UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MARYLAND

CITY OF COLUMBUS, *et al.*, Plaintiffs, v. ROBERT F. KENNEDY, JR., in his official capacity as Secretary of the United States Department of Health and Human Services, *et al.*, Defendants.	Civil Action No. 1:25-cv-2114-BAH

DEFENDANTS' REPLY IN SUPPORT OF THEIR CROSS MOTION FOR SUMMARY JUDGMENT AND OPPOSITION TO PLAINTIFFS' MOTION FOR SUMMARY JUDGMENT

TABLE OF CONTENTS

TABLE OF AUTHORITIES

Page(s)

Cases

Statutes

Regulations

Other Authorities

INTRODUCTION

In the Affordable Care Act ("ACA"), Congress vested the Secretary of Health and Human Services with broad discretion to issue regulations implementing its many requirements. Over the decade and a half since the Act's passage, Secretaries across administrations have done just that, issuing, amending, rescinding, and reinstating regulations to advance various policy goals. The principal issue in this case is whether the policy changes reflected in the latest of these efforts, the Marketplace Integrity and Affordability Rule, are reasonable and reasonably explained. Plaintiffs fundamentally contend that the Rule will decrease enrollment and assert that Defendants did not give sufficient weight to their views. But on issue after issue, the record shows that this is simply a policy dispute: Defendants indeed considered Plaintiffs' views, but disagreed with them, for reasons thoroughly explained in the preamble to the Rule itself.

In particular, the Rule seeks to address the high levels of improper enrollment in federally subsidized plans by better enforcing compliance with the eligibility requirements for such plans and by providing additional safeguards to protect consumers from unwanted changes to their coverage. As HHS explained, this growth in improper enrollments is a consequence of temporary legislative changes related to the COVID-19 pandemic that expanded access to ACA premium subsidies and made those subsidies more generous, which in turn increased the availability of fully subsidized health care coverage and fueled enrollment, some of it improper, in Exchange plans. Those enhanced subsidies expired at the start of this year. The Rule accordingly implements a number of policies meant to reduce improper enrollments over the short term as Exchanges readjust to a new subsidy environment. The Rule also makes permanent reforms to improve the stability of Exchanges, provide premium relief to enrollees who do not qualify for ACA premium subsidies, and protect the public fisc.

The agency's explanations for these reforms amply satisfy the Administrative Procedure Act's deferential standard of review at each turn, and the Court should decline Plaintiffs' invitation to substitute their policy judgment for that of the agency.

ARGUMENT

I. The $5 annual eligibility redetermination program is neither unlawful nor arbitrary and capricious.

The eligibility requirements for enrolling in an Exchange plan and for receiving premium tax credits ("PTCs") and advance premium tax credits ("APTCs") are set forth in the ACA and its implementing regulations. *See* 42 U.S.C. §§ 18081(a), 18082(a); 26 U.S.C. § 36B(a), (c)(1)(A); 45 C.F.R. § 155.305(a), (f). HHS is generally responsible for determining whether a customer satisfies those requirements. If a customer does, then he can enroll in an Exchange plan for the upcoming plan year and receive APTCs. As a general matter, the ACA requires plan issuers to renew an enrollee's coverage the next year, subject to certain statutory exceptions. 42 U.S.C. § 300gg-2(a). Even when an enrollee's plan is subject to that guaranteed-renewability provision, however, an Exchange must still "redetermine" the enrollee's eligibility for subsidized Exchange coverage "on an annual basis" in accordance with HHS regulations. 45 C.F.R. § 155.335(a)(1).

The Rule provides, for plan year 2026 only, that (1) if an enrollee does not submit an application for an updated eligibility determination for plan year 2026 on or before the deadline to select Exchange coverage on the federal platform and (2) that enrollee's post-APTC premium will be zero dollars (*i.e.*, the enrollee's coverage will be fully subsidized), then (3) the Exchange "must decrease the amount of" the APTC "applied to the [enrollee's] policy such that the remaining monthly premium owed for the policy equals $5." Notice of Proposed Rule Making ("NPRM"), 90 Fed. Reg. 12,942, 13,031 (Mar. 19, 2025).

A. The $5 annual eligibility redetermination program is lawful.

Plaintiffs argue the $5 annual eligibility redetermination is contrary to the ACA's text, but the ACA provides a clear grant of authority for HHS to "determine[e]" whether individuals enrolled in Exchange plans "meet[] the income and coverage requirements" for claiming PTCs, as well as with determining "the amount" of those tax credits. 42 U.S.C. § 18081(a)(2)(A). It is likewise HHS's responsibility to determine an Exchange enrollee's eligibility for APTCs (which mirrors the applicable requirements for PTC eligibility) and to calculate the amount of those APTCs. *See id.* § 18082(a)(1), (3); 45 C.F.R. § 155.305(f)(5). And the ACA grants the HHS Secretary the authority to "establish a program" for making these eligibility determinations, 42 U.S.C. § 18081(a)(1), and to "establish procedures" for "redetermin[ing] eligibility on a periodic basis in appropriate circumstances," *id.* § 18081(f)(1)(B). The Rule's eligibility redetermination provision comports with that grant of authority. The $5 premium is a program with procedures designed to redetermine eligibility through a fully waivable $5 premium, which is narrower and less invasive than the rescission of auto-enrollment entirely.

Plaintiffs respond by attacking a strawman. They argue this reading is designed to allow CMS to "override" the ACA's guaranteed coverage provision by permitting insurers to deny coverage for hospital stays for paperwork oversights. Pls.' Opp'n to Defs.' Cross Mot. for Summ. J. at 3 ("Pls.' Opp."), ECF No. 70. Not only is such a policy not at issue here, but it is grossly divorced from the rationale animating the $5 premium policy. Defendants elected for a fully waivable $5 premium precisely because of its nominal cost on enrollees. *See* Marketplace Integrity and Affordability Rule, 90 Fed. Reg. 27,074, 27,108, 27,194-95 (June 25, 2025). HHS considered commenters' concerns and concluded that a fully waivable $5 premium would not cause meaningful deprivation of coverage, and it would instead serve to reduce fraud—ultimately

benefitting the entire marketplace. *Id.*

B. The $5 annual eligibility redetermination program is not arbitrary and capricious.

Plaintiffs claim that CMS acted arbitrarily because it relied on the Paragon Health Institute study and because the Rule may confuse enrollees. Pls.' Opp. at 4-5. Plaintiffs again overlook CMS's thorough explanation of the problem it is trying to address. Plaintiffs' and commenters' concerns with the Paragon study are simply data limitations common to any study. In the final rule, HHS identified those data limitations and made clear that the estimates do not provide precise measures of take-up, but are, instead, "useful for understanding trends in Exchange enrollment over time and different patterns of enrollment across States[.]" 90 Fed. Reg. at 27,210. These enrollment trends over time and patterns across states contributed to HHS's independent estimate that there were "as many as 4.4 million erroneous or improper enrollments" in 2024. *Id.* at 27,211.

