**IN THE UNITED STATES DISTRICT COURT**
**FOR THE DISTRICT OF MARYLAND**

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| CITY OF COLUMBUS, *et al.*,<br><br>*Plaintiffs*,<br><br>v.<br><br>ROBERT F. KENNEDY, JR., *et al.*,<br><br>*Defendants*. | Case No. 1:26-cv-2215 |

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

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## INTRODUCTION

Congress enacted the Affordable Care Act (ACA) to provide all Americans with access to comprehensive, affordable insurance that will pay for their health needs. Throughout both of his terms in office, however, President Trump has demonstrated his hostility to the statute. His administrations, through legislative and executive measures, have tried to chip away at the ACA's promise of affordable coverage for all. In his first term, his appointees at the Department of Health and Human Services (HHS) and the Centers for Medicare & Medicaid Services (CMS) adopted a rule that imposed barriers on people seeking to enroll in plans offered on the ACA's health insurance Exchanges. A judge in this district rejected that effort, vacating several provisions that would have driven people off the insurance rolls. As his second term began, his appointees returned to the same playbook, issuing a rule last year that would have degraded the value of coverage and made obtaining coverage more difficult. This Court responded by staying those provisions.

Undaunted, the administration again seeks to undermine Congress's vision for the ACA. CMS has issued a new rule governing enrollment in subsidized coverage on the Exchanges. 91 Fed. Reg. 29,526 (May 20, 2026). Many of the rule's provisions will already be familiar to this Court. CMS seeks to reinstate several provisions from last year's rule that would impose paperwork barriers against people seeking to enroll on the Exchanges. These provisions are just as contrary to law, arbitrary, or both, as they were last year, and they should meet the same fate in this Court as they did then. It also aims to revive two measures from the first Trump administration that would permit insurers to market plans that would not adequately serve enrollees' needs for comprehensive coverage. Here, too, the rule repeats the agency's errors from before, and this Court need only follow the prior ruling to stay or vacate them. And, for good measure, CMS breaks new ground with novel provisions designed to steer enrollees to far less generous coverage. These provisions, too, are unlawful and arbitrary.

If these provisions take effect, they will impose irreparable harm on Plaintiffs. Municipalities like Pima County and the cities of Columbus, Baltimore, and Chicago are providers of last resort. Because they operate clinics and other facilities that treat all comers without regard to insurance status, they are left to foot the bill when more people cannot pay their deductibles or are driven off insurance coverage. Main Street Alliance's members are small business owners and entrepreneurs who rely on the ACA's promise of affordable coverage for themselves and their employees. And Doctors for America's members are clinicians across the nation, whose practices will suffer when their patients lose health coverage under the rule.

In the absence of a stay of the rule under 5 U.S.C. § 705 or a preliminary injunction, these provisions take effect on July 20, 2026. Plaintiffs respectfully seek relief from this Court on or before that date to protect themselves and their members from irreparable harm and to vindicate the promise of the Affordable Care Act.

## BACKGROUND

### I. Statutory Background

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

Before the Act's market reforms went into effect in 2014, "individual health insurance markets were dysfunctional." *City of Columbus v. Cochran* (*City of Columbus II*), 523 F. Supp. 3d 731, 740 (D. Md. 2021). Insurers were free to deny coverage for people with pre-existing conditions, to refuse to renew such coverage, or even to revoke such coverage after it had been issued. Now, however, the Act requires every "health insurance issuer that offers health insurance

coverage in the individual or group market in a State [to] accept every employer and individual in the State that applies for such coverage," 42 U.S.C. § 300gg-1(a), subject to specified exceptions, such as the restriction of enrollments to an annual open enrollment period or special enrollment periods, *id.* § 300gg-1(b); *see Me. Cmty. Health Options v. United States*, 590 U.S. 296, 301 (2020). "In other words, the Act 'ensure[s] that anyone can buy insurance.'" *Me. Cmty. Health Options*, 590 U.S. at 301 (quoting *King*, 576 U.S. at 493).

Health insurance plans must cover a set of "essential health benefits," such as prescription drugs. 42 U.S.C. § 300gg-6(a). And to protect patients from devastating costs when a medical condition exhausts their coverage, the Act limits so-called "cost-sharing"—like deductibles and copayments—for these essential health benefits. *See id.* § 18022(c)(3). The limitation on cost-sharing is adjusted each year by a "premium adjustment percentage," which compares average premiums for "health insurance coverage" in the current year with the same average for 2013, before the Act's marketplace reforms went into effect. *Id.* § 18022(c)(1), (4). Under the formula that CMS currently uses to calculate this premium adjustment percentage, the maximum out-of-pocket limit (MOOP) that a plan could impose on an enrollee for 2027 would be $12,000 for self-only coverage and $24,000 for family coverage. *See* 91 Fed. Reg. 29,526, 29,691 (May 20, 2026).[1]

To help individuals learn about and enroll in health insurance, the Act "requires the creation of an 'Exchange' in each State where people can shop for insurance, usually online." *King*, 576 U.S. at 482 (quoting 42 U.S.C. § 18031(b)(1)). These Exchanges, also known as health insurance Marketplaces, enable people not eligible for Medicare or Medicaid to obtain adequate, affordable insurance independent of their jobs. The Exchanges therefore serve as "marketplace[s] that allow[] people to compare and purchase" ACA-compliant plans. *Id.* at 479.

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[1] That formula is challenged in pending litigation. *See* Pls.' Mem. Supp. Summ. J. at 25-29, *City of Columbus v. Kennedy*, No. 1:25-cv-02114-BAH (D. Md. Jan. 20, 2026), ECF No. 65-1.

There are several different types of Exchanges. Some states have elected to create Exchanges themselves (state-based Exchanges or SBEs), as is the case in Maryland and Illinois, while others have created Exchanges that operate on the federal Healthcare.gov platform (state-based Exchanges on the federal platform, or SBE-FPs). The Exchange in other states, including Arizona, Ohio, and Wisconsin, is operated by the Centers for Medicare & Medicaid Services (CMS) (federally facilitated Exchange, or FFE). *See* CMS, Consumer Info. & Ins. Oversight, *State-Based Exchanges*, https://perma.cc/L4DF-DQYJ.

Plans that meet the requirements described above and that are offered on the Exchanges are known as "qualified health plans." CMS is responsible for "establish[ing] criteria for the certification of health plans as qualified health plans," including ensuring the plans' "network adequacy," to ensure the plan offers "a sufficient choice of providers" and includes within its network "essential community providers" that serve predominately low-income, medically underserved individuals. 42 U.S.C. § 18031(c)(1)(B), (C). Individuals enroll in qualified health plans for a given year during an annual open enrollment period or under specified special enrollment periods. *Id*. § 18031(c)(6).

Plans on the Exchanges offer various levels of generosity: a "bronze" plan is designed to provide benefits that are actuarially equivalent to 60% of the full value of benefits covered by the plan (meaning that premiums are calculated in the expectation that 40% of the cost of coverage would be paid for through enrollee out-of-pocket spending), and "silver," "gold," and "platinum" plans are designed to provide benefits that are actuarially equivalent to 70%, 80%, and 90%, respectively, of the full value of benefits under the plan. *Id*. § 18022(d)(1). Because actuarial predictions may be imprecise, the Act specifies that CMS may "provide for a de minimis variation … to account for differences in actuarial estimates." *Id.* § 18022(d)(3).

The Act also "seeks to make insurance more affordable by giving refundable tax credits to

individuals" who are enrolled in these metal levels of coverage. *King*, 576 U.S. at 482 (citing 26 U.S.C. § 36B). These "premium tax credits" (PTCs) vary depending on an individual's income 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). There was no income cap on these tax credits from 2021 to 2025, *see id.* § 36B(b)(3)(A)(iii), but a 400% income cap has been reinstated for 2026. In addition to PTCs, eligible individuals with incomes between 100% and 250% of the federal poverty level benefit from "cost-sharing reductions" that limit their exposure to out-of-pocket costs. 42 U.S.C. § 18071(c).

PTCs are claimed on an individual's tax return after the end of the year and are paid by the IRS. 26 U.S.C. § 36B(h). Rather than waiting to recover their costs later, enrollees may claim "advance premium tax credits" (APTCs) up front so that the value of the tax credits may be applied directly to the purchase of insurance. 42 U.S.C. §§ 18081, 18082; *City of Columbus II*, 523 F. Supp. 3d at 741. CMS is responsible for determining whether individuals meet the statutory eligibility requirements for APTCs and cost-sharing reductions, as well as for "redetermin[ing] eligibility on a periodic basis in appropriate circumstances." 42 U.S.C. § 18081(f)(1)(B).

In addition to the metal levels of coverage, the Act permits insurers to offer "catastrophic plans" that do not cover any benefits (with the exception of three primary care visits and certain preventive services) until the enrollee reaches the statutory cost-sharing limitation—*i.e.*, the out-of-pocket maximum—in a given year. *Id.* § 18022(e)(1). Enrollees in catastrophic plans are not eligible for PTCs or cost-sharing reductions. 26 U.S.C. § 36B(c)(3)(A). The Act limits enrollment in catastrophic plans to individuals who are under 30 years of age, who cannot access to affordable health coverage based on income, or who, in a given month, are found by CMS "to have suffered a hardship with respect to the capability to obtain coverage," *Id.* § 5000A(e)(5); *see* 42 U.S.C. § 18022(e)(2).

In sum, the Act requires that insurers generally offer only quality health insurance and aims to lower the cost of coverage to encourage individuals to enroll. This coverage improves access to care and overall health and reduces financial burdens on consumers as well as providers that pay for uncompensated care. Decl. of Jason Levitis ¶¶ 9-12. Increasing enrollment in quality health insurance coverage is not only the ACA's immediate goal; it is also key to the Act's long-term success. Insurance market stability requires robust enrollment, particularly by relatively healthy individuals. *Id.* ¶¶ 19-20; 42 U.S.C. § 18091(2)(I) ("broaden[ing] the health insurance risk pool to include healthy individuals … will lower health insurance premiums"); *King*, 576 U.S. at 480. Making health insurance affordable is, in turn, essential to promoting enrollment. Levitis Decl. ¶ 20; *King*, 576 U.S. at 480-81.

When faithfully implemented, the Act's reforms enable more individuals to enroll in health insurance coverage. *See* Levitis Decl. ¶ 20. More than 24 million individuals were enrolled in Marketplace coverage in 2025. CMS, Press Release, Over 24 Million Consumers Selected Affordable Health Coverage in ACA Marketplace for 2025 (Jan. 17, 2025), https://perma.cc/N8QF-NKHG. Enrollment has dropped significantly in 2026, however, due to actions of the new administration along with the expiration of the enhanced PTCs that were in effect for the last five years; it is likely that an average of 17.5 million people will be enrolled in the Marketplace over the course of 2026. *See* Matt McGough et al., *What We Know So Far About 2026 ACA Marketplace Enrollment, Premiums, and Deductibles*, KFF (May 19, 2026), https://perma.cc/BP79-D7RX.

## II. Prior Litigation

In 2018, CMS issued a rulemaking addressing the operation of the Marketplace for the following year. 83 Fed. Reg. 16,930 (Apr. 17, 2018). Several plaintiffs (including some of the Plaintiffs here) brought suit to challenge some of that rule's provisions, including provisions that

are materially identical to provisions in this year's rule. This Court determined that the plaintiffs had standing, *City of Columbus v. Trump (City of Columbus I)*, 453 F. Supp. 3d 770, 787-88 (D. Md. 2020), and vacated the challenged provisions—including provisions eliminating federal review of plans for network adequacy, eliminating requirements for insurers to offer standardized plans on the Exchanges, and imposing income verification requirements on low-income enrollees—as arbitrary. *City of Columbus II*, 523 F. Supp. 3d at 751, 754, 762.

In 2025, CMS published a rule that sought again to impose some of the challenged provisions from the 2018 rule, along with other provisions that would have raised consumer costs and driven individuals off insurance coverage. 90 Fed. Reg. 27,074 (June 25, 2025). The cities of Columbus, Baltimore, and Chicago, along with Doctors for America (DFA) and Main Street Alliance (MSA), challenged several provisions of the 2025 rule in this Court and sought a stay under 5 U.S.C. § 705. The Court granted the plaintiffs' motion in relevant part. It held that MSA and the municipal plaintiffs had standing because the challenged provisions would lead to higher premiums and more uncompensated care. *City of Columbus v. Kennedy (City of Columbus III)*, 796 F. Supp. 3d 123, 143, 147 (D. Md. 2025). This Court found that the plaintiffs were likely to succeed on the merits on each of the challenged provisions, concluding that (1) the policy requiring more stringent verification for enrollees using special enrollment periods lacked sufficient explanation "to address the very real concern raised by numerous commenters that the Rule change will improperly hinder the enrollment of eligible individuals," *id.* at 160; (2) the provision denying eligibility for APTCs to any person who had failed to reconcile a prior year's PTCs was contrary to law because the agency sought to add a criterion for tax credit eligibility not found in the statute itself, *id.* at 162-63; (3) the provision requiring enrollees projecting income above the federal poverty level, when data sources indicate they had lower income in a prior year, was arbitrary because CMS repeated the same errors it had committed in 2018 with respect to that provision, *id.*

at 168; and (4) the provision requiring verification procedures for enrollees when the IRS fails to report tax data for those enrollees was arbitrary because the agency had failed to address the burden that the provision would impose on low-income enrollees, *id.* at 170.

CMS appealed this Court's order granting the section 705 stay, and that appeal remains pending. The parties filed cross-motions for summary judgment with respect to the plaintiffs' challenges to these and other provisions of the 2025 rule, and those motions also remain pending.

**III. The 2026 Final Rule**

CMS has issued a new final rule adopting standards for the Exchanges for the upcoming 2027 plan year. 91 Fed. Reg. 29,526 (May 20, 2026). As in 2018 and 2025, the agency seeks to adopt (or re-adopt) several provisions that will raise consumers' premiums and out-of-pocket costs for Exchange plans, limit coverage under those plans, and deter millions of individuals from enrolling in coverage, leading to higher uncompensated care costs for providers. CMS itself projects that its rule will cause as many as two million additional enrollees to drop coverage and that the provisions of the rule at issue here will cause premiums to rise by as much as 2.4% next year. *Id.* at 29,854. The agency is almost certainly underestimating these effects; independent experts project that the rule will lead to at least three million fewer people enrolling on the Exchanges and will increase premiums substantially. Levitis Decl. ¶¶ 29-38. The rule accomplishes these results by imposing barriers on enrollees attempting to gain coverage, increasing costs for enrollees, and promoting less comprehensive coverage.

**A. The Final Rule Imposes Barriers on Obtaining Coverage**

*Failure-to-Reconcile Penalty*. The amount of APTCs that an enrollee receives over the course of a year and the amount of PTCs that the enrollee receives on his or her tax return depend on the same statutory formula; APTCs are intended to be a substitute for the tax credit. 26 U.S.C. § 36B; 42 U.S.C. § 18082. But APTCs are calculated based on projected income, so if that

projection turns out to be incorrect (because, for example, the enrollee works more hours than expected), the enrollee might unwittingly owe a tax payment at the end of the year. Under current policy, any such enrollee must be given a notice of the tax debt in the first year of enrollment in coverage after the debt is incurred, so that the debt can be repaid; if he or she does not do so, eligibility for APTCs may be revoked in the second year. 45 C.F.R. § 155.305(f)(4)(i), (ii). The new rule revokes that grace period and requires the Exchanges to find the enrollee to be ineligible for APTCs in the first year, *id.* § 155.305(f)(4)(iii), even though CMS lacks any authority to alter the statutory formula for eligibility for APTCs, and even though this Court stayed the operation of an identical provision in last year's rule, *City of Columbus III*, 796 F. Supp. 3d at 162-63. Both the one-year and two-year versions of this policy are unlawful.

*Mandatory Verification for Low-Income Enrollees*. The rule adopts a policy requiring Exchanges to conduct additional verification for enrollees who project that their household income for the upcoming year will be greater than 100% of the federal poverty level, if the IRS reports data indicating that the enrollee's current income is below that threshold. CMS has tried to adopt this policy twice before, and the Court has rejected that attempt both times, because this policy created "immense administrative burdens" for low-income enrollees, "defie[d] logic," and was arbitrary under the APA. *City of Columbus III*, 796 F. Supp. 3d at 168; *City of Columbus II*, 523 F. Supp. 3d at 763. CMS again acknowledges that this policy would cause tens of thousands of enrollees to lose their coverage, 91 Fed. Reg. at 29,836, but nevertheless attempts to reinstate this policy on a permanent basis, *id.* at 29,618.

*Refusal to Accept Attestations from Applicants When Tax Data Is Lacking.* Under current policy, an Exchange must accept an applicant's attestation of his or her projected annual income if the IRS reports that there is no tax return data available. 45 C.F.R. § 155.320(c)(5). The new rule revokes that policy, and CMS will now require Exchanges to verify income with other data

sources and to require applicants to submit documentary evidence or otherwise resolve the income inconsistency; if no such evidence is available, the applicant will lose eligibility for APTCs. 91 Fed. Reg. at 29,621. CMS projects that these policies will cause more than 400,000 people to lose coverage for plan year 2027. *Id.* at 29,837. CMS sought to adopt an identical policy in last year's rule, but this Court stayed it as arbitrary. *City of Columbus III*, 796 F. Supp. 3d at 169-70.

