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-0178-JCB

PLAINTIFFS' MOTION FOR SUMMARY JUDGMENT AND MEMORANDUM IN SUPPORT THEREOF

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INTRODUCTION

Federal law imposes numerous requirements on most health insurance policies sold in the United States. Policies generally cannot, for example, exclude preexisting conditions or prohibit renewal. *See* 42 U.S.C. §§ 300gg-3, 300gg-42. But Congress has provided that these requirements "shall not apply" to certain "excepted benefits," including fixed indemnity insurance, if the policy satisfies three enumerated criteria. *Id.* §§ 300gg-21(c)(2), 300gg-63(b), 300gg-91(c)(3)(B).

This case concerns an attempt by the federal Departments that administer those statutes to add a fourth criterion found nowhere in the statute. Under the final rule challenged here, a fixed indemnity insurance policy that satisfies all three statutory criteria nonetheless "would be subject to the Federal consumer protections and requirements applicable to comprehensive [health insurance] coverage" unless the issuer includes a conspicuous notice stating, falsely, that the product is "NOT health insurance." 89 Fed. Reg. 23,338, 23,382, 23,389 (Apr. 3, 2024).

The Departments' notice rule is plainly unlawful. As the D.C. Circuit held the last time the Departments attempted to graft an extrastatutory requirement onto the fixed indemnity exemption, the Departments have no authority to "tack on additional criteria" or "demand more of fixed indemnity providers than Congress required." *Cent. United Life Ins. Co. v. Burwell*, 827 F.3d 70, 73, 75 (D.C. Cir. 2016). Even beyond that fundamental flaw, the Departments justified their rule based on asserted widespread consumer confusion, yet they neither substantiated that claim nor explained why state consumer-protection laws are not an adequate solution.

Even if the notice rule were not unlawful *in toto* (it is), at a minimum the portion of the rule requiring insurers to state that fixed indemnity insurance is "NOT health insurance" is unlawful. That requirement contradicts the governing statutes, which uniformly treat fixed indemnity insurance as health insurance. It is arbitrary and capricious because it is internally inconsistent,

departs from the Departments' prior position without any acknowledgement, runs contrary to industry understanding and plain English, and lacks any explanation at all, let alone a reasoned explanation. And, if that weren't enough, it is also procedurally invalid because the Departments provided no notice that they were considering including this false statement in the notice.

Accordingly, the notice rule, or at least the portion stating that fixed indemnity insurance is "NOT health insurance," should be declared unlawful and vacated.

STATEMENT OF THE ISSUE

The issue presented is whether the Departments' new notice rule, or at least its requirement to tell consumers that fixed indemnity insurance is "NOT health insurance," must be set aside because it exceeds the Departments' statutory authority, is arbitrary and capricious, is not in accordance with law, and was issued without proper notice-and-comment procedure.

STATEMENT OF UNDISPUTED MATERIAL FACTS

I. The Federal Statutes Governing Fixed Indemnity Insurance

In our legal system, the States are generally "suprem[e] … in the realm of insurance regulation." *Dep't of Treasury v. Fabe*, 508 U.S. 491, 500 (1993). Congress recognized that primacy in the McCarran-Ferguson Act, which declares "the continued regulation and taxation by the several States of the business of insurance" to be "in the public interest." 15 U.S.C. § 1011. Accordingly, "insurance regulation" is left "generally to the States," *Am. Ins. Ass'n v. Garamendi*, 539 U.S. 396, 428 (2003), and unless a federal law "specifically" regulates "the business of insurance," the States' prerogative prevails, 15 U.S.C. § 1012(b); *see also Barnett Bank of Marion Cnty., N.A. v. Nelson*, 517 U.S. 25, 39 (1996) (McCarran-Ferguson prevents "inadvertent federal intrusion" on state insurance laws (emphasis omitted)).

Against that backdrop, Congress has enacted and amended in the past few decades two landmark laws that impose stringent requirements on most—but not all—health insurance products. First came the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Pub. L. No. 104-191, 110 Stat. 1936, which, for example, requires insurers to permit policyholders to renew their coverage except in limited circumstances. 42 U.S.C. § 300gg-42.[1] Then in 2010 came the Patient Protection and Affordable Care Act (ACA), Pub. L. No. 111-148, 124 Stat. 119, under which insurers, among other things, cannot impose preexisting condition exclusions, 42 U.S.C. § 300gg-3, and must cover all "essential health benefits," *id.* § 300gg-6.[2]

In both HIPAA and the ACA, however, Congress exempted from these requirements certain health insurance products (aptly) called "excepted benefits." Specifically, HIPAA provides that its requirements "shall not apply to any health insurance coverage in relation to its provision of excepted benefits described in paragraph (2), (3), or (4) of section 300gg-91(c) of this title if the benefits are provided under a separate policy, certificate, or contract of insurance." *Id.* § 300gg-63(b). The ACA similarly exempts:

> any individual coverage or any group health plan (and group health insurance coverage offered in connection with a group health plan) in relation to its provision of excepted benefits described in section 300gg-91(c)(3) of this title if all of the following conditions are met:
>
> (A) The benefits are provided under a separate policy, certificate, or contract of insurance.
>
> (B) There is no coordination between the provision of such benefits and any exclusion of benefits under any group health plan maintained by the same plan sponsor.

[1] HIPAA made materially identical amendments to the Public Health Service Act (PHSA), *see* 42 U.S.C. § 300gg-41 *et seq.*, which is enforced by the Department of Health and Human Services (HHS); the Employee Retirement Income Security Act (ERISA), *see* 29 U.S.C. § 1181 *et seq.,* which is enforced by the Department of Labor; and the Internal Revenue Code (IRC), *see* 26 U.S.C. § 9801 *et seq.*, which is enforced by the Department of the Treasury. For ease of reference, this memorandum cites the PHSA provisions and implementing regulations.

[2] The ACA added provisions to ERISA, 29 U.S.C. § 1185d, and the IRC, 26 U.S.C. § 9815, that incorporate by reference the new requirements in Title 42.

> (C) Such benefits are paid with respect to an event without regard to whether benefits are provided with respect to such an event under any group health plan maintained by the same plan sponsor or, with respect to individual coverage, under any health insurance coverage maintained by the same health insurance issuer.

Id. § 300gg-21(c)(2). In short, an excepted benefit in § 300gg-91(c)(3) is exempt from both HIPAA's and the ACA's requirements if the benefits it provides are separate from, not coordinated with, and independent of other health insurance.

One such excepted benefit is "[h]ospital indemnity or other fixed indemnity insurance." *Id.* § 300gg-91(c)(3)(B). Fixed indemnity insurance typically refers to health "insurance that pays a fixed amount under specified conditions without regard to other insurance." 79 Fed. Reg. 15,808, 15,818 (Mar. 21, 2014); *accord* 89 Fed. Reg. at 23,343 (fixed indemnity insurance pays "a flat ('fixed') cash amount following the occurrence of a health-related event"). A fixed indemnity policy might, for example, pay the policyholder $50 per office visit or $20 per generic prescription. *See* 88 Fed. Reg. 44,596, 44,621 (July 12, 2023). Some fixed indemnity policies offer discounts through a network of healthcare providers and pay benefits directly to providers. *See id.*

Given these features, the Departments have long considered fixed indemnity insurance to be a type of health insurance. *See, e.g.*, 62 Fed. Reg. 16,894, 16,903 (Apr. 8, 1997) (describing fixed indemnity insurance as "health insurance coverage" that is "excepted if certain conditions are met"); *see also infra* at 34. Some consumers "deliberately elect" this kind of health insurance because they "prefe[r] the lower premium and lower or absent deductible." Christen Linke Young & Kathleen Hannick, *Fixed Indemnity Health Coverage is a Problematic Form of "Junk Insurance,"* Brookings (Aug. 4, 2020), tinyurl.com/2x7vv6ee (cited by 89 Fed. Reg. at 23,350 n.107).

