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' OPPOSITION TO DEFENDANTS' MOTION FOR A STAY PENDING APPEAL

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INTRODUCTION

Plaintiffs respectfully request that the Court deny Defendants' motion for a stay pending appeal. Defendants seek an order reinstating, for the upcoming 2026 plan year, the portion of CMS's final rule that would have permitted insurers to market cheaper but less comprehensive plans, thereby eroding the value of coverage on the Affordable Care Act's Exchanges. Defendants, however, do not identify any error in this Court's reasoning that could justify the extraordinary remedy of a stay pending appeal. This Court correctly found that Main Street Alliance and the Plaintiff Cities have standing to challenge the final rule, including the provision allowing insurers to vary the actuarial value of their plan offerings more widely. This Court also correctly held that this provision is likely arbitrary, both because CMS disregarded the statutory standards governing actuarial valuations for plans on the Exchanges and because the agency failed to engage meaningfully with commenters' objections to its proposal. Defendants, moreover, do not identify any irreparable harm that they would suffer under this Court's order. They only speculate that some insurers might face challenges in revising their plan offerings, but even their declarant acknowledges that the agency will be able to implement this Court's ruling in time for the upcoming open enrollment period. And the equities weigh heavily in favor of keeping this Court's order in force while Defendants' appeal is pending and protecting the public from a rule that would raise health care costs for a typical family by more than $700 per year.

BACKGROUND

On March 19, 2025, while issuers were already in the process of preparing their plan offerings for the Affordable Care Act's Exchanges for the upcoming 2026 plan year, the Centers for Medicare & Medicaid Services (CMS) issued a notice of proposed rulemaking that, among other things, indicated the agency's intent to permit a wider range of actuarial valuations for plans on those Exchanges. 90 Fed. Reg. 12,942 (Mar. 19, 2025). In particular, the agency

proposed to permit "bronze" plans, which by statute are defined as plans that cover 60% of an enrollee's expected health care costs, to range to an actuarial value of coverage as high as 65%. The agency also proposed to permit "silver" plans, which by statute are defined as plans that cover 70% of expected health care costs, to range to an actuarial value of coverage as low as 66%. In other words, even though the statute specifies that bronze plans and silver plans should be meaningfully different insofar as the latter type of plan would cover ten percentage points more of a typical enrollee's health care expenditures than the former type of plan would, CMS proposed to all but erase the distinction between the two types of plans.

CMS's proposed rule, including the proposal to revise the actuarial value policy, was immediately controversial. The agency received more than 26,000 comments on the proposed rule during an unusually short comment period, many of which highlighted serious flaws with the agency's proposals. CMS nonetheless published a final rule that, along with other policies, adopted the proposed revisions to the agency's actuarial value policy without change. 90 Fed. Reg. 27,074 (June 25, 2025). Rather than substantively addressing the serious concerns presented in the public comments, CMS's promulgated rule only provided surface-level responses that excused Defendants from accounting for the burdensome effect of the rule's provisions.

Plaintiffs—the City of Columbus, Ohio; the Mayor and City Council of Baltimore, Maryland; the City of Chicago, Illinois; Main Street Alliance (MSA); and Doctors for America—filed a complaint for declaratory and injunctive relief challenging numerous provisions of the rule, including the proposed actuarial value policy, as arbitrary and capricious, Compl., ECF No. 1, and also moved for preliminary relief pursuant to 5 U.S.C. § 705, Pls.' Mot. for Stay, ECF No. 11. Defendants opposed Plaintiffs' motion. Defs.' Opp'n to Pls.' Mot. for Prelim. Relief, ECF No. 28. On August 22, 2025, the Court granted Plaintiffs' motion in

relevant part, staying the effective date of the actuarial value provision (and six other provisions). Mem. Op. 35-39, ECF No. 35; *see* Order, ECF No. 36; Order, ECF No. 38. Defendants have appealed the Court's order to the Fourth Circuit, Notice of Appeal, ECF No. 39, and now ask this Court for a stay pending appeal of the portion of its order that granted emergency relief with respect to the final rule's revisions to the actuarial value policy. Defs.' Mot. for Stay Pending Appeal, ECF No. 42.

ARGUMENT

"A stay [pending appeal] is not a matter of right." *Nken v. Holder*, 556 U.S. 418, 433 (2009). A party requesting a stay "bears the burden of showing that the circumstances justify" a stay, *id*. at 433–34, based on a consideration of "(1) whether the stay applicant has made a strong showing that he is likely to succeed on the merits; (2) whether the applicant will be irreparably injured absent a stay; (3) whether issuance of the stay will substantially injure the other parties interested in the proceeding; and (4) where the public interest lies," *id*. at 434 (quoting *Hilton v. Braunskill*, 481 U.S. 770, 776 (1987)). As to the first factor, "[i]t is not enough that the chance of success on the merits be better than negligible." *Id.* (internal quotation marks omitted). And "[b]y the same token, simply showing some possibility of irreparable injury fails to satisfy the second factor." *Id.* at 434-35.

