IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MARYLAND

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

DEFENDANTS' MEMORANDUM OF LAW IN SUPPORT OF THEIR MOTION TO DISMISS PLAINTIFFS' AMENDED COMPLAINT

TABLE OF CONTENTS

TABLE OF AUTHORITIES

CASES

UNITED STATES CONSTITUTION

STATUTES

REGULATIONS

OTHER AUTHORITIES

I. INTRODUCTION

Plaintiffs, five cities (the "City Plaintiffs") and two individuals (the "Individual Plaintiffs"), bring suit against the President of the United States, the Department of Health and Human Services ("HHS"), the Secretary of HHS, the Centers for Medicare & Medicaid Services ("CMS"), and the Administrator of CMS, alleging violations of the Administrative Procedure Act ("APA") and the Take Care Clause of the U.S. Constitution. They seek to enjoin a final agency rule governing aspects of the health insurance markets for the 2019 plan year and beyond (the "2019 Rule"), as well as numerous other executive actions, some of which are not final, but all of which, Plaintiffs assert, would undermine the Patient Protection and Affordable Care Act ("ACA"). At its core, Plaintiffs' suit reflects a political disagreement with the Federal Government's implementation of the ACA that is beyond the purview of an Article III court. Despite the laundry list of alleged grievances that Plaintiffs have compiled in their 142-page Amended Complaint, Plaintiffs have no standing to sue, and their claims, in any event, fail to state a claim upon which relief can be granted.

Most significantly, this Court has no jurisdiction over this lawsuit because Plaintiffs lack standing to bring their claims. Their alleged injury relies on highly speculative claims of harm, which are dependent on the independent actions of third parties not before this Court. Specifically, the Individual Plaintiffs allege that the challenged rules and executive actions have driven premiums for the ACA individual health insurance market higher than they otherwise would be, and made it harder for them to purchase health insurance on the individual market both because of the cost and the lack of insurer competition in Charlottesville, Virginia, where they reside. But these assertions are mere conjecture, given the highly variable market conditions for the ACA individual market across different States and the numerous factors that issuers consider when setting premium rates, including past and possible future behaviors of state legislators and regulators, other issuers, and consumers. Indeed, the D.C. Circuit recently rejected a nearly identical theory of standing, holding that the plaintiffs in that case, who were consumers of ACA-compliant health insurance, lacked standing to challenge an ACA-related agency policy based on their speculative assumption that the policy caused rate increases for

their plans. *See Am. Freedom Law Ctr. v. Obama*, 821 F.3d 44, 49-50 (D.C. Cir. 2016), *cert. denied*, 137 S. Ct. 1069 (2017). Moreover, the fact that the Individual Plaintiffs in this case were able to purchase an ACA-compliant health insurance plan for 2019 from a new issuer in the Charlottesville market at premium rates less than that offered by their prior health issuer underscores the highly speculative nature of their claim of injury.

The City Plaintiffs' alleged injury is even more speculative. They assert that the rules and executive actions they challenge have led and will continue to lead to rising premium costs for health plans on the Exchanges established under the ACA; that these higher costs will, in turn, cause individuals either to leave the ACA-regulated markets[1] or find it more difficult to purchase health insurance coverage; that, as a result, the uninsured or underinsured sicker individuals will then turn to the City Plaintiffs' health clinics and other services, including ambulance services, which then will force the City Plaintiffs to spend more money on such clinics and services; and that this alleged future financial burden will ultimately make the five Plaintiff Cities less desirable places to live and work. But this speculative chain of possibilities is based on several flawed assumptions.

First, contrary to Plaintiffs' assumption that premiums will trend higher, monthly premiums for individual market plans offered through the 39 Exchanges that rely on the federal Exchange's eligibility and enrollment platform (the "federal platform") generally decreased in 2019. For the average second-lowest cost silver plan, which is the benchmark plan for calculating a taxpayer's premium tax credit, average monthly premiums dropped by 1.5%. Meanwhile, those same Exchanges saw an increase in individual market insurers as compared to 2018, which means more consumer choices and healthier competition among the issuers.

Second, the assumption that rising premiums necessarily will force enrollees out of the ACA-regulated markets or to otherwise become uninsured is flawed. The vast majority of the Exchange

[1] The term "ACA-regulated markets" technically encompasses ACA-compliant health plans not sold on the Exchanges, as Plaintiffs appear to recognize, *see* Am. Compl. ¶ 186. However, the Amended Complaint sometimes appears to use the term to refer to only health plans sold on the Exchanges, *see, e.g.*, *id.* This brief, therefore, will use the same terminology without noting the distinction.

enrollees (87% in 2018) are generally unaffected by premium increases because they receive subsidies that are pegged to premiums; it is the federal government that generally absorbs the impact of premium increases for those enrollees. The remaining 13%, including those whose income is too high to qualify for subsidies, may choose to stay in the Exchanges, for example, to take advantage of consumer protection rules that only apply to qualified health plans sold on an Exchange, among other possible reasons, or may choose alternative insurance coverage better tailored to their individual needs.

Third, even if enrollees do decide to leave the ACA-regulated markets or premiums do increase in certain geographic regions, the notion that the challenged actions are the cause is pure speculation, particularly when other possible causes can readily be identified. For example, Congress's decision to reduce to zero the tax penalty for individuals failing to maintain the minimum essential coverage required by the ACA ("individual mandate") effective as of January 1, 2019, may lead healthier and younger individuals to decide that it is more cost-effective to have no insurance at all or to purchase a non-qualified health plan that is cheaper for enrollees in their health and age category. The resulting decrease in enrollments, and any secondary effects, would have nothing to do with the actions Plaintiffs challenge. Premium rates might also change due to State legislative or regulatory actions; after all, the ACA itself reflects Congress's longstanding recognition that States are the primary regulators of health insurance.

Even if Plaintiffs could overcome the jurisdictional obstacle of lack of standing, the Amended Complaint also fails to state a claim upon which relief can be granted. Count I—which raises an APA challenge to approximately nine separate provisions of the 2019 Rule—fails under APA's "ultimately narrow and highly deferential" standard of review. The 2019 Rule is an amalgamation of rules that govern the operation and stability of the ACA insurance markets, including but not limited to Federal- and State-based Exchanges. Such rules are promulgated annually pursuant to HHS's express rulemaking authority under the ACA and the Public Health Service Act. As the preamble to the 2019 Rule explains, each provision is a modification or amendment of prior similar rules and reflects the defendant agencies' experience gained in operating and administering the Exchange program, as well as in implementing the ACA's federal insurance market requirements. The nearly 100-page preamble

thoroughly explains the agency's rationale for promulgating each of the challenged provisions, defeating any contention that they are arbitrary or capricious, or that the agencies failed to articulate their reasoning or failed to respond to comments on the proposed rule. Moreover, the defendant agencies' interpretation of the relevant provisions of the ACA in the 2019 Rule is entitled to deference under the framework set forth in *Chevron, U.S.A., Inc. v. Natural Resources Defense Council, Inc.*, 467 U.S. 837 (1984). Indeed, despite Plaintiffs' assertion that many of the challenged provisions are "not in accordance with" the text of the ACA, they have identified no actual violation of the ACA.

Plaintiffs' Take Care Clause claim in Count II is on even more precarious legal footing. The claim is an apparent attempt to avoid both the legal hurdle that the President is not subject to the APA and the practical problem that Plaintiffs cannot identify any law or regulation that Defendants have violated. As an initial matter, the President must be dismissed from this lawsuit because the Supreme Court has long held that an Article III court "has no jurisdiction of a bill to enjoin the President in the performance of his official duties," *see Mississippi v. Johnson*, 71 U.S. (4 Wall) 475, 501 (1866), and the same separation-of-powers principle precludes the issuance of a declaratory judgment against the President in his official capacity. The Take Care Clause also provides no cause of action against the President. Although the Clause mandates that "[the President] shall take care that the Laws be faithfully executed," U.S. Const., art. II, § 3, the Supreme Court has held that the President's exercise of power under that Clause is purely executive and political, and not subject to judicial direction. *Mississippi*, 72 U.S. at 499. Indeed, the challenges in the Amended Complaint that relate to the President—such as issuing an executive order directing agencies to implement his policy objectives—are quintessential discretionary actions that fall within the Executive's exclusive prerogative.

What remain of Plaintiffs' Take Care Clause claim are challenges to various agency rules and actions, some of which were never issued or taken at all, or not by the defendant agencies. But regardless of the defendant agencies' actual roles in the rules and actions challenged in Count II, the Take Care Clause provides no basis for affirmative relief against them because the Clause addresses the President alone, not anyone else. Moreover, the actions at issue are reasonable discretionary acts

that are unreviewable even under the APA. Plaintiffs' novel Take Care Clause claim has no legal or factual basis and must be dismissed.

II. BACKGROUND

A. Statutory Background

In 2010, Congress enacted the ACA with the aim of "increas[ing] the number of Americans covered by health insurance and decreas[ing] the cost of health care." *Nat'l Fed'n of Indep. Bus. v. Sebelius*, 567 U.S. 519, 538 (2012) ("*NFIB*"). The ACA established, among other things, a series of new insurance market reforms in the individual and small group markets and also imposed a number of other requirements for plans in those markets, such as mandatory provision of essential health benefits. To facilitate a market for health insurance products that conform to its market reforms, the ACA established "Health Benefit Exchanges" or State-based virtual marketplaces where consumers can purchase qualified health plans. 42 U.S.C. § 18031. To help low-income individuals obtain such coverage in the individual market, the law provides subsidies in the form of premium tax credits to eligible taxpayers who purchase individual health insurance coverage through an Exchange for themselves or family members. 26 U.S.C. § 36B. The amount of the premium tax credit is determined in part based on the premium charged for a benchmark plan on the Exchange—*i.e.*, the applicable second lowest cost silver plan—and on the eligible taxpayer's household income. *See id.*; Wu Decl. ¶ 5. Thus, if premiums for the applicable benchmark plan increase, premium tax credits generally increase by a corresponding amount. Wu Decl. ¶ 5. As of 2018, roughly 87% of individual market consumers purchasing health insurance through an Exchange received subsidies. *Id.* These consumers are insulated from the effects of premium increases for qualified health plans purchased through the Exchanges.

After the Exchanges became operative in 2014, premiums for health plans sold in the individual markets rose drastically. Between 2013 and 2014, individual market premiums rose an

average of roughly 38%.[2] Overall, health insurance premiums, particularly for individual coverage (the markets most affected by the ACA), more than doubled between 2013 and 2017.[3] Higher-than-expected health care claims costs in the initial years following the enactment of the ACA led to substantial premium increases and also drove many issuers to exit the individual health insurance markets, leaving consumers with fewer and less affordable insurance choices.[4] Individual market premiums finally stabilized for the first time since the enactment of the ACA for the 2019 plan year. Wu Decl. ¶ 13. Premiums for individual health insurance coverage through the 39 ACA Exchanges that rely on the federal platform generally decreased for 2019. *Id.* ¶¶ 13-14. Specifically, the average monthly premiums for individual market coverage through these Exchanges dropped by an average of 1.5% for benchmark silver plans, and 1.0% for bronze plans.[5] *Id.*

Plans sold on an Exchange qualify as one of several forms of "minimum essential coverage" identified by the ACA. The ACA requires non-exempt individuals to obtain minimum essential coverage, and as of the end of 2018, those who failed to comply must pay a tax penalty. 26 U.S.C. § 5000A(a)-(b). In December 2017, Congress enacted the Tax Cuts and Jobs Act, which reduced the amount of the tax penalty to $0 beginning in 2019. *See* Budget Fiscal Year, 2018, Pub. L. No. 115-97 § 11081, 131 Stat. 2054 (2017).

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[2] *See, e.g.*, Forbes, Overwhelming Evidence that Obamacare Caused Premiums to Increase Substantially (July 28, 2016), https://www.forbes.com/sites/theapothecary/2016/07/28/overwhelming-evidence-that-obamacare-caused-premiums-to-increase-substantially/#61242bf715be (last visited March 7, 2019).

[3] Assistant Secretary for Planning and Evaluation, Individual market premium changes: 2013-2017, (May 23, 2017), https://aspe.hhs.gov/system/files/pdf/256751/IndividualMarketPremiumChanges.pdf.

[4] *See, e.g.*, The Brookings Institution & The Rockefeller Institute, A Study of Affordable Care Act Competitiveness in Texas (Feb. 2017), https://www.brookings.edu/wpcontent/uploads/2017/02/texas-aca-competitiveness-2-6-for-print.pdf (last visited March 7, 2019).

[5] A recent analysis of premium data by the Kaiser Family Foundation similarly found that nationally from 2018 to 2019, the average unsubsidized premium for the lowest-cost bronze plan is decreasing by 0.3%, the average unsubsidized lowest-cost silver premium is decreasing by 1%, and the average unsubsidized lowest-cost gold plan is decreasing by 2%. *See* Rachel Fehr, Rabah Kamal, Marco Ramirez, and Cynthia Cox, *How ACA Marketplace Premiums Are Changing by County in 2019* (Nov 20, 2018), Kaiser Family Foundation, https://www.kff.org/health-costs/issue-brief/how-aca-marketplace-premiums-are-changing-by-county-in-2019/.

On April 17, 2018, HHS issued the 2019 Rule, an annual rulemaking that governs many aspects of the ACA insurance markets and Exchanges for the 2019 plan year. *See* 83 Fed. Reg. 16930 (Apr. 17, 2018). In addition to providing certain payment and cost-sharing parameters and user fees for Federally-facilitated and State-based Exchanges, the 2019 Rule also increases the States' flexibility in operating the Exchanges and enhances the States' role regarding the certification of qualified health plans. *See id.* Additionally, the Rule includes changes to the rate review program, the medical loss ratio program, and a number of other issues related to the operation and functioning of the Exchanges and the ACA insurance markets. *See id.*

B. Factual Background

Plaintiffs are five cities, Columbus, Ohio; Cincinnati, Ohio; Chicago, Illinois; Baltimore, Maryland; and Philadelphia, Pennsylvania, Am. Compl. ¶¶ 16-25, and two individuals, who reside in Charlottesville, Virginia, and who are enrolled in a qualified health plan offered by HealthKeepers (an affiliate of Anthem), *id.* ¶¶ 26, 273, 277. Their two-count, 142-page Amended Complaint alleges claims under the APA and the Take Care Clause and seeks injunctive and declaratory relief.

The APA Claim in Count I challenges approximately nine aspects of the 2019 Rule issued by CMS to govern various aspects of the individual and group health insurance markets subject to the ACA for the 2019 benefit year. *See* HHS Notice of Benefit and Payment Parameters for 2019, 83 Fed. Reg. 16930 (Apr. 17, 2018). *See also* Am. Compl. ¶ 282. Briefly summarized, those nine aspects are:

- Amending the Advance Premium Tax Credit eligibility notification requirements to avoid violating Internal Revenue Code rules that bar disclosure of Federal tax information to third parties. *See* Am. Compl. ¶¶ 52-56, 282(a); *see also* 83 Fed. Reg. at 16982-16984.

- Eliminating duplicative Federal and State reviews of qualified health plans ("QHPs") on Federally-facilitated Exchanges by incorporating the results of the States' QHP reviews. *See* Am. Compl. ¶¶ 57-63, 282(b); *see also* 83 Fed. Reg. at 17024-17026.

- Implementing a new operational readiness review and audit approach pursuant to which health insurance agents, brokers, and insurers participating in direct enrollment may select their own independent third-party auditors for purposes of the annual operational readiness review. *See* Am. Compl. ¶¶ 64-68, 282(c); *see also* 83 Fed. Reg. at 16981-16982.

- Eliminating the standardized options that issuers could offer in Federally facilitated Exchanges in an effort to encourage competition in the individual market and "to maximize innovation by issuers in designing and offering a wide range of plans to consumers." *See* Am. Compl. ¶¶ 70-74, 282(d); *see also* 83 Fed. Reg. at 16974-16975.

- Removing the regulatory requirements that one of the two Navigators[6] for an ACA Exchange must be a community non-profit organization and that the Navigators must maintain a physical presence in the State. *See* Am. Compl. ¶¶ 75-79, 282(e); *see also* 83 Fed. Reg. at 16979-16980.

- Reducing regulatory burdens concerning the Small Business Health Options Program ("SHOP")—which provides qualified health plan options for small employers in each State with an Exchange—including enhancing States' flexibility to respond to decreases in issuer participation and lower-than-expected enrollment in the Federally-facilitated SHOPs and SHOPs operated by State-based Exchanges on the Federal platform. *See* Am. Compl. ¶¶ 80-82, 282(f); *see also* 83 Fed. Reg. at 16996-16706.

- Modifying the ACA's premium tax credit eligibility income verification requirements to require an individual who attests to a household income within 100% to 400% of the federal poverty line (which would make the individual eligible for premium tax credits for purchase of ACA-compliant plans), but whose attested income is contradicted by trusted electronic data sources, to submit additional documentation supporting the attested to income. *See* Am. Compl. ¶ 282(g); *see also* 83 Fed. Reg. at 16985-16987.

- Amending the ACA's rate review program regulations to, *inter alia*, (1) exempt student health insurance coverage from federal rate review, and (2) increase the federal minimum threshold that triggers an "unreasonableness" review of an issuers' proposed premium rate increase from 10% to 15%. *See* Am. Compl. ¶¶88-93, 282(h); *see also* 83 Fed. Reg. at 16972-16973.

- Amending the medical loss ratio (MLR) requirements to allow issuers the option to submit either a detailed, itemized report of quality improvement activity (QIA) expenditures or to report a single, fixed QIA amount. *See* Am. Compl. ¶¶ 94-98, 282(i); *see also* 83 Fed. Reg. at 17032-17036.