II. The Departments' Fixed Indemnity Rules

A. The prior rules

The Departments began promulgating regulations implementing the excepted benefits exemptions shortly after HIPAA's enactment. *See* 62 Fed. Reg. at 16,971 (interim rule establishing initial version of 45 C.F.R. § 146.145). For many years, the regulations for fixed indemnity insurance simply parroted the three statutory criteria. *See, e.g.*, 45 C.F.R. § 146.145(b)(4) (2004); 26 C.F.R. § 54.9831-1(c)(4) (2008); 29 C.F.R. § 2590.732(c)(4) (2012).

In 2014, however, HHS promulgated a rule purporting to "amend the criteria for fixed indemnity insurance to be treated as an excepted benefit in the individual health insurance market." 79 Fed. Reg. 30,240, 30,253 (May 27, 2014). Under the 2014 rule, a fixed indemnity policy sold in the individual market would not be "considered an excepted benefit" unless—in addition to meeting the statutory criteria—the benefits were "provided only to individuals who have other health coverage that" satisfied the ACA's individual mandate. *Id.* at 30,253, 30,257; *see also NFIB v. Sebelius*, 567 U.S. 519, 538–39 (2012). The rule also required fixed indemnity insurers operating in the individual market to state on their plan materials that the plan was "a supplement to health insurance" and "not a substitute for major medical coverage." 79 Fed. Reg. at 30,253, 30,257. Even though the ACA did not prohibit individuals from buying a standalone fixed indemnity policy, the Departments believed their rule was necessary to "maximiz[e] the number of individuals who have comprehensive, major medical coverage." *Id.* at 30,256.

In response to the 2014 rule, plaintiff ManhattanLife's predecessor, Central United Life Insurance Company, challenged the minimum-essential-coverage requirement of the 2014 rule as beyond HHS's statutory authority. The D.C. Circuit agreed. It held that "[n]othing in the PHSA suggests Congress left any leeway for HHS to tack on additional criteria" for a fixed indemnity

policy to be exempt, and that HHS had no "authority to demand more of fixed indemnity providers than Congress required." *Cent. United*, 827 F.3d at 73–75.

B. The Notice Rule

1. The proposed rule

On July 12, 2023, the Departments proposed to again amend the criteria for fixed indemnity insurance to be exempt. *See* 88 Fed. Reg. 44,596. Specifically, the Departments: proposed to require that fixed indemnity benefits be paid on a strictly "per-period" basis, *id.* at 44,620–24; contemplated prohibiting fixed indemnity plans from paying benefits directly to providers, *id.* at 44,624–25; offered a new, expansive understanding of "coordination" of benefits, *id.* at 44,628–30; and—relevant here—proposed to modify the notice requirement established under the 2014 rule and make it applicable in the group market as well, *id.* at 44,625–28.

The Departments proposed two alternative versions of the revised notice. Both stated that fixed indemnity insurance is not "*comprehensive* health insurance." *Id.* at 44,626, 44,628 (emphasis added). That wording aligned with the statutory scheme, which is clear that "fixed indemnity insurance" is a type of "health insurance coverage" that is exempt from the requirements applicable to comprehensive health insurance. *See, e.g.*, 42 U.S.C. §§ 300gg-63(b), 300gg-91(b)(1), (c)(3)(B). It aligned with the Departments' regulations, which include "fixed indemnity" insurance among types of exempted "health insurance coverage." 45 C.F.R. §§ 146.145(b), 148.220(b). And it aligned with the Departments' goal of "distinguishing fixed indemnity excepted benefits coverage from comprehensive coverage." 88 Fed. Reg. at 44,626.

The proposed rule never suggested that the Departments were considering a notice that would deem fixed indemnity insurance not to be "health insurance" at all. Nor did the Departments seek comments on this particular aspect of the proposed notices. Rather, the Departments sought

comments on matters such as whether to specify that the notice was legally required or whether to include state-specific contact information. *See id.* at 44,627–28.

The Departments sought to justify these proposed changes, including the proposed notice, as necessary to "address reports of troubling marketing and sales tactics … that mislead consumers to believe that hospital indemnity or other fixed indemnity insurance constitutes comprehensive coverage." *Id.* at 44,619. Yet the Departments offered little more than a few anecdotes to support their claim of widespread consumer confusion. *See infra* § I.B.

ManhattanLife submitted comments on several aspects of the proposed rule, including the proposed notices. *See* Comment Letter from ManhattanLife to Departments (Sept. 11, 2023), tinyurl.com/bdze2vv8. Among other things, ManhattanLife argued that the Departments lacked statutory authority to require a notice of any kind and that the Departments had not adequately supported their claims of rampant customer confusion. *Id.* at 7, 10 (citing *Cent. United*, 827 F.3d at 73–75). Because they could not reasonably have anticipated that the Departments would impose such a requirement, ManhattanLife had no opportunity to comment on a notice that would deem fixed indemnity insurance not to be health insurance at all.

2. The final rule

The Departments issued their final rule on April 3, 2024. 89 Fed. Reg. 23,338. Although they declined (for now) to finalize any other provision of the proposed fixed indemnity rule, the Departments adopted a revised version of the proposed notices. *Id.* at 23,388–89. Unlike the proposed notices, which both stated only that fixed indemnity insurance is not "comprehensive health insurance," *id.* at 23,386, the finalized notice requires fixed indemnity insurers to state that "a fixed indemnity policy" is "NOT health insurance," *id.* at 23,389. It further requires fixed indemnity insurers to state that, "[s]ince this policy isn't health insurance, it doesn't have to include most Federal consumer protections that apply to health insurance." *Id.* In full, the notice states:

IMPORTANT: This is a fixed indemnity policy, NOT health insurance

This fixed indemnity policy may pay you a limited dollar amount if you're sick or hospitalized. You're still responsible for paying the cost of your care.

- The payment you get isn't based on the size of your medical bill.
- There might be a limit on how much this policy will pay each year.
- This policy isn't a substitute for comprehensive health insurance.
- Since this policy isn't health insurance, it doesn't have to include most Federal consumer protections that apply to health insurance.

Looking for comprehensive health insurance?

- **Visit HealthCare.gov** or call **1-800-318-2596** (TTY: 1-855-889-4325) to find health coverage options.
- To find out if you can get health insurance through your job, or a family member's job, contact the employer.

Questions about this policy?

- For questions or complaints about this policy, contact your State Department of Insurance. Find their number on the National Association of Insurance Commissioners' website (naic.org) under "Insurance Departments."
- If you have this policy through your job, or a family member's job, contact the employer.