*Verification Requirements for Special Enrollment Periods*. The final rule also requires the federally facilitated Exchange to expand the scope of pre-enrollment verification for SEP eligibility to additional SEPs and conduct this verification for at least 75% of new enrollments through SEPs. 91 Fed. Reg. at 29,631. As they did in response to the materially identical provision in last year's rule, commenters noted that the addition of this paperwork burden will depress coverage on the Exchanges, and CMS itself estimated that it would cost consumers more than $7 million in 2026. 91 Fed. Reg. at 29,838. Although CMS had sought last year to impose this policy for one year only, it now intends to make this policy permanent, despite the agency's failure to grapple with the considerations that caused this Court to find to stay last year's version of the policy as arbitrary. *See City of Columbus III*, 796 F. Supp. 3d at 159-60.

### B. The Final Rule Increases Costs for Enrollees

*Increased Out-of-Pocket Spending Burdens for Certain Enrollees*. For each metal-level plan (bronze, silver, gold, and platinum), the statute sets an annual limitation on cost-sharing—*i.e.*, the maximum amount that an insured consumer may be required to spend on covered medical expenses each year through deductibles, copayments, and coinsurance. *See* 42 U.S.C. § 18022(c)(1), (3). For plan year 2027, the statutory cost-sharing limitations for these plans will be $12,000 for an individual and $24,000 for a family, *see* 91 Fed. Reg. at 29,691, meaning that an insurer must set the maximum out-of-pocket (MOOP) that an enrollee could incur annually under a bronze plan at or below these amounts. The new rule, however, allows insurers to offer

individual market bronze plans with MOOPs up to 130% of the statutory limitation ($15,600 for an individual or $31,200 for a family), as long as the insurer offers at least one bronze plan that complies with the statutory limitation. *Id.* at 29,699. By increasing the amount that bronze plan enrollees may pay out of pocket, this change exposes consumers to increased costs for medical care, burdening providers with more uncompensated care, and negatively affecting the risk pool. This policy takes effect in plan year 2027; a similar policy for catastrophic plans will take effect in 2028.

*Expansion of Eligibility for Less Comprehensive Forms of Coverage*. Catastrophic plans, unlike metal-level plans, do not cover most benefits until after an enrollee has reached the statutory limit on out-of-pocket spending.[2] In light of the high out-of-pocket costs associated with catastrophic plans, premiums are generally lower for catastrophic plans relative to metal-level plans, but PTCs cannot be used to purchase them. The Act limits catastrophic plan enrollment to individuals under 30 years old or those who are certified as exempt from the individual mandate based on a hardship or because they cannot afford to enroll in a qualified health plan. *See* 42 U.S.C. § 18022(e)(2); *see also* 26 U.S.C. § 5000A(e)(5). CMS has long defined a qualifying hardship narrowly, requiring certain unexpected expenses or circumstances such as homelessness, domestic violence, bankruptcy, or a natural disaster. *See* 45 C.F.R. § 155.605.

In September 2025, CMS promulgated guidance that drastically expanded the hardship exemption, such that many more people would be eligible to enroll in catastrophic coverage. CMS, *Guidance on Hardship Exemptions for Individuals Ineligible for Advance Payment of the Premium Tax Credit or Cost-Sharing Reductions* (Sept. 4, 2025), https://perma.cc/9QMD-RJH2 ("*Guidance on Hardship Exemptions*"). The new rule codifies and builds on this guidance. CMS will now

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[2] In plan year 2027, the MOOP under a catastrophic plan cannot exceed $12,000 for an individual or $24,000 for a family. *See* 91 Fed. Reg. at 29,691.

exempt anyone who is ineligible for PTCs or cost-sharing reductions because their projected annual household income is below 100% or above 250% of the federal poverty level. 91 Fed. Reg. at 29,634. This "broad nationwide hardship exemption," *id.*, will allow individuals over the age of 30 to obtain an exemption to enroll in catastrophic coverage based solely on income.

### C. The Final Rule Permits Insurers to Offer Less Comprehensive Coverage

*Reduced Standards for Network Adequacy*. The agency's current network adequacy standards ensure enrollees can access care from a sufficient number and type of providers "without unreasonable delay." 45 C.F.R. § 156.230(a)(1)(ii); *see id.* § 155.1050. These standards include time and distance thresholds to ensure a consumer can reach various in-network specialty providers. *Id*. § 156.230(a)(2)(i). The regulations also ensure access to essential community providers that serve primarily low-income and other underserved populations. *Id.* §§ 156.230(a)(1)(i), 156.235. Collectively, these standards set a "federal floor," 89 Fed. Reg. 26,218, 26,333 (Apr. 15, 2024), for network adequacy standards that apply to qualified health plans offered through the FFE, which reviews and determines whether plans meet these minimum federal standards. In addition, SBEs and SBE-FPs must "establish and impose network adequacy time and distance standards for [qualified health plans] that are at least as stringent as standards for [qualified health plans] participating on the [FFE]," 45 C.F.R. § 155.1050(a)(2)(i)(A), subject to limited exceptions.

The new rule (1) eliminates the quantitative network adequacy requirements for SBEs and SBE-FPs, 91 Fed. Reg. at 29,645; (2) adds new provisions permitting states, rather than the FFE, to conduct reviews of plans for network adequacy, including the adequacy of essential community provider networks, *id.* at 29,648, 29,650; and (3) modifies regulatory standards to make it harder for regulators to reject an insurer's narrative explanation of the network adequacy of the plans they submit for approval as qualified health plans, *id.* at 29,729, 29,739. These proposals mirror the

network adequacy provisions in the 2018 rule that the court vacated as arbitrary. *See City of Columbus II*, 523 F. Supp. 3d at 751. As was the case in 2018, these changes will hinder consumers' access to quality care. Many plans already have narrow network offerings, and the elimination of regulatory standards that have provided some measure of protection will jeopardize access to in-network providers and lead to more uncompensated care from safety net providers.

*Elimination of Standardized Plans and Non-standardized Plan Limits*. In an effort "to simplify the consumer shopping experience and to allow consumers to more easily compare plans across issuers," CMS introduced "standardized" plan options for 2017. 81 Fed. Reg. 12,204, 12,205 (Mar. 8, 2016); *see* 45 C.F.R. § 155.20. Standardized plans offer a standard cost-sharing structure specified by CMS that makes it easier for consumers to compare plans, including fixed deductibles, fixed annual limits on cost-sharing, and fixed copayments or coinsurance for specified benefits. 81 Fed. Reg. at 12,289-93. Issuers participating on the FFE must offer at least one standardized plan option at every product network type, at every metal level (except the non-expanded bronze metal level), and throughout every service area that it offers a non-standardized QHP option. 45 C.F.R. § 156.201(b) Issuers that offer "multiple standardized plan options within the same product network type, metal level, and service area," must ensure the plans meaningfully differ from one another. *Id*. § 156.201(c). Current regulations also impose limits on the number of "non-standardized" plans that issuers may offer on the FFE. *Id.* § 156.202(b).

Even though the court vacated the same policy in its 2018 rule, *City of Columbus II*, 523 F. Supp. 3d at 754-55, CMS once again seeks to discontinue the requirement that insurers offer standardized options. 91 Fed. Reg. at 29,708. Under the new rule, insurers may continue to offer standardized plans, with modified cost-sharing levels, but will not be required to do so, and any such offerings would not specifically be identified as "standardized" on Exchange websites. CMS also seeks to remove the limitations on the number of non-standardized plans that insurers may

offer. *Id.* at 29,720. These policies will make it harder for consumers to meaningfully compare plan options; as a result, confused consumers will be more likely to select plans that do not provide adequate coverage, or to drop out of the enrollment process altogether.[3]

**IV. The Disastrous Effects of the Final Rule**

The new rule contains numerous provisions that will heighten administrative obstacles to access coverage on the Exchanges, make coverage more expensive, and result in less comprehensive plan offerings. Levitis Decl. ¶¶ 5-8. These provisions will cause at least three million people to lose coverage. *Id.* ¶ 7. Younger and healthier people are more likely to drop from coverage, worsening the risk pool and leading to higher health insurance premiums, which in turn can cause additional people to become uninsured. *Id.* ¶ 34. Even those who are insured will have less comprehensive and more expensive plans to choose from. *Id.* ¶ 6.

Plaintiffs, like many others, will suffer significant and irreparable harm if the challenged provisions of the rule were to take effect. The rule's policies would harm members of MSA who, as small business owners, rely on affordable coverage through the Exchange not only to access the care they, their families, and their employees need, but also to provide them the financial freedom to operate their own businesses. *See* Decl. of Shawn Phetteplace ¶¶ 3-6; Decl. of Brooke Legler ¶¶ 8, 11; Decl. of Mike Ohlinger ¶¶ 5, 7. The rule jeopardizes that freedom and puts small business owners at risk of shutting down. Legler Decl. ¶ 11; Ohlinger Decl. ¶ 10.

The new rule would also harm medical providers, like members of DFA. Many clinicians serve patients regardless of their patient's insurance status, and treating increasingly uninsured and underinsured patients will have devastating consequences for medical professionals. DFA

[3] These are not the only objectionable provisions in the rule. The rule also violates the statute by permitting insurers to offer "non-network" plans, by permitting them to offer catastrophic plans for as long as ten years, by removing flexibilities for insurers to forgive small debts for unpaid premiums, and by effectively requiring insurers to price silver plans unfairly on the basis of a subset of the overall risk pool. These provisions will be the subject of later briefing.

members would see patients with more serious or urgent needs; would receive less compensation for many of their patients, even while expending more time navigating administrative barriers for their patients; and would lose contact with many of their patients, particularly in low-income and rural communities. Decl. of Janet Krommes ¶ 6; Decl. of Dr. Beth Oller ¶¶ 7-9; Decl. of Dr. Eric Fethke ¶ 9. This greater expenditure of time, effort, and resources, combined with decreased compensation, will hinder their ability to provide their patients with optimal health care and endanger some providers' medical practices entirely. Oller Decl. ¶ 10; Fethke Decl. ¶¶ 9-10.

The harms from the new rule would radiate out further to local governments like Columbus, Baltimore, Chicago, and Pima County and their residents. These municipalities fund and operate a range of community health centers, general and specialty clinics, and other health care services, as well as emergency medical transport. *See* Decl. of Fikirte Wagaw ¶¶ 5, 13-14; Decl. of Edward Johnson ¶¶ 7, 9-12; Decl. of Faith Leach ¶¶ 6-8; Decl. of Theresa Cullen ¶¶ 6-9, 11. To ensure that their residents get needed care, they all provide these services to patients regardless of their insurance coverage or ability to pay. An increase in the number of uninsured and underinsured residents will create a strain on those services and, ultimately, these local governments' budgets, forcing them to make up the shortfall from lost compensation and increased demand for emergency services. *See* Wagaw Decl. ¶¶ 8-9; Johnson Decl. ¶¶ 9-14; Leach Decl. ¶ 9; Cullen Decl. ¶¶ 11-14. An erosion of insurance coverage will also lead residents to neglect to get the medical care that they need, when they need it, resulting in less healthy and productive communities.

## STANDARD OF REVIEW

Under the APA, "a reviewing court may stay 'agency action' pending judicial review 'to prevent irreparable injury,'" *Casa de Maryland, Inc. v. Wolf*, 486 F. Supp. 3d 928, 949 (D. Md. 2020) (quoting 5 U.S.C. § 705), and "may issue all necessary and appropriate process to … preserve status or rights pending conclusion of the review proceedings," 5 U.S.C. § 705. "The

factors governing issuance of a preliminary injunction also govern issuance of a § 705 stay." *Casa de Maryland*, 486 F. Supp. 3d at 950. "A plaintiff seeking a preliminary injunction must establish that [it] is likely to succeed on the merits, that [it] is likely to suffer irreparable harm in the absence of preliminary relief, that the balance of equities tips in [its] favor, and that an injunction is in the public interest." *Winter v. Nat. Res. Def. Council, Inc*., 555 U.S. 7, 20 (2008).

## ARGUMENT

### I. Plaintiffs Are Likely to Succeed on Their Claims Against Provisions That Impose Barriers on Coverage

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

As noted above, enrollees are required to reconcile on their tax returns the APTCs that they have claimed, on the basis of projected income, with the PTCs to which they are entitled, on the basis of the income actually received. *See* 26 U.S.C. § 36B(f)(3). CMS requires applicants for coverage to report whether they have reconciled their tax credits on prior tax returns, and CMS checks that reporting against IRS data. 45 C.F.R. § 155.340(c). But many people are flagged in error, due to inaccuracies in IRS data and staffing cuts at that agency. *See* Jason Levitis et al. comment at 22 (Mar. 13, 2026), https://www.regulations.gov/comment/CMS-2026-0496-0989; Ctr. on Budget & Policy Priorities (CBPP) comment at 13 (Mar. 13, 2026), https://www.regulations.gov/comment/CMS-2026-0496-0922.

Under the policy in effect before 2025, an applicant might lose eligibility for APTCs if they do not reconcile their tax return in a second year, after receiving notice in the first year of the issue. 45 C.F.R. § 155.305(f)(4)(i), (ii) (2025). Last year, CMS sought to revise that policy, for 2026 only, to require the Exchanges to determine the enrollee to be ineligible for APTCs in the first year that the issue arises, *id.* § 155.305(f)(4)(iii) (2025), but this Court stayed that provision. *City of Columbus III*, 796 F. Supp. 3d at 162-63. CMS is now revising the rule to provide that, for

the 2027 plan year, the FFE would apply the one-year version of the failure-to-reconcile policy, and SBE could apply either the one-year or two-year version of that policy. 91 Fed. Reg. at 29,866 (revising 45 C.F.R. § 155.305(f)(4)). Enrollees who lose eligibility under either version become responsible for the full cost of their coverage, which in many cases is prohibitively expensive.

Both versions of the policy are unlawful. CMS has authority to "determine" whether the statutory standards for APTC eligibility are met, but it does not have authority to alter those standards. *See* 42 U.S.C. §§ 18081(a), (f); *Neumann v. Prudential Ins. Co. of Am.*, 367 F. Supp. 2d 969, 975 (E.D. Va. 2005) (ERISA plan administrator's authority to "determine" eligibility under the plan is not a discretionary power to alter the plan terms). Eligibility for APTCs turns on whether an applicant is eligible for tax credits, 42 U.S.C. § 18081(a)(2), and eligibility for tax credits turns on whether one is an "applicable taxpayer," 26 U.S.C. § 36B(c), a term that depends on the applicant's income. The statute does not contemplate the existence of a prior tax debt affecting an applicant's eligibility for APTCs in any way, and CMS's "invocation of its general rulemaking authority … does not authorize it to flout separate, express provisions of the statute." *City of Columbus III*, 796 F. Supp. 3d at 162-63. Moreover, if Congress intended to condition eligibility for a tax credit on the reconciliation of old tax debts, it knew how to do so. *See* 26 U.S.C. §§ 24(*l*), 32(k) (conditioning eligibility for future child and earned income tax credits); *see also Nat'l Elec. Mfrs. Ass'n v. Dep't of Energy*, 654 F.3d 496, 507 (4th Cir. 2011); *City of Columbus III*, 796 F. Supp. 3d at 162.[4] So, if debt for a PTC is unresolved, the statute contemplates that the IRS, not CMS, would use its enforcement tools to ensure the debt is collected. *See* 26 C.F.R. § 1.6011-8.

CMS acknowledges that this Court has held its failure-to-reconcile policy to be unlawful,

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[4] Last year, Congress adopted a version of this failure-to-reconcile policy, but pointedly chose to delay the effective date of this policy until 2028, thereby underscoring that the agency lacks authority to impose such a condition on eligibility for tax credits before that date. Pub. L. No. 119-21, § 71303(a), 139 Stat. 72, 324 (2025).

but it offers a new statutory theory this year. It reasons that "filing a tax return is a means of verifying a condition of eligibility and not itself a condition of eligibility." 91 Fed. Reg. at 29,609. It notes that the statute directs it to determine eligibility for APTCs on the basis of the individual's income "for the most recent taxable year" for which information is available, 42 U.S.C. § 18082(b)(1)(B), or on the basis of other information where an application form shows significant changes affecting eligibility, "including … cases where the taxpayer was not required to file a return of tax imposed by this chapter for the second preceding taxable year," *id.* § 18082(b)(2)(B). From this, CMS reasons that it may not determine eligibility based on anything other than last year's tax return in cases where the taxpayer was required to file a return. 91 Fed. Reg. at 29,609.

This theory is nonsensical. As an initial matter, "including" is a "term[] of enlargement, which clarify[ies] that given examples are merely illustrative." *Pharm. Coal. for Patient Access v. United States*, 126 F.4th 947, 960 (4th Cir. 2025). So the statutory mandate is precisely the opposite of the agency's reading; CMS must find eligibility on the basis of income for the most recent tax year for which information is available—meaning that it must look to other years if the previous year's return is not available, not deny eligibility altogether—and it further must adopt procedures to assess eligibility in any case where an application shows a significant change affecting eligibility, whether or not the taxpayer was required to file a return. *See* 42 U.S.C. § 18082(b)(1)(B), (b)(2)(B). In any event, section 18082 does not describe the information that an applicant must provide to show eligibility for APTCs; that list is instead set in the previous section, 42 U.S.C. § 18081(b), and nothing in that provision conditions eligibility on their filing of a tax return.[5]

[5] Moreover, CMS's new statutory theory doesn't match its policy. Under its (incorrect) logic, an applicant who filed a tax return but failed to reconcile tax credits should remain eligible for APTCs, while an applicant who didn't file a tax return but didn't claim APTCs in a prior year should lose eligibility, but its new policy reverses those outcomes.

