THE UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF TEXAS
TYLER DIVISION

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MANHATTAN LIFE INSURANCE AND ANNUITY COMPANY, et al	*	NO. 6:24-CV-178-JCB
VS.	*	Tyler, Texas
UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, et al	*	9:06 a.m. - 10:23 a.m.
	*	December 3, 2024

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SUMMARY JUDGMENT HEARING

BEFORE JUDGE J. CAMPBELL BARKER
UNITED STATES DISTRICT JUDGE

* * * * *

Proceedings recorded by computer stenography
Produced by computer-aided transcription

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P R O C E E D I N G S

9:06 A.M. - DECEMBER 3, 2024

THE COURT: Please be seated. Good morning to you all. We're here for a hearing on the Cross-Motions for Summary Judgment in Case No. 6:24-CV-178, Manhattan Life Insurance & Annuity Company vs. United States Department of Health and Human Services.

Will counsel for the each of the parties please make their appearances. For the Plaintiffs?

MR. McARTHUR: Good morning, Your Honor. Eric McArthur and Cody Akins on behalf of Plaintiffs.

THE COURT: Good morning.

MR. BICKFORD: Good morning, Your Honor. James Bickford on behalf of Defendant.

THE COURT: Good morning to you.

All right, let me engage in a few table-setting questions to make sure that we're all on the same page here. The parties have indeed filed Cross-Motions for Summary Judgment. Apart from the dispute about whether facts need to be found as it relates to some of the Plaintiffs' standing, are there any other factual disputes that would potentially need a trial for the Plaintiffs, in your view?

MR. McARTHUR: No, Your Honor.

THE COURT: And Mr. Bickford, in your view?

MR. BICKFORD: No, Your Honor.

THE COURT: Okay, that's what I thought, too, but I just want to make sure we're on the same page.

All right. Then as to the claims here, there is a claim that the rule exceeds statutory authority because the statute says that the various requirements for comprehensive health insurance "shall not apply" to any plan that needs some statutory requirements, and the Plaintiffs are claiming that the notice requirement in the rule is not a statutory requirement and therefore requiring it as a condition of the accepted status, it exceeds statutory authority. That's Claim 1.

Claim 2 is that the notice requirement substance is arbitrary and capricious for some related reasons that deal with the amount of notice that's provided or its phrasing. That's Claim 2.

And then Claim 3 is that the notice and comment procedure was deficient because there was not sufficient notice of this change in the opportunity to comment on the change from the proposed rule, which stated this is not comprehensive health insurance, to the final rule which has a notice requirement of stating this is not health insurance. And that's Claim 3.

Have I accurately summarized, Plaintiffs, your claims that are pending on your Cross-Motion for Summary Judgment? Or I suppose it's your Original Motion for Summary Judgment?

MR. BICKFORD: Yes, that's a fair summary of the claims. The only amendment I would make is we also have an argument that the rule is arbitrary and capricious because the Department didn't adequately justify their claim in the rule, that there is widespread consumer deception and confusion.

THE COURT: Right, okay.

All right. And for the Defendants, your Cross-Motion is for all three claims, I take it?

MR. BICKFORD: Yes, Your Honor. And we have no Cross-Claims.

THE COURT: Okay, very good. All right, so I think we're all on the same page there.

All right. I've read your moving papers and I've read the authorities you are citing. So, first, let me give you my ruling on standing and then I want to hear argument from you all on the merits.

I conclude that Plaintiffs' standing is sufficiently established by the standing of the insurance company, Manhattan Life, as the Fifth Circuit holds that as long as any one plaintiff has standing to

challenge the defendant's action, any other plaintiffs challenging the same defendant's action on the same theories are within the same -- excuse me, I said are within the same Article III case or controversy and, therefore, need not independently meet the test for establishing their own standing.

The citation for that is the Fifth Circuit's decision in *Texas vs. Rettig,* R-e-t-t--i-g, which itself collects some other cases.

So, for that reason, the Court need not examine and need not make a finding as to whether the other Plaintiffs, Paschall Health Insurance and the owner of that company, William Paschall, have Article III standing under the Fifth Circuit's holding in *Texas vs. Rettig.*

Now, as to venue, I deny the Motion to Dismiss or Transfer the case or for Summary Judgment in Defendants' favor based on lack of venue based on the Fifth Circuit's approach to venue in *R.J. Reynolds Vapor Company vs. FDA,* 65 F.4th 182, Fifth Circuit 2023, where the Court found standing based on one plaintiff and found proper venue based on another plaintiff. At least one of the Plaintiffs in this case, namely Paschall Health Insurance and its owner, William Paschall, would support venue in this court.

So applying that Fifth Circuit precedent to venue, I find that venue is proper.

In the alternative, even if some inquiry is required into the standing of the Plaintiffs to create venue in this court, my reading of the law before that Fifth Circuit decision was that the test is simply whether the venue creating Plaintiffs' pleading of standing and on the merits is something other than frivolous. I don't read the case law as requiring a full standing analysis for each Plaintiff creating venue so long as their pleading of standing is not frivolous. This is essentially the improper joinder test as applied to the issue of standing.

So, even under that case law before the Fifth Circuit's decision in *R.J. Reynolds Vapor,* I find that venue would be proper here because, at a minimum, the pleading of standing by the Paschal Plaintiffs is not frivolous, particularly on their first theory that the increased or that the more sweeping notice language would likely result in lost sales; and given the fact that they have standing, only one customer needs to be predictably likely to leave or to no longer maintain insurance with one of those plaintiffs.

So I don't find a need for factfinding on this. I find that it's a legal inquiry about, as I

say, at a minimum the frivolousness of the pleading of standing. And it's not a frivolous pleading, so there is no improper joinder. But, actually, I find that the Fifth Circuit's recent 2023 decision in *R.J. Reynolds Vapor* negates the need to engage in that.

So I make my findings in the alternative, but they are legal findings and there is no need for trial of factfinding on standing. So any Motion to Dismiss or Transfer based on venue is denied, and likewise with the Motion for Summary Judgment on that basis.

So that sets us up for argument on the merits, and it's on that matter that I'd like to hear from the Plaintiffs and the Defendants in the traditional format that we use for oral argument. The Plaintiffs, as the movants, can go first and just address all three of your theories, and then I'll give the Defendants time to respond, and then if the Plaintiffs want to save some time for rebuttal. And I'll interject with questions as I have them.

Okay, Mr. McArthur.

MR. MCARTHUR: Thank you, Judge Barker.

