IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MARYLAND

CITY OF COLUMBUS *et al.*, *Plaintiffs*, v. ROBERT F. KENNEDY JR. *et al.*, *Defendants*.	Case No. 1:25-cv-2114

PLAINTIFFS' REPLY IN SUPPORT OF THEIR MOTION FOR STAY UNDER 5 U.S.C. § 705 OR, IN THE ALTERNATIVE, FOR PRELIMINARY INJUNCTION

TABLE OF CONTENTS

INTRODUCTION

The Centers for Medicare & Medicaid Services ("CMS") committed a hodgepodge of errors when it rushed to issue its rule shortly before enrollment opens on the Affordable Care Act's (ACA) Exchanges for the coming year. In some instances, such as its attempt to revoke the ACA's promise that insurance coverage will be available for all comers, the agency asserted statutory powers that it doesn't have. In other instances, such as its adoption of a methodology to calculate tax credits that will inevitably raise costs for enrollees, the agency failed to recognize the statutory authorities that it does have. And in yet other instances, CMS may have understood the scope of its discretion, but it fell short of basic requirements of reasoned decision-making.

There is a common thread to all of the agency's errors, however. In each instance, CMS chose to make it harder to obtain health insurance coverage on the Exchanges, inflate the cost of that coverage, and drive people out of insurance coverage altogether. CMS did so largely in reliance on a report prepared by the Paragon Health Institute, which proposed extreme measures to combat a supposed problem of improper enrollments, even though these measures would lead to dropped coverage and higher costs. But that report—and CMS's derivative analysis—was fundamentally mistaken, for the reasons that commenters explained in detail to the agency during the rulemaking and that we reiterated in our opening brief. CMS made no effort to defend its analysis either in its final rule or in its opposition brief. Its silence speaks volumes.

Plaintiffs, accordingly, are likely to succeed on each of their challenges to the provisions in the rule that place burdens on the availability and costs of coverage on the Exchanges. CMS's protestations notwithstanding, Plaintiffs will be injured by the rule, and that injury would not be reparable without a stay of the effective date of the rule under 5 U.S.C. § 705. Because CMS departed from its usual procedures and issued its rule so late in the year, insurers are already in the process of setting rates and designing plans for the beginning of the open enrollment period on

November 1, and Exchanges are finalizing their enrollment systems and preparing to notify consumers of their expected premiums. Relief is accordingly needed now, before open enrollment starts, to protect the integrity of the Exchanges for the upcoming 2026 plan year. And that relief should apply on a nationwide basis, both because a Section 705 stay necessarily operates universally, and because there is no practical way to stay the rule only for the Plaintiffs.

ARGUMENT

I. Plaintiffs Are Injured by the Rule, and Irreparably So in the Absence of a Stay

Plaintiffs have standing to challenge CMS's rule, as they will "suffer[] an injury in fact, . . . that is fairly traceable to the challenged conduct of the defendant, and . . . that is likely to be redressed by a favorable judicial decision." *Curtis v. Propel Prop. Tax Funding, LLC*, 915 F.3d 234, 240 (4th Cir. 2019) (internal quotation omitted). And because these injuries "cannot be fully rectified" by a later judgment in their favor, they meet the irreparable harm prong for injunctive relief. *Mountain Valley Pipeline, LLC v. 6.56 Acres of Land*, 915 F.3d 197, 216 (4th Cir. 2019) (cleaned up). Plaintiffs and their members will suffer financial injury because the rule will cause as many as two million people to lose health insurance coverage, directly leading to increased costs from uncompensated care incurred by the municipal Plaintiffs and the providers who are members of Doctors for America. Pls.' Mem. in Supp. of Mot. for Stay 15–17, 39–43, ECF No. 11-1 ("Pls.' Mem."). These harms will be compounded for the provider Plaintiffs because the rule will also increase the cost of coverage, leading to even more people dropping out of the market, and leaving the members of Main Street Alliance with the Hobson's choice of retaining less generous but costlier coverage or dropping out of coverage altogether. *Id.*

CMS disparages these harms as "speculative." Defs.' Opp'n to Pls.' Mot for Prelim. Relief 9, ECF No. 28 ("Opp'n"). But the agency itself concedes that the rule will cause at least 800,000 Americans to lose coverage. 90 Fed. Reg. 27,074, 27,213 (June 25, 2025). And CMS also

repeatedly acknowledges that these coverage losses result in uncompensated care for health care providers, *id.* at 27,086, 27,171, 27,196, 27,207, 27,214, 27,219, including municipalities, *id.* at 27,145, 27,190, 27,192. The rule thus injures the provider Plaintiffs by requiring them to pay more for the cost of uncompensated care.

CMS disputes whether the rule will also lead to health care costs as well as coverage losses, Opp'n 10, which is puzzling, given that the rule *directly* increases enrollees' cost-sharing obligations and lowers the value of their tax credits (among other things). *See* Pls.' Mem. 7–8. The agency entirely ignores the declaration of Christen Linke Young, which set forth in detail the academic literature showing that each of the challenged provisions will increase coverage costs by disproportionately driving younger and healthier people out of the Exchanges, worsening the risk pool for those who remain, Young Decl., ¶¶ 4–6, ECF No. 11-2, increasing costs, and adding to existing headwinds for the individual insurance market. *See id.* ¶¶ 29–59; *see also* Wakely, *Future of the Individual Market: Impact of the House Reconciliation Bill and Other Changes on the ACA Individual Market* 11, n.24 (June 18, 2025), https://perma.cc/BS77-KBES (projecting that both gross and net premiums will increase under the rule).[1]

CMS also belittles Plaintiffs' injuries as the end result of an "attenuated chain of possibilities." Opp'n 13. But "what matters is not the 'length of the chain of causation,' but rather the 'plausibility of the links that comprise the chain.'" *Nat'l Audubon Soc'y, Inc. v. Davis*, 307 F.3d 835, 849 (9th Cir. 2002) (quoting *Autolog Corp. v. Regan*, 731 F.2d 25, 31 (D.C. Cir. 1984)).

[1] This, too, is common ground among the parties. CMS cites to the rule's regulatory impact analysis, which projects that it will lead to lowered premiums. Opp'n 11 (citing 90 Fed. Reg. at 27,212–13). But this was based entirely on a projected decrease from the termination of the low-income special enrollment period. 90 Fed. Reg. at 27,212. That projection was never credible, but any dispute on this score is now immaterial, as Plaintiffs no longer challenge that provision. CMS acknowledges that the remaining challenged provisions will increase premiums and net costs for consumers, *see id.*; *see also id.* at 27,107 (junk-fee rule); 27,171 (premium adjustment percentage); 27,176–77 (actuarial value calculations); 27,192 (guaranteed issue); 27,116 (failure-to-reconcile policy); 27,119, 27,131 (data matching policies), and indeed the agency repeatedly points to these acknowledgements to defend the rationality of its rulemaking, *see, e.g.*, Opp'n 20, 30, 47.

The ultimate question is whether the plaintiffs' injury can be fairly traced through the third party's intervening action back to the defendant, and "[w]hen third party behavior is predictable, commonsense inferences may be drawn." *Diamond Alt. Energy, LLC v. EPA*, 145 S. Ct. 2121, 2136 (2025). The chain of causation may be shown through means like "statistical analysis, common sense, or record evidence," *New York v. Dep't of Com.*, 351 F. Supp. 3d 502, 576 (S.D.N.Y. 2019, *aff'd in relevant part*, 588 U.S. 752, 768 (2019).

