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' CONSOLIDATED REPLY IN SUPPORT OF THEIR MOTION FOR SUMMARY JUDGMENT AND BRIEF IN OPPOSITION TO DEFENDANTS' CROSS-MOTION FOR SUMMARY JUDGMENT

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Other Authorities

Ensure, Oxford U. Press, https://www.lexico.com/en/definition /implement (last visited Oct. 26, 2020).....18

Facilitate, Oxford U. Press, https://www.lexico.com/en/definition/implement (last visited Oct. 26, 2020).....22

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Implement, Oxford U. Press, https://www.lexico.com/en/definition /implement (last visited Oct. 26, 2020).....9

INTRODUCTION

The proper implementation of the Affordable Care Act is a matter of the utmost national importance even in ordinary times, but especially so during a once-in-a-century global health crisis. As Plaintiffs explained in their opening brief ("MSJ"), ECF No. 108-1, however, Defendants have not properly implemented the Act. They have instead, through the 2019 Notice of Benefit and Payment Parameters (the "2019 Rule"), promulgated a number of policies that make it more difficult and more expensive for individuals to purchase health insurance, that deprive them of the Act's statutory protections and safeguards, and that lower the quality of insurance provided on the Act's Exchanges. Those policies must be set aside.

In several respects, Defendants' cross-motion and opposition ("Opp."), ECF No. 118-1, is more notable for what it does not say. Defendants do not dispute that Plaintiffs have standing to challenge the 2019 Rule. MSJ at 7-24, 26-28. And Defendants do not dispute that the Court must vacate any of the provisions of the 2019 Rule that the Court concludes are unlawful. *Id.* at 59-60. The sole question that remains is therefore whether the 2019 Rule is consistent with the Affordable Care Act and the Administrative Procedure Act.

It is not. Although the particulars differ, the challenged provisions of the 2019 Rule exhibit several recurring deficiencies that bring them into conflict with these statutes and that cause them to fall well short of the standard of reasoned decisionmaking.

Above all else, "an agency may not rewrite clear statutory terms to suit its own sense of how the statute should operate." *Util. Air Reg. Grp. v. EPA*, 573 U.S. 302, 328 (2014). But the policies adopted in the 2019 Rule repeatedly fail to fulfill the mandates imposed by the Act, like Defendants' duties to provide advance premium tax credits to consumers based on their income eligibility, to operate effective small business exchanges, and to require that insurers report how much they spend on improving their services.

An agency also may not "prioritize non-statutory objectives to the exclusion of the statutory purpose," *Gresham v. Azar*, 950 F.3d 93, 104 (D.C. Cir. 2020)—here, encouraging enrollment in high-quality, ACA-compliant plans. But Defendants repeatedly overlooked the

effect of decisions like scaling back network review, eliminating standardized options, and lifting Navigator requirements on the ACA's goals, instead prioritizing alternative objectives like state and issuer flexibility.

Beyond that, agencies must explain their policy changes, particularly when their "new policy rests upon factual findings that contradict those which underlay its prior policy." *FCC v. Fox Television Stations, Inc.*, 556 U.S. 502, 515 (2009). But, in many cases, Defendants changed policies without confronting their prior findings, including their conclusions that providing direct notification before stripping tax credits is "essential," that in-person, community-oriented Navigators provide the best assistance, and that student plans should receive the same rate review as other insurance plans.

Agencies cannot base policies on "conclusory or unsupported suppositions." *United Techs. Corp. v. U.S. Dep't of Def.*, 601 F.3d 557, 562 (D.C. Cir. 2010) (citation omitted). But Defendants often premised their decisions on findings that lacked any factual support, like their conclusions that direct notification processes are difficult to implement, that state review processes are sufficient to ensure adequate networks, and that low-income consumers routinely obtain tax credits they don't deserve.

And last, but certainly not least, "[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. But Defendants repeatedly ignored or responded in a perfunctory manner to comments that opposed their position, such as comments explaining that abolishing direct notification would leave significant numbers of people without tax credits, that HHS must itself approve auditors of potentially unscrupulous insurance agents and brokers, and that failing to track quality improvement expenditures will deter insurers from making them.

For these reasons, and others, the challenged provisions of the 2019 Rule are unlawful and must be set aside. The Court should therefore grant Plaintiffs' motion for summary judgment, deny Defendants' motion, and set aside the challenged provisions of the 2019 Rule.

ARGUMENT

I. The 2019 Rule is unlawful.

At every step, Defendants' decisions were at odds with the text and purpose of the Affordable Care Act, with the administrative record,[1] and with basic principles of reasoned decisionmaking. Plaintiffs address each of the challenged provisions of the 2019 Rule in turn.

A. Eliminating direct notification requirements

To start, Defendants' decision to eliminate the requirement that consumers receive direct notification before losing their eligibility for advance premium tax credits ("APTC") is contrary to law and arbitrary and capricious. MSJ at 31-35; Opp. at 9-16; *HHS Notice of Benefit and Payment Parameters for 2019*, 83 Fed. Reg. 16,930, 16,982-84 (Apr. 17, 2018) (AR463-604).

1. Contrary to law

Defendants' decision to eliminate the direct notification requirement is contrary to law for two reasons: (a) it deepens a conflict with the Affordable Care Act, which does not allow an individual's failure to reconcile previous receipt of tax credits to be used as a basis for denying credits in the future; and (b) stripping tax credits without first providing direct notification violates due process.

a. To start, Defendants misunderstand the relationship between the statute governing the Act's tax credits, 26 U.S.C. § 36B, and the statute providing for advance payments of those credits, 42 U.S.C. § 18082. As Plaintiffs explained in their opening brief, MSJ at 32, the Internal Revenue Code mandates that a taxpayer with income between 100 percent and 400 percent of the federal poverty line "*shall* be allowed as a credit against the tax imposed … an amount equal to the premium assistance credit amount of the taxpayer for the taxable year." 26 U.S.C. § 36B

[1] Defendants devote several pages to explaining why the Court should not consider the Declaration of Christen Linke Young or Plaintiffs' Request for Judicial Notice. Opp. at 7-8. But Plaintiffs explained that these materials were "submitted … for purposes of standing and other issues not reviewed on the basis of the administrative record," MSJ at 4, and relied on them for that purpose. *Cf., e.g.*, *Chesapeake Climate Action Network v. Export-Import Bank*, 78 F. Supp. 3d 208, 217 (D.D.C. 2015). Because Plaintiffs' standing is clear and, at this point, undisputed, the Court need not consider these materials.

(emphasis added). That, at least, Defendants do not appear to dispute. *See* Opp. at 11-12. The Affordable Care Act, however, further requires Defendants to make "advance determinations … with respect to the *income eligibility* of individuals enrolling in a qualified health plan," and if they fall within the specified income bracket, to inform the Secretary of the Treasury to "make[] advance payments of such credit." 42 U.S.C. § 18082 (emphasis added). In other words, Defendants' job is to assess whether a taxpayer falls within the relevant income bracket under Section 36B—not to punish taxpayers who failed to reconcile in a prior tax year.

Recognizing that their argument cannot be squared with the text of Section 18082, Defendants try to evade review. Defendants assert that because Plaintiffs focused on Section 36B in their Amended Complaint ("AC"), ECF No. 44, they have waived any argument about the 2019 Rule's inconsistency with Section 18082. Opp. at 12. But that makes no sense. Section 18082 simply parallels Section 36B, and Plaintiffs' Amended Complaint repeatedly alleges that "many provisions of the 2019 Rule roll back protections that the Act guarantees," AC ¶ 50, are "directly contrary to the purpose of the Act," *id.* ¶ 56, and "violate the Affordable Care Act," *id.* ¶ 282. A plaintiff need not name-check every statute the defendant is alleged to have violated if the contours of the plaintiff's legal theory are clear. *See, e.g.*, *Jones v. Koons Auto., Inc.*, 752 F. Supp. 2d 670, 683 (D. Md. 2010) (Chasanow, J.) ("[T]he failure in a complaint to cite a statute, or to cite the correct one, in no way affects the merits of a claim. Factual allegations alone are what matters.") (quoting *Albert v. Carovano*, 851 F.2d 561, 571 n.3 (2d Cir. 1988)).

Defendants also assert that Plaintiffs' challenge is time-barred. Wrong again. As an initial matter, the focus of Plaintiffs' challenge is not the failure-to-reconcile requirement, but rather the provision of the 2019 Rule eliminating the direct notification safeguard. Defendants' removal of that protection exacerbates the effect of their incorrect reading of the statute, and they cannot argue that challenges to that 2019 decision are time-barred. Even if Plaintiffs' challenge is construed as one to the failure-to-reconcile requirement itself, "[a]n 'agency's decision to adhere to the status quo ante under changed circumstances' can 'constructively reopen[]' a rule," including where "the revision of accompanying regulations 'significantly alters the stakes of

judicial review.'" *Sierra Club v. EPA*, 551 F.3d 1019, 1025 (D.C. Cir. 2008) (quoting *Kennecott Utah Copper Corp. v. U.S. Dep't of Interior*, 88 F.3d 1191, 1214, 1227 (D.C. Cir. 1996)). And the statute of limitations also does not apply to challenges which assert that "the issuing agency acted in excess of its statutory authority in promulgating them," or that "the rule conflicts with the statute from which [the agency's] authority derives." *Genuine Parts Co. v. EPA*, 890 F.3d 304, 316 (D.C. Cir. 2018) (quotations and citations omitted). That may be why Defendants failed to raise either their waiver or statute-of-limitations arguments in their motion to dismiss.

b. At the very least, the fact that the failure-to-reconcile regulation lacks support in the Affordable Care Act provides additional reason to interpret the statute to require direct notification before a consumer's tax credits may be rescinded. As Plaintiffs have explained, failing to provide advance, specific notification before terminating benefits needed to obtain medical care violates due process, and the statute should not be read to raise such concerns. MSJ at 33 (citing *O'Bannon v. Town Ct. Nursing Ctr.*, 447 U.S. 773, 786-87 (1980), and *Goldberg v. Kelly*, 397 U.S. 254, 264, 267-68 (1970)). Defendants' responses miss the mark.