Count II of the Complaint asserts a claim under the Take Care Clause challenging various other actions allegedly taken by Defendants and other federal agencies, *see* Am. Compl. ¶¶ 99-180, 283-85:

[6] A "Navigator" is an individual or organization that is trained to help consumers, small businesses, or their employees search for health coverage options through the ACA Exchanges. *See* Health Care Glossary, "Navigator," https://www.healthcare.gov/glossary/navigator/ (last visited: Dec. 2, 2018).

- The President's issuance of Executive Order No. 13,765, 82 Fed. Reg. 8351 (Jan. 20, 2017), which directs federal agencies to "take all actions consistent with law to minimize the unwarranted economic and regulatory burdens of the [ACA]." *See* Am. Compl. ¶ 100.

- The President's issuance of Executive Order No. 13,813, 82 Fed. Reg. 48,385 (Oct. 12, 2017), which directs federal agencies to consider expanding consumer access to association health plans, short-term, limited-duration insurance plans, and health reimbursement arrangements as alternatives to qualified health plans. *See id.* ¶ 109.

- Various proposed steps by Defendants that Plaintiffs assert were intended to weaken the ACA, but, in the case of proposals regarding cost-sharing reduction payments to insurers, were only implemented following an adverse judicial decision and advice from the Attorney General, and, in the case of proposals regarding the mandate to purchase minimum essential coverage, were never implemented at all. *See id.* ¶¶ 105-107, 116-118.

- CMS's issuance of guidance addressing eligibility for "hardship exemptions" from the individual mandate. *See id.* ¶ 119.

- Alleged delays or selective denials by CMS of state innovation waivers under Section 1332 of the ACA, 42 U.S.C. § 18052, and CMS's issuance of guidance addressing state eligibility for such waivers. *See id.* ¶¶ 123-128.

- CMS's issuance of a proposed Notice of Benefit and Payment Parameters to govern the operation and functioning of the ACA Exchanges and enrollment process in the 2020 plan year ("the proposed 2020 Rule"). *See id.* ¶¶ 173-76.

- The President's public statements, and federal agencies' social media posts, that were critical of the ACA. *See id.* ¶¶ 129-131.

- Shortening (by approximately 45 days) open enrollment on Federally-facilitated Exchanges. *See id.* ¶¶ 135-142.

- Not spending as much money on open enrollment advertising as Plaintiffs would prefer. *See id.* ¶¶ 143-150, 153.

- Spending only $36 million on Navigator programs for the Federally-Facilitated Exchanges in 2017 and $10 million in 2018. *See id.* ¶¶ 163, 165.

- Failing to establish enrollment targets for 2018 and 2019. *See id.* ¶¶ 168-69.

- Not sending HHS staff to regional enrollment events. *See id.* ¶ 171.

- Taking certain litigation positions regarding the constitutionality and enforceability of the ACA's individual mandate and two related provisions. *See id.* ¶ 174.

As a result of the challenged agency and executive actions, the Individual Plaintiffs claim that they face higher premiums, lower quality insurance, and less insurer competition, *see, e.g.*, *id.* ¶¶ 267, 269, while the City Plaintiffs claim that they are or will be forced to (i) devote more resources to subsidize and provide uncompensated health care for their uninsured or underinsured residents, *see, e.g.*, *id.*, ¶¶ 184, 191-92, and (ii) spend more money on ambulance services, *see, e.g.*, *id.* ¶ 203, both of which would make these cities less attractive places to live and work, *see, e.g.*, *id.* ¶ 229.

III. ARGUMENT

A. The Complaint Should be Dismissed for Lack of Subject Matter Jurisdiction.

1. Standard of Review

"No principle is more fundamental to the judiciary's proper role in our system of government than the constitutional limitation of federal-court jurisdiction to actual cases or controversies." *Clapper v. Amnesty Int'l USA*, 568 U.S. 398, 408 (2013) (citation omitted). One element of this constitutional limitation is that a plaintiff must establish that he has standing to sue. *Raines v. Byrd*, 521 U.S. 811, 818 (1997). The requirement is "built on separation-of-powers principles" and "serves to prevent the judicial process from being used to usurp the powers of the political branches." *Clapper*, 568 U.S. at 408. Because the relaxation of the standing inquiry "is directly related to the expansion of judicial power," that inquiry is "especially rigorous" when, like here, reaching the merits would force the judiciary "to decide whether an action taken by one of the other two branches of the Federal Government was unconstitutional." *Id.* at 408-09.

To establish "the irreducible constitutional minimum of standing" at the pleading stage, *Lujan v. Defs. of Wildlife*, 504 U.S. 555, 560 (1992), Plaintiffs bear the burden of alleging specific facts establishing that they have "(1) suffered an injury in fact, (2) that is fairly traceable to the challenged conduct of the defendant, and (3) that is likely to be redressed by a favorable judicial decision," *Spokeo, Inc. v. Robins*, 136 S. Ct. 1540, 1547 (2016). An "injury in fact" must be "'concrete and particularized' and 'actual or imminent, not conjectural or hypothetical.'" *Id.* at 1548 (quoting *Lujan*, 504 U.S. at 560). These standing requirements ensure that legal questions are "resolved, not in the rarified atmosphere of a debating society, but in a concrete factual context conducive to a realistic appreciation of the

consequences of judicial action." *Valley Forge Christian Coll. v. Ams. United for Separation of Church & State, Inc.*, 454 U.S. 464, 472 (1982).

Moreover, in a 12(b)(1) motion, the court may consider evidence outside of the pleadings to help determine whether it has jurisdiction over the case before it," *Int'l Ass'n of Machinists & Aerospace Workers v. Werner-Masuda*, 390 F. Supp. 2d 479, 491 (D. Md. 2005) (citation omitted), "without converting the proceeding to one for summary judgment." *Gilbert v. U.S. Bureau of Alcohol, Tobacco, Firearms & Explosives*, 306 F.Supp.3d 776, 783 (D. Md. 2018) (quoting *Velasco v. Gov't of Indonesia*, 370 F.3d 392, 398 (4th Cir. 2004)); *see also Richmond, Fredericksburg & Potomac* R.R. *Co. v. United States*, 945 F.2d 765, 768 (4th Cir. 1991)). The Court also "may take judicial notice of publicly available records without converting a motion to dismiss to one for summary judgment." *Fusaro v. Davitt*, 327 F. Supp. 3d 907, 916–17 (D. Md. 2018) (citing *Zak v. Chelsea Therapeutics Int'l, Ltd.*, 780 F.3d 597, 607 (4th Cir. 2015) ("[C]ourts are permitted to consider facts and documents subject to judicial notice without converting the motion to dismiss into one for summary judgment.")).

Finally, to survive a motion to dismiss, the plaintiff must allege "sufficient factual matter, accepted as true, to 'state a claim to relief that is plausible on its face.' " *Ashcroft v. Iqbal*, 556 U.S. 662, 678 (2009) (quoting *Bell Atl. Corp. v. Twombly*, 550 U.S. 544, 570 (2007)); *Cioca v. Rumsfeld*, 720 F.3d 505, 508 (4th Cir. 2013). The plausibility standard is not akin to a "probability requirement," but asks for more than a sheer possibility that a defendant has acted unlawfully. *Iqbal*, 556 U.S. at 678. That is, a plaintiff must offer more than "an unadorned, the-defendant-unlawfully-harmed-me accusation" and may not rely on "mere conclusory statements" or "'naked assertion[s]' devoid of 'further factual enhancement.'" *Iqbal*, 556 U.S. at 678 (quoting *Twombly*, 550 U.S. at 557).[7]

As discussed below, Plaintiffs have failed to meet the above requirements. Even assuming that the health insurance premiums for the individual markets are higher than they otherwise would

[7] Although *Twombly* and *Iqbal* set forth the standard for considering the plausibility of allegations pursuant to Rule 12(b)(6), the same standard applies in assessing the sufficiency of allegations of injury for purposes of a Rule 12(b)(1) challenge to standing. *See Reid v. Prince George's Cty. Bd. of Educ.*, 60 F. Supp. 3d 601, 605 (D. Md. 2014) (citing *Kerns v. United States*, 585 F.3d 187, 192 (4th Cir. 2009)).

be, leading to higher premiums for the Individual Plaintiffs and more expenditure of resources for the City Plaintiffs—propositions which are themselves highly speculative—Plaintiffs have not established that Defendants' actions are the cause of Plaintiffs' purported harms, nor can they make this showing. The nature of health care cost is inherently variable, and standing between Plaintiffs' asserted injuries and the challenged actions are third parties, such as insurers, state legislators and regulators, and consumers, whose independent actions break the causal link required to establish standing.

2. The Individual Plaintiffs lack standing because they fail to show that they have suffered any cognizable injury that is traceable to Defendants.

The Amended Complaint alleges that as a result of Defendants' alleged attempts to undermine the ACA, the Individual Plaintiffs are harmed by premiums that are higher than they would otherwise be without the challenged actions and a lack of insurer competition in Charlottesville, Virginia. As an initial matter, even assuming that rising premiums alone could constitute an injury in fact, which it cannot, the Individual Plaintiffs' prediction about continued rising individual market insurance premiums has been proven to be incorrect. Premiums for individual health insurance coverage through the ACA Exchanges have stabilized nationwide in 2019 for the first time since the enactment of the ACA. Wu Decl. ¶ 13. Significantly, the 2019 premiums for such insurance in Albemarle County, Virginia (the county that includes the City of Charlottesville) has seen dramatic decreases. The Individual Plaintiffs allege that they purchased a bronze plan in 2016, a silver plan in 2017, and then a bronze plan in 2018, all from Optima Health. Am. Compl. ¶¶ 275-276. For 2019, the average premiums for an Optima silver plan *decreased* by 26.1%, while the average premiums for an Optima bronze plan *decreased* by 31.7%. Wu Decl. ¶¶ 16-17. Additionally, a new insurer, HealthKeepers, Inc. (affiliated with Anthem, Inc.), entered the Charlottesville market in 2019. HealthKeepers' decision to enter the Charlottesville market in 2019 not only increased insurer competition but also afforded Charlottesville residents, including the Individual Plaintiffs, additional plan choices, including plans with premiums potentially lower than those offered by Optima. Indeed, for 2019, the Individual Plaintiffs have enrolled in a bronze plan offered by HealthKeepers, with a premium of $1,899.49 for the two of them, Am. Compl. ¶ 277, which is significantly cheaper than the premiums they paid for

an Optima bronze plan in 2018 ($3,327.65 for the two of them, Am. Compl. ¶ 276), or possibly an Optima bronze plan for 2019, *see* Wu Decl. ¶ 16 (chart of Optima premiums based on age group). Thus, the Individual Plaintiffs' assertion that they are nevertheless harmed and will continue to be harmed in 2020 and beyond is entirely conclusory and speculative. *See Iqbal*, 556 U.S. at 678; *Clapper*, 568 U.S. at 409 ("'[a]llegations of *possible* future injury' are not sufficient" to establish injury in fact) (quoting *Whitmore v. Arkansas*, 495 U.S. 149, 158 (1990) (emphasis in the original)).

More fundamentally, the Individual Plaintiffs have not shown that there is a causal link between their assertion that they "are paying prices higher than they would otherwise have to pay" and the alleged "ever-growing" list of executive actions "undertaken by" Defendants to undermine the ACA. Am. Compl. ¶¶ 9, 277. This is so because Defendants do not set individual health insurance premiums; rather, issuers set them by taking into account a wide range of factors that are in turn dependent on a whole host of other third party actors. Supreme Court precedent is clear that traceability and redressability may not be established under such circumstances. *See Allen v. Wright*, 468 U.S. 737, 739-40 (1984) (parents had no standing to challenge government's grant of tax-exempt status to racially discriminatory private schools because, among other things, it was speculative "whether withdrawal of [the] tax exemption from any particular school would lead the school to change its policies"); *Simon v. E. Ky. Welfare Rights Org.*, 426 U.S. 26, 33, 42-44 (1976) (indigent plaintiffs had no standing to challenge favorable tax benefits to hospitals that offered only emergency-room services to indigent individuals because even if the rules were modified, it was "just as plausible" that the hospitals "would elect to forgo favorable tax treatment to avoid the undetermined financial drain of an increase in the level of uncompensated service"). "*Allen* and *Simon* illustrate the fundamental tenet of standing doctrine: where a third party such as a private school or hospital makes the independent decision that causes the injury, that injury is not fairly traceable to the government." *Doe v. Obama*, 631 F.3d 157, 162 (4th Cir. 2011).

Consistent with Supreme Court precedent, the Fourth Circuit has held that the "traceability and redressability prongs [of standing] become problematic when third persons not party to the litigation must act in order for an injury to arise or be cured." *Doe v. Va. Dep't of State Police*, 713 F.3d

745, 755 (4th Cir. 2013). Thus, "[a]n injury sufficient to meet the causation and redressability elements of the standing inquiry must result from the actions of the [defendant], not from the actions of a third party beyond the Court's control." *Id.* (quoting *Mirant Potomac River, LLC v. EPA*, 577 F.3d 223, 226 (4th Cir. 2009)); *see, e.g.*, *Doe v. Obama*, 631 F.3d 157, 162 (4th Cir. 2011) (plaintiffs lack standing to challenge National Institutes of Health policy governing embryonic stem cell research because "the mere fact that the government permits private donors to choose to donate their embryos for research does not therefore make that decision fairly traceable to [the challenged Executive Order] or the NIH guidelines"); *Lane v. Holder*, 703 F.3d 668, 673-74 (4th Cir. 2012) (gun owners failed to show that the costs and expenses they incurred were fairly traceable to state law imposing limitations on the sale of guns to out-of-state residents, rather than a direct result of the fees imposed by third-party, federally-licensed firearm dealers); *id.* (gun owners alleged injury resulted from the "actions of third parties not before th[e] court" because "[n]othing in the challenged legislation or regulations direct[ed] [federally-licensed firearms dealers] to impose such charges"); *Bishop v. Barlett*, 575 F.3d 419, 425 (4th Cir. 2009) (plaintiffs failed to demonstrate a causal link between their inability to vote on future referendums and the passage of a state constitutional amendment authorizing the issuance of bonds for state development projects without a referendum because between plaintiffs' alleged harm and the challenged law was the independent decision of "a majority of voters" who broke the causal chain).

For example, in *Frank Krasner Enterprises, Ltd. v. Montgomery County*, 401 F.3d 230, 236 (4th Cir. 2005), a third-party venue refused to rent space to a gun show promoter, citing a county law that prohibited venues from receiving county funds if they displayed or sold guns at their site, and the gun show promoter challenged the county law. The Fourth Circuit held that the gun show promoter failed to establish causation because his injury stemmed from the third-party venue's refusal to rent space to the promoter, not the county law that made the choice "easy" for the third party venue or "perhaps prohibitively" more expensive for the venue to rent space to it. *Id.* at 236. As the court put it, "[t]he purported injury . . . is not directly linked to the challenged law because an intermediary (. . . here, the [venue]) stands directly between the plaintiffs and the challenged conduct in a way that breaks the causal chain." *Id.* For similar reasons, the gun show promoter failed to establish redressability because

as the Fourth Circuit explained, "we c[annot] not compel the [venue] to rent space to [the gun show promoter]. . . ." *Id.*

So, too, it is here. The Individual Plaintiffs' speculation that they are paying more for individual market health insurance premiums than they otherwise would be "is not directly linked" to the litany of executive actions that they challenge because the independent decisions of health plan issuers "stand directly" between the asserted harm and the challenged actions in a way that "breaks the causal chain." *Id.* at 236.

The D.C. Circuit's recent decision in *American Freedom Law Center*, 821 F.3d at 49, is illustrative of the difficulty that a plaintiff faces in establishing a causal link between an increase in premium rates and a challenged policy. There, consumers, whose insurer chose to no longer offer non-ACA compliant plans and who are then forced to purchase an ACA-compliant plan, alleged that an HHS policy would "cause them to pay more for their health insurance in the future," because the challenged policy permitted insurers to provide non-ACA-compliant health plans under certain circumstances and further allowed some individuals whose policies were cancelled for noncompliance to avoid the individual mandate tax penalty. *Id.* at 49. The D.C. Circuit concluded that the plaintiffs' claim of injury was "speculative" because although the insurer's rate filings indicated that on average premiums increased due to the challenged policy, they did not demonstrate that premiums for the plaintiffs' particular plan would increase. *Id.*

The court also expressly recognized that the inherently variable nature of health care cost renders it difficult to establish the requisite causal link between the alleged increased premiums and the challenged HHS policy. *Id.* at 50-51. As the D.C. Circuit explained, "although one of Congress's goals in drafting the ACA was to decrease the cost of health care, the ACA establishes no floor under which health care prices cannot drop, nor a ceiling above which prices cannot rise." *Id.* at 51 (citing *NFIB*, 567 U.S. at 538). Moreover, "many factors determine the cost of health care, including administrative costs, drug costs, and the health of the national populace[.]" *Id.* at 51. As a result, "[c]hanges in any of these factors could cause costs to increase or decrease, and it is difficult to separate out which factors actually cause any specific price adjustment." *Id.* The D.C. Circuit explained that

it is this difficulty in "separat[ing] out which factors" caused the increased health insurance cost that was fatal to the plaintiffs' ability to demonstrate causation for purposes of establishing their standing to sue.