I. Defendants Are Unlikely to Prevail on the Merits

A. Plaintiffs Have Standing to Challenge the Actuarial Value Policy

The Court correctly found that the Plaintiff Cities and MSA have standing to challenge CMS's new rule, including the actuarial value provision. Mem. Op. 20, 24. "To meet the constitutional minimum requirements for standing to sue, a 'plaintiff must have . . . suffered 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) (ellipses in original) (quoting *Spokeo, Inc. v. Robins*, 578 U.S. 330, 338 (2016)). Plaintiffs have made this showing. This Court found that the Plaintiff Cities suffer an injury traceable to the rule because they "will bear additional economic costs that come with treating people left uninsured by the implementation of the Rule," Mem. Op. 21, and it further found that MSA's members would face increased health insurance costs that are "fairly traceable to Defendants' conduct because Plaintiffs have established that 'insured and issuers reacted in predictable ways to Defendants' actions,'" *id.* at 18 (quoting *City of Columbus v. Trump*, 453 F. Supp 3d. 770, 789 (D. Md. 2020)).

Defendants argue that MSA lacks standing because the declaration from MSA's member, Brooke Legler, did not show "that any alleged premium increase would be attributed to the Rule's actuarial value policy." Defs.' Mem. in Supp. of Their Mot. for Stay Pending Appeal 8, ECF No. 42-1. They entirely ignore, however, the effect that the rule's actuarial value policy would have both on enrollees' premiums and on their out-of-pocket costs. By permitting cheaper, but less comprehensive, plans to qualify at the "silver" level of coverage, the rule will necessarily change the inputs for the statutory formula for premium tax credits in a way that will lower those tax credits across the board for any subsidized enrollee in the ACA Exchanges. *See* Mem. Op. 5, 36. Ms. Legler's declaration makes clear that her chronic medical condition makes her "dependent on substantial medication" for treatment, including a biologic that is covered by her marketplace plan and costs about $10,000 a month. Decl. of Brooke Legler ¶¶ 5, 6, ECF No. 11-4. Given her medical condition, she needs to maintain comprehensive coverage that covers these medications, which she can only afford thanks to the ACA's premium tax credits. *Id.* ¶¶ 6, 9. She will remain eligible for these tax credits next year, and will enroll in coverage that matches the level of coverage she is currently enrolled in. Second Decl. of Brooke Legler, ¶ 7 (attached hereto). Thus, given the effect of the actuarial value policy on the calculation of her

premium tax credit, if that policy were to go into effect, she would receive a lower tax credit and pay more in her net premium for the same level of coverage. These additional costs qualify as an injury in fact that is traceable to CMS's rule. *See* Mem. Op. 15.

Similarly, Defendants overlook the impact of the actuarial value policy on the Plaintiff Cities. By permitting issuers to market plans with lower actuarial value levels, CMS would expose enrollees to higher cost sharing when they obtain medical care, leaving these consumers who remain enrolled more likely to be *under*insured. In addition, the rule would lead to a drop in the overall rate of coverage, as fewer consumers would consider their higher net premiums to be a worthwhile bargain. Ctr. for Budget & Policy Priorities comment at 34–35 (Apr. 11, 2025), https://perma.cc/KP9W-J63N (noting that increased net premiums resulting from the revised actuarial value policy will cause enrollees to drop coverage). Cities, as providers of last resort, will be left to bear the resulting uncompensated care costs. Each of the Plaintiff Cities would receive lower reimbursement for the care that they provide to their uninsured or underinsured populations. *See* Decl. of Edward Johnson ¶¶ 9-14, ECF No. 11-7; Decl. of Faith Leach ¶¶ 9-13, ECF No. 11-8; Decl. of Olusimbo Ige ¶¶ 5, 12-14, ECF No. 11-9. This Court thus also correctly found that the Plaintiff Cities suffered an injury traceable to CMS's rule. Mem. Op. 22-24.

Defendants continue to assert that a plaintiff may not base standing on a claimed injury that is "'too speculative' and too 'far removed from its distant (even if predictable) ripple effects.'" Defs.' Mem. 8 (quoting *FDA v. All. for Hippocratic Med.*, 602 U.S. 367, 383 (2024)). This Court correctly concluded, however, that standing can be shown through a "'predictable chain of events leading from the challenged government action to the asserted injury.'" Mem. Op. 17 (quoting *All. for Hippocratic Med.*, 602 U.S. at 385); *see also Diamond Alt. Energy, LLC v. EPA*, 145 S. Ct. 2121, 2136 (2025). And, as this Court also correctly reasoned, it is readily predictable that a rule that leads to lower rates of insurance coverage will cause greater costs for

cities that are responsible for providing uncompensated care. Mem. Op. 22. This suffices to show the Plaintiff Cities' standing.[1]

