IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MARYLAND

CITY OF COLUMBUS *et al.*,

Plaintiffs,

v.

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

Defendants.

Case No. 1:25-cv-2114

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

TABLE OF CONTENTS

INTRODUCTION 1

ARGUMENT 2

I. The Provisions That Erode the Value of Coverage Should Be Set Aside 2

A. The Imposition of the Junk Fee Is Unlawful and Arbitrary 2

B. The Revised Premium Adjustment Methodology Is Unlawful and Arbitrary 5

C. The New Actuarial Value Policy Is Arbitrary 10

II. The Provisions That Impose Barriers on Enrollment Should Be Set Aside 12

A. The Rule Unlawfully and Arbitrarily Revokes the Act's Guarantee That Anyone Can Buy Insurance 12

B. The Shortened Open Enrollment Period Is Arbitrary 15

C. The Verification Requirements for SEP Enrollments Are Arbitrary 16

III. The Provisions That Limit the Availability of Subsidized Coverage Should Be Set Aside 17

A. The Failure-to-Reconcile Policy Is Unlawful and Arbitrary 17

B. The New Data-Matching Policies Are Arbitrary 20

IV. This Court Should Set Aside the Challenged Provisions of the Rule 25

CONCLUSION 26

TABLE OF AUTHORITIES

Cases

Air Alliance Houston v. EPA, 906 F.3d 1049 (D.C. Cir. 2018) 3, 18

Appalachian Voices v. State Water Control Bd., 912 F.3d 746 (4th Cir. 2019) 5, 15

Azar v. Allina Health Servs., 587 U.S. 566 (2019) 10

Bilski v. Kappos, 561 U.S. 593 (2010) 21

Bittner v. United States, 598 U.S. 85 (2023) 13

Caraco Pharm. Lab'ys, Ltd. v. Novo Nordisk A/S, 566 U.S. 399 (2012) 7

Children's Hosp. Ass'n of Tex. v. Azar, 933 F.3d 764 (D.C. Cir. 2019) 22

Chocolate Mfrs. Ass'n of U.S. v. Block, 755 F.2d 1098 (4th Cir. 1985) 5

City of Columbus v. Cochran, 523 F. Supp. 3d 731 (D. Md. 2021) .... *passim*

City of Columbus v. Kennedy, 796 F. Supp. 3d 123 (D. Md. 2025) .... *passim*

City of Columbus v. Trump, 453 F. Supp. 3d 770 (D. Md. 2020) 9

Caraco Pharm. Lab'ys, Ltd. v. Novo Nordisk A/S, 566 U.S. 399 (2012) 6

Corner Post, Inc. v. Bd. of Governors of Fed. Res. Sys., 603 U.S. 799 (2024) 25

Culbertson v. Berryhill, 586 U.S. 53 (2019) 8

Dep't of Com. v. New York, 588 U.S. 752 (2019) 17

Fishermen's Dock Co-op. v. Brown, 75 F.3d 164 (4th Cir. 1996) 17

Holland v. Pardee Coal Co., 269 F.3d 424 (4th Cir. 2001) 4

Judulang v. Holder, 565 U.S. 42 (2011) 9

King v. Burwell, 576 U.S. 473 (2015) 6-8

Koons Buick Pontiac GMC, Inc. v. Nigh, 543 U.S. 50 (2004) 21

Kravitz v. Dep't of Com., 366 F. Supp. 3d 681 (D. Md. 2019) 10

Merck & Co. v. U.S. Dep't of Health & Hum. Servs., 962 F.3d 531 (D.C. Cir. 2020) 3, 18

Merit Mgmt. Grp., LP v. FTI Consulting, Inc., 583 U.S. 366 (2018) 20

N.C. Growers' Ass'n v. United Farm Workers, 702 F.3d 755 (4th Cir. 2012) 10

Neumann v. Prudential Ins. Co. of Am., 367 F. Supp. 2d 969 (E.D. Va. 2005) 3

New York Stock Exch. LLC v. SEC, 962 F.3d 541 (D.C. Cir. 2020) 18

Ohio v. EPA, 603 U.S. 279 (2024) 14

Perez v. Cuccinelli, 949 F.3d 865 (4th Cir. 2020) 8, 22

Perez v. Mountaire Farms, Inc., 650 F.3d 350 (4th Cir. 2011) 11

Peter Pan Bus Lines, Inc. v. Fed. Motor Carrier Safety Admin.,
471 F.3d 1350 (D.C. Cir. 2006) 8

Sierra Club v. Dep't of Interior, 899 F.3d 260 (4th Cir. 2018) 11, 14, 22, 23, 25

Sierra Club v. U.S. Army Corps of Eng'rs, 909 F.3d 635 (4th Cir. 2018) 25

Trump v. CASA, Inc., 606 U.S. 831 (2025) 25

Vencor Hosps., Inc. v. Standard Life & Acc. Ins. Co., 279 F.3d 1306 (11th Cir. 2002) 21

Wis. Dep't of Revenue v. William Wrigley, Jr., Co., 505 U.S. 214 (1992) 11

Statutes

5 U.S.C. § 706 .... 2, 25

26 U.S.C. § 36B(b) 2

26 U.S.C. § 36B(f) 18

42 U.S.C. § 300gg(a) 13

42 U.S.C. § 300gg-1(a) 12

42 U.S.C. § 300gg-1(b) 12

42 U.S.C. § 300gg-1(d) 12

42 U.S.C. § 300gg-2(a) 12

42 U.S.C. § 300gg-2(b) 12

42 U.S.C. § 300gg-6 7

42 U.S.C. § 300gg-6(a) 3

42 U.S.C. § 18022(c) 6, 8-9

42 U.S.C. § 18022(d) 10, 11

42 U.S.C. § 18031(c) 16

42 U.S.C. § 18041 18

42 U.S.C. § 18081 .... 19, 20

42 U.S.C. § 18081(a) 2, 3, 18

42 U.S.C. § 18081(c) 20, 21, 24

42 U.S.C. § 18081(e) 20, 22

42 U.S.C. § 18081(f) 3, 18

42 U.S.C. § 18082 19

42 U.S.C. § 18082(a) 2

42 U.S.C. § 18082(c) 3

Regulations

45 C.F.R. § 147.102 7

45 C.F.R. § 147.116 7

45 C.F.R. § 147.126 7

45 C.F.R. § 155.304(f) 19

45 C.F.R. § 155.305(f) 18-19

45 C.F.R. § 155.315(f) 21

45 C.F.R. § 155.340(c) 18

45 C.F.R. § 155.410(e) 15

45 C.F.R. § 155.420(g) 16

45 C.F.R. § 156.135(a) 10

45 C.F.R. § 156.140(c) 10

Other Authorities

79 Fed. Reg. 13,744 (Mar. 11, 2014) 6

86 Fed. Reg. 24,140 (May 5, 2021) 6

88 Fed. Reg. 25,740 (Apr. 27, 2023) 21

90 Fed. Reg. 12,942 (Mar. 19, 2025) 9, 10

90 Fed. Reg. 27,074 (June 25, 2025) ..... *passim*

91 Fed. Reg. 6292 (Feb. 11, 2026) 6, 17-18, 23-24

Ctrs. for Mediare & Medicaid Servs., Ctr. for Consumer Info. & Ins. Oversight, *Premium Adjustment Percentage, Maximum Annual Limitation on Cost Sharing, Reduced Maximum Annual Limitation on Cost Sharing, and Required Contribution Percentage for the 2027 Benefit Year* (Jan. 29, 2026), https://perma.cc/LUK4-UQ2D 6