Thus, *American Freedom Law Center* teaches that a plaintiff must provide more than "unadorned speculation as to the existence of a relationship between the challenged government action and the third-party conduct [*i.e.*, the insurer's increase of premiums]." *Id.* at 49. Again, the D.C. Circuit reasoned:

> According to Appellants, "basic economic principles" establish a direct link between the supposed decrease in the number of individuals in ACA-compliant risk pools allegedly caused by HHS's [ ] Policy and the asserted increase in the price of Appellants' health insurance plan. But . . . the effect of various factors, including the size of risk pools, on health insurance pricing is far from "basic," and Appellants have made no concrete allegations, nor provided any specific evidence, establishing that the cost of their health insurance plan is likely to increase in the future, let alone that such an increase will stem from the [ ] Policy. This is a major missing link in the causal chain Appellants must establish to demonstrate that HHS's [ ] Policy is a "substantial factor motivating" Appellants' alleged harm.

Id. at 50 (internal citations omitted).

The Individual Plaintiffs' standing allegations suffer from the same deficiency. In an effort to establish a causal link between their purported injury and the challenged actions, they home in on HealthKeepers' statement that "'the elimination of the individual mandate penalty for lack of minimum essential coverage and potential movement into other markets'" are factors that the issuer considered in setting its 2019 health insurance rate in the Commonwealth of Virginia. *See* Am. Compl. ¶ 277 n.389 (quoting HealthKeepers' *Actuarial Memorandum*, healthcare.gov). According to the Individual Plaintiffs, that statement supports their contention that they "are paying prices higher than they would otherwise have to because of Defendants' actions[,]" "namely, the non-ACA compliant plans promoted by Defendants." *Id.* The Individual Plaintiffs are wrong.

As an initial matter, Congress's reduction of the individual mandate tax penalty to zero in the Tax Cuts and Jobs Act is not attributable to Defendants (nor do Plaintiffs allege otherwise), and if that reduction caused the departure of consumers from the ACA-regulated markets, as HealthKeepers

believes possible, that departure clearly is not traceable to Defendants. Moreover, any assertion that Defendants' actions caused the premiums in the Charlottesville market to be higher than they otherwise would be is pure conjecture. Again, the Individual Plaintiffs are paying *less* for their 2019 HealthKeepers bronze plan than the amount they paid for their Optima bronze plan in 2018, when Optima was the only issuer in the Charlottesville market, *id.* ¶¶ 276-77, or than what they possibly would be paying for an Optima bronze plan in 2019, *see* Wu Decl. ¶ 12 (chart of Optima's 2019 pricing). There are myriad of reasons why premiums increase or decrease in any given insurance plan benefit year. *See, e.g.*, *American Freedom Law Center*, 821 F.3d at 50-51. All that is clear is that the Individual Plaintiffs' ability to purchase a 2019 qualified health plan at approximately $1,900 for the both of them is a direct result of HealthKeepers' decision to enter the Charlottesville market in 2019. *See id.* And, the cost of the HealthKeeper's 2019 bronze plan in that market derives directly from HealthKeepers' assessment of numerous factors, including the factors identified by the D.C. Circuit when rejecting a similar standing claim as the one at issue here. *See American Freedom Law Ctr.*, 821 F.3d at 51 (opining that "[c]hanges in any of these factors," namely, "administrative costs, drug costs, and the health and age of the national populace" could "cause costs to increase or decrease"); *see also* HealthKeepers' *Actuarial Memorandum* at 2 ("factors that affect the rate changes for all plans" in Virginia include "[t]rend[s]" such as "the impact of inflation, provider contracting changes, [ ] changes in utilization of services[,]" and "[c]hanges in taxes, fees, and some non-benefit [administrative] expenses"). Although certain factors were considered across all health plans offered by HealthKeepers in Virginia in establishing the 2019 rates, the issuer makes clear that its proposed 2019 rates "vary by [health] plan" based on its consideration of still other factors, such as "[c]hanges in benefit design" and certain administrative costs. *See id.* at 2.

Therein is the fundamental flaw in Plaintiffs' standing theory. "While the defendant's conduct need not be the last link in the causal chain, the plaintiff must be able to demonstrate that the alleged harm was caused by the defendant, as opposed to the 'independent action of some third party not before the court.'" *Air Evac EMS, Inc. v. Cheatham*, 910 F.3d 751, 760 (4th Cir. 2018) (quoting *Frank Krasner Enters.*, 401 F.3d at 234)); *see also Va. Dep't of State Police*, 713 F.3d at 755 (a cognizable injury

"must result from the actions of the [defendant], not from the actions of a third party beyond the Court's control"). Plaintiffs cannot make this showing for the same reason that the D.C. Circuit rejected the *American Freedom Law Center* plaintiffs' standing claim in that case. Any purported injury that the Individual Plaintiffs suffer "stems not from the actions of [Defendants]," but from HealthKeepers' health plan pricing decision, which is in turn influenced by numerous factors not within Defendants' control. *Am. Freedom Law Ctr.*, 821 F.3d at 52. As a result, the Individual Plaintiffs' assertion that they are paying more for their 2019 health insurance plan than they would otherwise have to pay "'is not fairly traceable to the [litany of Executive actions and statements that are challenged here]." *Id.* (citing *Cutler v. HHS*, 797 F.3d 1173, 1175 (D.C. Cir. 2015)).

For similar reasons, "'nor would [the Individual Plaintiffs' asserted injury] be redressed by striking down'" the challenged actions. *Id.* Again, there are many factors that determine the cost of health care, which are in turn dependent on the actions of numerous third parties, and any combination of which factors may be the reason that a health plan issuer decides to increase or decrease premium rates. *See id.* at 49. This Court cannot compel a health plan issuer to maintain a certain premium rate level. *See Frank Krasner Enterps.*, 713 F.3d at 236. Nor would an order invalidating the litany of actions that Plaintiffs challenge necessarily lead to any rate decreases. This is so because a health plan issuer has the discretion to establish premium rates in a manner deemed appropriate by the issuer within the broad parameters set by federal and state laws. *See American Freedom Law Center*, 821 F.3d at 51 ("the ACA establishes no floor under which health care prices cannot drop, nor a ceiling above which prices cannot rise").

3. The City Plaintiffs lack standing because their alleged injury is based on speculative, contingent, and hypothetical harms.

The City Plaintiffs' standing allegations are even weaker. Their alleged injury is premised on an even greater number of uncertain links in the causal chain, which are either premised on invalid assumptions or are attributable to the City Plaintiffs themselves. According to the City Plaintiffs, "premiums for plans on the ACA [E]xchanges" are "increasing substantially" as a result of Defendants' actions, *see, e.g.*, Am. Compl. ¶¶ 178-79, 183, 238, 240; such "[i]ncreased premiums lead

to an increase in the rate of the uninsured," *id.* ¶ 188, requiring the City Plaintiffs "to confront the many downstream effects of a population that is necessarily sicker, less productive, and less able to participate in the community and civic life," *id.* ¶ 205; *see also id.* at ¶¶ 207, 209, 218, 228; and those downstream effects include the need "to devote additional funding, personnel, and other resources to subsidizing and providing uncompensated care" for such population, ultimately harming "the City Plaintiffs' budgets, including the budgets for their public health departments, free or reduced-cost clinics, and ambulance services," *id.* ¶ 197. They also assert that the same injuries would result from the challenged agency and executive actions that allegedly make it harder for Americans to afford and purchase quality health insurance. *Id.* ¶¶ 184, 192.

This speculative chain of events, including the hypothesized "downstream effects," plainly is insufficient to establish that the City Plaintiffs have suffered or will continue to suffer harm, let alone injury that is traceable to Defendants. First, Plaintiffs' speculation about increased premium rates is premised in part on the idea that there will be an "exodus of carriers," which can be expected to drive up prices. *Id.* ¶ 267 (internal quotation marks omitted). But at least for 2019, the ACA Exchanges that rely on the federal platform have seen an *increased* number of individual market insurers as compared to 2018; 23 more issuers in 2019 were participating during open enrollment than in 2018.[8]

[8] Indeed, the Kaiser Family Foundation recently drew the following conclusions about insurer participation in all 50 states (not just the ones that rely on the Federal platform) after analyzing data that was gathered from HealthCare.gov and State-Based Exchange enrollment websites and insurer rate filings to state regulators: (1) insurer participation on the ACA Marketplaces will improve in 2019, with an average of 4.0 insurers participating per state, up from 3.5 in 2018; (2) the average number of companies per state in 2019 ranges from one company in five states (Alaska, Delaware, Mississippi, Nebraska, and Wyoming) to more than 10 companies in three states (California, New York and Wisconsin); (3) in 2019, 58% of enrollees (living in about 23% of counties) have a choice of three or more insurers, up from 48% of enrollees in 2018; (4) the share of Marketplace enrollees with only one insurer option (17%) will be the lowest since 2016; (5) for the first time since 2015, there are more companies entering into markets or expanding their footprints within states than there are withdrawals; (6) on average, metro-area counties have 2.3 insurers participating in 2019, compared to 1.8 insurers in non-metro counties; (7) going into 2019, 608 counties are gaining at least one insurer, while only five counties nationwide will lose an insurer; (8) in 2019, about 17% of enrollees (living in 37% of counties) have access to just one insurer on the marketplace (down from 26% of enrollees living in 52% of counties in 2018); and (9) between 2018 and 2019, the total number of insurers by State will remain at 2 in Maryland, will increase from 8 to 9 in Ohio, will increase from 4 to 5 in Illinois,

Wu Decl., ¶ 9. Further, 29 current individual market issuers are expanding their service areas into new counties that they did not serve last year in States with an Exchange that relied on the federal platform. *Id.* Major insurers Anthem, Wellmark, Molina, and Cigna have returned to the Exchange individual markets they left in 2016 or 2017. *Id.* The number of counties with two or more individual market insurers operating in the ACA Exchanges increased in 2019 in States with an Exchange that relied on the federal platform. *Id.* ¶ 10. In 2019, only 39% of counties have a single individual market issuer offering qualified health plans on these Exchanges as compared to 56% in 2018. *Id.* This means that only 20% of these Exchange consumers have access to only one issuer, down from 29% in 2018. *Id.* Significantly, in 2019, the majority of enrollees – 57% – had access to *three or more* individual market issuers through the ACA Exchanges that rely on the federal platform. *Id.* Similarly, in 2018, 10 States had only one issuer in each county offering qualified health plans on the ACA Exchanges that relied on the federal platform. *Id.* ¶ 11. But in 2019, that number is cut in half, leaving only five States (Alaska, Delaware, Nebraska, Mississippi, and Wyoming) with only one ACA Exchange individual market issuer in each county, *id.*, and none of Plaintiffs in this action is in any of those five States. That is, Plaintiffs' speculation about 2019 is in significant tension with reality, and there is no basis to assume that their speculation for 2020 and beyond will be any more accurate.

Second, the assumption that premium increases for qualified health plans will inevitably lead to an exodus of current enrollees large enough to burden the City Plaintiffs is highly speculative. To begin, the vast majority of Americans (approximately 92%) do not participate in the ACA individual markets but obtain their healthcare insurance through large group market health plans, self-insured plans, and government sponsored plans, such as Medicare and Medicaid. *Id.* ¶ 3; *see also* 42 U.S.C. § 18013. These Americans generally are not directly affected by the rules or executive actions complained of in this lawsuit. Of the approximately 3% of the American population who receive their individual health insurance through an Exchange established under the ACA, Wu Decl. ¶ 3, 87% of

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and will increase from 6 to 7 in Virginia. *See* Rachel Fehr, Cynthia Cox, and Larry Levitt, Insurer Participation on ACA Marketplaces, 2014-2019 (Nov 14, 2018), https://www.kff.org/health-reform/issue-brief/insurer-participation-on-aca-marketplaces-2014-2019/.

them (as of 2018) receive refundable tax subsidies to help them pay for premiums, *id.* ¶ 4, which generally insulate them from the effects of premium increases. This is because these subsidies take the form of premium tax credits, *see generally* 42 U.S.C. §§ 18021-18044; 26 U.S.C. § 36B, and the amount depends in part on the premium charged for a benchmark plan (*i.e.*, the applicable second lowest cost silver plan) available on the relevant Exchange and on the eligible taxpayer's household income. *See* 26 U.S.C. § 36B; *see also* Wu Decl. ¶ 5. If premiums for the applicable benchmark plan increase, premium tax credits generally increase by a corresponding amount, thus insulating the taxpayer from the effect of the premium increase. Wu Decl. ¶ 5. Instead, it is the Federal Government that bears the brunt of the impact of any premium increase. *Id.*

Third, even if there were an exodus of enrollees, it would be difficult to determine whether that exodus is traceable to the recent change in the individual mandate tax penalty, other market factors beyond Defendants' control, or the actions complained of in this lawsuit. As noted before, in December 2017, Congress enacted the Tax Cuts and Jobs Act, which reduced the amount of the tax penalty to $0 beginning in 2019 for individuals who fail to comply with the individual mandate. As a result of this congressional action, some people may choose to go uninsured rather than purchase coverage subject to the ACA's market reforms. In particular, it is possible that younger and healthier individuals may choose to purchase less expensive alternative options to qualified health plans, such as short-term limited duration insurance coverage (*see* Am. Compl. ¶¶ 116-22), which, unlike the one-size-fits-all health plans in the individual market, is permitted under federal law to require underwriting and adjust premiums on the basis of age, pre-existing conditions, and other criteria. The City Plaintiffs therefore have not established that any alleged burden imposed by exodus of enrollees from the Exchanges would be traceable to Defendants' actions.

Similarly, the claim that Defendants' actions since 2017 have caused premiums to increase is belied by reality. As discussed above, health insurance premiums in the individual market more than doubled between 2013 and 2017—*i.e.*, before any of the challenged actions took place. And the individual health insurance market is inherently variable, with a slew of state-specific, market-specific, issuer-specific, and consumer-specific factors going into the determination of healthcare costs and

premium rates. All those factors make it impossible for this Court to determine with the requisite degree of certainty that any market will encounter an increase in premiums for ACA-compliant health insurance, and if premiums do increase, whether and to what extent they are attributable to the challenged rules and executive actions. *See Va. Dep't of State Police*, 713 F.3d at 755 (the "traceability and redressability prongs [of standing] become problematic when third persons not party to the litigation must act in order for an injury to arise or be cured."); *Am. Freedom Law Ctr.*, 821 F.3d at 49-50 ("When [t]he existence of one or more of the essential elements of standing depends on the unfettered choices made by independent actors not before the courts and whose exercise of broad and legitimate discretion the courts cannot presume either to control or to predict, it becomes substantially more difficult to establish standing.") (internal citations and quotation marks omitted). Indeed, premiums for the ACA individual markets have stabilized in 2019, Wu Decl. ¶¶ 13-14, even if there are variations across the regions, States, and counties as to the actual decreases or increases. Maryland, for example, where Plaintiff the City of Baltimore is located, all insurers for the individual market reported significantly greater decreases in premium rates than the national average for 2019. *Id.* ¶ 15. Similarly, in Pennsylvania, where Plaintiff City of Philadelphia is located, the final 2019 approved rates for the individual ACA market resulted in an aggregate statewide decrease of 2.3 percent.[9] These decreases demonstrate the variability inherent in health care costs. *See, e.g.*, *Am. Freedom Law Ctr.*, 821 F.3d at 51. This also means that it is equally plausible that premium rates may decrease or stay stabilized in 2020 and beyond.

Finally, even if Plaintiffs were correct that the populations in the City Plaintiffs' jurisdictions have or will become uninsured or underinsured and sicker due to Defendants' actions, the City Plaintiffs still cannot establish standing by claiming that they likely will need to increase expenditures to account for such populations. *See* Am. Compl. ¶¶ 183-84. No provision of federal law requires the City Plaintiffs to allocate any portion of their budgets to public health spending. Instead, the City

[9] Pennsylvania Insurance Commissioner's recent before Congress at 3, https://www.insurance.pa.gov/Documents/Press%20and%20Communications/Testimonies%2c%20Remarks%2c%20Speeches/2019/Testimony-Altman-ACA%20Leg%20Hearing-021319.pdf

Plaintiffs make their own political choices about budget priorities and healthcare spending, choices that are complicated and influenced by a variety of factors, including available tax revenue and the political will of the relevant decision-makers. Where, as here, "the plaintiff is not himself the object of the government action or inaction he challenges," standing "is ordinarily substantially more difficult to establish." *Lujan*, 504 U.S. at 562 (citation omitted); *see, e.g.,* Am. Compl. ¶¶ 52-56, 282(a) (challenging the 2019 Rule's change of the notification requirement regarding individual *taxpayers'* loss of eligibility of tax credits under certain circumstances, but failing to identify the connection between such taxpayers and the City Plaintiffs' alleged harm).

In sum, Plaintiffs' alleged injury depends upon multiple layers of speculation, third-party actions and tenuous causal links. It is evident that they seek to redress generalized grievances about the Executive Branch's policies by relying on their own unsubstantiated beliefs about the potential impact – primarily to others – of such policies. That is insufficient to establish Article III standing.

4. Plaintiffs' claims are not ripe.

For many of the same reasons that the Individual and City Plaintiffs have no standing to sue, many of Plaintiffs' claims also cannot satisfy the doctrine of ripeness. *See MedImmune, Inc. v. Genentech, Inc.*, 549 U.S. 118, 128 n.8 (2007) (recognizing that in some cases, "standing and ripeness boil down to the same question"); *Miller v. Brown*, 462 F.3d 312, 319 (4th Cir. 2006) ("Analyzing ripeness is similar to determining whether a party has standing."). "Ripeness is a justiciability doctrine designed to prevent the courts, through avoidance of premature adjudication, from entangling themselves in abstract disagreements over administrative policies, and also to protect the agencies from judicial interference until an administrative decision has been formalized and its effects felt in a concrete way by the challenging parties." *Nat'l Park Hosp. Ass'n v. Dep't of the Interior*, 538 U.S. 803, 807-08 (2003) (quoting *Abbott Labs. v. Gardner*, 387 U.S. 136, 148–49 (1967)). Ripeness depends on "(1) the fitness of the issues for judicial decision and (2) the hardship to the parties of withholding court consideration." *Id.* at 808. A claim is not ripe for adjudication if it "'rests upon contingent future events that may not occur as anticipated, or indeed may not occur at all.'" *Andrew v. Lohr*, 445 Fed. Appx. 714, 715 (4th Cir. 2011) (quoting *Texas v. United States*, 523 U.S. 296, 300 (1998)).

