IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MARYLAND

CITY OF COLUMBUS, et al.,

Plaintiffs,

v.

DONALD J. TRUMP, in his official capacity as President of the United States of America, et al.,

Defendants.

No. 18-cv-2364-DKC

ORAL ARGUMENT REQUESTED

PLAINTIFFS' MEMORANDUM IN SUPPORT OF THEIR MOTION FOR SUMMARY JUDGMENT

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INTRODUCTION

Over ten years since its enactment, the Affordable Care Act continues to provide millions of Americans with affordable, high-quality health insurance. By preventing insurers from discriminating against individuals with preexisting conditions, covering essential health benefits, and providing subsidies to individuals with low income, the Act brought coverage to many who could not have obtained it before. A central feature of the Act's reforms is its individual Exchanges, which allow Americans to find, compare, and purchase insurance plans to meet their needs. When left undisturbed, the Act works.

Yet Defendants have implemented many policies that distort the Act's requirements and undermine the Act's purpose. This case involves an important example of that sabotage: the 2019 Notice of Benefit and Payment Parameters, the 2019 iteration of a yearly rule promulgated to regulate the Act's Exchanges. The "2019 Rule" interferes with the effective operation of the Exchanges in nine distinct ways.

First, the 2019 Rule allows Exchanges to strip individuals of the subsidies they need to purchase health insurance without first providing direct notification. That change deepens a conflict with the Act's mandate that all eligible taxpayers may receive tax credits, violates fundamental notions of due process, and overlooks significant evidence-backed concerns that eliminating direct notification would leave many low-income consumers without insurance.

Second, the 2019 Rule outsources to states the federal government's statutory duty to ensure that insurance plans offer adequate provider networks. It does so even though commenters warned that this would disrupt care for vulnerable Americans, including those with preexisting conditions, and without any evidence that state regulators can or will pick up the slack.

Third, the 2019 Rule permits insurance brokers and agents to pick their own auditors without prior approval from the Department of Health and Human Services (HHS), increasing the likelihood that consumers will be given incorrect information and be shunted from high-quality, ACA-compliant plans to non-ACA-compliant junk plans.

Fourth, the 2019 Rule eliminates so-called "standardized options," which are plans designed to make it easier for consumers to make informed and appropriate choices. In doing so, Defendants failed to confront their own prior determination—one backed by abundant evidence—that standardized options are critical to helping consumers navigate the complicated world of insurance.

Fifth, the 2019 Rule slashes the standards for the Navigator program, which the Act established to provide consumers with assistance in selecting and enrolling in health plans. It thereby prevents Navigators from meeting their statutory duties, keeps diverse communities from obtaining assistance adequate to their needs, and ensures that many Americans will be unable to complete the enrollment process.

Sixth, the 2019 Rule weakens the Small Business Health Options Programs, or SHOPs, that the Act implemented to help small businesses provide coverage to their employees. By removing several of the SHOPs' core functionalities, like allowing employers to enroll their employees online, the 2019 Rule stops the SHOPs from functioning like Congress intended and renders them far less useful to small businesses.

Seventh, the 2019 Rule forces low-income consumers to submit additional documentation to verify their income when it conflicts with inaccurate or outdated government data. That onerous paperwork requirement effectively knocks many low-income consumers off coverage without any evidence that the added burden will prevent fraud or abuse.

Eighth, the 2019 Rule creates a new, unlawful exemption from insurance rate review—which has been shown to lower insurance premiums—for student health plans, and raises the threshold for rate review of all health plans. These changes will make it easier for insurers to raise premiums without sufficient regulatory scrutiny and without providing adequate public justification.

Ninth, the 2019 Rule waters down the requirement that insurers spend a sufficient amount of the premiums they receive on providing benefits to customers by allowing insurers to claim a flat deduction for money spent improving the quality of their services without any

evidence that they have actually done so. That change will make it easier for insurers to avoid paying rebates to their customers, thereby making insurance more expensive and disincentivizing insurers to provide better coverage.

These changes are unlawful. Many of them conflict with express statutory mandates and are therefore contrary to law. All are arbitrary and capricious: to use the formulation from *Motor Vehicle Manufacturers Association v. State Farm Mutual Automobile Insurance Co.*, Defendants "relied on factors which Congress has not intended [them] to consider, entirely failed to consider … important aspect[s] of the problem, [and] offered … explanation[s] for [their] decision[s] that run[] counter to the evidence," rendering decisions "so implausible that [they] could not be ascribed to a difference in view or the product of agency expertise." 463 U.S. 29, 43 (1983).

Defendants' changes also injure the five cities—Columbus, Ohio; Baltimore, Maryland; Cincinnati, Ohio; Chicago, Illinois; and Philadelphia, Pennsylvania (the "City Plaintiffs")—and two individuals—Steve Vondra and Bonnie Morgan (the "Individual Plaintiffs")—that have brought suit here. As Plaintiffs have now shown, through a declaration provided by an independent health economist and, in many respects, the administrative record, the challenged provisions of the 2019 Rule raise premiums, increase administrative barriers, and drive up the rates of uninsured and underinsured individuals. Those harms force the City Plaintiffs to pay more to provide uncompensated care to their residents and force the Individual Plaintiffs to pay more to purchase their insurance on the individual market. Thus, under established law, Plaintiffs have standing to advance the challenges outlined above.

The challenged provisions of the 2019 Rule must therefore be set aside. That is what the Administrative Procedure Act commands, and it is what the provisions' serious deficiencies warrant. The Court should therefore grant Plaintiffs' motion for summary judgment, vacate the challenged provisions of the 2019 Rule, and enter judgment for Plaintiffs.

STATEMENT OF FACTS

This statement of facts is based upon (1) the administrative record produced by Defendants in this case, pages of which are cited as "AR###"; (2) judicially noticeable

government documents, like the contents of the Federal Register, *see* 44 U.S.C. § 1507, and other publications attached to Plaintiffs' Request for Judicial Notice, cited as "RJN Ex. #"; and (3) the declarations (cited by the declarant's last name) submitted by Plaintiffs for purposes of standing and other issues not reviewed on the basis of the administrative record.

I. The enactment of the Affordable Care Act

In 2010, Congress passed, and the President signed, the Patient Protection and Affordable Care Act. Pub. L. No. 111-148, 124 Stat. 119 (2010) (as amended by Pub. L. No. 111-152, 124 Stat. 1029 (2010)). The Act "grew out of a long history of failed health insurance reform" that consistently struggled to address rising premiums, inadequate coverage, and high uninsured rates. *King v. Burwell*, 576 U.S. 473, 479 (2015).

A central purpose of the Act is "to expand coverage in the individual health insurance market." *Id.*; *see also Me. Cmty. Health Options v. United States*, 140 S. Ct. 1308, 1315 (2020) (explaining that the Act seeks "to improve national health-insurance markets and extend coverage to millions of people without adequate (or any) health insurance"); *Nat'l Fed'n of Indep. Bus. v. Sebelius*, 567 U.S. 519, 538 (2012) ("The Act aims to increase the number of Americans covered by health insurance and decrease the cost of health care."); *Doe #1 v. Trump*, 957 F.3d 1050, 1063 (9th Cir. 2020) (explaining that Congress aimed "[t]o incentivize the purchase of insurance"); *Maryland v. United States*, 360 F. Supp. 3d 288, 297 (D. Md. 2019) ("Congress endeavored to provide the opportunity for 'near-universal' health-insurance coverage and to reduce health insurance premiums.").

In enacting the ACA, Congress concluded that high rates of uninsured and underinsured individuals harm both those people who lack adequate insurance and society as a whole. Congress found, among other things, that when individuals "forego health insurance coverage," that "increases financial risks to households and medical providers"; that the uninsured suffer from "poorer health and shorter lifespan[s]"; that the "cost of providing uncompensated care to the uninsured" ($43 billion in 2008) is high; that "health care providers pass on the cost to private insurers, which pass on the cost to families" by "increas[ing] family premiums"; and that,

because many "personal bankruptcies are caused in part by medical expenses," "significantly increasing health insurance coverage … will improve financial security for families." 42 U.S.C. § 18091(2)(A), (E)-(G).

To facilitate individuals' ability to learn about and enroll in the health insurance options that are available to them, the Act "requires the creation of an 'Exchange' in each State where people can shop for insurance, usually online." *King*, 576 U.S. at 479 (quoting 42 U.S.C. § 18031(b)(1)); *Me. Cmty. Health Options*, 140 S. Ct. at 1315 (explaining that the Act "called for the creation of virtual health-insurance markets, or 'Health Benefit Exchanges,' in each State," to serve the "end" of increased coverage). These Exchanges, also known as health insurance Marketplaces, enable people not eligible for Medicare or Medicaid to obtain adequate, affordable insurance independent of their jobs. The Exchanges therefore serve as "marketplace[s] that allow[] people to compare and purchase" ACA-compliant plans. *King*, 576 U.S. at 479.

There are several different types of Exchanges. Some states have elected to create Exchanges themselves (state-based Exchanges or SBEs), as is the case in Maryland, while others have created Exchanges that operate on the federal Healthcare.gov platform, like Oregon and Pennsylvania (state-based Exchanges on the federal platform, or SBE-FPs). Others declined to establish an Exchange, and so the Exchanges in those states, including Illinois and Ohio, are operated by the Center for Medicare and Medicaid Services (CMS) (federally facilitated Exchanges, or FFEs). *See* RJN Exs. 1, 14.

All individual market health plans, referred to as "qualified health plans" (QHPs) under the Act, must meet certain requirements that guarantee quality coverage to all Americans. 42 U.S.C. § 18031(b)(1); *see id.* § 18021(a). Crucially, these plans cannot discriminate on the basis of health status or health history: they must cover preexisting conditions, including by not excluding services, denying coverage, or charging more. *Id*. §§ 300gg, 300gg-1(a), 300gg-4. They must cover "essential health benefits," *id*. § 300gg-6(a), including hospitalization, prescription drugs, maternity and newborn care, and preventive, pediatric, emergency, ambulatory, mental health, and substance use disorder services, *see id.* § 18022(b)(1). And to

protect patients from devastating costs when a medical condition exhausts their coverage, the Act limits so-called "cost-sharing"—for example, deductibles and copayments—for essential health benefits, and prohibits plans from imposing annual or lifetime limits on such coverage. *See id.* §§ 300gg-6(b), 18022(a)(2), (c).

Individuals primarily enroll in qualified health plans for a given benefit year during a specified annual open enrollment period, which usually occurs in November and December of the preceding year. *Id*. § 18031(c)(6); *see* RJN Ex. 2. To assist them, the Act requires Exchanges to award grants to healthcare "Navigators" that conduct public education and awareness campaigns, help consumers understand their choices, facilitate their enrollment, and ensure their access to consumer protections. 42 U.S.C. §§ 18031(i)(1), (3).

The Act also "seeks to make insurance more affordable by giving refundable tax credits to individuals with household incomes between 100 percent and 400 percent of the federal poverty line." *King*, 576 U.S. at 482 (citing 26 U.S.C. § 36B). These "advance premium tax credits" (APTCs) vary depending on an individual's income—individuals who make more must pay more toward the cost of procuring insurance—but are generally pegged to the cost of the so-called "benchmark silver plan," or the second-lowest cost silver plan offered within a market. *See, e.g.*, 26 U.S.C. § 36B(b)(3)(B)-(C); 42 U.S.C. §§ 18081, 18082.

In sum, the Act requires that insurers generally offer only quality health insurance and aims to lower the cost of coverage to encourage individuals to enroll. Such coverage has been found to improve access to care and overall health, and to reduce financial burdens on consumers as well as institutions that pay for uncompensated care. Young Decl. ¶¶ 60-73; RJN Ex. 10 at 27-32. But increasing enrollment in quality health insurance coverage is not only the ACA's immediate goal; it is also key to the Act's long-term success. Insurance market stability requires robust enrollment, particularly by relatively healthy individuals. Young Decl. ¶¶ 14-15; RJN Ex. 10 at 11-12; 42 U.S.C. § 18091(I) (finding that "broaden[ing] the health insurance risk pool to include healthy individuals … will lower health insurance premiums"); *King*, 576 U.S. at 480 (explaining the so-called "economic 'death spiral'"). Limiting the cost of health insurance is, in

turn, essential to promoting enrollment. Young Decl. ¶¶ 6-8; RJN Ex. 10 at 8-10; *King*, 576 U.S. at 480-81. By driving costs down and insured rates up, the Act ensures that insurance markets function smoothly.

When faithfully implemented, the Act's reforms successfully met Congress's goal of enabling more individuals—specifically, 20 million more individuals—to enroll in health insurance coverage. *See* Young Decl. ¶ 62; RJN Exs. 9 at 7-8, 10 at 3, 11 at 1, 13 at 1; Br. of *Amicus Curiae* Henry J. Aaron ("Aaron *Amicus* Br.") at 1-5, ECF No. 71-1; Br. of Families USA, et al., as *Amici Curiae* ("Families USA *Amici* Br.") at 2-4, ECF No. 67-1; Br. of U.S. House of Reps. as *Amicus Curiae* ("House *Amicus* Br.") at 9-10, ECF No. 65-1. For the 2016 coverage year, HHS reported that 12.7 million consumers had selected plans on the Exchanges during open enrollment. RJN Ex. 13 at 8. The Act's individual market reforms were particularly successful in reducing the uninsured rate among individuals with preexisting conditions. RJN Ex. 12 at 1. These coverage expansions similarly improved access to care, RJN Ex. 10 at 27-30, health outcomes, *id.* at 30-32, financial security, *id.* at 33, and the level of income inequality in the United States, *id.* at 35-36.

II. The 2019 Notice of Benefit and Payment Parameters

Defendants, however, are no longer faithfully implementing the Affordable Care Act. One of the President's first official acts was to issue an Executive Order directing his Administration to "take all actions consistent with law to minimize the unwarranted economic and regulatory burdens of the Act," "[p]ending [its] repeal." AR3801. As the President himself has explained, time and again, he intends to let "ObamaCare implode" to force his political opponents to "deal." RJN Ex. 3. Because Congress rejected his attempt to repeal the Affordable Care Act through legislation, the President instead elected to "go[] a little different route," RJN Ex. 4 at 6, and "[get] rid of a majority of Obamacare" through executive action, RJN Ex. 5 at 3. More recently, the President has stated that "what we really have left is the carcass of Obamacare," but "what we'd like to do is totally kill it." RJN Ex. 6 at 15-16; *see also* RJN Ex. 7 at 3-4 ("We slashed Obamacare's crippling requirements."); House *Amicus* Br. at 10-14

(describing such actions). "The President's profound disdain for the ACA cannot be seriously disputed." *Maryland*, 360 F. Supp. 3d at 315. Notwithstanding the President's opposition to the Act, however, it remains valid and binding law.

On April 17, 2018, Defendants promulgated a rule—the 2019 Notice of Benefit and Payment Parameters, or the "2019 Rule," 83 Fed. Reg. 16,930 (AR463-604)—that undermines the Act in a number of crucial respects. As the name suggests, the federal government promulgates a Notice of Benefit and Payment Parameters every year, typically well in advance of open enrollment, that provides rules to govern how Exchanges will operate during the designated benefit year. AR21-22.

The 2019 Rule, however, does not simply establish requirements for the Exchanges. It expressly references the President's directive to "exercise all authority and discretion available … to waive, defer, grant exemptions from, or delay the implementation of any provision or requirement of the [Affordable Care Act]." AR464. To that end, rather than focusing on how to increase coverage, as the Act commands, the 2019 Rule purports to give primary weight to "providing States with additional flexibilities," as well as "reducing unnecessary regulatory burden on stakeholders." AR463-64. In promulgating the 2019 Rule, Defendants admitted that they could not quantify many of its ostensible benefits. 83 Fed. Reg. at 17,044; AR267.

The 2019 Rule implements numerous policies that can be predicted to drive up health insurance premiums, create administrative barriers to enrollment, and increase the under- and uninsured rates, thereby harming health insurance markets and undermining the Act.

