

Complaint for Declaratory and Injunctive Relief

Introduction

Plaintiff **Lee Benham** brings this action under the Administrative Procedure Act (“APA”) to challenge the failure of the U.S. Department of Health and Human Services (“HHS”) and the Centers for Medicare & Medicaid Services (“CMS”) to respond to his petition for rulemaking, and to challenge HHS’s ongoing refusal to expand the use of premium tax credits beyond Affordable Care Act (“ACA”) Exchange plans. Mr. Benham lawfully petitioned HHS to allow Americans to use their federal health insurance tax credits on **any** lawful state-regulated insurance plan, not just on “Qualified Health Plans” (“QHPs”) sold through an ACA Exchange. Enough Time has passed with no agency response. HHS’s inaction violates the APA’s requirement that agencies conclude matters presented to them “**within a reasonable time**” [federalregister.gov](https://www.federalregister.gov). Moreover, HHS’s continued adherence to a **QHP-only** subsidy policy—while refusing to even consider reasonable alternatives—is **arbitrary, capricious, and an abuse of discretion** under 5 U.S.C. § 706(2)(A). Plaintiff seeks declaratory and injunctive relief to compel HHS to act on his petition and to set aside the agency’s unlawful refusal to consider a more flexible interpretation of ACA subsidy rules.

Jurisdiction and Venue

1. **Jurisdiction:** This Court has jurisdiction under 28 U.S.C. § 1331 because this action arises under federal law, specifically the Administrative Procedure Act (5 U.S.C. § 701 *et seq.*) and the ACA. The APA waives sovereign immunity for this non-monetary claim seeking judicial review of agency action (or inaction). Plaintiff seeks relief under the Declaratory Judgment Act, 28 U.S.C. §§ 2201–2202, to declare the rights of the parties.
2. **Venue:** Venue is proper in the District of Nebraska pursuant to 28 U.S.C. § 1391(e)(1) because the defendants are officers or agencies of the United States and the plaintiff resides in this judicial district. Mr. Benham’s injury—being unable to use his insurance tax credits on the plan of his choice—occurs in Nebraska, and the petition for rulemaking giving rise to this suit was submitted from Nebraska. No real property is involved in this action.
3. **Standing:** Plaintiff has standing under Article III of the U.S. Constitution. He suffers a concrete, ongoing injury because current federal regulations bar him from applying his ACA premium tax credit to the health insurance plan he would otherwise choose, imposing higher costs and limiting his personal freedom. As a self-employed insurance broker and consumer in Nebraska, Mr. Benham is directly harmed by HHS’s restrictive policy. A favorable court decision would likely redress these injuries by compelling the agency to consider and potentially adopt a rule allowing broader use of tax credits.

Parties

4. **Plaintiff Lee Benham:** Mr. Benham is a resident of Bellevue, Nebraska. He is a health insurance consumer who previously purchased coverage through the ACA Marketplace in order to utilize a federal premium tax credit under 26 U.S.C. § 36B. He would prefer to apply this tax credit toward an alternative state-regulated insurance plan outside the ACA Exchange (for example, a high-deductible plan paired with a Medical Savings Account, or a lower-cost indemnity plan), but is prevented from doing so by the “**QHP-only**” restriction in current regulations. Thus, he is effectively **locked into** a limited set of Exchange plans to avoid losing the tax credit, an ongoing financial injury and limitation on choice. Mr. Benham is also a licensed insurance **broker** who advises individuals and families on health coverage. In that professional capacity, he is injured by the current rules because they dissuade clients from choosing potentially optimal insurance solutions that happen to lie outside the ACA Exchange. Clients who might benefit from off-Exchange plans cannot use tax credits on them, forcing Mr. Benham to either recommend **suboptimal but subsidized** Exchange plans or risk clients losing thousands of dollars in credits. This **financial disincentive** skews the advice he can give and has caused him lost business when clients decline non-QHP options solely due to the loss of subsidies. In sum, Mr. Benham is personally and professionally affected by Defendants’ actions and inactions, and thus he brings this suit on his own behalf. He is the author of a health reform proposal informally known as “*TrumpCare, America First Healthcare Reform*” which advocates for portable, age-based tax credits to expand affordable coverage options; his petition for rulemaking was a step toward implementing those ideas administratively.
5. **Defendants: United States Department of Health and Human Services (HHS)** is a federal executive department responsible for administering the ACA’s health insurance provisions. (**Robert F. Kennedy Jr.**), sued in his official capacity as the Secretary of HHS, is the chief officer of HHS and has ultimate authority over HHS rulemaking and policy decisions. **Centers for Medicare & Medicaid Services (CMS)** is an agency within HHS that oversees the implementation of the ACA’s insurance marketplaces and subsidy programs. (**Dr. Mehmet Oz**), sued in his official capacity as the Administrator of CMS, is responsible for executing and enforcing the ACA’s regulations, including eligibility for premium tax credits. All defendants are collectively referred to as “HHS” or “the Department.” At all relevant times, Defendants have acted under color of federal law.