H.R. REP. NO. 111-433 (2010), *as reprinted in* 2010 U.S.C.C.A.N. 123, 133 7

Kaiser Family Found., *Why Premiums Will Change for People Who Now Have Nongroup Insurance* (2013), https://perma.cc/GM7C-NEFE 7

U.S. Dep't of Labor, *Selected Medical Benefits: A Report from the Department of Labor to the Department of Health and Human Services* (2011), https://perma.cc/QDP4-8K74 7

INTRODUCTION

The Centers for Medicare & Medicaid Services (CMS) committed a hodgepodge of errors when it rushed to issue its rule shortly before enrollment opened on the Affordable Care Act's (ACA) Exchanges for 2026. In some instances, such as its attempt to revoke the ACA's promise that insurance coverage will be available for all comers, the agency asserted statutory powers that it doesn't have. In other instances, such as its revocation of a policy affording enrollees more time to demonstrate their eligibility for insurance subsidies, the agency failed to recognize the statutory authorities that it does have. And in yet other instances, CMS may have understood the scope of its discretion, but it fell short of basic requirements of reasoned decision-making. There is a common thread to all of the agency's errors, however. In each instance, CMS chose to make it harder to obtain health insurance coverage on the Exchanges, inflate the cost of that coverage, and drive people out of insurance coverage altogether.

These new policies would impose grave harm on Plaintiffs if they were permitted to go into effect. 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. Doctors for America's members are clinicians across the nation, who similarly would be left to make up the cost of uncompensated care for their uninsured and underinsured patients. And 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.

CMS chose to impose these burdens largely in reliance on a report prepared by the Paragon Health Institute, which asserted that extreme measures were justified to combat a supposed problem of improper enrollments, even if these measures would lead to dropped coverage and

higher costs. But that report was fundamentally mistaken, for the reasons that commenters explained in detail to the agency during the rulemaking and that we reiterated in our opening brief. CMS made no effort to defend its reliance on the Paragon report either in its final rule or in its summary judgment brief. Its silence speaks volumes.

Accordingly, Defendants' summary judgment motion should be denied, and Plaintiffs are entitled to summary judgment with respect to each of their challenges to the provisions in the final rule that place burdens on the availability and costs of coverage on the Exchanges. For the reasons explained below, each of the challenged provisions is contrary to law, arbitrary and capricious, or both. Plaintiffs further respectfully request that the Court vacate these provisions on a nationwide basis, rather than merely enjoining particular applications of the rule against individual parties, given that this Court's judgment setting aside these provisions under 5 U.S.C. § 706 necessarily will operate on the rule itself. Plaintiffs respectfully ask the Court (as have Defendants in their summary judgment motion) for a ruling on the cross-motions for summary judgment by the end of May, so as to account for planning for the upcoming 2027 plan year.[1]

ARGUMENT

I. The Provisions That Erode the Value of Coverage Should Be Set Aside

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

The Affordable Care Act subsidizes health insurance coverage through tax credits and advance premium tax credits (APTCs), which are set by a statutory formula. 26 U.S.C. § 36B(b); 42 U.S.C. §§ 18081(a)(1), 18082(a)(1). CMS invoked its authority over procedures to "determine"

[1] CMS no longer disputes whether Main Street Alliance or the Cities have standing to challenge the final rule. In a footnote, the agency preserves its objections to the standing of Doctors for America (DFA). Defs.' Mem. in Supp. of Their Cross-Mot. for S.J. 5 n.2, ECF No. 68-1 ("Defs.' Br."). Plaintiffs maintain that DFA also has standing, for the reasons they have expressed in prior briefing. *See* Pls.' Mem. in Supp. of Their Mot. to Stay 40-42, ECF No. 11-1; Pls.' Reply in Supp. of Their Mot. to Stay 2-5, ECF No. 30.

or to "redetermine" eligibility for APTCs, 42 U.S.C. § 18081(a), (f), to revise the statutory formula to reduce payments for certain enrollees. The agency has authority, however, only to determine if the statutory criteria are met, not to *change* those criteria. Its rule imposing a junk fee is therefore unlawful. *See Neumann v. Prudential Ins. Co. of Am*., 367 F. Supp. 2d 969, 975 (E.D. Va. 2005) (authority to "determine" eligibility does not include the power to change eligibility standards).

CMS defends this rule through a convoluted line of reasoning. Defs.' Br. 9-10. By imposing a $5 surcharge on enrollees whose APTCs would otherwise fully cover their premiums, the agency reasons, the rule will prompt some of these enrollees to contact the Exchange to try to lift the surcharge, which they could accomplish by providing updated personal information to the Exchange. Because that new information could then be used to determine the enrollee's eligibility for APTCs, the fee qualifies as a procedure for redetermining eligibility, in the agency's telling.

This argument proves far too much. On this logic, any rule that prompts an enrollee to communicate information to an Exchange would fall within CMS's authority to set determination procedures. Under this theory, for example, CMS could override the ACA's guarantee of coverage for essential health benefits, *see* 42 U.S.C. § 300gg-6(a), and permit an insurer to refuse to cover a hospital stay until an enrollee submits a new form to the Exchange. CMS cannot negate statutory guarantees in this way. *See City of Columbus v. Kennedy*, 796 F. Supp. 3d 123, 150 (D. Md. 2025) (*City of Columbus III*); *see also Merck & Co. v. U.S. Dep't of Health & Hum. Servs*., 962 F.3d 531, 541 (D.C. Cir. 2020) ("Although the Secretary's regulatory authority is broad, it does not allow him to move the goalposts to wherever he kicks the ball."); *Air Alliance Houston v. EPA*, 906 F.3d 1049, 1061 (D.C. Cir. 2018) ("[I]t is well established that an agency may not circumvent specific statutory limits on its actions by relying on separate, general rulemaking authority.").

What's more, the ACA directs that the Treasury Department (not CMS) "shall" pay APTCs in the amount that is set by statute. 42 U.S.C. § 18082(c)(2). The statute's use of the mandatory

term "shall" deprives Treasury of discretion to pay anything other than the statutory amount, *see Holland v. Pardee Coal Co*., 269 F.3d 424, 431 (4th Cir. 2001), but under the rule Treasury will necessarily underpay APTCs for certain enrollees as a result of CMS's miscalculation of the amount owed. CMS responds that the rule "will not necessarily interfere" with Treasury's ability to make APTC payments, Defs.' Br. 9-10, but this misses the point; Treasury's duty is not simply to make a payment in some amount, it is to make a payment in the amount established by the statute.