A. Eliminating direct notification requirements

As noted above, many individuals who purchase health insurance through the Exchanges are eligible for premium subsidies known as advance premium tax credits (APTC), but the amount of those credits ultimately depends on the individual's income at the end of the year. Under CMS regulations, Exchanges must deny advance premium tax credits to an individual if the Internal Revenue Service notifies the Exchange that the individual or a member of their household failed to "reconcile"—or pay back—any excess APTC received in the previous tax

year. Recognizing the need to provide individuals with a chance to establish their eligibility for APTC, which may make the difference in whether they can afford health insurance, CMS amended those regulations in 2016 to require that individuals receive direct notification of their ineligibility. 81 Fed. Reg. 94,058, 94,124 (Dec. 22, 2016). In doing so, CMS explained "that targeted and detailed messaging to tax filers that highlights the specific requirement to file an income tax return and reconcile APTC paid on their behalf—and the potential adverse impact on APTC eligibility for future coverage years—is *essential*." *Id.* (emphasis added).

The 2019 Rule, however, eliminates this requirement. 83 Fed. Reg. at 16,982-84; *see* 45 C.F.R. § 155.305(f)(4). Because of this change, Exchanges "are free under the regulations to deny assistance without ever communicating with the consumer about the reason." Young Decl. ¶ 21. While "[s]ome consumers may be able to piece together the steps they must take to redress the denial from indirect communications that discuss these issues more generally, … others are likely to be deterred from enrolling." *Id.* ¶ 22; *see, e.g.*, AR909 (Consumers Union), 1314-15 (Chronic Illness & Disability Partnership), 1689 (UPMC Health Plan), 1823 (Association of Asian Pacific Community Health Organizations), 1859 (Community Catalyst), 1943 (Young Invincibles), 2493 (Georgetown University Health Policy Institute), 2590 (Asian & Pacific Islander American Health Forum), 2738 (Families USA), 3485 (Unidos US); House *Amicus* Br. at 11 (agreeing that this change "could reduce enrollment"). As Defendants acknowledged in promulgating the 2019 Rule, more indirect notices failed to prompt corrective action *forty percent* of the time. 83 Fed. Reg. at 16,983. Moreover, "healthy consumers … are the least likely to be motivated to successfully navigate this complex enrollment environment, so this policy will be expected to worsen the risk pool and increase gross premiums." Young Decl. ¶ 22.

B. Eliminating federal review of network adequacy

Starting in the 2018 plan year, CMS ceased conducting reviews of insurance plans and instead began relying on states to certify plans offered on the state's Exchange as qualified health plans. *See* 82 Fed. Reg. 18,346, 18,371-72 (Apr. 18, 2017). As part of that policy, states alone, rather than CMS, review plans to ensure that they offer adequate provider networks to their

customers—*i.e.*, networks that provide reasonable access to a sufficient number of providers close to the consumer and that can cover conditions the consumer may have. The 2019 Rule continues this policy. 83 Fed. Reg. at 17,024-26; *see* 45 C.F.R. § 156.230.

This policy will "lead to issuers offering narrower networks because state review will not require them to maintain an equally adequate network," including if states relax their standards in the future. Young Decl. ¶ 26. Those "inadequate networks may make it more difficult for enrollees to obtain care, including specialty care that may only be available from a limited number of providers." *Id.* ¶ 27. Commenters on the 2019 Rule identified many preexisting conditions that inadequate provider networks might not be able to cover. *See, e.g.*, AR740 (National Committee for Quality Assurance), 829 (Biotechnology Innovation Organization), 937-38 (Health & Medicine Policy Research Group), 986 (Congenital Heart Association), 989 (Hemophilia Alliance), 1002 (Federal AIDS Policy Partnership), 1065-66 (Parity Implementation Coalition), 1175 (Leukemia & Lymphoma Society), 1412 (American Academy of Pediatrics), 1581 (March of Dimes), 1587 (American Thoracic Society), 1611 (Children's Defense Fund), 1811 (American Lung Association), 2015 (Cystic Fibrosis Foundation), 2206 (National Hemophilia Foundation), 2275-76 (Catholic Health Initiatives), 2980-83 (Consortium for Citizens with Disabilities), 2997 (Cancer Leadership Council), 3034 (National Coalition for Cancer Survivorship). Moreover, consumers "who want to maintain the same size network" will face "increase[d] costs" that "may deter some from seeking coverage" in the event adequate coverage becomes unaffordable for them. Young Decl. ¶ 27.

C. Reducing oversight of direct enrollment

In addition to using Healthcare.gov, consumers can also enroll in insurance coverage through "direct enrollment." Direct enrollment is a process through which a consumer enrolls in an ACA-compliant health insurance plan through a third-party website instead of through the applicable governmental platform (Healthcare.gov for FFEs). It typically involves "agents, brokers, and issuers" who "use their own internet website for [qualified health plan] selection or to complete the Exchange eligibility application." 83 Fed. Reg. at 16,981. Recognizing the risk

of abuse, previous rules required these entities to select auditors that HHS would then review and approve. *Id.*

The 2019 Rule, however, allows agents, brokers, and insurers to "select their own third-party entities for conducting audits, rather than requiring HHS to initially review and approve these entities." 83 Fed. Reg. at 16,981-82; *see* 45 C.F.R. § 155.221. This change is significant because direct enrollment "requires close oversight to ensure that the consumer is presented with accurate and complete information and receives the support they need to get and stay enrolled." Young Decl. ¶ 28; *see, e.g.*, AR1625-27 (Center on Budget and Policy Priorities), 1822-23 (Association of Asian Pacific Community Health Organizations), 2063 (former Acting Administrator of CMS). "Consumers who receive inaccurate eligibility information may be asked to pay more for coverage than is necessary, which may deter them from enrolling, cause them to drop coverage, or cause them to enroll in coverage which is inappropriate for them." Young Decl. ¶ 29; *see also* AR1944 (comment by Young Invincibles explaining that change could "ultimately deter and reduce enrollment and reenrollment by consumers who qualify for, and are thus entitled to, coverage and subsidies").

Moreover, some entities may deter consumers from enrolling in Medicaid because they do not receive commissions for doing so or may push consumers to non-ACA-compliant plans that pay higher commissions. Young Decl. ¶¶ 29-30; *see, e.g.*, AR1625-26 (Center on Budget and Policy Priorities), 1822-23 (Association of Asian Pacific Community Health Organizations), 2737-38 (Families USA), 1712-13 (DC Health Benefit Exchange Authority). As the former Acting Administrator of CMS explained, those entities will "steer healthy applicants to non-ACA compliant plans, undermining the risk pool." AR2063. Thus, this change will both "increase the uninsured and underinsured rates and drive up gross premiums in the individual market." Young Decl. ¶ 31; House *Amicus* Br. at 11-12 (agreeing that this change could increase the uninsured rate).

D. Eliminating standardized options

In an effort "to simplify the consumer shopping experience and to allow consumers to more easily compare plans across issuers," CMS introduced "standardized options": qualified health plans offering different levels of coverage and price, but with a standard cost-sharing structure specified by HHS that makes it easier for consumers to compare plans, including fixed deductibles, fixed annual limitations on cost-sharing, and fixed copayments or coinsurance for certain specified benefits. 81 Fed. Reg. 12,204, 12,205, 12,289-293 (Mar. 8, 2016).

Standardized options have been proven to assist consumers in selecting plans, increasing the odds that they will enroll in coverage that is appropriate for their needs. Young Decl. ¶ 35; House *Amicus* Br. at 3, 10-11 (explaining that "'standardized options[]' … make it easier for consumers to compare plans and more likely that they will purchase insurance"). In providing for standardized options, CMS itself acknowledged that "[a]n excessive number of health plan options makes consumers less likely to make any plan selection, more likely to make a selection that does not match their health needs, and more likely to make a selection that leaves them less satisfied." 80 Fed. Reg. 75,488, 75,542 (Dec. 2, 2015). HHS determined that "standardized options will provide these consumers the opportunity to make simpler comparisons of plans offered by different issuers within a metal level" and to "focus their decision making on the providers in the plan networks, premiums, benefits, and quality," and would thereby prevent consumers from having "to make complex tradeoffs among cost-sharing differences among a large number of plans." *Id.*; *see, e.g.*, AR715 (American Congress of Obstetricians and Gynecologists), 894-96 (The Colorado Health Foundation), 905-06 (Consumers Union), 918 (Health & Medicine Policy Research Group), 980 (Arthritis Foundation), 1086 (American Medical Association), 1135 (Society for Public Health Education), 1623 (Center on Budget and Policy Priorities), 1704-05 (Pfizer), 1856-57 (Community Catalyst), 2650-51 (Covered California), 2735 (Families USA), 3008 (Planned Parenthood Federation of America), 3530 (National Health Council).

However, the 2019 Rule declines to specify any standardized options beginning for the 2019 plan year and ends differential display for standardized options on Healthcare.gov. 83 Fed. Reg. at 16,974-75; *see* 45 C.F.R. § 155.20. Eliminating standardized options will make it "more difficult for consumers to compare the choices available to them," increasing the odds that consumers will not enroll at all or that they will enroll in plans that are worse for them, particularly among healthy consumers. Young Decl. ¶ 36; *see, e.g.*, AR1172 (Leukemia & Lymphoma Society), 1623 (Center on Budget and Policy Priorities), 1695-96 (National Psoriasis Foundation), 1949-50 (Young Invincibles). Moreover, eliminating standardized options may undermine competition between plans, thereby increasing premiums. Young Decl. ¶ 37; *see also* AR2836 (Washington Health Plan Finder).

E. Undermining the Navigator program

The Affordable Care Act also provided for the designation of "Navigators" that assist consumers in enrolling in ACA-compliant health insurance on the Exchanges. Under prior rules, every Exchange needed to have two Navigators, one being a community- and consumer-focused nonprofit, and those Navigators had to have a physical presence in the areas they serve. The 2019 Rule eliminates these requirements. 83 Fed. Reg. at 16,979-81; *see* 45 C.F.R. § 155.210.

Abolishing these requirements allows the designation of Navigators that cannot fulfill their statutory duties. Specifically, "fewer Navigator grantees will mean fewer sources of consumer assistance," Young Decl. ¶ 40; "[a]warding grants to entities that do not have a physical presence in the service area means that affected consumers will no longer be able to receive in-person assistance," *id.* ¶ 41; and "preventing consumers from receiving assistance from a community-based non-profit will mean that affected consumers cannot get assistance from a trusted local partner," *id.*; *see also* Families USA *Amici* Br. at 7 (explaining that, as a result of Defendants' changes, "nine additional states had no navigators in large parts of their state"); House *Amicus* Br. at 3, 11 (explaining that eliminating the "physical presence" requirement "seriously undermin[es] their effectiveness").

These concerns were thoroughly documented in the administrative record. *See, e.g.*, AR682 (Arizona Alliance for Community Health Centers), 728 (Generations Health Care Initiatives), 797 (Healthy Asian Americans Project), 810 (National Center for Health Research), 889 (Human Rights Campaign), 908 (Consumers Union), 931 (Health & Medicine Policy Research Group), 948 (United Way of Anchorage), 1107 (Nebraska Appleseed), 1117 (New Mexico Superintendent of Insurance), 1172 (Leukemia & Lymphoma Society), 1189 (National Partnership for Women & Families), 1314 (Chronic Illness & Disability Partnership), 1446 (American Diabetes Association), 1503 (Myotonic Dystrophy Foundation), 1520 (American Osteopathic Association), 1590 (American Thoracic Society), 1616 (Alaska Division of Insurance), 1623-24 (Center on Budget and Policy Priorities), 1695 (National Psoriasis Foundation), 1712 (DC Health Benefit Exchange Authority), 1784 (Health Care for All New York), 1809 (American Lung Association), 1820 (Association of Asian Pacific Community Health Organizations), 1947 (Young Invincibles), 1962 (Coalition for Whole Health), 2029 (Tennessee Justice Center), 2062 (former Acting Administrator of CMS), 2096 (Charlotte Center for Legal Advocacy), 2151 (American Heart Association et al.), 2276 (Catholic Health Initiatives), 2517 (American Association of Retired People), 2544 (MNsure), 2587 (Asian and Pacific Islander American Health Forum), 2680 (America's Health Insurance Plans), 2718 (American Cancer Society Cancer Action Network), 2736 (Families USA), 2855 (Disability Rights Education & Defense Fund), 3009 (Planned Parenthood Federation of America), 3121 (Farmworker Justice), 3484 (Unidos US).

By "making it harder for individuals to find trusted assistance suitable to their unique needs, … these changes will decrease enrollment in coverage and increase the uninsured rate." Young Decl. ¶ 42. These changes will disproportionately deter healthy individuals, who are generally less willing to overcome administrative burdens to receive coverage, thereby worsening the risk pool and increasing premiums. *Id.* ¶¶ 14-15. As the American Hospital Association explained in commenting on the 2019 Rule, "proposed changes to the Navigator Program could reduce the number of individuals enrolled, which also could increase costs by

concentrating risk among fewer individuals." AR2001; *see also* AR1882-83 (comment by American Cancer Society Cancer Action Network et al. explaining that eliminating Navigator requirements would yield "greater confusion and less confidence in health insurance," yielding "increased costs as the individual and small group risk pools worsen over time"); Aaron *Amicus* Br. at 12 ("Without access to Navigators, consumers who need assistance when shopping for and enrolling in a health care plan are more likely to go without insurance.").

F. Weakening small business Exchanges

Exchanges under the Affordable Care Act are directed to "provide[] for the establishment of a Small Business Health Options Program." 42 U.S.C. § 18031(b)(1)(B). These "SHOPs" are "designed to assist … small employers in facilitating the enrollment of their employees in qualified health plans offered in the small group market." *Id.* The Act further requires SHOP Exchanges to "make available qualified health plans to … qualified employers," *id.* § 18031(d)(2)(A); to protect employers' and employees' ability to choose between certain qualified health plans, *id.* § 18032(a)(2); and to protect employees' ability to enroll even after their employer no longer qualifies as a small employer under the Act, *id.* § 18024(b)(4)(D). In past years, CMS interpreted the Act as requiring SHOPs to perform certain functions, like determining employee eligibility, aggregating premiums, and enrolling employees online, to make them as user-friendly as possible. 83 Fed. Reg. at 16,996.

However, Defendants have now reinterpreted the Act to remove these requirements. *Id.* at 16,996-706; *see* 45 C.F.R. § 700 *et seq.* This change "increases administrative barriers to enrollment for both small businesses and their individual enrollees." Young Decl. ¶ 44; *see also* AR1715 (comment by DC Health Benefit Exchange Authority explaining that removal of premium aggregation would make it "difficult or impossible for small businesses to offer a choice of multiple insurers and plans to their employees"). Indeed, in promulgating the 2019 Rule, Defendants acknowledged that their changes would further decrease the use of SHOPs, yielding a "[d]ecrease in user fee transfers … of approximately $6 million" in 2019. 83 Fed. Reg. at 17,045; *see also* AR270 (Proposed Rule). Specifically, "[t]he small business decisionmaker

may find it harder to compare plans and choose among options, increasing 'choice overload,'" which "could deter some businesses from enrolling at all, especially very small firms," and for others, "decrease the quality of the decisions made." Young Decl. ¶ 46. These changes will also "likely deter some individual enrollees from enrolling in coverage, or will result in those who do enroll being less satisfied with their coverage and less likely to stay enrolled over time," putting "upward pressure on the uninsured rate." *Id*.

G. Imposing burdensome and unnecessary income verification requirements

The Affordable Care Act seeks to lower the cost of health insurance on the individual market by allocating advance premium tax credits to consumers who have income between 100 and 400 percent of the federal poverty line (FPL). *See* 26 U.S.C. § 36B(c)(1)(A); 42 U.S.C. §§ 18081, 18082. Because lower-income households frequently experience substantial and unpredictable fluctuations in income, previous rules required Exchanges to "accept a consumer's attestation" of income between 100-400 percent FPL even if available government data sources indicate that their income is below 100 percent FPL. 83 Fed. Reg. at 16,985-87. The 2019 Rule removes that limitation and requires Exchanges to "request additional documentation to protect against overpayment of APTC" where data sources reveal a discrepancy. *Id.* at 16,985; *see* 45 C.F.R. § 155.320(c).

