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

MISSISSIPPI ASSOCIATION OF HEALTH PLANS, INC.	**PLAINTIFF**
V.	**CAUSE NO. 2:24-cv-379-HTW-LGI**
MIKE CHANEY, IN HIS OFFICIAL CAPACITY AS COMMISSIONER OF INSURANCE OF MISSISSIPPI	**DEFENDANT**

MISSISSIPPI ASSOCIATION OF HEALTH PLANS, INC.'S
RESPONSE IN OPPOSITION TO DEFENDANT'S MOTION TO DISMISS

The Mississippi Association of Health Plans, Inc. ("MAHP") submits its response in opposition to the motion to dismiss filed by Defendant Mike Chaney, in his official capacity as Commissioner of Insurance ("Commissioner"). In support, MAHP shows the following:

1. The Commissioner's Motion to Dismiss should be denied because (1) MAHP has standing to assert its claims; (2) the Commissioner is not immune from MAHP's claims; (3) this case is ripe for adjudication; and (4) MAHP has stated claims upon which relief can be granted.

2. In the alternative and pursuant to Federal Rule of Civil Procedure 15(a)(2), if the Court finds that any relief requested by the Commissioner should be granted because of a pleading deficiency or because any facts or allegations were otherwise absent from MAHP's Complaint, MAHP requests leave to amend its Complaint.

3. MAHP adopts and incorporates by reference, as if fully set forth herein, the references, arguments and authorities set forth in its *Memorandum Brief in Support of its Response in Opposition to the Commissioner's Motion to Dismiss*, being filed contemporaneously with this response.

ACCORDINGLY, MAHP requests the Court to enter an order denying the Commissioner's motion to dismiss. MAHP requests any further relief the Court deems just and proper.

Dated: August 19, 2024.

Respectfully Submitted,

MISSISSIPPI ASSOCIATION OF HEALTH PLANS

By: */s/ James A. McCullough, II*
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.

Dated: August 19, 2024.

/s/ James A. McCullough, II
James A. McCullough, II

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MISSISSIPPI ASSOCIATION OF HEALTH PLANS, INC.'S MEMORANDUM IN SUPPORT OF ITS RESPONSE IN OPPOSITION TO DEFENDANT'S MOTION TO DISMISS

The Mississippi Association of Health Plans, Inc. ("MAHP") submits this memorandum in opposition to the motion to dismiss filed by Defendant Mike Chaney, in his official capacity as Commissioner of Insurance ("Commissioner"). In support, MAHP states the motion to dismiss should be denied for the following reasons.

INTRODUCTION

The Commissioner has moved to dismiss MAHP's constitutional challenge to House Bill 1489, enacted during the 2024 Regular Session of the Mississippi Legislature ("House Bill 1489" or the "Bill"), the provisions of which violate MAHP's members' rights under Article I, Section 10 of the United States Constitution and the Due Process Clause of the Fourteenth Amendment to the United States Constitution. *See* Docs. 1, 10. But rather than challenging this action for what it is—an effort to prevent the Commissioner from exercising his regulatory authority to implement and enforce an unconstitutional law—the Commissioner is ignoring and misreading the allegations in the Complaint by arguing MAHP's members' *real* dispute is with their insureds and/or ambulance service providers, neither of which have filed suit to demand coverage or

reimbursement compelled by House Bill 1489.[1] This argument, respectfully, goes nowhere. MAHP requests the Court to declare the Bill unconstitutional and to enjoin the Commissioner from carrying out his statutorily-prescribed administrative authority in the specific ways that implement or enforce the Bill against MAHP's members, which are regulated by the Commissioner. Doc. 1 at ¶47. This constitutional challenge is ripe for adjudication and is unaffected by any civil action that might (or might not) be brought by an insured or ambulance service provider in the future. Indeed, no private right of action exists under House Bill 1489.

As discussed below, the Complaint clearly demonstrates MAHP satisfies both Article III standing and associational standing to bring this action, the Commissioner is the appropriate public official defendant for this constitutional challenge, and immunity does not bar MAHP from seeking declaratory and injunctive relief against him from enforcing an unconstitutional law. Although the Bill does not expressly direct the Commissioner to enact regulations to enforce its provisions, his statutory authority as the regulator of insurance companies in Mississippi requires him to ensure compliance with House Bill 1489. In addition to his broad powers to compel compliance with state insurance laws through examinations, regulatory proceedings and orders, the Commissioner is required to review certain insurance policies' changes of terms and benefits, and to disapprove those he determines are inconsistent with state law (to include new coverage benefits required by House Bill 1489). Indeed, certain policy language describing the benefits the

[1] *See* Doc. 12 at 7 ("This allegation, advancing uncertainty, is not an allegation that a member is currently or imminently facing a particular coverage dispute or legal action."); *id*. at 8 ("This is not an allegation that a member is currently or imminently facing a particular reimbursement dispute or legal action."); *id*. at 10 ("MAHP relies solely on speculative actions by either "an enrollee" (i.e., an insured individual consumer) or an "out-of-network ambulance provider" that might then lead to the claimed injury of MAHP or its members."); *id*. ("If one of MAHP's members fails to cover ambulance expenses for an insured, the insured (assuming arguendo that the insured is injured) could file a civil action against the member. Likewise, if one of MAHP's members fails to reimburse an "out-of-network" ambulance provider in accordance with the reimbursement mandate, that ambulance provider could sue to redress its commercial injury."); *id*. at 15 ("if one of MAHP's members fails to cover ambulance expenses for an insured, the insured may consider filing a civil action against the member. Likewise, if one of MAHP's members fails to reimburse an out-of-network ambulance provider, that ambulance provider may also consider filing a civil action.").

Bill attempts to mandate cannot go into effect without first passing the Commissioner's review. Only the Commissioner can make those determinations.

Lastly, MAHP has adequately pled its claims that the Bill violates the Contract Clause, Article I, Section 10 of the United States Constitution, and the Due Process Clause of the Fourteenth Amendment to the United States Constitution. The motion to dismiss should be denied.

BACKGROUND

A. Factual Background

House Bill 1489 imposes mandates on health insurance companies related to coverage for "ambulance service[s]" and reimbursement of charges by ambulance service providers. MAHP has provided a detailed summary of the relevant background in its complaint, Doc. 1, and brief in support of its motion for preliminary injunction, Doc. 12, which are incorporated here. In short, Section 1 of the Bill mandates health insurance companies provide coverage for 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 scope of vaguely defined lower-acuity facilities, at "advanced life support" rates although no such services may be necessary or provided (the "Coverage Mandate"). *See* Doc. 1 at ECF 20–22. Due to its vagueness, the Coverage Mandate provides no clear standard for the coverage health insurance companies are required to provide, and invites arbitrary enforcement.

Section 2, as of July 1, 2024, requires insurance companies to reimburse out-of-network ambulance providers whatever rate the ambulance service decides to charge—*no matter how much*—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"). Doc. 1 at ECF 22–23. The Reimbursement Mandate substantially

alters the terms of existing health plans between MAHP's members and their insureds by, among other ways, increasing reimbursement costs to MAHP's members and out-of-pocket costs (payable to the ambulance service) borne by insured Mississippians. House Bill 1489 provides a significant financial windfall for ambulance service providers—and for ambulance service providers *alone*.

B. The Commissioner's Authority To Regulate Insurers, Health Benefit Plans, and Insurance Policies

Despite his suggestions to the contrary, the Commissioner has statutory powers that are both broad and specific for implementing and enforcing House Bill 1489. The Coverage Mandate requires health insurers to provide new coverage benefits for vaguely described ambulance services, which the Commissioner's own rules require his review:

> No insurance company shall ever, under any circumstances, attempt to place any change of rate or any other change in a policy form into effect except after such change has been filed in this office and acknowledged, and where required by law, approved. In particular, any notice to an insured that a change in policy is being made, either a rate or other change, is prohibited except after filing of such change, acknowledgment thereof, and where required by law, approval.