CMS's failure-to-reconcile policy is also arbitrary. The rule will trap some consumers in a Catch-22. The one-year version of the policy that will be applied by the FFE, and by SBEs that choose to adopt it, will require APTCs to be revoked if tax issues aren't resolved immediately. But an applicant's federal tax information must be handled consistently with federal tax privacy law, and so many applicants with a failure-to-reconcile issue will learn only that they have been barred from subsidized insurance but not the reason why. *See* Levitis comment at 22. This "Kafka-esque" scenario will cause numerous people to lose coverage, *id.*; CMS estimates that 41,600 people will lose a total of $179 million in tax credits in 2027 as a result. 91 Fed. Reg. at 29,836.

CMS shows little concern that people will lose coverage, noting breezily that "for those who have lost coverage, many hospitals have charity care programs where consumers can apply to reduce their medical debt." 91 Fed. Reg. at 29,610. This misses the point. Charity care programs may reduce an individual's medical debt but will not eliminate it. And many people do not know of the availability of charity care, or they recognize that care will remain prohibitively expensive for them without insurance. As a result, they will skip care, leading to worse health outcomes and a greater reliance on safety net providers, at a higher cost, when patients' medical needs become too urgent for them to delay care any longer. *See* Zachary Levinson et al., *Hospital Charity Care: How It Works and Why It Matters*, KFF (Nov. 3, 2022), https://perma.cc/8XJZ-8U4Q.

At one time, CMS acknowledged a one-year failure-to-reconcile policy would be "overly punitive" on enrollees who lose access to subsidies as a result of "delayed data" from IRS, in many cases without knowing why their applications have been rejected. 87 Fed. Reg. 78,206, 78,256 (Dec. 21, 2022). Now, however, the agency brushes aside this concern, noting simply that rejected applicants may file an appeal. 91 Fed. Reg. at 29,610. This ignores that many frustrated applicants will drop out of the process altogether, and the loss of these enrollees, who tend to be healthier, will worsen the risk pool for everybody else. *See* Levitis comment at 22. CMS asserts that its

policy is nonetheless worthwhile to reduce improper enrollments by unscrupulous brokers. 91 Fed. Reg. at 29,608. But, even by the agency's own telling, that problem is not a genuine issue for the SBEs, and it has diminished substantially for the FFE, given the expiration of enhanced subsidies and CMS's efforts to address broker fraud. *Id.*[6] And, in any event, there is a fundamental mismatch between this rule and the problem that CMS claims it is trying to solve. The failure-to-reconcile policy does not in any way address the conduct of brokers, but it does deprive enrollees of coverage, often for reasons that the Exchange cannot even disclose to them. By failing to draw a "rational connection between the facts found and the choice made," CMS acted arbitrarily. *Appalachian Voices v. State Water Control Bd.*, 912 F.3d 746, 753 (4th Cir. 2019).

**B. The Verification Policy for Low-Income Enrollees Is Arbitrary**

For a third time, CMS seeks to require additional verification for enrollees who project a household income higher than the poverty level, if IRS data indicates that their income is below that level. 91 Fed. Reg. at 29,867 (revising 45 C.F.R. § 155.320(c)(3)). Although CMS previously would have sunset this policy after one year, it now seeks to require these audits on a permanent basis. *Id.* at 29,615. The agency's third attempt to impose this policy is arbitrary for precisely the same reasons that the court vacated the same policy five years ago and stayed it last year. *See City of Columbus II*, 523 F. Supp. 3d at 763; *City of Columbus III*, 796 F. Supp. 3d at 168.

There are many reasons why an individual could, in good faith, project that he or she will have income next year higher than the poverty level even if prior-year IRS data shows a lower income. *See* CBPP comment at 17; State of California et al. comment at 7 (Mar. 13, 2026), https://www.regulations.gov/comment/CMS-2026-0496-0797; *see also* Cynthia Cox et al.,

[6] At the same time that CMS asserts that the problem of broker fraud is so prevalent that it justifies a policy denying subsidies for eligible enrollees, it has proposed (and may yet finalize) a policy permitting the same brokers to operate the Exchange directly in the place of state officials. *See* 91 Fed. Reg. at 29,578. The agency's internal inconsistency on this score is yet another reason to conclude that its rationale is arbitrary.

*Repayments and Refunds: Estimating the Effects of 2014 Premium Tax Credit Reconciliation*, KFF (Mar. 24, 2015), https://perma.cc/AL3R-C5H5 (roughly half of low-income enrollees experience year-over-year income changes of 20% or more). Many such people are self-employed, or may have difficulty obtaining documentation to support their projections. *See City of Columbus II*, 523 F. Supp. 3d at 762. As a result, they will be more likely to drop out of the market. Although CMS expresses doubt that its new burdens "would deter many eligible people from enrolling," 91 Fed. Reg. at 29,622, by its own estimate, 81,000 people will lose coverage, *id.* at 29,836. And—as commenters noted, but the agency failed to acknowledge—this is almost certainly a vast understatement. *See* CBPP comment at 19 (citing Zachary Sherman et al., *2027 Proposed NBPP: Analyzing State and Consumer Impacts* 14 (Mar. 2026), https://perma.cc/V6SA-489C (noting that more than two million people may lose coverage under CMS's two new data-matching policies)). Because these individuals tend to be younger and healthier, their exit from the health insurance market will worsen the risk pool. *See* Levitis comment at 18-19.

As before, CMS improperly assumed, without evidence, that these enrollees must have been trying to defraud the Exchange. *See* Levitis comment at 14; California comment at 7. And it again "improperly elevated the objective of fraud prevention, for which it had no evidence, above the ACA's primary purpose of providing health insurance." *City of Columbus II*, 523 F. Supp. 3d at 762. Its "decision to prioritize a hypothetical risk of fraud over the substantiated risk that its decision result in immense administrative burdens at best, and a loss of coverage for eligible individuals at worst, defies logic." *City of Columbus III*, 796 F. Supp. 3d at 168 (quoting *City of Columbus II*, 523 F. Supp. 3d at 763).

CMS asserts that circumstances have changed since last year. It reasons (despite offering the opposite rationale for the same policy last year) that it is now more important to prevent broker fraud, because enrollees who are not aware that a broker has enrolled them will owe greater tax

liabilities, given that last year's budget reconciliation statute removed the cap on APTC repayments. 91 Fed. Reg. at 29,616. But individuals are already held harmless if they have incomes below the poverty level, *see* 26 C.F.R. § 1.36B-2(b)(6), or if they are fraudulently enrolled by a broker, *see* Levitis comment at 15, so this is a distinction without a difference. CMS also relies on a recent Government Accountability Office (GAO) study finding that fictitious applicants would remain enrolled after submitting false information. 91 Fed. Reg. at 29,615. But that study itself cautioned that it could not be extrapolated to make any conclusions whether fraud is widespread in the program. *See* CBPP comment at 16. And, by the agency's own telling, improper enrollment is not a genuine issue for the SBEs, but CMS imposes this requirement on these Exchanges nonetheless. *Id*. at 29,618. So CMS committed the same errors in this rule as it did before, and this provision should be vacated for the same reasons.

### C. The Audit Policy for Enrollees Where Tax Data Is Lacking Is Arbitrary

CMS once again seeks to revoke a rule that permits applicants to self-attest their income if IRS data is unavailable. 91 Fed. Reg. at 29,866-67 (removing 45 C.F.R. § 155.320(c)(5)). Although last year's policy would have sunset after one year, the agency now intends this policy to be permanent. 91 Fed. Reg. at 29,621. This Court stayed this policy last year, *City of Columbus III*, 796 F. Supp. 3d at 170, and it is arbitrary for the same reasons this year.

It is relatively common for tax data to be missing for an applicant, for entirely legitimate reasons. An individual might have had a change of name, family composition, or filing status, or might not have needed to file for the year in question. *See* CBPP comment at 18. CMS thus estimates its policy will generate *more than 2.7 million* instances of data discrepancies that Exchanges and applicants will need to resolve. 91 Fed. Reg. at 29,814. For many, documentation might not be readily available to substitute for tax data, which means that if these people cannot attest to their income, they will be deprived of subsidized coverage. *See* Levitis comment at 17.

Once again, younger and healthier people are more likely to be deterred by this paperwork burden, as sicker people will be more motivated to retain coverage. *Id.* at 18-19; CBPP comment at 16. CMS estimates that 407,000 people will lose some or all APTC as a result of this rule, 91 Fed. Reg. at 29,837, which again is almost certainly a vast undercount, *see supra* at 21.

CMS again attempts to justify these burdens and coverage losses by reciting, with no evidentiary support, that self-attestation "may have helped contribute to weakening the Exchange eligibility system." 91 Fed. Reg. at 29,619. Unscrupulous brokers, after all, would have no way of knowing whether tax data is available for a person before targeting him or her for unauthorized enrollment. Once again, CMS has adopted a rule that is entirely disconnected from the problem it claims it is trying to solve, with hundreds of thousands of people being driven out of coverage due to the IRS's inability to provide timely and accurate information regarding their income histories. *See* California comment at 7. This falls short of the basic standards for rational rulemaking. *See City of Columbus III*, 796 F. Supp. 3d at 170; *see also Appalachian Voices*, 912 F.3d at 753.[7]

**D. The Verification Requirements for SEP Enrollments Are Arbitrary**

CMS seeks to reimpose two additional verification requirements on the FFE. That Exchange must conduct pre-enrollment verification for additional special enrollment periods (SEPs), and must do so for at least 75% of new enrollments through each SEP. 91 Fed. Reg. at 29,867 (revising 45 C.F.R. § 155.420(g)). If the Exchange cannot complete the verification, the enrollment must be cancelled. *Id.* Even though last year CMS determined that, after one year, "the burden of continuing such policies will reach a point at which they outweigh any benefit," 90 Fed.

[7] The agency's reasoning is not apparent, but the preamble suggests that CMS believes it is compelled by the statute to revoke the self-attestation option. 91 Fed. Reg. at 29,620. CMS ignores 42 U.S.C. § 18081(c)(4)(B), which permits it to "modify" information verification methods if it finds that doing so "would reduce the administrative costs and burdens on the applicant." The agency properly invoked this modification authority when it adopted the self-attestation provision. 87 Fed. Reg. 78,206, 78,258 (Dec. 21, 2022). If CMS now believes that the statute requires it to revoke this rule, it has misread section 18081, and this provision must be vacated for that reason alone. *See Perez v. Cuccinelli*, 949 F.3d 865, 873 (4th Cir. 2020) (en banc).

Reg. at 27,151, this year CMS intends to make these policies permanent. 91 Fed. Reg. at 29,631-32.

This policy will generate an estimated 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 annually. 91 Fed. Reg. at 29,814. Younger and healthier people are more likely to drop coverage as a result, worsening the risk pool, as CMS itself recognized when it previously considered (and rejected) a similar policy. 87 Fed. Reg. 27,208, 27,279 (May 6, 2022); *see* Levitis comment at 26; Colo. Consumer Health Initiative comment at 5 (Mar. 13, 2026), https://www.regulations.gov/comment/CMS-2026-0496-0811; Nat'l Health Law Program comment at 25 (Mar. 13, 2026), https://www.regulations.gov/comment/CMS-2026-0496-0615.

CMS claims that these requirements will have a positive impact on the risk pool, lowering premiums. 91 Fed. Reg. at 29,633. The agency does not explain why it believes this to be the case, or why it repudiates its own view on risk pool effects from only four years ago. CMS disregards the body of research showing what is now a well-known effect: when paperwork barriers are imposed on coverage, sicker people are more motivated to overcome those barriers, while younger and healthier people are more likely to give up. So new burdens drive the very people out of the market that are needed to ensure the stability of the risk pool.

CMS also attempt to justify this policy by pointing to shifting patterns in SEP enrollments. When stricter verification requirements were imposed for the SEP for persons who lose other coverage, for example, this resulted in an increase in enrollments under other SEPs. 91 Fed. Reg. at 29,632. CMS intuits from these trends that fraud must be widespread among SEP enrollees. *Id.* But this conclusion does not follow; many individuals may be eligible for multiple SEPs, and it is only natural to assume that, given a choice, they would choose the process with less burdensome

red tape. *See* Levitis comment at 25; Nat'l Health Law Program comment at 26.

Moreover, since—even on the agency's own telling—the problem of improper enrollments hasn't arisen on the SBEs, CMS should have considered why the FFE might be different, such as the ability of enhanced direct enrollment entities to apply on behalf of enrollees. *See* CBPP comment at 23. The agency's "utter failure to consider obvious alternative actions" that would have directly addressed the problem that it identified, *Fishermen's Dock Co-op. v. Brown*, 75 F.3d 164, 172 (4th Cir. 1996), coupled with the "significant mismatch" between that problem and the measures the agency chose, *Dep't of Com. v. New York*, 588 U.S. 752, 783 (2019), demonstrate the irrationality of its approach. Given that "the agency's chosen solution [was] unmoored from the problem is [sought] to address," *City of Columbus III*, 796 F. Supp. 3d at 159, CMS acted arbitrarily in imposing these new burdens for 2026. *See Ohio v. EPA*, 603 U.S. 279, 292 (2024).

## II. Plaintiffs Are Likely to Succeed on Their Claims Against Provisions That Increase Costs for Enrollees

### A. The Cost-Sharing Limitation Policy for Bronze Plans Is Unlawful and Arbitrary

Under the new rule, starting in plan year 2027, CMS will allow insurers to offer bronze plans on the individual market with MOOPs up to 130% of the statutory limitation on annual cost-sharing, as long as the insurers offer at least one bronze plan with a compliant MOOP.[8] 91 Fed. Reg. at 29,697, 29,699; *see supra* at 10-11. This provision is contrary to law, and it is also arbitrary.

***First***, this policy is explicitly contrary to 42 U.S.C. § 18022(c) and exceeds the agency's statutory authority to regulate under that provision. As CMS acknowledges, under section 18022(c), the annual cost-sharing under an individual market bronze plan cannot lawfully exceed the statutory cap, which is set annually and which CMS calculates to be $12,000 for self-only

[8] Starting in plan year 2028, CMS will also allow catastrophic plans to exceed the statutory limit by 130%. 91 Fed. Reg. at 29,705. Because this change will not take immediate effect, plaintiffs do not seek preliminary relief as to that provision of the rule.

coverage or $24,000 for a family for 2027. *See* 91 Fed. Reg. at 29,691-92 & tbl. 9. And yet, the new rule allows an insurer to offer bronze plans with MOOPs that exceed those very limits by 30%, as long as the insurer also offers at least one bronze plan that complies with the statutory limits. 91 Fed. Reg. at 29,697, 29,699. By CMS's own telling, then, this policy is contrary to law and in excess of the agency's authority under the ACA.

Notwithstanding this express conflict with the statute, CMS defends this change based on a theory that at some point in the future it will become impossible for insurers to design bronze plans that both fall within the permissible range for the actuarial value of such plans and have MOOPs within the statutory cost-sharing limitation. 91 Fed. Reg. at 29,691, 29,694. CMS reasons that the components of the actuarial value calculation are changing at such a rate that insurers will face difficulty in designing bronze plans that comply with the statute and that are still significantly lower in value than silver plans. *Id.* at 29,693-29,696. The agency concludes that "eventually the maximum annual limitation on cost sharing will be too low to allow for an [actuarial value] calculation for the most basic bronze plan design." *Id.* at 29,694.

The agency's premise is incorrect; there is no serious danger that insurers will be unable to design bronze plans in the foreseeable future. *See* Matthew Fiedler comment at 3 (Mar. 13, 2026), https://www.regulations.gov/comment/CMS-2026-0496-1027. But even on the agency's own telling, it remains possible today to design bronze plans that comply with the ACA's limitations. Indeed, the new rule requires that insurers offering bronze plans on the individual market design at least one bronze plan that complies with the statutory limitations. 91 Fed. Reg. at 29,697. Only then may an insurer offer bronze plans that violate the statute. *Id.* CMS's theory of statutory infeasibility that may "eventually" occur, *id.* at 29,694, is thus no defense of the rule's unlawful change to bronze plans beginning in plan year 2027. Moreover, even if designing compliant bronze plans were currently impossible, that would still be no defense: the ACA does not require insurers

to offer any bronze plans in the first instance. *See* 42 U.S.C. § 18021(a)(1)(C)(ii) (requiring insurers on the Exchanges to offer at least one silver plan and one gold plan).

CMS invokes agencies' responsibility to "harmonize" statutory provisions "wherever possible," and, "where two statutory requirements cannot reasonably be satisfied simultaneously," to "act in a manner that best effectuates congressional intent and preserves the operability of the relevant statutory framework." 91 Fed. Reg. at 29,696 (citing *Loper Bright Enters. v. Raimondo*, 603 U.S. 369 (2024)). But this principle is not license for an agency to modify a statute by purporting to override its express limitations. Only Congress has the "constitutional authority to revise statutes in light of" subsequent changes in circumstances, and until Congress "exercises that power, the people"—and executive agencies tasked with enforcing the law—"may rely on the original meaning of the written law." *Wisc. Cent. Ltd. v. United States*, 585 U.S. 274, 284 (2018).