By increasing the likelihood that consumers will experience a data matching issue that prevents them from enrolling in coverage, the 2019 Rule creates "exactly the kind of administrative barrier that substantially reduces enrollment." Young Decl. ¶ 48. "[L]ow income consumers are likely to experience the greatest difficulty in obtaining income documentation, successfully mailing or uploading their documents, and in maintaining the mental bandwidth to complete these tasks on time." *Id.* ¶ 51. Such consumers are also particularly likely "to have fluctuating income, part-year or part-time employment, and multiple employers." *Id.* These concerns were also thoroughly highlighted in the administrative record. *See, e.g.*, AR909 (Consumers Union), 935-36 (Health & Medicine Policy Research Group), 1340-41 (Tennessee Health Care Campaign), 1449 (American Diabetes Association), 1458 (National Association of

Health Access Assisters), 1627-28 (Center on Budget and Policy Priorities), 1643-44 (Association of American Medical Colleges), 1824 (Association of Asian Pacific Community Health Organizations), AR1859 (Community Catalyst), 1943-44 (Young Invincibles), 2063 (former Acting Administrator of CMS), 2682-83 (America's Health Insurance Plan), 2720 (American Cancer Society Cancer Action Network), 2738 (Families USA), 3122-23 (Farmworker Justice), 3486 (Unidos US), 3529 (National Health Council).

Thus, "this policy change is likely to increase the uninsured rate as consumers lose their financial assistance (and therefore their coverage) due to a DMI." Young Decl. ¶ 51. That sort of administrative barrier is especially likely to deter healthy consumers from enrolling, thereby harming the risk pool and driving up premiums. Young Decl. ¶¶ 14-15; AR2063 (former Acting Administrator of CMS explaining that "this would likely discourage eligible and likely relatively healthy people"); Aaron *Amicus* Br. at 14 (referencing "studies showing that increased paperwork burdens reduce enrollment in health insurance, particularly for the healthy individuals essential to maintaining stable insurance markets").

H. Curtailing insurance rate review

Under the ACA, "[t]he Secretary, in conjunction with States, shall establish a process for the annual review … of unreasonable increases in premiums for health insurance coverage." 42 U.S.C. § 300gg-94(a)(1). To fulfill that duty, CMS promulgated regulations requiring insurers to justify annual rate increases above a certain threshold. *See* 45 C.F.R. §§ 154.101 *et seq*. The 2019 Rule scales back rate review by exempting student health plans, *see* 83 Fed. Reg. at 16,972, and by raising the threshold for rate review to rate increases of 15 percent rather than the current threshold of 10 percent, *id.* at 16,972-73; *see* 45 C.F.R. §§ 154.103, 154.200.

These changes can be expected to increase premiums by curtailing the rate review process, which has been shown to lower premiums. Young Decl. ¶ 55. Both changes also mean that insurers will face less pressure to justify their rate filings publicly. *Id.* ¶ 52. By driving up premiums, these changes will naturally increase the uninsured rate as well. *Id.* ¶ 7.

Specifically, Defendants' decision to raise the rate review threshold to 15 percent exempts "many rates from the review process, and means that rate review will have less of an impact on insurer behavior." *Id.* ¶ 55. In proposing the 2019 Rule, Defendants estimated that it would result in 125 fewer "written justifications," or about 16 percent fewer than before. AR247. Many commenters stressed that this change would "normalize excessive rate increases." AR903 (Consumers Union); *see, e.g.*, AR1104 (American College of Rheumatology), 1313 (The Chronic Illness & Disability Partnership), 1339 (Tennessee Health Care Campaign), 1503 (Myotonic Dystrophy Foundation), 1623 (Center on Budget and Policy Priorities), 1696-97 (National Psoriasis Foundation), 1782 (Health Care for All New York), 1808-09 (American Lung Association), 1855-56 (Community Catalyst), 1880 (American Cancer Society Cancer Action Network et al.), 2005-06 (American Hospital Association), 2029 (Tennessee Justice Center), 2039 (California Department of Insurance), 2138 (Federation of American Hospitals), 2150 (American Heart Association et al.), 2287-88 (U.S. Public Interest Research Group), 2512 (American Association of Retired People), 2733-34 (Families USA), 2836 (Washington Health Plan Finder), 2936 (Wisconsin Hospital Association), 3221 (West Virginia Together for Medicaid), 3439 (Colorado Consumer Health Initiative), 3529 (National Health Council).

The same is true of the exemption for student health plans. "Without rate review, students could see their premiums skyrocket and insurers could be incentivized to generate higher profits on products requiring less transparency." AR1945 (Young Invincibles); *see also* AR1339 (Tennessee Health Care Campaign), 1697 (National Psoriasis Foundation), 1782 (Health Care for All New York). In proposing the 2019 Rule, Defendants estimated that "75 student health insurance issuers [would] no longer be required to submit rate increases to HHS," and "that States will no longer submit rate increases for 188 student health insurance plans to HHS." 83 Fed. Reg. at 17,038; *see also* AR1622 (comment by the Center on Budget and Policy Priorities explaining that "[i]ncreased transparency about health insurance rates, including for plans that specifically serve students, has been an important advancement in recent years").

I. Reducing medical loss ratio rebates

Under the Affordable Care Act, insurers must pay rebates if the "medical loss ratio," or the percentage of each premium that they spend on paying claims and improving their services, drops below 85 percent (for large group insurance plans) or 80 percent (for small group and individual insurance plans). 42 U.S.C. § 300gg-18(b)(1)(A). "MLR standards … are intended to help ensure policyholders receive value for their premium dollars," and "also to create incentives for issuers to become more efficient in their operations." 75 Fed. Reg. 74,864, 74,866, 74,875 (Dec. 1, 2010).

The 2019 Rule, however, allows insurers to claim a flat 0.8 percent for "quality improvement activities" (QIA), rather than a percent based on the amount actually spent on such activities. 83 Fed. Reg. at 17,032-33; *see* 45 C.F.R. § 158.221. By allowing insurers to claim a flat credit, Defendants can "charge a higher premium without paying rebates." Young Decl. ¶ 58. Thus, "some consumers will receive smaller rebates than they otherwise would have and some issuers will charge slightly higher premiums because they have a larger cushion before they must begin rebating consumers." *Id.* ¶ 59. Indeed, in promulgating this provision, Defendants estimated that it would reduce rebates by approximately $23 million. 83 Fed. Reg. at 17,054; *see also* AR1636 (comment by the Center on Budget and Policy Priorities explaining that the change would "automatically giv[e] insurers credit in the MLR for conducting quality improvement activities, thus reducing consumer rebates, even if the insurers spend only trivial amounts on quality improvement"), 1867 (comment by Community Catalyst that "this proposal could result in a consumer losing their rebate while essentially providing insurers with an undeserved giveaway"). And Defendants expressly predicted that it would lead to "[p]otential increases in premiums." 83 Fed. Reg. at 17,046; AR270.

These increases in premiums will drive up the uninsured rate. Young Decl. ¶ 7. Moreover, the provision "allows issuers to claim credit for quality improvement activities without actually improving the quality of health care services." *Id.* ¶ 59. That concern, too, was thoroughly documented in the record. *See, e.g.*, AR741 (National Committee for Quality

Assurance), 914-15 (Consumers Union), 1088-89 (American Medical Association), 1598 (Washington Insurance Commissioner), 1782-83 (Health Care for All New York), 1946-47 (Young Invincibles), 2004-05 (American Hospital Association), 2143-44 (Federation of American Hospitals), 2157-58 (American Hospital Association & American Stroke Association), 2290 (U.S. Public Interest Research Group), 2712-13 (Service Employees International Union), 2730 (American Cancer Society Cancer Action Network), 2748-49 (Illinois Attorney General), 2842 (Washington Health Plan Finder), 2935-36 (Wisconsin Hospital Association), 3016 (Planned Parenthood Federation of America), 3227-28 (West Virginia Together for Medicaid), 3444 (Colorado Consumer Health Initiative).

III. Plaintiffs' harms from the 2019 Rule

Plaintiffs are paying the price for Defendants' actions and have brought suit to stop them. The City Plaintiffs are the cities of Columbus, Ohio; Baltimore, Maryland; Cincinnati, Ohio; Chicago, Illinois; and Philadelphia, Pennsylvania, which collectively represent over six million residents. The Individual Plaintiffs are Steve Vondra and Bonnie Morgan, two individuals now living in Corvallis, Oregon, who purchase insurance on the individual market. Each set of Plaintiffs has been harmed in the following ways.

A. The City Plaintiffs' harms

Each of the City Plaintiffs administers programs that provide uncompensated care to their residents, regardless of insurance status. These programs experience greater costs as the under- and uninsured rates go up, including in response to the challenged provisions of the 2019 Rule.

First, each of the City Plaintiffs operates a Health Department that provides, supports, and/or funds free- or reduced-cost health clinics to their residents. *See* Arwady Decl. ¶¶ 7-10; Dzirasa Decl. ¶¶ 6-7; Hinckley Decl. ¶¶ 7-13; Johnson Decl. ¶¶ 7-9; Muething Decl. ¶¶ 7-10. Those departments also provide other programs designed to address specific health issues in the community. *See* Arwady Decl. ¶ 23; Dzirasa Decl. ¶ 8; Johnson Decl. ¶ 10; Muething Decl. ¶ 11; As each of the City Plaintiffs attests, these programs experience increased costs as the under- and uninsured rates go up. *See* Arwady Decl. ¶ 9; Dzirasa Decl. ¶ 9; Hinckley Decl. ¶¶ 11-13;

Johnson Decl. ¶ 13; Muething Decl. ¶¶ 9-11. Chicago also provides support to and partners with local safety-net hospitals. Arwady Decl. ¶¶ 12-14.

Second, each of the City Plaintiffs operates an emergency medical services system that answers calls and provides ambulance transports to their residents, regardless of their insurance status. *See* Arwady Decl. ¶¶ 15-19; Hinckley Decl. ¶¶ 14-16; Johnson Decl. ¶¶ 11-13; Matz Decl. ¶¶ 4-5; Muething Decl. ¶¶ 12-16. In general, the City Plaintiffs recoup a minute fraction of the costs they incur to provide such services to their under- and uninsured residents, meaning that more uninsured transports means more costs. *See* Arwady Decl. ¶ 18; Matz Decl. ¶ 6; Muething Decl. ¶ 16; Hinckley Decl. ¶ 15; Johnson Decl. ¶ 13. As under- and uninsured rates have increased, several City Plaintiffs have specifically seen more calls from under- and uninsured individuals, in part because, in their experience, such individuals are more likely to use emergency services. *See* Arwady Decl. ¶¶ 18-19; Hinckley Decl. ¶ 16; Muething Decl. ¶¶ 13-15.

The relationship between under- and uninsured rates and uncompensated care costs is corroborated by extensive academic literature. As Christen Linke Young, a fellow with the USC-Brookings Schaeffer Initiative for Health Policy, explains, there is a well-established connection between policies that increase the under- and uninsured rates and increased costs for entities, like the City Plaintiffs, that provide uncompensated care. Young Decl. ¶¶ 60-66. When the Act decreased the uninsured rate by 20 million individuals, it simultaneously decreased spending on uncompensated care by billions. *Id.* ¶¶ 62-63. "That drop in uncompensated care costs is likely associated with the ACA's expansion of subsidized coverage that is comprehensive in scope and covers people with preexisting conditions, which gave vastly more people an affordable and non-discriminatory path to comprehensive coverage." *Id.* ¶ 64. In contrast, the non-ACA-compliant plans favored by the Trump Administration "would not be expected to reduce uncompensated care costs to the same degree as ACA-compliant coverage." *Id.* ¶ 65; *see also* Br. for *Amici Curiae* California et al. at 14, ECF No. 72 ("It is axiomatic that when the number of uninsured individuals rise, uncompensated care costs rise as well."); *Amicus* Br. of 13 Counties & Cities at

11, ECF No. 66-1 (explaining that while "[t]he ACA overwhelmingly reduced Amici's uncompensated costs," "Defendants' efforts to make the ACA fail aim to undo these gains").

Uninsured individuals also seek care in ways that increase costs for local governments and other providers. Specifically, studies show that "uninsured and underinsured individuals are more likely to use services like free clinics, community health centers, and emergency medical services," for which "local governments often bear a significant share of the costs." Young Decl. ¶ 66. Such individuals also delay care, allowing conditions to worsen and become more expensive, *id.* ¶¶ 67-73, lack a usual source of care, *id.* ¶ 70, "seek care in high acuity settings like an emergency room or other emergency facility," *id.* ¶ 71, and obtain treatment in person, thereby further straining health systems, *id.* ¶ 72. Thus, increases in the uninsured and underinsured rates predictably increase the cost to local governments of providing uncompensated care services, including through the clinics, community health centers, safety net hospitals, and emergency medical services supported by the City Plaintiffs.

Congress recognized this connection in enacting the Affordable Care Act. Indeed, Congress sought "to expand coverage in the individual health insurance market," *King*, 576 U.S. at 478-79, in part because the "cost of providing uncompensated care to the uninsured" is high, 42 U.S.C. § 18091(2)(F). Those costs were discussed at length during the debates over the Act. *See, e.g.*, 155 Cong. Rec. S13800 (daily ed. Dec. 23, 2009) (statement of Sen. Kaufman) ("Rising medical costs, skyrocketing premiums, increasing numbers of the uninsured and the strain on both business and providers have brought the critical need for health reform back to the Senate this year. Make no mistake, we need health care reform now."); 155 Cong. Rec. S14126 (daily ed. Dec. 24, 2009) (statement of Sen. Akaka) ("Our health care providers are struggling to meet the increasing burdens imposed on them by greater numbers of uninsured patients and rising costs."); 156 Cong. Rec. H1880 (daily ed. Mar. 21, 2010) (statement of Rep. Jackson Lee) (claiming that in her district, the Act would "[r]educe the cost of uncompensated care for hospitals and other health care providers by $27 million annually"); 156 Cong. Rec. H1871 (daily ed. Mar. 21, 2010) (statement of Rep. Ellison) ("When insurance coverage for 358,000

Fifth District residents is improved—and when the cost of uncompensated care for hospitals and other health care providers is reduced by $101 million—that is positive change.").

Defendants, too, have acknowledged the connection between greater rates of under- and uninsured Americans and greater uncompensated care costs. Drawing on the evidence above, HHS concluded in several reports issued by the Assistant Secretary for Planning and Evaluation that "uncompensated care costs will continue to fall substantially following major insurance coverage expansions." RJN Exs. 8, 9 at 1. As HHS recognized, "it is critical to determine how [uncompensated care] is changing following coverage expansion so as to avoid shifting a large financial burden to states, localities, and hospitals." RJN Ex. 9 at 5; *see also* RJN Ex. 10 at 4, 33-34 ("Expanded coverage has also reduced the burden of medical debt and generated corresponding reductions in the amount of uncompensated care."). Similarly, in promulgating the 2019 Rule, Defendants noted that changes in coverage can lead to "spillover effects," like "increased use of emergency services or increased use of public services provided by the State or other government entities." 83 Fed. Reg. at 17,052; AR291 (Proposed Rule). Thus, the 2019 Rule harms the City Plaintiffs by driving up the costs they must pay to provide uncompensated care to their residents.

B. The Individual Plaintiffs' harms

The Individual Plaintiffs, Steve Vondra and Bonnie Morgan, have purchased and will continue to purchase health insurance on the Affordable Care Act's Exchanges. At the time of filing the Amended Complaint, Steve and Bonnie lived in Charlottesville, Virginia, Vondra Decl. ¶ 2, but they moved to Corvallis, Oregon in July 2020, *id.* ¶ 10. Steve has a preexisting condition that, before the ACA, prevented him from obtaining health insurance. *Id.* ¶ 5. As a result of the Act's individual market reforms, he and Bonnie were finally able to purchase insurance on Virginia's Exchange. *Id.* ¶ 6. For 2016, they enrolled in a Bronze plan with a premium of around $1,050 a month for the two of them, and subsequently upgraded their coverage for 2017 to a Silver plan with a premium of around $1,270 a month. *Id.*

However, for 2018, they began to pay sharply more for coverage. Their premiums spiked nearly threefold to $3,327.65, with an annual deductible around $14,400. *Id.* ¶ 7. Their premiums decreased slightly in 2019 (to $1,899.49) and 2020 (to $1,576.71), with comparable deductibles, but did not return to their pre-2018 levels. *Id.* ¶ 8-9.