B. The Actuarial Value Policy Is Arbitrary and Capricious

This Court also correctly determined that the final rule's actuarial value policy is arbitrary and capricious, for two reasons. First, the ACA authorizes CMS 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). This Court reasoned that "the purpose of the standard is set forth in section 18022(d)(3) itself and the only permissible 'de minimis' variations are those that account for uncertainties in 'differences in actuarial estimates,' not variations to reflect a new Administration's policy preference for less generous subsidies." Mem. Op. 37 (internal quotation marks and alterations omitted). Because CMS had failed to consider the purpose of the standard in setting its new actuarial value policy, this Court determined that the agency had acted arbitrarily. *Id.* (citing *Sierra Club v. U.S. Dep't of Interior*, 899 F.3d 260, 293 (4th Cir. 2018)). Second, this Court concluded that CMS's reasoning was "conclusory and unsupported by the evidence." *Id.* at 38. This Court noted that the agency had failed to meaningfully engage with the points raised by commenters that the rule would decrease subsidies for coverage on the Exchanges by $1.2 billion in 2026, would raise the cost of coverage for a typical family of four by $714 per year, and would worsen the risk pool, leading to higher premiums across the board. *Id*. Although CMS stated simply that it "expected" the rule to lower premiums in the long run, this Court held that such a conclusory dismissal of commenters' concerns could not qualify as reasoned decisionmaking. *Id.* Defendants do not identify any error with respect to either holding.

[1] Plaintiffs continue to maintain that Doctors for America has shown its standing for similar reasons, but recognize that this Court has reserved its decision on that question. Mem. Op. 12.

First, the statute does not provide CMS with carte blanche to permit any range of actuarial valuations that it wishes, even to the point of almost completely erasing the distinction between the bronze and silver levels of coverage. Instead, CMS is authorized only to provide for a "de minimis variation" in these valuations. 42 U.S.C. § 18022(d)(3). And "[w]hether a particular activity is a de minimis deviation from a prescribed standard must, of course, be determined with reference to the purpose of the standard." *Wis. Dep't of Revenue v. William Wrigley, Jr., Co.*, 505 U.S. 214, 232 (1992); *see also Perez v. Mountaire Farms, Inc*., 650 F.3d 350, 378 (4th Cir. 2011) (Wilkinson, J., concurring in part and concurring in the judgment) ("to give the de minimis rule too broad a reach would contradict congressional intent by denying proper effect to a statute"). CMS gave no consideration at all to the purpose of the statutory standard, which, again, is to account for differences in actuarial estimates. *See* 90 Fed. Reg. at 27,174-78. Because the agency "entirely failed to consider an important aspect of the problem," *Sierra Club*, 899 F.3d at 293, this Court correctly held that the rule was arbitrary.

In the motion for stay pending appeal that Defendants have filed in the Fourth Circuit, they acknowledge that "HHS must consider differences in actuarial estimates when it sets the de minimis range." Emergency Motion for Stay Pending Appeal 23, Docket Entry 4-1, *City of Columbus v. Kennedy*, No. 25-2012 (4th Cir. filed Aug. 29, 2025). This concession is fatal to their motion, because the agency provided no indication in the rulemaking that it understood, or attempted to fulfill, this obligation. So Defendants instead attack a straw man. They assert that this Court erred in holding that "HHS can consider *only* 'differences in actuarial estimates' when setting 'de minimis' ranges." Defs.' Mem. 10 (emphasis in original). But this Court said no such thing. Rather, this Court concluded that the agency had erred by failing entirely to consider the statutory purposes of the de minimis standard. And because the agency completely failed to fulfill this obligation, this Court had no occasion to consider the separate question of whether, or

to what extent, the agency may take into account additional considerations when it evaluates how wide a range of variation would be permissible to account for differences in actuarial estimates. There may be room to argue over how wide that range should be, but certainly a rule that all but completely erases the statutorily mandated ten-percentage-point distinction between the actuarial values of bronze and silver coverage exceeds the agency's authority. *See Wis. Dep't of Revenue*, 505 U.S. at 232.

Defendants attempt to excuse their disregard for the statutory text by appealing to the absurdity canon. Defs.' Mem. 10. Such an appeal must be rejected if it is at all "plausible that Congress intended the result compelled" by the statutory text. *In re Sunterra Corp*., 361 F.3d 257, 268 (4th Cir. 2004). And it makes perfect sense to conclude that Congress intended the statutory distinction between bronze, silver, gold, and platinum coverage to be meaningful, and that it also intended that all plans within a given metal level of coverage should provide actuarially equivalent benefits, subject to a small degree of variation to account for the possibility that actuarial estimates may be imprecise.

This Court's first holding, that Defendants failed to account for the standard specified in 42 U.S.C. § 18022(d)(3), is enough to sustain this Court's order. But Defendants fail to identify any error in this Court's second holding, either. Defendants concede that the rule, by permitting cheaper plans that offer less generous coverage to qualify as silver plans, would change the inputs for the formula for tax credits for every subsidized enrollee in the Exchange, amounting to $1.2 billion in fewer credits being awarded for 2026. 90 Fed. Reg. at 27,208. Defendants also do not dispute commenters' calculations that a typical family of four would pay $714 more per year for equivalent coverage as a result of the rule. *Id.* Yet they inexplicably contend that enrollees would not necessarily be "worse off," Defs.' Mem. 10, because an enrollee could still pay the same amount in premiums for a benchmark plan. This ignores the fact that the

benchmark plan will now offer lower-value coverage, meaning that the enrollee could keep their net premiums constant only by enrolling in a plan that calls for them to pay more in cost-sharing. Alternatively, an enrollee who wishes to maintain coverage with the same level of generosity as his or her current plan would necessarily pay more in net premiums for that same level of coverage. And these harms would apply across the board, because the tax credit for *every* subsidized enrollee is calculated on the basis of the cost of the benchmark plan, no matter whether he or she enrolls in that benchmark plan or a different offering through the Exchanges.

