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

TABLE OF CONTENTS

INTRODUCTION 1
BACKGROUND 2
I. Statutory Background 2
II. The 2025 Marketplace Rule 6
A. The Final Rule Erodes the Value of Coverage 6
B. The Final Rule Imposes Barriers on Enrollment 8
C. The Final Rule Limits the Availability of Subsidized Coverage 10
III. The Disastrous Effects of the Final Rule 15
STANDARD OF REVIEW 17
ARGUMENT 18
I. Plaintiffs Are Likely to Succeed on Their Claims Against Provisions That Erode the Value of Coverage 18
A. The Rule's Imposition of a Junk Fee on Certain Plans Is Unlawful and Arbitrary 18
1. The Imposition of the Junk Fee Is Unlawful 18
2. The Imposition of the Junk Fee Is Arbitrary 19
B. The Revised Premium Adjustment Methodology Is Arbitrary 21
C. The New Actuarial Value Policy Is Arbitrary 24
II. Plaintiffs Are Likely to Succeed on Their Claims Against Provisions That Impose Barriers on Enrollment 26
A. The Rule Unlawfully and Arbitrarily Revokes the Act's Guarantee That Anyone Can Buy Insurance 26
B. The Revocation of the Low-Income Special Enrollment Period Is Arbitrary 28
C. The Verification Requirements for SEP Enrollments Are Arbitrary 31
III. Plaintiffs Are Likely to Succeed on Their Claims Against Provisions That Limit the Availability of Subsidized Coverage 32
A. The Failure-to-Reconcile Policy Is Unlawful and Arbitrary 32
B. The New Data-Matching Policies Are Arbitrary 35
IV. Plaintiffs Will Suffer Irreparable Harm in the Absence of a Preliminary Injunction 39
V. The Remaining Factors Weigh in Favor of an Injunction 44
VI. The Court Should Not Require a Bond 45
CONCLUSION 45

INTRODUCTION

The Affordable Care Act (ACA) extends a promise: all Americans are guaranteed access to insurance coverage that will pay for their health needs. One of the ways that the ACA seeks to fulfill that promise is by establishing health insurance Exchanges, through which individuals can shop for and buy an affordable policy that covers a set of essential health benefits. The Act aims to keep the costs of these policies down by subsidizing the cost of coverage, which attracts younger and healthier people into the market, improving the risk pool and lowering premiums for everyone. When the Act is implemented as Congress intended, it succeeds at this goal.

New policymakers at the Department of Health and Human Services (HHS) and the Centers for Medicare & Medicaid Services (CMS), however, do not share this vision. They prefer policies that would lower federal subsidy payments by driving people off coverage on the Exchanges. CMS is now seeking to accomplish this result through a new rule governing policies for enrollment in subsidized coverage on the Exchanges. 90 Fed. Reg. 27,074 (June 25, 2025). Through a combination of measures, the agency aims to drive up consumers' cost of coverage on the Exchanges, make it harder for people to enroll in policies through the Exchanges, and impose barriers on obtaining subsidized coverage even for those people who do successfully enroll. Many of the policies in this rule are unlawful, contrary to the ACA, and exceed CMS's statutory authority. All of the policies at issue are arbitrary, violating the Administrative Procedure Act (APA)'s requirements for reasoned decisionmaking. And several of the challenged policies will go into effect for only one year, although the proposed rule provided no notice of such one-year implementation, and CMS failed to justify that decision or consider the whiplash effect it will cause. The new Administration was not free to undermine the purposes of the Act simply because they disagree with it.

These new policies will impose grave and irreparable harm on Plaintiffs. Municipalities like the cities of Columbus, Baltimore, and Chicago are providers of last resort. Because they operate clinics and other facilities that treat all comers without regard to their insurance status, when more people are driven off insurance coverage, these cities are left to foot the bill. Main Street Alliance's members are small business owners and entrepreneurs, many of whom rely on the Act's promise of affordable insurance coverage through the Exchanges to keep employees healthy and their businesses afloat. And Doctors for America's members are clinicians across the nation, many of whose patients would have their health coverage limited or lost as a result of the final rule. This would lead to greater administrative hurdles and less compensation for clinicians, who would be hindered from providing all of their patients with optimal care.

In the absence of a stay of the rule under 5 U.S.C. § 705 or a preliminary injunction, the rule will go into effect on August 25, 2025. Plaintiffs respectfully seek relief from this Court on or before that date to protect themselves and their members from irreparable harm and to vindicate the promise of the Affordable Care Act.

BACKGROUND

I. Statutory Background

In 2010, Congress enacted the Patient Protection and Affordable Care Act. Pub. L. No. 111-148, 124 Stat. 119 (2010) (as amended by Pub. L. No. 111-152, 124 Stat. 1029 (2010)). "The Act aims to increase the number of Americans covered by health insurance and decrease the cost of health care." *Nat'l Fed'n of Indep. Bus. v. Sebelius*, 567 U.S. 519, 538 (2012); *see also King v. Burwell*, 576 U.S. 473, 479 (2015).

Before the Act's market reforms went into effect in 2014, "individual health insurance markets were dysfunctional." *City of Columbus v. Cochran*, 523 F. Supp. 3d 731, 740 (D. Md. 2021). Insurers were free to deny coverage for people with pre-existing conditions, to refuse to

renew such coverage, or even to revoke such coverage after it had been issued. Now, however, the Act's "guaranteed issue" requirement specifies that every "health insurance issuer that offers health insurance coverage in the individual or group market in a State must accept every employer and individual in the State that applies for such coverage," 42 U.S.C. § 300gg-1(a), subject to exceptions specified in the statute, such as the restriction of new enrollments to an annual open enrollment period or specified special enrollment periods, *id*. § 300gg-1(b); *see Me. Cmty. Health Options v. United States*, 590 U.S. 296, 301 (2020). "In other words, the Act 'ensure[s] that anyone can buy insurance.'" *Me. Comty. Health Options*, 590 U.S. at 301 (quoting *King*, 576 U.S. at 493).

Separately, the Act's "guaranteed renewability" provision requires issuers to renew or continue in force such coverage, 42 U.S.C. § 300gg-2(a), again subject to statutory exceptions, including an exception for persons who have failed to pay premiums owed on their policy, *id*. § 300gg-2(b)(1); *see also id.* §§ 300gg-12, 300gg-42.

Health insurance plans must cover a set of "essential health benefits," such as prescription drugs. *Id*. § 300gg-6(a). And to protect patients from devastating costs when a medical condition exhausts their coverage, the Act limits so-called "cost-sharing"—like, deductibles and copayments—for these essential health benefits. *See id.* § 18022(a)(2). The limitation on cost-sharing is adjusted each year by a "premium adjustment percentage," which compares average premiums for "health insurance coverage" in the current year with the same average for 2013, before the Act's marketplace reforms went into effect. *Id.* § 18022(c)(1), (4).

To help individuals learn about and enroll in health insurance, the Act "requires the creation of an 'Exchange' in each State where people can shop for insurance, usually online." *King*, 576 U.S. at 479 (quoting 42 U.S.C. § 18031(b)(1)); *see Me. Cmty. Health Options*, 590 U.S. at 301. These Exchanges, also known as health insurance Marketplaces, enable people not

eligible for Medicare or Medicaid to obtain adequate, affordable insurance independent of their jobs. The Exchanges therefore serve as "marketplace[s] that allow[] people to compare and purchase" ACA-compliant plans. *King*, 576 U.S. at 479.

There are several different types of Exchanges. Some states have elected to create Exchanges themselves (state-based Exchanges or SBEs), as is the case in Maryland, while others have created Exchanges that operate on the federal Healthcare.gov platform (state-based Exchanges on the federal platform, or SBE-FPs), such as the Exchange currently in use in Illinois while it transitions to an SBE. The Exchange in other states, including Ohio, is operated by the Centers for Medicare & Medicaid Services (CMS) (federally facilitated Exchange, or the FFE). See CMS, Consumer Info. & Ins. Oversight, *State-Based Exchanges*, https://perma.cc/JFT3-6EAK.

Plans that meet the requirements described above and that are offered on the Exchanges are known as "qualified health plans." Individuals primarily enroll in qualified health plans for a given benefit year during an annual open enrollment period, or under specified special enrollment periods. 42 U.S.C. § 18031(c)(6). To assist with enrollment, the Act requires Exchanges to award grants to healthcare "Navigators" that conduct public education and awareness campaigns, help consumers understand their choices, facilitate their enrollment, and ensure their access to consumer protections. *Id.* § 18031(i)(1), (3).

Plans on the Exchanges offer various levels of generosity: a "bronze" plan is designed to provide benefits that are actuarially equivalent to 60% of the full value of benefits to the plan (meaning that premiums are calculated in the expectation that 40% of the cost of coverage would be paid for through enrollee out-of-pocket spending), and "silver," "gold," and "platinum" plans are designed to provide benefits that are actuarially equivalent to 70%, 80%, and 90%, respectively, of the full value of benefits under the plan. *Id.* § 18022(d)(1). Because actuarial

predictions may be imprecise, the Act specifies that CMS may "provide for a de minimis variation . . . to account for differences in actuarial estimates." *Id.* § 18022(d)(3).

The Act also "seeks to make insurance more affordable by giving refundable tax credits to individuals." *King*, 576 U.S. at 482 (citing 26 U.S.C. § 36B). These "premium tax credits" (PTCs) vary depending on an individual's income—individuals who earn more must pay more toward the cost of their monthly premium—but are generally pegged to the cost of the so-called "benchmark silver plan," or the second-lowest-cost silver plan offered within a market. *See, e.g.*, 26 U.S.C. § 36B(b)(3)(B)–(C). The Act initially made these tax credits available to individuals with incomes between 100% and 400% of the federal poverty level. *Id.* There is no income cap on these tax credits under current law, *see* 26 U.S.C. § 36B(b)(3)(A)(iii), but the 400% income cap will be reinstated for 2026 absent further congressional action.

PTCs are claimed on an individual's tax return after the end of the year, and are paid by the IRS. *Id.* § 36B(h). Rather than waiting to recover their costs the next year, enrollees may claim "advance premium tax credits" (APTCs) up front so that the value of the tax credits may be applied directly to the purchase of insurance. 42 U.S.C. §§ 18081, 18082; *City of Columbus*, 523 F. Supp. 3d at 741. CMS is responsible for determining whether individuals meet the statutory eligibility requirements for APTCs, as well as for "redetermin[ing] eligibility on a periodic basis in appropriate circumstances." 42 U.S.C. § 18081(f)(1)(B).

In sum, the Act requires that insurers generally offer only quality health insurance and aims to lower the cost of coverage to encourage individuals to enroll. This coverage improves access to care and overall health and reduces financial burdens on consumers as well as institutions that pay for uncompensated care. Decl. of Christen Linke Young ¶¶ 6–10.

Increasing enrollment in quality health insurance coverage is not only the ACA's immediate goal; it is also key to the Act's long-term success. Insurance market stability requires

robust enrollment, particularly by relatively healthy individuals. *Id.* ¶ 9; 42 U.S.C. § 18091(2)(I) (finding that "broaden[ing] the health insurance risk pool to include healthy individuals . . . will lower health insurance premiums"); *King*, 576 U.S. at 480. Limiting the cost of health insurance is, in turn, essential to promoting enrollment. Young Decl. ¶ 10; *King*, 576 U.S. at 480–81. By driving costs down and insured rates up, the Act ensures that insurance markets function smoothly.

When faithfully implemented, the Act's reforms successfully meet Congress's goal of enabling more individuals to enroll in health insurance coverage. *See* Young Decl. ¶ 7. More than 24 million individuals are enrolled in Marketplace coverage in 2025. CMS, Press Release, Over 24 Million Consumers Selected Affordable Health Coverage in ACA Marketplace for 2025 (Jan. 17, 2025), https://perma.cc/N8QF-NKHG.

II. The 2025 Marketplace Rule

CMS new, final rule, 90 Fed. Reg. 27,074 (June 25, 2025), contains a number of provisions that, in their individual and collective effect, will raise consumers' premiums for plans on the Exchanges, limit coverage under those plans, and deter millions of individuals from enrolling in coverage, leading to higher uncompensated care costs for providers of last resort. Independent experts project that the rule will lead to at least 1.8 million fewer people enrolling on the Exchanges. Young Decl. ¶ 4. The rule accomplishes this result through measures that erode the value of coverage obtained through the Exchanges, impose barriers designed to depress enrollment in the Exchanges, and impose further barriers limiting the availability of subsidized insurance even for those enrollees that do successfully enroll.

A. The Final Rule Erodes the Value of Coverage

Imposition of a Junk Charge on Certain Enrollees. Under regulations that have been in place since the ACA was first implemented, 45 C.F.R. § 155.355(j), enrollees that remain

eligible for a Marketplace plan from one year to the next are automatically re-enrolled in the same plan unless they terminate coverage or actively enroll in a different plan. Depending on an enrollee's income level and the level of coverage selected, an enrollee may be eligible for a zero-premium plan, that is, a plan in which the entire cost of the premium is covered by the enrollee's APTCs. The new rule adds 45 C.F.R. § 155.355(n), only for the upcoming 2026 plan year, to require the federally facilitated Exchange to impose a monthly surcharge of $5 on each such enrollee until the enrollee confirms his or her intent and eligibility to remain on the zero-premium plan. CMS invokes 42 U.S.C. § 18081(f)(1)(B) as authority for this surcharge, 90 Fed. Reg. at 27,109, but that authority is limited to the establishment of procedures to redetermine an applicant's eligibility for APTCs, not to reduce the amount of the APTC that is awarded under the statutory formula. CMS acknowledges that research demonstrates this provision will reduce enrollment among enrollees who used to have access to a zero-premium plan by 14% to 33%. 90 Fed. Reg. at 27,195.

Increased Costs through Revisions to the Premium Adjustment Methodology. As noted above, the maximum annual limit on cost-sharing is adjusted annually by a "premium adjustment percentage," which measures the rate of premium growth. The IRS also uses the premium adjustment percentage to adjust the value of PTCs. CMS has historically used data from premiums for employer-sponsored insurance to calculate this percentage, because the individual insurance market premiums are more volatile. The final rule incorporates individual insurance market data into this measure, resulting in a 15% increase in the maximum annual out-of-pocket limit on cost sharing and a 4.5% increase in average premiums, which will lead to lost coverage, a worsened risk pool, and higher levels of uncompensated care.

Eroding the Actuarial Value of Coverage. As noted above, the Act sets targets for the actuarial value of bronze, silver, gold, and platinum plans on the Exchanges, subject to

permissible range of "de minimis" variation to "account for differences in actuarial estimates." 42 U.S.C. § 18022(d)(3). The final rule expands the range of de minimis variation to permit bronze plans to range from 5 points above to 4 points below the statutory target (that is, bronze plans may offer coverage ranging from 56% to 65% of anticipated expenditures) and silver, gold, and premium plans to fall 4 points below the target (that is, silver plans may cover as little as 66% of anticipated expenditures). 45 C.F.R. § 156.140(c)(1). By eroding the value of silver plan coverage, the final rule will also reduce PTCs, which are calculated based on silver plan premiums. 26 U.S.C. § 36B(b)(2)(B). Overall, net premiums on the Exchange will increase by up to $714 per year for a typical family as a result of this provision, as the rule acknowledges. 90 Fed. Reg. at 27,208.

B. The Final Rule Imposes Barriers on Enrollment

Revocation of the Act's Guarantee That Anyone Can Buy Insurance. In some instances, enrollees may incur debts for premiums owed without realizing it. For instance, some enrollees may believe that they may terminate their coverage simply by stopping premium payments, without realizing (or being informed) that the coverage remains in effect and they continue to owe payments to their insurer. The final rule permits insurers to refuse to enroll these individuals and to apply any payments that these individuals make to the outstanding debt instead of to the premium for new coverage, without prior notice to that enrollee. 45 C.F.R. § 147.104(i). In other words, an individual might complete all of the steps to enroll in coverage, including making the payment they understand to be needed to complete the transaction, only to learn at the end of the process that they have not been enrolled. This rule is contrary to the "guaranteed-issue" requirement of 42 U.S.C. § 300gg-1. CMS makes no attempt to quantify the impact of this change, but commenters offered analysis of data from the 2026 payment notice showing that 180,000 people owed debts for premiums as low as $10, all of whom would be

denied coverage under the 2025 rule. Indeed, CMS noted that more than 135,000 policies were terminated for the 2023 plan year for unpaid premiums of $10 or less—and this provision in the final rule could have an even bigger impact because it allows insurers to cover debts from *any time* in the past, not just the prior 12 months. 90 Fed. Reg. at 27,085.

Changes to Enrollment Periods. Under current policy, the open enrollment period for the Exchanges runs from November 1 to January 15. This two-and-a-half-month period has been beneficial for the health of the Exchanges, as younger and healthier people tend to enroll later in the process, and are particularly prone to enroll, if given the opportunity, after the end-of-the-year holiday period, when people face unusual financial distress. The final rule prohibits open enrollment in January by requiring all Exchanges to hold open enrollment periods that begin no later than November 1, end no later than December 31, and are no more than nine weeks in duration. 45 C.F.R. § 155.410(e).[1]

Current policy also provides a special enrollment period (SEP), on a monthly basis for persons with incomes at or below 150% of the federal poverty level. 45 C.F.R. § 155.420(d)(16). This SEP was established as an additional safety net for consumers with variable income who may transition from Medicaid eligibility to Exchange eligibility over the course of the year. *See* 86 Fed. Reg. 53,412, 53,434 (Sept. 27, 2021). These enrollees tend to pose a lower risk of serious health conditions, so easing their ability to enroll in Exchange coverage has improved the financial viability of the Exchanges. *See* Mark A. Hall & Michael J. McCue, *Does Making Health Insurance Enrollment Easier Cause Adverse Selection?*, Commonwealth Fund (Apr. 4, 2022), https://perma.cc/9P86-ZFCR. The final rule, however, revokes this SEP for 2025 and 2026. 90 Fed. Reg. at 27,079. This provision will lead to longer

[1] This rule goes into effect for 2027 and so is not challenged in this motion but will be addressed later in merits briefing.

periods of time where people lack insurance, resulting in uncompensated care costs for hospitals, providers, community health centers, and municipalities. *Id*. at 27,145.

The final rule also requires the federally facilitated Exchange to conduct pre-enrollment verification for SEP eligibility for at least 75% of new enrollments through SEPs. 45 C.F.R. § 155.420(g). Commenters noted that the addition of this paperwork burden will depress coverage on the Exchanges, and CMS itself estimated that it would cost consumers more than $7 million in 2026. 90 Fed. Reg. at 27,186–87, 27,204. CMS declined to make this policy permanent but is requiring it for the upcoming 2026 plan year.

C. The Final Rule Limits the Availability of Subsidized Coverage

Failure to Reconcile Penalty. The amount of APTCs that an enrollee receives over the course of a year and the amount of PTCs that the enrollee receives on his or her tax return depend on the same statutory formula; APTCs are intended to be a substitute for the tax credit. 26 U.S.C. § 36B; 42 U.S.C. § 18082. But APTCs are calculated based on the enrollee's projected income, so if the enrollee provides an incorrect estimate (because, for example, he or she works more hours than expected), the enrollee might owe a tax payment at the end of the year without realizing that any such debt is owed. Under current policy, any such enrollee must be given a notice of the tax debt in the first year of enrollment in coverage after the debt is incurred, so that the debt can be repaid; if the enrollee does not do so, eligibility for APTCs may be revoked in the second year. 45 C.F.R. § 155.305(f)(4)(i), (ii). The final rule revokes that grace period, for 2026 only, and requires the Exchanges to determine the enrollee to be ineligible for APTCs in the first year, *id.* § 155.305(f)(4)(iii), even though CMS lacks any authority to alter the statutory formula for eligibility for APTCs.