Defendants object that the "Amended Complaint does not allege a procedural due process violation." Opp. at 13. But, as Plaintiffs explained in the Amended Complaint (at ¶ 55), their opposition to Defendants' motion to dismiss (at 32-33), and in their motion for summary judgment (at 33), the direct notification requirement is necessary to satisfy constitutional due process. Admittedly, Plaintiffs do not bring a standalone due process claim; rather, the fact that Defendants' change raises substantial due process issues is reason to read the statute to require direct notification. "[W]hen deciding which of two plausible statutory constructions to adopt, a court must consider the necessary consequences of its choice. If one of them would raise a multitude of constitutional problems, the other should prevail—whether or not those constitutional problems pertain to the particular litigant before the Court." *Clark v. Martinez*, 543 U.S. 371, 380-81 (2005). Similarly, the rule 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), also warrants construing the statute to require direct notification.

Next, Defendants assert that "Plaintiffs fail to provide any meaningful assessment of due process in the particular circumstances at issue here." Opp. at 13. Quite the opposite. As Plaintiffs explained in their opening brief, due process requires "timely and adequate notice" before the government terminates "essential" benefits like "medical care." MSJ at 33 (quoting *Goldberg*, 397 U.S. at 264, 267-68). "[T]he strength" of a consumer's interest in those benefits "is self-evident." *Mallette v. Arlington Cty. Emps.' Supplemental Ret. Sys. II*, 91 F.3d 630, 640 (4th Cir. 1996) (disability retirement benefits); *see also O'Bannon*, 447 U.S. at 786-87 (financial payments under Medicare and Medicaid). And Defendants ignore that the "timing of the benefit," Opp. at 13, is crucial where the certainty of obtaining financial assistance may be necessary to enable a family to obtain health insurance.

Finally, Defendants argue that direct notification is too costly in light of other procedural safeguards. Opp. at 13-14. But the record amply established the need for direct notification. 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*." *HHS Notice of Benefit and Payment Parameters for 2018*, 81 Fed. Reg. 94,058, 94,124 (Dec. 22, 2016) (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 tax credits. 83 Fed. Reg. at 16,983; AR126. "[N]early all" of the commenters voiced these concerns. 83 Fed. Reg. at 16,982; *see also* MSJ at 34-35. The fact that consumers *might* be able to correct the deficiency or *might* be able to *request* to continue receiving tax credits, Opp. at 14, does them no good when they cannot understand the reason they lost those credits in the first place. For these reasons, the statute is best interpreted to require direct notification before a consumer may lose eligibility for potentially life-sustaining health benefits.

2. Arbitrary and capricious

These same due process concerns render Defendants' decision arbitrary and capricious—indeed, Kafkaesque. MSJ at 33-34. Defendants did not provide adequate justification for jettisoning a requirement they once deemed "essential," nor explain how they expect consumers to be able to correct a deficiency that the agency cannot even identify to them. Those are critical failures that go right to the heart of Defendants' choice. *See, e.g.*, *Fox*, 556 U.S. at 515.

Defendants' cursory treatment of these concerns also represents a failure to address substantial comments in the record. While Defendants assert that they "acknowledged the competing interests involved in its decision," Opp. at 14, Defendants simply have no rebuttal—either in the 2019 Rule itself, or in their brief—to the many significant concerns raised by commenters: that indirect notices are difficult to understand, AR1458 (National Association of Health Access Assisters), fail to give definitive guidance to consumers on how to correct their ineligibility, AR1627 (Center on Budget and Policy Priorities), and are provided only in English and Spanish, AR1824 (Association of Asian Pacific Community Health Organizations); and that consumers need "significant education" to assist them in establishing eligibility, AR2493 (Georgetown University Center for Children and Families). *See also* AR1689 (UPMC Health Plan), 2590 (Asian and Pacific Islander American Health Forum), 2907 (National Association of Health Underwriters). "Nodding 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; *see also Getty v. Fed. Savs. & Loan Ins. Corp.*, 805 F.2d 1050, 1055 (D.C. Cir. 1986) ("Stating that a factor was considered ... is not a substitute for considering it.").

Defendants also failed to provide adequate support for their assertion that Exchanges could not comply with the direct notification requirement. Defendants' brief conflates the purported implementation challenges identified in the text of the rule. As to the *federal* Exchange, Defendants asserted without evidence or elaboration that the direct notification requirement would entail "changes to its notice generation and storage infrastructure," 83 Fed. Reg. at 16,984—even though they had already identified a "workaround" to provide such notices

in compliance with privacy regulations, *id.* at 16,984 n.45. As to the *state* Exchanges, Defendants pointed to a single comment by Washington's Exchange suggesting that the requirement would entail "significant implementation challenges." *Id.* at 16,984 (referring to AR2838). But two other state Exchanges, Rhode Island and Oregon, advocated for the requirement, explaining that indirect notices were "vague and confusing to the recipient of the notice." AR2579 (Rhode Island); *see also* AR2769 (Oregon) ("A 60% success rate is insufficient and justifies maintaining the current requirement to notify the tax filer directly."). Defendants also continue to lack any reasoned response to the comment submitted by the Center for Budget and Policy Priorities, which questioned why the "workaround" identified by the federal Exchange would not work across the board. AR1627.

In sum, Defendants based their decision to eliminate a procedural safeguard they previously deemed "essential" on an inflated portrayal of the implementation challenges faced by federal and state Exchanges. Defendants could not simply rest on such "conclusory or unsupported suppositions," *United Techs. Corp.*, 601 F.3d at 562 (citation omitted), especially when their "new policy rest[ed] upon factual findings that contradict those which underlay its prior policy." *Fox*, 556 U.S. at 515. "Yet [Defendants] changed course without any explanation for why that analysis was faulty." *Casa De Maryland v. DHS*, 924 F.3d 684, 705 (4th Cir. 2019). Thus, judgment should be entered for Plaintiffs on this claim.

B. Eliminating federal review of network adequacy

Defendants' decision to again shirk their responsibility to ensure that plans sold on the Act's Exchanges comply with network adequacy standards is likewise both contrary to law and arbitrary and capricious. MSJ at 35-39; Opp. at 16-21; 83 Fed. Reg. at 17,024-26.

1. Contrary to law

In their opening brief, Plaintiffs explained that Defendants' decision to outsource their network review responsibilities on federal Exchanges violates subsections (c) and (d) of 42 U.S.C. § 18031, which, respectively, require the Secretary to establish criteria for network certification and require the Exchanges—which are operated by HHS in federally facilitated

Exchange states—to implement procedures to apply them. MSJ at 35-36. Defendants wisely do not dispute that these are "mandatory" duties. *Holland v. Pardee Coal Co.*, 269 F.3d 424, 431 (4th Cir. 2001). Deferring to state (or private) certification decisions is inconsistent with these unambiguous mandates, meaning that this provision of the 2019 Rule fails at *Chevron* step one.

Defendants' response—that nothing in the statute requires HHS to actually *apply* the procedures it creates when it acts as the Exchange operator—splits the hair too thin. Opp. at 18. The ordinary meaning of the term "implement" is to "[p]ut (a decision, plan, agreement, etc.) into effect." *Implement*, Oxford U. Press, https://www.lexico.com/en/definition/implement (last visited Oct. 26, 2020); *see also Implement*, Merriam-Webster Dictionary, https://www.merriam-webster.com/dictionary/implement (last visited Oct. 26, 2020) ("carry out, accomplish," or "especially: to give practical effect to and ensure of actual fulfillment by concrete measures."). The statute therefore envisions that the Exchange operator—*i.e.*, HHS in federally facilitated Exchange states—will effectuate the procedures it designs rather than leaving it to a third party. Defendants' reading is also inconsistent with other features of the statutory scheme—from the statute's emphasis that these are "minimum" standards (which Defendants do not address), 42 U.S.C. § 18031(c), to the statute's admonition that an Exchange may only certify a plan if "such health plan meets the requirements for certification," *id.* § 18031(e). Indeed, Defendants give the game away when they acknowledge that "the 2019 Rule addresses how Federal Exchanges should *implement* those standards on an ongoing basis," Opp. at 19 (emphasis added)—because "applying" procedures is part of "implementing" them.