Where third parties are a link in the chain, a plaintiff need only prove that "the agency action is at least a substantial factor motivating the third parties' actions." *Tozzi v. U.S. Dep't of Health & Human Servs.*, 271 F.3d 301, 308 (D.C. Cir. 2001) (quotation omitted). Here, we don't need to guess how the market will respond to the rule; insurers have already begun to increase their rates in response to the rule. *See* Pls.' Mem. 15. This will not only increase the cost of coverage but will also reduce enrollment and further increase uncompensated care costs. Pls.' Mem. 15–16. Ultimately, Plaintiffs will suffer the burden of these costs. Pls.' Mem. 39–43.

This analysis tracks this Court's conclusion in *City of Columbus v. Cochran*, 523 F. Supp. 3d 731 (D. Md. 2021), that cities—including Columbus, Chicago, and Baltimore—and individuals suffered injuries from uncompensated care and increased health care costs, and those harms were traceable to a CMS rule that, like its rule here, imposed greater administrative burdens on obtaining coverage. That rule led to predictable reactions from third parties, including insurers, who raised rates in response to that rule; this sufficed to show the plaintiffs' standing. *See id.* at 744; *see also City of Columbus v. Trump*, 453 F. Supp. 3d 770, 789 (D. Md. 2020). Likewise, here, Plaintiffs offer the same "independent analyses and issuers' explanations [to] confirm … that Defendants' actions [will] cause[] price increases." *City of Columbus v. Trump*, 453 F. Supp. 3d at 789.

Contrary to CMS's contentions, Opp'n 14, n. 3, nothing in later case law undermines this Court's reasoning. CMS relies on *FDA v. Alliance for Hippocratic Medicine*, 602 U.S. 367 (2024)

("*AHM*"), which held that physicians, morally opposed to a medication, lacked standing to challenge the FDA's approval of the drug, because they had alleged only that the approval had led them voluntarily to divert their resources in response. Unlike in *AHM*, Plaintiffs here will have no choice but to take on increased costs as a direct result of the rule's impact on the healthcare marketplace. *See* Pls.' Mem. 39–43; *see also* Decl. of Dr. Eric Fethke ¶¶ 5–9. These expenditures are not optional; cities and the physician members of Doctors for America must provide care whether or not they are compensated by insurance. Main Street Alliance's small business members likewise can't opt out of the higher costs that will result from CMS's rule. Plaintiffs may challenge the rule to protect themselves from these harms, just as other providers of last resort were able to challenge other actions by CMS that predictably increased the cost of health care. *See Massachusetts v. U.S. Dep't of Health & Human Servs.*, 923 F.3d 209, 225 (1st Cir. 2019); *California v. Azar*, 911 F.3d 558, 571 (9th Cir. 2018); *Pennsylvania v. Trump*, 351 F. Supp. 3d 791, 807 (E.D. Pa. 2019), *aff'd*, 930 F.3d 543 (3d Cir. 2019), *rev'd on other grounds*, 591 U.S. 657 (2020); *U.S. House of Representatives v. Price*, No. 16-5202, 2017 WL 3271445, at *1 (D.C. Cir. 2017) (per curiam).

Plaintiffs' injuries would be irreparable without a Section 705 stay of the rule's effective date. Although "economic losses generally do not constitute irreparable harm, this general rule rests on the assumption that economic losses are recoverable." *Mountain Valley Pipeline, LLC*, 915 F.3d at 218 (internal quotation marks omitted). Given sovereign immunity, Plaintiffs have no vehicle to recover their losses, in the form of uncompensated care costs and higher premiums, from CMS after the fact. And Plaintiffs need relief now from the rule because open enrollment for 2026 is fast approaching. *See* Am. Acad. of Actuaries, *Issue Brief: Drivers of 2026 Premium Changes* 3, 8 (July 21, 2025), https://perma.cc/YP3X-WS74. Absent a stay, the coverage losses and higher costs caused by the rule will be locked in for the coming year, ensuring that Plaintiffs will suffer

harm "before a decision on the merits can be rendered." *M.A.B. v. Bd. of Educ. of Talbot Cnty.*, 286 F. Supp. 3d 704, 726 (D. Md. 2018) (internal quotations omitted).

II. Plaintiffs Are Likely to Succeed on the Merits of Their Claims

A. Plaintiffs Are Likely to Succeed on Their Claims Against Provisions That Erode the Value of Coverage

1. The Imposition of the Junk Fee Is Unlawful and Arbitrary

The Affordable Care Act subsidizes health insurance coverage through tax credits and advance premium tax credits (APTCs), which are set by a statutory formula. 26 U.S.C. § 36B(b); 42 U.S.C. §§ 18081(a)(1), 18082(a)(1). CMS invoked its authority over procedures to "determine" or to "redetermine" eligibility for APTCs, 42 U.S.C. § 18081(a), (f), to revise the statutory formula to reduce payments for certain enrollees. The agency has authority, however, only to determine if the statutory criteria are met, not to *change* those criteria. Its rule imposing a junk fee is therefore unlawful. *See Neumann v. Prudential Ins. Co. of Am.*, 367 F. Supp. 2d 969, 975 (E.D. Va. 2005) (authority to "determine" eligibility does not include the power to change eligibility standards).[2]

CMS defends this rule through a convoluted line of reasoning. Opp'n 31. By imposing a $5 surcharge on enrollees whose APTCs would otherwise fully cover their premium, the agency reasons, the rule will prompt some of these enrollees to contact the Exchange to try to lift the surcharge, which they could accomplish by providing updated personal information to the Exchange. Because that new information could then be used to determine the enrollee's eligibility for APTCs, the fee qualifies as a procedure for redetermining eligibility, in the agency's telling.

This argument proves far too much. On this logic, any rule that prompts an enrollee to communicate information to an Exchange would fall within CMS's authority to set determination procedures. Under this theory, for example, CMS could override the ACA's guarantee of coverage

[2] Our proposed order (ECF No. 11–10) inadvertently misdescribed the regulatory provisions challenged here. We are submitting a corrected proposed order with this brief.

for essential health benefits, *see* 42 U.S.C. § 300gg-6(a), and permit an insurer to refuse to cover a hospital stay until an enrollee submits a new form to the Exchange. CMS cannot negate statutory guarantees in this way. *See Merck & Co. v. U.S. Dep't of Health & Hum. Servs*., 962 F.3d 531, 541 (D.C. Cir. 2020) ("Although the Secretary's regulatory authority is broad, it does not allow him to move the goalposts to wherever he kicks the ball."); *Air All. Hous. v. EPA*, 906 F.3d 1049, 1061 (D.C. Cir. 2018) ("[I]t is well established that an agency may not circumvent specific statutory limits on its actions by relying on separate, general rulemaking authority.").

What's more, the ACA directs that the Treasury Department (not CMS) "shall" pay APTCs in the amount that is set by statute. 42 U.S.C. § 18082(c)(2). The statute's use of the mandatory term "shall" deprives Treasury of discretion to pay anything other than the statutory amount, *see Holland v. Pardee Coal Co*., 269 F.3d 424, 431 (4th Cir. 2001), but under the rule Treasury will necessarily underpay APTCs for certain enrollees as a result of CMS's miscalculation of the amount owed. CMS responds that the rule "will not necessarily interfere" with Treasury's ability to make APTC payments, Opp'n 31, but this misses the point; Treasury's duty is not simply to make a payment in some amount, it is to make a payment in the amount established by the statute.