I am going to start out with what I think is the most fundamental flaw in the rule here, which is that the rule exceeds the Departments' statutory

authority. That conclusion follows from two simple premises.

The first is that the Departments lack authority to impose additional exemption conditions, and the second is that the notice rule imposes an additional exemption condition.

The Departments don't dispute the first premise and they can't credibly do so because the statutory conditions are plainly exclusive, as the text makes clear and as the DT Circuit in *Central United* unanimously held.

The Departments also don't really dispute the second premise and again they can't credibly do so because they wrote the notice rule as an exemption condition and that is how they justified it in the preamble, stating twice that the rule does not require the provision of a notice. It simply says that if the notice is not provided, then the policy does not qualified for the exemption for the exemption and remains subject to the requirements for comprehensive coverage.

So this case on statutory authority really is that simple, and the case can and should end there and the Court doesn't need to address any of the other issues on the merits.

THE COURT: Now, let's talk about remedies on statutory authority. So, if your statutory claim has merit and there is no statutory authority to make the notice requirement a condition of excepted status -- e-x-c-e-p-t-e-d status, not a-c-c-e-p-t-e-d status -- then is there any severance that could cure that? And I ask that because the rule has a pretty broad severability clause. In other words, can the Court just sever the linkage between the notice requirement and excepted benefit status?

MR. McARTHUR: I don't think so. The rules severability provision talks about provision being severable. I'm sure that provision is set up as an exemption condition, not that there is any language in there that you could strike to make it a free-standing notice requirement as opposed to an exemption condition.

And so the remedy on this, if we're right, that the rule exceeds the Departments' statutory authority, should be that the notice requirement is vacated in its entirety. It's not an objection to the specific language in this notice. We do have some of those. This would be taking down the notice entirely.

There is one other point on the remedy that is not fleshed out in the briefs that I wanted to

make sure Your Honor was aware of, and this goes to the question of whether, if the Court vacates the rule for lack of statutory authority, the 2014 notice would spring back into force. So, if you look at the relevant regulation, this only has to do with the individual market regulation for HHS. Because as to the group market regulations, there was no prior notice requirement. So we're only talking about here 42 CFR Section 148.220(b).

The relevant part of that rule is Subsection (b)(4), romanette III, and it has two parts. (A) is the part that imposes the new notice requirement effective January 1st of next year. And (B) is a provision that sumsets the prior notice at the end of this year. So in our proposed order we proposed that the Court would vacate only Part (A) that imposes the new requirement and leave in place Part (B) that sumsets the prior notice requirement.

The Government hasn't directly joined issue on that, although there are parts of their reply brief that to my mind seem to assume that the 2014 notice would come back if we prevailed on the statutory authority theory, and I don't think that's correct.

Number one, as Your Honor pointed out, there is a severability clause, that's in romanette IV

of the provision that says, if any provision is found to be facially invalid, it's severable. So, by the terms of the rule itself, (A) and (B) are severable.

And then even setting aside the severability provision, vacatur is always an equitable remedy and there are at least two reasons why it would be inequitable to vacate (B) and bring back that 2014 notice.

The first, the 2014 notice, is just as unlawful as the current notice requirement because it, too, is an unlawful exemption condition. And the second is that the 2014 notice is inaccurate. It has language at the end saying that if you don't have major medical coverage, you may be subject to a tax penalty. That's a reference to the Affordable Care Act's original tax penalty that no longer exists. That penalty has been zeroed out. And so it would be, I think, the opposite of equitable to reinstate a notice that provides false information to the public.

THE COURT: Or if the Agency could always -- if they wanted some notice, they could always just do an interim rulemaking without notice and comment and seek to justify it that way.

MR. McARTHUR: Right, they could always come back and try to impose a new notice requirement. Of

course, we think that that, if it's imposed as an exemption condition, it would be just as unlawful as this one.

THE COURT: Right. And that's the other point they make on your statutory claim is, I mean, they seem to essentially be saying that, well, there is no difference between what we've done in this final rule and what we could do independently under our rulemaking authority of just creating an independently enforceable notice requirement.

And your response is essentially, if it was an independent sort of freestanding notice requirement, the penalties for noncompliance would not be so drastic because you wouldn't be under the comprehensive health insurance requirement penalty regime. You would just be under something that's tailored to the notice. Is that essentially your answer?

MR. McARTHUR: Well, we think even if they tried to do this as a free-standing notice requirement, it would still exceed their statutory authority. The Court doesn't need to reach that question here because that's not what they did. And so this is all an impermissible post-talk rationale. But even setting aside the fact that it's post-talk, their first premise

in this argument is that an exemption condition is the functional equivalent of a freestanding notice and that's simply not the case. And the easiest way to see that that's not the case is to ask what is the consequence of failing to provide the notice under the two alternative versions of the requirement: Exemption condition or freestanding notice.

If it were a free-standing notice, the violation would simply be that the issuer would have violated the Departments' regulation requiring that the notice be provided. It's actually not clear to me that there would be any penalty at all for that because the statute's civil penalty provision authorizes penalties only for violation of statutory requirements, not for violations of the Departments' regulations, which frankly, as I suspect, why they wrote it as an exemption condition.

THE COURT: Right, but a new regulation, a free-standing regulation might itself include a penalty requirement. And then sometimes there's catchall provisions that might not be in the specific statutes, but there are sometimes catchall provisions that, you know, any violation of a regulation of HHS or some agency, IRS -- certainly IRS probably has a pretty broad set of catchalls and is subject to penalties.

MR. McARTHUR: Right. But either way, for purposes of this case, there is a significant practical difference between a freestanding requirement and an exemption condition. Because the nature of the violation, the number of violations, the potential penalties, all of that can differ depending on whether it's an exemption condition or a free-standing notice.

THE COURT: All right. And let me ask you one more clarifying question on your first claim, which is how much weight are you really placing on the McCarran-Ferguson Act. Is that just kind of background statutory authority? It seemed to me like your main statutory authority language was just the word "shall" and the word "any" in the relevant statutes. Can you clarify how much sort of disposition weight are you putting on it versus background weight?

MR. McARTHUR: I actually don't think we're putting any weight on it, on our threshold argument about this being an impermissible exemption condition. I would see that coming into play only if you reach the question, which you don't need to, of whether this could be justified as a freestanding notice requirement where they're relying on their general rulemaking authority to promulgate regulations that are necessary or appropriate to carry out the provisions of

the statute.

