IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF MISSISSIPPI
NORTHERN DIVISION

MISSISSIPPI ASSOCIATION OF HEALTH PLANS, INC. **PLAINTIFF**

V. **CAUSE NO. 3:24-cv-379-HTW-LGI**

MIKE CHANEY, IN HIS OFFICIAL CAPACITY AS COMMISSIONER OF INSURANCE OF MISSISSIPPI **DEFENDANT**

MISSISSIPPI ASSOCIATION OF HEALH PLANS, INC.'S MEMORANDUM BRIEF IN SUPPORT OF ITS MOTION FOR PRELIMINARY INJUNCTION

The Mississippi Association of Health Plans, Inc. ("MAHP") submits this Memorandum Brief in Support of its Motion for Preliminary Injunction. For the following reasons, as may be further developed at a hearing on this matter, the Commissioner of the Mississippi Insurance Department should be enjoined from taking any actions to, in any way, implement or enforce the provisions of House Bill 1489 until this Court makes a decision on the merits as to the constitutionality of House Bill 1489.

INTRODUCTION

Health insurance companies routinely provide coverage for medically necessary ambulance services for the transportation of sick or injured subscribers to the hospital to receive medical treatment, and the subscribers routinely benefit from rates negotiated between health insurers and providers through lower premium costs. House Bill 1489, enacted during the 2024 Regular Session of the Mississippi Legislature ("House Bill 1489" or the "Bill"), mandates a potentially massive expansion of coverage for "ambulance services" that is so unclear in the legislation so as to leave health insurance companies guessing what may be required of them and

for potentially non-emergency ambulance transportation to non-hospital, "alternative destination" facilities, which are so vaguely defined as to potentially include facilities incapable of providing emergency-level services. For ambulance service providers who have entered into network provider agreements with health insurance companies (i.e., in-network providers), the Bill purports to require reimbursement at the network rates paid for advanced life support medical services regardless if such level of care is required or even provided.

In addition to mandating this coverage, House Bill 1489 provides a windfall for out-of-network ambulance service providers who do not have special rates by contract or ordinance with a county, municipality or special purpose district or authority, requiring such out-of-network ambulance service providers to be reimbursed at whatever rate they decide to charge – mandating reimbursement at 325% of that allowed by Medicare ***or the provider's billed charges, whichever is greater.***[1] Such a mandate virtually guarantees ambulance service providers will cancel and/or refuse to enter into network provider agreements or local government rate agreements, resulting in increased costs of healthcare—costs that will be borne by insureds in Mississippi.

MAHP's members include health insurance companies licensed by the Mississippi Insurance Department, which is charged with the execution of the state's insurance laws, including House Bill 1489, through broad regulatory powers granted to the Commissioner of the Mississippi Insurance Department (the "Commissioner"). MAHP brought this action seeking a declaratory judgment that House Bill 1489 is unconstitutional because it (1) impairs existing contracts or policies of insurance in violation of Article I, Section 10 of the United States Constitution; and (2) lacks sufficient definiteness to give due notice of what is required to be covered and to avoid

[1] Because House Bill 1489 purports to mandate allowable rates and covered services, application of it to air ambulance provider claims is preempted by the Airline Deregulation Act ("ADA") as a state law related to rates or services of an air carrier. *See* 49 USC § 41713(b)(1).

arbitrary and discriminatory enforcement, in violation of the Due Process Clause of the Fourteenth Amendment to the United States Constitution.

MAHP requests the Court to enter a preliminary injunction to enjoin the Commissioner from exercising any regulatory authority to enforce or, in any way, implement the provisions of House Bill 1489 until this Court makes a decision on the merits. Without immediate judicial intervention enjoining the enforcement of the Bill, MAHP's members will continue to suffer irreparable harm and loss of their constitutional rights.

STATEMENT OF FACTS

A. MAHP

MAHP has associational standing to pursue the declaratory and injunctive relief sought. Membership in MAHP is voluntary, and its members include health insurance companies licensed by the Mississippi Insurance Department to sell health insurance, and who are issuers and/or administrators of health benefit plans as defined in Miss. Code Ann. § 83-63-3 and/or accident and sickness insurance policies as defined in Miss. Code Ann. § 83-9-1. It is governed by its board of directors selected from its members by its members, and is financed by its members. MAHP's mission is to champion high-quality, affordable and accessible healthcare and to work collaboratively with and for its members to address common challenges in the health benefits space, including coordinating state and federal legislative and regulatory activities pertaining to health benefits to promote and foster appropriate development and operation of health benefit programs. Enforcement of the Bill will impair the constitutional rights of some of MAHP's members and subject them to irreparable harm likely to be redressed by the requested declaratory judgment and injunction. *Students for Fair Admissions, Inc. v. Univ. of Texas at Austin*, 37 F.4th 1078, 1084 & n.5 (5th Cir. 2022).

B. House Bill 1489

House Bill 1489 contains two substantive sections, each imposing separate mandates on health insurance companies related to coverage for "ambulance service[s]" or reimbursement of charges imposed by ambulance service providers. Section 1 of the Bill enacts the "Mississippi Triage, Treat and Transport to Alternative Destination Act," which mandates health insurance companies to provide coverage for ambulance services, including non-transportation related ambulance services that may involve no medical services or care at all, and transportation of enrollees *not* to hospital emergency departments, but to an unlimited number of vaguely defined lower-acuity facilities that provide medical services. These facilities include urgent care centers, medical clinics and doctor's offices of the enrollee's choosing, among other places (the "Coverage Mandate").

Section 2 requires out-of-network ambulance providers—despite not having a provider contract with the health insurance company and the benefits inuring from such a contract, such as lower healthcare costs—to be paid at rates up to the amount unilaterally set by the ambulance service—*no matter how much that amount is*—so long as the ambulance service has no contract with the governing authorities of the county, municipality, or special purpose district in which the service originated (the "Reimbursement Mandate").

HB 1489's Coverage Mandate

Following a list of defined terms in Section 1 of the Bill, the Coverage Mandate is set out in Section 1(3) and requires any health benefit plan to provide coverage on and after July 1, 2024, for:

> (a) An ambulance service to:
> (i)Treat or assess an enrollee in place; or
> (ii)Triage or triage and transport an enrollee to an alternative destination; or

> (b) An encounter between an ambulance service and enrollee that results without transport of the enrollee.

