No. 25-2012

IN THE UNITED STATES COURT OF APPEALS
FOR THE FOURTH CIRCUIT

CITY OF COLUMBUS, *et al.*,
Plaintiffs-Appellants,

v.

ROBERT F. KENNEDY, JR., *in his official capacity as Secretary of the United States Department of Health and Human Services*, *et al.*,
Defendants-Appellees.

On Appeal from the United States District Court
for the District of Maryland

EMERGENCY MOTION FOR STAY PENDING APPEAL

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INTRODUCTION AND SUMMARY OF ARGUMENT

The Affordable Care Act established health insurance Exchanges, which allow millions of Americans to purchase individual coverage every year. This litigation concerns a number of technical changes the Department of Health and Human Services made to the rules for consumers to access and for issuers to offer coverage through the Exchanges. Plaintiffs challenged a slew of those changes, and the district court granted sweeping preliminary relief to prevent seven of them from going into effect. As applied to one provision of the Final Rule, known as the actuarial value policy, the district court's order granting preliminary relief threatens to throw the Exchanges into chaos in the lead up to the annual open enrollment period, which begins on November 1.

Issuers offer plans on the Exchanges at various tiers, from bronze to platinum, reflecting an estimate of the average percentage of healthcare expenses the plan will cover. This percentage is known as the plan's "actuarial value." The ACA authorizes HHS to "provide for a de minimis variation in the actuarial valuations used in determining the level of coverage of a plan." 42 U.S.C. § 18022(d)(3). Previously, the lower bound for variation was between 0% and 2% below the benchmark plan for each tier. In the

Final Rule, HHS allowed all plans to vary by as much as 4% below the benchmark. The district court held that this decision was likely unlawful and stayed the effective date of the actuarial value policy.

This seemingly technical dispute threatens cataclysmic effects for the Exchanges. Before any plan can be made available on an Exchange, HHS (or a state agency responsible for its own Exchange) must certify that the plan offers an acceptable actuarial value. Thus, because of the district court's last-minute grant of preliminary relief, issuers will need to rewrite hundreds of plans in just a few weeks. HHS estimates that 80% of issuers participating in federally facilitated exchanges will need to revise their plans. HHS and state agencies then will need to review and approve those revised plans and other related paperwork and update systems with this data before open enrollment commences on November 1. If issuers cannot comply or if their plans cannot be approved, consumers will have fewer insurance options. This sudden destabilization of the Exchanges could have a devastating effect on individual consumers.

To prevent destabilization of the Exchanges, this Court should stay paragraph 2(f) of the district court's order, which prevents implementation of the actuarial value policy. Otherwise, the district court's order will cause

irreparable harm to the government and to millions of consumers. Granting a stay would allow litigation to play out without disturbing the range of plans available in 2026. And, if this Court ultimately concludes that the wider range of variation is unlawful, issuers can revert to the narrower range for 2027 in an orderly manner.

The government is also likely to succeed on the merits. Plaintiffs have not established their standing to challenge the actuarial value policy. HHS plainly has the authority to consider factors like encouraging issuer participation when it determines the de minimis range. And HHS weighed the evidence, considered competing priorities, and explained its predictive policy judgment in the final rule.

To ensure enough time for HHS to provide guidance to issuers and States about the actuarial value policy in advance of open enrollment, the government respectfully requests that the Court resolve this motion **by September 5**. The government does not seek an administrative stay because temporarily reverting to the wider range before snapping back to the narrower one would be even more destabilizing on the insurance market.

Plaintiffs oppose a stay pending appeal and intend to file a response.[1]

STATEMENT

A. Statutory Background

1. Enacted in 2010, the ACA "adopts a series of interlocking reforms designed to expand coverage in the individual health insurance market" and "to make insurance more affordable." *King v. Burwell*, 576 U.S. 473, 478-79 (2015). Among its many provisions, the ACA provides for the creation of "Exchanges," which are State-specific marketplaces where consumers can compare and purchase private health insurance. 42 U.S.C. § 18031(d). Some exchanges are operated by individual States. *Id.* § 18041(b). Other exchanges are operated by the federal government within the States. *Id.* § 18041(c)(1). In each State, individuals typically can enroll in health insurance plans through the state Exchange for the upcoming plan year during an annual "open enrollment period," or for the current plan year during "special enrollment periods" that become available if a certain "triggering event" occurs (*e.g.*, a person loses employer-based coverage). *Id.* § 18031(c)(6).

[1] Pursuant to Fed. R. App. P. 8(a)(1)(A), the government has moved for a stay pending appeal in the district court. Add.23. Given the imminent open enrollment period, the government is simultaneously filing this motion and will notify this Court when the district court acts on the motion.

Under the ACA, most health insurance plans offered on Exchanges must cover certain "essential health benefits" and adhere to certain "level[s] of coverage" specified in the statute. 42 U.S.C. §§ 18021(a)(1)(B), 18022(a). Exchange plans are categorized into different "metal tiers"—bronze, silver, gold, and platinum—based on their "level of coverage"; "gold plans," for instance, must have an actuarial value of 80 percent, meaning the plan is designed such that the issuer will pay, on average, 80 percent of covered medical expenses, and the enrollee will pay the remaining 20 percent of expenses through out-of-pocket spending. *Id.* § 18022(d). Generally, higher actuarial value comes with higher premiums.

Actuarial values are calculated under regulations issued by HHS. *See* 42 U.S.C. § 18022(d)(2). The statute also instructs HHS to "develop guidelines to provide for a de minimis variation in the actuarial valuations used in determining the level of coverage of a plan to account for differences in actuarial estimates." *Id.* § 18022(d)(3). HHS initially allowed all plans to vary from the benchmark by up to 2% in either direction. 78 Fed. Reg. 12,834, 12,868 (Feb. 13, 2013). In 2016, HHS allowed certain bronze plans to vary by between 5% above or 2% below the benchmark. 81 Fed. Reg. 94,058, 94,181 (Dec. 22, 2016). In 2017, HHS expanded the range to allow most plans

to deviate by 2% above or 4% below the benchmark, and expanded bronze plans to deviate by 5% above or 4% below the benchmark. 82 Fed. Reg. 18,368, 18,382 (Apr. 18, 2017). It made this change to "provid[e] issuers increased [actuarial value] flexibility to improve the health and competitiveness of the markets." *Id.* at 18,369. Finally, starting in 2023, HHS again narrowed the de minimis range for most plans. 87 Fed. Reg. 27,208 (May 6, 2022). For most plans the range was set to 2% above or below the benchmark; some bronze plans were allowed to vary by between 5% above or 2% below the benchmark; and some silver plans were allowed to vary only by up to 2% above the benchmark. *Id.* at 27,391. The agency made this change because it believed it would allow consumers to more meaningfully compare plans in different tiers. *Id.* at 27,306-07. None of these prior changes were challenged in court.

2. To help make insurance more affordable, the ACA provides subsidies to eligible Exchange enrollees in the form of premium tax credits, which enrollees can claim on their annual federal income tax returns. *See* 26 U.S.C. § 36B. The subsidy caps the amount that a consumer would have to pay for a benchmark plan—*i.e.*, the second-lowest cost silver plan in the enrollee's Exchange—as a percentage of the consumer's annual household

income. *See id.* These tax credits may also be received in advance. *See* 42 U.S.C. § 18082.

B. Factual Background and Prior Proceedings

1. On March 19, 2025, HHS proposed a series of regulatory changes to the way Exchanges operate. 90 Fed. Reg. 12,942 (Mar. 19, 2025). One of the proposals was to expand the permissible range of variation for plans' actuarial values. HHS proposed allowing all standard tiers of plans to vary up to 4% below their benchmarks. *Id.* at 12,995-97.

HHS proposed this expanded range because, since the last change in 2023, the agency had "received considerable feedback from issuers that indicates narrower de minimis ranges substantially reduce issuer flexibility in establishing plan cost sharing." 90 Fed. Reg. at 12,996. While HHS acknowledged that plans under the narrower range were easier to compare, issuers were prohibited from designing plans to provide for optimal cost sharing. *Id.* The agency further noted that "issuers have also voiced concern about their ability to continue to participate in the market generally," and explained that "[s]ustained, robust issuer participation in the market is key to ensuring overall market stability and keeping costs down." *Id.* Under the expanded range, issuers could choose between issuing plans with higher

actuarial values to "attract enrollment" and plans with lower actuarial values to "appeal to wide segments of the population." *Id.*

HHS also acknowledged that expanding the de minimis range would likely cause premium tax credits to decline because they are calculated using a benchmark silver-level plan. 90 Fed. Reg. at 12,996-97. HHS noted that the change could diminish affordability for subsidized consumers, at least in the short term. *Id.* But it also projected that the change would increase affordability for unsubsidized consumers, which in turn would attract this group to expand the risk pool and reduce premiums as a whole. *Id.* at 12,997. HHS thus proposed to reject "a short-sighted approach to regulating the [actuarial value] de minimis ranges" in favor of ensuring that in the long-term "a sufficient choice of affordable plans" remains available. *Id.*

After considering more than 26,000 comments on the proposed rule, HHS finalized the actuarial value policy as proposed. 90 Fed. Reg. 27,074, 27,076, 27,176 (June 25, 2025). HHS reiterated that reverting to the wider de minimis range "will significantly improve issuer flexibility in plan design." *Id.* at 27,176. The agency projected three primary benefits from this increased flexibility. First, "these expanded ranges allow issuers to design plans that better promote competition in the market" by offering plans more

responsive to consumer needs. *Id.* Second, "the wider ranges provide flexibility for issuers to make adjustments to their plans within the same metal level," resulting in "greater continuity for consumers." Third, the "expanded ranges help maintain robust issuer participation" by "reducing compliance burdens." *Id.* The agency noted that this third goal was "particularly important considering that several issuers have publicly announced their intent to end participation in the Exchange in [Plan Year] 2026." *Id.*

HHS acknowledged that the new actuarial value policy could reduce the amount of tax credits available to subsidized consumers because they are calculated using a benchmark silver plan. 90 Fed. Reg. at 27,076. But, pointing to its rationale in the notice of proposed rulemaking, the agency explained that it was choosing to prioritize "access and affordability in the long term." *Id.* HHS determined that "this change will better incentivize unsubsidized enrollees to enroll in coverage, which [it] expect[s] to lower overall costs and further drive down premiums as the risk pool improves." *Id.* at 27,177.

2. Plaintiffs—three municipalities; Main Street Alliance, a group representing small business owners; and Doctors for America, a group of

physicians—sued and sought preliminary relief against nine provisions in the rule. Under § 705 of the Administrative Procedure Act, the district court stayed the effective date of seven of those provisions including the actuarial value policy. Add.25-26.

The district court first concluded that at least the municipalities and Main Street Alliance had standing to sue. Add.39-52. As relevant here, the district court then concluded that the actuarial value policy was likely arbitrary and capricious for two reasons. Add.63-67. First, the district court concluded that HHS relied on factors other than those Congress had intended because HHS did not justify the de minimis range it selected based solely on "uncertainties in differences in actuarial estimates." Add.65 (quotation marks omitted). Second, the district court held that the agency's reasoning for why the actuarial value policy would have long-term benefits was "conclusory and unsupported by evidence. Add.66. Specifically, the district court faulted the agency for referring to a "short-term trade off" without "data to back up the claim and reasoning that coverage would become 'more affordable' over time." Add.66.

The district court then concluded that the balance of the equities favored plaintiffs, relying primarily on the "strong public interest in

Americans maintaining affordable healthcare coverage." Add.99. Accordingly, the district court universally stayed the effective date of the actuarial value policy. Add.99; *see also* Add.26 ¶ 2(f) (staying implementation date of "changes to the de minimis ranges for actuarial value calculations").[2]

ARGUMENT

The government is entitled to a stay because it is likely to succeed on the merits, it will suffer irreparable harm absent a stay, and the balance of the equities and the public interest favor a stay. *See Nken v. Holder*, 556 U.S. 418, 426 (2009).

I. By forcing issuers to alter their Exchange plans weeks before open enrollment starts, the district court's order injects chaos into the markets for individual health insurance plans.

If the district court's order remains in full effect, 80% of issuers participating in federally facilitated Exchanges will need to revise their plans to come into compliance with the narrower de minimis range. Add.8. For these federal Exchanges, 99.6% of consumers would be affected. Add.8. HHS understands that there is a problem of a similar scale for at least some

[2] The district court issued an initial order on August 22, Add.27-28, and subsequently issued a corrected order on August 25, Add.25-26. The August 25 order is the operative stay order.

State-run Exchanges, but the agency does not have ready access to data for those Exchanges.[3] *See* Add.8.

Open enrollment begins on November 1. HHS believes that issuers must be given at least one month to revise their plans, although this timeline would be "more aggressive" than any the agency has ever required for so extensive a plan design change. Add.7. In that time, issuers would need to redo their plan rates, filings, and forms needed to allow them to offer plans on the Exchanges. Add.7. Then HHS (and the relevant state agency) would need to review and approve these changes. Add.6-7. Ordinarily, approving plans involves an iterative process lasting "about six months." Add.4. To be ready for open enrollment, HHS believes it must receive proposals to bring plans into compliance with the smaller de minimis range by October 1. Add.7. Thus, HHS must provide guidance to issuers and States by September 5. *See* Add.7.

This truncated window for altering their plans leaves issuers with a choice between two bad options. Some issuers likely will try to redo their

[3] Some States that operate their own Exchanges have sought a similar stay of the effective date of the actuarial value policy in parallel litigation. *See* Mot. for PI and Stay, *California v. Kennedy*, No. 1:25-cv-12019 (D. Mass. filed July 18, 2025).

plans and revise their forms at unprecedented speed. Add.7. If those issuers manage to submit accurate and fully compliant plans in time to be approved, then the plans will be available on Exchanges. Add.7. But if the short timeline results in issuers making errors, their plans cannot be approved and will not be available. Add.7, 9. And if HHS errs in approving a plan, it must go through a complicated process to correct its mistake and to offer enrollees the option to switch to another plan, which is likely to lead to consumer confusion and risk disruptions to medical care. Add.9-10.

Alternatively, HHS predicts that some issuers will withdraw from the market rather than go through the rate-setting and approval process for a second time for the upcoming plan year on a drastically shortened timeline. Add.8-9. HHS warns that "there is a risk of having counties in States without any plans at all, or counties in States with an insufficient number of plans." Add.8. And if some counties have too few plans for a market to be competitive, they are "likely to experience higher premiums in future plan years." Add.9.

Either way, consumers face significant and irreparable harms. And the government and the public alike have a strong interest in preventing them from occurring. The risk that some counties may be left without plans

at all, Add.8, far outweighs the possibility that some consumers may face higher costs for a year. The government disagrees with the district court's decision to preliminarily halt a range of provisions in the Final Rule, but it has sought emergency relief only as to the actuarial value policy, because of the risk of catastrophic consequences for the health insurance market.

II. The government is likely to succeed on the merits.

A. Plaintiffs lack standing to challenge the actuarial value policy.

To establish Article III standing, a plaintiff must have suffered an injury in fact that is fairly traceable to the defendant's conduct and likely to be redressed by a favorable decision. *TransUnion LLC v. Ramirez*, 594 U.S. 413, 423 (2021). A plaintiff must meet this requirement for each claim and each form of relief he seeks. *Id.* at 431. At the preliminary injunction stage, he must "make a 'clear showing'" that he is "'likely' to establish each element of standing." *Murthy v. Missouri*, 603 U.S. 43, 58 (2024). None of the plaintiffs have established standing to challenge the actuarial value policy.

1. The municipal plaintiffs assert standing based on their assertion that the Final Rule will cause their residents to lose coverage, which in turn will result in the municipalities' "shouldering the expense of uncompensated

care." Add.51-52. There are at least two major problems with this theory of standing.

First, it relies on a chain of speculation. It assumes that the actuarial value policy will increase net premiums for at least some consumers; that these consumers will choose to drop coverage rather than enroll in a less expensive plans; that these consumers will require medical care in Chicago, Columbus, or Baltimore; that they will obtain emergency medical transportation or care from the city; and that they will not pay for that care. A party lacks standing when "an independent third part[y] … st[ands] between the plaintiff and the challenged actions." *Frank Krasner Enters., Ltd. v. Montgomery Cty.*, 401 F.3d 230, 235 (4th Cir. 2005). Here, every link in the causal chain depends on the actions of independent third parties. Nor have the municipalities established that this increased burden on their fiscs is inevitable. As the Supreme Court has explained, a plaintiff fails to satisfy the "causation requirement" for standing if a challenged government action is "too speculative" and too "far removed from its distant (even if predictable) ripple effects." *FDA v. Alliance for Hippocratic Med.*, 602 U.S. 367, 383 (2024). Here there are many alternative paths for consumers to take that do not end with an uncompensated ride in a Columbus ambulance.

Second, the municipalities rely on self-inflicted injuries. Plaintiffs may not rely on the incidental effects of policies to establish standing. If the cities choose to provide services to their residents, they cannot complain that federal policy causes more residents to seek those services. *See Pennsylvania v. New Jersey*, 426 U.S. 660, 662–64 (1976) (per curiam). A local government's desire to "supply social services such as healthcare," *United States v. Texas*, 599 U.S. 670, 674 (2023), is not a cognizable injury.

2. Main Street Alliance invokes associational standing, which requires it to establish that at least one member could sue in her own right. *See Friends for Ferrell Parkway, LLC v. Stasko*, 282 F.3d 315, 320 (4th Cir. 2002). Main Street Alliance points to a single member, Brooke Legler, who asserts that she relies on insurance purchased through an Exchange to pay for expensive medicines. Add.115. Legler further asserts that she runs a small business "on narrow margins," predicts that the Final Rule "will cause [her] health insurance costs to increase to a level that [she] cannot afford," and surmises that these increased costs "will likely make it impossible for [her] to continue [her] business." Add.116. These allegations do not establish that the actuarial value policy causes Legler certainly impending harm.

Legler's assertion of standing rests on contingency and conjecture. While Legler notes that she currently receives premium subsidies, she does not allege that she will continue to receive those tax credits next year, after temporary expansion of the subsidy program expires. *See* 26 U.S.C. § 36B(b)(3)(a)(i), (iii). If Legler will be unsubsidized next year, then she has no basis to complain about the actuarial value policy's effect on affordability. In fact, the policy is projected to lower premium costs for unsubsidized consumers. *See* 90 Fed. Reg. at 27,176; *see also* Add.130 (plaintiffs' expert acknowledges that the policy will "lower gross premiums"). And even if Legler does receive subsidies next year, she still has not offered any details to show that her net costs will be higher. *See* Add.124 n.17 (plaintiffs' expert asserts only that "many" subsidized consumers will face higher net premiums). Indeed, the record contains no information about what tier of plan she currently purchases, which issuer issues that plan, whether her issuer intends to take advantage of the expanded de minimis range, and whether other issuers will offer comparably priced plans. Legler fails to "make a 'clear showing,'" *Murthy*, 603 U.S. at 58, that she will face higher costs, much less her forecasted loss of her business.

3. Doctors for America offers an even more attenuated theory of standing. This organization submitted declarations from two physician members, neither of whom asserts any cognizable injuries to themselves. *See* Add.106-07, 111-12. They mostly rely on asserted injuries to their patients, but they cannot raise claims on behalf of third parties. *See Hollingsworth v. Perry*, 570 U.S. 693, 708 (2013). Neither physician directly asserts a personal loss of income as a result of the rule, much less as a result of the actuarial value policy. Finally, while one of the physicians asserts that he will need to spend more time counseling his patients about paying for care, *see* Add.107, the Supreme Court has rejected such a diversion of resources as a basis for asserting standing, *see Alliance*, 602 U.S. at 395.

B. HHS lawfully expanded the permissible range for actuarial values.

1. Arbitrary and capricious review "is highly deferential, with a presumption in favor of finding the agency action valid." *Appalachian Voices v. State Water Control Bd.*, 912 F.3d 746, 753 (4th Cir. 2019) (quotation marks omitted). This is especially true when an agency's decision involves "not just simple findings of fact but complex predictions based on special expertise"—in those cases, "a reviewing court must generally be at its most deferential." *Id.* (quotation marks omitted). The court's job is to

determine "whether the agency considered the relevant factors and whether a clear error of judgment was made," without "substitut[ing] its judgment for that of the agency." *Id.* (quotation marks omitted). HHS's decision to revert to a broader de minimis range similar to prior rules was not arbitrary or capricious.

The ACA instructs HHS to "develop guidelines to provide for a de minimis variation in the actuarial valuations used in determining the level of coverage of a plan to account for differences in actuarial estimates." 42 U.S.C. § 18022(d)(3). In accounting for "differences in actuarial estimates," HHS must consider differences in cost-sharing and other components between plans. The statutory language calls for the agency to exercise discretion in how much variation to permit. The phrase "de minimis" implies some play in the joints. *Cf. Alabama Power Co. v. Costle*, 636 F.2d 323, 360 (D.C. Cir. 1979) ("Determination of when matters are truly de minimis naturally will turn on the assessment of particular circumstances …."). Congress did not, for example, demand that HHS select the "maximum feasible" standard, *cf.* 49 U.S.C. § 33902(a). Instead, it used an open-textured phrase to assign to HHS responsibility for setting the range,

see Loper Bright Enters. v. Raimondo, 603 U.S. 369, 395 (2024), and HHS must make policy judgments in carrying out that duty.

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

HHS also acknowledged that its decision involved trade-offs. Expanding the de minimis range, HHS acknowledged, would likely reduce tax credits for subsidized consumers. 90 Fed. Reg. at 27,076. But the reason for that reduced subsidy is that premiums would be cheaper, thus increasing affordability for unsubsidized consumers. *See id.* HHS decided to prioritize getting these unsubsidized consumers into risk pools because it believed that, in the long-term, the risk pools would be more stable and coverage would be more affordable. *See id.*; *see also id.* at 12,997 (warning that "healthier, unsubsidized enrollees are [being] priced out of the market" and criticizing

"short-sighted approach" of focusing only on maximizing subsidies). HHS did not act unreasonably in making that policy choice.

2. The district court construed HHS's authority under 42 U.S.C. § 18022(d)(3) too narrowly. That provision instructs HHS to "develop guidelines to provide for a de minimis variation in the actuarial valuations used in determining the level of coverage of a plan to account for differences in actuarial estimates." The district court read that provision to permit the agency to consider *only* "differences in actuarial estimates." *See* Add.65. By that logic, HHS would faithfully implement the statute by selecting the narrowest technically feasible range regardless of the consequences. Thus, if HHS concluded that issuers should be able to project their actuarial values within 0.01% of a benchmark plan, it would be required to set that range—even if most issuers fled the Exchanges because of the overly restrictive policy. But if HHS actually tried to implement such a policy and steadfastly refused to consider the resulting loss of coverage, a reviewing court would likely conclude that the agency failed to consider an important aspect of the problem. *Cf. Michigan v. EPA*, 576 U.S. 743, 759 (2015) (holding unreasonable agency's failure to consider costs of regulation). It follows, therefore, that HHS has authority (and indeed an obligation) to consider

more than just the technical limits of actuarial analysis when it sets the de minimis range.

The agency has consistently understood its statutory obligation in this more holistic light. *See Skidmore v. Swift & Co.*, 323 U.S. 134, 140 (1944) (consistency in agency interpretation bolsters its "power to persuade"). Indeed, every time that HHS has set or adjusted the de minimis range, it has looked to factors beyond "differences in actuarial estimates." When HHS set the range initially in 2013, it sought to "strik[e] a balance between ensuring comparability of plans within each metal level and allowing plans the flexibility to use convenient cost-sharing metrics," and sought to "allo[w] plans to retain the same plan design year to year." 78 Fed. Reg. at 12,851. When the agency subsequently adjusted the range, it based its reasoning on these factors, 87 Fed. Reg. at 27,307, as well as others such as market competitiveness, 82 Fed. Reg. at 18,369. As plaintiffs and the district court understand the statutory scheme, all of these decisions were unlawful. That is incorrect—indeed, none of those prior adjustments was ever challenged—and the district court erred in invalidating HHS's most recent adjustment to the actuarial range, which relied on many of the same considerations.

HHS must consider differences in actuarial estimates when it sets the de minimis range but, to fulfill its obligation to engage in reasoned decision making, it must also consider other important parts of the problem facing the agency. *See Michigan*, 576 at 750. Setting a permissible range for actuarial values is one element of ensuring access to affordable healthcare—a complex and multifaceted problem with various overlapping elements. Not only was HHS allowed to consider effects like the overall health of the risk pool and the insurance market when it established the de minimis range, it was required to consider those factors. And it properly discharged that obligation here.

3. In concluding that HHS lacked evidence for its conclusions, the district court misunderstood the record before the agency. *See* Add.66. The district court concluded that because widening the de minimis range will reduce subsidies, HHS lacked "data to back up the claim and reasoning that coverage would become 'more affordable' over time. Add.66.

