combined payments would need to treat the "portion of the premium attributable to coverage of…abortion services as a separate payment and must disaggregate the amounts into the separate allocation accounts,

consistent with § 156.280 (e)(2)(iii)." *Id.* Further, while HHS will not penalize issuers that adopt a uniform policy that declines to place policy holders in grace periods or terminate coverage for failure to pay the separate bill attributable to abortion coverage, the Rule does not relieve the policy holder from making the missing payment and requires issuers to employ resources to effectuate the collection of the premium for abortion coverage. *Id.* at 71,705.

Finally, without opportunity for public comment, the Rule adds a new policy allowing policy holders to "opt-out" of abortion coverage by choosing not to pay the abortion premium bill. 84 Fed. Reg. 71,686. The Rule's new opt-out policy effectively allows issuers to modify their plan benefits either at the time of enrollment or during a plan year, despite a state's benchmark plan requiring such coverage. And this decision would be final, leaving consumers without abortion coverage for the remainder of the plan year. *Id.* at 71,687 (policy holders "would not be allowed to retract their opt-out decision and reinstate coverage" by similarly choosing to simply opt back in and pay $1). In addition, a policy holder's decision to opt out would apply to everyone in the enrollment group under the policy, such as covered dependents (children up to the age of 26) and spouses. *Id*. In effect, a policy holder confused by the ability to opt out of coverage benefits may unknowingly deprive others under the health plan of needed healthcare services without an opportunity to re-enroll for the remainder of the plan year.

C. Impact of The Rule on the Plaintiff States

The Rule specifically impacts states that require or allow qualified health plans to provide abortion coverage in their state-run Exchanges. First, the States' regulators and Exchanges have been forced to expend additional resources and personnel to devise implementation plans. The changes include absorbing significant increases in call center inquiries, resolving new enrollment system issues, and redirecting the allocation of resources from consumer outreach to mitigate the risk of policy holders' termination of coverage. *See* Doug McKeever Decl. ¶¶ 13-15 (hereinafter McKeever Decl.); Donna Frescatore Decl. ¶ 8 (hereinafter Frescatore Decl.); David Patterson Decl. ¶¶ 8, 11 (hereinafter Patterson Decl.); Mila Kofman Decl. ¶¶ 8-11, 13-14 (hereinafter Kofman Decl.); Michelle Eberle Decl. ¶¶ 10-12 (hereinafter Eberle Decl.); Carmina Flowers Decl. ¶ 8(hereinafter Flowers Decl.); Adaline Strumolo Decl. ¶¶ 16-17 (hereinafter Strumolo

Decl.). For example, the DC HBX expects the Rule will result in a 50% increase in inadvertent terminations due to: 1) miscommunication; 2) confusion; 3) non-payment of premiums; 4) partial payment of premiums; or 5) misapplication of paid premiums. Kofman Decl. ¶ 9.

In addition, the Rule will impose unnecessary administrative burdens on the States' regulating agencies, spanning from an increase in call volume at call centers, the expense of additional consumer services training and education materials, to new regulatory and guidance packages to ensure compliance. *See* Bruce Hinze Decl. ¶¶ 9-10 (hereinafter Hinze Decl.) (e.g. 1,739 extra hours of workload, amounting to an excess of $85,000 per year); Sara Ream Decl. ¶¶ 11-13 (hereinafter Ream Decl.); John Powell Decl. ¶¶10-12 (hereinafter Powell Decl.); Michael Conway Decl. ¶¶ 12-13 (hereinafter Conway Decl.); Karima Woods Decl. ¶¶ 9-11(hereinafter Woods Decl.); Al Redmer Decl. ¶¶ 6, 8-9 (hereinafter Redmer Decl.); Eric Cioppa Decl. ¶¶ 10-11(hereinafter Cioppa Decl.); Andrew Stolfi Decl. ¶¶ 8-10 (hereinafter Stolfi Decl.). For example, for California regulating agencies, the promulgation of newly revised regulatory packages requires legal, policy, and support staff to conduct extensive research, develop appropriate proposed regulatory text, and engage in a notice and comment process in compliance with the Administrative Procedure Act. Ream Decl. ¶ 14; Hinze Decl. ¶ 11. This can take a year or more depending on required stakeholder engagement common for sensitive or complex regulations. *Id.*

The States' regulators also anticipate a rise in complaints and appeals for inadvertent termination of coverage if policy holders fail to pay the separate premium attributable to abortion coverage. *Id.*; Stolfi Decl. ¶ 10 ("because there is no opportunity for consumers to re-enroll after being terminated for non-payment, these consumers will be expected to remain uninsured for the remainder of the calendar year."). States' regulators are remiss to acknowledge these portent consequences of the Rules' implementation, despite the fact that issuers are already in compliance with the many strict guidelines previously set by Section 1303. Indeed, issuers "already submit annual filings with respect to the premium segregation plan," that provide sufficient assurance of compliance with Section 1303. Redmer Decl. ¶ 7; *see also* Stolfi Decl. ¶ 7-8; Cioppa Decl. ¶ 9; Ruth Greene Decl. ¶ 5 (hereinafter Greene Decl.). Segregation plans are complete with separate

financial accounting systems, monthly reconciliation processes, and internal controls to ensure that issuers are in accordance with federal regulations. Hinze Decl. ¶ 7.

Second, in light of the Rule's significant implementation requirements and ongoing costs, issuers—like Blue Cross and Blue Shield of Vermont—may need to increase premium costs for qualified health plans, harming the public's affordability of coverage. Greene Decl. ¶ 11. If, as a result of the Rule policy holders are left without health insurance coverage, this will increase out-of-pocket costs for all needed health services, including abortion services—services previously covered by their health plan. *See* Strumolo Decl. ¶¶ 14-15. This increases the costs to the States, resulting from the consequences of rising uninsured rates and uncompensated care. Cioppa ¶ 13.

Ominously, the Rule reminds the States that under the ACA, if "the Secretary determines that an Exchange has engaged in serious misconduct with respect to compliance with the requirements of, or carrying out of activities required," HHS has the authority to rescind up to one percent (1%) of the federal funding dollars due to a state *under any program administered by HHS*. 84 Fed. Reg. 71,678 (citing 42 U.S.C. § 18033(a)(4) (2018). While the States would strongly dispute that any non-compliance with the Rule would constitute such a pattern of abuse, the Rule's ambiguity prompts the States to evaluate if noncompliance with the Rule might lead HHS to put at risk federal dollars paid to the States for the administration of health programs.

Finally, HHS's actions threaten the States' sovereignty in their regulation of healthcare, and their authority to regulate in the area of abortion care. The Rule makes clear that where a "state operating its own Exchange fails to substantially enforce these [separate billing] requirements, HHS is authorized to enforce them directly." 84 Fed. Reg. 71,692 (citing 42 U.S.C. § 18041(c)(2)). The Rule does not address how, if at all, HHS intends to implement this statutory provision regarding state compliance. The States' harm is unknown but ongoing and alarming, as millions of dollars could potentially be stripped from state coffers.

ARGUMENT

I. LEGAL STANDARD OF REVIEW

Agency actions must be set aside when they are "arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law" or "in excess of statutory jurisdiction,

authority, or limitations, or short of statutory right." 5 U.S.C. § 706(2)(A), (C). In reviewing an administrative agency decision, "summary judgment is an appropriate mechanism for deciding the legal question of whether the agency could reasonably have found the facts as it did." *City & Cty. of San Francisco v. United States*, 130 F.3d 873, 877 (9th Cir. 1997). Summary judgment is appropriate "if the movant shows that there is no genuine dispute as to any material fact and the movant is entitled to judgment as a matter of law." Fed. R. Civ. P. 56(a). Declaratory relief is appropriate "[i]n a case of actual controversy" in order to "declare the rights and other legal relations of any interested party seeking such declaration." 28 U.S.C. § 2201(a).