CMS also cites *Gustafson v. Alloyd Co.*, 513 U.S. 561, 570 (1995), for the proposition that "statutory provisions should not be interpreted in a manner that renders any part 'superfluous.'" 91 Fed. Reg. at 29,696 n.276. But the agency does not explain how enforcing compliance with the annual cost-sharing limitation under 42 U.S.C. § 18022(c) would render any provision of the ACA superfluous. In fact, CMS's new policy does just that: allowing noncompliant bronze plans would render section 18022(c) superfluous.

In any event, CMS admits that its perceived future statutory conflict is not real today. The agency states that "*[i]f* the market reaches th[e] point … that a bronze plan with a MOOP set at the maximum annual limitation on cost sharing will be unable to fit within the bronze [actuarial value] *de minimis* range" *then* the agency believes it "would need to propose a new approach to maintaining bronze plans' viability through future notice-and-comment rulemaking." 91 Fed. Reg. at 29,698. So the agency "intend[s] to require [statutorily compliant] plans for as long as these bronze plans remain actuarially viable." *Id.* In other words, CMS is allowing insurers to violate

the statute, as long as they sometimes comply with the statute, because it *might one day* be infeasible for insurers who offer bronze plans to comply with the statute. This is not a lawful policy under any theory of statutory construction.[9]

***Second***, the rule's change to bronze plans is neither reasonable nor reasonably explained. *See Ohio*, 603 U.S. at 292. Most obviously, as just explained, CMS disregards that the new policy reflects a blatant violation of the statutory cost-sharing limitations. CMS also ignores that it could adjust the components of its actuarial value calculations in future years to address any issues that might arise in the design of bronze plans. *See* Fiedler comment at 3. But CMS is equally insouciant about the negative effects of its policy on financially vulnerable consumers and their providers. CMS does not dispute commenters' concerns that higher cost-sharing limits for bronze plans would lead to more unexpected health care costs, increased medical debt, coverage losses, increased uncompensated care for safety net providers, and worse health outcomes as enrollees delay or forgo care. *See* 91 Fed. Reg. at 29,699-700; *see also, e.g.*, Levitis comment at 40; California comment at 12. Indeed, it acknowledges that this change "could shift more of the increasing costs of health care and potentially result in more enrollees who are unable to pay for their share of the cost," 91 Fed. Reg. at 29,699, an outcome it waves away elsewhere in the preamble with the suggestion that insurers could offer a cascading series of loans to enrollees who face difficulty paying their out-of-pocket costs, *id*. at 29,687. CMS also acknowledges commenters' concerns regarding the impact of this policy change on the risk pool, conceding that it creates a "downside risk of an adverse enrollment shift." *Id.* at 29,700.

CMS brushes aside these concerns about the effects on the risk pool and on consumers and

[9] Elsewhere, CMS insists that the fact that insurers that offer bronze plans are required to offer one plan that still complies with the statutory cost-sharing limitation "is not an acknowledgement that the underlying conflict does not exist." 91 Fed. Reg. at 29,702. This is nonsensical: if insurers are still able to offer bronze plans that are in compliance with the statute, then there is manifestly no "conflict" rendering statutory compliance impossible.

providers by emphasizing that the rule does not "*require* any issuer to offer an individual market bronze plan with a plan design that exceeds" the statutory cost-sharing limitation; it merely provides insurers with "full discretion over whether to offer such plans." *Id.* at 29,699 (emphasis added); *see id.* at 29,701. But permitting statutory violations by private actors is no more reasonable than requiring statutory violations. At the same time, CMS insists that this change is necessary to solve a perceived problem and preserves "meaningful differentiation between metal tiers." *Id.* at 29,703. CMS thus tries to justify an unlawful and harmful policy by contending that the policy is both optional and yet essential. The agency cannot have it both ways. *See Ohio*, 603 U.S. at 292 (an agency must articulate "a rational connection between the facts found and the choice made" (quoting *Motor Vehicle Mfrs. Assn. of U.S., Inc. v. State Farm Mut. Auto. Ins. Co.*, 463 U.S. 29, 43 (1983))). An agency does not have authority to permit private actors—or, indeed, anyone else—to violate the clear terms of a statute, much less in a way that would increase negative outcomes for consumers that the statute was designed to decrease.[10]

The arbitrariness of the new policy is further revealed by the fact that the rule imposes the same 130% cost-sharing limitation on catastrophic plans, even though, unlike bronze plans, catastrophic plans do not have prescribed actuarial value requirements and therefore do not even arguably face the same future statutory difficulties that the agency perceives as to bronze plans. Nonetheless, the agency cites the unjustified 130% limitation for catastrophic plans as a principal basis for also capping bronze plan cost-sharing at 130% in the final rule. 91 Fed. Reg. at 29,700.

In support of its selected 130% annual cost-sharing limitation, CMS also asserts that this value "preserves the core consumer protection function of the annual limitation on cost sharing,"

[10] As to the risk pool, CMS states that it "believe[s] this policy would attract currently uninsured individuals who are deterred by the high deductibles of bronze plans and not eligible for subsidies, which could improve the overall risk pool," but it provides no data or other evidence in support of this belief. 91 Fed. Reg. at 29,700-01.

*id.*—but this assertion is irrational. Exceeding the statutory limitation by any amount—much less by one-third—necessarily undermines the "function of [that] annual limitation." *Id.* The agency is also wrong to suggest that a higher limit would "restore a meaningful distinction" between catastrophic and bronze plans that it believes Congress intended. *Id.* at 29,706. This suggestion ignores that (1) millions of consumers enrolled in bronze plans in 2026 while only about 67,500 consumers (0.3%) enrolled in catastrophic plans; (2) the ACA requires catastrophic plans to comply with the annual cost-sharing limitation, *see* 42 U.S.C. § 18022(e)(1)(B); and (3) the ACA limits eligibility for catastrophic plans, showing that Congress did not intend for catastrophic plans to compete alongside bronze plans for the healthiest consumers, *see id.* § 18022(e)(2).[11]

Contrary to its suggestions, CMS can "best signal [its] good faith efforts to adhere to the statute," 91 Fed. Reg. at 29,698, by actually adhering to the statute. Because the new rule's rewrite of the statute does not comply with the ACA and is arbitrary, the rule is unlawful.

**B. The Expansion of Catastrophic Plan Eligibility Is Unlawful and Arbitrary**

Codifying and elaborating on the September 2025 guidance, CMS is drastically expanding eligibility for catastrophic plans. The agency will allow a hardship exemption for anyone, in any state, who is ineligible for PTCs or cost-sharing reductions because their projected annual household income is below 100% of the federal poverty level or above 250% of the federal poverty level. 91 Fed. Reg. at 29,634; *see Guidance on Hardship Exemptions* at 2. This far-reaching expansion cannot be squared with the meaning and purpose of the exceptions for catastrophic coverage under the ACA and is neither reasonable nor reasonably explained.

***First***, this categorical expansion of the hardship exemption—as set forth in both the September 2025 guidance and the new rule—is contrary to the ACA and in excess of CMS's

[11] CMS also states that a 120% limit would not be "sufficient to address" its perceived "viability problem," and only a 130% limit would give insurers "adequate flexibility" in designing bronze plans. 91 Fed. Reg. at 29,700. It cites no data or evidence in support of these conclusory assertions.

authority under the statute, which specifically limits eligibility for catastrophic plans to narrow categories. The statute limits eligibility "only" to those who have "not attained the age of 30" or who "ha[ve] a certification" of exemption (1) "relating to individuals without affordable coverage" or (2) "relating to individuals with hardships." 42 U.S.C. § 18022(e)(1), (2). An individual qualifies for the affordability exemption if his or her required insurance contribution exceeds 8.5% of his or her household income. 26 U.S.C. § 5000A(e)(1); 42 U.S.C. § 18022(e)(2)(B)(i). For the exemption relating to individuals with hardships, the statute says nothing of income; rather, it applies to individuals who CMS determines have "suffered a hardship with respect to the capability to obtain coverage under a qualified health plan," based on the individual's particular circumstances. 26 U.S.C. § 5000A(e)(5). Accordingly, an individual may qualify for a catastrophic plan under narrow exceptions pertaining to age, income, or individualized hardship.

Rather than treating hardship as a narrow exception, CMS leverages that provision to render a majority of adults categorically eligible for catastrophic coverage. Moreover, CMS will automatically certify that exemption on the FFE.[12] 91 Fed. Reg. at 29,636. Catastrophic plans will now be available to about 80% of adults under the age of 64, without any individualized proof of hardship. *See* Levitis comment at 41. As a result, eligibility for catastrophic plans becomes the rule rather than the exception. The administration projects that about three million people will take up catastrophic coverage now, a dramatic increase relative to the tens of thousands of people who had enrolled before. Levitis comment at 43 (citing Council of Econ. Advisors, *Expansion of HSA Eligibility Under OBBB Act to Improve Marketplace Coverage, Affordability, and Access* 2 (Sept. 2025), https://perma.cc/3JZR-LHDZ).

[12] CMS provides that individuals may either (1) attest to their income for the hardship exemption when applying for coverage through the Exchange, and their eligibility will be automatically adjudicated on the federally facilitated Exchange, or (2) attest on a paper request form that "they are no longer eligible for financial assistance." 91 Fed. Reg. at 29,636. In stark contrast to the rule's other provisions, neither method requires income documentation. *Id.*

This result cannot be reconciled with the text or structure of the ACA, which make clear that catastrophic plans may be made available to narrow categories of consumers who, for specific reasons, cannot access affordable coverage through the metal-level plans. To start, the hardship exemption is a distinct provision from the income-based affordability exemption. It is necessarily more circumscribed, speaking to individual circumstances, such as "an unexpected natural or human-caused event" causing "a significant, unexpected increase in essential expenses," or "other circumstances that prevented [the individual] from obtaining coverage under a qualified health plan," as determined by the Exchange. 45 C.F.R. § 155.605(d)(1). A broad, categorical, income-based, and automatic "hardship" exemption is therefore wholly incompatible with section 50001(e)(5). Even if the statute allowed for the hardship exemption to be categorically defined by income alone, making *any* amount greater than 250% of the federal poverty level—even as much as, say, 3,000% or more—could scarcely be described as a "hardship." *See, e.g.*, *Hardship*, Black's Law Dictionary (12th ed. 2024) ("[p]rivation; suffering or adversity").

The agency defends its new expansion of eligibility by pointing to "market-wide premium increases" that have "far outpace[ed] inflation and wage growth" over the last several years. 91 Fed. Reg. at 29,634. But Congress already provided an exemption intended to address these affordability-related concerns—that is, the affordability exemption described at section 5000A(e)(1). *See Gustafson*, 513 U.S. at 575 (describing principle that "a word is known by the company it keeps," so courts "avoid ascribing to one word a meaning so broad that it is inconsistent with its accompanying words"). Congress further provided that the eligibility criteria for the affordability exemption be indexed to reflect the excess rate of premium growth over the rate of income growth over time. *See* 26 U.S.C. § 5000A(e)(1)(D). In providing for this updating mechanism, Congress thus already addressed the divergence between premium growth rates and income growth that CMS points to as justification for expanding the hardship exemption. CMS

cannot purport to replace the policy choice that Congress made with its own, preferred affordability exemption under the guise of a hardship exemption. *See Brown & Williamson Tobacco Corp. v. FDA*, 153 F.3d 155, 176 (4th Cir. 1998) ("[N]either federal agencies nor the courts can substitute their policy judgments for those of Congress."), *aff'd*, 529 U.S. 120 (2000).

CMS reasons that "[t]he indexing mechanism in section 5000A(e)(1)(D) governs the affordability exemption; it does not constrain the Secretary's independent authority under section 5000A(e)(5)" to determine the scope of "the hardship pathway." 91 Fed. Reg. at 29,637. But the indexing mechanism necessarily informs the correct interpretation of the hardship exemption—that is, one distinct from the exemption concerned with household income. Underscoring that the plain meaning of the statute distinguishes between the income-based affordability exemption and the hardship exemption, CMS appears to acknowledge inadvertently that its categorical income-based policy does not constitute a "hardship circumstance" under the statute. The agency states that the pathways for obtaining certification of the new hardship exemption "ensure that the exemption is grounded in an affirmative attestation by the individual, *whether of income or of hardship circumstance*." 91 Fed. Reg. at 29,637 (emphasis added).

What's more, CMS's expanded hardship exemption would entirely subsume the statute's affordability exemption. This result is insupportable under the statute: "When a statutory construction thus renders an entire subparagraph meaningless," as CMS's construction of "hardship" does to the affordability exemption here, "the canon against surplusage applies with special force." *Pulsifer v. United States*, 601 U.S. 124, 143 (2024) (cleaned up); *see also BLOM Bank SAL v. Honickman*, 605 U.S. 204, 211 (2025) ("catchall provision" should not be read to "swallow the preceding paragraphs"). The expanded hardship exemption would similarly render the age-related exemption largely redundant. *See* 42 U.S.C. § 18022(e)(1).

CMS attempts to compare the new expanded eligibility with the scope of the existing

hardship exemption regulations, but that comparison only underscores that the new categorical exemption is beyond the pale. 91 Fed. Reg. at 29,637. Since 2013, CMS regulations have included an "other circumstances" category, under which the Exchange may grant a hardship exemption to an individual who "has experienced other circumstances that prevented him or her from obtaining coverage under a qualified health plan." *Id.* (quoting 45 C.F.R. § 155.605(d)(1)(iii)). As CMS explains, the 2013 rule "noted that the hardship exemption was drafted with 'broad language to include a range of *personal scenarios*' and that [CMS] expected to 'clarify these criteria in future guidance.'" *Id.* (emphasis added) (quoting 78 Fed. Reg. 39,494, 39,499 (July 1, 2013)). Thus, the broad language of this catchall provision is intended not to sweep in huge swaths of the population but to avoid excluding individuals who may encounter unanticipated "personal scenarios" constituting a hardship circumstance that is not expressly contemplated in the regulations. 78 Fed. Reg. at 39,510. Unlike the expansive, new categorical exemption, the existing regulations provide for individual determinations of hardship, premised on an inability to obtain coverage otherwise, which fits comfortably within section 5000A(e)(5).

Even if this expansion of eligibility for catastrophic coverage were not so clearly contrary to the statutory text providing for the relevant exemptions, it would still be contrary to the ACA because it undermines the statutory structure—i.e., the design of the ACA marketplace. Through its metal-level plans, the ACA requires that insurers generally offer only quality health insurance and aims to lower the cost of coverage to encourage individuals to enroll. This coverage improves access to care and overall health and reduces financial burdens on consumers as well as institutions that pay for uncompensated care. *See* Levitis Decl. ¶¶ 14-20. The catastrophic plans were created not to compete with those metal-level plans but to serve as a backstop for those few Americans who, for specified reasons, could still not obtain coverage through metal-level plans. *See* 42 U.S.C. § 18032(d)(3) (limiting eligibility); S. Rep. No. 111-89, at 33 (2009) (describing limited backstop).

CMS's expansion of the hardship exemption to cover the vast majority of adults functionally creates a parallel insurance market for catastrophic plans that would compete with the metal-level plans, thereby directly undermining the statutory goals. As CMS itself recognizes, "statutes should be interpreted" not in this self-defeating way but "as a 'symmetrical and coherent regulatory scheme.'" 91 Fed. Reg. at 29,636 n.276 (quoting *FDA v. Brown & Williamson Tobacco Corp.*, 529 U.S. 120, 133 (2000)).

At bottom, the new rule does not define the scope of the hardship exemption so much as bulldoze over it by making the vast majority of adults eligible for catastrophic coverage. CMS does not have the authority to rewrite the law in this way. *See Biden v. Nebraska*, 600 U.S. 477, 494 (2023) (authority to define exceptions in statute "does not authorize basic and fundamental changes in the scheme designed by Congress"); *Wisc. Cent. Ltd.*, 585 U.S. at 284 ("Congress alone has the institutional competence, democratic legitimacy, and (most importantly) constitutional authority to revise statutes in light of new social problems and preferences.").

***Second***, even if this expansion of eligibility could be squared with the ACA, it is neither reasonable nor reasonably explained. CMS has failed to articulate "a rational connection between the facts found and the choice made." *State Farm*, 463 U.S. at 43.

To start, CMS avers that its goal is to "expand[] access to affordable coverage options," 91 Fed. Reg. at 29,634, but its policy will likely have the opposite effect by increasing out-of-pocket costs for consumers. It asserts that individuals who do not qualify for PTCs or cost-sharing reductions face a "structural" barrier to coverage and thus, in the agency's view, should qualify for catastrophic coverage. *Id.* Because Congress's chosen affordability exemption does not stretch this far, CMS leverages the hardship exemption to reach that outcome. Although it is true that premiums and deductibles on market-level plans can be high, CMS's solution to affordability challenges is for consumers to enroll in catastrophic plans for which no premium subsidies are

available and under which deductibles are even higher than metal-level plans (other than bronze).