First, the district court failed to consider that subsidized consumers will be able to buy less expensive plans. A decreased subsidy, therefore, does not necessarily imply that the consumer will be worse off. The ACA's tax credit system is designed to ensure that certain consumers can obtain

insurance and pay no more than a fixed portion of their income (between 0% and 8.5%) for a benchmark plan. For example, consider an individual who is entitled to pay no more than $3,000 per year in premiums. If this year he purchased the benchmark silver plan in his Exchange for $6,000, he would be entitled to a $3,000 tax credit and would effectively pay $3,000. And if, under the new actuarial value policy, his issuer charges only $5,000 in premiums for the same plan, he will get only a $2,000 tax credit but will still effectively pay $3,000. Consumers who choose to purchase more expensive plans may be slightly worse off in the short run, but they too will benefit in the long-term from a healthier, broader risk pool. Contrary to the assumption undergirding the district court's conclusion, it does not inexorably follow that when subsidies decrease, plans become less affordable.

Second, the district court erred by assuming that all consumers benefit from subsidies to purchase their plans. When a temporarily expanded subsidy expires at the end of this year, only some consumers will be eligible for tax credits. *See* 26 U.S.C. § 36B(b)(3)(a)(i), (iii). For unsubsidized consumers, it is true that they will have plans available to them with lower premiums. After all, the reason that subsidies will decline is that the premiums will decrease for the second-cheapest silver plans. HHS did not

face a choice between offering higher or lower subsidies in a vacuum, as the district court believed. *See* Add.66 (suggesting change was based on "a new Administration's policy preference for less generous subsidies" (quotation marks omitted)). Rather, HHS had to decide as a matter of policy whether higher subsidies were worth a smaller risk pool and higher premiums for everyone. HHS expressly explained that it was choosing the long-term health of the risk pools over a short-term increase in subsidies for a portion of the population. 90 Fed. Reg. at 27,076. The district court was not free to second guess that policy judgment.

CONCLUSION

For the foregoing reasons, this Court should stay paragraph 2(f) of the district court's order pending the government's appeal. Given the imminent open enrollment period, the government respectfully requests that the Court resolve this motion by September 5.

Respectfully submitted,

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U.S. Department of Health and Human Services

AUGUST 2025

CERTIFICATE OF COMPLIANCE

This motion complies with the type-volume limit of Federal Rule of Appellate Procedure 27(d)(2)(A) because it contains 5,194 words. This motion also complies with the typeface and type-style requirements of Federal Rule of Appellate Procedure 32(a)(5)-(6) because it was prepared using Word for Microsoft 365 in Century Expanded BT 14-point font, a proportionally spaced typeface.

/s/ Maxwell A. Baldi
MAXWELL A. BALDI

No. 25-2012

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ADDENDUM TO EMERGENCY MOTION FOR STAY PENDING APPEAL

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UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MARYLAND

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

DECLARATION OF JEFF WU

Pursuant to 28 U.S.C. § 1746, I, Jeff Wu, make the following declaration based on my personal knowledge, information contained in the records of the U.S. Department of Health and Human Services ("HHS") and its subsidiary agencies, and information provided to me by HHS employees:

1. I am the Deputy Director for Policy at the Center for Consumer Information and Insurance Oversight ("CCIIO"), one of the centers within the Centers for Medicare & Medicaid Services ("CMS"), a component of HHS. CCIIO is charged with operating HealthCare.gov, including the Federally-facilitated Exchanges and certain State-based Exchanges that use the federal HealthCare.gov infrastructure, as well as overseeing State-based Exchanges to ensure they comply with federal requirements. CCIIO is also responsible for administering the program for enrollment in qualified health plans offered through Exchanges, including advance payment of the premium tax credit and cost-sharing reductions created by the Patient Protection and Affordable Care Act ("ACA"). In addition, CCIIO enforces federal health insurance regulations

covering the individual, small group, and insured large group health insurance markets, and non-federal governmental plans.

2. I graduated from Harvard College in 1992 with a bachelor's degree in economics, and from Stanford Business School and Stanford Law School in 2001 with a master's degree in business administration and a juris doctor degree, respectively.

3. In 2011, I joined CCIIO as a health insurance specialist, and I have served in various policy roles at CCIIO since then. I am currently the senior member of the career staff responsible for overseeing CCIIO's policy and regulatory activities, including policymaking with respect to the Exchanges, the advance payment of the premium tax credit and cost-sharing reductions, as well as our payment policies.

4. I am providing this declaration testimony for use in *City of Columbus v. Kennedy*, No. 1:25-cv-2114-BAH (D. Md.). I am testifying to the best of my knowledge and recollection.

5. My role at CCIIO encompasses policy matters pertaining to the recently promulgated final rule entitled "Patient Protection and Affordable Care Act; Marketplace Integrity and Affordability," 90 Fed. Reg. 27,074 (June 25, 2025), which contains the disputed policies at issue in *City of Columbus*.

6. I also understand that the District Court in this case recently issued a stay order under 5 U.S.C. § 705, prohibiting CMS from implementing a number of provisions of the Marketplace Integrity and Affordability final rule pending a final ruling on the merits of the case. One of those provisions concerns changes the final rule made to the *de minimis* ranges for actuarial value calculations, as codified at 45 C.F.R. §§ 156.140(c), 156.200(b)(3), and 156.400 (the "AV Policy"). If the court's stay of those provisions remains in effect, consumers, insurance plans, and states will be at significant risk of harm, as I describe in more detail below.

Rate-Setting and Certification Process

7. Section 2707 of the Public Health Service Act, added by the ACA, requires health insurance issuers that offer non-grandfathered health insurance coverage in the individual or small group markets, irrespective of whether the plan is a qualified health plan, to include the essential health benefits package required under § 1302(a) of the ACA. Section 1301(a)(1)(B) of the ACA also specifically requires qualified health plans to provide the essential health benefits package at § 1302(a).

8. The essential health benefits package includes, among other things, a requirement at §§ 1302(a)(3) and (d) for these plans to provide either the bronze, silver, gold, or platinum level of coverage, or actuarial value (except for the catastrophic plans described at § 1302(e)). The level of coverage refers to the percentage of costs that the plan is projected to pay for essential health benefits. For example, to qualify as a gold plan, it must be designed such that the issuer will pay, on average, 80 percent of essential health benefits, with the enrollee paying the remaining 20 percent.

9. A plan's actuarial value is calculated pursuant to the actuarial methods specified in regulation at 45 C.F.R. § 156.135. Specifically, issuers must use an Actuarial Value Calculator tool developed and made available by HHS for a given benefit year to calculate a plan's actuarial value. Pursuant to § 156.135(b), issuers may utilize an independent methodology to assess a plan's actuarial value only to the extent that a particular plan design does not fit into the parameters of the Actuarial Value Calculator.

10. Section 1302(d)(3) delegates to the Secretary the authority to develop guidelines to provide for a *de minimis* variation in the actuarial variations used in determining the actuarial value of a plan to account for differences in actuarial estimates. 45 C.F.R. § 156.140(c) describes

the acceptable de minimis variations. In addition to calculating a plan's actuarial value, the Actuarial Value Calculator also automatically verifies that the plan's actuarial value fits within the applicable de minimis range for a particular level of coverage. The Marketplace Integrity and Affordability final rule made changes to the permissible *de minimis* ranges at 45 C.F.R. §§ 156.140(c), 156.200(b)(3), and 156.400.

11. Each year, issuers spend months designing their plans so that they will be profitable and competitive in the market. A great deal of design effort goes into establishing a plan's cost-sharing structure—that is, the plan's coinsurance rates, co-pays, deductible, and maximum out-of-pocket limits—to manage the plan's liability, meet regulatory requirements, and appeal to consumers.

12. Once a plan's cost-sharing structure is established, the issuer calculates the actuarial value of the plan in accordance with 45 C.F.R. § 156.135, and the applicable regulatory entity reviews the issuer's data and calculations and determines whether the plan complies with essential health benefits requirements and whether to certify the plan as a qualified health plan permitted to be offered on that Exchange, pursuant to § 1301(a)(1)(B). In the case of plans offered on the Federally-facilitated Exchanges, CMS performs the certification review. For plans listed on a State-based Exchange, the State performs the review.

13. For CMS, this qualified health plan certification process takes about six months beginning when issuers first submit their plan design and rates to the agency. It is an iterative review process, with fewer and fewer changes and corrections being made during each subsequent round. CMS also endeavors to identify and have issuers correct any particularly significant deficiencies with certification requirements as early as possible in this process. State-based Exchanges follow similar processes.

14. For the 2026 plan year, the process began in January 2025. On January 15, CMS wrote to issuers that offer plans on the Federally-facilitated Exchanges or State-based Exchanges on the Federal Platform with instructions on how to work with their state health insurance regulator to certify their plans as qualified health plans for the 2026 plan year. Issuers began submitting initial applications and plan data for proposed qualified health plans to CMS for review in April, 2025, with a deadline to submit such an initial application of June 11, 2025.

15. After receiving them, in May, June, and July, CMS reviewed the applications and data it received and provided feedback to issuers and states to inform them of any errors CMS identified in that preliminary review. Issuers were then required to submit corrected qualified health plan application data by mid-July to CMS to correct the errors CMS identified in its first round of review. CMS reviewed those resubmissions between mid-July and early August and provided another round of feedback to states and issuers for their review.

16. Issuers then had until mid-August to submit any further changes to their qualified health plan application and finalize their applications. Finally, CMS reviewed those final applications and issued Qualified Health Plan Certification Agreements to qualifying issuers for signature by early September. CMS will issue certifications for those plans that CMS determines to be compliant with the statute and regulations to issuers and states in early October.

17. The 2026 plan year will be CMS's 13th year facilitating the certification of health plans as qualified health plans for the Federally-facilitated Exchanges, and this stay will impose an unprecedented burden on CMS and State Exchanges well past our established deadlines for the finalization of plan data for 2026. Requiring such significant changes so late in the process will require CMS, State Exchanges, State insurance regulators, and issuers to make significant corrections to a large number of plans across the country, creating the likelihood of significant

plan errors requiring corrections and consumer disenrollments or re-enrollments throughout the year, or of issuers, States, and Exchanges simply being unable to complete these processes for plans, reducing consumers' ability to enroll in the plans of their choice and harming those issuers' businesses. Some issuers may choose to leave the Exchanges altogether because of perceived market instability. These conclusions are based on our knowledge of how long the certification process takes, gleaned from 13 years of experience with this process, and our knowledge of market sensitivities.

Consequences of the District Court's Stay of the Actuarial Value Policy

18. Issuers, states, State-based Exchanges, and CMS have completed the certification process for the upcoming 2026 plan year using the ranges set forth in the AV Policy. Open enrollment for the 2026 plan year begins on November 1, 2025. This stay order will impose an unprecedented burden on CMS and State-based Exchanges well past our established deadlines for the finalization of plan data for 2026. Requiring such significant changes so late in the process will increase the likelihood that issuers leave the Exchanges altogether, out of an inability to complete the required changes on time or perceived market instability. This is based on our knowledge of how long the certification process takes, gleaned from 13 years of experience with this process, and our knowledge of market sensitivities.

19. If the Court's order remains in effect beyond September 5, 2025, CMS will endeavor to comply to the best of its ability. To do that, CMS will need to notify states and issuers of the change to the 2026 plan year compliance standard and identify specific plans that are out of compliance with the extant Actuarial Value Policy. To help issuers through this process, CMS will update and re-release a revised Actuarial Value Calculator. CMS will also provide technical direction to plans about how to meet the revised standard and a timeline for plans to submit revised plan data. Issuers that are unable to provide compliant plan designs on

this timeline will be considered non-compliant and any plans CMS had previously certified to be included on the Federally-Facilitated Exchange will be removed from the Exchange and unavailable for sale during the open enrollment period unless and until the issues we identified can be corrected.

20. CMS will provide states and issuers as much time as possible to successfully implement these changes that will allow the Exchanges to begin open enrollment as planned on November 1. We believe we can accept changes in plan design, cost sharing, rates and benefits data until around October 1 in order to be able to ingest this data, perform some superficial quality control, and display it in time for November 1. To give issuers sufficient time to meet that October 1 deadline, we would need to notify issuers and states of this re-certification process by the end of the first week in September.

21. This timeline, however, is far more aggressive than our usual process and consequently presents significant risk. Issuers would be required to make changes and conduct analysis to restructure their plans to make them compliant with the narrower permissible actuarial value ranges. State regulators will also have to re-review these plan submissions for compliance with federal and State rules. There is significant risk that issuers or States will decide that they do not have sufficient time to make those changes and conduct the necessary analysis. If a plan or State were not able to implement required actuarial value changes, the plan would need to be removed from the Exchange, potentially harming the availability of health care coverage for consumers. And for plans that do elect to go through this recertification process, there is risk that there will be errors in their calculations, resulting in confusion and harm to consumers. Although we hope that the aggressively accelerated timeline outlined above will enable many issuers and States to meet these deadlines, it is likely that a number will not.

22. Accordingly, we anticipate substantial instability in the ACA Marketplace if the court's order remains in effect for the Actuarial Value Policy.

23. This will create substantial burden not just for CMS, but also for States that operate their own Exchanges and conduct their own oversight and certification processes. While CMS may be able to effectuate the court's order with respect to the actuarial value ranges in time for open enrollment, we cannot speak to whether State officials will be able to do so on such an accelerated timeline.

24. Of the 185 qualified-health-plan issuers participating in the Healthcare.gov Exchanges for plan year 2026, 80%, or 148 issuers in 28 States, designed plans with actuarial value percentages that fall within expanded *de minimis* ranges in the Actuarial Value Policy. Thus, if this Court's stay order remains in effect past September 5, approximately 99.6% of consumers shopping for plans on HealthCare.gov during open enrollment in those areas will potentially have fewer options than they would have had absent the stay order. Many other plans on State-based Exchanges would be impacted as well, though we do not have the data on the extent of that impact presently available. All these plans would no longer be compliant with the Actuarial Value Policy, and all of those plan's issuers would need to decide which of its plans that fall within the expanded range they want to remove from certification, and which ones they want to try to salvage by adjusting cost-sharing parameters to bring them into compliance with the legacy *de minimis* range.

25. If issuers leave the Exchanges by withdrawing plans from consideration, there is a risk of having counties in States without any plans at all, or counties in States with an insufficient number of plans (e.g., where there is only one issuer offering plans, or there are no plans at a certain metal tier). And counties in States with an insufficient number of plans as a result of the

Court's stay are likely to experience higher premiums in future plan years. Accordingly, the Court's stay of the Actuarial Value Policy presents the following risks to consumers and the Marketplace generally:

26. **Consumer harm resulting from issuer withdrawals**. 2026 has already seen a higher than typical number of issuer withdrawals and contractions from the Marketplace. Additional instability at the federal level risks additional incentive for issuers to increase rates or to withdraw from the Marketplace altogether.

27. **Consumer harm resulting from plan data errors resulting in suppressions**. If issuers are required to suddenly make major changes to their plan designs and are given about a month to do so, there is substantial risk that issuers submissions will contain significant errors. If an issuer is not able to correct those errors before open enrollment begins, CMS would likely not certify the plan, meaning it would not be available to consumers on HealthCare.gov until the issuer corrects those errors. This means that consumers could have fewer plans from which to choose during open enrollment. It also means that any consumers that are currently enrolled in any such plans for 2025 could not be automatically re-enrolled in the plans for 2026, throwing them off of their coverage.

28. **Consumer harm leading to special enrollment period**s. This compressed timeline also increases the risk that CMS fails to identify errors in issuers' submissions, resulting in plans that contain data errors being displayed on HealthCare.gov. Consumers may erroneously rely on this data and select a plan that is more expensive than advertised. When CMS eventually identifies significant data errors, it gives consumers a special enrollment period as a remedy, allowing them to choose a different plan outside of open enrollment. However this remedy does not alleviate the risk to consumers because CMS may never identify those errors

and, in any event, such a mid-plan-year special enrollment period is likely to cause consumer confusion and potentially result in disruptions to medical care.

29. **Inconsistent nationwide application of court rulings**. We anticipate that the Court's stay order will also harm States that run their own Exchanges, as well as issuers of non-grandfathered, non-qualified health plans offered in the individual or small group markets that are also required to comply with the actuarial value requirement. While CMS will operationalize the court order for the FFEs, State officials will do so for State-based Exchanges and non-grandfathered, non-qualified health plans offered in the individual or small group markets. Those States will have even less time to come into compliance with the Court's order than CMS, since they would have to wait for CMS to issue guidance before implementing their own processes. Moreover, States often have fewer resources available to conduct a certification process in such a short amount of time.

30. **Further market instability and uncertainty**. Premiums for 2026 are already projected to be significantly higher due to the expiration of enhanced American Rescue Plan Act subsidies at the end of 2025. We expect that the Court's stay order will cause premiums to increase even more than they already have for the reasons stated above.

I declare under penalty of perjury that the foregoing is true and correct to the best of my knowledge and belief. Executed this 29th day of August, 2025.

JEFFREY C. WU -S
Digitally signed by JEFFREY C. WU -S
Date: 2025.08.29 14:16:07 -04'00'

JEFF WU

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MARYLAND

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

DEFENDANTS' MEMORANDUM IN SUPPORT OF THEIR MOTION FOR A STAY PENDING APPEAL

Defendants respectfully request that this Court stay, pending appeal, paragraph 2(f) of this Court's August 25, 2025 Order, ECF No. 38 ("Stay Order"). That Order stayed the effective date of seven provisions of the Final Rule at issue in this case pursuant to 5 U.S.C. § 705, pending a final ruling on the merits. *See id.* Paragraph 2(f) of the Order specifically stayed a Rule provision that adjusts the allowable ranges of actuarial values applicable to the different health care plan types offered on Exchanges under the Affordable Care Act. *Id.* at 2.

While the Court's Stay Order will undoubtedly hamstring the Department of Health and Human Services' efforts to address legitimate concerns about improper enrollments in Exchange plans that are subsidized by taxpayers, the Court's preliminary stay of the Rule's actuarial value policy will be especially harmful to the government and to the millions of consumers who obtain health care coverage through Exchanges. Indeed, HHS estimates that roughly 80 percent of issuers participating in federally facilitated Exchanges took advantage of that policy by designing health plans that fall within the expanded "de minimis" ranges of allowable actuarial values. Yet as a result of the Court's Stay Order, all of those issuers will now need to revise those plans to comport with the narrower "de minimis" ranges that applied under the pre-Rule regulatory scheme. HHS

and State agencies will then need to review and approve those revised plans before open enrollment for 2026 begins on November 1, 2025. And if issuers are unable to comply with this abrupt regulatory change, or if their plans are not approved in time, Exchange customers will have fewer plan options to choose from. Such a sudden and severe disruption to the Exchange marketplace could have a devastating effect on the availability of Exchange coverage. This prospect of irreparable harm to the government and the public interest thus weighs in favor of granting Defendants' motion to stay this Court's Stay Order pending appeal.

Defendants are also likely to succeed on the merits with respect to the Rule's actuarial value policy. Plaintiffs have not established their standing to challenge that policy. Moreover, contrary to what the Court concluded in its August 22, 2025 Memorandum Opinion, ECF No. 35 ("Opinion"), HHS clearly has the authority to consider factors like issuer participation in Exchanges when it determines the applicable "de minimis" ranges. And in revising those "de minimis" ranges via the Rule, HHS considered the evidence before it, balanced competing priorities, and made a predictive policy judgment that was reasonable and reasonably explained. That is all that the Administrative Procedure Act requires.

Defendants' motion for a stay pending appeal should accordingly be granted. In light of the urgency of the harms Defendants face as a result of the Court's Stay Order, Defendants respectfully request that the Court rule on this motion expeditiously. If upon reviewing this motion the Court does not believe Defendants have met the requirements for a stay pending appeal, Defendants request that the Court summarily deny this motion without awaiting a response from Plaintiffs. Defendants further note that, given the intense time pressure for obtaining relief, they intend to also seek relief in the Fourth Circuit today (*i.e.*, August 29, 2025).

BACKGROUND

This case concerns a Final Rule promulgated by HHS in June 2025 that makes several regulatory changes to strengthen the integrity of the Exchanges where consumers purchase health care coverage under the ACA and to make that coverage more affordable. As relevant here, one of those changes concerns the allowable ranges of actuarial values applicable to the different plan

types sold on Exchanges.

Under the ACA, health insurance plans offered on Exchanges must adhere to certain "level[s] of coverage," or actuarial values, specified in the statute. 42 U.S.C. § 18022(a). "Silver plans," for instance, must have an actuarial value of 70 percent, meaning that such plans are designed to pay, on average, 70 percent of covered medical expenses, and the enrollee will pay the remaining 30 percent through a combination of deductibles, coinsurance, co-payments, and maximum out-of-pocket limits. *Id.* (setting the "level of coverage" for bronze, gold, and platinum plans as well). As a general matter, plans that have a higher actuarial value also have higher premiums. The actuarial values of Exchange plans are calculated pursuant to regulations issued by the HHS Secretary. *Id.* § 18022(d)(2). The ACA also instructs the Secretary to "develop guidelines to provide for a de minimis variation in the actuarial valuations used in determining the level of coverage of a plan to account for differences in actuarial estimates." *Id.* § 18022(d)(3). The Rule changes the allowable "de minimis" ranges applicable to silver, gold, and platinum plans to two percentage points above and four percentage points below each plan type's respective benchmark actuarial value (*i.e.*, +2/-4 percentage points). *See* 90 Fed. Reg. at 27,074. And it changes the allowable "de minimis" range for bronze plans to +5/-4. *Id.*

On July 1, 2025, Plaintiffs filed a complaint challenging several provisions of the Rule under the APA. *See* ECF No. 1 ¶¶ 74-82. As relevant here, they alleged that the Rule's actuarial value policy was arbitrary and capricious. *Id.* ¶ 80(j). Plaintiffs moved for preliminary relief the following day, *see* ECF No. 11, which Defendants opposed, *see* ECF No. 28 ("Opposition Brief"). And on August 22, 2025, the Court granted Plaintiffs' motion in part and stayed the effective date of the actuarial value policy and six other Rule provisions pursuant to 5 U.S.C. § 705. *See* Opinion at 35-39; *see also* ECF No. 38.[1]

In its Opinion, the Court first concluded that Plaintiff Main Street Alliance ("MSA") and the three municipal Plaintiffs had standing to sue. *See* Opinion at 11-24. As relevant here, the

[1] The Court initially issued an Order in conjunction with its August 22, 2025 Opinion. *See* ECF No. 36. On August 25, 2025, Plaintiffs filed an unopposed motion to clarify that Order, which the Court granted the same day. ECF Nos. 37, 38. The operative stay order is thus the amended one the Court issued on August 25, 2025. ECF No. 38.

Court then concluded that the Rule's actuarial value policy was likely arbitrary and capricious for two reasons. First, the Court concluded that HHS relied on factors other than those Congress intended it to consider because the agency did not justify the "de minimis" ranges it selected based solely on "uncertainties in differences in actuarial estimates." *Id.* at 36. Second, the Court concluded that HHS's reasoning in support of the Rule's actuarial value policy was "conclusory and unsupported by evidence." *Id.* at 38. According to the Court, HHS failed to offer data "back[ing] up the claim and reasoning that coverage would become 'more affordable' over time" as a result of the policy and "provided an insufficient and conclusory rationale for altering the de minimis variation." *Id.* at 38-39. The Court then concluded that the balance of equities weighed in Plaintiffs' favor, based largely on the "strong public interest in Americans maintaining affordable healthcare coverage." *Id.*

ARGUMENT

"There are four factors relevant to the issuance of a stay pending appeal: '(1) whether the stay applicant has made a strong showing that he is likely to succeed on the merits; (2) whether the applicant will be irreparably injured absent a stay; (3) whether issuance of a stay will substantially injure the other parties interested in the proceeding; and (4) where the public interest lies." *Nat'l Ass'n of Diversity Officers in Higher Educ. v. Trump*, 768 F. Supp. 3d 735, 737-38 (D. Md. 2025) (quoting *Hilton v. Braunskill*, 481 U.S. 770, 776 (1987)).

Here, the significant and irreparable disruption the Court's preliminary stay of the Rule's actuarial value policy will cause within the Exchange marketplace, combined with the public's strong interest in having access to a robust range of Exchange plan options and the substantiality of Defendants' arguments regarding the lawfulness of the actuarial value policy, weigh in favor of granting a stay pending appeal.

I. The Government and the Public Will Be Irreparably Injured Absent a Stay

The detrimental impact that the Court's preliminary stay of the actuarial value policy will have on the Exchange marketplace cannot be overstated: 80 percent of issuers participating in federally facilitated Exchanges will need to redo their plans to come into compliance with the

narrower pre-Rule "de minimis" ranges, which would affect 99.6 percent of the consumers who obtain coverage through those Exchanges. Wu Decl. ¶ 24.[2] State-run Exchanges will likely face disruptions of a similar scale (although HHS does not have ready access to data for those Exchanges). *Id.* ¶¶ 22, 24. And such Exchange-wide changes would need to be made on a timeline that is more compressed than any HHS has ever required. *See id.* ¶¶ 17-18, 21; *see also id.* ¶¶ 11, 14-16.