II. THE RULE IS ARBITRARY AND CAPRICIOUS

A regulation is arbitrary and capricious if the agency has "entirely failed to consider an important aspect of the problem" or "offered an explanation for its decision that runs counter to the evidence before the agency." *Motor Vehicle Mfrs. Ass'n of U.S., Inc. v. State Farm Mut. Auto. Ins.*, 463 U.S. 29, 43 (1983). When an agency has failed to "give adequate reasons for its decisions," to "examine the relevant data," or to offer a "rational connection between the facts found and the choice made," the regulation must be set aside. *Id.* To change its policy, an agency must "show that there are *good reasons* for the new policy." *FCC v. Fox Television Stations, Inc.*, 556 U.S. 502, 515 (2009) (emphasis added). The failure to satisfy those requirements makes a regulation invalid. *Encino Motorcars, LLC v. Navarro*, 136 S. Ct. 2117, 2125 (2016).

The Rule radically alters a regulatory scheme without *any* good reasons for the new policy, at enormous cost to states and issuers and with resultant harmful consumer consequences. HHS's action is not supported by—and is in fact contrary to—the evidence before the agency. Further, HHS failed to meaningfully weigh and respond to comments.

A. HHS Failed to Provide Good Reasons for the Change in Policy

First, HHS's sole reason for promulgating the Rule is to "better align" the regulations with its new interpretation of Section 1303. However, HHS does not examine relevant data or articulate a satisfactory explanation, beyond its belief that this is a better policy. *State Farm*, 463 U.S. at 43. For example, HHS fails to identify any evidence indicating that the current regulations have resulted in noncompliance with Section 1303. In contrast, HHS issued the prior

rule to address conclusions by the GAO report that noted issuer confusion about premium segregation in compliance with Section 1303.[5] Moreover, HHS fails to explain how the prior rule did not "align" with Section 1303, especially as the prior scheme remained in place for several years.

Second, having finalized the Rule, HHS now purports to use a minority of comments objecting to "the lack of transparency" in health plans sold in the Exchange to bolster its justification for the Rule. 84 Fed. Reg. 71,690. The justification is insufficient. Claimed evidence of public perception and confusion, *post hoc*, is not evidence of a good reason to initiate promulgating a rule. *See Nat'l Fuel Gas Supply Corp. v. FERC*, 468 F.3d 831, 841 (D.C. Cir. 2006) (holding agency rule arbitrary and capricious where alleged record of abuse indicates "no evidence of a real problem"). And "courts may not accept … *post hoc* rationalizations for agency action." *State Farm*, 463 U.S. 29, 50 (1983) (citing *Burlington Truck Lines, Inc. v. United States*, 371 U.S. 156,168, (1962)). An agency's action must be upheld, if at all, on the basis articulated by the agency itself. *Id.; SEC v. Chenery*, 332 U.S. 194, 196 (1947). Even if the agency had offered the justification of consumer confusion at the onset, "an agency's predictive judgments about the likely economic effects of a rule…must be based on some logic and evidence, not sheer speculation." *Sorenson Commc'ns Inc. v. FCC*, 755 F.3d 702, 708 (D.C. Cir. 2014) (internal alterations omitted) (holding the agency had "failed to articulate a satisfactory explanation for its action" because its claimed fear of fraud was speculative).

Of the approximately 17,600 comments supporting the Rule (roughly 23% of the total submission of over 74,000), most comments fall into three different sets of comment letters: (1) focusing on conscience objections, (2) raising objections to the separate abortion premium charge as hidden insurance surcharges; and (3) outright opposition to the constitutional right to abortion. *See* Catholic Bishops for America Comment, AR 20131; American Center for Law and Justice (ACLJ) Comment, AR 55794; and Concerned Women for America Comments, AR 58522; *see*

[5] *See U.S. Government Accountability Office, Health Insurance Exchanges: Coverage of Non-excepted Abortion Services by Qualified Health Plans* (Sept. 15, 2014), available at http://www.gao.gov/products/GAO-14-742R.

e.g. Barbara Saldivar Comment, AR 51517 (Concerned Women for America member). But none of these comments, or HHS's own Rule, provide any actual evidence of violation of Section 1303's segregation of funds requirements. In fact, issuers are already in compliance with the mandatory segregation requirements. Commenters explained that issuers already submit annual filings to their respective regulatory agencies regarding their premium segregation plans, and comply with previous HHS guidance in several ways, including single payment transactions by consumers. *See* Covered California Comment, AR 078651.

The APA requires more. An agency must provide good reasons for promulgating policy changes from the onset of the rulemaking process, not use post-publication reasoning as the stated purpose of the proposed rule. HHS cannot now rely on the Rule's stated purpose of helping alleviate consumer confusion "given that [HHS is] *now* aware of these consumer concerns," 84 Fed. Reg. 71,690 (emphasis added). The NPRM did not include a single instance of public confusion or consumer concern as a stated basis for the rule change that HHS now claims it needs to address. Where an agency only provides notice of the general substance of a proposed rule, it fails to satisfy the APA because it does not "provide sufficient detail and *rationale* for the rule to permit interested parties to comment meaningfully." *Fertilizer Inst. v. EPA*, 935 F.2d 1303, 1311 (D.C. Cir. 1991) (citation omitted, emphasis added). In fact, the NPRM refers to confusion only three separate times—all concern the confusion the Rule's separate abortion billing requirements will create. 83 Fed. Reg. 56,023, 56,028. Additionally, the final Rule fails to consider any targeted alternatives to address such confusion, besides unnecessarily imposing billions of dollars of costs on issuers, consumers, and states. *Wilderness Watch, Inc. v. U.S. Fish & Wildlife Serv.*, 629 F.3d 1024, 1039 (9th Cir. 2010) (finding agency action invalid where record demonstrates many alternative actions not prohibited by law very well could have attained the agency's goal).

But even if this Court accepted HHS's justifications, the agency cannot prioritize its purported desire to respond to transparency concerns in disregard of Section 1303, or the ACA as a whole. *State Farm*, 463 U.S. at 43 (reliance on nonstatutory factors "which Congress has not intended it to consider" constitutes arbitrary and capricious action). As the D.C. Circuit recently held, "[w]hile we have held that it is not arbitrary or capricious to prioritize one statutorily

identified objective over another, it is an entirely different matter to prioritize non-statutory objectives to the exclusion of the statutory purpose." *Gresham v. Azar*, 950 F.3d 93, 104 (D.C. Cir. 2020). The Rule prioritizes non-statutory objectives, namely increasing transparency regarding the existence of coverage for abortion care, over statutory objectives of increasing access to healthcare and decreasing healthcare costs. And it bears no relation to the statutory purpose of Section 1303, which is simply to ensure that federal funds are not spent on abortion care. As such, the Rule is arbitrary and capricious.

B. HHS Ignored the Exorbitantly High Costs their Own Analysis Revealed

HHS's insistence that the Rule *only* clarifies the statute because "the changes do not directly impose *new* requirements on states other than to adjust how they check for compliance" is contradicted by HHS's own cost-benefit analysis. 84 Fed. Reg. 71,694 (emphasis added). The Rule reflects that an unreasonable amount of money is required to implement these changes. *See generally id.* at 71,698. The Supreme Court has recognized that "[c]onsideration of cost reflects the understanding that reasonable regulation ordinarily requires paying attention to the advantages *and* the disadvantages of agency decisions." *Michigan v. EPA*, 135 S. Ct. 2699, 2707 (2015) (emphasis in original). HHS cannot "ignore that a change in policy requires the agency to have 'good reasons'" and that such reasons justify requiring the massive expenditures imposed on issuers, consumers, and states. *Fox Television*, 556 U.S. at 515. But HHS has provided none. HHS simply claims that promulgation of its Rule is required to "align" with Section 1303. That rings hollow in the face of Congressional acquiescence to the prior scheme, which operated for several years without any action by Congress to alter Section 1303 or the agency's implementing regulations. Based on the costs alone, and lacking any statutory or other justification for them, the Rule should be vacated.