Though Section 1(3) states the Coverage Mandate commences on an after July 1, 2024, House Bill 1489 was amended prior to passage to add Section 1(6), which provides: "This section shall apply to all contracts described in this section that are entered into or renewed on or after July 1, 2024."

Section 1(2)(c) defines "ambulance service provider" as "a person or entity that provides ambulance transportation and emergency medical services to a patient for which a permit is required under Section 41-59-9." Section 1(2)(b) defines "alternative destination" as "a lower-acuity facility that provides medical services, including, without limitation", the following locations:

1. A federally qualified health center;
2. An urgent care center;
3. A physician's office or medical clinic, as chosen by the patient; and
4. A behavioral or mental health care facility, including, without limitation, a crisis stabilization unit and a diversion center.

Only five specific locations are explicitly exempted from the broad term "alternative destination":

1. Critical access hospital;
2. Dialysis center;
3. Hospital;
4. Private residence; or
5. Skilled nursing facility.

The Coverage Mandate is triggered upon "the initiation of ambulance service treatment as a result of a 911 call that is documented in the records of the ambulance service." H.B. 1489 § 1(4)(a). A "911 call" is defined not as a call to a local government's E-911 service by dialing "9-1-1", but as any "communication made on behalf of an enrollee indicating that the enrollee may need emergency medical services." H.B. 1489 § 1(2)(a).

Although dictating coverage for potentially non-emergent ambulance services and transportation to non-emergency alternative destinations, Section 1 requires an ambulance service provider to be reimbursed "not less than the minimum allowable reimbursement for advanced life support rate with mileage to the scene." H.B. 1489 § 5.

HB 1489's Reimbursement Mandate

The Reimbursement Mandate is set out in Section 2 of the Bill and requires "[t]he minimum allowable reimbursement rate" payable "to an out-of-network ambulance service provider for all covered services" to be "the rates contracted between an ambulance service provider and a county, municipality or special purpose district or authority, or otherwise approved or established by ordinance or regulation enacted by any such county, municipality or special purpose district or authority in which the covered healthcare services originated." H.B. 1489 § 2(1)(a).

If no such rates are established by contract or ordinance of the specified local government, "the minimum allowable reimbursement rate to an out-of-network ambulance service provider shall be **the greater of**" the following: (a) 325% of the reimbursement allowed by Medicare for the respective services originating in the respective geographic area; or (b) the ambulance service provider's billed charges. H.B. 1489 § 2(1)(b).

While the Bill has not yet been codified, Section 3 instructs that both the Coverage Mandate and Reimbursement Mandate shall be codified within Title 83, Chapter 9 of the Mississippi Code, which governs health insurance in Mississippi.

ARGUMENT

Pursuant to Federal Rule of Civil Procedure 65(a), MAHP requests this Court to grant a preliminary injunction enjoining the Commissioner from exercising any regulatory authority to enforce or implement House Bill 1489 until the Court decides the merits of MAHP's constitutional

claims. "The very purpose of an injunction under Rule 65(a) is to give temporary relief based on a preliminary estimate of the strength of plaintiff's suit, prior to the resolution at trial of the factual disputes and difficulties presented by the case." *Huston-Tillotson Univ. v. Sprint Corp.*, No. 1:20-CV-192-RP, 2020 WL 1695690, at *3 (W.D. Tex. Apr. 7, 2020) (quoting 11A Charles A. Wright, et al., Federal Practice and Procedure § 2948.3 (3d ed. Aug. 2019 update)).

The preliminary injunction standard is familiar: a movant must demonstrate (1) a substantial likelihood of success on the merits; (2) a substantial threat of irreparable harm if the injunction does not issue; (3) that the threatened injury outweighs any harm that will result if the injunction is granted; and (4) that the injunction is in the public interest. *McRorey v. Garland*, 99 F.4th 831, 836 (5th Cir. 2024) (citing *Moore v. Brown*, 868 F.3d 398, 402 (5th Cir. 2017)). These factors weigh in favor of granting an injunction in this case.

1. MAHP is substantially likely to succeed on the merits of its claims.

MAHP satisfies the first factor in the preliminary injunction analysis: it is substantially likely to succeed on the merits of its constitutional claims. MAHP "is not required to prove its entitlement to summary judgment in order to establish a substantial likelihood of success on the merits for preliminary injunction purposes." *Little v. Llano Cnty.*, 103 F.4th 1140 (5th Cir. 2024) (quoting *Byrum v. Landreth*, 566 F.3d 442, 446 (5th Cir. 2009)); *see also All. for Hippocratic Med. v. U.S. Food & Drug Admin.*, 78 F.4th 210, 242 (5th Cir. 2023) (reversed and remanded on other grounds) ("[W]e note that 'substantial' does not mean 'certain.'").

MAHP seeks declaratory relief, finding that House Bill 1489 is unconstitutional because it (1) impairs existing policies and contracts of insurance, in violation of Article I, Section 10 of the United States Constitution; and (2) lacks sufficient definiteness to give due notice of what is required to be covered and to avoid arbitrary and discriminatory enforcement, in violation of the

Due Process Clause of the Fourteenth Amendment to the United States Constitution. MAHP is substantially likely to succeed on these claims.

A. House Bill 1489 impairs existing policies and contracts of insurance, in violation of Article I, Section 10 of the United States Constitution.

The United States Constitution provides that "[n]o State shall … pass any … Law impairing the Obligation of Contracts." U.S. Const. Art. I, § 10. "If any such are nevertheless passed by the legislature of a state, they are unconstitutional, null, and void." *Carter v. Greenhow*, 114 U.S. 317, 322 (1885). "If the Contract Clause is to retain any meaning at all, . . . it must be understood to impose some limits upon the power of a State to abridge existing contractual relationships, even in the exercise of its otherwise legitimate police power." *Allied Structural Steel Co. v. Spannaus*, 438 U.S. 234, 242 (1978). "Contracts Clause claims are analyzed using a three-step analysis: (1) the state law must have substantially impaired a contractual relationship; (2) the state's asserted justification for the impairment must serve a significant and legitimate public purpose; and (3) the challenged law must be reasonably necessary to achieve the public purpose." *Babin v. Breaux*, 587 F. App'x 105, 114 (5th Cir. 2014). MAHP's claim satisfies these factors.