Legal Background

6. **ACA Premium Tax Credits (26 U.S.C. § 36B):** The Affordable Care Act (ACA) provides refundable tax credits to help offset the cost of health insurance premiums for eligible individuals. By statute, these premium tax credits (PTCs) are generally available to taxpayers with household incomes between 100% and 400% of the federal poverty level (with recent temporary expansions beyond that range) who enroll in coverage through an ACA **Exchange**. Specifically, 26 U.S.C. § 36B(c)(2) ties eligibility for credits to enrollment in a “**qualified health plan**” (**QHP**) obtained through an Exchange established under the ACA. Federal regulations likewise stipulate that a taxpayer is eligible for a credit only for months in which the taxpayer (or a dependent) is enrolled in one or more QHPs through an Exchange. A “**Qualified Health Plan**” is defined by

regulation as a health plan certified to meet ACA standards and **offered through an Exchange** ecfr.gov. In practice, this means **no insurance plan sold outside of an official ACA Exchange is eligible for premium tax credits**, even if the plan is otherwise regulated by a state and compliant with certain ACA requirements. For example, an individual who purchases an ACA-compliant policy **directly from an insurer** (off-Exchange) or who opts for a non-ACA plan (such as a short-term medical policy or indemnity plan) **cannot receive** any premium assistance, whereas the same individual *could* receive thousands of dollars in credits for buying an approved QHP through the government Exchange. This Exchange-only restriction effectively creates a **financial penalty** for consumers who prefer alternative insurance options.

7. **Right to Petition for Rulemaking (APA § 553(e)):** The APA guarantees that “*each agency shall give an interested person the right to petition for the issuance, amendment, or repeal of a rule.*” 5 U.S.C. § 553(e). This provision allows members of the public to formally request regulatory changes. Federal agencies, including HHS, have a **duty to at least consider and respond** to such petitions. While the APA does not mandate an immediate response, it implicitly requires a response within a **reasonable time**. Agencies often have their own regulations or procedures governing the handling of rulemaking petitions (for instance, some agencies must post petitions for public comment or issue a decision to grant or deny the petition). HHS’s failure to respond to a properly submitted petition for rulemaking constitutes a failure to perform a required agency action.
8. **Duty to Conclude Matters Presented (APA § 555(b)):** The APA further provides that “*within a reasonable time, each agency shall proceed to conclude a matter presented to it.*” 5 U.S.C. § 555(b). This is a statutory command that agencies not unduly delay action when someone invokes an administrative process (like a rulemaking petition). If an agency **unreasonably delays or withholds action**, a court may step in. Specifically, 5 U.S.C. § 706(1) authorizes courts to “**compel agency action unlawfully withheld or unreasonably delayed.**” In evaluating what constitutes an “unreasonable” delay, courts consider factors such as the length of time that has elapsed, the nature of the action withheld, the effect of the delay on public welfare, and any indications that agency prioritization or bad faith may be at play. In short, **protracted silence** or indecision by an agency on a matter it is legally required to address can violate the APA federalregister.gov.
9. **Arbitrary and Capricious Standard (APA § 706(2)(A)):** The APA also requires courts to set aside agency action that is “*arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law.*” 5 U.S.C. § 706(2)(A). Under this standard, an agency must demonstrate that it engaged in **reasoned decision-making**. An action (or refusal to act) is arbitrary and capricious if the agency “*entirely failed to consider an important aspect of the problem*” or “*offered an explanation for its decision that runs counter to the evidence*”, among other shortcomings clarkcountybar.org. Even an agency’s **inaction**—such as a refusal to initiate rulemaking or a denial of a petition—can be deemed arbitrary and capricious if it lacks a rational basis. Agencies are expected to **examine relevant data, articulate a satisfactory explanation** for their course of action, and **treat similar situations consistently**. A hallmark of arbitrary agency behavior is when an agency’s stance **ignores precedent or evidence** that contradicts its position, without a reasonable explanation.

10. **Historical Flexibility in ACA Implementation:** Since its enactment in 2010, the ACA’s coverage and subsidy provisions have been adjusted and interpreted in various ways to expand access and affordability—sometimes through legislation, and sometimes through **administrative action**. These examples form an important backdrop to Plaintiff’s claims, as they show that the rigid QHP-only credit rule is not an inexorable mandate but rather a policy choice that can be revisited:

