IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF TEXAS
TYLER DIVISION

MANHATTANLIFE INSURANCE AND ANNUITY COMPANY, PASCHALL AND ASSOCIATES, INC., and WILLIAM C. PASCHALL,

Plaintiffs,

v.

UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, DEPARTMENT OF THE TREASURY, DEPARTMENT OF LABOR, XAVIER BECERRA *in his official capacity as Secretary of Health and Human Services*, JANET YELLEN *in her official capacity as Secretary of the Treasury*, and JULIE A. SU *in her official capacity as Acting Secretary of Labor*,

Defendants.

Civil Action No. 6:24-cv-00178-JCB

DEFENDANTS' REPLY IN SUPPORT OF THEIR MOTION TO DISMISS AND CROSS-MOTION FOR SUMMARY JUDGMENT

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INTRODUCTION

Fixed indemnity insurance pays a flat, pre-determined amount when certain health-related events occur, whether or not the insured individual incurs any medical cost. For example, an individual with a fixed indemnity plan paying $50 per doctor's visit will receive that payment whether his comprehensive health insurance covers the entire cost of the visit—or none of it. Health insurers do not pay for care that has already been reimbursed by another insurer, and they do not leave the insured entirely "responsible for paying the cost of [their] care," no matter "the size of [their] medical bill." 89 Fed. Reg. 23,338, 23,389 (Apr. 3, 2024) ("Final Rule"). The Departments' decision to require that fixed indemnity insurers clearly label their policies was statutorily authorized, reasoned, and did not involve any procedural error. If the Court were to reach the merits—which it should not, because ManhattanLife cannot lay venue here and its co-plaintiffs lack standing—the Departments would therefore be entitled to summary judgment.

ARGUMENT

A. Only ManhattanLife has standing and it cannot establish venue here.

In their motion, the Departments explained that ManhattanLife (a Houston-based corporation) could not ordinarily sue in this Court. Although Paschall Health Insurance and its owner, William Paschall, reside in Tyler and can therefore lay venue here, the challenged rule "does not regulate their conduct," Defs.' Mot. at 16, ECF No. 27, and they do not assert otherwise. Because a passing reference to standing in "a single sentence with no evidentiary support" did not establish their right to pursue this case, *id.* at 17, the Departments moved to dismiss their claims. Mr. Paschall now offers a declaration and expands upon his theory of injury.

First, Mr. Paschall says that he "will suffer financial injury because the notice rule will likely depress his fixed indemnity sales, and thus his commissions." Pls.' Reply at 8, ECF No. 30.

Mr. Paschall sells fixed indemnity policies "to individuals in and around Tyler, Texas." Paschall Decl. ¶ 3, ECF No. 30-1. He does "not sell comprehensive health insurance," *id.*, and does not declare that he sells fixed indemnity policies in the group market. Under the notice rule that has been in place since 2014, the individual fixed indemnity policies that Mr. Paschall sells have informed potential consumers that they are "A SUPPLEMENT TO HEALTH INSURANCE"—i.e., not health insurance themselves, *see* Defs.' Mot. at 30—and "NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE," 45 C.F.R. § 148.220(b)(4)(iv) (2014). Although Mr. Paschall says that he is "certain" that he "will sell fewer fixed indemnity policies, and thus earn less in commissions, if [the revised] notice requirement takes effect," he offers no evidence beyond "common sense" to support his certainty. Paschall Decl. ¶ 8. He does not indicate what effect, if any, the adoption of the current notice in 2014 had on his sales and commissions—which his "decades of experience" suggest that he should have been able to describe, *id.*—nor explain why he believes that the revised notice will depress his sales relative to a baseline in which he has already been providing a similar notice for the last ten years. In addition to his own unsupported speculation, Mr. Paschall offers citations to the challenged rule. But the portion on which he relies only says that "[t]here is the potential for agent and broker compensation associated with the sale of . . . fixed indemnity . . . coverage to be negatively affected if there is a reduction in the sale of th[is] type[] of coverage." Final Rule, 89 Fed. Reg. at 23,402. That is hardly the firm prediction that Mr. Paschall implies. *See* Pls.' Reply at 10. "Allegations of possible future injury" do not suffice, *Whitmore v. Arkansas*, 495 U.S. 149, 158 (1990), and Mr. Paschall has offered nothing more in support of his argument that he will suffer financial injury as a result of the challenged rule. *See Abdullah v. Paxton*, 65 F.4th 204, 208 (5th Cir. 2023) (explaining that the alleged injury "cannot be speculative, conjectural, or hypothetical").

