No. 26-1938

IN THE UNITED STATES COURT OF APPEALS
FOR THE FOURTH CIRCUIT

CITY OF COLUMBUS, *et al.*,
Plaintiffs-Appellees,

v.

ROBERT F. KENNEDY, JR., *in his official capacity as Secretary of the United States Department of Health and Human Services*, *et al.*,
Defendants-Appellants.

On Appeal from the United States District Court
for the District of Maryland

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INTRODUCTION AND SUMMARY OF ARGUMENT

A basic misconception mars plaintiffs' framing of this appeal. They offer a Manichean view of health insurance in which anything that increases enrollment and makes plans more generous is good and anything that may have opposite effects is bad. But all policies have tradeoffs; there are no unalloyed goods. Raising the lower bound on the range of actuarial values produces more generous plans, but it also makes plans more expensive for unsubsidized consumers. Weakening measures to prevent ineligible consumers from claiming subsidies swells the enrollment rolls, but it also siphons off funds Congress never authorized for those purposes. Lengthening the open-enrollment period into the new year allows marginally more consumers to enroll in plans, but it also increases the burdens on plan issuers because it allows more time for consumers to delay purchasing insurance until they become sick.

The Department of Health and Human Services (HHS) approached these policy tradeoffs in good faith. It examined its options, considered comments from plan issuers and consumers and providers alike, made predictive judgments about the likely outcomes of various alternatives, and then exercised the policy judgment Congress delegated to it. HHS explained

each of its decisions in a 151-page rule. 90 Fed. Reg. 27,074 (June 25, 2025) (Final Rule). In invalidating the agency's policy choices on numerous issues, the district court far exceeded the limited role prescribed for courts under the Administrative Procedure Act (APA): to determine whether an agency's actions are arbitrary or capricious. As another district court recently emphasized in largely rejecting parallel challenges to the same Final Rule, "[a] court must not substitute its judgment for that of the agency, even if it disagrees with its conclusions." *California v. Kennedy*, No. 25-cv-12019, 2026 WL 2364297, at *3 (D. Mass. Aug. 14, 2026) (cleaned up).

Plaintiffs do not even have standing to challenge HHS's choices. They are not directly regulated by any of the provisions of the Final Rule; they allege no direct harm from the Final Rule; they do not even assert that any insurance plans their members purchase will be unavailable under the Final Rule. Instead, plaintiffs point to a chain of events that they insist will result in downstream harms to them. At bottom, they say that the Final Rule will inevitably result in more uncompensated rides in Columbus ambulances. But the Supreme Court and this Court both have rejected such attenuated harms as a basis for standing—and for good reason. Under plaintiffs' theories, they

would be able to challenge any regulation so long as they could predict some increase in the costs of providing social services. Article III demands more.

Standing is crucial here because it will determine who gets to set policy for the Exchanges: HHS or the district court. Plaintiffs' arguments that HHS acted unlawfully stem from their disagreements with the policy choices the agency made. But courts are not free to substitute their policy preferences for an agency's. Nor may courts micromanage decisions taken well within the bounds of an agency's policy discretion. And such extraordinary judicial intervention is particularly inappropriate when plaintiffs allege only attenuated harms. The district court erred in accepting plaintiffs' invitation to violate this trio of limits on the scope of judicial review. Its judgment should be reversed in full.

ARGUMENT

I. Plaintiffs' boundless theory of standing is not tenable

Plaintiffs fail to establish standing to challenge the Final Rule. Their arguments to the contrary lack any meaningful limiting principle. Under their view, every municipality, insurance consumer, and doctor may seek universal vacatur of virtually any Exchange regulation. Those arguments flout basic limitations on the jurisdiction of federal courts.

1. The municipal plaintiffs argue (Br. 28-32) that they have standing because their healthcare facilities and ambulance services will encounter more uninsured patients as a result of the Final Rule. Those alleged injuries are far too attenuated to support standing.

Plaintiffs focus (Br. 25-28, 30-31) on whether their injuries are predictable. But they wholly fail to address a separate problem with their theory of standing: attenuation. Article III precludes reliance not just on "speculative links" but also on "attenuated" ones. *FDA v. Alliance for Hippocratic Med.*, 602 U.S. 367, 383 (2024). Thus, "where the government action is [too] far removed from its distant (even if predictable) ripple effects … plaintiffs cannot establish Article III standing." *Id.*

United States v. Texas, 599 U.S. 670 (2023), is on point. There, States argued that the federal government's immigration-enforcement decisions would shift costs onto the States by forcing them to "supply social services such as healthcare and education" to additional persons. *Id.* at 674. In rejecting the holding of the district court that it had standing to adjudicate the dispute, the Supreme Court observed that "federal courts must remain mindful of bedrock Article III constraints in cases brought by States against an executive agency or officer." *Id.* at 680 n.3. The Court emphasized that "in

our system of dual federal and state sovereignty, federal policies frequently generate indirect effects on state revenues or state spending." *Id.* In doing so, the Court described as "attenuated" theories of state standing resting on claims that a federal policy "has produced only" "indirect effects on state revenues or state spending." *Id.* Such "attenuated links" cannot establish causation. *Alliance*, 602 U.S. at 383; *see also Arizona v. Biden*, 40 F.4th 375, 386 (6th Cir. 2022) (rejecting contention that any federal policy that "imposes peripheral costs on a State creates a cognizable Article III injury").