Such is the case here. As shown above, the harm allegedly suffered by Plaintiffs is based on contingent events, including impact flowing from the 2019 Rule and other administrative and executive actions. In addition to the fact that it is entirely speculative that premiums will rise in 2020 or beyond, the impact of some of the challenged actions are not yet known, even assuming the impact can actually be assessed. It is also too soon to know whether the challenged rules that expand access to association health plans ("AHPs") and health reimbursement arrangements ("HRAs") will have any concrete impact on Plaintiffs. *See* Am. Compl. ¶¶ 109-11, 115. The rule change regarding HRAs is not even final yet, as HHS and the Departments of the Treasury and Labor have only issued a Notice of proposed rulemaking, and are reviewing the comments received in response to the Notice. *See* 83 Fed. Reg. 54420 (Oct. 29, 2018). The AHP rule will not be fully effective until April 1, 2019, *see* 83 Fed. Reg. 28912 (June 21, 2018).[10] And although the challenged rule on short-term, limited-duration insurance ("STLDI") went into effect on October 2, 2018, *see* 83 Fed. Reg. 38212 (Aug. 3, 2018), many States (including Illinois, Maryland, Ohio, and Virginia, where Plaintiffs are located) have already responded to the STLDI rule by providing more restrictions than federal requirements. Wu. Decl. ¶ 8. For example, although the STLDI rule changed the maximum permissible contract term from three months to less than 12 months, Maryland has enacted a law limiting the term to less than three months, *id.*; *see also* Md. Ins. Code § 15-1301(s), as amended by HB 1782 (2018), while Illinois and Virginia prohibit issuers from selling STLDI policies with terms exceeding 185 days, Wu Decl. ¶ 8. And Ohio has placed restriction on renewals, even though under the STLDI rule, a policy may be renewed or extended for up to 36 months. *Id.*

Also clearly premature is Plaintiffs' claim that premium rates will increase as a result of CMS's proposed 2020 Rule. Am. Compl. ¶¶ 173-76. As with the 2019 Rule, the proposed 2020 Rule

[10] The AHP final rule establishes three "phased applicability dates." *See generally* 83 Fed. Reg. 28912 (June 21, 2018). The first date (September 1, 2018) allowed fully insured plans, such as an AHP that purchases insurance from another provider, to begin operation. *See id.* Existing self-insured AHPs—those that pay out of their own assets—were permitted to begin operating under the new rule on January 1, 2019. *Id.* The remaining date, however, has not yet occurred. *See id.* New self-insured AHPs may only begin operation on April 1, 2019. *Id.*

proposes to amend or modify certain aspects of the operation of the health insurance markets and Exchanges. But as even Plaintiffs acknowledge, the proposed 2020 Rule has not been finalized. In fact, the public comment period closed on February 19, 2019, and CMS has begun the process of reviewing submitted comments. Thus, there is no way to know whether any of the provisions about which Plaintiffs object will be finalized in their proposed form or how or if there will be any impact on Plaintiffs. In sum, judicial consideration of many of Plaintiffs' claims is premature, and the case should be dismissed as unripe.

B. The Complaint Fails to State a Claim upon Which Relief Can be Granted.

1. Plaintiffs' APA challenge to the 2019 Rule should be dismissed.

Even if Plaintiffs can overcome the insurmountable jurisdictional hurdle, their APA claim should be dismissed for failure to state a claim. As an initial matter, the President is not subject to the APA, *Franklin v. Massachusetts*, 505 U.S. 788, 828, 796 (1992), and thus, this claim can only proceed as against the other defendants.

Under the APA, the Court may set aside an agency action if the Court finds that challenged action is "arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law." 5 U.S.C. § 706(2)(A). The Court's review is "ultimately narrow and highly deferential" and focused on "ensur[ing] that the agency has 'examine[d] the relevant data and articulate[d] a satisfactory explanation for its action.'" *Am. Whitewater v. Tidwell*, 770 F.3d 1108, 1115 (4th Cir. 2014) (internal citation). The agency need only "provide[] an explanation of its decision that includes a rational connection between the facts found and the choice made'" to have its decision sustained. *Id.* (quoting *Ohio Valley Envt'l Coal. v. Aracoma Coal Co.*, 556 F.3d 177, 192 (4th Cir. 2009)). A court "is not to substitute its judgment for that of the agency." *Motor Vehicle Mfrs. Ass'n of U.S., Inc. v. State Farm Mut. Auto. Ins. Co.*, 463 U.S. 29, 43 (1983). The agency need not "demonstrate to [the] court's satisfaction that the reasons for the new policy are *better* than the reasons for the old one; it suffices that the new policy is permissible under the statute, that there are good reasons for it, and that the agency *believes* it to be better, which the conscious change of course adequately indicates." *F.C.C. v. Fox Television Stations, Inc.*, 556 U.S. 502, 515 (2009) (emphasis in original).

Moreover, to the extent Plaintiffs allege that the agency action is contrary to law, the action is reviewed under the deferential framework set out in *Chevron U.S.A., Inc. v. Natural Resources Defense Council, Inc.*, 467 U.S. 837, 845 (1984). That framework is based on the presumption "'that Congress, when it left ambiguity in a statute administered by an agency, 'understood that the ambiguity would be resolved, first and foremost, by the agency, and desired the agency (rather than the courts) to possess whatever degree of discretion the ambiguity allows.'" *City of Arlington v. FCC*, 569 U.S. 290, 296 (2013) (citation omitted). Thus, if Congress has not "directly addressed the precise question at issue," *Mayo Found. for Med. Educ. & Research v. United States*, 562 U.S. 44, 52 (2011), *i.e.*, when the statute is silent or ambiguous with respect to the specific issue under consideration, then "the question for the court is whether the agency's answer is based on a permissible construction of the statute," *City of Arlington*, 569 U.S. at 296 (quoting *Chevron*, 467 U.S. at 842-43). This last analysis is coextensive with arbitrary or capricious review. *Judulang v. Holder*, 565 U.S. 42, 52 n.7 (2011).

As explained in detail below, each of the approximately nine challenged provisions of the 2019 Rule more than satisfies this highly deferential standard.

a. The 2019 Rule provisions amending CMS's rate review requirements are permissible interpretations of the ACA. [Am. Compl. ¶ 282(h)]

Plaintiffs challenge two provisions of the 2019 Rule that amend CMS's regulations governing premium rate review under the ACA: 1) the provision that exempts student health insurance coverage from the federal rate review process; and 2) the provision that increases the rate increase threshold that triggers the federal rate review process. *See* Am. Compl. ¶¶ 89-93, 282(h). Both challenges fail.

As to the first provision, the exemption is not contrary to the ACA as Plaintiffs argue. *See id.* ¶ 90. Although student health insurance is a form of individual health insurance, CMS has long interpreted the ACA to exclude student health insurance plans from ACA requirements that "would have, as a practical matter, the effect of prohibiting an institution of higher education from offering a student health plan otherwise permitted under federal, state, or local law." Patient Protection and Affordable Care Act; Health Insurance Market Rules; Rate Review, 78 Fed. Reg. 13406, 13424 (Feb.

27, 2013) (interpreting 42 U.S.C. § 18118(c)). Thus, for example, student health insurance coverage is exempted from the ACA's guaranteed availability and renewability requirements to the extent that such requirements would require a student health insurance plan to accept enrollment or renew coverage of individuals who are not students or dependents of students. *See* 45 C.F.R. § 147.145(b)(1); *see also* Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2015, 79 Fed. Reg. 13744 (Mar. 11, 2014); Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2017, 81 Fed. Reg. 12204 (Mar. 8, 2016). The same is true regarding the ACA requirement that coverage be offered on a calendar year basis; student health insurance coverage generally is instead offered based on the academic calendar year. 45 C.F.R. § 147.145(b)(1)(ii). Moreover, student health insurance coverage is not included in the ACA's individual market single risk pool in a State because issuers of student health insurance coverage typically contract with colleges and universities to issue a blanket health insurance policy based on total expected claims from which students may buy coverage. *See id.* § 147.145(b)(3).

With the 2019 Rule, CMS determined that student health insurance coverage should also be exempt from the federal rate review process under 42 U.S.C. § 300gg-94. *See* 83 Fed. Reg. at 16972. Although that provision requires that both the Secretary and the States "monitor premium increases of health insurance coverage offered through an Exchange and outside of an Exchange," CMS explained that student health insurance coverage is "generally rated and administered differently" from other individual health plans; indeed, States have "allowed rating practices for student health insurance coverage to be more in line with large group pricing." 83 Fed. Reg. at 16972 (citing Final Rule, "Health Insurance Market Rules; Rate Review," 78 Fed. Reg. 13406, 13424 (Feb. 27, 2013)). As a result of these differences, CMS reasonably determined that student health insurance coverage should be exempt from federal rate review, except that CMS plans to continue to generally review such coverage rates "[i]n States that do not have an Effective Rate Review Program to monitor the compliance of student health insurance coverage with applicable market rating reforms based on complaints and as part of targeted market conduct examinations." 83 Fed. Reg. at 16972. States retain the flexibility to review rate increases of any size and other aspects of student health insurance coverage. *Id.* Given

these explanations and safeguards, Plaintiffs' challenge to the student health insurance coverage provision fails.

Equally meritless is Plaintiffs' contention that CMS has arbitrarily and capriciously increased the threshold for federal premium rate review from 10 percent to 15 percent. *See* Am. Compl. ¶ 92; *see also* 42 C.F.R. § 154.200. Section 300gg-94 provides that the 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). Section 300gg-94, however, does not define what constitutes an "unreasonable" premium rate increase nor does it define the process that should be used for determining whether a particular increase is "unreasonable." 42 U.S.C. § 300gg-94 (requiring that a review be conducted and a justification submitted). The statute's silence on this score is a "gap" that Congress left for CMS to fill based on its expertise and pursuant to its rulemaking authority under the ACA. *See, e.g.*, *The Md. Dep't of Health & Mental Hygiene v. CMS*, 542 F.3d 424, 434 (4th Cir. 2008) (deferring to CMS's interpretation of the phrase "not covered under the State plan" in the Medicaid statute because "[b]y failing to define the phrase, Congress left an interpretive gap that CMS may fill"). As CMS explained in initial rulemaking implementing 42 U.S.C. § 300gg-94, CMS regulations provide a definition of an "unreasonable" rate increase and outline the process HHS would use to review rate increases, which includes the process of determining which rates are subject to review in the first instance. *See* Rate Increase Disclosure and Review; Proposed Rule, 75 Fed. Reg. 81003, 81005-81008 (Dec. 23, 2010). If a proposed rate increase equals or exceeds the defined threshold, it would be considered "subject to review." *Id.* The review process would then determine if the increase is, in fact, "unreasonable." *Id.*

In the 2019 Rule, CMS explained that its decision to increase the threshold for review under the federal rate review process was based on its "recognition of [the] significant rate increases in the past number of years." 83 Fed. Reg. at 16972. To that point, CMS reviewed all rating filings "since the inception of the review threshold" to identify those that were subject to review and ultimately determined to be "unreasonable." *Id.* at 16973. The result of CMS's analysis was that "only one filing" that fell "between the 10 to 15 percent range" over a seven year period was deemed "unreasonable"

after further review. *Id.* Moreover, CMS reasoned that many States already "apply a stricter (lower threshold) standard" and thus, the 15 percent threshold would merely set "a [federal] minimum standard." *Id.*; *see also* 76 Fed. Reg. 29964, 29967 (May 23, 2011) at 29967. For these reasons, CMS rationally decided to increase the threshold for review under the federal rate review process to 15 percent. *See Am. Whitewater v. Tidwell*, 770 F.3d 1108, 1116 (4th Cir. 2014) ("so long as the agency 'provides an explanation of its decision that includes a rational connection between the facts found and the choice made,' its decision should be sustained") (citation omitted).

Plaintiffs take issue with CMS's "invo[cation]" of the States' rate review process, arguing that it is a "stopgap measure," and thus impermissible. *See* Am. Compl. ¶ 92. But Congress expressly contemplated such reliance: it directed CMS to establish a process "in conjunction with the States" for monitoring and reviewing unreasonable premium increases. *See* 42 U.S.C. §§ 300gg-94(a)(1), 300gg-94(a)(2)(A). Also unwarranted are Plaintiffs' arguments that CMS "gave short shrift" to commenters' concerns, "ignored" the deterrent purpose of the reasonableness review, and improperly made it easier for insurers to increase rates without adequate justification. *See* Am. Compl. ¶¶ 92-93. First, CMS's analysis of seven years of rate filings found "only one" rate filing within the 10 to 15 percent range that was deemed "unreasonable." 83 Fed. Reg. at 16973. Second, as noted, "most States" have "stricter rate review standards" to which issuers offering health insurance coverage in ACA markets are also subject. *Id.* Third, the challenged provision represents a reasonable effort to balance the need to review and monitor unreasonable premium rate increases against CMS's interest in decreasing the regulatory burden on insurers and other interested stakeholders. *See* 83 Fed. Reg. at 16972-73. Where, as here, "the new policy is permissible under the statute, [ ] there [is] good reason[ ] for it, and [the] agency *believes* it to be better," the Court must uphold the agency's judgment. *Fox Television Stations*, 556 U.S. at 515.

b. Plaintiffs' challenge to six separate provisions of the 2019 Rule that modify certain Exchange functions and streamline the direct enrollment and eligibility verification processes also fails. [Am. Compl. ¶ 282(a), (c), (d)-(g)]

Equally unavailing is Plaintiffs' challenge to six provisions of the 2019 Rule, *see* Am. Compl. ¶¶ 282(a), (c), (d), (g), that modify or amend "Exchange Establishment Standards and Other Related Standards Under the Affordable Care Act," *see* 83 Fed. Reg. at 16930. CMS determined that these regulatory changes were necessary to mitigate insurers exiting the individual and small group markets, thereby causing insurance premium rates to increase and "threaten[ing] the stability of the individual and small group Exchanges" in those geographic areas. *Id.* As explained in detail below, each of the challenged provisions is focused on "enhancing the role of States in these programs and providing States with additional flexibilities, reducing unnecessary regulatory burden on stakeholders, empowering consumers, and improving affordability," *see id.* at 16930-31, all of which fall well within CMS's broad regulatory authority under the ACA.

CMS's Decision to Discontinue Standardized Options **[Am. Compl. ¶ 282(d)].** In the 2017 health insurance benefit year, CMS "introduced standardized options (also now referred to as Simple Choice plans)," which are qualified health plans offered for sale through an individual market Exchange that have either a standardized cost-sharing structure or other specified cost-sharing structures. *Id.* at 16974. Such plans are a creation of HHS's regulation and not mandated by the ACA. With the challenged 2019 Rule, CMS has opted not to offer standardized options in an effort to encourage competition in the individual market and "to maximize innovation by issuers in designing and offering a wide range of plans to consumers." *See id.*

Although "[m]any commenters supported" the decision to discontinue standardized options, *see id.* at 16973, Plaintiffs do not, and they urge the Court to invalidate the challenged provision on two grounds. First, they argue that CMS failed to explain the basis of its decision. *See* Am. Compl. ¶ 72. But the 2019 Rule's preamble expressly explains that CMS decided to eliminate the standardized options to "encourag[e] innovation," which "is especially important now, given the stresses faced by the individual market." 83 Fed. Reg. at 16974. The agency was also "concern[ed] that providing

differential display for these plans may limit enrollment in coverage with plan designs that do not match the standardized options" when the latter plan designs may be a better fit for individual consumers. Am. Compl. ¶ 72. Plaintiffs' assertion that the provision "will limit the degree to which health plans will compete on price," *see id.*, reflects nothing more than a disagreement with CMS's assessment that eliminating the standardized options would encourage competition and innovation, and thereby reduce prices.

Plaintiffs next insist that eliminating the standardized option is unlawful because CMS "has cited no data to support" its assertion that these plans stymied innovation. *Id.* ¶ 72. But the agency has substantial expertise in administering the Federally facilitated Exchanges ("FFEs") and, as discussed in detail in the Preamble, 83 Fed. Reg. at 16975, has determined that the benefits of the change outweigh the potential concerns, especially given that the proposed change is necessary to encourage insurers to design and offer innovative health care plans in the individual market. Nothing more is required.