CMS attributes this problem in part to agents and brokers improperly enrolling consumers in fully subsidized Exchange plans "without their knowledge" to earn commission payments. *Id.* at 27,103; *see id.* ("Because these enrollees do not receive a monthly premium bill requiring action on their part, they may not be aware they are enrolled."). CMS also notes that the recent expansion of premium subsidies via the American Rescue Plan Act ("ARPA") and the Inflation Reduction Act ("IRA") "significantly increased the number of enrollees" who are enrolled in fully subsidized Exchange plans. *See id.* (explaining that 2.68 million enrollees were automatically re-enrolled in fully subsidized plans on federal Exchanges in plan year 2025, compared to 270,000 such enrollees in plan year 2019). Though those subsidies may have expired, the underlying problem persists to a lesser but still significant degree. The Rule thus addresses this enrollment issue by "prompt[ing]" individuals enrolled in fully subsidized Exchange plans to "update or confirm" their eligibility for such plans "or else pay a $5 monthly premium" until they do so. *Id.* at 27,103; *see id.* at 27,102.

Accordingly, CMS had well-founded bases, including its own internal estimate, to conclude there are persistent improper enrollments. *Id.* at 27,102-03, 27,211.

CMS also acknowledged the potential effect a $5 premium could have on enrollment and the risk pool in Exchanges, as well as on individuals who are accustomed to fully subsidized coverage, *see id.* at 27,108, 27,194-95, and reasonably concluded that the $5 figure would likely encourage consumers to actively confirm their plan eligibility (because they want to avoid paying even this "nominal" cost) without risking "undue financial hardship," *id.* at 27,107. As Defendants thoroughly explained in their earlier briefing, there is enough time to familiarize enrollees with the reenrollment program. *See id.* Further, CMS has a strong interest in ensuring comprehensive education on this policy because the $5 eligibility redetermination program will be more effective at identifying improper automatic enrollees if all genuine automatic enrollees are aware of the policy, affirmatively verify their reenrollment, and have the annual eligibility redetermination removed.

Lastly, Plaintiffs' "logical outgrowth" argument, *see* Pls.' Opp. at 5, also fails for the same reasons that it does with respect to the Rule's failure to file and reconcile provision, as explained in Defendants' earlier briefing. *See* Defs.' Cross Mot. for Summ. J. and Opp'n to Pls.' Mot. for Summ. J. at 5 ("Defs.' Cross. Mot."), ECF No. 69. Here, the change that Plaintiffs contest in the final rule is simply the length of the policy's implementation; its substantive portions remain untouched. Case law is clear: a logical outgrowth of a proposal to implement a policy indefinitely "is surely" a final rule that "refrain[s] from taking the proposed step" at all or, alternatively, implements the policy for a limited duration. *New York v. EPA*, 413 F.3d 3, 44 (D.C. Cir. 2005) (quoting *Am. Iron & Steel Inst. v. EPA*, 886 F.2d 390, 400 (D.C. Cir. 1989)).

II. The premium adjustment percentage policy is neither unlawful nor arbitrary and capricious.

The ACA directs the HHS Secretary to determine an annual "premium adjustment percentage" based on "the average per capita premium for health insurance coverage in the United States for the preceding calendar year." 42 U.S.C. § 18022(c)(4). That measure of premium growth is then used to set the rate of increase for a number of parameters defined in the ACA, such as the maximum annual limitation on cost sharing under Exchange plans. *See* 45 C.F.R. § 156.130(a). Because the IRS traditionally adopts the same premium growth indexing methodology as HHS, the methodology used to calculate the premium adjustment percentage also affects how PTC and APTC amounts are calculated and, by extension, the cost of health care coverage on Exchanges. *See* 90 Fed. Reg. at 27,171. In the early days of the ACA, the premium adjustment percentage was calculated based solely on estimates of average premiums for employer-sponsored health plans because that approach "reflected trends in health care costs without being skewed by . . . premium fluctuations" in the individual insurance market. *Id.* at 27,166. HHS later adopted a methodology that also included estimates of individual premiums. *Id.* at 27,166-67 (citing 84 Fed. Reg. at 17537-41); *see also* 84 Fed. Reg. at 17538 (describing aim to "use a more comprehensive premium measure that captures increases across the market, including individual market premiums and employer-sponsored insurance premiums"). But in 2021, HHS reversed course to consider only premiums for employer-sponsored coverage in the premium adjustment percentage calculation. *Id.* at 27,166-67. In the Rule, HHS once again adopts a premium adjustment percentage methodology that takes account of premium changes in both the individual and employer-sponsored (or group) health insurance markets. *See id.* at 27,167.

A. The premium adjustment percentage policy is lawful.

Plaintiffs contend that, by using the term "such," Congress unambiguously required the agency to base this comparison on growth rates in the group market, which they say are the only ones that permit "apples-to-apples" comparisons; the Rule's inclusion of individual market data into this calculation, they claim, compares time periods that are "meaningful[ly]" "different" in terms of coverage requirements. Pls.' Opp. at 7. As Defendants explained in their earlier briefing, this argument places far more weight on the word "such" than it can bear. Defs. Cross Mot. at 13. Plaintiffs respond by trying to evade their burden, arguing that the statute does not specifically endorse the methodology embraced by the Rule. Pls.' Opp. at 7. But, as noted, in the years since the ACA's enactment, the premium adjustment percentage methodology has now been set or adjusted by rulemaking four times, sometimes including individual market data, sometimes not. It is Plaintiffs who, nearly 15 years in, now contend that the statutory text clearly demands their reading—and thus they who bear the burden of demonstrating the Rule is contrary to law, *Vanda Pharms., Inc. v. United States Food & Drug Admin.*, 766 F. Supp. 3d 85, 94 (D.D.C. 2025). Their reliance on a ubiquitous word like "such" does not suffice.