Next, Mr. Paschall argues that he will need to invest time and resources "dispelling the false impression created by the notice," and "explaining that fixed indemnity insurance is in fact health insurance." Pls.' Reply at 9; *see* Paschall Decl. ¶ 9. But again, although Mr. Paschall has a decade of experience with the effects of a notice declaring that fixed indemnity policies are only "A SUPPLEMENT TO HEALTH INSURANCE," and are "NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE," 45 C.F.R. § 148.220(b)(4)(iv) (2014), he says nothing about how he currently addresses that notice with customers, when he evidently believes that fixed indemnity policies are more than a "SUPPLEMENT" to comprehensive health insurance and can in fact "SUBSTITUTE" for it, nor why he believes that the revised notice will cause him to divert more time and resources than the pre-existing notice does. Mr. Paschall presumably has such "specific facts" at his disposal, but he has not offered them—nor any other "manner . . . of evidence" that would establish his standing to bring these claims. *Lujan*, 504 U.S. at 561 (cleaned up).

Finally, Mr. Paschall says that the notice rule will injure him by compelling his speech. But it does not. The rule does not compel Mr. Paschall to say anything or provide any notice—and he does not meaningfully argue otherwise. Instead, Mr. Paschall says that he will be put to an "injurious dilemma," because he will "have to distribute brochures bearing objectionable government-mandated speech or cease using insurer-created marketing materials at expense to his business." Pls.' Reply at 10. But where there is no showing of compelled speech or economic harm, this "injurious dilemma" does not articulate a separate theory of standing.[1] If Mr. Paschall

[1] Plaintiffs take this phrase from *Book People Inc. v. Wong*, 91 F.4th 318 (5th Cir. 2024), which involved a prohibition on book sales to schools by vendors who did not provide sexual-content ratings of their books. The Fifth Circuit concluded that the forced submission of ratings was compelled speech, and that the loss of sales if booksellers did not comply would constitute economic injury. *Id.* at 329–32. In a discussion of traceability, it noted that an injunction would "free" the plaintiff booksellers "from the injurious dilemma that [the challenged scheme] creates:

has not established that the notice will cause him financial injury or the loss of time and resources—which he has not—then he cannot salvage his standing through the "dilemma" of whether to use marketing materials carrying the revised notice. Mr. Paschall and his business have not established standing to bring their claims, and should therefore be dismissed from this case.

And without its co-plaintiffs, ManhattanLife cannot proceed in this district. Arguing the contrary, ManhattanLife suggests that transactional venue to challenge a rule is available under 28 U.S.C. § 1391(e)(1)(B) whenever a corporation does regulated business in the venue. Pls.' Reply at 11. But no "events or omissions" giving rise to the claims in this case "occurred" here, 28 U.S.C. § 1391(e)(1)(B), nor could they "occur[]" wherever their effects are felt. The rule of universal venue for major corporations challenging government action, which ManhattanLife seems to advance, is flatly inconsistent with *Leroy v. Great Western United Corp.*, 443 U.S. 173 (1979). In that case, a Texas corporation brought suit in Texas against Idaho officials, challenging an Idaho statute. *Id.* at 175–77. Relying on the then-current version of 28 U.S.C. § 1391(b), which provided that a suit could be brought in a judicial district "in which the claim arose," the *Leroy* plaintiff argued that its "claim arose" in Texas because the plaintiff proposed to engage in regulated activity there and would thus feel the "impact" of Idaho's statute in Texas. *Leroy*, 443 U.S. at 185-86. The Supreme Court held that the plaintiff's "contacts" fell "far short" of establishing a sufficient connection between the "claim" and the Northern District of Texas. *Id.* A contrary holding would have subjected Idaho officials to "suit in almost every district in the country," and left venue "entirely in the hands of plaintiffs"—a result "inconsistent with the underlying purpose"

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either submit unconstitutionally compelled ratings to the Agency at great expense or refuse to comply and lose customers and revenue." *Id.* at 333. But that dilemma was not a separate injury.

of Section 1391, *id.*, and one which ManhattanLife seems to advance here.[2] If ManhattanLife could sue here, then it could sue anywhere, but Section 1391 does not provide for venue so broadly. Without Mr. Paschall and his business as co-plaintiffs, ManhattanLife's claims must therefore be dismissed for lack of venue or transferred.