19 Miss. Code R. § 3-4.01 (MID Rule 19-3-4.01). The Rule also requires that no health benefit changes shall be implemented in certain health insurance policies unless "notice is provided to the policyholder at least seventy-five (75) days prior to the effective date." *Id*. The Commissioner is also statutorily-empowered to "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 . . . ." Miss. Code Ann. § 83-9-4; *see* Doc. 1 at ¶44. According to the Commissioner's website, the Mississippi Department of Insurance's ("MID") "Life and Health Actuarial Division is responsible for receiving and analyzing all individual/group **forms** and rates for . . . accident and health insurance . . . sold by licensed insurance companies in the State."[2] MID's website continues: "This

[2] MISSISSIPPI DEPARTMENT OF INSURANCE, *Rate Filing Information*, https://www.mid.ms.gov/mississippi-insurance-department/healthcare/rate-filing-information/ (last visited August 6, 2024); *see also* MISSISSIPPI

ensures that the forms for the aforementioned products are fair and reasonable and that the premium rates are calculated in accordance with State law."[3]

In addition to his duty to review and approve or disapprove certain policy forms and benefit changes before they may become effective, the Commissioner is also authorized to examine and investigate licensees to determine if they are in compliance with state insurance laws, and to impose sanctions on them to enforce those laws. Doc. 1 at ¶44 (citing Miss. Code Ann. §§ 83-1-51, 83-5-209). The Commissioner is further empowered "to order [an insurer] to take any action the commissioner considers necessary and appropriate to cure [] violations [of any law or regulation]," to "initiate any [regulatory] proceedings or actions as provided by law," and to "issue a cease and desist order with or without notice and a prior hearing . . . directing them to cease and desist from further activities," with the failure to comply constituting a misdemeanor and possible fine of $5,000. Doc. 1 at ¶45 (citing Miss. Code Ann. §§ 83-5-209(3), (6)(c)) and 83-1-51(2)).

ARGUMENT

The Commissioner insinuates he has no role whatsoever in implementing or enforcing House Bill 1489, and contends MAHP's members' dispute is with their insureds and/or ambulance service providers. But neither these nor any of the Commissioner's arguments withstand scrutiny, and the motion to dismiss should be denied.

I. MAHP HAS STANDING TO BRING ITS CLAIMS.

The Commissioner contends MAHP lacks Article III standing to pursue its claims because it has not alleged an injury-in-fact, Doc. 13 at 7–8, and the complaint "fails to establish the requisite causation and redressability elements for standing", *id*. at 9–11. The Commissioner also argues

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DEPARTMENT OF INSURANCE, *Life and Health Actuarial Division*, https://apps.mid.ms.gov/about/life-health-actuarial-division.aspx (last visited August 11, 2024) (same). The Court may take judicial notice of MID's website. *See supra* n. 2.

[3] *See id*.

MAHP does not satisfy the first element of associational standing, which requires that at least one of MAHP's members have standing to sue in its own right, nor the third element because they require the individualized participation of MAHP's members. The Commissioner's standing arguments are wrong on all fronts. MAHP has standing to pursue the claims in this matter on behalf of its members, and has adequately pled as much.

A. Article III Standing

Article III standing contains three elements: (1) the plaintiff must have suffered an injury in fact—an invasion of a legally protected interest which is concrete and particularized and actual or imminent, not conjectural or hypothetical; (2) there must be a causal connection between the injury and the conduct complained of—the injury has to be fairly traceable to the challenged action of the defendant, and not the result of the independent action of some third party not before the court; and (3) it must be likely, as opposed to merely speculative, that the injury will be redressed by a favorable decision. *Lujan v. Defs. of Wildlife*, 504 U.S. 555, 561 (1992). To have standing when seeking injunctive or declaratory relief, a plaintiff must merely allege: facts from which it appears there is a substantial likelihood that he will suffer injury in the future, demonstrating a substantial and continuing controversy between two adverse parties; facts from which the continuation of the dispute may be reasonably inferred; and the controversy is real and immediate, creating a definite, rather than speculative threat of future injury. *Serafine v. Crump*, 800 F. App'x 234, 236–37 (5th Cir. 2020).

While MAHP "bears the burden of establishing these elements", *see id.* at 561, "[a]t the pleading stage, general factual allegations of injury resulting from the defendant's conduct may suffice, for on a motion to dismiss [courts] presume that general allegations embrace those specific facts that are necessary to support the claim." *Id.* (citing *Lujan v. Nat'l Wildlife Fed'n*, 497 U.S.

871, 889 (1990)) (analyzing standing as part of appeal of ruling on summary judgment, not motion to dismiss); *Louisiana Fair Hous. Action Ctr., Inc. v. Azalea Garden Properties, L.L.C.*, 82 F.4th 345, 350 (5th Cir. 2023) ("When reviewing standing 'on the basis of the pleadings, we must accept as true all material allegations of the complaint and ... construe the complaint in favor of the complaining party.'"). Doc. 1 at ¶¶31–41.

1. MAHP has adequately alleged an injury-in-fact.

As to the Coverage Mandate, the Commissioner argues that "MAHP does not allege some concrete, particularized, or actual or imminent injury for any one member. It only alleges a range of *possible future injuries*." Doc. 13 at 7 (emphasis in original). The Commissioner selectively quotes a single sentence from the Complaint—"The vague language [of the coverage mandate] will create uncertainty for MAHP's member plans, leaving plans without direction as to what claims may require coverage and what claims may not."—alleging "[t]his allegation, advancing uncertainty, is not an allegation that a member is currently or imminently facing a particular coverage dispute or legal action." *Id*. Rather, argues the Commissioner, "[t]his opinion is only a general allegation that members will face a range of uncertainties regarding insurance coverage in the future." *Id*. Again, this civil action is not about whether MAHP's members are "facing a particular coverage dispute or legal action" from an unidentified third party. It seeks to prevent the Commissioner from exercising his regulatory authority to implement and enforce the vague Coverage Mandate, including through his duty to review and disapprove certain plan terms and benefit changes for coverage compelled under the Coverage Mandate.

MAHP challenges the Coverage Mandate as being void for vagueness under the Due Process Clause. *Complaint*, Doc. 1 at ¶¶31–41. The Complaint identifies specific terms and provisions within the Coverage Mandate that are "so vague and indefinite" that they "are

substantially incomprehensible" and constitute "no rule or standard at all," and "fail[ ] to provide the kind of notice that will enable ordinary people to understand what conduct [they] prohibit[ ] and authorize[ ], and encourage[ ] arbitrary and discriminatory enforcement" by the Commissioner. *Id*. at ¶33. MAHP alleges with specificity the impact of each vague term and provision. *See id*. at ¶36 (*Definition of "alternative destination"*: "As written, it is substantially unclear what constitutes an 'alternative destination' and if an 'alternative destination' includes medical providers who do not provide any degree of emergency medical services, such as a dermatologist, pharmacist, chiropractor, and the like."); *id*. at ¶37 (*Meaning of the term "encounter"*: "Thus, it is substantially unclear what level of service an ambulance service provider 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."); *id*. at ¶38 (*Meaning of the term "911 call"*: "It is substantially unclear whether coverage for ambulance services and transportation at the advanced life support rates would be triggered when a caller contacts an ambulance service directly, not through a governmental E-911 service, which will encourage calls for service that are not truly emergency in nature."); *id*. at ¶39 (*Scope of the term "contracts" in Section 1(6)*: "The vagueness of this section makes it substantially unclear if Section 1(6) imposes the Coverage Mandate on existing plan year terms . . . ."). In light of the "uncertainty" created by these vague terms and provisions, MAHP's member plans are "without direction as to what claims may require coverage and what claims may not." Doc. 1 at ¶40.

These vagaries do not merely harm MAHP's members in the abstract and are not "possible future injuries" as the Commissioner alleges. Doc. 13 at 7. Rather, as the Complaint makes clear, MAHP's members have to craft benefit plan language and benefits structures for coverage provided under those benefit plans and claim processing guidelines related to the new benefits,

and "the provisions of health benefit plans, including benefits structure . . . must be approved by the Commissioner months before plans may be issued." Doc. 1 at ¶25; *id*. at 39. To craft plan terms, MAHP's members have to know what specific conduct requires coverage and what specific events trigger coverage. MAHP has identified the exact provisions of the Coverage Mandate that make these tasks impossible. The Coverage Mandate's "significant lack of clarity will leave the interpretation and enforcement of these provisions to the sole discretion of the Commissioner . . . ." *Id*. at ¶40.