Since moving to Oregon, Steve and Bonnie have applied to purchase a Bronze plan offered by PacificSource Health Plans, with a monthly premium of $1,608 and a $13,500 deductible. *Id.* ¶ 11. Combining a year's worth of premiums and the annual deductible, they would still have to spend around $32,796 before receiving any benefit from their insurance. *Id.* For 2021, they intend to continue purchasing their insurance on Oregon's Exchange. *Id.* ¶ 12.

Steve and Bonnie have been forced to pay higher premiums than they otherwise would as a consequence of the challenged provisions of the 2019 Rule. As noted above, several of the challenged provisions of the 2019 Rule, including eliminating federal review of network adequacy, eliminating standardized options, curtailing insurance rate review, and reducing medical loss ratio rebates, directly increase the cost of coverage. Those changes, as well as eliminating direct notification requirements, reducing oversight of direct enrollment, undermining the Navigator program, and imposing income verification requirements, also deter enrollment, particularly among young, healthy people, and therefore increase premiums indirectly. Thus, the challenged provisions of the 2019 Rule have caused the Individual Plaintiffs' premiums to be higher than they would otherwise be.

IV. Procedural history

The cities of Columbus, Baltimore, Cincinnati, and Chicago, along with the Individual Plaintiffs, filed suit on August 2, 2018. ECF No. 1. Those Plaintiffs, joined by the city of Philadelphia, filed an Amended Complaint ("AC") on January 25, 2019. ECF No. 44.

The Amended Complaint asserts two causes of action. ***First***, Plaintiffs challenge the enumerated provisions of the 2019 Rule under the Administrative Procedure Act, *see* 5 U.S.C. § 706(2), alleging that several of those provisions are contrary to the Affordable Care Act and other applicable laws, and that all of those provisions are arbitrary and capricious. *See* AC ¶¶ 50-

98, 279-82. ***Second***, Plaintiffs assert a claim under the Constitution's Take Care Clause, alleging that the challenged provisions of the 2019 Rule as well as additional actions taken by Defendants to undermine the Affordable Care Act violate the Executive's obligation to "take care that the [Act] be faithfully executed." U.S. Const. art. II, § 3; *see* AC ¶¶ 99-180, 283-85.

Defendants moved to dismiss the Amended Complaint, which the Court granted in part and denied in part on April 10, 2020. ECF Nos. 102 (hereinafter "MTD Op."), 103.[1] The Court held that Plaintiffs had plausibly alleged that they had standing to challenge the provisions of the 2019 Rule and that their claims were ripe. MTD Op. at 23-41. With respect to injury-in-fact, the Court held that the Individual Plaintiffs suffered injury from having to pay increased premiums to obtain insurance, *id.* at 27, and that the City Plaintiffs suffered injury from having to pay greater costs to provide uncompensated care to their under- and uninsured residents, *id.* at 28-29.

Turning to causation and redressability, the Court held that Plaintiffs had plausibly alleged that "insureds and issuers would react in predictable ways to Defendants' actions." *Id.* at 32. Specifically, as to the 2019 Rule, the Court credited the Amended Complaint's allegations that the 2019 Rule would harm health insurance markets in the ways described above. *Id.* at 35-36. The Court also held that Plaintiffs had plausibly alleged that their requested relief "would redress [their] injuries by ameliorating the predictable results of the Defendants' challenged actions." *Id.* at 39-40.

The Court then turned to the merits. As to Plaintiffs' APA claim, the Court held that it would be "premature" to decide whether the challenged provisions of the 2019 Rule were arbitrary and capricious until Defendants produced the administrative record, and that "although the contrary to law challenge is not necessarily premature, it is underdeveloped." *Id.* at 43. The

[1] The Court also granted leave to five groups of *amici curiae*, including the U.S. House of Representatives, thirteen other cities and counties, four non-profit health advocacy organizations, and two independent health economists, to file briefs in support of Plaintiffs' opposition to Defendants' motion to dismiss. ECF No. 102; *see* ECF Nos. 65-1, 66-1, 67-1, 71-1, 76-1. Those *amici* were also joined by a coalition of states in opposition to Defendants' motion. *See* ECF No. 72. Those briefs remain relevant to the Court's consideration of the parties' cross-motions for summary judgment, as explained herein.

Court noted, however, that while "Defendants here attempt 'to interpret and apply' the ACA[,] … they fail to grapple with Congress's intent." *Id.* at 57. The Court therefore denied Defendants' motion to dismiss as to the APA claim. *Id.* However, the Court granted Defendants' motion as to Plaintiffs' Take Care Clause claim, holding that it failed to state a cause of action. *Id.* at 67.

Plaintiffs now move for summary judgment on their APA claim.

LEGAL STANDARD

Typically, "[t]he court shall grant summary judgment 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. "In a case involving review of a final agency action under the APA, however, the standard set forth in Rule 56(a) does not apply because of the limited role of a court in reviewing the administrative record." *Ctr. for Sci. in the Pub. Interest v. Perdue*, 438 F. Supp. 3d 546, 556 (D. Md. 2020). "Summary judgment thus serves as a mechanism for deciding, as a matter of law, whether the agency action is supported by the administrative record and is otherwise consistent with the APA standard of review." *Id.* at 557.

ARGUMENT

I. Plaintiffs have standing to challenge the 2019 Rule.

The principles governing Plaintiffs' standing are familiar. "To meet the constitutional minimum requirements for standing to sue, a 'plaintiff must have … suffered an injury in fact, … that is fairly traceable to the challenged conduct of the defendant, and … that is likely to be redressed by a favorable judicial decision.'" *Curtis v. Propel Prop. Tax Funding, LLC*, 915 F.3d 234, 240 (4th Cir. 2019) (quoting *Spokeo, Inc. v. Robins*, 136 S. Ct. 1540, 1547 (2016)). In particular, it is black-letter law that "standing does not require the challenged action to be the sole or even immediate cause of the injury," *Sierra Club v. Dep't of the Interior*, 899 F.3d 260, 284 (4th Cir. 2018). A plaintiff need only show that, in response to the challenged action, "third parties will likely react in predictable ways" that cause the plaintiff's harms. *Dep't of Com. v. New York*, 139 S. Ct. 2551, 2566 (2019). Causation and redressability also "often overlap[]," because an order setting aside an action that causes the plaintiff's harms will typically redress

those harms as well. *Friends of the Earth, Inc. v. Gaston Copper Recycling Corp.*, 204 F.3d 149, 154 (4th Cir. 2000).

As Plaintiffs have now shown, the 2019 Rule predictably harms insurance markets—and Plaintiffs—by driving up premiums, making it more difficult to enroll, and ultimately, increasing the rates of the under- and uninsured. Indeed, Plaintiffs have now corroborated the allegations that the Court found sufficient to plausibly allege standing. *See* MTD Op. at 35-36.

A. The City Plaintiffs have standing.

The City Plaintiffs have standing because the 2019 Rule predictably increases the uninsured rate above what it would otherwise be and thereby inflicts greater uncompensated care costs upon each of the City Plaintiffs' budgets. As the Court acknowledged in its earlier decision, a city has standing "when a harm *to the city itself* has been alleged." *Olmsted Falls v. FAA*, 292 F.3d 261, 268 (D.C. Cir. 2002). As a matter of law, these pocketbook injuries therefore "satisfy the first element of constitutional standing." MTD Op. at 29; *see, e.g.*, *New York*, 139 S. Ct. at 2566; *U.S. House of Reps. v. Price*, 2017 WL 3271445, at *1 (D.C. Cir. 2017) (per curiam); *Texas v. United States*, 945 F.3d 355, 386-87 (5th Cir. 2019), *cert. granted*, 140 S. Ct. 1262 (2020); *California v. Azar*, 911 F.3d 558, 571 (9th Cir. 2018).

Plaintiffs have now established that the challenged provisions of the 2019 Rule drive up the uninsured rate and that their vacatur would redress that effect. And there is no reasonable dispute that each of the City Plaintiffs can be expected to bear increased costs as the uninsured rate increases. They do so in two principal ways. ***First***, the City Plaintiffs provide forms of health services to their uninsured and underinsured residents, including free or reduced-cost health clinics, safety net hospitals, and/or other programs designed to ensure health and wellness. ***Second***, the City Plaintiffs provide emergency medical transports to their residents regardless of insurance status, but typically recoup only a minute fraction of the costs for providing such services to uninsured patients. The challenged provisions of the 2019 Rule therefore increase the costs the City Plaintiffs can expect to bear to provide both sets of services, and an order setting aside those provisions would decrease those costs. *See supra* pages 20-23.

B. The Individual Plaintiffs have standing.

The Individual Plaintiffs similarly have standing because the challenged provisions of the 2019 Rule predictably increase the premiums they must pay to obtain health insurance. As this Court has already held, an "increase in premiums constitutes economic harm and is therefore 'a classic and paradigmatic form of injury in fact[.]'" MTD Op. at 27 (quoting *Air Evac EMS, Inc. v. Cheatham*, 910 F.3d 751, 760 (4th Cir. 2018)); *see, e.g.*, *Stewart v. Azar*, 313 F. Supp. 3d 237, 252 (D.D.C. 2018) ("Plaintiffs would be required to pay increased premiums and thus would suffer a concrete injury."); *AARP v. EEOC*, 226 F. Supp. 3d 7, 18 (D.D.C. 2016) ("An increase in premiums would certainly constitute an injury.").

Much like the City Plaintiffs, the Individual Plaintiffs have also shown that the challenged provisions of the 2019 Rule are responsible for premiums that are higher than they would otherwise be, and that vacating those provisions would remedy their effects. In this respect, Plaintiffs' showing is quite similar to that put forward by the individual plaintiffs in *California v. Texas*, where the federal government has declined to defend the Affordable Care Act's constitutionality. There, the government recently admitted once again, this time to the Supreme Court, that "individual plaintiffs … are injured" by policies that "increase their costs of obtaining coverage." Consol. Opening Br. on the Merits for the Fed. Resps. at 17, *California v. Texas*, Nos. 19-840 & 19-1019 (June 25, 2020). As the government explained, the plaintiffs in that case had purportedly shown that the provisions challenged in that case "operate to increase the cost of obtaining insurance for some individuals … who otherwise could obtain less expensive coverage." *Id.* at 17-18. The same is true here. *See supra* pages 23-24.

II. The 2019 Rule is unlawful.

Given how the challenged provisions of the 2019 Rule thoroughly undermine insurance markets, driving up premiums and driving people off ACA-compliant health insurance, it should be no surprise that they are also unlawful. The Administrative Procedure Act mandates that a "court shall … hold unlawful and set aside agency action … found to be arbitrary, capricious, an

abuse of discretion, or otherwise not in accordance with law," 5 U.S.C. § 706(2)(A). Several background principles inform a court's review of agency action under the APA.

It should go without saying that an agency's action cannot be upheld where it conflicts with the governing statute. "An agency has no power to 'tailor' legislation to bureaucratic policy goals by rewriting unambiguous statutory terms," *Util. Air Reg. Grp. v. EPA*, 573 U.S. 302, 325 (2014), and an agency cannot "modify unambiguous requirements imposed by a federal statute," *id.* at 327. While an agency is entitled to deference under *Chevron* when interpreting ambiguous statutory terms, "an agency's interpretation of a statute is not entitled to deference when it goes beyond the meaning that the statute can bear." *MCI Telecomms. Corp. v. AT&T Co.*, 512 U.S. 218, 229 (1994).

Even where the agency's decision is consistent with "the agency's authorizing statute," it must still show that it "engaged in reasoned decisionmaking." *Animal Legal Def. Fund, Inc. v. Perdue*, 872 F.3d 602, 619 (D.C. Cir. 2017). "One of the basic procedural requirements of administrative rulemaking is that an agency must give adequate reasons for its decisions." *Encino Motorcars, LLC v. Navarro*, 136 S. Ct. 2117, 2125 (2016). The Court must therefore "ensure that the agency has examined the relevant data and articulated a satisfactory explanation for its action." *N.C. Wildlife Fed'n v. N.C. Dep't of Transp.*, 677 F.3d 596, 601 (4th Cir. 2012) (quotations omitted). To that end, the court must "engage in a 'searching and careful' inquiry of the record," rather than simply "rubber-stamp" the agency's decision. *Ohio Valley Envtl. Coal. v. Aracoma Coal Co.*, 556 F.3d 177, 192 (4th Cir. 2009) (quoting *Citizens to Preserve Overton Park, Inc. v. Volpe*, 401 U.S. 402, 416 (1971)); *see* MTD Op. at 44.

In *State Farm*, the Supreme Court outlined the circumstances in which an agency's action must be set aside as arbitrary and capricious. 463 U.S. at 43. Specifically, an agency's decision must be set aside where the agency "relied on factors which Congress has not intended it to consider, entirely failed to consider an important aspect of the problem, offered an explanation for its decision that runs counter to the evidence before [it]," or where the decision "is so implausible that it could not be ascribed to a difference in view or the product of agency

expertise." *Id.* These requirements are not mere buzzwords—each imposes a vital guardrail on the agency's exercise of its discretion.

Relied on factors which Congress has not intended it to consider. It is fundamental that "the President and federal agencies may not ignore statutory mandates or prohibitions merely because of policy disagreement with Congress." *In re Aiken Cty.*, 725 F.3d 255, 260 (D.C. Cir. 2013). Indeed, agencies are "bound, not only by the ultimate purposes Congress has selected, but by the means it has deemed appropriate, and prescribed, for the pursuit of those purposes." *Gresham v. Azar*, 950 F.3d 93, 101 (D.C. Cir. 2020) (quoting *MCI Telecomms. Corp.*, 512 U.S. at 231 n.4). The agency therefore cannot elevate other non-statutory objectives over the "principal objective" of the statutory scheme. *Id.*

Entirely failed to consider an important aspect of the problem. The agency must weigh both the "potential harms" and "additional … costs" of its chosen course of action. *SecurityPoint Holdings, Inc. v. TSA*, 769 F.3d 1184, 1188 (D.C. Cir. 2014). "An agency also violates this standard if it fails to respond to 'significant points' and consider 'all relevant factors' raised by the public comments," *Carlson v. Postal Reg. Comm'n*, 938 F.3d 337, 344 (D.C. Cir. 2019) (citation omitted)—"[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. In *Gresham*, for example, the agency elevated alternative objectives over the Medicaid statute's primary purpose of "providing health care coverage" and failed to consider significant comments explaining how the agency's policy would decrease Medicaid coverage. *Id.* at 102.

Offered an explanation for its decision that runs counter to the evidence. In reviewing agency action, the Court cannot "defer to the agency's conclusory or unsupported suppositions," *United Techs. Corp. v. U.S. Dep't of Def.*, 601 F.3d 557, 562 (D.C. Cir. 2010) (quoting *McDonnell Douglas Corp. v. Dep't of the Air Force*, 375 F.3d 1182, 1187 (D.C. Cir. 2004)). "An unjustified leap of logic or unwarranted assumption … can erode any pillar underpinning an agency action, whether constructed from the what-is or the what-may-be." *Friends of Back Bay v. U.S. Army Corps of Eng'rs*, 681 F.3d 581, 588 (4th Cir. 2012). And an agency's appeal to its

"expert judgment" is unavailing if it does not "point … to any data of the sort it would have considered if it had considered [the issue] in any meaningful way." *Nat'l Treasury Emps. Union v. Horner*, 854 F.2d 490, 499 (D.C. Cir. 1988).

So implausible that it could not be ascribed to a difference in view or the product of agency expertise. "An agency acts arbitrarily and capriciously when it offers inaccurate or unreasoned justifications for a decision." *Envtl. Def. Fund v. EPA*, 922 F.3d 446, 454 (D.C. Cir. 2019). An agency's decision therefore cannot be upheld where it is "so implausible that it does not represent reasonable administration" of the statutory scheme. *Bedford Cty. Mem'l Hosp. v. Health & Human Servs.*, 769 F.2d 1017, 1022 (4th Cir. 1985).