B. The notice requirement was lawfully adopted.

i. The Departments have statutory authority to require a notice.

Under the challenged rule, fixed indemnity plans sold in the group and individual markets must carry a federally-mandated notice. The Departments decided to "requir[e] a prominent disclosure notice to consumers who are considering enrolling or reenrolling in individual or group market fixed indemnity . . . coverage," so that "consumers are informed about the type of coverage they are purchasing." Final Rule, 89 Fed. Reg. at 23,380. The Departments intended this notice to "reduce the potential for consumers to mistakenly enroll in such coverage as their primary source of coverage," "to increase consumer understanding of the differences between fixed indemnity . . . coverage and comprehensive coverage," and to "help ensure that all consumers . . . have the necessary information to make an informed choice after considering and comparing the full range of health coverage options available to them." *Id.* The challenged rule superseded an earlier regulation that required a notice for fixed indemnity plans sold in the individual market. 45 C.F.R. § 148.220(b)(4)(iv) (2014); *see* 79 Fed. Reg. 30,240, 30,255 (May 27, 2014) ("2014 Rule")

[2] That Congress amended Section 1391 in 1990 to clarify that venue can be proper in multiple districts does not change the Court's analysis. Compare *Leroy*, 443 U.S. at 178 n.8 (quoting the pre-amendment statute), with 28 U.S.C. § 1391(b)(2). *Leroy* explicitly did not turn on "whether [the pre-amendment statute] adopt[ed] the occasionally fictive assumption that a claim may arise in only one district." 443 U.S. at 184–85. Under the 1990 amendments, venue must be based on events or omissions that "occurred" in the forum district. An event or omission does not "occur" everywhere its effects are felt, as Plaintiffs' interpretation would suggest.

(adopting the individual-market "disclosure requirement in order to inform consumers of the nature and extent of fixed indemnity insurance coverage").

As the Departments explained in their opening brief, they adopted this notice under their broad, parallel authorities to "promulgate such regulations as may be necessary or appropriate to carry out the provisions" of HIPAA and the ACA. *See* 26 U.S.C. § 9833; 29 U.S.C. § 1191c; 42 U.S.C. § 300gg-92. Those statutes generally require certain protections in the group and individual health insurance markets, including coverage without regard to preexisting conditions, 42 U.S.C. § 300gg-3, and the provision of certain essential health benefits, *id.* § 300gg-6. But those federal consumer protections do not apply to "excepted benefits," 42 U.S.C. § 300gg-91(c), including "fixed indemnity insurance," *id.* § 300gg-91(c)(3)(B); *see id.* §§ 300gg-21(c)(2), 300gg-63(b).

In the challenged rule, the Departments concluded that it was necessary and appropriate "to adopt a consumer disclosure notice in regulation to ensure that the [Federal consumer protection] statutes . . . function as Congress intended," because "[c]onsumers cannot adequately access Federal consumer protections to which they are entitled when it is unclear to which products they apply, and the effects of these protections are diluted when consumers are unclear what type of product they are purchasing and how and when they are protected by Federal law." Final Rule, 89 Fed. Reg. at 23,381. The Departments therefore found it "necessary and appropriate for plans and issuers to provide consumers with a consumer notice that clearly labels fixed indemnity . . . coverage and provides consumers with information sufficient to notify the consumer that such coverage is not subject to the Federal consumer protections and requirements for comprehensive coverage." *Id.*