Indeed, open enrollment for plan year 2026 begins on November 1, and before a plan can be made available on an Exchange, HHS (or the state agency tasked with administering a State-run Exchange) must certify that the plan offers an acceptable actuarial value under the ACA and its implementing regulations. *See id.* ¶ 12. HHS believes that issuers affected by the Court's stay of the actuarial value provision would need to be given at least one month to revise their plans and to redo their plan rates, filings, and Exchange-related forms. *Id.* ¶ 20. HHS (or the relevant State agency) would then need to review and approve these changes. *See id.* ¶¶ 17-21. To be ready for the start of open enrollment, HHS therefore believes it must receive issuers' proposals to bring their plans into compliance with the narrower "de minimis" ranges by October 1. *Id.* ¶ 20.

Issuers faced with this compressed timeline will thus be presented with two undesirable options. On the one hand, they could rush to redesign and submit fully compliant plans in time for HHS (or the relevant State agency) to approve those plans ahead of the start of open enrollment. *Id.* ¶¶ 19-21. But if this unprecedently quick turnaround causes those issuers to make errors in their plan design, those plans would then not be available for purchase on Exchanges until such errors are fixed. *Id.* ¶¶ 21, 27. Or, if HHS (or the relevant State agency) errs in approving a plan, then the agency must go through a complicated process to remedy those mistakes and offer enrollees the option to switch to another plan, which could cause consumer confusion. *Id.* ¶ 28. On the other hand, HHS predicts that some issuers may simply withdraw from Exchanges altogether rather than go through the rate-setting and approval process all over again on a rushed

[2] The Declaration of Jeff Wu is attached as an exhibit to this memorandum.

timeline. *Id.* ¶¶ 17-18, 25-26. In either case, Exchange enrollees face an imminent risk of fewer plan options and confusion stemming from hurried plan revisions that fail to comport with the abrupt change in applicable regulations.

The Court's stay of the actuarial value policy, in short, will inject instability and uncertainty into the Exchange marketplace, which will harm the government (which administers federally facilitated Exchanges) and members of the public (many of whom purchase health insurance on Exchanges) in turn. Defendants and the public have a strong interest in preventing this substantial and irreparable harm from occurring, which a stay pending appeal would ensure. Such relief would allow this litigation to proceed in the ordinary course without causing severe disruptions to Exchanges in the interim. And if the Court ultimately concludes that the Rule's actuarial value policy is unlawful, issuers can revert back to the narrower pre-Rule "de minimis" ranges for 2027 in an orderly manner. The risk of irreparable harm and the balance of the equities thus strongly weigh in favor of granting Defendants' motion for a stay pending appeal here.

II. Defendants Are Likely to Prevail on the Merits

The standard for obtaining a stay pending appeal "does not require the trial court to change its mind or conclude that its determination on the merits was erroneous." *St. Agnes Hosp. of City of Baltimore, Inc. v. Riddick*, 751 F. Supp. 75, 76 (D. Md. 1990). Rather, "a stay may be appropriate in a case where the threat of irreparable injury to the applicant is immediate and substantial," and "the appeal raises serious and difficult questions of law." *Id.* (quoting *Goldstein v. Miller*, 488 F. Supp. 156, 173 (D. Md. 1980)); *see Maryland v. U.S. Dep't of Agric.*, 777 F. Supp. 3d 496, 500 (D. Md. 2025) ("The Court agrees that this approach makes good sense; otherwise, a district court would *never* stay an order pending appeal, as 'every court that renders a judgment does so in the belief that its judgment is the correct one.'"). And here, because Defendants' appeal will raise "serious" questions concerning Plaintiffs' standing to challenge the Rule's actuarial value policy as well as HHS's compliance with the APA's deferential arbitrary-and-capricious standard in issuing that policy, a stay pending appeal is warranted.

A. Plaintiffs Lack Standing to Challenge the Actuarial Value Policy

To obtain preliminary relief, Plaintiffs were required to "make a 'clear showing'" that they are "'likely' to establish each element of standing." *Murthy v. Missouri*, 603 U.S. 43, 58 (2024). Otherwise, the Court "lack[s] jurisdiction to reach the merits of" Plaintiffs' claims. *Id.* at 56. As Defendants amply explained in their Opposition Brief, none of the Plaintiffs established that they had standing to challenge the Rule because the injuries in fact they asserted all rested on speculative predictions about the Rule's potential effects on a complex health insurance market and attenuated chains of contingencies that were unlikely to materialize. *See* Opposition Br. at 8. And Plaintiffs certainly failed to establish that they will suffer an injury in fact traceable to the Rule's actuarial value policy specifically. *See TransUnion LLC v. Ramirez*, 594 U.S. 413, 423 (2024) ("[P]laintiffs must demonstrate standing for each claim that they press and for each form of relief that they seek . . . ."). Defendants recognize that the Court rejected their arguments. Accordingly, they refrain from reiterating each of those arguments in detail here; incorporate those previously asserted arguments by reference, *see* Opposition Br. at 8-15; and respectfully submit that those arguments raise questions that are serious enough to warrant a stay pending review by the Fourth Circuit.

In its Opinion, the Court found that MSA and the three municipal Plaintiffs established their standing to challenge the Rule. *See* Opinion at 12. Defendants respectfully disagree with the Court's reasoning and conclusions. With respect to MSA—which asserted associational standing based on a single declaration from a member who owns a small business in Wisconsin and is enrolled in an Exchange plan—the Court concluded that the MSA member had "state[d] with precision how the [Rule] will directly impact her." *Id.* at 15. Yet the Court, respectfully, treated the unsubstantiated assertions in the member's declaration—*e.g.*, that the Rule will cause the member's monthly premium to increase post-APTCs, that the member would categorically be unable to afford that indeterminate premium increase, that such an increase would somehow result in her losing coverage for "critical medications," *etc.*—as if they were allegations that must be accepted as true. That is not the proper standard at the preliminary-relief stage. *See Lujan v. Defs.*

of Wildlife, 504 U.S. 555, 561 (1992) ("[E]ach element [of standing] must be supported . . . with the manner and degree of evidence required at the successive stages of the litigation."). Beyond conclusory assertions, the MSA member offered no record evidence demonstrating that the Rule would cause *her* insurance premium to increase, or that such an increase would ineluctably prompt her to drop her current Exchange coverage, close down her business, and seek insurance elsewhere.

As relevant here, moreover, the MSA member certainly did not demonstrate that any alleged premium increase would be attributable to the Rule's actuarial value policy. Indeed, if the member will no longer be eligible for subsidized coverage after the enhanced premium subsidy regime expires at the end of the year, her premium would likely *decrease*, given that, as the Court noted, the actuarial value policy is expected to make plans cheaper. *See* Opinion at 36. And even if the member will still be eligible for premium subsidies—a critical fact that her declaration leaves unaddressed—the record contains no information about the particular plan in which the member is enrolled; the issuer of that plan; and whether that issuer has modified that plan in response to the Rule's actuarial value policy. The MSA member thus provides no basis for concluding that the actuarial value policy will impact her in any concrete and particularized way.

The Court separately concluded that the three municipal Plaintiffs had sufficiently shown that they will "bear additional economic costs that come with treating people left uninsured by the implementation of the Rule." Opinion at 21. And the Court rejected Defendants' argument that such alleged downstream economic harms were too speculative and non-imminent to confer standing. *See id.* at 22 ("Here, the City Plaintiffs have adequately 'outline[d] the predictable results' of the challenged provisions of the Rule."). But in reaching its conclusions, the Court relied on authorities that predated the several recent Supreme Court decisions addressing Article III standing, *see id.* at 22-23, which make clear that a plaintiff fails to satisfy the "causation requirement" for standing if a challenged government action is "too speculative" and too "far removed from its distant (*even if predictable*) ripple effects." *FDA v. All. for Hippocratic Med.*, 602 U.S. 367, 383 (2024) (emphasis added). The municipal Plaintiffs' theory of injury here—which hinges on the Rule's actuarial value policy causing a net increase in premiums for at least

some subsidized Exchange customers, some of those affected customers dropping Exchange coverage altogether, and some of those newly uninsured customers eventually seeking medical care in Columbus, Baltimore, or Chicago that ultimately goes uncompensated—depends on precisely the sort of elaborate "chain of causation" that is "simply too attenuated" to establish standing. *Id.* (rejecting the proposition that doctors can establish standing based on monetary injuries purportedly stemming from changes to "general public safety requirements" that potentially result in "more individuals . . . show[ing] up at emergency rooms or in doctor's offices with follow-on injuries"). Like MSA, the municipal Plaintiffs thus failed to satisfy their standing burden here.

B. The Actuarial Value Policy Is Not Arbitrary and Capricious

After finding that Plaintiffs had sufficiently established their standing to sue, the Court then concluded, as relevant here, that the Rule's actuarial value policy was arbitrary and capricious under the APA. *See* Opinion at 35-38. Defendants respectfully disagree for the reasons provided in their Opposition Brief, which they incorporate by reference here. *See* Opposition Br. at 48-51. As Defendants explained, HHS, in adopting the actuarial value policy, considered several factors that are implicated by "differences in actuarial estimates" of the value of Exchange plans, *see* 42 U.S.C. § 18022(d)(3), including issuers' "flexibility" to "create more differentiated combinations of premiums and cost-sharing structures," as well as the value of those diverse plan options to Exchange consumers who, as a practical matter, care less about a "1-point separation between a 65 percent AV bronze plan and a 66 percent AV silver plan" than they do about more "meaningful differences" like deductible and premium amounts. 90 Fed. Reg. at 27,176-77. HHS also reasonably considered the effect of "de minimis" ranges on other Exchange-related factors, including "robust issuer participation." *Id.* at 27,177. And after acknowledging that adopting wider "de minimis" ranges would have tradeoffs, HHS made the reasonable predictive judgment that, while the amount of premium subsidies received by certain Exchange customers would likely decrease as a result of the Rule's actuarial value policy, that outcome would be a consequence of cheaper premiums, which would increase the affordability of Exchange coverage for unsubsidized

consumers and likely improve Exchange risk pools. *See id.* at 27,176-77. HHS thus made a policy decision that was both "reasonable and reasonably explained." *FCC v. Prometheus Radio Project*, 592 U.S. 414, 423 (2021).

The Court instead concluded that the Rule's actuarial value policy is arbitrary and capricious for two reasons. First, the Court read the ACA to provide that HHS can consider *only* "differences in actuarial estimates" when setting "de minimis" ranges. Opinion at 35. But respectfully, that reading of the statute would mean that HHS could permissibly adopt exceedingly narrow "de minimis" ranges without considering the effect that such an overly restrictive policy would have on issuer participation in Exchanges and, by extension, the availability of Exchange coverage. Indeed, under the Court's reading, HHS would be *prohibited* from taking those considerations into account. It simply cannot be true that hyper-technical concerns about "differences" in "actuarial valuations" must take precedence, and exclusively so, over all other factors when HHS sets "de minimis" ranges. *Cf. Timms v. U.S. Attorney General*, 93 F.4th 187, 191 (4th Cir. 2024) ("[W]hen possible, we construe statutes to avoid absurd results.").

Second, the Court determined that HHS's rationale for, and policy balancing related to, the actuarial value policy were "conclusory" and "unsupported" by evidence. Opinion at 38-39. In reaching that determination, however, the Court incorrectly assumed that the reduction in aggregate premium subsidies that the policy would likely cause would necessarily make recipients of such subsidies worse off. *See id.* at 38. By way of example, consider an individual who is required to pay no more than $3,000 per year in premiums. *See* 26 U.S.C. § 36B(b)(3)(A). If that individual's benchmark silver plan currently costs $6,000 annually, he would be entitled to a premium tax credit equivalent to $3,000—*i.e.*, the cost of the annual premium minus the individual's maximum contribution to premium payments. If the actuarial value policy were to make that same benchmark silver plan cheaper, however—say, by reducing the annual premium to $5,000—the individual would still only be required to pay a maximum of $3,000 in premiums, but the amount of that individual's premium subsidies would fall to $2,000 (*i.e.*, $5,000 minus $3,000). As this example illustrates, a decrease in the amount of premium subsidies does not

necessarily translate into more expensive plans for consumers enrolled in subsidized coverage. Moreover, even if some subsidized customers who elect to purchase more expensive non-benchmark plans might see the cost of those plans increase due to a reduction in premium subsidy amounts, that does not necessarily mean that Exchange coverage writ large will become less affordable. To the contrary, neither the parties nor the Court dispute that the Rule's actuarial value policy is expected to reduce premiums for various Exchange plans. *See* Opinion at 36 (accepting Plaintiffs' argument that the policy will permit issuers to sell "cheaper" silver plans). And cheaper premiums are, by definition, more affordable to consumers who are not eligible for ACA premium subsidies. HHS explained that, in adopting the actuarial value policy, it was prioritizing the long-term health of the risk pool that would flow from more unsubsidized consumers buying Exchange coverage over a short-term increase in subsidies that only benefitted a subset of health insurance purchasers. Respectfully, the deferential arbitrary-and-capricious standard did not give the Court license to second-guess that policy decision. *See Prometheus*, 592 U.S. at 423 ("[A] court may not substitute its own policy judgment for that of the agency.").

CONCLUSION

For the foregoing reasons, and all the reasons provided in Defendants' Opposition Brief, the Court should stay its Stay Order with respect to the Rule's actuarial value policy pending final resolution of Defendants' appeal of that Order. Defendants also respectfully request that the Court rule on this motion as soon as possible.

DATED: August 29, 2025

Respectfully submitted,

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UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MARYLAND

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

DEFENDANTS' MOTION FOR A STAY PENDING APPEAL

Defendants respectfully move the Court for a stay of paragraph 2(f) of this Court's August 25, 2025 Order, ECF No. 38, pending appeal to the United States Court of Appeals for the Fourth Circuit. The basis for Defendants' motion is set forth in the attached Memorandum.

DATED: August 29, 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. ROERT F. KENNEDY, JR. *et al.*, *Defendants*.	Civil No. 25-2114-BAH

ORDER

For the reasons stated in the Court's memorandum opinion, ECF 35, it is, by the United States District Court for the District of Maryland, hereby **ORDERED** that Plaintiffs' unopposed motion for clarification is **GRANTED**, and this Court's order of August 22, 2025 is amended as clarified to provide as follows:

1. Plaintiffs' motion for a stay under 5 U.S.C. § 705 or, in the alternative, for a preliminary injunction, ECF 11, construed as a motion for a stay under 5 U.S.C. § 705, is **GRANTED** in part and **DENIED** in part;
2. The effective dates of the following provisions of the final rule entitled "Patient Protection and Affordable Care Act; Marketplace Integrity and Affordability," 90 Fed. Reg. 27074, are **STAYED** pursuant to 5 U.S.C. § 705 pending a final ruling on the merits of this case:
    a. The imposition of a $5 premium penalty on automatic re-enrollees, through the addition of 45 C.F.R. § 155.335(a)(3) and (n) and revisions to 45 C.F.R. § 155.330(j);

b. The revocation of guaranteed insurance coverage for individuals with past-due premiums, through revisions to 45 C.F.R. § 147.104(i);

c. The failure to reconcile policy in 45 C.F.R. § 155.305(f)(4), including the final rule's amendments to that policy through the addition of 45 C.F.R. § 155.305(f)(4)(iii);

d. The imposition of eligibility verification for the special enrollment period, through the revisions to 45 C.F.R. § 155.420(g);

e. The imposition of a requirement that Exchanges verify household income inconsistencies when a tax filer's attested projected annual household income differs from "trusted data sources," through revisions to 45 C.F.R. § 155.320(c)(3)(iii) and the addition of 45 C.F.R. § 155.320(c)(3)(vi)(C)(2);

f. The changes to the de minimis ranges for actuarial value calculations, through revisions to 45 C.F.R. §§ 156.140(c), 156.200(b)(3), and 156.400;

g. The changes to the policy regarding self-attestation of projected income, through revisions to 45 C.F.R. § 155.320(c)(5).

3. The Court **DECLINES** to stay the effective dates of the following provisions:

a. The change to the measure for calculating the premium adjustment percentage set forth in 90 Fed. Reg. 27,166 through 27,178;

b. The elimination of the 60-day extension of time to resolve inconsistencies in household income data, through the removal of 45 C.F.R. § 155.315(f)(7) and revisions to 45 C.F.R. § 155.320(c)(5).

SO ORDERED.

August 25, 2025

/s/
Brendan A. Hurson
U.S. DISTRICT JUDGE

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MARYLAND

*

CITY OF COLUMBUS ET AL.,

*

Plaintiffs,

*

v.

* Civil No. 25-2114-BAH

ROBERT F. KENNEDY, JR. ET AL.,

*

Defendants.

*

* * * * * * * * * * * * *

ORDER

For the reasons stated in the accompanying memorandum opinion, it is, by the United States District Court for the District of Maryland, hereby **ORDERED** that:

1. Plaintiffs' motion for a stay under 5 U.S.C. § 705 or, in the alternative, for a preliminary injunction, ECF 11, construed as a motion for a stay under 5 U.S.C. § 705, is **GRANTED** in part and **DENIED** in part;

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

    a. The imposition of a $5 premium penalty on automatic re-enrollees, through the addition of 45 C.F.R. § 155.335(a)(3) and (n) and revisions to 45 C.F.R. § 155.330(j);

    b. The revocation of guaranteed insurance coverage for individuals with past-due premiums, through revisions to 45 C.F.R. § 147.104(i);

    c. The failure to reconcile policy in 45 C.F.R. § 155.305(f)(4), including the final rule's amendments to that policy through the addition of 45 C.F.R. § 155.305(f)(4)(iii);

    d. The imposition of eligibility verification for the special enrollment period, through the revisions to 45 C.F.R. § 155.420(g);

e. The imposition of a requirement that Exchanges verify household income inconsistencies when a tax filer's attested projected annual household income differs from "trusted data sources," through revisions to 45 C.F.R. § 155.320(c)(3)(iii);

f. The changes to the de minimis ranges for actuarial value calculations, through revisions to 45 C.F.R. §§ 156.140(c), 156.200(b)(3), and 156.400.

3. The Court **DECLINES** to stay the effective dates of the following provisions:

a. The change to the measure for calculating the premium adjustment percentage set forth in 90 Fed. Reg. 27,166 through 27,178;

b. The elimination of the 60-day extension of time to resolve inconsistencies in household income data, through the removal of 45 C.F.R. § 155.315(f)(7) and revisions to 45 C.F.R. § 155.320(c)(5).

SO ORDERED.

Dated: August 22, 2025

/s/
Brendan A. Hurson
United States District Judge

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MARYLAND

*

CITY OF COLUMBUS ET AL.,

*

Plaintiffs,

*

v.

* Civil No. 25-2114-BAH

ROBERT F. KENNEDY, JR. ET AL.,

*

Defendants.

*

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MEMORANDUM OPINION

Plaintiffs filed suit under the Administrative Procedure Act ("APA") seeking to prevent Defendants from implementing changes to federal regulations enforcing the Patient Protection and Affordable Care Act (the "ACA," or the "Act"). ECF 1 (complaint). These changes, embodied in the Marketplace Integrity and Affordability Rule (the "Rule"), are set to take effect on August 25, 2025. *See* Patient Protection and Affordable Care Act; Marketplace Integrity and Affordability, 90 Fed. Reg. 27,074 (June 25, 2025). Plaintiffs—three cities, a coalition of doctors, and an interest group representing small business owners—allege they will shoulder increased costs or see their members lose health insurance coverage if these changes are implemented. *See generally* ECF 1; ECF 11 (motion for preliminary relief). Defendants, the Secretary of the Department of Health and Human Services ("HHS") and many in his employ charged with crafting and implementing the Rule, counter that changes to ACA-related regulations are needed to prevent fraud and to readjust the cost of health insurance. *See* ECF 28 (opposition to preliminary relief motion).

This matter is currently before the Court on Plaintiffs' motion for a stay under 5 U.S.C. § 705 or, in the alternative, for a preliminary injunction (the "Motion"). ECF 11. Upon consideration of the parties' filings and after a robust oral argument on the Motion, the Court **GRANTS** in part and **DENIES** in part Plaintiffs' Motion and enters a **STAY** enjoining certain provisions of the Rule from taking effect on August 25, 2025.

The Court finds that Plaintiffs have met their burden of showing that there is a strong likelihood that they will succeed on the merits of their challenges to seven provisions of the Rule. Plaintiffs have failed to show likelihood of success on the merits sufficient to warrant preliminary relief on the remaining challenges to two other provisions of the Rule. As to the seven provisions in which Plaintiffs have shown a likelihood of success on the merits, Plaintiffs have also shown they will face irreparable harm if the challenged portions of the Rule are not enjoined. Finally, the balance of equities and the public interest weigh in favor of a stay. This memorandum opinion is offered to explain the Court's reasoning.

I. BACKGROUND

A. The Affordable Care Act

In 2010, Congress enacted the ACA "to increase the number of Americans covered by health insurance and decrease the cost of health care." *NFIB v. Sebelius*, 567 U.S. 519, 538 (2012). "Prior to the enactment of the ACA, individual health insurance markets were dysfunctional." *City of Columbus v. Trump*, 453 F. Supp. 3d 770, 778 (D. Md. 2020).[1] The ACA "adopts a series of interlocking reforms designed to expand coverage in the individual

[1] The Court frequently cites two prior opinions by Judge Chasanow, which included the same City Plaintiffs involved in this case. One opinion is from 2020 and addresses a motion to dismiss. *See City of Columbus*, 453 F. Supp. 3d at 770. The other opinion, from the same case, addresses the parties' cross-motions for summary judgment. *See City of Columbus v. Cochran*, 523 F. Supp. 3d 731 (D. Md. 2021).

health insurance market."[2] *King v. Burwell*, 576 U.S. 473, 478–79 (2015). Individual market health plans are referred to as qualified health plans ("QHPs"). Individuals primarily enroll in QHPs for a given benefit year during an annual open enrollment period, or under specified special enrollment periods. 42 U.S.C. § 18031(c)(6). Ultimately, the ACA "aims to achieve systemic improvements in the individual health insurance market by means of certain key reforms[.]" *City of Columbus*, 453 F. Supp. 3d at 778.

First, 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 limiting sign-ups to the aforementioned 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. Cmty. Health Options*, 590 U.S. at 301 (quoting *King*, 576 U.S. at 493).

Second, the Act's "guaranteed renewability" provision requires issuers to renew or continue in force such coverage. 42 U.S.C. § 300gg-2(a). This provision, too, is 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.

Third, the Act requires all QHPs to cover "essential health benefits" and limits cost-sharing (in the form of deductibles and co-pays) by enrollees for these essential health benefits. 42 U.S.C. § 300gg-6(a); *id.* § 18022(a)(2). The limitation on cost-sharing is adjusted each year by a "premium adjustment percentage," which is "the percentage (if any) by which the average

[2] "Individual health insurance is insurance that individuals purchase themselves, in contrast to, for example, joining employer-sponsored group health plans." *City of Columbus*, 453 F. Supp. 3d at 778 (citation omitted).

per capita premium for health insurance coverage in the United States for the preceding calendar year [] exceeds such average per capita premium for 2013," the year before the Act's reforms to the individual health insurance market went into effect *Id.* § 18022(c)(1),(4).

Fourth, 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 also Me. Cmty. Health Options*, 590 U.S. at 301. The Act "gives each State the opportunity to establish its own Exchange, but provides that the Federal Government will establish the Exchange if the State does not." *King*, 576 U.S. at 479; *see also* 42 U.S.C. §§ 18031, 18041. The purpose of the Exchange is to serve as a "marketplace that allows people to compare and purchase" ACA-compliant plans.[3] *Id.*

Fifth, exchange plans are categorized into different "metal tiers"—bronze, silver, gold, and platinum—based on their "level of coverage." 42 U.S.C. § 18022(d) (setting the "level of coverage" for each of the plan types). For example, "silver plans," must have an actuarial value of 70%, meaning the plan is designed such that the issuer will pay around 70% of covered medical expenses, and the enrollee will pay the remaining 30% of expenses through out-of-pocket spending.[4] *Id.* Because actuarial predictions may be imprecise, the Act specifies that the

[3] As Plaintiffs describe, "[s]ome 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)." ECF 11-1, at 6 (citing CMS, Consumer Info. & Ins. Oversight, *State-Based Exchanges*, https://perma.cc/JFT3-6EAK).

[4] Bronze, gold, and platinum plans are designed to provide benefits that are actuarially equivalent to 60%, 80%, and 90%, respectively, of the full value of benefits under the plan. 42 U.S.C. § 18022(d)(1).

Centers for Medicare & Medicaid Services ("CMS"), an agency within HHS, may "provide for a de minimis variation . . . to account for differences in actuarial estimates." *Id.* § 18022(d)(3).

Sixth, the Act "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 ("FPL"). 26 U.S.C. § 36B(c)(1)(A). During the COVID-19 pandemic, Congress—via the American Rescue Plan Act of 2021, Pub. L. No. 117-2, 135 Stat. 4 ("ARPA")—temporarily increased the generosity of the ACA's premium subsidies and expanded subsidy eligibility to enrollees with household incomes above 400% of the FPL. The 2022 Inflation Reduction Act, Pub. L. No. 117-169, 136 Stat. 1818 ("IRA"), extended these enhanced subsides through 2025. The enhanced subsidies are set to expire at the end of 2025.