1. The Reimbursement Mandate substantially impairs existing policies and contracts of insurance between MAHP's members and insureds.

In analyzing a challenge to state action under the Contract Clause, "[t]he threshold inquiry is whether the state law has, in fact, operated as a substantial impairment of a contractual relationship." *Lipscomb v. Columbus Mun. Separate Sch. Dist.*, 269 F.3d 494, 504 (5th Cir. 2001). "To determine whether an impairment was substantial, the Supreme Court has considered 'factors that reflect the high value the Framers placed on the protection of private contracts,' namely, the parties' entitlement to rely on rights and obligations set by the contract so that they can 'order their personal and business affairs according to their particular needs and interests.'" *United Healthcare*

Ins. Co. v. Davis, 602 F.3d 618, 628 (5th Cir. 2010) (quoting *Spannaus*, 438 U.S. at 244). "Total destruction of contractual expectations is not necessary for a finding of substantial impairment." *Id.* (quoting *Energy Reserves Group, Inc. v. Kansas Power & Light Co.*, 459 U.S. 400, 412 (1983)).

The Reimbursement Mandate contained in Section 2 of House Bill 1489 substantially impairs existing contracts between MAHP's members and their subscribers. Effective July 1, 2024,[2] the Reimbursement Mandate requires insurance policies to provide a minimum allowable reimbursement rate for out-of-network ambulance providers equal to the rate set by contract or ordinance with a county, municipality or special purpose district or authority, if any. H.B. 1489 § 2(1)(a). If none exists, the Reimbursement Mandate requires the minimum allowable reimbursement rate for out-of-network ambulance providers shall be ***the greater of***: (1) 325% of the reimbursement allowed by Medicare; or (2) ***the ambulance service provider's billed charges***. H.B. 1489 § 2(1)(b).

Health plans and policies are typically issued on an annual basis (referred to as a plan or policy year), many of which follow a calendar year. Policy provisions, including benefits structure, and certain premium rates must be filed with and approved by the Commissioner[3] months before health insurance companies may issue the policies to their insureds. Thus, calendar-year polices in effect on July 1, 2024, were approved in 2023 to be issued in 2024. Because the Reimbursement Mandate of Section 2 became effective on July 1, 2024, it affects those policies that were issued for the 2024 policy year in the middle of the policy year.

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[2] *See* House Bill 1489 § 4 ("This act shall take effect and be in force from and after July 1, 2024.").

[3] *See* Miss. Code Ann. § 83-9-4 ("The Commissioner . . . may *disapprove* a policy form, amendatory rider or endorsement currently in effect if the Commissioner finds [it is] in violation of any state or federal laws or contains or incorporates by reference any inconsistent, ambiguous or misleading clauses or exceptions and conditions."); Mississippi Insurance Department Bulletin 2011-7 (June 29, 2011) ("MID Bulletin 2011-7") ("all plans of insurance, group or individual, [must] be filed for purposes of review and approval or disapproval prior to use.").

Health plans and policies routinely provide for reimbursement of providers based on an allowable amount established by the health insurance companies and incorporated into the plan or policy benefits, and anticipated reimbursements to providers based on allowables are critical factors in establishing premium rates. Plans and policies also routinely include patient-responsibility obligations on subscribers (such as co-insurance), providing they are to pay a portion of allowed provider charges themselves. Plaintiff's members and their subscribers entered into or continued their health plans or policies with the expectation their obligations would continue throughout the full term. However, the Reimbursement Mandate alters the health insurance companies' and their subscribers' payment obligations to be based on an amount up to whatever billed charges out-of-network ambulance service providers decide to submit. Thus, the Bill unilaterally expands the obligations (and costs) of both Plaintiff's members and their individual subscribers under existing plans and policies without their consent.

"An important consideration in [the] substantial impairment analysis is the extent to which the law upsets the reasonable expectations the parties had at the time of contracting, regarding the specific contractual rights the state's action allegedly impairs." *United Healthcare*, 602 F.3d at 627. Courts also "consider the expectations of the parties with respect to changes in the law." *Id.* The reimbursement rates paid under health plans and policies are a critical aspect of the agreement between health insurance companies and their subscribers. While the provision of health care coverage is regulated in Mississippi and across the country, legislative price-setting is exceedingly rare. Price-setting in the manner imposed by the Reimbursement Mandate—requiring reimbursement of any amount an out-of-network ambulance service provider wishes to charge—is unprecedented and could not have been reasonably expected by the parties when the health plans

and policies were issued. The Reimbursement Mandate alters the parties' agreed-to reimbursement rates, "an area [of the contract] where the element of reliance was vital." *See id.* at 628.

In *United Healthcare*, the Louisiana Legislature enacted a law requiring the Louisiana Office of Governmental Benefits ("OGB") to contract with Louisiana Health Maintenance Organizations to provide fully-insured plans to state employees. *United Healthcare*, 602 F.3d at 623. The law took effect during the terms of existing contracts between the OGB and United Healthcare Insurance Company and Humana Insurance Company for the provision of self-insured health plans for state employees. *Id.* at 622–23. Reviewing the provisions of the contracts with United and Humana, the Fifth Circuit determined that the law violated the Contract Clause because the legislation altered those contracts in ways in which the parties did not anticipate. *Id.* at 629–30. According to the court, the legislation mandated "an unexpected and extraordinary enrollment period in the middle of the contract year," that was not anticipated in the contracts. *Id.* at 30. "The insurance companies had accounted for the cost of one enrollment drive in their bids (estimated as approximately $300,000); thus, paying for another, unexpected enrollment drive would offset their expected returns from the contracts in a way that was not foreseeable when the contracts began." *Id.*

The impairment on the contracts between MAHP's members and their subscribers is similar to the impairment analyzed in *United Healthcare*. The Reimbursement Mandate's alteration of allowable reimbursement rates previously established under plans or policies existing and in effect on July 1, 2024, results in increased and unanticipated reimbursement and administrative costs on health insurance companies, and increased and unanticipated patient-responsibility obligations on their subscribers. "These impairments are substantial and disrupt the purpose of the contracts at issue here; that is, to allow the parties to rely on their contractual

expectations of . . . the approximate expense of administering the plans." *United Healthcare*, 602 F.3d at 630. "Avoiding these risks [allows MAHP's members] to plan for the year ahead financially, and to enter into other agreements (for instance, with providers in their networks). The [Reimbursement Mandate's] spoiling of the parties' contractual expectations regarding these risks is the type of impairment that the Contract Clause prohibits." *Id.*

The Reimbursement Mandate impairs existing contracts between MAHP's members and their subscribers, and those impairments are substantial.