- **“Family Glitch” Fix (2022):** In 2022, the federal government *reinterpreted* the ACA’s subsidy regulations to fix the “family glitch” without any new act of Congress. Previously, if a worker had an offer of affordable self-only employer coverage, their entire family was ineligible for ACA tax credits, even if the cost of family coverage was actually unaffordable. The Treasury Department and IRS, at the prompting of HHS, issued new regulations basing affordability on the cost of **family coverage** rather than self-only coverage [groom.com](https://www.groom.com). This **executive action** extended premium tax credit eligibility to an estimated 1 million more family members commonwealthfund.org. President Biden heralded this administrative fix as “the most significant administrative action to improve implementation of the ACA since its enactment” commonwealthfund.org. The family glitch fix demonstrates the agencies’ ability to **creatively reinterpret** statutory terms in 26 U.S.C. § 36B to broaden coverage in line with the ACA’s goals.
- **Expanded Tax Credits Under ARPA (2021–2025):** Congress temporarily expanded ACA premium tax credits via the American Rescue Plan Act of 2021 (ARPA) and extended those enhancements through 2025 via the Inflation Reduction Act. These changes removed the 400% FPL income cap for subsidies and increased subsidy amounts, resulting in **record-high enrollment** in the ACA Marketplaces. By the 2025 coverage year, 24.2 million Americans enrolled in Marketplace plans—**more than double** the number from 2021 [cms.gov](https://www.cms.gov). According to CMS, this “**record-breaking enrollment**” is largely attributable to the **enhanced financial assistance** making coverage more affordable [cms.gov](https://www.cms.gov). This legislative example underscores the importance of **wider availability of credits** to achieving broader coverage. It also shows that many Americans just above the prior income limit were eager for coverage once credits were extended to them—by analogy, there may likewise be millions who would benefit if credits were usable on more diverse insurance products.
- **DACA Recipient Coverage (2024):** In 2024, HHS and CMS finalized a rule expanding access to ACA Marketplace coverage for recipients of Deferred Action for Childhood Arrivals (DACA). For a decade, DACA recipients were classified as not “lawfully present” for ACA purposes and thus barred from purchasing Marketplace QHPs or receiving subsidies. The new HHS rule **revised eligibility definitions** so that DACA recipients “*will no longer be excluded*” from enrolling in QHPs or a Basic Health Program, and will be eligible for premium tax credits if they meet income requirements [cms.gov](https://www.cms.gov). This administrative change is expected to bring health coverage to tens of thousands of previously uninsured immigrants. It exemplifies HHS using its discretion to **eliminate an exclusionary rule** that was not required by explicit statute but rather by prior interpretation. The agency acknowledged this would “reduce barriers” and make coverage available to a group historically left out [cms.gov](https://www.cms.gov).

- **State Innovation Waivers (ACA § 1332):** The ACA itself contains a mechanism for flexibility: **Section 1332 State Innovation Waivers**. Under 42 U.S.C. § 18052, states can apply for waivers to implement innovative healthcare coverage approaches, as long as they meet guardrails for coverage, affordability, and federal cost-neutrality [cms.gov](https://www.cms.gov). Approved § 1332 waivers allow states to **restructure how ACA funds and subsidies flow**. For instance, some states have used waivers to run reinsurance programs that indirectly lower premiums; at least one state sought to use waiver authority to let residents use subsidies to buy plans outside the federal Exchange. The existence of § 1332 waivers demonstrates Congress’s intent that the **method of delivering affordable coverage not be one-size-fits-all**. It shows that, in principle, ACA subsidy funds could be channeled through alternative coverage arrangements while maintaining ACA protections and goals. HHS’s steadfast refusal to even explore flexibility at the federal level sits uneasily with this built-in **policy flexibility** afforded to states.

In summary, these examples show that ACA insurance subsidy policy has **evolved over time** through both legislation and administrative action. Defendants have in the past **recognized and addressed gaps or rigidities** in the subsidy framework—extending credits to new populations or circumstances when warranted. The core legal question presented here is why HHS refuses to apply similar **problem-solving to the “QHP-only” restriction**, and whether its failure to act is legally justifiable under the APA.

Factual Background

11. **Plaintiff’s Rulemaking Petition:** On June 10, 2025, Mr. Benham submitted a **formal petition for rulemaking** to the Secretary of HHS pursuant to 5 U.S.C. § 553(e). The petition, titled “*Petition for Reinterpretation of QHP-Only Limitation on ACA Premium Tax Credits*,” was sent to HHS’s Office of General Counsel – Regulatory Affairs, as per HHS’s procedural rules. In this petition, Mr. Benham urged HHS to **amend or reinterpret** its regulations so that eligible individuals could apply their ACA premium tax credits to **any lawful, state-regulated health insurance policy** – not solely to QHPs on the federal or state Exchanges. The petition specifically mentioned categories of plans that should qualify, including:

- State-approved **short-term limited duration insurance** plans (which are exempt from certain ACA requirements but offer temporary catastrophic coverage at lower cost);
- Fixed indemnity insurance plans (which pay set cash benefits for medical events);
- High-deductible health plans coupled with tax-advantaged **Health Savings Accounts (HSAs)** or Medical Savings Accounts (MSAs);
- Any other insurance product that is **licensed and regulated by a state** and provides genuine risk-pooling or coverage for medical expenses (as opposed to, say, purely excepted benefits).

Essentially, the petition asked HHS to **level the playing field** by allowing ACA subsidies to follow the consumer to the plan of their choice, provided the plan is legal to sell under state law. This would **empower consumers** to choose coverage that best fits their needs and budget, without losing the federal assistance they rely on for affordability.