National Press Photographers Assoc. v. McCraw, cited by the Commissioner, must be read in line with binding Supreme Court precedent, which makes clear that "where threatened action by *government* is concerned" a plaintiff is not required "to expose himself to liability before bringing suit to challenge the basis for the threat—for example, the constitutionality of a law threatened to be enforced". *MedImmune, Inc. v. Genentech, Inc.*, 549 U.S. 118, 128–29 (2007) (emphasis in original). Indeed, since *National Press* was decided, courts in the Fifth Circuit have continued to find Article III standing where a plaintiff alleges they risk prosecution if they fail to abide by the allegedly unconstitutional law. *See, e.g., Pharm. Rsch. & Manufacturers of Am. v. Fitch*, No. 1:24-CV-160-HSO-BWR, 2024 WL 3277365, at *5 (S.D. Miss. July 1, 2024). MAHP's concerns are not hypothetical or conjectural because its members would be in violation of the Bill and risk regulatory enforcement if they "do[] what [they] claim[] the right to do", which is sufficient for Article III standing. *MedImmune*, 549 U.S. at 129.

To prevent the Commissioner's disapproval of plan terms on the basis of non-conformance with House Bill 1489, MAHP has asked this Court to prohibit the Commissioner from "[r]efusing to approve health benefit plans submitted to him or his office that do not provide coverage for ambulance services under" the Coverage Mandate. *Id*. at ¶47. That the Commissioner can

disapprove MAHP's members' plan terms for non-compliance with House Bill 1489 is not conjectural or hypothetical; it is his job, and he has an entire division of MID employees dedicated to carrying out these duties—the Life and Health Actuarial Division.[4] *See K.P. v. LeBlanc*, 627 F.3d 115, 122 (5th Cir. 2010) ("Still, both this court and the Supreme Court have generally permitted future events which are sufficiently likely to occur to serve as a basis for standing when the plaintiffs, as here, are seeking injunctive relief.").

The Commissioner similarly argues that MAHP has not alleged an injury-in-fact with respect to its claim that the Reimbursement Mandate substantially impairs existing contracts between MAHP's members and their insureds and, as a result, violates the Contract Clause. Doc. 13 at 8. The Commissioner points to a single allegation in the Complaint, which provides "[m]andating a minimum allowable reimbursement rate up to any amount an out of network ambulance service provider wishes to charge imposes a significant change in coverage obligations and cost increase on current health benefit plans and health insurance policies that unreasonably and substantially impairs bargained for terms." Doc. 1 at ¶26. Despite the clarity of this language that with higher reimbursement obligations come higher costs to insurers and insureds, the Commissioner attempts to diminish it to a mere allegation that "members *might* face increased reimbursement demands from an ambulance service in the future." Doc. 13 at 8. This assertion is unavailing.

Absent a local government contract for specific rates, the Reimbursement Mandate requires health insurance companies to provide a minimum allowable reimbursement rate for out-of-network ambulance providers up to whatever amount they decide to charge. MAHP has sufficiently alleged this Reimbursement Mandate substantially impairs existing contracts between

[4] *See supra* n. 3.

MAHP's members and their subscribers and that the higher mandated reimbursement rates will impose "a significant change in coverage obligations and cost increase on current health benefit plans and health insurance policies that unreasonably and substantially impairs bargained for terms." Doc. 1 at ¶26; *see also id*. at ¶27 ("The Bill seeks to unilaterally expand the obligations (and costs) of both Plaintiff's members and their subscribers/insureds under existing health benefit plans and insurance policies without their consent."). Aside from MAHP's allegation that House Bill 1489 violates the constitutional rights of its members, which itself may constitute an injury-in-fact, *Abdullah v. Paxton*, 65 F.4th 204, 210 (5th Cir.), *cert. denied*, 144 S. Ct. 188, 217 L. Ed. 2d 75 (2023) ("We recognize that violations of constitutional rights may of course, in some instances, satisfy the injury-in-fact requirement."), MAHP has clearly pled the Reimbursement Mandate will impose significant (and likely unrecoverable) cost increases on MAHP's members.[5] *See TransUnion LLC v. Ramirez*, 594 U.S. 413, 425 (2021) ("certain harms readily qualify as concrete injuries under Article III. The most obvious are traditional tangible harms, such as physical harms and monetary harms."); *Gen. Land Off. v. Biden*, 71 F.4th 264, 272 (5th Cir. 2023) (finding injury-in-fact due to financial harms which "are readily cognizable and well-established in this court's precedents"); *United Healthcare Ins. Co. v. Davis*, 602 F.3d 618, 628 (5th Cir. 2010) (finding Contract Clause violation where legislative mandate resulted in insurers incurring costs not anticipated at inception of contracts).

MAHP has adequately pled an injury-in-fact. *See Azalea Garden Properties*, 82 F.4th at 350 ("When reviewing standing 'on the basis of the pleadings, we must accept as true all material

[5] Additionally, the record developed in the case demonstrates the scope of the impact on existing plans. *See* MAHP's Supplemental Support for Motion for Preliminary Injunction [Dkt. 17] Exhibit 2, Declaration of Bryan Lagg ¶ 15 (identifying out of network ambulance charges filed after July 1, 2024, as high as 1,921% higher than Medicare's reimbursement rate); Exhibit 3, Declaration of Aaron Riley Sisk ¶ 13 (identifying ambulance charges filed after July 1, 2024, as high as 1,393.15% higher than Medicare's reimbursement rate).

allegations of the complaint and ... construe the complaint in favor of the complaining party.'").

2. MAHP has adequately pled the causation and redressability elements of standing.

Citing *Campaign for S. Equal. v. Miss. Dep't of Hum. Servs.*, 175 F. Supp. 3d 691, 702 (S.D. Miss. 2016), the Commissioner contends that "[w]here the defendant is an executive-branch officer, 'the required causal connection comes from an officer's "coercive power" *regarding the disputed statute.*'" Doc. 13 at 9 (emphasis in original). The Commissioner argues despite his broad regulatory authority—including his authority to approve policy terms and coverage changes—this authority "is not specific to the coverage or reimbursement mandates challenged by MAHP in the Complaint," *id*., though *Campaign for S. Equal.* does not require enforcement authority to arise from the "specific" statute; it merely finds that the defendant must have "'coercive power' regarding the disputed statute." 175 F. Supp. 3d at 702. The Commissioner boldly claims that "what is clear from the Complaint is that regardless of Commissioner Chaney's acts, omissions or authority, there is no alleged injury that will result only because *of Chaney's actions*." Doc. 13 at 10 (emphasis in original). This statement is simply inaccurate. As MAHP has made clear, it is precisely the Commissioner's actions—his coercive power to compel compliance with House Bill 1489 through his duty to approve or disapprove certain policy changes before they can be issued effective January 1, 2025, as well as his broad powers to compel compliance through examinations, orders and regulatory enforcement—and the resulting injury to MAHP's members that this action seeks to enjoin.

"Even though Article III requires a causal connection between the plaintiff's injury and the defendant's challenged conduct, it doesn't require a showing of proximate cause or that 'the defendant's actions are the very last step in the chain of causation.'" *Inclusive Communities Project, Inc. v. Dep't of Treasury*, 946 F.3d 649, 655 (5th Cir. 2019) (citing *Bennett v. Spear*, 520

U.S. 154, 169 (1997)). To satisfy the causation element of Article III standing at the pleading stage, MAHP is only required to allege facts showing the Commissioner's conduct is *a* cause-in-fact of the injury that MAHP asserts. *Gen. Land Off. v. Biden*, 71 F.4th 264, 272 (5th Cir. 2023) ("As to causation, Texas needs only to have alleged facts showing the Federal Defendants' conduct is a cause-in-fact of the injury that the State asserts. Texas has done so here, alleging facts that, if true, demonstrate DHS's June 2021 decision to divert 2020 and 2021 funds away from the creation of a border wall will result in fiscal injuries to the State") (citations omitted). "Article III requires no more than *de facto* causality." *Dep't of Com. v. New York*, 588 U.S. 752, 768 (2019). MAHP has clearly met that burden.