The Rule imposes extreme costs without any discernable benefit to the public. HHS admits that it initially drastically underestimated the financial cost of the regulatory change on the States, issuers, and consumers. 84 Fed. Reg. 71,697. The agency's final estimates state that the Rule will impact 2.6 million enrollees, 2.3 million enrollees in the Plaintiff States alone, 12 state-based Exchanges, and 71 issuers that offer 1,129 plans that include abortion coverage. 84 Fed. Reg.

71,696-71,698. Issuers will be required to spend $385 million in one-time costs (or 2.9 million hours implementing technical changes) and $1.07 million in ongoing costs per issuer, totaling $50.1 million for the six months in 2020 alone and approximately $100.2 million annually. In addition, the Rule will initially cost consumers about $35.5 million in the hours spent trying "to read and understand the separate bills…and seek help from customer service if necessary." *Id.* at 71, 706. Even HHS's estimate of only "5 minutes for each of the subsequent 5 months," and months thereafter, the burden to consumers will still be a $25.1 million in ongoing expenses. *Id.* And HHS projects that 12 states will incur costs of approximately $11.4 million in 2020 alone ($9 million in one-time costs and $2.4 million in ongoing costs).[6] *Id.* at 71,705. Under the Rule, the Plaintiff States will spend approximately $7.6 million dollars to implement the Rule in 2020.

HHS failed to provide sufficient reasons to justify such an exorbitantly high cost—especially where no problem exists. The agency did not quantify *any* benefit resulting from the Rule. Indeed, HHS dismissed commenters' significant concerns over additional personal and public health costs that the agency was failing to count, even after having acknowledged that "consumer confusion could still lead to inadvertent coverage losses." 84 Fed. Reg. 71,686. HHS also gave no real weight to multiple consumer advocate groups who stressed the reasons to prefer single, or bundled billing, especially in the health insurance industry. The California Insurance Commissioner stated that "[c]onsumers are accustomed to receiving and paying bills in total amounts, even when the bill includes charges for a variety of items." CDI Comment, AR 072862. This billing practice is intentional in healthcare; "[c]onsumers purchase a *package* of medical benefits" to "ensure health coverage markets work efficiently and are affordable for everyone." AHIP Comment, AR 80207. For example, when issuers cover benefits, either voluntarily or because it is mandated—such as substance use disorder treatment— "consumers do not have the option [to] pay only a portion of the premium because they do not use—or expect to use—those

[6] "We estimate that ongoing annual costs will be approximately $300,000 for each State Exchange in 2022 and $200,00 in 2023 and after. The total one-time cost for all 12 State Exchanges affected by these requirements will be approximately $9 million in 2020. Total ongoing costs for all 12 State Exchanges is estimated to be approximately $2.4 million in 2020, $4.8 million in 2021, $3.6 million in 2022 and $2.4 million 2023 onwards." *Id.*

services." *Id.* Ultimately, "[i]f consumers were able to selectively purchase only benefits and services they knew they would use, the associated premiums for those coverage products would quickly become unaffordable due to adverse selection." *Id.*

HHS even imposed an arbitrary deadline for implementation of the Rule, which principally increases costs and confusion. Although HHS recognizes that to "begin complying mid-plan year may pose implementation challenges for some states and issuers," and "increase[s] the total costs for each issuer by 50 percent, to approximately $4.1 million," the Rule nevertheless requires compliance within six months after the effective date—after open enrollment has been finalized and mid-plan year. 84 Fed. Reg. at 71,689, 71,697. Despite its own acknowledgment that the six month deadline increases costs by *fifty percent* and that some issuers "may seek to exit the individual market," HHS merely states that, "we believe six months is sufficient…to implement the administrative and operational changes to billing processes necessary to comply." *Id.* But, "[n]odding to concerns raised by commenters only to dismiss them in a conclusory manner is not a hallmark of reasoned decisionmaking." *Gresham*, 950 F.3d at 103 (vacating agency action, holding that HHS Secretary's bare analysis of the substantial and important problems, merely noting the public's concerns and dismissing those concerns in a handful of conclusory sentences, is insufficient and constitutes arbitrary and capricious action) (citing *Am. Wild Horse Pres. Campaign v. Perdue*, 873 F.3d 914, 932 (D.C. Cir. 2017) (critiquing an agency for "brush[ing] aside critical facts" and not "adequately analyz[ing]" the consequences of a decision)); *Getty v. Fed. Savs. & Loan Ins. Corp.*, 805 F.2d 1050, 1055 (D.C. Cir. 1986) (analyzing whether an agency actually considered a concern rather than merely stating that it considered the concern)).

HHS purports to alleviate commenters' concerns by offering issuers and Exchanges a discretionary period to present "good faith efforts" to demonstrate compliance within another 6 months, but no "more than 1 year." 84 Fed. Reg. 71,690. But HHS fails to explain why, if full implementation is not required by HHS until plan year 2021—which coincides with comments by issuers and Exchanges stressing that implementation *should be postponed at least until the following plan year*—HHS's effective date of June 27, 2020 is rational. At the very least, these increased expenses caused by a six-month implementation period are wholly unnecessary.

Moreover, on March 17, 2020, the Office of Management and Budget issued a directive, "Federal Agency Operational Alignment to Slow the Spread of Coronavirus COVID-19" which requires the federal government to "prioritize all resources to slow the transmission of COVID-19" and otherwise focus exclusively on mission-critical functions.[7] By forcing the States' agencies to prioritize altering their billing processes in order to comply with the new Rule by June 27, 2020—despite suggesting enforcement will not occur until plan year 2021—HHS necessarily detracts from the States' abilities to prioritize responding to the national crisis of COVID-19, and contravenes the White House's directive to federal agencies "to ensure that available resources can be re-prioritized to mission-critical activities." *Id.* The Rule's high expense and serious risk of health insurance coverage termination for millions, during a pandemic of a contagious disease, significantly undermines the States' concerted efforts on the mission-critical functions of assuring access to and maintenance of health coverage for treatment and testing of COVID-19. And HHS's decision to move forward with the Rule is a prime example of capricious agency action.[8]

On the agency's own calculations and predictions, the Rule will cost billions of dollars to implement and could lead to people losing their insurance coverage and issuers exiting the markets. But despite lacking any need for a six-month implementation timeline, the agency offers only its belief that the new Rule "better aligns" with Section 1303. Yet, the prior scheme operated for years, and the agency raises no evidence of lack of compliance with Section 1303, or customer confusion prior to the NPRM. The Rule's cost benefit analysis is illogical and therefore patently arbitrary and capricious and should be vacated.

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[7] *See* Memorandum for the Heads of Departments and Agencies from Russell T. Vought, Acting Director of OMB, re: Federal Agency Operational Alignment to Slow the Spread of Coronavirus COVID-19 (Mar. 17, 2020) available at https://www.whitehouse.gov/wp-content/uploads/2020/03/M-20-16.pdf.

[8] On March 26, 2020, Defendants notified Plaintiffs that HHS intends to delay the Rule's implementation deadline by 60 days in light of the COVID-19 pandemic and the concomitant burdens on state and federal health agencies. *See* Brenda Ayon Verduzco Decl. ¶¶ 5-7. Such delayed implementation is currently insufficient for the States' and their agencies to concentrate all necessary resources on the COVID-19 pandemic facing the country. Absent official agency action withdrawing the Rule, Plaintiff States continue to seek relief on all legal claims to relieve their respective state agencies from the illegal and onerous administrative burdens caused by the Rule.