Plaintiffs assert that *Texas* was limited to the context of States "demand[ing] the prosecution of a third party." Br. 29 n.3. But the Court's discussion of the insufficiency of the States' indirect harms was plainly not limited to that context. *See Texas*, 599 U.S. at 680 n.3. Indeed, this Court has recently applied the reasoning of *Texas* outside the enforcement context. In *Maryland v. USDA*, 151 F.4th 197 (4th Cir. 2025), States alleged that the federal government's decision to fire federal employees without providing 60-days' notice would harm them by imposing "various indirect impacts to state budgets" such as "the costs of processing heightened volumes of applications for state-subsidized health insurance" and "income tax losses." *Id.* at 209. This Court held that the States had not established a cognizable Article III

injury. *Id.* at 210 (citing *Texas*, 599 U.S. 670). Noting that "[i]nnumerable federal actions impact state budgets and programs," the Court rejected an "open-ended" approach to standing that would allow States to sue over any such action. *See id.* It specifically rejected the States' allegations of "increased social services expenses," because "[i]f states could claim these 'peripheral costs' for purposes of standing, there would effectively be no barrier to suit." *Id.* This was true even though it was undisputed that the States would in fact suffer monetary harm. That reasoning applies equally to the municipalities' invocation of "increased social services expenses" as a basis for standing in this case. Increases in operational costs several steps "downstream" of the Final Rule "are often too generally applicable and too attenuated from the [alleged] legal violation to serve as cognizable injuries-in-fact." *Id.*

Plaintiffs' reliance (Br. 29) on two other cases (decided before *Texas* and *Maryland*) is equally flawed. They cite *Massachusetts v. HHS*, 923 F.3d 209 (1st Cir. 2019), in which the First Circuit permitted Massachusetts to challenge exemptions to the Affordable Care Act's (ACA) contraceptive coverage mandate because women without access to insurance-provided contraception were likely to seek it from state-funded sources.

Massachusetts, however, predates and is inconsistent with the Supreme Court's decision in *Texas*. Plaintiffs also cite *Mayor & City Council of Baltimore v. Azar*, 973 F.3d 258 (4th Cir. 2020) (en banc), where this Court considered a challenge to restrictions imposed on recipients of certain funding. But in that case Baltimore operated clinics directly regulated by the rule; its harms were not merely incidental increases in costs. *See id.* at 274 n.5. And the Court did not discuss its jurisdiction, so that decision sets no precedent on jurisdictional questions. *See Sheppheard v. Morrisey*, 143 F.4th 232, 248 (4th Cir. 2025). More recent decisions, which plaintiffs largely ignore, reject standing based on indirect, downstream costs. For example, in *Washington v. FDA*, 108 F.4th 1163 (9th Cir. 2024), the Ninth Circuit rejected Idaho's attempt to establish standing based on "an alleged uptick in Medicaid costs" because it "is exactly the kind of indirect effect on state spending that the Supreme Court has rejected." *Id.* at 1176 (cleaned up). This Court should similarly reject plaintiffs' arguments here.

2. Plaintiffs' theory of standing with respect to Main Street Alliance and its members is even broader. Plaintiffs quibble (Br. 33) about what exactly they need to show about the plans available to identified member Brooke Legler—and they do not point to evidence that *her* out-of-pocket

costs will rise as a result of any of the policies in the Final Rule—but at the end of the day, they say that the parameters of Legler's plans and the actions Legler intends to take are irrelevant, *see* Br. 32, 34. Instead, plaintiffs contend (Br. 34) that Legler may sue—and seek universal vacatur of provisions of the Final Rule that will not affect her directly—because the Final Rule may affect the overall composition of the risk pool.

Yet nothing about plaintiffs' theory is unique to Legler. Rather, their theory would allow any consumer of health insurance to challenge any Exchange regulation. That outcome cannot be squared with modern standing jurisprudence; courts "ha[ve] consistently rejected as flatly inconsistent with Article III" "approach[es] to standing" that would allow "virtually every citizen … standing to challenge virtually every government action that they do not like." *Alliance*, 602 U.S. at 392.