Our point on that is Congress drew a line in this statute between federal regulation and state regulation. And there I think McCarran-Ferguson is helpful background representing Congress's judgment that insurance is traditionally regulated by the states; and unless Congress specifically says that it's subject to federal regulation, then it's not subject to federal regulations. And that is, I think, the problem with their -- the other problem with their free-standing notice theory is they can't use their general delegation of rulemaking authority to override the line Congress drew in this statute between state and federal regulation.

THE COURT: All right. Would you like to turn to your arbitrary and capricious claim?

MR. McARTHUR: Right. So I think we have a couple of different arbitrary and capricious claims. There's one I mentioned earlier about their failure to adequately justify their claim in the rule that there is widespread consumer confusion and deception. I'm happy to rest on our brief on that argument, unless Your Honor has specific questions.

THE COURT: Right.

MR. MCARTHUR: The ones I do want to address

are ones that go to the specific language in the notice that says that fixed indemnity insurance is not health insurance. So separate and apart from everything I've said to this point about statutory authority, that language is unlawful both procedurally and substantively. I'll start out with the procedure and there are a number of procedural problems here. I'll highlight just two of them.

The first -- and I think this is Your Honor's third claim -- is that the Departments violated the APA's notice and comment requirement because they made a material change to the proposed notice that commentors could not have reasonably foreseen and therefore lacks the opportunity to comment on.

Both versions of the proposed notice stated only that fixed indemnity insurance was not comprehensive health insurance. And the Departments' entire rationale for the notice centered on ensuring that customers who buy fixed indemnity insurance do not do so under the mistaken impression that they are buying comprehensive health insurance.

The Departments said nothing, didn't give any hint at all that they were considering deeming fixed indemnity insurance not to be health insurance at all. On the contrary, by saying that it was not

comprehensive health insurance, they were clearly implying that it was health insurance because you don't need to qualify what kind of health insurance it is if it's not health insurance at all.

So the final rule is not only not a logical output of the proposal, it is a complete 180 from the proposal, it's a negation of the proposal. And the proof is really in the pudding here because the Departments don't identify a single commentor who weighed in, pro or con, on whether to say that fixed indemnity insurance is not health insurance at all. Had commentors thought that was a possibility that it was on the table, they surely would have commented on it, as they did on far less important aspects of the proposal.

THE COURT: Now, on that claim, the notice and comment claim, given the severability clause, the remedy there that you are asking for would be just vacating, you know, some aspect of the notice, maybe all of the not health insurance language, but then remanding for more process so that the Agency could give proper -- in your view, proper notice and opportunity for comment?

MR. McARTHUR: That is correct. It would be striking the language in the caption that says it's not

health insurance. And the there is similar language in the fourth, I believe it is, or the final bullet point that says since this isn't health insurance.

THE COURT: Right. And similarly, given the severability clause, I take it that it's not any part of your requested remedy to strike the notice requirement as it concerns short-term limited duration insurance as opposed to one of those forms of indemnity insurance; correct?

MR. McARTHUR: That is correct, our claims have nothing to do with the short-term insurance.

THE COURT: Okay, I thought so.

All right, very well. Well, I think I have your argument on those three points.

Mr. Bickford, may I hear from you?

MR. BICKFORD: Thank you, Your Honor.

I'll start with the statutory point. What Departments have done here is **[XX]** the *Central United* Court made clear as to the requirement that it was at issue here, it imposed a notice requirement. There has been a notice requirement as to fixed indemnity plans sold in the individual market for the last 10 years. What this rulemaking did was change the language of that notice and extend its protection to the group market. Manhattan Life's predecessor --

THE COURT: You mentioned *Central United,* but am I correct in reading that *Central United* noted the notice requirement? In other words, it cited the fact that there is a notice requirement, but the Court, the D.C. Circuit there, that did not pass on the legality of that notice requirement?

MR. BICKFORD: That is correct. And the reason they did not pass on the legality is that Manhattan Life's corporate predecessor, Central United, chose not to challenge the notice requirement when it was issued 2014.

THE COURT: And are you arguing that that fact has some legal consequence here, the fact that Manhattan Life's corporate predecessor did not challenge the 2014 notice requirement?

MR. BICKFORD: Well, I think at the end of the argument as to remedy, it may come into play as to, I take it, that Manhattan Life intends this case to be an attack not only though they chose not to brief the issue on the 2024, this year's notice requirement, but also seeks now to vacate the 10-year-old notice requirement.

I guess I can begin there and come back to the merits. The severability is ultimately a test, and again we're happy to brief this if Your Honor would

like. It's essentially a test of Agency intent. I think it's perfectly clear from the rulemaking that the Agency intents were the 2024 notice not to be enforced would not be to remove all notices from the fixed indemnity market.

Certainly, as Your Honor says, if the Court chooses to do so, it can remand for further proceedings and the Agency may choose to update that notice language. But there is no reason to believe that the Agency would have separately removed the 2014 notice if the updated notice were not to go into effect.

THE COURT: I mean, I'm reading the severability clause. This is at page 23-391 of the Federal Register publication of the rule. And it says -- this is a quote -- "Similarly, if any finalized provision in this rulemaking related to group or individual market fixed indemnity excepted benefits coverage is held to be invalid or unenforceable by its terms, or as applied to any person or circumstance, or stayed from any further agency action, it shall be considered severable from its section and other sections of these rules and such invalidation shall not affect the remainder thereof or the application of the provision to other entities not similarly situated or

to dissimilar conditions."

MR. BICKFORD: Yes, Your Honor.

THE COURT: So I think that the Plaintiffs are saying there's two parts, two relevant parts of the rule. Part No. 1 creates a new notice requirement and Part No. 2 rescinds the 2014 notice requirement.

MR. BICKFORD: Right, that is their argument, Your Honor.

THE COURT: So, if I'm applying this language of the rule, you know, hypothetically, if their statutory challenge to the new notice requirement succeeds, that provision shall be -- this is a quote -- "shall be considered severable from its section and other sections of these rules."

So wouldn't the rule's rescission of the 2014 notice requirement be one of the those "other sections" and is severable.

MR. BICKFORD: Your Honor, I think the question there is what is the relevant provision? And again, and as I say, ultimately, the severability test in APA cases is a question of Agency intent. I think it would be somewhat perverse to take this rule, which is all about how important it is that there are notices and the importance of informing consumers, and conclude that the Departments would have chosen to remove the

2014 notice separately from their decision to impose a new notice. I think there is nothing in the rule that would suggest that was the Agencies' intent. And in construing the broad severability provision, the way to reach that conclusion would be to say that A and B were not separate provisions, but were two moving parts of a single provision, which did not independently remove one notice and separately impose a new notice, but would intend to clarify that when the new notice requirement went into effect, the old notice requirement would no longer be enforced. I think it would be quite a stretch to treat those as independent agency actions.