PTCs are claimed on an individual's tax return after the end of the year, and are paid by the Internal Revenue Service ("IRS"). 26 U.S.C. § 36B(h). Rather than an enrollee paying the entire insurance premium up front and then later claiming a credit toward that amount on the taxpayer's tax return, the Department of Health and Human Services ("HHS"), the federal agency that largely administers the ACA, may also make an advance payment of the premium tax credit amount directly to the enrollee's insurance provider. 42 U.S.C. §§ 18081, 18082. Such credits are known as advance premium tax credits ("APTCs"). "APTCs act as a subsidy for low-income individuals who could not afford to purchase insurance outright." *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). The amount of the APTC owed ultimately depends on the individual's income at the end of the year. Thus, individuals must file a federal tax return each year to "reconcile" the APTCs they received with the PTC amount they ultimately qualify for based on their actual income during the applicable tax year. *See* 26 U.S.C. § 36B(f)(1).

"Each year, HHS promulgates rules pursuant to its rulemaking authority under the ACA and the Public Health Service Act ("PHS Act"). Such rules are the mechanisms by which HHS makes ongoing adjustments to the regulations and processes surrounding ACA insurance markets." *City of Columbus*, 523 F. Supp. 3d at 741.

B. The Marketplace Integrity and Affordability Rule

On March 19, 2025, CMS issued a Notice of Proposed Rulemaking for a proposed rule that would implement "several regulatory actions aimed at strengthening the integrity of the [ACA] eligibility and enrollment systems to reduce waste, fraud, and abuse." 90 Fed. Reg. 12,942 (Mar. 19, 2025) ("NPRM"). CMS further explained that it "expect[ed] these actions would provide premium relief to families who do not qualify for [ACA] subsidies and reduce the burden of . . . [ACA] subsidy expenditures on the Federal taxpayer." *Id.* CMS received more than 26,000 comments on the proposed rule. After reviewing those comments and revising certain provisions of the proposed rule, HHS issued (and publicly released) the Rule on June 20, 2025, and it was published in the Federal Register on June 25. 90 Fed. Reg. 27,074.

As relevant here, the Rule implements policies concerning the effectuation of new Exchange coverage when a customer owes past-due premiums to an issuer, *id.* at 27,084–91; the

requirement that recipients of APTCs file a federal tax return and reconcile those APTCs with the recipient's PTC amount, *id.* at 27,113–17; and the procedures HHS uses to annually redetermine Exchange enrollees' eligibility to receive APTCs, *id.* at 27,102–10. The Rule additionally makes changes to the procedures that HHS uses to verify enrollees' eligibility for APTCs, *id.* at 27,118–32; pauses an income-based special enrollment period ("SEP"), *id.* at 27,140–48; and amends certain verification procedures that apply to SEPs, *id.* at 27,148–52. The Rule also updates the methodology used to calculate the "premium adjustment percentage," *id.* at 27,166–74, and makes adjustments to the allowable ranges of actuarial values applicable to the different plan types sold on Exchanges, *id.* at 27,174–78.

HHS explained in the Rule's preamble that, "[b]ased on [its] review of enrollment data and [its] experience fielding consumer complaints," it believes that the "temporary expansion of ACA premium subsidies" via the ARPA and IRA "resulted in conditions that were exploited to improperly gain access to fully-subsidized coverage" on Exchanges. *Id.* at 27,074. More specifically, "the widespread availability" of fully subsidized plans—*i.e.*, plans with post-subsidy net premiums of $0—"created the incentive and opportunity for fraudulent and improper enrollments at scale," either by individual enrollees wanting no-cost Exchange coverage or by third-party brokers that collected commissions on improper enrollments that were made without customers' knowledge. *Id.* The Rule purports to "take[] a carefully curated set of temporary actions to immediately reduce the crisis-levels of improper enrollments over the short-term as the market readjusts to the new subsidy environment in which enhanced subsidies are no longer available." *Id.* The Rule also implements a number of "permanent reforms to help the markets reset to the changing subsidy environment to improve affordability and stability over the long-term" *Id.*

Plaintiffs contend that the Rule "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." ECF 11-1, at 8. According to Plaintiffs, "the [R]ule will lead to at least 1.8 million fewer people enrolling on the Exchanges." *Id.* (citing ECF 11-2, at 2 ¶ 4). Plaintiffs argue that "[t]he [R]ule 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." *Id.*

The Rule is set to take effect next week, on August 25, 2025, 90 Fed. Reg. 27,074, but many of its provisions will apply to Exchange plans that will first be available in 2026, *see id.* at 27,178–79.

C. Procedural History

Plaintiffs are three city governments—the City of Columbus, Ohio; the Mayor and City Council of Baltimore, Maryland; and the City of Chicago, Illinois (collectively the "City Plaintiffs")—and two nonprofit organizations, Main Street Alliance ("MSA"), a "national network of small businesses," and Doctors for America ("DFA"), an advocacy organization consisting of "member physicians and medical trainees . . . in all 50 states." ECF 1, at 5–6 ¶¶ 8–12. Plaintiffs seek review of agency action under the APA, claiming that three of the Rule's provisions are contrary to law (Count I), and that those same three provisions plus seven others are arbitrary and capricious (Count II).[5] *Id.* at 26 ¶¶ 74–82. On July 2, 2025, Plaintiffs filed a

[5] While the Complaint and the initial Motion sought relief on the revocation of the low-income SEP, Plaintiffs clarified in their Reply brief that they are no longer seeking a stay of that provision given the enactment of Pub. L. No. 119-21 §§ 71301–71305. ECF 30, at 15 n.7.

motion for preliminary relief, in which they seek a stay of the August 25, 2025 effective date of the challenged Rule provisions under 5 U.S.C. § 705 or, in the alternative, a preliminary injunction. *See* ECF 11. Defendants filed an opposition arguing that Plaintiffs lack standing to bring suit and the provisions at issue are lawful. *See* ECF 28. Plaintiffs filed a reply brief. *See* ECF 30. The Court held a hearing on the Motion on August 14, 2025. *See* ECF 34 (Tr. of Hearing). The Motion is now ripe for decision.

II. LEGAL STANDARDS

A. Preliminary Injunction / Section 705 Stay

A preliminary injunction is warranted when the movant demonstrates four factors: (1) that the movant is likely to succeed on the merits, (2) that the movant will likely suffer irreparable harm in the absence of preliminary relief, (3) that the balance of equities favors preliminary relief, and (4) that injunctive relief is in the public interest. *League of Women Voters of N.C. v. North Carolina*, 769 F.3d 224, 236 (4th Cir. 2014) (quoting *Winter v. Nat. Res. Def. Council, Inc.*, 555 U.S. 7, 20 (2008)); *Frazier v. Prince George's Cnty.*, 86 F.4th 537, 543 (4th Cir. 2023). Where the government is a party the balance of equities and public interest factors merge. *Nken v. Holder*, 556 U.S. 418, 435 (2009). The movant must establish all four elements to prevail. *Pashby v. Delia*, 709 F.3d 307, 320–21 (4th Cir. 2013). A preliminary injunction is an "extraordinary remed[y] involving the exercise of very far-reaching power [that is] to be granted only sparingly and in limited circumstances." *MicroStrategy, Inc. v. Motorola, Inc.*, 245 F.3d 335, 339 (4th Cir. 2001).

Section 705 of the APA permits a court to "issue all necessary and appropriate process to postpone the effective date of an agency action or to preserve status or rights pending conclusion of review proceedings" where "required and to the extent necessary to prevent irreparable injury." 5 U.S.C. § 705. "The factors governing issuance of a preliminary injunction

also govern issuance of a § 705 stay." *Casa de Maryland, Inc. v. Wolf*, 486 F. Supp. 3d 928, 950 (D. Md. 2020) (quoting *District of Columbia v. Dep't of Agric.*, 444 F. Supp. 3d 1, 16 (D.D.C. 2020)).

B. Review Under the APA

The APA requires courts to "hold unlawful and set aside agency action, findings, and conclusions" that are "arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law." 5 U.S.C. § 706(2)(A). Previously, "[w]hen a challenger assert[ed] that an agency action conflicts with the language of a statute, [the reviewing court] generally appl[ied] the two-step analytical framework set forth in *Chevron, U.S.A., Inc. v. Nat. Res. Def. Council, Inc.*, 467 U.S. 837, 842–43 (1984)." *City of Columbus*, 523 F. Supp. 3d at 744. However, *Loper Bright* overturned *Chevron* and changed this Court's role in reviewing an administrative agency's interpretation of a statute. *See Loper Bright Enters. v. Raimondo*, 603 U.S. 369, 412 (2024). Section 706 of the APA requires courts to decide "'all relevant questions of law' arising on review of agency action." *Id.* at 392 (quoting 5 U.S.C. § 706). "A court may give weight to an agency's authoritative interpretation but ultimately must rule on matters of law." *Molina-Diaz v. Bondi*, 128 F.4th 568, 574–75 (4th Cir. 2025) (first citing *Loper Bright*, 603 U.S. at 2262; and then citing *Skidmore v. Swift & Co.*, 323 U.S. 134, 140 (1944)); *see also Loper Bright*, 603 U.S. at 400–01 ("[A]gencies have no special competence in resolving statutory ambiguities. Courts do.").

"The scope of review under the 'arbitrary and capricious' standard is narrow and a court is not to substitute its judgment for that of the agency." *Motor Vehicle Mfrs. Ass'n of U.S., Inc. v. State Farm Mut. Auto. Ins. Co.*, 463 U.S. 29, 43 (1983). However, the agency must "articulate a satisfactory explanation for its action including a 'rational connection between the facts found

and the choice made.'" *Id.* (quoting *Burlington Truck Lines v. United States*, 371 U.S. 156, 168 (1962)). Agency action is generally considered arbitrary or capricious if the agency "has relied on factors which Congress has not intended it to consider, entirely failed to consider an important aspect of the problem, offered an explanation for its decision that runs counter to the evidence before the agency, or is so implausible that it could not be ascribed to a difference in view or the product of agency expertise." *Id.*

III. ANALYSIS

A. Standing

Standing is an "irreducible constitutional minimum" of federal jurisdiction. *Lujan v. Defs. of Wildlife*, 504 U.S. 555, 560 (1992). "The party invoking federal jurisdiction bears the burden of establishing" that it has standing. *Id.* Where a plaintiff lacks standing, "there is no case or controversy for the federal court to resolve." *TransUnion LLC v. Ramirez*, 594 U.S. 413, 423 (2021) (citation omitted). Standing "tends to assure that the legal questions presented to the court will be resolved, not in the rarified atmosphere of a debating society, but in a concrete factual context conducive to a realistic appreciation of the consequences of judicial action." *Valley Forge Christian Coll. v. Ams. United for Separation of Church & State*, 454 U.S. 464, 472 (1982). Thus, "[f]or a plaintiff to get in the federal courthouse door and obtain a judicial determination of what the governing law is, the plaintiff cannot be a mere bystander, but instead must have a 'personal stake' in the dispute." *Food & Drug Admin. v. All. for Hippocratic Med.*, 602 U.S. 367, 379 (2024) (quoting *TransUnion*, 594 U.S. at 423).

A plaintiff seeking relief in federal court must establish standing by showing: (1) that it suffered an injury in fact, which is a concrete and particularized harm that is actual or imminent, rather than hypothetical, (2) a causal connection between the injury and the challenged conduct that is fairly traceable to the defendant's actions, and (3) a non-speculative likelihood that the

injury will be redressed by a decision in the plaintiff's favor. *See Lujan*, 504 U.S. at 560–61. Only one Plaintiff must have standing for the case to proceed. *See Outdoor Amusement Bus. Ass'n, Inc. v. Dep't of Homeland Sec.*, 983 F.3d 671, 681 (4th Cir. 2020); *Bowsher v. Synar*, 478 U.S. 714, 721 (1986).

Defendants argue that each of Plaintiffs' "alleged injuries rests on speculative predictions about the Rule's potential effects on a complex health insurance market and a multistep chain of possibilities that is unlikely to materialize any time soon." ECF 28, at 12. Plaintiffs maintain that they "may challenge the rule to protect themselves from [uncompensated care costs and higher premiums], just as other providers of last resort were able to challenge other actions by CMS that predictably increased the cost of health care." ECF 30, at 7 (citing *Massachusetts v. U.S. Dep't of Health & Hum. Servs.*, 923 F.3d 209, 225 (1st Cir. 2019); *California v. Azar*, 911 F.3d 558, 571 (9th Cir. 2018); *Pennsylvania v. Trump*, 351 F. Supp. 3d 791, 807 (E.D. Pa. 2019), *aff'd*, 930 F.3d 543 (3d Cir. 2019), *rev'd on other grounds*, 591 U.S. 657 (2020); *U.S. House of Representatives v. Price*, Civ. No. 16-5202, 2017 WL 3271445, at *1 (D.C. Cir. 2017) (per curiam)). For the reasons stated below, the Court finds that Plaintiffs have established standing as to MSA and the City Plaintiffs based on the increased premiums and uncompensated care costs that are "predictable results" of the challenged provisions of the Rule. *City of Columbus*, 453 F. Supp. 3d at 791. As noted at the hearing, the Court has some doubt as to the extent of the injury to DFA, *see* ECF 34, at 7:12–17, but the Court need not reach the question of standing for DFA because only one Plaintiff must have standing for the case to proceed. *See Outdoor Amusement Bus. Ass'n,* 983 F.3d at 681. Because the Court has found that the other Plaintiffs have standing to sue, the Court defers judgment on the question of DFA's standing.

i. Main Street Alliance

Main Street Alliance is a "national association of approximately 30,000 small businesses." ECF 11-4 (Legler Decl.), at 1 ¶ 2. "[A]n association may have standing solely as the representative of its members." *Warth v. Seldin*, 422 U.S. 490, 511 (1975); *see also Hunt v. Wash. St. Apple Advert. Comm'n*, 432 U.S. 333, 343 (1977) ("[A]n association has standing to bring suit on behalf of its members."). This is often called "associational" standing, which is a type of representational standing. *White Tail Park, Inc. v. Stroube*, 413 F.3d 451, 459 n.3 (4th Cir. 2005). Here, as to MSA, Plaintiffs claim associational standing. For associational standing to exist, an organization must demonstrate that (a) "'its members would otherwise have standing to sue in their own right; (b) the interests it seeks to protect are germane to the organization's purpose; and (c) neither the claim asserted nor the relief requested requires the participation of individual members in the lawsuit.'" *Students for Fair Admissions, Inc. v. President & Fellows of Harvard Coll.*, 600 U.S. 181, 199 (2023) (quoting *Hunt*, 432 U.S. at 343).

1. Member Standing to Sue

As noted, the first element of associational standing requires that at least one member of each plaintiff organization has standing to sue in his or her own right. *Id.* Defendants argue that because Brooke Legler, the MSA member-declarant, ECF 11-4, fails to establish standing in her own right, MSA does not have associational standing to challenge the Rule. ECF 28, at 14. Defendants aver that "MSA attempts to base its associational standing on a single declaration from a member who owns a small business in Wisconsin and is enrolled in a health plan through the ACA's individual marketplace. ECF 28, at 12 (citing ECF 11-4, at 1 ¶¶ 1–4). According to Defendants, Legler "does not claim that any of the challenged Rule provisions would impact her directly or otherwise interfere with her eligibility to remain enrolled in her current Exchange plan." *Id.* at 13 (citation omitted). Further, Defendants maintain that Legler's "assertion that the Rule's impact on insurance markets more broadly will necessarily cause *her* particular insurance

premium to increase is likewise wholly speculative." *Id.* (emphasis in original) (citation omitted). Accordingly, Defendants conclude that Legler has "failed to establish that the future economic injury she claims she will suffer as a result of the Rule is sufficiently likely to materialize, let alone imminently so." *Id.* (cleaned up).

Plaintiffs respond that the Rule will "increase the cost of coverage," and "leav[e] members of [MSA] with the Hobson's choice of retaining less generous but costlier coverage or dropping out of coverage altogether." ECF 30, at 4. Plaintiffs point to the declaration of Christen Linke Young, a visiting fellow with the Brookings Center on Health Policy, ECF 11-2, at 1 ¶ 2, to show that "each of the challenged provisions will increase coverage costs by disproportionately driving younger and healthier people out of the Exchanges, worsening the risk pool for those who remain, increasing costs, and adding to existing headwinds for the individual insurance market." ECF 30, at 5 (citations omitted). According to Plaintiffs, MSA's "small business members [] can't opt out of the higher costs that will result from CMS's rule." *Id.* at 7.

Defendants' objection to Legler's standing on the basis that she "does not claim that any of the challenged Rule provisions would impact her directly or otherwise interfere with her eligibility to remain enrolled in her current Exchange plan," ECF 28, at 13, appears to be based on an incomplete reading of her declaration. Legler explains in detail her significant underlying condition, the cost of essential medication to treat that condition, and the freedom the ACA gave her to operate her small business while still maintaining affordable health insurance despite her condition. ECF 11-4, at 2 ¶¶ 6, 8. She goes on to explain that she "operate[s] [her] business on narrow margins" and the new Rule will "cause [her] health insurance coverage costs to increase to a level that [she] cannot afford." *Id.* at 3 ¶ 11. Legler explicitly affirms that "continuing [her]

business would not be an option" because the Rule will "cause [her] health insurance coverage costs to increase to a level that [she] cannot afford." *Id.* at 3 ¶¶ 11, 12. Legler attests that she would be "forced either to find different employment with employer-sponsored insurance, or to terminate [her] business and explore other coverage options through Wisconsin's BadgerCare system." *Id.* ¶ 11. Thus, Legler states with precision how the regulation change will directly impact her.

Defendants further argue that Legler "provides no factual basis for assuming that, even if there were some increase in her premium (whether caused by the Rule or not), she would ineluctably decide to drop her Exchange coverage, close down her business, and seek insurance elsewhere, notwithstanding her satisfaction with her current Exchange plan and the uncertainty of finding alternative coverage that is both adequate and affordable." ECF 28, at 13. This reading of Legler's declaration is inaccurate. Legler affirms that she "take[s] a biologic" which costs about $10,000 per month, ECF 11-4, at 2 ¶ 6, and she "would not be able to afford this medication without health insurance, or with a less comprehensive insurance plan," *id.* She emphasizes that the new Rule will "cause [her] health insurance coverage costs to increase to a level that [she] cannot afford." *Id.* at 3 ¶ 11. According to Legler, "[c]ontinuing [her] business would not be an option in this circumstance, because [she] need[s] to have access to affordable insurance that will cover the medications [she] need[s]." *Id.* ¶ 12. An "increase in premiums constitutes economic harm and is [] 'a classic and paradigmatic form of injury in fact[.]'" *City of Columbus*, 453 F. Supp. 3d at 787 (quoting *Air Evac EMS, Inc. v. Cheatham*, 910 F.3d 751, 760 (4th Cir. 2018)). Legler's attestations are thus sufficient to establish injury-in-fact for Article III standing purposes.

Further, the Court is satisfied that this injury is sufficiently likely to materialize, given the conclusions reached by independent experts on the effects of the Rule and the fact that at least one QHP insurer has already raised rates for 2026. *See* ECF 11-2, at 11 ¶ 29 (explaining that the Rule is expected "to increase net premiums for people receiving financial assistance, increase gross premiums for at least some plans, and impose additional administrative obstacles"); *see also* United Healthcare, *Optimum Choice, Inc., Part III: Actuarial Memorandum: PUBLIC; Maryland 2026 Individual Exchange Rates* 7 (May 22, 2025), https://perma.cc/35L2-M49D (increasing premiums to account for impact of Rule). Legler is not required to prove that she has suffered *actual* injury before filing suit. *See Adams v. Watson*, 10 F.3d 915, 921 (1st Cir. 1993) ("[I]t could hardly be thought that administrative action likely to cause harm cannot be challenged until it is too late." (quoting *Rental Hous. Ass'n of Greater Lynn v. Hills*, 548 F.2d 388, 389 (1st Cir. 1977))). Rather, Legler has shown enough to establish that there is a "'substantial risk' that the harm will occur." *Susan B. Anthony List v. Driehaus*, 573 U.S. 149, 158 (2014) (quoting *Clapper v. Amnesty Int'l, USA*, 568 U.S. 398, 409, 414 n.5 (2013)). Accordingly, Legler has suffered a concrete injury sufficient for Article III standing.

Separately, Defendants argue that the claimed harm is not traceable to the Rule provisions. ECF 28, at 13. "For an injury to be traceable, 'there must be a causal connection between the injury and the conduct complained of' by the plaintiff." *Air Evac EMS, Inc.*, 910 F.3d at 760 (quoting *Lujan*, 504 U.S. at 560). "The causation requirement precludes speculative links—that is, where it is not sufficiently predictable how third parties would react to government action or cause downstream injury to plaintiffs." *All. for Hippocratic Med.*, 602 U.S. at 383 (citing *Allen v. Wright*, 468 U.S. 737, 757–59 (1984)). Although a plaintiff's theory of standing may "not rest on mere speculation about the decisions of third parties[,]" it may "rel[y] instead

on the predictable effect of Government action on the decisions of third parties." *Dep't of Com. v. New York*, 588 U.S. 752, 768 (2019). In short, to establish causation, a plaintiff must show "a predictable chain of events leading from the government action to the asserted injury—in other words, that the government action has caused or likely will cause injury in fact to the plaintiff." *All. for Hippocratic Med.*, 602 U.S. at 385. Here, Plaintiffs have clearly articulated this "predictable chain of events." *Id.*

According to Defendants, "CMS attributes the estimated increase in 2026 premiums" not to the changes embodied in the Rule, but "to the expiration of the enhanced subsidies that were enacted during the COVID-19 pandemic—a statutory change that Plaintiffs do not challenge." ECF 28, at 14 (citing 90 Fed. Reg. at 27,212). Defendants posit that "the Rule will actually cause premiums to be *lower than* they would be otherwise in that post-expiration environment." *Id.* (emphasis in original) (citations omitted). In response, Plaintiffs argue that "CMS cites to the rule's regulatory impact analysis, which projects that it will lead to lowered premiums . . . [b]ut this was based entirely on a projected decrease from the termination of the low-income special enrollment period."[6] ECF 30, at 5 n.1. Plaintiffs point out that "CMS acknowledges that the remaining challenged provisions will increase premiums and net costs for consumers, and indeed the agency repeatedly points to these acknowledgements to defend the rationality of its rulemaking." *Id.* (citations omitted).

The Court is unpersuaded by Defendants' attempt to blame the increased cost of premiums on the expiration of subsidies alone. First, CMS itself has acknowledged in various sections of the challenged provisions that there will be increased premiums and costs for

[6] Plaintiffs clarify that the "projection was never credible, but any dispute on this score is now immaterial, as Plaintiffs no longer challenge" the Rule's provision addressing termination of the low-income special enrollment period. ECF 30, at 5 n.1.

consumers as a result of the implementation of the Rule. *See* 90 Fed. Reg. at 27,212; *see also id.* at 27,107 (reconfirming eligibility rule); *id.* at 27,171 (premium adjustment percentage); *id.* at 27,176–77 (actuarial value calculations); *id.* at 27,192 (guaranteed issue); *id.* at 27,116 (failure-to-reconcile policy); *id.* at 27,119, 27,131 (data matching policies). And as Plaintiffs point out, the Court "[need not] guess how the market will respond to the rule; insurers have already begun to increase their rates in response to the rule." ECF 30, at 6. In issuing 2026 Individual Exchange Rates in Maryland, UnitedHealthcare issued the following statement: "An adjustment of 1.009 was applied to account for the impact of the CMS 2025 Marketplace Integrity and Affordability Proposed Rule. We believe that the changes in the proposed rule, including shortening of the open enrollment period and stricter verification requirements, 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. Thus, the Court finds that Plaintiffs have offered "independent analyses and issuers' explanations [to] confirm . . . that Defendants' actions [will] cause[] price increases." *City of Columbus*, 453 F. Supp. 3d at 789. Finally, while the expiration of subsidies will plausibly cause an increase in premiums, that fact does not defeat causation, as Defendants' actions need not be "the sole or even immediate cause of the injury." *Sierra Club v. U.S. Dep't of the Interior*, 899 F.3d 260, 284 (4th Cir. 2018). Accordingly, the injury is fairly traceable to Defendants' conduct because Plaintiffs have established that "insureds and issuers reacted in predictable ways to Defendants' actions." *City of Columbus*, 453 F. Supp. 3d at 789.

Defendants do not appear to directly challenge redressability. *See* ECF 28. The Court is satisfied that the relief sought here—a stay enjoining the agency from enforcing the challenged

provisions—would redress Plaintiffs' injuries by "ameliorating the predictable results of Defendants' challenged actions." *City of Columbus*, 453 F. Supp. 3d at 792. As such, Legler has established standing to sue in her own right, and therefore MSA also has associational standing to sue, so long as the organization can satisfy the second and third prongs of associational standing.