The junk fee rule is arbitrary as well as unlawful. CMS sought to minimize commenters' concerns by describing the junk fee as a "nominal" amount that would not cause "undue financial hardship" on enrollees. 90 Fed. Reg. 27,074, 27,107 (June 25, 2025). But the agency didn't engage with commenters' main point: even seemingly small additional charges will depress enrollment by low-income consumers, and younger and healthier people will be more likely to drop coverage, worsening the risk pool for everybody else. *See* Pls.' Mem. in Supp. of Their Mot. for S.J. 23-24, ECF No. 65-1 ("Pls.' Br.").

CMS belatedly concedes this point and argues that these harms are worthwhile to combat the problem of "improper enrollments." Defs.' Br. 11. But the agency's analysis on this score tracked that of a report prepared by the Paragon Health Institute. We comprehensively explained in our opening brief (as did commenters during the rulemaking proceedings) that this analysis was fundamentally flawed. The report looked to the wrong sets of data when it attempted to calculate improper enrollments in the Exchanges, it ignored the success of the agency's more recent efforts to address insurance broker misconduct, and its findings could not support the measures that CMS ended up adopting that punish enrollees, not brokers. *See* Pls.' Br. 12-14. CMS offers no defense of the report's analysis in its brief. Because the agency "made no attempt to refute, mitigate, or explain away" commenters' concerns that challenged the "fundamental premise" of its rule, it

acted arbitrarily in violation of the APA. *City of Columbus v. Cochran*, 523 F. Supp. 3d 731, 752 (D. Md. 2021) (*City of Columbus II*).

We have also explained that the junk fee will create confusion among enrollees who will not understand why they are subject to a surcharge. Pls.' Br. 24. CMS blithely responds that there will be "sufficient time" to educate enrollees about the new rule, Defs.' Br. 11, but it fails entirely to engage with the point raised by commenters that there won't be personnel in place to provide this education, given the agency's own actions this year to eviscerate the ACA's Navigator program. By ignoring this "important aspect[] of the problem," CMS acted arbitrarily for this reason as well. *Appalachian Voices v. State Water Control Bd.*, 912 F.3d 746, 753 (4th Cir. 2019).

Moreover, CMS violated notice-and-comment requirements by adopting a one-year policy, for 2026 only, that departed from its proposal for a permanent policy.[2] The agency reasons that, because it could have decided not to adopt the policy at all, it must have been foreseeable that it would take the lesser step of adopting the policy for only one year. Defs.' Br. 10. But this misses the point: the on-again-off-again policy created unique burdens for stakeholders by forcing them to incur a second round of administrative costs to implement a different rule for 2027. Commenters did not have the chance to address the irrationality of this approach, and CMS should have reopened the comment period before springing this surprise on the public. *See Chocolate Mfrs. Ass'n of U.S. v. Block*, 755 F.2d 1098, 1105 (4th Cir. 1985).

B. The Revised Premium Adjustment Methodology Is Unlawful and Arbitrary

The Act directs CMS to calculate an annual "premium adjustment percentage" that is used to update maximum limits on cost-sharing, with the same formula used to update the value of

[2] CMS committed the same procedural error with respect to the verification of enrollment during special enrollment periods, its failure-to-reconcile policy, and its data-matching policies, discussed *infra*, pp. 16-17, 17-19, and 20-24.

premium tax credits. 42 U.S.C. § 18022(c)(4). CMS adopted a new methodology to calculate this adjustment that necessarily will increase costs, and decrease the value of tax credits, for enrollees in the Exchanges. *See* Pls.' Br. 25-26.[3] CMS historically has calculated the premium adjustment percentage by referring to the growth rate in employer-sponsored insurance, but in the final rule the agency chose to incorporate data from the individual health insurance market as well. The agency deliberately chose a method that would impose higher costs on enrollees, departing from the ACA's core statutory purpose of lowering the cost of coverage. *See King v. Burwell*, 576 U.S. 473, 479 (2015).

The agency's change in methodology was unlawful. Section 18022(c)(4) requires CMS to compare average premiums for two years for equivalent coverage. *See* Pls.' Br. 26-27; *King*, 576 U.S. at 487. But the individual health insurance market is fundamentally different today from the market that existed in 2013, before the ACA's market reforms went into effect. So any measurements of premiums for individual policies in 2013 wouldn't capture the cost of "health insurance coverage" within the meaning of the ACA, as CMS historically has recognized. *See* 86 Fed. Reg. 24,140, 24,234 (May 5, 2021) (explaining that the use of employer-sponsored insurance to measure the premium adjustment percentage "aligns with the statutory language"); 79 Fed. Reg. 13,744, 13,801 (Mar. 11, 2014) (same). Because the coverage available on the individual market in 2013 "differ[ed] in [a] meaningful way," *King*, 576 U.S. at 487, from the coverage available on

[3] CMS has issued a notice of proposed rulemaking setting forth policies for the Exchanges for the 2027 plan year, in which the agency proposes to retain the premium adjustment methodology that it adopted in the final rule. 91 Fed. Reg. 6292, 6370 (Feb. 11, 2026). Under this methodology, the maximum annual limitation on cost-sharing would increase by 13.2 percent from 2026 to 2027, to $12,000 for self-only coverage and $24,000 for family coverage. CMS, Ctr. for Consumer Info. & Ins. Oversight, *Premium Adjustment Percentage, Maximum Annual Limitation on Cost Sharing, Reduced Maximum Annual Limitation on Cost Sharing, and Required Contribution Percentage for the 2027 Benefit Year* (Jan. 29, 2026), https://perma.cc/LUK4-UQ2D.

that market now, data on health insurance premiums from that year cannot usefully be compared to data on health insurance premiums in that market today.

CMS responds primarily that, if Congress intended this result, "it could easily have been more specific." Defs.' Br. 13-14. "But the mere possibility of clearer phrasing cannot defeat the most natural reading of a statute." *Caraco Pharm. Lab'ys, Ltd. v. Novo Nordisk A/S*, 566 U.S. 399, 416 (2012). "That is especially so because we can turn this form of argument back around on [CMS]", *id.*; Congress also easily could have written the statute to specify the result that the agency now prefers. This Court's obligation is to read the statute as it was written, and that text requires the comparison of the cost of equivalent coverage between 2013 and the present day.

CMS further argues that coverage in the large-group market has also changed as a result of the ACA's reforms. Defs.' Br. 14 (citing 45 C.F.R. §§ 147.102, 147.116, 147.126). But the ACA fundamentally transformed the individual health insurance market; in contrast, the Act's consumer protections reforms for employer-sponsored insurance were more incremental and limited. *See* H.R. REP. NO. 111-443, pt. I, at 209 (2010), *as reprinted in* 2010 U.S.C.C.A.N. 123, 133. For instance, 42 U.S.C. § 300gg-6 requires insurers that offer "health insurance coverage" in the individual or small group markets to cover the essential health benefits package, consisting of at least ten benefit categories, beginning in 2014. Many of these benefits were regularly excluded from individual policies available in 2013, but were already generally covered by employer plans. *Compare* Kaiser Family Found., *Why Premiums Will Change for People Who Now Have Nongroup Insurance* (2013), https://perma.cc/GM7C-NEFE, *with* U.S. Dep't of Labor, *Selected Medical Benefits: A Report from the Department of Labor to the Department of Health and Human Services* (2011), https://perma.cc/QDP4-8K74. The individual insurance market was thus "meaningful[ly]" "different," *King*, 576 U.S. at 487, before and after 2014 in a way that the market for employer-sponsored insurance was not.