The Commissioner's prior approval or disapproval of certain plan term and coverage changes "is the first step in the path" of MAHP's members' forced-compliance with House Bill 1489. *See Campaign for S. Equal.*, 175 F. Supp. 3d at 704; *Air Evac EMS, Inc. v. Texas, Dep't of Ins., Div. of Workers' Comp.*, 851 F.3d 507, 514 (5th Cir. 2017) ("By setting the reimbursement rates, state defendants initiate the first step in the workers' compensation payment process."). And the Commissioner "is solely responsible for" and has a demonstrated history of exercising this and other regulatory authority granted him by law. *Id.*[6] The Commissioner, as the "initial arbiter" of such policy changes, is "among those who would contribute to [MAHP's members'] harm." *Id.*

[6] As MAHP alleged in its Complaint, the Commissioner is authorized to examine and investigate licensees to determine if he believes they are in compliance with state insurance laws, and to impose sanctions on them to enforce state insurance laws. Doc. 1 at ¶44 (citing Miss. Code Ann. §§ 83-1-51, 83-5-209). The Commissioner is further empowered "to order [an insurer] 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." Doc. 1 at ¶45 (citing Miss. Code Ann. § 83-5-209(3), (6)(c)). If the Commissioner believes an insurer "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." Doc. 1 at ¶45. Failure to comply with the cease and desist order constitutes a misdemeanor, and may be punished by a fine of $5,000 per violation. Doc. 1 at ¶45 (citing Miss. Code Ann. § 83-1-51(2)). These coercive powers force MAHP's members to comply with the unconstitutional provisions of House Bill 1489. *See Air Evac EMS*, 851 F.3d at 514 (finding Article III standing where state defendants were charged with enforcing provisions of workers' compensation laws and empowered to levy fines).

(quoting *K.P. v. LeBlanc*, 627 F.3d 115, 122 (5th Cir. 2010)). Thus, MAHP has adequately pled the Commissioner "has definite responsibilities relating to *the application of* [House Bill 1489]" and MAHP has standing to pursue this claim. *See Id*. (quoting *K.P.*, 627 F.3d at 124) (emphasis added).

To satisfy redressability, MAHP must show that "it is likely, as opposed to merely speculative, that the injury will be redressed by a favorable decision." *Friends of the Earth, Inc. v. Laidlaw Envtl. Servs. (TOC), Inc.*, 528 U.S. 167, 181 (2000)). The relief sought need not completely cure the injury; it is enough if the desired relief would lessen it. *Sanchez v. R.G.L.*, 761 F.3d 495, 506 (5th Cir. 2014). "When the suit is one challenging the legality of government action or inaction," of which the plaintiff is the object, as are MAHP's members, "there is ordinarily little question that the action or inaction has caused him injury, and that a judgment preventing or requiring the action will redress it." *Lujan v. Defs. of Wildlife*, 504 U.S. at 561–62; *Hope v. Harris*, 861 F. App'x 571, 576 (5th Cir. 2021). Certainly, an order declaring the Bill unconstitutional and enjoining the Commissioner's enforcement of these provisions through his authority to review and approve or disapprove certain plan terms would redress the injuries MAHP alleges its members will suffer. *See Campaign for S. Equal.*, 175 F. Supp. 3d at 704–05 ("Finally, if DHS has authority to erect a barrier to foster-care adoption . . . it likewise has the ability to remove that barrier if so ordered.").[7]

[7] The Commissioner contends this dispute is between MAHP's members and their insureds and ambulance service providers, and that insureds and ambulance providers can file a civil suit against MAHP's members for billing disputes under House Bill 1489. *Id*. However, there is no express private right of action under which an insured or ambulance service provider can enforce House Bill 1489. Nor is there any implied private right of action. *See Major Mart, Inc. v. Mitchell Distributing Co., Inc.*, 46 F.Supp.3d 639, 655 (2014) (finding no private right of action to enforce statutes governing beer wholesaler because the Mississippi Commissioner of the Department of Revenue was charged with licensing and regulating beer wholesalers and "the statutes and regulations governing beer wholesalers . . . are conditions attached to the exercise of a legislative privilege to be enforced by the Commissioner, not a source of tort law to be invoked by private litigants . . . ."). Moreover, it matters not for standing purposes that MAHP's members *might* suffer a *separate* injury through civil lawsuits that *might* be filed by insureds or ambulance providers. *See K.P.*, 627 F.3d at 123 ("We acknowledge that the Board is far from the sole participant in the application of the challenged

MAHP has met its burden, "which is relatively modest at this stage of the litigation", of alleging its injury is fairly traceable to the Commissioner's exercise of his authority and that such injury will "likely be redressed." *Bennett*, 520 U.S. at 171.

B. MAHP has adequately alleged Associational Standing.

"An association has standing to bring claims on behalf of its members when (1) individual members would have standing, (2) the association seeks to vindicate interests germane to its purpose, and (3) neither the claim asserted nor the relief requested requires the individual members' participation."[8] *Students for Fair Admissions, Inc. v. Univ. of Texas at Austin*, 37 F.4th 1078, 1084 (5th Cir. 2022). As shown above, the first prong is satisfied because MAHP's individual members have standing. The Commissioner argues "MAHP also fails to allege the third element [of] associational standing because MAHP is asserting that some of its members will suffer increased costs—an evidentiary issue which varies by member—so both the claim asserted, and the relief requested, will require the participation of individual MAHP members in discovery." Doc. 14 at 11.

"The third prong [of associational standing] focuses importantly on 'matters of administrative convenience and efficiency." *Texas Med. Bd.*, 627 F.3d at 551 (citing *United Food & Commercial Workers Union Local 751 v. Brown Grp., Inc.*, 517 U.S. 544, 557 (1996)). "Courts assess this prong by examining both the relief requested and the claims asserted." *Id*. (citing

statute. For example, litigants may bypass the Board and proceed directly in the courts. But at several points, Section 9:2800.12 impacts the Board's actions sufficiently to confer standing on these Plaintiffs."). "[A] plaintiff satisfies the redressability requirement when he shows that a favorable decision will relieve a discrete injury to himself. He need not show that a favorable decision will relieve his every injury." *Id*. (quoting *Larson v. Valente*, 456 U.S. 228, 243 n. 15 (1982)).

[8] The Commissioner does not challenge whether the second prong of associational standing is met here—that is, whether "the association seeks to vindicate interests germane to its purpose." *Students for Fair Admissions*, 37 F.4th at 1084. "The germaneness requirement is 'undemanding' and requires 'mere pertinence' between the litigation at issue and the organization's purpose." *Ass'n of Am. Physicians & Surgeons, Inc. v. Texas Med. Bd.*, 627 F.3d 547, 551 n.2 (5th Cir. 2010). That prong is satisfied here.

Cornerstone Christian Schs. v. Univ. Interscholastic League, 563 F.3d 127, 134 n.5 (5th Cir. 2009)). While generally "an association's action for damages running solely to its members would be barred," *Texas Med. Bd.*, 627 F.3d at 551 (quoting *Brown Grp.*, 517 U.S. at 546), that is not the case when the plaintiff seeks equitable relief. *Id*. at 553 ("Because AAPS also seeks only equitable relief from these alleged violations [of constitutional rights], both the claims and relief appear to support judicially efficient management if associational standing is granted.").

MAHP satisfies this third prong. MAHP alleges that its members will suffer injury by, among other reasons, being unable to decipher how to implement and craft adequate and approvable coverage terms, as necessary, and being forced to expend significant and unexpected costs to do so (under the Coverage Mandate) and to pay increased but unanticipated reimbursement and administrative costs in the current 2024 plan or policy year (under the Reimbursement Mandate). Doc. 1 at ¶¶26, 27, 29, 40. House Bill 1489 affects one or more of the relevant MAHP members the same. MAHP does not seek damages from the Commissioner. Under these circumstances, not only is associational standing proper, it will "support judicially efficient management." *See Texas Med. Bd.*, 627 F.3d at 551; *see also Pharm. Rsch. & Manufacturers of Am. v. Fitch*, No. 1:24-CV-160-HSO-BWR, 2024 WL 3277365, at *6 (S.D. Miss. July 1, 2024) (finding "requests for declaratory or injunctive relief rarely require individual determinations"). Here, any testimony necessary to demonstrate whether the Bill impacts MAHP's members "can be proven by evidence from representative injured members, without a fact-intensive-individual inquiry," and "the participation of those individual members will not thwart associational standing." *Texas Med. Bd.*, 627 F.3d at 552; *see also Fitch*, 2024 WL 3277365, at *6 ("Individual participation from PhRMA's members is not required in order for the Court to determine the constitutional validity of H.B. 728, or whether it should enjoin the Mississippi Attorney General

from enforcing it."). Because "individual inquiries are unnecessary and the case only requires minimal factual development," MAHP has satisfied the third prong of associational standing. *See Guild v. Securus Techs., Inc.*, No. 1:14-CV-366-LY, 2015 WL 10818584, at *5 (W.D. Tex. Feb. 4, 2015), *report and recommendation adopted sub nom. Austin Laws. Guild v. Securus Techs., Inc.*, No. 1:14-CV-366-LY, 2015 WL 11237655 (W.D. Tex. Mar. 23, 2015).