THE COURT: That makes some sense. And the severability clause does also say that any invalidation "shall not affect the application of ... dissimilar conditions." That arguably shows that similar conditions should be treated as part of the same provision that's invalidated.

MR. BICKFORD: But our principal argument -- thank you, Your Honor. Our principal argument on statutory authority is that the Departments have broad rulemaking authority that the en banc Fifth Circuit in *Brackeen* has affirmed the [vitality] of *Mourning*, that broad delegations of rulemaking authority allow the Departments to impose rules that are reasonably related

to the purposes of the underlying statutes. That is true as to delegations of implemented provisions, as well as the purposes as the language of *Brackeen* itself makes clear. That was a case about provisions rather than purposes. And that the imposition of a notice requirement to ensure that the consumers are informed about the nature of the policies they are purchasing and whether those policies include the consumer protections begun with HIPPA and expanded by the APA certainly reasonably related to the purposes of the statutes that imposed those requirements. That is our central argument.

As to the penalties, we have defended it, we have defended this requirement as a requirement and not as an additional condition of exemption. I understand that the regulatory language is drafted in that way, but I would expect that it would be enforced as the Government has defended it, to the extent that it is enforceable, and that any insurer in the quite unlikely hypothetical situation in which the Government attempted to enforce this as a condition of exemption rather than a requirement, I'm confident that the bar would make the Government's representations in this case available to anyone facing such an unlikely action.

THE COURT: So, on that point, the rule is drafted as adding a condition to 26 CFR Section 54.9831-1 --

MR. BICKFORD: It appears in several places because of the Departments --

THE COURT: There's three different Agencies. But in each of those -- I'm just going to use the first one as an example. In each of those -- so this would be -- just to finish my thought, subsection (c)(4), Roman numeral lower case (ii). And then the rule is added to that regulation a new Part (B), which has the notice requirement.

But what -- in that regulation, and this is true of the others as well, what that romanette (ii) is doing is defining when benefits are described in a certain earlier provision that makes them excepted benefits -- e-x-c-e-p-t-e-d benefits -- that are not subject to the requirements for comprehensive.

So, if the Court were to conclude there is not statutory authority to do that, but maybe reserve the issue of whether there is simply a freestanding authority, I don't see how it's possible how to sever any aspect of this rule, but still let the rule create a notice requirement. I mean, wouldn't the agency then have to take some sort of responsive action and

identify, "Okay, well, we're appealing this, but in the meantime here's some other authority that we're relying on?" Can the Court just come up with some other authority for the Agencies?

MR. BICKFORD: Well, Your Honor, I think the authority -- the separate references to broad rulemaking authority are in the preamble and we've cited a number of them. So I don't think that the -- the form of the drafting rather than the substance of the statutory authority that's at issue, I think it would be a matter of construing the regulation rather than a severability argument.

I agree, I don't think that the Court can strike out (B) and put in whatever the -- I lose track of my romanettes and my subsections and my paragraphs. But I think the Court certainly can construe it in substance as the *Central United* court dealt with that separate requirement and substance and say, look, what this regulation is doing and everyone understands what it is doing is saying that fixed indemnity insurers who are offering excepted benefits must provide this notice.

We understand that that is the effect of the notice. We construe it that way. The Government has represented that it will not be enforced as a separate -- the penalties associated with offering

deficient comprehensive health insurance will not be applied to such violations. This is substantively what the Government has done. That would, I think, be the way to arrive at that conclusion.

THE COURT: Okay. Well, I think I have your argument on the statutory authority point and the remedies for that. Would you like to move on to the arbitrary and capricious claim or the notice and comment claim?

MR. BICKFORD: Yes, thank you, Your Honor.

The issue on the arbitrary/capricious claim is quite straightforward. The only requirement is reasoned decision-making. The Departments adopted the rule. And I'm quoting from 89 Federal Register 23-380 -- I apologize that was a little fast. They adopted the notice requirement so that "consumers are informed about the type of coverage they are purchasing." That is the reasoned basis for the rule. That certainly survives an arbitrary and capricious test.

I think the only argument to the contrary that Plaintiffs are forcefully making at this point of the case has to do with claims of widespread consumer misunderstanding in the market. The drafting of the rule, I think, makes fairly clear, as we have set out

in our reply brief, that those claims apply to the STLDI, the Short Term Limited Duration Insurance, a component that is also part of this rule.

There is no finding in the preamble but there is widespread consumer misunderstanding as to the fixed indemnity market, but there is no requirement that there be such a finding. We cite the Government's authority to engage in prophylactic rulemaking. So that is they can choose to impose notice requirements to avoid problems rather than in response to problems. And if they can do that, they can certainly impose a notice requirement because there is some evidence -- as there is, and I don't believe Plaintiffs dispute -- of misunderstanding in the market, even if it is not such substantial evidence as to be evidence of widespread consumer exception.

THE COURT: Okay. And then as to notice and comment --

MR. BICKFORD: If I may briefly address the language of the "not health insurance." I apologize, Your Honor.

THE COURT: Sure. So they have two challenges to that. They have an arbitrary and capricious and a notice and comment?

MR. BICKFORD: Yes, Your Honor.

And the argument as to the statutory authority on that point is simply the notice that they say the statute and regulations define fixed indemnity insurance to be health insurance under various provisions. The notice does not say this is not health insurance within the terms of these statutes and regulations. It says it is not health insurance as the term is commonly understood. So the argument should be resolved on that basis.

And as the term is commonly understood, health insurers indemnify against medical costs. Fixed indemnity plans pay without regard to medical costs. So, if a beneficiary is hospitalized and fully insured, they get the fixed indemnity benefit. If they are hospitalized and receive charity care at no cost, they get the fixed indemnity benefit if it is not tied to medical cost in the way that traditional health insurance is.

On the notice and comment point, which is their last argument, the Supreme Court has been very clear in its recent decisions that the APA sets out the full bounds of what is procedurally required. And under the terms of the APA, the Departments did not even need to provide language of the draft notice. It would have been enough to say, "We are considering

updating the notice Language. Please send your comments as to what the notice ought to say. Here are the things we're thinking about."

Instead of that, they provided two draft notices. The final notice was, I believe, only different in one word from the draft. Now, we concede that it is an important word. But to suggest that the APA required the Departments to highlight in yellow or somehow indicate in the particular words of the draft on which they were seeking comments for, or at pains of being unable to change the draft far exceeds what the APA requires.