CMS's lack of authority here is underscored by Congress's refusal to adopt legislation that would have granted it the power that it seeks. Since the filing of our opening brief, the House passed, but the full Congress refused to adopt, legislation that would have reduced the amount of APTCs owed for enrollees in fully subsidized plans under the same terms that the agency now seeks to impose by rule. *Compare* H.R. 1, § 44201(g) (as engrossed in the House), https://perma.cc/G4C9-BCTD , *with* Pub. L. No. 119-21, §§ 71301–71305, 139 Stat. 72, 321–325

(2025) (not enacting this provision).[3] That "Congress considered and rejected a version of the statute that would have done exactly what" CMS seeks to do here confirms the agency's lack of authority. *Garey v. James S. Farrin, P.C.*, 35 F.4th 917, 926 (4th Cir. 2022); *see PFLAG, Inc. v. Trump*, 769 F. Supp. 3d 405, 441 (D. Md. 2025), *appeal pending*, No. 25-1279 (4th Cir.).[4]

The junk-fee rule is arbitrary as well as unlawful. CMS sought to minimize commenters' concerns by describing the junk fee as a "nominal" amount that would not cause "undue financial hardship" on enrollees. 90 Fed. Reg. at 27,107. But the agency didn't engage with commenters' main point: even seemingly small additional charges will depress enrollment by low-income consumers, and younger and healthier people will be more likely to drop coverage, worsening the risk pool for everybody else. *See* Pls.' Mem. 19.

CMS belatedly concedes this point, and argues that these harms are worthwhile to combat the problem of "improper enrollments." Opp'n 29. But the agency's analysis on this score tracked that of a report prepared by the Paragon Health Institute. We comprehensively explained in our opening brief (as did commenters during the rulemaking proceedings) that this analysis was fundamentally flawed. The report looked to the wrong sets of data when it attempted to calculate improper enrollments in the Exchanges, it ignored the success of the agency's more recent efforts to address insurance broker misconduct, and its findings could not support the measures that CMS ended up adopting that punish enrollees, not brokers. *See* Pls.' Mem. 12–15. CMS offers no

[3] Congress adopted a provision addressing automatic re-enrollment in the Exchanges, effective in 2028, Pub. L. No. 119-21, § 71303, but it conspicuously declined to adopt CMS's proposed rule, or to change the statutory standards for enrollment for 2025 or 2026.

[4] At the same time that CMS proceeded with this rulemaking, it also sought legislative authority for each of the provisions challenged here. Congress considered and rejected each of these proposals. In some instances, Congress declined to adopt legislation endorsing the agency's approach; in other instances, Congress adopted a modified version of the proposal but delayed the effective date of its legislation until 2028, demonstrating its intent not to add to the agency's regulatory authorities for 2025 and 2026. *See* H.R. 1, § 44201(a)(2) (verification requirements for special enrollment periods), 44201(b)(1), (3) (data-matching policies), 44201(b)(2) (denials of subsidies for failure to reconcile tax returns), 44201(c)(1) (variations in actuarial valuations), 44201(d) (premium adjustment percentage), 44201(j) (denials of coverage for past-due premiums). CMS cannot create by rule the authorities that Congress specifically chose to deny it. *See Garey*, 35 F.4th at 926; *PFLAG, Inc.*, 769 F. Supp. 3d at 441.

defense of its analysis in its brief. Because the agency "made no attempt to refute, mitigate, or explain away" the concerns of commenters that challenged the "fundamental premise" of its rule, it acted arbitrarily. *City of Columbus*, 523 F. Supp. 3d at 752.

Plaintiffs also explained that the junk fee will create confusion among enrollees who will not understand why they are subject to a surcharge. Pls.' Mem. 20. CMS blithely responds that there will be "sufficient time" to educate enrollees about the new rule, Opp'n 30, but it fails entirely to engage with the point raised by commenters that there won't be personnel in place to provide this education, given the agency's own actions this year to eviscerate the ACA's Navigator program. By ignoring this "important aspect[] of the problem," CMS acted arbitrarily for this reason as well. *Appalachian Voices v. State Water Control Bd.*, 912 F.3d 746, 753 (4th Cir. 2019).

Moreover, CMS violated notice-and-comment requirements by adopting a one-year policy, for 2026 only, that departed from its proposal for a permanent policy.[5] The agency reasons that it chose to sunset its policy "in response to submissions" by commenters, and so it must have been foreseeable that it would do so. Opp'n 32. But commenters asked CMS to do precisely the opposite. They asked it not to impose the junk-fee rule at all, or at the very least to delay it until a later year. *See* 90 Fed. Reg. at 27,108. They didn't ask the agency to rush to impose it for 2026 and then force stakeholders to incur a second round of administrative costs to implement a different rule for 2027. Commenters did not have the chance to address the irrationality of this approach, and CMS should have reopened the comment period before springing this surprise on the public. *See Chocolate Mfrs. Ass'n of U.S. v. Block*, 755 F.2d 1098, 1105 (4th Cir. 1985).

[5] CMS committed the same procedural error with respect to the verification of enrollment during special enrollment periods, its failure-to-reconcile policy, and its data-matching policies, discussed *infra*, at 16–17, 17–20, and 20–23.

2. The Revised Premium Adjustment Methodology Is Arbitrary

The Act directs CMS to calculate an annual "premium adjustment percentage" that is used to update maximum limits on cost-sharing, with the same formula used to update the value of premium tax credits. 42 U.S.C. § 18022(c)(4). CMS adopted a new methodology to calculate this adjustment that necessarily will increase costs, and decrease the value of tax credits, for enrollees in the Exchanges. *See* Pls.' Mem. 21–22.[6] Although CMS historically has used a different method that calculated a lower growth rate for health care premiums, this year the agency deliberately chose a method that would impose higher costs on enrollees, departing from the ACA's core statutory purpose of lowering the cost of coverage. *See King v. Burwell*, 576 U.S. 473, 479 (2015).

CMS forthrightly declared that it wouldn't consider the ACA's central purpose when it decided whether it should impose higher or lower costs on consumers. 90 Fed. Reg. at 27,172; *see also* 90 Fed. Reg. 12,942, 12,990 (Mar. 19, 2025) (proposed rule). This was per se error, as the requirements of reasoned decision-making under the APA always demand that an agency take its statute's purposes into account when it formulates policy. *See Judulang v. Holder*, 565 U.S. 42, 64 (2011) (invalidating rule that was "unmoored from the purposes and concerns" of the statute).

The agency attempts to paper over this error by asserting that it did (silently) consider the ACA's purpose of lowering the cost of health coverage after all, but that its hands were tied as a "consequence of *Congress's* decision to tie the value of certain forms of financial assistance under the ACA to the premium adjustment percentage." Opp'n 47 (emphasis in original). This argument is unclear. CMS may mean to argue that it was compelled by the statute to choose the rule that imposed higher costs on consumers. If this is the case, the agency was plainly incorrect. As we

[6] As expected, after we filed our opening brief, the IRS followed its ordinary practice of deferring to CMS's calculation, thereby confirming that tax credits will be lower for Exchange enrollees across the board. Rev. Proc. 2025-25, https://perma.cc/SZ5A-LDBG ; *see* Gideon Lukens and Elizabeth Zhang, Centers for Budget & Policy Priorities, *Administration's ACA Marketplace Rule Will Raise Health Care Costs for Millions of Families* (Aug. 1, 2025), https://perma.cc/VZ43-SNJY .

have explained, Pls.' Mem. 23 n.4, the statute requires the agency to compare the costs of "health insurance coverage" between the present year and 2013, the year before the Act's reforms to the individual health insurance market went into effect. 42 U.S.C. § 18022(c)(4). Premiums on the individual market that year were not premiums for policies that met the Act's standards for "health insurance coverage," and for that reason CMS has historically, and correctly, calculated the premium adjustment using growth rates in the group market. CMS fails entirely to respond to this statutory point, and so forfeits any argument to the contrary. And, where the agency wrongly believed the statute compelled it to adopt a policy, this error requires vacatur of the rule. *See Perez v. Cuccinelli*, 949 F.3d 865, 873 (4th Cir. 2020) (en banc); *see also Peter Pan Bus Lines, Inc. v. Fed. Motor Carrier Safety Admin*., 471 F.3d 1350, 1354 (D.C. Cir. 2006).