The relief plaintiffs seek underscores the inadequacy of their theory of consumer injury. "The broader and deeper the remedy the plaintiff wants, the stronger the plaintiff's story needs to be." *Maryland*, 151 F.4th at 210. (cleaned up). Here, plaintiffs seek universal vacatur of regulations governing insurance plans for millions of consumers many of whom will benefit from the

changes HHS seeks to implement. To obtain such relief, they must rely on more than generalized grievances applicable to all consumers of insurance.

3. As for Doctors for America, plaintiffs have only two weak rejoinders in their efforts to establish standing. They claim (Br. 34) that the organization's members in fact asserted a personal loss of income because of the Final Rule. But the declarations do not support that claim. One member, Dr. Beth Oller, said that she practices at Rooks County Health Center and provided no information about how she is compensated. *See* JA144-145. The other member, Dr. Eric Fethke, said that he founded a cardiology practice and noted that if he treats uninsured patients and cannot "find alternative sources of payment for services provided," then "my practice and I are left to incur these costs of treating patients who lack insurance." JA162-163. This declaration fails to describe how the practice's profits influence Fethke's personal compensation, and it alleges no loss of *revenue*. And while Fethke asserts costs from treating uninsured patients, he also describes the mix of patients he treats as all insured. *See* JA162 ("Roughly a quarter of my patients are on Medicaid; another quarter have private, non-exchange insurance; and over half of my patients have health care insurance via ACA Exchanges."). Fethke also says that "my practice does not turn away

patients who come seeking emergency healthcare simply because they do not have insurance," JA163, but he does not explain the circumstances in which his practice encounters emergent patients. He thus fails to supply evidence demonstrating that the Final Rule will lead to more people showing up to his practices without insurance in an emergency.

Furthermore, even if they could show some link to their compensation, physicians lack standing to challenge governmental policy "simply because more individuals might then show up at emergency rooms or in doctors' offices." *Alliance*, 602 U.S. at 391.

Plaintiffs also argue (Br. 34-35) that they can establish standing because Fethke will need to spend more time counseling his patients about paying for care, *see* JA163. They assert that notwithstanding *Alliance*, they may rely on a diversion-of-resources theory because Fethke's "'core mission'" is "the provision of medical care." Br. 35. But *Alliance* only accepted that standing could be found in more limited circumstances: when the defendant "*directly* affected and interfered with [the plaintiff]'s core business activities." 602 U.S. at 395 (emphasis added); *see also Republican Nat'l Comm. v. North Carolina State Bd. of Elections*, 120 F.4th 390, 397 (4th Cir. 2024) (accepting as sufficient allegations of direct harm). It rejected

the type of attenuated harms plaintiffs identify here, where they are not directly regulated by the Final Rule.[1]

II. The district court erred in vacating four policies modified in the Final Rule

On the merits, the district court's decision violates several fundamental principles of administrative law. First, an agency need not spell out every element of its reasoning; if the rule and the record show a reasonably discernable path to the decision, that suffices. *See Alaska Dep't of Env't Conservation v. EPA*, 540 U.S. 461, 497 (2004). Second, an agency may act based on the information it has in front of it. It need not "conduct or commission [its] own empirical or statistical studies." *FCC v. Prometheus Radio Project*, 592 U.S. 414, 427 (2021). Rather, it may "ma[k]e a reasonable predictive judgment based on the evidence it ha[s]." *Id.* Third, "[a]n agency is not obliged to respond to every comment, only those that can be thought to challenge a fundamental premise" of the rulemaking. *MCI WorldCom, Inc. v.*

[1] Plaintiffs question (Br. 26 n.2) the breadth of the government's standing argument. Plaintiffs lack standing to challenge any aspect of the Final Rule, and the government may not stipulate away that Article III defect. *See Rouse v. Fader*, 171 F.4th 272, 279 (4th Cir. 2026). Nevertheless, absent further rulemaking, HHS will not enforce the following vacated provisions of the Final Rule: 45 C.F.R. §§ 147.104(i), 155.320(c)(3)(iii) and (c)(5), 155.335(a)(3) and (n), and 155.420(g).

FCC, 209 F.3d 760, 765 (D.C. Cir. 2000). And those responses need not spell out the agency's disagreement in exacting detail. *See, e.g.*, *Vanda Pharms., Inc. v. CMS*, 98 F.4th 483, 498 (4th Cir. 2024). Fourth, "it is firmly established that the mere presence of competing views about scientific data and policy choices is insufficient to show that the agency acted arbitrarily." *New Mexico Cattle Growers' Ass'n v. U.S. Fish & Wildlife Serv.*, 148 F.4th 755, 767 (D.C. Cir. 2025) (cleaned up). The agency may choose between competing views even if a reviewing court thinks the other side has the better argument and evidence. *See California v. Kennedy*, No. 25-12019, 2026 WL 2364297, at *3 (D. Mass. Aug. 14, 2026) (citing *Sig Sauer, Inc. v. Brandon*, 826 F.3d 598, 601 (1st Cir. 2016)).