Changes to Data-Matching Policies. When an Exchange attempts to verify an applicant's income for purposes of determining his or her eligibility for, and the amount of,

APTCs, and it finds an inconsistency in that applicant's data, it notifies the applicant and provides him or her with an opportunity to respond. 42 U.S.C. § 18081(e)(4). The statute provides a default period of 90 days for that response, subject to CMS's authority to modify the procedures for this verification process. *Id.* §§ 18081(c)(4), (e)(1), (e)(4). In many cases, 90 days is not enough time for an applicant to track down the proof of income needed to verify APTC eligibility. The current regulations accordingly provide for an additional 60 days where necessary. 45 C.F.R. § 155.315(f)(7). The final rule revokes that 60-day extension. 90 Fed. Reg. at 27,120.

The final rule further implements changes to a 2017 policy that required Exchanges to audit all enrollees who project that their household income for the upcoming year will be greater than 100% of the federal poverty level, if the IRS reports data indicating that the enrollee's current income is below that threshold. Because this policy created "immense administrative burdens" for low-income enrollees, this Court held that it "defie[d] logic" and vacated it as arbitrary and capricious under the APA. *City of Columbus*, 523 F. Supp. 3d at 763. CMS did not appeal that judgment, and it again acknowledges that this policy would cause tens of thousands of enrollees to lose their coverage. 90 Fed. Reg. at 27,200. The final rule nevertheless attempts to reinstate this policy for the 2026 plan year, forthrightly asserting its disagreement with this Court's prior decision. *Id.* at 27,121.

Following the *City of Columbus* decision, under current policy, an Exchange must accept an applicant's attestation of his or her projected annual income if the IRS reports that there is no tax return data available. 45 C.F.R. § 155.320(c)(5). The final rule revokes that policy, and for the 2026 plan year will require Exchanges to verify income with other data sources and to require applicants to submit documentary evidence or otherwise resolve the income inconsistency; if no such evidence is available, the applicant will lose eligibility for APTCs. 90

Fed. Reg. at 27,131. These new data-matching policies are projected to cause more than 400,000 people to lose coverage for the upcoming plan year. 90 Fed. Reg. at 27,199–200.[2]

* * *

The final rule acknowledges that these provisions will cause many people to lose access to affordable coverage through the Exchange. Nonetheless, it asserts that these provisions are needed to address the problem of unscrupulous brokers enrolling people on the Exchanges without their knowledge or consent. The final rule cites a report from the Paragon Health Institute that purports to find a high rate of fraudulent enrollments. 90 Fed. Reg. at 27,025; Brian Blase & Drew Gonshorowski, *The Great Obamacare Enrollment Fraud*, Paragon Health Inst. (June 2024), https://perma.cc/4BCT-S63E (Paragon Report). This report, however, suffers from numerous methodological errors that render its conclusions useless. It predates numerous efforts that CMS put in place in the second half of 2024 to address the issue of improper enrollments. And, even if the report's conclusions were accurate, there is a fundamental disconnect between the problem described in that report and the measures adopted in the final rule, which are designed to make it more difficult for eligible individuals to enroll in the Exchanges, rather than to focus on the wrongful conduct of certain brokers.

First, Paragon estimates that as many as 5 million low-income people were improperly enrolled in coverage in the Exchanges, based on a comparison of the number of people who applied for APTCs (which, as noted above, is based on the enrollee's projection of their anticipated income for the coming year) with the number of people whose income ended up falling within the range entitling them to subsidies. *See* Paragon Report at 15; 90 Fed. Reg. at

[2] These are not the only objectionable provisions in the final rule. The rule also misinterprets CMS's legal authorities by revoking the eligibility for coverage of recipients of Deferred Action for Childhood Arrivals and by excluding the treatment of gender dysphoria from the set of essential health benefits. Those provisions are, or likely will be, the subject of other litigation.

27,122. But this is the wrong comparison; there are many legitimate reasons why an enrollee might not accurately estimate his or her future income. Lower-income people in particular tend to have incomes that fluctuate widely, and these amounts are "hard to estimate, especially for households whose members may work part-time or seasonally, expect to change jobs, or are self-employed." Urban Institute comment at 2 (Apr. 11, 2025), https://perma.cc/7457-27KN.[3] Moreover, the Paragon report compared apples to oranges by including children in its estimated number of applicants but not in its count of eligible persons; by mismatching 2023 data to estimate improper enrollments for 2024, when many more people gained eligibility for the Exchanges in light of changes in Medicaid enrollment standards; and by using fundamentally different measures of income for its two data sets. *See id.* at 2–3; *see also* Jason Levitis et al. comment at 28–31 (Apr. 11, 2025), https://perma.cc/X3KY-KZLW; Ctr. for Budget & Policy Priorities comment at 4–5 (Apr. 11, 2025), https://perma.cc/KP9W-J63N. These flaws in the Paragon analysis were pointed out to CMS by commenters, but CMS did not explain why it chose to ignore them.

Second, both the Paragon report and the final rule itself relied on estimates of fraudulent enrollments from early in 2024, without acknowledging that since that time CMS had put in place enforcement efforts against unscrupulous brokers, and those measures have since borne fruit. *See* 90 Fed. Reg. at 27,074 n.2 (citing data from January through August 2024); Paragon

[3] Plaintiffs respectfully request that the Court take judicial notice of the cited public comments to the proposed rule, which are publicly available at Regulations.gov. "Courts are . . . permitted to consider facts and documents subject to judicial notice because, under Federal Rule of Evidence 201, courts 'at any stage of a proceeding' may 'judicially notice a fact that is not subject to reasonable dispute.'" *City of Columbus v. Trump*, 453 F. Supp. 3d 770, 793 (D. Md. 2020) (quoting *Zak v. Chelsea Therapeutics Int'l, Ltd.*, 780 F.3d 597, 606 (4th Cir. 2015)); *see also, e.g.*, *United States v. Garcia*, 855 F.3d 615, 621 (4th Cir. 2017) (noting that "[t]his court and numerous others routinely take judicial notice of information contained on state and federal government websites"); *Hall v. Virginia*, 385 F.3d 421, 424 n.3 (4th Cir. 2004) (taking judicial notice of publicly available information on state government's website).

Report at 25 & n.40. CMS itself has recited, "Marketplace system changes that were implemented in July 2024 are having the desired effect of successfully preventing consumers from being switched to different plans or enrolled in coverage without their informed consent." CMS, *Update on Actions to Prevent Unauthorized Agent and Broker Marketplace Activity* (Oct. 17, 2024), https://perma.cc/M79K-CVL6. These measures include new documentation requirements for brokers to show that individuals have consented to enroll, enhanced IT systems to detect suspicious activity, and regulatory changes strengthening CMS's enforcement authority against brokers. Levitis comment at 30–31. These measures are working; indicators of potentially improper enrollments have dropped by as much as 90% since they were put into place. *Id.* at 31. Yet the final rule does not account for these recent efforts in any way.

Third, even if the Paragon analysis were accurate or reflective of current circumstances, it could not justify the provisions of the final rule. The final rule attempts to justify many measures as efforts to combat the phenomenon of brokers fraudulently enrolling consumers without their consent. 90 Fed. Reg. at 27,091–92. But there is a basic disconnect between that rationale and the measures that the final rule adopts. Many of its provisions are targeted at enrollees who are attempting to gain subsidized coverage for themselves and for their families, and not at brokers. For example, the revocation of the 60-day grace period for individuals to document their incomes wouldn't matter to an unscrupulous broker, but it could matter immensely to an actual enrollee who has difficulty documenting his or her income. Moreover, the Paragon analysis is based on a review of nine states, all of which use the federally facilitated Exchange. The report did not identify any systematic issues with enrollment on the state-based Exchanges. *See* Levitis comment at 30–32. Yet the final rule imposes many of its policies on a nationwide basis. *See, e.g.*, 45 C.F.R. § 155.305(f)(4)(iii). It would have made more sense for CMS to target its efforts against practices unique to the federally facilitated Exchange states, such as the practice of

permitting enhanced direct enrollment entities to submit enrollment paperwork on an enrollee's behalf. *See* Levitis comment at 32–33. What's more, even by CMS's own telling, the problem of improper enrollments has been driven by the enhanced subsidies available through the end of 2025. 90 Fed. Reg. at 27,091. CMS assumes that those subsidies will expire this year, which "will substantially mitigate the threat of future improper enrollments," *id.* at 27,075, but CMS imposes new policies to be effective in 2026 (and, in some cases, for 2026 only) when the incentive for unscrupulous broker behavior will no longer be in place.

III. The Disastrous Effects of the Final Rule

As noted above, the 2025 rule contains numerous provisions that will worsen the barriers to coverage on the Exchanges by making coverage more expensive or by heightening the administrative obstacles consumers face. Young Decl. ¶ 29. These provisions will decrease the number of people with coverage by nearly 2 million; some of these people will find other coverage, but overall, 1.8 million more people will be uninsured. *Id.* ¶ 4. Younger and healthier people are more likely to drop from coverage, worsening the risk pool and leading to higher health insurance premiums, further exacerbating the problem of high costs, which in turn can cause additional people to become uninsured. *Id.* ¶ 5. This will lead to increased burdens of uncompensated care, especially for safety net providers. *Id.* ¶ 6.

These predictions are not merely hypothetical. Insurers are currently preparing rates for the coming year, and they are incorporating substantial premium increases in their models to account for CMS's rule. As one Maryland insurer noted, it needs to raise its premiums substantially because the rule "will lead to healthier enrollees leaving the market and an overall worsening of the risk pool." United Healthcare, *Optimum Choice, Inc.*, *Part III: Actuarial Memorandum: PUBLIC; Maryland 2026 Individual Exchange Rates* 7 (May 22, 2025), https://perma.cc/35L2-M49D. This coverage loss and erosion, and overall increase in health care

costs will cause harms that radiate out from individuals to their businesses, medical providers, and broader communities.

Among many others, Plaintiffs will suffer significant and irreparable harm if the challenged provisions of the rule were to go into effect. The rule's policies would harm the owners and employees of small businesses like members of Main Street Alliance (MSA), many of whom rely on affordable health coverage through the Exchanges—not only to access the health care they need but, by extension, to provide them the freedom to operate their own businesses without seeking employer-sponsored insurance elsewhere. *See* Decl. of Shawn Phetteplace ¶¶ 3–6; Decl. of Brooke Legler ¶¶ 8. By eroding the value of their insurance coverage and creating additional administrative barriers, the final rule's provisions would strip that freedom from many small business owners operating on narrow margins, as well as their employees. Legler Decl. ¶ 11.

The final rule would also harm medical providers in myriad ways. Because patients with no or inadequate insurance are less likely to seek the medical care they need until conditions become serious, clinicians like members of Doctors for America (DFA) would see patients with more serious or emergency needs; would receive less compensation for many of their patients, even while expending more time navigating the administrative barriers to coverage for their patients; and would lose contact with many of their patients, particularly in low-income and rural communities. Decl. of Janet Krommes ¶ 6. This greater expenditure of time and effort, even while seeing decreased compensation, will hinder clinicians' ability to provide their patients with optimal health care.

The harms from the final rule would radiate out further to patients' communities and local governments in cities like Columbus, Baltimore, and Chicago. These cities fund and operate a range of community health centers, general and specialty clinics, and other health care

services, as well as emergency medical transport. *See* Decl. of Olusimbo Ige ¶ 5; Decl. of Edward Johnson ¶ 11; Decl. of Faith Leach ¶¶ 7–8. To ensure that their residents get the care that they need, they all provide these services to patients regardless of their insurance coverage or ability to pay. An increase in the number of uninsured and underinsured residents resulting from the final rule would create a strain on those services and, ultimately, the cities' budgets, which must make up the shortfall from decrease compensation and increased demand for emergency services. *See* Ige Decl. ¶¶ 6, 14; Johnson Decl. ¶¶ 9–11; Leach Decl. ¶ 12. An erosion of insurance coverage will also lead residents to neglect to get the medical care that they need, when they need it, resulting in less healthy and productive communities.

STANDARD OF REVIEW

Under section 705 of the APA, "a reviewing court may stay 'agency action' pending judicial review 'to prevent irreparable injury,'" *Casa de Maryland, Inc. v. Wolf*, 486 F. Supp. 3d 928, 949 (D. Md. 2020) (quoting 5 U.S.C. § 705), and "may issue all necessary and appropriate process to . . . preserve status or rights pending conclusion of the review proceedings," 5 U.S.C. § 705. "The factors governing issuance of a preliminary injunction also govern issuance of a § 705 stay." *Casa de Maryland*, 486 F. Supp. 3d at 950 (quoting *District of Columbia v. USDA*, 444 F. Supp. 3d 1, 16 (D.D.C. 2020)). "A plaintiff seeking a preliminary injunction must establish that [it] is likely to succeed on the merits, that [it] is likely to suffer irreparable harm in the absence of preliminary relief, that the balance of equities tips in [its] favor, and that an injunction is in the public interest." *Winter v. Nat. Res. Def. Council, Inc*., 555 U.S. 7, 20 (2008).

ARGUMENT

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

A. The Rule's Imposition of a Junk Fee on Certain Plans Is Unlawful and Arbitrary

1. The Imposition of the Junk Fee Is Unlawful

Eligibility for PTCs and APTCs and the calculation of those credits are determined by statutory formula set forth in the ACA. A taxpayer is eligible for tax credits if he or she enrolls in coverage through the Exchange, falls within the specified income thresholds, and lacks an offer for other affordable health insurance. 26 U.S.C. § 36B(c)(1), (2). The amount of the tax credit is determined by the taxpayer's income and the cost of a benchmark plan offered through the Exchange. *Id.* § 36B(b). Eligibility for, and the amount of, APTCs turn on the same statutory criteria. 42 U.S.C. § 18081(a)(2); *see also id.* § 18082(a)(1). CMS is responsible for establishing a program "for determining" an applicant's eligibility for and the amount of APTCs, *id.* § 18081(a), and for "redetermin[ing] eligibility on a periodic basis in appropriate circumstances," *id.* § 18081(f)(1)(B).

CMS's authority under the statute is to determine whether the statutory criteria for APTC eligibility are met, not to alter those criteria. *See Neumann v. Prudential Ins. Co. of Am.*, 367 F. Supp. 2d 969, 975 (E.D. Va. 2005) (ERISA plan administrator's authority to "determine" eligibility under the plan is not a discretionary power to alter the plan terms). Yet CMS invoked its redetermination authority under section 18081(f)(1)(B) to change the statutory formula for APTCs. In particular, it requires the federally facilitated Exchange to reduce APTCs by $5 per month for applicants who automatically re-enroll in a plan that would otherwise be fully subsidized. Nothing in section 18081 or the remainder of the Act grants CMS the power to change the statutory calculation in this way. *See Nat'l Fed'n of Indep. Bus. v. OSHA*, 595 U.S.

109, 117 (2022) ("Administrative agencies . . . possess only the authority that Congress has provided.").

Moreover, the authority and obligation to pay APTCs lies with the Treasury, not with CMS. Once CMS applies the statutory criteria to determine eligibility and the amount of APTCs, it reports that information to the Treasury, which then "shall make the advance payment . . . under this section of any premium tax credit allowed under section 36B of title 26" to the enrollee's insurer. 42 U.S.C. § 18082(c)(2). The statute's use of the word "shall" "creates an obligation impervious to discretion," *Me. Cmty. Health Options*, 590 U.S. at 310, and Treasury's obligation is to pay the amount that would be owed under the section 36B formula, not a different amount arbitrarily selected by CMS. CMS accordingly lacks authority to require enrollees to pay a junk fee where the statutory formula would otherwise entitle them to a payment that fully covers their premiums.

2. The Imposition of the Junk Fee Is Arbitrary

CMS describes the $5 per month junk fee as a "nominal" amount that will not impose "undue financial hardship" on enrollees. 90 Fed. Reg. at 27,107. But a wealth of empirical evidence shows that the addition of even nominal charges can profoundly depress coverage for low-income enrollees. When Massachusetts introduced a nominal payment for zero-premium plans, "1 in 7 enrollees lost coverage as a result of new monthly premiums," Adrianna McIntrye comment at 10 (Apr. 11, 2025), https://perma.cc/3VKT-NRLJ (citing Adrianna McIntyre et al., *Small Marketplace Premiums Pose Financial and Administrative Burdens: Evidence from Massachusetts, 2016-17*, 43 Health Affairs 80, 80 (2024)), demonstrating that "even small premium burdens act to depress enrollment, particularly by health consumers." Partnership to Protect Coverage comment at 7, https://perma.cc/74R9-D2Q6. Moreover, younger and healthier enrollees are more likely not to notice that they now owe a payment, while sicker enrollees will

be more likely to resolve paperwork issues more quickly. As a result, this policy will worsen the risk pool and raise premiums for other participants. *See id.* at 6; *see also* Avalere Health, *HHS Proposed Changes Could Reduce ACA Coverage and Increase Premiums* (Feb. 18, 2019), https://perma.cc/48GB-HBT3 (projecting a 5.7% increase in premiums from a proposal to end auto-enrollment).

CMS acknowledged that "even small premium increases may affect enrollment patterns and risk pool composition," but still finalized this provision, asserting that it would be helpful to combat improper enrollments. 90 Fed. Reg. at 27,195. But, as discussed above, the agency has inflated the problem of improper enrollments, has ignored the effect of its own efforts over the past year to address that problem, and has adopted a policy that is at best tangentially related to the problem the agency claims it is aiming to address. CMS has thus acted arbitrarily by ignoring important aspects of the problem, by failing to reasonably explain its policy, and by failing to establish a rational connection between the facts found and the policy choice that it made. *See Ohio v. EPA*, 603 U.S. 279, 292–93 (2024).

Moreover, Exchanges, insurers, and individuals will all now incur costs in responding to the confusion that the new policy will cause, given that many individuals will not understand why they suddenly owe a payment that is not connected with the value of their policy. *See* Nat'l Ass'n of Community Health Ctrs. comment at 5–6 (Apr. 11, 2025), https://perma.cc/Y4AU-DUQ7; Nat'l Ass'n of Insurance Comm'rs comment at 2 (Apr. 10, 2025), https://perma.cc/948V-URWU. CMS recognized this possibility, but it asserted without evidence that education efforts should suffice to address it. 90 Fed. Reg. at 27,196. Yet CMS has also virtually eliminated funding for the Act's Navigators, cutting funding by 90% for the organizations that would provide these public education efforts. CMS, *CMS Announcement on Federal Navigator Program Funding* (Feb. 14, 2025), https://perma.cc/ZYC8-54YZ. It is implausible that the

remaining Navigators will be able to fully handle the increased workload that CMS's new policy creates. CMS ignores this "important aspect of the problem," *Appalachian Voices v. Dep't of Interior*, 25 F.4th 259, 269 (4th Cir. 2022), and so acted arbitrarily. CMS also ignored the reliance interests of consumers who have come to expect that they will be able to continue in zero-premium coverage without unexpected fees, and the rule is arbitrary for this reason as well. *See DHS v. Regents of Univ. of Cal.,* 591 U.S. 1, 29 (2020).

In addition, the final rule's provision departs from the proposed rule significantly by sunsetting this provision after 2026. This departure fails to accord with the APA's "requirement that the notice in the Federal Register of a proposed rulemaking contain 'either the terms or substance of the proposed rule or a description of the subjects and issues involved.'" *Chocolate Mfrs. Ass'n of U.S. v. Block*, 755 F.2d 1098, 1102 (4th Cir. 1985). Numerous commenters asked CMS, at a minimum, to delay the imposition of the junk fee until 2027, given the sizable administrative costs that stakeholders would incur if they were required to implement this rule on short notice for 2026. CMS acknowledged this concern but responded by imposing the rule for 2026 only. 90 Fed. Reg. at 27,108. Thus, CMS is imposing these costs on stakeholders for the coming year, and then requiring them to incur even greater costs to switch back to the original system for 2027. Commenters could have pointed out the absurdity of this approach if it had been described in the proposed rule. The final provision is therefore not "a 'logical outgrowth' of the notice and comments already given." *Chocolate Mfrs. Ass'n*, 755 F.2d at 1105. By adopting this unexpected policy, CMS "substantially depart[ed] from the terms or substance of the proposed rule," rendering the notice-and-comment process "inadequate." *Id.* (cleaned up).