C. HHS Ignored the Evidence Before the Agency Showing Significant Harms

HHS fails to offer satisfactory justification for the costs and personal administrative expense that will befall policy holders. First, HHS justifies the expenses of the Rule by "assuming that more consumers will opt to receive electronic bills over time" and this will alleviate the costs to policy holders from multiple paper bills and multiple paper payments. 84 Fed. Reg. 71,699. But HHS itself estimates that approximately 90% of policy holders impacted by the Rule will receive paper bills in 2020. 84 Fed. Reg. 71,699. Accordingly, HHS's justification—which will only impact approximately 10 percent of the consumer population—is further evidence of unreasonable agency action. Further, the agency merely "nods" to commenters' concerns, stating it "understand[s] that many enrollees face barriers to accessing the internet and have little choice but to receive paper bills;" yet the Rule neither addresses these concerns in a substantive manner, nor reasonably explains why it chooses to proceed with the Rule in spite of such concerns. *See Gresham*, 950 F.3d at 103 ("[n]odding to concerns raised by commenters only to dismiss them in a conclusory manner is not a hallmark of reasoned decisionmaking."). Finally, the Rule fails to consider the costs to low-income individuals without financial instruments, like banking accounts or credit cards. And individuals who pay bills through mail, either because they lack access to reliable broadband service at home or do not have access to electronic payment instruments, will be unduly burdened by writing separate checks, buying money orders, or even traveling to mail separate payments in person, if they inadvertently miss the separate bill. *See* National Health Law Program Comment, AR 80977; AHIP Comment, AR 80213; NWLC Comment, AR 79395; Vermont Legal Aid Comment, AR 78721 ("In Vermont, 13% of households have no internet access"). Indeed, it would be unreasonably burdensome even for policy holders with access to electronic bills to make their premium payments with different instruments (such as multiple credit cards, automatic withdrawals, or e-checks) as required by the Rule. Ultimately, "[i]f distinct policies can be paid for through the same instrument or transaction, it only makes sense that payment for a covered health service would operate similarly in a single billing statement." WCLP Comment, AR 81337. HHS

categorically fails to justify these burdens on low-income consumers who lack access to reliable internet or electronic bills.

HHS similarly discounts the resultant harms arising from the inadvertent termination of health coverage, despite numerous commenters explaining that "an increase in the number of people without health insurance…raises the risk of uncompensated costs." State of Washington Comment, AR 81040; *see also* AG Multistate Comment, AR 78745; NYSoH Comment, AR 81028; PPFA Comment, AR 79786. For example, "in Washington State, each one percentage point decline in the uninsured rate is associated with a $167 million drop in uncompensated care." *Id.* Rising uncompensated costs harm the quality of care that is possible when hospitals have "regular and reliable source[s] of payment," which in turn can result in poorer public health outcomes for the states. NYSoH Comment, AR 81028. The States anticipate that a rise in uninsured rates will cause individuals to seek emergency care rather than timely and preventive care, rolling back the gains Plaintiff States have made since the implementation of the ACA. But HHS does not consider these harms at all.

The Rule also ignored the costs to women and individuals with the ability to bear children who may lose abortion coverage. Clinic-based abortions are costly, and without insurance many women cannot afford the out-of-pocket costs ranging from $400 to $1,650. PPFA Comment, AR 79785. In addition to severe restrictions on abortion in a number of jurisdictions, the American College of Obstetricians and Gynecologists emphasize that, "navigating health coverage options for abortion services is fraught with confusion," and the Rule only decreases the availability of coverage options for abortion services in the Exchanges. AR 81311. Further, not having coverage can delay a person's ability to obtain an abortion, a time sensitive procedure, which can increase out-of-pocket costs or result in individuals being forced to carry pregnancies to term. Those who are denied or unable to obtain an abortion have a higher likelihood of falling into cycles of poverty and reliance on public assistance programs. PPFA Comment, AR 79785; AG Multistate Comment, AR 78739-78740. In addition, women denied access to abortion care will face adverse long-term health consequences. *See* APIAHF Comment, AR 70985; APHA Comment, AR 81295. Women whose healthcare coverage is terminated or non-initiated, and do

not have the knowledge, time, or resources to obtain or reinstate that coverage, often turn to state-funded programs and will be at risk of poorer health outcomes. AG Multistate Comment, AR 78740. Again, HHS did not adequately consider any of these harms.

HHS acknowledges that one consequence of the Rule is the potential loss of insurance. 84 Fed. Reg. 71,686. Without healthcare coverage, women are often limited in the quality of care they can access. Risk of coverage loss impedes women's ability to seek and afford medical care, and constitutes "intervention into medical decision[]making [that] is inappropriate, ill advised, and dangerous for women's health." ACOG Comment, AR 81312. The Rule merely states that it considered commenters' concerns that coverage loss could leave women to pay higher out-of-pocket costs for abortion care. 84 Fed. Reg. 71,705. But it instead concludes that "any additional burden these enrollees experience" due to confusion, "is unrelated to whether [enrollees] actually do access coverage" for abortion services. *Id.* at 71,695. HHS ignores the evidence before it and disregards a likely consequence of the Rule. ACOG Comment, AR 81312; Physicians for Reproductive Health Comment, AR 70905-70907; APHA Comment, AR 81295-81296.

D. HHS Imposes Measures with No Rational Connection to the Choice Made

In addition to the significant problems ignored by the agency, the Rule is arbitrary because it fails to require issuers to make policy holders *pay* the bill attributable to abortion coverage "in a separate transaction from any payment [to] the policy,"—its purported goal for implementing the new Rule. 84 Fed. Reg. 71,684. The Rule does nothing to require a policy holder to make the payment separately; policy holders can effectively continue to make combined payments in a single transaction. *See, e.g., Air Transport Assn. of America v. Dep't of Trasnp.*, 119 F.3d 38, 43 (D.C. Cir. 1997) (vacating rule where agency explanation was inconsistent with the regulation's language). Indeed, the Rule requires issuers to accept policy holders' combined payments, acknowledging—as it must—that "potential loss of coverage would be an unreasonable result of an enrollee paying in full, but failing to adhere to the QHP issuer's requested payment procedure." *Id*. at 71,685. HHS explains that any issuer receiving combined payments must treat the "portion of the premium attributable to coverage of…abortion services as a separate payment and must disaggregate the amounts into the separate allocation accounts, consistent with

§ 156.280 (e)(2)(iii)." *Id.* As commenters stated, the Rule "adds financial and administrative burdens on issuers and consumers without necessarily achieving a different result" or accomplishing HHS' stated goal. American Academy of Nursing Comment, AR 79385. HHS's explanation for its decision is "so implausible that it could not be ascribed to a difference of view or the product of agency expertise." *State Farm*, 463 U.S. at 43. The Rule is irrational and should be vacated.

HHS considered alternatives in lieu of promulgating the Rule but determined that several alternatives only increased implementation costs further (even though it dismissed maintaining the inexpensive status quo). 84 Fed. Reg. 71,708. However, the consideration of one alternative is instructive. To reduce costs, HHS considered eliminating the requirement that issuers provide instruction to consumers who fail to make payments separately. *Id.* But the agency concluded that consumer education is important to achieve better alignment with Section 1303. 84 Fed. Reg. at 71,689, 71,708. Yet, HHS never considers the same consumer education alternative to help remedy the perceived public confusion and transparency about abortion coverage that some commenters raise, and upon which HHS relies to justify the Rule *post hoc*. 84 Fed. Reg. 71,690, 71,695. Undeniably, *this* is a prime example of where regulatory efforts can help address the important consumer education concerns.

In sum, the Rule represents unreasonable agency action in search of a problem. The exorbitant costs and harms to issuers, consumers, and states significantly outweigh even the purported benefits of the Rule—benefits which the agency fails to substantiate. The agency's failure to provide a reasonable justification for the Rule compels the conclusion that the agency acted solely to impose regulatory barriers that frustrate the delivery of abortion services in any regulatory scheme—no matter how tenuous the connection to the provision of abortion services.

III. THE RULE IS CONTRARY TO THE ACA

The Rule must be held "unlawful and set aside" because it is "not in accordance with the law." 5 U.S.C. § 706(2)(A).