In defending the district court's decision, plaintiffs largely ignore these basic tenets of administrative law. Instead, they contend that the court was free to micromanage the highly technical rules HHS promulgates to govern the Exchanges based on their policy preferences. That is incorrect; the APA does not authorize the district court to sit as a self-appointed superintendent second-guessing the agency's reasonably explained policy choices.

A recent decision in parallel litigation illustrates how far the district court strayed from its limited role in reviewing agency action. In *California*,

States (many of which have also filed an amicus brief in this case) brought arbitrary-and-capricious challenges to several provisions of the Final Rule including, as relevant here, the adjustment of the permissible range for actuarial values, the failure-to-file-and-reconcile policy, and the shortening of the open-enrollment period. 2026 WL 2364297, at *2. The district court in *California* rejected all three challenges while repeatedly emphasizing the narrow scope of its review under the APA. *See id.* at *3-4, *6-7. As the court explained, its job was to decide "whether [HHS]'s decision was rational, not whether it is the best one possible or even whether it is better than the alternatives." *Id.* at *4 (quotation marks omitted). That approach—not the aggressive second-guessing of myriad agency policy choices employed by the district court here—reflects the proper judicial role under the APA.

A. HHS lawfully expanded the permissible range for actuarial values

The ACA expressly instructs HHS to "develop guidelines to provide for a de minimis variation in the actuarial valuations used in determining the level of coverage of a plan to account for differences in actuarial estimates." 42 U.S.C. § 18022(d)(3). That authority has always been understood to permit HHS to extend some leeway to issuers to design plans with different cost-sharing structures.

Plaintiffs contend that HHS failed to consider the right questions in adopting the actuarial-value policy. While plaintiffs now appear to concede that HHS may be able to consider a broader range of factors than simply variance in actuarial estimates, they argue that HHS did not consider the primary purpose behind allowing de minimis variation: the possibility of "variance in comparing plans with different cost-sharing structures." Br. 46. Plaintiffs apparently interpret that phrase to mean technical differences in how an issuer prepares its actuarial value calculation. But most issuers calculate actuarial value with HHS's actuarial value calculator, while the others must rely on generally accepted actuarial principles. 45 C.F.R. § 156.135(a)-(b); *see* 90 Fed. Reg. at 27,174 & n.242. So, by plaintiffs' reading, the de minimis variation need not exist at all. *But see Pulsifer v. United States*, 601 U.S. 124, 143 (2024) (rule against superfluity has "special force" where interpretation would negate entire provision of a statute). A much more reasonable way to interpret "differences in actuarial estimates" is that it allows HHS to consider differences between plans in elements like cost-sharing. As a result, issuers may take advantage of a degree of flexibility to design plans to serve consumers better. And that is exactly the rationale

HHS gave when it adopted the wider de minimis ranges. *See* 90 Fed. Reg. at 27,176; *see also California*, 2026 WL 2364297, at *6-7.

Notably, each time HHS has set or altered the de minimis ranges, it has relied on similar considerations. *See* 78 Fed. Reg. 12,834, 12,851 (Feb. 25, 2013) (explaining that the range "gives issuers the flexibility to set cost-sharing rates that are simple and competitive" while "ensuring consumers can easily compare plans"); 81 Fed. Reg. 94,058, 94,142 (Dec. 22, 2016) (proposing amendment to avoid "limit[ing] issuers' flexibility in designing bronze plans"); 82 Fed. Reg. 18,346, 18,369 (Apr. 18, 2017) (altering limits to "provide[ ] the flexibility necessary for issuers to design new plans while ensuring comparability of plans within each metal level"); 87 Fed. Reg. 27,208, 27,309-10 (May 6, 2022) (considering "comparability" of plans and "plan design flexibility"). The agency has never relied solely on technical considerations of actuarial reliability. Faced with this consistent practice (which was never previously challenged in litigation), plaintiffs object that the agency may not "adverse[ly] possess[ ]" statutory authority. Br. 46 n.9. But that argument ignores the deference owed to consistent practices of an expert agency, *see Loper Bright Enters. v. Raimondo*, 603 U.S. 369, 388 (2024), as well as the destabilizing effects of upending the way HHS and

issuers have understood § 18022(d)(3) for more than a decade. Plaintiffs offer no compelling reason to jettison those powerful reliance interests.