B. The Revised Premium Adjustment Methodology Is Arbitrary

As noted above, the Act requires CMS to calculate an annual "premium adjustment percentage," which is used both to update the maximum limits on cost-sharing that an enrollee in

the Exchanges will owe and to adjust the value of PTCs that these enrollees receive. This percentage also has effects beyond Exchange coverage and is used to set the maximum limits on cost-sharing for most individual and employer-based coverage. *See* 42 U.S.C. § 300gg-6(a), (b); *id.* § 18022(c)(1). The percentage is based on a comparison of the current "average per capita premium for health insurance coverage in the United States" with the same average premium for such coverage for 2013, before the Act's reforms to the health insurance market took effect. *Id.* § 18022(c)(4). CMS initially used data from the market for employer-sponsored insurance to perform this comparison, because data from the individual insurance market was too volatile to provide a useful measure. 79 Fed. Reg. 13,744, 13,802 (Mar. 11, 2014). Although CMS briefly experimented with a different measure, it reverted to its original methodology, given continued volatility in individual insurance market data and the fact that premiums in this market are more likely to be influenced by risk premium pricing. 86 Fed. Reg. 24,140, 24,234 (May 5, 2021). CMS reasoned at that time that its original methodology was more in keeping with the Act's purpose to lower health care costs for individuals and families. *Id.* The rule, however, now incorporates individual insurance market data into this measure, 90 Fed. Reg. at 27,169, even though individual insurance premiums from 2013, before the Act's market reforms went into effect, could not provide an apples-to-apples measure to the present-day market.

As a result, the maximum out-of-pocket limit in 2026 will be about $450 higher for an individual and $900 higher for a family than it otherwise would have been. 90 Fed. Reg. at 27,206. This will lead to increased premiums across the board and 80,000 fewer enrollments in the Exchanges under CMS's own estimates, *id.*, running the risk of "a spiral of a worsening risk pool and increased premiums," Ass'n of Community Affiliated Plans comment at 21 (Apr. 11, 2025), https://perma.cc/E44R-J6X6, as well as "higher volumes of uninsured patients being seen by health centers," Nat'l Ass'n of Community Health Ctrs. comment at 2.

CMS acknowledged that its choice ran contrary to the Act's goals, but it brushed this concern aside, reasoning that it didn't need to take these issues into account when it exercised its discretion under section 18022(c)(4) to adopt an "appropriate" methodology. 90 Fed. Reg. at 27,172; *see also* 90 Fed. Reg. 12,942, 12,990 (Mar. 19, 2025) (proposed rule).[4] This was error. It is black-letter law that an agency's rationale for a rule cannot be "unmoored from the purposes and concerns" of the statute as a whole. *Judulang v. Holder*, 565 U.S. 42, 64 (2011). And the central purpose of the Act is to lower health care costs for Americans. *See King*, 576 U.S. at 479. *See also* 42 U.S.C. § 18114(1) (prohibiting CMS from adopting rules that create "unreasonable barriers" to obtaining health care). CMS, then, was not free to disregard the costs it was imposing on Exchange enrollees.

CMS might have avoided these errors had it not had an unalterably closed mind on this matter. The proposed rule candidly declared that CMS would disregard "special interests" if they asked it to retain the original methodology. 90 Fed. Reg. at 12,989–90. Since it would ignore these commenters anyway, it provided only a 23-day period for them to offer evidence on its complex proposal. *Id.* at 12,942. And seven days after it published the proposed rule, it published a calculator that instructed insurers to assume that its proposal would be finalized. CMS, *Revised Final 2026 Actuarial Value (AV) Calculator Methodology* (Mar. 26, 2025), https://perma.cc/S4QQ-9W7D. It is thus no surprise that CMS finalized this provision without change, even in the face of comments showing the harms it would cause to enrollees. By

[4] Although CMS recognized it had discretion to choose a methodology, the final rule contains language also suggesting that it believed the new method was required by the statute. 90 Fed. Reg. at 27,206. To be clear, the Act does not require CMS to shift to a calculation that will add hundreds of dollars of costs to each enrollee. The Act requires CMS to compare the relative costs of "health insurance coverage" in 2013 and the present, 42 U.S.C. § 18022(c)(4), and premiums for individual health insurance in 2013 were not premiums for "health insurance coverage," as that term is used in the Act, because plans on that market were not yet subject to the Act's core requirements like the guaranteed-issue and community-rating requirements.

arriving at a "predetermined answer," *Kravitz v. Dep't of Com.*, 366 F. Supp. 3d 681, 750 (D. Md. 2019), CMS rendered the notice-and-comment process to be an empty formality. The new methodology should be vacated on this ground as well.

C. The New Actuarial Value Policy Is Arbitrary

An individual shopping for health insurance on the Exchange would expect to buy a plan with a certain level of generosity. For example, someone shopping for a silver plan would expect coverage for 70% of expected health costs, leaving 30% to be covered by cost-sharing. The rule permits insurers to engage in a bait-and-switch by allowing plans to be marketed as silver plans that cover as low as 66% of anticipated expenditures. 45 C.F.R. § 156.140(c)(1).

The formula for PTCs turns on the cost of the second-lowest-cost silver plans available on the Exchange. 26 U.S.C. § 36B(b)(2)(B). By permitting insurers to sell cheaper, but less comprehensive, silver plans, CMS will therefore decrease the value of the tax credits for all enrollees, leading to a reduction in PTCs by $1.22 billion overall for 2026 alone, by CMS's own calculation. 90 Fed. Reg. at 27,208. A typical family of four would see their subsidies decrease, and their cost of coverage rise, by up to $714 for the year. Ctrs. for Budget & Policy Priorities comment at 34–35. And, because healthier people are more likely to drop out of coverage when premiums rise, the result will be a weaker risk pool, leading to even higher premiums for those who remain in the market. *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 relationship between subsidies and the strength of the risk pool is well established by empirical research, but CMS simply stated that it "expect[ed]" its rule to have the opposite effect, 90 Fed. Reg. at 27,107, without citing any evidence to support this subjective belief or engaging with the record. This was arbitrary. *See Ohio v. EPA*, 603 U.S. at 292.

CMS permitted this erosion in the value of coverage by invoking 42 U.S.C. § 18022(d)(3), which instructs the agency 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." But the rule permits far more than a "de minimis" variation. "Whether 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." *Wisc. 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"). The purpose of the standard is set forth in section 18022(d)(3) itself; 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. The rule does not even attempt to justify the new policy as an effort to account for differences in actuarial estimates. *See* 90 Fed. Reg. at 27,175. By "rel[ying] on factors which Congress has not intended it to consider," *Sierra Club v. Dep't of Interior*, 899 F.3d 260, 293 (4th Cir. 2018), CMS acted arbitrarily.

CMS also displayed an unalterably closed mind with respect to this proposal. The calculator mentioned above informed insurers that they should assume that the agency would finalize its proposal to permit less valuable coverage. *See supra* at 24. Again, by treating its rule as a foregone conclusion, CMS rendered the notice-and-comment process to be meaningless. *See Kravitz*, 366 F. Supp. 3d at 750.

II. Plaintiffs Are Likely to Succeed on Their Claims Against Provisions That Impose Barriers on Enrollment

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

The 2025 rule permits any insurer (within the same controlled group as an insurer that previously extended coverage to the enrollee) to deny coverage to any person who might owe a premium on an old policy, 45 C.F.R. § 147.104(i), which could cause hundreds of thousands of people to lose coverage for old debts as low as $10 that they might not even know about, 90 Fed. Reg. at 27,085. This runs flatly contrary to one of the core provisions of the ACA. The statute uses absolute terms to guarantee the availability of health insurance coverage: "each health insurance issuer that offers health insurance coverage in the individual or group market in a State must accept *every* employer and individual in the State that applies for such coverage," subject only to specified exceptions. 42 U.S.C. § 300gg-1(a) (emphasis added); *see also id.* §§ 18032(a)(1), (d)(3)(C). By requiring insurers to accept "every" individual, the statute does not admit of any exceptions, apart from those listed in section 300gg-1 itself. *See Conner v. Cleveland Cnty.*, 22 F.4th 412, 425 (4th Cir. 2022) ("Simply put, all means all."). An exception for past-due premiums is not one of the Act's enumerated exceptions to the guaranteed-issue requirement, as CMS itself has long understood. *See* 77 Fed. Reg. 70,584, 70,599 (Nov. 26, 2012). The agency was not free to rewrite the text to carve out a new exception to the statute's categorical rule. *See TRW, Inc. v. Andrews*, 534 U.S. 19, 28 (2001) ("[w]here Congress explicitly enumerates certain exceptions to a general prohibition, additional exceptions are not to be implied, in the absence of evidence of a contrary legislative intent" (cleaned up)).

Notably, there is such an exception for past-due premiums in the Act's parallel provision that guarantees the renewability of policies. *See* 42 U.S.C. § 300gg-2(b)(1). But, again, that exception is absent from the guaranteed-issue provision. This demonstrates Congress's

understanding that an outstanding debt could prevent an enrollee from maintaining the policy he or she currently has, but that the debt wouldn't lock the enrollee out of the market altogether. *See Bittner v. United States*, 598 U.S. 85, 94 (2023).

CMS's statutory theory is not clear on this point, but it apparently believes that it would make sense for the guaranteed-renewability exception to apply to the guaranteed-issue provision as well. 90 Fed. Reg. at 27,087. Simply put, statutory interpretation doesn't work in this way. Agencies "aren't free to rewrite clear statutes under the banner of [their] own policy concerns." *Azar v. Allina Health Servs*., 587 U.S. 566, 581 (2019).

In any event, the agency's asserted policy concerns do not justify this rule. Commenters noted the potential for widespread coverage losses, but CMS derided that possibility by describing any such losses as "small" or "minimal." 90 Fed. Reg. at 27,087. This is internally inconsistent with the agency's recognition that even small payment obligations can have outsized effects on enrollment, *see supra* at 20, and the rule should be set aside for this reason alone, *see ANR Storage Co. v. FERC*, 904 F.3d 1020, 1024 (D.C. Cir. 2018)). The rule would have far more than "minimal" effects; commenters submitted empirical evidence based on data in the 2026 payment notice that 180,000 people who owe less than $10 would lose access to insurance on the Exchanges as a result of this trap for the unwary. 90 Fed. Reg. at 27,085. Lower-income people would be more likely to be cut off from coverage from owing small back debts, as CMS previously recognized. 87 Fed. Reg. 27,208, 27,218 (May 6, 2022). The result will be more people lacking insurance and greater strains on providers of last resort that are left to shoulder the burden of uncompensated care, as CMS now acknowledges. 90 Fed. Reg. at 27,192.

Moreover, as commenters explained, there are many legitimate reasons why individuals might fail to pay a premium. Enrollees often don't realize that they need to take steps to terminate their old coverage when they switch to other coverage. 90 Fed. Reg. at 27,088. The

agency acknowledged this point, but responded only that individuals have "the ability to contact their issuer[s]." *Id.* This entirely misses the point that many people wouldn't know that they need to do so. CMS claimed that this provision "is principally intended to prevent the minimum debt in the first instance," *id.* at 27,089, but if CMS's goal is prevention, it makes little sense not to impose an attendant notice requirement to ensure that consumers know of the policy, which would allow them to avoid or resolve that debt before facing the draconian, and unlawful, consequence. And, to the extent that CMS was motivated by a desire to address enrollees who are somehow gaming the system, it simply failed to engage with the point that there is no evidence of any such widespread gaming, and that this rule is instead far more likely to create a barrier for people who would not know that they owe any back payment. *See* Ctrs. for Budget & Policy Priorities comment at 6. By failing to engage with this important aspect of the problem, CMS acted arbitrarily. *See Wild Va. v. U.S. Forest Serv.*, 24 F.4th 915, 926 (4th Cir. 2022).

B. The Revocation of the Low-Income Special Enrollment Period Is Arbitrary

There is currently a monthly SEP for persons at or below 150% of the federal poverty level. 45 C.F.R. § 155.420(d)(16). This SEP, which helps ensure that qualifying people have an opportunity to enroll in free or low-cost healthcare coverage, has become an important safety net for individuals who cycle in and out of Medicaid eligibility. 89 Fed. Reg. 26,218, 26,320 (Apr. 15, 2024). Initially, individuals eligible for a zero-premium plan on the Exchanges could take advantage of the SEP only while enhanced PTCs were authorized by Congress. But in 2024, recognizing the SEP's success and a lower-than-anticipated risk of adverse selection,[5] CMS eliminated the requirement. *Id.* at 26,321. The final rule revokes this SEP for the remainder of

[5] The term "adverse selection" refers to "problems that can arise in insurance markets when the healthy have insufficient incentive to purchase health insurance, and thus the resulting pool of insureds consists predominantly of the sick and those actively using their insurance." *Cutler v. HHS*, 797 F.3d 1173, 1176 n.1 (D.C. Cir. 2015).

2025 and through the end of 2026. As a result, for at least the next year, individuals who want to enroll in coverage but do not qualify for another type of SEP could remain uninsured until the 2026 open enrollment period, incurring uncompensated care costs in the meantime that will be borne by providers of last resort like municipalities and many DFA members. 90 Fed. Reg. at 27,145.

CMS reasoned that the statute compelled it to revoke this SEP. 90 Fed. Reg. at 27,147. This is plainly incorrect. The ACA instructs CMS to "provide for . . . special enrollment periods . . . under circumstances similar to such periods under part D of title XVIII of the Social Security Act," that is, Medicare Part D. 42 U.S.C. § 18031(c)(6). Medicare Part D has had a similar low-income SEP since the beginning of that program. 42 C.F.R. 423.38(c)(4); 70 Fed. Reg. 4194, 4530 (Jan. 28, 2005). CMS acknowledges this point, but it contends that the Medicare low-income SEP was established under a regulation, not under the Medicare statute itself. 90 Fed. Reg. at 27,147. This is a distinction without a difference. Medicare Part D gives CMS rulemaking authority to establish procedures for enrollment, 42 U.S.C. § 1395w-101(b)(1)(A), (b)(3), and CMS established the Medicare low-income SEP under that authority. That SEP thus falls "under," meaning "pursuant to or by reason of the authority of," Medicare Part D. *Nat'l Ass'n of Mfrs. v. DOD*, 583 U.S. 109, 124 (2018) (cleaned up). So the ACA provision establishing a similar SEP fell squarely within the agency's section 18031(c)(6) authority, if the agency chose to exercise it. But, because CMS incorrectly believed that it was compelled by the statute to adopt this rule, the provision must be vacated. *See Perez v. Cuccinelli*, 949 F.3d 865, 873 (4th Cir. 2020) (en banc); *Me. Lobstermen's Ass'n v. Nat'l Marine Fisheries Serv.*, 70 F.4th 582, 597 (D.C. Cir. 2023) ("agency action may not stand if the agency has misconceived the law").

Despite representing that its hands were tied by the statute, CMS assured the public that it would be adopting this rule only for one year. 90 Fed. Reg. at 27,147. If the agency genuinely believed it lacked authority to establish a low-income SEP, it would be absurd for it to bring that SEP back into operation for 2027. "This logical inconsistency alone renders the [rule] arbitrary and capricious." *Evergreen Shipping Agency (Am.) Corp. v. Fed. Mar. Comm'n*, 106 F.4th 1113, 1117–18 (D.C. Cir. 2024).

CMS relied on the purportedly temporary nature of this policy to discount concerns raised by commenters that eliminating the SEP will lead to coverage losses, financial instability, and uncompensated care, especially for vulnerable populations who may face barriers to enrollment during the open enrollment period or other SEPs. *See* 90 Fed. Reg. at 27,145. Similarly, CMS acknowledged the point that state-based Exchanges have not seen the same issue of improper enrollments that the agency claims to be solving, but it nonetheless relied on the supposedly short-term nature of the policy to impose administrative costs on these states as well. *Id.* at 27,147. Moreover, although the best data shows that the low-income SEP has not been a driver of adverse selection, the agency acknowledged these studies and responded only by noting its unexplained disagreement with that data, *id.* at 27,146, again relying on the one-year nature of the policy to discount the harms that its rule would cause to lower-income persons. CMS's logical error in treating a rule that it claimed to be legally required as only a temporary measure, then, infected its entire approach, and the rule cannot stand. *See Ohio v. EPA*, 603 U.S. at 292.

In any event, CMS failed to explain how pausing the SEP would accomplish the agency's goal of addressing "the currently high rate of improper enrollments." 90 Fed. Reg. at 27,145. In fact, the agency's own data indicates that improper enrollments are already being addressed under its current policy. The agency received 7,000 complaints in December 2024, a decrease of more than 75% from the number of complaints it received in February 2024. 90 Fed. Reg. at

12,980. But even if improper enrollments remain at high levels, as CMS claims, there is a fundamental mismatch between that problem and the agency's chosen solution. Ending the SEP to reduce improper enrollments is like "trying to prevent car theft by making it more difficult for people to own cars." Levitis comment at 10 (citing Justin Giovannelli & Stacey Pogue, *Policymakers Can Protect Against Fraud in the ACA Marketplaces without Hiking Premiums*, Commonwealth Fund (Mar. 5, 2025), https://perma.cc/V54M-TK7R).

Finally, CMS did not notify the public in its proposed rule that this policy would apply only on a one-year basis, *see* 90 Fed. Reg. at 12,979, and resultingly, commenters had no opportunity to point out the fundamental illogic of this approach. CMS's failure to make this disclosure renders the notice-and-comment process inadequate. *See Chocolate Mfrs. Ass'n*, 755 F.2d at 1105; *Ctr. for Sci. in the Pub. Int. v. Perdue*, 438 F. Supp. 3d 546, 558 (D. Md. 2020).

C. The Verification Requirements for SEP Enrollments Are Arbitrary

CMS imposed two new requirements on the federally facilitated Exchange for 2026. That Exchange must conduct pre-enrollment verification for each of its SEPs, and it must conduct eligibility verification for at least 75% of new enrollments through SEPs. 45 C.F.R. § 155.420(g). If the Exchange cannot complete the verification for an applicant, the enrollment must be cancelled. *Id.* This rule will generate 293,000 verification issues to resolve in the coming year, 90 Fed. Reg. at 27,186, resulting in a further barrier to coverage, through additional paperwork and administrative burdens, and costing consumers more than $7 million in 2026, *id.* at 27,186. Younger and healthier people are more likely to drop coverage as a result, leading to a worsening of the risk pool, as CMS itself realized the last time it considered (and rejected) a similar policy. 87 Fed. Reg. at 27,279; *see* Levitis comment at 14–15 (discussing evidence of adverse selection from paperwork burdens).

CMS acknowledged the harm that this new policy would cause but reasoned that it had adequately addressed commenters' concerns by applying the rule only for 2026 and only for the federally facilitated Exchange. 90 Fed. Reg. at 27,151. This may explain why the agency chose not to go farther, but it is not an adequate explanation for why the agency acted at all. CMS attempted to justify this policy as a response to the problem of improper enrollments by brokers. *Id.* at 27,150. But, for the reasons discussed above, the agency fundamentally misconceived the scope of that problem and ignored the success of recent efforts to address broker misconduct. *See supra* at 14. And there is no evidence that imposing this obstacle for *enrollees* would affect the behavior of *brokers*. *See* Ctrs. for Budget & Policy Priorities comment at 30. Moreover, since—even on the agency's own telling—the problem of improper enrollments hasn't arisen on the state-based Exchanges, CMS should have focused its attention on why the federally facilitated Exchange might be different, such as the ability of enhanced direct enrollment entities to submit applications on behalf of enrollees. Given this fundamental mismatch between the agency's policy and the problem it claimed it was trying to solve, CMS acted arbitrarily in imposing these new burdens for 2026, for which it also did not provide adequate notice. *See Ohio v. EPA*, 603 U.S. at 292; *supra* at 21–22.

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

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

As noted above, enrollees are required to reconcile the APTCs that they claim on the basis of their projected income with the PTCs that they receive on their tax return on the basis of the income they actually received. *See* 26 U.S.C. § 36B(f)(3). CMS has a process that requires applicants for coverage to report whether they have reconciled their tax credits on prior tax returns and that checks that reporting against IRS data. 45 C.F.R. § 155.340(c). But many

people are flagged in error, often because the data that the IRS reports to the Exchange lags in time. *See* Ctr. for Budget & Policy Priorities comment at 12. This issue is particularly acute for the 3.3 million people who are self-employed, many of whom do not file their tax returns until October, leaving insufficient time for the IRS to update records before the next enrollment season. *See* Families USA comment at 7 (Apr. 11, 2025), https://perma.cc/2NTV-DZS3.