Indeed, the plain language of the statute expressly grants the Secretary of Health and Human Services the authority to "determine[]" the average premium per capita for 2013. 42 U.S.C. § 18022(c)(4). "The word 'determine' means 'to fix conclusively or authoritatively' as well as 'to come to a decision concerning as the result of investigation or reasoning.'" *Bakran v. DHS*, 894 F.3d 557, 563 (3d Cir. 2018) (quoting Webster's Third New International Dictionary 616 (1993)). This language implicitly acknowledges that the Secretary must exercise at least some judgment in fixing the average premium for 2013; there would be no need for Congress to entrust the Secretary to "determine[]" the average premium if it saw the rate as an entirely non-discretionary standard. *See, e.g.*, *Transitional Hosps. Corp. of La. v. Shalala*, 222 F.3d 1019, 1025 (D.C. Cir. 2000)

(explaining that the phrase "as determined by the Secretary," identical to the statutory language here, is an "express delegation of authority" to exercise "discretion" (citation omitted)). Such discretion is the antithesis of the kind of mandatory apples-to-apples comparison Plaintiffs put forward. Had Congress intended only for policies qualifying as "health insurance coverage" to be considered in the calculation of the average per capita premium for 2013, it would not have delegated that determination to the Secretary. 42 U.S.C. § 18022(c)(4). Contrastingly, the statute only permits the Secretary to "estimate[]" the average per capita premium for the "preceding calendar year" using the metrics required—namely, policies qualifying as "health insurance coverage." *See id*. This variation should not be construed as incidental. Longstanding canons of statutory interpretation provide "a material variation in terms suggests a variation in meaning." Scalia & B. Garner, *Reading Law: The Interpretation of Legal Texts* 170 (2012).

B. The premium adjustment percentage policy is not arbitrary and capricious.

In the Rule, HHS once again adopts a premium adjustment percentage methodology that takes account of premium changes in both the individual and group health insurance markets. *See* 90 Fed. Reg. at 27,167. HHS explains in the Rule's preamble that this updated approach will allow it to "better achieve the statutory and regulatory goals of adopting a more comprehensive and accurate measure of premium costs across the private health insurance market[,]" *id.* at 27,171, in keeping with the ACA's command that the premium adjustment percentage reflect the average premium "for health insurance coverage in the United States," 42 U.S.C. § 18022(c)(4). *See* 90 Fed. Reg. at 27,171 ("As the purpose of this index is to measure growth in premiums, we believe it is appropriate to use a premium measure that comprehensively reflects the actual growth in premiums in the related insurance markets.").

Contrary to Plaintiffs' arguments, HHS thoroughly explained it was adopting a new premium adjustment percentage methodology to "appropriately index various parameters defined

in the ACA[.]" *Id.* at 27,172. Given how the ACA defines that percentage, "the primary consideration for setting [its] value" should be "whether it accurately and comprehensively captures the rate of premium growth in the United States." *Id.*; 42 U.S.C. § 18022(c)(4). HHS acknowledges that the methodology used to calculate the premium adjustment percentage will have an impact on the cost of Exchange coverage, enrollment, and access to health care more broadly. *See* 90 Fed. Reg. at 27,171. But placing undue weight on considerations other than the rate of premium growth "in the United States" when calculating that percentage, 42 U.S.C. § 18022(c)(4), could yield a figure that "artificially inflat[es] the generosity of provisions of the ACA beyond the intent of Congress[,]" 90 Fed. Reg. at 27,172.

HHS therefore concluded that a premium adjustment percentage methodology that considers "all private health insurance premiums," which includes individual and group markets broadly, is "more consistent with" that congressional intent and the ACA's text. *Id.* Plaintiffs disagree with Defendants' interpretation of congressional intent because it produces a policy result of which Plaintiffs disapprove. But Defendants properly considered the Rule's effect on enrollees as well as the requisite characteristics that Congress intended the premium adjustment percentage methodology to possess.

Lastly, Plaintiffs again argue that the new premium adjustment percentage methodology must be vacated because HHS "had an unalterably closed mind" when adopting it. Pls.' Opp. at 10. But their characterization of CMS's publication of an "Actuarial Value Calculator" is inaccurate. CMS published this online calculator seven days after the proposed rule was published for notice and comment to offer the public a more thorough understanding of the proposed Rule's effects. *Id.*[1] The agency clearly stated, however, that the changes being proposed in the proposed

[1] *See* Ctrs. for Medicare & Medicaid Servs., *Revised Final 2026 Actuarial Value (AV) Calculator Methodology* (Mar. 26, 2025), https://perma.cc/Z6UL-JQ65 ("Updated AV Calculator").

rule were just that—proposals. *See, e.g.*, Updated AV Calculator at 2. The publication also included a disclaimer stating that the document "accommodates proposed changes" that had been "published for public comment" and directed readers to the website where comments could be submitted. *Id.* at 1 n.1. Indeed, CMS sought to solicit *greater* and *more informed* feedback on the proposed Rule through the calculator's publication, not less. Accordingly, CMS received and considered commenters' concerns as the APA requires.