Plaintiffs also seek (Br. 46) to read into the statutory text some unwritten limit on the ranges HHS can set. In their current view, 4% is too much. But in seeking vacatur of this provision of the Final Rule, plaintiffs ask to reinstate a rule that allowed bronze plans to vary up to 5% above the target actuarial value. *See* Opening Br. 9-10. And HHS had previously permitted plans to vary by 4% below the target for years without anyone seeking judicial review. *See id.* Even more fundamentally, there is no basis in the statutory text for the hard numerical cap plaintiffs seek.

In a related vein, plaintiffs also criticize HHS for failing to consider "Congress's purpose," Br. 47, in establishing metal tiers. This argument seems to rest "on the fictional premise that hundreds of legislators (not to mention the President) shared a unified private view of how the statute should apply in a contested circumstance." *FS Credit Opportunities Corp. v. Saba Cap. Master Fund, Ltd.*, 608 U.S. 608, 621 (2026). But to the extent plaintiffs' argument is that Congress wanted distinct tiers, the Final Rule maintains tiers without overlap. *See also* JA637 (comment from insurance trade group acknowledging risk that consumers may have more difficult time

distinguishing between metal tiers but further recognizing that "from an actuarial standpoint … additional flexibility may be needed for plan design purposes").

Plaintiffs further argue (Br. 47-48) that HHS failed to engage with comments asserting that reduced subsidies would cause healthier consumers to drop coverage and thus weaken the risk pool. But HHS acknowledged that there were "differing viewpoints" on this issue. 90 Fed. Reg. at 27,177; *see also, e.g.*, AR30325 ("[B]roaden[ing] the AV range[ ] … contributed directly to a drop in average premiums and an increase in insurer participation, helping to stabilize the market."), available at https://perma.cc/7A65-KVL2. And it acknowledged that "discontinuing enrollees are likely to be healthier than those remaining in the risk pool." 90 Fed. Reg. at 27,212. HHS then made a policy determination: it was willing to trade "some initial weakening of the risk pool" for the projected "long-term benefits of wider de minimis ranges," which "are likely to strengthen overall market stability." *Id.* at 27,177. The agency was entitled to choose between competing views about data and policy choices, *see New Mexico Cattle Growers*, 148 F.4th at 767, based on its own predictive judgment, *see Prometheus Radio*, 592 U.S. at 427. That decision was not arbitrary. *See California*, 2026 WL 2364297, at *6.

B. HHS lawfully required enrollees to comply with the Reconciliation Requirement to maintain eligibility for advance premium tax credits

The ACA authorizes HHS to "issue regulations setting standards for meeting the requirements under [Title I of the ACA] … with respect to … the establishment and operation of Exchanges." 42 U.S.C. § 18041(a)(1)(A). A regulation is permissible under that provision so long as it (1) points to a requirement under Title I of the ACA, (2) relates to operating an Exchange, and (3) sets a standard for meeting the requirement. *See* Opening Br. 48-49. Plaintiffs do not contest that the failure-to-file-and-reconcile policy meets those three criteria. *Cf.* Br. 39 (arguing only that § 18041 provides a generic grant of rulemaking authority). Plaintiffs instead advance two theories for why HHS has implicitly been precluded from using its rulemaking authority here. Neither has merit.

1. Plaintiffs point (Br. 37-38) to a pair of provisions containing the word "shall." Neither constrains HHS's authority here.

26 U.S.C. § 36B(a) provides that "[i]n the case of an applicable taxpayer, there shall be allowed as a credit against the tax" owed to the Treasury in the amount of the applicable premium subsidy. But HHS agrees that a taxpayer may collect a premium tax credit in arrears when he files his

tax return, so this provision has no applicability to advance premium tax credits.

42 U.S.C. § 18082(c)(2)(A) provides that "[t]he Secretary of the Treasury shall make the advance payment under this section of any premium tax credit allowed under [26 U.S.C. § 36B]" to the enrollee's plan issuer. In plaintiffs' view, this provision means that premium tax credits must be offered in advance, no matter what. Plaintiffs have forfeited that argument by not developing it in the district court. *See Sines v. Hill*, 106 F.4th 341, 349 (4th Cir. 2024); *cf.* Dkt. 65-1, at 38-40; Dkt. 70, at 17-20.[2] And even if the argument were preserved, it would still fail. The provision may restrict the discretion of the Treasury, but it does not speak to HHS.