These requirements apply with special force where the agency has "change[d] [its] existing policies." *Encino Motorcars*, 136 S. Ct. at 2125 (citing *Nat'l Cable & Telecomm. Ass'n v. Brand X Internet Servs.*, 545 U.S. 967, 981-82 (2005)). At minimum, the agency must "'display awareness that it is changing position' and 'show that there are good reasons for the new policy.'" *Id.* at 2126 (quoting *FCC v. Fox Television Stations, Inc.*, 556 U.S. 502, 515 (2009)). But it must also provide a "more detailed justification … when, for example, its new policy rests upon factual findings that contradict those which underlay its prior policy; or when its prior policy has engendered serious reliance interests that must be taken into account." *Fox Television Stations*, 556 U.S. at 515; *accord, e.g.*, *DHS v. Regents of the Univ. of Cal.*, 140 S. Ct. 1891, 1913 (2020).

The agency transgressed every one of these guardrails in promulgating the 2019 Rule. Plaintiffs discuss each of the challenged provisions of the 2019 Rule in turn.

A. Eliminating direct notification requirements

The 2019 Rule removes the requirement that individuals receive direct notification of their ineligibility for advance premium tax credits before an Exchange may cut those benefits off for failing to reconcile any excess APTC received in the prior year. 83 Fed. Reg. at 16,982-84. That decision is both contrary to law and arbitrary and capricious.

1. Contrary to law

The 2019 Rule deepens a conflict between CMS regulations and the Internal Revenue Code. Under the Code, "[i]n the case of an applicable taxpayer, there *shall* be allowed as a credit against the tax imposed … for any taxable year an amount equal to the premium assistance credit amount of the taxpayer for the taxable year." 26 U.S.C. § 36B(a) (emphasis added). That "mandatory" language requires that any applicable taxpayer be allowed to claim an APTC. *Holland v. Pardee Coal Co.*, 269 F.3d 424, 431 (4th Cir. 2001). An applicable taxpayer is defined as, "with respect to any taxable year, a taxpayer whose household income for the taxable year equals or exceeds 100 percent but does not exceed 400 percent of an amount equal to the poverty line for a family of the size involved." 26 U.S.C. § 36B(c)(1)(A). Whether an individual has reconciled their APTC has no bearing on whether she is an applicable taxpayer under that definition. Depriving an applicable taxpayer of the credit that the statute says "shall be allowed" based on a failure to reconcile their taxes therefore violates the statute's plain language.

Nor does the Affordable Care Act make a previous failure to reconcile a basis for withholding advance payment of a tax credit. Under the Act, Defendants must make "advance determinations … with respect to the income eligibility of individuals enrolling in a qualified health plan in the individual market through the Exchange for the premium tax credit allowable under section 36B of Title 26." 42 U.S.C. § 18082(a)(1). In other words, Defendants' role is simply to determine whether a taxpayer meets the income eligibility standards provided by the Internal Revenue Code. If he or she does, then Defendants must inform the Secretary of the Treasury, who then "makes advance payments of such credit … to the issuers of the qualified health plans in order to reduce the premiums payable by individuals eligible for such credit." *Id.* § 18082(a)(3). The fact that the statute expressly prohibits "[f]ederal payments … for individuals who are not lawfully present," *id.* § 18082(d), further indicates that "additional exceptions are not to be implied." *TRW Inc. v. Andrews*, 534 U.S. 19, 28 (2001). Nothing in this scheme allows Defendants to erect new barriers to advance premium tax credits.

Stripping subsidies from taxpayers who need them to obtain medical care without first providing adequate notification also raises significant due process concerns. As the Supreme Court established in *Goldberg v. Kelly*, due process requires that "a recipient have timely and adequate notice detailing the reasons for a proposed termination, and an effective opportunity to defend" before the government terminates "essential" benefits like "medical care." 397 U.S. 254, 264, 267-68 (1970); *see also O'Bannon v. Town Court Nursing Ctr.*, 447 U.S. 773, 786-87 (1980) (noting that the government could not withdraw Medicare and Medicaid benefits, which "give … patients an opportunity to obtain medical services," without "notice and an opportunity for a hearing on the issue of their eligibility for benefits."). "No process, however thorough, can provide what is due without notice to those who stand to lose out thereby." *Lane Hollow Coal Co. v. Dir., Off. of Workers' Comp. Programs*, 137 F.3d 799, 807 (4th Cir. 1998) (quotation omitted). The 2019 Rule therefore offends two canons of construction: that courts must interpret ambiguous statutes to avoid constitutional problems, even where those problems involve litigants not before the court, *see Clark v. Martinez*, 543 U.S. 371, 380 (2005), and that "taxing statutes are strictly construed against the government and in favor of the taxpayer." *Lilly v. United States*, 238 F.2d 584, 587 (4th Cir. 1956). For those reasons as well, this provision is contrary to law.

2. Arbitrary and capricious

The 2019 Rule's elimination of the direct notification requirement is also arbitrary and capricious. Most importantly, Defendants ignored how eliminating direct notification would almost certainly ensure that individuals lose premium tax credits through no fault of their own. The Court need not take Plaintiffs' word for it. When adding the direct notification requirement in 2016, CMS explained "that targeted and detailed messaging to tax filers that highlights the specific requirement to file an income tax return and reconcile APTC paid on their behalf—and the potential adverse impact on APTC eligibility for future coverage years—is *essential*." 81 Fed. Reg. at 94,124 (emphasis added). In the 2019 Rule, Defendants themselves also noted that *forty percent* of households failed to take "appropriate action" in response to more indirect notices that listed a failure to reconcile as one of several reasons that the household might be

ineligible for APTC. 83 Fed. Reg. at 16,983; AR126. Those undisputed facts illustrate how Defendants turned a blind eye to the necessity of direct notification before terminating an individual's eligibility for APTC.

Indeed, "nearly all" of the commenters voiced these concerns. 83 Fed. Reg. at 16,982. As commenters explained, CMS's "notices are notoriously difficult for consumers to understand" as it is, AR1458 (National Association of Health Access Assisters); the combined notices CMS sent before failed to "give consumers definitive guidance on whether they will be denied APTC, why, [and] how to correct the problem," AR1627 (Center on Budget and Policy Priorities); many consumers struggle to read the notices, which are "only provided in English and Spanish," AR1824 (Association of Asian Pacific Community Health Organizations); and "consumers and enrollees need significant education to guide them through the complex relationship between Marketplace financial assistance and tax filing," AR2493 (Georgetown University Health Policy Institute), especially considering that "the population involved may be unused to having tax liability and may not need to file a return otherwise," AR2907 (National Association of Health Underwriters). Health plans also stressed that questions about failure to reconcile, "often posed in response to an enrollee's receipt of the personalized notice that the Department propose[d] to eliminate, represent a comparatively significant volume of our customer-service related inquiries," AR1689 (UPMC Health Plan)—demonstrating the importance of such notices in prompting action. *Accord, e.g.*, AR1458 (National Association of Health Access Assisters), 2590 (Asian and Pacific Islander American Health Forum).

Defendants responded that, in their view, "there are adequate protections for due process" even in the absence of direct notification. 83 Fed. Reg. at 16,983. But those "protections" include the same notices that commenters described as inadequate, and they largely entail allowing consumers to contest their eligibility *after* their APTCs are discontinued—cutting them off from access to necessary health coverage. *Id.* Moreover, Defendants never explained why they find those protections "adequate" now, but did not when they promulgated the direct notification requirement they deemed "essential" in 2016. An agency may change its mind, of course, but not

without acknowledging that it has done so and not without explaining why good reasons support its changed factual findings and its new policies. *Fox Television Stations*, 556 U.S. at 515; *see also Casa de Md. v. DHS*, 924 F.3d 684, 705 (4th Cir. 2019) (holding that agency's decision was arbitrary and capricious because "the Department changed course without any explanation for why [its] analysis was faulty"). Defendants did not do so here.

Defendants also relied on speculative concerns about the need to ensure "consumers are not receiving APTC improperly," 83 Fed. Reg. at 16,984, and how it "*may* be" difficult for state-based Exchanges to provide direct notification given rules prohibiting unauthorized disclosures of tax information, *id*. at 16,983 (emphasis added). But Defendants failed to provide any evidence of either concern, and neither is corroborated by the record. Indeed, Exchanges were already providing direct notification without any sign that doing so imposed insuperable burdens or harmed program integrity. *See* AR1627 (comment by Center on Budget and Policy Priorities noting that "information can be provided in this more consumer-friendly form, and is being provided"). The Court cannot defer to Defendants' "conclusory or unsupported suppositions," particularly when they fly in the face of reality. *United Techs. Corp.*, 601 F.3d at 562 (quotation omitted). Thus, the elimination of the direct notification requirement is arbitrary and capricious.

B. Eliminating federal review of network adequacy

The 2019 Rule also continues to shift to states the federal government's duty to ensure that plans sold on the Exchanges have adequate provider networks. 83 Fed. Reg. at 17,024-26. That policy is both contrary to law and arbitrary and capricious.

1. Contrary to law

Defendants' decision to outsource their network review responsibilities is contrary to the Affordable Care Act. Under the Act, HHS "*shall*, by regulation, establish criteria for the certification of health plans as qualified health plans." 42 U.S.C. § 18031(c)(1) (emphasis added). Those criteria must include standards that "ensure a sufficient choice of providers"—*i.e.*, criteria that ensure that plans provide networks which are adequate to meet their customers' needs. *Id.* § 18031(c)(1)(B) (emphasis added). And "[a]n Exchange *shall, at a minimum*[,]

implement procedures for the certification, recertification, and decertification … of health plans as qualified health plans." *Id*. § 18031(d)(4)(A) (emphasis added).

Again, the statute's repeated use of the term "shall" makes plain that these are "mandatory" duties. *Holland*, 269 F.3d at 431. And the statute is likewise clear that the Exchange—which, in states with federally facilitated Exchanges, is CMS—must carry them out. Defendants plainly have not met their burden to "implement procedures for … certification" by leaving certification to others. Adding a belt to the suspenders, the statutory requirement to certify health plans is a "minimum" requirement, 42 U.S.C. § 18031(d)(4)(A), below which an Exchange cannot fall.

In this respect, the 2019 Rule is strikingly similar to the scheme rejected by the D.C. Circuit in *U.S. Telecom Association v. FCC*, where the FCC subdelegated authority to state regulatory commissions to make decisions Congress entrusted to the FCC itself. 359 F.3d 554 (D.C. Cir. 2004). Recognizing that, "when an agency delegates power to outside parties, lines of accountability may blur," the court held that federal agencies "may not subdelegate to outside entities—private or sovereign—absent affirmative evidence of authority to do so." *Id.* at 565-66. Likewise, "[a]n agency may not … merely 'rubber-stamp' decisions made by others under the guise of seeking their 'advice.'" *Id.* at 568 (quotation omitted). That principle applies with full force here.

To the extent Defendants' statutory obligations are ambiguous, the ACA's fundamental purpose—"increas[ing] the number of Americans covered by health insurance" that is adequate to meet their needs, *NFIB*, 567 U.S. at 538—must control. After all, "Congress passed the Affordable Care Act to improve health insurance markets." *King*, 576 U.S. at 498. But health insurance cannot meet a consumer's needs if it offers an inadequate provider network—that is, if the network lacks facilities close to the consumer's home or that are equipped to handle the consumer's specific medical conditions. Defendants' decision is therefore contrary to law.

2. Arbitrary and capricious

Defendants' policy is also arbitrary and capricious. Defendants overlooked the many commenters that explained how continuing to defer to states, particularly states with deficient network review practices, would perpetuate inadequate coverage. As Consumers Union explained at length:

> A 2014 Survey on State Insurance Standards conducted on behalf of the Consumer Representatives at the National Association of Insurance Commissioners (NAIC) found state oversight is primarily complaint-driven, with few states enforcing their "reasonable access" standard. For example, less than 10 percent of state regulators reported performing "secret shopper" calls to confirm that listed providers were actually in network and accepting new patients, and almost 80 percent of regulators reported taking only one enforcement action in response to network adequacy concerns in the past year. Moreover, states lacking the authority or means to perform their own reviews often rely on private accreditors to oversee network adequacy for the state. Private accreditation, however, typically relies only on self-certification of networks; that is, insurers set and verify their own standards. Private accreditors also have virtually no method of enforcing such standards beyond revoking or suspending an insurer's accredited status. With oversight so uneven across the states, state network adequacy requirements often only applying in certain circumstances, and most states using qualitative rather than bright-line, quantitative measures, wholly ceding network assessment to the states may result in substantial gaps and disparities in network adequacy.

AR906-07 (footnotes omitted); *see, e.g.*, AR835 (Consumers for Quality Care), 937 (Health & Medicine Policy Research Group), 1086 (American Medical Association), 1092 (American College of Physicians), 1319 (The Chronic Illness & Disability Partnership), 2139 (Federation of American Hospitals), 2513 (American Association of Retired People), 2743 (Families USA), 3226 (West Virginia Together for Medicaid), 3548 (National Alliance on Mental Illness). Another study found that "only twelve [] states have adopted both quantitative travel time and distance standards to assess network adequacy." AR1963 (Coalition for Whole Health). The "narrow or insufficient provider network[s]" that result from inadequate state review "may cause patients to delay needed care or treatment, causing undue harm." AR829-30 (Biotechnology Innovation Organization); *see, e.g.*, AR1518 (American Osteopathic Association), 1864-65 (Community Catalyst).

CMS also overlooked how inadequate networks shortchange especially vulnerable consumers and those who require specialty care, including individuals with preexisting conditions like:

- leukemia and lymphoma, AR938 (Health & Medicine Policy Research Group), 1175 (Leukemia & Lymphoma Society);
- congenital heart disease, AR986 (Adult Congenital Heart Association);
- bleeding disorders, AR989 (Hemophilia Alliance), 2207 (National Hemophilia Foundation); HIV, AR1002 (Federal AIDS Policy Partnership);
- mental health and substance-use disorders, AR1065 (Parity Implementation Coalition);
- high-risk pregnancies, AR1581 (March of Dimes);
- respiratory diseases, AR1587 (American Thoracic Society), 1811 (American Lung Association);
- cystic fibrosis, AR2014-15 (Cystic Fibrosis Foundation);
- disabilities, AR2981 (Consortium for Citizens with Disabilities);
- and cancer, AR2997 (Cancer Leadership Council), 3034 (National Coalition for Cancer Survivorship).

Americans living in rural areas are likewise disadvantaged, AR2275-76 (Catholic Health Initiatives), as are children, AR1412 (American Academy of Pediatrics et al.), 1611 (Children's Defense Fund). While inadequate provider networks harm all Americans, these populations in particular are likely to suffer from deficient network reviews.

Defendants responded by asserting that existing state review processes "provide adequate review." 83 Fed. Reg. at 17,025. But commenters explained at length—and backed by considerable evidence—how existing state review processes are inadequate. Defendants did not discuss those concerns, much less explain why they should be disregarded. They therefore failed to "address comments and evidence that undercut [their] conclusion." *Nat'l Lifeline Ass'n v. FCC*, 921 F.3d 1102, 1114 (D.C. Cir. 2019). Moreover, Defendants were required to provide *evidence* to buttress their assertion that state review procedures are sufficient to guarantee

network adequacy, such as an analysis of the rigor of state procedures or assessments of plans certified by state regulators. Defendants may not simply appeal to their "expert judgment" without "point[ing] … to any data of the sort [they] would have considered if [they] had considered [the issue] in any meaningful way." *Nat'l Treasury Emps. Union*, 854 F.2d at 499.

Instead of addressing these weighty concerns, Defendants declared that they are "committed to recognizing States' role as the primary regulator of their insurance markets," 83 Fed. Reg. at 17,024, and to "reducing regulatory burden on issuers," *id.* at 17,025. Leaving aside whether Defendants may lawfully subdelegate their responsibilities to states, it was arbitrary and capricious for them to do so where there were serious concerns raised about whether the states are up to the task. Defendants' decision therefore "prioritize[d] non-statutory objectives"—increasing state and insurer flexibility—"to the exclusion of the statutory purpose"—providing adequate coverage. *Gresham*, 950 F.3d at 104.