The Departments implemented that decision through a set of regulations providing that "fixed indemnity insurance is excepted" from otherwise-applicable HIPAA and ACA consumer

protections "only if" the notice is provided. *E.g.*, 45 C.F.R. § 146.145(b)(4)(i). That structure appears to pose a choice to fixed indemnity insurers: provide the HIPAA and ACA protections, or else provide notice that you do not. As the D.C. Circuit noted in *Central United Life Insurance Co. v. Burwell*, the practical reality is that "[t]he very nature of fixed indemnity insurance . . . renders such plans incapable of satisfying those [HIPAA and ACA] requirements." 827 F.3d 70, 73 (D.C. Cir. 2016). But under the literal terms of the challenged rule, they must carry the federal notice *unless* they comply with those protections. This amounts to a *requirement* that fixed indemnity plans carry the federal notice, and the Departments have described it as such. Final Rule, 89 Fed. Reg. at 23,380 (explaining that the challenged rule "requir[es] a prominent disclosure notice to consumers who are considering enrolling or reenrolling in individual or group market fixed indemnity . . . coverage"); *see also Central United*, 827 F.3d at 75 n.1 ("HHS's [2014] rule . . . requires fixed indemnity application materials to include a notice . . . ."). Plaintiffs first deny that the Departments have actually imposed a requirement, and then challenge their authority to do so.

Plaintiffs' first argument rests substantially on the D.C. Circuit's decision in *Central United*. That case concerned a regulatory provision which "effectively eliminated stand-alone fixed indemnity plans" purchased "as a substitute for minimum essential coverage." 827 F.3d at 73 (emphasis removed). The *Central United* court found this to be an unlawful "attempt to regulate consumers"—by requiring them to purchase minimum essential health coverage if they wished to buy fixed indemnity insurance—under a statutory provision that "regulates providers, not consumers." *Id.* at 74. But on Plaintiffs' reading, *see* Pls.' Reply at 12, it was the form of this regulation—which was phrased as an "additional criterion" for fixed indemnity insurance to be excepted from the HIPAA and ACA requirements, 827 F.3d at 73—rather than its substance that

led the *Central United* court to strike it down. That argument ignores what the D.C. Circuit emphasized: fixed indemnity plans are, as a practical matter, "incapable of satisfying" the HIPAA and ACA requirements. *Id.* That is why the rule challenged there "effectively eliminated stand-alone fixed indemnity plans," *id.* at 73 (emphasis removed), and the rule challenged here would effectively require the provision of a notice. To be sure, the D.C. Circuit sometimes pointed to the form of the regulation challenged in *Central United*, just as the Departments did in the preamble to the rule challenged here. *See* Defs.' Mot. at 23 (quoting Final Rule, 89 Fed. Reg. at 23,382). But neither that decision nor this rule left any meaningful doubt that the conditions of exemption being imposed were, in substance, requirements. And, although *Central United* held that the requirement reviewed there was unlawful, the requirement imposed here is not.

As the en banc Fifth Circuit explained only three years ago, "'[w]here the empowering provision of a statute states simply that the agency may 'make . . . such rules and regulations as may be necessary to carry out the provisions of this Act' . . . the validity of a regulation promulgated thereunder will be sustained so long as it is 'reasonably related to the purposes of the enabling legislation.'" *Brackeen v. Haaland*, 994 F.3d 249, 354 (5th Cir. 2021) (en banc) (quoting *Mourning v. Family Publications Serv., Inc.*, 411 U.S. 356, 369 (1973)) (all but first alteration in original), *aff'd in part and rev'd in part on other grounds*, 599 U.S. 255 (2023). Plaintiffs invite this Court to ignore the clear direction of the en banc court of appeals, suggesting that the force of the Supreme Court's decision in *Mourning* has been "diluted," Pls.' Reply at 16 (quoting *NYSE LLC v. SEC*, 962 F.3d 541, 546 (D.C. Cir. 2020)), or does not fully apply to statutes that delegate authority to carry out the "provisions" rather than the "purposes" of a given statute, *id.* at 15. Both arguments are directly contrary to *Brackeen*, which obviously binds this Court. In the Fifth Circuit, there is no question that "the Supreme Court's holdings in *Mourning* and related cases" continue

to affirm "the breadth of authority delegated by broadly worded rules-enabling statutes," *Brackeen,* 994 F.3d at 355 n.65, including those of the form at issue here.

The question, then, is whether the notice requirement imposed by the challenged rule is "reasonably related to the purposes of" HIPAA and the ACA. *Mourning*, 411 U.S. at 369 (citation omitted). And as the Departments explained in their motion, it clearly is. "A regulation requiring insurers to inform consumers that fixed indemnity insurance is not subject to the federal consumer protections and requirements for comprehensive health coverage, so that consumers may make an informed decision about whether to forego those protections, is 'reasonably related to the purposes of the enabling legislation' that established the protections, and therefore within the Departments' broad statutory authority" under *Mourning* and *Brackeen*. Defs.' Mot. at 22 (citation omitted).