Defendants also fail to distinguish *U.S. Telecom Association v. FCC*, which rejected a similar attempt to delegate regulatory decisions to state authorities. Defendants assert that "there is no such sub-delegation here" because "the 2019 Rule does not even change the standards for network adequacy." Opp. at 18. But that was true in *U.S. Telecom* as well. In *U.S. Telecom*, the FCC promulgated broad standards to govern telecommunications access, but left it to state regulators to apply those standards to their markets. 359 F.3d 554, 564 (D.C. Cir. 2004). It therefore "delegated to another actor almost the entire determination of whether a specific

statutory requirement … has been satisfied." *Id.* at 567. While the D.C. Circuit acknowledged that state recommendations might be informative, it affirmed that "[a]n agency may not, however, merely 'rubber-stamp' decisions made by others under the guise of seeking their 'advice.'" *Id.* at 568. That is precisely what this provision of the 2019 Rule does.

2. Arbitrary and capricious

Nor did Defendants rationally decide to shirk their responsibilities. As Plaintiffs explained in their opening brief, commenters gave many reasons why state review processes are inadequate: among other things, they are primarily complaint-driven; they rely on private accreditors, who in turn rely on self-certification and have limited enforcement authority; and they use qualitative assessments rather than bright-line, quantitative measurements focused on travel time and distance standards. *See* MSJ at 37. For these reasons, commenters feared that states would allow inadequate networks that cause patients to delay or skip needed care. *Id.* That is not an abstract concern—it has dire consequences for people with pre-existing conditions, *id.* at 38, the protection of whom was one of the Act's core objectives and achievements, *id.* at 5-6.

Defendants claim that they "responded in detail" to these concerns regarding state review processes. Opp. at 19. But that response—the entirety of which is excerpted in Defendants' brief—simply asserts Defendants' belief that state regulators "provide appropriate review." 83 Fed. Reg. at 17,025. Again, this is a paradigmatic example of "[n]odding to concerns raised by commenters only to dismiss them in a conclusory manner." *Gresham*, 950 F.3d at 103. "[W]hen faced with considerable evidence that its preferred measure was inappropriate or incomplete … , the agency needed to provide a meaningful response to that evidence." *Dist. of Col. v. U.S. Dep't of Agric.*, 444 F. Supp. 3d 1, 23 (D.D.C. 2020).

Defendants also assert that deferring to states is sufficient because, if states lack adequate review processes, HHS can instead defer to private accrediting agencies. Opp. at 21. But the problem is that, as commenters explained, Defendants have not provided "strong federal minimum standards" for network adequacy, AR907 (Consumers Union)—meaning that what Defendants would deem "a sufficient network adequacy process" can be anything but. *See, e.g.*,

AR621 (one of multiple medical professionals), 829 (Biotechnology Innovation Organization). Moreover, Defendants focus on whether a state has the *capacity* to review network adequacy, not whether, in practice, the state actually does so. AR940 (Health & Medicine Policy Research Group). That leaves private accreditation agencies as the fallback, but a lack of adequate enforcement power is only one of the many objections commenters raised. As the American Medical Association explained, "[a]ccreditation standards are not available to the public, accreditors do not have regulatory authority over plans, and these organizations are not in a position to monitor network adequacy via consumer complaints or other such commonly used means." AR1087; *see also* AR1865 (Community Catalyst), 1964 (Coalition for Whole Health). Indeed, "most plans have been accredited for years but network adequacy problems persist." AR2744 (Families USA). Defendants' explanation therefore lacks an adequate account of how these mechanisms will be sufficient to guard against poor networks.

What Defendants are left with is an appeal to their experience. Opp. at 19. While an agency may rely on experience, it must "adequately record[] and explain[] that experience on the record." *Dist. of Col.*, 444 F. Supp. 3d at 27 (quoting *Nat'l Tour Brokers Ass'n v. ICC*, 671 F.2d 528, 533 (D.C. Cir. 1982)). And it must provide "factual support," which "does need to be based in fact and 'real' rather than manufactured." *Id.* "[R]ecord facts are the grist of reasoned agency decisionmaking." *Am. Wild Horse Pres. Campaign v. Perdue*, 873 F.3d 914, 932 (D.C. Cir. 2017). Plaintiffs mentioned various studies Defendants might have conducted solely for the purpose of describing, as *NTEU v. Horner* put it, "data of the sort [Defendants] would have considered if [they] had considered [the issue] in any meaningful way." 854 F.2d 490, 499 (D.C. Cir. 1988)—not because Defendants were obligated to conduct those studies in particular. Put differently, Defendants have failed to explain *why* they think state review processes are adequate and what facts support their view. That is precisely the sort of explanation that *PhRMA v. FTC*, 790 F.3d 198 (D.C. Cir. 2015), *National Tour Brokers Association v. ICC*, 671 F.2d 528 (D.C. Cir. 1982), and other cases have required.

Defendants also rely on the fact that they received comments in support of their decision. Opp. at 20. But those comments came primarily from health insurers or insurer trade associations, including Anthem, Centene, BCBSA, NMHC, Kaiser Permanente, ACAP, Cigna, AAAHC, AHIP, NAHU, United HealthCare, and the U.S. Chamber of Commerce. *Id.* To the extent those comments provided any analysis on the issue, they unsurprisingly focused on the burdens that additional review imposes on *insurers*. *See, e.g.*, AR869 (Anthem: "administrative burden"), 1484 (NMHC: "eliminate the burden of submitting access plans to HHS"), 2116 (Cigna: "reduce duplicative reviews"), 2535 (AAAHC: "regulatory burden for insurers"), 2688 (AHIP: "reduce duplicative reviews"). Those comments cannot substitute for a reasoned response to the many comments that pointed out flaws in state review processes. The remaining comments cited by Defendants are weakly supportive at best; as Defendants acknowledge, several explicitly "warn[ed] of uneven oversight and application." Opp. at 21; *see, e.g.*, AR3242 (Utah Health Policy Project: "The rule as proposed will gut federal protections to identify and improve the most egregious of inadequate insurer networks."). Regardless, APA review is not a popularity contest; the point is that Defendants failed to justify a critical part of their decision, relying instead on conclusory comments submitted by the parties that stood the most to gain.

Finally, Defendants do not respond at all to Plaintiffs' argument that, by eliminating federal network review, they prioritized expanding state and issuer flexibility at the expense of ensuring adequate coverage—one of the Act's statutory purposes. MSJ at 38-39. When coupled with the decisionmaking flaws outlined above, that provides more than enough reason to call into question Defendants' decision. Judgment for Plaintiffs is proper on this claim as well.

C. Reducing oversight of direct enrollment

Defendants' decision to allow entities engaging in direct enrollment, like insurance agents and brokers, to select their own auditors without advance approval by HHS is similarly arbitrary and capricious. MSJ at 39-40; Opp. at 22-25; 83 Fed. Reg. at 16,981-82. As Plaintiffs explained in their opening brief, Defendants decided to scale back oversight even though many commenters explained how doing so would increase the likelihood that customers would be

subject to mistreatment by unscrupulous agents and brokers, including by being channeled away from ACA-compliant plans. MSJ at 39-40.

Defendants again rely on the mere existence of "requirements and processes" to ensure that direct enrollment entities and auditors will comply with federal regulations and avoid conflicts of interest. Opp. at 24-25. But commenters repeatedly explained why review by an HHS-approved auditor is essential. Take the D.C. Exchange: "[G]uidance or oversight by CMS … ensures that direct enrollment entities are contracting with competent and impartial third party entities." AR1713. Or America's Health Insurance Plans: "Prior review and approval by HHS of third party audit entities provide direct enrollment partners with assurance that an auditor meets HHS' criteria," ensuring "consistent implementation of direct enrollment and protection of consumers." AR2681. And Consumers Union: HHS approval is necessary to "ensure [auditors] meet all of the necessary requirements and to protect against any potential impropriety." AR908; *see also* AR1625 (Center for Budget and Policy Priorities), 1944 (Young Invincibles), 1448 (American Diabetes Association), 1823 (Association of Asian Pacific Community Health Organizations), 2063 (former CMS Administrator), 2153 (American Heart Association), 2719 (American Cancer Society Cancer Action Network), 2737 (Families USA). Notably, the only supportive comments Defendants identify are from the Association of Web-Based Health Insurance Brokers and the National Association of Insurance and Financial Advisors—*i.e.*, brokers and agents. *See* Opp. at 24 (citing AR995, 1206). By focusing only on oversight in a general sense, Defendants "[did] not seriously respond to the actual concerns raised." *Am. Coll. of Emergency Physicians v. Price*, 264 F. Supp. 3d 89, 94 (D.D.C. 2017).

In that respect, this case is on all fours with *Friends of Back Bay v. U.S. Army Corps of Engineers*, which Defendants do not address. In *Back Bay*, the U.S. Army Corps of Engineers relied on the existence of a no-wake zone (NWZ) in concluding that a boat ramp would not disturb the local ecosystem. 681 F.3d 581, 587-88 (4th Cir. 2012). The problem: "[t]he NWZ … is entirely unenforced." *Id.* at 588. The Court rejected the Corps' assurance that "it was 'hopeful' that the public would comply with the secret NWZ," noting that "hopes" of compliance "often

remain unfulfilled." *Id.* at 588-89. The same is true here. Simply hoping that direct enrollment entities will comply with federal regulations without guaranteeing oversight by effective, unbiased auditors is no less arbitrary than the agency's decision in *Back Bay*.