2. Interests Germane to Organization's Purpose

As discussed, the second element of associational standing requires that the interests the organization "seeks to protect are germane to the organization's purpose." *Students for Fair Admissions, Inc.*, 600 U.S. at 199 (quotation marks and citation omitted). Shawn Phetteplace, the National Campaigns Director at MSA, indicates that "MSA [] 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." ECF 11-3, at 1 ¶ 2. According to Phetteplace, "MSA's founding was directly focused on the passage of the [ACA], and the organization has remained focused on the subsequent strengthening of the law over the past 15 years." *Id.* at 2 ¶ 6. "According to a recent survey, over 45% of MSA members access health insurance either through the marketplace or Medicaid." *Id.* ¶ 3. Defendants do not contend that the interests of Plaintiffs in protecting their members' ability to operate their businesses with affordable health insurance are not germane to MSA's purpose. The Court is therefore satisfied that the interests MSA seeks to protect are "germane" to MSA's organizational purposes.

3. Individual Member Participation

The third element of associational standing requires that "neither the claim asserted nor the relief requested requires the participation of individual members in the lawsuit." *Students for Fair Admissions, Inc.*, 600 U.S. at 199 (quotation marks and citation omitted). "'[I]ndividual

participation' is not normally necessary when an association seeks prospective or injunctive relief for its members . . . ." *United Food & Com. Workers Union Loc. 751 v. Brown Grp., Inc.*, 517 U.S. 544, 546 (1996) (quoting *Hunt*, 432 U.S. at 343).

Plaintiffs seek a stay under § 705 of the APA, not monetary damages. If MSA's members were to each bring suit on their own behalf, the challenged conduct would generally implicate the same facts, the same defendants, and the same arguments regarding rulemaking procedure.[7] The Court is thus satisfied that the participation of individual members is not necessary. In sum, MSA has established associational standing to sue.

ii. City Plaintiffs

The Court now turns to standing for the City Plaintiffs. As noted, to establish injury in fact, "a plaintiff must show that he or she suffered 'an invasion of a legally protected interest' that is 'concrete and particularized' and 'actual or imminent, not conjectural or hypothetical.'" *Spokeo, Inc. v. Robins*, 578 U.S. 330, 339 (2016) (quoting *Lujan*, 504 U.S. at 560). A future injury must be "certainly impending." *Clapper*, 568 U.S. at 409. "If a defendant's action causes an injury, enjoining the action or awarding damages for the action will typically redress that injury." *All. for Hippocratic Med.*, 602 U.S. at 381.

Plaintiffs argue that "[b]y 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." ECF 11-1, at 44. The City Plaintiffs will "have no choice but to take on increased costs as a direct result of the rule's impact on the healthcare marketplace." ECF 30, at

[7] Additionally, Defendants have not asserted that individual member participation is required for the relief requested.

7. According to Plaintiffs, the cities "must provide care whether or not [residents] are compensated by insurance," thus as "providers of last resort," they are able to challenge the actions by CMS that "predictably increase[] the cost of health care." *Id.* The Court finds that this is sufficient to show injury-in-fact, as the City Plaintiffs will bear additional economic costs that come with treating people left uninsured by the implementation of the Rule. *See City of Columbus*, 453 F. Supp. 3d at 787–88 (finding plaintiffs had standing to sue where policies shifted costs onto city governments to provide uncompensated healthcare); *see also Massachusetts*, 923 F.3d at 223 (finding injury-in-fact where "the Commonwealth has demonstrated that there is a substantial risk of fiscal injury to itself").

Defendants maintain that the injury claimed by City Plaintiffs "lies at the end of a highly attenuated chain of possibilities." ECF 28, at 16 (citation omitted). Defendants argue that "the budgetary harms they fear could materialize only if (1) the Rule provisions Plaintiffs challenge cause a certain number of individuals currently enrolled in Exchange plans to disenroll or otherwise lose coverage, and (2) a portion of that recently uninsured group—which, Plaintiffs note, is likely to be 'relatively young[] and health[y],'—seeks medical care (3) in the city Plaintiffs' jurisdictions (4) specifically at city-run health care facilities (rather than privately operated ones) or through a city-funded emergency medical service and (5) receives services at such a rate that the cities (6) are required to increase the budgets for their respective public health departments to cover that increase in potentially uncompensated care." ECF 28, at 16 (citing ECF 11-2, at 2 ¶ 5). Defendants aver that standing cannot derive from such a "lengthy chain of assumptions." ECF 28, at 17 (citing *Chambliss v. Carefirst, Inc.*, 189 F. Supp. 3d 564, 569 (D. Md. 2016)).

Importantly, however, "[a] causal chain does not fail simply because it has several 'links,' provided those links are not hypothetical or tenuous." *Maya v. Centex Corp.*, 658 F.3d 1060, 1070 (9th Cir. 2011) (internal quotation marks and citation omitted); *see also California*, 911 F.3d at 571 (finding standing where the interim final rules "first le[]d to women losing employer-sponsored contraceptive coverage, which [] then result[ed] in economic harm to the states"). In *City of Columbus v. Trump*, Judge Chasanow, in evaluating a nearly identical fact pattern involving the same plaintiffs, held that the plaintiffs had standing to challenge the provisions at issue in that case. 453 F. Supp. 3d at 788. There, defendants lodged a similar argument to the one advanced here, namely that the alleged injury to the plaintiffs was founded on a "number of uncertain links in the causal chain, which are either premised on invalid assumptions or are attributable to the City Plaintiffs themselves." *Id.* Judge Chasanow noted that "this challenge does not dispute that budgetary outlays constitute injury in fact but rather focuses on traceability." *Id.* Ultimately, Judge Chasanow held that Plaintiffs "tie[d] . . . the challenged provisions of the 2019 Rule to increased costs, inaccessibility of quality coverage, and rises in the uninsured and underinsured rates." *Id.* at 790–91. The holding was based on numerous "allegations outlin[ing] the predictable results of the 2019 Rule." *Id.* at 791.

Here, the City Plaintiffs have adequately "outline[d] the predictable results" of the challenged provisions of the Rule. *Id.* First, Plaintiffs have pointed to sufficient record evidence to establish that the rate of uninsured people will go up as a direct result of the implementation of the Rule, a fact confirmed in the Rule itself. *See* ECF 11-2, at 2 ¶ 4 (estimating 1.8 million more people will be insured as a result of the Rule); *see also* 90 Fed. Reg. at 27,074, 27,213 (acknowledging that the Rule will cause at least 800,000 Americans to lose coverage). As Young explains, "[t]he decrease in Marketplace enrollment and increase in the uninsured will result in

[an] increased burden of uncompensated care, especially for safety net providers." ECF 11-2, at 3 ¶ 6. Dr. Olusimbo Ige, the Commissioner of Chicago's Department of Public Health, explains that "[i]n Chicago's experience, the uninsured and underinsured disproportionately rely on ambulance services for transport to the emergency department." ECF 11-9, at 5–6 ¶ 14. Because such individuals 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." *Id.* Additionally, Ige affirmed that "[t]he 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." *Id.* at 3 ¶ 6.

Similarly, Edward Johnson, the Assistant Public Health Commissioner for External Affairs for the Columbus Department of Public Health, and Faith Leach, the Chief Administrative Officer of the City of Baltimore, outlined the same effects on the cities of Columbus and Baltimore. *See* ECF 11-7 (Johnson Decl.), at 2–3 ¶¶ 9–11 (noting that if the rate of uninsured individuals increases, the health care system designed to serve the uninsured residents within the community "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"); ECF 11-8 (Leach Decl.), at 3–4 ¶¶ 12, 13 (explaining that an increased uninsured rate will cause "further strain on a system that is already overstretched," and more ambulance calls for which Baltimore does not receive reimbursement and must make up for in its budget). What is more, the Rule itself acknowledged that if enrollees become uninsured as a result of the Rule, they "may face higher costs for care and medical debt

if care is needed," and that "[t]hese costs may, in turn, be incurred by hospitals and municipalities in the form of uncompensated care." 90 Fed Reg. at 27,192; *see also* 90 Fed. Reg. at 27,213 (acknowledging that an "increase in the rate of uninsurance may impose greater burdens on the health care system through strain on emergency departments").

Accordingly, the Court finds that the City Plaintiffs have sufficiently shown that they are likely to suffer financial injury because the Rule will directly lead to increased costs incurred by the City Plaintiffs in the form of shouldering the expense of uncompensated care. Further, the asserted imminent fiscal injury is clearly "fairly traceable" to the Defendants' actions. *Lujan*, 504 U.S. at 560–61. As to redressability, a stay preventing the challenged provisions from going into effect would unquestionably stop the alleged fiscal injury from occurring. Therefore, the City Plaintiffs have established standing.[8]

B. Motion to Stay

As noted above, Plaintiffs challenge nine provisions as either contrary to law, arbitrary and capricious, or both. Plaintiffs initially challenged the revocation of the low-income SEP in their opening brief but abandoned that claim on Reply. *See* ECF 30, at 15 n.7 ("Given the enactment of Pub. L. No. 119-21 §§ 71301–71305, Plaintiffs no longer seek a Section 705 stay with respect to the revocation of the low-income special enrollment period."). Plaintiffs separate their challenges into three categories: challenges to provisions that erode the value of coverage, challenges to provisions that impose barriers on enrollment, and challenges to provisions that limit the availability of subsidized coverage. ECF 11-1, at 2.

Plaintiffs' first three challenges under the "erosion of the value coverage" section seek relief from a provision imposing a monthly surcharge of $5 on enrollees to reconfirm eligibility,

[8] As previously described, the Court need not reach the question of standing for DFA at this time.

a provision revising the premium adjustment methodology, and a provision revising the actuarial value policy. *See generally* ECF 11-1. Plaintiffs' next two challenges under the "barriers to enrollment" section seek relief from a provision requiring enrollees to pay past-due premiums before receiving new coverage and a provision adding verification requirements for SEP enrollments. *Id.* Plaintiffs' final three challenges under the "limiting the availability of subsidized coverage" section seek relief from a provision re-instituting a policy regarding failure-to-reconcile tax data and two provisions requiring heightened income verification when a person's projected annual income does not match IRS data or when tax data is unavailable. *Id.* The Court will address each challenge in turn.

1. Likelihood of Success on the Merits

i. Eligibility Redetermination / Imposition of a "Junk Fee"

As noted, a taxpayer is eligible for tax credits to cover the cost of premiums 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). As Plaintiffs describe, "[t]he amount of the tax credit is determined by the taxpayer's income and the cost of a benchmark plan offered through the Exchange." ECF 11-1, at 20 (citing 26 U.S.C. § 36B(b)). Additionally, "[e]ligibility for, and the amount of, APTCs turn on the same statutory criteria." *Id.* (first citing 42 U.S.C. § 18081(a)(2), and then citing *id.* § 18082(a)(1)). The Rule provides that (1) if an enrollee does not submit an application for an updated APTC eligibility determination for plan year 2026 on or before the deadline to select Exchange coverage and (2) that enrollee's post-APTC premium will be zero dollars (*i.e.*, the enrollee's coverage will be fully subsidized), then (3) the Exchange "must decrease the amount of" the APTC "applied to the [enrollee's] policy such that the remaining monthly premium owed for the policy equals $5."

90 Fed. Reg. at 13,031. Plaintiffs colorfully describe this requirement to reduce the value of the APTC by at least $5.00 a month as a "junk fee." ECF 11-1, at 20.

To justify the fee, Defendants argue that "many consumers are unknowingly enrolled in [subsidized Exchange] plans or in multiple forms of coverage" because brokers allegedly improperly enroll consumers in fully subsidized plans to earn commission payments. ECF 28, at 32. According to Defendants, these "improper enrollments can persist due to enrollees being continuously reenrolled in fully subsidized Exchange plans from year to year without having to take any action." *Id.* Defendants maintain that "[t]he Rule [] addresses this enrollment issue by 'prompt[ing]' individuals enrolled in fully subsidized Exchange plans 'to update or confirm' their eligibility for such plans 'or else pay a $5 monthly premium' until they do so." *Id.* at 33 (first quoting 90 Fed. Reg. at 27,103; and then citing *id.* at 27,102).[9]

As the basis for the agency's authority, Defendants argue that the "ACA grants the HHS Secretary the authority to 'establish a program' for making [APTC] eligibility determinations and to 'establish procedures' for 'redetermin[ing] eligibility on a periodic basis in appropriate circumstances.'" ECF 28, at 34 (first quoting 42 U.S.C. § 18081(a)(1); and then quoting *id.* § 18081(f)(1)(B)). Plaintiffs acknowledge the agency's obligation to redetermine eligibility on a periodic basis in appropriate circumstances. ECF 11-1, at 20 (citations omitted). However, they argue that "CMS's authority under the statute is to determine *whether* the statutory criteria for APTC eligibility are met, not to *alter* those criteria." *Id.* (emphasis added) (citing *Neumann v. Prudential Ins. Co. of Am.*, 367 F. Supp. 2d 969, 975 (E.D. Va. 2005)). Plaintiffs contend that "[n]othing in section 18081 or the remainder of the Act grants CMS the power to change the

[9] The Rule states that "the full amount of" an enrollee's APTC will be "reinstate[d]" once the enrollee submits an application "confirm[ing] [their] eligibility for APTC that covers the entire monthly premium." 90 Fed. Reg. at 27,102.

statutory calculation" to reduce APTCs by $5 per month for applicants who automatically re-enroll in a plan that would otherwise be fully subsidized. *Id.*

Relying on 42 U.S.C. § 18081(a)(2), Defendants counter that the "ACA tasks HHS with 'determining' whether individuals enrolled in Exchange plans 'meet[] the income and coverage requirements' for claiming PTCs, and with determining 'the amount' of those tax credits." ECF 28, at 34 (quoting 42 U.S.C. § 18081(a)(2)).[10] Defendants further argue that it is "likewise HHS's responsibility to determine an Exchange enrollee's eligibility for APTCs and to calculate the amount of those APTCs (which mirror the applicable PTC amount)." *Id.* (first citing 42 U.S.C. § 18082(a)(1), (3); and then citing 45 C.F.R. § 155.305(f)(5)). Importantly, however, 26 U.S.C. § 36B provides a formula for calculation of tax credits, which is determined by income and the cost of a benchmark plan offered through the Exchange. That statutory provision states:

> The premium assistance amount determined under this subsection with respect to any coverage month is the amount equal to the lesser of—
>
> (A) the monthly premiums for such month for 1 or more qualified health plans offered in the individual market within a State which cover the taxpayer, the taxpayer's spouse, or any dependent (as defined in section 152) of the taxpayer and which were enrolled in through an Exchange established by the State under 1311 of the Patient Protection and Affordable Care Act, or
>
> (B) the excess (if any) of—
>
> > (i) the adjusted monthly premium for such month for the applicable second lowest cost silver plan with respect to the taxpayer, over
> > (ii) an amount equal to 1/12 of the product of the applicable percentage and the taxpayer's household income for the taxable year.

[10] Under 42 U.S.C. § 18081(a)(2), the Secretary "shall establish a program meeting the requirements of this section for determining . . . in the case of an individual claiming a premium tax credit or reduced cost-sharing under section 36B of title 26 or section 18071 of this title—(A) whether the individual meets the income and coverage requirements of such sections; and (B) the amount of the tax credit or reduced cost-sharing."

26 U.S.C. § 36B. The agency cannot utilize its general rulemaking authority to override explicit statutory provisions. *See Air All. Hous. v. EPA*, 906 F.3d 1049, 1061 (D.C. Cir. 2018) ("[I]t is well established that an agency may not circumvent specific statutory limits on its actions by relying on separate, general rulemaking authority."). As such, CMS lacks authority to tinker with the premium cost structure outlined in 26 U.S.C. § 36B.

Relatedly, CMS does not have the authority to change the statutory formula for APTCs under 42 U.S.C. § 18081(f)(1)(B). That section provides that the Secretary of HHS "shall establish procedures by which the Secretary or one of such other Federal officers—redetermines eligibility on a periodic basis in appropriate circumstances." 42 U.S.C. § 18081(f)(1)(B). The Court finds that the relatively limited grant of authority to "redetermine[] eligibility" for APTCs under "appropriate circumstances" does not encompass broad power to adjust the amount of APTCs, which are set according to a statutory formula. *Id.* According to Defendants, "the provision's very purpose is to facilitate HHS's ability to *redetermine* enrollees' *eligibility* to remain enrolled in fully subsidized Exchange plans, and the 'procedure[]' HHS opted for in the Rule is the assessment of a nominal premium that is designed to prompt certain enrollees to affirmatively reconfirm their eligibility." ECF 28, at 34 (emphasis in original) (quoting 42 U.S.C. § 18081(f)(1)(B)). But "an agency may not rewrite clear statutory terms to suit its own sense of how the statute should operate." *Util. Air Regul. Grp. v. EPA*, 573 U.S. 302, 328 (2014). Merely stating that the purpose of the provision comports with the agency's general rulemaking authority to "redetermine eligibility" does nothing to address Plaintiffs' argument that Defendants were not free to choose a procedure that "change[d] the statutory calculation in this way." ECF 11-1, at 20. Defendants' interpretation of its authority stretches the "redetermine eligibility" language beyond its plausible meaning and scope. *See Util. Air Regul. Grp.*, 573

U.S. at 328 ("Agencies are not free to "adopt . . . unreasonable interpretations of statutory provisions and then edit other statutory provisions to mitigate the unreasonableness." (quotation marks and citation omitted)). In short, the authority to verify eligibility does not infuse the agency with authority to re-write Congress's unambiguous statutory formulas. Indeed, even Defendants, in a separate section of their brief, explicitly acknowledge that tax credits are based on a statutory formula:

> Eligibility to claim such a premium tax credit [] is governed by the Internal Revenue Code [], which provides that an 'applicable taxpayer' whose annual household income is below a certain level can claim on his federal return a PTC amount that turns on (1) the percentage of annual household income that the individual is required to contribute to monthly health insurance premiums (as prescribed by statute) and (2) the monthly premium cost of a "benchmark" silver plan on the relevant Exchange.[11]

ECF 28, at 24 (citing 26 U.S.C. § 36B(b)(2)–(3)).[12]

The Court finds that HHS lacks the authority to impose a fee on plans that would otherwise be fully subsidized through APTCs via the formula prescribed by Congress. There are explicit formulas in the statutes for calculating APTCs, and Defendants do not have authority to re-write those formulas by reading broad authority into the limited statutory directive allowing HHS to "redetermine[] eligibility" for enrollment under "appropriate circumstances." 42 U.S.C. § 18081(f)(1)(B). Additionally, the Court agrees that the "Treasury's obligation is to pay the

[11] Defendants further acknowledge that "[a]n individual's eligibility for these APTCs is tied to his or her eligibility for PTCs[.]" ECF 28, at 25 (citing 42 U.S.C. § 18082(c)).

[12] Though certainly not conceding the point, Defendants at least acknowledged at the hearing that there exists an incongruity between the imposition of the $5.00 charge and the statutory framework for setting APTCs. *See* ECF 34, at 72:9–15 ("And I think, Your Honor, if I were to concede of the three contrary to law claims here, this one [the "junk fee"], I think, is a little bit less clear-cut for us in that [the question] does amount to, is this Agency's authority to re-determine eligibility, does that encapsulate its ability to -- or its obligation, also, to determine eligibility for a set amount of an advanced premium tax credit?").

amount that would be owed under the section 36B formula, not a different amount arbitrarily selected by CMS." ECF 11-1, at 21.

In short, Plaintiffs are likely to succeed in showing that the "junk fee" provision is contrary to law because applicants cannot be compelled to pay a fee that is untethered to the statutory formula.[13]

ii. Revised Premium Adjustment Percentage Methodology

The ACA directs the HHS Secretary to determine an annual "premium adjustment percentage" based on "the average per capita premium for health insurance coverage in the United States for the preceding calendar year." 42 U.S.C. § 18022(c)(4). This measure of premium growth is then used to set the rate of increase for a number of parameters defined in the ACA, such as the maximum annual limitation on cost sharing under Exchange plans, *see* 45 C.F.R. 156.130(a). Because the IRS traditionally adopts the same premium growth indexing methodology as HHS, the methodology used to calculate the premium adjustment percentage also affects how PTC and APTC amounts are calculated and, by extension, the cost of health care coverage on Exchanges.[14] *See* 90 Fed. Reg. at 27,171. HHS presently only considers premiums for *employer*-sponsored coverage in the premium adjustment percentage calculation, not insurance purchased by *individuals* on the marketplace. The Rule, however, incorporates

[13] Because the Court finds that Plaintiffs are likely to succeed on their argument that this provision of the Rule is contrary to law, the Court need not reach Plaintiffs' alternative argument that adopting the provision was arbitrary and capricious.

[14] In the reply brief, Plaintiffs confirmed: "[a]s expected, after we filed our opening brief, the IRS followed its ordinary practice of deferring to CMS's calculation, thereby confirming that tax credits will be lower for Exchange enrollees across the board." ECF 30, at 12 (first citing Rev. Proc. 2025-25, https://perma.cc/SZ5A-LDBG; and then citing Gideon Lukens and Elizabeth Zhang, Centers for Budget & Policy Priorities, *Administration's ACA Marketplace Rule Will Raise Health Care Costs for Millions of Families* (Aug. 1, 2025), https://perma.cc/VZ43-SNJY).

individual insurance market data into this measure. *Id.* at 27,169. Section 1302(c)(4) of the ACA and § 156.130(e) provide that the premium adjustment percentage is the percentage (if any) by which the average per capita premium for health insurance coverage for the preceding calendar year exceeds such average per capita premium for health insurance for 2013. *Id.* at 27,166. In response to the proposed rule, commenters expressed concern that "individual market premiums should not be used to measure premium growth since 2013 because premiums in the early years of ACA were volatile[.]" *Id.* at 27,173.

Plaintiffs contend that "[a]s a result" of the Rule's incorporation of individual plan prices into the premium growth indexing methodology, "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." ECF 11-1, at 24 (citing 90 Fed. Reg. at 27,206). According to Plaintiffs, "[t]his will lead to increased premiums across the board and 80,000 fewer enrollments in the Exchanges under CMS's own estimates, running the risk of a spiral of a worsening risk pool and increased premiums, as well as higher volumes of uninsured patients being seen by health centers." *Id.* (internal quotation marks and citations omitted). Plaintiffs argue that "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." ECF 11-1, at 25 (first citing 90 Fed. Reg. at 27,172, then citing 90 Fed. Reg. 12,942, 12,990 (Mar. 19, 2025)). Plaintiffs conclude that "CMS was not free to disregard the costs it was imposing on Exchange enrollees." *Id.*

Defendants do not dispute that the new Rule will affect the cost of Exchange plans. *See* ECF 28, at 50 ("HHS acknowledges that the new methodology will increase the maximum annual limitation on cost sharing and net premiums for enrollees with incomes under 400 percent

of the FPL, which could in turn negatively impact the cost of Exchange coverage and enrollment." (citing 90 Fed. Reg. at 27,171, 27,206–07)). However, Defendants maintain that "any such impact would be a consequence of *Congress's* decision to tie the value of certain forms of financial assistance under the ACA to the premium adjustment percentage." ECF 28, at 50 (emphasis in original). Defendants also argue that "HHS [] concluded—and reasonably so—that a premium adjustment percentage methodology that considers 'all private health insurance premiums' is 'more consistent with' that congressional intent and the ACA's text." ECF 28, at 50 (quoting 90 Fed. Reg. at 27,172). In the Rule, CMS explained that "[b]ecause the role of the premium adjustment percentage is to appropriately index various parameters defined in the ACA, the primary consideration for setting the value of the premium adjustment percentage should be whether it accurately and comprehensively captures the rate of premium growth in the United States rather than the impact of the indexing methodology on net premiums, enrollment, access to health care, health outcomes, or out-of-pocket costs for those who receive non-covered or out-of-network care." 90 Fed. Reg. at 27,172. According to the agency, "[c]onsidering these other impacts when setting the premium adjustment percentage may result in a measure of premium growth that does not accurately reflect actual premium growth in the United States, artificially inflating the generosity of provisions of the ACA beyond the intent of Congress." *Id.*

That the agency changed its view on how to set the premium adjustment percentage does not mean its position was not substantially justified. "Agencies are free to change their existing policies as long as they provide a reasoned explanation for the change." *Encino Motorcars, LLC v. Navarro*, 579 U.S. 211, 221 (2016). "In such cases it is not that further justification is demanded by the mere fact of policy change; but that a reasoned explanation is needed for

disregarding facts and circumstances that underlay or were engendered by the prior policy." *FCC v. Fox Television Stations, Inc.*, 556 U.S. 502, 515–16 (2009). "We defer to the agency's new position no less than the old, so long as we are satisfied that the agency's change in position was intentional and considered." *Philip Morris USA, Inc. v. Vilsack*, 736 F.3d 284, 290 (4th Cir. 2013).