Plaintiffs do not seem to deny that the challenged rule is reasonably related to the purposes of HIPAA and the ACA. But they argue that it is nonetheless beyond the Departments' authority, because it is contrary to the "design" of those statutes. Pls.' Reply at 14–15. HIPAA and the ACA impose specific federal consumer protection requirements on fixed indemnity insurance that does not satisfy certain conditions. Plaintiffs argue that, in doing so, the statutes make fixed indemnity plans meeting those conditions broadly "exempt from federal regulation," even a simple notice requirement. *Id.* at 14 But the statutes do not say that "excepted benefits" are exempt from all federal regulation: the statutory text only provides exemptions from the specific federal consumer protection requirements that the statutes would otherwise impose. Plaintiffs are wrong to read a more broadly prohibitive "design" into those limited exceptions.

Plaintiffs rely on *Ragsdale v. Wolverine World Wide, Inc.*, 535 U.S. 81 (2002), *see* Pls.' Reply at 14, 16, but that case illustrates the limits of arguments from statutory "design." In *Ragsdale*, the Supreme Court reviewed a regulation issued under the Family and Medical Leave

Act (FMLA), which "guarantees eligible employees 12 weeks of leave in a 1–year period following certain events," 535 U.S. at 86, though it does not require that the leave be paid. The respondent had a more generous policy, under which employees were "eligible for seven months of unpaid sick leave," which the petitioner exhausted. *Id.* at 84. Her employer denied her request for an extension, and then fired her. *Id.* at 85. She sued under a regulation providing "that if an employee takes medical leave 'and the employer does not designate the leave as FMLA leave, the leave taken does not count against an employee's FMLA entitlement.'" *Id.* at 85 (quoting 29 C.F.R. § 825.700(a) (2001)). The employer "conceded it had not given Ragsdale specific notice that part of her absence would count as FMLA leave." *Id.* Under the challenged regulation, she was therefore entitled to twelve weeks of unpaid FMLA leave, which the Supreme Court construed as a "punish[ment]" for the "employer's failure to provide timely notice of the FMLA designation[,] by denying it any credit for leave granted before the notice." *Id.* at 88. The Court concluded that the "categorical penalty" imposed by the regulation was "incompatible with the FMLA's comprehensive remedial mechanism," under which "an employee must prove, as a threshold matter, that the employer . . . interfer[ed] with, restrain[ed], or den[ied] his or her exercise of FMLA rights," and then show that the employee was "prejudiced by the violation." *Id.* at 89. It held the regulation to be "invalid because it alters the FMLA's cause of action in a fundamental way: It relieves employees of the burden of proving any real impairment of their rights and resulting prejudice." *Id.* at 90.

The regulation reviewed in *Ragsdale* was "contrary to the [FMLA's] remedial design" because it imposed a "categorical penalty" when the Act only allowed for penalties after particular findings were made. *Id.* at 88. The Court did not, as Plaintiffs do here, infer a broadly prohibitive "design" from narrower statutory text. Instead, it identified a particular conflict between statute

and regulation and struck down the rule on that basis. Because the notice requirement challenged here is "reasonably related to the purposes of" HIPAA and the ACA, and not contrary to any of their provisions, the Departments had the statutory authority to adopt it. *Mourning*, 411 U.S. at 369 (citation omitted).

ii. The Departments articulated a reasoned basis for requiring a notice.

As the Departments explained in their motion, they adopted the challenged notice requirement to ensure that "consumers are informed about the type of coverage they are purchasing." Final Rule, 89 Fed. Reg. at 23,380; *see supra* at 9 (listing additional reasons for adopting the notice requirement). That is a more than sufficiently reasoned basis on which to rest a rule, and Plaintiffs do not argue otherwise.