Commenters observed that, contrary to CMS's assertions, there is no evidence that increased access to catastrophic plans would increase the affordability of medical care for consumers. *See, e.g.*, Levitis comment at 43. Under the new rule, individuals enrolled in catastrophic coverage would receive almost no benefits until they pay $15,600 out of pocket (or $31,200 for a family). *Id.*; *see* 91 Fed. Reg. at 29,699. This amount "dwarf[s] the $535 average increase in premium from 2013 to 2026 and far exceed[s] what most Americans can afford to pay out-of-pocket on medical bills." Levitis comment at 43. Enrollment in catastrophic plans, for which the deductible far exceeds what most Americans can afford to spend on an unexpected medical cost,[13] leads individuals to "skip[] recommended treatments, or not fill[] prescriptions due to cost, which for many is followed by worsening health problems." *Id.* Those who proceed with treatment they cannot afford "face medical debt and worsening credit scores," and the costs of that uncompensated care are often "borne by providers and state and local governments." *Id.* at 44; *see* California comment at 14; Nat'l Nurses United comment at 1 (Mar. 13, 2026), https://www.regulations.gov/comment/CMS-2026-0496-0571; Mass. Health Connector comment at 11 (Mar. 13, 2026), https://www.regulations.gov/comment/CMS-2026-0496-0740.

CMS does not dispute these likely outcomes but merely emphasizes that the "final rule expands consumer choice; it does not require any individual to enroll in a catastrophic plan." 91 Fed. Reg. at 29,635. In neglecting to balance its goals of expanding consumer choice with actually improving the affordability of healthcare for consumers, CMS thus entirely "failed to consider [these] important aspect[s] of the problem." *State Farm*, 463 U.S. at 43.

CMS also fails to meaningfully compare the costs of catastrophic plans with the lower-cost

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[13] *See, e.g.*, Bd. of Govs. of the Fed. Res. Sys., *Report on the Economic Well-Being of U.S. Households in 2024 – May 2025*, at fig. 20 (June 12, 2025), https://perma.cc/PGN5-PDFR.

metal-level plans. Even although the premiums for catastrophic plans are lower than those for metal-level plans, the average lowest-cost catastrophic plan in 2026 costs $346 per month, CBPP comment at 25, which is only $23 more than for the average lowest-cost bronze plans—and yet enrollees cannot use PTCs to reduce the cost for catastrophic plans, unlike for bronze plans, *id.*; UnidosUS comment at 33 (Mar. 13, 2026), https://www.regulations.gov/comment/CMS-2026-0496-0801; *see* Partnership to Protect Coverage comment at 3-4 (Mar. 13, 2026), https://www.regulations.gov/comment/CMS-2026-0496-0762. Lowest-cost bronze plans can thus be *more* affordable on net—and provide essential health benefits before the deductible that catastrophic plans do not cover. Relatedly, CMS fails to acknowledge that expanding access to catastrophic coverage to older people would likely increase those premiums even more, as people typically need more care as they age. CBPP comment at 25.

Commenters also pointed out that a drastic increase in enrollment in catastrophic plans would increase premiums for everyone and risk destabilizing the market. *See* Levitis comment at 43; California comment at 14-15; Covered California comment at 7-8 (Mar. 13, 2026), https://www.regulations.gov/comment/CMS-2026-0496-0926. Catastrophic plans are in a separate risk pool from metal-level plans, for purposes of risk adjustment. *See* 91 Fed. Reg. at 29,638. The expanded eligibility for catastrophic coverage risks drawing away relatively healthier enrollees, creating a parallel market that would compete with the metal-level plans and causing an increase in premiums for those enrolled in metal-level plans. *See* Ass'n for Cmty. Affiliated Plans comment at 7 (Mar. 13, 2026), https://www.regulations.gov/comment/CMS-2026-0496-0800; Nat'l Ass'n of Ins. Comm'rs comment at 6 (Mar. 13, 2026), https://www.regulations.gov/comment/CMS-2026-0496-0812; Levitis comment at 43.

CMS acknowledges this risk to the risk pool in the new rule, but it states—without support or evidence—that it concluded that concerns regarding market stability "do not outweigh" the

"barriers" that the agency believes consumers who are newly eligible for catastrophic plans face. 91 Fed. Reg. at 29,639. CMS also observes that enrollment in catastrophic plans was "minimal" for 2026, *id.*, but it does not support its expectation of similarly low uptake for 2027 following codification of the September 2025 guidance in the new rule, or acknowledge the administration's estimates that three million people will now take up catastrophic coverage. *See supra* at 32.

The result of the new rule's expansion of the hardship exemption is therefore likely to be even higher costs for most consumers across all plans and more uncompensated care. The expansion of eligibility for catastrophic plans is therefore arbitrary and capricious.

## III. Plaintiffs Are Likely to Succeed on Their Claims Against Provisions That Permit Insurers to Offer Less Comprehensive Coverage

### A. Provisions Reducing Standards for Network Adequacy Are Arbitrary

Before 2018, CMS reviewed plans to be offered on the Exchanges to ensure that they offered a network of providers that complied with time and distance network adequacy standards. *See City of Columbus II*, 523 F. Supp. 3d at 750. In the 2018 rule, CMS deferred network adequacy review and certification solely to state regulators. 83 Fed. Reg. at 17,025. The court vacated that policy as arbitrary and capricious. *City of Columbus II*, 523 F. Supp. 3d at 751-52. CMS resumed network adequacy evaluation beginning in 2023, and it imposed time and distance network adequacy standards for plans on the FFE. *See* 87 Fed. Reg. 27,208, 27,322 (May 6, 2022). And beginning in 2025, CMS required SBEs and SBE-FPs to establish quantitative time and distance network adequacy standards at least as stringent as the FFE, subject to limited exceptions. 89 Fed. Reg 26,218, 26,328 (Apr. 15, 2024); 45 C.F.R. § 155.1050(a)(2)(i).

The new rule eliminates this federal floor. Instead of requiring network adequacy standards as strong as federal thresholds, CMS will now require only that SBEs and SBE-FPSs ensure "sufficient" access to providers in network and non-network plans, without further defining that

term. 91 Fed. Reg. at 29,727. The rule also establishes an "Effective Provider Access Review Program" and an "Effective ECP [Essential Community Provider] Review Program" that transfers reviews of provider access standards from the FFE to states that demonstrate sufficient authority and technical capacity to conduct the reviews by meeting certain criteria; CMS will continue to conduct reviews for states that do not conduct reviews themselves. 91 Fed. Reg. at 29,736-37.

CMS fails to reasonably explain its about-face from its prior rulemakings on the need for meaningful network adequacy standards. Its justification depends on its belief "that restoring authority to the States will enable them to proactively adapt their Exchange standards to meet their market's needs, as they will be better able to take into consideration the needs of their enrollee population." 91 Fed. Reg. at 29,655. But CMS offers no meaningful support for this conclusion. It simply appeals to its "expert judgment," without "point[ing] … to any data of the sort it would have considered if it had considered [the issue] in any meaningful way." *Nat'l Treasury Emps. Union v. Horner*, 854 F.2d 490, 499 (D.C. Cir. 1988). Such conclusory reasoning is arbitrary.

Moreover, numerous commenters noted that removing the FFE network adequacy standards as the minimum requirements for SBEs and SBE-FPs risks states *lowering* adequacy standards, at the particular expense of rural communities and consumer access to mental health, substance use disorders, and other specialty care. *See* Levitis comment at 60; Nat'l Health Law Program comment at 34; Families USA comment at 6 (Mar.13, 2026), https://www.regulations.gov/comment/CMS-2026-0496-0945; Am. Acad. of Family Physicians comment at 13-14 (Mar. 13, 2026), https://www.regulations.gov/comment/CMS-2026-0496-0634 (detailing ways in which "removing the federal time-and-distance standards harms patients" and noting that harms "are not theoretical" based on GAO reporting that "provider network oversight varies substantially across states and federal agencies and that inadequate networks can impede timely access and push patients out of network" (citing U.S. Government Accountability Office,

*Private Health Insurance: State and Federal Oversight of Provider Networks Varies* (Dec. 2022), https://www.gao.gov/assets/gao-23-105642.pdf)).

These comments challenged a fundamental premise of the agency's decision to entrust network adequacy standards to the states. CMS was obligated to respond to them. *See Grand Canyon Air Tour Coalition v. FAA*, 154 F.3d 455, 468 (D.C. Cir. 1998). And because the policy "rests upon factual findings that contradict those which underlay its prior policy," CMS also needed to "provide a more detailed justification." *FCC v. Fox Television Stations, Inc.*, 556 U.S. 502, 515 (2009). As it did eight years ago, however, CMS "made no attempt to refute, mitigate, or explain away any of these significant concerns" let alone offer any detailed justification for its change. *City of Columbus II*, 523 F. Supp. 3d at 752. Instead, CMS merely stated that any advantages to a uniform federal standard do not outweigh the cost of impeding states' ability to "adapt their standards as they see fit," 91 Fed. Reg. at 29,648, and opined without any supporting evidence that "States will not see this change in policy as an opportunity to roll back their current programs," *id*. These "conclusory or unsupported suppositions" are not reasoned decisions. *United Techs. Corp. v. U.S. Dep't of Def.*, 601 F.3d 557, 562 (D.C. Cir. 2010).

Similarly, CMS's decision to shift review of network adequacy from the FFE to states with "effective" review programs is also arbitrary**.** CMS acknowledges commentors' concerns that deferring provider access reviews to these states "may result in negative impacts in rural areas, such as longer wait times, reduced access to specialty care, including mental health and substance use disorder services, or the removal of certain specialties from their standards entirely; and generally narrower networks compared to those in FFE States where [CMS] will continue to conduct provided access reviews." 91 Fed. Reg. at 29,733. But CMS dismisses these concerns as mere possibilities, noting that a state "*could* choose to implement standards that differ from the Federal review standards and *hypothetically* opt to remove a specialty type," yet it accepts such an

outcome because insurers would not be prevented "from continuing to contract with that provider type in an effort to better serve their enrollees." *Id*. (emphasis added). Commenters, however, specifically noted that these harms "are not theoretical," pointing to empirical evidence that insurers will race to the bottom and offer inadequate networks when they are permitted to do so. *See* Am. Acad. of Family Physicians comment at 13-14; *see also supra* at 39.

Commenters also highlighted states' inability to review and enforce network adequacy reviews. *See* Nat'l Health Law Program comment at 33 ("[M]ore recent analyses have continued to find that state enforcement to network adequacy provisions in private insurance plans has been 'severely underwhelming,' with most state insurance regulators reporting an average of one to zero enforcement actions related to network adequacy annually." (citing Abigail Burman, *Laying Ghost Networks to Rest: Combatting Deceptive Health Plan Provider Directories*, 40 Yale L. & Pol'y Rev. 78, 122 (2021)); *see also, e.g*., Shawnna Read-Richards & Teresa Keller, *The Marketplace Illusion: Coverage Without Care*, Health Aff. (Feb. 26, 2026), https://perma.cc/7MYJ-MKRH). In response to comments that many states lack this capacity, the agency deflected. CMS pointed to other regulations that require states to provide "sufficient access" to providers (sections 156.230(a)(1)(ii), (iii), and 156.236(a)), and the alternative provider access review activities—like checking appointment wait times and conducting "spot check" reviews—that states might chose to employ in lieu of matching federal standards. 91 Fed. Reg. at 29,648. But CMS did not address states' review capacity and "summarily concluded without explanation or evidence that the alternative procedures were adequate." *City of Columbus II*, 523 F. Supp. 3d at 752. Such "failure to consider or respond meaningfully to the significant points raised is not indicative of reasoned decision-making." *Id.*

### B. Provisions Eliminating Standardized Plans and Discontinuation of Non-standardized Plan Limits and Exceptions Are Arbitrary

The new rule's discontinuance of standardized plan options is arbitrary and capricious for many of the same reasons the court rejected the materially identical policy in *City of Columbus II*, 523 F. Supp. 3d at 754. Standardized options have been proven to assist consumers in selecting affordable plans with consumer-friendly cost sharing, increasing the odds that consumers will enroll in coverage that is appropriate for their needs. *See* CBPP comment at 31-32. When consumers have their choices clearly explained to them, they are more likely to complete the enrollment process, and they are more likely to enroll in more generous coverage that meets their health needs. *See* Levitis comment at 35-36. On average, enrollees in standardized plans pay about 15% less out of pocket than other enrollees. Community Catalyst comment at 8 (Mar. 13, 2026), https://www.regulations.gov/comment/CMS-2026-0496-0872. So, when it first provided for standardized options, CMS recognized that "[a]n excessive number of health plan options makes consumers less likely to make any plan selection, more likely to make a selection that does not match their health needs, and more likely to make a selection that leaves them less satisfied." 80 Fed. Reg. 75,488, 75,542 (Dec. 2, 2015); *see also* 87 Fed. Reg. 27,208, 27,316 (May 6, 2022).

Now, however, CMS contends that its plan standardization polices have "failed to achieve the originally articulated objectives of enhancing the consumer experience, increasing consumer understanding, and combatting discriminatory benefit designs." 91 Fed. Reg. at 29,715. "While [CMS] is not required to refute the factual underpinnings of its prior policy with new factual data, it must provide a reasoned explanation for discounting the importance of the facts that it had previously relied upon." *City of Columbus II*, 523 F. Supp. 3d at 755. The agency did not do so here. It does not suggest that market conditions have changed in any material way. Instead, CMS concludes that plan standardization has been ineffective because "each issuer on average tended

to offer a higher number of plans after the imposition of the requirement to offer standardized plan options than the year before this requirement was made effective." 91 Fed. Reg. at 29,722. But this increase occurred only in the first year that standardized plans were required, and the proliferation of plans was instead addressed in a separate provision limiting the number of non-standardized offerings (which the agency also now intends to repeal, as addressed below). *See* P'ship to Protect Coverage comment at 13.

CMS also uses "the comparatively low uptake" in standardized plan options despite differential display features to justify its reversal in policy. 91 Fed. Reg. at 29,715. Contrary to this characterization, more than eight million enrollees chose standardized plans last year, according to the agency's own data. *See* Families USA comment at 2. And the agency even acknowledges that "a significant number of consumers have actively selected and enrolled in standardized plan options." 91 Fed. Reg. at 29,717. CMS's failure to meaningfully support its change in policy renders it decision-making arbitrary and capricious.

CMS acknowledges commenters' concerns that enrollees would be steered to inadequate plans if standardized options weren't available for those enrollees to review. It asserted, however, that there are more effective and less burdensome alternatives to standardized plan options, like making enhancements to "plan display, choice architecture, decision-support tools, and other forms of consumer assistance" online, *id.*, and that maintaining standardized plans might not be the "most effective means" to address the issue, *id.* at 29,719. But the agency did not adopt any of these alternatives, committing instead only to "continue to research" them. *Id.* The agency's casual suggestion that there may by multiple ways to protect consumers from information overload cannot justify its failure to adopt any of those methods; such "mere nodding" to commenters' concerns does not reflect reasoned decision-making. *City of Columbus III*, 796 F. Supp. 3d at 156.

The elimination of non-standardized plan limits is also arbitrary and capricious. These limits prevent excessive plan proliferation and reduce consumer choice overload. *See* Levitis comment at 37. Without these limits, enrollees will have greater difficulty comparing plans, leading to dropped enrollments, harm to the risk pool, and increased premiums. *See id.* CMS acknowledges that this policy has succeeded in reducing duplicative plan offerings, but it dismisses this effect as a "marginal" one that does not justify a burden on insurers. 91 Fed. Reg. at 29,723. The agency does not explain why it prioritizes insurers' interests over the need to protect consumers. Given that CMS acknowledged the severe problems that choice overload can pose for the health of the Exchange, its choice of a policy that will only increase that problem, without substituting any other policies that could address it, shows a "significant mismatch" between the problem that CMS identified and the measures the agency chose, *Dep't of Com. v. New York*, 588 U.S. 752, 783 (2019), further demonstrating the irrationality of its approach.

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

The new rule will cause Plaintiffs irreparable harm sufficient to warrant preliminary relief. A plaintiff seeking a section 705 stay or preliminary injunction must "demonstrate that irreparable injury is *likely* in the absence of an injunction," *Winter*, 555 U.S. at 22, and that it will suffer actual, imminent harm that "cannot be fully rectified" by a final judgment, *Mountain Valley Pipeline, LLC v. 6.56 Acres of Land*, 915 F.3d 197, 216 (4th Cir. 2019) (cleaned up). Though "[m]ere injuries, however substantial, in terms of money, time and energy necessarily expended in the absence of an injunction are not enough, irreparable harm may still occur in extraordinary circumstances, such as when monetary damages are unavailable or unquantifiable." *Am. Ass'n of Colleges for Tchr. Educ. v. McMahon*, 770 F. Supp. 3d 822, 858 (D. Md. 2025) (cleaned up). "[E]conomic damages may constitute irreparable harm where no remedy is available at the conclusion of litigation," *Mountain Valley Pipeline, LLC v. W. Pocahontas Properties Ltd. P'ship*,

918 F.3d 353, 366 (4th Cir. 2019), or where such injury "threaten[s] a party's very existence," *Mountain Valley Pipeline*, 915 F.3d at 218. Plaintiffs' injuries easily meet these standards.

The final rule's challenged provisions, both individually and in combination, will raise premiums for plans on the Exchanges, limit and reduce the quality of coverage under those plans, and deter millions of individuals from enrolling in coverage, leading to higher uncompensated care costs for providers of last resort. Levitis Decl. ¶¶ 5-8. The resulting increase in costs, erosion of coverage, and decreased enrollment will increase the number of uninsured and underinsured individuals and will cause Plaintiffs irreparable harm.