Under the current policy, an applicant might lose eligibility for APTCs if they do not reconcile their tax return in a second year, after receiving notice in the first year of the issue. 45 C.F.R. § 155.305(f)(4)(i), (ii). CMS has now revised that policy, for 2026 only, to require the Exchanges to determine the enrollee to be ineligible for APTCs in the first year that the issue arises. *Id.* § 155.305 (f)(4)(iii). Enrollees who lose this eligibility become responsible for the full cost of their coverage, which in many cases is prohibitively expensive.

Both the current rule and the new rule are unlawful.[6] As discussed above, *supra* at 5, CMS has authority to determine whether the statutory standards for APTC eligibility are met, but it does not have authority to alter those standards. *See* 42 U.S.C. §§ 18081(a), (f). Eligibility for APTCs turns on whether an applicant is eligible for tax credits, *id.* § 18081(a)(2), and eligibility for tax credits turns on whether one is an "applicable taxpayer," 26 U.S.C. § 36B(c), a term that depends on the applicant's income. The statute does not contemplate that the existence of a prior tax debt affects an applicant's eligibility for APTCs in any way. And if Congress intended to condition eligibility for a tax credit on the reconciliation of old tax debts, it knew how to do so. *See* 26 U.S.C. §§ 24(*l*), 32(k) (conditioning eligibility for future child and earned income tax credits); *see also Nat'l Elec. Mfrs. Ass'n v. Dep't of Energy*, 654 F.3d 496, 507 (4th Cir. 2011).

[6] Although this motion does not seek relief as to the current failure-to-reconcile rule, Plaintiffs intend to seek final relief on that policy as well.

So, if debt for a PTC is unresolved, the statute contemplates that the IRS, not CMS, would use its enforcement tools to ensure the debt is collected. *See* 26 C.F.R. § 1.6011-8.

In any event, CMS has now compounded this error in its new failure-to-reconcile (FTR) policy. The new rule will trap some consumers in a Catch-22. Although current policy requires notice in the first year before APTC eligibility may be revoked in a second year, the new policy will require APTCs to be revoked if tax issues aren't resolved immediately. But an applicant's federal tax information must be handled consistently with federal tax privacy law, and so in many cases an applicant with a failure-to-reconcile issue will learn only that they have been barred from subsidized insurance, but not the reason why. *See* Young Decl. ¶ 54. This "Kafka-esque" scenario will cause numerous people to lose coverage, worsening the risk pool. *Id.* ¶ 55. And this problem of delayed IRS reporting will only worsen, given the Administration's large-scale staff reductions at the IRS. *See* Ctrs. for Budget & Policy Priorities comment at 12; *see also* 90 Fed. Reg. at 27,117 (acknowledging IRS "data constraints" and "error" in FTR data).

At one time, CMS acknowledged a one-year FTR policy would be "overly punitive" on enrollees who lose access to subsidies as a result of "delayed data" from IRS, in many cases without knowing why their applications have been rejected. 87 Fed. Reg. 78,206, 78,256 (Dec. 11, 2022). Now, however, the agency brushes aside this concern, noting simply that rejected applicants may file an appeal if they wish. 90 Fed. Reg. at 27,116. This ignores the point that many frustrated applicants will drop out of the process altogether, and the loss of these enrollees, who tend to be healthier, will worsen the risk pool for everybody else. Young Decl. ¶ 55. CMS asserts that its policy is nonetheless worthwhile, albeit only for 2026, to address the "imminent" concern of widespread improper enrollments identified in the Paragon Institute report. 90 Fed. Reg. at 27,116. But, as discussed above, that report is fatally flawed, for reasons that were identified by commenters but that the agency refused to address. *See supra* at 12–15. In any

event, there is a fundamental mismatch between this rule and the problem that CMS claims it is trying to solve. The FTR policy does not in any way address the conduct of brokers, but it does deprive enrollees of coverage, oftentimes for reasons that the Exchange cannot even disclose to them. By failing to draw a "rational connection between the facts found and the choice made," *Appalachian Voices*, 912 F.3d at 753, CMS acted arbitrarily. And by again failing to notify the public in its proposed rule that this policy would be on a one-year basis only, CMS failed to provide adequate notice. *See Chocolate Mfrs. Ass'n*, 755 F.2d at 1105.

B. The New Data-Matching Policies Are Arbitrary

As discussed above, CMS has made it more difficult for applicants to resolve any concerns that the Exchange identifies with their applications for subsidized coverage by (a) shortening the period for an applicant to provide requested information from 150 days to 90 days, 90 Fed. Reg. at 27,120; (b) reinstating a requirement to audit all enrollees who project a household income higher than the poverty level, if IRS data indicates income below that level; and (c) revoking a rule that permitted applicants to self-attest their own income if IRS data is unavailable. Each of these policies will make it harder for people to enroll in coverage, and each of these policies is arbitrary.

First, CMS wrongly reasoned that it was compelled by the statute to impose a 90-day policy. *Id.* at 27,119; *see also id.* at 12,962 (proposed rule). It notes that 42 U.S.C. § 18081(e)(4)(A) describes a 90-day period for applicants to verify their information for the Exchanges, and that the provision expressly permits CMS to extend that period for 2014. From there, the agency concludes that Congress withheld the authority to grant extensions after 2014. But the Act also permits CMS to "modify the methods under the program established by [section 18081] for . . . verification of information." 42 U.S.C. § 18081(c)(4)(B). CMS asserts that this provision addresses only the relationship between the agency and "trusted data sources," 90 Fed.

Reg at 27,119, but nothing in the text of the provision itself even hints at this limitation. Instead, by its express terms, the statute grants the agency the power to modify any of the methods set forth in section 18081, and this includes the power to modify the timeline described in paragraph (e)(4)(A). Indeed, CMS must itself understand the statute to operate in this way, given that it has allowed for extensions of the 90-day period in other circumstances. *See* 45 C.F.R. § 155.315(f)(3).

Nor did Congress revoke the modification power that it granted in paragraph (c)(4)(B) by reiterating in the next paragraph that extensions could be granted in 2014. After all, "redundancies are common in statutory drafting," sometimes due to "a congressional effort to be doubly sure," *Barton v. Barr*, 590 U.S. 222, 239 (2020), an observation that applies with particular force to the ACA, *see King*, 576 U.S. at 491. Because CMS wrongly believed that it was required by the statute to adopt this rule, the provision must be vacated. *See Perez*, 949 F.3d at 873; *Me. Lobstermen's Ass'n*, 70 F.4th at 597.

If CMS had correctly understood its statutory authority, it could have engaged with the evidence showing the need for a 150-day verification period. By the agency's own telling, this provision will cause 226,000 enrollees to lose eligibility for tax credits on the Exchanges, 90 Fed. Reg. at 27,199, and these individuals will almost certainly be thrown off coverage altogether. These enrollees tend to be healthier, so if they do not participate in the Exchanges, the risk pool will worsen, and premiums will increase for remaining enrollees. *Id*. at 27,119; *see* Young Decl. ¶¶ 5, 26. Apart from incorrectly asserting that its hands were tied, CMS only briefly averted to "program integrity" needs, without explaining how those needs would be advanced in any way. CMS, then, acted arbitrarily by failing to address the relevant factors that should have driven its decision. *See Sierra Club*, 899 F.3d at 270.

Second, the mandatory audit policy is arbitrary for precisely the same reasons that this Court vacated the same policy four years ago. *See City of Columbus*, 523 F. Supp. 3d at 763. There are many reasons why an individual could, in good faith, project that he or she will have income next year higher than the federal poverty level even if current-year IRS data shows a lower income. Governing for Impact comment at 12, https://perma.cc/745K-J55Q; *see also* Cynthia Cox et al., *Repayments and Refunds: Estimating the Effects of 2014 Premium Tax Credit Reconciliation*, KFF (Mar. 24, 2015), https://perma.cc/AL3R-C5H5 (roughly half of low-income ACA enrollees experience year-over-year income changes of 20% or more). Many such people are self-employed, or may have difficulty obtaining documentation to support their projections. *See City of Columbus*, 523 F. Supp. 3d at 762. As a result, these people will be more likely to drop out of the market; by CMS's own estimate, 81,000 people will lose coverage. 90 Fed. Reg. at 27,200. And because these individuals tend to be younger and healthier, their exit from the health insurance market will worsen the risk pool. *See* Ctrs. for Budget & Policy Priorities comment at 14–15.

As it did before, CMS improperly assumed that these enrollees must have been attempting to defraud the Exchanges. And CMS again "improperly elevated the objective of fraud prevention, for which it had no evidence, above the ACA's primary purpose of providing health insurance." *City of Columbus*, 523 F. Supp. 3d at 762. The agency's "decision to prioritize a hypothetical risk of fraud over the substantiated risk that its decision result in immense administrative burdens at best, and a loss of coverage for eligible individuals at worst, defies logic." *Id*. at 763.

CMS did assert that some new evidence has arisen supporting its claim that fraud is prevalent among the individuals that would be subject to its mandatory audit policy. 90 Fed. Reg. at 27,122 (citing Hopkins et al., *How Did Take-Up of Marketplace Plans Vary with Price,*

Income, and Gender?). But one of the authors of that study submitted a comment to CMS (which the agency ignored) cautioning that the report did not support the agency's conclusions, given the difficulties that low-income people face in estimating their future incomes. Urban Institute comment at 2; *see supra* at 13. CMS, then, committed the same errors in this rule as it did before, and this provision should be vacated for the same reason.

Third, CMS acted arbitrarily by revoking the option for applicants to attest to their own income where tax data is unavailable. It is a relatively common occurrence for tax data to be missing for an applicant, for entirely legitimate reasons. An individual might have changed his or her name, had a change in family composition, had a change in filing status, or might not have been subject to a filing requirement for the year in question. *See* Ctrs. for Budget & Policy Priorities comment at 15. For this reason, by CMS's own estimate, its rule will generate *more than 2.7 million* instances of data discrepancies that Exchanges and applicants will need to resolve. 90 Fed. Reg. at 27,185. For many of these people, other documentation might not be readily available to substitute for tax data, which means that if these people are not permitted to attest to their income, they will be deprived of subsidized coverage. *Id.* And once again, it is younger and healthier people who are more likely to be deterred from coverage by this paperwork burden, as sicker people will be more motivated to take the needed steps to retain their coverage. *Id.* CMS estimates that 407,000 people will lose some or all APTC as a result of this rule. 90 Fed. Reg. at 27,200.

CMS attempted to justify these burdens and these coverage losses simply by reciting that self-attestation "may have played a role in weakening the Exchange eligibility system," but it provided no support for this assertion. *Id.* at 27,130. Unscrupulous brokers, after all, would have no way of knowing whether tax data is available for a given person before targeting him or her for an unauthorized enrollment. Once again, CMS has adopted a rule that is entirely

disconnected from the problem it claims it is trying to solve, with hundreds of thousands of people being driven out of coverage as a result. This fell short of the basic standards for rational rulemaking that the APA requires. *See Appalachian Voices*, 912 F.3d at 753.

IV. Plaintiffs Will Suffer Irreparable Harm in the Absence of a Preliminary Injunction

The 2025 rule will cause Plaintiffs irreparable harm that warrants a section 705 stay or preliminary injunction of the challenged provisions. A plaintiff seeking a preliminary injunction must "demonstrate that irreparable injury is *likely* in the absence of an injunction." *Winter*, 555 U.S. at 22. A plaintiff must clearly show that it will suffer actual, imminent harm that "cannot be fully rectified" by a final judgment after trial. *Mountain Valley Pipeline, LLC v. 6.56 Acres of Land*, 915 F.3d 197, 216 (4th Cir. 2019) (cleaned up). Plaintiffs easily meet this standard.

Although "[m]ere injuries, however substantial, in terms of money, time and energy necessarily expended in the absence of an injunction are not enough, irreparable harm may still occur in extraordinary circumstances, such as when monetary damages are unavailable or unquantifiable." *Am. Ass'n of Colleges for Tchr. Educ. v. McMahon*, 770 F. Supp. 3d 822, 858 (D. Md. 2025) (cleaned up). For example, "economic damages may constitute irreparable harm where no remedy is available at the conclusion of litigation," *Mountain Valley Pipeline, LLC v. W. Pocahontas Properties Ltd. P'ship*, 918 F.3d 353, 366 (4th Cir. 2019), and where such injury "threaten[s] a party's very existence," *Mountain Valley Pipeline*, 915 F.3d at 218.

The final rule's challenged provisions, both individually and in combination, will raise premiums for plans on the Exchanges, limit coverage under those plans, and deter millions of individuals from enrolling in coverage, leading to higher uncompensated care costs for providers of last resort. Young Decl. ¶¶ 4–5. The resulting increase in costs, erosion of coverage, and decreased enrollment will increase the number of uninsured and underinsured individuals and will cause Plaintiffs irreparable harm.

First, the erosion of coverage under the 2025 rule will create burdensome additional costs for MSA members and will negatively affect the health of the member businesses' owners and employees who rely on care or medication that they cannot afford without insurance coverage. *See* Phetteplace Decl. ¶¶ 3–5. Crucially, the increase in premiums and limitations on insurance coverage will threaten the "very existence" of some of MSA's members. *Mountain Valley Pipeline*, 915 F.3d at 218. For example, Brooke Legler is a small business owner and MSA member located in Wisconsin. Legler Decl. ¶¶ 2–4. She has a chronic condition that requires her to take significant medication, including a biologic that costs approximately $10,000 per month. *Id.* ¶¶ 5–6. By giving her access to affordable and comprehensive health insurance, the ACA gave her the freedom to start and operate her small business, which now employees about 10 individuals. *Id.* ¶ 8. Like many other small business owners, she operates that business on narrow margins. *Id.* ¶ 11. The increase in premiums that will result from the final rule would likely force her to shut down her business, because her current insurance through the ACA would no longer be affordable and comprehensive enough to cover her medications, so she would need to find different employment with employer-sponsored insurance or explore other state-sponsored coverage options. *Id.* The rule therefore threatens the "very existence" of her business, and those of other MSA members, causing them irreparable harm. *Mountain Valley Pipeline*, 915 F.3d at 218.

Second, DFA's members, including physicians and medical trainees, will also be irreparably harmed by the 2025 rule. With the increased number of uninsured and underinsured patients, DFA's members would be more likely to see patients who delay care until their needs are acute; they would receive less than full reimbursement for those patients who lose insurance or whose coverage becomes more limited; and they would lose contact with many patients altogether, particularly in low-income communities. Krommes Decl. ¶ 6.

Appropriate medical care includes referral to a specialist when needed, the prescription of medicine as warranted, and recommendation for procedures when necessary. *Id.* ¶ 7. Even when clinicians provide uncompensated patient care—which will occur increasingly if the final rule is implemented—their work does not end with the patient visit. *Id.* When a patient requires treatment but lacks insurance, clinicians must spend time finding a specialist willing to provide care, trying to find an alternative medicine that a patient may be able to afford but is not the optimal treatment, and intervening on behalf of a patient in an attempt to get testing or procedures performed. *Id.* These efforts consume greater amounts of clinicians' time as patients lose coverage. *Id.* The end result is additional time for which DFA members do not get paid that detracts from patient care. *Id.* At bottom, medical providers will expend more time and effort and receive less compensation, all of which will prevent them from providing optimal care to their patients.

For example, DFA member Dr. Beth Oller is a family medicine physician in Rooks County, Kansas. Decl. of Dr. Beth Oller ¶¶ 3–4. She treats a panel of more than 800 patients of all ages for a broad range of health care needs, ranging from wellness checks to treating illnesses and chronic conditions to providing the full range of reproductive health care. *Id.* Sustaining a medical practice is particularly difficult in a rural area like hers, where health care providers are sparse and many residents are low-income and self-employed (for example, as farmers and ranchers). *Id.* ¶ 5. Even after the ACA allowed many of her patients to access affordable health insurance—and thus preventative care and early treatment—for the first time, Dr. Oller was unable to sustain an independent practice, and she now practices as a primary care provider with a county health center. *Id.* ¶ 4. But the continued operation of rural hospitals and health centers would be put at risk if the rule were to go into effect and cause many patients like Dr. Oller's to see the value of their insurance coverage erode or to lose that coverage altogether. *Id.* ¶ 6–7, 9.

As a result, Dr. Oller would receive compensation for less of the treatment she provides and would receive compensation for fewer patients overall. *Id.* ¶¶ 7, 8. The increase in administrative burdens would also require Dr. Oller and her practice to spend more time (without compensation) helping patients navigate red tape to determine their coverage. *Id.* ¶ 7. These results would hinder Dr. Oller's ability to provide optimal care to her patients and ultimately jeopardize their long-term health. *Id.*

Third, Columbus, Baltimore, and Chicago (the city Plaintiffs) would likewise suffer irreparable injury that could not be rectified after final judgment on the merits if the final rule were to go into effect. By driving up the rate of uninsured or underinsured individuals within the city Plaintiffs' jurisdictions, the rule would force these cities to devote additional funding, personnel, and other resources to subsidizing and providing uncompensated care for their residents. The rule thereby hits the city Plaintiffs' budgets, including the budgets for their public health departments, free or reduced-cost clinics, and ambulance services.

Fulfilling their responsibility to care for their residents, all of the city Plaintiff governments operate a range of clinics and programs that offer health care services to residents regardless of their insurance coverage and ability to pay. *See* Ige Decl. ¶ 5, 11; Johnson Decl. ¶ 11; Leach Decl. ¶¶ 7–8. Because the rule would cause an increase in the number of uninsured and underinsured individuals, *see, e.g.*, Young Decl. ¶ 4, it would increase the burden on those city programs and services and therefore on the cities' budgets. The city Plaintiffs would necessarily be servicing more individuals with no or inadequate coverage, and the cities would not be able to recoup the costs of those services. *See* Ige Decl. ¶¶ 6, 14; Johnson Decl. ¶¶ 9–11; Leach Decl. ¶ 12; *see also City of Columbus v. Trump*, 453 F. Supp. 3d 770, 787–88 (D. Md. 2020) (recognizing that city plaintiffs challenging CMS's 2019 rule "suffered injury from having

to pay greater costs to provide uncompensated care to their under- and uninsured residents"); *City of Columbus*, 523 F. Supp. 3d at 744.[7]

In addition, individuals who lack insurance coverage are more likely to wait until their conditions are more severe before seeking care, so the increase in the number of such individuals would lead to an increase in ambulance calls and other emergency medical services. *See* Ige Decl. ¶ 8.[8] This would increase the strain on the city Plaintiffs' often already overstretched emergency medical services and, again, create budgetary shortfalls that the cities will have to make up. *See* Ige Decl. ¶ 9; Johnson Decl. ¶¶ 12–14; Leach Decl. ¶¶ 11–13.

Moreover, the city Plaintiffs would be irreparably harmed by the increase in uninsured and underinsured individuals caused by the rule for the additional reason that when individuals do not get the medical care that they need, they are necessarily less healthy, less productive, and less able to participate in city life. *See, e.g.*, Ige Decl. ¶ 14; Johnson Decl. ¶ 15; Leach Decl. ¶ 14. This would have cascading negative and irreparable effects on city programs and communities.

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[7] *See also* John Holahan & Bowen Garnett, *The Cost of Uncompensated Care With and Without Health Reform* 4, Urban Institute (Mar. 2010), https://www.urban.org/sites/default/files/publication/28431/412045-The-Cost-of-Uncompensated-Care-with-and-without-Health-Reform.PDF (an increase in "number of uninsured and the amount of uncompensated care . . . will translate into increased pressure on state and local government to finance the growing cost of the uninsured"); Erin F. Taylor et al., *Community Approaches to Providing Care for the Uninsured*, 25 Health Affairs 173, 173 (2006), https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.25.w173 ("[i]ncreases in the number of uninsured people often strain local safety nets and health systems").