2. There is no significant or legitimate public purpose for the Reimbursement Mandate, which was designed to benefit special interests.

"If the state regulation constitutes a substantial impairment, the State, in justification, must have a significant and legitimate public purpose behind the regulation, such as the remedying of a broad and general social or economic problem." *Energy Rsrvs. Grp., Inc.*, 459 U.S. at 411–12 (quoting *United States Trust Co. v. New Jersey*, 431 U.S. 1, 22 (1977)); *see also Lipscomb*, 269 F.3d at 504. There is no significant or legitimate public purpose for the state to impose the financial burden on health insurance companies – and their subscribers – to pay out-of-network ambulance companies based on whatever amount they decide to bill. Rather than providing a benefit to the public, the Reimbursement Mandate was designed to benefit special interests, including ambulance service providers, who will have total control of pricing in their market. "Providing a benefit to a narrow group or special interest is insufficient justification" for substantially impairing contract rights.[4] *United Healthcare*, 602 F.3d at 631; *see also Advocs. for Arts-Based Educ. Corp. v. Orleans Par. Sch. Bd.*, No. CIV.A. 09-6607, 2010 WL 375223, at *4 (E.D. La. Jan. 26, 2010) ("Requiring a legitimate public purpose ensures that the state is exercising its police power, instead

[4] While "the elimination of unforeseen windfall profits is a legitimate state interest sufficient to justify state impairment of contracts", *Lipscomb*, 269 F.3d at 504, House Bill 1489 does the opposite—it creates windfall profits for out-of-network ambulance service providers.

of providing a benefit to special interests."); *Spannaus*, 438 U.S. at 248–49 (finding law with "narrow focus" that only affected a limited category of employers "can hardly be characterized . . . as one enacted to protect a broad societal interest rather than a narrow class").

Had the state wanted to "remedy a broad and general societal or economic harm", it could have regulated coverage and/or reimbursement for ambulance services in a manner that would *decrease* the costs of healthcare for Mississippi citizens. *See 21st Century Oncology, Inc. v. Moody*, 402 F. Supp. 3d 1351, 1360 (N.D. Fla. 2019) (citing *Chicago, B. & Q. Ry. Co. v. Illinois*, 200 U.S. 561, 592 (1906)) ("It is well settled that access to affordable healthcare is a legitimate state interest."). House Bill 1489, to the contrary, enriches special interests, at the expense of *increased* costs of healthcare, to be borne by MAHP's members and Mississippi residents. The state lacks any significant and legitimate purpose for enacting House Bill 1489's mandates.

3. The Reimbursement Mandate is not reasonably necessary to achieve any significant and legitimate public purpose.

Even if there was a significant and legitimate public purpose in increasing reimbursements for out-of-network ambulance service providers, mandating health insurance companies to pay up to whatever they decide to charge was not reasonably necessary to achieve that purpose. Accordingly, MAHP is substantially likely to succeed on its claim that Section 2 of House Bill 1489 violates the Contract Clause of Article 1, Section 10 of the U.S. Constitution.

B. House Bill 1489 is void for vagueness under the Due Process Clause of the Fourteenth Amendment to the United States Constitution.

The Due Process Clause of the Fourteenth Amendment to the U.S. Constitution dictates that no State shall "deprive any person of life, liberty, or property, without due process of law." U.S. Const. amend. XIV, § 1. A corporation is a "person" within the meaning of the Due Process Clause. *See First Nat'l Bank of Boston v. Bellotti*, 435 U.S. 765, 780 n. 15 (1978). "It is a basic

principle of due process that an enactment is void for vagueness if its prohibitions are not clearly defined." *Stockstill v. City of Picayune*, No. 1:16CV4-LG-RHW, 2017 WL 3037431, at *6 (S.D. Miss. July 18, 2017) (quoting *Grayned v. City of Rockford*, 408 U.S. 104, 108 (1972)). "'Vagueness' is a question of notice, i.e., procedural due process . . . ." *Id*. (quoting *Scott v. Schedler*, 826 F.3d 207, 211 (5th Cir. 2016)).

A statute that imposes criminal penalties "is unconstitutionally vague if it does not give a person of ordinary intelligence a reasonable opportunity to know what is prohibited or is so standardless that it invites arbitrary enforcement." *Johnson v. United States*, 135 S.Ct. 2551, 2556 (2015). "A less stringent standard is applied to *civil* statutes that regulate economic activity." *Ford Motor Co. v. Texas Dep't of Transp.*, 264 F.3d 493, 507 (5th Cir. 2001) (emphasis added). "An economic regulation is invalidated "only if it commands compliance in terms 'so vague and indefinite as really to be no rule or standard at all' . . . or if it is 'substantially incomprehensible.'" *Id.* (quoting *United States v. Clinical Leasing Service, Inc.*, 925 F.2d 120, 122 n. 2 (5th Cir.1991)); *see also Boutilier v. INS*, 387 U.S. 118, 123 (1967).

"There is, however, a caveat to this general rule. Civil statutes or regulations that contain quasi-criminal penalties may be subject to the more stringent review afforded criminal statutes." *Id*.; *see also United States v. Clinical Leasing Service, Inc.*, 925 F.2d 120, 122 (5th Cir. 1991) (finding civil statute prescribing penalties for "[a]ny party who distributes or authorizes the distribution of controlled substances without adequate registration" to have a "quasi-criminal" effect warranting "a relatively strict test" and requiring statute to define offense "with sufficient definiteness that ordinary people can understand what conduct is prohibited and in a manner that does not encourage arbitrary and discriminatory enforcement"). Because MAHP's members will be subject to administrative enforcement by the Commissioner, *including the potential for*

misdemeanor fines and penalties, if they fail to interpret and apply House Bill 1489 in the manner in which the Commissioner deems correct—as discussed in more detail in Part 2, *infra*—the Coverage Mandate must "give a person of ordinary intelligence a reasonable opportunity to know what is prohibited" and may not be "so standardless that it invites arbitrary enforcement." *See id*.; *Johnson*, 135 S.Ct. at 2556. The Coverage Mandate's vague provisions do not meet this standard.