Plaintiffs' contention that CMS failed to offer a reasonable explanation in response to commenters who believe that standardized options would encourage issuers to develop innovative plan features, *see* Am. Compl. ¶ 70, is simply wrong. CMS considered these comments and ultimately rejected the premise, reasoning that standardized options create disincentives for issuers to innovate and that issuers are in the best position to design and offer innovative plan designs. 83 Fed. Reg. at 16975. CMS further explained that because the agency had designed standardized options "to be[] similar[] to the most popular (weighted by enrollment) [qualified health plans] in the FFEs [Federally Facilitated Exchanges]," the plan "design features, such as annual limitations on cost sharing and deductibles, previously specified as part of standardized options are mostly available to consumers in FFEs" and, therefore, it is unnecessary to "mandate or otherwise further provide an incentive for issuers to offer plans that meet the characteristics of standardized options." *Id.*

Plaintiffs also speculate that without the ability to choose from among standardized options on the federal Exchanges, "it [will be] more difficult for consumers to select" appropriate health plans, which, in turn, will increase the risk that individuals "will go without coverage," thereby "increase[ing]

the size of the underinsured and uninsured populations." Am. Compl. ¶¶ 72-73. But as CMS explained, there are currently "other tools" to assist consumers with their health plan selection, including "HealthCare.gov plan filters." 83 Fed. Reg. at 16975. Moreover, the agency is continuing to "explore strategies to make shopping on HealthCare.gov as easy as possible, and . . . better [able to] support customers in choosing coverage that is best for them." *Id.*

Modifications to Standards for Navigator Certification **[Am. Compl. ¶ 282(e)].** Prior to the 2019 Rule, CMS required that each Exchange have "at least two Navigator[s]," *i.e.*, entities that conduct public education and other activities aimed at increasing public awareness about QHPs and enrollment in the individual and small group market pursuant to grants awarded by each Exchange; "that one of these [two] entities [] be a community and consumer-focused nonprofit group"; and that "each Navigator entity maintain a physical presence in the Exchange service area" to facilitate "face-to-face assistance." *Id.* at 16979. CMS has now removed these requirements, while allowing the Exchanges to choose to use their Navigator grant funds in the same manner as they did before. *Id.* The challenged amendment is intended "[t]o maximize the flexibility and efficiency of the Navigator program" through the Exchanges' "improved flexibility to award funding to the number and type of entities that will be most effective for the specific Exchange." *Id.* CMS stated its belief that each Exchange is best suited to determine for itself how to select Navigators, and that allowing the Exchanges the flexibility to do so would "best serve the Exchange service areas." *Id.* at 16979. After all, CMS's experience shows that Navigators "with strong relationships in their [Exchange] service areas tend to deliver the most effective outreach and enrollment results." *Id.* at 16979-80.

Plaintiffs contend that the provision violates the ACA because should an Exchange choose not to require the Navigator to have a physical presence, or be a consumer-focused non-profit organization, in the Exchange service area, the Navigator program "cannot adequately carry out [its] statutory duties." Am. Compl. ¶¶ 76-77. But the ACA provision governing Navigators does not speak to the issue. *See* 42 U.S.C. § 18031(i)(2)(A) (providing only that an eligible Navigator entity must "demonstrate . . . that [it] . . . has existing relationships, or could readily establish relationships, with employers, . . . consumers . . . or self-employed individuals likely to be qualified to enroll in a qualified

health plan"). In the absence of any statutory directive, the same statutory authority that allowed CMS to establish the prior standards for Navigator certification, *see* 42 U.S.C. §§ 18031(i)(4)(A), 18041(a)(1), now allows CMS to modify those standards. Indeed, there can be no dispute that the new standard is consistent with § 18031 and CMS's regulations. 83 Fed. Reg. at 16980; *see, e.g.*, 45 C.F.R. § 155.210. Plaintiffs' subjective beliefs about how best to implement the Navigator program cannot invalidate the agency's decision to allow more flexibility to Exchanges to control their programs, consistent with the statute.

Nor is that decision arbitrary or capricious. *See* Am. Compl. ¶¶ 78-79. During rulemaking, CMS considered and rejected many of the same objections that Plaintiffs advance here, *see* 83 Fed. Reg. at 16980-81. In particular, 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," *id.* at 16981, concluding that the Exchanges are better suited to determine "the weight to give a [Navigator's] physical presence in the Exchange service area," *id.* at 16980. And in removing the requirement that each Exchange must have at least one community and consumer-focused non-profit organization, CMS examined Section 18031(i)(2)(A)'s requirement that the entity needs to demonstrate that it has "existing relationships, or could readily establish relationships" with prospective consumers, and that such an entity could include "trade, industry, and professional associations, commercial fishing industry organizations, ranching and farming organizations, . . . chambers of commerce, unions, [and] resource partners of the Small Business Administration." 42 U.S.C. § 18031(i)(2)(B). CMS also considered the concern that the Exchanges will select "conflict[ed]" Navigators, Am. Compl. ¶ 77, concluding that the Exchanges "are able to determine the type of entity or entities that will serve their Exchange service area best" in a manner consistent with established statutory and regulatory standards and obligations. 83 Fed. Reg. at 16980. In sum, because the challenged provision is a permissible interpretation of the ACA and is neither arbitrary nor capricious, it should be upheld.

New Audit Standards for Entities Participating in Direct Enrollment **[Am. Compl. ¶ 282(c)].** As part of HHS's effort to reduce regulatory burden, the 2019 Rule now provides that for

purposes of the annual operational readiness review, agents, brokers, and issuers participating in direct enrollment "would select their own third-party entities for conducting audits, rather than requiring HHS to initially review and approve these entities [as was the case under CMS's prior rule]." 83 Fed. Reg. at 16981. CMS explained that it intends "to publish technical guidance outlining the review standards and other operational details, as well as [to] provide other resources to assist third-party entities in conducting the reviews." *Id.* Moreover, third party entities will "be subject to HHS oversight" and "the agent, broker, or issuer will remain responsible for compliance with all applicable direct enrollment requirements." *Id.*

Plaintiffs speculate about a host of harms that allegedly would result from this regulatory change and accuse CMS of "fail[ing] to grapple with evidence" and to respond to comments expressing concern about this change. *See* Am. Compl. ¶¶ 67-68. None of these arguments has merit. First, CMS considered the concern that the new provision may "increase the likelihood that consumers [will] receive inaccurate information," *see id.* ¶ 68; *see also* 83 Fed. Reg. at 16982. But it concluded that such concern is addressed by established "standards" that "help promote informed consumer choice" in the individual and small group markets, including but not limited to the requirement to "display all [qualified health plan] data." 83 Fed. Reg. at 16982. Indeed, regulations require that agents, brokers, and issuers participating in direct enrollment provide consumers with correct information. *See* 45 C.F.R. §§ 155.220(j)(2)(i) and 156.1230(b)(3). CMS explained in the 2019 Rule that there are guidelines and processes in place to oversee the activities of agents, brokers, and issuers participating in direct enrollment, and the agency is committed to continuous monitoring and oversight of such entities. *See* 83 Fed. Reg. at 16982.

CMS also considered Plaintiffs' concern "that enrollment through a non-governmental site would occur without proper oversight and controls," including "the potential for conflicts of interest arising from relationships between the agents, brokers, and issuers and the third-party auditors they select to conduct their audits." *Id.* But again, CMS concluded that these concerns are mitigated by the requirements and processes the agency has put in place. *Id.* CMS indicated that it intends to continue "to monitor enrollments through the direct enrollment pathway for evidence of fraud and

abuse." *Id.* And, although the agency "acknowledge[d] the potential for conflicts of interest," in its view, the "required disclosures, continuous monitoring and oversight, and standards established for third-party auditors will sufficiently mitigate these concerns." *Id.* Plaintiffs cannot invalidate CMS's decision based on their own unsubstantiated fear that there will be widespread fraud or abuse by insurance issuers, agents, or auditors.[11] *See Am. Whitewater*, 770 F.3d at 1116 ("[T]he APA does not give us license to second-guess an agency's well-reasoned decision simply because a party disagrees with the outcome.").

Decision to Amend Tax Credit Eligibility Determination Processes **[Am. Compl. ¶ 282(a)].** Similarly without merit is Plaintiffs' challenge to the provision in the 2019 Rule that amends the notification requirement regarding an individual's eligibility for advance payments of the premium tax credit for purposes of purchasing qualified health plans on the Exchanges. As noted before, under the ACA, certain enrollees in the individual market Exchanges are eligible to receive a premium tax credit to reduce their costs for health insurance premiums. 83 Fed. Reg. at 16930. Under CMS's regulations, an individual is ineligible to receive advance payments of the premium tax credit ("APTC") if, *inter alia*, "the tax filer or his or her spouse" fails to file an income tax return and reconcile APTC received for the individual for a previous year. 45 C.F.R. § 155.305(f)(4). Under the prior regulations, the Exchanges (Federal and State-based) could "not discontinue APTC due to [this] failure" "unless direct notification [wa]s first sent to the tax filer that his or her eligibility w[ould] be discontinued." 83 Fed. Reg. at 16982. The 2019 Rule amends this provision by "removing the direct notification requirement." *Id.*

CMS explained that it promulgated the challenged 2019 Rule provision to address concerns that Internal Revenue Service ("IRS") rules "generally prohibit the disclosure of FTI [federal tax

[11] The challenged 2019 audit and monitoring standards also substantially mitigate any concern that CMS's recently-published guidance streamlining the direct enrollment process, *see* CMS, Enhanced Direct Enrollment for 2019 FAQs (Nov. 28, 2018), "will expose health insurance purchasers to under-regulated agents, brokers, and issuers" as Plaintiffs speculate. Am. Compl. ¶ 68 n.77. As the challenged provision makes clear, there are robust guidelines in place to oversee the activities of agents, brokers, and issuers participating in direct enrollment and these entities are subject to continuous monitoring and oversight. *See* 83 Fed. Reg. at 16,892.

information] to anyone other than the tax filer," and FTI includes "information as to whether a tax return has been filed with [the] IRS." *Id.* The direct notice "unambiguously explain[s] that the tax filer has been identified as having failed to meet the requirement to file and reconcile" and urges "the tax filers to file and reconcile to avoid losing APTC." *Id.* "To avoid unauthorized disclosure of FTI" and ensure that consumers receive appropriate APTC eligibility notification when necessary, the federal exchanges will now send two notices: (1) a "combined notice," *i.e.*, written notices (electronically or via U.S. Mail), sent to consumers (failure to reconcile ("FTR") and non-FTR), which explains in general terms the need to address their failure to reconcile the APTC but does not include any FTI, *see id.* at 16983, and (2) "warning notices" or "direct notices" to "tax filers on whose behalf APTC was being paid but for whom the [Federally Facilitated Exchange] ha[s] information [that] the tax filer had not met the requirement to file and reconcile." *Id.* With respect to the State-based Exchanges ("SBEs"), CMS noted the "infeasib[ility]" of "upgrading their systems to be FTI compliant . . . in the short term" and their "varying capacities," and thus "encourage[d] SBEs to take a similar noticing approach [as the federal exchanges], where feasible" and offered "to provide technical assistance, as needed." *Id.* at 16984.

Plaintiffs contend that CMS's decision to amend the direct notice requirement in this manner is both contrary to 26 U.S.C. § 36B, the Internal Revenue Code ("IRC") provision authorizing the receipt of APTC for an "applicable taxpayer," and arbitrary and capricious. *See* Am. Compl. ¶¶ 53-54. Plaintiffs are wrong on both scores. As an initial matter, the IRC provision on which Plaintiffs rely is not under the jurisdiction of CMS, and the provision does not limit CMS's authority to promulgate regulations governing the functioning of the Exchanges under Section 18041(a)(1) of the ACA, which authorizes CMS to establish the eligibility requirements for the APTC program. CMS's decision to modify the regulations governing notification of APTC eligibility is a permissible interpretation of the ACA and is entitled to deference.

Moreover, Plaintiffs' argument runs afoul of the "canon against reading conflicts into statutes." *Epic Sys. Corp. v. Lewis*, 138 S. Ct. 1612, 1630 (2018). Contrary to Plaintiffs' argument, *see* Am. Compl. ¶ 54, there is no conflict between the challenged provision and § 36B of the IRC because

nothing in the challenged provision deprives an individual from receiving APTC as long as she or he complies with the statutory and regulatory eligibility requirements, including the obligation to file a federal tax return and reconcile a prior year's APTC, if any. *See* 42 U.S.C. § 18081(a)(1), (2); *see also* 45 C.F.R. § 155.305. Again, the challenged provision simply amends the process by which the Exchanges provide written notice of APTC eligibility to ensure that the Exchanges' written notices do not run afoul of IRS rules barring the disclosure of FTI to third parties.

There is also no merit to Plaintiffs' claim that the challenged provision is arbitrary and capricious. Plaintiffs argue that CMS failed to provide "evidence" indicating that consumers are "receiving APTC improperly." Am. Compl. ¶ 55. But CMS need not do so because its decision is a prophylactic measure to *avoid* program integrity issues. *See, e.g.*, *F.C.C. v. Nat'l Citizens Comm. For Broad.* 436 U.S. 775, 813-14 (1975) (a "forecast of the direction in which future public interest lies necessarily involves deductions based on the expert knowledge of the agency") (citation omitted). As CMS explained, while it "is committed to ensuring consumers eligible for APTC maintain that important benefit," it "also believe[s] that *ensuring* consumers are not receiving APTC improperly is necessary for program integrity." 83 Fed. Reg. at 16984 (emphasis added). Moreover, as already discussed, CMS proffered two other bases for its decision: (1) the "importan[ce] . . . [of] reduc[ing] burden on Exchanges, which have varying capacities," and (2) the need to "[e]stablish[] a mechanism through which to notify tax filers without making an unauthorized disclosure of protected FTI." *Id.*

Finally, Plaintiffs insist that the challenged provision is arbitrary and capricious because CMS itself "recognizes the utility and importance of [direct] notifications" as evidenced by the fact that the federal exchanges will continue to provide them. Am. Compl. ¶ 55. But as CMS explained, "the direct notices were not generated by the [Federally Facilitated Exchange] itself; rather, data was securely sent to an FTI-compliant print contractor for printing and mailing." 83 Fed. Reg. at 16983. State-based Exchanges, on the other hand, "may have fewer options available to them"; indeed, CMS has learned that some of them "are required to use only in-State contractors, which can create a significant barrier if there are not FTI-compliant contractors in the State." *Id.* CMS also emphasized that the agency "remain[s] committed to improving the clarity and effectiveness of the FTR notification process," *see*

id. at 16985, and will do so "as part of broader rulemaking and guidance" on this and other issues related to program integrity, *id.* at 16986. For now, the challenged rule should be upheld because it properly balances the Exchanges' obligation to provide APTC eligibility notices, the need to avoid unlawful disclosure of FTI, and the undue or "infeasible" burden on State-based Exchanges that are unable to upgrade their systems to be FTI compliant in short order without great expense.

Revisions to the Income Verification Requirements for APTC Eligibility **[Am. Compl. ¶ 282(g)].** Plaintiffs also challenge a provision of the 2019 Rule that requires a tax filer to submit additional documentation in which he or she attests to income between 100 and 400 percent of federal poverty level—making him or her eligible for APTC—but CMS would rely on electronic data sources that reflect a taxpayer's income under 100 percent of the federal poverty level. 83 Fed. Reg. at 16985. The prior rule required the Exchanges "to accept the [tax filer's] attestation without further verification" even when the attested income is contradicted by income data from the IRS and the Social Security Administration. *Id.* CMS explained that the new requirement is "a critical program integrity measure" and that "without proper procedures for verifying income and family sizes, the risk of providing APTC [to] individuals who do not meet the minimum income eligibility requirements—including those who may purposefully misstate their incomes in order to gain access to APTC—is increased." *Id.* at 16986.

Wholly ignoring this sound policy objective, Plaintiffs assert that it is arbitrary and capricious to require tax filers to clarify the income inconsistencies before their APTC eligibility can be determined. *See* Am. Compl. ¶¶ 83-86. Plaintiffs first argue that CMS "does not have firm data" indicating that individuals may attempt to inflate their income to gain APTC. But lack of "firm data" does not undermine the validity of the challenged provision, which CMS implemented based on its experience and expertise that income-dependent benefits programs, such as the APTC program, may be subject to abuse. *See, e.g.*, *Huncto Pawn Holdings, LLC v. U.S. Dep't of Def.*, 240 F. Supp. 3d 206, 225 (D.D.C. 2016) (rejecting plaintiffs' argument that rule was arbitrary and capricious because agency did not "support its belief that such misuse [that is, falsifying self-certification forms] was occurring with any technical data"). And contrary to Plaintiffs' argument, *see* Am. Compl. ¶ 84, this valid concern is

not mitigated by the ACA's requirement that eligible individuals reconcile their prior year's premium tax credit with the income tax return. *See* 83 Fed. Reg. at 16986 (explaining the agency's view that this new requirement is "a critical program integrity measure, notwithstanding any liability that the tax filer may have when filing income taxes and reconciling APTC paid during the inconsistency period"). "[T]o the extent that funds paid for APTC cannot be recouped through the tax reconciliation process, it is important to ensure these funds are not paid out inappropriately in the first instance." *Id.*; *see also Stillwell v. Office of Thrift Supervision*, 569 F.3d 514, 519 (D.C. Cir. 2009) ("agencies can, of course, adopt prophylactic rules to prevent potential problems before they arise").

Plaintiffs next fault CMS for failing to sufficiently answer commenters' concern that low-income individuals may have difficulty complying with the additional documentation requirement. *See* Am. Compl. ¶ 84. In the 2019 Rule's preamble, CMS expressly acknowledged this potential problem and outlined the available resources to assist such individuals. 83 Fed. Reg. at 16986 (citing the "modified" calculator used by HHS "to handle instances where income fluctuates, or is seasonal in nature"; the "consumer guide to households to help them provide correct documentation"; and "a worksheet for households to help verify their attested income"). Indeed, not only have these resources significantly improved the income verification process since the launch of the APTC program, CMS further emphasized its intent to "explor[e] strategies to promote more timely and accurate reporting of changes in circumstances by consumers." *Id.* In light of these current and future resources, Plaintiffs' various conjectures about the possible negative effects of the rule, *see* Am. Compl. ¶¶ 85-86, are insufficient to call into doubt CMS's new verification requirement.