The Departments offered no explanation for their sudden change. *See id.* at 23,387–88 (explaining other changes). Nor did they even acknowledge, let alone explain, why they departed from their longstanding view that fixed indemnity insurance *is* health insurance. Nor did they attempt to square their decision to deem fixed indemnity insurance "NOT health insurance" with the statute, their own regulations, industry understanding, or even common English.

Beginning January 1, 2025, a fixed indemnity policy that fails to provide this notice—including the statement that it is "NOT health insurance"—"would not qualify as fixed indemnity excepted benefits coverage and would be subject to the Federal consumer protections and requirements applicable to comprehensive coverage." *Id.* at 23,383. The Departments did not

acknowledge that for those requirements to apply at all, the policy must be "health insurance coverage" in the first place. *See, e.g.*, 42 U.S.C. § 300gg-6(a).

The Departments offered two sources of authority for the notice rule. First, they asserted that it was a permissible exercise of their "authority to interpret and implement the statutory provisions governing [excepted benefit] insurance products." 89 Fed. Reg. at 23,381 & n.237. They did not specify, however, what specific statutory text the notice rule could be understood to "interpret" or "implement." Second, the Departments asserted that the rule was permissible under their "authority to promulgate regulations as [they] determine may be necessary or appropriate to carry out the provisions" of the governing statutes. *Id.* at 23,381 & n.238. Again, the Departments did not point to any particular "provision" the notice rule was "carry[ing] out."

The Departments claimed that the notice rule was necessary to combat "prevalen[t] … deceptive marketing practices." *Id.* at 23,360. In support, however, they pointed primarily to evidence of deceptive marketing associated with a different type of health insurance, short-term limited-duration insurance. *See infra* § I.B. Commenters also urged that a federal notice was unnecessary because States, the traditional regulators of insurance, are fully capable of regulating deceptive marketing and addressing any consumer confusion. The Departments disagreed, asserting simply that they *could* regulate in this area and that States *might* not act. 89 Fed. Reg. at 23,382–83.

III. This Lawsuit

Shortly after the Departments issued the notice rule, ManhattanLife Insurance and Annuity Company and William C. Paschall filed this APA suit to challenge the rule's legality. ManhattanLife issues fixed indemnity policies in both the individual and group health insurance markets, and Mr. Paschall sells fixed indemnity policies, including those issued by ManhattanLife, to individuals in East Texas. If the notice rule takes effect, ManhattanLife will be compelled to either stop selling its fixed indemnity policies in their current form or alter its marketing, application, and

enrollment materials to include the new notice falsely stating that the policy is "NOT health insurance." If it takes the latter course, ManhattanLife will lose customers who are dissuaded by the notice. Mr. Paschall will also lose customers and will be forced to attempt to dispel the confusion created by the false notice, risking his reputation (and thus his business) in the process.

LEGAL STANDARDS

Summary judgment is proper "if the movant shows that there is no genuine dispute as to any material fact and the movant is entitled to judgment as a matter of law." Fed. R. Civ. P. 56(a). "In the context of a challenge under the APA, '[s]ummary judgment is the proper mechanism for deciding, as a matter of law, whether an agency action is supported by the administrative record and consistent with the APA standard of review.'" *Texas v. EPA*, 389 F. Supp. 3d 497, 503 (S.D. Tex. 2019). Under the APA, courts will "hold unlawful and set aside" agency action that is "in excess of statutory jurisdiction, authority, or limitations," 5 U.S.C. § 706(2)(C), "arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law," *id.* § 706(2)(A), or made "without observance of procedure required by law," *id.* § 706(2)(D). "Courts must exercise their independent judgment in deciding whether an agency has acted within its statutory authority … ." *Loper Bright Enters. v. Raimondo*, 144 S. Ct. 2244, 2273 (2024).

"An agency action qualifies as 'arbitrary' or 'capricious' if it is not 'reasonable and reasonably explained.'" *Ohio v. EPA*, 144 S. Ct. 2040, 2053 (2024). Arbitrary-and-capricious review "is not toothless." *Sw. Elec. Power Co. v. EPA*, 920 F.3d 999, 1013 (5th Cir. 2019). "In fact, … it has serious bite." *Wages & White Lion Invs., LLC v. FDA*, 16 F.4th 1130, 1136 (5th Cir. 2021). Agency action must be set aside if the agency "entirely failed to consider an important aspect of the problem, offered an explanation for its decision that runs counter to the evidence before the agency, or is so implausible that it could not be ascribed to a difference in view or the product of agency expertise." *Motor Vehicle Mfrs. Ass'n v. State Farm Mut. Auto. Ins. Co*., 463 U.S. 29, 43

(1983). Further, a court cannot uphold a rule based on grounds not given by the agency in the rule. *See SEC v. Chenery Corp.*, 318 U.S. 80, 87 (1943); *Dish Network Corp. v. NLRB*, 953 F.3d 370, 379–80 (5th Cir. 2020).

ARGUMENT

I. The Notice Rule Is Unlawful.

A. The rule exceeds the Departments' statutory authority.

Fixed indemnity insurance is exempt from the requirements for comprehensive health insurance when three conditions are met. 42 U.S.C. § 300gg-21(c)(2). The Departments' notice rule adds a fourth: fixed indemnity insurance is "subject to the" federal insurance requirements "unless the coverage includes the requisite notice." 89 Fed. Reg. at 23,382. Because the Departments have no authority to rewrite the statute, the notice rule is unlawful.

When "a statute's language carries a plain meaning, the duty of an administrative agency is" simple: "follow its commands as written" without "supplant[ing] those commands with others [the agency] may prefer." *SAS Inst., Inc. v. Iancu*, 584 U.S. 357, 363 (2018). The plain text of § 300gg-21 includes an "unmistakable comman[d]," *id.*: federal health insurance requirements "shall not apply" to fixed indemnity insurance "if all of" the three statutory "conditions are met." 42 U.S.C. § 300gg-21(c)(2). This text leaves no room for the Departments to add conditions.

Start with the first part of this provision: the requirements "shall not apply." The phrase "shall not" is used to "den[y] permission"—it is "prohibitory and *limits* what can properly be done." *Young Conservatives of Tex. Found. v. Smatresk*, 73 F.4th 304, 312–13 (5th Cir. 2023) ("[Y]ou shall not means you may not."). The statute's second part explains what the requirements cannot apply to: "any" fixed indemnity policies that satisfy the three conditions. 42 U.S.C. § 300gg-21(c)(2). "[T]he word 'any' naturally carries 'an expansive meaning," showing that the statute is "comprehensive," *SAS Inst.*, 584 U.S. at 362, and subject only to Congress's specific

"limiting" language on the "breadth of th[e] word," *United States v. Gonzales*, 520 U.S. 1, 5 (1997). By using "'any' to modify" the policies that are exempt, Congress has said that fixed indemnity policies "of whatever kind" are exempt subject only to the limit that they satisfy the three statutory conditions. *See Ali v. Fed. Bureau of Prisons*, 552 U.S. 214, 220 (2008). By providing that fixed indemnity policies are *not* exempt unless they satisfy a further, extrastatutory condition invented by the Departments, the notice rule attempts to "punch holes in the rules Congress has laid down." *Djie v. Garland*, 39 F.4th 280, 285 (5th Cir. 2022). This, the Departments cannot do. *See id.* ("When a regulation attempts to override statutory text, the regulation loses every time[.]").