CMS next argues that "the term 'health insurance coverage' only appears in the first half of [Section 18022](c)(4)." Defs.' Br. 14. But this simply misreads the statute, which, again, requires a comparison of "the average per capita premium for health insurance coverage in the United States for the preceding calendar year" with "such average per capita premium for 2013." 42 U.S.C. § 18022(c)(4). By using the term "such," Congress referred to what had "just been mentioned," *King*, 576 U.S. at 487, meaning that Congress intended a calculation of the cost of qualifying "health insurance coverage" in 2013. *See also Culbertson v. Berryhill*, 586 U.S. 53, 59 (2019) ("the adjective 'such' means '[o]f the kind or degree already described or implied'"). So the statute directs the agency to compare like to like.

Finally, the agency contends that it has greater discretion to "determine" average premiums for 2013 than it does to "estimate" current average premiums. Defs.' Br. 15. But it fails to identify any meaningful distinction between those two terms, both of which depend on a calculation of a definitive figure. Congress most likely used differing terminology because it directed that the calculation of 2013 premiums would be performed after the fact, while it contemplated that the calculation of "the average per capita premium for health insurance coverage in the United States for the preceding calendar year" would be performed before that year was complete. 42 U.S.C. § 18022(c)(4).

CMS therefore adopted an approach that the statue forbids, and its change to the premium adjustment percentage methodology must be vacated. Alternatively, because the agency (apparently) wrongly believed that the statute compelled it to adopt a policy, this error requires vacatur of the rule. *See Perez v. Cuccinelli*, 949 F.3d 865, 873 (4th Cir. 2020) (en banc); *see also Peter Pan Bus Lines, Inc. v. Fed. Motor Carrier Safety Admin.*, 471 F.3d 1350, 1354 (D.C. Cir. 2006).

In any event, the rule is arbitrary and capricious as well. Even if the statute did leave any

room for the agency to select a methodology, CMS abused that discretion. The foregoing discussion should show that, at the very least, Section 18022(c)(4) does not require the result that CMS adopted. But the agency nonetheless reasoned that its hands were tied as a "consequence of *Congress's* decision to tie the value of certain forms of financial assistance under the ACA to the premium adjustment percentage," Defs.' Br. 16 (emphasis in original), and on that basis refused to consider the ACA's central purpose when it decided whether it should impose higher or lower costs on consumers. 90 Fed. Reg. at 27,172; *see also* 90 Fed. Reg. 12,942, 12,990 (Mar. 19, 2025) (proposed rule). This was per se error, as the requirements of reasoned decision-making under the APA always demand that an agency take its statute's purposes into account when it formulates policy, and require that the agency reasonably explain why it chose not to further that purpose, rather than falling back on an incorrect claim that the statute required its preferred result. *See Judulang v. Holder*, 565 U.S. 42, 64 (2011) (invalidating rule that was "unmoored from the purposes and concerns" of the statute).

CMS also generally asserted a need to adopt a more "accurat[e]" measure, Defs.' Br. 15, but it entirely failed to engage with the point raised by commenters that the new methodology would be *less* accurate, since it incorporated data from individual insurance premiums in 2013 that wouldn't provide an apples-to-apples measure of growth in health care costs, but that would inevitably inflate the premium adjustment percentage. *See, e.g.*, Jason Levitis et al. comment at 3 (Apr. 11, 2025), AR33743; Ctr. on Budget & Policy Priorities comment at 34 (Apr. 11, 2025), AR31785. Because CMS both "failed to consider an important part of the problem" and also "offered an explanation [for its rule] that was contradicted by the evidence before the agency," it acted arbitrarily. *City of Columbus v. Trump*, 453 F. Supp. 3d 770, 794 (D. Md. 2020) (*City of Columbus I*).

CMS also rendered the notice-and-comment process an empty formality by displaying an unalterably closed mind on this topic (as well as the topic of permissible variations in actuarial value calculations, discussed *infra*, pp. 10-12), when it expressly declared in the proposed rule that it would ignore adverse comments. 90 Fed. Reg. at 12,989–90. This candid admission explains why it chose to depart from the "APA minimum of 30 days" for comment. *Azar v. Allina Health Servs*., 587 U.S. 566, 570 (2019); *see also N.C. Growers' Ass'n v. United Farm Workers*, 702 F.3d 755, 770 (4th Cir. 2012). And in March it published a "final" actuarial-value calculator that treated the proposed rule as if it were currently in effect, which—far from serving merely as a "proposal," as CMS now would have it, Defs.' Br. 16—insurers were r*equired* to use in preparing their rates. *See* 45 C.F.R. § 156.135(a). Each of these points shows that the agency had a "predetermined answer," *Kravitz v. Dep't of Com*., 366 F. Supp. 3d 681, 750 (D. Md. 2019), and that it treated its solicitation of comments as mere window dressing.

C. The New Actuarial Value Policy Is Arbitrary

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

This greatly exceeds CMS's limited authority "to provide for a de minimis variation in the actuarial valuations used in determining the level of coverage of a plan to account for differences in actuarial estimates." 42 U.S.C. § 18022(d)(3). The rule is far from "de minimis"; it will cut tax

credits by more than a billion dollars and raise health care costs for a typical family by more than $700 a year. Pls.' Br. 29. CMS does not even try to square its rule with the language of Section 18022(d)(3). It instead suggests that it need not be bound by that language because it understands "its statutory obligation" in a "more holistic light." Defs.' Br. 19; *see also id.* 18 (suggesting that the statute allows for "some play in the joints"). The scope of the agency's discretion, however, is defined by the statutory text itself. Actuarial estimates are imprecise, and so Congress allowed for the possibility that there may be some variance in comparing plans with different cost-sharing structures. There may be room to argue over how much "de minimis variation" is permissible to account for these differences, or even over what additional factors the agency could take into account so long as it is also considering the statutorily required factors, but certainly a rule that all but completely erases the distinction between bronze and silver coverage exceeds the agency's authority. *See Wis. Dep't of Revenue v. William Wrigley, Jr., Co.*, 505 U.S. 214, 232 (1992); *Perez v. Mountaire Farms, Inc.*, 650 F.3d 350, 378 (4th Cir. 2011) (Wilkinson, J., concurring in part and concurring in the judgment).