Or CMS may mean to acknowledge that it *did* have a choice. If that's the case, it failed to explain why it chose to impose higher costs on enrollees. The agency generally asserted a need to adopt a more "accurat[e]" measure, Opp'n 47, but it entirely failed to engage with the point raised by commenters that the new methodology was *less* accurate, since it incorporated data from individual insurance premiums in 2013 that wouldn't provide an apples-to-apples measure of growth in health care costs, but that would inevitably inflate the premium adjustment percentage. *See, e.g.*, Jason Levitis et al. comment at 28–31 (Apr. 11, 2025), https://perma.cc/X3KY-KZLW.

In either event, CMS rendered the notice-and-comment process an empty formality by displaying a closed mind on this topic (as well as the topic of permissible variations in actuarial value calculations, discussed *infra*, at 12–13), when it expressly declared in the proposed rule that it would ignore adverse comments. 90 Fed. Reg. at 12,989–90. This candid admission explains why it chose to depart from the "APA minimum of 30 days" for comment. *Azar v. Allina Health Servs*., 587 U.S. 566, 570 (2019); *see also N. Carolina Growers' Ass'n v. United Farm Workers*, 702 F.3d 755, 770 (4th Cir. 2012). And in March it published a "final" actuarial-value calculator

that treated the proposed rule as if it were currently in effect, which insurers were required to use in preparing their rates. *See* 45 C.F.R. § 156.135(a). Each of these points shows that the agency had a "predetermined answer," *Kravitz v. Dep't of Com.*, 366 F. Supp. 3d 681, 750 (D. Md. 2019), and that it treated its solicitation of comments as mere window dressing.

3. The New Actuarial Value Policy Is Arbitrary

The ACA generally requires insurers to offer plans that meet certain targets for generosity. For example, a silver plan "is designed to provide benefits that are actuarially equivalent to 70 percent of the full actuarial value of the benefits provided under the plan," 42 U.S.C. § 18022(d)(1)(B), meaning that the premium (whether paid by the enrollee or by APTCs) would be expected to cover 70% of the cost of coverage, leaving 30% to be paid for through cost-sharing tools such as deductibles or co-pays. The rule permits insurers to miss this target; for example, insurers may market plans as "silver" even if they would only cover 66% of expenditures, leaving 34% to be covered by the enrollee. 45 C.F.R. § 156.140(c)(1).

This greatly exceeds CMS's limited authority "to provide for a de minimis variation in the actuarial valuations used in determining the level of coverage of a plan to account for differences in actuarial estimates." 42 U.S.C. § 18022(d)(3). The rule is far from "de minimis"; it will cut tax credits by more than a billion dollars and raise health care costs for a typical family by more than $700 a year. Pls.' Mem. 24. CMS does not even try to square its rule with the language of Section 18022(d)(3). It instead expresses confusion as to what that language "means as a practical matter." Opp'n 50. Any confusion can be resolved by the statutory text itself. Actuarial estimates are imprecise, and so Congress allowed for the possibility that there may be some variance in comparing plans with different cost-sharing structures. There may be room to argue over how much "de minimis variation" is permissible to account for these differences, but certainly a rule

that all but erases the distinction between bronze and silver coverage exceeds the agency's authority. *See Wisc. Dep't of Revenue v. William Wrigley, Jr., Co.*, 505 U.S. 214, 232 (1992).

CMS seeks to justify this rule as one that would promote "innovative plan designs." Opp'n 50. It may or may not be "innovative" for an insurer to call a plan "silver" even if it requires the enrollee to pay more than 10% more in cost sharing than what is permitted under the statutory standard for such a plan. But in any event, Congress did not instruct CMS to promote this form of "innovation"; it instead instructed CMS simply to account for differences in actuarial estimates. The agency acted arbitrarily, then, by relying on a factor that "Congress has not intended it to consider." *Sierra Club v. Dep't of Interior*, 899 F.3d 260, 293 (4th Cir. 2018).

CMS also brushed off concerns that the rule would cause enrollees to drop coverage, and will lead to increased costs across the board, since the amount of tax credits available for anybody turns on the cost of the cheapest silver plans. *See* Pls.' Mem. 24. CMS simply responded that it "expected" the rule would lead to lower costs by improving the risk pool, 90 Fed. Reg. at 27,177, but it failed to engage with the voluminous research proving that lower subsidies, on balance, drive healthier people out of coverage, leading to higher premiums for those who remain. CMS acted arbitrarily by failing to account for this evidence. *See Ohio v. EPA*, 603 U.S. 279, 294 (2024); *see also City of Columbus*, 523 F. Supp. 3d at 763 ("nodding to concerns raised by commenters only to dismiss them in a conclusory manner is not a hallmark of reasoned decision-making").

B. Plaintiffs Are Likely to Succeed on Their Claims Against Provisions That Impose Barriers on Enrollment[7]

1. The Rule Unlawfully and Arbitrarily Revokes the Act's Guarantee That Anyone Can Buy Insurance

The Affordable Care Act ensures the availability of health insurance coverage by imposing

[7] Given the enactment of Pub. L. No. 119-21 §§ 71301–71305, Plaintiffs no longer seek a Section 705 stay with respect to the revocation of the low-income special enrollment period. *See* Pls.' Mem. 28–31.

overlapping "guaranteed issue" and "guaranteed renewability" obligations on insurers in the individual market. Under the "guaranteed issue" provision, an insurer must "accept every … individual" who applies for coverage, 42 U.S.C. § 300gg-1(a), subject to certain exceptions, which don't include the existence of any outstanding debt, 42 U.S.C. § 300gg-1(b)-(d). Under the "guaranteed renewability" provision, an insurer must renew or continue in force existing coverage at the individual's option, subject to certain exceptions, including the nonpayment of premiums. 42 U.S.C. § 300gg-2(a), (b)(1). CMS confused the two statutes by adopting a rule permitting insurers to refuse to issue coverage to an enrollee who owes a back debt for premiums. The agency wasn't free to rewrite Sections 300gg-1 and 300gg-2 in this way. *See* Pls.' Mem. 26–27.

CMS compounds this error in its opposition brief, again citing Section 300gg-2, the guaranteed renewability provision, as support for its attempt to add a new exception to Section 300gg-1, the guaranteed issue provision. Opp'n 19. This approach is squarely precluded by the statute. *See Bittner v. United States*, 598 U.S. 85, 94 (2023) ("When Congress includes particular language in one section of a statute but omits it from a neighbor, we normally understand that difference in language to convey a difference in meaning.").