Nor do Plaintiffs attempt to "second-guess an agency's well-reasoned decision." Opp. at 25 (quoting *Am. Whitewater v. Tidwell*, 770 F.3d 1108, 1116 (4th Cir. 2014)). Nothing in Defendants' decision rests on a "firm factual basis"—neither "significant data" nor "a wealth of public comments" explaining why turning oversight over to self-selected auditors would ensure compliance. *Am. Whitewater*, 770 F.3d at 1116. And unlike in *American Whitewater*, Defendants have chosen to "experiment with a practice," rather than "continuing preexisting policies." *Id.* Defendants' cursory treatment of commenters opposing their change in course renders judgment for Plaintiffs proper on this claim as well. *See, e.g.*, *Fox*, 556 U.S. at 515; *Gresham*, 950 F.3d at 102-03.

D. Eliminating standardized options

Defendants also failed to justify their decision to eliminate so-called "standardized options" (marketed as "Simple Choice" plans), rendering it arbitrary and capricious as well. MSJ at 40-43; Opp. at 25-28; 83 Fed. Reg. at 16,974-75. As Plaintiffs explained in their opening brief, CMS originally based its support for standardized options on analyses of consumer behavior that showed consumers face choice paralysis when presented with an "excessive number" of options, have trouble navigating "the large variety of cost-sharing structures available on the Exchanges," and can therefore make "simpler comparisons of plans" when presented with simple, easy-to-understand choices. *Proposed HHS Notice of Benefit and Payment Parameters for 2017*, 80 Fed. Reg. 75,488, 75,542 (Dec. 2, 2015). Each of these conclusions was echoed by a wide range of commenters on the 2019 Rule. *See* MSJ at 41-42.

Strikingly, Defendants do not dispute any of these evidence-backed findings or comments in the 2019 Rule or in their brief. Opp. at 27-28. Instead, Defendants assert that, whether or not standardized options increase enrollment, HHS decided that "encouraging Simple Choice plan

enrollment was no longer desirable," *id.* at 27—*i.e.*, that its original findings might have been true, but are now irrelevant. That admission is both stunning and wrong.

To start, Defendants misunderstand the core issue. The problem is not that fewer consumers might enroll in standardized options, but that, lacking the easy choice of standardized options, fewer consumers would enroll *period*. *See, e.g.*, 80 Fed. Reg. at 75,542 ("An excessive number of health plan options makes consumers less likely to make *any* plan selection.") (emphasis added); AR1857 (Community Catalyst: "Research confirms that individuals who are presented with too many choices are often less likely to make decisions."), 1949 (Young Invincibles: "The complexity of sorting through multiple plan options can often immobilize consumers and runs the risk that some people will decide to forgo picking a plan altogether"), 3530 (National Health Council: "This could present patients with challenges that may lead to inappropriate coverage selections or discourage enrollment altogether."). By asserting that "encouraging Simple Choice plan enrollment was no longer desirable," Opp. at 27, Defendants therefore miss the mark entirely.

Properly framed, enrollment is not a factor that Defendants can "discount[]" or dismiss as not "significant" or "relevant." Opp. at 27-28 (quotations omitted). An agency must respond to all "significant" comments, defined as all those "which, if true, raise points relevant to the agency's decision and which, if adopted, would require a change in an agency's proposed rule." *Portland v. EPA*, 507 F.3d 706, 715 (D.C. Cir. 2007) (quotation omitted). That is the case where, as here, the comments at issue go to the heart of the statutory scheme. *Cf. Price*, 264 F. Supp. 3d at 96 (finding comments significant where, if true, the proposal would "defeat the purpose of the protections in the statute") (citation omitted). Enrollment is indisputably one of the Act's core objectives. *See, e.g.*, *Me. Cmty. Health Options v. United States*, 140 S. Ct. 1308, 1315 (2020); *King v. Burwell*, 576 U.S. 473, 479 (2015); *Nat'l Fed'n of Indep. Bus. v. Sebelius*, 567 U.S. 519, 538 (2012); *cf. Gresham*, 950 F.3d at 103 (concluding that the failure to consider enrollment under Medicaid was fatal to the agency's decision). Defendants' failure to explain away their previous findings or engage with negative comments on the critical subject of enrollment—as

opposed to enrollment in standardized options in particular—is therefore a fatal defect in their decision.

With respect to *overall* enrollment, the best Defendants can do is invoke the other tools offered by Exchanges. But those tools are a thin reed, at best; they hardly redress the concerns outlined by the agency and by commenters regarding how consumers experience difficulty in comparing plans and understanding cost-sharing features. *See, e.g.*, AR905 (Consumers Union: "Standardized designs enable the apples-to-apples comparisons that are essential for sound consumer decision making."), 2735 (Families USA: reporting results of a survey showing that enrollment assisters found standardized options useful to the consumers they serve), 3008 (Planned Parenthood Federation of America: "[W]ithout standardized options, consumers frequently choose plans based only on premiums—without a clear understanding of additional out-of-pocket costs they might experience, as well as the benefits covered under the plan."). Moreover, these tools existed when HHS first established standardized options, and so deciding to offer standardized options in the first place reflects HHS's judgment that those tools were insufficient.

Defendants' focus on these tools also shows how their argument is contradictory. Defendants dismiss all talk of decreased enrollment as "not relevant," Opp. at 28 (quotation omitted), while, at the same time, relying on comments about enrollment that support their position. "[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) (emphasis added). If Defendants choose to predicate their decision on the assumption that it will not harm enrollment, then they must engage with the comments—not to mention their *own findings*—that point the other way.

Finally, Defendants' emphasis on innovation is unsustainable on its own terms. Again, HHS itself previously explained that "[w]e are not requiring issuers to offer standardized options, nor limiting their ability to offer other QHPs, and as a result, we do not believe that standardized options will hamper innovation or limit choice." *HHS Notice of Benefit and Payment Parameters*

for 2017, 81 Fed. Reg. 12,204, 12,292 (Mar. 8, 2016). Similarly, HHS rejected concerns that "differential or preferential display of standardized options could inadvertently steer consumers" to unsuitable plans, finding that "most consumers with specialized health care needs will carefully shop for coverage that provides the right mix of cost-sharing protections, benefits, and networks." *Id.* Defendants do not explain why those conclusions were incorrect, or address their failure to engage with the many commenters who made the same points. *See, e.g.*, MSJ at 42-43 (citing AR1135 (Society for Public Health Education), 1172 (Leukemia & Lymphoma Society), 1313 (The Chronic Illness & Disability Partnership), 1445-46 (American Diabetes Association), 1695 (National Psoriasis Foundation), 2151 (American Heart Association et al.), 2836 (Washington Health Benefit Exchange), 2924 (Colorado Center on Law and Policy)). In other words, the same basic flaws infected Defendants' appraisal of both the costs and the benefits of their decision.

For these reasons, Defendants' decision is even more arbitrary than the policy set aside in *United Steel v. Mine Safety & Health Administration*. In *United Steel*, the Mine Safety and Health Administration required mines to inspect for adverse conditions before miners start work, finding that to do otherwise would risk exposing miners to safety risks, but did not address that finding in rescinding that requirement. 925 F.3d 1279, 1284 (D.C. Cir. 2019). Like in *United Steel*, Defendants here reversed course in a manner that implicates a core statutory objective—indeed, one that underpinned the agency's original choice—without adequate explanation, no matter how much they try to cast that objective as irrelevant. But Defendants also contradicted their previous findings in concluding that their new policy was necessary to facilitate innovation. Their decision therefore violates the basic maxim that an agency explain its change of course and revised factual findings, *see, e.g.*, *Fox*, 556 U.S. at 515, and warrants judgment for Plaintiffs.

E. Undermining the Navigator program

Defendants' decision to weaken the standards for the Navigator program similarly violates their statutory duties and is arbitrary and capricious. MSJ at 43-47; Opp. at 29-33; 83 Fed. Reg. at 16,979-82.

1. Contrary to law

Navigators play an indispensable role in ensuring that consumers can access reliable information about the Act's Exchanges and find their way through the enrollment process. For that reason, as Plaintiffs explained in their opening brief, Navigators have long been subject to a detailed set of criteria designed to ensure that Navigators can perform their statutory functions. MSJ at 43. But Defendants' changes to the regulations governing Navigators permit an Exchange to select Navigators that cannot perform those functions, including by selecting a single Navigator that lacks connections to the many populations an Exchange must serve, by selecting a for-profit Navigator that lacks any ties to the community, or by selecting a distant Navigator that lacks a physical presence in the area. *Id.* at 44. Defendants largely do not dispute the importance of these criteria in selecting Navigators.

Instead, Defendants' sole rebuttal is that "[t]he 2019 Rule does not purport to relieve Navigators of their statutory duties," and that one cannot assume that an "Exchange will willfully violate these statutory requirements" by selecting unfit Navigators. Opp. at 30. But the statute requires Defendants to do more than simply assume that Exchanges will select appropriate Navigators. Under the statute, "[t]he Secretary *shall* establish standards for navigators … , including provisions to *ensure* that any private or public entity that is selected as a navigator is qualified, and licensed if appropriate, to engage in the navigator activities described in this subsection and to avoid conflicts of interest." 42 U.S.C. § 18031(i)(4)(A). This "mandatory" duty, *Holland*, 269 F.3d at 431, requires Defendants to "ensure," defined as "[m]ake certain that (something) shall occur or be the case," that Exchanges select Navigators that can perform their statutory functions. *Ensure*, Oxford U. Press, https://www.lexico.com/en/definition/implement (last visited Oct. 26, 2020). If Defendants could instead simply reiterate the statutory criteria in their regulations and hope that others take action to ensure that the statutory requirements are met, that prophylactic requirement would be meaningless.