THE COURT: Well, do you think there is a difference in terms of notice of the need to comment between what you hypothesize, which is the agency thing, "We are anticipating updating our notice, please send us your comments," on the one hand, because that exposes an intent to do sort of any change within that broad category; and on the other hand, a proposed rule that says, "We're deciding to change the notice and here's option 1 and here's option 2," which would operate perhaps something like a head fake and encourage people to think that those are the two options they need to comment on and there would be no need to comment on some other language?

In other words, you know, giving notice of specific changes could make the logical out risk as hard to satisfy. What do you have to say to that idea?

MR. BICKFORD: Two things to say. I'm looking for the language. This is 88 Federal Register, at 44627, comments on all aspects of the proposed consumer notice for both individual and group market fixed indemnity benefits coverage, including whether it's language, formatting and placement would achieve its stated aim.

So I don't think certainly there was any head stake. I think that a ruling in that light may have perverse consequence if Agencies are essentially penalized for more fully describing their intended plans. You would assume that an actual response to that development in the law would be terser and terser descriptions of what the Agencies intend to do, which I don't expect would benefit anyone. But certainly, you know, the Agencies did their best to describe their intent.

THE COURT: Wouldn't the consequence just be, if you decide to drop a very important word, you just do a second proposed rulemaking or like a supplemental proposed rule that says that?

MR. BICKFORD: There is certainly always that

procedure or option, as well. But I think the central point of the Agencies not comment on every aspect of the rule and change a single word --

THE COURT: Okay.

MR. BICKFORD: -- and a rule that tried to distinguish between important words and unimportant words. It would be unmanageable and not required by the APA.

THE COURT: But you are conceding that the word that was dropped is an important word; right? Like "comprehensive"? Changing "not comprehensive health insurance" to "not health insurance," that is an important word that's dropped?

MR. BICKFORD: Well, it's giving rise to federal litigation, so it must be important.

THE COURT: Well, it changes the meaning, doesn't it?

MR. BICKFORD: Both phrases were an attempt to achieve, to arrive at the same understanding in the public reader. The rulemaking makes a number of references to consumer testing, which happens between the proposal and the final rule. The Agencies' intents or the Departments' intent in the notice is to inform the consumer that this is not health insurance as the term is traditionally understood. And health insurance

is more broadly legible than comprehensive health insurance, which is perfectly plain to me and my colleagues and any health care lawyer, but not necessarily to a non-lawyer reading this material.

THE COURT: Right. But just in terms of the notice, I mean, if a newspaper contacted me and said, we're going to run a story that says, "You are not a smart judge," I might decide, that's fine, you can write what you want.

If they were to then say, "You are not a judge" and drop the word "smart," then I might have something to say to point to my commission. It's kind of what's going on here, right?

MR. BICKFORD: Yes, Your Honor, I certainly -- I take the force of the other side's argument. I think the question is, when the general public says this is health insurance, what is it that they understand? And that the rest of the notice fairly clearly fleshes out what it means to say that fixed indemnity -- why it is and what it means to say that fixed indemnity insurance is not health insurance. "You are still responsible for paying the costs of your care. The payment you get isn't based on the size of your medical bill."

THE COURT: Well, some of those points are blending back to the arbitrary and capricious point, I

think.

MR. BICKFORD: Sure, right. But I think it would be -- if the Court accepts that the Departments have statutory authority and accepts that this was a reasonable notice to require because the public's understanding of fixed indemnity plans match well onto the statement that this is not health insurance, that's the only point that you arrive at the procedural claim, having made those two decisions and arrive at the procedural claim --

THE COURT: Yeah.

MR. BICKFORD: -- It would be strange to say, but the difference between comprehensive health insurance and health insurance is so large that despite the fact that the public understands them as effective synonyms and there is statutory authority, there was a procedural deficiency that --

THE COURT: Well, maybe. But, I mean, procedural claims are known for that feature is that you have to -- you know, if the procedure was hypothetically bad, you have to kind of be creative and imagine, you know, there is always a prejudice test. Even Section 706 of the APA says that. But the prejudice test under Section 706, which is I think what you are getting to, is notoriously easy to satisfy. If

you can sort of just imagine that a comment might have changed the thinking cell.

In other words, maybe a comment would have proposed some other language to alert the public in plain words that this is not what they may be thinking of, but is also literally, you know, less objectionable, this is not traditional health insurance or something of that nature.

Have you cited any of the case law on the prejudice standard on under APA Section 706?

MR. BICKFORD: Yes, Your Honor, that's in our opening brief.

THE COURT: I mean, you agree with me, right, that it's pretty easy to satisfy, at least as the Fifth Circuit interprets it?

MR. BICKFORD: Your Honor, there are certainly -- I'm not sure that I would agree that it's pretty easy to -- procedural claims often fail, yes, but we are here today in roughly the same place we would otherwise have been, that all of the claims are being aired in this case. The Department sought very broad comments on this. If someone wished to suggest that traditional health insurance was a better course, they were free to do so.

And it's just very hard for me to walk

from the APA simple requirement that you provide the public with notice that you're thinking about changing the language, "Please send in your comments, let us know what you think we should do," and the suggestion that by proposing specific notice language, the agency then vastly restricts what it -- the language of the final notice that I might be willing to adopt. Those seem like two very hard arguments to hold together in the mind.

THE COURT: Okay.

MR. BICKFORD: And with that, I'll rest, Your Honor. We encourage the Court to enter summary judgment in our favor on all claims.

THE COURT: Okay, thank you, Mr. Bickford.

All right. Mr. McArthur, would you like to reply briefly?

MR. McARTHUR: I would. Thank you, Your Honor.

I'll start out with just one brief point on the arbitrary and capricious claim about the failure to justify the claims of widespread confusion. And I'm happy to accept the Government's concession that there isn't any real evidence of widespread confusion in this particular market, but that is not what the Departments said in the rule and that is their main defense on this claim. They say, "We never claimed there was

widespread confusion." Maybe they didn't use the word "widespread," but here's what they did say on page 23,409. And there are some elipses in what I'm about to quote, but I'm not omitting anything material.

The Departments said that they were "of the view that there is a need for action regarding fixed indemnity coverage at the federal level given the prevalence of aggressive and deceptive sales and marketing practices."

I don't have any problem with Mr. Bickford's point that Agencies can regulate prophylactically, but what they can't do under the APA is claim that their rule remedies a real problem in the industry without substantiating their claim that there is a real problem in the industry, and that's what makes the rule arbitrary and capricious on this point.