II. THE COMMISSIONER IS NOT IMMUNE FROM THIS CONSTITUTIONAL CHALLENGE OF A STATUTE REGULATING HEALTH BENEFIT PLANS AND INSURANCE POLICIES.

"As an exception to the general rule of state sovereign immunity, *Ex parte Young* permits plaintiffs to sue a state officer in his official capacity for an injunction to stop ongoing violations of federal law." *Nat'l Press Photographers Ass'n v. McCraw*, 90 F.4th 770, 785 (5th Cir. 2024). "*Ex parte Young* created a narrow doorway through the sovereign immunity defense. To turn the key on the *Ex parte Young* door, a plaintiff must sue the right defendants and ask for the right remedy." *Jackson v. Wright*, 82 F.4th 362, 367 (5th Cir. 2023). And "the officers who are sued must have 'some connection with the enforcement' of the challenged law or policy." *Id*. (citing *Ex parte Young*, 209 U.S. 123, 157 (1908)). The Fifth Circuit "has struggled to define this 'connection' requirement." *Id*. (quoting *Lewis v. Scott*, 28 F.4th 659, 663 (5th Cir. 2022)). But "some guideposts have emerged." *Id*. With respect to the "right remedy", "a court is permitted to 'command[ ] a state official to do nothing more than refrain from violating federal law.'" *Id*. (quoting *Va. Off. for Prot. & Advoc. v. Stewart*, 563 U.S. 247, 255 (2011)).

"In determining whether the doctrine of *Ex parte Young* avoids an Eleventh Amendment bar to suit, a court need only conduct a straightforward inquiry into whether [the] complaint alleges an ongoing violation of federal law and seeks relief properly characterized as prospective." *Verizon Maryland, Inc. v. Pub. Serv. Comm'n of Maryland*, 535 U.S. 635, 645, 122 S. Ct. 1753, 1760, 152

L. Ed. 2d 871 (2002) ("The prayer for injunctive relief—that state officials be restrained from enforcing an order in contravention of controlling federal law—clearly satisfies our 'straightforward inquiry.' We have approved injunction suits against state regulatory commissioners in like contexts."). "To be amenable to suit under *Ex parte Young*, the state actor must *both* possess the authority to enforce the challenged law and have a sufficient connection to the enforcement of the challenged act." *Mi Familia Vota v. Ogg*, 105 F.4th 313, 328 (5th Cir. 2024) (quoting *Haverkamp v. Linthicum*, 6 F.4th 662, 670 (5th Cir. 2021)).

MAHP has sued the right defendant. Despite claiming he can do nothing to implement or enforce House Bill 1489, the Commissioner cannot in good faith contest his duty to review and disapprove certain coverage benefit changes that do not comply with state law, nor can he deny his authority and long record of enforcing compliance with state insurance laws through examinations, orders and, if necessary, regulatory proceedings. Even so, the Commissioner alleges he is not a proper defendant in this action, which seeks injunctive relief to prevent him from exercising that duty and authority on account of non-compliance with House Bill 1489. To find support for this curious position, he points to three "guideposts" laid out by the Fifth Circuit over time: "First, an official must have more than the general duty to see that the laws of the state are implemented. Second, the official must have the particular duty to enforce the statute in question and a demonstrated willingness to exercise that duty. Third, 'enforcement' means compulsion or constraint." *Nat'l Press Photographers Ass'n*, 90 F.4th at 785–86. These guideposts provide no aid to the Commissioner.

1. **The Commissioner's statutory duties are more than a general duty to see that the laws of the state are implemented—they require him to implement and enforce House Bill 1489.**

For MAHP to invoke *Ex parte Young*, the Commissioner must be "statutorily tasked with

enforcing the challenged law." *See Texas Democratic Party v. Abbott*, 978 F.3d 168, 179 (5th Cir. 2020). While House Bill 1489, itself, does not direct the Commissioner to do anything, this makes no difference here in determining whether *Ex parte Young* applies. "*Ex Parte Young* gives some guidance about the required 'connection' between a state actor and an allegedly unconstitutional act." *K.P.*, 627 F.3d at 124. "The fact that the state officer, by virtue of his office, has some connection with the enforcement of the act, is the important and material fact, and **whether it arises out of the general law, or is specially created by the act itself, is not material so long as it exists**." *Id.* (quoting *Ex Parte Young*, 209 U.S. at 157) (emphasis added)[9]; *McLemore v. Hosemann*, 414 F. Supp. 3d 876, 884 (S.D. Miss. 2019) (same). To be sure, "[t]he statutory text [at issue] does not need to 'state the official's duty to enforce it, although such a statement may make that duty clearer.'" *Mi Familia Vota*, 105 F.4th at 326.

As alleged in MAHP's Complaint, the Mississippi Legislature directed that the Bill "shall be codified as new sections in [the Mississippi Insurance Code,] Title 83, Chapter 9, Mississippi Code of 1972." Doc. 1 at ¶3; Doc. 1 at ECF 23, §3. The Commissioner is the "chief officer" of the Mississippi Insurance Department, Miss. Code Ann. § 83-1-3, which is charged with the execution of all laws relative to all insurance and all insurance companies, Miss. Code Ann. § 83-1-1. Doc. 1 at ¶3. While the Commissioner is correct that "[a] general duty to enforce the law is insufficient" to unlock *Ex parte Young's* door, Doc. 13 at 13 (quoting *Mi Familia Vota*, 105 F.4th at 326), the Commissioner's enforcement obligations are not "general" but narrowly-focused on Mississippi's insurance laws—laws governing the businesses that are subject to his oversight. *Compare Nat'l Press Photographers*, 90 F.4th at 786 ("As heads of Texas law-enforcement agencies, Director McCraw and Chief Mathis have more than just the general duty to see that the state's laws are

[9] The Fifth Circuit in *K.P.* "explicitly declin[ed] to follow" the stringent "connection" standard set forth in the plurality decision in *Okpalobi v. Foster*, 244 F.3d 405 (5th Cir. 2001). *Air Evac EMS*, 851 F.3d at 517.

implemented—they are directly responsible for enforcing Texas's criminal laws, including those set forth in Chapter 423."), *with Air Evac EMS*, 851 F.3d at 517 (citing *Morris v. Livingston*, 739 F.3d 740, 745–46 (5th Cir. 2014) ("For example, a state governor with a broad duty to uphold state law is not a proper defendant.")).

And more specifically, the Commissioner's authority to "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," Miss. Code Ann. § 83-9-4; *see* Doc. 1 at ¶44, requires him to ensure each and every policy submitted to him for review contains the coverage required by the Coverage Mandate. In short, in addition to his broad authority to enforce state insurance laws, the Commissioner's duties require him to ensure certain policies comport with Mississippi law, including House Bill 1489. Thus, he has a "particular duty to enforce the statute in question" not just a mere "general duty to see that the laws of the state are implemented." *See Mi Familia Vota*, 105 F.4th at 325.

The Commissioner relies heavily on the Fifth Circuit's recent opinion in *Mi Familia Vota*, the facts of which are markedly different from those here. In *Mi Familia Vota*, various parties sued one of hundreds of Texas' district attorneys alleging that amendments to the Texas Election Code violated the United States Constitution and federal statutes. 105 F.4th 313. Analyzing whether the single district attorney was immune from suit, the court found she, like all prosecutors, possessed prosecutorial discretion "to bring criminal prosecutions within her jurisdiction, including for violations of the Texas Election Code"—and this "mere authority" to bring a prosecution was not a "'specific duty' required for *Ex parte Young* to apply." *Id.* at 326, 28. This was so, according to the court, because the district attorney's prosecutorial authority was purely discretionary, stemming from "a general duty to 'see that justice is done' . . . but that is not enough." *Id.* at 328.