Defendants further assert that "neither the parties nor the Court dispute that the Rule's actuarial value policy is expected to reduce premiums for various Exchange plans." Defs.' Mem. 11. To the contrary, this point is very much in dispute, and the agency's failure to engage in that dispute renders its rule arbitrary. CMS stated in the rulemaking simply that it "expected" the rule to lead in the long run to lower premiums by drawing in healthier unsubsidized enrollees. 90 Fed. Reg. at 27,177. But, apart from that conclusory statement, it failed entirely to engage with commenters who raised the substantial body of empirical research showing that, on balance, a reduction in subsidies will cause healthier people to drop out of coverage, resulting in a weaker risk pool and higher premiums for all. Ctr. for Budget & Policy Priorities comment at 34–35 (Apr. 11, 2025), https://perma.cc/KP9W-J63N; *see also id.* at 35 (citing Am. Acad. of Actuaries, *Issue Brief: Ensuring Access, Affordability, Choice, and Competition in the Individual Health Insurance Market* at 5 (Mar. 2025), https://perma.cc/Z8L2-ECXH). This Court correctly concluded that "[s]uch nodding to concerns raised by commenters only to dismiss them in a conclusory manner is not a hallmark of reasoned decisionmaking," Mem. Op. 38, and the actuarial value policy is invalid for this reason as well.

II. Defendants Will Not Be Irreparably Injured by This Court's Order, but Plaintiffs and the Public Will Be Irreparably Injured If This Court's Order Is Stayed

Defendants assert that it would be impossible to "overstate[]" the "detrimental impact" of this Court's order. Defs.' Mem. 4. Yet Defendants manage to do just that. Their filing concedes that CMS will be able to successfully unwind its unlawful policy before the start of this fall's open enrollment period. (Indeed, they could hardly contend otherwise, given their previous argument that this Court could wait until later in the year to award effective relief. Transcript of Motions Hearing 54:11-13, ECF No. 34.) They base their request for a stay instead on the possibility that some insurers might make mistakes in revising some of their plan offerings, or that some insurers might choose as a result of this Court's ruling to drop out of the market. Defendants offer nothing more than speculation that either eventuality might occur, however, and there is no reason to believe that either consideration presents a serious concern.

In the ordinary course of affairs, CMS completes its annual rulemaking with respect to the ACA's Exchanges in advance of the rate filing season, to provide insurers with a measure of certainty as to the legal landscape as they prepare their offerings. In keeping with this timeline, CMS published a final rule governing the operation of the Exchanges for the coming year in January 2025. 90 Fed. Reg. 4424 (Jan. 15, 2025); *see* Second Decl. of Christen Linke Young ¶ 18 (attached hereto). That rule kept in place the agency's then-existing rules governing the permissible range of actuarial valuations in Exchange plans. *Id.* The plan design period then began for most issuers, and they would have begun to prepare their offerings for 2026 with the expectation that those rules would remain in place. *Id.* During the middle of this plan design period, however, CMS created uncertainty by first proposing, in March 2025, and then finalizing, in June 2025, the rule at issue here that permitted a wider range of actuarial variations. *Id.* Both the proposed rule and the final rule were immediately controversial, and issuers would have

continued in the preparations of their plan offerings with the recognition that this rule might not survive a legal challenge. *Id.*

Accordingly, issuers most likely engaged in contingency planning to prepare for the possibility that the new actuarial value policy would not remain in force. *Id.* Indeed, CMS itself encouraged issuers to engage in this contingency planning, given the uncertainties in the legal landscape that would govern the Exchanges for the coming year. *Id.* ¶ 19; *see* CMS, *Plan Year 2026 Individual Market Rate Filing Instructions* (May 2, 2025), https://www.cms.gov/files/document/py-26-individual-market-rate-filing-instructions.pdf. And because well-advised issuers would have undertaken these preparations, there is at most a minimal risk that issuers will now be unable to conform their plan offerings to the rules that were in place at the beginning of the rate filing season, and that remained in place through June 2025. Second Young Decl. ¶ 20. And there is no reason at all to suspect that any insurers will drop out of the market. *Id.*

CMS's experience with other late-breaking policy changes provides confidence that the agency, state regulators, and issuers will be able to respond adequately to this Court's order. On October 12, 2017—only nineteen days before the beginning of the open enrollment period for 2018—the agency announced that the federal government would no longer make cost-sharing reduction payments to issuers of plans on the ACA Exchanges. *Id.* ¶ 6. This eleventh-hour policy change required federal and state regulators and issuers to work together to redesign plan offerings in time for open enrollment. *Id.* ¶¶ 8, 10. These efforts were successful. *Id.* ¶ 8. The redesign in October 2017 occurred over a much more compressed timeline than stakeholders face now, thereby demonstrating that regulators and issuers will be able to respond to this Court's ruling over the next two months. *Id.* ¶ 12.