Modifications to the Small Business Health Options Program **[Am. Compl. ¶ 282(f)].** The ACA requires each State to establish an Exchange that provides for the establishment of a Small Health Options Program ("SHOP") that is designed to assist qualified employers in the State who are small employers in facilitating the enrollment of their employees in QHPs offered in the small group market in the State. *See* 42 U.S.C. § 18031(b)(1)(B). CMS previously promulgated regulations establishing standards and processes governing SHOP operations. *See, e.g.,* 78 Fed. Reg. 15410, 15413 (Mar. 11, 2013) (Final Rule, "Patient Protection and Affordable Care Act; HHS Notice of Benefit and

Payment Parameters for 2014"). Those regulations required all SHOPs to determine employer and employee eligibility for SHOP plans and to provide certain enrollment functions, including premium aggregation functions. 83 Fed. Reg. at 16996. The 2019 Rule has removed some of those regulatory burdens on SHOPs, including verification of employee eligibility, premium aggregation, and online enrollment functionality. *Id.*

As CMS explained, it decided to remove those burdens because of "the significant decreases in SHOP [qualified health plan] issuer participation and enrollment for plan year 2018," and the "lower than expected enrollment" in the Federally-Facilitated SHOPs and State-based Exchanges on the federal platform for SHOP. *Id.* According to CMS, it is no longer "cost effective for the Federal government to continue to maintain certain Federally-Facilitated SHOP functionalities, collect significantly reduced user fees on a monthly basis, maintain the technologies required to maintain a Federally-Facilitated SHOP website and payment platform, generate enrollment and payment transaction files, and perform enrollment reconciliation." *Id.* Although CMS decided to remove many of these regulatory requirements, it made clear that "SHOPs that opt to operate in a leaner fashion, such as the Federally-Facilitated SHOPs, will still assist qualified employers . . . in facilitating the enrollment of their employees in [qualified health plans] offered in the small group market in the State." *Id.* at 16997. In CMS's view, that would be consistent with the ACA's provisions governing SHOPs, "because the basic functionalities of an Exchange will still be provided." *Id.* CMS also clarified that "State Exchanges will continue to have the flexibility to operate their SHOPs as they choose, in accordance with applicable Federal and State law." *Id.* at 16996.

Plaintiffs seek to invalidate the challenged provision on two grounds. First, Plaintiffs argue that CMS's decision to "allow SHOPs to operate in a leaner fashion," *id.* at 16996, violates the ACA. *See* Am. Compl. ¶¶ 80-81. But there is no provision in the ACA (or elsewhere) requiring SHOPs to perform the functions removed by the new rule. To the contrary, as CMS explained, all SHOPs will continue to provide ACA-mandated "basic [SHOP] functionalities," including certifying plans for sale, providing small employers the option to offer a choice of plans, and providing eligibility determinations for small employers. 83 Fed. Reg. at 16997; *see also id.* at 16996 (reiterating that the

decision to remove certain functionality "that is not expressly required by the [ACA]" does not affect the "appropriate implementation of statutorily required functions of the SHOP").

There is also no merit to Plaintiffs' assertion that the decision to scale back SHOP functionality in response to reduced utilization is arbitrary and capricious. Plaintiffs complain that "making SHOPs even less functional and less user friendly" will exacerbate "declining enrollment in SHOPs," ultimately increasing the uninsured population. Am. Compl. ¶¶ 80-81. Setting aside the entirely speculative nature of their argument, "[t]he primary purpose of these regulatory changes was not to increase the attractiveness of SHOPs to small employers, but to remove the regulatory burden on SHOPs to give Exchanges the flexibility to operate their SHOPs in a cost-effective way that best meets the needs of their State's small group market." 83 Fed. Reg. at 16998. As CMS reiterated, "SHOPs will continue to offer a centralized system that will provide certain free and impartial information to small employers looking for coverage." *Id.* CMS's decision to remove costly and under-utilized functionality requirements while maintaining the core statutory functions of SHOPs is neither arbitrary nor capricious but a reasoned response to decreased utilization, and as explained in the preamble to the 2019 Rule, consistent with the ACA's requirements.

c. CMS's decision to continue its prior qualified health plan certification standards for network adequacy and essential community providers is a permissible interpretation of the ACA and is neither arbitrary nor capricious [Am. Compl. ¶ 282(b)].

In addition to promulgating regulations that modify certain functions of, and remove regulatory burdens imposed on, the Exchanges, the 2019 Rule builds on efforts established in a prior rule governing the qualified health plan ("QHP") certification processes. *See* 83 Fed. Reg. at 16935, 17024-26. Starting in the 2018 plan year, HHS began relying on State reviews of QHP certification standards in States with Federally-Facilitated Exchanges ("FFEs"). For those States with FFEs that performed plan management functions in partnership with HHS, HHS relied on State plan data review for QHP certification. *Id.* at 17024. And for those States with FFEs that did not perform plan management functions, HHS continued to review QHP data, but relied on State review for licensure

and good standing and for network adequacy. *Id.* "[CMS] made these changes to streamline the QHP certification process and avoid duplicative Federal and State efforts." *Id.*

Specifically, the Federal QHP certification process incorporated "the States' [network adequacy] reviews in States in which a FFE is operating," provided that CMS determines that "the State has a sufficient network adequacy review process." *Id.* at 17025. And "[i]n States that [did] not have the authority and means to conduct sufficient network adequacy reviews," the Federal QHP certification review process relied on "an issuer's accreditation (commercial, Medicaid, or Exchange) from an HHS-recognized accrediting entity." *Id.* The process also incorporated access to essential community providers by requiring an "issuer that uses a provider network [to] include in its provider network a sufficient number and geographic distribution of essential community providers (ECPs), where available, to ensure reasonable and timely access to a broad range of such providers for low-income individuals" and medically underserved individuals. 45 C.F.R. § 156.235(a)(1); *see* 83 Fed. Reg. at 17025.

The challenged 2019 Rule provision is simply a continuation of the processes utilized under the 2018 rule. *See id.* ("We proposed to extend for the 2019 benefit year and beyond [rules] related to QHP certification standards for network adequacy . . . and essential community providers that we had finalized in [a] . . . final rule for only plan year 2018."). As CMS determined, these are areas in which "States are already performing reviews that are duplicative of the Federal QHP certification process," and therefore, it makes sense from a regulatory burden perspective to "incorporat[e] these reviews into the QHP certification process." *Id.*

Plaintiffs fault CMS for extending the 2018 rule into the 2019 plan year. They first argue that the challenged provisions violate the ACA's directive in 42 U.S.C. § 18031(d)(4)(A) that an Exchange "at a minimum, implement procedures for the certification, recertification, and decertification, [consistent with guidelines developed by the Secretary] . . . of health plans as qualified health plans." *See* Am. Compl. ¶ 60 (emphasis omitted). But by its plain terms, Section 18031(d)(4) does not require CMS, as the administrator of the FFEs, to conduct the QHP certification process or assess network adequacy itself. And the challenged provision does what § 18031(d)(4) requires: implementing a

procedure for FFE QHP certification—one that relies on States' processes in an effort to avoid duplicative Federal and State efforts. *See* 83 Fed. Reg. at 17024.

Moreover, contrary to Plaintiffs' argument, the challenged 2019 provision falls well within CMS's authority to promulgate regulations that "establish criteria for the certification of health plans as qualified health plans," *see* 42 U.S.C. § 18031(c)(1), just as it did in 2018. According to Plaintiffs, relying on the States' QHP certification and network adequacy reviews will result in "inadequate" provider networks. Am. Compl. ¶ 61. But that is an entirely speculative harm, and one that was not borne out when FFEs relied on the States' QHP certification process in the 2018 plan year. Nor is this purported harm likely to occur, given CMS's explicit commitment to "monitor enrollee complaints for access concerns." 83 Fed. Reg. at 17026. Finally, notwithstanding Plaintiffs' contrary argument, CMS fully justified its decision to extend the policy of relying on States' QHP certification process and network adequacy assessment: the purpose is to "allow States and issuers greater flexibility in facilitating the certification of plans best suited to their markets, while avoiding duplicative State and Federal [QHP certification] activities." *Id.* at 17025.

Plaintiffs are also wrong to accuse CMS of "offer[ing] virtually no response" to commenters who claimed that the States' review processes are inadequate. *See* Am. Compl. ¶ 62. In fact, CMS explained that it has "relied on State[s] . . . for this review in the past, and believe[s] they provide appropriate review because [the States] typically have requirements in place that specifically address access to adequate networks." *See* 83 Fed. Reg. at 17025. CMS further explained that "[m]any States already address issuer network adequacy in State-specific regulation." *Id.* And, Plaintiffs' related argument that CMS failed to consider "how an [E]xchange operator may be uniquely positioned to assess plan adequacy," *see* Am. Compl. ¶ 62, is belied by CMS's explicit determination that States' review of plan adequacy is "duplicative of the Federal QHP certification process" and review. 83 Fed. Reg. at 17025. Finally, Plaintiffs argue that CMS failed to provide evidence to buttress its conclusion that State procedures are sufficient to guarantee adequacy. *See* Am. Compl. ¶ 62. But this assertion ignores CMS's prior experience implementing this policy in the 2018 plan year, including the agency's experience in "monitor[ing] enrollee complaints for access concerns." 83 Fed. Reg. at 17025.

d. The option to allow issuers to report quality improvement activity as a single fixed percentage is permissible under the ACA [Am. Compl. ¶ 282(i)].

Plaintiffs' remaining challenge to the 2019 Rule governing issuers' reporting of quality improvement activity ("QIA") expenditures, *see* Am. Compl. ¶¶ 94-98, is also without merit.

The 2019 Rule grants issuers the option to report QIA expenses as a single, fixed percentage of earned premiums in order to satisfy the issuers' statutory obligation for medical loss ratio ("MLR") reporting, *i.e.*, "[a] ratio of the incurred loss (or incurred claims) plus the loss adjustment expense (or change in contract reserves) to earned premiums." 42 U.S.C. § 300gg-18(a); *see also* 83 Fed. Reg. at 17032-34. As CMS explained in its initial rulemaking implementing the MLR standard in 2010, the ACA requires health plan issuers "in the group or individual market, including grandfathered health plans, to provide an annual rebate to enrollees, if the issuer's MLR fails to meet minimum requirements," which generally is "85 percent in the large group market and 80 percent in the small group or individual market." 75 Fed. Reg. 74864, 74865 (Dec. 1, 2010). The purpose of this requirement is to "provide consumers with information needed to better understand how much of the premium paid to the issuer is used to reimburse providers for covered services, to improve health care quality, and to pay for the 'non-claims,' or administrative expenses, incurred by the issuer." *Id.* at 74866.

The ACA specifies the items that an issuer must include in its MLR report, including, as relevant here, expenses "for activities that improve health care quality." 42 U.S.C. § 300gg-18(a)(2). CMS regulations identify five separate categories of QIA that are eligible expenditures for purposes of reporting and calculating MLR, *see id.* § 300gg-18(b)(3); 45 C.F.R. §§ 158.150(b)(1)(i)-(iv), 158.150(b)(2)(i)-(v), and also identify those activities that do not qualify as QIA, *see id.* § 158.150(c). Issuers are required to report QIA expenditures in alignment with the five specified types. 83 Fed. Reg. at 17032; 45 C.F.R § 158.150(b)(2)(i)-(v). They are also required "to use and disclose specific allocation methods to report expenses, including QIA expenditures." 83 Fed. Reg. at 17032 (citing 45 C.F.R. § 158.170).

In the course of conducting MLR audits, "HHS observed that the current MLR regulations require a substantial effort by issuers to accurately identify, track[,] and report QIA expenses." *Id.* HHS has also observed that "between 2011 and 2015, issuers that did report QIA expenses have reported spending, on average, a consistent percentage of premium on total QIA: approximately 0.7 percent in 2011, and 0.8 percent in 2012 through 2015." *Id.* In order to address the "significant burden associated with identifying, tracking[,] and reporting [QIA] expenditures," CMS adopted the provision of the 2019 Rule that allows issuers the "option to report on their MLR reporting form a single QIA amount equal to 0.8 percent of earned premium in the relevant State and market, in lieu of tracking and reporting the issuer's actual expenditures for QIA." *Id.* The challenged rule allows issuers that expend more than 0.8 percent of earned premium on QIA "to report the total actual, higher amount spent and, if choosing this option, . . . [must] report QIA in the five categories described in" the MLR regulations governing the allocation of expenses. *Id.* at 17032.

Plaintiffs argue that CMS's decision to permit issuers the option of reporting a single QIA expenditure amount is contrary to Section 300gg-18(a)(2), which requires insurers to report "how much they *actually* spend on reimbursement claims." Am. Compl. ¶ 96. This is wrong. Section 300gg-18(a)(2) directs insurers to report "the percentage of total premium revenue, after accounting for collections or receipts for risk adjustment and risk corridors and payments of reinsurance, that such coverage expends . . . for activities that improve health care quality." 42 U.S.C. § 300gg-18(a). By its express terms, the statute does not require issuers to provide an itemized list of each QIA expenditure that contributes to the calculation of the MLR; the itemized method was imposed only by regulation. Nor is the challenged new rule arbitrary and capricious, as Plaintiffs contend, *see* Am. Compl. ¶ 97. CMS explained that based on its experience over several years of conducting audits of issuers' MLR reports, the existing requirement for detailed reporting of individual QIA expenditures by category were costly and burdensome and that allowing issuers to claim a standard QIA cost of 0.8 percent of earned premiums was reflective of what most health plan issuers would claim under the itemized method. 83 Fed. Reg. at 17032-17033.

Plaintiffs also argue that CMS did not meaningfully account for comments that suggested that the challenged rule "would disincentivize issuers from making" quality improvement investments. Am. Compl. ¶ 97. This argument ignores CMS's discussion in the preamble "that issuers also have financial incentives to improve the health of their enrollees because healthier populations incur lower medical costs, and reducing the administrative burden associated with tracking QIA will free up funds that issuers can invest in QIA." 83 Fed. Reg. at 17033. As the foregoing demonstrates, the standardized QIA reporting option is a considered and reasonable response to the "burden[s]" associated with "analyzing, documenting, tracking, allocating, and reporting QIA expenses." *Id.*

Finally, Plaintiffs speculate that the challenged provision "will increase the rate of the uninsured and underinsured" and "cause consumers to pay more for worse insurance." Am. Compl. ¶ 98. But the challenged QIA reporting method "is optional." *Id.* Issuers may elect to specifically track and report their allocated QIA expenditures, rather than report a single, fixed QIA amount. *See id.* Moreover, issuers have "financial incentives" "to improve the health of their enrollees," *see* 83 Fed. Reg. at 17033, and in some circumstances, State-imposed obligations to report QIA data require "even more detailed . . . data [than] previously collected by HHS."

* * *

In short, as it has done every year since the ACA's enactment, CMS exercised its authority under the ACA to promulgate policies that govern the functioning and stability of the health insurance markets, including the Federal and State-Based Exchanges, the entities through which qualified individuals and employers can purchase health insurance coverage. It did so based on actual experience from State-based Exchanges and CMS's own experience with the Federally-based and State-based Exchanges that rely on the federal platform, as well as on CMS and State experience in the ACA insurance market requirements. The challenged policies are a direct response to changes in the individual and group markets, and serve to achieve CMS's objectives to decrease the regulatory and administrative burdens on stakeholders, empower consumers, and improve affordability. Accordingly, Plaintiffs have failed to state a claim as to their challenges to the 2019 Rule.

2. Plaintiffs fail to state a claim under the Take Care Clause.

Count II should also be dismissed. As described above, Plaintiffs' APA challenge in Count I is limited to a claim against the agency Defendants with respect to the 2019 Rule. This is not surprising because, as noted above, the APA provides a private right of action only against agencies, and only with respect to final agency action. *See* 5 U.S.C. §§ 704, 706. Yet, beyond the 2019 Rule, Plaintiffs also seek to challenge, in Count II, "a long list, ever-growing, of other executive actions," Am. Compl. ¶¶ 9, 284-85, which, Plaintiffs concede, do not qualify as final agency action and thus are not subject to APA review. Included on this list, for example, are two Executive Orders, *id.* ¶¶ 100-103 (E.O. 13,765), 109 (E.O. 13,813); agency "announcements," "letters," "guidance," and "discussion papers," *id.* ¶¶ 68, 116-117, 119, 124, 127; an agency proposed rule, *id.* ¶¶ 173-76; agency and White House website and social media content, *id.* ¶¶ 130-131; agency decisions regarding website maintenance schedules and advertising funding, *id.* ¶¶ 138, 147; and statements and tweets by the President, *id.* ¶¶ 105, 118, 129. Not only could none of these individual actions be subjected to APA review, but the broad programmatic challenge that Plaintiffs seek to mount, through this litany against the Administration's implementation of the ACA, is exactly what the APA does not permit. *Norton v. SUWA*, 542 U.S. 55, 64 (2004) ("The [APA's] limitation to discrete agency action precludes the kind of broad programmatic attack we rejected in *Lujan v. National Wildlife Federation*, 497 U.S. 871 (1990)."); *Lujan*, 497 U.S. at 691 (plaintiff "cannot seek wholesale improvement of this program by court decree, rather than in the offices of the Department or the halls of Congress, where programmatic improvements are normally made").