The vague, undefined and ill-defined provisions of Section 1 create significant ambiguity and many unanswered questions regarding what ambulance services health insurance companies are required to cover, allow and reimburse. Processing and adjudicating insurance claims involves an intricate procedure, including among other steps, the submission of detailed claims by providers utilizing nationally standardized forms and codes, and a claim review by health insurance companies to determine if the specific services provided fall within a covered benefit and otherwise satisfy policy terms. Health insurance companies utilize claim processing guidelines to clearly define the parameters of covered services in an effort to eliminate ambiguity in the claim submission and adjudication process. However, the vagueness of House Bill 1489 makes it impossible for Plaintiff's members to discern precisely what the legislature intended to be covered and reimbursed. Absent a clearly defined coverage obligation, which is completely lacking here, Plaintiff's members cannot develop claim processing guidelines or benefit plan language with any degree of certainty that they will be in compliance with Section 1, or for their subscribers to know what is covered.

The Coverage Mandate of Section 1 requires health insurance companies to provide coverage for ambulance services to "treat or assess an enrollee in place" or to "triage or triage and transport an enrollee to an *alternative destination*," and for any "*encounter* between an ambulance service and enrollee that results *without transport* of the enrollee." H.B. 1489 § 1(3) (emphasis

added). Ambulance service providers covered by Section 1 are those who provide both "ambulance transportation" ***and*** "emergency medical services," which must be initiated by a "911 call that is documented in the records of the ambulance service." H.B. 1489 § 1(2)(c), (4)(a). On the whole, the ambiguity in the text renders it substantially incomprehensible, and will leave health insurance companies, including Plaintiff's members, guessing as to what is required to be covered.

The Bill defines the term "alternative destination" as "a lower-acuity facility that provides medical services, *including, without limitation*: (1) A federally qualified health center; (2) An urgent care center; (3) A physician's office or medical clinic, as chosen by the patient; and (4) A behavioral or mental health care facility, including, without limitation, a crisis stabilization unit and a diversion center", but excludes five types of facilities from this definition: critical access hospitals, dialysis centers, hospitals, private residences, and skilled nursing facilities. H.B. 1489 § 2(b).

The definition of "alternative destination" renders the Bill unconstitutionally vague. The Bill's use of "including but not limited to" specific examples is seemingly endless in scope to include non-emergency facilities, yet other provisions require some heightened degree of emergency medical service to trigger coverage. Specifically, to constitute an "ambulance service provider" both "ambulance transportation" and "emergency medical services" have to be performed, and covered ambulance services must be reimbursed at the advanced life support rate plus mileage. H.B. 1489 § 1(2)(c), (5). Yet the Bill fails to define or establish any parameters for what level of "lower-acuity" "medical services" a provider or facility is capable of providing causes the provider or facility to qualify as an "alternative destination" for covered "ambulance services." As written, it is substantially unclear if an "alternative destination" is intended to include medical providers who do not provide any degree of emergency medical services, such as

a dermatologist, pharmacist, chiropractor, and the like, or if coverage is required at the advanced life support rate to transport an enrollee to their personal physician or favorite clinic for routine, non-emergency care at the enrollee's request. How is a health insurer to know based on the text of the Bill?[5]

The Bill's non-transport based requirements to cover ambulance services to "treat or assess an enrollee in place," "triage" (without transport), and for "[a]n encounter between an ambulance service and enrollee that results without transport of the enrollee," creates significant ambiguity. The Bill provides no guidance as to the intended meaning of or distinctions among the terms used. The Bill purports to require coverage for "triage" even without transportation to any facility, yet gives no direction for coverage purposes as to what medical benefit is provided through "triage" alone. The Bill does not define for coverage purposes the term "encounter," a word which is generally defined as "to meet as an adversary or enemy; to engage in conflict with; to come upon face-to-face; to come upon unexpectedly." Merriam–Webster Dictionary (online ed.), *available at* http://www.merriam-webster.com (last visited June 20, 2024) (defining "encounter"). Additionally, providers' insurance claims utilize standardized Current Procedural Terminology ("CPT") codes created and maintained by the American Medical Association to identify the specific services rendered in connection with a claim, and health insurance companies' claim processing and reimbursement guidelines utilize those CPT codes submitted to evaluate compliance with plan terms and available coverage. On information and belief, no CPT code defines "triage" or "encounter" as used in the Bill, thus ambulance companies have no CPT code to use to file claims and health insurance companies have no CPT code to use to make coverage determinations. As a result, it is substantially unclear what services an ambulance service provider

[5] Notably, H.B. 1489 does not direct or authorize the Commissioner to promulgate regulations to clarify.

must actually provide to an enrollee, if any at all, to trigger coverage of an ambulance service provider's claim at advanced life support rates with mileage, and how health insurance companies are to evaluate those purported services.

Furthermore, to qualify for coverage under the Coverage Mandate, ambulance services are subject to being initiated by a "911 call," which is defined as any "communication made on behalf of an enrollee indicating that the enrollee may need emergency medical services." House Bill 1489 § 1(4)(a), (2)(a). It is substantially unclear whether coverage for ambulance services and transportation at the advanced life support rates is intended if an enrollee calls the ambulance service directly, or requires a call to a county's or municipality's E-911 service reached by dialing "9-1-1," as contemplated by the Mississippi Department of Health's emergency management services regulations[6] and some, if not all, Mississippi county ordinances related to emergency services.[7] Thus, health insurance companies cannot be certain how to comply.

Lastly, and alternatively, the term "contracts" in Section 1(6) is unconstitutionally vague as to which "contracts" Section 1 of the Bill is intended to apply. Section 1(6) provides Section 1 "shall apply to all contracts described in this section that are entered into or renewed on or after July 1, 2024." The Coverage Mandate in Section 1 purportedly applies to terms of coverage

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[6] Miss. Dept. Health Emergency Medical Services Rule 1.1.7 provides "911 is the universal emergency phone number for public access of Emergency Medical Services in the State. Ambulance service providers shall only advertise 911 as their emergency number [unless] a municipality or county has not implemented 911." Miss. Admin. Code Title 15, Part 12, Subpart 31.