The larger statutory context indicates that HHS has considerable discretion here. Not only is HHS generally empowered to make rules to facilitate the operation of exchanges, 42 U.S.C. § 18041(a)(1), it also has statutory authority to establish a program to determine eligibility for Exchange participation, premium tax credits, advance determinations of premium tax credits, and other benefits, *see id.* §§ 18081-18082. These

[2] Plaintiffs advanced a related argument with respect to another provision of the Final Rule not at issue in this appeal. *See* Dkt. 65-1, at 22.

provisions confer authority on HHS to set up systems and processes to ensure that consumers are actually eligible for the benefits they claim because when Congress directs agencies to establish a program, it gives the agency flexibility to determine how to address a problem. As for plaintiffs' textual hook, only after HHS has determined that a consumer is eligible for advance premium tax credits does the Treasury's duty to pay credits kick in. *See id.* § 18082(a)(2)-(3) (under the program for making advance determinations, HHS must notify the Treasury of determinations of eligibility and then "the Treasury makes advance payments of such credit[s]"). That provision still leaves HHS ample leeway to design the system and processes by which it determines and verifies eligibility.

2. Plaintiffs' reliance (Br. 39-40) on the *absence* of a statutory provision expressly conditioning advance premium tax credits on complying with the Reconciliation Requirement is equally flawed. Plaintiffs' negative inference might make sense if Congress had said that HHS must deny eligibility for advance premium tax credits if a consumer failed to meet one of an enumerated set of requirements and that list excluded the Reconciliation Requirement. But Congress did not specify how HHS must implement and enforce the Reconciliation Requirement. Rather, it gave the agency broad

discretion to draw on its experience in running the Exchanges and to adopt a policy to incentivize reconciliation and deter fraud. *Cf. California*, 2026 WL 2364297, at *4 (concluding that HHS appropriately balanced competing policy concerns in adopting one-year failure-to-file-and-reconcile policy). No negative implication can properly be drawn from that grant of discretion.

C. HHS lawfully rescinded an automatic 60-day extension of an income-verification period

Plaintiffs attack both HHS's statutory interpretation and the reasonableness of its decision to rescind an automatic extension of the income-verification period. Neither challenge has merit.

1. As explained in our opening brief (at 53-55), HHS lacked statutory authority to extend the income verification period across the board, and the district court erred in concluding otherwise. Plaintiffs all but acknowledge (Br. 56-57) that it would be odd for Congress to expressly authorize HHS to modify the income-verification period in 2014 if it understood HHS to already have authority to take that step. They offer some fig leaves for this redundancy—noting that Congress may have been overly cautious—before settling on their best effort at divining an explanation. In plaintiffs' view Congress wanted to "remove any doubt as to the scope of [the agency]'s authority in the first year of implementation for the ACA." Br. 57. That

explanation might make sense if Congress had simply said, "The Secretary may extend the 90-day period under subclause (II)"—such a provision could be read as clarifying extant authority—but Congress expressly limited this authority to "enrollments occurring during 2014." *See* 42 U.S.C. § 18081(e)(4)(ii). Plaintiffs read the temporal limitation out of the statute entirely.

Plaintiffs fare little better in attempting to read away the context for HHS's modification authority (Br. 55-56), which indicates that the authority covers only the information exchanged between HHS and other trusted data sources. Plaintiffs argue that section headers cannot constrain plain text. But there is an evident mismatch between the broad authority granted in § 18081(c)(4)(B) and the time-limited authority in § 18081(e)(4)(ii), and section headers and structure do provide "useful clue[s]" to discern the meaning of ambiguous text, *see Dubin v. United States*, 599 U.S. 110, 121 (2023) (quotation marks omitted). Here, the heading for subsection (c) indicates that the provision is aimed at "[v]erification of information contained in records of specific Federal officials." 42 U.S.C. § 18081(c). So too does the example of the type of modification Congress contemplated: "allowing an applicant to request the Secretary of the Treasury to provide

the information … directly to the Exchange or to [HHS]." *Id.* § 18081(c)(4)(B). And this conclusion is only underscored by the Secretary's obligation to ensure data-security provisions of the Internal Revenue Code will be met. *See id.* Plaintiffs also note that HHS may modify "methods used under the program established by *this section*" of the Act "for the Exchange and verification of information." *Id.* (emphasis added) (footnote omitted). But HHS having authority to modify procedures discussed in other subsections is consistent with the government's reading of the statute because some of these provisions apply to interagency data exchange too. *See, e.g.*, *id.* § 18081(e)(3) (describing procedures for verification of citizenship or lawful presence).[3]

2. In any event, even if HHS had authority to authorize a blanket 60-day extension of the income-verification period, the district court erred in setting aside the agency's reasonable decision to rescind that policy.

[3] Plaintiffs fall back (Br. 58) on the argument that HHS's understanding of the statute is inconsistent with its unchallenged regulation permitting ad hoc extensions of the data verification period. 45 C.F.R. § 155.315(f)(3). That interpretation, however, is irrelevant to this challenge. And regardless, any authority HHS may have to modify burdens placed on particular applicants would not necessarily allow it to replace a requirement categorically. *See Biden v. Nebraska*, 600 U.S. 477, 494 (2023).