On the notice, I think Your Honor understands our arguments on the notice requirement. This absolutely was a head fake. I'm not sure that Mr. Bickford is correct that they could have provided no draft language at all for the notice requirement, but even accepting that premise, it does not follow that they can do what they did here, which was in essence lull parties into a false sense of security by putting on the table we're only considering saying this

is not comprehensive health insurance and centering their entire rationale around that point and then doing a complete 180 in the final rule without also a word of explanation in the final rule for that change, which is an independent procedural problem under the APA.

I do want to say a few words in our response to Mr. Bickford's claim that this is not health insurance, and then I'll come back and end on statutory authority.

So the "not health insurance" language is arbitrary and capricious not just because of the procedural violation, but also because it is false, which makes it arbitrary and capricious. The Departments don't dispute that it's false as a statutory matter, and they can't, because fixed indemnity insurance is clearly health insurance coverage within the meaning of the statutes and regulations. Instead, they argue that it's not health insurance within the ordinary understanding of that term. But that is both an impermissible post-op rationale, yet again, and it's wrong. It's post-op because they didn't say a single word in the rule about the meaning of the term health insurance, whether statutory, regulatory, or ordinary. Not having made their case in the rule, they can't now defend the rule

in court on that basis.

Even setting that aside, the Departments litigation position that this isn't health insurance is simply wrong. They don't dispute that it's insurance and they don't explain what kind of insurance it could be if not health insurance. It's obviously health insurance because the benefits are triggered by covered medical events and are both designed to and do help defray the costs of medical care. And that is why everyone in this rulemaking, the commentors, the Departments' own studies. The Departments themselves consistently referred to fixed indemnity insurance as a kind of health insurance.

Now, if you want to talk about what ordinary seekers understand, I think most ordinary Americans, if they had a question about what fixed indemnity insurance is, they would probably just Google it. And if you Google the question, "What is fixed indemnity insurance?" you will see that you get a string of links to sources, like *healthinsurance.org*, that all describe fixed indemnity insurance at health insurance. So you can say it's not comprehensive health insurance, could maybe even say it's not traditional health insurance, but you can't say that it's not health insurance at all.

Finally, coming back on statutory authority, the Government's principal defense is about the language in the Supreme Court's decision in *Mourning* and reiterated in the Fifth Circuit's decision in *Brackeen* about having a general delegation of rulemaking authority allowing you to promulgate any rules that are consistent and carry out the statutory purpose. You only reach that argument if you get past our threshold argument about this being an impermissible exemption condition and you're asking whether they have authority to impose a freestanding requirement. So I don't think Your Honor needs to address any of that.

And the only answer I heard from Mr. Bickford about my point that an exemption condition is not the functional equivalent of a free-standing requirement is a representation from the podium that the Government is going to enforce this requirement as they defended it in court.

Now, that is something new. That is really doubling down on post-health rationale. The Departments wrote the exemption condition, that's how they justified it in the preamble. And I mean justified it. When they made those statements that I spoke about earlier in the preamble, they were responding to

comments where she said, "You lack the legal authority to do this and it violates the First Amendment."

And in response they said, "We're not imposing a requirement. We're imposing an exemption condition." So, having justified the rule on that basis, they cannot come into court and defend it on the complete opposite.

THE COURT: What do you have to say about the severability issue regarding your -- I guess this would apply to both the notice and comment -- well, really apply to all three of your claims, and I'm speaking here about severing the rule's creation of new notice language from the rule's rescission of the prior notice language.

I take it, for your statutory authority claim, you would argue there, well, if there is not authority to do it as a condition of excepted status, then there is no reason to strike the rule's rescission of the old language. You know, if that first claim of lack of authority succeeds, there wouldn't have been statutory authority to do it in 2014 either.

MR. McARTHUR: That is correct.

THE COURT: So I think, you know, your severability argument is easiest for you on your statutory authority claim. But moving on, let's say

there is statutory authority, and I'm just looking at the arbitrary and capricious or notice and comment claim. Which there, those defects in theory could be cured if more findings were made about misrepresentations or perhaps if more procedure was issued.

What do you do with that?

MR. McARTHUR: Yeah, on the claims targeting the objectionable language in the notice, the "not health insurance" language, our request mainly on that is essentially to take a red line to the notice and vacate the language that says it's not health insurance. So I don't even think there would need to be any additional work done by the agency to just vacate that language.

But on our primary statutory authority argument, the remedy that we're asking for is to vacate (A) of the regulation and leave in place (B). I understand it's Mr. Bickford's argument about severability is a question of intent. That may be the case, it's a question of intent when there isn't a severability clause in the rule. Here there is a severability clause in the rule that says, if any provision is found invalid and enforceable in all circumstances, and the provision here that is invalid

and unenforceable in all circumstances is (A), it's not (B), then that provision shall be severable.

But even if you disagree with that reading of the severability clause, I come back to what I said earlier, which is vacatur is always a remedy that is addressed to discretion of the Court and it would be inequitable to vacate (B) here because that would reinstate a notice that the Departments lack authority to promulgate and the language of that notice is inaccurate.

I didn't hear any response to my point that the language talking about being subject to a tax penalty if you don't get major medical coverage is simply wrong today and you shouldn't put out a notice in the name of --

THE COURT: Well, I think he would say you have the word "may" to admit that you may be subject to a penalty.

MR. MCARTHUR: Well, that's --

THE COURT: And even though it got zeroed currently, you never know and I guess in the future it could be --

MR. McARTHUR: I suppose it could become true if they reinstate your tax penalty. But under the state of the law today, it is false to say that you may

be subject to a tax penalty.

THE COURT: Well, I think I may have stepped on Mr. Bickford's toes a little bit. So I assume he would have said something like that.

Why did Manhattan Life's corporate predecessor not challenge statutory authority to issue a rule requiring notice as a condition of excepted status in the litigation over the prior rule in *Central United Life?*

MR. McARTHUR: I don't know the answer to that question. I was not involved in that litigation, so I can only speculate. But my guess would be that they didn't challenge the notice requirement, number one, because they had bigger fish to fry at the time with the provision effectively banning stand-alone fixed indemnity policies.

Number two, I suspect they didn't have a particular objection to that language like they have an objection to the language here saying that this policy isn't health insurance. The prior notice does not state or imply that fixed indemnity insurance is not health insurance.

THE COURT: Okay, so that would be your answer to res judicata. As you know, res judicata applies not only to claims that were raised in prior litigation,

but claims that could have been raised. And your argument is, because the language is different, it's more -- your argument that the language here is literally false --

MR. MCARTHUR: Yes.