C. Reducing oversight of direct enrollment

Defendants' decision to reduce federal oversight of insurance brokers, agents, and insurers engaging in direct enrollment, 83 Fed. Reg. at 16,981-82, is arbitrary and capricious.

The 2019 Rule puts the fox in charge of the henhouse, permitting direct enrollment entities to choose their own auditors without requiring HHS to approve them. 83 Fed. Reg. at 16,981. In contrast, many commenters urged Defendants to implement *stronger* oversight of direct enrollment. *See, e.g.*, AR1625 (Center on Budget and Policy Priorities), 1944 (Young Invincibles), 1713 (DC Health Benefit Exchange Authority). As commenters explained, further reducing oversight of the direct enrollment process would increase the likelihood that consumers enroll in non-ACA-compliant plans that undermine the risk pool, decline to enroll in other programs for which they may be eligible, like Medicare and Medicaid, receive inadequate information about their rights and responsibilities under the ACA, and expose their personal information to brokers that lack stringent compliance with privacy and security standards. *See, e.g.*, AR1448 (American Diabetes Association), 1625-26 (Center on Budget and Policy Priorities), 1713 (DC Health Benefit Exchange Authority), 1822-23 (Association of Asian

Pacific Community Health Organizations), 2063 (former Acting Administrator of CMS), 2681 (America's Health Insurance Plans), 2719 (American Cancer Society Cancer Action Network), 2737-38 (Families USA). Defendants also overlooked the risk of conflicts of interest, given that auditors have a financial incentive to be selected by entities engaging in direct enrollment and to have those entities continue to retain them. *See, e.g.*, AR908 (Consumers Union), 2719 (American Cancer Society Cancer Action Network), 2737 (Families USA).

Rather than addressing these problems head-on, Defendants claim only to have "put in place guidelines and processes to oversee the activities of agents, brokers, and issuers participating in direct enrollment." 83 Fed. Reg. at 16,982. But exhortations without enforcement—for example, audits by vetted third parties—are no answer to the demonstrated potential for abuse. As the Fourth Circuit has explained, "[n]o doubt the thoughtful folks who leave cauldrons of candy on their front porches at Halloween hope the neighborhood trick-or-treaters will behave themselves and take only their fair share, but common experience has shown that those hopes often remain unfulfilled." *Friends of Back Bay*, 681 F.3d at 589 (holding that reliance on a "no wake zone" rendered environmental impact statement arbitrary and capricious because zone went unenforced). Indeed, that Defendants previously saw fit to impose greater oversight of auditors simply reflects how regulatory requirements alone cannot adequately protect consumers. Because CMS's new policy ignores these problems, and provides an inadequate justification for its change of course, it is arbitrary and capricious. *State Farm*, 463 U.S. at 43; *Fox Television Stations*, 556 U.S. at 515.

D. Eliminating standardized options

Aside from removing protections that the Act guarantees, the 2019 Rule also makes it harder to enroll in ACA-compliant health plans, including by eliminating standardized options. 83 Fed. Reg. at 16,974-75. That decision is arbitrary and capricious.

CMS previously gave a thorough explanation of how its decision to offer standardized plans fulfilled the Act's mandate of "allow[ing] people to compare and purchase" qualified health plans. *King*, 576 U.S. at 479. Citing analyses of consumer behavior, CMS found that "[a]n

excessive number of health plan options makes consumers less likely to make any plan selection, more likely to make a selection that does not match their health needs, and more likely to make a selection that leaves them less satisfied." 80 Fed. Reg. 75,488, 75,542 (Dec. 2, 2015). CMS buttressed that finding with reference to its experience during past open enrollment periods, which showed "that many consumers, particularly those with a high number of health plan options, find the large variety of cost-sharing structures available on the Exchanges difficult to navigate." *Id*. CMS concluded that "standardized options will provide these consumers the opportunity to make simpler comparisons of plans," while relieving consumers from having "to make complex tradeoffs among cost-sharing differences." *Id.* CMS therefore supported standardized options in the 2017 and 2018 benefit years.

Because their decision to eliminate standardized options "rests upon factual findings that contradict those which underlay [their] prior policy," Defendants were obligated to "provide a more detailed justification." *Fox Television Stations*, 556 U.S. at 515. Instead, Defendants offered only bare assertions that "HealthCare.gov plan filters for other tools are sufficient," and that "consumers with specific health conditions may be better served by a different [qualified health plan]," 83 Fed. Reg. at 16,975—a far cry from the independent analyses it cited before, *see* 80 Fed. Reg. at 75,542. Nor did Defendants give any reason why those analyses were flawed, outdated, or inapplicable. That is the essence of arbitrary action.

In reversing course, Defendants also failed to respond to extensive comments explaining the benefits of standardized options. A diverse cross-section of stakeholders explained that standardized options "help[] consumers navigate the wide range of health options available on the marketplace." AR1086 (American Medical Association); *see, e.g.*, AR715 (American Congress of Obstetricians and Gynecologists), 894 (Colorado Health Foundation), 918 (Health & Medicine Policy Research Group), 980 (Arthritis Foundation), 1623 (Center on Budget and Policy Priorities), 1705 (Pfizer), 1856-57 (Community Catalyst), 3530 (National Health Council). Commenters also explained that standardized plan options benefit vulnerable populations, including consumers with "low health literacy," AR1818 (Association of Asian

Pacific Community Health Organizations), and "individuals with higher-cost chronic health conditions," AR1323 (The Chronic Illness & Disability Partnership). But they also encourage enrollment among healthy, young people, for whom ease of enrollment is key. *See, e.g.*, AR1857 (Community Catalyst), 1949 (Young Invincibles). Defendants did not provide a reasoned response to any of these points.

Many commenters also provided evidence of the importance of standardized options that overlapped with CMS's own prior experience. For instance, commenters pointed to the success of standardized options in California and other states. *See, e.g.*, AR905 (Consumers Union), 1135 (Society for Public Health Education), 2651 (Covered California). Families USA provided a survey of enrollment assisters who attested to the value of standardized options, AR2735, while Planned Parenthood pointed to multiple studies regarding how consumers make choices, AR3008. Again, Defendants merely "[n]odd[ed] to concerns raised by commenters only to dismiss them in a conclusory manner," *Gresham*, 950 F.3d at 103, rather than carefully "address[ing] comments and evidence that undercut [their] conclusion." *Nat'l Lifeline Ass'n*, 921 F.3d at 1114.

Defendants justified their decision to eliminate standardized options by explaining that it would "encourage free market principles in the individual market, and … maximize innovation by issuers in designing and offering a wide range of plans to consumers." 83 Fed. Reg. at 16,974. But commenters debunked this rationale as well. Among other things, "there is no requirement that issuers offer them, and issuers are allowed to offer other plans," AR1135 (Society for Public Health Education), 1445-46 (American Diabetes Association), 1695 (National Psoriasis Foundation), 2151 (American Heart Association et al.), 2924 (Colorado Center on Law and Policy); "standardized options encourage plans to compete based on the generosity of other plan design elements, such as by providing more robust provider networks and formularies," AR1313 (The Chronic Illness & Disability Partnership), 2836 (Washington Health Benefit Exchange); and "standardized plan options were based on the most popular qualified health plans (QHP) in individual market federally-facilitated exchanges," meaning that they by definition represent the

"most appealing plans to consumers among other competitor plans," AR1446 (American Diabetes Association) (emphasis omitted). Moreover, "more 'innovative' benefit design" is not an end in itself; it "does not inevitably mean benefit designs that will provide better, more affordable coverage for patients." AR1172 (Leukemia & Lymphoma Society). Defendants did not address these points either, which cut to the heart of their rationale—rendering their action arbitrary and capricious.

E. Undermining the Navigator program

The 2019 Rule also dramatically lowers the standards for the Navigator program by removing the requirements that each Exchange have two Navigators, that one must be a community- and consumer-focused nonprofit, and that Navigators must have a physical presence in the areas they serve. 83 Fed. Reg. at 16,979-81. These changes are contrary to law and arbitrary and capricious.

1. Contrary to law

Defendants' decision to eliminate these requirements is contrary to law because it permits entities to qualify as Navigators that cannot satisfy the relevant statutory criteria. Under the Affordable Care Act, Navigators must demonstrate that they have "existing relationships, or could readily establish relationships, with employers and employees, consumers (including uninsured and underinsured consumers), or self-employed individuals likely to be qualified to enroll." 42 U.S.C. § 18031(i)(2)(A). Moreover, the Act requires Navigators to "conduct public education activities to raise awareness of the availability of qualified health plans," *id.* § 18031(i)(3)(A); "distribute fair and impartial information concerning enrollment in qualified health plans, and the availability of premium tax credits," *id.* § 18031(i)(3)(B); "facilitate enrollment in qualified health plans," *id.* § 18031(i)(3)(C); provide enrollees with grievances, complaints, or questions about their health plans with referrals to specified entities, *id.* § 18031(i)(3)(D); and "provide information in a manner that is culturally and linguistically appropriate to the needs of the population," *id.* § 18031(i)(3)(E). Any requirements promulgated by Defendants to govern the Navigator program must be consistent with these mandates.

Under Defendants' revised approach, however, an Exchange could designate a single Navigator of a kind that plainly could not perform these duties. To take an extreme example, the Exchange in Arizona could select a single Navigator outside the state, like a "commercial fishing industry organization[]," 83 Fed. Reg. at 16,979, or one with ties to the insurer that serves its members, and claim that it will be sufficient to provide assistance to all of the state's communities. That cannot be right. Navigators without a physical presence in an area cannot effectively perform these duties because they cannot, in the terms CMS itself used in proposing the presence requirement in the first place, "provide[]" "face-to-face assistance … to applicants and enrollees." 79 Fed. Reg. 15,808, 15,832 (Mar. 21, 2014). And an Exchange's Navigators cannot adequately build relationships with consumers, 42 U.S.C. § 18031(i)(2)(A), or perform the duties listed above, *id.* § 18031(i)(3)(A)-(E), if they lack the coverage, diversity, and approach to serve all of the populations that seek to enroll on the Exchange. In sum, Defendants' elimination of these basic requirements is inconsistent with the Act's mandates.

2. Arbitrary and capricious

Leaving aside whether the Affordable Care Act permitted Defendants' decision, that decision is nonetheless arbitrary and capricious. In general, commenters strongly supported the Navigator program as effective and urged Defendants not to water it down. *See, e.g.*, AR1091 (American College of Physicians: "As health insurance becomes more complex, Navigators offer objective education that other entities may not provide."), 1647 (Association of American Medical Colleges: "Navigators are needed now more than ever to provide guidance to consumers."). To that end, commenters provided abundant reason for Defendants to abandon their proposed changes.

As to the requirement that an Exchange have at least two Navigators, commenters frequently highlighted the diverse populations that Navigators may serve, and which a single Navigator could not conceivably cover. *See, e.g.*, AR728 (Generations Health Care Initiatives), 931 (Health & Medicine Policy Research Group), 1117 (New Mexico Superintendent of Insurance), 1446 (American Diabetes Association), 1784 (Health Care for All New York), 2544

(MNsure), 2855 (Disability Rights Education & Defense Fund). Commenters identified many specific groups, including:

- LGBTQ individuals, AR889 (Human Rights Campaign);
- low-income families, AR948 (United Way of Anchorage), 2062 (former Acting Administrator of CMS);
- rural populations, AR1616 (State of Alaska Division of Insurance), 3121 (Farmworker Justice);
- cultural and linguistic minorities and immigrants, AR1624 (Center on Budget and Policy Priorities), 1820 (Association of Asian Pacific Community Health Organizations), 2544 (MNsure), 2587 (Asian and Pacific Islander American Health Forum), 2680 (America's Health Insurance Plans), 3484 (Unidos US);
- individuals with chronic, complex conditions, AR1695 (National Psoriasis Foundation), 1809 (American Lung Association), 2718 (American Cancer Society Cancer Action Network);
- young adults, AR1947 (Young Invincibles);
- seniors, AR2276 (Catholic Health Initiatives);
- individuals with disabilities, AR2096 (Charlotte Center for Legal Advocacy); and
- those who are eligible for Medicaid, CHIP, and other programs with which Navigators can assist, AR2029 (Tennessee Justice Center).

Commenters also noted that, even with two Navigators, Exchanges often "struggle to accommodate[]" the "volume of consumer requests for enrollment assistance." AR1520 (American Osteopathic Association).

As to the requirement that one Navigator be a community-focused group, commenters explained that such groups "are better equipped to provide unbiased advice and information, are more attuned to consumer needs, and have a better understanding of the unique opportunities and challenges within the respective community." AR810 (National Center for Health Research); *see, e.g.*, AR797 (Healthy Asian Americans Project), 1107 (Nebraska Appleseed), 1947 (Young Invincibles), 1962 (Coalition for Whole Health), 3009 (Planned Parenthood Federation of America). "These organizations can also leverage existing trust and relationships within their

local communities to best serve consumers." AR2096 (Charlotte Center for Legal Advocacy). Commenters also flagged the possibility that "consumers [might be] inappropriately steered toward particular plans" by self-interested or insurer-affiliated Navigator programs. AR1173 (Leukemia & Lymphoma Society); *see, e.g.*, AR2517 (American Association of Retired People), 2736 (Families USA).

And, as to the requirement that Navigators have a physical presence, commenters underscored that Defendants' decision would "open the door for entities that are unfamiliar with the community and consumers' needs to take over existing work." AR797 (Healthy Asian Americans Project); *see, e.g.*, AR908 (Consumers Union), 931 (Health & Medicine Policy Research Group), 1590 (American Thoracic Society), 1712 (DC Health Benefit Exchange Authority). Moreover, "[i]t would … likely create insurmountable barriers for enrollment of consumers who lack a phone or access to internet, as well as those who require extensive follow-up assistance." AR797 (Healthy Asian Americans Project); *see, e.g.*, AR810 (National Center for Health Research), 931 (Health & Medicine Policy Research Group), 1107 (Nebraska Appleseed), 1314 (Chronic Illness & Disability Partnership), 1503 (Myotonic Dystrophy Foundation), 1623 (Center on Budget and Policy Priorities), 1820 (Association of Asian Pacific Community Health Organizations), 2151 (American Heart Association et al.), 2276 (Catholic Health Initiatives), 2736 (Families USA). Indeed, "consumers enrolling with the help of in-person assisters are nearly twice as likely to successfully enroll as those enrolling online without help." AR1189 (National Partnership for Women & Families). Defendants' change-of-course is particularly stunning given that the 2019 Rule itself acknowledges "that entities with a physical presence and strong relationships in their [Exchange] service areas tend to deliver the most effective outreach and enrollment results." 83 Fed. Reg. at 16,980.

On each of these fronts, Defendants dismissed the "many commenters" that opposed their decision by noting that Exchanges remain free to select Navigators in accord with the previous requirements. 83 Fed. Reg. at 16,979-81. But a regulated party can always choose to hold itself to higher standards than those imposed by the law; that is not itself a reason not to impose a

given set of standards. Moreover, Defendants' argument does not apply to FFEs, where the *federal government* selects Navigators. AR681 (Arizona Alliance for Community Health Centers). Defendants also suggested that "other resources," like self-interested "agents, brokers, and direct enrollment partners," can pick up the slack for deficient Navigators. 83 Fed. Reg. at 16,981. But that ignores the need to ensure that Navigators themselves can perform their statutory duties, and the unique benefits that come from having selfless, community-focused organizations provide assistance, both points which commenters flagged on the record. *See, e.g.*, AR682 (Arizona Alliance for Community Health Centers), 2151 (American Heart Association et al.), 2517 (Leukemia & Lymphoma Society), 2680 (America's Health Insurance Plans). Defendants' "willful blindness in this regard fully deserves the label 'arbitrary and capricious.'" *MCI Telecomms. Corp. v. FCC*, 842 F.2d 1296, 1304 (D.C. Cir. 1988).