Ignoring HHS's express evaluation of the costs and benefits of the prior automatic-extension policy, plaintiffs assert (Br. 58-59) that any error in statutory interpretation renders the agency's action unlawful. But the *Chenery* doctrine is not nearly so broad. True, "*if the action* [*under review*] *is based upon a determination of law* … , an order may not stand if the agency has misconceived the law." *Perez v. Cuccinelli*, 949 F.3d 865, 873 (4th Cir. 2020) (en banc) (first alteration in original) (emphasis added) (quoting *SEC v. Chenery Corp.*, 318 U.S. 80, 94 (1943)). But "[w]hen an agency offers multiple grounds for a decision, [courts] will affirm the agency so long as any one of the grounds is valid, unless it is demonstrated that the agency would not have acted on that basis if the alternative grounds were unavailable." *BDPCS, Inc. v. FCC*, 351 F.3d 1177, 1183 (D.C. Cir. 2003) (citing, *inter alia*, *Chenery*, 318 U.S. at 88); *see also Massachusetts Trs. of E. Gas & Fuel Assocs. v. United States*, 377 U.S. 235, 248 (1964) (similar); *Ngarurih v. Ashcroft*, 371 F.3d 182, 190 n.8 (4th Cir. 2004) (citing *Massachusetts Trs.*, 377 U.S. at 248). Here, HHS explained that "*even if the statute allowed an automatic 60-day extension*, [its] review of how applicants used the 60-day extension shows that the benefits we previously anticipated have not materialized." 90 Fed. Reg. at 27,119 (emphasis added).

And the agency did not rely solely on a lack of statutory authority to justify the recission but instead thoroughly explained why the costs of the program outweighed the benefits. *See id.* at 27,119-21. The Final Rule thus establishes that HHS would have rescinded the automatic-extension policy regardless of whether it had statutory authority to implement it in the first place.

On the merits, plaintiffs do not defend the district court's reasoning that HHS failed to consider administrative costs on applicants. Instead, they seek to minimize the $170 million in annual costs by arguing that those costs (Br. 60-61) were not central to the agency's decision. But HHS explained that "the cost of the extension outweighs the benefits." 90 Fed. Reg. at 27,119. The costs are considerable, especially when, as HHS determined, the automatic extension did not provide meaningful benefits. *See id.*

Plaintiffs assert that "it would always cost money to extend subsidies to applicants who Congress deemed … eligible for assistance." Br. 60. The key assumption there is that the individuals obtaining subsidies during the extended data-verification period are in fact eligible for subsidies. But the record shows otherwise. HHS estimated that 140,000 enrollees would lose eligibility for advance premium tax credits without the automatic extension. 90 Fed. Reg. at 27,199. But the data also showed that few of these people

would be able to verify eligible income. *See id.* Instead, the automatic extension simply extended subsidies for those who would *not* in the end be able to demonstrate eligibility. *Id.* Contrary to plaintiffs' view, HHS believes that paying out additional subsidies to ineligible recipients is a result to be avoided not embraced.

HHS also invoked program integrity concerns as another basis for rescinding the rule. *See* 90 Fed. Reg. at 27,119-20. HHS noted extensive reports of broker-initiated fraud and misconduct by which ineligible people are enrolled in subsidized coverage without their knowledge. *E.g.*, *id.* at 27,074 & n.2. And a policy that automatically extends the coverage of everyone with a data-verification issue ensures that those who are unwittingly caught up in a fraudulent scheme continue collecting subsidies (and accruing tax liability) until the verification period ends. *See id.* at 27,120. By contrast, a mechanism that requires consumers to take active steps to extend the data-verification period helps to weed out those who do not know they have been enrolled and would not think to seek an extension. These considerations provide additional support for HHS's determination.

Plaintiffs also assert that HHS failed to consider two relevant factors: staffing shortages (Br. 62) and how many applicants would lose eligibility

because the automatic extension was revoked (Br. 61). Plaintiffs misstate the import of the comment about staffing levels. A commenter raised concerns that HHS was losing staff who "monitor contractor performance" in dealing with data-matching issues. JA580. Those staff would not "provide crucial assistance in resolving data-matching issues" as plaintiffs claim. Br. 62. And the comment offered no basis to believe that agency capabilities would be so denuded as to affect the contractors themselves. This comment hardly challenges "a fundamental premise" of the rulemaking. *MCI WorldCom*, 209 F.3d at 765. As for the second objection, HHS expressly considered how many people would lose eligibility, 90 Fed. Reg. at 27,199, and it adequately explained why dropping the automatic-extension policy would not harm those people, *id.* at 27,119.

D. HHS lawfully standardized and shortened the open-enrollment period for Exchanges

Plaintiffs concede that HHS has discretion in setting the length of the open-enrollment period. *See* Br. 48. The sole dispute on this point is whether HHS adequately explained its decision to shorten the open enrollment period and adequately considered countervailing evidence.