Here, the agency's change in position was not arbitrary and capricious because it provided the necessary reasoned explanation for the change. In the Rule, HHS clarified that premiums from the individual market were previously excluded because they were "most affected by the significant changes in benefit design and market composition in the early years of implementation of the ACA market rules and were most likely to be subject to risk premium pricing," and later, in 2022, the agency "anticipated that these premiums would be more volatile in response to the COVID-19 PHE than employer-sponsored premiums." 90 Fed. Reg. at 27,173. However, the agency reasoned that "the ACA is now past the initial years of implementation and issuers have had the opportunity to collect data on the risk composition of the individual market and adjust pricing accordingly . . . [a]dditionally . . . premiums in the employer-sponsored market increased more rapidly than premiums in the individual market during the COVID-19 PHE, the impact of which has led to a decreasing gap in premium growth between the individual market and employer-sponsored market." *Id.* In light of those findings, the agency determined that "a comprehensive measure incorporating both individual market and employer-sponsored premiums will more accurately reflect true premium growth going forward." *Id.*

While Plaintiffs argue that the agency "entirely failed to engage with the point raised by commenters that the new methodology was *less* accurate, since it incorporated data from individual insurance premiums in 2013 that wouldn't provide an apples-to-apples measure of

growth in health care costs, but that would inevitably inflate the premium adjustment percentage," ECF 30, at 13, the Rule reflects that the agency explicitly responded to this concern by commenters:

> We acknowledge that the premium adjustment percentage is a cumulative measure and, as such, the market fluctuations in the early years of ACA implementation are included in the calculation when using private health insurance premiums (excluding Medigap and property and casualty insurance) as the data source for indexing. However, because it is a cumulative measure, the impact of these early years decreases as more time elapses between the applicable plan year and the benchmark year (2013). For example, for PY 2018, PY 2014 was 1 of 4 years of growth included in the premium adjustment percentage measure and therefore the weight of PY 2014 premium growth was approximately one quarter of the overall measure. For PY 2026, PY 2014 is 1 of 12 years of growth included in the measure. Therefore, for PY 2026, the weight of PY 2014 is only one twelfth of the overall measure. As such, the greater time between the benchmark year and the applicable plan year reduces the impacts of any individual year, even if the premium growth in that year is unusual.

90 Fed. Reg. at 27,173. HHS both explained the reasoning behind the policy change and addressed commenters' concerns that the new methodology would lead to less accurate measures of premium growth. While this policy change will undoubtedly have effects on the broader insurance market, including, as HHS concedes, an increase in premiums and a worsening risk pool, the Court is constrained to conclude that HHS did not act without explanation or rationale in making this decision. In fact, the agency took these negative effects into account when responding to comments in the final Rule, but ultimately concluded that the new methodology was more closely aligned with Congressional intent and the text of the ACA, and therefore should nonetheless be adopted. *See id.* at 27,172 (acknowledging commenters' concern that healthy enrollees "may be less likely to enroll due to the higher net premiums that result from the change in the premium adjustment methodology" but ultimately finding "consideration of the impact of this proposal on the risk pool to be outside the scope of the indexing provisions of

the ACA because the purpose of the premium adjustment percentage is to accurately index program parameters against the growth in premiums, not to control the growth of those premiums"). Accordingly, the Court is satisfied that "such a change in course was made as a genuine exercise of the agency's judgment." *Philip Morris*, 736 F.3d at 290; *see also City of Columbus*, 523 F. Supp. 3d at 758 ("The court may not supplant the agency's view that the new policy is better than the old one simply because Plaintiffs prefer the old policy.").[15] Consequently, Plaintiffs have not shown likelihood of success on the merits on their claim that the provision was arbitrary and capricious.

iii. Actuarial Value Policy

Under the ACA, health insurance plans offered on Exchanges must cover certain "essential health benefits" and adhere to certain "level[s] of coverage" specified in the statute. 42 U.S.C. § 18022(a). A plan's "level of coverage," or actuarial value, reflects the estimated average percentage of covered health care expenses that will be paid by the insurance plan. For example, under a plan with an actuarial value of 80%, the insurer will pay, on average, 80% of covered medical expenses, and the enrollee will pay the remaining 20% of expenses through a combination of deductibles, coinsurance, co-payments, and maximum out-of-pocket limits. Consequently, the higher a plan's actuarial value, the lower an enrollee's out-of-pocket costs, on average. Plans that have a higher actuarial value also have higher premiums.

[15] In light of the Court's finding on this point, the Court is unconvinced that Plaintiffs' argument that the agency had an "unalterably closed mind" during rulemaking could provide an independent basis for relief on this claim. ECF 11-1, at 25. The examples put forth by Plaintiffs, *see id.*, are insufficient to show that Defendants were "unwilling or unable to rationally consider arguments." *Mississippi Comm'n on Env't Quality v. EPA*, 790 F.3d 138, 183 (D.C. Cir. 2015) (quotation marks and citations omitted).

The statute instructs the Secretary 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." 42 U.S.C. § 18022(d)(3). As relevant here, current regulations provide that the "allowable variation" in the actuarial value of silver, gold, and platinum plans is two percentage points above and below their respective benchmark actuarial values (*i.e.*, +2/-2 percentage points). 45 C.F.R. § 156.140(c)(2). The Rule will change this range to +2/-4 percentage points. *See* 90 Fed. Reg. at 27,174. And for bronze plans, current regulations allow for a +5/-2 percentage point range, which the Rule will change to +5/-4 percentage points. *Id.*

Plaintiffs explain that "[t]he formula for PTCs turns on the cost of the second-lowest-cost silver plans available on the Exchange." ECF 11-1, at 26 (citing 26 U.S.C. § 36B(b)(2)(B)). Thus, "[b]y 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." *Id.* (citing 90 Fed. Reg. at 27,208). Plaintiffs argue that "[t]he rule does not even attempt to justify the new policy as an effort to account for differences in actuarial estimates." *Id.* at 27 (citation omitted). Defendants counter that "CMS [] made the reasoned judgment that such 'short-term' concerns about how wider ranges would affect subsidized enrollees should not necessarily take priority over the longer-term prospect of plans with lower premiums and competitive cost-sharing structures drawing unsubsidized consumers to Exchanges, 'potentially improv[ing] the risk pool as coverage becomes more affordable for generally healthy people who currently may opt to forgo coverage altogether.'" ECF 28, at 54 (quoting 90 Fed. Reg. at 27,175).

Generally, "an agency decision is arbitrary and capricious if 'the agency has relied on factors which Congress has not intended it to consider, entirely failed to consider an important aspect of the problem, offered an explanation for its decision that runs counter to the evidence before the agency, or is so implausible that it could not be ascribed to a difference in view or the product of agency expertise.'" *Sierra Club*, 899 F.3d at 293 (quoting *Motor Vehicle Mfrs. Ass'n*, 463 U.S. at 43). Defendants posit that "HHS [] made the reasonable observation that consumers considering different plan options typically care less about marginal differences in the actuarial values of plans than they do about more 'meaningful differences' that they can 'understand and appreciate,' such as whether a high-deductible plan with no coinsurance is a better value than a plan with a lower deductible but more co-payments." ECF 28, at 53 (quoting 90 Fed. Reg. at 27,177). That may well be true, but the agency is nonetheless constrained to rely only "on factors which Congress has [] intended it to consider" when exercising its authority under the statute. *Sierra Club*, 899 F.3d at 293. Here, as Plaintiffs point out, "[t]he purpose of the standard is set forth in section 18022(d)(3) itself [and] the only permissible 'de minimis' variations are those that account for uncertainties in 'differences in actuarial estimates,' not variations to reflect a new Administration's policy preference for less generous subsidies." ECF 11-1, at 27.

Moreover, the agency was obligated to establish a "rational connection between the facts found and the choice made." *Motor Vehicle Mfrs. Ass'n*, 463 U.S. at 43. The agency stated that it believes that "lower AVs would lead to lower premiums, and in turn potentially improve the risk pool as coverage becomes more affordable for generally healthy people who currently may opt to forgo coverage altogether." 90 Fed. Reg. at 27,175. The agency then acknowledged that "although this may mean that those eligible for APTCs receive less money in tax credits, we believe that in the long term there would be a sufficient choice of affordable plans." *Id.*

Similarly, in response to commenters' concerns that the provision would "lead to increased out-of-pocket consumer costs as plan cost-sharing generosity decreases and higher overall premiums for some consumers given a potential impact on the generosity of the SLCSP, the benchmark plan used to determine an individual's PTC," *id.* at 27,176, the agency merely stated that the "change is essential to restoring greater balance between access and affordability in the long term," and "the overall benefits to the risk pool as a result of this change will better incentivize unsubsidized enrollees to enroll in coverage, which we expect to lower overall costs and further drive down premiums as the risk pool improves," *id.* at 27,176–77.

This reasoning is conclusory and unsupported by evidence. Defendants cannot merely label something a "short-term" trade-off to avoid engaging with data and justifying the change during the rulemaking process. There is no data to back up the claim and reasoning that coverage would become "more affordable" over time when *even CMS itself* estimates that the policy widening the de minims range will reduce aggregate PTCs by $1.2 billion in 2026. *See* 90 Fed. Reg. at 27,208. And, as Plaintiffs note, data shows that "[a] typical family of four would see their subsidies decrease, and their cost of coverage rise, by up to $714 for the year." ECF 11-1, at 26 (citing Ctr. for Budget & Policy Priorities comment at 34–35 (Apr. 11, 2025), https://perma.cc/KP9W-J63N). Plaintiffs argue, and the Court agrees, that the "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, without citing any evidence to support this subjective belief or engaging with the record." *Id.* (quoting 90 Fed. Reg. at 27,107). Such "[n]odding to concerns raised by commenters only to dismiss them in a conclusory manner is not a hallmark of reasoned decisionmaking." *Gresham v. Azar*, 950 F.3d 93, 103 (D.C. Cir. 2020). Thus, the Court finds that Defendants provided an insufficient and

conclusory rationale for altering the de minims variation, and Plaintiffs are likely to succeed on their claim that the agency acted in an arbitrary and capricious manner.

iv. Revocation of Guaranteed-Issue / Past Due Premium

The next challenged provision will allow issuers to require a customer to pay (1) any past-due premiums the customer owes the issuer (or related issuers) for prior coverage *and* (2) the initial premium amount (also known as a "binder payment") required for new coverage before the latter coverage is effectuated. *See* 90 Fed. Reg. at 27,084, 27,220. If the customer fails to pay that combined amount in full, the issuer can decline to effectuate the new coverage. *Id.* at 27,084.

Defendants argue that "an issuer's provision of coverage is of course contingent on the enrollee's payment of premiums." ECF 28, at 22 (citing 42 U.S.C. § 300gg-2(b)(1) (providing that an issuer may "nonrenew or discontinue health insurance coverage" if an enrollee "has failed to pay premiums")). Defendants also cite 45 C.F.R. § 155.400(e) in support of their argument, which provides that federally facilitated Exchanges and State-based Exchanges on the federal platform "will[] require payment of a binder payment" equivalent to "the first month's premium" to "effectuate an enrollment" in an Exchange plan. *Id.* According to Defendants, "[t]he Rule simply allows an issuer who is owed past-due premiums from a particular customer to lawfully credit any payments made by that customer for new coverage to the past-due balance before crediting any payments to the initial premium amount for the new coverage." *Id.* In doing so, "if, as a result of such a lawful allocation policy, the consumer still has an outstanding balance on the initial premium amount, then the issuer can decline to effectuate the new policy for failure to pay the requisite initial premium." *Id.* (citations omitted). Plaintiffs maintain that "[t]he

agency was not free to rewrite the text to carve out a new exception to the statute's categorical [guaranteed-issue] rule." ECF 11-1, at 28 (citation omitted).

The ACA's guaranteed-issue requirement provides that "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). Defendants invoke separate statutory provisions that relate to renewability and termination of coverage, rather than issuance, to justify the new past-due premium policy. *See* 42 U.S.C. § 300gg-2(b)(1).

The Court finds no authority in the text of the statute for the agency's decision to "credit any payments made by that customer for new coverage to the past-due balance before crediting any payments to the initial premium amount for the new coverage." ECF 28, at 22. As Plaintiffs point out, "[a]n 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." ECF 11-1, at 28 (citing 77 Fed. Reg. 70,584, 70,599 (Nov. 26, 2012)). Plaintiffs clarify that "[t]here is such an exception for past-due premiums in the Act's parallel provision that guarantees the *renewability* of policies. But, [] that exception is absent from the guaranteed-issue provision." ECF 11-1, at 28 (emphasis added) (citing 42 U.S.C. § 300gg-2(b)(1)). 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." *Id.* at 29 (citation omitted). Had Congress wanted to condition issuance of a new policy on payment of past premiums, it clearly knew how to do so expressly. *See* 42 U.S.C. § 300gg-2(b)(1) (providing that an issuer may "nonrenew or discontinue health insurance coverage" if an enrollee "has failed to pay premiums"). In the absence of an enumerated exception to the guaranteed-issue

requirement, the agency "has no power to tailor legislation to bureaucratic policy goals by rewriting unambiguous statutory terms." *Util. Air Regul. Grp.*, 573 U.S. at 325 (internal quotation marks omitted); *see also TRW, Inc. v. Andrews*, 534 U.S. 19, 28 (2001) ("Where 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)); *Polselli v. IRS*, 598 U.S. 432, 439 (2023) ("We assume that Congress acts intentionally and purposely when it includes particular language in one section of a statute but omits it in another section of the same Act." (internal quotation marks and citations omitted)).

Defendants put forth various concerns and objections to the current regulation, including the alleged "perverse incentives" it creates. ECF 28, at 21. According to Defendants, the Rule's past-due premium policy will "help to promote continuous coverage, reduce gaming and adverse selection, ensure that ACA subsidies are targeted to those who are eligible, and allow issuers to more accurately predict costs and prices." *Id.* (citing 90 Fed. Reg. at 27,084). Regardless of the merits of those arguments, they are best directed to Congress, as it is only Congress who can add enumerated exceptions to the guaranteed-issue requirement. *See Brown & Williamson Tobacco Corp. v. Food & Drug Admin.*, 153 F.3d 155, 161 (4th Cir. 1998), *aff'd*, 529 U.S. 120 (2000) ("[N]either federal agencies nor the courts can substitute their policy judgments for those of Congress."). The Court is bound by the plain text of the statute in its current form, which contains a guaranteed-issue requirement, subject only to specific, enumerated exceptions. The exceptions do not include a provision permitting insurers to deny issuance of coverage based on

failure to pay a past-due premium. Accordingly, Plaintiffs are likely to succeed in challenging the provision as contrary to law.[16]

v. SEP Eligibility Verification Requirements

The ACA requires Exchanges to provide for SEPs during which qualifying individuals may enroll for coverage in between the annual open enrollment periods. 42 U.S.C. § 18031(c)(6)(C). Under current regulations, federally facilitated Exchanges are required to conduct pre-enrollment eligibility verification only for applicants seeking to enroll in an Exchange plan under the loss-of-minimum-essential-coverage SEP; they are not permitted to conduct such pre-enrollment eligibility verification in conjunction with any other category of SEP. *See* 45 C.F.R. § 155.420(g). Under the Rule, federally facilitated Exchanges will instead be required to conduct pre-enrollment eligibility verification for other categories of SEPs as well (*e.g.*, permanent move, marriage, etc.), which is consistent with the eligibility verification policy that was in place between 2017 and 2022. *See* 90 Fed. Reg. at 27,148–49. The Rule further requires those federal Exchanges to conduct pre-enrollment eligibility verification "for at least 75 percent of new enrollments through SEPs." *Id.* at 27,148, 27,223. The Rule is time-limited and will sunset at the end of 2026, and the eligibility verification requirements do not apply to State Exchanges.[17] *Id.* at 27,151.

[16] Because the Court finds that Plaintiffs are likely to succeed on their argument that this provision of the Rule is contrary to law, the Court need not reach Plaintiffs' alternative argument that the agency's adoption of this provision was arbitrary and capricious.

[17] States are given the "option" to conduct pre-enrollment eligibility verification for SEP enrollment, but they are not required to do so, a policy unchanged by the Rule. *See* 90 Fed. Reg. at 27,151 ("[T]he program integrity issues are largely concentrated in Exchanges utilizing the Federal platform.").

Plaintiffs maintain that "[t]his rule will generate 293,000 verification issues to resolve in the coming year, resulting in a further barrier to coverage, through additional paperwork and administrative burdens, and costing consumers more than $7 million in 2026." ECF 11-1, at 33 (citing 90 Fed. Reg. at 27,186). According to Plaintiffs, "[y]ounger 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." *Id.* (citations omitted). Plaintiffs argue that Defendants failed to provide "an adequate explanation for why the agency acted at all," and there was a "fundamental mismatch between the agency's policy and the problem it claimed it was trying to solve." *Id.* at 34. Specifically, "CMS attempted to justify this policy as a response to the problem of improper enrollments by brokers," but according to Plaintiffs, "the agency fundamentally misconceived the scope of that problem and ignored the success of recent efforts to address broker misconduct." *Id.* (citing 90 Fed. Reg. at 27,150).

Defendants respond that "because of their limited scope, the regulations 'do not provide enough protection against misuse and abuse' of SEPs, which enables otherwise ineligible individuals to enroll in Exchange plans 'only after they become sick or . . . need expensive health care services,' which in turn 'negatively impacts both the risk pool and program integrity around determining eligibility for' APTCs and other subsidies." ECF 28, at 47 (quoting 90 Fed. Reg. at 27,148). According to the Rule, requiring pre-enrollment eligibility verification for all SEP categories "improves the risk pool by restricting people from gaming SEPs to wait to enroll until they need health care services."[18] 90 Fed. Reg. at 27,150. Additionally, CMS reasons that "pre-

[18] The agency suggested that pre-enrollment verification requirements that previously applied to SEPs did not create substantial barriers to Exchange enrollment, and that such requirements had the effect of "encourag[ing] continuous enrollment by making it more difficult to engage in strategic enrollment and disenrollment" based on customers' changing health status. 90 Fed. Reg. at 27,149.

enrollment verification for SEPs strengthens program integrity by denying ineligible enrollments and discouraging ineligible enrollees who know they cannot meet verification standards from attempting to enroll which, in turn, reduces Federal subsidies to ineligible consumers who would otherwise enroll and receive APTC and CSR subsidies." *Id.*

While an agency "is not required to choose the best solution, only a reasonable one," *Petal Gas Storage, LLC v. FERC*, 496 F.3d 695, 703 (D.C. Cir. 2007), it is required to "provide[] an explanation of its decision that includes a rational connection between the facts found and the choice made," *Nat'l Audubon Soc'y v. U.S. Army Corps of Eng'rs*, 991 F.3d 577, 583 (4th Cir. 2021). Importantly, courts are not free to "ignore the disconnect between the decision made and the explanation given." *Dep't of Com.*, 588 U.S. at 785. "The reasoned explanation requirement of administrative law, after all, is meant to ensure that agencies offer genuine justifications for important decisions, reasons that can be scrutinized by courts and the interested public." *Id.*

Here, the Court finds that the agency's chosen solution is unmoored from the problem it seeks to address. The provision purports to address "urgent program integrity concerns," 90 Fed. Reg. at 27,151, and alleged "gaming" of SEPs through enrollees waiting until they are sick to enroll in coverage, *id.* at 27,150, in an effort to "discourag[e] ineligible enrollees who know they cannot meet verification standards from attempting to enroll," *id.* But the agency offers no current data, reports, or evidence establishing that the "misuse and abuse" of SEPs, 90 Fed Reg. at 27,148, stems from SEP enrollment *in particular*. In the Rule, the agency cites to a "GAO undercover testing study of SEPs" from 2016, which found that "9 of 12 of GAO's fictitious applicants were approved for coverage on the Federal and selected State Exchanges." *Id.* But as noted, that study was from 2016, and the parties have not identified, nor can the Court locate, any evidence in the Rule to corroborate Defendants' conclusory assertion that abuse of SEPs is

currently contributing to the "program integrity concerns" the agency seeks to address through this provision. Accordingly, it remains merely a theory that the "temporary policy will help stabilize the marketplace in [Plan Year] 2026 as the subsidy environment normalizes and the high levels of improper enrollments are reduced before reverting back in PY 2027." 90 Fed. Reg. at 27,152. Further, the agency's conclusion that "the additional burden [on enrollees] is not significant enough to outweigh the merits of SEP verification and the increases in program integrity that it provides," *id.* at 27,151, is insufficient to address the very real concern raised by numerous commenters that the Rule change will improperly hinder the enrollment of eligible individuals.[19] Defendants similarly fail to articulate how an audit of 75% of new enrollments will curb the alleged problem.

After reviewing the record, the Court finds that Plaintiffs' disagreement with CMS is more than a mere policy debate on the merits of the provision, as Plaintiffs have established that Defendants' rationale was not indicative of reasoned decision-making. In short, the hypothesis that such "gaming" and "abuse" of subsidized coverage stems from enrollees and brokers fabricating events triggering SEPs is without support. *See Dep't of Com.*, 588 U.S. at 783 (remanding rule to agency where the record "reveal[ed] a significant mismatch between the decision the Secretary made and the rationale he provided"). The Court agrees with Plaintiffs' principal argument that "CMS offered no good reason to impose this burden on enrollees." ECF 30, at 18. As such, the Court finds that Plaintiffs have shown a likelihood of success on the

[19] Indeed, one commenter noted that "a study published by the American Economic Association found that adding one single additional step to the enrollment process prompted a 33 percent decline in enrollment, predominantly among young, healthy, and economically disadvantaged people." *See* Ctr. for Budget & Policy Priorities comment at 29 (Apr. 11, 2025), https://perma.cc/KP9W-J63N (citing Mark Shepard & Myles Wagner, *Do Ordeals Work for Selection Markets? Evidence from Health Insurance Auto-Enrollment*, 115 Am. Econ. Rev. 772 (2025), doi: 10.1257/aer.20231133).

merits on their claim that instituting SEP pre-enrollment verification procedures was arbitrary and capricious.

vi. Failure-to-Reconcile Provision

This provision reinstates a prior Failure to File and Reconcile ("FTR") policy that requires an Exchange to determine that a "tax filer" is ineligible for APTCs under the ACA if the applicant (1) received APTCs the prior year and (2) failed to comply with the statutory requirement to file a tax return and "reconcile APTC" for that year. *See* 90 Fed. Reg. at 27,113, at 27,221. This provision, which will apply only through the end of 2026, *see id.* at 27,115, amends the current requirement that such a determination be made only after a tax filer fails to reconcile for two consecutive tax years. *See* 45 C.F.R. § 155.305(f)(4).

The IRS requires taxpayers who receive APTCs—which are typically scaled to the recipient's projected annual household income—to reconcile those advanced payments with the PTC amount they otherwise qualify for in the applicable tax year, as determined by their actual annual household income in that year. *See* 26 U.S.C. § 36B(f). If the APTCs the taxpayer received exceed that allowable PTC amount, then the taxpayer may incur a tax liability, subject to certain income-based caps. *Id.* § 36B(f)(2). Since 2012, HHS has prohibited an Exchange from "determin[ing] a tax filer eligible for" APTCs if the filer (1) received APTCs the prior year and (2) failed to comply with the requirement to file a federal income tax return and reconcile those APTCs for that year. 45 C.F.R. § 155.305(f)(4). Taxpayers who are determined ineligible for APTCs due to their failure to reconcile can still claim on their tax returns the full amount of the PTC they are otherwise eligible for; such taxpayers just would not be able to receive that PTC amount in advance. *Id.*

In 2023, CMS amended the failure-to-reconcile regulations such that a taxpayer becomes ineligible for APTCs only after failing to file a federal income tax return and reconcile their APTCs for *two* consecutive tax years. *See* 90 Fed. Reg. at 27,113. The current Rule provision reverts back to the requirement that a taxpayer be deemed ineligible for APTCs after one year of failing to reconcile, and that change applies only through plan year 2026. *Id.*

In their contrary to law claim, Plaintiffs challenge the agency's authority to "condition eligibility for a tax credit on the reconciliation of old tax debts." ECF 11-1, at 35. Plaintiffs posit that "while CMS may establish procedures to determine whether the statutory standards for APTC eligibility are met, it may not use that procedural authority to change the substantive standards for eligibility." ECF 30, at 20 (first citing 42 U.S.C. § 18081(a), (f); and then citing *N.Y. Stock Exch. LLC v. SEC*, 962 F.3d 541, 546 (D.C. Cir. 2020)). According to Plaintiffs, "[n]othing in the statute conditions eligibility for tax credits or APTC on reconciliation of debts shown on a prior year's tax return." *Id.*

Defendants rightly point out that "the regulation precluding a taxpayer from being eligible for APTCs because of a failure to reconcile, 45 C.F.R. § 155.305(f)(4), was promulgated back in 2012, and the Rule will not change that aspect of the regulation." ECF 28, at 27. According to Defendants, "because Plaintiffs' contrary-to-law claim against the Rule's failure-to-reconcile provision is effectively a challenge to a regulation that has been in force for over a decade, that claim is barred by the six-year statute of limitations applicable to suits against the United States." ECF 28, at 27 (citing 28 U.S.C. § 2401(a)). Plaintiffs respond that "commenters on this year's rule asked the agency to 'fully repeal' the failure-to-reconcile rule on the ground that even the older version of the rule was unlawful," and "CMS understood that these comments were within the scope of the rulemaking and engaged with them on the merits, invoking

(incorrectly) its Section 18041 rulemaking authority." ECF 30, at 20 (quoting 90 Fed. Reg. at 27,117). Plaintiffs continue that, even if the rule were time-barred, they "may nonetheless challenge the new rule, because an agency 'cannot take by adverse possession the authority to impose [a rule] in a way that shields the devaluation of statutory language from judicial review.'" *Id.* at 21 (quoting *City of Providence v. Barr*, 954 F.3d 23, 45 (1st Cir. 2020)).