CMS further points to regulatory provisions that establish that an enrollee effectuates new coverage by making a "binder payment" for the first month of coverage. Since an enrollee must pay for new coverage, CMS posits, an insurer should also be permitted to apply any payments from the enrollee to old debts before any payment is applied to the cost of new coverage. Opp'n 19. But, again, this logic flies in the face of the language of Section 300gg-1, which requires insurers to accept every individual who applies for coverage, without any exception for outstanding debts. And to the extent that CMS now intends to defend this rule as one that permits insurers to charge different first-month premiums to different enrollees, the rule independently violates 42 U.S.C. § 300gg(a), which requires insurers to set uniform premiums for all enrollees

(subject to certain statutory exceptions, which don't include past debts).

The rule is also arbitrary. Commenters submitted empirical evidence showing that as many as 180,000 people would lose coverage under this rule, placing greater burdens on providers of last resorts such as health clinics operated by municipalities. *See* Pls.' Mem. 27. CMS acknowledges that many of these people may have an outstanding debt for entirely legitimate reasons, including that they simply couldn't have known that they continued to accrue debt for coverage that they thought they had cancelled. Opp'n 20. CMS nonetheless defends its rule on its "intuitive expectation" that coverage losses would be "minimal," given the relatively small amounts of debt at issue. *Id.* The agency's intuitions can't overcome commenters' empirical evidence showing that even seemingly minor additional financial burdens can lead to outsized coverage losses, however. By failing to engage with the evidence that was before it, CMS fell short of the APA's requirements for reasoned decision-making. *See Ohio v. EPA*, 603 U.S. at 294; *City of Columbus*, 523 F. Supp. 3d at 763.

CMS also reasoned that these coverage losses would be justified as collateral damage from the agency's campaign to prevent attempts to game enrollment in coverage. But, as we explained, there simply is no evidence that gaming is a widespread problem, and the new rule accordingly is far more likely to act as a trap for the unwary. Pls.' Mem. 28. CMS concedes this point but argues that it didn't need to offer any such evidence. Opp'n 20. The agency here committed the same error here that it did four years ago: its "decision to prioritize a hypothetical risk of fraud over the substantiated risk that its decision result in immense administrative burdens at best, and a loss of coverage for eligible individuals at worst, defies logic." *City of Columbus*, 523 F. Supp. 3d at 763.

CMS inexplicably compounded these errors by refusing to require any notification to enrollees. Under the agency's rule, the first time that an enrollee would learn that there is any issue would be when he or she tries to sign up for coverage, only to see their first premium payment

redirected for another purpose. There is no policy rationale that could justify this scenario if CMS's true goal was to encourage payment of past debts, rather than just to create another barrier against enrollment. Pls.' Mem. 28. The agency tries to wave this problem away by asserting that states might choose to address it, Opp'n 20, but its failure to address this "important aspect of the problem," *Sierra Club v. U.S. Forest Serv.*, 897 F.3d 582, 594 (4th Cir. 2018), shows that the rule is arbitrary.

2. The Verification Requirements for SEP Enrollments Are Arbitrary

The Affordable Care Act requires Exchanges to provide for special enrollment periods (SEPs) during which qualifying individuals may enroll for coverage in between the annual open enrollment periods. 42 U.S.C. § 18031(c)(6)(C). CMS made it harder for enrollees to obtain coverage through these SEPs by requiring (for 2026 only) that the federally facilitated Exchange conduct pre-enrollment verification for each of its SEPs, and that it verify eligibility for at least 75% of new SEP enrollments. 45 C.F.R. § 155.420(g). This rule will generate hundreds of thousands of verification issues, driving younger and healthier people out of coverage. *See* Pls.' Mem. 31–32. CMS offered no good reason to impose this burden on enrollees.

CMS does avert to its desire to respond to the problem of improper enrollments by unscrupulous brokers. Opp'n 44–45. But the agency commits the same error here as it did with respect to its junk-fee rule, discussed *supra*, at 6–9. Its analysis of improper enrollments followed the methodology of the Paragon report, which was fatally flawed for multiple reasons. *See* Pls.' Mem. 12–15. CMS offers no defense of this approach, and so it fails to justify a "fundamental premise" of its rulemaking. *City of Columbus*, 523 F. Supp. 3d at 752.

CMS, moreover, entirely fails to respond to the point that, once it (correctly) recognized that it was describing a problem that did not exist on state-based Exchanges, it should have looked to solutions that addressed reasons why the federally facilitated Exchange might be unique, such

as that Exchange's policy of permitting enhanced direct enrollment entities to submit applications on behalf of enrollees. *See* Pls.' Mem. 32. The agency's "utter failure to consider obvious alternative actions" that would have directly addressed the problem that it identified, *Fishermen's Dock Co-op. v. Brown*, 75 F.3d 164, 172 (4th Cir. 1996), coupled with the "significant mismatch" between that problem and the measures the agency chose, *Dep't of Com. v. New York*, 588 U.S. 752, 783 (2019), demonstrate the irrationality of its approach.

C. Plaintiffs Are Likely to Succeed on Their Claims Against Provisions That Limit the Availability of Subsidized Coverage

1. The Failure-to-Reconcile Policy Is Unlawful and Arbitrary

When an enrollee files his or her tax return for a given year, he or she reconciles the amount of tax credits to which he or she is entitled (on the basis of actual income) with the APTCs that he or she received over the course of the year (on the basis of projected income). 26 U.S.C. § 36B(f)(3). CMS has established a process by which it requires applicants for coverage to report whether they have reconciled their tax credits on prior tax returns, and it checks that reporting against IRS data. 45 C.F.R. § 155.340(c). As we noted in our opening brief, this process is flawed; many people are incorrectly flagged, in part due to the considerable time lag in tax reporting. And this problem will only be compounded now that the IRS is proceeding with the wholesale terminations of many of its employees. *See* Pls.' Mem. 32–34.

Despite these flaws, under its current policy, CMS will deprive an applicant of eligibility for APTCs if he or she does not reconcile tax credits for two years in a row, after receiving notice of the issue in the first year. 45 C.F.R. § 155.305(f)(4)(i), (ii). CMS's new rule requires the Exchanges (for 2026 only) to revoke APTC eligibility in the first year that a reconciliation issue arises, whether or not the applicant first receives notice of the issue. 45 C.F.R. § 155.305(f)(4)(iii). Both the current policy and the new policy are unlawful. (In this motion, however, Plaintiffs seek

only a stay of the new policy, and will challenge the old policy in subsequent briefing).