[7] For example, Section 4 of the Rankin County, Mississippi, Ordinance for Ambulance Services provides:

> 4.1 The Emergency Operations Center (E-911) in Brandon, Mississippi operates a 911 emergency call processing system and receives emergency calls to said system directly from the general public and as referred from certain other emergency call processing centers in Rankin County, Mississippi. The Emergency Operations Center (E-911) establishes the call's classification, determines the Patient's location, determines the need for First Responder Service and, if appropriate, alerts the First Responder, dispatches the appropriate ambulance and, if appropriate, delivers pre-arrival instructions, all according to policies and guidelines established by the Emergency Operations Center (E-911).
>
> 4.2 *It shall be unlawful for any Ambulance Service Provider or anyone else to publish or advertise any phone number other than 911 for the purpose of soliciting requests for its services.*

https://www2.rankincounty.org/ordinances/ambulance-service.html (*last visited June 27, 2024*) (emphasis added).

contained in health plans and policies. However, as discussed above, health plans and policies typically are issued on a plan year basis, thus a new enrollee on August 1, 2024, would receive the covered benefits provided throughout the current 2024 plan year, not a new plan with additional benefits. The ambiguity created by the term "contracts" in Section 1(6) makes it substantially unclear if Section 1(6) imposes the Coverage Mandate on currently existing plan year benefit terms for new enrollees after July 1, 2024, but not those who enrolled before, and thus is void for vagueness. If it does, Section 1(6) constitutes an unlawful impairment to Plaintiff's members' existing health plans and policies in violation of the Contract Clause. *See* Part 1.A. *supra*.

The requirements of the Coverage Mandate can hardly be described as "clearly defined." *See Stockstill*, 2017 WL 3037431, at *6. These unintelligible provisions make it impossible for MAHP's members to decipher or implement many of the Coverage Mandate's provisions. Because MAHP's members will be subject to the Commissioner's administrative enforcement—authority that could authorize the Commissioner to impose misdemeanor fines and penalties on MAHP's members if they disagree with the Commissioner about the meaning of the Coverage Mandate—the Coverage Mandate must "give a person of ordinary intelligence a reasonable opportunity to know what is prohibited" and may not be "so standardless that it invites arbitrary enforcement." *See Ford Motor Co.*, 264 F.3d at 508 (discussing holding in *Clinical Leasing Service, Inc.*, 925 F.2d at 122, which found civil statute's "prohibitory effect is quasi-criminal and warrants a relatively strict test"); *Johnson*, 135 S.Ct. at 2556. The Coverage Mandate does not meet this threshold. Many of its key terms, when read alone or together, are wholly incapable of discernment, leaving enforcement to the subjective interpretation of the Commissioner or to courts deciding whether a denied claim is required to be covered as a matter of law. This concentration of authority invites arbitrary application and enforcement, even if done in good faith.

The vague provisions of Section 1, in all applications, will create uncertainty for MAHP's members, leaving them without direction as to what claims may require coverage and what claims may not. Accordingly, MAHP is substantially likely to succeed on its claim that Section 1 of House Bill 1489 violates the Due Process Clause of the Fourteenth Amendment to the U.S. Constitution.

2. MAHP's members face a substantial threat of irreparable harm if the Court does not enjoin the enforcement of House Bill 1489.

While a preliminary injunction "will not be issued simply to prevent the possibility of some remote future injury," *Brown v. Auble*, No. 5:20-CV-138-KS-MTP, 2020 WL 5603919, at *2 (S.D. Miss. Sept. 18, 2020), MAHP is not required "to demonstrate that harm is inevitable," *Jackson Womens' Health Org. v. Currier*, 940 F. Supp. 2d 416, 423 (S.D. Miss. 2013). MAHP must show only "a significant threat of injury from the impending action, that the injury is imminent, and that money damages would not fully repair the harm." *Id*. (citing *Humana, Inc. v. Avram A. Jacobson, M.D., P.A.*, 804 F.2d 1390, 1394 (5th Cir. 1986)).

Mississippi law affords broad powers to the Commissioner to regulate the actions of MAHP's members and the insurance services they provide to Mississippi residents. The Commissioner is empowered to disapprove insurance policies he finds inconsistent with state law, and to deny approval of insurance premium rates he determines to be excessive, unjustified or unfairly discriminatory. *See* Miss. Code Ann. §§ 83-9-4; MID Bulletin 2011-7. Moreover, the Commissioner is empowered to examine and investigate licensees to determine if he believes they are in compliance with state insurance laws, to require the insurer to pay for the costs of the examination, and to impose sanctions on them to enforce state insurance laws. *See, e.g.*, Miss. Code Ann. §§ 83-1-51, 83-5-205, 83-5-207 and 83-5-209.

The Commissioner's broad regulatory authority is accompanied by broad powers to enforce state insurance laws. For example, in enforcing the state insurance laws and regulations, the Commissioner is empowered "to order [an insurance company] to take any action the commissioner considers necessary and appropriate to cure [] violations [of any law or regulation]," and "may initiate any [regulatory] proceedings or actions as provided by law." Miss. Code Ann. § 83-5-209(3), (6)(c). If the Commissioner believes a health insurance company "is engaging in any improper or unauthorized activity in violation of any insurance law, [he] may issue a cease and desist order with or without notice and a prior hearing . . . directing them to cease and desist from further activities." Failure to comply with the cease and desist order constitutes a misdemeanor, and may be punished by a fine of $5,000 per violation. Miss. Code Ann. § 83-1-51(2). In certain situations, the Commissioner may subject an insurance company to "administrative supervision by the commissioner" if in his discretion he determines an insurer has failed to comply with applicable provisions of the insurance code. Miss. Code Ann. § 83-1-155.

Subjecting MAHP's members to potential regulatory examinations and enforcement actions, including penalties, by the Commissioner related to the Bill will result in irreparable harm. *VanDerStok v. Garland*, 633 F. Supp. 3d 847, 856 (N.D. Tex. 2022), *appeal dismissed*, No. 22-11071, 2023 WL 7318088 (5th Cir. Sept. 6, 2023) (noting effect on plaintiff's conduct arising from threat of criminal and civil penalties was sufficient to establish irreparable harm).