Indeed, Defendants concede that they will be able to implement this Court's order. *See* Decl. of Jeff Wu ¶ 20, ECF No. 42-2. They instead assert that there is a "significant risk" that an issuer would remove a noncompliant plan from its offerings rather than revising that plan, or that an issuer would make mistakes in attempting such a revision. *Id.* ¶ 21. Defendants cannot meet their heavy burden to justify a stay pending appeal with speculation about such possibilities, *see Nken*, 556 U.S. at 434-35, particularly where the agency itself created the issue by rushing to promulgate a mid-year policy change, *cf. Di Biase v. SPX Corp.*, 872 F.3d 224, 235 (4th Cir. 2017) (proponent of emergency relief may not complain of self-inflicted harms).

But, in any event, Defendants vastly overstate the task that issuers now face. Although 80% of issuers on the federal Exchange may be planning on offering at least one plan with wider actuarial value variations, Wu Decl. ¶ 24, this does not mean that 80% of plans would need to be resubmitted. These issuers intend to offer multiple plans on the federal Exchange, and most of those offerings are likely already in compliance with the pre-existing actuarial value policy.[2] Data for the current year are not publicly available, but on the basis of a review of analogous data from 2022, it is likely that only about one out of four of these issuers' plan offerings would need to be revised this year. Second Young Decl. ¶ 16. Indeed, there is good reason to believe that the proportion of plans that would require revisions could be considerably smaller. Under rules that were adopted after 2022, issuers on the federal Exchange are required to offer standardized plans (which by definition could not have been subject to the wider actuarial value calculation in the challenged rule), and these issuers are limited in the number of non-

[2] Similarly, although Defendants assert that this Court's order "would affect 99.6 percent of consumers" on the federal Exchange, Defs.' Mem. 5, this does not mean that 99.6% of consumers would be enrolled in a noncompliant plan. It instead means that this proportion of enrollees would shop for coverage in a market that would include at least one noncompliant plan, *see* Wu Decl. ¶ 24, thereby almost certainly reducing the tax credits they would otherwise be entitled to, but still leaving them with a broad range of compliant plans to choose from.

standardized plans they can offer. *Id.* ¶ 17; *see* 45 C.F.R. §§ 156.201(b), 156.202(b). So the three quarters of the plans on the federal Exchange that already comply with the narrower actuarial value ranges would require no new action, as CMS itself recognized when it issued its final rule. *See* 90 Fed. Reg. at 27,176 (declining suggestion to delay changes to actuarial value policy until 2027 because issuers would not be required "to take any additional action to revise existing plan designs"); *see also id.* at 27,218 (same). And, as noted above, even for the smaller fraction of plans that do require revisions, there is no reason to suspect that regulators and issuers will be unable to complete the revisions needed for this smaller pool of noncompliant plans. *See* Second Young Decl. ¶ 20.

The equities thus weigh heavily against a stay pending appeal. Defendants, on the one hand, have offered only speculation that there may be some hiccups while issuers work to conform a subset of their plan offerings to the rules that were in place earlier this year. On the other hand, Plaintiffs and the public at large would suffer irreparable harm if the new actuarial value rule were allowed to go into effect for the 2026 plan year. Virtually all subsidized enrollees on the Exchanges would realize lower tax credits and higher costs, as the rule would reduce federal premium tax credits next year by $1.2 billion, 90 Fed. Reg. at 27,208, resulting in a typical family of four paying $714 more for their health care needs per year, *see id*. And, although Defendants have (incorrectly) attempted to explain away these harms as a worthwhile trade-off in their effort to bring unsubsidized enrollees into the market, even under their own theory there would be an "initial weakening of the risk pool," *i.e.*, in 2026, and the "long-term benefits" would be realized only in later years. 90 Fed. Reg. at 27,177. The *Nken* factors thus all point in favor of protecting affordable coverage for 2026 by maintaining this Court's order during the pendency of the appeal.

CONCLUSION

For these reasons, the Court should deny Defendants' motion to stay pending appeal.

Dated: September 2, 2025

Respectfully submitted,

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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

SECOND DECLARATION OF BROOKE LEGLER

I, Brooke Legler, 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 have previously submitted a declaration in this action. I respectfully provide this supplemental declaration to further explain why the cost increases that would be caused by the new Centers for Medicare and Medicaid Services rule, "Patient Protection and Affordable Care Act; Marketplace Integrity and Affordability," would threaten my ability to access medication that I require for my health and risk the loss of my small business.

2. I am a member of the Main Street Alliance, which is a national association of approximately 30,000 small businesses.

3. I am a resident of New Glarus, Wisconsin.

4. I am a small business owner. My business is an early childhood education program with about 10 employees.

5. I have rheumatoid arthritis and I am dependent on substantial medication to treat the condition, including medications that address secondary issues caused by the primary

medications. I also take a biologic to protect my health by suppressing my immune system, which costs about $10,000 per month.