The agency's legal error on this score parallels its error with respect to its junk-fee rule, discussed *supra*, at 6–9. CMS invokes its general rulemaking authority over the Exchanges under 42 U.S.C. § 18041, Opp'n 22, but a general grant of authority like Section 18041 can't authorize an agency to override the specific provision of a statute. *See Air All. Hous.*, 906 F.3d at 1061. Thus, while CMS may establish procedures to determine whether the statutory standards for APTC eligibility are met, 42 U.S.C. §§ 18081(a), (f), it may not use that procedural authority to change the substantive standards for eligibility. *See New York Stock Exch. LLC v. SEC*, 962 F.3d 541, 546 (D.C. Cir. 2020). And nothing in the statute conditions eligibility for tax credits or APTC on reconciliation of debts shown on a prior year's tax return. *See* Pls.' Mem. 33–34.[8]

Unable to defend the rule on the merits, CMS contends that this challenge is time-barred. Opp'n 24. It argues that the legality of its new rule, cutting off eligibility for APTCs in the first year, depends on the legality of its 2012 rule linking APTC eligibility to the reconciliation of tax data in the first place, and that the first rule should have been challenged earlier if Plaintiffs wished to preserve their right to challenge this year's rule. This is incorrect, for multiple reasons. First, commenters on this year's rule asked the agency to "fully repeal" the failure-to-reconcile rule on the ground that even the older version of the rule was unlawful. CMS understood that these comments were within the scope of the rulemaking and engaged with them on the merits, invoking (incorrectly) its Section 18041 rulemaking authority. 90 Fed. Reg. at 27,117. "When a later proceeding explicitly or implicitly shows that the agency actually reconsidered the rule, the matter has been reopened and the time period for seeking judicial review begins anew." *Growth Energy*

[8] CMS cites (Opp'n 25) 42 U.S.C. § 18081(e)(2)(A), which establishes that an applicant may prove APTC eligibility by providing information to the Exchange. That statute describes procedures for verifying eligibility, but it doesn't alter the substantive eligibility standards.

v. EPA, 5 F.4th 1, 21 (D.C. Cir. 2021). Second, the statute of limitations is an affirmative defense, Fed. R. Civ. P. 8(c), but CMS only speculates that Main Street Alliance's or Doctors for America's cause of action accrued more than six years ago, a theory that is impossible to square with its argument that these Plaintiffs lack standing altogether. *See Corner Post, Inc. v. Bd. of Govs. of Fed. Reserve Sys*., 603 U.S. 799, 804 (2024).[9] Third, even if a challenge to the old rule were time-barred, Plaintiffs may nonetheless challenge the new rule, because an agency "cannot take by adverse possession the authority to impose [a rule] in a way that shields the devaluation of statutory language from judicial review." *City of Providence v. Barr*, 954 F.3d 23, 45 (1st Cir. 2020).

Even if CMS had authority to adopt this rule, it abused its discretion by imposing a "Kafka-esque" scenario under which applicants will lose eligibility for APTCs for reasons that the Exchange can't disclose to them. The agency's current rule, while imperfect, at least allowed for applicants to be notified of inconsistencies in their tax data, and had provided them with time to resolve the issue. Now, however, applicants will immediately lose coverage without any such notice. *See* Pls.' Mem. 34. CMS denies that this scenario will arise, pointing to data from the last time it tried a one-year failure-to-reconcile policy. Opp'n 25–26. But, as CMS itself acknowledges, Opp'n 16, n.5, the newest iteration of this rule is even harsher than its prior experiment on this score, which had required notice to applicants before APTC eligibility could be terminated. So the older data that CMS takes stock in couldn't speak to the effects of a new policy under which applicants will lose coverage without advance warning. And CMS failed entirely, moreover, to engage with the point that drastic cuts this year in IRS employment will only exacerbate the problem of delays in the exchange of tax data. *See* Pls.' Mem. 34.

[9] The municipal Plaintiffs pursued a separate challenge to CMS's failure-to-reconcile policies in the first *City of Columbus* case, but the Court did not reach the question of the validity of 45 C.F.R. § 155.305(f). 523 F. Supp. 3d at 748. The municipal Plaintiffs therefore may pursue their challenge here, given that CMS has reopened the issue.

CMS also defends this rule as one that is needed to address program integrity concerns, even if it does lead to enrollees losing coverage for undisclosed reasons. Opp'n 26. But, again, as with other aspects of this rulemaking, CMS relied on the deeply flawed Paragon methodology to conclude that the problem of improper enrollments was severe enough to justify widespread coverage losses. Plaintiffs have comprehensively explained the defects in that report, and CMS has failed entirely to engage with these critiques. *See supra*, at 1, 8–9; *see also* Pls.' Mem. 12–15. The agency's failure in this regard undermines the rationale for this rule.

2. The New Data-Matching Policies Are Arbitrary

CMS imposed further paperwork barriers on enrollment by adopting three measures, each of which will make it harder for enrollees to show that they are eligible to enroll in subsidized coverage on the Exchanges. The agency acted arbitrarily in each instance.

Revocation of the 150-day period for resolving inconsistencies. CMS currently grants a 60-day extension, beyond the 90-day default period under the statute, for enrollees to complete the process of responding to requests to confirm their eligibility for APTCs. The agency revoked that automatic extension, reasoning that it was bound by the statute to do so. This was error, since the agency may "modify the methods under the program established by this section [*i.e.*, Section 18081] for . . . verification of information if the Secretary determines such modifications would reduce the administrative costs and burdens on the applicant." 42 U.S.C. § 18081(c)(4)(B). The 90-day default verification period also falls within Section 18081, *see id.* § 18081(e)(4)(A)(ii), and so under the plain language of the statute it is subject to the agency's modification authority.

CMS resists this conclusion by pointing to the section heading for Section 18081(c), Opp'n 35, but "section headings cannot limit the plain meaning of a statutory text." *Merit Mgmt. Grp., LP v. FTI Consulting, Inc.*, 583 U.S. 366, 380 (2018). The subsection heading is further beside the point here, given that the relevant statute gives the authority to modify procedures anywhere

in the "section" (not just the subsection). *See Koons Buick Pontiac GMC, Inc. v. Nigh*, 543 U.S. 50, 60 (2004). And CMS's reading of the statute is nonsensical, given that Section 18081(c)(4) authorizes modification of methods in order to reduce administrative burdens on the applicant, and this language would make little sense if the statute permitted the agency only to modify the procedures it used with other federal agencies without the applicant's involvement.

CMS, of course, understands these points, because it has used this authority to modify the 90-day time limit in other contexts. *See* 45 C.F.R. § 155.315(f)(3). The agency tries to explain this inconsistency away by positing a distinction between an automatic extension and an extension for particularized reasons. Opp'n 35. This is a distinction without a difference under the statutory text, which permits the agency to modify its methods if doing so "would reduce the administrative costs and burdens on the applicant." 42 U.S.C. § 18081(c)(4). CMS could permissibly (and at one point did) find that it would be less burdensome on applicants to permit a blanket extension rather than requiring each applicant to jump through a paperwork hoop to request one. 88 Fed. Reg. 25,740, 25,819 (Apr. 27, 2023). And, because the agency misunderstood the scope of its authority on this score, its revocation of this rule must be vacated. *See Perez*, 949 F.3d at 873.

Mandatory audit policy. CMS seeks here to re-adopt the same policy that this Court invalidated in *City of Columbus*, 523 F. Supp. 3d at 763. Nothing has changed that would undermine this Court's conclusion that the agency's "decision to prioritize a hypothetical risk of fraud over the substantiated risk that its decision result in immense administrative burdens at best, and a loss of coverage for eligible individuals at worst, defies logic." *Id.* CMS candidly admits as much, forthrightly asserting that it had the same reasons for adopting this policy "then and now." Opp'n 37. So this Court need only to refer to its prior analysis to invalidate this rule a second time.

The agency does assert that it has new data from "one study" that it reads as proving that enrollees are gaming the system to qualify for APTCs. Opp'n 38 (citing 90 Fed. Reg. at 27,122).

But it entirely ignores the comment submitted by the study's author, who explained in careful detail why the publication doesn't support the conclusions that CMS sought to draw from it. *See* Urban Institute comment at 2 (Apr. 11, 2025), https://perma.cc/F5PH-WVN2; Pls.' Mem. 38.[10] CMS acted arbitrarily by taking an "unjustified leap of logic" from this study that its author expressly cautioned it not to make. *City of Columbus*, 523 F. Supp. 3d at 762.