*First*, the erosion of coverage under the 2026 rule will create burdensome additional costs for MSA members and will negatively affect the health of the member businesses' owners and employees who rely on care or medication that they cannot afford without insurance coverage. *See* Phetteplace Decl. ¶¶ 3-5. Crucially, the increase in premiums and limitations on insurance coverage will threaten the "very existence" of some of MSA's members' businesses. *Mountain Valley Pipeline*, 915 F.3d at 218. For example, Mike Ohlinger, an MSA member, and his wife own a small business in Wisconsin. Ohlinger Decl. ¶ 4. They have six employees and would like to be able to provide them with quality healthcare. *Id.* ¶ 5. But costs are too high. *Id.* When the Ohlingers offered insurance coverage in 2023 to their employees, the plan option cost $1,000 per person in out-of-pocket costs, not including dependents. *Id.* Their employees ultimately chose coverage under the ACA or via their spouse's insurance, where they were able to get better out-of-pocket rates. *Id.* If ACA coverage becomes even more unaffordable, their employees will likely leave for jobs that will sponsor their healthcare. *Id.* ¶ 10. The loss of their employees could force the Ohlingers to shut down their company. *Id.* ¶ 5. The rule therefore threatens the existence of the Ohlingers' business, and those of other MSA members, causing them irreparable harm.

The Ohlingers also struggle to afford health insurance for themselves. *Id.* ¶ 7. Mike and

their children have coverage through the ACA. *Id.* Their monthly premium used to be subsidized, but after Congress refused to extend ACA subsidies last year, they became unsubsidized. *Id.* ¶ 8. Today, the family's monthly premium is about the same cost as their monthly mortgage payment. *Id.* ¶ 7. The Ohlingers need healthcare and are willing to continue to pay for it, even if the new rules make coverage more expensive. *Id.* ¶ 8. But the Ohlingers will not purchase a plan that provides less than the level of coverage they have now, even if CMS permits the sale of cheaper plans of lesser quality. *Id.* ¶ 9.

Brooke Legler, another MSA member located in Wisconsin, has a chronic condition that requires her to take significant medication, including a biologic that costs approximately $10,000 per month. Legler Decl. ¶ 5. By giving her access to affordable and comprehensive health insurance, the ACA gave her the freedom to start and operate her small business. Legler's business operated on narrow margins, and last year she sold it. *Id.* ¶¶ 4, 11. Legler hopes to enter the industry again if economic factors, like the cost of health insurance, allow her to do so. *Id.* ¶ 4. But because of her medical condition, Legler is dependent on unaffordable medication. *Id.* ¶ 8. If her health insurance coverage costs increase, or the quality of her insurance plan is diminished, it will be impossible for Legler to re-enter her line of work, let alone afford the medications she needs to survive. *Id.* ¶¶ 8, 11.

*Second*, the 2026 rule will irreparably harm DFA's members, including physicians and medical trainees. If implemented, the challenged provisions will increase the number of uninsured and underinsured patients whom DFA's members treat. Krommes Decl. ¶ 5. As a result, DFA's members will bear the cost caring for patients who are sicker (because they have delayed care until their needs are acute), who cannot afford to pay out of pocket for healthcare, or who do not have insurance coverage (or have limited coverage) to reimburse DFA members for their services. *Id.* ¶ 6. Some members will lose contact with many patients altogether, particularly in low-income

communities. *Id.* And all of this will reduce total compensation for DFA's members and put their medical practices under financial strain or at risk of closing altogether. *Id.* ¶¶ 6-7.

Even when clinicians provide uncompensated care—which will occur more often if the final rule is implemented—their work does not end with the patient's visit. *Id* ¶ 7. When a patient requires treatment but lacks insurance, clinicians must spend time finding a willing and available specialist, trying to find an alternative medicine that the patient may be able to afford but is not the optimal treatment, and intervening on the patient's behalf to get testing or procedures performed. *Id.* As patients lose coverage, these efforts will consume greater amounts of clinicians' time—for which DFA members do not get paid—that detracts from patient care. *Id.* Ultimately, medical providers will expend more time and effort and receive less compensation, all of which will prevent them from providing optimal care to their patients. Over time, the burden of caring for uninsured and underinsured patients will jeopardize the operations of these doctors' practices and harm DFA members' compensation and livelihood. *See* Oller Decl. ¶ 7; Fethke Decl. ¶¶ 9-10.

For example, DFA member Dr. Beth Oller is a family medicine physician who treats more than 800 patients of all ages in Rooks County, Kansas, for a broad range of health care needs. Oller Decl. ¶¶ 3-4. Sustaining her practice is particularly difficult in a rural area like hers, where providers are sparse and many residents are low-income and self-employed (for example, as farmers and ranchers). *Id.* ¶¶ 4-5. If the rule were to go into effect, many of her patients would see the value of their insurance coverage erode or lose coverage altogether. *Id.* ¶¶ 6-7, 9. Dr. Oller would treat fewer patients and would be paid less for the treatments she provides. *Id.* ¶¶ 7, 8. The increase in administrative burdens would also require Dr. Oller and her practice to spend more time (without compensation) helping patients navigate red tape to determine their coverage. *Id.* ¶ 7. These results would hinder her ability to provide optimal care to her patients and jeopardize their long-term health. *Id.* Uncompensated care costs put Dr. Oller's entire practice at risk. *Id.*

Dr. Eric Fethke faces similar harms. His pediatric cardiology practice does not turn away uninsured or underinsured patients seeking emergency care. Fethke Decl. ¶ 7. Treating those patients is costly, resulting in hours of uncompensated work for both him and his staff, and less revenue for his practice. *Id.* ¶¶ 9-10. Even though Dr. Fethke's practice operates within a larger group of providers, his practice cannot survive an increase in uncompensated care costs. *Id.* ¶ 10.

*Third*, Columbus, Baltimore, Pima County, and Chicago (the municipal Plaintiffs) would likewise suffer irreparable injury. Fulfilling their responsibility to care for their residents, the municipal Plaintiff governments operate a range of clinics and programs that offer health care services to residents regardless of their insurance coverage and ability to pay. *See* Wagaw Decl. ¶ 5, 10; Johnson Decl. ¶¶ 7, 9-12; Leach Decl. ¶¶ 6-8; Cullen Decl. ¶¶ 6-9, 14. By driving up the rate of uninsured or underinsured individuals within the municipal Plaintiffs' jurisdictions, *see, e.g.*, Levitis Decl. ¶¶ 5, 7, 28, the rule would force these cities and county to devote additional funding, personnel, and other resources to subsidizing and providing uncompensated care for their residents. The rule thereby hits the municipal Plaintiffs' funding decisions and budgets, including the budgets for their public health departments, free or reduced-cost clinics, and ambulance services. *See* Wagaw Decl. ¶¶ 8-9, 13-14; Johnson Decl. ¶¶ 9-14; Leach Decl. ¶¶ 9-11, Cullen Decl. ¶¶ 6, 11; *see also Columbus I*, 453 F. Supp. 3d at 787-88 (recognizing that city plaintiffs challenging CMS's 2018 rule suffered injury from having to pay greater costs to provide uncompensated care to their under- and uninsured residents); *Columbus II*, 523 F. Supp. 3d at 744 (same); *Columbus III*, 796 F. Supp. 3d at 147-48.

In addition, uninsured individuals often delay seeking care until conditions become severe, which will likely increase the volume of ambulance calls and demand for emergency medical services. *See* Wagaw Decl. ¶ 14. This would increase the strain on the municipal Plaintiffs' often already overstretched emergency medical services and, again, create budgetary shortfalls that the

cities will have to make up. *See* Wagaw Decl. ¶¶ 8-9, 13-14; Johnson Decl. ¶¶ 12-14; Leach Decl. ¶¶ 11-14; Cullen Decl. ¶ 11. Moreover, as uninsured and underinsured individuals neglect the medical care that they need, they are necessarily less healthy, less productive, and less able to participate in city life. *See, e.g.*, Wagaw Decl. ¶ 14; Johnson Decl. ¶ 15; Leach Decl. ¶ 15; Cullen Decl. ¶ 12. This would have cascading negative and irreparable effects on municipal Plaintiffs' programs and communities.

These injuries could not be rectified after final judgment. Issuers are preparing for next year's plan offerings right now based on the new rule's provisions and how it will impact the market. *See Columbus III*, 796 F. Supp. 3d at 173 (noting that the insurance marketplace does not just "spring into effect on October 31st to allow open enrollment to happen on November 1st" (cleaned up)). As a result, "[o]nce the rule goes into effect, it will be difficult, if not impossible to unwind the harm Plaintiffs complain of." *Id.* at 172.

## V. The Remaining Factors Weigh in Favor of an Injunction

The balance of equities and public interest prongs merge when the government is the opposing party. *Nken v. Holder*, 556 U.S. 418, 435 (2009). Preliminary relief here is in the public interest. The challenged provisions of the rule will reduce enrollment and coverage loss for millions of Americans. Levitis Decl. ¶ 5-8. And those who manage to stay insured will see higher out-of-pocket costs, less comprehensive coverage, and greater administrative burdens. *Id*. Increases in uninsured people lead to more uncompensated care, straining providers of last resort and emergency services. *Supra* at 45. These circumstances create life-or-death situations for both the insured and uninsured, as patients without coverage forgo standard medical care altogether, with particularly harmful consequences for lower-income people. Krommes Decl. ¶¶ 6, 8.

In light of these real and immediate harms, the equities and public interest strongly favor preliminary relief. Additionally, "the public undoubtedly ha[s] an interest in seeing its

governmental institutions follow the law." *Roe v. Dep't of Defense*, 947 F.3d 207, 230-31 (4th Cir. 2020). In particular, "[t]he public interest is served when administrative agencies comply with their obligations under the APA." *N. Mariana Islands v. United States*, 686 F. Supp. 2d 7, 21 (D.D.C. 2009). A stay under the APA would require nothing more. And on the other side, the burden of a stay or injunction on the government would be minimal. "It is well established that the Government cannot suffer harm from an injunction that merely ends an unlawful practice." *C.G.B. v. Wolf*, 464 F. Supp. 3d 174, 218 (D.D.C. 2020) (cleaned up); *see Newsom ex rel. Newsom v. Albemarle Cnty. Sch. Bd.*, 354 F.3d 249, 261 (4th Cir. 2003).

**CONCLUSION**

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

Dated: June 4, 2026

Respectfully submitted,

*/s/ Joel McElvain*
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*Counsel for Plaintiffs*

**IN THE UNITED STATES DISTRICT COURT**
**FOR THE DISTRICT OF MARYLAND**

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|---|---|
| CITY OF COLUMBUS, *et al.*,<br><br>*Plaintiffs*,<br><br>v.<br><br>ROBERT F. KENNEDY, JR., *et al.*,<br><br>*Defendants*. | Case No. 1:26-cv-2215 |

**DECLARATION OF DR. THERESA CULLEN**

I, Dr. Theresa Cullen, 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.

2. I am the Director of the Pima County Health Department (PCHD). I have served in this role since May 2020. In my role, I protect and advocate for the health and safety of Pima County and the lives therein.

3. Pima County is the second most populous county in Arizona, with a population of around 1,074,685 according to 2025 Census estimates.[1]

4. According to Census estimates, 12.1% of Pima County's population under the age of 65 lacks health insurance.[2]

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

[2] *Id.*

5. Pima County is a county in the state of Arizona, entrusted with all the powers of county government afforded by the Arizona Constitution and the Arizona Revised Statutes.

6. PCHD is the Health Department for the regional jurisdiction, including for the City of Tucson. PCHD works to improve community health by delivering accessible, equitable, and prevention-focused care across Pima County. The department operates four clinic sites, as well as four mobile health units which expand access to care in underserved and rural communities.

7. Each of these County clinics bill health insurance for those who are insured. The clinics also offer a free or reduced-fee scale for the uninsured and underinsured populations. Thus, when fewer Pima County residents have adequate insurance, PCHD will incur additional costs for providing care to those residents.

8. PCHD delivers immunization services across the lifespan, including no-cost vaccinations for uninsured individuals and homebound vaccination services for residents who cannot access care in traditional healthcare settings.

9. PCHD also provides tuberculosis treatment and case management, including directly observed therapy and contact investigation services to support treatment adherence and reduce community transmission. Clinics deliver sexually transmitted infection (STI) testing and treatment, HIV prevention services including PrEP and PEP, reproductive health and family planning services, birth control services, Title X services, and Well Woman HealthCheck services that improve access to preventive care, cancer screening, sexual health services, and early intervention for uninsured, underinsured, and medically underserved populations. PCHD also conducts hypertension screening and bridge-to-care services and provides medication for

opioid use disorder (MOUD) screening and bridge-to-care prescription services to connect individuals with ongoing treatment and support.

10. PCHD serves a large and geographically diverse population that includes urban, rural, tribal, border, and medically underserved communities.

11. The Arizona Department of Health Services and state law requires the Pima County Health Department to administer certain services. These services include maternal child health, preschool health screening, family planning, public health nursing, premature and newborn immunizations, nutrition, dental care prevention, preschool health screening, as well as disease control programs that address and support diagnosis and treatment of chronic disease, communicable disease, tuberculosis, and venereal disease.[3] If more people become uninsured or underinsured, the County will continue to be required to provide mandatory services such as these, but will no longer receive compensation from health insurance for these services. This will significantly impair the County's ability to provide the legally required health services to its population.

12. If the proposed Rules were to go into effect, many more Pima County residents would not have access to affordable healthcare and will experience worsening health outcomes, increased chronic disease burden, delayed treatment, and greater reliance on County-provided healthcare services. A lack of affordable healthcare increases pressure and financial strain on County-provided healthcare services. The effects of a reduction in affordable healthcare extend beyond the County's healthcare system itself: the workforce participation is reduced, families are strained, community systems are overburdened, and the County's overall stability and economic wellbeing is injured.

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[3] Ariz. Revised Statutes (A.R.S.) § 36-104.

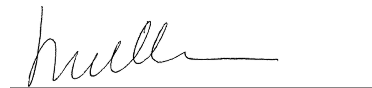
13. If uninsured and/or underinsured rates rise, it will increase the community's need for accessible and affordable healthcare. The Pima County Health Department will have no choice but to expand healthcare services to meet community needs. This, combined with the fact that the County would no longer be receiving the same level of compensation from health insurance for these services, would be an enormous financial challenge for the County: the County will be required to provide far more community health services for far less compensation.

14. In addition, PCHD routinely works closely with the Arizona Department of Health Services, county healthcare systems, community organizations, and regional partners to improve care coordination, enrollment assistance, and resource navigation for vulnerable populations. Increased coverage losses will strain these collaborative systems and require greater cross-sector coordination to ensure residents can access essential healthcare and supportive services, adding to the burden that reduced insurance coverage would foist upon the County.

* * *

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

Dated: June 2, 2026.



Dr. Theresa Cullen

**IN THE UNITED STATES DISTRICT COURT**
**FOR THE DISTRICT OF MARYLAND**

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| CITY OF COLUMBUS, *et al.*,<br><br>*Plaintiffs*,<br><br>v.<br><br>ROBERT F. KENNEDY, JR., *et al.*,<br><br>*Defendants*. | Case No. 1:26-cv-2215_ |

**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, HHS Notice of Benefit and Payment Parameters for 2027; and Basic Health Program," 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 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. In 2016 my practice expanded its clinical services by joining the Boston Children's Health Physicians (BCHP). I have 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, our patients include children and adults from all backgrounds: rural, suburban, metropolitan, low-income, and immigrant.

Roughly a quarter of our 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 our 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 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 pediatric cardiology practice as well as the BCHP practice as a whole. There are administrative burdens associated with taking care of patients when they are uninsured. Our 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 the 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 or who are in need of urgent heart surgery 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

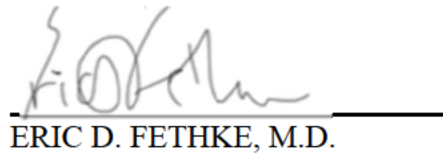
often forced to rely on other providers who are extremely far from their homes. And when their child has an emergency, and they come back to my office in crisis, I am often forced to provide care without compensation. Or, those parents try to travel long distances to make it to a covered, healthcare 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 new rule.

9. Treating uninsured populations results in doctors providing uncompensated care. Under the new rule, more of our patients will become uninsured. The BCHP staff and I will spend even more hours than we currently do working without pay to provide services to our patients whom we cannot ethically neglect. Funds allocated for overhead expenses, like medical equipment, treatment, and testing cannot be reduced, so with less revenue for the practice, we may be forced to cut the salaries of our staff and our physicians like myself. If we are unable to pay our staff adequately, they may leave the practice, which would make the business inoperable. Even if we can pay them, they may leave on their own volition due to the stress of increased workload attending to uninsured patients. Without our highly-specialized staff, our practice may have to reduce services, close some of our sites, and jeopardize my own livelihood.

10. Even operating within a larger group of healthcare providers like BCHP, 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 31 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.

Executed on June 3, 2026 in Middletown, New York.



ERIC D. FETHKE, M.D.