III. The actuarial value range policy is not arbitrary and capricious.

Under the ACA, health insurance plans offered on Exchanges must cover certain "essential health benefits" and adhere to certain "level[s] of coverage" specified in the statute. 42 U.S.C. § 18022(a). A plan's "level of coverage," or actuarial value, reflects the estimated average percentage of covered health care expenses that will be paid by the insurance plan. *Id.*

The actuarial values of Exchange plans are calculated pursuant to regulations issued by the HHS Secretary. *See id.* § 18022(d)(2). HHS's decision to revert to a broader de minimis range similar to prior rules was not arbitrary and capricious. The ACA instructs HHS to "develop guidelines to provide for a de minimis variation in the actuarial valuations used in determining the level of coverage of a plan to account for differences in actuarial estimates." *Id.* § 18022(d)(3). The statute necessarily calls for the agency to exercise discretion in how much variation to permit. The phrase "de minimis" implies some play in the joints. *Cf. Ala. Power Co. v. Costle*, 636 F.2d 323, 360 (D.C. Cir. 1979) ("Determination of when matters are truly de minimis naturally will turn on the assessment of particular circumstances."). And contrary to Plaintiffs' assertion, Defendants do not suggest they "need not be bound" by the statutory language. Pls.' Opp. at 11. The Rule merely takes into account "some variance" as Plaintiffs concede the statute permits. *Id.* Congress did not, for example, demand that HHS select the "maximum feasible" standard. *Cf.* 49 U.S.C. § 32902(a) (setting such a requirement for fuel economy standards). Instead, it used an open-

textured phrase to assign to HHS responsibility for setting the range, thus delegating to the agency the discretion to make reasonable policy judgments in carrying out that duty. *See Loper Bright Enters. v. Raimondo*, 603 U.S. 369, 395 (2024).

HHS explained that it sought to "significantly improve issuer flexibility in plan design." 90 Fed. Reg. at 27,176. The agency predicted that this increase in flexibility would have three key benefits: It would (1) "promote competition" by allowing issuers to be more responsive to consumer needs, (2) allow "greater continuity for consumers[,]" and (3) encourage issuers to continue participating in the Exchanges. *Id.* The agency therefore provided a reasoned explanation for its decision to alter the actuarial-value policy.

HHS also acknowledged that its decision involved trade-offs. The agency recognized that expanding the de minimis range would likely reduce tax credits for subsidized consumers. *Id.* But the reason for that reduced subsidy is that premiums would be cheaper, thus increasing affordability for unsubsidized consumers. *See id.* HHS decided to prioritize getting these unsubsidized consumers into risk pools because it believed that, in the long-term, the risk pools would be more stable and coverage would be more affordable. *See id.*; *see also* NPRM, 90 Fed. Reg. at 12,997 (warning that "healthier, unsubsidized enrollees are [being] priced out of the market" and criticizing "short-sighted approach" of focusing only on maximizing subsidies). HHS did not act unreasonably in making that policy choice.

Every time that HHS has set or adjusted the de minimis range, it has looked to factors beyond "differences in actuarial estimates." 90 Fed. Reg. at 27,174. When HHS set the range initially in 2013, it sought to "strike[] a balance between ensuring comparability of plans within each metal level and allowing plans the flexibility to use convenient cost-sharing metrics[,]" and sought to "allow[] plans to retain the same plan design year to year." 78 Fed. Reg. 12,834, 12,851

(Feb. 25, 2013). When the agency subsequently adjusted the range, it also based its reasoning on these factors, 87 Fed. Reg. 27,208, 27,307 (May 6, 2022), as well as others such as market competitiveness, 82 Fed. Reg. 18,346, 18,369 (Apr. 18, 2017).

CMS squarely considered the "impact" a wider de minimis range would have on PTCs and the "burden that increased cost-sharing and decreased PTCs may have on enrollees in the short-term." 90 Fed. Reg. at 27,176, 27,208. These are "short-term" concerns because new plans with lower premiums and competitive cost-sharing structures will draw unsubsidized consumers to Exchanges, "improv[ing] the risk pool as coverage becomes more affordable for generally healthy people who currently may opt to forgo coverage altogether." *Id.* at 27,175. HHS, in particular, considered the decline of unsubsidized enrollees over time, which was contrary to certain government projections. *See id*. at 27,076. Far from reflecting a failure to consider relevant factors or merely "nodding to concerns raised by commenters," as Plaintiffs seem to claim, Pls.' Opp. at 12, CMS's reasoning represents a paradigmatic "policy balance" between short-term costs and long-term benefits. *Owner-Operator Indep. Drivers Ass'n v. Fed. Motor Carrier Safety Admin.*, 494 F.3d 188, 211 (D.C. Cir. 2007). Plaintiffs' mere disagreement with Defendants' conclusion does not render it arbitrary and capricious. *See id.*

IV. The past-due premium policy is neither unlawful nor arbitrary and capricious.

Under the Rule, issuers will be allowed—subject to applicable state law—(1) to attribute payments made to effectuate new coverage to past-due premium amounts owed to the issuer or an issuer in the same controlled group, and (2) to then refuse to effectuate the new coverage if both the past-due and initial premium amounts are not paid in full. 90 Fed. Reg. at 27,084. Put another way, the Rule will allow issuers to require a customer to pay (1) any past-due premiums the customer owes the issuer (or related issuers) for prior coverage *and* (2) the initial premium amount (also known as a "binder payment") required for new coverage after enrollment is accepted. *Id.* at

27,084, 27,088.[2] And if the customer fails to pay that combined amount in full, the issuer can discontinue the new coverage. *Id.* at 27,084. The Rule's past-due premium policy is similar to one that CMS implemented in 2017, *see* NPRM, 90 Fed. Reg. at 12,951[3], which was later replaced in 2022 with the current regulation regarding past-due premiums and new coverage. Plaintiffs argue that this Rule provision is both contrary to the ACA and arbitrary and capricious, *see* Pls.' Opp. at 12-14, but it is neither.

A. The past-due premium policy is lawful.

The ACA is clear. Under 42 U.S.C. §§ 300gg-1(a), 2(b)(1), an issuer's provision of coverage is contingent on the enrollee's payment of premiums. An issuer may "nonrenew or discontinue health insurance coverage" if an enrollee "has failed to pay premiums." *See id.* § 300gg-2(b)(1). Plaintiffs argue that Section 300gg-2(b)(1), titled "[g]uaranteed renewability of coverage," permits an insurer to discontinue coverage while 300gg-1(a), titled "[g]uaranteed availability of coverage" does not. Pls.' Opp. at 13. But this argument relies on section headings, which cannot "override the plain words" of a statute. *Fulton v. Philadelphia*, 593 U.S. 522, 536-37 (2021) (citation omitted).