THE COURT: -- and that that wasn't true of the prior litigation, so this claim was not one that could have been raised in the prior litigation?

MR. McARTHUR: That's correct, this is an entirely new rule imposed in 2024. Obviously, we couldn't have brought a challenge to that rule.

THE COURT: So, even if there was a lack of statutory authority that existed just as much then as it does now, the way that that authority mapped onto real consequences wasn't as severe --

MR. McARTHUR: That is correct as well.

THE COURT: So would it be res judicata as to Manhattan Life and its corporate successors that the 2014 notice language is lawful because you could have raised that claim in the *Central United Life* litigation and didn't raise that claim?

MR. McARTHUR: It might well be but for the fact that there has been a material change in factual circumstances, which is that the tax penalty has been zeroed out.

THE COURT: Right. And so if that's res judicata as to Manhattan Life and its corporate predecessor, then would a vacatur -- how would this work? So let's say I accept all three of your clients' statutory authority claim and I would vacate the new notice requirement as to all three, and then as to two of them I would leave intact the rules rescission of the old notice requirement, but as to Manhattan Life I would actually vacate the rules rescission of the 2014 notice language because the res judicata effect of its prior litigation precludes it from back-dooring the challenge to the language that existed in 2014, but it had an opportunity to challenge in 2014 and that it decided not to challenge 2014, is that essentially how this maps out?

MR. McARTHUR: I don't think so. To be frank, I haven't studied the question of how res judicata would apply here, but I would not think that doctrine would have any application to a challenge to a new rule, whether it's part A or part B.

THE COURT: Okay. So your point is because the agency itself rescinded the 2014 rule, then res judicata wouldn't apply?

MR. MCARTHUR: Correct.

THE COURT: That actually may be right. I

think that may be right, actually.

All right. Thank you, Mr. McArthur.

Mr. Bickford, would you like to just briefly respond on that remedial point about the effect of the *Central United Life* litigation as to *Manhattan Life?* I'm not sure I gave you a chance to respond to that.

MR. BICKFORD: Sure, thank you, Your Honor.

We did not brief this Court as well. But I believe if the Court were thinking through that issue, it would want to think in terms of issue preclusion and claim preclusion as relevant, which is versions of res judicata. Certainly, a direct claim as to the invalidity of the 2014 notice requirement should be precluded by the decision in *Central United* because it plainly could have been raised there.

I don't believe, although I would want to go research it, that issue preclusion applies to issues that could have been raised, but were not in an earlier litigation. So I don't think that -- we don't argue and haven't argued that Manhattan Life is broadly precluded from ever challenging the statutory authority to require notices in the fixed indemnity market because it chose not to raise that issue in *Central United.* But if the question is a claim as to the

particular validity of the 2014 notice, clearly, that is a claim that could have been raised and that its predecessor chose not to perhaps because it had bigger fish to fry. That would be how I would analyze it.

THE COURT: Okay. Well, thank you, Mr. Bickford.

All right. Your motions are submitted. I'm prepared to issue my ruling. I'm going to rule orally in this case on your Cross-Motions as opposed to issue a written decision, and then I'll issue my final judgment forthwith.

The Plaintiffs' Motion for Summary Judgment is granted and the Defendants' Cross-Motion for Summary Judgment is denied.

As to the Plaintiffs' first claim on lack of statutory authority, Plaintiffs' motion is granted for essentially the reasons that the D.C. Circuit articulated in the *Central United* litigation, that the statute says that an insurance product that meets the statutory conditions shall not be subject to the regulations for comprehensive insurance and it is instead treated accepted.

That's the language in 42 U.S.C., Section 300gg-21, Subsection (c)(2). Also in 26 U.S.C. Section 9831, Subsection (c)(2). Also in 29 U.S.C. Section

1191a, Subsection (c)(2).

Those provisions provide that each statutory schemes respective version of the health insurance requirements, those being separateness, no coordination, independence -- I'm sorry, those being the no pre-existing conditions, exclusions, and so forth, the essential health benefits packages. Each of those cited provisions says those requirements shall not apply to any plan in relation to its provision of accepted benefits if all of the conditions are met. And those are quotations of the statutory language. And the three statutory conditions for that are separateness, no coordination, and independence.

For essentially the same reasons that the D.C. Circuit found that that precludes adding further conditions, I agree that that precludes adding a notice condition to qualify as an accepted benefit.

I understand the Defendants' arguments about the Supreme Court's decision in *Mourning* (M-o-u-r-n-i-n-g) *vs. Family Publication Service, Inc.*, 411 U.S. 356, 1973. However, the Supreme Court has also held that even when a delegation of authority is broad, that does not authorize Agencies to contravene Congress's will. That a quotation from *Ragsdale?* (R-a-g-s-d-a-l-e) *vs. Wolverine Worldwide, Inc.*, 535

U.S. 81, at page 92, 2002.

And here the text of the relevant statute is unambiguous. The requirement of each statute, "shall not apply" to "any" relevant plan in relation to its provision of accepted benefits "if the benefits" meet the three criteria.

So, by adding to though three notice criteria, the Departments have made the federal statutory requirements for comprehensive plans applicable to some fixed indemnity plans that meet the three statutory criteria, essentially as the D.C. Circuit reasoned, that exceeds the Departments' authorities.

The words "any" and "shall" in the statute do not leave room for discretion in that regard. The Fifth Circuit held in *Tula-Rubio vs. Lynch*, 787 F.3d, 288, Fifth Circuit 2015, "Where Congress did not add any language limiting the breadth of the word 'any' must be read as referring to all of the type to which it refers."

The Fifth Circuit reached a similar result in the analogous case of *Luminant Generation Company vs. EPA*, 675 F.3d, 917, at 2012, rejecting to EPA's attempt to graft onto a requirement in the statutory list an additional requirement including that it

exceeded the EPA's authority because the language of the statute left no room to deny a plan that met the statutory requirements.

That's the case here as well. That's essentially why the D.C. Circuit reached its results in *Central United.* I understand the Defendants' point that *Central United* relied on the additional fact that the criterion there, unlike the one here, effectively regulated consumers rather than issuers. But that additional fact was not essential to the D.C. Circuit's reasoning. The D.C. Circuit in *Central United* reached its conclusion even before mentioning that distinction and treated that distinction only confirming its conclusion.

And in any event, *Central United* is merely persuasive authority. The controlling authority in this Court was the Supreme case I cited and the Fifth Circuit's precedence in *Tula-Rubio, Luminant Generation,* and other cases there cited therein.