**IN THE UNITED STATES DISTRICT COURT**
**FOR THE DISTRICT OF MARYLAND**

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|---|---|
| CITY OF COLUMBUS *et al.*,<br><br>*Plaintiffs*,<br><br>v.<br><br>ROBERT F. KENNEDY JR. *et al.*,<br><br>*Defendants*. | Case No. 26-cv-**2215** |

## DECLARATION OF EDWARD JOHNSON

I, Edward Johnson, declare under penalty of perjury as prescribed in 28 U.S.C. § 1746:

1. The facts contained in this declaration are known personally to me and, if called as a witness, I could and would testify competently thereto under oath. I submit this sworn declaration in support of Plaintiffs' challenge to the Centers for Medicare & Medicaid Services rule, "Patient Protection and Affordable Care Act, HHS Notice of Benefit and Payment Parameters for 2027; and Basic Health Program."

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

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

4. Plaintiff the City of Columbus is a municipal corporation organized under Ohio

law. *See* Ohio Const. art. XVIII. Columbus has all the powers of local self-government and home rule under the constitution and laws of the state of Ohio, which are exercised in the manner prescribed by the Charter of the City of Columbus.[1]

5. Columbus, located in Franklin County, is the capital of Ohio. It is the largest city in the state and the fifteenth largest city in the United States, with a population of over 938,000, according to U.S. Census Bureau calculations.[2]

6. According to U.S. Census Bureau estimates, 11.4% of Columbus's population under the age of 65 lacks health insurance.[3]

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

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

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

10. Columbus Public Health also financially supports PrimaryOne Health, which is a

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

[2] *QuickFacts,* U.S. Census Bureau, https://www.census.gov/quickfacts/fact/table/columbuscityohio,US/PST045225.

[3] *Id.*

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

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

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

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

13. If possible, "[r]eimbursement for the expense of emergency ambulance transport is sought from a patient's Medicare, Medicaid, or commercial health insurance provider."[9] If an

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

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

[7] *See, e.g., Healthy Moms and Babies*, City of Columbus, https://www.columbus.gov/Services/Public-Health/Healthy-Moms-and-Babies.

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

[9] *Id.*

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

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

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

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

Dated: June 1, 2026

Columbus, Ohio

EDWARD JOHNSON

[10] *Id.*

[11] *Id.*

**IN THE UNITED STATES DISTRICT COURT**
**FOR THE DISTRICT OF MARYLAND**

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|---|---|
| CITY OF COLUMBUS, *et al.*,<br><br>*Plaintiffs*,<br><br>v.<br><br>ROBERT F. KENNEDY, JR., *et al.*,<br><br>*Defendants*. | Case No. 26-cv-02215 |

**DECLARATION OF DR. JANET KROMMES**

I, Janet Krommes, declare as follows:

1. I am over 18 years old and competent to make this declaration. I have personal knowledge of the facts and information in this declaration. I respectfully provide this declaration to explain why the barriers to insurance and cost increases that would be caused by the new Centers for Medicare and Medicaid Services rule, "Patient Protection and Affordable Care Act, HHS Notice of Benefit and Payment Parameters for 2027; and Basic Health Program," would significantly harm the members of Doctors for America (DFA). The rule would create significant hurdles to the provision of standard medical care to patients such that chronic diseases cannot be treated consistently, screening procedures cannot be done, and patients with critical conditions will be lost to follow-up. To address these failings, medical providers, including members of DFA, will direct more time to providing uncompensated care, more administrative time to determining whether insurance coverage is possible, and more time locating patients who are no longer seeking care for serious conditions.

2. I am a retired rheumatologist and member of DFA. I serve as an impact area leader at DFA. In that role, I use my 36 years of experience in clinical medicine to educate our members on healthcare policy.

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

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

5. DFA understands that the new Centers for Medicare & Medicaid Services (CMS) rule, "Patient Protection and Affordable Care Act, HHS Notice of Benefit and Payment Parameters for 2027; and Basic Health Program," will increase the cost of health insurance and limit insurance coverage, creating harmful effects for our members and their patients.

6. When health care costs increase and insurance coverage becomes more limited, patients are less likely to seek the medical care they need and more likely to delay care until conditions become serious. The CMS rule would have this effect in communities throughout the country by increasing the number of uninsured and underinsured individuals. Our members would therefore see patients who delay care until their needs are acute; they would receive less

than full reimbursement for those patients who lose insurance or whose coverage becomes more limited; and they would lose contact with many patients altogether, particularly in low-income communities.

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

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

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

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

*Signature on following page.*

Executed on June 4, 2026 in Washington, D.C.

JANET KROMMES

**IN THE UNITED STATES DISTRICT COURT**
**FOR THE DISTRICT OF MARYLAND**

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| CITY OF COLUMBUS *et al.*,<br><br>*Plaintiffs*,<br><br>v.<br><br>ROBERT F. KENNEDY JR. *et al.*,<br><br>*Defendants*. | Case No. 1:26-cv-2215 |

**DECLARATION OF FAITH LEACH**

I, Faith Leach, declare under penalty of perjury as prescribed in 28 U.S.C. § 1746:

1. The facts contained in this declaration are known personally to me and, if called as a witness, I could and would testify competently thereto under oath. I submit this sworn declaration in support of Plaintiffs' Motion for Stay or Preliminary Injunction.

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

3. Baltimore is the largest city in Maryland and the thirtieth largest city in the United States, with a population of around 570,000 according to 2025 Census estimates.[1]

4. According to 2024 Census estimates, 6.9% of Baltimore's population under the age of 65 lacks health insurance.[2]

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[1] *QuickFacts*, U.S. Census Bureau, https://www.census.gov/quickfacts/fact/table/baltimorecitymaryland,US/PST045225.

[2] *Id*.

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

6. The Baltimore City Health Department (BCHD) is a City agency and the oldest continuously operating health department in the United States. BCHD has wide-ranging responsibilities for providing health services to residents of the City, including those related to acute communicable diseases, chronic disease prevention, HIV/STD, maternal-child health, school health, and senior services. My duties as Chief Administrative Officer include oversight of BCHD, which is staffed by approximately 800 employees and has an annual budget of approximately $203 million.

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

8. BCHD also provides or subsidizes a number of other services for Baltimore's uninsured and underinsured residents. Specifically, BCHD funds nursing assessments at the homes of older adults, including those with chronic health conditions like diabetes, hypertension, asthma, dementia and mental health disorders. These assessments support critical eligibility determinations for subsidized care. The Department also funds a number of other programs focused on specific health conditions, including a Community Asthma Program, a Tuberculosis Control Program, a Childhood Lead Poisoning Prevention Program, and programs for substance

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[3] *Health Clinics & Services*, Baltimore City Health Department, https://www.baltimorecity.gov/health/our-work/health-clinics-services (last accessed May 18, 2026).

abuse.[4] And BCHD subsidizes a number of other entities that provide services to Baltimore residents, including the Baltimore Family League and Health Care Access Maryland.

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

10. The Baltimore City Fire Department (BCFD) also maintains an ambulance system that responds to calls covering 92 square miles with a daytime population exceeding 1,000,000. BCFD's emergency medical service (EMS) seeks reimbursement for its costs from patients' Medicare, Medicaid, or commercial health insurance, but BCFD answers calls regardless of the individuals' health insurance coverage or ability to pay. In FY 2025, EMS continued to experience a high volume of emergency medical incidents consistent with prior years. Preliminary data reflects that the department responded to approximately 160,000 EMS calls, including approximately 17,000 involving uninsured patients.

11. If a patient lacks insurance, BCFD will seek reimbursement from the patient personally, making several attempts to collect on the debt. However, these attempts are rarely successful. To illustrate, EMS was able to recoup 95.6% of costs from patients with insurance coverage in FY 2025, but only 4.1% of those costs from uninsured patients in that same period. Uncompensated care places a real financial strain on EMS operations.

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[4] *See*, *e.g.*, *Asthma*, Baltimore City Health Department, https://www.baltimorecity.gov/health/blog/asthma (last accessed May 18, 2026); *Health Clinics & Services*, Baltimore City Health Department, https://www.baltimorecity.gov/health/our-work/health-clinics-services (last accessed May 18, 2026); *Lead Poisoning*, Baltimore City Health Department, https://www.baltimorecity.gov/health/our-work/lead-poisoning-prevention/childhood-lead-poisoning-prevention (last accessed May 18, 2026); *Substance Use*, Baltimore City Health Department, https://www.baltimorecity.gov/health/substance-use (last accessed May 18, 2026).

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

13. In addition, as one of the busiest emergency medical services departments in the nation, BCFD's emergency medical service is often taxed beyond its capabilities. Wait times exceed national rates, and transport units often wait up to an hour to offload patients, contributing to resource strain across the EMS system.

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

15. Finally, Baltimore—a city of over 560,000 people, at the center of a $259.7 billion regional economy—is harmed by the need to care for a population that is increasingly uninsured. When individuals cannot seek medical treatment, they are necessarily less healthy, less productive, and less able to participate in city life. Increased reliance on the 911 system of non-emergency healthcare needs due to limited access to preventative and primary care services results in higher utilization of EMS resources for chronic medical conditions that could

otherwise be managed in outpatient settings and increased strain on community paramedicine and population health initiatives that are designed to reduce avoidable emergency system utilization. Those impacts have ripple effects throughout the City's programs and the community.

* * *

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

Dated: __May 28, 2026.

Baltimore, MD

Faith Leach

**IN THE UNITED STATES DISTRICT COURT**
**FOR THE DISTRICT OF MARYLAND**

| CITY OF COLUMBUS, *et al.*,<br><br>*Plaintiffs*,<br><br>v.<br><br>ROBERT F. KENNEDY, JR., *et al.*,<br><br>*Defendants*. | Case No. 1:26-cv-2215 |
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**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, HHS Notice of Benefit and Payment Parameters for 2027; and Basic Health Program," would threaten my ability to access medication that I require for my health.

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 former small business owner. I ran an early childhood education program with about 10 employees. I sold my business earlier this year, but I will seek to enter again into this line of work if economic factors, including the cost of health insurance, make it possible for me to do so.

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 depend on substantial medication to treat the condition, including medications that address secondary issues caused by the primary medications. Among other medications, I take a biologic to protect my health by suppressing my immune system, which costs about $10,000 per month.

6. I have purchased individual insurance on the Exchange for 2026 and I receive subsidized coverage under a silver "Quartz One Achieve" plan. My income falls within the range that qualifies me for subsidies under the Affordable Care Act. With those subsidies, I currently pay a net premium of about $200 per month. My insurance covers my rheumatoid arthritis medication and a portion of my biologic medication. I also qualify for payment assistance through the biologic drug company. I would not be able to afford my medications 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. My personal income will be about $30,000 for 2026. I project that my personal

income for 2027 will be about the same amount. At that income level I will remain eligible for ACA premium tax credits. If insurers are permitted to sell cheaper plans next year that offer less generous benefits, I would not wish to purchase such a plan. In shopping for a plan next year, I will seek to retain the comprehensive benefits that I have under my current plan, which I need to be able to afford my medications. If lower tax credits are available to subsidize my coverage, I will be required to pay more in net premiums to maintain the same level of coverage

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

11. I operated 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 would have made it impossible for me to continue my business, and would make it more difficult for me to re-enter this line of work.

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 on June 2, 2026 in New Glarus, Wisconsin.

BROOKE LEGLER

**IN THE UNITED STATES DISTRICT COURT**
**FOR THE DISTRICT OF MARYLAND**

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| CITY OF COLUMBUS, *et al.*,<br><br>*Plaintiffs*,<br><br>v.<br><br>ROBERT F. KENNEDY, JR., *et al.*,<br><br>*Defendants*. | Case No. 1:26-cv-2215 |

**DECLARATION OF JASON LEVITIS**

I, Jason Levitis, declare under penalty of perjury as prescribed in 28 U.S.C. § 1746:

1. The facts contained in this declaration are known to me personally 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 2027 Notice of Benefit and Payment Parameters Final Rule (Final Rule).

2. I am a senior fellow in the Health Policy Division within the Urban Institute, a non-partisan, non-profit organization committed to rigorous research. The views expressed here are my own and do not represent the Urban Institute, its trustees, or its funders. My research concerns a variety of topics in health policy, including the regulation of health insurance, how health insurance is financed, how Americans enroll in health insurance, and how the system can be improved to make health care more affordable and accessible. I have published many pieces of scholarly analysis on these topics. I have testified before Congress and state legislatures; my work is frequently cited in national and local media; and I have served in the federal government,

leading the Treasury Department's work implementing the Affordable Care Act (ACA). My full curriculum vitae, including a list of publications, appears as an Appendix to this declaration.

**Summary of Observations**

3. Health insurance is crucial to protecting Americans' health and financial well-being. Americans go without health insurance for two primary reasons. Health insurance remains too expensive for some people to purchase, despite the availability of federal subsidies. And the enrollment process is beset with administrative burdens that make it confusing, costly, and frustrating.

4. The ACA sought to expand enrollment in quality, affordable health coverage by reforming the individual market for health insurance. The ACA regulated this coverage to ensure quality and fairness, established Marketplaces to promote competition and ease enrollment, and provided financial assistance to help people afford coverage. Together, these provisions ensured the broad availability of quality, affordable coverage, with a strong single risk pool.

5. The rule includes several provisions that would impose substantial new administrative burdens and higher costs on individuals seeking to enroll in Marketplace coverage. This will reduce enrollment and worsen risk pools, raising premiums overall and hurting providers that rely on revenue from Marketplace enrollees. These provisions will be particularly harmful for safety net providers, such as clinics operated by municipalities, which disproportionately serve Marketplace enrollees and serve patients without regard to their insurance status.

6. The rule also includes several provisions that will expand the availability of lower-quality health plans. The expanded availability of such plans will tend to siphon the healthiest enrollees away from higher-quality plans, thereby increasing premiums for the people

who remain in those plans and increasing providers' uncompensated care costs, again especially harming safety net providers.

7. While CMS claims that the rule would reduce Marketplace enrollment by 1.2 to 2 million people and that the rule as a whole would reduce the premiums charged by insurance companies, more reasonable estimates suggest the rule would reduce Marketplace enrollment by closer to 3 to 4 million people and would substantially increase premiums.

8. CMS's analysis of the challenged provisions and other aspects of the rule includes numerous errors that do not indicate reasoned consideration. The Final Rule repeatedly fails to acknowledge or respond to comments raising questions about the analysis in the proposed rule.

**Background on Health Insurance and the Affordable Care Act**

9. Health insurance is crucial to protecting Americans' health and financial well-being. There is extensive evidence that health insurance leads to better health outcomes, lower mortality, and better financial well-being.[1] About 97 percent of Americans either have health insurance or wish that they did.[2]

10. Almost all Americans qualify for substantial federal subsidies to help pay for health insurance. About 120 million Americans receive coverage from Medicare, Medicaid, or

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[1] Amy Finkelstein et al, The Oregon Health Insurance Experiment: Evidence from the First Year, *National Bureau of Economic Research* (2011), https://pubmed.ncbi.nlm.nih.gov/23293397/;
Mark Borgschulte and Jacob Vogler, Did the ACA Medicaid expansion save lives? *Journal of Health Economics*, *72*, 102333 (2020), https://pubmed.ncbi.nlm.nih.gov/32592924/; and
Angela Wyse and Bruce D. Meyer, "Saved by Medicaid: New Evidence on Health Insurance and Mortality from the Universe of Low-Income Adults," *NBER* Working Paper 33719 (2025), https://doi.org/10.3386/w33719; Jacob Goldin, Ithai Z Lurie, and Janet McCubbin, Health Insurance and Mortality: Experimental Evidence from Taxpayer Outreach, 136 *The Quarterly Journal of Economics* 1 (2020), https://doi.org/10.1093/qje/qjaa029; and Darius Erlangga, Marc Suhrcke, Shehzad Ali S, and Karen Bloor, The impact of public health insurance on health care utilisation, financial protection and health status in low- and middle-income countries: A systematic review, 14 PLOS ONE 8: e0219731 (2019), https://doi.org/10.1371/journal.pone.0219731.
[2] Jennifer Tolbert, Sammy Cervantes, Clea Bell, and Anthony Damico, Key Facts about the Uninsured Population, KFF (Apr 9, 2026), https://www.kff.org/uninsured/key-facts-about-the-uninsured-population/.

the Children's Health Insurance Program.[3] Another 160 million or so have employer-sponsored coverage, which is subsidized by the tax exclusion for employer-sponsored health benefits, the largest tax benefit in the Internal Revenue Code.[4] Individuals ineligible for these types of coverage have long relied on the individual market for health insurance. Before the ACA, such individuals were generally not eligible for any federally subsidized coverage. Today, about 20 million people have subsidized individual market coverage through the ACA Marketplaces.[5]

11. Americans go without health insurance for two primary reasons. First, health insurance remains too expensive for some people to purchase, despite the availability of federal subsidies.[6] Second, the enrollment process is beset with "administrative burdens" that make it confusing, costly, and frustrating.[7]

12. A primary goal of the ACA was to expand enrollment in quality, affordable health coverage at a reasonable cost. The ACA achieved this through two primary mechanisms: first, it expanded Medicaid eligibility to low-income adults and simplified Medicaid eligibility rules; second, it reformed the individual market by regulating it to ensure quality and fairness, established Marketplaces to promote competition and ease enrollment, and provided financial assistance to help people afford coverage and ensure a broad risk pool.