Plaintiffs' first argument appears to invoke the "reopening doctrine," which "allows an otherwise stale challenge to proceed because the agency opened the issue up anew, and then reexamined and reaffirmed its prior decision." *Wash. All. of Tech. Workers v. U.S. Dep't of Homeland Sec.*, 892 F.3d 332, 346 (D.C. Cir. 2018) (internal quotation marks and citation omitted). Specifically, the "doctrine arises where an agency conducts a rulemaking or adopts a policy on an issue at one time, and then in a later rulemaking restates the policy or otherwise addresses the issue again without altering the original decision." *CTIA–Wireless Ass'n v. FCC*, 466 F.3d 105, 110 (D.C. Cir. 2006) (internal quotation and alterations omitted). "The doctrine only applies, however, where the entire context demonstrates that the agency has undertaken a serious, substantive reconsideration of the existing rule." *All. for Safe, Efficient & Competitive Truck Transp. v. Fed. Motor Carrier Safety Admin.*, 755 F.3d 946, 954 (D.C. Cir. 2014) (internal quotation marks and citation omitted). In 2017, another trial court in this Circuit noted that it "[could not] find [any] Supreme Court or Fourth Circuit precedent recognizing the reopening doctrine." *Indep. Cmty. Bankers of Am. v. Nat'l Credit Union Admin.*, No. 16-cv-1141, 2017 WL 346136, at *4 (E.D. Va. Jan. 24, 2017). This Court has similarly not been able to find, and the parties have not provided, any in-circuit case law addressing this doctrine. However, the reopening doctrine is well-established in the D.C. Circuit, which regularly hears APA claims. *See, e.g.*, *Growth Energy v. EPA*, 5 F.4th 1, 21 (D.C. Cir. 2021) ("When a later proceeding

explicitly or implicitly shows that the agency actually reconsidered the rule, the matter has been reopened and the time period for seeking judicial review begins anew." (internal quotation marks and citations omitted)). As such, despite the lack of in-circuit precedent, the Court cannot identify a reason the reopening doctrine would not apply.

Assuming the doctrine does apply, Plaintiffs have shown it likely cures the statute of limitations issue Defendants identify here. By explicitly re-evaluating and subsequently affirming its statutory authority to issue the failure-to-reconcile provision during the notice and comment rulemaking process, CMS reopened the issue of Congressional authorization for the provision. According to the Rule, "commenters stated that HHS should fully repeal [the failure-to-reconcile] processes because there is no statutory authority for it." 90 Fed. Reg. at 27,117. The agency responded to the comment by evaluating, and then confirming, the purported statutory authority for its action:

> We disagree with commenters that there is no statutory authority for Exchanges to conduct FTR. Consumers who receive APTC are required to file income taxes pursuant to section 6011(a) of the Code and regulations prescribed by the Secretary of Treasury. Section 36B(f) of the Code requires taxpayers to reconcile their APTC under section 1412 of the ACA with their PTC allowed under section 36B of the Code. FTR regulations, implemented pursuant to the Secretary of HHS' general rulemaking authority under section 1321(a) of the ACA, facilitate compliance with those requirements and were implemented as part of the original Exchange Establishment Rule.

Id. In the Court's view, this constitutes a "serious, substantive reconsideration of the existing rule." *All. for Safe, Efficient & Competitive Truck Transp.*, 755 F.3d at 954. Even though conditioning APTC eligibility on tax return reconciliation existed in the prior provision, and the Rule re-affirms it, "the [agency] opened its (previous) decisions up to legal challenge when [it] promulgated the Rule through notice and comment rulemaking." *Doe v. U.S. Dep't of Just.*, 650 F. Supp. 3d 957, 984 (C.D. Cal. 2023). The agency explicitly engaged with the statutory

authority for its action in response to targeted comments claiming the full provision must be repealed. Thus, the Court finds that Plaintiffs are likely to succeed in showing that CMS's re-evaluation and subsequent affirmance of its statutory authority to issue the provision during rulemaking falls within the reopening doctrine, thereby curing the statute of limitations issue.

As to the merits, the Court agrees with Plaintiffs that, "[t]he 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." ECF 11-1, at 35 (first citing 26 U.S.C. §§ 24(*l*), 32(k); and then citing *Nat'l Elec. Mfrs. Ass'n v. Dep't of Energy*, 654 F.3d 496, 507 (4th Cir. 2011)). Once again, Defendants' invocation of its general rulemaking authority under 42 U.S.C. § 18041(a)(1) does not authorize it to flout separate, express provisions of the statute. ECF 28, at 28; *see NRDC v. Reilly*, 976 F.2d 36, 40 (D.C. Cir. 1992) (explaining that a "general grant of rulemaking power . . . [cannot] trump the specific provisions of the act"); *see also Air All. Hous.*, 906 F.3d at 1061 ("[I]t is well established that an agency may not circumvent specific statutory limits on its actions by relying on separate, general rulemaking authority."). CMS is not free to re-write the statutory formula to accomplish its policy goals, irrespective of the efficacy of such a policy. As the Court previously described in evaluating the provision addressing the $5 fee, even Defendants acknowledge that PTCs (and thus, by extension, APTCs) are prescribed by statutory formula. *See* ECF 28, at 24 (citing 26 U.S.C. § 36B(b)(2)-(3)). Thus, the agency's decision to condition APTC eligibility on reconciling tax information reads an exception into the statutory formula that is simply not there. Because the plain text of the statute contradicts the agency's

provision, Plaintiffs have shown they are likely to succeed on their claim that the failure-to-reconcile provision is contrary to law.[20]

vii. Data-Matching Policies / Income Eligibility Verification

(1) Recission of Automatic 60-Day Extension

When an Exchange attempts to verify an applicant's income for purposes of determining an applicant's eligibility for APTCs, and it finds an inconsistency in that applicant's data, it notifies the applicant and provides the applicant with an opportunity to respond. 42 U.S.C. § 18081(e)(4). The statute provides a default period of 90 days for that response. *Id.* §§ 18081(c)(4), (e)(1), (e)(4). The current regulations 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. Plaintiffs argue that "CMS wrongly reasoned that it was compelled by the statute to impose a 90-day policy." ECF 11-1, at 37. Defendants respond that "[i]t is Plaintiffs' flawed reading of the ACA's plain text that is arbitrary, not the Rule." ECF 28, at 38.

The Supreme Court recently held that "[c]ourts must exercise their independent judgment in deciding whether an agency has acted within its statutory authority, as the APA requires." *Loper Bright*, 603 U.S. at 412. The Court explained that "[c]areful attention to the judgment of the Executive Branch may help inform that inquiry," however, "courts need not and under the APA may not defer to an agency interpretation of the law simply because a statute is ambiguous." *Id.* at 412–13. "If a statute is ambiguous, courts exercise their independent judgment to determine the single, best meaning, but do so with the agency's body of experience

[20] Because the Court finds that Plaintiffs are likely to succeed on their argument that this provision of the Rule is contrary to law, the Court need not reach Plaintiffs' alternative argument that the agency's adoption of this provision of the Rule was arbitrary and capricious.

and informed judgment . . . at [their] disposal." *Valladares v. Ray*, 130 F.4th 74, 83–84 (4th Cir. 2025) (alterations in original) (internal quotation marks and citations omitted).

According to Plaintiffs, 42 U.S.C. § 18081(e)(4)(A)(ii) and 42 U.S.C. § 18081(c)(4)(B) grant the agency power to modify the timeline described in paragraph (e)(4)(A). *Id.* at 37–38. However, according to Defendants, "one of those provisions expressly states that the HHS Secretary 'may extend the 90-day period' for resolving income-related inconsistencies 'for enrollments *occurring during 2014*,' and makes no mention of extensions being available during any other year." ECF 28, at 37 (emphasis in original) (citing 42 U.S.C. § 18081(e)(4)(A)(ii)). Further, Defendants argue that while the other provision "provides that the HHS Secretary 'may modify' the 'methods' for verifying information prescribed by the ACA, that provision plainly limits such modifications to the methods by which HHS verifies information with trusted data sources and other federal agencies, not the methods by which Exchanges must try to resolve income-related inconsistencies *with applicants*." *Id.* at 37–38 (emphasis in original) (citing 42 U.S.C. § 18081(c)(4)(B)). Defendants further point out that "§ 18081(c)(4)(B) falls under a subsection titled 'Verification of information contained in records of specific Federal officials,' and the example of a permissible modification that the provision provides concerns the transfer of tax return information from a federal official (*i.e.*, the Treasury Secretary) directly to another trusted data source (*i.e.*, an Exchange or the HHS Secretary)." *Id.* at 38. Plaintiffs respond that "section headings cannot limit the plain meaning of a statutory text." ECF 30, at 22 (citing *Merit Mgmt. Grp., LP v. FTI Consulting, Inc.*, 583 U.S. 366, 380 (2018)). Additionally, Plaintiffs argue "[t]he 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)." *Id.* at 22–23 (citation omitted).

The Court begins, as it must, with the statutory text. 42 U.S.C. § 18081(c)(4)(B) provides that "[t]he Secretary may modify the methods used under the program established by this section for the Exchange and verification of information if the Secretary determines such modifications would reduce the administrative costs and burdens on the applicant." 42 U.S.C. § 18081(e)(4)(A)(ii) provides that the Exchange, in the case of an inconsistency or inability to verify, shall "provide the applicant an opportunity to either present satisfactory documentary evidence or resolve the inconsistency with the person verifying the information under subsection (c) or (d) during the 90-day period beginning the date on which the notice required under subclause (I) is sent to the applicant." The section also states that "[t]he Secretary may extend the 90-day period under subclause (II) for enrollments occurring *during 2014*." 42 U.S.C. § 18081(e)(4)(A)(ii) (emphasis added).

It is not clear to the Court that Plaintiffs are likely succeed on their argument that "the agency misunderstood the scope of its authority on this score." ECF 30, at 23. In short, Plaintiffs assert that the 2014 limiting provision in 42 U.S.C. § 18081(e)(4)(A)(ii) is merely a redundancy, ECF 11-1, at 38, and the heading of Section 18081(c) should be ignored because the plain meaning of the text prevails, and the authority to modify is granted anywhere in the "section," not just the subsection, ECF 30, at 22–23. As to 42 U.S.C. § 18081(c)(4)(B), the Court agrees with Plaintiffs that the mere title of the subsection cannot alter the otherwise unambiguous meaning of the language in its text. And the Court further agrees that CMS's reading of 42 U.S.C. § 18081(c)(4)(B) is unreasonable given that the Section "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." ECF 30, at 23.

However, the 2014 limiting provision gives the Court pause. In 42 U.S.C. § 18081(e)(4)(A)(ii), Congress expressly indicated that the agency could extend the 90-day deadline for enrollments occurring *in 2014*. Thus, the Court is inclined to find that this time-limited extension provision prevents the Court from interpreting the statute as allowing blanket modifications for enrollments *at any time*. "When Congress provides exceptions in a statute, it does not follow that courts have authority to create others. The proper inference . . . is that Congress considered the issue of exceptions and, in the end, limited the statute to the ones set forth." *United States v. Johnson*, 529 U.S. 53, 58 (2000).

The Court notes, however, that the matter is further complicated by the agency's internal inconsistency in applying its own modification authority. Curiously, the agency claims that its modification power is limited, but simultaneously uses that modification authority to allow extensions on a case-by-case basis to individual applicants in years other than 2014. In an attempt to reconcile this inconsistency, Defendants argue that "any authority the HHS Secretary might have to '*modify*' a statutorily prescribed timeline in order to 'reduce the administrative costs and burdens' faced by a particular '*applicant*' cannot be reasonably understood to include the authority to promulgate a regulation that categorically *replaces* a statutorily prescribed timeline (90 days) with a different one (90 days plus an automatic 60-day extension) for *all applicants*." ECF 28, at 38 (emphasis in original) (first quoting 42 U.S.C. § 18081(c)(4)(B); then citing 45 C.F.R. § 155.315(f)(7); and then citing *Util. Air Regul. Grp.*, 573 U.S. at 328). Plaintiffs insist "[t]his is a distinction without a difference under the statutory text, which permits the agency to modify its methods if doing so 'would reduce the administrative costs and burdens on the applicant.'" ECF 30, at 23 (citing 42 U.S.C. § 18081(c)(4)). According to Plaintiffs, "CMS could permissibly (and at one point did) find that it would be less burdensome on

applicants to permit a blanket extension rather than requiring each applicant to jump through a paperwork hoop to request one." *Id.* (citing 88 Fed. Reg. 25,740, 25,819 (Apr. 27, 2023)). And as Plaintiffs point out, even CMS must understand its authority with respect to modification to operate in this way, as the agency has "used this authority to modify the 90-day time limit in other contexts." *Id.* (citing 45 C.F.R. § 155.315(f)(3)).

While this is a close call, the Court finds, at least at this preliminary stage, that Plaintiffs have not shown a likelihood of success on the merits on their argument that CMS misunderstood the scope of its authority in revoking the 60-day extension. Nonetheless, the Court invites further briefing on this claim at subsequent stages of the litigation, as this determination in the preliminary relief context is not dispositive on the merits.

Further, Plaintiffs' complaints about the agency's failure to engage with the evidence fails to provide an independent basis for relief. Plaintiffs claim that CMS did not "engage[] with the evidence showing the need for a 150-day verification period." ECF 11-1, at 38. However, CMS explained that a 150-day stay provided no "meaningful benefit to consumers" compared to a process in which extensions can be granted on a case-by-case basis as appropriate. 90 Fed. Reg. at 27,119; *see also id.* at 27,120 (explaining that a review of "income inconsistency resolution data" indicates that "under most conditions[,] consumers across all income data matching issue scenarios . . . can verify their data matching issues in the provided timeframe").[21] Additionally, in response to commenters' concerns that the reported metrics did not "sufficiently demonstrate[] evidence of widespread fraudulent behavior," the agency clarified that "this change [was] determined to be necessary on the grounds of statutory alignment and thus is

[21] Additionally, CMS "estimated this increased APTC expenditures by $170 million in 2024," and therefore, "the automatic 60-day extension did not provide a meaningful benefit to consumers and weakened program integrity." 90 Fed. Reg. at 27,119.

independent of the identified data concerns." 90 Fed. Reg. at 27,120. In sum, on this record, Plaintiffs have failed to show likelihood of success on their arbitrary and capricious claim because Plaintiffs have not sufficiently shown that the agency misinterpreted its modification authority.

(1) Income Verification When Data Shows Income Below 100 Percent of FPL

Under current regulations, if an applicant's attestation regarding their projected annual household income reflects a higher household income than that reflected in income data provided by the IRS or certain other sources, an Exchange generally "must accept the applicant's attestation . . . without further verification." 45 C.F.R. § 155.320(c)(3)(iii)(A). The Rule amends this provision by requiring an Exchange to instead further verify an applicant's household income if (1) an applicant attests to income that is between 100% and 400% of the FPL, (2) income data from the IRS indicates household income below 100% of the FPL, and (3) the former income amount exceeds the latter amount by a "reasonable threshold." 90 Fed. Reg. at 27,123. The applicant would then be given an opportunity to resolve the inconsistency by providing additional documentation and taking other steps to verify their household income. *See* 45 C.F.R. § 155.315(f)(1)-(4).

Plaintiffs argue that "the mandatory audit policy is arbitrary for precisely the same reasons that this Court vacated the same policy four years ago." ECF 11-1, at 39 (citing *City of Columbus*, 523 F. Supp. 3d at 731). According to Plaintiffs, "CMS improperly assumed that these enrollees must have been attempting to defraud the Exchanges," even though "[t]here 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." *Id.* Plaintiffs further argue that the additional verification will cause significant

obstacles to enrollment, as "[m]any such people are self-employed, or may have difficulty obtaining documentation to support their projections." *Id.*

Defendants acknowledge that the Rule "parallels a provision from a 2018 rule that was vacated in *City of Columbus v. Cochran* []." ECF 28, at 40. Defendants maintain that the verification measures are necessary because an applicant may be "overestimating his or her projected household income in order to obtain APTCs for which the applicant is not otherwise eligible—an incentive that is especially strong in states that did not expand their Medicaid programs under the ACA." *Id.* According to Defendants, "it is reasonable [] to request additional documentation verifying an applicant's actual income in such circumstances, so as to protect against overpayment of APTCs." *Id.*; *see also* 90 Fed. Reg. at 27,123 ("[W]e believe it would be reasonable, prudent, and even necessary in light of the program integrity weaknesses just outlined to request additional documentation, since the consumer's attested household income could make the consumer eligible for APTC that would not be available using income data from electronic data sources.").

As noted, a similar challenge to a similar proposed change in the Rule was raised in 2018. *See City of Columbus*, 523 F. Supp. 3d at 762 ("Plaintiffs contend that HHS's decision to impose income verification requirements is arbitrary and capricious because it failed to support its decision with anything more than unsubstantiated conclusions and failed to acknowledge the impracticability of low-income applicants being able to meet this requirement."). There, Judge Chasanow held that "Defendant's stated rationale for imposing income verification requirements—to prevent fraud in states that did not expand Medicaid—[was] unfounded," because "Defendants failed to point to any actual or anecdotal evidence indicating fraud in the record." *Id.* Judge Chasanow reasoned that "HHS improperly elevated the objective of fraud

prevention, for which it had no evidence, above the ACA's primary purpose of providing health insurance. *Id.* (citing *King*, 759 F.3d at 373–74). This time around, Defendants posit that their justification "does not suffer from the same flaws that were fatal to the 2018 provision." ECF 28, at 41.

In its current effort to change the regulation, HHS cited to a study that "compared estimated potential enrollment in Exchanges based on income data reported in census surveys to actual enrollment by enrollees who reported household income above the FPL-based eligibility threshold and found that actual enrollment was 136 percent higher than the total population of potential enrollments." *Id.* (citing 90 Fed. Reg. at 27,122). Defendants also point out that the "same study also found that a far higher number of enrollees reported household income that was just above the Exchange eligibility threshold in non-Medicaid expansion States compared to those in States that did expand Medicaid." *Id.* (citing 90 Fed. Reg. at 27,122). However, Plaintiffs respond that "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." ECF 11-1, at 40 (citing Urban Institute comment at 2 (Apr. 11, 2025), https://perma.cc/F5PH-WVN2). It appears that the agency did not directly address the comment by one of the study's authors in the final Rule, and Defendants did not respond directly to Plaintiffs' argument in the response brief.[22] Despite a compelling challenge to HHS's use of the study by one of the study's own authors,

[22] At the hearing, the Court asked counsel for Defendants how it could not be considered arbitrary and capricious for the agency to continue 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. ECF 34, at 61:1–9. In response, counsel conceded, "[t]hat is something difficult to address," and noted that "[he] [was] not familiar with the precise facts of what the Agency was using, the proposition for which the Agency was using the study compared to what the author was disagreeing with." *Id.* at 61:13–16.

HHS continued to rely on the data in that study to justify the Rule's income verification provision.

The Rule also cites the Paragon Health Report to show that "[a] more recent analysis of 2024 open enrollment data shows plan selections on HealthCare.gov among people ages 19–64 who reported household income between 100 percent and 150 percent of the FPL in non-Medicaid expansion States were 70 percent higher than potential enrollments estimated from Census data at that same income level." 90 Fed. Reg. at 27,122. The agency thus reasoned that "[b]ased on this mismatch between enrollment and the eligible population, this study estimates four to five million people improperly enrolled in QHP coverage with APTC in 2024 at a cost of $15 to $20 billion." *Id.* Plaintiffs point out that "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." ECF 11-1, at 15 (first citing Urban Institute comment at 2-3 (Apr. 11, 2025), https://perma.cc/7457-27KN; then citing Jason Levitis et al. comment at 28–31 (Apr. 11, 2025), https://perma.cc/X3KY-KZLW; and then citing Ctr. for Budget & Policy Priorities comment at 4–5 (Apr. 11, 2025), https://perma.cc/KP9W-J63N). Plaintiffs contend that "[t]hese flaws in the Paragon analysis were pointed out to CMS by commenters, but CMS did not explain why it chose to ignore them." ECF 11-1, at 15.

Against this backdrop, the Court concludes that HHS failed to meaningfully address the comments pointing out potential flaws in the data contained in the Paragon report, despite continuing to rely on such data to justify the provision in the Rule. *See* 90 Fed. Reg. at 27,215

(explaining in response to commenters expressing concerns over unsound data in the Paragon Report that the agency "noted these limitations in the proposed rule and continue to reference them in this final rule. The Paragon report analysis informed our analysis, but we also incorporated Exchange data for a more fulsome analysis."). Defendants have essentially ignored the Paragon Report (and its flaws) during this litigation, as it is not mentioned a single time in their response brief in opposition to Plaintiffs' Motion. Defendants are not free to support a rule change with data of questionable validity and limited relevance, and then refuse to engage with commenters' reasonable concerns that the data fails to support the conclusion the agency drew from that data. This is particularly problematic where, as here, an *author* of one of the studies relied upon timely noted that the study she contributed to "did not support the agency's conclusions, given the difficulties that low-income people face in estimating their future incomes," ECF 11-1, at 40 (citations omitted), which is the issue that purportedly motivated the rule change in the first place. The agency was thus required to meaningfully contend with this comment because it affected a "fundamental premise" of the Rule, namely the very justification for the Rule. *See MCI WorldCom, Inc. v. FCC*, 209 F.3d 760, 765 (D.C. Cir. 2000) ("An agency is not obliged to respond to every comment, only those that can be thought to challenge a fundamental premise."). In short, the agency refused to meaningfully engage with challenges to the data and reports used to justify the Rule, which began at the time of promulgating the final Rule and continues through this litigation. As Judge Chasanow previously (and eloquently) explained, 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." *City of Columbus*, 523 F. Supp. 3d at 763. Accordingly, Plaintiffs are likely to succeed on the merits of their claim that CMS acted

arbitrarily by instituting additional verification requirements without sufficient data justifying the need to do so.

(2) Income Verification When Tax Data is Unavailable

This provision of the Rule rescinds a regulation that requires an Exchange to accept an applicant's self-attestation of projected annual household income "without further verification" whenever (1) the Exchange requests tax return data from the IRS to verify the applicant's attested income, but (2) the IRS confirms that there is no such data available, 45 C.F.R. § 155.320(c)(5). *See* 90 Fed. Reg. at 27,130. The current regulation, which was adopted in 2023, creates an exception to the general requirement that an Exchange must verify an applicant's annual household income with certain trusted data sources, 45 C.F.R. § 155.320(c)(1)(ii), and otherwise follow an alternative verification process if tax return data for an applicant is unavailable, *id.* § 155.320(c)(3)(vi). The Rule removes this exception and requires Exchanges to follow standard verification and data-matching procedures "when tax return data is unavailable to immediately verify a consumer's attestation of annual household income." 90 Fed. Reg. at 27,132.

Plaintiffs explain that "[i]t is a relatively common occurrence for tax data to be missing for an applicant, for entirely legitimate reasons," for example, "[a]n 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." ECF 11-1, at 40. According to Plaintiffs, "[m]any 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." ECF 30, at 24. Defendants argue that "the agency ultimately concluded that the 'administrative burden' of requiring applicants with no tax return data 'to provide documentation to verify [their] income' would be 'more than offset by the program integrity benefits' related to

addressing improper enrollments in subsidized Exchange coverage." ECF 28, at 43 (first quoting 90 Fed. Reg. at 27,130; and then citing *id.* at 27,131). Plaintiffs argue "the premise of each of the agency's program integrity measures is undermined by its reliance on the flawed Paragon methodology, which CMS hasn't even tried to defend here." ECF 30, at 24. Additionally, Plaintiffs point out that "[t]here 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." *Id.* at 24–25.

The question for the Court is not simply whether Defendants have presented sufficient evidence of fraudulent enrollment, but also whether there is sufficient evidence of a *nexus* between fraudulent enrollment and self-attestation to tax data such that it justifies requiring heightened income verification. Put differently, if the agency cannot point to data showing that self-attestation meaningfully contributes to increased fraud, then the agency adopted an incongruent solution to the problem. *See City of Columbus*, 523 F. Supp. 3d at 762 ("HHS improperly elevated the objective of fraud prevention, for which it had no evidence, above the ACA's primary purpose of providing health insurance. (citing *King*, 759 F.3d at 373–374)).

After reviewing the agency's reasoning in the Rule, the Court finds that CMS concluded in a conclusory fashion that program integrity benefits would outweigh the administrative burden on applicants. The Court agrees with Plaintiffs that 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." ECF 11-1, at 40 (emphasis added) (citing 90 Fed. Reg. at 27,130). Additionally, while Defendants argue "[t]he agency made the reasonable observation that applicants without tax return data will likely have documentation verifying their household income (*e.g.*, pay stubs) 'readily available'

to them and that the burden of submitting that documentation, by extension, would be relatively minimal," ECF 28, at 43 (quoting 90 Fed. Reg. at 27,131–32), the agency provides no basis for this conclusory statement. In fact, this assertion is not even internally consistent, as CMS separately acknowledges in the Rule that "income verification can be more challenging for lower-income tax filers due to less consistent employment." 90 Fed. Reg. at 27,200. To address this concern, CMS merely stated "our experience with income verifications suggests the process does not impose a substantial burden." *Id.* The agency never explains what this history is or how it led to the conclusion it purportedly supports. The circular reasoning and conclusory statements offered to justify the policy change are not indicative of reasoned decision-making. This is particularly troubling because CMS, by its own estimation, acknowledges that 407,000 people will lose some, or all, of their APTCs as a result of this change. *See id.* Given the lack of sufficient data to justify the rule, and the agency's lack of meaningful explanation for the provision, the Court finds that this provision was not "reasonable and reasonably explained."[23] *FCC v. Prometheus Radio Project*, 592 U.S. 414, 423 (2021).