Those Fifth Circuit authorities don't conflict with the broad band of authority that the Supreme Court recognizes in *Mourning.* Even in *Mourning* the Supreme Court observed that nothing short of an express limitation will undermine the Agencies' authority, but here an express limitation does exist,

namely the statutes provide that what's called the baseline requirements for comprehensive plans shall not apply, and that's to any fixed indemnity policy that meets the three statutory criteria. So that is an express limitation within the meaning of the Supreme Court's decision in *Mourning*.

The Fifth Circuit has reached a similar conclusion about what qualifies as an express limitation in the case of *Djie vs. Garland*, 39 F.4th 280, in 2022, where the Fifth Circuit explained at page 284 of its opinion, to the extent the regulation attempts to carve out exception from a clear statutory requirement, the regulation is invalid.

As to whether some other statutory authority could support a notice requirement that is not a condition of excepted benefit status, but it is instead a free-standing requirement with some sort of free-standing penalty scheme or enforcement scheme. The Court's not going to decide that question today. That's not the issue before the Court. The agency has not invoked some other authorities. It invoked the authority to define conditions for the exception here.

Moving on, I grant the Defendants' Motion for Summary Judgment on the arbitrary and capricious claim and find that if there is statutory authority, if

I'm reversed on my first point, that the notice is not arbitrary and capricious; namely, the APA doesn't impose some obligation on an agency to produce empirical evidence. It has to justify its rule with reasoned explanation, and the agency is free to adopt prophylactic rules to prevent potential problems before they arise. As the D.C. Circuit explained in *Stillwell vs. Office of Thrift Supervision* in 2009, an agency need not suffer the flood before building the levee.

The agency did cite some evidence of non-generalizable deceptive practices. And even if the Plaintiffs wouldn't have treated those as justifying this regulation, it's within the agency -- it was not arbitrary and capricious for the agency to conclude that it justified this requirement. Again, I find it lacks statutory authority to do that, but if I'm reversed, I would not conclude that this was arbitrary and capricious for that reason.

Likewise, with the language chosen, the agency articulated a non-arbitrary and capricious explanation for why the "not health insurance" language would not be misleading because the public understands health insurance to essentially mean comprehensive health insurance because of the way the term has been used in popular culture and common language over the

years, and the agency articulated non-arbitrary and capricious basis for choosing that language. Even though it might not be the legal classification of fixed indemnity insurance under 45 CFR Section 148.220, the agency had a non-arbitrary basis for drawing a distinction between how some provision of the Code of Federal Regulation treats fixed indemnity insurance and how the public would understand the language in a notice that is aimed at a non-legal population.

So Defendants' Motion for Summary Judgment is granted as to that claim.

Finally, as to the notice and comment claim, Plaintiffs' Motion for Summary Judgment is granted on that claim. This claim would not authorize any broader relief than would be authorized by the statutory authority claim. But in the interest of completeness, I'll enter my summary judgment for Plaintiffs on this claim as well.

Essentially, the logical at risk test was not satisfied here because of the specific proposals that the Agency identified in its notice of proposed rulemaking, both of which had the word "comprehensive" in the clause describing these fixed indemnity plans as not comprehensive health insurance. And it was not a logical outlook of that overall notice of proposed

rulemaking for commentors to expect that the final rule would go so far as to call these plans not health insurance at all.

As I found, it was not arbitrary for the Agencies to do that. However, it was also not something that commentors who were on fair notice was on the table given the specificity of the proposed rulemaking in identifying its two alternative reasons for comment.

And I understand that the proposed rule does have some general language saying that it was considering all comments about the formatting and such, including the location of the notice, but commentors are understood to read proposed rulemaking as a whole.

And given that this proposed rulemaking had the two specific alternatives and also just given the importance of the word "comprehensive," I find that the logical outlook test was not satisfied here and that the harmless air standard was not met here by the lack of proper notice of proposed rulemaking because Plaintiffs did not get a chance to comment on the specifics of the final rule. There was a vast difference. The Fifth Circuit has held that especially when it comes to notice and comment claims, the rule of prejudicial error, which is how the APA describes this

rule, is easily proven in *Mock vs. Garland*, 75 F.4, 563, at page 586, Fifth Circuit in 2023, as well as in cases like *United States vs. Johnson*, 632 F.3d 912, Fifth Circuit 2011, where the Fifth Circuit finds -- it explains that generally a deficiency is not prejudicial only when it is one that clearly had no bearing on the substance of the decision reached, and the Court cannot say that it's clear that the lack of notice of this language had no bearing.

As to remedy, given that I've granted summary judgment to Plaintiffs on their statutory authority claim, I don't need to consider severing certain language of the notice requirement and instead will simply enter a declaratory judgment that the notice requirement, as it exists in the challenge regulations, exceeds the Agencies' statutory authority to add by adding additional conditions of accepted benefit status. To be clear, however, I'm not ruling that the Agencies lack any authority to create a notice requirement so long as it's not a condition of accepted benefit status.

I'll also enter a final judgment vacating those aspects of the rule as they concern fixed indemnity plans. That vacatur will sever the aspects of the rule that creates a requirement for a short-term

limited duration insurance plan since those are not before the Court.

As to whether this vacatur remedy will be party restricted, I read the Fifth Circuit's precedent as interpreting vacatur to be applicable to everyone that the vacated provisions apply to. And since here they apply to all issuers of fixed indemnity, the vacatur would apply to that.

To the extent the Fifth Circuit's precedent to that extent is reversed by the Supreme Court, and this is an issue that, you know, is under a lot of consideration these days, I would make this vacatur party restricted to the Plaintiffs. However, the Fifth Circuit holds that vacatur is not a party restricted remedy, although it does recognize that vacatur can apply to only portions of the rule, and so the rule will be severed in that regard as it concerns the difference between STLDI short-term limited duration insurance and fixed indemnity insurance.

So I'll issue my final judgment forthwith. I believe that resolves all the pending motions. Does any party want to be heard on housekeeping matters or remedy?

For the Plaintiffs?

MR. McARTHUR: No, Your Honor.

THE COURT: All right. And for the Defendants?

MR. BICKFORD: No, Your Honor.

THE COURT: All right. Well, thank you both for your extensive briefing, which was very helpful, for your argument here today, making the trip out to Tyler, and your professional presentations.

With that, court is adjourned.

[10:23 a.m. - Proceedings adjourned]

REPORTER'S CERTIFICATE

I certify that the foregoing is a correct transcript from the record of proceedings in the above-entitled cause.

/s/ Ed Reed — 12-18-24
Edward L. Reed — Date
Court Reporter