Prohibition on self-attestation where tax data is missing. As we explained in our opening brief, enrollees are often missing tax data for entirely benign reasons. CMS's new rule prohibiting Exchanges from accepting an applicant's attestation as to his or her income when tax data is unavailable, then, will generate about 2.7 million instances of data discrepancies for applicants and Exchanges to resolve. Many people, such as self-employed individuals, lack the ability to document their income, so they will necessarily lose access to subsidized coverage under this rule. And the rule's new administrative burdens will drive many more people out of coverage; younger and healthier people will be more likely to drop coverage (since sicker people have a greater incentive to keep working through any red tape barriers that CMS might put in their way), leading to a worsened risk pool and higher premiums for everybody else. *See* Pls.' Mem. 38–39.

CMS brushes off these concerns by describing the added paperwork burden as "minimal" and justified by its program integrity concerns. Opp'n 40. But, once again, the premise of each of the agency's program integrity measures is undermined by its reliance on the flawed Paragon methodology, which CMS hasn't even tried to defend here. Pls.' Mem. 12–15. Nor could this rationale support this rule, given the disconnect between this measure and the problem the agency claimed it was trying to solve. There would be no way for a broker to know one way or the other

[10] Our opening brief inadvertently linked to inaccurate URLs for the Urban Institute comment and one additional comment, which we correct here. *See* Nat'l Ass'n of Ins. Comm'rs comment (Apr. 11, 2025), https://perma.cc/3TS3-WGB8 (cited at Pls.' Mem. 20).

if tax data is unavailable for a particular individual before targeting him or her for an unauthorized enrollment. So CMS adopted a measure that is entirely tangential to the problem that it described, but that will nonetheless drive hundreds of thousands of people out of coverage.

III. The Remaining Equitable Factors Weigh in Favor of Relief

The balance of the equities and the public interest weigh heavily in favor of staying the effective date of the challenged provisions of CMS's rule. The rule's harms will not be limited to Plaintiffs and their members, but will extend to the millions of Americans who will lose coverage on the Exchanges and who will suffer from higher health care costs as a result. Pls.' Mem. 44. These include individuals across the nation who depend on affordable coverage under the ACA to treat serious health conditions, and who will struggle to maintain that coverage as a result of the rule. *See* Br. of *Amici Curiae* of Nat'l Health Law Program et al., at 5–18, ECF No. 68, *California v. Kennedy*, No. 1:25-cv-12019 (D. Mass. July 28, 2025).

CMS notes that the public interest turns on "the strength of [our] showing on likelihood of success on the merits," Opp'n. 52, a point that we have no occasion to dispute given the patent illegality and irrationality of each of the provisions discussed above. CMS also asserts a countervailing interest in its "efforts to address legitimate concerns about improper enrollments in Exchange plans that are subsidized by taxpayers," *id.*, but once again it fails to address, or even acknowledge, the basic flaws in the Paragon analysis that it relied on to conclude that it would be worth it to throw millions of people off coverage to address a problem of broker fraud that it could address (and has addressed) through more targeted methods. Even if CMS had legitimate concerns on this score, they wouldn't permit the agency to ignore the statute or the APA's requirements of reasoned decision-making. *See Roe v. Dep't of Def.*, 947 F.3d 207, 230–31 (4th Cir. 2020).

IV. This Court Should Stay the Effective Date of the Challenged Provisions of the Rule

This Court has authority to "issue all necessary and appropriate process to postpone the effective date of an agency action or to preserve status or rights pending conclusion of the review proceedings." 5 U.S.C. § 705. A Section 705 stay "operates upon the [agency action] itself by halting or postponing some portion of [it], or by temporarily divesting a rule or policy of enforceability." *Orr v. Trump*, 778 F. Supp. 3d 394, 430 (D. Mass. 2025), *appeal pending*, No. 25-1579 (1st Cir.) (internal quotation marks omitted).[11]

Section 705 relief, which tracks the scope of relief under Section 706's ordinary remedy of vacatur, is necessarily universal. *Career Colls. & Sch. of Tex. v. U.S. Dep't of Educ.*, 98 F.4th 220, 255 (5th Cir. 2024), *cert. granted on other issue*, 145 S. Ct. 1039 (2025); *see also Corner Post, Inc.*, 603 U.S. at 831 (Kavanaugh, J., concurring) ("When a reviewing court determines that agency regulations are unlawful, the ordinary result is that the rules are vacated—not that their application to the individual petitioners is proscribed."); *Sierra Club v. U.S. Army Corps of Eng'rs.*, 909 F.3d 635, 655 (4th Cir. 2018). CMS nonetheless asks this Court to limit relief to the Plaintiffs here. Opp'n 53. This request can't be squared with the text of Section 705, which instructs that "the effective date," in the singular, of the rule should be postponed if the standards for relief are met. Each challenged provision of the rule has only one effective date, not different effective dates that apply for plaintiffs and non-plaintiffs. *See David v. King*, 109 F.4th 653, 661–62 (4th Cir. 2024) (the definite article "the" "normally indicates that the statute refers to only one such object").

[11] *Trump v. CASA, Inc.*, 145 S. Ct. 2540 (2025), does not change this result. The Court was not considering an APA action, and it expressly reserved judgment as to remedial authority under the APA. *Id.* at 2554 n.10; *see also id.* at 2567 (Kavanaugh, J., concurring); *Ass'n of Am. Univs. v. U.S. Dep't of Def.*, No. 1:25-cv-11740, 2025 WL 2022628, at *27 (D. Mass. July 18, 2025).

In any event, CMS does not explain how it would be workable to limit relief only to Plaintiffs. There would be no feasible way, for example, for the agency to set one premium adjustment percentage for insurers to use in setting rates only for those plans that the small business owner Plaintiffs enroll in. And there is no way to protect the municipal and provider Plaintiffs from the burden of uncompensated care costs without protecting all providers of last resort from the same harm. Moreover, patchwork relief would be particularly inappropriate here, as Plaintiffs include national associations that require nationwide relief to remedy the harms that their members face. *See PFLAG, Inc.*, 769 F. Supp. 3d at 452.

V. Plaintiffs Should Not be Required to Post Bond

"The APA has no bond requirement." *Am. Fed'n of Tchrs. v. Dep't of Educ.*, No. CV SAG-25-628, 2025 WL 1191844, at *23 n.14 (D. Md. Apr. 24, 2025); *see also Seafreeze Shoreside, Inc. v. U.S. Dep't of Interior*, No. 1:22-CV-11091-IT, 2023 WL 3660689, at *3 (D. Mass. May 25, 2023); *Cabrera v. U.S. Dep't of Lab*, No. 25-CV-1909, 2025 WL 2092026, at *9 n.3 (D.D.C. July 25, 2025). Nor would a bond be appropriate even if the Court considered Plaintiffs' motion under Federal Rule of Civil Procedure 65. The central point of our motion for emergency relief is that Plaintiffs would be devastated if they were forced to incur the costs that CMS seeks to foist upon them; it would defeat the purpose of this motion to grant interim relief only to take that relief away in the form of a bond. *See RFE/RL, Inc. v. Lake*, No. 1:25-cv-799-RCL, 2025 WL 2023252, at *8 (D.D.C. July 18, 2025).

CONCLUSION

For these reasons, the Court should grant Plaintiffs' motion for a stay of the effective date of the challenged provisions of the final rule or, in the alternative, enter a preliminary injunction.