6. I purchase individual insurance on the Exchange and receive subsidized coverage under a silver "Quartz One Achieve" plan. I currently pay a net premium of about $200 per month, after application of the Affordable Care Act's subsidies for my coverage.

7. My personal income will be about $30,000 for 2025. I project that my personal income in 2026 will be about the same amount. I understand that, at this income level, I will remain eligible for Affordable Care Act premium tax credits next year, even if legislation is not adopted to extend subsidies that are currently available for other people with higher income levels.

8. My insurance covers my rheumatoid arthritis medications, and a portion of my biologic. I also qualify for payment assistance through the biologic drug company. I would not be able to afford the biologic, or my other medications, without health insurance, or with a less comprehensive insurance plan.

9. As explained in my prior declaration, without access to an insurance plan with the benefits and affordability of my current coverage, I would not be able to afford the medications I need or continue my small business' operations.

10. Accordingly, even if insurers are permitted to sell cheaper plans next year that offer less generous benefits, I would not wish to purchase such a plan. In shopping for a plan next year, I will seek to retain the comprehensive benefits that I have under my current plan, which I need to be able to afford my medications. If lower tax credits are available to subsidize my coverage, I will be required to pay more in net premiums to maintain the same level of coverage.

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.

Executed this 2nd of September, 2025 in New Glarus, Wisconsin.

BROOKE LEGLER

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

SECOND DECLARATION OF CHRISTEN LINKE YOUNG

I, Christen Linke Young, declare under penalty of perjury as prescribed in 28 U.S.C. § 1746:

1. The facts contained in this declaration are known personally to me and, if called as a witness, I could and would testify competently thereto under oath. I submit this sworn declaration in support of Plaintiffs' opposition to the motion for stay pending appeal. I have previously submitted a declaration in support of Plaintiffs' motion for interim relief.

2. I am a visiting fellow with the Brookings Center on Health Policy, a research center within the Economic Studies program at the Brookings Institution. My research concerns a variety of topics in health policy, including issues related to health insurance: how Americans get health care coverage, how that coverage is financed, and how the health care system can be improved to make coverage more affordable and accessible. I have published many pieces of scholarly analysis on these topics. I have testified before Congress and before state legislatures, my work is frequently cited in national media, and I have served in multiple leadership roles in state and federal government. My full curriculum vitae, including a list of publications, was submitted as an Appendix to my first declaration.

Summary of Observations

3. Implementing more narrow *de minimis* ranges will require action by federal and state regulators and by issuers over the next two months, in order to provide consumers the benefits to which they are entitled.

4. It is feasible for regulators and issuers to take these actions. Marketplace actors have made changes on far more aggressive timelines in the past, most notably in October 2017 in response to federal policy changes that resulted in the loss of $7 billion in federal payments just three weeks before the start of Open Enrollment.

5. Consumers will be harmed with higher out-of-pocket spending – some with higher deductibles and cost-sharing and others with higher premiums – if these changes are not made.

Although Changes Related to Cost-Sharing Reductions in October 2017 Were a Major Disruption, Issuers Could and Did Quickly Adapt to Those Changes

6. On October 12, 2017, the federal government announced that it would no longer make Cost-Sharing Reduction (CSR) payments to issuers.[1] This was a major disruption to Marketplace operations that cut payments to Marketplace health plans by $7 billion.[2] The change was made *after* that year's September 27 deadline for issuers to finalize premiums and sign contracts for Marketplace participation for the following year.[3]

7. At the time, this change was understood to be a very significant disruption to Marketplace operations and issuers on a timeline that posed threats to the market. Observers said

[1] U.S. Dep't of Health & Hum. Servs., Memorandum on Discontinuance of Cost-Sharing Reduction Payments (Oct. 12, 2017), https://www.hhs.gov/sites/default/files/csr-payment-memo.pdf.
[2] Alison Kodjak, Halt in Subsidies for Health Insurers Expected to Drive Up Costs for Middle Class, NPR (Oct. 13, 2017), https://www.npr.org/sections/health-shots/2017/10/13/557541856/halt-in-subsidies-for-health-insurers-expected-to-drive-up-costs-for-middle-clas.
[3] Rabah Kamal, Ashley Semanskee, Michelle Long, Gary Claxton & Larry Levitt, How the Loss of Cost-Sharing Subsidy Payments Is Affecting 2018 Premiums, KFF (Oct. 27, 2017), https://www.kff.org/private-insurance/issue-brief/how-the-loss-of-cost-sharing-subsidy-payments-is-affecting-2018-premiums/

it was a "a dramatic move"[4] or an "Obamacare bombshell"[5] that would "roil individual markets."[6] President Trump wrote the next day that "Obamacare is imploding" in association with the change.[7]

8. However, in the days immediately after the October announcement, issuers, the Centers for Medicare & Medicaid Services (CMS), and states worked together to quickly update issuers' individual market filings to react to the change. Issuers generally needed to adopt revised premiums for their plan offerings using novel pricing strategies that differed in important ways from any they had used in the past. CMS and states provided flexibility to allow changes that otherwise were not contemplated under the Marketplace timeline, and by the end of October issuers had made the necessary changes.[8] Open Enrollment began on time on November 1, 2017, nineteen days after the federal government's announcement.