F. Weakening small business exchanges

The 2019 Rule similarly undermines the SHOPs established by the Act to assist small employers in providing health insurance to their employees by removing the requirement that SHOPs offer certain core functions, like determining employee eligibility, aggregating premiums (so that employers receive a single monthly bill), and enrolling employees online. 83 Fed. Reg. at 16,996-706. That decision is both contrary to law and arbitrary and capricious.

1. Contrary to law

Exchanges under the Affordable Care Act "shall … provide[] for the establishment of a Small Business Health Options Program." 42 U.S.C. § 18031(b)(1)(B). These SHOPs must be "designed to assist … small employers in facilitating the enrollment of their employees in qualified health plans offered in the small group market," *id.*, much like Exchanges must "make available qualified health plans to qualified individuals and qualified employers," *id.* § (d)(2)(A). Again, Congress used "mandatory" language to impose duties. *Holland*, 269 F.3d at 431; *see also* 83 Fed. Reg. at 16,996 (acknowledging that these are "statutorily required functions").

Defendants, however, have now lifted the very requirements needed to ensure that SHOPs fulfill those duties. A SHOP cannot "assist" with "enrollment," 42 U.S.C.

§ 18031(b)(1)(B), where it no longer provides the functionality to ascertain whether employees are eligible to enroll or to actually enroll those employees. Similarly, removing the ability to aggregate premiums across insurance plans makes it "difficult or impossible for small businesses to offer a choice of multiple insurers and plans to their employees." AR1715 (DC Health Benefit Exchange Authority). By the same token, plans cannot be deemed "available" when the Exchange does not enable employers to enroll their employees in them. As multiple commenters explained, these changes instead push small businesses to complete enrollment with insurance brokers or to buy directly from an insurance company. AR1630-31 (Center on Budget and Policy Priorities), 2064 (former Acting Administrator of CMS). Because these changes will permit SHOPs to operate even where they cannot meet the Act's commands, the 2019 Rule is unlawful.

2. Arbitrary and capricious

Defendants' decision to eliminate the employee enrollment, eligibility, and premium aggregation requirements is also arbitrary and capricious. In particular, Defendants ignored how their decision would either drive small businesses and their employees off the Exchanges entirely or impose significant additional costs on employers who seek to use SHOPs to find insurance. As one commenter explained, "small firms that have been utilizing the SHOP could find it difficult, or even impossible, to obtain fair and impartial information about their coverage options, offer workers a choice of small-group health plans, or meet minimum participation requirements outside of open enrollment." AR1631 (Center on Budget and Policy Priorities); *see also* AR3172 (American Physical Therapy Association voicing "concerns that these proposals could impose an unnecessary burden on employers seeking coverage"). DC's Exchange described online enrollment as the "cornerstone" of the SHOPs and explained that premium aggregation is critical to enabling businesses to offer a choice of plans to their employees. AR1715. Defendants overlooked these "important aspect[s] of the problem," *State Farm*, 463 U.S. at 43, including the degree to which small businesses relied on the SHOPs in the past, *Fox Television Stations*, 556 U.S. at 515.

Defendants justified their decision as an effort to reduce "regulatory burden" in the face of declining insurer participation and enrollment. 83 Fed. Reg. at 16,996. Commenters explained, however, that "low enrollment in SHOPs to date has occurred for a variety of reasons such as initial technical and operational problems and low awareness among employers, but not because the SHOPs somehow did not provide value to firms that enrolled through them." AR1631 (Center on Budget and Policy Priorities). Defendants' changes will worsen participation and enrollment rates. Defendants offer only the unsupported conclusion that, despite these cuts, "SHOPs that opt to operate in a leaner fashion … will still assist qualified employers … in facilitating the enrollment of their employees." 83 Fed. Reg. at 16,997. Such conclusory statements do not suffice. *United Techs. Corp.*, 601 F.3d at 562.

Ultimately, the 2019 Rule is responsive only to one concern: the cost to SHOP *operators*, like CMS, of running user-friendly SHOPs. *See* 83 Fed. Reg. at 16,996. That is incomplete. "[W]hen an agency decides to rely on a cost-benefit analysis as part of its rulemaking, a serious flaw undermining that analysis can render the rule unreasonable." *Nat'l Ass'n of Home Builders v. EPA*, 682 F.3d 1032, 1040 (D.C. Cir. 2012). Because Defendants utterly ignored the interests of the small businesses and their employees who rely on SHOPs in favor of speculative and unquantified costs to SHOP operators, their decision was arbitrary and capricious.

G. Imposing burdensome and unnecessary income verification requirements

The 2019 Rule requires consumers who attest to greater income than the government's records reflect to supply unnecessary documentation to maintain their eligibility for premium tax credits. 83 Fed. Reg. at 16,985-87. That decision is arbitrary and capricious for two reasons.

First, Defendants failed to adequately "consider an important aspect of the problem" and to "respond to relevant, significant issues," *N.C. Growers' Ass'n, Inc. v. United Farm Workers*, 702 F.3d 755, 769 (4th Cir. 2012) (quotation omitted): namely, the effect of its new income verification requirement on lower-income households. As Defendants acknowledged, "many commenters expressed concern that low-income consumers have difficulty in providing documentation to resolve their annual income data matching issues," and "households with lower

income might experience higher relative levels of variance in their income." 83 Fed. Reg. at 16,986; *see, e.g.*, AR909 (Consumers Union), 935-36 (Health & Medicine Policy Research Group), 1340-41 (Tennessee Health Care Campaign), 1449 (American Diabetes Association), 1458 (National Association of Health Access Assisters), 1627-28 (Center on Budget and Policy Priorities), 1643-44 (Association of American Medical Colleges), 1824 (Association of Asian Pacific Community Health Organizations), 1943-44 (Young Invincibles), 2063 (former Acting Administrator of CMS), 2682-83 (America's Health Insurance Plan), 2720 (American Cancer Society Cancer Action Network), 2738 (Families USA), 3122-23 (Farmworker Justice), 3486 (Unidos US), 3529 (National Health Council). Specifically, "[m]any low-income people work part-time or in hourly positions," "rely on multiple part-time or part-year jobs," "work in cash industries, such as food service, where tip-income makes up the largest portion of their earnings," and, "[i]n all these cases, documentation from an employer may be hard to obtain." AR1657 (Center for Budget and Policy Priorities).

Defendants failed to rebut these concerns in any detail, noting only that they would impose a "threshold" for income inconsistencies and that they would continue to provide resources to consumers to assist in verifying income. 83 Fed. Reg. at 16,986. But Community Catalyst, a nationwide organization of enrollment assisters, explained that "[their] experience working with enrollment stakeholders over the last few years has shown that the income inconsistency process is often inefficient and ineffective, imposing an immense administrative burden on both individuals and exchanges and often resulting in eligible individuals erroneously losing coverage or financial assistance," even despite the tools offered by Defendants. AR1859. Nor do any of these tools address the challenges in verifying income listed above.

Second, Defendants failed to support their decision with anything more than "conclusory or unsupported suppositions." *United Techs. Corp.*, 601 F.3d at 562 (quotation omitted). Defendants defended their decision as a critical "program integrity" measure, designed to guard against excess payments of APTC. 83 Fed. Reg. at 16,986. But Defendants themselves "acknowledge[d] that [they] do[] not have firm data on the number of applicants that might be

inflating their income to gain APTC." *Id.* at 16,986. That is because, as explained above, discrepancies in income often result from natural income fluctuations, rather than fraud. Moreover, as commenters pointed out, with no response from Defendants, "[t]here is no incentive to inflate income" where consumers would otherwise be eligible for Medicaid. AR1605 (Department of Vermont Health Access); *see also* AR935 (Health & Medicine Research Policy Group), 2030 (Tennessee Justice Center), 2101-02 (Charlotte Center for Legal Advocacy). The Court cannot "simply accept whatever conclusion an agency proffers merely because the conclusion reflects the agency's judgment," and it "owe[s] no deference to [CMS's] purported expertise" where it has failed to "offer[] data" to support its conclusion. *Tripoli Rocketry Ass'n, Inc. v. ATF*, 437 F.3d 75, 77 (D.C. Cir. 2006).

In other words, Defendants arbitrarily opted to minimize an entirely hypothetical and unproven risk (fraud) in exchange for worsening a well-documented and pressing one (consumers opting out). That decision is "so implausible that it does not represent reasonable administration" of the statutory scheme. *Bedford Cty. Mem'l Hosp.*, 769 F.2d at 1022.

H. Curtailing insurance rate review

The 2019 Rule unlawfully drives up the cost of insurance by relieving CMS of its obligation even to *review* the cost of insurance. 83 Fed. Reg. at 16,972-73. Specifically, Defendants' decision to exempt student health plans from rate review is contrary to law, and both that exemption and Defendants' decision to raise the threshold for rate review to increases of 15 percent are arbitrary and capricious.

1. Contrary to law

Defendants' decision to exempt student health plans is contrary to the text of the Affordable Care Act. The Act requires review of "unreasonable increases in premiums for health insurance coverage," 42 U.S.C. § 300gg-94(a)(1), which is defined as "benefits consisting of medical care," *id.* § 300gg-91(b)(1). Under that definition, student coverage is coverage. Moreover, as Defendants acknowledged in the 2019 Rule, "[s]tudent health insurance coverage is considered by HHS to be a type of individual market coverage and is generally subject to …

individual market requirements … includ[ing] rate review." 83 Fed. Reg. at 16,972. Defendants' obligation to review rate increases therefore applies with full force.

Defendants may assert that conducting rate review of student health plans violates a separate provision that bars the Act from being "construed to prohibit an institution of higher education … from offering a student health insurance plan." 42 U.S.C. § 18118(c). But Defendants did not invoke Section 18118 in the 2019 Rule—let alone articulate this novel rationale—and cannot do so now. *See SEC v. Chenery Corp.*, 332 U.S. 194, 196 (1947).

Regardless, that argument makes little sense. Nothing about rate review "prohibit[s]" a university from offering a student health plan. *See Prohibit*, Black's Law Dictionary (11th ed. 2019) ("1. To forbid by law. 2. To prevent, preclude, or severely hinder."); *Perrin v. United States*, 444 U.S. 37, 42 (1979) ("[U]nless otherwise defined, words will be interpreted as taking their ordinary, contemporary, common meaning."). As Defendants have previously explained, Section 18118 applies to "provisions … that would be fundamentally incompatible with the very concept of a student health plan," like allowing students to remain on a plan after graduation or letting nonstudents enroll. Defs.' Mem. in Support of Mot. to Dismiss or, in the Alternative, for Summ. J. at 44, *Roman Catholic Archbishop of Wash. v. Sebelius*, No. 1:13-cv-1441 (D.D.C. Oct. 16, 2013), ECF No. 26-1. The court in that case—in a decision that has since been vacated—is the only one that has extended the meaning of "prohibit" any further, and it nevertheless limited it to requirements that would make student plans "economically unfeasible" or "impossible," which the contraceptive coverage requirement at issue there would not. *Roman Catholic Archbishop of Wash. v. Sebelius*, 19 F. Supp. 3d 48, 109-10 (D.D.C. 2013), *aff'd in part, vacated in part sub nom. Priests for Life v. HHS*, 772 F.3d 229 (D.C. Cir. 2014), *vacated and remanded sub nom. Zubik v. Burwell*, 136 S. Ct. 1557 (2016).

Regardless, whether the test is "forbids," "fundamentally incompatible," or "economically unfeasible," rate review does not qualify. If anything, rate review helps to ensure that plans marketed to institutions of higher education do not see severe and unjustifiable rate increases. Indeed, Defendants previously emphasized that Section 18118 "*does not allow CMS* to

except student health insurance coverage from compliance with all Federal requirements," including "the Federal rate review process." 77 Fed. Reg. 16,453, 16,458 (Mar. 21, 2012) (emphasis added). Perhaps that is why CMS reviewed student plan rate increases for roughly *six years* before inexplicably changing course in the 2019 Rule, without any suggestion that student health plans were on the verge of ceasing to exist. *Cf. Encino Motorcars*, 136 S. Ct. at 2125.

Moreover, the statute exempts other categories of insurance from rate review, including "excepted benefits" and "grandfathered health plan" coverage. *See* 42 U.S.C. §§ 300gg-91(c), 18011(a)(3)-(4). Again, "[w]here Congress explicitly enumerates certain exceptions … , additional exceptions are not to be implied." *TRW Inc.*, 534 U.S. at 28 (quotation omitted). Congress did not give Defendants the authority to carve out categories of rates at their whim.

2. Arbitrary and capricious

a. Even assuming that the Act permits Defendants to exempt student health plans from rate review, their decision to do so is arbitrary and capricious. Defendants justified their decision by arguing that, even though "[s]tudent health insurance coverage is considered by HHS to be a type of individual market coverage and is generally subject to … individual market requirements," student coverage is nonetheless "rated and administered differently" from other individual plans. 83 Fed. Reg. at 16,972. But Defendants did not point to any changes in how student plans are rated nor explain why those differences preclude rate review. They therefore failed to provide "adequate reasons for [their] decision[]." *Encino Motorcars*, 136 S. Ct. at 2125.

On the other side of the ledger, Defendants failed to adequately address the evidence that eliminating systematic review of student health plans would allow for unjustifiable rate increases. As Young Invincibles, an organization focused on enrolling young adults in coverage, commented, "[w]ithout rate review, students could see their premiums skyrocket and insurers could be incentivized to generate higher profits on products requiring less transparency." AR1945; *see also* AR1697 (National Psoriasis Foundation), 1782 (Health Care for All New York). Indeed, Defendants themselves estimated that "75 student health insurance issuers [would] no longer be required to submit rate increases to HHS," and "that States will no longer

submit rate increases for 188 student health insurance plans to HHS." 83 Fed. Reg. at 17,038; *see also* AR1622 (comment by the Center on Budget and Policy Priorities explaining that "[i]ncreased transparency about health insurance rates, including for plans that specifically serve students, has been an important advancement in recent years"). Again, Defendants failed to address these "important aspect[s] of the problem." *State Farm*, 463 U.S. at 43.

b. Defendants' decision to raise the threshold for rate review from 10 to 15 percent was also arbitrary. Defendants raised the threshold "in recognition of significant rate increases," asserting that it would "provid[e] an opportunity for States to reduce their review burden" and "reduce burden for issuers." 83 Fed. Reg. at 16,972-73. In other words, Defendants sought to relieve states from having to review, and insurers from having to submit, justifications for rate increases that Defendants themselves acknowledged were increasingly common.

That does exactly what "many" commenters worried about: "normalize excessive increases." *Id.* at 16,973; *see, e.g.*, AR1104 (American College of Rheumatology), 1313 (The Chronic Illness & Disability Partnership), 1339 (Tennessee Health Care Campaign), 1503-04 (Myotonic Dystrophy Foundation), 1623 (Center on Budget and Policy Priorities), 1696-97 (National Psoriasis Foundation), 1782 (Health Care for All New York), 1808-09 (American Lung Association), 1855-56 (Community Catalyst), 1880 (American Cancer Society Cancer Action Network et al.), 2005-06 (American Hospital Association), 2029 (Tennessee Justice Center), 2039 (California Department of Insurance), 2138 (Federation of American Hospitals), 2150 (American Heart Association et al.), 2287-88 (U.S. Public Interest Research Group), 2512 (American Association of Retired People), 2733-34 (Families USA), 2836 (Washington Health Plan Finder), 2936 (Wisconsin Hospital Association), 3221 (West Virginia Together for Medicaid), 3439 (Colorado Consumer Health Initiative), 3529 (National Health Council). There is also a meaningful difference between a 10 percent increase and a 15 percent increase for low-income consumers who already devote 10 percent of their income to premiums. *See* AR1104 (American College of Rheumatology). Thus, the prospect of significant rate increases means that more review, not less, is needed.