2. Irreparable Harm

Having addressed the likelihood of success on the merits of each of the challenged provisions of the Rule, the Court turns to the question of whether Plaintiffs have "demonstrate[d] that irreparable injury is *likely* in the absence of an injunction." *Winter*, 555 U.S. at 22 (emphasis in original) (citing cases). "To establish irreparable harm, the movant must make a 'clear showing' that it will suffer harm that is 'neither remote nor speculative, but actual and imminent.'" *Mountain Valley Pipeline, LLC v. 6.56 Acres of Land, Owned by Sandra Townes*

[23] This holding is bolstered by the fact that the Rule relied on the Paragon report, which as the Court described above, Defendants do not even attempt to address, let alone defend.

Powell, 915 F.3d 197, 216 (4th Cir. 2019) (quoting *Direx Israel, Ltd. v. Breakthrough Med. Corp.*, 952 F.2d 802, 812 (4th Cir. 1991)). Irreparable harm is harm that "cannot be fully rectified by the final judgment after trial." *Id.* (quoting *Stuller, Inc. v. Steak N Shake Enters.*, 695 F.3d 676, 680 (7th Cir. 2012)).

While "[m]ere injuries, however substantial, in terms of money, time and energy necessarily expended in the absence of [an injunction] are not enough," *see Roe v. Dep't of Def.*, 947 F.3d 207, 228 (4th Cir. 2020), *as amended* (Jan. 14, 2020) (quoting *Di Biase v. SPX Corp.*, 872 F.3d 224, 230 (4th Cir. 2017)), "irreparable harm may still occur in extraordinary circumstances, such as when monetary damages are unavailable or unquantifiable." *Handsome Brook Farm, LLC v. Humane Farm Animal Care, Inc.*, 700 F. App'x 251, 263 (4th Cir. 2017). For instance, "economic damages may constitute irreparable harm where no remedy is available at the conclusion of litigation." *Mountain Valley Pipeline, LLC v. W. Pocahontas Props. Ltd. P'ship*, 918 F.3d 353, 366 (4th Cir. 2019). Similarly, harm that "threaten[s] a party's very existence" can qualify as irreparable. *Mountain Valley Pipeline v. 6.56 Acres of Land*, 915 F.3d at 218. The Fourth Circuit has indicated that where an organizational plaintiff's standing is based on a representation theory (as is the case with respect to MSA), district courts should look at the irreparable harm to its members. *N.C. State Conf. of the NAACP v. Raymond*, 981 F.3d 295, 311 n.9 (4th Cir. 2020).

Plaintiffs argue that their injuries would be irreparable without a § 705 stay of the Rule's effective date. While Plaintiffs acknowledge that "economic losses generally do not constitute irreparable harm," they clarify that "[g]iven sovereign immunity, Plaintiffs have no vehicle to recover their losses, in the form of uncompensated care costs and higher premiums, from CMS after the fact." ECF 30, at 7. According to Plaintiffs, "open enrollment for 2026 is fast

approaching," and "[a]bsent a stay, the coverage losses and higher costs caused by the rule will be locked in for the coming year, ensuring that Plaintiffs will suffer harm 'before a decision on the merits can be rendered.'" ECF 30, at 7–8 (quoting *M.A.B. v. Bd. of Educ. of Talbot Cnty.*, 286 F. Supp. 3d 704, 726 (D. Md. 2018)).

Defendants insist that neither MSA nor the City Plaintiffs have made out irreparable harm sufficient to justify preliminary relief. As for MSA, Defendants argue that "the challenged Rule provisions will apply to Exchange plans that will not take effect until 2026 at the earliest, meaning that the Rule will have no immediate impact on the member's current coverage." ECF 28, at 13. As such, according to Defendants, MSA has "failed to establish that any such injury would occur before Plaintiffs' claims could be resolved in the regular course of litigation—an essential feature of irreparable harm." *Id.* (citations omitted). As for the City Plaintiffs, Defendants maintain that any "remote harm" suffered is "certainly not imminent enough to qualify as the sort of irreparable injury that warrants extraordinary preliminary relief." *Id.* at 17.

The Court finds that Plaintiffs will suffer significant and irreparable harm if the challenged provisions of the Rule go into effect next week. As discussed in the standing analysis, it is reasonably probable that the Plaintiffs will suffer economic injury from the challenged provisions. Of course, economic harm is not normally considered irreparable. *See Mountain Valley Pipeline v. 6.56 Acres of Land*, 915 F.3d at 218. However, "economic damages may constitute irreparable harm where no remedy is available at the conclusion of litigation." *Mountain Valley Pipeline v. W. Pocahontas Properties*, 918 F.3d at 366 (citation omitted). Moreover, where "a temporary delay in recovery somehow translates to permanent injury—threatening a party's very existence by, for instance, driving it out of business before litigation

concludes—could [] qualify as irreparable." *Mountain Valley Pipeline v. 6.56 Acres of Land*, 915 F.3d at 218 (citation omitted).

Here, Legler affirmed that she "operate[s] [her] business on narrow margins," the Rule will "cause [her] health insurance coverage costs to increase to a level that [she] cannot afford," and as a result, "[t]hese increased costs will likely make it impossible for [her] to continue [her] business, as [she] would be forced either to find different employment with employer-sponsored insurance, or to terminate [her] business and explore other coverage options through Wisconsin's BadgerCare system." ECF 11-4, at 3 ¶ 11. Legler further explains that "[c]ontinuing [her] business would not be an option in this circumstance because [she] need[s] to have access to affordable insurance that will cover the medications [she] need[s]." *Id.* ¶ 12; *see also* United Healthcare, *Optimum Choice, Inc., Part III: Actuarial Memorandum: PUBLIC; Maryland 2026 Individual Exchange Rates* 7 (May 22, 2025), https://perma.cc/35L2-M49D (increasing insurance premiums to account for impact of Rule). Because the final Rule going into effect "threatens a party's very existence," the type of harm Legler, and thus MSA, attests to constitutes irreparable harm sufficient to warrant a stay. *Mountain Valley Pipeline v. 6.56 Acres of Land*, 915 F.3d at 218 (citation omitted).

Additionally, the harm to the City Plaintiffs is irreparable because money damages are likely not available. *See City of New York v. U.S. Dep't of Def.*, 913 F.3d 423, 430 (4th Cir. 2019) ("The APA waives the federal government's sovereign immunity for a limited set of suits, brought by 'a person suffering legal wrong because of agency action' to obtain relief '*other than money damages*.'" (emphasis added) (quoting 5 U.S.C. § 702)). As Plaintiffs explain, "[t]hese 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." ECF 11-1, at 18–19 (citing

ECF 11-9 (Ige Decl.), at 2 ¶ 5; ECF 11-7 (Johnson Decl.), at 3 ¶ 11; ECF 11-8 (Leach Decl.), at 2–3 ¶¶ 7–8). City Plaintiffs "provide these services to patients regardless of their insurance coverage or ability to pay." *Id.* at 19. 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 decreased compensation and increased demand for emergency services. *See* ECF 11-9, at 3 ¶ 6, at 5–6 ¶ 14; ECF 11-7, at 2–3 ¶¶ 9–11; ECF 11-8, at 3–4 ¶¶ 12, 13. Once the Rule goes into effect, it will be difficult, if not impossible, to unwind the harm Plaintiffs complain of. Young explained that the Congressional Budget Office has concluded that the rule as a whole will "increase the number of uninsured by 1.8 million." ECF 11-2, at 2 ¶ 4. Additionally, "[p]eople who are relatively younger and healthier are more likely to be deterred from enrolling by higher costs or additional administrative obstacles," and therefore the policies in the Rule are "generally [] expected to worsen the Marketplace risk pool." *Id.* ¶ 5. Plus, "[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 insured." *Id.* As Plaintiffs point out, 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." ECF 11-1, at 44; *see also Chef Time 1520 LLC v. Small Bus. Admin.*, 646 F. Supp. 3d 101, 115–16 (D.D.C. 2022) (explaining that the unavailability of money damages for APA claims counsels in favor of a finding of irreparable harm).

Separately, Defendants argue that "the challenged Rule provisions will apply to Exchange plans that will not take effect until 2026 at the earliest, meaning that the Rule will have no immediate impact on the member's current coverage." ECF 28, at 13. Defendants thus urge

that "there is still time to decide this case on the merits without having to necessarily enjoin the provisions prior to the effective date." ECF 34, at 54:11–13; *see also* ECF 28, at 13. Plaintiffs counter that they "need relief now to allow time for the market to adjust in advance of the opening of open enrollment on November 1st." ECF 34, at 88:10–12.

It is true that the provisions go into effect on January 1, 2026 for the 2026 year and open enrollment begins on November 1 of this year. Thus, there is some surface appeal to Defendants' argument that the Plaintiffs have failed to meet their burden to establish irreparable harm because increased costs, decreased coverage, and uncompensated care costs will not suddenly materialize on August 26, 2025, the day after the Rule goes into effect. But as Plaintiffs explained at the hearing, "insurers' plans and the preparation that the exchanges need to engage in, and all of the underlying machinery, don't spring into effect on October 31st to allow open enrollment to happen [on] November 1st." *Id.* at 88:1–5. Rather, "[i]nsurers *right now* are in the process of finalizing the plan offerings and setting their plan rates in reliance on what the current rule offers, and what they anticipate the market will look like on the basis of this rule." *Id.* at 88:6–9; *see also* United Healthcare, *Optimum Choice, Inc., Part III: Actuarial Memorandum: PUBLIC; Maryland 2026 Individual Exchange Rates* 7 (May 22, 2025), https://perma.cc/35L2-M49D (increasing insurance rates to account for impact of Rule). Moreover, the record evidence shows that at least one insurer has already increased rates as a result of the Rule's anticipated effect on the insurance market, and Plaintiffs have pointed out that "open enrollment for 2026 is fast approaching," and "[a]bsent a stay, the coverage losses and higher costs caused by the rule will be locked in for the coming year, ensuring that Plaintiffs will suffer harm 'before a decision on

the merits can be rendered.'"[24] ECF 30, at 7–8 (first citing Am. Acad. of Actuaries, *Issue Brief: Drivers of 2026 Premium Changes* 3, 8 (July 21, 2025), https://perma.cc/YP3X-WS74; and then quoting *M.A.B.*, 286 F. Supp. 3d at 726). So, while it may be true that the harms to Plaintiffs may not be felt until later in time, it is also true that the first domino in the "predictable chain of events leading from the government action to the asserted injury," *All. for Hippocratic Med.*, 602 U.S. at 385, will fall when the regulation goes into effect next week.

Further, despite arguing that preliminary relief is not warranted because the Court has time to decide the case on the merits before open enrollment begins, ECF 28, at 13, Defendants have not addressed whether (or even how) the readjustment of insurance rates can be righted by a later finding that the Rule was promulgated in violation of the APA.[25] Thus, Plaintiffs have shown irreparable harm, both in terms lack of remedy at the conclusion of litigation and imminence. *See Habeas Corpus Res. Ctr.*, 2009 WL 185423, at *9 (finding irreparable harm where plaintiff faced a myriad of immediate decisions about how to handle clients' post-conviction claims "even though it would take some amount of time" for the rule to apply to the state because if the rule were to go into effect, it would "thrust [p]laintiff into uncertainty over the legal framework"); *California*, 911 F.3d at 581 (finding irreparable harm where it was "reasonably probable that the states [would] suffer economic harm" from the rule and "the states [would] not be able to recover monetary damages connected to the [rule]"). While Defendants

[24] The Court notes that "[a]llowing the rule to go into effect for a time, only later to determine it invalid, would serve no purpose." *Habeas Corpus Res. Ctr. v. U.S. Dep't of Justice*, Civ. No. 08-2649, 2009 WL 185423, at *10 (N.D. Cal. Jan. 20, 2009). It would waste the resources of the litigants and the Court and cause significant chaos in the insurance market. This too tips the scales in favor of Plaintiffs in the irreparable harm analysis.

[25] There is no evidence in the record to suggest that insurers can continue to adjust rates up until the eve of the open enrollment period on November 1, 2025.

insist that the harms are too speculative, the Court finds, as it did with respect to standing, that the harm is sufficiently concrete, imminent, and supported by the record. Accordingly, MSA and the City Plaintiffs have demonstrated they will suffer irreparable harm in the absence of a stay.

3. Prejudice and Public Interest

The final two factors—balance of the equities and weighing the public interest—"merge when the Government is the opposing party." *Nken*, 556 U.S. at 435. The court "must balance the competing claims of injury and must consider the effect on each party of the granting or withholding of the requested relief," with "particular regard for the public consequences in employing the extraordinary remedy of injunction." *Winter*, 555 U.S. at 24 (quoting *Amoco Prod. Co. v. Vill. of Gambell*, 480 U.S. 531, 542 (1987)). Logically, "[t]here is generally no public interest in the perpetuation of unlawful agency action." *League of Women Voters of U.S. v. Newby*, 838 F.3d 1, 12 (D.C. Cir. 2016). On the other hand, there is a substantial public interest "in having governmental agencies abide by the federal laws that govern their existence and operations." *Washington v. Reno*, 35 F.3d 1093, 1103 (6th Cir. 1994); *see also HIAS, Inc. v. Trump*, 415 F. Supp. 3d 669, 686 (D. Md. 2020) (same), *aff'd*, 985 F.3d 309 (4th Cir. 2021). The Court is mindful that the Fourth Circuit recently cautioned against collapsing "the first *Winter* factor—likelihood of success on the merits—with the merged balance of equities and public interest factor." *USA Farm Lab. Inc. v. Micone*, No. 23-2108, 2025 WL 586339, at *4 (4th Cir. Feb. 24, 2025). As such, "[l]ikelihood of success on the merits alone does not suffice." *Am. Fed. of State, Cnty. & Mun. Emps., ALF-CIO et al., v. Soc. Sec. Admin. et al.*, 778 F. Supp. 3d 685, 779 (D. Md. 2025).

Plaintiffs argue that "[t]he rule's harms will not be limited to Plaintiffs and their members, but will extend to the millions of Americans who will lose coverage on the Exchanges

and who will suffer from higher health care costs as a result." ECF 30, at 25. According to Plaintiffs, "[i]ncreases 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." *Id.* Defendants respond that "staying the effective date of the Rule would hamstring Defendants' efforts to address legitimate concerns about improper enrollments in Exchange plans that are subsidized by taxpayers, as well as interfere with Defendants' lawful implementation of their policy priorities." ECF 28, at 55. Additionally, Defendants aver that "when a law is stayed, 'the inability to enforce its duly enacted plans clearly inflicts irreparable harm on' the government that enacted it." *Id.* (quoting *Abbott v. Perez*, 585 U.S. 579, 602 n.17 (2018)).

There is a strong public interest in Americans maintaining affordable healthcare coverage. Indeed, that was the primary purpose of enacting the ACA. *See NFIB*, 567 U.S. at 538 (explaining that the purpose of the ACA is "to increase the number of Americans covered by health insurance and decrease the cost of health care"). Moreover, eliminating coverage for an estimated 1.8 million people will drive up costs for the insured and lead to a significant decrease in the quality of care for the newly uninsured, which is unquestionably not in the public interest. Defendants concede as much in admitting that the Rule will likely lead to decreased coverage and increased costs, 90 Fed. Reg. at 27,074, 27,213, but nonetheless maintain that intervention is warranted based on program integrity concerns, *see, e.g.*, 90 Fed. Reg. at 27,116. It is of course the case that reducing fraud by both brokers and Exchange applicants, thereby reducing the burden of subsidy expenditures on taxpayers, is also in the public interest. But the Court is not convinced that this concern outweighs the damage that will flow from enactment of the Rule. Further, though the agency no doubt posits a laudable goal it wishes to achieve through

the enactment of the Rule, "that does not mean that the government can flout the law to do so." *Am. Fed. of State, Cnty. & Mun. Emps., AFL-CIO*, 778 F. Supp. 3d at 779.

Defendants' claim that they will suffer irreparable harm is similarly unpersuasive. Beyond its argument that a stay would "hamstring" its efforts to address improper enrollments, ECF 28, at 55, Defendants fail to explain how the stay would cause it irreparable harm. Indeed, as the Court has noted above, many of the provisions purportedly targeting fraud are unsupported by data showing that if enacted, they will, in fact, reduce any such fraud. Plus, simply preventing the government from "enforc[ing] its duly enacted plans," ECF 28, at 55, does not tip the scales in favor of Defendants on the third and fourth factors, particularly given the significant harms suffered by Plaintiffs in the absence of a stay. Accordingly, the Court is satisfied that the balance of equities and the public interest favor the issuance of a stay.

4. Scope of Injunction

CMS asks this Court to limit relief to the Plaintiffs here. *See* ECF 28, at 56 (arguing that any relief should be "no broader than necessary to afford relief to those Plaintiffs who have established standing and irreparable harm"). Plaintiffs respond that "[t]his request can't be squared with the text of Section 705, which instructs that 'the effective date,' in the singular, of the rule should be postponed if the standards for relief are met." ECF 30, at 26. As such, "[e]ach challenged provision of the rule has only one effective date, not different effective dates that apply for plaintiffs and non-plaintiffs." *Id.* (citing *David v. King*, 109 F.4th 653, 661–62 (4th Cir. 2024) (the definite article "the" "normally indicates that the statute refers to only one such object")).

This Court finds that the appropriate course of action here is to temporarily stay the challenged provisions—that is, to postpone its effective date—under 5 U.S.C. § 705 pending a

final resolution in this matter. Under § 705, when "justice so requires" and "to the extent necessary to prevent irreparable injury," a reviewing court may "issue all necessary and appropriate process to postpone the effective date of an agency action or to preserve status or rights pending conclusion of the review proceedings." "APA suits ultimately target the rule, and not necessarily the application of it to a particular person." *Am. Fed'n of Tchrs. v. Dep't of Educ.*, --- F. Supp. 3d ---, Civ. No. SAG-25-628, 2025 WL 2374697, at *33 (D. Md. Aug. 14, 2025); *see also Corner Post, Inc. v. Bd. of Governors*, 603 U.S. 799, 831 (2024) (Kavanaugh, J., concurring) ("When a reviewing court determines that agency regulations are unlawful, the ordinary result is that the rules are vacated—not that their application to the individual petitioners is proscribed.").

Here, Plaintiffs' requested relief, to postpone the enforceability of certain provisions in the Rule, is properly within the scope of the APA. *See* 5 U.S.C. § 705 (allowing courts to "postpone the effective date of an agency action"); *see also Loper Bright*, 603 U.S. at 391 (explaining that courts must serve "'as a check upon administrators whose zeal might otherwise have carried them to excesses not contemplated in legislation creating their offices.'" (quoting *United States v. Morton Salt*, 338 U.S. 632, 644 (1950)). Additionally, setting aside an agency action is the standard remedy for APA cases. *See* 5 U.S.C. § 706(2)(A) ("The 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[.]").

The recent Supreme Court case, *Trump v. CASA*, does not change the outcome. In *CASA*, the Supreme Court held that injunctive relief must be limited to "administer[ing] complete relief between the parties." *Trump v. CASA, Inc.*, 606 U.S. ---, 145 S. Ct. 2540, 2557 (June 27, 2025). However, the Supreme Court explicitly left open "whether the [APA] authorizes federal courts

to vacate federal agency action." *Id.* at 2554 n.10 (citing 5 U.S.C. § 706(2) (authorizing courts to "hold unlawful and set aside agency action")). Justice Kavanaugh's concurrence highlighted that, even after *CASA*, "plaintiffs may ask a court to preliminarily 'set aside' a new agency rule" "in cases under the Administrative Procedure Act." *Id.* at 2567 (Kavanaugh, J., concurring).

Accordingly, the Court finds, in line with other recent cases addressing the issue, that the limiting principle on universal or national injunctions announced in *CASA* does not apply to APA cases like the one at bar. *See, e.g., Drs. for Am. v. Off. of Pers. Mgmt.*, No. 25-cv-322 , 2025 WL 1836009, at *22 (D.D.C. July 3, 2025) ("[A]s this is a case involving APA vacatur, not a universal or national injunction, . . . [*CASA*] does not apply."); *Walker v. Kennedy*, --- F. Supp. 3d. ---, No. 20-CV-2834, 2025 WL 1871070, at *7 (E.D.N.Y. July 8, 2025) ("*CASA* does not require the Court to reconsider its stay."); *Ass'n of Am. Univs. v. Dep't of Defense*, --- F. Supp. 3d. ---, No. 25-cv-11740, 2025 WL 2022628, at *27 (D. Mass. July 18, 2025) (finding that "a stay under the APA" is not "subject to the same limitations espoused in *CASA*"); *Refugee & Immigrant Ctr. for Educ. & Legal Servs. v. Noem*, --- F. Supp. 3d. ---, Civ. No. 25-306, 2025 WL 1825431, at *51 (D.D.C. July 2, 2025) (noting that binding precedent and the text of the APA plainly authorize vacatur).[26]

Additionally, limiting postponement to Plaintiffs would be impractical. The complicated interplay between the ACA and numerous market actors would make it exceedingly difficult if

[26] The Court is unpersuaded by Defendants' citation to *Casa de Maryland*, 486 F. Supp. 3d at 971–72, a case in which Judge Xinis of this Court limited preliminary relief in the APA context to the plaintiffs. In making that decision, Judge Xinis explicitly noted that the limited stay was compelled by an earlier decision of the Fourth Circuit on facts that she could not "meaningfully distinguish." *Id.* at 972 (citing *CASA de Maryland, Inc. v. Trump*, 971 F.3d 220, 236 (4th Cir. 2020)). Given that just over two months ago the Supreme Court considered the propriety of national injunctions and explicitly left open "whether the [APA] authorizes federal courts to vacate federal agency action," *CASA,* 145 S. Ct. at 2554 n.10, the Court is satisfied that the relief need not be limited to Plaintiffs.

the challenged provisions went into effect for some of the population served by the Exchange but were stayed as to others. Defendants have "failed to identify any plausible manner in which the Court could set the guidance aside as to the individual plaintiffs and the organizational plaintiffs, while leaving it in place as to all others." *Refugee & Immigrant Ctr. for Educ. & Legal Servs.*, 2025 WL 1825431, at *51.

Accordingly, the Court finds the scope of Plaintiffs' relief, requesting a stay of the challenged provisions under the Rule, proper.

C. Security

The government has requested that, if the Court were to issue a preliminary injunction, it order Plaintiffs to provide an injunction security under Fed. R. Civ. P. 65(c).[27] ECF 28, at 57. This Court is not granting a preliminary injunction. The Supreme Court has explained that "[a]n injunction and a stay have typically been understood to serve different purposes." *Nken*, 556 U.S. at 428. "The APA only authorizes courts to 'set aside' and 'postpone' agency actions—a far narrower authority than the court's equitable power to issue preliminary injunctive relief." *Am. Fed'n of Tchrs. v. Dep't of Educ.*, 779 F. Supp. 3d 584, 623 n.14 (D. Md. 2025).

The APA has no bond requirement. *See* 5 U.S.C. § 705; *see also Seafreeze Shoreside, Inc. v. U.S. Dep't of Interior*, No. 22-cv-11091, 2023 WL 3660689, at *3 (D. Mass. May 25, 2023) ("Unlike a preliminary injunction, a stay under 5 U.S.C. § 705 does not expressly require the movant post a bond."); *Coal. for Humane Immigrant Rights v. Noem*, No. 25-cv-872, 2025 WL 2192986, at *38 (D.D.C. Aug. 1, 2025) (declining to require a bond because "Plaintiffs here seek a stay under APA section 705, which is neither a preliminary injunction nor a temporary

[27] Fed. R. Civ. P. 65(c) states, in relevant part: "The court may issue a preliminary injunction . . . only if the movant gives security in an amount that the court considers proper to pay the costs and damages sustained by any party found to have been wrongfully enjoined . . . ."

restraining order"). Because the Court is issuing a stay under § 705, not a preliminary injunction, the Court declines to require a bond.

IV. CONCLUSION

For the foregoing reasons, Plaintiffs' motion for a stay under 5 U.S.C. § 705 or, in the alternative, for a preliminary injunction, ECF 11, construed as a motion for a stay under 5 U.S.C. § 705, is **GRANTED** in part and **DENIED** in part. A separate implementing Order will issue.

Dated: August 22, 2025

/s/
Brendan A. Hurson
United States District Judge

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MARYLAND

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

DECLARATION OF DR. ERIC D. FETHKE

I, Eric Fethke, declare as follows:

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

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

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

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

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

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

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

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

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

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

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

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

Signature on following page.

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

ERIC D. FETHKE, M.D.

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MARYLAND

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

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 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 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