12. **Rationale for Requested Reform:** Mr. Benham’s petition laid out a detailed justification for this reform. He argued that the current limitation of credits to Exchange QHPs is **outdated, overly restrictive, and harmful**:

- It “**arbitrarily punish[es]**” families and individuals who choose more affordable or personalized insurance options outside the Exchange. Many Americans can find plans off-Exchange that better suit their circumstances (for example, plans with narrower coverage but much lower premiums, or innovative arrangements like direct primary care memberships coupled with catastrophic insurance). But if they opt for those plans, they lose potentially thousands of dollars in tax credits, effectively **penalizing** them for making a financially prudent choice. This pushes people into Exchange plans they may not want, simply to keep their subsidy.
- It **stifles consumer choice and competition**. By funneling subsidy dollars only into Exchange-certified plans, the government is “**picking winners and losers**” in the insurance market. Exchange plans (which must comply with all ACA mandates and cover a broad range of benefits) receive a significant advantage, while other legitimate plans are relegated to *unsubsidized* status. This dynamic not only limits choice but also drives up prices in both markets: Exchange plans face less competition (allowing premiums to remain high, cushioned by subsidies), and off-Exchange plans see reduced enrollment (since many potential customers won’t forgo subsidies), which impedes their ability to achieve economies of scale and keep premiums low.
- It has a **chilling effect on licensed insurance brokers and advisors**, creating what the petition describes as “distortive, speech-based disincentives”. Professionals like Mr. Benham want to recommend the best insurance solution for each client. However, under the current regime, advising a client to take an off-Exchange plan (even if it’s the optimal coverage) requires also telling them they’ll lose out on tax credits – a tradeoff most low- or middle-income clients cannot accept. This effectively **skews professional advice** and makes discussing non-QHP options futile for subsidy-eligible clients. The petition notes that this dynamic undermines trust and the client’s best interest, and it is a form of government interference in the advisor-client relationship (though the petition stops short of raising constitutional claims in this submission).
- It is **inconsistent with the ACA’s core mission** of expanding affordable coverage. The petition points out that the ACA was designed to increase insurance coverage and affordability, and that HHS has **flexibility** in implementation to further those aims. By rigidly sticking to Exchange-only credits, HHS is failing to consider alternative approaches that could extend affordable coverage to more people. For instance, a family that can’t afford an unsubsidized off-Exchange plan might go uninsured, whereas if credits could apply outside the Exchange, they would take that plan and gain coverage. In short, the current policy “ignores important aspects” of the problem of affordability and leaves potential solutions on the table.
- Finally, the petition cites the precedent of the 2022 family glitch fix as evidence that agencies *can* **reinterpret statutory provisions** to fix problems in subsidy policy. It argues that if the executive branch could, without new legislation, broaden tax credit eligibility for millions of dependents by re-reading the term “affordable” coverage, then surely it has the authority (or at least the obligation to *attempt*) to similarly reinterpret or adjust the QHP-only restriction in pursuit of greater equity and flexibility. Otherwise, the

inconsistency becomes stark: *Why* show flexibility in one context (employer coverage vs. Marketplace) but not even consider flexibility in another (Marketplace vs. other markets)? The petition implies that such uneven treatment of similar situations is **arbitrary** and could amount to an abuse of discretion.

13. **Requested Agency Action:** The petition formally requested that HHS “**initiate a rulemaking process or guidance clarification**” to effectuate the above change. This could take the form of HHS (in coordination with the Treasury/IRS, which writes 26 U.S.C. § 36B regulations) issuing a notice of proposed rulemaking to amend relevant regulations. For example, HHS could redefine the scope of “qualified health plan” for tax credit purposes or carve out an exception in 45 C.F.R. § 155.20 and related rules that allows credits to attach to certain non-QHP plans meeting basic criteria. Alternatively, HHS could issue sub-regulatory guidance (or work with IRS to issue guidance) interpreting the statutory phrase “qualified health plan... enrolled in through an Exchange” in a more accommodating way—perhaps through demonstration projects or waivers. The petition did not dictate the exact mechanism; it left it to HHS’s expertise to figure out *how* to lawfully implement the requested flexibility, but it made clear that *some* action was needed to remove the all-or-nothing choice facing consumers.
14. **Concurrent Filing of Lawsuit:** Notably, Mr. Benham stated in his petition letter that he was “concurrently filing a civil complaint” challenging the legality of the QHP-only restriction. This reflects the urgency and importance of the issue to Plaintiff. While he strongly prefers a voluntary administrative solution, he indicated that he would pursue judicial relief to compel change if necessary. The present action is that very lawsuit. By filing both a petition and this complaint, Plaintiff is preserving his rights: giving the agency an opportunity to act on its own, but also seeking court oversight to ensure the matter is not ignored indefinitely.
15. **HHS’s Failure to Respond:** As of the date of this filing (late November 2025), **HHS has not provided any response**—not even an acknowledgment—to Mr. Benham’s June 10, 2025 rulemaking petition. HHS has published no notice in the Federal Register regarding the petition, nor communicated with Mr. Benham about the status of the request. More than five months (approximately 167 days) have elapsed. During this time, HHS has continued to issue other regulations and guidance regarding ACA coverage (for example, finalizing routine annual payment notices and other rules), but **nowhere has it addressed Plaintiff’s petition**. The silence is conspicuous given that some agencies, when presented with rulemaking petitions, will at least send a letter of acknowledgment or an interim response. Here, Plaintiff has been met with **total silence**.
16. **Reasonableness of the Delay:** In the context of APA § 555(b), a five-month silence on a straightforward petition is **unreasonable**. The petition in question is not frivolous nor overly complex – it deals with a **single discrete issue** (the scope of premium tax credit eligibility) and cites relevant precedent and justifications. Deciding whether to grant or deny the petition, or to commence rulemaking, does not require an endless fact-finding process; it is a policy choice squarely within HHS’s expertise. Each month of inaction is a month in which Americans like Mr. Benham remain unable to use their earned tax credits for potentially preferable insurance options. Courts have compelled agency responses in far shorter and longer timeframes depending on context, but several factors highlight the unreasonableness here:

- **Human Health and Welfare at Stake:** Delays that affect health and welfare are viewed with less tolerance. Here, the policy in question involves access to health insurance—a fundamental matter of health security. Every open enrollment period that passes without action effectively locks people into choices they might not otherwise make. The harm is ongoing.
- **Agency Priorities:** HHS under the current administration has professed a commitment to expanding coverage and addressing affordability (as evidenced by efforts like the family glitch fix and DACA rule). That it has taken no action on a proposal aligned with those goals suggests the matter may be languishing without good reason, or that the agency has **arbitrarily put it on the back-burner**.
- **No Timetable or Explanation:** HHS has given Plaintiff no indication of *when* it might act or *why* it has not acted yet. The absence of any explanation or projected timeline makes the delay unjustified. Plaintiff cannot even ascertain if the petition is under active consideration or simply ignored.
- **Comparable Administrative Timelines:** Other rulemaking petitions to HHS (and to other agencies) often receive at least an initial decision within a few months. For instance, minor technical petitions might be denied within 90 days; significant ones might be granted or flagged for rulemaking in 6–12 months. Here, the core issues have been known to HHS for years (stakeholders have long criticized the QHP-only subsidy rule), so HHS should be well equipped to respond promptly.

In sum, HHS’s failure to respond **within a reasonable time** is apparent, and each additional day of silence only compounds the violation of § 555(b).

17. **HHS’s Continued Refusal to Act (Substantive Stance):** Beyond the timing issue, all indications are that HHS (in concert with the Treasury Department) currently **refuses on the merits** to expand premium tax credit eligibility to non-QHP plans. The administration has made no moves to amend 45 C.F.R. § 155.20’s definitions or the IRS’s regulation 26 C.F.R. § 1.36B-2, which codify the Exchange-only rule. Nor has HHS shown openness to **alternative approaches** like waivers or pilot programs that could achieve a similar result. This **entrenched position** appears to be driven by a belief that the ACA statute rigidly requires the QHP-only limitation. However, as discussed, the statute has been interpreted flexibly in analogous contexts. HHS’s unwillingness to even *grapple* with the idea through the petition process suggests an **unyielding, and thus arbitrary, mindset**. Agency officials have not pointed to any specific statutory prohibition that would prevent the requested change; instead, they simply have not engaged. This lawsuit treats HHS’s non-response as, effectively, a **denial of the petition** or a **refusal to initiate rulemaking**, which is reviewable as final agency action or as a failure to act that the Court can remedy.
18. **Inconsistency with ACA Goals and Evidence Ignored:** The status quo that HHS defends (silently, by its inaction) is increasingly untenable when measured against the evidence and goals in the healthcare arena:
 - The ACA’s overriding goal is to make insurance **affordable and accessible**. Defendants’ interpretation undermines affordability for those who might prefer cheaper plans outside the Exchange by withholding subsidies from them. It also leaves a segment of people

uninsured or underinsured: for example, some middle-income families find Exchange plans (even with subsidies) still too costly or not worth the price for coverage they don't value; they might choose no coverage or a non-ACA short-term plan without subsidy, at great risk. The agency has not addressed this phenomenon at all.

- **Economic analyses** and enrollment data post-ARPA (see ¶10 above) suggest that subsidies are a powerful lever for increasing coverage. HHS has crowed about record Marketplace enrollment when subsidies were enhanced [cms.gov](https://www.cms.gov), yet ignores the logical extension of that lesson: if subsidies can be used for a wider array of plans, more people might take up coverage in those forms. HHS has conducted or cited **zero studies** on whether broadening subsidy eligibility could improve the uninsured rate or reduce premiums overall via competition. This is an *important aspect of the problem* that the agency has failed to consider.
- **Consumer preference surveys** often show that significant numbers of people, especially younger and healthier individuals, do not value the full suite of ACA-mandated benefits and would opt for leaner, cheaper plans if they had help paying for them. HHS has not acknowledged these preferences in any rulemaking document related to the ACA subsidies. By ignoring consumer diversity and insisting that “one size fits all” for subsidy-eligible plans, the agency fails to consider whether a more tailored approach could better serve some populations (while still protecting the vulnerable – note that Plaintiff's proposal does *not* eliminate ACA plans or their subsidies, it simply adds options).
- The existence of **Section 1332 waivers** (10, above) is a glaring reminder that alternative subsidy uses are plausible and **foreseen by law**. Some states have indeed considered waiver concepts to utilize ACA subsidies outside of the traditional Exchange QHP framework (subject to federal approval). Instead of embracing this spirit of innovation, HHS's inaction effectively dismisses it. The agency record (to the extent one exists in its prior rules) does not articulate why only state-led innovations via waivers are acceptable but a federal rulemaking to similar ends is not even worthy of consideration. This disparity is unexplained.