[8] *See also* Institute of Medicine, "Who Pays for Uninsured Persons," *A Shared Destiny: Community Effects of Uninsurance* (2003), https://perma.cc/468G-ZZB9; James Benedict, *Chronic Disease Management of the Uninsured Patient at Ohio Free Clinics* 5, Walden University (2016), https://scholarworks.waldenu.edu/cgi/viewcontent.cgi?article=3816&context=dissertations.

V. The Remaining Factors Weigh in Favor of an Injunction

The balance of equities and public interest prongs merge when the government is the opposing party. *Nken v. Holder*, 556 U.S. 418, 435 (2009). While "[t]here is generally no public interest in the perpetuation of unlawful agency action," *League of Women Voters of the United States, v. Newby*, 838 F.3d. 1, 12 (D.C. Cir. 2016), "the public undoubtedly ha[s] an interest in seeing its governmental institutions follow the law," *Roe v. Dep't of Defense*, 947 F.3d 207, 230–31 (4th Cir. 2020). In particular, "[t]he public interest is served when administrative agencies comply with their obligations under the APA." *N. Mariana Islands v. United States*, 686 F. Supp. 2d 7, 21 (D.D.C. 2009). The Plaintiffs' requested relief—a stay under the APA—would require nothing more.

Granting preliminary relief here in the public interest because, as detailed above, the challenged provisions of the rule will reduce enrollment and result in coverage loss for millions of Americans. Young Decl. ¶ 4. And those who manage to keep their health insurance can anticipate higher out-of-pocket costs and administrative burdens in the marketplace. *Id.* ¶ 29. Increases in uninsured people lead to increases in uncompensated care, putting a strain on providers of last resort and emergency services and limiting the quality of care that medical professionals can deliver, with particularly harmful results for lower-income people. *See supra* at 41–42. These circumstances create life-or-death situations for both the insured and uninsured, as patients without insurance coverage forgo standard medical care altogether. Krommes Decl. ¶ 8. Those patients—even those under the care of diligent physicians—will end up in emergency rooms where care is less comprehensive and more expensive and health outcomes are worse long-term. *Id.*

In light of the real and immediate harm that the public faces as a result the rule's provisions, the equities and public interest strongly favor preliminary relief. On the other side,

the burden of a stay or injunction on the government would be minimal. "It is well established that the Government cannot suffer harm from an injunction that merely ends an unlawful practice." *C.G.B. v. Wolf*, 464 F. Supp. 3d 174, 218 (D.D.C. 2020) (cleaned up); *see also Newsom ex rel. Newsom v. Albemarle Cnty. Sch. Bd.*, 354 F.3d 249, 261 (4th Cir. 2003).

VI. The Court Should Not Require a Bond

Federal Rule of Civil Procedure 65(c) "vest[s] broad discretion in the district court" to require bonds, *DSE, Inc. v. United States*, 169 F.3d 21, 33 (D.C. Cir. 1999), including "to require no bond at all," *P.J.E.S. ex rel. Escobar Francisco v. Wolf*, 502 F. Supp. 3d 492, 520 (D.D.C. 2020) (quotation marks omitted). The bond amount "ordinarily depends on the gravity of the potential harm to the enjoined party." *Hoechst Diafoil Co. v. Nan Ya Plastics Corp.,* 174 F.3d. 411, 421 n.3 (4th Cir. 1999)). And a bond "is not necessary where requiring [one] would have the effect of denying the plaintiffs their right to judicial review of administrative action." *Nat. Res. Def. Council, Inc. v. Morton*, 337 F. Supp. 167, 168 (D.D.C. 1971) (collecting cases). Here, staying provisions of the rule will not create monetary injury for Defendants, particularly when a number of the provisions the government hopes to impose will only be effective for the 2026 plan year. Plaintiffs thus request that the Court not require a bond.

CONCLUSION

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

Dated: July 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

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' challenge to the Marketplace Program Integrity Final Rule (Final Rule).

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, appears as an Appendix to this declaration.

Summary of Observations

3. The American health insurance system is complicated. Most Americans who do not get health insurance from their own or a family member's employer are eligible for a form of subsidized coverage, but many face barriers accessing that coverage. For people seeking coverage through the Health Insurance Marketplaces, these barriers include (1) the fact that coverage may be too expensive, and (2) that the system of applying for and obtaining coverage may create administrative obstacles that consumers do not successfully navigate. As a result, people who are eligible for coverage often remain uninsured.

4. Several provisions of the Marketplace Program Integrity Final Rule (Final Rule) are expected to worsen the barriers to Marketplace coverage by making coverage more expensive or by heightening the administrative obstacles consumers face. These changes are expected to directly *decrease* the number of people with coverage and *increase* the number of uninsured. For example, the Congressional Budget Office has concluded that the rule as a whole will decrease enrollment in Marketplace coverage by 2.2 million and increase the number of uninsured by 1.8 million.[1]

5. People who are relatively younger and healthier are more likely to be deterred from enrolling by higher costs or additional administrative obstacles. Therefore, the policies in the final rule that raise costs and increase administrative obstacles will generally be expected to worsen the Marketplace risk pool. A worse risk pool will generally lead to higher health insurance premiums, further exacerbating the problem of high costs, which in turn can cause additional people to become uninsured.

[1] *See* Email from Cong. Budget Office, Estimated Effects of Proposed Marketplace Rule (Apr. 9, 2025), https://democrats-waysandmeans.house.gov/sites/evo-subsites/democrats-waysandmeans.house.gov/files/evo-media-document/cbo-aca-coverage-loss-estimates.pdf.

6. The decrease in Marketplace enrollment and increase in the uninsured will result in increased burden of uncompensated care, especially for safety net providers.

The Structure of the Affordable Care Act and the Health Insurance Marketplaces

7. A primary goal of the Affordable Care Act (ACA) was to create pathways to quality, affordable health insurance for Americans who do not get coverage from their jobs. The law did this through two primary mechanisms: expanding Medicaid and creating the Health Insurance Marketplaces where individuals could buy regulated and often subsidized coverage. Promoting access to health coverage was designed to ensure that Americans had access to the health care system and the health benefits that flow from reliable health care, had financial protection in the event of illness or injury, and benefited from improved overall health and well-being. Analyses since passage of the law consistently demonstrate that the law has helped to achieve those goals.[2]

8. The Health Insurance Marketplaces are the mechanism the ACA created to provide coverage to people with incomes generally over the poverty level. A critical feature of the Marketplaces is that all available plans meet standards for health plan quality by covering a robust set of benefits and protecting consumers from exposure to very high-cost care. This

[2] *See, e.g.*, Jacob Goldin, Ithai Z. Lurie & Janet McCubbin, *Health Insurance and Mortality: Experimental Evidence from Taxpayer Outreach*, 136 Q.J. Econ. 1 (2021), https://academic.oup.com/qje/article-abstract/136/1/1/5911132 (experimental evidence that health insurance reduces mortality through a randomized study of taxpayers who received informational letters about ACA penalty requirements); American Hospital Association, Report: The Importance of Health Coverage, https://www.aha.org/guidesreports/report-importance-health-coverage (health insurance coverage improves access to care, health outcomes, and financial well-being, while highlighting the continuing challenges faced by the uninsured population); Kaiser Family Foundation, The Effects of Medicaid Expansion under the ACA: Studies from January 2014 to January 2020, https://www.kff.org/medicaid/report/the-effects-of-medicaid-expansion-under-the-aca-updated-findings-from-a-literature-review/ (analyzing 404 studies published from January 2014 through January 2020 on Medicaid expansion impacts, finding positive effects on coverage gains, access to care, financial security, health outcomes, and economic benefits for states and providers); Kosali Simon, Aparna Soni & John Cawley, The Impact of Health Insurance on Preventive Care and Health Behaviors: Evidence from the First Two Years of the ACA Medicaid Expansions, 36 J. Pol'y Analysis & Mgmt. 390 (2017), https://onlinelibrary.wiley.com/doi/abs/10.1002/pam.21972 (the Affordable Care Act affected preventive healthcare utilization and health behaviors during the first two years of implementation).

allows consumers to shop and insurers to compete on a level playing field.[3]

9. Marketplaces serve to pool risk between healthy and sick individuals. Health insurance premiums in the Marketplace are set by insurance plans based on the total costs of providing coverage to the entire covered population in the state, not on the expected costs of any one individual. If only the very sickest individuals enroll, then coverage will be extremely expensive; if a robust mix of healthy and sick individuals enroll, then premiums will be lower because they reflect the average cost of a much healthier pool.[4]

10. Critically, the premiums that individuals have to pay influence their decisions about whether or not to enroll. Economic theory and empirical evidence show that when coverage is expensive, only people with high expected health care costs choose to enroll, because they are the only individuals for whom the expected value of the coverage exceeds its costs. However, if coverage is less expensive, individuals in better health will find it attractive to enroll.[5] For this reason, affordable premiums that draw in healthy individuals are an important predicate for a stable and well-functioning Marketplace.

A Wide-Ranging Literature Establishes that High Costs and Increased Administrative Obstacles Decrease Enrollment and Worsen Risk Pools

11. Twenty-eight million Americans are currently uninsured.[6] Studies have established that most people who are uninsured are eligible for subsidized coverage through Medicaid or the Health Insurance Marketplaces established by the ACA. For instance, a recent

[3] *See* Christen Linke Young, Taking a Broader View of "Junk Insurance," Brookings Institution (July 2020), https://www.brookings.edu/articles/taking-a-broader-view-of-junk-insurance/.

[4] *See, e.g.,* American Academy of Actuaries, Risk Pooling: How Health Insurance in the Individual Market Works (June 2023), https://actuary.org/wp-content/uploads/2017/11/RiskPoolingFAQ071417.pdf.

[5] For a discussion of this literature, *see, e.g.*, Linda J. Blumberg & John Holahan, Early Experience with the ACA: Coverage Gains, Pooling of Risk, and Medicaid Expansion, 44 J Law Med Ethics 538 (2016), https://pubmed.ncbi.nlm.nih.gov/28661254/.

[6] Elizabeth M. Briones & Robin A. Cohen, Health Insurance Coverage: Early Release of Quarterly Estimates from the National Health Interview Survey, 2023–December 2024, Nat'l Ctr. for Health Statistics (June 2025), https://www.cdc.gov/nchs/nhis/early-release/health-insurance-coverage.html.

analysis using data from 2023 to study the nonelderly uninsured finds that 57 percent are eligible for subsidized coverage, 25 percent through Medicaid and 32 percent through the Marketplaces.[7] These results are generally consistent across age and race and for most income categories, but do vary by geography and for certain income groups.[8]

12. Eligible people remain uninsured for a variety of reasons. In one survey, about one quarter of the uninsured say that they do not need or want coverage, while most report that the reason they are uninsured is because they are experiencing some sort of barrier to obtaining health insurance.[9]

Costs

13. Cost is a common reason that uninsured people do not enroll in coverage for which they are eligible; in the survey described above, 62 percent of the uninsured indicated that they did not have coverage because it was too expensive.[10]

14. For consumers shopping for coverage through the Health Insurance Marketplaces, a number of factors affect the costs faced by different groups. Some potential enrollees—including those who are relatively higher income—pay the gross or "sticker" premium charged by insurance companies. Therefore, policies that increase gross premiums will directly increase the cost of coverage for this group.

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[7] Jennifer Tolbert et al., Key Facts About the Uninsured Population, KFF (Dec. 18, 2024), http://kff.org/uninsured/issue-brief/key-facts-about-the-uninsured-population.

[8] *See, e.g.*, Patrick Drake et al., A Closer Look at the Remaining Uninsured Population Eligible for Medicaid and CHIP, KFF (Mar. 15, 2024), https://www.kff.org/uninsured/issue-brief/a-closer-look-at-the-remaining-uninsured-population-eligible-for-medicaid-and-chip/, Jameson Carter et al., Uninsurance and Medicaid Eligibility Among Young Adults in 2025, Urban Inst. (Mar. 18, 2025), https://www.urban.org/research/publication/uninsurance-and-medicaid-eligibility-among-young-adults-2025; Linda J. Blumberg, et al., Characteristics of the Remaining Uninsured: An Update,
Urban Inst. 2 (July 2018), https://www.urban.org/sites/default/files/publication/98764/2001914-characteristics-of-the-remaining-uninsured-an-update_2.pdf.

[9] *See* Tolbert et al., *supra* note 7.

[10] *Id.*; *see also*, Reaching the Remaining Uninsured: An Evidence Review on Outreach & Enrollment, Ass't Sec'y for Planning & Evaluation (Oct. 2021), https://aspe.hhs.gov/sites/default/files/documents/666bcb121e373ec517def3b1fcd4af23/aspe-remaining-uninsured-outreach-enrollment.pdf.

15. Most consumers who buy coverage through the Marketplace qualify to receive financial assistance.[11] These consumers pay a "net premium" that is the gross premium for coverage less the amount of financial assistance they receive. The structure of this assistance means that gross premiums are not usually the most important factor influencing the net cost the household will pay for coverage. For this group, household net premiums are primarily affected by policies that change the terms on which they receive financial assistance.

16. For any product, higher costs are associated with reduced demand. A body of literature has specifically examined how increased premiums affect enrollment in health coverage through Health Insurance Marketplaces. This literature demonstrates that even small increases or decreases in premiums have significant impacts on enrollment. For example:

- Decreases in financial assistance, and the associated increase in net premiums, has a large enrollment effect: each $40 increase in net monthly premiums decreases enrollment by 25 percent.[12]
- For enrollees without financial assistance, increases in gross premiums are associated with large reductions in Marketplace enrollment, including a decline of more than 5 percent in one year.[13]
- A premium increase of less than $10 per month was associated with a 14% reduction in enrollment.[14]

[11] For 2025, 92% of Marketplace enrollees receive financial assistance. 2025 Marketplace Open Enrollment Period Public Use Files, Ctrs. for Medicare & Medicaid Servs., https://www.cms.gov/data-research/statistics-trends-reports/marketplace-products/2025-marketplace-open-enrollment-period-public-use-files.

[12] Amy Finkelstein et al., Subsidizing Health Insurance for Low-Income Adults: Evidence from Massachusetts, 109 Am. Econ. Rev. 1530 (2019), https://pubs.aeaweb.org/doi/pdfplus/10.1257/aer.20171455.

[13] Michael Cohen & Michelle Anderson, Premium Effects on ACA Enrollment, Wakely (Apr. 2019), https://www.wakely.com/wp-content/uploads/2024/04/premium-effects-aca-enrollment-final.pdf.

[14] Adrianna McIntyre, Mark Shepard & Timothy J. Layton, Small Marketplace Premiums Pose Financial and Administrative Burdens: Evidence from Massachusetts, 2016–17, 43 Health Aff. 80 (2024), https://www.healthaffairs.org/doi/10.1377/hlthaff.2023.00649.

- The availability of $0 premium plans increases days of enrollment in the Marketplace.[15]
- Overall, studies find a high price elasticity of demand for coverage in the Marketplaces: a 1 percent premium increase for a plan decreases enrollment by 1.7 percent[16] (though note that this is not a direct measure of coverage loss).

17. Therefore, there is significant evidence that policies that increase gross and net premiums by even small amounts are expected to lead to reduced enrollment and an increased number of uninsured.

18. Policy changes can affect gross premiums in different ways. For example, policies that decrease the benefits covered by plans in the Marketplace will decrease gross premiums, while policies that decrease the share of relatively healthy people covered by Marketplace plans will increase gross premiums.[17]

19. Similarly, policies can change net premiums for people receiving financial assistance through a variety of mechanisms. At the most extreme end, policies that eliminate (or newly provide) eligibility for financial assistance will dramatically increase (or decrease)

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[15] Coleman Drake et al., Financial Transaction Costs Reduce Benefit Take-up Evidence from Zero-Premium Health Insurance Plans in Colorado, 89 J. Health Econ. 102752 (2023), https://www.sciencedirect.com/science/article/abs/pii/S0167629623000292.

[16] Jean Abraham et al., Demand for Health Insurance Marketplace Plans Was Highly Elastic in 2014–2015, 159 Econ. Letters 69 (2017), https://www.sciencedirect.com/science/article/abs/pii/S0165176517302823; *see also* Benjamin Hopkins, Jessica Banthin & Alexandra Minicozzi, How Did Take-up of Marketplace Plans Vary with Price, Income, and Gender?, 11 Am. J. Health Econ. (2025), https://www.journals.uchicago.edu/doi/10.1086/727785.

[17] Policies that decrease the share of low-income people covered by Marketplaces can also decrease gross premiums for certain types of Marketplace plans (specifically "silver" plans). This is because of a practice referred to as "silver-loading," under which premiums for silver plans in Marketplaces are raised to cover the cost of providing cost-sharing reductions. Independent of any risk pool effects, policies that decrease the share of low-income people in Marketplaces will decrease silver plan gross premiums. However, such policies may worsen the risk pool overall and therefore increase premiums for other types of plans. Further, lower silver plan premiums mean higher net premiums for many people with financial assistance, and do not affect the lowest-cost options available for people who pay gross premiums. Therefore, lower silver plan premiums do not mean consumers face lower costs; instead, it will often mean the opposite. *See, e.g.,* Christen Linke Young, Understanding Marketplace "Silver Loading," Brookings Inst. (May 9, 2025), https://www.brookings.edu/articles/understanding-marketplace-silver-loading/.

premiums. Policies can also change the formula used for calculating financial assistance, which will have smaller impacts.

Administrative Obstacles

20. Beyond costs, administrative obstacles—like paperwork submission requirements—are also a significant factor that results in eligible people remaining uninsured. Twenty-four percent of the uninsured say the primary reason they do not have coverage is that "signing up was too difficult or confusing." An additional 18 percent report difficulty finding a plan, which may also reflect administrative barriers.[18]

21. The Marketplace application process contains a number of steps. At a minimum, consumers (on their own, or in partnership with a broker or assister) must (1) submit an application that contains responses to questions, (2) receive and understand fairly detailed information about their eligibility, (3) select a health plan from among the dozens of options available, and (4) establish a relationship with the insurance company offering their coverage, including providing payment information in most cases. Some consumers are also required to submit additional documentation by mail or upload to an online portal, or to resolve issues that may be affecting their coverage with other entities, like the Internal Revenue Service (IRS), their state Medicaid agency, or an insurance plan.[19]

22. Literature within and outside health care has established that administrative obstacles generally reduce enrollment of eligible people. Analyses looking specifically at Marketplace health insurance have found:

- Adding an additional step to the reenrollment process for Marketplace health

[18] Tolbert et al., *supra* note 7.

[19] *See. e.g.,* Rachel Schwab et al., Policy Innovations in the Affordable Care Act Marketplaces, Commonwealth Fund (Nov. 21, 2023), https://www.commonwealthfund.org/publications/issue-briefs/2023/nov/policy-innovations-affordable-care-act-marketplaces.

insurance decreases enrollment by 33 percent.[20]

- A randomized experiment examining a checkbox to reduce a step in the enrollment process increased enrollment by 11 percent.[21]
- Scholars argue that the literature on the ways in which *costs* deter Marketplace enrollment can also be understood as administrative burdens deterring enrollment, because the costs are often small and it is likely that the time and paperwork burden of establishing payment contributes to the enrollment effects.[22]

23. Outside of the Marketplaces, researchers have documented similar impacts. For example:

- Making an administrative component of the food assistance application process more flexible increases enrollment by 6 percentage points.[23]
- Offering assistance resolving administrative obstacles to enroll in food assistance increases enrollment by 12 percentage points.[24]
- Many researchers have shown that simplifying enrollment in retirement savings plans increases take-up significantly.[25]

24. Thus, there is significant evidence that policies that an increase in administrative

[20] Mark Shepard & Myles Wagner, Do Ordeals Work for Selection Markets? Evidence from Health Insurance Auto-Enrollment, 115 Am. Econ. Rev. 772 (2025), https://doi.org/10.1257/aer.20231133.

[21] Keith Marzilli Ericson et al., Reducing Administrative Barriers Increases Take-Up of Subsidized Health Insurance Coverage: Evidence from a Field Experiment, Rev. Econ. & Stat., Mar. 5, 2025, at 1, https://doi.org/10.1162/rest_a_01573.