Plaintiffs insist that the challenged rule also rested on a finding of "widespread consumer deception and confusion" that was not supported by the evidence. Pls.' Reply at 16; *see* Pls.' Mot. at 26, ECF No. 23 (arguing that "the record does not support the Departments' claims of widespread consumer deception or confusion"). But the challenged rule does not say that anywhere.[3] What the rule says is that the Departments have seen evidence of deceptive marketing and aggressive sales tactics in the fixed indemnity market and that, among other benefits, the challenged notice requirement would "combat misinformation and misleading or aggressive sales practices." 89 Fed. Reg. at 23,380. Plaintiffs do not deny that such evidence was indeed before the Departments. *See* Pls.' Mot. at 26–28. Instead, their argument seems to be that a) there was not *enough* evidence for the Departments to conclude that consumer confusion and deceptive

[3] The rule makes one reference to "widespread deceptive marketing practices that play on consumer confusion about the benefits and limitations of STLDI"—that is, short-term limited-duration insurance, which is not at issue here. Final Rule, 89 Fed. Reg. at 23,368. And in two places, the rule summarizes comments suggesting that consumer confusion in the fixed indemnity market is not "widespread." *Id.* at 23,383, 23,399.

practices in the fixed indemnity market were "widespread"; and b) unless those problems were "widespread," it was arbitrary and capricious to promulgate a rule defending against them.

But the Departments did not conclude that these problems were "widespread" in the fixed indemnity market, and were not required to do so. To the contrary, the Departments are entitled to "adopt prophylactic rules to prevent potential problems" without any "general obligation . . . to produce empirical evidence" that such problems are already occurring. *Stilwell v. Off. of Thrift Supervision*, 569 F.3d 514, 519 (D.C. Cir. 2009). And if the Departments could regulate without evidence of "misinformation and misleading or aggressive sales practices," Final Rule, 89 Fed. Reg. at 23,380, but simply to prevent such issues from arising, then they could certainly do so in response to some such evidence, without any obligation to wait until the problems had become "widespread." The challenged rule was the product of reasoned decisionmaking.[4]

iii. The notice language is not prohibited by statute, and was reasonably chosen.

As the challenged notice informs potential consumers, fixed indemnity insurance does not make payments "based on the size of [one's] medical bill," and fixed indemnity insurers are not "responsible for paying the cost of your care." Final Rule, 89 Fed. Reg. at 23,389. For that reason, fixed indemnity insurance is not "health insurance" as that phrase is commonly understood: it is not "insurance providing compensation for medical expenses,"[5] because it does not depend on the size of the medical expenses incurred—or indeed on whether any expenses have been incurred at all. An individual who bears no cost for a doctor's visit could still receive an additional payment for that visit under the terms of her fixed indemnity plan. *Cf. Margolis v. Prudential Ins. Co.*, 629

[4] In their motion, Plaintiffs also argued that the Departments failed to consider whether state regulation sufficiently informed consumers about the nature of fixed indemnity insurance. Pls.' Mot. at 28–30. The Departments explained that they had adequately responded to comments of this nature, Defs.' Mot. at 28–29, and Plaintiffs do not contend otherwise on reply.

[5] Merriam-Webster.com Dictionary, https://www.merriam-webster.com/dictionary/.

F. Supp. 195, 198 (D.D.C. 1985) (no payment due from health insurer where the insured individual obtained medical care but "did not sustain medical expense losses for which [the insurer] had a duty to indemnify her"). The notice therefore tells consumers that "[t]his is a fixed indemnity policy, NOT health insurance." Final Rule, 89 Fed. Reg. at 23,389.

The notice does not say that fixed indemnity insurance is not "health insurance" as defined by certain statutory provisions, and no reasonable reader would infer that meaning. It is not a *post hoc* justification to point out what is obviously true. *Contra* Pls.' Reply at 18. Nor do those technical definitions prohibit the Departments from adopting a notice that uses plain English to inform consumers that fixed indemnity insurance makes pre-determined payments without regard to medical costs. It is not "insurance against loss through illness of the insured," *id.* at 18 (quoting Merriam-Webster, *see* supra note 4), but rather insurance *without regard to loss through illness*. It therefore is not health insurance as the term is commonly used, but rather "A SUPPLEMENT TO HEALTH INSURANCE," as the previous notice said, 45 C.F.R. § 148.220(b)(4)(iv) (2014)—and nothing prohibited the Departments from informing consumers of that fact.

iv. The Departments provided an opportunity to comment on the notice language.