Here, Section 300gg-1 guarantees insurers will accept an individual's enrollment, and once accepted, Section 300gg-2 governs when that insurer may nonrenew or discontinue coverage, including for failure to pay a binder payment. Importantly, an insurer's acceptance of enrollment occurs prior to an enrollee's premium payment. Thus, failure to pay that first premium would

[2] The Rule provides that an issuer "may require a consumer to pay past-due premiums owed to that issuer, or owed to another issuer in the same controlled group." 90 Fed. Reg. at 27,089; *see* 45 C.F.R. § 147.106(d)(4) (defining "controlled group"). The Rule also provides that "[t]he amount of the past-due premium an issuer may require" before effectuating new coverage "is subject to any premium payment threshold the issuer has adopted pursuant to [45 C.F.R.] § 155.400(g)." 90 Fed. Reg. at 27,191.

[3] HHS explains in the Rule that unlike the 2017 policy, the Rule's past-due premium policy will not (1) "limit the policy to past-due premium amounts accruing over the prior 12 months" only or (2) "require the issuer to provide any notice of" any past-due premium policy the issuer adopts consistent with the Rule. 90 Fed. Reg. at 27,084.

permit an insurer to "discontinue" coverage. *See* 45 C.F.R. § 155.400(e) (providing that federally facilitated Exchanges and State-based Exchanges on the federal platform "will . . . require payment of a binder payment" equivalent to "the first month's premium" to "effectuate an enrollment" in an Exchange plan). This is generally true when coverage is attempted to be purchased off Exchange as well. The Rule simply allows an issuer who is owed past-due premiums from a particular customer to include the amount of those past-due premiums in the initial premium amount due for the continuation of newly accepted coverage. The Rule's past-due premium policy is thus entirely consistent with the text of the ACA.

B. The past-due premium policy is not arbitrary and capricious.

Plaintiffs also contend that the past-due premium policy is arbitrary and capricious, but Plaintiffs are again fixated on the Rule's purportedly negative effects. This is not the operative standard under the APA, and Plaintiffs' judgment should not be substituted for Defendants'. Indeed, CMS expressly acknowledged the very concerns about potential coverage losses that Plaintiffs raise. *See* Defs.' Cross Mot. at 24-25 (citing 90 Fed. Reg. at 27,087). As for Plaintiffs' argument that the Rule creates a "barrier against enrollment," Pls.' Opp. at 14, CMS acknowledged those concerns too. *Id.* (citing 90 Fed. Reg. at 27,085).

Defendants promulgated this Rule to resolve ongoing, well-placed concerns about the integrity of the predecessor regulations. As explained in the Rule's preamble, CMS anticipates that the Rule's past-due premium policy will "help to promote continuous coverage, reduce gaming and adverse selection, ensure that ACA subsidies are targeted to those who are eligible, and allow issuers to more accurately predict costs and prices." 90 Fed. Reg. at 27,084. Indeed, CMS predicts that enrollees, including healthier ones who improve the risk pool, will likely "be more inclined to remain in their coverage" if they know that they would have to pay any past-due premiums before

effectuating new coverage, which would in turn encourage continuous coverage more broadly. *Id.* at 27,086. This expectation is consistent with data indicating that, when the 2017 past-due premium policy was in effect, the percentage of Exchange enrollees who had their coverage terminated for non-payment of premiums "dropped substantially," from 17.3 percent in 2017 to 7.8 percent in 2020. *Id.* at 27,087; *see* NPRM, 90 Fed. Reg. at 12,951-52. The Rule also eliminates the perverse incentives created by the predecessor regulation, given that an enrollee's obligation to pay past-due premium debt "[will] not change" based on whether the enrollee renews a current plan or seeks to enroll in new coverage. *Id.* at 12,953. Accordingly, the Rule is well tailored to address the predecessor regulations' shortcomings, and its thorough explanation of its reasoning readily satisfies review under the APA.

V. The shortened open enrollment period policy is not arbitrary and capricious.

Beginning in 2027, the Rule will create a standardized open enrollment period ("OEP") beginning no later than November 1 and ending no later than December 31, with a maximum duration of 9 weeks. This Rule thus rescinds the extended OEP which was in effect over the last four years because the expected benefits of that extension "did not materialize." 90 Fed. Reg. at 27,137. HHS was also responsive to comments it received; it delayed this policy's effective date to mitigate commenters' concerns over the change. Plaintiffs' dissatisfaction with Defendants' justifications for the Rule again amounts to a policy disagreement. Defendants have sufficiently justified their reasoning for the Rule's implementation, as explained in the Rule itself.

HHS considered Plaintiffs' concerns carefully and concluded that the Rule's benefits outweighed any new minimal burdens the Rule concurrently imposed. *Id.* at 27,139. In particular, HHS found the delayed start of this provision of the Rule provides extensive time to "message the clearer [open enrollment period] end date to consumers, especially the younger and healthier consumers[.]" *Id.* Plaintiffs dismiss Defendants' responsiveness because it does not suit their

narrative, but the Rule addressed any significant comments that Defendants received. Indeed, HHS found that a standardized open enrollment period would actually reduce confusion "by aligning more closely with the open enrollment dates for other coverage for many employer-based health plans." *Id.* at 27,136.

Plaintiffs continue to argue that the new enrollment period will eliminate enrollees' ability to switch plans before the end of the open enrollment period if they find the policy to be inadequate or too expensive. Pls.' Opp. at 16. HHS considered this concern but found few individuals took advantage of this option. 90 Fed. Reg. at 27,137 ("[O]nly a small number of consumers took advantage of the additional time to switch to a lower-cost plan after receiving a bill from their issuer in January with higher plan costs. During the OEP for plan year 2025, fewer than 3 percent of enrollees ended their FFE or state-based exchange on the federal platform coverage between December 15, 2024, and January 15, 2025, including those enrollees who switched to other plans as well as those who did not."). As 97 percent of enrollees do not use the OEP in this manner, Defendants reasonably concluded that the Rule's standardization outweighed any disadvantages. Particularly given the limited change that this Rule imposes, effectively reverting to the prior policy in view of the limited benefits that an extended OEP yielded, as well as an anticipated improvement in the risk pool due to reduced confusion, HHS's decision to create a standardized OEP is well reasoned and not arbitrary and capricious.