[22] *See, e.g.,* Adrianna McIntyre, Mark Shepard & Myles Wagner, Can Automatic Retention Improve Health Insurance Market Outcomes?, 111 AEA Papers & Proc. 560 (2021), https://doi.org/10.1257/pandp.20211083; Letter from Matthew Fiedler to Ctrs. for Medicare & Medicaid Servs., Patient Protection and Affordable Care Act; Marketplace Integrity and Affordability [CMS-9884-P] (Apr. 11, 2025), https://www.brookings.edu/wp-content/uploads/2025/04/Fiedler-Comment-on-Program-Integrity-Rule-FINAL.pdf.

[23] Eric Giannella et al., Administrative Burden and Procedural Denials: Experimental Evidence from SNAP, 16 Am. Econ. J.: Econ. Pol'y 316 (2024), https://doi.org/10.1257/pol.20220701

[24] Amy Finkelstein & Matthew J. Notowidigdo, Take-Up and Targeting: Experimental Evidence from SNAP, 134 Q.J. Econ. 1505 (2019), https://economics.mit.edu/sites/default/files/2022-08/aaFinkelstein_Noto_QJE_August_2019%20%281%29.pdf.

[25] *See, e.g.*, Brigitte C. Madrian & Dennis F. Shea, The Power of Suggestion: Inertia in 401(k) Participation and Savings Behavior, 116 Q.J. Econ. 1149 (2001), https://doi.org/10.1162/003355301753265543.

obstacles leads to reduced enrollment and an increased number of uninsured.

25. Policy changes can add additional administrative obstacles or complexify administrative burdens that already exist. For example, more consumers can be required to submit additional documentation, the document process can be made more challenging, or consumers can be required to interact with third parties in more or different circumstances. Such changes can affect all Marketplace enrollees or certain subsets. The evidence indicates that these policy changes would be expected to decrease enrollment.

Risk Pool Impacts

26. The economic literature has also established that the individuals deterred from enrollment by higher costs and administrative obstacles tend to be healthier. For example:

- Enrollees who would potentially lose coverage if an additional administrative step was required at reenrollment have health costs 44% lower than those who are not likely to be affected.[26]
- The group of enrollees retained through a change to reduce administrative burden have spending 2.5% lower than other enrollees.[27]

27. When healthy people exit health insurance markets, the risk pool worsens and gross premiums for the market as a whole tend to go up. That is, the insurance market becomes less effective at pooling risk and has higher overall costs.

28. As noted above, higher gross premiums resulting from worsened risk pools can further deter enrollment and increase the number of uninsured.

[26] Shepard & Wagner, *supra* note 20.
[27] McIntyre, Shepard & Wagner, *supra* note 22.

The Challenged Provisions of the Final Rule Are Expected to Increase Costs and Administrative Obstacles, and Therefore Reduce Enrollment

29. The Final Rule includes a variety of policies that are expected to increase net premiums for people receiving financial assistance, increase gross premiums for at least some plans, and impose additional administrative obstacles, which are in turn expected to cause decreases in enrollment.

$5 Premium at Reenrollment

30. The Final Rule makes changes for enrollees who are being automatically enrolled into plans that would otherwise have a $0 net premium. Specifically, the rule requires a $5 premium charge be added unless the individual actively reenrolls.

31. This is transparently an increase in net premiums. Consistent with all of the evidence described above, it would be expected to decrease enrollment.

32. Moreover, there are several analyses that look *specifically* at the impacts of added premium charges at reenrollment—examining how a change from a $0 net premium to a small charge (generally under $10) decreases enrollment. This literature consistently finds large decreases in enrollment associated with the exact policy change advanced in the Final Rule.[28]

33. The individuals deterred from enrollment under this policy are likely to be healthier than average, worsening risk pools.

Premium Adjustment Percentage

34. The Final Rule alters the formula that is the basis for calculating the value of

[28] *See, e.g.*, McIntyre, Shepard & Layton, *supra* note 14 (increasing premiums at reenrollment from $0 to less than $10 decreases enrollment 14 percent); Drake et al., *supra* note 15 ($0 premium at reenrollment meaningfully increases enrollment); Laura Dague, The Effect of Medicaid Premiums on Enrollment: A Regression Discontinuity Approach, 37 J. Health Econ. 1 (2014), https://doi.org/10.1016/j.jhealeco.2014.05.001 (adding premiums at reenrollment in Medicaid decreases enrollment).

financial assistance.[29] The changes mean that financial assistance will be lower for nearly all enrollees who receive it, and net premiums will be higher. CMS notes that net premiums will be about 2 percent higher on average.

35. This increase in net premiums will decrease enrollment. Indeed, CMS reaches the same conclusion and estimates 80,000 people will lose coverage as a result of this change.[30]

36. Consistent with the literature described above, these enrollees are likely to be healthier than average, and their loss will likely worsen the risk pool.

Actuarial Value

37. Marketplace plans are generally required to cover a specified percentage (60, 70, 80, or 90 percent) of total health care costs, and rules have long allowed some de minimis variation from the target amount. The Final Rule asymmetrically widens the allowable de minimis range, including allowing plans to be as much as 4 percentage points below the target and still be considered in compliance. Prior policy had allowed variation only 2 percentage points below the target, and 0 for silver plans.

38. This change will generally decrease the value of the health insurance purchased through the Marketplace and lower gross premiums for this reason. It will also affect net premiums. Because the policy's impact on silver plans is larger compared to prior law than on other types of plans, the gross premium impact for silver plans will be larger as well. This will reduce the value of financial assistance and *increase* net premiums for people seeking to buy

[29] The CMS Final Rule changes regulatory text that establishes a formula used to calculate cost-sharing in private health insurance. IRS, through separate guidance, applies the formula to calculations for Marketplace financial assistance. In the regulatory impact analysis for the final rule, CMS unambiguously treats its policy change as affecting financial assistance and net premiums. Patient Protection and Affordable Care Act; Marketplace Integrity and Affordability, 90 Fed. Reg. 27,074, 27,206-27,207 (June 25, 2025), https://www.federalregister.gov/documents/2025/06/25/2025-11606/patient-protection-and-affordable-care-act-marketplace-integrity-and-affordability ("Net premium increases of approximately $530 million per year for PY 2026 through PY 2030"). Accordingly, it is appropriate to attribute these premium increases to the Final Rule.

[30] *Id.*

non-silver plans with financial assistance.[31]

39. As with other policies increasing net premiums, this change may reduce Marketplace enrollment.

Denial of Coverage for Past Non-payment of Premiums

40. The Final Rule includes a policy that allows insurers to deny coverage to enrollees for past non-payment of premiums. An individual will not be able to begin enrollment into a new health plan unless she has paid any past-due premium debts associated with prior enrollment with the insurer.

41. This functions as an increase in net and/or gross premiums for the first month of coverage. Specifically, in order to start her first month of coverage, she must pay an amount larger than her "true" monthly premium. If her prior enrollment was associated with an amount of financial assistance similar to the new enrollment, then she would have to pay roughly double her actual premium to begin coverage. These are the sorts of premium increases that the literature discussed above demonstrates lead to reduced enrollment.

42. This policy can also function as a particularly confusing sort of administrative obstacle for some consumers, even if they are willing to pay the additional amount. A consumer in this situation may have selected a plan at the website of the Health Insurance Marketplace (i.e., HealthCare.gov) and then visited the insurer's website to make a payment that she believes is the payment for her first month of coverage. The insurance company may *accept* the payment she has provided, but treat some or all of it as payment of the past-due premium debt; therefore, the consumer will have to make an additional, separate payment to the insurer even though she believes she is fully paid. While no literature speaks directly to this precise form of unusual

[31] For an explanation of the mechanics of this impact, *see* Young, *supra* note 17.

consumer burden, it is consistent with the broader literature on administrative complexity of a long, multi-step enrollment process to conclude the consumer confusion associated with this policy change is also likely to lead to reduced enrollment.

Open Enrollment Period

43. The Final Rule shortens the annual Open Enrollment Period (OEP) by one month in states that use the federal Marketplace, and by varying amounts in other states.

44. This is mechanically an increased administrative burden that will decrease enrollment. Consumers will have fewer available weeks, and fewer are expected to enroll as a result.

45. The risk pool and premium impacts are more complicated, but available data tend to suggest this policy change will worsen risk pools and increase gross premiums. In the Final Rule preamble, the Centers for Medicare & Medicaid Services (CMS) expressed concern about individuals who identified a health concern in late December or early January (e.g., an injury or new symptoms of illness) and decided to enroll in coverage only after the issue emerged. It is likely that some number of people enroll on that basis. These individuals would be expected to have higher health care costs, and so blocking their enrollment with a shorter OEP will improve risk pools. On the other hand, because healthy individuals are less motivated to enroll in coverage, longer enrollment windows provide more time to recruit these marginal consumers. A shorter OEP will also block this group from enrolling, which will worsen risk pools. Data from state-based Marketplaces tend to suggest that there is a much larger set of people in the latter category. Data from California show that in past years, OEP enrollees in January are about 5 percent healthier (as measured by prospective risk scores) than enrollees prior to December 15.[32]

[32] Data Snapshot: Covered California Open and Special Enrollment Periods, Covered Cal. (Apr. 3, 2025), https://hbex.coveredca.com/data-research/library/CoveredCA_OE_SEP_Data_Snapshot_20250403.pdf.

New York also finds January enrollees to be younger on average than enrollees earlier in OEP.[33] Based on these state findings, it is reasonable to expect this change to worsen risk pools and increase gross premiums.

Special Enrollment Periods

46. The Final Rule also eliminates an existing Special Enrollment Period (SEP) for consumers with incomes below 150 percent of the Federal Poverty Level, and requires most people applying for coverage through an SEP to submit documentation establishing that they meet the criteria for an SEP.

47. As with a shorter OEP, eliminating the low-income SEP will mechanically reduce the number of people enrolled because there are fewer available opportunities. There is limited nationwide data available about use of the low-income SEP, but available information suggests it has been a major source of enrollment. For example, CMS reported that in an 11-month period ending in mid-2023, 1.3 million enrollees selected a plan through the low-income SEP.[34] While some of these individuals may have otherwise obtained coverage through another SEP or during the OEP for a past or subsequent year, these results are suggestive that eliminating the low-income SEP will result in a large reduction in enrollment and increase in the uninsured.

48. The administrative obstacles associated with documenting eligibility for an SEP are also expected to reduce enrollment. Affected individuals must obtain some specific document (like a letter from their former employer about the loss of employer-based coverage or a

[33] Letter from N.Y. State of Health to Ctrs. for Medicare & Medicaid Servs., Comments on the Patient Protection and Affordable Care Act; Market Stabilization [CMS-9929-P] (Mar. 7, 2017), https://info.nystateofhealth.ny.gov/sites/default/files/Comments%20on%20Proposed%20Market%20Stabilization%20Regulations%203.7.17.pdf

[34] Patient Protection and Affordable Care Act, HHS Notice of Benefit and Payment Parameters for 2025; Updating Section 1332 Waiver Public Notice Procedures; Medicaid; Consumer Operated and Oriented Plan (CO-OP) Program; and Basic Health Program, 88 Fed. Reg. 82,510 (Nov. 24, 2023), https://www.federalregister.gov/documents/2023/11/24/2023-25576/patient-protection-and-affordable-care-act-hhs-notice-of-benefit-and-payment-parameters-for-2025#p-655

marriage certificate) and upload or mail that information. These documents are not the sort of information that consumers tend to keep readily available; this is substantially more complicated than simply removing one's driver's license from a purse or wallet. Consumers will need to set aside time and attention to complete the process and some will fail to do so. Consistent with the literature above, this will decrease enrollment.

49. Some economic theory suggests these changes to SEP policies could improve the risk pool, while other theory suggests the opposite. Empirical data provided by states, however, indicates that it is more likely that these policies would worsen the risk pool.

50. With respect to the low-income SEP, in the preamble to the Final Rule, CMS discusses their concern that individuals with low incomes could opt not to enroll during the usual OEP, and wait until they had some reason to be concerned about their health to enroll through the SEP. Alternatively, individuals may only begin seeking information about health insurance, which ultimately leads to an enrollment through the SEP, when they have some sort of health concern. It is likely that these factors explain some enrollment through the low-income SEP, and eliminating the associated enrollment would improve risk pools. On the other hand, overall uptake of coverage is fairly low, especially for people who become eligible mid-year. For example, in the early years of the Marketplaces, one group of researchers estimated that less than 15 percent of people who were eligible to enroll through an SEP did in fact do so, and the people who did enroll were likely to be less healthy than the 85 percent that did not.[35] Low-income people may be especially likely to forego the opportunity to enroll. Therefore, policies that increase take-up among eligible people would likely bring healthier people into the

[35] Matthew Buettgens, Stan Dorn & Hannah Recht, More than 10 Million Uninsured Could Obtain Marketplace Coverage Through Special Enrollment Periods, Urban Inst. (Nov. 2015), https://www.urban.org/sites/default/files/publication/74561/2000522-More-than-10-Million-Uninsured-Could-Obtain-Marketplace-Coverage-through-Special-Enrollment-Periods.pdf

Marketplaces, and blocking these enrollments would worsen risk pools.

51. The same basic dynamic applies to additional document submission requirements for SEP enrollments. To the extent individuals are improperly claiming eligibility for an SEP because they need health care services, blocking these enrollments will improve risk pools; to the extent that healthy people are deterred by additional submission requirements, the deterred enrollments will tend to be among healthier people and will worsen risk pools.

52. Across both policies, data from California tend to suggest that the risk pool worsening effects of these policy changes may be more pronounced. Specifically, California has shared information about the relative health, as measured by prospective risk scores, of SEP and OEP enrollees. They find that the overall health profile of SEP enrollees is consistently slightly better than those enrolling during the OEP.[36] Similarly, other state Marketplaces have indicated they do not find their SEP enrollee population to be sicker than OEP enrollees.[37] Note that these data generally look at all SEP enrollees together, not just those enrolling through the low-income SEP, and they do not specifically identify who would be deterred from enrollment by administrative barriers, so they are not a perfect predictor. Nonetheless, they suggest that eliminating the low-income SEP and creating additional verification burden would worsen risk pools.[38]

[36] Data Snapshot: Covered California Open and Special Enrollment Periods, Covered Cal. (Apr. 3, 2025), https://hbex.coveredca.com/data-research/library/CoveredCA_OE_SEP_Data_Snapshot_20250403.pdf.

[37] *See, e.g.,* Letter from Audrey Morse Gasteier, Chief of Policy & Strategy, Mass. Health Connector, to Ctrs. for Medicare & Medicaid Servs., Notice of Proposed Rulemaking, "Patient Protection and Affordable Care Act; Updating Payment Parameters, Section 1332 Waiver Implementing Regulations, and Improving Health Insurance Markets for 2022 and Beyond" (July 28, 2021), https://www.regulations.gov/comment/CMS-2021-0113-0240; Letter from Jason Levitis, Sabrina Corlette & Christen Linke Young to Ctrs. for Medicare & Medicaid Servs., Re: Patient Protection and Affordable Care Act; Marketplace Integrity and Affordability (Apr. 11, 2025).

[38] Because this policy is likely to reduce the share of enrollment attributable to low-income people, gross silver plan premiums will likely fall, separate from any risk pool effects, but this will not translate to consumers facing lower costs as described above.

Failure to Reconcile

53. The Final Rule makes changes to a Marketplace administrative process known as Failure to Reconcile. Marketplace consumers cannot receive financial assistance if data from the IRS show that they received financial assistance in a prior year and have not "reconciled" on their tax return. Consumers are blocked from financial assistance until they correct the issue with the IRS. The prior policy required two years of IRS demonstrating a failure to reconcile before financial assistance was denied; the Final Rule changes that to one year.

54. This process operates as a complicated administrative obstacle for some consumers. Because whether or not an individual has reconciled their tax credit is considered Federal Tax Information (FTI), that information must be protected from disclosure and handled consistently with federal tax privacy laws. Specifically, rules around the handling of FTI limit the ways in which Marketplaces are able to display in their computer systems (for enrollees and for customer service representatives) the notation that an individual is affected by a failure to reconcile blocking their financial assistance. A consumer may find himself blocked from financial assistance, but the explanation for this block and information on how to correct it may not be accessible outside of specialized channels that he does not know he needs to access.

55. The literature described above generally shows that even simple administrative obstacles like the submission of a single form deter enrollment, especially by healthier people. The Kafka-esque circumstances of the failure to reconcile block are likely to have even greater effects. The existence of the process and the expansion of the number of affected enrollees is expected to decrease enrollment and worsen risk pools.

Data Matching Issues

56. The ACA and Marketplace rules require that consumers submit documentation to prove their eligibility for enrollment and financial assistance if their eligibility cannot be

established through trusted data sources. The document submission requirement is known as a "data-matching issue." The Final Rule changes Marketplace policies so that income information that was treated as adequately verified under prior rules will no longer be designated as such, thus triggering a data-matching issue and requiring affected consumers to submit documentation. If consumers fail to submit adequate documentation, they will generally lose their financial assistance, and generally drop from Marketplace coverage as a result.[39]

57. Consumers generally will need to submit information like paystubs, invoices, or a narrative explaining their income situation. Similar to the information required for SEP verification, obtaining and submitting the needed documents requires time and attention from consumers, and these are the sorts of burdens that the literature above demonstrates lead to reduced enrollment in coverage.

58. CMS estimates in the Final Rule that 488,000 people will fail to successfully resolve a data-matching issue triggered under the rule[40] and will have their financial assistance reduced—generally to $0. Most of this group can be reasonably expected to lose coverage.

59. As with other policies, this coverage loss is likely to affect disproportionately healthy consumers, worsening risk pools.

Conclusion

60. The challenged provisions of the Final Rule each operate to increase gross premiums, increase net premiums, impose administrative burdens, worsen Marketplace risk

[39] Marketplace rules specify that if a data-matching issue cannot be successfully resolved, financial assistance is to be recalculated based on available information; the circumstances of these new data-matching issues mean that in most cases the Marketplace will not have information or the information it has will result in no financial assistance being available. Loss of financial assistance will mean that, on average, premiums increase from $113 to $619. *See* Health Insurance Exchanges 2025 Open Enrollment Report, Ctrs. for Medicare & Medicaid Servs., https://www.cms.gov/files/document/health-insurance-exchanges-2025-open-enrollment-report.pdf. These very large cost increases mean that people will generally drop coverage if they cannot restart their financial assistance.

[40] Patient Protection and Affordable Care Act; Marketplace Integrity and Affordability, 90 Fed. Reg. 27,074 (June 25, 2025), https://www.federalregister.gov/documents/2025/06/25/2025-11606/patient-protection-and-affordable-care-act-marketplace-integrity-and-affordability.

pools, or some combination of those effects. They are expected to decrease Marketplace enrollment and increase the number of uninsured.

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

Dated: June 28, 2025

Washington, D.C.

CHRISTEN LINKE YOUNG

APPENDIX

CHRISTEN LINKE YOUNG

Career

Brookings Institution, 2025-Present
Visiting Fellow, Center on Health Policy

White House Domestic Policy Council, 2021-2025
Deputy Director and Deputy Assistant to the President for Health and Veterans

Biden-Harris Transition Team, 2020
Director of Health Policy

Brookings Institution, 2018-2021
Fellow, Schaeffer Initiative for Health Policy

NC Department of Health and Human Services, 2017-2018
Deputy Secretary

Centers for Medicare & Medicaid Services, 2015-2017
Principal Deputy Director of the Center for Consumer Information and Insurance Oversight

White House Domestic Policy Council, 2013-2015
Senior Policy Advisor for Health Reform

U.S. Department of Health and Human Services, 2013
Director of Coverage Policy, Office of Health Reform

Education

Yale Law School
Juris Doctor, 2009
Editor-in-Chief, Yale Journal of Health Policy, Law, and Ethics
Senior Editor & Admissions Committee, Yale Law Journal

Stanford University
Bachelor of Science with Honors and with Distinction, Biological Sciences, 2004
Phi Beta Kappa

Publications

Jason Levitis, Christen Linke Young, Sabrina Corlette, Ellen Montz, and Claire O'Brien, "The Reconciliation Bill Eliminates Long-Standing State Flexibility to Operate Marketplaces and Regulate Private Health Insurance" *Georgetown Center for Health Insurance Reforms* (June 13, 2025).