CMS seeks to justify this rule as one that would "promote competition." Defs.' Br. 18-19. An insurer may indeed have a competitive edge if it could call a plan "silver" even if it requires the enrollee to pay more than 10% more in cost sharing than what is permitted under the statutory standard for such a plan. But in any event, this is not the form of competition among insurers that Congress sought to promote; it instead instructed CMS to provide for plans at specified actuarial values, with an allowance for minimal variation to account for differences in actuarial estimates. The agency acted arbitrarily, then, by relying on a factor that "Congress has not intended it to consider." *Sierra Club v. Dep't of Interior*, 899 F.3d 260, 293 (4th Cir. 2018).

CMS also brushed off concerns that the rule would cause enrollees to drop coverage, and will lead to increased costs across the board, since the amount of tax credits available for anybody

turns on the cost of the second lowest cost silver plan. *See* Pls.' Br. 29. The agency attempts to defend the rule as one designed to bring unsubsidized enrollees into the market by offering plans with lower premiums and less generous coverage. Defs.' Br. 20. But the final rule stated simply that CMS "expected" the rule would lower premiums in the long run by drawing in healthier, unsubsidized enrollees. 90 Fed. Reg. at 27,177. Apart from that conclusory statement, CMS failed entirely to engage with commenters who raised the substantial body of empirical research showing that, on balance, a reduction in subsidies will cause healthier people to drop out of coverage, resulting in a weaker risk pool and higher premiums, even if some unsubsidized people are drawn into coverage by the cheaper plan with less generous coverage. *See, e.g.*, Ctr. on Budget & Policy Priorities comment at 34–35 (Apr. 11, 2025), AR31785–31786; Jason Levitis *et al*. comment at 5 (Apr. 11, 2025), AR33745. "Such nodding to concerns raised by commenters only to dismiss them in a conclusory manner is not a hallmark of reasoned decisionmaking." *City of Columbus III*, 796 F. Supp. 3d at 156. The rule is invalid for the reason as well.

II. The Provisions That Impose Barriers on Enrollment Should Be Set Aside

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

The Affordable Care Act ensures the availability of health insurance coverage by imposing overlapping "guaranteed issue" and "guaranteed renewability" obligations on insurers in the individual market. Under the "guaranteed issue" provision, an insurer must "accept every … individual" who applies for coverage, 42 U.S.C. § 300gg-1(a), subject to certain exceptions, which don't include the existence of any outstanding debt, *id.* § 300gg-1(b)-(d). Under the "guaranteed renewability" provision, an insurer must renew or continue in force existing coverage at the individual's option, subject to certain exceptions, including the nonpayment of premiums. *Id.* § 300gg-2(a), (b)(1). CMS confused the two statutes by adopting a rule permitting insurers to

refuse to issue coverage to an enrollee who owes a back debt for premiums. The agency wasn't free to rewrite Sections 300gg-1 and 300gg-2 in this way. *See* Pls.' Br. 31-32.

CMS compounds this error in its summary judgment brief, again citing Section 300gg-2, the guaranteed renewability provision, as support for its attempt to add a new exception to Section 300gg-1, the guaranteed issue provision. Defs.' Br. 23. This approach is squarely precluded by the statute. *See Bittner v. United States*, 598 U.S. 85, 94 (2023) ("When Congress includes particular language in one section of a statute but omits it from a neighbor, we normally understand that difference in language to convey a difference in meaning."); *see also City of Columbus III*, 796 F. Supp. 3d at 157.

CMS further points to regulatory provisions that establish that an enrollee effectuates new coverage by making a "binder payment" for the first month of coverage. Since an enrollee must pay for new coverage, CMS posits, an insurer should also be permitted to apply any payments from the enrollee to old debts before any payment is applied to the cost of new coverage. Defs.' Br. 23. But, again, this logic flies in the face of the language of Section 300gg-1, which requires insurers to accept every individual who applies for coverage, without any exception for outstanding debts. And to the extent that CMS now intends to defend this rule as one that permits insurers to charge different first-month premiums to different enrollees, the rule independently violates 42 U.S.C. § 300gg(a), which requires insurers to set uniform premiums for all enrollees (subject to certain statutory exceptions, which don't include past debts).

The rule is also arbitrary. Commenters submitted empirical evidence showing that as many as 180,000 people would lose coverage under this rule, placing greater burdens on providers of last resorts such as health clinics operated by municipalities, like Plaintiff Cities. *See* Pls.' Br. 33. CMS acknowledges that many of these people may have an outstanding debt for entirely legitimate reasons, including that they simply couldn't have known that they continued to accrue debt for

coverage that they thought they had cancelled. *See* Defs.' Br. 24. CMS nonetheless defends its rule on its "intuitive expectation" that coverage losses would be "minimal," given the relatively small amounts of debt at issue. *Id.* The agency's intuitions can't take precedence over commenters' empirical evidence showing that even seemingly minor additional financial burdens can lead to outsized coverage losses, however. By failing to engage with the evidence that was before it, CMS fell short of the APA's requirements for reasoned decision-making. *See Ohio v. EPA*, 603 U.S. 279, 294 (2024); *City of Columbus II*, 523 F. Supp. 3d at 763.

CMS also reasoned that these coverage losses would be justified as collateral damage from the agency's campaign to prevent attempts to game enrollment in coverage. But, as we explained, there simply is no evidence that gaming is a widespread problem, and the new rule accordingly is far more likely to act as a trap for the unwary. Pls.' Br. 33. CMS concedes this point but argues that it didn't need to offer any such evidence. Defs.' Br. 25. The agency here committed the same error here that it did four years ago: its "decision to prioritize a hypothetical risk of fraud over the substantiated risk that its decision result in immense administrative burdens at best, and a loss of coverage for eligible individuals at worst, defies logic." *City of Columbus II*, 523 F. Supp. 3d at 763.

CMS inexplicably compounded these errors by refusing to require any notification to enrollees. Under the agency's rule, the first time that an enrollee would learn that there is any issue would be when he or she tries to sign up for coverage, only to see their first premium payment redirected for another purpose. There is no policy rationale that could justify this scenario if CMS's true goal was to encourage payment of past debts, rather than just to create another barrier against enrollment. *See* Pls.' Br. 33. The agency tries to wave this problem away by asserting that states might choose to address it, Defs.' Br. 25, but its failure to address this "important aspect of the problem," *Sierra Club*, 899 F.3d at 594, shows that the rule is arbitrary.

B. The Shortened Open Enrollment Period Is Arbitrary

The final rule would prohibit open enrollment in January by requiring all Exchanges to hold an open enrollment period that begins no later than November 1, ends no later than December 31, and is no more than nine weeks in duration. 45 C.F.R. § 155.410(e). CMS sought to justify this truncation of the open enrollment period (OEP) as a measure designed to guard against adverse selection in the Exchanges. *See* 90 Fed. Reg. at 27,136. But, as we demonstrated in our opening brief, the agency ignored the overwhelming evidence that the extension of the open enrollment period into January tends to bring younger and healthier people into the Exchanges, improving the risk pool for all enrollees. *See* Pls.' Br. 34. By "offer[ing] an explanation for its decision that runs counter to the evidence before the agency," CMS acted arbitrarily. *Appalachian Voices*, 25 F.4th at 269.