Defendants also misread the comments submitted by certain state Exchanges. Opp. at 31. Washington's Exchange criticized the changes on the grounds that "it is critical that any

Navigator organization maintain a local presence in Washington"; that "it would be difficult for out-of-state organizations to adequately serve in the Navigator capacity"; and that community-focused organizations often "keep … in touch with customers and create a relationship with them." AR2838. But because Washington intended to maintain the same approach regardless, the proposed changes would have no effect on its program. *Id.*; *see also* AR2769 (Oregon also taking no position because it would retain control over its Navigators). Similarly, Colorado defended its "strong enrollment assistance network with a team of trusted, local experts who are available across the state." AR2988. In context, these Exchanges were explaining why the proposed changes would *prevent* Navigator programs from meeting their statutory duties. Defendants' decision to eviscerate the regulations designed to ensure that Navigators live up to their statutory functions is therefore contrary to law.

2. Arbitrary and capricious

Defendants' attempts to explain why their Navigator changes are not arbitrary and capricious are simply more of the same. Opp. at 31-33. The critical question is whether Defendants reasonably concluded that eliminating a minimum floor for Navigator programs and instead giving complete discretion to Exchanges with respect to the number, location, and type of Navigators would facilitate enrollment in ACA-compliant health coverage. It is no answer to say that Exchanges "retain flexibility to select the Navigators they believe will best serve their population," Opp. at 32; the question is what minimum standards HHS should insist upon, rather than leaving everything in the hands of the Exchanges. *See* MSJ at 46-47; *Friends of Back Bay*, 681 F.3d at 589 (noting that "hopes" of compliance "often remain unfulfilled").

Once the question is properly framed, the cursory quality of Defendants' response to adverse comments is apparent. Commenters explained, at length, how eliminating these minimum standards would mean that "marketplace service areas may lack sufficient access to navigators and the marketplaces may not meet their statutory requirement to ensure navigators carry out all duties required under law." AR1623 (Center for Budget and Policy Priorities). Minnesota's Exchange, for example, "appreciate[d] that the proposed changes to the regulations

would leave Minnesota with the flexibility to maintain our current standards," but "oppose[d] these proposed changes because our experience tells us they are not in the best interests of *any* Exchange customers." AR2545 (emphasis added). Similarly, Young Invincibles noted that "[w]e share HHS' stated goal of ensuring that the strongest applicants are selected to serve as navigators," but found "that groups that have strong community ties and are physically present in the community … provide the best support to consumers and are *necessary* to the enrollment process." AR1947-48 (emphasis added); *see also* AR908 (Consumers Union: "[F]lexibility must not be at the expense of efficacy and quality."). These comments underscore the need for a sufficient set of minimum standards to ensure that Navigator programs fulfill their statutory purposes.

Defendants' arguments as to the specific requirements also miss the mark.

As to the physical presence requirement, Defendants asserted that increased flexibility allows Exchanges to determine whether "other considerations" outweigh presence in the area. Opp. at 31. But Defendants themselves found that, "[b]ased on HHS's experience with Navigator programs in FFEs and other public programs, we believe entities with a physical presence and strong relationships in their FFE service areas tend to deliver the *most effective* outreach and enrollment results." AR118 (emphasis added); *see also* MSJ at 46. To then allow Exchanges to deviate from the physical presence requirement based on undefined and, by Defendants' own admission, less important criteria is therefore "internally inconsistent." *Air Transp. Ass'n of Am. v. Dep't of Transp.*, 119 F.3d 38, 43 (D.C. Cir. 1997).

As to the two-Navigator requirement, Defendants invoke HHS's belief that its change would not affect the availability of assistance. Opp. at 32. But that assertion continues to lack any factual foundation. In contrast, commenters explained how a single Navigator cannot, to use the statute's language, maintain "relationships" or "facilitate enrollment" among diverse populations, "provide information in a manner that is culturally and linguistically appropriate to the needs of the population" as a whole, or even accommodate the volume of support needed in a given area. MSJ at 43-44. Again, "when faced with considerable evidence that its preferred

measure was inappropriate or incomplete … , the agency needed to provide a meaningful response to that evidence." *Dist. of Col.*, 444 F. Supp. 3d at 23.

And, as to the community and consumer-focused requirement, Defendants claim that "the[] strongest applicant may not be a community and consumer-focused nonprofit group." Opp. at 32. But Defendants' argument simply begs the question of which sorts of groups are the "strongest." As commenters explained, at length, community-focused Navigators "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); MSJ at 45-46. To dismiss these concerns based solely on a hypothetical situation where a non-community focused group is the only strong option is unreasonable. To the extent that may be the case, that simply provides another reason for requiring Exchanges to select more than one Navigator, so they select the "strongest" applicant as well as another candidate with stronger ties to the community.

Defendants then try to back away from their assertion that other entities, like agents, brokers, and other direct enrollment entities, could supplant Navigators—in other words, letting biased, commercial entities take over from non-profit, consumer-focused organizations. Specifically, Defendants protest that "[n]owhere did HHS suggest that such entities would take over functions that the ACA assigns to Navigators." Opp. at 33. But Defendants in fact did "agree that agents, brokers, and direct enrollment partners can be well situated to provide enrollment assistance or remote services to consumers" instead of Navigators. 83 Fed. Reg. at 16,981. Indeed, in Defendants' motion to dismiss the Amended Complaint, Defendants themselves explained that "in removing the physical presence requirement, CMS considered the availability of other resources (*e.g.*, agents, brokers, and direct enrollment partners) 'to provide enrollment assistance or remote services to consumers.'" Defs.' Mem. of Law in Supp. of Mot. to Dismiss Pls.' AC ("MTD"), ECF No. 52-1 at 33 (quotation omitted). That admission, coupled with Defendants' decision to allow Exchanges to select a single, commercially focused

Navigator, illuminates how Defendants decided to undermine the Navigator program in the guise of providing additional flexibility.

Once again, Defendants elected to remove essential requirements without adequately responding to adverse comments, without justifying their change in course or their changed factual findings, and in derogation of the Act's central purposes. *See, e.g.*, *Fox*, 556 U.S. at 515; *Gresham*, 950 F.3d at 103. Judgment is therefore warranted for Plaintiffs on this claim.

F. Weakening small business exchanges

The same is true of Defendants' decision to remove core functionalities from the Small Business Health Options Programs ("SHOPs"), which is both contrary to law and arbitrary and capricious. MSJ at 47-49; Opp. at 33-38; 83 Fed. Reg. at 16,996-17,006.

1. Contrary to law

As Plaintiffs explained in their opening brief, and Defendants do not dispute, SHOPs have mandatory duties to "assist … small employers in facilitating the enrollment of their employees" and to "make available qualified health plans." 42 U.S.C. § 18031(b)(1)(B), (d)(2)(A). Defendants also agree that SHOPs must provide "basic SHOP functionalities"—defined as functionalities "essential to ensure that SHOPs will meet their statutory obligation to assist small businesses." Opp. at 35 (quotation omitted). Both sides agree, then, that the key question is whether the functions eliminated by the 2019 Rule are necessary to meet these statutory mandates.

They are. Start with the requirement to directly enroll employees, which "enables a transparent, competitive marketplace, unimpeded consumer choice, and purchasing power." AR1715 (D.C. Health Benefit Exchange Authority). A SHOP that simply directs employers to a private insurer or broker to complete the enrollment process—*i.e.*, exactly how employers would have enrolled employees prior to the Act—has not "facilitat[ed] the enrollment" of those employees in any meaningful sense. 42 U.S.C. § 18031(b)(1)(B); *see also Facilitate*, Oxford U. Press, https://www.lexico.com/en/definition/implement (last visited Oct. 26, 2020) ("Make (an action or process) easy or easier."). Put differently, it clearly would not count as facilitation if a

SHOP simply operated a website that gave small businesses a list of private insurers. Defendants respond with a legal fiction of their own creation: that enrollment "with a SHOP-registered agent or broker … will be considered to be an enrollment through a SHOP." Opp. at 36 (quotation omitted). But a provision must be interpreted to "produce[] a substantive effect that is compatible with the rest of the law," *King*, 576 U.S. at 492-93 (citation omitted)—here, actually helping employees enroll in coverage. An enrollment conducted through a third party is not an enrollment that the SHOP has "facilitated."

Similarly, verifying enrollee eligibility is a "basic [] functionalit[y]" of an Exchange. Defendants admit that "providing eligibility determinations for small *employers*," Opp. at 35 (emphasis added), is such a function. But if one is essential, then so must be the other: both are necessary components of verifying whether an employee can use the SHOP to obtain health insurance. Moreover, as one trade association noted, "[i]f SHOPs no longer are required to notify an employer of eligibility in advance of the purchase of a QHP, employers that purchase a QHP but are subsequently found ineligible—possibly in error—must undertake an arduous campaign to appeal the decision" or procure insurance elsewhere. AR3172 (American Physical Therapy Association). Indeed, if verifying *consumer* eligibility were removed from the individual ACA Exchanges, it is hard to imagine how a consumer could readily use them to enroll in coverage.