9. Prior to the October 12 announcement, there were widespread rumors that the federal government could take this step, and so most insurance companies likely engaged in some degree of contingency planning to prepare.

10. Facilitating Marketplace premium updates in the days after October 12, 2017 was undoubtedly a complex undertaking that required careful work by dedicated staff at CMS, state-based Marketplaces, state insurance regulators, and issuers. The staff undertook those efforts to

[4] Kevin Liptak, Tami Luhby & Phil Mattingly, CNN, Trump Will End Health Care Cost-Sharing Subsidies (Oct. 12, 2017), https://www.cnn.com/2017/10/12/politics/obamacare-subsidies
[5] Dan Mangan, Obamacare Bombshell: Trump Kills Key Payments to Health Insurers, CNBC (Oct. 12, 2017), https://www.cnbc.com/2017/10/12/obamacare-bombshell-trump-kills-key-payments-to-health-insurers.html
[6] Timothy Jost, Administration's Ending of Cost-Sharing Reduction Payments Likely to Roil Individual Markets, Health Affairs Forefront (Oct. 13, 2017), https://www.healthaffairs.org/do/10.1377/forefront.20171022.459832/
[7] Kevin Liptak, Tami Luhby and Phil Mattingly, CNN, Trump Will End Health Care Cost-Sharing Subsidies (Oct. 12, 2017), https://www.cnn.com/2017/10/12/politics/obamacare-subsidies
[8] Rabah Kamal, Ashley Semanskee, Michelle Long, Gary Claxton & Larry Levitt, How the Loss of Cost-Sharing Subsidy Payments Is Affecting 2018 Premiums, KFF (Oct. 27, 2017), https://www.kff.org/private-insurance/issue-brief/how-the-loss-of-cost-sharing-subsidy-payments-is-affecting-2018-premiums/

support the successful functioning of the Marketplaces in the wake of a last-minute policy change made by the federal government.

11. I am not aware of any issuers that dropped out of the Marketplace as a result of the events in October 2017. Every county was served by at least one Marketplace issuer in 2018, as has been the case every year of Marketplace operations.

12. This experience that CMS, states, and issuers had in implementing novel pricing strategies shortly before the open enrollment period at the end of 2017 demonstrates that it will be feasible for these actors to implement the District Court's order before open enrollment begins this year. The task that these actors were faced with in 2017 was undertaken over a much shorter time period than the task that these actors now face in conforming plan offerings to the version of the CMS rule governing permissible actuarial value ranges that was in place before June 2025.

It Is Feasible For Plans To Adapt to Changes to the *De Minimis* Range

13. To respond to the District Court's ruling, some issuers will be required to change the deductibles and cost-sharing for some of the plans that they will offer on the Exchanges, and to update the premiums for these plans in association with the change.

14. The result of these changes by issuers will be to make health care more affordable for consumers.

- Consumers receiving advance premium tax credits (APTC) and purchasing benchmark silver plan coverage will pay the same premium for more generous coverage.
- Consumers receiving APTC and purchasing coverage other than the benchmark silver plan will generally pay lower premiums for the same coverage or the same premium for more generous coverage, or some combination.

- The small share of consumers not receiving APTC will generally pay slightly higher premiums for more generous coverage.

These impacts are described in more detail in the following section.

15. Changing deductibles, cost-sharing, and premiums to be consistent with more narrow *de minimis* ranges requires issuers to use straightforward plan design tools. While the timeline will be different and more compressed than usual, issuers will not need to develop any novel designs or work with any new types of tools to achieve the changes.

16. It is critical to note that not all plans will require changes: issuers will only be required to change plans with actuarial values outside the *de minimis* ranges that are permissible under the District Court's ruling. CMS possesses data from issuers on the share of plans filed for 2026 that fall outside the permissible ranges but those data are not publicly available. However, one can use data from 2022 to understand the likely scope. Specifically, CMS rules applicable to the 2022 plan year allowed *de minimis* ranges as wide as those the agency attempted to allow for 2026. In 2022, only about one quarter of plans had actuarial values that were outside the ranges that are allowed under the District Court's ruling.[9] While issuers may have behaved somewhat differently for 2026 than they did in 2022, these data support the reasonable inference that the share of filed plans for 2026 that will require changes is likely to be around one quarter.

17. There is reason to think that the share of plans that will require changes for 2026 could be considerably smaller than the share that fell outside the more narrow *de minimis* ranges in 2022. That is because, unlike in 2022, issuers in the federally-facilitated Marketplace are now required to offer standardized plans (i.e. plans with cost-sharing designs specified by CMS, and

[9] Email from Jason Levitis & Claire O'Brien to Christen Linke Young (Sep. 11, 2025) (on file with author) (citing Marketplace Public Use Files for 2022, Ctrs. for Medicare & Medicaid Servs., https://www.cms.gov/marketplace/resources/data/public-use-files).

those designs were finalized in 2024 and not changed by the 2025 rulemaking) and are limited in the number of non-standardized plans that they can offer. Only non-standardized plans can fall outside the more narrow *de minimis* ranges. Thus, the plans even potentially affected by the District Court's ruling constitute a limited slice of Marketplace offerings.