CMS reasons that consumers are "deadline-driven," and so would enroll at the end of the open enrollment period no matter what date the agency sets. Defs.' Br. 26 (quoting 90 Fed. Reg. at 27,139). But this rationale simply does not engage with the point that commenters brought to the agency's attention: a January deadline offered unique advantages for the health of the Exchanges because younger and healthier enrollees are more likely to face financial pressure at the end of the year, causing them to forgo coverage if they need to decide whether to enroll or not in December. *See* Pls.' Br. 35. The agency also acted arbitrarily by "entirely fail[ing] to consider [this] important aspect of the problem." *Appalachian Voices*, 25 F.4th at 269.

CMS further surmises that, by choosing to delay the effective date of this provision to 2027, it offered sufficient time to "message the clearer OEP end date to consumers." 90 Fed. Reg. at 27,139; *see* Defs.' Br. 26. But it failed to explain who would be performing this "messaging," given the added strains that the shortened open enrollment period would place on the Navigators who are supposed to facilitate enrollment, given the agency's extensive cuts to that program. *See*

Pls.' Br. 35. On that score, the agency only vaguely implored the Exchanges to "work with the enrollment support interested parties in their States to establish the OEP dates that best align with their capacity," 90 Fed. Reg. at 27,139, which entirely misses the point that Navigators would be strained under any nine-week open enrollment period, even if states retained some flexibility in setting the start and end dates of that period before the end of the calendar year.

CMS also failed to take into account the point that an open enrollment period that runs into January would afford consumers time to review their plan offerings, and to switch coverage if they learn that a particular plan's offerings didn't meet their needs. *See* Pls.' Br. 35-36. CMS minimizes this issue, noting that only about 3% of enrollees took advantage of this option. But even on the agency's own telling, it fails to explain why it had any good reason to take this choice away from the 470,000 individuals who relied on the opportunity to review their plan offerings, and to find a better plan, during the 2024-2025 open enrollment period, leaving these individuals with no meaningful recourse if they learn too late that a plan does not meet their needs. *See* 90 Fed. Reg. at 27,137. This provision was arbitrary for this reason as well.

C. The Verification Requirements for SEP Enrollments Are Arbitrary

The ACA requires Exchanges to provide for special enrollment periods (SEPs) during which qualifying individuals may enroll for coverage in between the annual open enrollment periods. 42 U.S.C. § 18031(c)(6)(C). CMS made it harder for enrollees to obtain coverage through these SEPs by requiring (for 2026 only) that the federally facilitated Exchange conduct pre-enrollment verification for each of its SEPs, and that it verify eligibility for at least 75% of new SEP enrollments. 45 C.F.R. § 155.420(g). This rule will generate hundreds of thousands of

verification issues, driving younger and healthier people out of coverage. *See* Pls.' Br. 36-37. CMS offered no good reason to impose this burden on enrollees.[4]

CMS does advert to its desire to respond to the problem of improper enrollments by unscrupulous brokers. Defs.' Br. 28. But the agency commits the same error here as it did with respect to its junk fee rule, discussed *supra*, pp. 2-4. Its analysis of improper enrollments depended on the findings of the Paragon report, but that report was fatally flawed for multiple reasons. *See* Pls.' Br. 12-14. CMS offers no defense of its reliance on the Paragon report, and so it fails to justify a "fundamental premise" of its rulemaking. *City of Columbus II*, 523 F. Supp. 3d at 752.

CMS, moreover, entirely fails to respond to the point that, once it (correctly) recognized that it was describing a problem that did not exist on state-based Exchanges, it should have looked to solutions that addressed reasons why the federally facilitated Exchange might be unique, like that Exchange's policy of permitting enhanced direct enrollment entities to submit applications on behalf of enrollees. *See* Pls.' Br. 37. The agency's "utter failure to consider obvious alternative actions" that would have directly addressed the problem that it identified, *Fishermen's Dock Co-op. v. Brown*, 75 F.3d 164, 172 (4th Cir. 1996), coupled with the "significant mismatch" between that problem and the measures the agency chose, *Dep't of Com. v. New York*, 588 U.S. 752, 783 (2019), demonstrate the irrationality of its approach.

III. The Provisions That Limit the Availability of Subsidized Coverage Should Be Set Aside

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

When an enrollee files his or her tax return for a given year, he or she reconciles the amount of tax credits to which he or she is entitled (on the basis of actual income) with the APTCs that an insurer received on his or her behalf over the course of the year (on the basis of projected income).

[4] CMS now proposes to re-adopt this rule on a permanent basis for Exchanges on the federal platform, beginning with the 2027 plan year. 91 Fed. Reg. at 6352.

26 U.S.C. § 36B(f)(3). CMS has established a process by which it requires applicants for coverage to report whether they have reconciled their tax credits on prior tax returns, and it checks that reporting against IRS data. 45 C.F.R. § 155.340(c). As we noted in our opening brief, this process is flawed; many people are incorrectly flagged, in part due to the considerable time lag in tax reporting. And this problem will only be compounded now that the IRS is proceeding with the wholesale terminations of many of its employees. *See* Pls.' Br. 38-40.

Despite these flaws, under its current policy, CMS will deprive an applicant of eligibility for APTCs if he or she does not reconcile tax credits for two years in a row, after receiving notice of the issue in the first year. 45 C.F.R. § 155.305(f)(4)(i), (ii). CMS's new rule would require the Exchanges (for 2026 only) to revoke APTC eligibility in the first year that a reconciliation issue arises, whether or not the applicant first receives notice of the issue. *Id.* § 155.305(f)(4)(iii). Both the current policy and the new policy are unlawful.[5]

The agency's legal error on this score parallels its error with respect to its junk fee rule, discussed *supra*, pp. 2-4. CMS invokes its general rulemaking authority over the Exchanges under 42 U.S.C. § 18041, Defs.' Br. 29, but a general grant of authority like Section 18041 can't authorize an agency to override the specific provision of a statute. *See Air Alliance Houston*, 906 F.3d at 1061; *see also City of Columbus III*, 796 F. Supp. 3d at 162-63; *Merck & Co.*, 962 F.3d at 536. Thus, while CMS may establish procedures to determine whether the statutory standards for APTC eligibility are met, 42 U.S.C. §§ 18081(a), (f), it may not use that procedural authority to change the substantive standards for eligibility. *See New York Stock Exch. LLC v. SEC*, 962 F.3d 541, 546

[5] In its notice of proposed rulemaking for the upcoming 2027 plan year, CMS proposes to require the federal Exchange to apply the one-year failure-to-reconcile policy for 2027, and to give the state Exchanges the option to apply either the one-year or two-year versions of that policy. 91 Fed. Reg. at 6474-75 (proposing to amend 45 C.F.R. § 155.305(f)(4)); *see also id.* at 6342 (clarifying that, if the proposal is finalized, the federal Exchange would follow the one-year failure-to-reconcile policy).