A. The Rule is Contrary to Section 1303 of the ACA

1. Section 1303 Limits Notice and Prohibits Separating the Cost of Abortion Coverage

The Rule violates Section 1303's notice limitations in two ways: (1) it requires issuers to provide notice of abortion coverage more times than permitted by the statute; and (2) it requires notice of the abortion coverage price carve-out, when the statute only allows notice of total premium amount. 42 U.S.C. § 18023(b)(3)(A)-(B).

First, Section 1303 states that "[a] qualified health plan shall provide a notice to enrollees, *only* as part of the summary of benefits and coverage explanation, at the time of enrollment, of such coverage." *Id*. § (b)(1)(i); (3)(A) (emphasis added). The plain meaning of the statute states that notice of abortion coverage must be provided only at the time of enrollment. § 18023(b)(3)(A). The Rule, however, requires that issuers provide notice of abortion coverage *every month*, by requiring notice of abortion coverage as a separate monthly bill. 84 Fed. Reg. 71,694. This violates the plain language of the statute.

HHS attempts to sidestep Section 1303 by suggesting that a bill is not a notice. *Id.* HHS instead claims that the primary purpose of the separate bill is to ensure that issuers collect the premium payments separately and any "insight the policy holder gains from the separate bill for…abortion services is incidental…". *Id.* But HHS's other statements make clear that a separate bill is a backdoor way to sidestep the single notice requirement. HHS states "that the separate bill will serve to clarify" for policy holders that their qualified health plan covers "abortion services and at what cost, information which many…would use to decide whether to remain enrolled…or seek a [qualified health plan] without such coverage." *Id*. at 71,695. HHS uses consumer confusion and transparency as *post hoc* justifications for the Rule. 84 Fed. Reg. 71,690, 71,695. HHS also states that the Rule must be implemented in six months to provide "clarity," even though the rush to implementation increases compliance costs by over 50 percent. 84 Fed. Reg. 71,690, 71,695 (concluding that "delaying further implementation would be imprudent" in light of the new public concern HHS allegedly unearthed). Accordingly, HHS's insistence that the Rule is not a violation of the statute's notice provisions falls flat, given that

HHS clearly states that it intends the Rule will provide notice to consumers of their plan's abortion coverage.

Second, Section 1303 states "[t]he notice [], any advertising used by the issuer with respect to the plan, any information provided by the Exchange, and any other information specified by the Secretary shall provide information only with respect to *the total amount* of the combined payments for services[, including abortion] and other services covered by the plan." § 18023 (b)(1)(i); (b)(3)(B). HHS again violates the plain language of the notice requirement by requiring that issuers bill policy holders for the cost of abortion services separately from "the total amount of the combined payments for services," including all other covered services. *Id.*

HHS asserts that the statute's notice limitation "should be read harmoniously with the separate payment requirement, rather than in conflict." 84 Fed. Reg. 71,694. But by mandating that each additional bill separately identify the premium amount attributable to abortion coverage from the rest of coverage benefits, instead of identifying the *total amount* of the premium, the Rule creates a direct conflict with the statute. The statute forecloses HHS's interpretation.

Therefore, not only is notice required only at the time of enrollment, but it is also limited to the *total amount* of the combined premium for the entire policy. As demonstrated by comments, these requirements make sense because they reflect common insurance industry practices, which the Rule would undermine.[9]

2. Section 1303 Prohibits Opt-Out Policies of Abortion Coverage

In addition, the Rule's new opt-out policy is contrary to the text of the statute itself. Section 1303 requires that policy holders pay the issuer for the abortion coverage included in their qualified health plan. § 18023(b)(2)(B)(i) ("the issuer of the plan shall collect from each enrollee"). "This language does not confer on the agency discretion to decide… [t]he word

[9] *See* WCLP Comment, AR 81334 (to "itemize the cost of, or separately bill for specific benefits that are incorporated in a comprehensive benefit plan…go against standard practice in the insurance industry."); CDI Comment, AR 072862 ("Consumers are accustomed to receiving and paying bills in total amounts, even when the bill includes charges for a variety of items."). And this billing practice is intentional; "[c]onsumers purchase a *package* of medical benefits" to "ensure health coverage markets work efficiently and are affordable for everyone." AHIP Comment, AR 80207.

'shall' is ordinarily [t]he language of command." *Serv. Employees Int'l Union v. United States*, 598 F.3d 1110, 1113 (9th Cir. 2010) (internal quotations omitted). Yet, the Rule purports to provide issuers the discretion to give policy holders the ability to opt out of the abortion coverage—coverage that may be required by state law, or otherwise allowed by the States. Thus, the Rule removes from issuers the statutory obligation to collect payments for abortion coverage, in violation of the statute.

Pursuant to Section 1303 issuers are not required to offer abortion services and can make the "voluntary choice" to cover these. 42 U.S.C. § 18023(b)(1). But issuers are nevertheless "subject to" state laws that mandate abortion coverage or allow qualified health plans to cover certain health benefits, such as abortion, and where these benefits are included as part of the state's selected benchmark plan. *Id.* § 18023(b)(1)(A)(ii). HHS has no authority to allow policy holders to opt out of state-required benefits included in its benchmark plan or voluntarily offered in qualified health plans.[10]

B. The Rule is Contrary to Section 1554 of the ACA

The ACA provides specific limits on the discretion of the Secretary of HHS to issue rules implementing the ACA. Under Section 1554, the Secretary "shall not promulgate any regulation that—(1) creates any unreasonable barriers to the ability of individuals to obtain appropriate medical care; (2) impedes timely access to health care services; [or]… (6) limits the availability of health care treatment for the full duration of a patient's medical needs." 42 U.S.C. § 18114. "When Congress speaks clearly," as it did here, "administrative agencies must listen." *Sunrise Coop., Inc. v. U. S. Dep't of Agric.*, 891 F.3d 652, 654 (6th Cir. 2018). The Rule creates barriers, impedes, and interferes with access to health services that include abortion for women and individuals capable of reproduction, and the entire public's access to healthcare coverage. It violates Section 1554 and must be set aside.

The Rule creates barriers to healthcare because it requires policy holders to receive and

[10] Though Colorado does not require issuers to provide abortion coverage in its benchmark plan, issuers may nonetheless offer it in their plans and some qualified health plans in Colorado provide such coverage.

make two separate payments for health coverage where the lack of payment of the premium bill attributable to abortion (at least $1) places individuals at risk of health coverage termination, leaving them uninsured. 84 Fed. Reg. 71,686.[11] Without health insurance, the Rule inevitably "impedes a patient's ability" to seek the healthcare services they need or allow them "to make the best medical decision for… [their] family." *Id.*; *see also* Physicians Group Comment, AR 80953. In fact, "[t]he connection between health insurance and health outcomes is clear and well documented…lack of access to timely, quality health care can have lifelong consequences for [women] and their infants."[12] The inability to connect with a provider and seek medical advice because individuals cannot afford the out-of-pocket costs without private health insurance coverage necessarily "interfere[s] with the patient-physician relationship."[13]

HHS simply rejects concerns that the Rule's effects, such as increases to out-of-pocket costs, reductions in the availability of abortion coverage, or loss of coverage, would constitute a violation of Section 1554. 84 Fed. Reg. 71694. HHS, however, previously acknowledged that its NPRM included precisely the type of barriers Section 1554 contemplates:

> [T]he combination of issuer burden and consumer confusion could have potentially led to a reduction in the availability of [abortion] coverage…(either by issuers choosing to drop this coverage to avoid additional costs or by enrollees having their coverage terminated for failure to pay the second bill) thereby potentially increasing out-of-pocket costs for some women seeking those services.

84 Fed. Reg. 71, 694. Instead, HHS suggests that its mitigation efforts—which were primarily

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[11] *See also* California Medical Association Comment, AR 79371 ("CMS's reversal of statutory interpretation in this respect is arbitrary and capricious, and serves no benefit other than to add significant cost burden on health plans and cause consumer harm in the form of loss of health coverage and confusion.").