Finding that *Ex parte Young* applied to the district attorney under these circumstances, "would make district attorneys the proper defendants in challenges to *all* criminal statutes categorically. Our precedent demands more from a state statute." *Id*. at 327.

Here, the Commissioner has the express duty to execute Mississippi's insurance laws and is required to review certain plan changes MAHP's members must submit with revised coverage benefits based on their attempt to understand House Bill 1489, and determine whether such changes comply with state law, including House Bill 1489. Thus, MAHP has adequately pled the requisite connection between the Commissioner and House Bill 1489 to satisfy the first *Ex parte Young* guidepost.

2. The Commissioner has a demonstrated willingness to exercise his enforcement authority.

A plaintiff must show at least "some scintilla" of enforcement by the defendant state official. *See City of Austin v. Paxton*, 943 F.3d 993, 1002 (5th Cir. 2019). While "[a] history of prior enforcement is not required" to demonstrate the Commissioner's willingness to enforce the Bill, such a history is present here. *Mi Familia Vota*, 105 F.4th at 330. As noted above, MID Rule 19-3-4.01 requires MAHP members to submit certain policy changes to the Commissioner for review and approval as complying with state law. *See* Doc. 1 at ¶¶39, 44–45.[10] This review necessarily requires the Commissioner to determine whether MAHP members comply with House Bill 1489. Thus, there is more than a mere "willingness" for the Commissioner to carry out these duties.

Reading *Mi Familia Vota* to require the Commissioner to have taken specific action to

[10] Notably, the MID's 2022 Annual Report (the most recent version on MID's website) boasts its Life and Health Actuarial Division reviewed approximately 4,607 electronic rate and form filings for life, health, accident, and annuity products and collected $421,489.97 in electronic filing fees." MISSISSIPPI DEPARTMENT OF INSURANCE, *Annual Report 2022* at 10, https://www.mid.ms.gov/wp-content/uploads/2023/04/annual-report-2022.pdf (last visited August 11, 2024).

enforce House Bill 1489 *before it went into effect* would effectively bar any pre-enforcement constitutional challenge to any statute. This is especially true given the Fifth Circuit's finding that "our cases do not support the proposition that an official's public statement alone establishes authority to enforce a law, or the likelihood of his doing so, for *Young* purposes." *Texas Democratic Party*, 978 F.3d at 181 (citing *In re Abbott*, 956 F.3d 696, 709 (5th Cir. 2020), *cert. granted, judgment vacated sub nom. Planned Parenthood Ctr. for Choice v. Abbott*, 141 S. Ct. 1261, 209 L. Ed. 2d 5 (2021)).

In light of the Commissioner's long-standing history of enforcing Mississippi's insurance laws and his duty to review and approve or disapprove certain policy forms, MAHP has adequately pled the second *Ex parte Young* guidepost. *See Air Evac EMS*, 851 F.3d at 519 ("To the extent *Ex parte Young* requires that the state actor "threaten" or "commence" proceedings to enforce the unconstitutional act, state defendants' pervasive enforcement satisfies that test."); *id* at 520 ("State defendants' pervasive authority to oversee and enforce Texas' workers' compensation system satisfies the *Ex parte Young* exception.").

3. The Commissioner compels and constrains MAHP's members to comply with House Bill 1489.

"To determine whether an official has a sufficient connection to the challenged statute," courts "analyze what 'enforcement' means in the context of that statute." *Mi Familia Vota*, 105 F.4th at 332. Enforcement typically involves compulsion or constraint. *Id*. If the official does not compel or constrain anyone to obey the challenged law, enjoining that official could not stop any ongoing constitutional violation. *Id.*

The Commissioner claims immunity by alleging "MAHP cannot show that an order enjoining Commissioner Chaney would protect MAHP's members from legal action by third parties under [House Bill] 1489." Doc. 13 at 16. Again, any civil action that might (or might not)

be brought against MAHP's members by one or more third parties is irrelevant. The Commissioner has the power to compel MAHP's members to comply with his interpretation of the Bill through his enforcement power and his prior approval process *before new plans or policies can go into effect*, *see* Doc. 1 at ¶¶39, 40, 44–45, thus his authority to disapprove terms for non-compliance with House Bill 1489 constrains MAHP's members to implement policies for the 2025 plan or policy year. MAHP has adequately pled the Commissioner's authority to compel and constrain the conduct of MAHP's members relative to House Bill 1489. Because each of the *Ex parte Young* guideposts are satisfied here, the Commissioner is not immune from this constitutional challenge.

III. THIS CASE IS RIPE FOR ADJUDICATION.

The Commissioner argues that this case is not ripe "because a substantial quantum of future factual development is required" and because "MAHP's claims" "necessarily depend upon factual situations that admittedly have not or may never occur." Doc. 13 at 16–17. This flawed reasoning is premised on the theme that MAHP's members' real dispute is with their insureds and third party ambulance service providers, none of whom have filed suit against MAHP's members for non-compliance with House Bill 1489.

"[A] court must look at two factors to determine ripeness: (1) the fitness of the issues for judicial decision and (2) the hardship to the parties of withholding court consideration." *Braidwood Mgmt., Inc. v. Equal Emp. Opportunity Comm'n*, 70 F.4th 914, 930 (5th Cir. 2023) (quotations omitted). "[A] claim is 'fit for judicial decision' if it presents a pure question of law that needs no further factual development." *Id.* This dispute is between MAHP, on behalf of its health plan members, and the Commissioner and seeks declaratory and injunctive relief to prevent the Commissioner from exercising his statutorily-prescribed duties and authority in ways that implement or enforce House Bill 1489 against MAHP's members. MAHP has thoroughly

explained the ways in which the Commissioner's duties require him to implement and enforce House Bill 1489. The Commissioner cannot deny this authority, and MAHP's claims are not conjectural or hypothetical, as the Commissioner alleges. No additional factual development is needed in this case to determine whether the Reimbursement Mandate impairs existing contracts or policies of insurance in violation of Article I, Section 10 of the United States Constitution and whether the Coverage Mandate 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 has filed a motion for preliminary injunction and an accompanying memorandum brief, Docs. 9, 10 and 17, where it has further explained in detail the ways in which House Bill 1489 is unconstitutional, and MAHP will put on testimony at the hearing on its motion to further demonstrate House Bill 1489's impact on its members. But the crucial facts of this case are fully developed.

MAHP "does not have to await the consummation of threatened injury to obtain preventive relief. If the injury is certainly impending, that is enough." *Braidwood Mgmt.*, 70 F.4th at 926. Here, having certain policy term or benefits changes rejected satisfies this requirement.[11] "Litigants are entitled to relief where they remain under a constant threat that government officials will use their power to enforce the law against them." *Id.* (quotations omitted). "Indeed, [t]he purpose of the Declaratory Judgment Act is to settle actual controversies before they ripen into violations of law or breach of some contractual duty." *Id.* (quotations omitted).

As to the second factor, MAHP's members will be significantly harmed if the Court

[11] In addition to the requirement to submit policy benefit changes to the Commissioner and his duty to approve or disapprove if non-compliant with Mississippi law, health insurance companies must give notice to their policy holders at least seventy-five days prior to the effective date of such changes. Thus, for insurers who renew policies on a calendar year, as at least two MAHP members do, with revised policies to go into effect January 1, 2025, the injury to them arising from the Commissioner having a different reading of House Bill 1489 is imminent. *See* 19 Miss. Code R. § 3-4.01 (MID Rule 19-3-4.01); Miss. Code Ann. § 83-9-4.

withholds consideration. As explained more thoroughly in MAHP's memorandum brief in support of its motion for preliminary injunction, Doc. 10, MAHP's members will be irreparably harmed in the absence of injunctive relief. First, 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). Second, because the Reimbursement Mandate 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 in 2023 when entering into plan contracts and policies of insurance for policy year 2024. All of these additional costs likely are unrecoverable. *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.").

Finally, the Coverage Mandate 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. 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 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. For these reasons, MAHP's members will be significantly harmed if the Court withholds consideration. This matter presents a pure question of law that needs no further factual development. It is not conjectural or hypothetical and, as a result, is ripe for adjudication.