Premium aggregation is also necessary to fulfill the statute's mandates. As the D.C. Exchange explained, "[p]remium aggregation is another core SHOP function that allows employers to offer true employee choice." AR1715. Defendants respond that the D.C. Exchange "did not provide any evidence," Opp. at 36, but it explained how premium aggregation "free[s] employers from the burden of managing premium billing processes from multiple health insurance carriers," AR1715. As a result, "[a]pproximately 61% of people in DC Health Link SHOP chose their coverage among many QHPs offered by their employers." *Id.* But "[w]ithout premium aggregation, it is difficult or impossible for small businesses to offer a choice of multiple insurers and plans to their employees." *Id.* Premium aggregation is therefore a core function of a small business exchange.

More fundamentally, however, Defendants have no response to how their changes alter the nature of the enrollment process. As multiple commenters explained, these changes 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). In that respect, the SHOP changes are of a piece with other efforts by Defendants to shunt enrollment away from the marketplaces established by the Act and toward a loosely regulated cohort of self-interested agents and brokers. By doing so through removing these "basic functionalities" of a SHOP, these changes are contrary to law.

2. Arbitrary and capricious

Even if Defendants could permissibly eliminate these SHOP requirements, they did so by ignoring the impact on those who use the SHOPs. Defendants spill much ink explaining how they conducted a "*policy* assessment" rather than an "*economic* analysis of costs and benefits," which they think somehow relieves them of the burden to consider the costs to the public. Opp. at 37. But the point is simply that an agency must consider all "important aspect[s] of the problem" before it, *Motor Vehicle Mfrs. Ass'n of U.S., Inc. v. State Farm Mut. Auto. Ins. Co.*, 463 U.S. 29, 43 (1983), including "potential harms" and "additional … costs," *SecurityPoint Holdings, Inc. v. TSA*, 769 F.3d 1184, 1188 (D.C. Cir. 2014); *see also Mingo Logan Coal Co. v. EPA*, 829 F.3d 710, 733 (D.C. Cir. 2016) (Kavanaugh, J., dissenting) ("[C]ommon administrative practice and common sense require an agency to … reasonably decide and explain whether the benefits outweigh the costs."). That obligation persists regardless of how an agency tries to frame its analysis.

Here, that means adequately considering the interests of the small businesses that rely on SHOPs to provide health insurance to their employees. As explained above, "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"). Defendants' brief does not even mention these concerns, perhaps because their treatment of them in the 2019 Rule itself was dismissive and cursory, *see* AR531—again, hardly "a hallmark of reasoned decisionmaking." *Gresham*, 950 F.3d at 103.

Defendants rely on comments from certain Exchanges and others that supported the proposed changes. Opp. at 37-38. But those comments are unilluminating. To the extent they provide reasoning at all, they wanted Defendants to allow employers to access small business tax credits without having to go through the SHOPs, which could be accomplished without removing core SHOP functions. *See, e.g.*, AR1616 (Alaska Division of Insurance); 3629 (Doc. ID CMS-2017-0078-2686, Blue Cross Blue Shield Association). Retaining those functions but allowing access to the tax credits was a "responsible alternative[]" to the agency's "chosen policy" that required the agency to provide "a reasoned explanation for its rejection." *Am. Radio Relay League, Inc. v. FCC*, 524 F.3d 227, 242 (D.C. Cir. 2008) (quotation omitted). Other commenters sought the elimination of SHOPs entirely, which is plainly incompatible with the statutory mandate. *See* AR3587 (Doc. ID CMS-2017-0078-0138, West Virginia Offices of the Insurance Commissioner). None provide good reason to eliminate these functions. Defendants also rely on the fact that several other state Exchanges were already operating "leaner" SHOPs, Opp. at 38, but notably, do not point to any evidence that those SHOPs were effective at connecting employers and employees to coverage.

In basing their decision on low SHOP usage, Defendants also ignored the degree to which low usage was likely to be temporary or a product of factors other than the utility of the SHOPs. As the Center for Budget and Policy Priorities explained, "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. "In addition, many small firms opted to remain with pre-ACA 'transition' (also known as 'grandmothered') plans, which reduced the potential market for the SHOPs." *Id.* Again, Defendants merely reiterate that their changes were a "reasoned

response to decreased utilization of SHOPs" without engaging with these points. Opp. at 38. Defendants therefore failed to reasonably assess the costs or the benefits of their decision, and judgment is again warranted for Plaintiffs.

G. Imposing burdensome and unnecessary income verification requirements

Defendants also did not adequately consider the costs and benefits of imposing burdensome new income verification requirements for low-income consumers, rendering that decision arbitrary and capricious as well. MSJ at 49-51; Opp. at 38-42; 83 Fed. Reg. at 16,985-87. As Plaintiffs explained in their opening brief, those requirements threaten to prevent consumers from obtaining tax credits they need to access medical care in order to solve an entirely illusory concern of fraud—one for which Defendants admitted they lacked "firm data." MSJ at 49-51.

Defendants respond that they "acknowledged" the effect on low-income consumers, which they assert is sufficient for purposes of arbitrary and capricious review. Opp. at 40. But, at risk of beating a dead horse, that is not the law. *See, e.g.*, *Gresham*, 950 F.3d at 103 ("Nodding to concerns raised by commenters only to dismiss them in a conclusory manner is not a hallmark of reasoned decisionmaking."); *Getty*, 805 F.2d at 1055 ("Stating that a factor was considered ... is not a substitute for considering it."). The question is therefore whether Defendants actually grappled with the concerns raised by commenters.

They did not. Defendants primarily rely on the ten percent threshold for income verification and the existence of tools to guide consumers in the verification process. Opp. at 40. But neither of these points gets to the heart of the issue: that increased administrative burdens will "likely deter enrollment or leave low-income consumers without affordable access to coverage." AR909 (Consumers Union); MSJ 49-50 (citing additional comments). Comments also explained that a ten percent threshold is too low for low-income consumers, who can easily experience fluctuations that exceed that threshold. *See, e.g.*, AR1628 (Center for Budget and Policy Priorities). When consumers do experience such fluctuations, the tools cited by Defendants provide little help; a calculator cannot complete the verification process for a

consumer, and a guide cannot help consumers obtain documentation that may be difficult to access or nonexistent. *See, e.g.*, *id.*; AR1943 (Young Invincibles), 2063 (former CMS Administrator), 2682 (America's Health Insurance Plans), 2738 (Families USA). The fact that Defendants might come up with additional "strategies," Opp. at 40 (quotation omitted), to help low-income consumers in the future does nothing to help such consumers now. (Tellingly, Defendants do not point to any such strategies they have since adopted.) Defendants therefore failed to provide a reasoned response to these issues.

Defendants also defend their reliance on unquantified and uncorroborated concerns regarding fraud. Defendants attempt to distinguish *Tripoli Rocketry Association, Inc. v. ATF*, 437 F.3d 75 (D.C. Cir. 2006), on the grounds that *Tripoli* involved a "highly technical scientific question," rather than a "policy choice." Opp. at 41. But the flaw in Defendants' decision is not their policy choice *per se*, but rather the lack of factual support for a critical element of their decision. In any event, Defendants' argument gets it precisely backwards. As *Tripoli* recognized, "court[s] routinely defer[] to administrative agencies on matters relating to their areas of technical expertise," 437 F.3d at 77, because agencies are typically more qualified to determine what "conclusions to draw from technical evidence or how to adjudicate between rival scientific theories," *id.* at 83. Even in that deferential context, however, *Tripoli* held that the agency had failed to supply a reasoned basis for its determinations regarding rocket fuel. *Id.* at 84. In contrast, whether income verification requirements are needed to address fraud, despite their deterrent effect on low-income consumers, does not involve any technical scientific expertise, and the standard to which Defendants' factual determination must be held is necessarily higher.

Defendants also cite *Huntco Pawn Holdings, LLC v. U.S. Department of Defense*, 240 F. Supp. 3d 206, 225-26 (D.D.C. 2016), but that case is inapposite. *Huntco* recognized that, although the APA does not require agencies to "obtain[] the unobtainable," it is a different matter to "set aside agency action … because of failure to adduce empirical data that can readily be obtained." *Id.* (quoting *BNSF Ry. Co. v. U.S. Dep't of Transp.*, 566 F.3d 200, 203 (D.C. Cir. 2009)). Defendants provide no reason why such information could not have been obtained—*i.e.*,

through targeted audits of a sample of consumers, through consultation with the IRS, or through other methods. *Huntco* is also distinguishable because the agency in that case at least pointed to "anecdotal evidence of misuse," *id.* at 225; here, Defendants have provided nothing to support their assertions of fraud. Finally, although there may theoretically be an incentive for consumers to inflate their income in non-Medicaid expansion states, there is obviously no incentive for consumers to do so in states that did expand Medicaid, as Defendants seem to acknowledge. Opp. at 41-42.

Defendants imposed a significant administrative hurdle for the consumers who most need the Act's financial support without anything more than a suspicion of fraud. The APA requires more than reliance on such "conclusory or unsupported suppositions." *United Techs. Corp.*, 601 F.3d at 562 (citation omitted). Judgment is therefore warranted for Plaintiffs.

H. Curtailing insurance rate review

Defendants also decided to scale back procedural protections designed to prevent insurers from overcharging consumers. Defendants' decisions to exempt student health plans from federal rate review requirements and to lift the threshold for rate review to increases of fifteen percent or more are contrary to law and arbitrary and capricious. MSJ at 51-55; Opp. at 42-50; 83 Fed. Reg. at 16,972-73.