[12] Patient Group Coalition Comment (the Adult Congenital Heart Association, American Diabetes Association, American Liver Foundation, American Lung Association, Cystic Fibrosis Foundation, Global Healthy Living Foundation, Hemophilia Federation of America, Leukemia & Lymphoma Society, March of Dimes, Mended Little Hearts, National Alliance on Mental Illness, National Health Council, National Hemophilia Foundation, National Multiple Sclerosis Society, National Organization for Rare Disorders, United Way Worldwide, and the WomenHeart: The National Coalition for Women with Heart Disease), AR 79070.

[13] *See* Physicians Group Comment, AR 80953; *also* CPEHN Comment, AR 80488 (the Rule "undermine[s] access to quality health care, including essential reproductive health services.").

incorporated to curb the loss of coverage—could decrease the likelihood of these barriers. *Id.* But none of these problems have been eliminated in the Rule; in fact, they have been accelerated by the adoption of the opt-out policy and the 6-month compliance timeline.

"The most natural reading of § 1554 is that Congress intended to ensure that HHS, in implementing the broad authority provided by the ACA, does not improperly impose regulatory burdens on doctors and patients." *California v. Azar*, 950 F.3d 1067, 1094 (9th Cir. 2020) (en banc). Here, the Rule does just that—it imposes significant regulatory burdens on individuals who purchase private insurance coverage in the healthcare market. *See* 42 U.S.C.A. § 300gg(a)(2) ("medical care" means "insurance covering medical care"). Through Section 1554, Congress sought to ensure that no future regulatory barriers undermined the ACA's expansion of coverage and benefits. Section 1554 applies regardless of any other provision, affirming that "[n]otwithstanding any other provision of this Act," HHS may not take certain steps to create barriers to care. 42 U.S.C. § 18114. As the Ninth Circuit concluded, "Congress showed its intent to ensure that certain interests of individuals and entities would be protected notwithstanding the broad scope of the ACA, and that such protections would supersede any other provision of the ACA 'in the event of a clash.'" *California*, 950 F.3d 1067 at 1094 (citing *N.L.R.B. v. SW Gen., Inc.*, 137 S. Ct. 929, 939 (2017) (the ordinary meaning of "notwithstanding" is "in spite of," and in statutes, the word shows which provision prevails in the event of a clash)).

The agency's own predictions of the consequences of the Rule—reduction in availability of abortion coverage, potential loss of coverage for individuals, and departure from the markets by issuers—demonstrate that the Secretary issued the Rule in violation of the restrictions on his discretion imposed by Section 1554.

C. The Rule is Contrary to Section 1557 of the ACA

The Rule also conflicts with Section 1557 of the ACA, because the Rule targets a healthcare service unique to those with the ability to bear children and women—abortion. Section 1557 provides anti-discrimination protections in health programs based on any ground listed under four different federal civil rights statutes, including Title IX of the Education Amendments of 1972. 42 U.S.C. § 18116. Title IX prohibits discrimination "on the basis of sex"

in federally funded educational programs. 20 U.S.C. § 1681(a). In general, establishing discrimination on the basis of sex in violation of Title IX requires proof of an intentional discriminatory act. *See e.g., Cannon v. Univ. of Chicago*. 648 F.2d 1104, 1109 (7th Cir. 1981); *Mabry v. State Bd. of Cmty. Coll.*, 813 F.2d 311, 315–316 (10th Cir. 1987); *Chance v. Rice University*, 984 F.2d 151, 153 n.8 (5th Cir. 1993).

Here, HHS concedes that abortion services are sought almost exclusively by women. HHS recognizes, as it must, that "only women access [] abortion services." 84 Fed. Reg. 71,694. HHS asserts that the Final Rule does not discriminate on the basis of sex because "both men and women in plans covering…abortion services will receive a separate bill for the portion of the premium attributable to coverage of these services, not just the women who may ultimately access such services." *Id.* This assertion ignores the consequences the Rule will have on the healthcare system's ability to provide a medical service that, per HHS, "only women access."

HHS finalized the Rule despite the adverse consequences to women and the exorbitantly high costs of its implementation. For example, in contrast to men, women encounter specific barriers related to access to and affordability of health insurance and healthcare. [14] Affordability was a primary feature of the ACA, where federal subsidies enabled many, including women, to afford private health insurance plans. This is especially important, as women are more likely to be covered by health insurance as a dependent, and thus they are at greater risk for insurance instability and coverage loss if the spouse dies, divorces, or becomes unemployed. *Id.* Women have less access to employer sponsored insurance, as they are more likely to work part time or be unemployed. *Id.* They also have increased affordability challenges because they have lower average incomes and higher out-of-pocket spending. *Id.*

HHS admits that meeting the Rule's six-month compliance deadline, alone, would impose about $385 million in one-time compliance costs on each issuer that offers abortion coverage, for contracting and overtime personnel payments. 84 Fed. Reg. 71,697. Each issuer will assume an

[14] Lois K. Lee et al., Women's Coverage, Utilization, Affordability, And Health After The ACA: A Review of The Literature, 39 *Health Affairs* No. 3, 387–394 (2020), accessible at https://doi.org/10.1377/hlthaff.2019.01361.

additional $1.07 million in annual compliance costs. *Id.* at 71,698. HHS concedes that consumers will collectively incur a personal administrative burden totaling at least $35.5 million in the first year alone. *Id.* at 71,707. But HHS offers no justification for imposing these costs beyond the frivolous assertion that the Rule will "better align" with Section 1303 as abruptly reinterpreted by HHS. *See* 83 Fed. Reg. 56,022.

Imposing these unjustified costs punishes issuers that continue to offer abortion coverage. HHS rewards issuers that eliminate abortion coverage, at least in the sense that they are spared having to spend $1.07 million a year, and $4.1 million in losses for compliance costs during the first year alone. HHS reinterpreted Section 1303 to create a problem that issuers can "fix" by making abortion services more difficult for consumers to keep or obtain. 84 Fed. Reg. 71,699. In this way, the Rule pressures issuers into eliminating abortion coverage, erecting an additional barrier to abortion services for consumers. To the extent that the Rule achieves this result, it will deprive "only women" of an essential medical benefit that, HHS acknowledges, "only women access." 84 Fed. Reg. 71,694. Almost half of U.S. pregnancies are unintended, which has important implications for the health and wellbeing of women.[15] The Rule presents "a clear pattern, unexplainable on grounds other than" the suspect classification at issue and which "emerges from the effect of the state action even when the governing legislation appears neutral on its face." *Village of Arlington Heights v. Metropolitan Housing Development Corp.*, 429 U.S. 252, 266 (1977).

IV. THE RULE EXCEEDS HHS'S STATUTORY AUTHORITY

HHS does not have unfettered discretion to revise the clear congressional directive that protects state flexibility. HHS's power to promulgate legislative regulations "is limited to the authority delegated by Congress." *Bowen v. Georgetown Univ. Hosp.*, 488 U.S. 204, 208 (1988). It is well settled that "an agency literally has no power to act . . . unless and until Congress confers power upon it." *La. Pub. Serv. Comm'n v. FCC*, 476 U.S. 355, 374 (1986). Accordingly, agency action must be set aside if it is found to be "in excess of statutory jurisdiction [or] authority." 5 U.S.C. § 706(2)(C). "[T]he question […] is always whether the agency has gone

[15] *Supra* Lee et al. at 391.

beyond what Congress has permitted it to do." *City of Arlington v. FCC*, 569 U.S. 290, 297-98 (2013). Here, the Rule exceeds HHS's statutory authority in two ways: (a) HHS seeks to reinterpret the text of Section 1303 in a manner that far exceeds Congressional intent; and (b) Congress has not delegated to HHS the broad authority to disassemble state health plan benefits.