Congress's level of detail further confirms that the statutory scheme is comprehensive and leaves no room for agency additions. *See, e.g.*, *Nat'l Pork Producers Council v. EPA*, 635 F.3d 738, 753 (5th Cir. 2011) (holding agency had no power to "supplemen[t]" a "comprehensive" statutory scheme). Congress began by parsing the kinds of excepted benefits, deciding that different benefits should be exempt from federal requirements under different conditions. *Compare* 42 U.S.C. § 300gg-21(b), *with id.* § 300gg-21(c)(1), *and id.* § 300gg-21(c)(2). It then enumerated three detailed conditions a fixed indemnity policy must meet to qualify for the exemption. *Id.* § 300gg-21(c)(2). Having "ma[de] an explicit provision for apples, oranges and bananas, it is most unlikely" Congress left room for agencies to add "grapefruit" too. *Am. Petrol. Inst. v. EPA*, 198 F.3d 275, 278 (D.C. Cir. 2000); *see also BP Am., Inc. v. FERC*, 52 F.4th 204, 214–16 (5th Cir. 2022) (Congress "carefully divided up regulatory power" by providing that certain statutory "provisions … shall not apply" to particular activities). Congress's "carefully drafted scheme" in § 300gg-21 "reflects a considered balancing of competing concerns"—one the agencies "must listen" to. *Hearth, Patio, & Barbecue Ass'n v. Dep't of Energy*, 706 F.3d 499, 504 (D.C. Cir. 2013).

The statute's plain text and its comprehensiveness compel the obvious conclusion the D.C. Circuit has already reached: because "Congress exempted *all* … conforming plans" from federal insurance regulations, the Departments cannot "exemp[t] *less than all*" with their "additional criterion." *Cent. United*, 827 F.3d at 73. The notice rule is another unlawful attempt to do just that, providing that even a "conforming" fixed indemnity policy is not exempt unless it provides the requisite notice. The Departments have no authority to "tack on additional criteria." *Id.* Their attempt to do so is nothing more than a "[d]isagree[ment] with Congress's expressly codified policy choices," which "isn't a luxury administrative agencies enjoy." *Texas v. EPA*, 829 F.3d 405, 411 (5th Cir. 2016) (quoting *Cent. United*, 827 F.3d at 73).

The Fifth Circuit soundly rejected a similar attempt by an administrative agency to "graft" a new requirement onto a statutory list of conditions in *Luminant Generation Co. v. EPA*, 675 F.3d 917, 930 (5th Cir. 2012). The Clean Air Act provides that EPA "shall approve a [state implementation plan] if it meets all of the applicable requirements of [the Act]." *Id.* at 921 (quoting 42 U.S.C. § 7410(k)(3)). *Luminant* considered whether EPA could, consistent with this mandate, deny a state implementation plan on grounds that "f[ound] no purchase in the text of any applicable provision of the Act." *Id.* at 929–30. It was "beyond cavil" that the answer was "no," because the Act's "statutory imperative" left EPA "no discretion to do anything other than ensure that a state's submission meets the [Act's] requirements and, if it does, approve it." *Id.* at 926.

So too here. Like the Clean Air Act, the ACA directs that a fixed indemnity policy "shall" be exempt if it meets "all of" the listed conditions. 42 U.S.C. § 300gg-21(c)(2). And the Departments, like EPA, have no authority to deny a policy exempted status "based on its purported nonconformity with [an] extra-statutory standar[d] that [the Departments] created out of whole cloth." *Luminant*, 675 F.3d at 932. *See also, e.g.*, *Tula-Rubio v. Lynch*, 787 F.3d 288, 292, 293–94 & n.5

(5th Cir. 2015) (finding "no basis" to include an "additional requirement"); *CFPB v. Consumer First Legal Grp.*, 6 F.4th 694, 704–05 (7th Cir. 2021) (holding CFPB lacked authority to "add extra conditions that an attorney must meet to qualify for [statutory] exemption"); *City of Portland v. United States*, 969 F.3d 1020, 1040–41 (9th Cir. 2020) (rejecting agency's attempt to "plac[e] a limitation" on Congress's exemption); *Merck & Co. v. Hi-Tech Pharmacal Co.*, 482 F.3d 1317, 1318–22 (Fed. Cir. 2007) (rejecting additional requirement where statute provided that patent term "shall" be extended when "enumerated conditions" were met).

The Departments cannot salvage the notice requirement as an interpretation or implementation of either the term "fixed indemnity" or one of the statutory conditions. For starters, the Departments did not purport to justify the rule in this way, and they are "not free to defend [their] decision by supplying new, *post hoc* rationalizations for it when sued." *Wages & White Lion Invs., LLC v. FDA*, 90 F.4th 357, 371 (5th Cir. 2024) (en banc), *cert. granted*, No. 23-1038, 2024 WL 3259693 (U.S. July 2, 2024). Although the Departments cursorily asserted authority to "interpret and implement the requirements for … fixed indemnity insurance to qualify as excepted benefits coverage," they never identified the statutory term they were purportedly interpreting. 89 Fed. Reg. at 23,381. Indeed, the Departments *separated* their interpretive authority from that used for the notice requirement. *See id.* at 23,382 (asserting that 42 U.S.C. § 300gg-92 provides "authority for the Departments to interpret and implement the requirements for … fixed indemnity insurance to qualify as excepted benefits coverage under the Federal law, *and also* provides the authority to adopt a consumer notice" (emphasis added)). And the Departments have been clear in this rulemaking when they purport to "interpret" a statutory term. *See* 88 Fed. Reg. at 44,621 ("HHS proposes to *reinterpret* what it means for … fixed indemnity insurance to provide 'fixed' benefits … ." (emphasis added)). Here, the Departments said that requiring the notice was "necessary

and appropriate"—not that the notice reflected an interpretation of either the term "fixed indemnity" or any of the statutory conditions for exemption. *Id.*

Nor could the Departments plausibly claim that the notice rule merely interprets the statute. The term "fixed indemnity" cannot be "interpreted" to impose a notice requirement. Nor can any of the three statutory conditions. A consumer notice has nothing to do with the statutory separateness, non-coordination, or independence requirements. *See* 42 U.S.C. § 300gg-21(c)(2). If that weren't clear enough, Congress has "clearly specified" notice requirements "when it so intended." *Tula-Rubio*, 787 F.3d at 294. *See* 42 U.S.C. §§ 300gg-21(a)(2)(C), 300gg-133. Any attempt to impose a notice by "interpretation" would not be "a construction of [the] statute, but, in effect, an enlargement of it." *Lamie v. U.S. Trustee*, 540 U.S. 526, 539 (2004); *see also Tex. Med. Ass'n v. HHS*, 587 F. Supp. 3d 528, 542 (E.D. Tex. 2022) ("The Rule thus impermissibly 'rewrite[s] statutory language by ascribing additional, material terms.'" (quoting *Texaco Inc. v. Duhe*, 274 F.3d 911, 920 (5th Cir. 2001))). As *Central United* recognized, the Departments' efforts to add new exemption conditions are "act[s] of amendment, not interpretation." 827 F.3d at 74.