VI. The verification of eligibility for special enrollment periods policy is not arbitrary and capricious.

Under the Rule, federally facilitated Exchanges ("FFEs") will be required to conduct pre-enrollment eligibility verification for certain categories of special enrollment periods ("SEPs") (*e.g.*, permanent move, marriage, etc.), which is in line with the eligibility verification policy that was in place between 2017 and 2022. *See* 90 Fed. Reg. at 27,148-49. The Rule further requires

State Exchanges to conduct pre-enrollment eligibility verification "for at least 75 percent of new enrollments through SEPs [or Special Enrollment Periods]." *Id.* at 27,150-51. And for reasons related to the recent expiration of enhanced APTCs, the requirements will automatically sunset after program year 2026. *Id.*

CMS pointed to data suggesting that pre-enrollment verification requirements that previously applied to SEPs did not create substantial barriers to Exchange enrollment, and that such requirements had the effect of "encourag[ing] continuous enrollment by making it more difficult to engage in strategic enrollment and disenrollment" based on customers' changing health status. 90 Fed. Reg. at 27,149. CMS also underscored its general "responsibility to comply with the ACA[,]" *id.* at 27,152, which includes faithfully adhering to statutory and regulatory eligibility requirements, *see, e.g.*, 45 C.F.R. § 155.420(a)(3) (providing that an Exchange "must allow a qualified individual" to enroll via a SEP only if a specified "triggering event[] . . . occur[s]"). It ultimately concluded that the "positive impact" of the more robust SEP eligibility verification requirements in the Rule "far exceeds" any potential negative impacts. 90 Fed. Reg. at 27,148; *see id.* at 27,151 ("[W]e believe that the additional burden is not significant enough to outweigh the merits of SEP verification and the increases in program integrity that it provides . . . .").

CMS clearly identified what it deemed a critical shortcoming of the current SEP eligibility verification regulations—namely that, because of their limited scope, the regulations "do not provide enough protection against misuse and abuse" of SEPs, which enables otherwise ineligible individuals to enroll in Exchange plans "only after they become sick or . . . need expensive health care services," which in turn "negatively impacts both the risk pool and program integrity around determining eligibility for" APTCs and other subsidies. *Id.* at 27,148. HHS made clear that it did not rely on the Paragon study for precise measures of take-up, but instead "for understanding trends

in Exchange enrollment over time and different patterns of enrollment across States[.]" *Id.* at 27,210. HHS further performed its own estimate that there were "as many as 4.4 million erroneous or improper enrollments" in 2024. *Id.* at 27,211. This is the problem Defendants sought to solve, and this Rule is tailored to accomplish that goal. Plaintiffs disregard this problem and, likewise, disregard Defendants' efforts to address it. Nonetheless, the Rule is sufficiently reasoned under the APA.

VII. The one-year failure to file and reconcile policy is not arbitrary and capricious.

A basic principle animates the failure to file and reconcile policy: when means-tested subsidies are provided in advance based on projected income, there must be some way to reconcile the estimated subsidy paid with the amount a beneficiary is actually entitled to receive. The Rule will reinstate the notice procedures that CMS used before the current two-year policy was adopted in 2023, under which enrollees received their first failure to file and reconcile notice approximately six months before their APTC eligibility was impacted, and additional notices after that. 90 Fed. Reg. at 27,118. Moreover, CMS provided data suggesting that notices sent during the open enrollment period for Exchange plan enrollment "were relatively effective" in resolving failure to file and reconcile issues. *Id.* at 27,114.

In establishing the failure to file and reconcile policy—both in its one-year form in 2015-24 and 2026-27 and in its two-year form in 2024-25—HHS relied on its general rulemaking authority under 42 U.S.C. § 18041(a)(1). Plaintiffs now contend that decade-old use of rulemaking authority was unlawful.[4] However, they concede that "[t]he statute does describe procedures for

[4] Defendants maintain that Plaintiffs arguments here are time-barred under the six-year statute of limitations for APA claims, 28 U.S.C. § 2401, and the "reopening doctrine" is inapplicable here. *See* Defs.' Opp'n to Pls.' Mot. for Prelim. Relief at 24, ECF No. 28. A reduction from two years to one year is not "a serious, substantive reconsideration of the existing rule." *All. for Safe, Efficient & Competitive Truck Transp. v. Fed. Motor Carrier Safety Admin.*, 755 F.3d 946, 954 (D.C. Cir. 2014). Likewise, a response to a comment raising concerns about Section 1321(a) of the ACA, which is HHS's general rulemaking authority, is also not "a serious, substantive reconsideration of the existing rule." *Id.*

verifying eligibility which establish that an applicant may prove APTC eligibility by providing information to the Exchange." Pls.' Opp. at 19, n.6. Contrary to Plaintiffs assertion, HHS is not "alter[ing] the substantive eligibility standards," *Id.* Indeed, 26 U.S.C. § 36B(f)(1) establishes the reconciliation requirements for APTCs: "The amount of the credit allowed under this section for any taxable year *shall* be reduced (but not below zero) by the amount of any advance payment of such credit under section 1412 of the Patient Protection and Affordable Care Act." *Id.* (emphasis added). Put another way, APTCs are implicitly predicated on reconciliation. If APTC recipients can violate this requirement, it would create a perverse incentive that would invite fraud. Thus, Section 36B(f)(1) and Section 18082 should be read harmoniously, *in pari materia*, such that Section 36B(f)(1) imposes conditions upon Section 18082. *See United States v. Broncheau*, 645 F.3d 676, 685 (4th Cir. 2011). A contrary reading would create absurd results, inviting gross gamesmanship of the APTC system. *See Lara-Aguilar v. Sessions*, 889 F.3d 134, 144 (4th Cir. 2018) ("[Courts must] avoid interpretations of a statute which would produce absurd results[.]")