In short, HHS's maintenance of the QHP-only rule appears to “**entirely fail to consider**” **several critical aspects**: consumer choice, market competition, partial fixes for the uninsured gap, and consistency with Congress's flexible framework clarkcountybar.org. Such oversight is the hallmark of arbitrary decision-making.

19. **Exhaustion of Administrative Remedies**: There are no further administrative steps for Mr. Benham to take. He has formally presented the issue to the agency via the 5 U.S.C. § 553(e) petition. The APA does not require a petitioner to wait indefinitely for an answer, especially when the agency's delay itself is what necessitates judicial intervention. Additionally, there is no statutory appeal process or alternative forum within HHS for this kind of request; the only path to relief is through the courts if the agency fails to act. Thus, Plaintiff has constructively exhausted his administrative remedy, and his claims are ripe for review.
20. **Injury to Plaintiff**: Every month that HHS delays and refuses to act, Plaintiff suffers real harm. Personally, he remains unable to apply his roughly \$500/month premium tax credit (as an example figure) to the **lower-cost high-deductible plan** he would prefer; instead,

he must either pay full price for that preferred plan (which is economically infeasible) or stay on an Exchange plan that he finds inferior, simply to keep the credit. Professionally, he continues to lose clients who, absent the subsidy issue, would likely purchase alternative plans through him. Some prospective customers walk away when they learn a non-Exchange plan would forfeit their credit—either staying uninsured or grudgingly using the Exchange (sometimes directly through the government site, cutting out the broker). These are **economic and opportunity losses** to Mr. Benham’s business. Furthermore, the **mental and constitutional interests** at stake (while not being adjudicated as separate counts here) are non-trivial: the feeling of being coerced in economic choices by government policy, and the restriction on his professional speech, weigh on Mr. Benham. This Court’s intervention is necessary to prevent these injuries from continuing unabated.

Claims for Relief

Each of the following claims is pleaded in the alternative and cumulatively. All paragraphs above are incorporated by reference in each claim below.

Count I: Agency Action Unlawfully Withheld or Unreasonably Delayed (APA – 5 U.S.C. §§ 555(b) & 706(1))

Defendants’ failure to respond to Plaintiff’s rulemaking petition or otherwise act on the requested issue violates their duty to conclude matters presented to them within a reasonable time.

21. **Legal Duty:** Under 5 U.S.C. § 555(b), HHS was required to proceed to address the petition for rulemaking submitted by Mr. Benham “**within a reasonable time.**” This duty is **nondiscretionary** as to the obligation to make some response or decision. While the substance of HHS’s response (granting or denying the petition) might involve discretion, the requirement to *respond* and not interminably delay is mandatory. The APA (5 U.S.C. § 706(1)) empowers this Court to compel agency action that is **unlawfully withheld or unreasonably delayed** [federalregister.gov](https://www.federalregister.gov).
22. **Unreasonable Delay:** HHS has failed to **grant, deny, or otherwise respond** to Plaintiff’s June 10, 2025 petition as of the filing of this Complaint, over five months later. In light of the circumstances described, this delay is unreasonable. No valid excuse has been given for the lack of action. The issue presented by the petition is important and time-sensitive, affecting the affordability of insurance for the upcoming coverage years. Each Open Enrollment period that passes without a policy change effectively decides the issue (against Plaintiff) for that year, which magnifies the need for timely resolution. Courts have found much shorter delays to be actionable, especially where human health is concerned. Conversely, the **14-year delay** in another context was clearly unreasonable [federalregister.gov](https://www.federalregister.gov); while this case has not reached such extremes, Plaintiff need not wait a decade to get a yes-or-no answer.
23. **Harm from Delay:** Plaintiff and thousands of similarly situated individuals are suffering ongoing harm due to HHS’s inaction. The **status quo**—which the petition challenges—remains in effect by default. In essence, by not acting, HHS is **withholding relief** and

continuing a policy that Plaintiff contends is unlawful. The APA does not permit an agency to sit silently and thereby effectively **deny relief without judicial review**. Such a result would thwart the petition process established by § 553(e).

24. **No Administrative Path Forward:** Because HHS has not responded, Plaintiff cannot even pursue an internal appeal or know if the petition was denied (which could allow a direct challenge to that denial). The indefinite delay is tantamount to agency stonewalling, leaving the courts as the only avenue to vindicate Plaintiff's rights. The APA's unreasonable delay provision is designed for exactly this scenario.
25. **Violation:** Defendants' failure to act on the petition constitutes agency action **"unlawfully withheld or unreasonably delayed"** within the meaning of 5 U.S.C. § 706(1). It violates § 555(b)'s requirement of timeliness and amounts to a refusal to carry out a **clear legal duty**. Therefore, Plaintiff is entitled to relief compelling Defendants to act.