The Rule cannot be reconciled with either the text or the purpose of Section 1303 and requiring two separate transactions is not a permissible application of the statute. Section 1303 is concerned solely with effectuating the provision of abortion coverage while ensuring the segregation of federal funds. The section's provisions for "collection" of payments and "establishment of allocation accounts" does not authorize HHS to mandate separate bills and separate payments in separate transactions. 42 U.S.C. § 18023(b)(2)(B). Such decisions are well beyond the scope of the authority that Congress delegated to HHS. For example, in *California v. U.S. Dep't of Health & Human Servs*., the Ninth Circuit held that HHS acted in excess of statutory authority because the statute delegated to the agency "discretion to determine *which types of preventative care* are covered" but not "the discretion to exempt *who must meet the obligation*. To interpret the statute's limited delegation more broadly would contradict the plain language of the statute." 941 F.3d 410, 425 (9th Cir. 2019).

First, HHS's Rule falls outside the bounds of the text, history, and purpose of Section 1303. The text of Section 1303 makes clear its principal purpose: to effectuate coverage of abortion services in states that choose to provide it. Congress first established that any state "may elect" to prohibit or authorize abortion coverage. 42 U.S.C. § 18023(a). To facilitate this, Section 1303 establishes a "prohibition on the use of Federal funds" by issuers making the "voluntary choice" to offer abortion coverage in the Exchanges and sets out "special rules relating to coverage of abortion services." § 18023(b)(1)-(2). It also makes clear that the law does not "preempt or otherwise have any effect on State laws" regarding the requirement of abortion coverage, § 18023(c)(1). Further, Section 1303 does not have any effect on federal civil rights laws, laws regarding conscience protection, or willingness or refusal to provide abortion. § 18023(c)(2).

The Rule's requirement of separate billing and separate payment is outside the authority delegated to HHS under this section. The Rule improperly expands the meaning of "collection"

to achieve other goals not concerned with the "establishment of allocation accounts." Sending separate monthly bills or instructing policy holders to make separate payments in separate transactions is not material to ensuring that issuers set up "allocation accounts" to maintain appropriate segregation of funds. Congress's use of "separate payment" in the text of the statute is intended to make clear that the funds must be segregated by the issuer upon receipt. It does not follow that limiting the way in which issuers send bills and collect payments or establishing new requirements for separate transactions by the consumer, would further the same end.

Further, the term "collect" does not include the distribution of the bills, but anticipates the intake of payment. Congress did not define *how* the payments should be collected from policy holders. Instead, the import of Section 1303 is how federal funds are separately maintained and how they are ultimately *spent*. And "an agency's interpretation of a statute is not entitled to deference when it goes beyond the meaning that the statute can bear." *MCI Telecomm. Corp. v. AT&T*, 512 U.S. 218, 229 (1994). For example, in *MCI*, the FCC announced that it would exempt all long-distance telephone carriers, except the most dominant one (AT&T), from having to submit tariffs to the agency specifying the rates they would charge. The Commission relied on its statutory power to "modify" the filing requirements of the Communications Act. The Court, however, concluded that that the word modify connotes moderate change, and the agency's wholesale dismantling of its rate regulation program for the smaller carriers was too sweeping to qualify as a "modification." The Court found "[i]t is highly unlikely that Congress would leave the determination of whether an industry will be entirely, or even substantially, rate-regulated to agency discretion—and even more unlikely that it would achieve that through such a subtle device as permission to 'modify' rate-filing requirements." *Id.* at 231.

Here, HHS similarly usurps the authority to "collect" and "segregate funds" in order to dismantle the flexible regulatory scheme Congress intended. Imbued in Section 1303 is a recognition of State control over healthcare in its markets, to adapt the minimum Exchange functions to their local markets and the unique needs of their residents. Section 1303 is designed and included for a specific purpose, to permit the manner in which states and issuers choose to provide abortion coverage. It operationalizes "special rules" because it presupposes a central

feature of the ACA—that states will have different laws with respect to abortion coverage and different platform enrollment or billing processes for developing unique Exchanges.[16] State flexibility is showcased even in comments submitted by the Silver State Health Insurance Exchange, admitting that "[w]hile there are no Nevada insurers currently covering non-Hyde abortion services, the Exchange recognizes that this may not always be the case." AR 76518. Indisputably, Section 1303 of the ACA respected and anticipated precisely this dynamic healthcare environment amongst the states. [17]

Second, HHS does not have the authority to interfere in a state's certification of qualified health plan benefits that include abortion coverage. Issuers are nevertheless "subject to" the state laws that mandate qualified health plans to cover abortion coverage. 42 U.S.C. § 18023(b)(1)(A)(ii). Nor can HHS interfere with state-selected benchmark plans that include abortion coverage as part of the covered health benefits package. 45 C.F.R. §156.111(a)-(b). In states without laws mandating abortion coverage, the Rule's implementation of the opt-out policy effectively grants issuers permission to excise health benefits from policy holders' plans and prohibits abortion coverage reinstatement for the remainder of the plan year, contrary to covered health benefit packages offered in those states. In states with laws mandating abortion coverage, the Rule's opt-out policy is in direct conflict with those states' laws. [18]

HHS's efforts are untethered to the statute's plain text, which consistently underscores the states' discretion over abortion coverage. Congress requires issuers to collect payments for abortion coverage, deposit these into separate accounts to ensure segregation, and nothing more.

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[16] *See* Cal. Health & Saf. Code §§ 123462(b), 123466; N.Y. Pub. Health L. § 2599-aa, N.Y. Comp. Codes R. & Regs. tit. 11, § 52.16(c); Me. Rev. Stat. tit. 24-A, §§ 4320-D & 4320-M; Or. Rev. Stat. Ann. § 743A.067(2)-(3). While the states of Colorado, Maryland, Vermont, and the District of Columbia do not have state laws mandating abortion coverage, these states have selected benchmark plans under which issuers provide coverage for abortion services.

[17] State flexibility is preserved throughout the ACA. Nevada is currently in the process of transitioning away from its existing State-Based Exchange utilizing the Federal Platform (SBE-FP) operations towards operation as a State-Based Exchange (SBE), effective Plan Year 2020. *Id.*

[18] *Id.*

V. HHS FAILED TO FOLLOW PROCEDURES REQUIRED BY THE APA

The APA requires agencies to provide the public notice and an opportunity to be heard before formulating, amending, or repealing a rule. 5 U.S.C. §§ 551(5), 553. After such notice has issued, "the agency shall give interested persons an opportunity to participate in the rulemaking through submission of written data, views, or arguments with or without opportunity for oral presentation." *Id*. § 553(c). The APA notice requirement may be satisfied where "the final rule is a logical outgrowth of the proposals on which the public had the opportunity to comment." *Hall v. U.S. EPA*, 273 F.3d 1146, 1163 (9th Cir. 2001). The Ninth Circuit has affirmed, "[t]he 'logical outgrowth' doctrine does not extend to a rule that finds no roots in the agency's proposal because '[s]omething is not a logical outgrowth of nothing[.]'" *Marsh v. J. Alexander's LLC*, 905 F.3d 610, 639 (9th Cir. 2018).

HHS violated the procedural requirements of the APA because the Final Rule contains a new opt-out provision not previously included in the NPRM. The new opt-out policy would allow policy holders to excise abortion benefits from their plans and will eliminate abortion coverage from plans mid-year. Because this new provision was not included in the NPRM, the States were deprived of notice and opportunity for comment. 5 U.S.C. § 553(b). The States could not reasonably anticipate that the final Rule would contain a limitation on the applicability of abortion coverage benefits statutorily designated to be a part of the policy for the entire plan year. The limitation is not the logical outgrowth of the NPRM. The NPRM required separate bills and separate payments— mandating completely separate transactions—in order for a consumer to pay their insurance premium. It does not follow that any changes added to the final Rule would include eliminating the abortion coverage benefit—a benefit that Section 1303's special rules were intended to facilitate in state Exchanges.