The rule also cannot be justified as an implementing regulation untethered to the statutory exemption. The Departments did not write the notice requirement as a freestanding regulation of fixed indemnity insurance, but as a condition of exemption. 45 C.F.R. § 148.220(b)(4)(iii)(A) (providing that fixed indemnity insurance is exempt "only if," in addition to meeting the statutory criteria, the notice is provided). And the Departments specifically *disclaimed* imposing a freestanding notice requirement, stating that "the rules do not require the provision of a notice, but instead simply provide that insurance offered without such a notice would not qualify as fixed indemnity excepted benefits coverage and would be subject to the Federal consumer protections and requirements applicable to comprehensive coverage." 89 Fed. Reg. at 23,382. So any effort to

justify the rule as something other than an additional condition of exemption would be "barred by the venerable prohibition on *post hoc* justifications." *Wages & White Lion Invs.*, 90 F.4th at 373.

In any event, the Departments have identified no authority to regulate fixed indemnity insurance when the statutory exemption applies. The whole point of the exemption is to *deny* the Departments regulatory authority over excepted benefits that meet the statutory conditions, thereby leaving regulation of those insurance products to the States. *See* 15 U.S.C. § 1012. The Departments cannot override Congress's decision to "declin[e] to provide for … federal regulation" of fixed indemnity insurance when the statutory conditions are satisfied. *BP Am., Inc.*, 52 F.4th at 214; *see also Gulf Fishermens Ass'n v. Nat'l Marine Fisheries Serv.*, 968 F.3d 454, 461 (5th Cir. 2020) (statute's failure to "expressly negate the existence of a claimed administrative power" does not suggest agency may exercise such power). The Departments invoked § 300gg-92, which authorizes them to promulgate regulations "as may be necessary and appropriate to carry out the provisions of this subchapter." But a "general grant of authority cannot displace the clear, specific text of a statute." *Allegheny Def. Project v. FERC*, 964 F.3d 1, 16 (D.C. Cir. 2020). And the authority to "carry out" a statute still requires a statutory "task to be done." *Kentucky v. Biden*, 57 F.4th 545, 552 (6th Cir. 2023). The Departments never identified which "provisions" the notice requirement could be "carry[ing] out." So even if § 300gg-92 is a "broad grant of general rulemaking authority," it "does not allow [the Departments] to make amendments to statutory provisions," *Contender Farms, LLP v. Dep't of Agric.*, 779 F.3d 258, 273 (5th Cir. 2015), or to "carry out" policy goals unmoored from statutory text, *Kentucky*, 57 F.4th at 552.

No matter how much the Departments disagree with Congress's decisions about fixed indemnity insurance, they may not "tack on additional criteria" for such policies to be exempt. *Cent. United*, 827 F.3d at 73. Because that is what the Departments have done, the notice rule is plainly

"in excess of statutory jurisdiction, authority, or limitations." 5 U.S.C. § 706(2)(C). For that reason alone, the rule is unlawful and should be vacated, and this Court's analysis need proceed no further.

B. The rule is arbitrary and capricious.

The Departments premised the notice requirement on the need to address alleged consumer confusion, particularly confusion resulting from "deceptive or aggressive marketing of … fixed indemnity" coverage. 89 Fed. Reg. at 23,349. But the record does not support the Departments' claims of widespread consumer deception or confusion. And even if it did, the Departments gave no cogent explanation as to why the States cannot adequately address the Departments' concerns. For each reason, the notice rule is arbitrary and capricious. *See* 5 U.S.C. § 706(2)(A).

An agency must offer "a satisfactory explanation for its action[,] including a rational connection between the facts found and the choice made." *State Farm*, 463 U.S. at 43. This means the agency must offer evidence supporting the existence of the problem it seeks to address; a regulation is arbitrary and capricious if it "was intended to defeat a bogeyman whose existence was never verified." *Sorensen Commc'ns Inc. v. FCC*, 755 F.3d 702, 709–10 (D.C. Cir. 2014); *see also Nat'l Fuel Gas Supply Corp. v. FERC*, 468 F.3d 831, 843–44 (D.C. Cir. 2006) (Kavanaugh, J.) ("Professing that an order ameliorates a real industry problem but then citing no evidence demonstrating that there is in fact an industry problem is not reasoned decisionmaking.").

The Departments failed to meet these obligations in large part because they focused on short-term, limited-duration insurance ("STLDI") rather than fixed indemnity insurance. In the proposal, the Departments asserted that "recent reports of consumer confusion regarding STLDI and fixed indemnity … support the need" for a notice requirement. 88 Fed. Reg. 44,638–69. In support, the Departments cited seven sources "related to [STLDI]" and only one "related to fixed indemnity" insurance. *Id.* at 44,638 n.229. That lone source, moreover, concedes there is "a far less comprehensive and data-informed view of the fixed indemnity market." Brookings, *supra*.

And when discussing the "need for regulatory action at the Federal level," the Departments identified concerns with "marketing of and enrollment in STLDI." 88 Fed. Reg. at 44,649.

The final rule offers little more to support the Departments' claims of widespread consumer confusion and deception. The Departments relied primarily on the Brookings Report, which is openly hostile to fixed indemnity insurance—disparaging it as "junk insurance." But that report cannot bear the weight the Departments place on it. The authors concede they lack evidence about the extent of the problems they claim to identify; they "are not aware of systematic data on fixed indemnity coverage." Brookings, *supra*. Instead, the report examines the "most extreme example" of a "fixed indemnity produc[t]" that "var[ies] payment amounts with the intensity of the medical care received." *Id.* But as ManhattanLife explained, an "insurance plan … that cannot vary its benefits in any way based on the severity or expected cost of a beneficiary's covered medical event is one that no insurer can sell and no customer would buy." Comment Letter, *supra*, at 3. Neither the Brookings Report nor the Departments explain how such variance deceives consumers so long as the policy accurately reports what the varying benefits are. In short, the Departments' key source for consumer deception not only concedes the absence of systematic evidence, but at best offers isolated anecdotes that provide no support for claims of widespread consumer confusion.

Similarly, the "covert studies" cited by the Departments are anecdotal and provide no basis for sweeping generalizations. For example, the Departments cited a 2020 GAO study in which "undercover agents conducted 31 tests on health insurance sales representatives." GAO, *Private Health Coverage: Results of Covert Testing for Selected Offerings* (Aug. 24, 2020), tinyurl.com/4hfx3rzb (cited by 89 Fed. Reg. at 23,350 n.106). According to the study, 21 representatives "referred our agents to an appropriate plan," 2 were unclear but not deceptive, and 8 "en-

gaged in potentially deceptive practices." *Id.* Understandably, the GAO discouraged drawing conclusions from this small sample size, explaining that the results were "illustrative only of the sales and related behaviors we experienced during the calls and are *not generalizable to … the PPACA-exempt health insurance industry at large*." *Id.* at 2 (emphasis added). The Departments' other sources suffer from the same limitations. *See* Rachel Schwab & JoAnn Volk, *The Perfect Storm: Misleading Marketing of Limited Benefit Products Continues as Millions Losing Medicaid Search for New Coverage* 4 (Aug. 2023), tinyurl.com/496f4jc9 (cited by 89 Fed. Reg. at 23,356 n.141) (researchers identified only "two products as fixed indemnity plans"); Dania Palanker & JoAnn Volk, *Misleading Marketing of Non-ACA Health Plans Continued During COVID-19 Special Enrollment Period* 2 (Oct. 2021), tinyurl.com/mr299hm5 (cited by 89 Fed. Reg. at 23,396 n.296) ("[R]esearchers were able to identify … four plans as fixed indemnity insurance … .").