Christen Linke Young, "New CBO Estimates Show 2025 Reconciliation Bill Would Have Impacts Similar in Magnitude to 2017 ACA Repeal Bills," *Brookings Institution* (June 4, 2025).

Christen Linke Young and Jason Levitis, "The Sleeper Provision in the Reconciliation Bill That Could Hobble the ACA Marketplaces," *Georgetown Center for Health Insurance Reforms* (May 19, 2025).

Christen Linke Young, "The Inflation Rebate for Medicare Part B-Covered Drugs Should Apply to Medicare Advantage," *Brookings Institution* (May 14, 2025).

Christen Linke Young, "Understanding Marketplace Silver-Loading," *Brookings Institution* (May 9, 2025).

Jason Levitis, Sabrina Corlette & Christen Linke Young, "Comments on the Patient Protection and Affordable Care Act; Marketplace Integrity and Affordability Rule" (Apr. 11, 2025).

Christen Linke Young, "Medicare's Recent Actions To Promote Access to Lower Cost Drugs," *Brookings Institution* (March 28, 2025).

Christen Linke Young and Matthew Fiedler, "Federal Policy Options To Realize the Potential of APCDs," *Brookings Institution* (October 23, 2020).

Aviva Aron-Dine and Christen Linke Young, "Silver-Loading Likely To Continue Following Federal Circuit Decision On CSRs," *Health Affairs* (October 13, 2020).

Christen Linke Young, "A Supreme Court Decision To Strike Down the ACA Would Create Chaos in the Health Care System," *Brookings Institution* (October 13, 2020).

Christen Linke Young and Jason Levitis, "Georgia's Latest 1332 Proposal Continues to Violate the ACA," *Brookings Institution* (September 1, 2020).

Christen Linke Young and Kathleen Hannick, "GAO Report Sheds Additional Light on Misleading and Deceptive Marketing Practices," *Brookings Institution* (September 25, 2020).

Christen Linke Young, James C. Capretta, Stan Dorn, David Kendall, and Joseph R. Antos, "How To Boost Enrollment: Three Practical Steps That Merit Bipartisan Support," *Health Affairs* (August 17, 2020).

Christen Linke Young and Kathleen Hannick, "Fixed Indemnity Health Coverage is a Problematic Form of 'Junk Insurance'," *Brookings Institution* (August 4, 2020).

Loren Adler and Christen Linke Young, "The Laws Governing COVID Test Payment and How To Improve Them," *Brookings Institution* (July 13, 2020).

Christen Linke Young, "Taking a Broader View of Junk Insurance," *Brookings Institution* (July 6, 2020).

Christen Linke Young and Sobin Lee, "Making ACA Enrollment More Automatic for the Newly Unemployed," *Brookings Institution* (May 28, 2020).

Christen Linke Young and Sobin Lee, "How Well Could Tax-Based Auto-Enrollment Work," *Brookings Institution* (April 14, 2020).

Christen Linke Young, Stan Dorn, Loren Adler, Cheryl Fish-Parcham, Tara Straw, "Responding To COVID-19: Using The CARES Act's Hospital Fund To Help The Uninsured, Achieve Other Goals," *Health Affairs* (April 10, 2020).

Christen Linke Young and Kathleen Hannick, "Misleading Marketing of Short-Term Plans Amid COVID-19," *Brookings Institution* (March 24, 2020).

Erica Turret, Abbe R. Gluck, Adam L. Beckman, Suhas Gondi, Sara Rosenbaum, Ruth J. Katz, Kavita K. Patel, Brendan G. Carr. Christen Linke Young, Elizabeth Fowler, Megan L. Ranney, Timothy Jost, and Howard P. Forman, "The Families First Coronavirus Response Act Is Necessary But Not Sufficient – Here's What Congress Should Do Next," *Health Affairs* (March 18, 2020).

Christen Linke Young, "What Do I Do If I Lose My Job Based Health Insurance?," *Brookings Institution* (March 17, 2020).

Matthew Fiedler, Christen Linke Young, and Loren Adler, "What Are the Health Coverage Provisions in the House Coronavirus Bill?," *Brookings Institution* (March 13, 2020).

Christen Linke Young, "There Are Clear Race-Based Inequalities in Health Insurance and Health Outcomes," *Brookings Institution* (February 19, 2020).

Matthew Fiedler, Loren Adler, and Christen Linke Young, "Health Care in President Trump's Fiscal Year 2021 Budget," *JAMA Health Forum* (February 13, 2020).

Christen Linke Young and Jason Levitis, "Georgia's 1332 Waiver Violates the ACA and Cannot Lawfully Be Approved," *Brookings Institution* (January 23, 2020).

Christen Linke Young, "Remanding Texas V. U.S. to the Lower Court Prolongs Harms to Consumers and the Health Care Industry," *Brookings Institution* (January 3, 2020).

Matthew Fiedler, Christen Linke Young, and Fred Dews, "The Biggest Health Care Issues of the 2020 Election," *Brookings Institution* (November 15, 2019).

Christen Linke Young, "The Supreme Court Will Hear a Health Care Case in December, But Its Decision on Risk Corridors Won't Affect the ACA," *Brookings Institution* (November 4, 2019).

Christen Linke Young and Abigail Durak, "How Do We Tackle the Opioid Crisis," *Brookings Institution* (October 18, 2019).

Christen Linke Young, Matthew Fiedler, Loren Adler, and Sobin Lee, "What Is Surprise Billing for Medical Care?" *Brookings Institution* (October 15, 2019).

Matthew Fiedler and Christen Linke Young, "Current Debates in Health Care Policy: A Brief Overview," *Brookings Institution* (October 15, 2019).

Christen Linke Young, "Retroactive Enrollment: A Feasible Way To Bring Auto-Enrollment To The Individual Market," *Health Affairs* (October 10, 2019).

Christen Linke Young, "The Trump DOJ Has Taken an Unexpected and Unworkable Position on the ACA," *Brookings Institution* (September 18, 2019).

Loren Adler, Steven M. Lieberman, Christen Linke Young, and Paul B. Ginsburg, "Considerations for Expanding International Reference Pricing Beyond Medicare Part B," *Brookings Institution* (September 9, 2019).

Christen Linke Young, Matthew Fiedler, Loren Adler, and Sobin Lee, "What Is Surprise Billing?" *Brookings Institution* (August 1, 2019).

Loren Adler, Erin Duffy, Paul B. Ginsburg, Mark Hall, Erin Trish, and Christen Linke Young, "Rep. Ruiz's Arbitration Proposal For Surprise Billing (H.R. 3502) Would Lead To Much Higher Costs And Deficits," *Brookings Institution* (July 16, 2019).

Christen Linke Young, "Federal Surprise Billing Legislation Does Not Violate the Constitution," *Brookings Institution* (July 1, 2019).

Sobin Lee and Christen Linke Young, "Insurance Status Churn and Auto-Enrollment," *Brookings Institution* (June 19, 2019).

Christen Linke Young, Matthew Fiedler, and Jason Levitis, "The Trump Administration's Final HRA Rule: Similar to the Proposed but Some Notable Choices," *Brookings Institution* (June 14, 2019).

Christen Linke Young, "Three Ways To Make Auto-Enrollment Work," *Brookings Institution* (June 13, 2019).

Matthew Fiedler, Henry J. Aaron, Loren Adler, Paul B. Ginsburg, and Christen Linke Young, *Building on the ACA To Achieve Universal Coverage*, 380 N. ENGL. J. MED. 1685 (2019).

Loren Adler, Matthew Fiedler, Paul B. Ginsburg, and Christen Linke Young, "Comments on the Lower Health Care Costs Act Of 2019," *Brookings Institution* (June 6, 2019).

Loren Adler, Matthew Fiedler, Paul B. Ginsburg, and Christen Linke Young, "Comments On The No Surprises Act," *Brookings Institution* (May 29, 2019).

Christen Linke Young, Loren Adler, Paul B. Ginsburg, and Mark Hall, "The Relationship Between Network Adequacy and Surprise Billing," *Brookings Institution* (May 10, 2019).

Christen Linke Young, "Examining Surprise Billing: Protecting Patients from Financial Pain," *Brookings Institution* (April 3, 2019).

Christen Linke Young, "The Trump Administration's New Challenge to the Affordable Care Act," *Brookings Institution* (March 27, 2019).

Loren Adler, Matthew Fiedler, Paul B. Ginsburg, Mark Hall, Erin Trish, Christen Linke Young, and Erin Duffy, "State Approaches To Mitigating Surprise Out-Of-Network Billing," *Brookings Institution* (February 19, 2019).

Christen Linke Young, "Testimony on Texas V. U.S.: The Republican Lawsuit and its Impacts On Americans With Pre-Existing Conditions," *Brookings Institution* (February 6, 2019).

Christen Linke Young, Jason Levitis, and Matthew Fiedler, "Evaluating the Administration's Health Reimbursement Arrangement Proposal," *Brookings Institution* (December 11, 2018).

Christen Linke Young, "The Trump Administration Side-Stepped Rulemaking Processes On The ACA's State Innovation Waivers—And It Could Make Their New Section 1332 Guidance Invalid," *Brookings Institution* (November 28, 2018).

Christen Linke Young, Note, *Pay or Play and ERISA Section 514*, 10 YALE J. HEALTH POL'Y, L. & ETHICS 197 (2009)

Christen Linke Young, Note, *Childbearing, Childrearing, and Title VII*, 118 YALE L.J. 1182 (2009)

Christen Linke Young, *FDA Preemption Inputs in* Riegel v. Medtronic, 118 YALE L.J. POCKET PART 22 (2008)

Christen Linke Young, *State Based Environmentalism*, 117 YALE L.J. POCKET PART 218 (2007)

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.*	No. 25-cv-2114

DECLARATION OF DR. OLUSIMBO IGE

I, Dr. Olusimbo Ige, declare under penalty of perjury as prescribed in 28 U.S.C. § 1746:

1. I am a resident of the City of Chicago ("City" or "Chicago") in the State of Illinois. I am over the age of 18 and have personal knowledge of all the facts stated herein, except to those matters stated upon information and belief; as to those matters, I believe them to be true. If called as a witness, I could and would testify competently to the matters set forth below.

2. I currently serve as Commissioner of Chicago's Department of Public Health ("CDPH"). I have held this position since December 2023. Before my appointment as CDPH Commissioner, I served as the Managing Director of Programs at the Robert Wood Johnson Foundation. There, I oversaw partnerships with health organizations nationwide working towards making public health and health care systems accountable and equitable. Previously, I served as the Assistant Commissioner for the New York City Department of Health and Mental Hygiene, where I provided oversight to a wide range of programs, including New York City's pandemic response, food security programs, housing and health initiatives, mental health programs, violence prevention, and the Public Health Corps initiative.

3. I have a Bachelor of Medicine and Surgery and a Master of Science degree in Epidemiology and Biostatistics from the University of Ibadan in Nigeria. I received a Public Health Master's degree from the University of Manchester in the United Kingdom.

4. As Commissioner of CDPH, I make strategic decisions, in collaboration with the Mayor's Office and stakeholders across the City, to manage public health threats; design and deliver disease control services; and protect the food, air, and environment for 2.7 million Chicago residents.[1] I serve as a liaison and subject matter expert on all related policy matters, and use of authorities and resources to promote and protect public health. I have built and currently manage an executive team of ten professionals, a budget of $750M, and approximately 760 employees, with a dedication to sustaining a strong public health workforce and capacity.

5. CDPH's overarching mission is to work with communities and partners to create an equitable, safe, resilient, and healthy Chicago. While Chicago does not operate a fully integrated health and hospital system, the Department operates seven mental health centers that provide low-barrier services to uninsured and underinsured Chicago residents, four immunization clinics, and three clinics that provide free testing and treatment for sexually transmitted infections. The City also provides certain at-home and in-field health programs, such as nursing home support for pregnant people and newborn babies and directly observed therapy for tuberculosis. Additionally, the City funds and staffs a network of Women, Infants, and Children (WIC) clinics providing nutrition counseling and supplemental food to pregnant, post-partum and breastfeeding women, their infants and children. Collectively, these clinics and services serve thousands of uninsured and underinsured City residents and support the City's safety net for health-related services. Each of these clinics faces greater demand when there is an increase in either the health needs of Chicago

[1] U.S. Census Bureau QuickFacts (V2024). https://www.census.gov/quickfacts/fact/table/chicagocityillinois/HSG010224.

residents or in the number of uninsured or underinsured individuals who cannot obtain those services or other forms of health care elsewhere.

6. I am deeply concerned with CMS's "Patient Protection and Affordable Care Act; Marketplace Integrity and Affordability Final Rule" and its potentially harmful impacts on our residents. In Chicago, nearly one in ten residents is uninsured.[2] The Rule would significantly increase barriers to coverage and the number of uninsured residents, increase health care costs for residents, and further burden the City's health care safety net. Under the guise of increased "integrity" and "affordability," the Rule would implement exactly the opposite. For example, eliminating monthly Special Enrollment Periods for individuals with low incomes to enroll in coverage outside of standard enrollment cycles will make affordable insurance harder to obtain for many Chicago residents. The monthly Special Enrollment Periods are a safeguard for people and families who experience unexpected life events. A single parent in our City working part-time with fluctuating work hours and income too high for Medicaid would lose the ability to enroll in affordable coverage outside of the regular enrollment period.

7. Per our Department's analysis of CMS data, 113,038 Chicagoans are enrolled in Marketplace coverage, and the overwhelming majority (approximately 98,908 residents) receive premium tax credits, or subsidies from the federal government, to make their coverage more affordable.[3] The Inflation Reduction Act of 2022 enhanced these subsidies through the end of 2025 and the average tax credit among Chicagoans enrolled in Marketplace coverage is $431.[4] With the anticipated end of these subsidy enhancements after 2025 leading to higher monthly premiums, the Rule will compound the effect on Marketplace enrollees by allowing insurers to deny new

[2] Chicago Health Atlas. Uninsured rate. https://chicagohealthatlas.org/indicators/UNS?tab=map.
[3] Centers for Medicare and Medicaid Services. 2025 Marketplace Open Enrollment Period Public Use Files. CMS.gov. https://www.cms.gov/data-research/statistics-trends-reports/marketplace-products/2025-marketplace-open-enrollment-period-public-use-files.
[4] *Id.*

coverage for individuals with past-due premiums. This alarming rise in premium costs would lead to potentially thousands of Chicago residents losing health insurance, and thus losing access to preventative services to keep them out of the hospital, primary care, mental health services, and medications, in addition to causing unnecessary and unsafe disruption to residents undergoing active treatment.

8. Residents who lose health coverage would likely delay essential visits – including preventative screenings, primary care appointments, and recommended treatments – until conditions worsen and emergency care and hospital services are needed. This would lead to later-stage disease detection, higher risks of complications exacerbated by untreated chronic diseases, and increased utilization of Chicago's emergency departments and hospitals – increasing uncompensated care and further straining safety net providers in our City beyond repair.

9. The higher the uninsured and underinsured rate, the more that the clinics operated by CDPH and its community-based partners will necessarily have to provide forms of low-barrier and reduced-cost care to patients. In that event, Chicago either must provide the Department and its partners with more funding, or the Department and its partners must decrease the services that they provide. Furthermore, the Department works collaboratively with the State of Illinois, Cook County, and service providers across the City to strengthen resource navigation for Chicago residents who are uninsured and underinsured. The Rule's effects will increase the burden on the City to coordinate essential resources and services across agencies and sectors to ensure that the hardest-to-reach communities receive care.

10. The Department also partners with all hospitals and healthcare organizations in the City through the Healthcare System Preparedness Program, which supports the Chicago Health System Coalition for Preparedness and Response. This program includes coordination of all thirty-five acute care and specialty hospitals, 110 long term care facilities, 50 dialysis centers, all

Federally Qualified Health Centers, and other organizations that provide health care services within the City.

11. This program includes safety net hospitals which, as part of their participation, demonstrate their ability to react to patient surges and complete accreditation requirements. Safety net hospitals provide healthcare for individuals regardless of their insurance status or ability to pay, and typically serve a higher proportion of uninsured, low-income, and other vulnerable individuals than do other hospitals.

12. Chicago's partnership with these hospitals includes financial support such as situational awareness communication, support for data collection and reporting, disaster exercises, clinical trainings, and providing supplies, such as personal protective equipment, mechanical ventilators, and radios. In particular, this program benefits patients during surge events, like the COVID-19 pandemic and other public health emergencies.

13. The Chicago Fire Department provides ambulance transportation services to its residents, including its uninsured and underinsured residents, and regardless of income and insurance status. Chicago generally seeks reimbursement for ambulance services from the patient or, if applicable, the patient's insurer. However, Chicago usually does not receive full reimbursement for ambulance services from its uninsured and underinsured residents. For example, based on our review of Chicago Fire Department ambulance records, in 2024, the City provided 56,556 ambulance transports to Chicago residents for whom no insurance was identified. The City's net charges for these patients were $173,672,181, but the City collected just $5,647,941 – a loss of over $168 million. The Rule would only exacerbate this loss further, and other big cities and jurisdictions will also likely experience similar shortfalls.

14. In Chicago's experience, the uninsured and underinsured disproportionately rely on ambulance services for transport to the emergency department. Such individuals, for instance, are

more likely to wait until their conditions become more severe and then use ambulance services to receive necessary care. A higher number of uninsured and underinsured individuals will therefore result in more ambulance transports for which Chicago does not receive reimbursement and thus must make up for the shortfall in its budget. Aside from these budgetary impacts, Chicago is harmed by the need to care for a population that is increasingly uninsured. When individuals cannot seek medical treatment, they are necessarily less healthy, less productive, and less able to participate in city life – all of which has cascading impacts throughout the City's programs and the community.

15. We are alarmed by the potential harms of this Rule on our City's residents, including our most vulnerable communities for which other forms of health coverage are out of reach. The Rule would significantly degrade access, affordability, and the integrity of Marketplace coverage for our residents.

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

Dated: July 1, 2025

Chicago, Illinois

Dr. Olusimbo Ige

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MARYLAND

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

DECLARATION OF DR. JANET KROMMES

I, Janet Krommes, declare as follows:

1. I am over 18 years old and competent to make this declaration. I have personal knowledge of the facts and information in this declaration. I respectfully provide this declaration to explain why the barriers to insurance and 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 significantly harm DFA members. The rule would create significant hurdles to the provision of standard medical care to patients such that chronic diseases cannot be treated consistently, screening procedures cannot be done, and patients with critical conditions will be lost to follow-up. To address these failings, medical providers will direct more time to providing uncompensated care, more administrative time to determining whether insurance coverage is possible, and more time locating patients who are no longer seeking care for serious conditions.

2. I am a retired rheumatologist and member of DFA. I serve as an impact area leader at DFA. In that role, I use my 35 years of experience in clinical medicine to educate our members on healthcare policy.

3. DFA is a nonpartisan, not-for-profit, 501(c)(3) organization of over 27,000 physicians and medical trainees, including medical residents and students in all 50 states, representing all medical specialties. DFA mobilizes doctors, other health professionals, and medical trainees to be leaders who put patients over politics to improve the health of patients, communities, and the nation. DFA equips physicians and medical trainees with skills and resources to advocate for health care issues at the local, state, and federal level. DFA members include clinicians who provide direct care to patients, those who provide education to other clinicians and trainees, and those who conduct clinical and public health research.

4. DFA's work focuses on access to affordable care, community health and prevention, and health justice and equity. We advocate at the national and state levels for comprehensive health system reform, expansion of health insurance coverage, and improvements to health care delivery so that it better meets our patients' needs.

5. DFA understands that the new Centers for Medicare & Medicaid Services (CMS) rule, "Patient Protection and Affordable Care Act; Marketplace Integrity and Affordability," will increase the cost of health insurance and limit insurance coverage, creating harmful effects for our members and their patients.