Allowing policy holders the ability to selectively eliminate abortion coverage in a health plan, for all enrollees, at any time during a plan year, renders meaningless the purpose of the "open enrollment" periods, one-year contracts, and the stability afforded to the insurance market. The States were deprived of the opportunity to file comments that would have informed HHS's

deliberations on the issue and would have established an evidentiary record for review. Because HHS failed to follow the notice and comment procedures of the APA, the Rule is invalid.

VI. THE RULE VIOLATES THE TENTH AMENDMENT

HHS's disregard for the States' laws and policies violates the Tenth Amendment's federalism principles, because the Rule penalizes the States for requiring and allowing qualified health plans to provide abortion coverage in its state-based Exchanges. The Tenth Amendment to the United States Constitution provides, "[t]he powers not delegated to the United States by the Constitution, nor prohibited by it to the States, are reserved to the States respectively, or to the people." States have "the power to create and enforce a legal code, both civil and criminal." *Alfred L. Snapp & Son, Inc. v. Puerto Rico*, 458 U.S. 592, 601 (1982); *Virginia ex rel. Cuccinelli v. Sebelius*, 656 F.3d 253 (4th Cir. 2011). And Congress may not infringe on the States' sovereign authority to enforce their own laws. "[W]hen a federal law interferes with a state's exercise of its sovereign 'power to create and enforce a legal code' [ ] it inflict[s] on the state the requisite injury-in fact." *Cty. of Santa Clara v. Trump*, 250 F. Supp. 3d 497, 526 (N.D. Cal. 2017).

The Plaintiff States all require or allow abortion coverage to be provided in qualified health plans. While the ACA limited the use of federal subsidies for purchase of private health plans by prohibiting that funds be used to pay abortion services and requiring separate accounting rules, Congress explicitly recognized state governments' ability to continue to address the critical life needs of their residents by providing them abortion coverage benefits. 42 U.S.C. § 18022; *see generally* 45 C.F.R. § 156.111. HHS did so by granting states the ability to mandate such coverage or authorizing the design of their own standardized set of essential health benefits that must be offered in a qualified health plan, 45 C.F.R. § 155.20. In addition, all issuers must adhere to the requirements "imposed by the Exchange, or a State in connection with its Exchange, that are conditions of participation or certification with respect to each of its QHPs." 45 C.F.R. § 155.200(d). Moreover, the ACA itself authorized the States' insurance commissioners as the entities primarily responsible for monitoring, overseeing, and enforcing the provisions in Section 1303 related to qualified health plans segregation of funds for abortion services. 42 U.S.C.

§ 18023(b)(2)(E)(i); 45 C.F.R. § 156.280(e)(5). Thus, the Rule's reinterpretation of Section 1303 that now imposes onerous and costly changes—solely on states that have enacted protections for abortion coverage—is inconsistent with Congress's intent and the ACA's respect for federalism principles that allow states to support all its residents by providing comprehensive health benefits.

HHS ignores the statutory flexibility Congress recognized in the States' authority, and instead threatens to step in and enforce these unreasonable changes in their place—or worse, seek to short-change the States entitled to HHS funding. But the Constitution "confers upon Congress the power to regulate individuals, not States." *New York v. U.S.*, 505 U.S. 144, 166 (1992). Still, the Rule states that "if HHS determines that a state (or State Exchange) has failed to substantially enforce a federal requirement related to Exchanges and the offering of QHPS through Exchanges, including section 1303 of the PPACA's separate payments requirement (or other requirements), the Secretary may step in to enforce the requirement against the non-compliant issuer." 84 Fed. Reg. at 71,692 (citing 42 U.S.C. § 18041(c)(2)). Further, under 42 U.S.C. § 18033(a)(4), HHS may conclude that the States' inability to comply, or allow issuers to comply, with the Rule amounts to a "pattern of abuse" seemingly allowing HHS to rescind up to one percent (1%) of the federal funding dollars due to a state. *Id.* at 71,678.

The States' Exchanges and regulatory agencies anticipate that implementation by 2020 will costs millions of dollars. *See* McKeever Decl. ¶¶ 13-15; Frescatore Decl. ¶¶ 8-9; Patterson Decl. ¶ 8; Kofman Decl. ¶¶ 8-11, 13-14; Eberle Decl. ¶ 10; Flowers Decl. ¶ 8; Hinze Decl. ¶¶ 9-10; Ream Decl. ¶¶ 11-13; Powell Decl. ¶¶10-12; Conway Decl. ¶¶ 12-13; Woods Decl. ¶¶ 9-11; Redmer Decl. ¶¶ 6, 8-9; Cioppa Decl. ¶¶ 10-11; Stolfi Decl. ¶¶ 8-10. And absent clarification by HHS, the States have no assurances of what, if any, federal funds are at risk, if they fail to reach compliance by the June 27, 2020 deadline, the following discretionary 6-month "good faith effort" period, or beyond. HHS cannot require the States to impose Rules that are unjustifiably costly and risk critical federal funds. Nor can HHS deprive the States their authority (pursuant to the ACA) to enact state laws that include abortion coverage as a protected benefit or are part of the selected benchmark plans. *See Murphy v. Nat'l Collegiate Athletic Ass'n*, 138 S. Ct. 1461, 1478 (2018) (Congress cannot issue direct orders to state legislatures).

At bottom, the Rule's sole function is to make it more burdensome and more confusing for women to pay for health plans that include legal abortion services and frustrate the receipt of such coverage in states that require or allow it.

VII. THE COURT SHOULD VACATE THE RULE

The Court should vacate the Rule because, by promulgating it, HHS exceeded its statutory authority, acted arbitrarily and contrary to law, and the Rule unconstitutionally interferes in the States' sovereign authority over its healthcare laws. 5 U.S.C. § 706(2)(A)-(B); *Regents of Univ. of Cal. v. U.S. Dep't of Homeland Sec.*, 908 F.3d 476, 511 (9th Cir. 2018) ("'[W]hen a reviewing court determines that agency regulations are unlawful, the ordinary result is that the rules are vacated—not that their application to the individual petitioners is proscribed.'"); *All. for the Wild Rockies v. U.S. Forest Serv.*, 907 F.3d 1105, 1121-1122 (9th Cir. 2018) ("[O]rdinarily when a regulation is not promulgated in compliance with the APA, the regulation is invalid.").

Under the APA, a reviewing court shall ". . . hold unlawful and set aside agency action, findings, and conclusions found to be . . . arbitrary, capricious, an abuse of discretion, otherwise not in accordance with law; [or] without observance of procedure required by law." 5 U.S.C. § 706(2)(A), (B) & (D). Thus, by statute, Congress has directed reviewing courts as to what the remedy must be: the Court must "set aside" unlawful rules. This Court should follow Congress's express instruction. *See, e.g., State v. Ross*, 358 F. Supp. 3d 965, 1050-51 (N.D. Cal. 2019).

Here, the Rule must be set aside because it is unlawful. The States will incur unnecessary new administrative costs to their Exchanges and regulatory bodies that include changes to the enrollment processes, new package approvals, and an increased need for call center training and services. *See* McKeever Decl. ¶¶ 13-15; Frescatore Decl. ¶ 8; Patterson Decl. ¶¶ 8, 11; Kofman Decl. ¶¶ 8-11, 13-14; Eberle Decl. ¶¶ 10-12; Flowers Decl. ¶ 8; Strumolo Decl. ¶¶ 16-17; Hinze Decl. ¶¶ 9-10; Ream Decl. ¶¶ 11-13; Powell Decl. ¶¶10-12; Conway Decl. ¶¶ 12-13; Woods Decl. ¶¶ 9-11; Redmer Decl. ¶¶ 6, 8-9; Cioppa Decl. ¶¶ 10-11; Stolfi Decl. ¶¶ 8-10. Such administrative burdens and costs militate in favor of striking down the Rule.

CONCLUSION

The Court should grant the States' motion, find the Rule unlawful, and vacate the Rule.

Dated: March 30, 2020

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