IV. MAHP'S CONSTITUTIONAL CLAIMS ARE ADEQUATELY PLED

The Commissioner argues MAHP's claims should be dismissed under Federal Rule of Civil Procedure 12(b)(6). Doc. 13 at 17–30. Contrary to the Commissioner's assertion, and viewed through the "strict standard of review" employed by courts analyzing a Rule 12(b)(6) motion, *Lowrey v. Texas A & M Univ. Sys.*, 117 F.3d 242, 247 (5th Cir. 1997), MAHP's claims are valid, and the Complaint adequately pleads facts to state plausible claims for relief. The Commissioner's motion to dismiss under Rule 12(b)(6) should be denied entirely.

A. Legal Standard

When presented with a motion to dismiss pursuant to Rule 12(b)(6), a court "must assess whether the complaint contains sufficient factual matter, accepted as true, to state a claim for relief that is plausible on its face." *Spitzberg v. Houston Am. Energy Corp.*, 758 F.3d 676, 683 (5th Cir. 2014) (citing *Ashcroft v. Iqbal*, 556 U.S. 662, 678 (2009); *Bell Atl. Corp. v. Twombly*, 550 U.S. 544, 570 (2007)). "A complaint 'does not need detailed factual allegations,' but the facts alleged 'must be enough to raise a right to relief above the speculative level.'" *Cicalese v. Univ. of Texas Med. Branch*, 924 F.3d 762, 765 (5th Cir. 2019) (quoting *Twombly*, 550 U.S. at 555). "Dismissal under Rule 12(b)(6) is not proper unless it appears, based solely upon the pleadings, that the plaintiff can prove no set of facts in support of the claim(s) warranting relief." *Minter-Smith v. Ashcroft*, No. 3:03-CV-1057WS, 2005 WL 8171879, at *3 (S.D. Miss. June 23, 2005). "The

complaint must be liberally construed in favor of the plaintiff, and all facts pleaded in the complaint must be taken as true." *Lowrey*, 117 F.3d at 247.

B. MAHP's claim that the Reimbursement Mandate violates the Contract Clause is adequately pled.

"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). The Commissioner challenges the first and second steps of the analysis, claiming "MAHP's complaint fails to show that the reimbursement mandate has caused a significant impairment to its members' contracts" and "MAHP has failed to allege that the mandate is contrary to the public interest." Doc. 13 at 17–18, 20. On the contrary, these claims are adequately pled under Rule 12(b)(6)'s "strict standard of review." *Lowrey*, 117 F.3d at 247.

1. The Complaint adequately alleges that the Reimbursement Mandate substantially impairs existing contracts between MAHP's members and their insureds/subscribers.

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) (finding legislation enacted by Louisiana Legislature imposed unanticipated changes

on existing contracts with health insurers and therefore violated Contract Clause). "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." *Id.* at 627 (emphasis added). "Total destruction of contractual expectations is not necessary for a finding of substantial impairment." *Id.* at 628 (quoting *Energy Reserves Group, Inc. v. Kansas Power & Light Co.*, 459 U.S. 400, 412 (1983)).

Health policies and amendments to them are typically issued on an annual basis, and those in effect on July 1, 2024, when the Reimbursement Mandate took effect were submitted to and approved by the Commissioner in 2023 for issuance in 2024. Complaint ¶ 25. These policies include provider reimbursement based on an allowable amount incorporated into the policy benefits, which are critical factors in establishing premium rates. Complaint at ¶26. Policies also routinely provide subscribers are to pay a portion of allowed provider charges themselves. MAHP's members and their subscribers entered into these agreements with the expectation their obligations would continue throughout the full term, but the Reimbursement Mandate alters these payment obligations to be based on an amount up to whatever billed charges out-of-network ambulance service providers decide to submit, unilaterally expanding the obligations (and costs) of both MAHP's members and their subscribers under existing plans and policies without their consent. *Id*.

The Commissioner alleges "[t]here is no basis to conclude that ambulance service providers intend to submit unreasonable bills for their services." Doc. 13 at 19. But whether MAHP's claims are "corroborated" is immaterial in this procedural posture, and whether an ambulance service providers' bills are "unreasonable" has no bearing on the substantial impairment analysis. MAHP has alleged the Reimbursement Mandate "operates as a substantial

impairment to MAHP's members' health benefit plans and health insurance policies," "expand[s] the obligations (and costs) of both Plaintiffs members and their subscribers/insureds under existing health benefit plans and insurance policies without their consent and" "upsets the reasonable expectations the parties had at the time of contracting," an "important consideration in the substantial impairment analysis," *United Healthcare*, 602 F.3d at 627. *See* Complaint at ¶27. MAHP's allegations "must be liberally construed in favor of [MAHP]" and "must be taken as true." *Lowrey*, 117 F.3d at 247.

The Commissioner further contends that "the parties' duties have not been significantly altered *as the purpose of any health plan policy is to provide medical coverage in exchange for a premium*" and, accordingly, he posits, the Reimbursement Mandate "does not change the central undertaking of [MAHP's] members[']s health plans." *Id*. at 20 (emphasis added). The Commissioner's argument here, inconsistent as it may be, supports MAHP's position. He concedes "*the purpose of*" the insurer-insured relationship is for the insurer to pay benefits to providers for covered health care services—what he refers to as the insurer's duty to "provide medical coverage." *See id*. As alleged, benefits paid by MAHP's members are based on allowable reimbursement rates as defined in their contracts with subscribers. Complaint at ¶26. For many plans, the allowable is the same for network and out-of-network ambulance service providers. The Reimbursement Mandate significantly alters these reimbursement rates, which in turn results in significant change in coverage obligations and cost increases on current health benefit plans that impair bargained for terms. *Id*. at ¶¶ 26 and 27. In this way, the substantial impairments created by the Reimbursement Mandate affect "the purpose of" the contact between MAHP's members and their insureds/subscribers, "go to the heart of the contract" and "significantly alter the duties of the parties." *See* Doc. 13 at 20.

Finally, the Commissioner's argument that section 2(2) of the Bill "minimize[s] its effect on insurance policies" because it allows patient cost sharing is no support, Doc. 13 at 20, as it simply prohibits ambulance companies from balance billing patients after insurance benefits and co-payments have been paid based on a statutorily inflated allowable which, as alleged, "unilaterally expand the obligations (and costs) of both Plaintiff's members and their insureds under existing health benefit plans and insurance policies without their consent." Complaint at ¶27.

Despite the Commissioner's argument that parties in regulated industries "are considered to have less reasonable expectations that legislation will not alter their contractual arrangements," Doc. 13 at 18-19, this does not defeat MAHP's claim. Indeed, cases decided since *Energy Reserves Group* have held that entities in highly regulated industries adequately plead Contracts Clause violations when they allege (as MAHP did here) that the challenged regulation would interfere with underlying contractual rights and substantially increase the plaintiff's costs under the contract. *See, e.g., S. California Edison Co. v. City of Laguna Beach*, No. SACV1700618JVSDFMX, 2017 WL 4480827, at *6 (C.D. Cal. July 28, 2017). Further, courts have recognized that "Contract Clause analysis would be enervated if the mere fact of regulation meant there was always foreseeability of more regulation and thus no substantial impairment." *Mercado-Boneta v. Administracion del Fondo de Compensacion al Paciete Through Ins. Com'r of Puerto Rico*, 125 F.3d 9, 14 n.7 (1st Cir. 1997). MAHP adequately pled its claim for violation of the Contract Clause.

2. The Complaint adequately alleges that the Reimbursement Mandate is not in the public interest.

The Commissioner contends "MAHP has failed to allege that the [reimbursement] mandate is contrary to the public interest" without identifying any alleged pleading deficiency, arguing

instead the court must rule now on the merits of whether the Legislature's justification serves a significant and legitimate public purpose. Doc. 13 at 20. ("Assuming this Court finds a substantial impairment from H.B. 1489, it must still consider whether there is a 'significant and legitimate public purpose behind the regulation.'"); *id*. at 21 ("MAHP thus bears the burden of showing that the law does not serve a valid public purpose or that it is unreasonable."). But at this juncture, the Court is to review the Complaint to ensure it "contains sufficient factual matter, accepted as true, to state a claim for relief that is plausible on its face." *Spitzberg*, 758 F.3d at 683.