6. When health care costs increase and insurance coverage becomes more limited, patients are less likely to seek the medical care they need and more likely to delay care until conditions become serious. The CMS rule would have this effect in communities throughout the country by increasing the number of uninsured and underinsured individuals. Our members would therefore see patients who delay care until their needs are acute; they would receive less than full reimbursement for those patients who lose insurance or whose coverage becomes more limited; and they would lose contact with many patients altogether, particularly in low-income communities.

7. Appropriate medical care includes referral to a specialist when needed, the prescription of medicine as warranted, and recommendation for procedures when necessary. Even when a clinician provides patient care that will go uncompensated—which will occur increasingly if the final rule is implemented—the clinician's work does not end with the visit. Lack of insurance coverage when a patient needs treatment will require finding a specialist willing to provide care, trying to find an alternative medicine that a patient may be able to afford but is not the optimal treatment, and intervening on behalf of a patient in an attempt to get testing or procedures performed. This will take up greater amounts of time as patients lose coverage. The end result is uncompensated time that detracts from patient care.

8. Some patients will be forced to forgo standard medical care despite the efforts of their physician to solve these problems. Some patients will be forced to go to an emergency room. Not only will this strain community resources, but the care will be limited to what an emergency room can provide. The outcomes will be worse, and the cost will be greater.

9. If the CMS rule were to go into effect, therefore, it would cause significant and irreparable injury to DFA members, their patients, and their communities.

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 1st day of July 2025 in Washington, D.C.

Janet J Krommes MD

JANET KROMMES

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MARYLAND

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

DECLARATION OF DR. BETH OLLER

I, Beth Oller, declare as follows:

1. I am over 18 years old and competent to make this declaration. I have personal knowledge of the facts and information in this declaration. I respectfully provide this declaration to explain the devastating effects that the new Centers for Medicare & Medicaid Services (CMS) rule, "Patient Protection and Affordable Care Act; Marketplace Integrity and Affordability," would have on my medical practice, my patients, and my community.

2. I have a Bachelor of Science in Nursing from the University of Kansas and received my medical degree from the University of Kansas School of Medicine. I did my residency at the Wesley Family Medicine Residency Program in Wichita, Kansas. Since completing my residency more than fifteen years ago, I have practiced medicine in Rooks County, Kansas—a rural part of the state with approximately 5,000 residents. I have been a member of DFA since 2022.

3. As a family medicine physician, I care for patients of all ages. My daily practice involves everything from conducting yearly check-ups to treating common illnesses, such as colds and the flu, to screening and treating for conditions such as high blood pressure or diabetes,

to providing comprehensive reproductive healthcare.

4. For more than a decade, I ran a small private practice in Rooks County. Practicing as a family medicine physician in a rural community like mine means seeing many patients who are on Medicare, Medicaid, or uninsured—and many of whom have no other options in our rural community for getting the care that they need. Operating an independent practice became impossible in light of the insurance coverage and payment difficulties that are compounded in my rural community. For the last couple of years, I have practiced as a primary care provider at the Rooks County Health Center. I have a patient panel of more than 800 patients.

5. After the Affordable Care Act (ACA) was enacted in 2010, many patients gained access to health insurance that they could afford for the first time. The ACA had an especially positive effect in states like Kansas, which has not expanded Medicaid coverage, and in rural areas like Rooks County, where many residents are employed by small companies or self-employed, for example, as farmers or ranchers. As a result of getting affordable insurance through the ACA, many of my patients sought preventative care for the first time, which allows patients to identify potential health problems early and get the care they need before conditions become serious and require more acute or emergency care.

6. The new CMS rule would put many of those patients back in the position they were in before: unable to access affordable, comprehensive health insurance and therefore unable to get the preventative care that they need. Because of the administrative red tape that the rule would create and the ways it would limit coverage and ultimately increase costs for individuals, many of my patients would lose their insurance or have their coverage limited as a result of the rule.

7. This rule would have a devastating effect on my practice and my community. Because many of my patients would become uninsured or underinsured, they would be more

likely to opt out of critical preventative care services that my practice provides, hindering my ability to provide optimal care to my patients and jeopardizing their long-term health. For those services that we do provide, we would receive less compensation, as coverage becomes limited (meaning less reimbursement for medical services) and patients cannot pay (meaning no reimbursement for those who lose insurance). And all the red tape means our patients may not even be aware of the changes to their coverage until my practice seeks that reimbursement and it is too late.

8. Patients who are uninsured or underinsured are also more likely to see family medicine physicians for conditions that may normally be provided by a specialist. I regularly perform minor procedures for which I cannot be reimbursed even if the patient is insured because of the barriers and limitations to coverage that the insurance-driven fee schedules create. For example, a patient's coverage may require a mole removal to be performed at a separate appointment from their wellness check, but that patient may not have the means or flexibility to travel to the clinic again for a follow-up appointment. Seeing a specialist is financially out of the question for many of my patients.

9. Uninsured or underinsured patients who forgo or delay the preventive care for which they would normally see a family medicine physician end up with severe or chronic conditions that are not diagnosed or treated until they are forced to seek delayed, emergency care in the hospital. Because those patients are unable to pay, their time in the hospital is uncompensated care. The increase in uncompensated care ultimately increases the cost of healthcare. The increase in uncompensated and undercompensated care that the new rule would cause will force more hospitals and clinics to close, as providers will be unable to make a living, especially in rural areas like mine.

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 1st day of July 2025 in Stockton, Kansas.

BETH OLLER

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MARYLAND

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

DECLARATION OF EDWARD JOHNSON

I, Edward Johnson, 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' challenge to the Centers for Medicare & Medicaid Services rule, "Patient Protection and Affordable Care Act; Marketplace Integrity and Affordability."

2. I am currently the Assistant Public Health Commissioner for External Affairs for the Columbus Department of Public Health ("Columbus Public Health"). I have served as an Assistant Public Health Commissioner for close to three years. Prior to my role as Assistant Public Health Commissioner, I served Columbus Public Health as the Director of Public Health Policy for over four years.

3. As Columbus Public Health's Assistant Public Health Commissioner for External Affairs, I assist the Health Commissioner with representing the needs and concerns of Columbus's residents to protect their health and improve their lives.

4. Plaintiff the City of Columbus is a municipal corporation organized under Ohio law. *See* Ohio Const. art. XVIII. Columbus has all the powers of local self-government and home rule

under the constitution and laws of the state of Ohio, which are exercised in the manner prescribed by the Charter of the City of Columbus.[1]

5. Columbus, located in Franklin County, is the capital of Ohio. It is the largest city in the state and the fifteenth largest city in the United States, with a population of nearly 905,748, according to the 2020 Census.[2]

6. According to 2022 Census estimates, 10.8% of Columbus's population under the age of 65 lacks health insurance.[3]

7. Columbus provides a wide range of services on behalf of its residents, including health services for families and children, public health, public assistance, and emergency medical care.

8. Columbus Public Health employs close to 600 employees who operate more than 90 different public health programs and provide critical services to residents. These programs and services include disease investigation, immunizations, and testing, treatment, and prevention of sexually transmitted infections, among others.[4]

9. Columbus Public Health subsidizes a community health center, which faces greater demand from uninsured or underinsured individuals who cannot obtain health care elsewhere as the uninsured and uninsured rate rises.

10. Columbus Public Health also financially supports PrimaryOne Health, which is a collection of eleven Columbus neighborhood health centers in medically underserved areas. PrimaryOne

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[1] *See City Code and Charter*, City of Columbus, https://library.municode.com/oh/columbus/codes/code_of_ordinances; O.R.C. § 715.01.

[2] *QuickFacts,* U.S. Census Bureau, https://www.census.gov/quickfacts/fact/table/columbuscityohio/PST045224.

[3] *Id.*

[4] *More About Columbus Public Health,* City of Columbus, https://www.columbus.gov/Services/Public-Health/About-Public-Health/About-Columbus-Public-Health.

is designed to be a "system of health center sites throughout Columbus and Franklin County to serve the health care needs of vulnerable, un/under and insured residents within the community."[5] If the rate of uninsured or underinsured individuals increases, then the PrimaryOne Health centers will necessarily see even more patients, and either Columbus will have to provide them with additional funding or they will have to decrease the range of services or patients they are able to cover.

11. Columbus Public Health also operates a number of specialty clinics for alcohol and drug abuse prevention, dental services, family planning, immunizations, sexual health, tuberculosis control, women, infants, and children nutrition, and women's health and wellness.[6] Each of these clinics operates on a free or reduced-fee scale and principally serves the uninsured and underinsured populations.[7] As with PrimaryOne Health, growth in the uninsured and underinsured population will translate to additional costs for Columbus.

12. Columbus also maintains "one of the best Emergency Medical Services (EMS) in the United States," operated by the Columbus Division of Fire.[8] That system dispatches ambulances to meet urgent health needs, regardless of whether the call comes from an individual who has health insurance or is otherwise able to pay for the call.

13. If possible, "[r]eimbursement for the expense of emergency ambulance transport is sought from a patient's Medicare, Medicaid, or commercial health insurance provider."[9] If an individual "live[s] in the City of Columbus and do[es] not have health insurance coverage, [they] will

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[5] *The History of PrimaryOne Health,* PrimaryOne, http://www.primaryonehealth.org/about/.

[6] *See About Columbus Public Health,* City of Columbus, https://www.columbus.gov/Services/Public-Health/About-Public-Health.

[7] *See, e.g., Dental Clinic,* City of Columbus, https://www.columbus.gov/Services/Public-Health/Find-Health-Care-Resources/Dental-Services.

[8] *Division of Fire,* City of Columbus, https://www.columbus.gov/Services/Public-Safety/Fire/About-Us/Reports/EMS-Report.

[9] *Id.*

not receive a bill for transport"; thus, "no Columbus resident will pay anything 'out of pocket' as the result of being transported to a hospital by The Columbus Division of Fire."[10] They will still receive a bill, but it does not get sent to collections. Thus, while Columbus recoups the majority of its costs for transportation for individuals with private insurance, Columbus only recoups a small fraction of its costs for uninsured individuals. For that reason, reimbursements "in no way cover all the costs incurred for treatment and transport."[11]

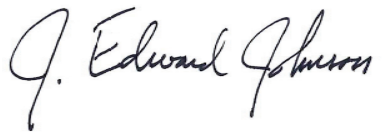
14. An increase in the number of uninsured or underinsured individuals will result in more transports for which Columbus does not receive reimbursement and thus must make up for the shortfall in its budget.

15. Aside from these budgetary impacts, Columbus—a city of over 900,000 people, with an economy of approximately $182 billion—is harmed by the need to care for a population that is increasingly uninsured. When individuals cannot seek medical treatment, they are necessarily less healthy, less productive, and less able to participate in city life. That has ripple effects throughout the City's programs and the community.

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

Dated: July 1, 2025

Columbus, Ohio



EDWARD JOHNSON

[10] *Id.*

[11] *Id.*

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MARYLAND

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

DECLARATION OF FAITH LEACH

I, Faith Leach, 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' Motion for a Preliminary Injunction.

2. I am the Chief Administrative Officer of the City of Baltimore. I have served in this role since March 2023. In my role, I manage the day-to-day government operations across the entire City enterprise, ensuring the effective, eficient, and equitable delivery of City services.

3. Baltimore is the largest city in Maryland and the thirtieth largest city in the United States, with a population of around 568,000 according to 2024 Census estimates.[1]

4. According to 2024 Census estimates, 6.7% of Baltimore's population under the age of 65 lacks health insurance.[2]

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[1] *QuickFacts*, U.S. Census Bureau, https://www.census.gov/quickfacts/fact/table/baltimorecitymaryland/PST045224.

[2] *Id*.

5. The City of Baltimore is a municipal corporation organized pursuant to Articles XI and XI-A of the Maryland Constitution, entrusted with all the powers of local self-government and home rule afforded by those articles.

6. The Baltimore City Health Department (BCHD) is a City agency and the oldest continuously operating health department in the United States. BCHD has wide-ranging responsibilities for providing health services to residents of the City, including those related to acute communicable diseases, chronic disease prevention, HIV/STD, maternal-child health, school health, and senior services. My duties as Chief Administrative Officer include oversight of BCHD, which is staffed by approximately 900 employees and has an annual budget of approximately $200 million.

7. In particular, BCHD operates a number of specialty clinics out of two principal facilities. These include clinics for reproductive health, sexually transmitted diseases, dental and oral health care, and immunizations.[3]

8. The Baltimore City Health Department also provides or subsidizes a number of other services for Baltimore's uninsured and underinsured residents. In particular, the Department funds a visiting-nurse program that makes house calls for older adults, including those with chronic health conditions like diabetes, hypertension, asthma, and mental health disorders. The Department also funds a number of other programs focused on specific health conditions, including a Community Asthma Program, a Tuberculosis Control Program, a Childhood Lead Poisoning Prevention Program, and programs for substance abuse.[4] And the

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[3] *Health Clinics & Services*, Baltimore City Health Department, https://health.baltimorecity.gov/programs/health-clinics-services.

[4] *See*, *e.g.*, *Asthma*, Baltimore City Health Department, https://health.baltimorecity.gov/node/454; *Health Clinics & Services*, Baltimore City Health Department, https://health.baltimorecity.gov/programs/health-clinics-services; *Lead Poisoning*, Baltimore City Health Department,

Department subsidizes a number of other entities that provide services to Baltimore residents, including the Baltimore Family League and Health Care Access Maryland.

9. An increase in the uninsured rate will impose additional burdens on each of these programs and therefore require more funding from the City.

10. The Baltimore City Fire Department (BCFD) also maintains an ambulance system that responds to calls covering 92 square miles with a daytime population exceeding 1,000,000. BCFD's emergency medical service seeks reimbursement for its costs from patients' Medicare, Medicaid, or commercial health insurance, but BCFD answers calls regardless of the individuals' health insurance coverage or ability to pay. In 2023, with a budget of more than $62 million for emergency medical services, BCFD answered over 145,000 emergency medic calls, including 15,398 from uninsured residents. In 2024, BCFD answered roughly the same number of total calls, including 17,259 from uninsured residents.

11. If a patient lacks insurance, BCFD will seek reimbursement from the patient personally, making several attempts to collect on the debt. However, these attempts are rarely successful. While EMS was able to recoup about 90.5% of costs from patients with insurance coverage, it only recovered 3.8% of costs from uninsured patients.

12. Thus, an increase in the number of uninsured and underinsured individuals results in more ambulance calls for which Baltimore does not receive reimbursement and thus must make up for the shortfall in its budget.

13. In addition, as one of the busiest emergency medical services departments in the nation, BCFD's emergency medical service is often taxed beyond its capabilities. Wait times

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https://health.baltimorecity.gov/lead/lead-poisoning; *Substance Use and Misuse*, Baltimore City Health Department, https://health.baltimorecity.gov/programs/substance-abuse; *Tuberculosis*, Baltimore City Health Department, https://health.baltimorecity.gov/node/164.

exceed national rates, and transport units often wait up to an hour to offload patients. To help reduce strain on our overburdened emergency systems, BCFD developed the population health program. BCFD's Population Health Units are a community-focused arm of its EMS Division, designed to improve public health outcomes by delivering care outside the traditional 911-response model. These units are central to Baltimore's shift toward proactive, community-based healthcare. By integrating EMS with public health strategies including harm reduction, in-home care, and transitional support, the unit works to reduce unnecessary 911 calls, emergency department strain, and hospital readmissions, while improving access, equity, and outcomes across vulnerable communities. An increase in the uninsured rate will only increase the avoidable use of acute health services that these programs are designed to address, causing further strain on a system that is already overstretched.

14. Finally, Baltimore—a city of over 560,000 people, at the center of a $259.7 billion regional economy—is harmed by the need to care for a population that is increasingly uninsured. When individuals cannot seek medical treatment, they are necessarily less healthy, less productive, and less able to participate in city life. That has ripple effects throughout the City's programs and the community.

* * *

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

Dated: June 30, 2025.

Baltimore, MD

Faith P. L

Faith Leach

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MARYLAND

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

DECLARATION OF 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 respectfully provide this declaration to 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. When I was 10 years old, I was diagnosed with rheumatoid arthritis. Rheumatoid arthritis is an autoimmune condition that causes inflammation in the joints and damage to various parts of the body, leading to bone degradation. My condition has never been in remission. Since

my diagnosis, I have dependent on substantial medication to treat the condition, including medications that address secondary issues caused by the primary medications.

6. Among other medications, I take a biologic to protect my health by suppressing my immune system, which costs about $10,000 per month. My insurance covers a portion of that medication, and I also qualify for payment assistance through the drug company. I would not be able to afford this medication without health insurance, or with a less comprehensive insurance plan.

7. I know from past experience that the consequences to my health are severe if I am off the biologic for any period of time. Several years ago, when I had my children, I had to stop taking the biologic for a period of time, and my bones quickly began to cripple. I experienced such severe bone damage that I had to have surgery on my left foot, which is now supported by screws and rods. The medication I take is crucial to prevent further such damage.

8. Because of my condition and dependence on unaffordable medication, health insurance has always been crucial to me. Before the Affordable Care Act (ACA), I had to make major life decisions—including my career and personal relationships—based on what would help me keep my health insurance coverage. Among other things, the ACA gave me the freedom to operate my own small business and keep about 10 employees.

9. Because of the ACA, I have been able to enroll in a plan on the individual insurance market through Healthcare.gov. I currently pay about $200 per month, after ACA subsidies, for an insurance plan that provides me access to my critical medications.

10. For my employees who are not on their spouses' insurance plans, I am able to offer up to $150 per month for them to likewise enroll in an insurance plan through the ACA Marketplace.

11. I operate my business on narrow margins. The new Centers for Medicare and Medicaid Services rule will cause my health insurance coverage costs to increase to a level that I cannot afford. These increased costs will likely make it impossible for me to continue by business, as I would be forced either to find different employment with employer-sponsored insurance, or to terminate my business and explore other coverage options through Wisconsin's BadgerCare system.

12. Continuing my business would not be an option in this circumstance, because I need to have access to affordable insurance that will cover the medications I need. My employees may also lose their jobs, and they may also lose access to affordable coverage through the Exchange.

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

Executed this 30th day of June 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

DECLARATION OF SHAWN PHETTEPLACE

I, Shawn Phetteplace, declare as follows:

1. I am the National Campaigns Director at Main Street Alliance ("MSA"). I have held that position since 2023, and have been on staff with MSA since 2020. In my role as national campaigns director, I work closely with MSA's small business members. I make this statement based on personal knowledge and if called as a witness could and would testify competently thereto.

2. MSA is a § 501(c)(3) organization and national network of small businesses, with approximately 30,000 members throughout the United States. MSA helps small business owners realize their full potential as leaders for a just future that prioritizes good jobs, equity, and community through organizing, research, and policy advocacy. MSA also seeks to amplify the voices of its small business membership by sharing their experiences with the aim of creating an economy where all small business owners have an equal opportunity to succeed.

3. Many of MSA's members rely on the ACA marketplace for health insurance. According to a recent survey, over 45% of MSA members access health insurance either through the marketplace or Medicaid.

4. Those members will be negatively impacted by the new Centers for Medicare & Medicaid Services (CMS) rule, "Patient Protection and Affordable Care Act; Marketplace Integrity and Affordability," which will increase the cost of health insurance and limit insurance coverage. The financial and health impact of the rule will cause direct harm to MSA members, their families, and their businesses.

5. The erosion of coverage under the new rule will create additional costs for MSA members and negatively impact the health of those who rely on care or medication that they cannot afford without insurance coverage. The increase in costs will even threaten the continued operation of some MSA members. Small businesses often operate on small profit margins, so if health insurance through the marketplace becomes unaffordable or inadequate, then owners and their employees may be forced to seek alternative employment to have access to employer-sponsored health insurance.

6. MSA's founding was directly focused on the passage of the Affordable Care Act, and the organization has remained focused on the subsequent strengthening of the law over the past 15 years. The new CMS rule undermines the hard-fought legislative victories that MSA helped to secure.

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 30th day of June 2025 in Madison, Wisconsin.

SHAWN PHETTEPLACE