(D.C. Cir. 2020). Moreover, "if Congress intended to condition eligibility for a tax credit on the reconciliation of old tax debts, it knew how to do so," *City of Columbus III*, 796 F. Supp. 3d at 162; Congress exercised that power to require a version of the failure-to-reconcile policy for 2028 and going forward, but pointedly withheld the same authority for 2026 and 2027. *See* Pls.' Br. 39 n.1.[6]

Even if CMS had authority to adopt this rule, it abused its discretion by imposing a "Kafka-esque" scenario under which applicants will lose eligibility for APTCs for reasons that the Exchange can't disclose to them. Pls.' Br. 39. The agency's current rule, while imperfect, at least allowed for applicants to be notified of inconsistencies in their tax data and provided them with time to resolve the issue. Now, however, applicants will immediately lose coverage without any such notice. *See id.* CMS denies that this scenario will arise, pointing to data that it believed showed that notices were "relatively effective" in resolving failure-to-reconcile issues in early 2025. Defs.' Br. 32. But the agency's policy in effect in 2025, unlike the new policy that CMS seeks to adopt for 2026, had required notice to applicants before APTC eligibility could be terminated. *Compare* 45 C.F.R. § 155.305(f)(4)(i), (ii) *with id.* § 155.304(f)(4)(iii). So the older data that CMS takes stock in couldn't speak to the effects of a new policy under which applicants will lose coverage without advance warning. Moreover, even under the agency's account, the "relatively effective" solution that the agency arrived upon would still cause 27 percent of consumers to lose eligibility for APTCs. *See* 90 Fed. Reg. at 27,114. And CMS failed entirely,

[6] CMS cites 42 U.S.C. §§ 18081–18082 as giving HHS authority to determine "Exchange participation, premium tax credits, and other benefits." Defs.' Br. 31. The statute does describe procedures for verifying eligibility which establish that an applicant may prove APTC eligibility by providing information to the Exchange. But the statute does not authorize CMS to alter the substantive eligibility standards.

moreover, to engage with the point that drastic cuts this year in IRS employment will only exacerbate the problem of delays in the exchange of tax data. *See* Pls.' Br. 39.

CMS also defends this rule as one that is needed to address program integrity concerns, even if it does lead to enrollees losing coverage for undisclosed reasons. Defs.' Br. 32. But, again, as with other aspects of this rulemaking, CMS relied on the deeply flawed Paragon report to conclude that the problem of improper enrollments was severe enough to justify widespread coverage losses. Plaintiffs have comprehensively explained the defects in that report, and CMS has failed entirely to engage with these critiques. *See* Pls.' Br. 12-14. The agency's failure in this regard undermines the rationale for this rule.

B. The New Data-Matching Policies Are Arbitrary

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

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

CMS resists this conclusion by pointing to the subsection heading for Section 18081(c), Defs.' Br. 35, but "section headings cannot limit the plain meaning of a statutory text." *Merit*

Mgmt. Grp., LP v. FTI Consulting, Inc., 583 U.S. 366, 380 (2018). The subsection heading is further beside the point here, given that the relevant statute gives the authority to modify procedures anywhere in the "section" (not just the subsection). *See Koons Buick Pontiac GMC, Inc. v. Nigh*, 543 U.S. 50, 60 (2004). And CMS's reading of the statute is nonsensical, given that Section 18081(c)(4) authorizes modification of methods in order to reduce administrative burdens on the applicant, and this language would make little sense if the statute permitted the agency only to modify the procedures it used with other federal agencies without the applicant's involvement.

CMS, of course, understands these points, because it has used this authority to modify the 90-day time limit in other contexts. *See* 45 C.F.R. § 155.315(f)(3). The agency tries to explain this inconsistency away by suggesting that the statute might only authorize it "to 'modify' a statutorily prescribed timeline in order to 'reduce the administrative costs and burdens' faced by a particular 'applicant.'" Defs.' Br. 36 (quoting 42 U.S.C. § 18081(c)(4)(B); emphases omitted). But the word "particular" doesn't appear in the statutory text; under the actual statutory language, it would be perfectly permissible for CMS to find (as it did at one point) that it "would reduce the administrative costs and burdens for the applicant" if it were to permit a blanket extension rather than requiring each applicant to jump through a paperwork hoop to request one. 88 Fed. Reg. 25,740, 25,819 (Apr. 27, 2023).[7]

Nor does the *expressio unius* canon require a different conclusion. As CMS acknowledges, Defs.' Br. 36, this canon is a "feeble helper in an administrative setting" in cases such as this one,

[7] CMS also expresses doubt (Defs.' Br. 35) as to whether either blanket extensions or individualized extensions could be described as a "method" under Section 18081, but its reasoning is unclear. Either version of the policy describes "[a]n orderly procedure or process," a "regular way or manner of doing anything," or "a set form of procedure adopted in investigation or instruction." *Bilski v. Kappos*, 561 U.S. 593, 607 (2010) (adopting dictionary definition). *Cf. Vencor Hosps., Inc. v. Standard Life & Acc. Ins. Co.,* 279 F.3d 1306, 1311 (11th Cir. 2002) (describing "method for extending a party's time to appeal").

where a statute contains multiple overlapping grants of authority to an agency. *Children's Hosp. Ass'n of Tex. v. Azar*, 933 F.3d 764, 770–71 (D.C. Cir. 2019). The agency suggests that the canon applies more strongly here, however, because "Congress has directly resolved the scope of an agency's authority." Defs.' Br. 36. But, for the reasons discussed above, CMS has misread Section 18081(c) to limit to authority to extend the deadlines to resolve data-matching issues, and the additional authority that Congress afforded the agency under Section 18081(e) should not be read as a limit on that subsection (c) authority. And, because the agency misunderstood the scope of its authority on this score, its revocation of this rule must be vacated. *See Perez*, 949 F.3d at 873.

In any event, the agency also acted arbitrarily in adopting this policy. CMS recites data comparing the number of consumers who *successfully* resolved data matching issues during the initial 90-day period with the number of consumers who *successfully* resolved those issues during the extended 60-day period; because the proportion of successful applicants did not vary greatly from 2022 to 2024, the agency surmises, the automatic 60-day extension did not have much of an impact. Defs.' Br. 34-35. But the agency asked, and answered, the wrong question. The issue is not the percentage of successful applicants who relied on the additional 60 days to resolve data issues (a percentage that has nearly doubled over the last five years, in any event), but instead how many applicants *lost* eligibility because they were prevented (or deterred) from resolving data issues due to the revocation of the extension. The agency offered no evidence, or even any reasoning, on that question, and so acted arbitrarily. Moreover, CMS failed to address the point raised by commenters that, because other aspects of the 2025 rule would make it harder for enrollees to prove their eligibility within the 90-day default period, the need for the automatic 60-day extension would be even more acute going forward. *See* Pls.' Br. 43. 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.