The basic contours of selecting an open enrollment period are well-established: a shorter open-enrollment period limits risk of adverse selection,

while a longer open enrollment period gives consumers a greater opportunity to enroll. *See* Opening Br. 58-59. In the Final Rule, HHS concluded that shortening the open-enrollment period by approximately two weeks would strike a better balance between deterring adverse selection and enabling enrollment in plans. *See* 90 Fed. Reg. at 27,137-38. As another district court recently concluded, that decision was, at a minimum, rational. *See California*, 2026 WL 2364297, at *3.

Plaintiffs object (Br. 52-53) that HHS failed to justify its contention that a shorter open-enrollment period would mitigate risks of adverse selection. That proposition, however, is self-evident. The ACA "provid[es] an incentive for individuals to delay purchasing health insurance until they become sick, relying on the promise of guaranteed and affordable coverage." *National Fed'n of Indep. Bus. v. Sebelius*, 567 U.S. 519, 548 (2012). If consumers could enroll in coverage at any time, few people would purchase insurance until they required care; in contrast, if the open-enrollment window lasted a single day, no consumers could delay enrollment. But both of those options would produce disastrous outcomes. Instead, it has long been settled that HHS must strike a balance by selecting a period long enough to enable consumers to register but short enough to curtail efforts to game the

system. Indeed, in setting the standard plaintiffs wish to revert to, HHS relied on the same factors but balanced them differently. *See* 86 Fed. Reg. 53,412, 53,432 (Sep. 27, 2021).

Plaintiffs ignore (Br. 52) HHS's explanations for the length of the period it chose. Because HHS saw no significant benefits from increasing the open-enrollment period from 45 days to 76 days, HHS initially proposed reverting to a 45-day period. *See* 90 Fed. Reg. at 27,137. But in response to comments, HHS decided to select a longer-than-proposed 63-day period tied to the end of the calendar year in order to benefit consumers by "align[ing] more closely with enrollment periods for other coverage such as employer coverage." *Id.* at 27,140.

Further, plaintiffs argue (Br. 51-52) that HHS failed to give adequate weight to the size and composition of the population that switches or enrolls in plans towards the end of the open-enrollment period. But HHS expressly considered these factors. Data indicated that 97% of enrollees signed up within the first nine weeks of the period and that, compared to shorter open-enrollment windows in the past, the longer window did not meaningfully grow enrollment rates. 90 Fed. Reg. at 27,137-38. HHS thus reasonably concluded that the longer period did not produce meaningful benefits.

Plaintiffs note that the 3% of consumers who delayed until the end of the longer period represent "470,000 individuals." Br. 52 (quotation marks omitted). That number says much more about the magnitude of Exchange enrollment than about the impact of the policy. A small percentage of a large number may be a large number, but this does not constrain HHS's discretion to balance competing concerns while administering a program used by millions. As for the composition of the late-enrolling group, HHS acknowledged that "younger and healthier consumers … may tend to enroll later." 90 Fed. Reg. at 27,139. HHS, however, chose to prioritize "addressing adverse selection" based on its predictive judgment that "lower premiums … will do more to encourage younger and healthier consumers to enroll than additional time does today." *Id.* The district court had no proper basis to invalidate HHS's reasonable policy choice.

Plaintiffs raise two last arguments. They contend (Br. 51) that HHS failed to address end-of-year financial pressures that are not present in January. These comments, however, are essentially non sequiturs because initial premium payments are not due until the "coverage effective date" at the earliest. *See* 45 C.F.R. § 155.400(e)(1)(i). HHS had no obligation to respond to a comment with so little relevance to its decision. *See MCI*

WorldCom, 209 F.3d at 765. Plaintiffs also argue (Br. 52-53) that HHS failed to consider comments about difficulties Navigators would face in helping consumers enroll during a shortened period. But HHS acknowledged the concern and explained that because "97 percent of all Exchange enrollments occurred by the end of the ninth week," it did not anticipate significant problems especially if States elect for dates "that best align with their capacity" to provide assistance. 90 Fed. Reg. at 27,139. In short, HHS's decision to shorten the open enrollment period was reasonable and reasonably explained.

CONCLUSION

For the foregoing reasons and those stated in the opening brief, the judgment should be reversed.

Respectfully submitted,

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CERTIFICATE OF COMPLIANCE

This brief complies with the type-volume limit of Federal Rule of Appellate Procedure 32(a)(7)(B) because it contains 6,500 words. This brief also complies with the typeface and type-style requirements of Federal Rule of Appellate Procedure 32(a)(5)-(6) because it was prepared using Word for Microsoft 365 in Century Expanded BT 14-point font, a proportionally spaced typeface.

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