Count II: Arbitrary, Capricious, and Abuse of Discretion (APA – 5 U.S.C. §§ 706(2)(A) & 553(e))

Defendants' effective denial of Plaintiff's petition and their refusal to consider expanding tax credit eligibility beyond QHPs are arbitrary, capricious, and an abuse of discretion, ignoring important aspects of the problem and contradicting the evidence and established policies.

26. **Final Agency Action / Constructive Denial:** Although HHS has not issued a formal decision, its **prolonged inaction** on the petition and clear maintenance of the existing policy constitute a **constructive denial** of the petition. In the alternative, should Defendants respond during this litigation by explicitly denying the petition, Plaintiff pleads that such denial would be arbitrary and capricious for the reasons below. Likewise, any continued refusal to initiate a rulemaking or to otherwise consider the issue is a **final agency action** for purposes of APA review, as it marks the consummation of the agency's decision-making process (a decision *not* to act) and determines rights or obligations (by leaving the restrictive rules in place, it determines that Plaintiff has no right to use his credit outside an Exchange).
27. **Arbitrary and Capricious Standard:** Under 5 U.S.C. § 706(2)(A), this Court must hold unlawful agency actions (or inactions tantamount to actions) that are arbitrary or capricious. An action is arbitrary and capricious if, inter alia, the agency **"has relied on factors which Congress has not intended it to consider," "entirely failed to consider an important aspect of the problem," or "offered an explanation for its decision that runs counter to the evidence before the agency."**clarkcountybar.org Defendants' conduct meets this definition on multiple counts.
28. **Failure to Consider Important Aspects:** In effectively rejecting Plaintiff's proposal, HHS **entirely failed to consider several important aspects** of the issue:
 - HHS gave no consideration to the **plight of consumers** who do not wish to purchase Exchange plans. Many middle-class individuals get minimal or no subsidies under current rules yet are still constrained to Exchange plans if they want any assistance. Others slightly above the income cutoff (when it existed) or with unique health plan

preferences are similarly situated. This is an important cohort for coverage expansion that HHS ignored.

- HHS did not weigh the **benefits of alternative coverage options** or the innovations in the insurance market since 2010. Short-term plans, direct primary care arrangements, indemnity policies, and other products have evolved. The agency acted as if ACA Exchanges are the only source of “real” insurance, a premise belied by market reality. An agency must engage with such realities rather than ignore them.
- HHS failed to consider how the QHP-only rule may be **counterproductive** to ACA’s goal of affordability. By ignoring evidence that some people find Exchange plans unaffordable or poor value (even with credits), HHS bypassed a key aspect: affordability is not just about giving people money, but also about enabling them to buy something that fits their budget and needs. The petition highlighted this, yet HHS’s silence shows no consideration of it.
- No consideration was given to **compromise solutions or partial measures**. For example, HHS might have considered allowing credits on off-Exchange plans that meet certain basic requirements (like a cap on catastrophic costs, or state certification). The refusal to even explore alternatives, or explain why none are feasible, is the essence of arbitrary decision-making.

29. **Consideration of Improper Factors / Political Influence:** On information and belief, HHS’s refusal to expand credits beyond QHPs may stem from **improper factors** not intended by Congress. For instance, HHS might be sticking to the Exchange-only rule to **bolster Exchange participation numbers** or to avoid upsetting certain stakeholders (like insurance companies that benefit from the current setup or ideological commitments to the ACA status quo). While agencies can have policy preferences, they cannot ignore statutory aims. Congress did not intend for tax credits to serve as a tool to coerce marketplace participation at the expense of consumer preference—indeed, the presence of § 1332 waivers suggests Congress expected evolution and adaptation. If HHS’s motive is simply to protect Exchange insurers or an institutional status quo, that is not a legally defensible basis and would be arbitrary.

30. **Counter to Evidence and Precedent:** Defendants’ stance runs **counter to the evidence** before the agency and is unexplainedly inconsistent with past precedent:

- The **evidence of increased enrollment and reduced uninsured rates due to enhanced credits (ARPA/IRA)** is stark [cms.gov](https://www.cms.gov). This indicates that making subsidies more accessible (whether by amount, eligible income, or eligible insurance vehicle) **improves** the ACA’s outcomes. Yet HHS’s refusal to apply that lesson to the present context (insurance vehicle) is inexplicable. The agency cannot simply cherry-pick which evidence to act on and which to ignore when both speak to the same ultimate goal (coverage expansion).
- **Historical precedent:** As outlined, HHS and related agencies have shown flexibility (family glitch, DACA, etc.). An agency must provide a “**reasoned explanation**” when it chooses a different course from past practice. Here, HHS offers nothing to reconcile why it embraced flexibility in those cases but rejects it here. The inconsistency suggests the decision (or indecision) is not the product of reasoned analysis but of caprice or oversight.