In short, the Departments premised the rule on the assertion that their new notice was necessary to combat widespread deceptive marketing and consumer confusion, but they failed to substantiate that assertion. That "is not reasoned decisionmaking." *Nat'l Fuel*, 468 F.3d at 843–44.

Compounding the error, the Departments also "fail[ed] to analyze" the ability of "the existing state law regime" to address any consumer confusion and deception. *Am. Equity Invs. Life Ins. Co. v. SEC*, 613 F.3d 166, 179 (D.C. Cir. 2010). As HHS has recognized, "[t]he business of insurance, including health insurance, has traditionally been regulated at the state level." HHS Off. of Health Pol'y, *The Regulation of the Individual Health Insurance Market* 3 (2008), tinyurl.com/ttzvrcxn. And "[e]very state has adopted certain basic standards for health insurance" that "protect consumers" by imposing certain "[m]arket conduct requirements relat[ing] to … advertising" and "marketing." *Id.* at 4. These requirements, HHS has explained, "allow states to address unfair trade and claims practices" and "to make sure insurers are … describing products

accurately" and "avoiding deceptive advertising." *Id.*; *see also, e.g.*, Dee Pridgen, *The Dynamic Duo of Consumer Protection: State and Private Enforcement of Unfair and Deceptive Trade Practices Laws*, 81 Antitrust L.J. 911, 911 (2018) ("State consumer protection statutes, otherwise known as Unfair and Deceptive Acts or Practices (UDAP) laws, have been on the books of all states for some 40-plus years."). Given this backdrop of state regulation, commenters told the Departments that any consumer confusion and deception could and should be handled by the States. *See* 89 Fed. Reg. at 23,380–82; Comment Letter from Am. Council of Life Insurers to Departments at 8–9, 17–19 (Sept. 11, 2023), tinyurl.com/6w6v8khw.

The Departments' response reflects their "failure to analyze" the adequacy of state regulation. *Am. Equity*, 613 F.3d at 179. The Departments responded only by pointing to their alleged regulatory authority and asserting that States might not adopt "model acts and regulations related to marketing and sales practices." 89 Fed. Reg. at 23,382–83. As to the former, the Departments' (incorrect) claim that they have authority to impose a federal notice requirement is not a rational response to the argument that federal regulation is unnecessary because the States have ample tools at their disposal to police deceptive marketing. *See Ohio*, 144 S. Ct. at 2055 ("EPA's response did not address [commenters'] concern so much as sidestep it"). As to the latter, the Departments' response does not address the adequacy of *existing* state regulatory authority; nor does it explain why a federal notice is required in those states that do adopt model rules that the Departments acknowledged "might address some of [their] concerns." 89 Fed. Reg. at 23,383.

Rather than fulfill their "responsibility to address reasonable alternatives," *Del. Dep't of Nat. Res. & Env't Control v. EPA*, 785 F.3d 1, 18 (D.C. Cir. 2015), the Departments "simply dismissed the alternative proposal"—namely, state regulation—"in conclusory terms," *Canadian Ass'n of Petrol. Producers v. FERC*, 254 F.3d 289, 299 (D.C. Cir. 2001). And the Departments'

"vague desire for uniformity" does not "address why a more limited rule would not" suffice. *Del. Dep't of Nat. Res. & Env't Control*, 785 F.3d at 17; *see also Spirit Airlines, Inc. v. Dep't of Transp.*, 997 F.3d 1247, 1255 (D.C. Cir. 2021) (holding FAA order arbitrary and capricious because the agency did not "grappl[e] with an important aspect of the problem before it or conside[r] another reasonable path forward" that had been proposed).

Given these shortcomings in the record, one wonders why the Departments forged ahead. Perhaps it's because they disagree with Congress's decision to allow consumers to choose fixed indemnity insurance "as an alternative to comprehensive coverage," 89 Fed. Reg. at 23,349, just as they did a decade ago, *see Cent. United*, 827 F.3d at 72. But simply disagreeing with Congress's policy choice is not reasoned agency decisionmaking.

II. At A Minimum, The Portion Of The Notice Falsely Stating That A Fixed Indemnity Policy Is "NOT Health Insurance" Is Unlawful.

A. The rule is not in accordance with law.

The APA requires courts to "hold unlawful and set aside agency action" that is "not in accordance with law." 5 U.S.C. § 706(2)(A). The portion of the Departments' new notice requiring insurers to falsely state that fixed indemnity insurance is "NOT health insurance" is "not in accordance with" HIPAA, the ACA, or the IRC because all of those statutes treat fixed indemnity insurance as health insurance. Accordingly, even if the notice rule were not unlawful in its entirety—which it is, *see supra* § I—this portion of the notice must be held unlawful and set aside.

As an initial matter, there can be no debate that fixed indemnity insurance is, as a statutory matter, "insurance." HIPAA called it that, including "[h]ospital indemnity or other fixed indemnity *insurance*" among the list of excepted benefits. 42 U.S.C. § 300gg-91(c)(3)(B) (emphasis added). The ACA did not change that designation. Accordingly, the only question is whether the governing statutes treat fixed indemnity insurance as "health" insurance. Across the board, they do.

Start again with HIPAA. It defines "health insurance coverage" as "benefits consisting of medical care (provided directly, through insurance or reimbursement, or otherwise and including items and services paid for as medical care) under any hospital or medical service policy or certificate … ." 42 U.S.C. § 300gg-91(b)(1); *see also id.* § 300gg-91(a)(2) (defining "medical care"). Fixed indemnity insurance easily satisfies this definition: it provides "medical care … through insurance or reimbursement" by offering cash benefits to policyholders upon the occurrence of a specified medical event. In short, fixed indemnity insurance is, by definition, "health insurance coverage" under HIPAA. Until recently, the Departments agreed. *See, e.g.*, 62 Fed. Reg. at 16,903 (initial interim HIPAA regulations) (fixed indemnity insurance is "generally health insurance coverage but [is] excepted if certain conditions are met").

HIPAA's exemption for fixed indemnity insurance confirms this understanding. HIPAA imposes numerous requirements on "health insurance coverage," *see, e.g.*, 42 U.S.C. §§ 300gg-41(a)(1), 300gg-42(a), but provides that those requirements "shall not apply to any health insurance coverage in relation to its provision of excepted benefits," including fixed indemnity insurance, if those benefits are provided under a separate policy, *id.* § 300gg-63(b). By its text, § 300gg-63(b) contemplates that fixed indemnity benefits are "provi[ded]" as part of "health insurance coverage." That makes good sense. After all, there would be little reason to exempt fixed indemnity insurance from the rules governing "health insurance coverage" if it was "NOT health insurance" in the first place. *See Merit Mgmt. Grp. v. FTI Consulting, Inc.*, 583 U.S. 366, 380–81 (2018) (statutory exception exempted item that would "otherwise" fall within enumerated class).