The Commissioner concedes "providing a benefit to a narrow group of people will not constitute a significant and legitimate public purpose." Doc. 13 at 21 (citing *Allied Structural Steel Co. v. Spannaus*, 438 U.S. 234, 247 (1978)), and MAHP has alleged the Reimbursement Mandate will only enrich ambulance companies, at the expense of MAHP's members and their subscribers (through increased co-insurance requirements), placing this cost of healthcare completely in the control of ambulance companies with a law that requires health insurers to pay whatever they decide to charge. Complaint at ¶29. MAHP has adequately pled the lack of significant and legitimate public purpose behind the Reimbursement Mandate.

C. MAHP adequately pled its claim that the Coverage Mandate violates the Due Process Clause of the Fourteenth Amendment.

A statute "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*, 576 U.S. 591, 594 (2015). MAHP's Complaint alleges several terms and phrases within the Coverage Mandate do not meet this standard. Complaint at ¶¶35–39.

The first of those vague terms is "alternative destination." *Id*. at ¶35. "The Coverage Mandate requires health benefit plans 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,***" defined 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 . . .". Complaint at ¶¶ 34, 35. MAHP alleged "alternative destination" is impermissibly vague because it "is seemingly endless in scope to include non-emergency facilities," although other provisions require a heightened degree of emergency medical service, such as defining an "ambulance service provider" to require "emergency medical services" be performed and reimbursement "at the advanced life support rate plus mileage." Complaint at ¶35. "Yet the Coverage Mandate 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, leaving it substantially unclear what facilities may be included. *Id*. at ¶36.

Adding to the vagueness is the juxtaposition of these provisions requiring some level of "emergency" services with others that seemingly do not. The Complaint alleges vagueness because the Bill provides coverage is triggered by a "911 call," yet defines the term such that a call directly to the ambulance company could trigger coverage in lieu of calling a county's or municipalities E-911 service by dialing "9-1-1." Complaint at ¶38. The Complaint further alleges the requirement 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," are so vague as to provide no guidance of what level of services, much less emergency services, are required. Complaint at ¶37.

The Commissioner challenges the adequacy of MAHP's Due Process claim by arguing

"when read in its entirety, the law concerns itself *with emergency medical care . . .*". Doc. 13 at 27 (emphasis added). Regarding what constitutes an "alternative destination," the Commissioner argues"[i]f the Legislature had intended the specific words to be used in their unrestricted sense, they would have made no mention of the four categories of facilities" in Section 2(b)(i), Doc. 13 at 25, and states his position that "alternative destination" does not include facilities that do not provide emergency services. *Id*. at 26–27. [12] Similarly, the Commissioner opines coverage is only triggered by an enrollee dialing "9-1-1" even though the statute does not define it as such. Complaint at ¶38. But the Commissioner gives no clarity to the level of emergency services requiring coverage for the confusingly similar terms to "***treat*** or ***assess*** an enrollee ***in place***," "***triage***" (without transport), or for "[a]n ***encounter*** between an ambulance service and enrollee that results without transport of the enrollee." Complaint at ¶37. Rather, he merely identifies a Department of Health form with "encounter" included in its title, with no guidance whatsoever of what the term "encounter" means, much less how that term differs, for coverage purposes, from the terms "treat", "assess", or "triage". Doc. 13 at 28.

While the Commissioner may have an opinion about what the questionable terms mean, MAHP has alleged certain of its members do not, and those members must craft policy language and guidelines to implement the Coverage Mandate in a way that complies with the law and clearly informs insureds of the specific services covered under their health plans. Absent a clearly defined coverage obligation, MAHP's members cannot do this. To be sure, the Commissioner, if he

[12] The Commissioner could have pointed to Mississippi law providing that where "specific words" follow "general ones", the doctrine of *ejusdem generis* "restricts application of the general term to things that are similar to those enumerated." *Flye v. Spotts*, 94 So. 3d 240, 245 (Miss. 2012). This doctrine provides no assistance here, where facilities "similar to those enumerated" in Section 2(b)(i) are endless. The examples listed in MAHP's complaint—dermatologists' offices, pharmacies, and chiropractors—could all fall within the umbrella of "similar" facilities. A dermatologist's office is either a "physician's office," which is included in the list of examples of "alternative destinations" in Section 2(b)(i), or is "similar" to one. Chiropractor's offices across Mississippi operating as "clinics," which is included in or "similar" to "medical clinics" in the list of examples in Section 2(b)(i). Pharmacists routinely provide vaccinations and other medical services that occur at facilities that are arguably "similar" to "medical clinics".

chooses, is empowered to issue regulations or a special bulletin to provide health insurance companies clear guidance on House Bill 1489, but he has not done so. Rather, it took litigation to elicit these views. Yet by providing his views, he proves MAHP's point – its members are justified in their confusion caused by the Bill's unconstitutionally vague terms, and as their regulator, his reading of the Bill demonstrates a potential for arbitrary and discriminatory application.

The requirements of the Coverage Mandate can hardly be described as "clearly defined." *See Stockstill*, 2017 WL 3037431, at *6. MAHP has alleged "[t]hese unintelligible provisions create no standard at all and/or cause House Bill 1489, Section 1 to be substantially incomprehensible." Complaint at ¶40. "The vague language will create uncertainty for MAHP's member plans, leaving plans without direction as to what claims may require coverage and what claims may not." *Id.* And the provisions of the Coverage Mandate "are impermissibly vague in all of their applications" leaving "the interpretation and enforcement of these provisions to the sole discretion of the Commissioner, who "is charged with execution of all laws relative to insurance companies." *Id.*; *see also City of El Cenizo, Texas v. Texas*, 890 F.3d 164, 190 (5th Cir. 2018) ("A facially vague provision is 'so standardless that it invites arbitrary enforcement.'") (quoting *Johnson*, 576 U.S. at 594). The Commissioner's arguments serve to highlight these defects.

At this stage of the dispute, despite the Commissioner's statements as to the meaning of these vague terms and phrases, the Court must only "assess whether the complaint contains sufficient factual matter, accepted as true, to state a claim for relief that is plausible on its face." *Spitzberg*, 758 F.3d at 683. In other words, the Court should merely determine "whether in the light most favorable to [MAHP] and with every doubt resolved in [its] behalf, the complaint states any valid claim for relief.'" *Lowrey*, 117 F.3d at 247. MAHP has adequately pled its claims, and the Commissioner's arguments under Rule 12(b)(6) should be denied.

V. MAHP ALTERNATIVELY REQUESTS LEAVE TO AMEND ITS COMPLAINT

In the alternative and pursuant to Federal Rule of Civil Procedure 15(a)(2), if the Court finds that any relief requested by the Commissioner should be granted because of a pleading deficiency or because any facts or allegations were otherwise absent from MAHP's Complaint, MAHP requests leave to amend its Complaint.

"Rule 15(a) requires a trial court to grant leave to amend freely, and the language of this rule evinces a bias in favor of granting leave to amend." *Marucci Sports, L.L.C. v. Nat'l Collegiate Athletic Ass'n*, 751 F.3d 368, 378 (5th Cir. 2014). "Leave to amend is in no way automatic, but the district court must possess a substantial reason to deny a party's request for leave to amend." *Weyerhaeuser Co. v. Burlington Ins. Co.*, 74 F.4th 275, 288 (5th Cir. 2023). Alternatively, and to the extent necessary, allowing MAHP to amend its Complaint would advance justice in this case. *See Calhoun v. Collier*, 78 F.4th 846, 854 (5th Cir. 2023), *as revised* (Aug. 31, 2023) ("As the Court has instructed, leave to amend shall be freely given when justice so requires; this mandate is to be heeded.") (quotations omitted).

VI. CONCLUSION

For the foregoing reasons, Plaintiff Mississippi Association of Health Plans requests the Court to enter an Order denying Defendant's Motion to Dismiss in its entirety, and requests such other relief as the Court deems just and proper.

Dated: August 19, 2024.

Respectfully Submitted,

MISSISSIPPI ASSOCIATION OF HEALTH PLANS

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.

Dated: August 19, 2024.

/s/ James A. McCullough, II
James A. McCullough, II