- **Ignoring the petition record:** Plaintiff’s petition itself marshaled facts and arguments. An agency presented with a rulemaking petition should address the main points raised in it when deciding. Because HHS gave no response, it by definition **failed to address the evidence and arguments submitted** by Plaintiff. Should HHS belatedly issue a denial letter now, any such letter would similarly be suspect if it does not grapple with the petition’s content (which, at this stage, it cannot without appearing post hoc and pretextual).
31. **Abuse of Discretion:** Defendants’ actions and omissions also amount to an **abuse of discretion**. They have been entrusted with implementing the ACA in a manner consistent with its purpose. By rigidly insisting on an interpretation of 26 U.S.C. § 36B that maximizes restriction rather than flexibility, they are abusing that discretion—especially given that the statute’s text (“qualified health plan... enrolled in through an Exchange”) was interpreted in *King v. Burwell* to include federal Exchanges (a non-obvious reading), demonstrating that terms can be read **purposively**. If HHS has discretion to interpret ambiguities, it should use it to further affordability and coverage unless there is a strong countervailing reason. Here, their discretionary choices (or refusal to exercise discretion at all) have produced an outcome that is **irrational** when viewed in context of the ACA’s structure (which encourages state innovation, and which, through other programs like Medicare Part C, often allows subsidies for private plan choices). The one-size-fits-all subsidy policy is an outlier that HHS clings to without justification.
 32. **Arbitrariness of Outcome:** The end result of Defendants’ stance is arbitrary and inequitable: a family can use a federal subsidy on one set of health plans but not on another set, often for no reason other than the *transactional venue* (an ACA Exchange vs. a private market). Two individuals with the same income could get vastly different government support depending on whether the plan they prefer happens to be an ACA-certified QHP. This creates bizarre scenarios—for instance, a plan **identical** to an Exchange plan in coverage, offered by the same insurer off-Exchange, is not eligible for subsidy, whereas the Exchange-sold twin is. No rational health or fiscal policy is served by that distinction; it merely locks consumers into a government-run marketplace. Agencies are not free to implement statutes in a way that yields such internally inconsistent and senseless results without a compelling explanation, which is lacking here.
 33. **Summary of Violation:** By failing to meaningfully respond to the petition and by refusing to consider revising the QHP-only subsidy rule, Defendants have acted arbitrarily, capriciously, and contrary to law. Their inaction should be **set aside** under 5 U.S.C. § 706(2)(A) as unlawful agency action. Even if technically framed as a “failure to act,” the Court’s review can treat the failure as a constructive final action denying the petition and uphold or vacate that denial. Plaintiff contends vacatur is warranted, and the Court should remand with instructions for HHS to properly consider the issue and come to a reasoned decision.

Prayer for Relief:

Plaintiff **Lee Benham** respectfully requests that this Court enter judgment in his favor and grant the following relief:

- **Declaratory Relief:** A declaration pursuant to 28 U.S.C. § 2201 that Defendants' failure to timely respond to Plaintiff's June 10, 2025 petition for rulemaking is unlawful, and that the continued restriction of premium tax credits solely to QHPs obtained through ACA Exchanges—without consideration of Plaintiff's proposed alternative—constitutes agency action that is arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law.
- **Injunctive Relief (Compel Agency Action):** An order compelling Defendants, under 5 U.S.C. § 706(1), to **act on Plaintiff's petition** forthwith. This should include, at minimum, requiring HHS to issue a written response to the petition by a date certain. The Court may further order HHS to **commence a rulemaking proceeding** to consider amending or revising the relevant regulations consistent with the petition. In doing so, the Court should retain jurisdiction and set appropriate deadlines to ensure that HHS's response and any rulemaking are not indefinitely delayed.
- **Injunctive/Remedial Relief (Addressing the Policy):** In addition or in the alternative, an injunction prohibiting Defendants from enforcing the QHP-only limitation on premium tax credits **until** such time as the agency has lawfully considered and disposed of Plaintiff's petition in a manner consistent with the APA. This would prevent irreparable harm during the remand process and ensure that Plaintiff and similarly situated individuals can obtain relief if the agency continues to delay. The Court might craft this relief, for example, by tolling the restriction or by ordering interim relief (such as allowing Plaintiff to claim his credit for an alternative plan, subject to true-up depending on final agency action).
- **Vacatur:** If the Court finds that the effective denial of Plaintiff's petition or the underlying policy is arbitrary and capricious, the Court should **vacate** the relevant agency action. This could entail vacating HHS's interpretation and rule (45 C.F.R. § 155.20 insofar as it ties subsidies to Exchange plans) and the IRS's rule (26 C.F.R. § 1.36B-2(a)(1)) to the same extent, and remanding to the agencies for reconsideration. The Court's order should make clear that absent a new lawful rule, the agencies may not refuse tax credits solely on the basis that a plan was not purchased through an Exchange.
- **Attorneys' Fees and Costs:** An award to Plaintiff of his reasonable costs and, if applicable, attorneys' fees (should he retain counsel or if pro se costs are awardable) under the Equal Access to Justice Act, 28 U.S.C. § 2412, or any other provision deemed appropriate, as Plaintiff has had to pursue this action due to Defendants' unlawful conduct.
- **Other Relief:** Any other relief the Court deems just and proper, including equitable relief to ensure that the objectives of a lawful decision-making process are carried out. This might include status reports to the Court on agency progress, or any declarations to clarify the rights of affected non-parties under the Court's ruling.

Respectfully submitted,

Dated: November 24, 2025

Lee Benham

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