Defendants also overlooked the reasons behind rising premiums. As commenters explained, rising premiums over the course of 2017 were the result of substantial uncertainty stemming from "the Administration's ambivalence with respect to cost-sharing reduction subsidies and enforcement of the individual mandate." AR1313 (The Chronic Illness & Disability Partnership); *see also* AR1339 (Tennessee Health Care Campaign), 1622 (Center on Budget and Policy Priorities). Defendants' own data suggested that premium growth would be slower in the future. AR2733-34 (Families USA). Nevertheless, even during that time frame, there were multiple rates within the 10-15 percent range that underwent adjustment, including one rate in Oregon. *Id.* Indeed, in promulgating the 2019 Rule, Defendants estimated that it would result in 125 fewer "written justifications" on a yearly basis, or about 16 percent of the prior total. 83 Fed. Reg. at 17,038. These shifts therefore provide no basis for making permanent adjustments to insurers' rate review obligations.

I. Reducing medical loss ratio rebates

Finally, the 2019 Rule allows insurers to take credit for improving the quality of their services even when they do not—making it easier for them to avoid paying rebates to consumers. 83 Fed. Reg. at 17,032-33. That, too, is both contrary to law and arbitrary and capricious.

1. Contrary to law

The ACA forecloses Defendants' decision to allow insurers to claim a flat credit for quality improvement activities untethered to their actual investment. It does so by requiring insurers to report "the percentage of total premium revenue … that such coverage *expends*" for such activities, as well as for paying claims and other non-claims costs, and to "provide an annual rebate" based on "the amount of premium revenue *expended*" on those costs. 42 U.S.C. § 300gg- 18(a)(2), (b)(1)(A) (emphasis added). The statute therefore "requires a rebate when reported amounts paid out for actual clinical and related services are less than 80% of reported premium revenue." *Morris v. Cal. Physicians' Serv.*, 918 F.3d 1011, 1013 (9th Cir. 2019).

Much like insurers must report the *actual* amount they expended on paying claims, this text can only be read to require issuers to report the amount they in fact expended on quality

improvement, not some flat amount determined by HHS. Indeed, CMS previously acknowledged this statutory limitation. In crafting the initial medical loss ratio regulations in 2010, CMS emphasized that the statute requires insurers to report their actual expenditures, noting that "[t]he statute does not simply require the issuer to report the numeric ratio of the incurred loss to earned premium," and that it specifically "requires health insurance issuers to submit an annual report to the Secretary concerning the percent of total premium revenue that is spent on activities that improve health care quality." 75 Fed. Reg. at 74,866, 74,875. Moreover, allowing insurers to claim a credit whether they improve quality or not undermines one of the provision's primary purposes: "incentivizing issuers to maximize spending on health care and activities that improve health care quality, thereby promoting greater efficiency in health insurance markets." *Id.* at 1016; *see also* 42 U.S.C. § 300gg-18(a), (b) (sections titled "Clear accounting for costs" and "Ensuring that consumers receive value for their premium payments").

The ACA provides two limited exceptions to this clear statutory requirement, neither of which save the 2019 rule. In a subsection titled "Adjustments," Section 300gg-18(d) provides that "[t]he Secretary may adjust the rates described in subsection (b) if the Secretary determines appropriate on account of the volatility of the individual market due to the establishment of State Exchanges." And the similarly worded Section 300gg-18(b)(1)(A)(ii) provides "the Secretary may adjust such percentage with respect to a State if the Secretary determines that the application of such 80 percent may destabilize the individual market in such State." Here, however, the Secretary made no such adjustments or determinations. Instead, Defendants decided to provide insurers with a flat credit in an effort to "reduce unwarranted regulatory and economic burdens for issuers that do not want to track and report the exact QIA amounts for their MLR calculation." 83 Fed. Reg. at 17,056. This the ACA prohibits.

2. Arbitrary and capricious

Even if the ACA permitted Defendants' decision to apply a flat credit for quality improvement activities, that decision is arbitrary and capricious and thus unlawful.

First, Defendants failed to provide any evidence to corroborate their assertion that issuers faced "significant burden" in reporting quality improvement activity that could be alleviated only by allowing them to claim a flat credit. 83 Fed. Reg. at 17,032. Defendants surmised that "many issuers likely do engage in QIA but forego reporting that spending because of the burden." *Id.* at 17,056. But they similarly provided no evidence that insurers are not reporting their investments on QIA as opposed to simply not making those investments. *See* AR1636 (comment by the Center on Budget and Policy Priorities noting that "many insurers do not currently report undertaking [QIA]."). Insurers who do in fact make such expenditures "would likely continue to track expenses in order to make sure they incorporate actual expenses into the MLR calculation if they exceed 0.8 percent." AR1797 (American Academy of Actuaries). Further, Defendants failed to consider alternatives presented by commenters that could reduce whatever burden may be involved in QIA tracking without incurring the detrimental effects of using a flat percent, including "remov[ing] the necessity to split QIA into five categories, while still requiring actual QIA expenses." *Id.* Defendants' failure to engage in a reasoned, evidence-backed comparison of alternatives was quintessentially arbitrary and capricious. *United Techs. Corp.*, 601 F.3d at 562.

Second, Defendants failed to meaningfully address "many" comments explaining that "a standardized credit for [quality improvement activities] would disincentivize issuers from making such investments," 83 Fed. Reg. at 17,032, thus reducing the value their coverage provides to consumers. *See, e.g.*, AR741 (National Committee for Quality Assurance), 914-15 (Consumers Union), 1088-89 (American Medical Association), 1598 (Washington Insurance Commissioner), 1782-83 (Health Care for All New York), 1946-47 (Young Invincibles), 2004-05 (American Hospital Association), 2143-44 (Federation of American Hospitals), 2157-58 (American Hospital Association & American Stroke Association), 2290 (U.S. Public Interest Research Group), 2712-13 (Service Employees International Union), 2730 (American Cancer Society Cancer Action Network), 2748-49 (Illinois Attorney General), 2842 (Washington Health Plan Finder), 2935-36 (Wisconsin Hospital Association), 3016 (Planned Parenthood Federation of America), 3227-28 (West Virginia Together for Medicaid), 3444 (Colorado Consumer Health

Initiative). Defendants' assertions that insurers have other incentives to improve quality and that they can use administrative savings to do so are both insufficient; in establishing the medical loss ratio system, Congress recognized that it provided a needed incentive for quality improvement. *Morris*, 918 F.3d at 1016. Again, Defendants merely "nodd[ed] to concerns raised by commenters only to dismiss them in a conclusory manner." *Gresham*, 950 F.3d at 103.

Similarly, Defendants failed to consider how allowing insurers to claim a flat credit for quality improvement expenses would increase health care costs by letting them charge higher premiums and avoid paying rebates. Indeed, in promulgating this provision, Defendants estimated that it would reduce rebates by approximately $23 million. 83 Fed. Reg. at 17,054; *see also* AR1636 (comment by the Center on Budget and Policy Priorities explaining that provision would "automatically giv[e] insurers credit in the MLR for conducting quality improvement activities, thus reducing consumer rebates, even if the insurers spend only trivial amounts on quality improvement"), 1866 (comment by Community Catalyst that "this proposal could result in a consumer losing their rebate while essentially providing insurers with an undeserved giveaway"). Defendants also predicted that it would lead to "[p]otential increases in premiums." 83 Fed. Reg. at 17,046; AR270. Defendants' decision therefore undermines the ACA's goal of improving access to affordable, quality healthcare.

* * *

Ultimately, what the 2019 Rule provisions addressed above share is, at best, a blindness to how they would harm health insurance markets and, at worst, a purpose fundamentally at odds with Congress's purpose in enacting the Affordable Care Act. "As the name implies, the [Act] was designed to provide 'quality, affordable health care for all Americans.'" *Stewart*, 313 F. Supp. 3d at 261 (quoting 124 Stat. at 130). And agencies are "bound … by the ultimate purposes Congress has selected," even if they disagree with Congress's choice. *MCI Telecomms. Corp*, 512 U.S. at 231 n.4. Because Defendants did not comply with that mandate, and for the many other reasons described above, the challenged provisions of the 2019 Rule are unlawful.

III. The challenged provisions of the 2019 Rule should be vacated.

The challenged provisions of the 2019 Rule violate the Affordable Care Act, the Administrative Procedure Act, and other federal laws. The proper response is to vacate those provisions. When the court concludes that agency action is unlawful, "the practice of the court is ordinarily to vacate the rule." *Illinois Pub. Telecomms. Ass'n v. FCC*, 123 F.3d 693, 693 (D.C. Cir. 1997); *see also Allina Health Servs. v. Sebelius*, 746 F.3d 1102, 1110 (D.C. Cir. 2014) ("vacatur is the normal remedy").

Under the D.C. Circuit's decision in *Allied-Signal*, however, courts will occasionally remand the agency's decision without vacating it. *See Allied-Signal, Inc. v. U.S. Nuclear Reg. Comm'n*, 988 F.2d 146, 150 (D.C. Cir. 1993). The Fourth Circuit "has never formally embraced the *Allied-Signal* remand-without-vacatur approach," *Sierra Club v. U.S. Army Corps of Eng'rs*, 909 F.3d 635, 655 (4th Cir. 2018), and multiple judges on the D.C. Circuit have called it into question as well, *see, e.g.*, *Milk Train, Inc. v. Veneman*, 310 F.3d 747, 757 (D.C. Cir. 2002) (Sentelle, J., dissenting) (explaining that vacatur is required); *Checkosky v. SEC*, 23 F.3d 452, 491 (D.C. Cir. 1994) (Randolph, J., concurring) (same). It is therefore unclear whether the Court possesses authority to remand without vacatur.

Even assuming that remand without vacatur is an option, Defendants are not entitled to it. Under *Allied-Signal*, "a court should consider 'the seriousness of the order's deficiencies (and thus the extent of doubt whether the agency chose correctly),' and whether 'there is at least a serious possibility that the [agency] will be able to substantiate its decision on remand.'" *Sierra Club*, 909 F.3d at 655 (quoting *Allied-Signal*, 988 F.2d at 150-51). Both factors compel vacatur.

To start, the deficiencies in the challenged provisions are serious. In many respects, the challenged provisions exceed Defendants' authority under the law or violate applicable requirements or prohibitions. While remand without vacatur may be permissible in limited cases where an agency's decision was poorly explained, "[t]hat is not the case here," where these provisions "exceeded [Defendants'] statutory authority." *Sierra Club*, 909 F.3d at 655. In such cases, "[t]he Supreme Court has recognized that Section 706(2)(A) 'requires federal courts to set

aside federal agency action' that is 'not in accordance with law.'" *Id.* (quoting *FCC v. NextWave Pers. Commc'ns Inc.*, 537 U.S. 293, 300 (2003)).

Even as to Plaintiffs' arbitrary-and-capricious claims, vacatur is required. "[T]he court must vacate a decision that 'entirely failed to consider an important aspect of the problem.'" *SecurityPoint Holdings, Inc. v. TSA*, 867 F.3d 180, 185 (D.C. Cir. 2017) (quoting *State Farm*, 463 U.S. at 43); *see also Comcast Corp. v. FCC*, 579 F.3d 1, 8 (D.C. Cir. 2009) (explaining that courts have "not hesitated to vacate a rule when the agency has not responded to empirical data or to an argument inconsistent with its conclusion"). Where there is "substantial doubt whether the [government] chose correctly … [,] [t]hat makes vacatur appropriate." *Humane Soc'y v. Zinke*, 865 F.3d 585, 614-15 (D.C. Cir. 2017) (citation omitted). For each of these provisions, "there is not a 'serious possibility' that the agency will be able to 'substantiate its decision on remand.'" *Sierra Club*, 909 F.3d at 655 (quoting *Allied-Signal*, 988 F.2d at 151).

"[T]he second *Allied-Signal* factor is weighty only insofar as the agency may be able to rehabilitate its rationale for the regulation." *Comcast Corp.*, 579 F.3d at 9. Regardless, any disruptive impact is likely to be minimal. As explained above, the challenged provisions harm the Exchanges, and were, in many cases, strenuously opposed by various stakeholders. Vacating those provisions would restore critical protections provided by the Act and ensure that more individuals are able to purchase ACA-compliant insurance. Moreover, to the extent vacating the challenged provisions would have any disruptive effect, the agency has the power to issue interim rules to smooth any transition.

What the Court should not do, however, is allow Defendants to continue applying rules that undermine the Affordable Care Act—a duly enacted federal law which has brought insurance coverage to millions of Americans. Thus, the challenged provisions must be set aside.

CONCLUSION

The Court should grant Plaintiffs' motion for summary judgment, vacate the challenged provisions of the 2019 Rule, and enter judgment for Plaintiffs.

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Respectfully submitted,

/s/ *John T. Lewis*

John T. Lewis (DC Bar No. 1033826)
(*pro hac vice*)
Counsel

Sean A. Lev (DC Bar No. 449936)
(*pro hac vice*)
Legal Director

Democracy Forward Foundation
1333 H St. NW
Washington, DC 20005
(202) 448-9090
jlewis@democracyforward.org
slev@democracyforward.org

Sara Kropf (D. Md. Bar No. 26818)
Kropf Moseley PLLC
1100 H Street NW, Suite 1220
Washington DC 20005
(202) 627-6900
sara@kmlawfirm.com

Counsel for All Plaintiffs

Stephen W. Miller (D. Md. Bar No. 19957)
Harris, Wiltshire & Grannis LLP
1919 M Street NW, Eighth Floor
Washington, DC 20036
(202) 730-1305
smiller@hwglaw.com

Counsel for Plaintiffs Columbus, Baltimore, Cincinnati, Chicago, Steve Vondra, and Bonnie Morgan

City of Columbus
Zach Klein (OH Bar No. 0078222)
City Attorney

Richard N. Coglianese (OH Bar No. 0066830)
City Solicitor General

Lara N. Baker-Morrish (OH Bar No. 0063721)
Chief Counsel

Jennifer L. Shea (OH Bar No. 0085239)
Assistant City Attorney

Columbus City Attorney's Office
77 North Front Street, 4th Floor
Columbus, OH 43215
(614) 645-7385
zmklein@columbus.gov
rncoglianese@columbus.gov
lnbaker@columbus.gov
jlshea@columbus.gov

Mayor and City Council of Baltimore
Dana P. Moore (D. Md. Bar No. 03632)
Acting Baltimore City Solicitor

Suzanne Sangree (D. Md. Bar No. 26130)
Senior Public Safety Counsel & Director of Affirmative Litigation

Jane Lewis (D. Md. Bar No. 20981)
Assistant Solicitor

Baltimore City Department of Law
City Hall, Room 109
100 N. Holliday Street
Baltimore, MD 21202
(443) 388-2190
Law.danapmoore@baltimorecity.gov
suzanne.sangree2@baltimorecity.gov
jane.lewis@baltimorecity.gov

City of Cincinnati
Andrew W. Garth (OH Bar No. 089349)

Interim City Solicitor

Emily Smart Woerner (OH Bar No. 089349)
Deputy City Solicitor

Jacklyn Gonzales Martin (OH Bar No. 0090242)
Assistant City Solicitor

Office of the City Solicitor, Cincinnati
City Hall, Room 214
801 Plum St.
Cincinnati, OH 45202
(513) 352-3315
Emily.Woerner@cincinnati-oh.gov
jacklyn.martin@cincinnati-oh.gov

City of Chicago
Mark A. Flessner (IL Bar No. 6194599)
Corporation Counsel

Stephen J. Kane (IL Bar No. 6272490)
Deputy Corporation Counsel
Affirmative Litigation Division

City of Chicago Department of Law
121 N. LaSalle St., Room 600
Chicago, IL 60602
(312) 744-6934
mark.flessner@cityofchicago.org
stephen.kane@cityofchicago.org

City of Philadelphia
Marcel S. Pratt
Solicitor of the City of Philadelphia

Diana P. Cortes (PA Bar No. 204274)
Chair, Litigation Group

Eleanor N. Ewing (PA Bar No. 28226)
Chief Deputy Solicitor, Affirmative & Special Litigation Unit

Benjamin H. Field (PA Bar No. 204569)
Divisional Deputy City Solicitor, Affirmative & Special Litigation Unit

City of Philadelphia Law Department
1515 Arch Street, 17th Floor
Philadelphia, PA 19102
(215) 683-5000
diana.cortes@phila.gov
eleanor.ewing@phila.gov
benjamin.field@phila.gov