1. Contrary to law

Defendants' decision to exempt student health plans from rate review is contrary to law. As Plaintiffs explained in their opening brief, the Affordable Care Act requires Defendants to review "unreasonable increases in premiums for health insurance coverage," 42 U.S.C. § 300gg-94(a)(1)—a category that indisputably includes *student* health insurance coverage. MSJ at 51. That alone should warrant judgment in Plaintiffs' favor on this claim.

Plaintiffs also explained that a separate provision of the Act, which bars it from being "construed to prohibit an institution of higher education … from offering a student health insurance plan," 42 U.S.C. § 18118(c), does not exempt student health plans from federal rate review requirements. MSJ at 52. That provision was the crux of Defendants' motion to dismiss

as to this claim. MTD at 26-27. Now, however, Defendants do not so much as mention that provision—instead concocting a new theory that "nothing in § 300gg-94 expressly requires the Secretary to apply uniform rate review requirements to all health insurance coverage," and so HHS permissibly "exercised its discretion to determine that student health insurance should not be subject to the process for revising proposed rate increases." Opp. at 46.

Nearly every part of Defendants' new theory is wrong. To start, HHS did not decide to modify rate review requirements for student health plans; it exempted student health plans wholesale. That decision violates the requirements—again, couched in mandatory language, *Holland*, 269 F.3d at 431—that HHS "*shall* establish a process for the annual review … of unreasonable increases in premiums for health insurance coverage," which "*shall* require health insurance issuers to submit to the Secretary and the relevant State a justification for an unreasonable premium increase." 42 U.S.C. § 300gg-94(a) (emphasis added). HHS's power to "promulgate such regulations as may be necessary or appropriate to carry out" rate review, *id.* § 300gg-92, is not the power to exempt categories of insurance from rate review at whim. *See Colo. River Indian Tribes v. Nat'l Indian Gaming Comm'n*, 466 F.3d 134, 139 (D.C. Cir. 2006) ("An agency's general rulemaking authority does not mean that the specific rule the agency promulgates is a valid exercise of that authority."). When Congress wanted to exempt forms of insurance from ACA requirements, it knew how to do so. *See, e.g.*, 42 U.S.C. §§ 300gg-91(c), 18011(a)(3)-(4). Defendants say that the canon against implying additional exceptions is "inapposite," Opp. at 46, but whether Defendants create new exceptions through redefining statutory terms or through nullifying statutory requirements is semantics.

The provision that *actually* gives Defendants the authority to waive certain statutory requirements is Section 18118, which bars the Act from being interpreted to prohibit student health plans. Indeed, the prior exemptions that Defendants cite, *see* Opp. at 43-44, expressly relied on this provision. But then we're back where we started. Defendants still have not explained how subjecting student health plans to rate review would have the effect of prohibiting such plans within the meaning of Section 18118, and have now waived any argument to that

effect. As CMS itself explained, that section "permits limited exemptions for student health insurance coverage"; it "does not allow CMS to except student health insurance coverage from compliance with all Federal requirements," including, as CMS admitted, "rate review." *Student Health Insurance Coverage*, 77 Fed. Reg. 16,453, 16,458 (Mar. 21, 2012); *see also* 81 Fed. Reg. at 12,214-15; *Health Insurance Market Rules; Rate Review*, 78 Fed. Reg. 13,406, 13,424 (Feb. 27, 2013) (similar). And if Defendants' general regulatory authority encompassed the authority to exempt student health insurance from ACA requirements wholesale, then Section 18118 would serve little purpose. *Cf.* Opp. at 47 n.5.

Defendants also analogize student health insurance to large group coverage. Opp. at 47. But that is beside the point; as Defendants acknowledge, they have themselves treated student coverage as "a type of individual market coverage … generally subject to … individual market requirements … includ[ing] rate review." 83 Fed. Reg. at 16,972. And the legality of exempting large group coverage from rate review requirements is not at issue in this case. Regardless, when HHS first proposed to exempt large group coverage, it recognized that its decision was in tension with the statute, which "contain[s] no specific exclusion for the large group market." *Rate Increase Disclosure and Review*, 75 Fed. Reg. 81,004, 81,009 (Dec. 23, 2010). It also predicated its decision on the facts that "[t]he significant majority of States focus their efforts on review of rates within the small group and individual markets," and that "few States could satisfy the standards for an effective review process in the large group market." *Id.*; *see also id.* at 81,024. In contrast, student health plans have been subject to rate review since the beginning of the rate review system. HHS's decision to open one hole in the statute is hardly reason to tear another.

2. Arbitrary and capricious

Even assuming that Defendants had the authority to exempt student health plans, that decision and their decision to raise the threshold for rate review are both arbitrary and capricious.

a. As to student health plans, Defendants reiterate their view that "student health insurance coverage resemble[s] large group coverage" because "institutions of higher education are sophisticated entities with considerable negotiating power." Opp. at 48. But Defendants have

repeatedly concluded that student health insurance is a form of individual insurance and is presumptively subject to the regulations governing such insurance. *See, e.g.*, *HHS Notice of Benefit and Payment Parameters for 2015*, 79 Fed. Reg. 13,744, 13,752 (Mar. 11, 2014); 77 Fed. Reg. at 16,458. Indeed, because "student health insurance plans are not employment-based, they do not meet the definition of a group health plan" under the Public Health Service Act. *Student Health Insurance Coverage*, 76 Fed. Reg. 7,767, 7,769 (Feb. 11, 2011). Defendants were therefore required to explain one of two things: either (1) how the nature of student health insurance has changed over time to warrant treatment as large group insurance, or (2) why Defendants decided, after seven years, to change their understanding of student coverage. Their failure to adequately explain these "factual findings that contradict those which underlay its prior policy" renders their decision arbitrary and capricious. *Fox*, 556 U.S. at 515.

Defendants also assert that they were not required to respond to comments arguing that exempting student health plans would increase rates because commenters failed to provide sufficient evidence. Opp. at 48. That is incorrect. The comment by Young Invincibles, for example, cited a nationwide investigation by the New York Attorney General that found that "conflicting relationships between insurers and agents ... created incentives to work against the best interests of the students and persuade schools into offering overly costly plans," as well as a Massachusetts study finding that student health plans were vastly more profitable than other forms of coverage. AR1945 (quotation omitted). That amply meets the minimal requirement that there be "*some* basis for thinking a position taken in opposition to the agency is true." *HBO v. FCC*, 567 F.2d 9, 35 n.58 (D.C. Cir. 1977) (emphasis added). The idea that scaling back rate review would lead to rate increases is not exactly rocket science. In any event, the agency itself has agreed with past commenters that "compliance solely with State laws has failed to ensure that students had access to comprehensive coverage in the past." 77 Fed. Reg. at 16,458. Defendants were therefore required to provide a non-conclusory response to these important points. *Gresham*, 950 F.3d at 102-03.

Defendants' other arguments are similarly unavailing. Defendants note that some comments supported their decisions, but what they fail to acknowledge is that, again, many of those comments came from *insurers*, which would obviously be expected to oppose barriers to raising rates. Opp. at 44, 49. Defendants cannot simply rely on comments that support their outcome; they need to supply a reasoned response to the substantial, evidence-backed concerns outlined above. Defendants also observe that "[s]tates are … free to continue to review student health rates," *id.* at 49, but that undermines Defendants' position that student plans resemble large group coverage—it demonstrates that, unlike with large group coverage, *see* 75 Fed. Reg. at 81,009, states possess the authority and the ability to review student rates. The fact that states might continue to review student rates is, in any event, no reason to stop requiring them to do so.

b. Defendants' decision to increase the threshold for rate review was also arbitrary. Defendants place great weight on the fact that only one rate that fell between ten percent and fifteen percent was deemed arbitrary. But that response overlooks several key benefits of rate review, as discussed in the record. As a general matter, rates may change before or during the rate review process; according to Families USA, "ratereview.gov shows numerous examples where initially proposed rates below 15 percent decreased further before they were approved in the last three years." AR2734; *see also* AR2005-06 (American Hospital Association: "In many instances, rates have changed after plans have submitted additional information to state regulators."), 2138 (Federation of American Hospitals referring to "the moderating pressures of rate review"). Moreover, as Community Catalyst explained, Defendants' "proposal would … mean fewer plans would be required to submit a narrative justification for their rates," resulting in "less transparency in the rate-setting process." AR1856. Defendants themselves 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. By focusing narrowly on how many rates were deemed unreasonable at the end of the process, rather than as a result of the existence of the process itself, Defendants took a myopic view of the harms of their policy change.

Defendants also dismiss comments about how future rate increases were likely to fall closer to the revised threshold by asserting that, "if warranted in the future, HHS may adjust the threshold again at that time." Opp. at 50. But that response is cursory at best. As the Center for Budget and Policy Priorities explained, "market conditions can change quickly from one year to the next"; past increases were based on "extraordinary circumstances," like uncertainty caused by the Administration's policy changes, and "do[] not indicate that rate increases of this magnitude should be automatically considered reasonable going forward." AR1623; *see also* AR2288 (U.S. Public Interest Research Group: "The current 10% threshold is far higher than the rate of health care cost growth, currently estimated by CMS at 5.7%."), 2734 (Families USA citing additional data concerning premium growth). Defendants therefore set the threshold at a place that current evidence did not justify.