The ACA did nothing to change these provisions. *Compare, e.g.*, 42 U.S.C. § 300gg-91(b)(1) (2000), *with* 42 U.S.C. § 300gg-91(b)(1) (2012). Rather, the ACA doubled down, using the same structure to exempt fixed indemnity insurance from its new requirements for "health

insurance coverage." *See* 42 U.S.C. § 300gg-21(c)(2) (requirements "shall not apply to any individual coverage or any … group health insurance coverage … in relation to its provision of excepted benefits"). Nor is that exemption the ACA's lone word on the matter. Its centerpiece, the individual mandate, similarly contemplates that "health insurance coverage" may "consis[t] of" excepted benefits like fixed indemnity insurance. *See* 26 U.S.C. § 5000A(f)(3)(B).

The tax code similarly treats fixed indemnity insurance as health insurance. Under 26 U.S.C. § 104(a)(3), with certain exceptions, an individual's gross income does not include "amounts received through … health insurance." And while the tax code does not define "health insurance," the IRS has said that fixed indemnity insurance fits the bill: because "[a] fixed indemnity health plan … pays covered individuals a specified amount of cash for the occurrence of certain health-related events," those payments "are excluded under § 104(a)(3)." IRS Gen. Couns. Mem. 201703013 at 5 (Dec. 12, 2016); *see also* 88 Fed. Reg. at 44,604 ("Hospital indemnity or other fixed indemnity insurance and coverage only for a specified disease or illness are treated as 'accident or health insurance' under sections 104, 105, and 106 of the [tax code] … .").

Congress has thus consistently treated fixed indemnity insurance as "health insurance." The Departments apparently disagree with that decision. But just as they "ha[ve] no power to 'tailor' legislation to bureaucratic policy goals by rewriting unambiguous statutory terms," *Util. Air Regul. Grp. v. EPA*, 573 U.S. 302, 325 (2014), they cannot compel insurers to tell consumers that fixed indemnity insurance is "NOT health insurance" when the relevant statutes say otherwise.

B. The rule is arbitrary and capricious.

Even if this portion of the notice were not inconsistent with the statutes, it would still be unlawful because it is arbitrary and capricious. That is so for at least four reasons.

First, requiring insurers to state that fixed indemnity insurance is "NOT health insurance" conflicts with the notice rule itself. The introductory clause to 45 C.F.R. § 148.220(b) provides

that "[t]he requirements of this part do not apply to individual health insurance coverage described in paragraphs (b)(1) through (b)(6)." Paragraph (b)(4) includes fixed indemnity insurance "only if" it satisfies specified conditions, including providing the required notice. 45 C.F.R. § 148.220(b)(4). The notice rule thus "describe[s]" a fixed indemnity policy that satisfies the other conditions as "health insurance" "only if" it states on its face that it is "NOT health insurance." *Id.* That kind of "illogic and internal inconsistency [is] characteristic of arbitrary and unreasonable agency action." *Chamber of Com. of U.S. v. Dep't of Lab.*, 885 F.3d 360, 382 (5th Cir. 2018).

Nor is this the only place the Departments have contradicted themselves. The preamble to the proposed rule repeatedly spoke of fixed indemnity insurance as a type of health insurance. *See* 88 Fed. Reg. at 44,620 (asserting that "individuals who rely on [fixed indemnity insurance] as their primary form of health insurance are at risk of financial harm"); *id.* at 44,644 (predicting that restricting fixed indemnity insurance would "increase …the number of individuals without some form of health insurance coverage"). The final rule did the same. *See* 89 Fed. Reg. at 23,396 (noting broker commissions "vary significantly between health insurance coverage options, though … fixed indemnity insurance tend[s] to pay higher commissions" (emphasis added)). But the Departments "cannot have it both ways." *Chamber of Com. of U.S. v. SEC*, 85 F.4th 760, 778 (5th Cir. 2023). "It is illogical"—and hence arbitrary and capricious—"for the rule simultaneously to accept and reject" the premise that fixed indemnity insurance is health insurance. *Id.*

Second, in taking the position that fixed indemnity insurance is "NOT health insurance," the Departments have impermissibly "depart[ed] from a prior policy *sub silentio*." *FCC v. Fox Television Stations, Inc.*, 556 U.S. 502, 515 (2009). In the quarter-century leading up to this rule, the Departments consistently viewed fixed indemnity insurance as health insurance. *See* 62 Fed. Reg. at 16,903 (distinguishing "[t]he benefits identified in paragraph (b)(2) [of 45 C.F.R.

§ 146.145]," which "are generally not health insurance coverage" from "the benefits identified in paragraphs (b)(3), (4), and (5)," which include fixed indemnity insurance, and which "are generally health insurance coverage but are excepted if certain conditions are met"); 79 Fed. Reg. at 30,242 (requiring that fixed indemnity insurance "be sold only to individuals who have *other* health coverage" (emphasis added)); 79 Fed. Reg. 59,130, 59130 (Oct. 1, 2014) ("[T]he benefits in the … third … categor[y]," which includes fixed indemnity insurance, are a "typ[e] of health coverage … ."); 80 Fed. Reg. 13,995, 13,995–96 (Mar. 18, 2015) (same); 81 Fed. Reg. 75,316, 75,319 (Oct. 31, 2016) (similar). But in the final rule here, the Departments departed from that longstanding view and decided that fixed indemnity insurance is "NOT health insurance." That kind of unexplained "'about-face' maneuve[r]" is textbook arbitrary-and-capricious agency action. *R.J. Reynolds Vapor Co. v. FDA*, 65 F.4th 182, 191 (5th Cir. 2023). An agency that changes its position "must at least 'display awareness'" that it is doing so. *Encino Motorcars, LLC v. Navarro*, 579 U.S. 211, 221 (2016). Here, the Departments have failed to do even that, offering not a word of recognition or explanation for their sudden reversal. Having "shift[ed] [their] understanding" of whether fixed indemnity insurance is health insurance without any acknowledgement of the change, the Departments "cannot … escape vacatur." *Wages & White Lion Invs.*, 90 F.4th at 381.

Third, the Departments' decision to deem fixed indemnity insurance "NOT health insurance" "runs counter to the evidence before" the Departments. *State Farm*, 463 U.S. at 43. In explaining how fixed indemnity insurance works, the Departments cited a brochure drafted by America's Health Insurance Plans (AHIP) that described fixed indemnity insurance as a type of "[s]upplemental health insurance." AHIP, *Supplemental Health Insurance* at 1 (Apr. 2019), tinyurl.com/mvnfkdrh (cited by 89 Fed. Reg. at 23,343 n.43). A neighboring source similarly describes fixed indemnity insurance as a type of "health and health-like benefi[t]." Timothy Jost,

ACA Round-Up: Market Stabilization, Fixed-Indemnity Plans, Cost-Sharing Reductions, And Penalty Updates (Feb. 8, 2017), tinyurl.com/pmdsrs7u (cited by 89 Fed. Reg. at 23,343 n.42). And even the Departments' oft-cited article on alleged deceptive marketing deems fixed indemnity insurance to be a type of "health coverage" or "health insurance." *See* Brookings, *supra*.