Mandatory audit policy. CMS seeks here to re-adopt the same policy that this Court invalidated in *City of Columbus II*, 523 F. Supp. 3d at 763. Nothing has changed that would undermine this Court's conclusion that the agency's "decision to prioritize a hypothetical risk of fraud over the substantiated risk that its decision result in immense administrative burdens at best, and a loss of coverage for eligible individuals at worst, defies logic." *Id.* CMS candidly admits as much, forthrightly asserting that it had the same reasons for adopting this policy "[b]oth then and now." Defs.' Br. 38. So this Court need only to refer to its prior analysis to invalidate this rule a second time.[8]

The agency does assert that it has new data from "one study" that it reads as proving that enrollees are gaming the system to qualify for APTCs. Defs.' Br. 39 (citing 90 Fed. Reg. at 27,122). But it entirely ignores the comment submitted by the study's author, who explained in careful detail why the publication doesn't support the conclusions that CMS sought to draw from it. *See* Urban Institute comment at 2 (Apr. 11, 2025), AR31663; Pls.' Br. 44. CMS acted arbitrarily by "continu[ing] to rely on a report to justify its action after the author of that report indicated that the conclusions in the report do not support the agency's action." *City of Columbus III*, 796 F. Supp. 3d at 167 n.22. CMS also relies on the Paragon report, Defs.' Br. 39 (citing 90 Fed. Reg. at 27,122), but, as noted above and explained in prior briefing, the agency has made no effort to address the multiple flaws in that report's reasoning. *See City of Columbus III*, 796 F. Supp. 3d at 167. CMS, then, acted arbitrarily by failing to address these gaps in its reasoning. *See Sierra Club*, 899 F.3d at 270.

Prohibition on self-attestation where tax data is missing. As we explained in our opening brief, enrollees are often missing tax data for entirely benign reasons. Pls.' Br. 44-45. CMS's rule

[8] In its recent notice of proposed rulemaking, CMS proposes, yet again, to adopt this rule, this time on a permanent basis, beginning with the upcoming 2027 plan year. 91 Fed. Reg. at 6346.

prohibiting Exchanges from accepting an applicant's attestation as to his or her income when tax data is unavailable, then, would generate about 2.7 million instances of data discrepancies for applicants and Exchanges to resolve.[9] Many people, such as self-employed individuals, lack the ability to document their income, so they will necessarily lose access to subsidized coverage under this rule; by the agency's own telling, about one half of all individuals who would be flagged to lose subsidies under the new rule would be unable to resolve the agency's concern before losing coverage. 90 Fed. Reg. at 27,130. And the rule's new administrative burdens will drive many more people out of coverage; younger and healthier people will be more likely to drop coverage (since sicker people have a greater incentive to keep working through any red tape barriers that CMS might put in their way), leading to a worsened risk pool and higher premiums for everybody else. *See* Pls.' Br. 44-45. The agency's protestation that many people have payroll information "readily available," Defs.' Br. 40, simply is not responsive to this point.

CMS recognized that 42 U.S.C. § 18081(c)(4) afforded it the discretion to retain its self-attestation rule, *see* 90 Fed. Reg. at 27,131, but it chose to proceed anyway. The agency brushes off these concerns by describing the added paperwork burden as "minimal" and justified by its program integrity concerns. Defs.' Br. 40. But, once again, the premise of each of the agency's program integrity measures is undermined by its reliance on the flawed Paragon report, whose analysis CMS hasn't even tried to defend here. *See* Pls.' Br. 12-14. Nor could this rationale support this rule, given the disconnect between this measure and the problem the agency claimed it was trying to solve. There would be no way for a broker to know one way or the other if tax data is unavailable for a particular individual before targeting him or her for an unauthorized enrollment. So CMS adopted a measure that is entirely tangential to the problem that it described,

[9] CMS has also proposed to adopt this rule again, and to do so on a permanent basis. 91 Fed. Reg. at 6348.

but that will nonetheless drive hundreds of thousands of people out of coverage. The agency acted arbitrarily in so doing. *See Sierra Club*, 899 F.3d at 270.

IV. This Court Should Set Aside the Challenged Provisions of the Rule

In an APA case, "[t]he reviewing court shall … set aside agency action, findings, and conclusions found to be … arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law." 5 U.S.C. § 706(2)(A). "APA suits ultimately target the rule, and not necessarily the application of it to a particular person." *City of Columbus III*, 796 F. Supp. 3d at 175 (internal quotation omitted). As a result, "[w]hen a reviewing court determines that agency regulations are unlawful, the ordinary result is that the rules are vacated—not that their application to the individual petitioners is proscribed." *Id.* (quoting *Corner Post, Inc. v. Bd. of Governors of Fed. Res. Sys.*, 603 U.S. 799, 831 (2024) (Kavanaugh, J., concurring)).[10]

CMS nonetheless asks this Court to limit relief to the Plaintiffs here. Defs.' Br. 42. This request can't be squared with the text of Section 706(2)(A), which "requires federal courts to set aside federal agency action that is not in accordance with law," or that is arbitrary, capricious, or an abuse of discretion. *Sierra Club v. U.S. Army Corps of Eng'rs*, 909 F.3d 635, 655 (4th Cir. 2018) (internal quotation omitted); *see also City of Columbus II*, 523 F. Supp. 3d at 772.

In any event, CMS does not explain how it would be workable to limit relief only to Plaintiffs. There would be no feasible way, for example, for the agency to set a different permissible range of actuarial values only for those plans that the small business owner Plaintiffs enroll in. And there is no way to protect the municipal and provider Plaintiffs from the burden of uncompensated care costs without protecting all providers of last resort from the same harm. As

[10] *Trump v. CASA, Inc.*, 606 U.S. 831 (2025), does not change this result. The Court was not considering an APA action, and it expressly reserved judgment as to remedial authority under the APA. *Id.* at 847 n.10; *see also id.* at 869 (Kavanaugh, J., concurring); *City of Columbus III*, 796 F. Supp. 3d at 175.

this Court noted in applying its Section 705 stay on a national basis, "[t]he complicated interplay between the ACA and numerous market actors would make it exceedingly difficult if the challenged provisions went into effect for some of the population served by the Exchange but were stayed as to others." *City of Columbus III*, 796 F. Supp. 3d at 176. It would be no easier to apply a final judgment on a patchwork basis. In any event, patchwork relief would be particularly inappropriate here, as Plaintiffs include national associations that require nationwide relief to remedy the harms that their members face.

CONCLUSION

For these reasons, the Court should grant Plaintiffs' motion for summary judgment and deny Defendants' cross-motion for summary judgment.

Dated: March 16, 2026

Respectfully submitted,

*/s/ Joel McElvain*_____________
JOEL MCELVAIN (BAR NO. 31673)
CORTNEY ROBINSON HENDERSON (BAR NO. 31968)
CHRISTINE L. COOGLE (BAR NO. 21846)
DEMOCRACY FORWARD FOUNDATION
P.O. Box 34553
Washington, D.C. 20043
(202) 935-2082
jmcelvain@democracyforward.org
crhenderson@democracyfoward.org
ccoogle@democracyfoward.org

Counsel for Plaintiffs