As the Departments explained in their motion, the final rule was a logical outgrowth of the proposal, which sought "comments on all aspects of the proposed consumer notice . . . , including whether its language . . . would achieve the stated aims . . . and . . . whether alternative or additional language . . . could better accomplish these goals." 88 Fed. Reg. 44,565, 44,627 (July 12, 2023). Interested parties should therefore have reasonably "anticipated the possibility that the final notice might differ by a single word—'comprehensive'—from the versions . . . in the notice of proposed rulemaking." Defs.' Mot. at 32. Plaintiffs object that they could not have anticipated an alteration which "changed the notice from true to false." Pls.' Reply at 20. This argument merely recasts

Plaintiffs' substantive objections in procedural terms. If the language of the notice was false then the challenged rule would have more fundamental problems than a lack of logical outgrowth—but it is not false, for the reasons explained above and in the Departments' opening brief.

Plaintiffs also assert that it was not enough for the Departments to propose notice language and indicate that they were open to the adoption of "alternative . . . language," 88 Fed. Reg. at 44,627, and that the Administrative Procedure Act instead required the Departments to specifically identify which words it was open to changing. Reply at 20. But the APA would have been satisfied if the proposed rule merely provided "a description of the subjects and issues involved," 5 U.S.C. § 553(b)(3), and did not provide draft text for the consumer notice at all. As the Supreme Court has "repeatedly stated . . . the text of the APA provides the maximum procedural requirements that an agency must follow in order to promulgate a rule." *Little Sisters of the Poor v. Pennsylvania*, 591 U.S. 657, 685 (2020) (citation omitted). The Departments did more than was necessary here, and clearly indicated that the entirety of the draft notice was subject to change. In doing so, they did not commit any procedural error.

C. Any relief should be limited to Plaintiffs' request and the parties before the Court.

Plaintiffs do not dispute that if the Court finds the Departments' decision to require a notice to be statutorily authorized, but their decision to include the statement that fixed indemnity insurance is "NOT health insurance" to be unlawful, then the Court should limit its relief to striking that phrase from the language of the notice. Nor do they contend that, if the Court finds the notice reqirement to be unlawful, vacatur would be required. Pls.' Reply at 20. But they offer three arguments that the Court should vacate the notice provision nonetheless. None are persuasive.

First, Plaintiffs assert that vacatur is a "less drastic remedy" than a party-specific injunction. *Id.* at 21 (quoting *All. For Hippocatic Med. v. FDA*, 78 F.4th 210, 254 (5th Cir. 2023)).

But the "traditional principles of equity" favor party-specific relief whenever possible, *Starbucks Corp. v. McKinney*, 144 S. Ct. 1570, 1576 (2024), and nationwide vacatur is hardly less drastic than an injunction barring enforcement against the parties. Next, Plaintiffs argue that an injunction would provide incomplete relief to ManhattanLife, because States generally enforce the notice requirement against it, and to Mr. Paschall, because other insurers' material would still include the notice. As to ManhattanLife, its corporate predecessor received relief through a permanent injunction in the *Central United* case, *see* 827 F.3d at 73; the company does not offer any reason to believe that this relief was inadequate. And, with an injunction protecting him, Mr. Paschall would be free to obscure the challenged notice or omit it from any marketing materials that he used. Finally, Plaintiffs suggest that the interests of uniformity counsel in favor of vacatur. But, although the Departments would prefer a uniform, nationwide notice, it is better for the vast majority of consumers to have the accurate, helpful information provided by the notice than for no one to have it. Moreover, a narrow injunction would not result in *inconsistent* messages to consumers. Covered materials sold in the group market would simply not carry a notice; they would not carry a notice that said the opposite of the challenged notice. And covered materials sold in the individual market would carry the earlier notice, which is not inconsistent with the revised version. Neither of these outcomes provides any reason for the Court to enter relief that is broader than would otherwise be necessary.

CONCLUSION

The claims of Mr. Paschall and his business should be dismissed for lack of standing, and ManhattanLife's claims should be dismissed or transferred for improper venue. But if the Court reaches the merits of those claims, it should find that the Departments' fixed indemnity notice requirement was lawfully adopted and enter summary judgment in their favor.

Respectfully submitted,

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