That understanding aligns with common sense. "Health insurance" is "[i]nsurance that protects the insured against medical expenses resulting from sickness or accidental bodily injury." Black's Law Dictionary (12th ed. 2024). That is exactly what fixed indemnity insurance does. *See, e.g.*, Comment Letter from Nat'l Ass'n of Ins. Comm'rs to Departments at 4 (Sept. 11, 2023), tinyurl.com/tcujmrjj (rejecting the "false assertion that fixed indemnity benefits do not provide reimbursement for medical expenses"). To be sure, these sources correctly distinguish fixed indemnity insurance from "comprehensive" health insurance. *See, e.g.*, AHIP, *supra*, at 2. But to go further and deem fixed indemnity insurance "NOT health insurance" at all not only contradicts the record—it's simply false. It is patently arbitrary and capricious to require fixed indemnity insurers, in the name of combatting consumer confusion, to make false statements about their products.

Fourth, the Departments' decision is not "reasonably explained." *Ohio*, 144 S. Ct. at 2054. An agency must always "articulate a satisfactory explanation for its action." *Fox Television*, 556 U.S. at 513. But here, "[n]ot one sentence of [the Departments'] rulemaking discusses" why, contrary to the proposed notice, they decided to label fixed indemnity insurance "NOT health insurance." *State Farm*, 463 U.S. at 48. Accordingly, this part of the notice is arbitrary and capricious "for the obvious reason" that the agency gave "no explanation whatsoever" for its decision. *Clarke v. CFTC*, 74 F.4th 627, 641 (5th Cir. 2023).

C. The rule was issued without notice and opportunity for comment.

The portion of the notice requiring insurers to state that fixed indemnity insurance is "NOT health insurance" is also unlawful because it was issued without notice and opportunity for comment. "The APA requires agencies to publish a notice of proposed rulemaking that includes 'either the terms or substance of the proposed rule or a description of the subjects and issues involved.'" *Tex. Ass'n of Mfrs. v. Consumer Prod. Safety Comm'n*, 989 F.3d 368, 381 (5th Cir. 2021) (quoting 5 U.S.C. § 553(b)). If the final rule the agency adopts is not a "logical outgrowth of the rule proposed," then a court "must set aside the agency action" as taken "'without observance of procedure required by law.'" *Mock v. Garland*, 75 F.4th 563, 583 (5th Cir. 2023) (quoting 5 U.S.C. § 706(2)(D)). A rule is not a "logical outgrowth" unless "interested parties 'should have anticipated' that the change was possible" based on the content of the proposed rule. *Tex. Ass'n of Mfrs.*, 989 F.3d at 381. Merely giving a "generic sense" of the "broad subjects and issues" the final rule may address "is insufficient." *Mock*, 75 F.4th at 584. Rather, the proposed rule must "describe the range of alternatives being considered with reasonable specificity." *Id.*

The final rule's requirement to state that fixed indemnity insurance is "NOT health insurance" is not a logical outgrowth of the proposed rule. The Departments proposed two options for the fixed indemnity notice. *See* 88 Fed. Reg. at 44,626–28. Those options varied in many ways, but on one thing they were aligned—both treated fixed indemnity insurance as "health insurance," just not "comprehensive" health insurance. *See* 88 Fed. Reg. at 44,626 ("This is fixed indemnity insurance. This isn't comprehensive health insurance … ."); *id.* at 44,628 ("This is not comprehensive health insurance. This is fixed indemnity insurance."). Nowhere did the Departments give notice that they were considering scrapping that common ground.

To the contrary, everything about the proposed rule indicated that the "health insurance" label was not up for debate. Consider, for example, the Departments' stated goal: to "distinguis[h]

fixed indemnity excepted benefits coverage *from comprehensive coverage*." 88 Fed. Reg. at 44,626 (emphasis added). Or consider the fact that the Departments solicited comments on a slew of different aspects of the proposed notices—everything from the notices' "formatting" and "placement" to the "benefits or burdens" of requiring State-specific information, *see id.* at 44,627–28—yet they didn't ask for any input about whether fixed indemnity insurance should be considered health insurance. *See Env't Integrity Project v. EPA*, 425 F.3d 992, 998 (D.C. Cir. 2005) ("If the APA's notice requirements mean anything, they require that a reasonable commenter must be able to trust an agency's representations about *which particular* aspects of its proposal are open for consideration."); *Mock*, 75 F.4th at 584 (agency's request for comments on criteria used in proposed worksheet undercut claim that it was considering "getting rid of the [w]orksheet" entirely). Indeed, the proposal repeatedly treated fixed indemnity insurance as health insurance. *See supra* at 15. The Departments' "decision to repudiate" that understanding and "adopt its inverse" lies well beyond the bounds of logical outgrowth. *Env't Integrity Project*, 425 F.3d at 998.

This violation was not harmless. Bypassing notice and comment can be deemed harmless only when "it is clear that the lack of notice and comment did not prejudice the petitioner." *United States v. Johnson*, 632 F.3d 912, 931 (5th Cir. 2011); *see also Tex. Med. Ass'n*, 587 F. Supp. 3d at 546–47 ("Courts should rarely find harmless error for failure to provide notice and comment because the vast majority of agency rulemaking, which produces nuanced and detailed regulations, greatly benefits from expert and regulated entity participation." (cleaned up)). Prejudice is "easily proven" when a lack of notice prevents the plaintiff from "comment[ing] on the specifics of the Final Rule." *Mock*, 75 F.4th at 586.

That's precisely what happened here. Plaintiffs took a serious interest in the proposed rule, submitting a 23-page letter commenting on nearly every aspect of the proposal. Had the Departments properly noticed that they were considering deeming fixed indemnity insurance to be "NOT health insurance" at all, plaintiffs could have explained why that understanding conflicts with the governing statutes, the Departments' own regulations, and common industry usage—just as they have in this case. But "given how vastly different the Proposed and Final Rule turned out," plaintiffs were robbed of that chance. *Mock*, 75 F.4th at 586. "That is sufficient prejudice." *Id.*

III. The Rule Should Be Vacated.

The Court should vacate the notice rule. "The default rule is that vacatur is the appropriate remedy" for unlawful agency action. *Data Mktg. P'ship, LP v. Dep't of Lab.*, 45 F.4th 846, 859 (5th Cir. 2022); *accord Cargill v. Garland*, 57 F.4th 447, 472 (5th Cir. 2023) (en banc), *aff'd*, 144 S. Ct. 1613 (2024). Because the Departments will not be able to fix the notice rule's "serious procedural and substantive deficiencies" on remand, and vacatur will cause no disruption given that the rule has not yet taken effect, this is not one of the "rare cases" justifying a departure from that default rule. *Chamber of Com. of the U.S. v. SEC*, 88 F.4th 1115, 1118 (5th Cir. 2023).

CONCLUSION

The Court should grant plaintiffs' motion for summary judgment, declare the notice rule unlawful, and vacate the challenged provisions as set forth in the accompanying proposed order.

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Respectfully submitted,

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CERTIFICATE OF SERVICE

The undersigned hereby certifies that a true and correct copy of the foregoing document has been served on all counsel of record in accordance with the Federal Rules of Civil Procedure and this Court's CM/ECF filing system on July 19, 2024.

/s/ *Eric D. McArthur*
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