In adopting these two changes to the rate review process, Defendants again eliminated key procedural protections needed to avoid raising prices on consumers. Because they again did so against their prior legal and factual conclusions and without an adequate response to the concerns raised by commenters, judgment is again warranted for Plaintiffs. *See, e.g.*, *Fox*, 556 U.S. at 515; *Gresham*, 950 F.3d at 103.

I. Reducing medical loss ratio rebates

The final provision at issue in this case—Defendants' decision to allow insurers to avoid paying rebates by claiming a flat 0.8% rate for improving the quality of their services—exhibits many of the same flaws described above. It is both contrary to law and arbitrary and capricious. MSJ at 55-58; Opp. at 50-55; 83 Fed. Reg. at 17,032-33.

1. Contrary to law

As Plaintiffs explained in their opening brief, the ACA requires insurers to report "the percentage of total premium revenue … that such coverage *expends*" on quality improvement 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), (b)(1)(A) (emphasis added). The statute thus can only reasonably be read to "require[] 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). To allow insurers to instead claim a flat 0.8% rate for quality improvement activities ("QIA") amounts to a de facto adjustment of the medical loss ratio ("MLR") from 80% to 79.2% without complying with the statutory procedures for making such an adjustment. *See* 42 U.S.C. § 300gg-18(b)(1)(A)(ii), (d).

Defendants cannot and do not dispute these points, so they again attack a strawman. Defendants assert that "the statute does not require issuers to detail each QIA expenditure that contributes to the calculation of the MLR." Opp. at 52. As Plaintiffs explained in opposing Defendants' motion to dismiss, *see* Pls.' Opp'n to Defs.' Mot. to Dismiss Pls.' AC at 48, ECF No. 61, the statute requires insurers to report the *actual* amount they expended, even if it does not require them to do so in a particular manner. In that vein, Defendants have no response to how CMS itself recognized in promulgating the initial MLR regulations that the statute "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." *Health Insurance Issuers Implementing Medical Loss Ratio (MLR) Requirements*, 75 Fed. Reg. 74,864, 74,865-66, 74,875 (Dec. 1, 2010).

Defendants fall back on HHS's general authority to promulgate regulations. Opp. at 52. Again, however, "[a]n agency's general rulemaking authority does not mean that the specific rule the agency promulgates is a valid exercise of that authority," *Colo. River Indian Tribes*, 466 F.3d at 139—particularly when the agency's regulations are contrary to the statute's text. Defendants also contend that the "requirement was overly burdensome," but even assuming that Defendants are correct, "an agency may not rewrite clear statutory terms to suit its own sense of how the statute should operate." *Util. Air Reg. Grp.*, 573 U.S. at 328. In enacting the Act, Congress placed primary emphasis on "incentivizing issuers to maximize spending on health care and activities that improve health care quality, thereby promoting greater efficiency in health insurance markets," even if that imposed burdens on insurers. *Morris*, 918 F.3d at 1016.

Defendants' remaining arguments go to the policy soundness of their proposal, rather than whether it is consistent with the statute. Opp. at 53. But those arguments are also incorrect. Whether or not the 0.8% rate reflects what insurers spend, "on average," is beside the point; the point is that the MLR statute requires insurers to report what they *actually spent*. Similarly, whether Defendants have adopted adequate protections against "gaming," whether insurers have other incentives to make quality improvement expenditures, and whether reduced administrative burdens free insurers to make additional expenditures are not only irrelevant to the interpretation of the statute, but also affirmatively contradict Congress's purpose in enacting it: to provide an additional incentive to engage in quality improvement through a credit pegged to insurers' actual expenditures. *See Morris*, 918 F.3d at 1016. Defendants' failure to grapple with the statute's text and purpose renders their decision contrary to law.

2. Arbitrary and capricious

Defendants' decision to give insurers credit for making expenditures they may not have actually made is also unreasonable. Boiled down, Defendants' argument is that the quality improvement reporting requirement was unduly burdensome because most insurers would claim 0.8% anyway. Opp. at 53-54. The only evidence they provide for that assertion is that some commenters claimed that "the *current* process for identifying, tracking and reporting QIA expenses is burdensome, time consuming and costly." *Id.* at 54 (quoting 83 Fed. Reg. at 17,033) (emphasis added). Defendants never attempt to quantify or describe that burden. But the agency also failed to address several other key points, including that insurers that forgo reporting QIA investments likely do not make any substantial investments and that insurers that do make such investments would continue to track them for the purpose of claiming a higher credit. MSJ at 57 (citing AR1636 (Center on Budget and Policy Priorities), 1797 (American Academy of Actuaries)). Those comments, which Defendants do not address either, suggest that Defendants' change is unlikely to meaningfully decrease burdens on insurers that actually make quality improvement expenditures.

Even taking Defendants' "evidence" on its own terms, however, it only underscores the significance of Defendants' failure to consider reasonable alternatives to the current QIA reporting process. As the American Academy of Actuaries explained, one alternative that cuts right to the heart of Defendants' concern about burden "would be to remove the necessity to split QIA into five categories, while still requiring actual QIA expenses rather than a flat percentage." AR1797. Yet Defendants deride that alternative as not "significant" and unworthy of a response. Opp. at 54. That is flat wrong. "An agency is required 'to consider responsible alternatives to its chosen policy and to give a reasoned explanation for its rejection of such alternatives.'" *Am. Radio Relay League*, 524 F.3d at 242 (quoting *City of Brookings Mun. Tel. Co. v. FCC*, 822 F.2d 1153, 1169 (D.C. Cir. 1987)). "Although this obligation extends only to significant and viable alternatives," the Academy's proposal "was neither frivolous nor out of bounds." *Id.* (quotation omitted). And there is no requirement that a proposed alternative be "a technological alternative within the ambit of the existing standard," Opp. at 54 (quoting *State Farm*, 463 U.S. at 51), which simply changing the method of reporting expenditures would constitute anyway. Defendants' admission that they failed to consider a reasonable alternative that would have achieved their goal should, on its own, doom Defendants' decision.

In their brief, Defendants now say that "[s]uch an alternative would not reduce the burdens involved in tracking QIA expenditures and would require revising the entire framework." Opp. at 54. "But these are not the agency's reasons for rejecting [that alternative]. Not having discussed the possibility, the agency submitted no reasons at all. The short—and sufficient—answer to [Defendants'] submission is that the courts may not accept … counsel's *post hoc* rationalizations for agency action." *State Farm*, 463 U.S. at 50; *see also Kansas City v. HUD*, 923 F.2d 188, 192 (D.C. Cir. 1991) ("[A]gency rationales developed for the first time during litigation do not serve as adequate substitutes."). Those rationalizations are also conclusory at best; it is easy to imagine how permitting insurers to report how much they actually spent on quality improvement expenditures, without tracking five different categories and reporting them in detail, would meaningfully reduce burden while holding insurers

accountable. Regardless, the fundamental point is that this was a decision for the agency to make when it promulgated the 2019 Rule, not for counsel to make now in defending it.

Defendants also failed to adequately address the benefits of requiring QIA reporting. Specifically, Defendants did not explain why they dismissed the concern that allowing insurers to claim a flat credit would, by their own admission, lead to "[p]otential increases in premiums" and reduce rebates by approximately $23 million. MSJ at 58 (quoting 83 Fed. Reg. at 17,046, 17,054). As to whether insurers will continue to improve their services, Defendants assert that insurers still have incentives to do so, and that they structured their proposal to prevent insurers from gaming the system. Opp. at 55. But commenters addressed both of these points, with no response from Defendants. As the American Medical Association explained, "the proposed 0.8 percent of earned premiums is on the higher end of what most insurers are reporting for quality improvement expenses currently, thereby allowing many insurers to claim more quality expenses than appropriate." AR1088; *see also, e.g.*, AR1636 (Center for Budget and Policy Priorities), 1946 (Young Invincibles), 2143 (Federation of American Hospitals), 2290 (U.S. Public Interest Research Group), 2842 (Washington Health Benefit Exchange). Indeed, if insurers would make quality improvement expenditures regardless, then Congress might as well have not allowed them to claim quality improvement credit at all.

At bottom, and like so many of the policies adopted in the 2019 Rule, Defendants' decision to let insurers claim a flat rate is at odds with the very premise of the statutory provision it purports to implement, and with basic principles of reasoned decisionmaking. *See, e.g.*, *Gresham*, 950 F.3d at 102-03. Judgment for Plaintiffs is therefore warranted here as well.

* * *

In isolation, the challenged provisions of the 2019 Rule may seem like complicated, technical changes to how the Act's Exchanges operate. But they amount to fundamental changes to how consumers enroll in insurance, how much they pay and whether they receive financial support, and whether they can use their insurance to see doctors who can meet their needs. These matters require reasoned, fact-based, responsive decisionmaking. In enacting these provisions of

the 2019 Rule, Defendants engaged in anything but. The proper response is to set aside those provisions, and to allow the Affordable Care Act to function as it was intended—"to provide 'quality, affordable health care for all Americans.'" *Stewart v. Azar*, 313 F. Supp. 3d 237, 261 (D.D.C. 2018) (quoting Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119, 130 (2010) (as amended by Pub. L. No. 111-152, 124 Stat. 1029 (2010))).

CONCLUSION

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

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Respectfully submitted,

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