A. The Reimbursement Mandate will irreparably harm MAHP's members by impairing their existing contracts with insureds.

The Mandatory Reimbursement provision of Section 2 became effective July 1, 2024, and thus impacts health plans or policies currently in effect. Health plans and policies provide health coverage on an annual plan or policy year basis, many of which follow the calendar year, with lead-in "open enrollment" windows of time for groups or individuals to enroll in new policies, or

to adjust their current coverage options or cancel. Prior to open enrollment, insurers, including MAHP's members, must make any needed adjustments to policies' benefits structure to be offered in the following plan or policy year, and must determine an appropriate premium rate to be charged in the following plan or policy year for the coverage to be provided. Changes to coverage provided in certain policies and certain premium rates must be submitted to the Commissioner for approval in advance of offerings to current or potential insureds. *See* Miss. Code Ann. § 83-9-4; MID Bulletin 2011-7.

For some health plans or policies, insurers rely on highly skilled actuaries and complex rating models to calculate premium rates to be charged to their subscribers for the coverage provided. When setting premium rates, the objective is to establish premiums that are, in the aggregate, sufficient to cover claims that will be paid out in the following plan or policy year, expenses, risk margin and profit. Premium rate calculations are performed well in advance of the start of a plan or policy year. In calculating premium rates, actuaries take into account, among other factors, the anticipated frequency of covered claims and the expected total claims reimbursement cost. This process is dependent on having a known "allowable" for covered services – a term used by health insurance companies in health plans and policies referring to the negotiated reimbursement rates for in-network providers with whom they have a network provider agreement, and to the reimbursement rates established by the health insurance company for out-of-network providers.

Premiums for other health plans or policies are subject to experience rating. In other words, health insurance companies utilize historical claim and payment information to estimate anticipated future claims and payments, and use that estimate to establish the next year's premium. Thus, effective experience rating relies on coverage terms and allowable provider reimbursement

rates that are constant year over year, or are otherwise known to the health insurance company when premium rating is performed.

For the plans and policies currently in effect in policy year 2024, the premium rates were calculated, submitted, and if required, approved, based on coverage terms and allowable rates existing and in place months before House Bill 1489 was first proposed. Because Section 2 imposes increased and potentially unlimited reimbursement obligations on health plans or policies in the middle of a policy year, enforcement of the Reimbursement Mandate on existing policies will result in additional, unexpected and incalculable administrative expenses to implement, and significantly increased claim reimbursement costs which were not (and could not be) considered when entering into plan contracts and policies of insurance for policy year 2024. All of these additional costs likely are unrecoverable. *See VanDerStok*, 633 F. Supp. 3d at 855 (citing *Wages & White Lion Invs., L.L.C. v. FDA*, 16 F.4th 1130, 1142 (5th Cir. 2021)) ("Where costs are nonrecoverable because the government-defendant enjoys sovereign immunity from monetary damages, as is the case here, irreparable harm is generally satisfied."); *see also Nat'l Rifle Ass'n of Am., Inc. v. Bureau of Alcohol, Tobacco, Firearms & Explosives*, No. 3:23-CV-1471-L, 2024 WL 1349307, at *9 (N.D. Tex. Mar. 29, 2024) (quoting *Rest. L. Ctr. v. United States Dep't of Lab.*, 66 F.4th 593, 597 (5th Cir. 2023) (finding that in the Fifth Circuit, "the nonrecoverable costs of complying with a putatively invalid regulation typically constitute irreparable harm."); *Louisiana v. Biden*, 55 F.4th 1017, 1034 (5th Cir. 2022) (citing *Texas v. EPA*, 829 F.3d 405, 433 (5th Cir. 2016)) ("[C]omplying with a regulation later held invalid almost *always* produces the irreparable harm of nonrecoverable compliance costs.").

Of even more concern is the financial impact the Reimbursement Mandate will have on subscribers. Health plans and policies typically include a "patient responsibility" portion, which

means insureds are responsible for paying a percentage of out-of-network provider charges as co-insurance (e.g., deductibles and co-pays). The allowable reimbursement rate establishes the baseline for how much of a provider's billed charges the patient himself must pay. For example, a health plan or policy may provide for a 20% co-pay for out-of-network ambulance services. A forced increase in the allowable reimbursement rate paid to ambulance service providers will correspondingly increase the subscriber's out of pocket expense. Thus, enforcement of the Reimbursement Mandate's financial windfall for ambulance service providers will likewise impose unexpected, incalculable and unrecoverable increased costs on individual subscribers in Mississippi.

By imposing mandatory modifications on existing health plans or policies to provide a minimum allowable reimbursement rate at an amount up to whatever ambulance service providers wish to charge, Section 2 violates the Contract Clause of the U.S. Constitution because it significantly impairs contracts and policies of insurance in place between health insurance companies and their subscribers, to the irreparable detriment of both. Pending this Court's determination of the constitutionality of Section 2 on the merits, the Commissioner should be enjoined from exercising any of his broad regulatory powers to implement or enforce it.

B. The Coverage Mandate's impermissibly vague language will irreparably harm MAHP's members.

Given the Commissioner's broad powers to regulate licensed health insurance companies in Mississippi, the unconstitutional vagueness of the Coverage Mandate in Section 1 imposes a substantial risk of irreparable harm to MAHP's members. As addressed above, Mississippi law empowers the Commissioner to examine and investigate MAHP's members to determine if he believes they are in compliance with state insurance laws, to require them to pay for the costs of the examination, and to impose sanctions on them to enforce state insurance laws. *See, e.g.*, Miss.

Code Ann. §§ 83-1-51, 83-5-205, 83-5-207 and 83-5-209. The Commissioner may order them to take any action he considers necessary to comply with state insurance laws, issue cease and desist orders, and impose misdemeanor fines of $5,000 per violation if they fail to comply. *See* Miss. Code Ann. §§ 83-5-209(3), (6)(c); 83-1-51(2). Moreover, in certain circumstances the Commissioner is empowered to disapprove insurance policies he finds inconsistent with state law, and to deny approval of insurance premium rates he determines to be excessive, unjustified or unfairly discriminatory. *See* Miss. Code Ann. §§ 83-9-4; MID Bulletin 2011-7.