Ultimately, the Rule's one-year reconciliation policy will more quickly identify fraud than the current two-year reconciliation policy for self-evident reasons: the one-year policy occurs annually rather than biennially. Indeed, a major problem the failure to file and reconcile provision aims to address is the improper receipt of APTCs by enrollees who do not comply with the ACA's reconciliation requirement, and CMS explained that a one-year failure to file and reconcile policy will address that very problem by ensuring that individuals who are improperly enrolled in subsidized Exchange coverage "lose[] APTC after 1 year of failing to file and reconcile instead of 2 years." 90 Fed. Reg. at 27,115. Accordingly, Defendants weighed the Rule's benefits with its impact on enrollees and determined it nonetheless merited implementation.

Instead, the comment merely "summarize[d] and explain[ed]" existing rationale and did not "alter" that rationale. *See id.* Thus, the reopening doctrine is inapplicable here.

VIII. The data matching policy is not arbitrary and capricious.

Plaintiffs challenge three Rule provisions that concern the processes by which HHS verifies "income eligibility" for APTC and cost-sharing-reduction subsidies. *See* 90 Fed. Reg. at 27,112. These provisions address the "critical balance HHS must achieve between assuring responsible stewardship of taxpayer dollars with protecting access to Federal program[s] for those who qualify for them." *Id.* at 27,113. None are arbitrary-and-capricious.

A. Recission of Automatic 60-Day Extension.

In 2023, HHS issued a regulation providing that Exchanges must automatically extend the 90-day period by an additional 60 days whenever an applicant needs to verify his or her household income with additional documentation. 45 C.F.R. § 155.315(f)(7). The Rule will rescind this automatic 60-day extension because it is contrary to law. *See* 90 Fed. Reg. at 27,120 ("[W]e believe that this change is necessary given that the requirement to automatically provide a 60-day extension . . . is inconsistent with our statutory authority."). Even if the automatic extension were lawful, it was not greatly beneficial. CMS reviewed data indicating that the automatic 60-day extension did not have a measurable impact on consumers' ability to resolve income-related verification issues compared to the pre-existing regime, under which consumers who needed a 60-day extension could get one by "demonstrat[ing] . . . a good faith effort" to obtain the requisite documentation, 45 C.F.R. § 155.315(f)(3). *See* 90 Fed. Reg. at 27,119.

Plaintiffs claim two provisions in the ACA give HHS the requisite authority to adopt an automatic 60-day extension to the time period for applicants to resolve inconsistencies with their income verification. But one of those provisions expressly states that the HHS Secretary "may extend the 90-day period" for resolving income-related inconsistencies "for enrollments *occurring during 2014*," 42 U.S.C. § 18081(e)(4)(A)(ii) (emphasis added), and makes no mention of extensions being available during any other year. Likewise, the *expressio unius* canon applies

where Congress has "directly resolved" the scope of an agency's authority, as it has here. *See Cheney R.R. Co. v. Interstate Com. Comm'n*, 902 F.2d 66, 69 (D.C. Cir. 1990). There is simply no ambiguity in the plain text of the statute: automatic 60-day extensions countermand the ACA's limited grant of extension authority in 42 U.S.C. § 18081(e)(4)(A)(ii).

The other provision Plaintiffs cite provides that the HHS Secretary "may modify" the "methods" for verifying information prescribed by the ACA. *Id.* § 18081(c)(4)(B). That provision plainly limits such modifications to the methods by which HHS verifies information with trusted data sources and other federal agencies, not the methods by which Exchanges must try to resolve income-related inconsistencies *with applicants*. Indeed, Section 18081(c) falls under a subsection titled "Verification of information contained in records of specific Federal officials," and the example of a permissible modification that the provision provides concerns the transfer of tax return information from a federal official (*i.e.*, the Treasury Secretary) directly to another trusted data source. *Id.* § 18081(c)(4)(B).

Regardless, any authority the HHS Secretary might have to "*modify*" a statutorily prescribed timeline in order to "reduce the administrative costs and burdens" faced by a particular "*applicant*," 42 U.S.C. § 18081(c)(4)(B) (emphasis added), cannot be reasonably understood to include the authority to promulgate a regulation that categorically *replaces* a statutorily prescribed timeline (90 days) with a different one (90 days plus an automatic 60-day extension) for *all applicants*, *see* 45 C.F.R. § 155.315(f)(7). *MCI Telecommunications Corp. v. American Telephone & Telegraph Co.*, 512 U.S. 218, 225 (1994) ("'modify' means to change moderately or in minor fashion") (citation modified); *see Util. Air Regul. Grp. v. EPA*, 573 U.S. 302, 328 (2014) ("[A]n agency may not rewrite clear statutory terms to suit its own sense of how the statute should operate."). Plaintiffs fail to adequately respond to any of these arguments.

B. Provision Requiring Income Verification When Data Sources Indicate Income Less Than 100 Percent of the Federal Poverty Level.

Under current regulations, if an applicant's attestation regarding their projected annual household income reflects a higher household income than reflected in income data provided by the IRS or certain other sources, an Exchange generally "must accept the applicant's attestation without further verification," 45 C.F.R. § 155.320(c)(3)(v), because it would result in a lower APTC amount. The Rule amends this provision by requiring an Exchange to instead further verify an applicant's household income if (1) an applicant attests to income that is between 100 and 400 percent of the FPL, (2) income data from the IRS indicates household income below 100 percent of the FPL, and (3) the former income amount exceeds the latter amount by a "reasonable threshold[.]" 90 Fed. Reg. at 27,123. The applicant may then resolve the inconsistency by providing additional documentation and taking other steps to verify their household income. *See* 45 C.F.R. § 155.315(f)(1)-(4). Because individuals with household incomes below that threshold are generally not eligible for PTCs or, by extension, APTCs, *see* 26 U.S.C. § 36B(a), (c)(1), an applicant who attests to having a projected household income that is equal to or above 100 percent of the FPL might be deemed eligible for APTCs despite income data from other sources showing otherwise, 90 Fed. Reg. at 27,121. Such a discrepancy could be a consequence of an applicant overestimating his or her projected household income to obtain APTCs for which the applicant is not otherwise eligible. *Id.*

This Rule provision parallels a provision from a 2018 rule that was vacated in *City of Columbus v. Cochran*, 523 F. Supp. 3d 731 (D. Md. 2021). HHS's justification for the provision this time around does not suffer from the same flaws that were fatal to the 2018 provision. HHS now points to data that "provide substantial evidence that applicants with household incomes below the APTC income eligibility threshold"—that is, 100 percent of the FPL—"are strategically

inflating their household incomes[,]" or are "getting assistance from" agents and brokers that have a "financial incentive" to maximize Exchange enrollments, in order to obtain subsidized coverage in an Exchange despite their actual household incomes rendering them ineligible for such coverage. 90 Fed. Reg. at 27,122.