18. CMS first published a final Marketplace rule for 2026 coverage in January 2025, which made no changes to the then-existing rules governing *de minimis* ranges for actuarial value calculations.[10] The publication of that rule kicked off the plan design period for most issuers, and issuers likely began designing plans based on more narrow *de minimis* ranges that had been in effect since the 2023 plan year. In March 2025, CMS proposed wider ranges in its Notice of Proposed Rulemaking,[11] and the rule was finalized at the end of June.[12] Issuers in many states were required to begin filing proposed individual market fillings with their state insurance regulators prior to the publication of the final rule. Thus, issuers would have gone through the early plan design period with the expectation that the pre-existing rules governing *de minimis* ranges would govern their plan offerings, and would have continued through the plan design period in recognition that there was significant uncertainty about what *de minimis* ranges would apply. The proposed and then final rules were immediately controversial and litigation commenced quickly after finalization, thus reinforcing for issuers that there was continuing uncertainty about the rules that would govern Marketplaces in 2026. Given this significant and extended period of uncertainty, I expect issuers will have engaged in some degree of contingency

[10] Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2026; and Basic Health Program, 90 Fed. Reg. 4424 (Jan. 15, 2025).
[11] Patient Protection and Affordable Care Act; Marketplace Integrity and Affordability, 90 Fed. Reg. 12,942 (Mar. 19, 2025) (proposed rule).
[12] Patient Protection and Affordable Care Act; Marketplace Integrity and Affordability, 90 Fed. Reg. 27,074 (June 25, 2025) (final rule).

planning, which will likely facilitate the changes necessary to return to more narrow *de minimis* ranges.

19. Indeed, in the spring of 2025, CMS was encouraging issuers to engage in contingency planning for possible changes that Congress could -- or could not -- make that would affect Marketplace plans. In early May, CMS told plans "to be prepared to react to Congressional action that could affect PY 2026 individual market premiums."[13] Notably, legislation that passed the House (but not the Senate) a few weeks after this memorandum included changes to permissible actuarial value *de minimis* ranges consistent with the CMS proposed (and then final) rule.[14] That is, CMS has since May advised plans to be prepared for possible changes in these areas.

20. In my view, CMS, states, and issuers will be able to work together over the next two months to achieve these changes. There is at most a minimal risk that issuers would be unable to conform their plan offerings to the actuarial value rule that was in place prior to June of this year, or that issuers would drop out of the Marketplace. I am not aware of any issuer that has indicated it would leave the Marketplace in association with these changes; issuers generally publicize these actions as far in advance as possible to avoid surprising customers and regulators, so one would expect issuers to have made any such plans public by now.

Allowing Wider *De Minimis* Ranges To Continue Would Harm Consumers

21. As noted above, to respond to the District Court's ruling, some issuers will be required to change the deductibles and cost-sharing for some of the plans that they will offer on the Exchanges, and to update the premiums for these plans in association with the changes.

[13] Ctrs. for Medicare & Medicaid Servs., Plan Year 2026 Individual Market Rate Filing Instructions (May 2, 2025), https://www.cms.gov/files/document/py-26-individual-market-rate-filing-instructions.pdf
[14] H.R. 1, 119th Cong. § 44201(c) (as passed by House, May 22, 2025).

22. The result of these changes will be to make health care more affordable for consumers in a wide range of common scenarios.

23. Consumers receiving APTC and purchasing benchmark silver plan coverage will pay the same premium for more generous coverage. That's because the APTC amount changes dollar-for-dollar with changes to the benchmark silver premium. If the benchmark plan is changed to have a higher actuarial value (and thus typically to have a higher premium), APTC recipients enrolled in it will get more generous coverage for the same price.

24. Consumers receiving APTC and purchasing coverage other than the benchmark silver plan will generally pay lower premiums for the same coverage or the same premium for more generous coverage, or some combination.

25. Specifically, consumers receiving APTC and intending to purchase coverage that is not affected by the District Court's order will generally pay a lower premium for that coverage. That's because, as explained above, the APTC amount changes dollar for dollar with the benchmark silver premium. So, if the benchmark premium increases while the consumer's plan's premium remains unchanged, the consumer's *net premium* will fall. Moreover, because the benchmark premium is the second-lowest-cost silver plan available, it typically has an actuarial value at the low end of the permissible range.

26. Consumers receiving APTC who would have otherwise purchased coverage that is affected by the District Court's order will generally have a choice between paying about the same net premium for more generous coverage that they would have otherwise received, or using their greater purchasing power on a different plan. Whatever they decide, the larger APTC means a better deal on their coverage.

27. The small share of consumers not receiving APTC may or may not be affected by the ruling. Those intending to purchase coverage not affected by the District Court's ruling will not generally be affected. Those who would have otherwise purchased coverage that is changed due to the District Court's ruling will generally pay slightly higher premiums for more generous coverage. Since all plans must have actuarially justified rates, the consumer would not generally receive a worse deal under this scenario.

I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct.

Dated: September 1, 2025

Christen Linke Young
Washington, D.C.