Plaintiffs nevertheless attempt to circumvent the limitations of the APA by asserting what can only be characterized as a broad programmatic attack against the President as well as the agency Defendants under the Take Care Clause, U.S. Const. art. II, § 3. *See* Am. Compl. ¶¶ 12, 99-264, 284-85.[12] Plaintiffs' theory is that Defendants have failed to "take care to faithfully execute the Affordable

[12] Plaintiffs appear to suggest that their challenge to the 2019 Rule also arises under the Take Care Clause. *See* Am. Compl. ¶¶ 11, 99. However, Congress clearly did not intend to allow claimants to challenge a final agency action through the APA while simultaneously challenging the very same final

Care Act," and thus, the Court should issue declaratory and injunctive relief to correct this alleged failure. *Id.* ¶ 285; *see also id.* Prayer for Relief ¶¶ 3-5. At the outset, the law is clear that this Court has no jurisdiction to issue declaratory or injunctive relief against the President in his official capacity. The Take Care Clause, in any event, does not provide a cause of action against the President or any other Defendant; indeed, no court has ever held that the Clause can be used as a mechanism to obtain affirmative relief against the Executive. *Cf. Am. Fed'n of Gov't Employees, AFL-CIO v. Trump*, 318 F. Supp. 3d 370, 439 (D.D.C. 2018) *appeal filed*, No. 18-5289 (D.C. Cir. Sept. 26, 2018) ("As an initial matter, it is not at all clear that a claim under the Take Care Clause presents a justiciable claim."). Even if the Clause could furnish a basis for affirmative relief, Plaintiffs seek to rely on violations of purported duties that are found nowhere in the ACA itself, but rather, are based on Plaintiffs' subjective views about how to best implement and administer the ACA.

a. The Take Care Clause Provides No Right to Relief Against the President.

i. Separation of powers principles bar a court from issuing declaratory or injunctive relief against the President.

As an initial matter, this Court has no jurisdiction to issue the requested declaratory and injunctive relief against the President whether under the Take Care Clause or otherwise. The Supreme Court has long held that an Article III court "has no jurisdiction of a bill to enjoin the President in the performance of his official duties." *Mississippi v. Johnson*, 71 U.S. 475, 501 (1866); *see also id.* at 499 (when presidential action requires "the exercise of judgment," "general principles . . . forbid judicial interference with the exercise of Executive discretion").[13] A majority of the Supreme Court reaffirmed

agency action via another cause of action. *Cf.* 5 U.S.C. § 704 (indicating APA claims are unavailable where a claimant has another "adequate remedy in a court"). Because, as discussed herein, the Take Care Clause is not an available vehicle for any of Plaintiffs' claims, the Court need not address whether Plaintiffs can assert a challenge to the 2019 Rule under the Take Care Clause as well as under the APA.

[13] While it has been suggested that the Court in *Mississippi* left open "the question whether the President might be subject to a judicial injunction requiring the performance of a purely 'ministerial' duty," *Franklin v. Massachusetts*, 505 U.S. 788, 823, 827 n.2 (1992) (Scalia, J., concurring), that possibility has no relevance here. A ministerial duty is "a simple, definite duty" that is "imposed by law" where "nothing is left to discretion." *Mississippi*, 71 U.S. at 498; *see also Swan v. Clinton*, 100 F.3d 973, 977

this principle in *Franklin v. Massachusetts*, 505 U.S. 788, 802–03 (1992), where the plurality observed that a "grant of injunctive relief against the President himself is extraordinary, and should . . . raise[] judicial eyebrows." *Id.* at 802; *see also id.* at 828 (Scalia, J. concurring).

Concurring in *Franklin*, Justice Scalia emphasized that courts may not impose any equitable relief against the President because that principle is "implicit in the separation of powers." *Id.* at 827. As he reasoned, "[p]ermitting declaratory or injunctive relief against the President personally would not only distract him from his constitutional responsibility to 'take Care that the Laws be faithfully executed,'" *id.* at 828 (quoting U.S. Const., art. II, § 3), but also "produce needless head-on confrontations between district judges and the Chief Executive." *Id.* at 828. Thus, "[u]nless the other branches are to be entirely subordinated to the Judiciary, [the courts] cannot direct the President to take a specified executive act." *Id.* at 829; *cf. Swan*, 100 F.3d at 978 ("for the President to 'be ordered to perform particular executive . . . acts at the behest of the Judiciary,' at best creates an unseemly appearance of constitutional tension and at worst risks a violation of the constitutional separation of powers.").

In line with *Mississippi* and *Franklin*, courts have rejected the notion that they could issue declaratory or injunctive relief against the President.[14] For example, in a recent Fourth Circuit case

(D.C. Cir. 1996) ("A ministerial duty is one that admits of no discretion, so that the official in question has no authority to determine whether to perform the duty." (citing *Mississippi*, 71 U.S. at 498)). In contrast, "a duty is discretionary if it involves judgment, planning, or policy decisions." *Beatty v. Wash. Metro. Area Transit Auth.*, 860 F.2d 1117, 1127 (D.C. Cir. 1988) (citation omitted). Plaintiffs here have identified no ministerial duty at issue; rather, they ask the Court to require the President to exercise his discretion according to their own policy preferences. Such discretionary actions go to the heart of the President's authority as Chief Executive.

[14] *See, e.g.*, *Hawaii v. Trump*, 859 F.3d 741, 788 (9th Cir. 2017), *vacated and remanded on other grounds*, 138 S. Ct. 377 (2017); *Newdow v. Roberts*, 603 F.3d 1002, 1013 (D.C. Cir. 2010) ("With regard to the President, courts do not have jurisdiction to enjoin him and have never submitted the President to declaratory relief." (internal citation omitted)); *Swan*, 100 F.3d at 976 n.1 (citing *Mississippi v. Johnson* and reasoning that similar considerations regarding a court's power to issue injunctive relief against the President himself apply to the request for a declaratory judgment); *Doe 2 v. Trump*, 319 F. Supp. 3d 539, 541-44 (D.D.C. 2018) (dismissing the President from suit challenging a presidential policy because "[s]ound separation-of-power principles counsel the Court against granting [declaratory and injunctive] relief against the President directly"); *Cty. of Santa Clara v. Trump*, 250 F. Supp. 3d 497, 539–40 (N.D. Cal. 2017); *Settle v. Obama*, No. 15-cv-365, 2015 WL 7283105, at *6 (E.D. Tenn. Nov. 17,

that has since been vacated as moot, *International Refugee Assistance Project v. Trump*, the district court issued an injunction against several federal defendants and the President, preliminarily enjoining the implementation of the President's Executive Order. 857 F.3d 554, 557, 573, 579, 605 (4th Cir. 2017) (en banc), *vacated as moot*, 138 S. Ct. 353 (2017). The Fourth Circuit found "that the district court erred in issuing an injunction against the President himself," "[i]n light of the Supreme Court's clear warning [in *Mississippi* and in *Franklin*] that such relief should be ordered only in the rarest of circumstances." *Id.* The Court thus "lift[ed] the [preliminary] injunction as to the President only." *Id.*; *see also Int'l Refugee Assistance Project v. Trump*, 265 F. Supp. 3d 570, 633 (D. Md. 2017) (preliminary injunction issued regarding another Executive Order against "[a]ll Defendants with the exception of the President of the United States"), *cert. granted, judgment vacated*, 138 S. Ct. 2710 (2018); *Anderson v. Obama*, No. CIV. PJM 10-17, 2010 WL 3000765, at *2 (D. Md. July 28, 2010).

This overwhelming weight of authority compels the conclusion that no relief against the President is available here, and the President thus should be dismissed as a defendant in this case. Indeed, "[i]n most cases, any conflict between the desire to avoid confronting the elected head of a coequal branch of government and to ensure the rule of law can be successfully bypassed, because the injury at issue can be rectified by injunctive relief against subordinate officials." *Swan*, 100 F.3d at

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2015); *Day v. Obama*, No. 15-cv-00671, 2015 WL 2122289, *1 (D.D.C. May 1, 2015) (denying writ of mandamus requiring the President to conform to what prisoner asserted was the President's statutory responsibility to protect him because "it is doubtful that this Court may issue such writs against the President himself"), *aff'd*, 860 F.3d 686 (D.C. Cir. 2017); *Willis v. Dep't of Health & Human Servs.*, 38 F. Supp. 3d 1274, 1277 (W.D. Okla. 2014) (finding that "[l]ongstanding legal authority establishes that the judiciary does not possess the power to issue an injunction against the President" and dismissing the complaint as to the President); *McMeans v. Obama*, No. 11-cv-891, 2011 WL 6046634, at *3 (D. Del. Dec. 1, 2011); *Shreeve v. Obama*, No. 10-cv-71, 2010 WL 4628177, at *5 (E.D. Tenn. Nov. 4, 2010); *Carlson v. Bush*, No. 6:07-cv-1129-ORL-19UAM, 2007 WL 3047138, at *3 (M.D. Fla. Oct. 18, 2007); *Comm. to Establish the Gold Standard v. United States*, 392 F. Supp. 504, 506 (S.D.N.Y. 1975); *Nat'l Ass'n of Internal Revenue Emps. v. Nixon*, 349 F. Supp. 18, 21–22 (D.D.C. 1972) (holding that the court "lacks jurisdiction over the President of the United States either officially or personally for his acts in the performance of his duties under the [Federal Pay Comparability Act] and the [Economic Stabilization Act]" because "[t]he fundamental doctrine of separation-of-powers dictates this result, and it has been settled since [*Mississippi v. Johnson*]"); *Reese v. Nixon*, 347 F. Supp. 314, 316–17 (C.D. Cal. 1972); *S.F. Redevelopment Agency v. Nixon*, 329 F. Supp. 672, 672 (N.D. Cal. 1971); *Suskin v. Nixon*, 304 F. Supp. 71, 72 (N.D. Ill. 1969).

978–79 (citing *Franklin*, 505 U.S. at 803; *Chamber of Commerce v. Reich*, 74 F.3d 1322, 1331 n. 4 (D.C. Cir. 1996); *Harlow v. Fitzgerald*, 457 U.S. 800, 811 n.17 (1982)). Plaintiffs have named as defendants such subordinate officials as the Secretary of HHS and the Administrator of CMS. Plaintiffs could obtain relief for their alleged injuries through injunctive relief against those Defendants if they are entitled to such relief. Accordingly, the President should be dismissed as a defendant.

ii. The Take Care Clause is not a proper vehicle for challenging the President's discretionary, political acts.

Even if this Court does not dismiss the President as a defendant on separation-of-powers grounds, it should still find that the Take Care Clause furnishes no basis for affirmative relief against the President. Through the Take Care Clause, the Constitution vests broad, discretionary authority to "take Care that the Laws be faithfully executed" in the President. U.S. Const. art. II, § 3, cl. 5. Inevitably, the Laws that the President executes are those enacted by Congress. But no court has read the Take Care Clause as opening the door to any plaintiff seeking to challenge the manner in which the President executes Congress's law. Rather, as the Supreme Court has recognized, the duty of the President when exercising his power to see that the laws are faithfully executed is "purely executive and political," and not subject to judicial direction. *Mississippi*, 71 U.S. at 499; *Marbury v. Madison*, 5 U.S. (1 Cranch) 137, 165-166 (1803) ("the President is invested with certain important political powers, in the exercise of which he is to use his own discretion, and is accountable only to his country in his political character"). To hold otherwise would upset our constitutional scheme of separation of powers and allow judicial superintendence over the exercise of Executive power that the Clause commits to the President alone. *Baker v. Carr*, 369 U.S. 186, 217 (1962) (courts lack jurisdiction over a claim where there is "a textually demonstrable constitutional commitment of the issue to a coordinate political department"); *see also Dalton* v. *Specter*, 511 U.S. 462, 474-475 (1994) (judicial review of discretionary Presidential decisions "is not available"); *Lujan v. Defs. of Wildlife*, 504 U.S. 555, 577 (1992) (holding that it would be improper for the courts to take over the President's duty to "take Care that the Laws be faithfully executed"); *Marbury*, 5 U.S. (1 Cranch) at 170 ("The province of the court is, solely, to decide on the rights of individuals, not to enquire how the executive, or executive

officers, perform duties in which they have a discretion. Questions, in their nature political, or which are, by the constitution and laws, submitted to the executive, can never be made in this court."); *Chi. & S. Air Lines, Inc. v. Waterman S. S. Corp.*, 333 U.S. 103, 114 (1948) (refusing to review President's decision that "embod[ied] Presidential discretion as to political matters beyond the competence of the courts to adjudicate"); *Mississippi*, 71 U.S. at 499.[15]

The Executive actions challenged in this case underscore the significant separation of powers constraint on this Court's review: they are all discretionary political decisions that the President is entitled to make as the Chief Executive of this Nation. For example, Plaintiffs fault the President for making statements critical of the ACA, which allegedly "[d]estabilize" or "[w]eaken [p]ublic [c]onfidence" in the ACA Exchanges, *see* Am. Compl. ¶¶ 104-08, 118, 122, 129-32; and for issuing Executive Order No. 13,765, which directs federal agencies to "take all actions consistent with law to minimize the unwarranted economic and regulatory burden[] of the [ACA]," *see id.* ¶¶ 100-03, 116. But it is hard to imagine more quintessential Executive actions. Surely, the Judiciary has no role in superintending the Executive's political statements or policy directives. In the absence of any statutory violation, Plaintiffs' challenges are no more than political disagreements with the President's policy decisions, and are beyond the purview of Article III courts.

Plaintiffs also fault the Executive Branch for not defending the ACA's individual mandate (on grounds of unconstitutionality once the penalty for violating the mandate is reduced to zero on January 1, 2019) as well as two other inseverable ACA provisions in *Texas, et al. v. United States, et al.*, No. 4:18-cv-00167-O (N.D. Tex.). *See* Am. Compl. ¶¶ 177-79. But the decision not to defend an Act of

[15] The analysis does not change even if a plaintiff asserts that the President is acting contrary to the law that Congress passed. The Supreme Court has rejected the notion that every claim of statutory violation by the President or any other Executive Branch official automatically gives rise to a constitutional claim. "The distinction between claims that an official exceeded his statutory authority, on the one hand, and claims that he acted in violation of the Constitution, on the other, is . . . well established." *Dalton v. Specter*, 511 U.S. 462, 474 (1994); *see also id.* at 473 ("[C]laims simply alleging that the President has exceeded his statutory authority are not 'constitutional' claims[] subject to judicial review."). While *Dalton* addressed an attempt to turn a claim of acting in excess of statutory authority into a separation-of-powers claim, the same reasoning applies when a plaintiff seeks to invoke the Take Care Clause for this purpose. *See id.* at 472.

Congress on grounds of unconstitutionality has long been exercised by the Executive Branch and is indeed a part of the Executive Branch's duty to uphold the Constitution. *See* 28 U.S.C.A. § 530D (setting forth process for Attorney General notification to Congress under certain circumstances when the Attorney General has determined an Act of Congress to be unconstitutional); *see, e.g.*, Department of Justice Letters Submitted to Congress Pursuant to 28 U.S.C. § 530D, https://www.justice.gov/oip/letters-submitted-congress-pursuant-28-usc-§-530d.

Here, moreover, apart from the merits of Plaintiffs' challenge, the Executive's litigation position on the ACA cannot cause Plaintiffs any harm because the litigation's outcome will be determined by independent Article III courts. Indeed, even after the district court in the *Texas* litigation declared the entire ACA invalid on December 14, 2018, HHS immediately and unequivocally assured the public that it will continue administering and enforcing all aspects of the ACA until there is a final decision or other judicial order directing otherwise.[16] It did so before the *Texas* Court stayed enforcement of its decision. And contrary to Plaintiffs' assertion that the proper functioning of the adversary system is inhibited by the Executive's litigation position in the *Texas* litigation, *see* Am. Compl. ¶ 179, the ACA is being vigorously defended by 16 States and the District of Columbia, including Illinois (the home state of Plaintiff Chicago) and Virginia (the home state of the Individual Plaintiffs).[17] Plaintiffs' Take Care Clause claims against the President therefore should be rejected as a matter of law and fact.

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[16] *See* Press release, https://www.hhs.gov/about/news/2018/12/17/statement-from-the-department-of-health-and-human-services-on-texas-v-azar.html.

[17] Plaintiffs also cite to statements by the President in summer 2017 suggesting he would stop cost-sharing reduction payments to insurers. Am. Compl. ¶¶ 105-106. In fact, however, the Administration ceased such payments following a court holding that they were unauthorized by any Congressional appropriation, *see U.S. House of Representatives v. Burwell*, 185 F. Supp. 3d 165, 168 (D.D.C. 2016), and only after advice from the Attorney General that the payments should stop, *see* Letter from Jefferson B. Sessions III, U.S. Attorney General, to Steven Mnuchin, Sec'y of the Treasury, and Don Wright, M.D., M.P.H., Acting Sec'y of HHS 1 (Oct. 11, 2017), *available at* http://www.hhs.gov/sites/default/files/csr-payment-memo.pdf. Subsequently, a group of states suspended their lawsuit challenging that decision. See Pl. Mot. to Stay or, in the Alternative, to Dismiss [ECF No. 102], *California v. Trump*, No. 3:17-cv-5895 (N.D. Cal. filed July 16, 2018). Most recently, the

b. The defendant agencies' discretionary actions cannot give rise to a claim under the Take Care Clause.

Nor does the Take Care Clause provide a basis to review the actions of subordinate Executive officials. The Clause speaks only to the President, not to his subordinates, and ensures that the President is principally responsible for the actions of the Executive Branch and directly accountable to the people through the political process. *See Free Enter. Fund v. Pub. Co. Accounting Bd.*, 561 U.S. 477, 492-93 (2010) ("It is *his* responsibility to take care that the laws be faithfully executed."); *id.* at 495-97; *Printz v. United States*, 521 U.S. 898, 922 (1997); *Morrison v. Olson*, 487 U.S. 654, 689-90 (1988); *Clinton v. Jones*, 520 U.S. 681, 712-13 (1997) (Breyer, J., concurring). A subordinate Executive officer cannot violate the President's duty to faithfully execute the laws. To the extent Plaintiffs seek to challenge the other federal defendants' alleged attempt to undermine the ACA, they cannot do so through the Take Care Clause, but must do so, if at all, through the APA, as Plaintiffs already do with respect to the 2019 Rule.