Dated: August 8, 2025

Respectfully submitted,

/s/ Joel McElvain

JOEL MCELVAIN (BAR NO. 31673)
CORTNEY ROBINSON*
CHRISTINE L. COOGLE (BAR NO. 21846)
DEMOCRACY FORWARD FOUNDATION
P.O. Box 34553
Washington, D.C. 20043
(202) 935-2082
jmcelvain@democracyforward.org
crhenderson@democracyfoward.org
ccoogle@democracyfoward.org

Counsel for Plaintiffs

**Admitted pro hac vice*

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MARYLAND

CITY OF COLUMBUS *et al.*, *Plaintiffs*, v. ROBERT F. KENNEDY JR. *et al.*, *Defendants*.	Case No. 25-cv-2114

DECLARATION OF DR. ERIC D. FETHKE

I, Eric Fethke, declare as follows:

1. I am over 18 years old and competent to make this declaration. I have personal knowledge of the facts and information in this declaration. I respectfully provide this declaration to explain the ways the Centers for Medicare & Medicaid Services (CMS)'s "Patient Protection and Affordable Care Act; Marketplace Integrity and Affordability" rule will harm my medical practice and endanger the children who rely on my services. My statements in this declaration are my own, based on my own professional experience, and do not reflect the views, opinions, policies, or position of Boston Children's Health Physicians; I do not speak on the behalf of the Boston Children's Health Physicians or any other entities associated with my medical practice.

2. I have a Bachelor of Arts from Princeton University and received my medical degree from Columbia University. I completed my pediatric residency and pediatric cardiology fellowship at the Children's Hospital of New York Presbyterian in New York, New York. For the last 30 years, I have been an active physician in New York, while also teaching medical, nursing and physician assistant students, residents and fellows at Columbia, Albert Einstein and Touro universities. I have been a member of Doctors for America since 2023.

3. I am a pediatric cardiologist known for successfully treating the most difficult heart conditions in babies, children and adults. I specialize in noninvasive pediatric cardiology, including pediatric exercise testing, pediatric and fetal echocardiography, fetal and congenital heart disease, noninvasive cardiac diagnostic testing and community-based care. My practice is highly specialized and not readily available to most patients. The children I care for often live several counties, states and hours away from any alternative pediatric cardiology care. Children with the complex heart conditions I care for who cannot access the kind of specialty care I provide are at a higher risk of preventable sudden death or serious morbidity than their peers who have access to my clinical services.

4. In 1998, I founded the Pediatric Cardiology Associates of Greater Hudson Valley, which provides specialty, regional community-based services for patients across a large expanse of the Hudson Valley, New York community—in some cases as far north as Albany, New York; west into Pennsylvania; and south into northern New Jersey. My group has spent nearly three decades building out the practice's health care provider network through various alliances and partnerships, to create a complex web of localized, highly skilled children health specialists to serve patients in the Hudson Valley. As a result, my patients include children and adults from all backgrounds: rural, suburban, metropolitan, low-income, and immigrant. Roughly a quarter of my patients are on Medicaid; another quarter have private, non-exchange insurance; and over half of my patients have health care insurance via ACA Exchanges.

5. CMS' new rule would make it more complicated and expensive for many of my patients to obtain or keep their health coverage. In my experience, the more complicated and expensive it is for people to access care and insurance, the more my patients— predominantly vulnerable and dependent babies, children and youth with complex conditions I have spent years creating access to care for—will go uninsured.

6. An increase in the uninsured population creates devastating problems for my

practice. There are administrative burdens associated with taking care of patients when they are uninsured. My staff and I spend hours, uncompensated and often after our office has closed, trying to find alternative sources of payment for services provided to the uninsured. These efforts are often unsuccessful, and my practice and I are left to incur these costs of treating patients who lack insurance.

7. Further, my practice does not turn away patients who come seeking emergency healthcare simply because they do not have insurance; when, for example, a parent shows up with a baby or newborn who is turning blue and needs help, I have an ethical responsibility to provide care.

8. As an additional example, I have had young patients with heart rhythm abnormalities who are uninsured or whose insurance will not cover specialty care beyond their local community's general cardiologist, even if that generalist does not perform the life-saving procedures my patient needs. As a result, I spend hours writing letters to insurance companies fighting to have specialty care such as catheterizations, electrophysiology studies and surgery at my trusted and accessible pediatric tertiary centers covered under their insurance. If I am unsuccessful, those patients' parents are often forced to rely on other providers who are extremely far from their homes. And when their child has an emergency, and they come back to my office in crisis, I am often forced to provide care without compensation. Or, those parents try to travel long distances to make it to a covered, healthcare provider, risking that they might not get there in time to save their child. These emergencies will only be more frequent and overwhelming if more of my patients are under or uninsured as a result of the proposed rule.

9. Even operating within a larger group of healthcare providers, my practice cannot survive increased uncompensated care costs. The 25 percent of my patients with private insurance cannot make up for financial loss from increased uncompensated costs that will arise when even a fraction of my patients who formerly had ACA coverage lose or drop that coverage

(especially considering the government's recent cuts to Medicaid). The network of care I have built over the last 30 years will collapse. And the burden of providing care will fall on tertiary health centers, city hospitals and clinics—even if patients can make it there in time during life-threatening emergencies.

I declare under penalty of perjury under the laws of the United States of America, pursuant to 28 U.S.C. § 1746, that the foregoing is true and correct to the best of my knowledge.

Signature on following page.

Executed this 6th day of August, 2025 in Middletown, New York.

ERIC D. FETHKE, M.D.

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MARYLAND

CITY OF COLUMBUS *et al.*,

Plaintiffs,

v.

ROBERT F. KENNEDY, JR. *et al.*,

Defendants.

Case No. 25-cv-2114

[AMENDED PROPOSED] ORDER STAYING EFFECTIVE DATE UNDER 5 U.S.C. § 705

Upon consideration of Plaintiffs' Motion for Stay or Preliminary Injunction, and the parties' briefing thereon, it is hereby

ORDERED that the motion is **GRANTED**; and it is further

ORDERED that the effective dates of the following provisions of the final rule entitled "Patient Protection and Affordable Care Act; Marketplace Integrity and Affordability," 90 Fed. Reg. 27074, are **STAYED** pursuant to 5 U.S.C. § 705 pending a final ruling on the merits of this case:

1. The imposition of a $5 premium penalty on automatic re-enrollees, through the addition of 45 C.F.R. § 155.335(a)(3) and (n).
2. The revocation of guaranteed insurance coverage for individuals with past-due premiums, through revisions to 45 C.F.R. § 147.104(i).
3. The revision to the failure-to-reconcile policy through the addition of 45 C.F.R. § 155.305(f)(4)(iii).
4. The imposition of eligibility verification for the special enrollment period, through the revisions to 45 C.F.R. § 155.420(g).

5. The elimination of the 60-day extension of time to resolve inconsistencies in household income data, through the removal of 45 C.F.R. § 155.315(f)(7) and revisions to 45 C.F.R. § 155.320(c)(5).
6. The imposition of a requirement that Exchanges generate household income inconsistencies when a tax filer's attested projected annual household income differs from "trusted data sources," through revisions to 45 C.F.R. § 155.320(c)(3)(iii).
7. The change to the measure for calculating the premium adjustment percentage set forth in 90 Fed. Reg. 27,166 through 27,178.
8. The changes to the de minimis ranges for actuarial value calculations, through revisions to 45 C.F.R. §§ 156.140(c), 156.200(b)(3), and 156.400.

SO ORDERED.

_____, 2025

_____
U.S. DISTRICT JUDGE