Plaintiffs rely on a comment from one of the three authors of the American Journal of Health Economics ("AJHE") study to claim that study, as well as the Paragon methodology, suffers from major methodological flaws. Pls.' Opp. at 23. Notably, the other two authors of the AJHE did not join their coauthor's comments. Moreover, the commenter admitted that her own research "provides evidence of some improper enrollment in the marketplace by people with incomes below the eligibility threshold of 100 percent of the federal poverty line (FPL) from 2015 to 2017." AR 31663-64. These "flaws" are simply data limitations common to any study, which HHS identified. 90 Fed. Reg. at 27,210. Far more useful from the studies that Plaintiffs criticize are enrollment trends over time and patterns across states that contributed to HHS's estimate that there were "as many as 4.4 million erroneous or improper enrollments" in 2024. *Id.* at 27,211.

HHS "examined the relevant data," "provided an explanation of its decision," and established with data a "rational connection between the facts found and the choice made." *Ohio Valley Env't Coal. v. Aracoma Coal Co.*, 556 F.3d 177, 192 (2009) (citation omitted). Plaintiffs merely disagree with HHS's interpretation of the evidence before it. Defendants concluded that mitigating risks of fraud warranted this policy; contrary to Plaintiffs' arguments, all commenters' concerns were considered prior to the Rule's promulgation. Accordingly, Defendants promulgated a rule with burdens congruent to the problem it seeks to resolve. That comports with the APA's arbitrary-and-capricious standard.

C. Change Requiring Income Verification When Tax Data Is Unavailable.

The current regulation, which was adopted in 2023, creates an exception to the general

requirement that an Exchange must verify an applicant's annual household income with certain trusted data sources, 45 C.F.R. § 155.320(c)(1)(ii), and otherwise follow an alternative verification process if tax return data for an applicant is unavailable, *id.* § 155.320(c)(3)(vi). The Rule simply removes this exception and requires Exchanges to follow standard verification and data-matching procedures "when tax return data is unavailable to immediately verify a consumer's attestation of annual household income[.]" 90 Fed. Reg. at 27,132.[5]

CMS specifically considered commenters' concerns about the burden that extra verification steps might place on enrollees. *See id.* at 27,131. The agency made the reasonable observation that applicants without tax return data will likely have documentation verifying their household income (*e.g.*, pay stubs) "readily available" to them and that the burden of submitting that documentation, by extension, would be relatively minimal. *Id.* at 27,131-32; *see also id.* at 27,132 ("[HHS] is of the view that th[e] 90-day period provided under statute [for resolving data inconsistencies] provides ample time for applicants to provide proof of their household income before their APTC is reduced."). Even for enrollees with nontraditional employment or diverse sources of income, the Rule provides ample time for "gig economy" workers to collect their paystubs, which should already be preserved for future tax filings, and share them with HHS. *Id.* at 27,120.

The annual household income is a crucial metric in determining eligibility for subsidized coverage on Exchanges, *see* 26 U.S.C. § 36B(a), (c)(1)(A), and the unavailability of tax return data does not relieve HHS of its statutory obligation to ensure compliance with such eligibility requirements, *see, e.g.*, 42 U.S.C. § 18081(a)(2)(A) (tasking HHS with determining "whether [an] individual meets the income and coverage requirements" for claiming a PTC and "the amount of"

[5] This policy requiring Exchanges to verify an applicant's attested annual household income when tax return data is unavailable will sunset at the end of program year 2026, and the current verification policy under 45 C.F.R. § 155.320(c)(5) will become effective again. *See* 90 Fed. Reg. at 27,131. Plaintiffs do not challenge this facet of the policy.

that credit); *id.* § 18081(e)(4)(A) (prescribing procedures Exchanges must follow when an applicant's information cannot be verified with certain data sources). Defendants have statutory obligations they must fulfill regardless of Plaintiffs' policy disagreements, and those policy disagreements are properly resolved through the legislative process. Thus, this provision readily survives arbitrary and capricious review

IX. Any relief granted should be narrowly tailored.

If this Court enters judgment for Plaintiffs, it should not grant the extraordinarily sweeping relief that they seek. Plaintiffs request for universal relief would transgress basic principles of jurisdiction, equity, and judicial review under the APA. This Court also has equitable alternatives to vacatur. Rather than vacating the Rule nationwide, the Court could simply enjoin Defendants from enforcing the Rule against Plaintiffs, which would alleviate any adverse effects applicable to them. In contrast, the problems caused by overbroad universal remedies are well catalogued and apply whether such a remedy takes the form of a universal vacatur or a nationwide injunction. Importantly, nearly identical parallel litigation under the APA is taking place in the District of Massachusetts, *California v. Kennedy*, No. 1:25-cv-12019 (D. Mass.), in which motions for summary judgment have already been briefed. Universal vacatur in this case could deprive another court of the opportunity to resolve this question on its own terms or, perhaps more problematically, create substantial nationwide confusion in the event of competing district court orders. This Court should provide relief only to the parties before it. *See* Defs. Cross Mot. at 41-43.

Dated: April 14, 2026

Respectfully Submitted,

BRETT SHUMATE
Assistant Attorney General
Civil Division

ERIC B. BECKENHAUER
Assistant Director
Federal Programs Branch

/s/ Jordan A. Hulseberg
JORDAN A. HULSEBERG
(D.C. Bar No. 90033542)
Trial Attorney
United States Department of Justice
Civil Division
Federal Programs Branch
1100 L Street NW
Washington, DC 20005

Phone: (202) 598-3856
Fax: (202) 616-8470
Email: jordan.a.hulseberg2@usdoj.gov

Counsel for Defendants