Moreover, as with Plaintiffs' claims against the President, their invocation of the Take Care Clause against other federal defendants is particularly inappropriate as a mechanism to advance Plaintiffs' own political and policy views. Their challenge must fail because the actions that they identify are discretionary in nature. For example, Plaintiffs challenge HHS's decision to spend less money than budgeted by Congress on various advertising and Navigator activities, *see* Am. Compl. ¶¶ 143-65, but these are discretionary budgetary decisions made by the agency based on its experience and expertise in operating the Navigator program. Nor does a July 2018 report issued by the U.S Government Accountability Office ("GAO"), which questioned HHS's 2017 Navigator funding allocation, *see id.* ¶ 164, in any way suggest that HHS does not have the authority or discretion to make judgment calls on funding decisions in this area, even if GAO disagree with those decisions. *See Delta*

Court of Federal Claims held insurers are nevertheless entitled to these payments. *Common Ground Healthcare Coop. v. United States*, No. 17-877C, 2019 WL 642892, at *1 (C.F.C. Feb. 15, 2019).

Data Sys. Corp. v. Webster, 744 F.2d 197, 201 (D.C. Cir. 1984) ("GAO's advice is not binding upon the agency.").

Plaintiffs also would prefer that HHS participate in more education and outreach activities and send staff to regional enrollment events. *See* Am. Compl. ¶¶ 171-72. And Plaintiffs disagree with the decision to shorten the open enrollment period from approximately 90 days to 45 days, *see id.* ¶¶ 135-42, even though the decision is committed by statute to the HHS Secretary's sound discretion, *see* 42 U.S.C. § 18031(c)(6)(B) ("The Secretary shall require an Exchange to provide for . . . annual open enrollment periods, *as determined by the Secretary*." (emphasis added)). These preferences and disagreements do not give rise to a constitutional claim. The Secretary reasonably could determine that longer enrollment periods would contribute to the problem of "adverse selection"—i.e., consumers waiting until they get sick to purchase insurance, *King v. Burwell*, 135 S. Ct. 2480, 2485 (2015). Indeed, it was in part for that reason HHS first proposed shortening the open enrollment to the current 45 days in 2016. *See* 81 Fed. Reg. 12204, 12206, 12274 (Mar. 8, 2016).

The other agency actions that Plaintiffs identify as part of their Take Care Clause claim similarly involve exercises of agency discretion, as discussed below. It would be inappropriate for the Court to enjoin or declare invalid such acts simply because Plaintiffs disagree with the Administration's policy choices.

i. The Executive Branch's decision to promulgate rules promoting AHP, STLDI, and HRA is a valid exercise of discretion and does not give rise to a claim under the Take Care Clause.

First, Plaintiffs challenge the Executive Branch's regulatory reforms, or proposed reforms, in three areas—association health plans ("AHP"), short-term, limited-duration insurance ("STLDI"), and health reimbursement arrangements ("HRA")—which were identified in the President's Executive Order 13,813 as priorities to lessen regulatory burdens and increase healthcare options for consumers. *See* Am. Compl. ¶¶ 109-15. In Plaintiffs' view, promoting these three options undermines the ACA because they provide allegedly "bare-bones coverage[] that does not need to comply with the ACA's requirements." *Id.* ¶ 109. But that is a policy disagreement which this Court has no

authority to review. The Executive Branch reasonably could determine, consistent with governing law, that it is more beneficial for consumers to have those alternative options.

While Plaintiffs' allegations focus almost exclusively on the President's Executive Order, the agency rules implementing the E.O. more fully set forth the Administration's reasoning. The AHP rule, for example, expands access to affordable, quality healthcare for employees of some small businesses and some self-employed individuals by clarifying the definition of "employer" for purposes of sponsoring a single multiple-employer "employee welfare benefit plan" or "group health plan" under the Employee Retirement Income Security Act ("ERISA"). *See* 83 Fed. Reg. 28912, 28961-63 (June 21, 2018). The STLDI rule, on the other hand, governs plans that provide temporary health insurance for individuals who encounter gaps in their coverage (such as those who have lost their jobs, graduated from college, missed an enrollment deadline, or been priced out of more comprehensive coverage) and are explicitly exempt from many of the ACA's requirements. *See, e.g.,* 83 Fed. Reg. 38212, 38213 (Aug. 3, 2018). And HRAs are "employer-funded group health plans from which employees are reimbursed tax-free for qualified medical expenses up to a fixed dollar amount per year."[18] Similar to a health savings account ("HSA"), an HRA can be used as a supplemental source of funding for a person's medical needs. *See, e.g.*, 75 Fed. Reg. at 37188, 37190-91 (June 28, 2010) (describing how HRAs can be "integrated with other coverage as [a] part of a group health plan").

None of these options is new. The AHP rule adheres to the Department of Labor's longstanding interpretation of ERISA to permit employers to join together as a single association to offer health benefits to their employees, while clarifying the term "employer." The STLDI rule largely restores the definition of STLDI that existed under HHS's regulations from 1997 until 2017, including at the time Congress enacted the ACA, by changing the permissible initial term of such coverage from less than three months (first instituted in a rulemaking finalized in 2016) to any period of less than 12 months. It additionally caps the total duration of coverage under an STLDI policy, including any renewals or extensions of the initial term, at 36 months. And HRAs have generally been permitted

[18] *See* HealthCare.gov Glossary, "Health Reimbursement Account," https://www.healthcare.gov/glossary/health-reimbursement-account-hra/ (last visited: Dec. 4, 2018).

since 2002 by the Internal Revenue Service as a tool to help consumers fund medical expenses. *See* I.R.S. Notice 2002-45 (June 26, 2002), https://www.irs.gov/pub/irs-drop/n-02-45.pdf (last accessed: Dec. 4, 2018); *see also* I.R.S. Notice 2013-54 (Sept. 13, 2013) (guidance regarding tax treatment of HRAs under the ACA), https://www.irs.gov/pub/irs-drop/n-13-54.pdf (last accessed: Dec. 4, 2018). It is eminently reasonable for the Executive Branch to make these options more readily available to consumers who find them suitable to their individual needs.

Again, to the extent Plaintiffs believe that the Executive Branch's revisions to any of these options violates any statute or regulation or is arbitrary or capricious, they need to challenge them, if at all, under the APA, as other litigants have done. *See, e.g.*, *State of New York, et al. v. United States Dep't of Labor, et al.*, Civ. No. 1:18-cv-1747 (D.D.C.) (suit challenging the AHP rule); *Association for Community Affiliated Plans v. Dep't of Treasury, et. al.*, Civ. No. 1:18-cv-2133 (D.D.C.) (suit challenging the STLDI rule). They must also sue the federal agencies that promulgated the challenged rules. For example, the AHP rule was promulgated by the U.S. Department of Labor, a non-party to this case. *See* 83 Fed. Reg. at 28912. And, they must wait for final agency action before proceeding with such a lawsuit. For example, the HRA rule is in the midst of rulemaking, *see* 83 Fed. Reg. 54420 (Oct. 29, 2018), and as noted before, the AHP rule will not be fully effective until April 2019. Neither the Take Care Clause nor the APA allows Plaintiffs to lump these rules together and challenge them wholesale on the basis of Plaintiffs' own subjective views that they undermined the ACA as a whole.

ii. The Executive Branch's issuance of guidance addressing "hardship exemption" eligibility does not give rise to a Take Care Clause claim.

Second, Plaintiffs identify two documents issued by CMS, providing guidance on claiming hardship exemptions from the ACA's individual mandate, which requires individuals either to maintain coverage under a qualified health plan or pay a tax penalty (which, as of the 2019 tax year, has been set at zero). Am. Compl. ¶ 119. According to Plaintiffs, these guidance documents qualify as steps taken by the Administration to "weaken" the individual mandate. *Id.* However, these guidance documents could have little bearing on the overall "strength" of the individual mandate,

given that even before they were issued, Congress had already reduced the tax penalty to $0 for tax years beginning in 2019. Even apart from their necessarily limited application, the guidance documents merely reflect discretionary policy choices that in large part were already made through notice and comment rulemaking. Section 1501(b) of the ACA authorizes the Secretary of HHS to grant hardship exemptions to those whom the Secretary determines have "suffered a hardship with respect to the capability to obtain coverage under a qualified health plan." 26 U.S.C. § 5000A(e)(5). CMS has set forth the criteria for obtaining a hardship exemption through annual rounds of notice and comment rulemaking. *See* 45 C.F.R. § 155.605(d).[19] Most recently, in the 2019 Final Rule, CMS modified the exemption eligibility criteria by ensuring that those who lived in an area with limited plan offerings could still qualify for an exemption. *See* 83 Fed. Reg. at 16995.

The first guidance document that Plaintiffs challenge, issued on April 9, 2018, recognized at the outset that hardship exemptions would shortly become unnecessary in order to avoid a tax penalty from failing to maintain minimum essential coverage because Congress had reduced the individual shared responsibility to $0 after 2018.[20] However, in light of the fact that individuals still might seek an exemption for the 2018 tax year, the guidance provided "new examples of hardships that people may encounter this year or in future years," focusing primarily on the possibility that, as the 2019 Final Rule had suggested, an individual might live in a location where access to qualified health plans was

[19] It bears noting that CMS has revised the criteria for hardship exemption eligibility in its annual rulemakings setting ACA benefit and payment parameters both in the prior and in the current Administration. *See* 2016 Proposed Rule, 79 Fed. Reg. 70674-01 (Nov. 26, 2014); 2016 Final Rule, 80 Fed. Reg. 10750-01, 10801 (Feb. 27, 2015); 2017 Proposed Rule, 80 Fed. Reg. 75488-01 (Dec. 2, 2015); 2017 Final Rule, 81 Fed. Reg. 12204-01, 12280 (Mar. 8, 2016); 2019 Proposed Rule, 82 Fed. Reg. 51052-01 (Nov. 2, 2017); 2019 Final Rule, 83 Fed. Reg. 16930-01, 16995 (Apr. 17, 2018). However, Plaintiffs have not challenged any of those revisions under the APA.

[20] *See* CMS, Guidance on Hardship Exemptions from the Individual Shared Responsibility Provision for Persons Experiencing Limited Issuer Options or Other Circumstances ("April Guidance"), at 1 n.1 (Apr. 9, 2018), *available at* https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2018-Hardship-Exemption-Guidance.pdf; *see also* https://www.healthcare.gov/health-coverage-exemptions/exemptions-from-the-fee/.

somehow limited. CMS Guidance on Hardship Exemptions at 1-4. At the same time, the guidance emphasized that it "d[id] not alter current CMS regulations and d[id] not create any new substantive requirements for people seeking a hardship exemption." *Id.* at 1.

The second guidance, issued on September 12, 2018, indicated that, for the 2018 tax year, individuals could claim any hardship exemption for which they were eligible under § 155.605(d)(1) directly on their federal income tax return while keeping any necessary documentation with their tax records.[21] This guidance expanded upon CMS's regulation, which expressly states that the IRS may allow individuals to claim any of the hardship exemptions listed in § 155.605(e) without first obtaining an exemption certificate from an Exchange. *See* 45 C.F.R. § 155.605(e). The guidance is also consistent with IRS regulations issued in 2014, which allow individuals to claim a hardship exemption on their tax return without first obtaining an exemption certificate, as long as they are eligible under both HHS and Department of the Treasury ("Treasury") guidance. *See* IRS, Notice 2014-76, 2014 WL 6600338 (Dec. 8, 2014).[22]

Nothing in these guidance documents supports Plaintiffs' attempt to assert a violation of the Take Care Clause. Indeed, to the extent Plaintiffs rely on the notions that there should be a tax penalty for failure to maintain qualified health coverage or that exemptions to such penalties should be more limited than what is reflected in these guidance documents, their claim is wholly undermined by the fact that Congress reduced the tax penalty to zero.

iii. The Executive Branch's issuance of guidance and a discussion paper regarding state innovation waivers does not give rise to a Take Care Clause claim.

Finally, Plaintiffs' assertions concerning the discretionary actions taken by the Administration in regard to state innovation waivers under Section 1332 of the ACA, 42 U.S.C. § 18052, also fail to state a claim. Section 1332 allows a state to apply to HHS or Treasury for a waiver of certain ACA

[21] *See* CMS, Guidance on Claiming a Hardship Exemption through the Internal Revenue Service (IRS), at 2 (Sept. 12, 2018), *available at* https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Authority-to-Grant-HS-Exemptions-2018-Final-91218.pdf.

[22] In its Proposed Rule for 2020, CMS has proposed that § 155.605(e) be amended to solidify the ability of individuals to claim these exemptions directly on their tax returns. *See* 84 Fed. Reg. at 281.

coverage requirements, provided that the relevant agency determines in its discretion that a state's plan (1) "will provide coverage that is at least as comprehensive as the coverage" offered through the Exchanges, (2) "will provide coverage and cost sharing protections against excessive out-of-pocket spending that are at least as affordable" as the ACA would provide, (3) and "will provide coverage to at least a comparable number of [the state's] residents" as the ACA would provide, and (4) "will not increase the Federal deficit." 42 U.S.C. § 18052(a)(1), (b)(1)(A)-(C). HHS and Treasury issued regulations implementing the waiver provision in 2012. *See* Application, Review, and Reporting Process for Waivers for State Innovation, Final Rule, 77 Fed. Reg. 11700 (Feb. 27, 2012) (promulgated at 31 C.F.R. pt. 33, 45 C.F.R. pt. 155). HHS and Treasury then issued guidance in 2015, which addressed the four statutory guardrails (coverage, affordability, comprehensiveness, and deficit neutrality) in greater detail. *See* Waivers for State Innovation; Guidance, 80 Fed. Reg. 78131-01, 78132 (Dec. 16, 2015).

In October 2018, HHS and Treasury issued an updated guidance to ensure that states have the flexibility "to address problems with their individual insurance markets and increase coverage options for their residents," while also "adopt[ing] innovative strategies to reduce future overall health care spending." State Relief and Empowerment Waivers; Guidance, 83 Fed. Reg. 53575-03, 53576 (Oct. 24, 2018). The agencies explained that they were adopting a "more flexible interpretation of the section 1332 guardrails," focusing on "the nature of coverage that is made available to state residents (access to coverage), rather than on the coverage that residents actually purchase," in order to "lower barriers to innovation and allow states to implement waiver plans that will strengthen their health insurance markets by providing a variety of coverage options." *Id.* at 53577. The agencies pointed out that the statutory language of the first and second guardrails focused only on the comprehensiveness and affordability of the coverage that was offered, rather than on how many residents chose to purchase that coverage.[23] *Id.* Nevertheless, the agencies emphasized that the

[23] In contrast, the statutory language of the third guardrail specifically requires that a comparable number of state residents be *provided* coverage. *See id.* The agencies noted that the 2015 Guidance had imported that requirement into the first and second guardrails as well, but that this reading was not

comprehensiveness and affordability guardrails had to be evaluated in conjunction, such that a state plan must "make[] coverage that is both comprehensive and affordable available to a comparable number of otherwise qualified residents as would have had such coverage available absent the waiver." *Id.* The 2018 Guidance also indicated that the agencies would evaluate comprehensiveness and affordability based on "the aggregate effects of a waiver" on state residents as a whole, rather than denying waivers that made coverage less comprehensive or affordable for any particular group of residents regardless of the overall improvements that a waiver might provide. *See id.* at 53578. While analysis will continue to consider effects on all categories of residents, the new guidance will give states more flexibility to decide that improvements in comprehensiveness and affordability for state residents as a whole offset any small detrimental effects for particular residents. *See id.* A November 2018 Discussion Paper illustrated various possible ways that states might "take advantage of [the] new flexibilities" identified in the 2018 Guidance.[24]

Plaintiffs assert that the Administration has denied or delayed responding to waiver requests from states with plans that comply with the statutory guardrails while encouraging states to seek waivers with plans that would not comply with the statutory guardrails. Am. Compl. ¶¶ 124-127. Plaintiffs do not assert, however, they are from any of the States whose waiver requests have allegedly been affected. Instead, Plaintiffs apparently simply disagree with the agencies' interpretation of the statute. For the same reasons discussed above, the Take Care Clause is not a proper vehicle to pursue Plaintiffs' policy disagreement. To the extent Plaintiffs believe the agencies' interpretation is arbitrary, capricious, or contrary to law, they must identify a final agency action that has caused them injury, and bring their claim under the APA.

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required by the statute. *See id.* Ultimately, the agencies concluded that the 2015 Guidance had unnecessarily "deterred states from providing innovative coverage that, while potentially less comprehensive than coverage established under the PPACA, could have been better suited to consumer needs and potentially more affordable and attractive to a broad range of residents." *Id.* at 53578.

[24] *See* CMS, Section 1332 State Relief and Empowerment Waiver Concepts, Discussion Paper (2018), *available at* https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Downloads/Waiver-Concepts-Guidance.PDF.

CONCLUSION

For the foregoing reasons, this Court should grant Defendants' motion to dismiss.

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Respectfully submitted,

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CERTIFICATE OF SERVICE

The undersigned counsel certifies that on March 8, 2019, a true and accurate copy of the foregoing was electronically filed with the CM / ECF system, which will send a Notice of Electronic Filing to all counsel of record in this matter.

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