The Coverage Mandate in Section 1 is unquestionably vague, making it impossible for ***either*** the Commissioner ***or*** MAHP's members to discern precisely what the legislature intended to be covered and reimbursed. *See* Section 1.B., *supra*. Thus, in addition to imposing a significant and costly administrative burden on health insurance companies who will struggle to decipher and implement what may be required of them, the risk is significant that health insurance companies and the Commissioner will disagree, resulting in potentially extensive and expensive examinations and enforcement actions, including potential fines and penalties, and an unnecessarily protracted policy and premium rate submission and approval process where required. Indeed, the deprivation of MAHP's members' procedural due process rights, as a result of House Bill 1489's vague terms, in itself demonstrates substantial harm. *See VanDerStok*, 633 F. Supp. 3d at 856 (citing *Opulent Life Church v. City of Holly Springs, Miss.*, 697 F.3d 279, 294–97 (5th Cir. 2012) ("Even 'alleged' deprivations of constitutional or procedural rights may" impose such irreparable harm to "justify injunctive relief.").

3. The threatened injury to MAHP's members is outweighed by any harm that will result if the Court enjoins the enforcement of House Bill 1489.

The balancing of equities favors injunctive relief. In deciding whether to grant a preliminary injunction, courts "must balance the competing claims of injury and must consider the

effect on each party of the granting or withholding of the requested relief." *Winter v. Nat. Res. Def. Council, Inc.*, 555 U.S. 7, 24 (2008). A preliminary injunction that maintains the status quo harms no one—neither the Commissioner, nor any non-party ambulance service provider or subscriber. The Commissioner does not stand to suffer any damage should this Court enjoin his enforcement of the Bill. Nevertheless, even if the Commissioner claims some harm by being prevented from exercising his administrative authority, such indefinite harm is greatly outweighed by the injury faced by MAHP's members should an injunction not be issued.

If the Commissioner is permitted to exercise his broad regulatory powers to enforce and compel health insurance companies to comply with the unconstitutional provisions of House Bill 1489, health insurance companies, including MAHP's members, face immediate risk of irreparable harm. Health insurance companies (and the covered citizens of Mississippi) will face unexpected, incalculable and likely unrecoverable increased costs of healthcare through the Reimbursement Mandate imposed for the sole benefit of ambulance service provider special interest groups, not for the benefit of the state's healthcare system as a whole. Moreover, health insurance companies, including MAHP's members, risk the expense and uncertainty of examinations, enforcement actions and regulatory penalties due to the vagueness of the Section 1 Coverage Mandate. These represent the greater harms to Mississippi's healthcare system, and they significantly outweigh enjoining the Commissioner's enforcement of the Bill pending this Court's ruling on the merits.

4. Enjoining the enforcement of House Bill 1489 is in the public interest.

Federal courts have considered the balance-of-equities and public-interest elements together as they overlap considerably. *Texas v. United States*, 555 F. Supp. 3d 351, 436 (S.D. Tex. 2021). Where the defendant is the government, these two elements "merge." *Id.* (citing *Nken v. Holder*, 556 U.S. 418, 435 (2009).

Enjoining the enforcement of the Bill is in the public interest because doing so will avoid depriving health insurers, including MAHP's members, of their constitutional rights and protections. *Womens' Health Org.*, 940 F. Supp. 2d at 424 ("Finally, the grant of an injunction will not disserve the public interest, an element that is generally met when an injunction is designed to avoid constitutional deprivations."); *State v. Biden*, 10 F.4th 538, 560 (5th Cir. 2021) (quoting *League of Women Voters of U.S. v. Newby*, 838 F.3d 1, 12 (D.C. Cir. 2016) (finding "[t]here is generally no public interest in the perpetuation of unlawful agency action"); *Ingebretsen v. Jackson Pub. Sch. Dist.*, 864 F. Supp. 1473, 1491 (S.D. Miss. 1994), *aff'd sub nom. Ingebretsen on Behalf of Ingebretsen v. Jackson Pub. Sch. Dist.*, 88 F.3d 274 (5th Cir. 1996) ("The court finds that the public interest will not be disserved by the issuance of an injunction aimed at preventing the enforcement of a potentially unconstitutional statute."). In this case, a preliminary injunction particularly benefits the public interest as emergency medical services are, undoubtedly, vital to the public, and maintaining the status quo pending this Court's decision on the merits will preserve predictable and affordable healthcare coverage in Mississippi in the interim.

CONCLUSION

For the foregoing reasons, MAHP requests the Court to grant its Motion for Preliminary Injunction, and enter an order enjoining the Commissioner, until such time as the Court decides MAHP's request for declaratory judgment on the merits, from taking any actions to implement or enforce House Bill 1489, including without limitation:

1. Exercising any authority to disapprove health benefit plans or health insurance policies submitted to him or his office pursuant to Miss. Code Ann. § 83-9-4, on account of purported non-compliance with the Bill;

2. Initiating any examination or investigation or making any determinations that health insurers are in violation of state or federal law on account of purported non-compliance with the Bill, including without limitation, those permitted under Miss. Code Ann. §§ 83-1-51 and 83-5-205;

3. Instituting any enforcement or regulatory action or proceeding permitted under Mississippi law against health insurers on account of purported non-compliance with the Bill, including without limitation, those permitted under Miss. Code Ann. § 83-5-209(6)(c);

4. Issuing any orders against health insurers finding non-compliance with state law on account of purported non-compliance with the Bill, including without limitation, those permitted under Miss. Code Ann. §§ 83-1-51 and 83-5-209(3)(a); and/or

5. Imposing any penalties, sanctions or fines permitted under Mississippi law on or against health insurers on account of purported non-compliance with the Bill, including without limitation, those permitted under Miss. Code Ann. §§ 83-1-51 and 83-9-19.

MAHP requests the Court to grant such other relief, whether in law or in equity, as the Court may deem just and proper following a hearing on this matter.

Dated: July 18, 2024.

Respectfully Submitted,

MISSISSIPPI ASSOCIATION OF HEALTH PLANS, INC

By: */s/ James A. McCullough, II*
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CERTIFICATE OF SERVICE

I hereby certify that on this day, a true and accurate copy of the foregoing was electronically transmitted to the Clerk of the Court using the ECF System for filing, which delivered notice of same to all counsel of record. I further certify that I have caused the foregoing to be delivered by hand delivery to the following recipients:

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Dated: July 18, 2024.

/s/ James A. McCullough, II
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