13. The ACA's regulation of the individual market for health insurance is an interlocking set of provisions to ensure that coverage is of high quality, fairly designed and priced, relatively easy to understand and compare, and broadly accessible, including to those

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[3] Health Insurance Coverage of the Total Population, KFF (accessed June 4, 2026), https://www.kff.org/state-health-policy-data/state-indicator/total-population/.
[4] Tax Expenditures, *US Department of the Treasury* (Feb. 8, 2025), https://home.treasury.gov/policy-issues/tax-policy/tax-expenditures and Health Insurance Coverage of the Total Population, *supra* note 3.
[5] Health Insurance Exchanges 2026 Open Enrollment Report, CMS (Mar. 2026), https://www.cms.gov/files/document/health-insurance-exchanges-2026-open-enrollment-report.pdf.
[6] *See* Tolbert et al., *supra* note 2.
[7] *See* Tolbert et al., *supra* note 2.

with greater health care needs. Requirements include coverage of essential health benefits; limits on enrollees' out-of-pocket spending; prohibitions on benefits caps, enrollment denials, and exclusions for pre-existing conditions; and adequate networks of providers. It ensures fair and uniform health insurance premiums by prohibiting price differentials based on gender and health status and requiring a "single risk pool" in each state so insurers can't subdivide enrollment into a healthier group paying less and a sicker group paying more. The ACA also established a risk adjustment program that requires insurers enrolling healthier people to compensate insurers that enroll sicker people, though, like other risk adjustment systems, it is far from perfect at eliminating insurers' incentive to attract the healthiest enrollees.[8] Finally, to help consumers understand their choices, it created four "metal levels" that categorize plans based on actuarial value, which is a measure of plan generosity. Bronze plans have an actuarial value of 60 percent, silver 70 percent, gold 80 percent, and platinum 90 percent. There are also "catastrophic" plans that can have an actuarial value below 60 percent, but by statute they are available only to limited groups and do not qualify for subsidies.

14. The Marketplaces are centralized purchasing hubs where consumers can learn about and compare these plans, apply for coverage and financial assistance, and enroll in the plan of their choice.

15. The subsidies for Marketplace coverage are the premium tax credit (PTC) and cost-sharing reductions (CSRs). They are available to relatively low-income individuals who are ineligible for Medicaid or other affordable coverage.

[8] Matthew Fiedler and Timothy Layton, CMS should abandon its "two-stage" risk adjustment estimation proposal, Brookings (Jan. 27, 2022), https://www.brookings.edu/articles/cms-should-abandon-its-two-stage-risk-adjustment-estimation-proposal/.

16. Among consumers shopping for coverage through the Health Insurance Marketplaces, some enrollees—including those with relatively higher incomes—pay the full or "gross" premium charged by insurance companies. Therefore, policies that increase gross premiums will directly increase the cost of coverage for this group.

17. The gross premium of Marketplace coverage is determined by two key factors. The first is the plan's characteristics, including the benefits provided, the reimbursement rates paid to providers, and the cost-sharing (deductibles and co-payments) that consumers must pay to use the coverage. The second is the risk pool, which reflects the claims experience of individuals enrolled in the insurer's plans in the state. A risk pool consisting of sicker individuals will mean higher health care spending on average and thus higher premiums needed to cover that cost. A healthier risk pool will mean lower average health care spending and thus lower premiums.

18. Most consumers who enroll through the Marketplace qualify for the PTC and so pay a net premium smaller than the gross premium.[9] The PTC is based on the premium of a "benchmark plan"–the second lowest-cost silver plan. As a result, individuals receiving the tax credit are insulated from changes in gross premiums that affect all plans equally. Allowing insurers to offer lower-quality coverage would reduce this benchmark premium while leaving the premiums of existing plans unchanged. This would leave PTC recipients with the option of either paying higher net premiums for the same coverage or paying the same amount for lower-quality coverage. Thus, maintaining quality standards is an important part of supporting affordability.

[9] Health Insurance Exchanges 2026 Open Enrollment Report, *supra* note 5.

19. Taken together, this system makes coverage affordable in two crucial ways. First, the subsidies directly reduce individuals' cost to enroll and their deductibles and other cost-sharing. Second, the subsidies attract healthier people into the risk pool, which lowers gross premiums throughout the system.

20. The ACA's structure has been broadly successful in meeting its goals—all Americans can now purchase quality coverage on the same terms, and subsidies have proven sufficient to ensure broad enrollment that has kept premiums relatively stable and generally in line with group insurance premiums.[10] The rate of uninsurance has fallen dramatically,[11] though recent policy changes threaten those gains.[12]

**Extensive Literature Establishes that High Premiums and Increased Administrative Obstacles Decrease Enrollment and Worsen Risk Pools**

21. As noted above, the two main reasons people go without health insurance are high costs and administrative burdens. Both barriers can substantially reduce enrollment and

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[10] Between 2020 and 2025, Marketplace benchmark premiums grew by an average annual rate of just 2 percent — slower than employer-sponsored insurance and inflation, both of which grew at around 5 percent annually. *See* Marketplace Average Monthly Benchmark Premiums, KFF (accessed June 4, 2026), https://www.kff.org/affordable-care-act/state-indicator/marketplace-average-benchmark-premiums/; Premiums and Worker Contributions Among Workers Covered by Employer-Sponsored Coverage, 1999-2025, KFF (Oct. 22, 2025), https://www.kff.org/health-costs/premiums-worker-contributions-among-workers-covered-by-employer-sponsored-coverage/; and Current US Inflation Rates: 2000-2026, US Inflation Calculator (accessed June 4, 2026), https://www.usinflationcalculator.com/inflation/current-inflation-rates/.

[11] Lisa N. Bunch and Halelujha Ketema, Health Insurance Coverage in the United States: 2024, Current Population Reports P60-288, US Census Bureau (Sept. 9, 2025), https://www.census.gov/library/publications/2025/demo/p60-288.html.

[12] Jason Levitis, Statement of Jason Levitis Before the Senate Finance Committee, Urban Institute (Nov. 19, 2025), https://www.urban.org/research/publication/statement-jason-levitis-senate-finance-committee; Matthew Buettgens et al., Projected Reductions in Medicaid Expansion Enrollment Under OBBBA's Work Requirements and Six-Month Redeterminations, Urban Institute (Mar. 25, 2026), https://www.urban.org/research/publication/projected-reductions-medicaid-expansion-enrollment-under-obbbas-work; Matthew Buettgens et al., 4.8 Million People Will Lose Coverage in 2026 If Enhanced Premium Tax Credits Expire, Urban Institute (Sept. 17, 2025), https://www.urban.org/research/publication/48-million-people-will-lose-coverage-2026-if-enhanced-premium-tax-credits; and Matthew Buettgens et al., Reconciliation Bill Would Cut Marketplace Enrollment by over 5 Million People, Urban Institute (June 13, 2025), https://www.urban.org/research/publication/reconciliation-bill-would-cut-marketplace-enrollment-over-5-million-people.

disproportionately reduce enrollment among healthier people, and thus tend to increase insurance premiums.

***Premiums***

22. Enrollment decisions are highly sensitive to the premium the consumer is charged. Higher costs significantly reduce enrollment and hurt the risk pool, which increases gross premiums.

- Sixty-two percent of uninsured adults reported that coverage was not affordable as a reason for being uninsured.[13]
- A study published in the American Economic Review found that decreases in financial assistance and the associated increase in net premiums have a large enrollment effect: each $40 increase in net monthly premiums decreases enrollment by 25 percent. The study also found that healthier enrollees are most subject to discouragement.[14]
- The American Academy of Actuaries has explained[15] that higher premiums disproportionately deter enrollment among healthier people,[16] since they expect to use less health care.[17]
- A study by the actuarial firm Wakely found that, for enrollees without financial

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[13] *See* Tolbert et al., *supra* note 2.

[14] Amy Finkelstein et al., Subsidizing Health Insurance for Low-Income Adults: Evidence from Massachusetts, 109 *American Economic Review* 1530 (2019), https://doi.org/10.1257/aer.20171455.

[15] Academy Dissects What the Shifting Health Care and Policy Landscape Could Mean for 2026 ACA Premium Rates and Under-65 Health Insurance Markets, The American Academy of Actuaries (2025), https://actuary.org/academy-dissects-what-the-shifting-health-care-and-policy-landscape-could-mean-for-2026-aca-premium-rates-and-under-65-health-insurance-markets/.

[16] Drivers of 2026 Health Insurance Premium Changes Effects on Premiums, The American Academy of Actuaries (2025), https://actuary.org/wp-content/uploads/2025/07/Infographic-26-Premiums.pdf.

[17] For a discussion of this literature, see, e.g., Linda J. Blumberg and 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/.

assistance, increases in gross premiums are associated with large reductions in Marketplace enrollment, including a decline of more than 5 percent in one year.[18]

- A study of the Massachusetts health reform finds that reducing the effective price of health insurance mitigates adverse selection and improves the risk pool.[19]
- 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,[20] although it should be noted that this is not a direct measure of coverage loss.

***Administrative Burdens***

23. The Marketplace application process is complex, especially for individuals with limited time, education, or language proficiency. Consumers (on their own, or with help from a broker or assister) must (1) collect application information about themselves and their family members, including details about sources of income, family structure, residency, and other health insurance options available to them; (2) complete an application attesting to this information; (3) receive and understand fairly detailed information about their eligibility; (4) select a health plan from among the (often dozens of) available options; (5) make decisions about the financial assistance they will receive, with the potential to owe back any overpayments; and (6) establish a relationship with the insurance company offering their coverage, including providing payment

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[18] Michael Cohen and 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.

[19] Martin B. Hackmann, Jonathan T. Kolstad, and Amanda E. Kowalski, Adverse Selection and an Individual Mandate: When Theory Meets Practice, 105 *American Economic Review* 3: 1030–66 (2015), https://doi.org/10.1257/aer.20130758.

[20] 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 and Alexandra Minicozzi, How Did Take-up of Marketplace Plans Vary with Price, Income, and Gender?, 11 *Am. J. Health Econ.* (2025), https://doi.org/10.1086/727785.

information in most cases. Some applicants must submit additional documentation by mail or through an online portal, or 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.[21]

24. There is extensive evidence that administrative burdens reduce take-up, and that this attrition disproportionately affects lower-risk individuals, since sicker people are more willing to fight through obstacles to gain or maintain coverage. For example:

- A KFF brief reported that 21 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 that meets their needs, which may also reflect administrative barriers.[22]
- A 2025 study in the American Economic Review finds that adding one step to the enrollment process prompted a 33 percent decline in enrollment. Moreover, imposing administrative burdens on enrollment "differentially exclud[es] young, healthy, and economically disadvantaged people." Enrollees who would potentially lose coverage if an additional administrative step were required at reenrollment have health costs 44 percent lower than those who are not likely to be affected.[23]

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[21] 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.

[22] Tolbert et al., *supra* note 2.

[23] Mark Shepard and Myles Wagner, Do Ordeals Work for Selection Markets? Evidence from Health Insurance Auto-Enrollment,115 *American Economic Review* 3: 772–822 (2025), https://doi.org/10.1257/aer.20231133.

- A 2021 study in the American Economic Review finds that healthier individuals are more responsive to the removal of administrative frictions.[24]
- A 2021 study published by the American Economic Association on auto-retention–a key tool for bypassing administrative burdens–finds that "automatic retention has a sizable impact...differentially retaining healthy, low-cost individuals."[25]
- A 2024 study in Health Affairs finds that states that implemented nominal monthly premiums (meaning the main bar is not the monetary cost but the administrative burden of paying it) saw enrollment fall by 14 percent, with larger effects among younger individuals.[26]
- A nominal premium of less than $10 per month was associated with a 14 percent reduction in enrollment.[27]
- The availability of $0 premium plans increases days of enrollment in the Marketplace.[28]
- A report in The Review of Economics and Statistics found that reducing administrative barriers increases take-up of subsidized health insurance coverage.[29]

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[24] Richard Domurat, Isaac Menashe, and Wesley Yin, The Role of Behavioral Frictions in Health Insurance Marketplace Enrollment and Risk: Evidence from a Field Experiment, 111 *American Economic Review* 5: 1549–74 (2021). https://doi.org/10.1257/aer.20190823.
[25]Adrianna McIntyre, Mark Shepard, and Myles Wagner, Can Automatic Retention Improve Health Insurance Market Outcomes?, 111 *AEA Papers and Proceedings* 560–66 (2021), https://doi.org/10.1257/pandp.20211083.
[26] Adrianna McIntyre, Mark Shepard, and Timothy J. Layton, Small Marketplace Premiums Pose Financial and Administrative Burdens: Evidence From Massachusetts, 2016–17, 43 *Health Affairs* 1 (2024), https://doi.org/10.1377/hlthaff.2023.00649.
[27] Adrianna McIntyre, Mark Shepard and Timothy J. Layton, Small Marketplace Premiums Pose Financial and Administrative Burdens: Evidence from Massachusetts, 2016-17, 43 *Health Affairs* 80 (2024), https://www.healthaffairs.org/doi/10.1377/hlthaff.2023.00649.
[28] 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.
[29] Keith Marzilli Ericson, Timothy J. Layton, Adrianna McIntyre, and Adam Sacarny, Reducing Administrative Barriers Increases Take-Up of Subsidized Health Insurance Coverage: Evidence from a Field Experiment, *The Review of Economics and Statistics* (2025), https://doi.org/10.1162/rest_a_01573.

25. Outside of the Marketplaces, researchers have documented similar impacts, including the following examples:

- Making an administrative component of the food assistance application process more flexible increased enrollment by 6 percentage points.[30]
- Offering assistance in resolving administrative obstacles to enrollment in food assistance increased enrollment by 12 percentage points.[31]
- Simplifying enrollment in retirement savings plans increases take-up significantly.[32]

26. Because of administrative burdens, take-up rates have consistently remained well below 100 percent even for programs like Medicaid that don't charge a premium.[33] Most uninsured people are eligible for subsidized coverage. For instance, a recent analysis using data from 2024 to study the nonelderly uninsured finds that 52 percent are eligible for subsidized coverage, 24 percent through Medicaid, and 28 percent for subsidized ACA coverage.[34]

27. This evidence suggests that the large and widespread administrative burdens imposed by the rule would substantially reduce enrollment and increase premiums.

28. Reductions in Marketplace enrollment and the increase in the uninsured population will reduce provider revenue and increase the burden of uncompensated care, especially for safety net providers.[35]

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[30] 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.

[31] Amy Finkelstein and Matthew J. Notowidigdo, Take-Up and Targeting: Experimental Evidence from SNAP, 134 *Q.J. Econ.* 1505 (2019), https://doi.org/10.1093/qje/qjz013.

[32] See, e.g., Brigitte C. Madrian and 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.

[33] Rebecca Brooks Smith, Gabriella Aboulafia, and Benjamin D. Sommers, Who Enrolls in Coverage and Who Remains Uninsured? Medicaid Take-Up Before and After the Affordable Care Act and During Unwinding, 103 *Milbank Quarterly*: 349-389 (2025), https://onlinelibrary.wiley.com/doi/10.1111/1468-0009.70020.

[34] *See* Tolbert et al., *supra* note 2.

[35] *See*, for example, an Urban Institute report found that if 2.4 million people disenrolled in Marketplace coverage and became uninsured, hospitals would experience a $5.3 billion decrease in revenue. Fredric Blavin, Reconciliation

**The Rule Is Expected to Substantially Reduce Marketplace Coverage and Increase Gross Premiums, Contrary to CMS's Projections.**

29. CMS projects that the rule will reduce 2027 enrollment by 1.2 to 2 million people and that the rule, as a whole, will reduce individual market premiums by 1.2 to 1.8 percent.[36] Both of these estimates are implausibly rosy. More plausible estimates suggest the rule will lead to coverage losses of 3 to 4 million people and to substantial premium increases.

30. While CMS's coverage loss estimates seem understated in general, its estimates for two provisions are especially implausible.

31. First, CMS claims that provisions requiring several million individuals to submit additional documentation to verify their income to gain subsidized coverage would reduce enrollment by less than half a million people. As explained below, this appears to be based on implausible assumptions about attrition due to administrative burdens. Using more reasonable assumptions, Wakely estimates coverage losses due to these provisions at 2.3 million people.[37]

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Bill and End of Enhanced Subsidies Would Cut Health Care Provider Revenue and Spike Uncompensated Care, Urban Institute (May 29, 2025), https://www.urban.org/research/publication/reconciliation-bill-and-end-enhanced-subsidies-would-cut-health-care-provider; Fredric Blavin and Michael Simpson, Changes in Health Care Spending and Uncompensated Care under Enhanced Tax Credit Expiration for Marketplace Coverage, Urban Institute (Sept.25, 2025), https://www.urban.org/research/publication/changes-health-care-spending-and-uncompensated-care-under-enhanced-tax-credit; Fredric Blavin, Matthew Buettgens, Michael Simpson, Health Care Providers Would Experience Significant Revenue Losses and Uncompensated Care Increases in the Face of Reduced Federal Support for Medicaid Expansion, Urban Institute (March 11, 2025), https://www.urban.org/research/publication/health-care-providers-would-experience-significant-revenue-losses-and-uncompensated-care-increases-in-the-face-of-reduced-federal-support-for-medicaid-expansion; and Fredric Blavin, Michael Simpson, and Laura Skopec, Rural Hospital Revenue Could Drop by $87 Billion over 10 Years Because of the Reconciliation Bill and Expiring Enhanced Tax Credits, Urban Institute (June 30, 2025), https://www.urban.org/urban-wire/rural-hospital-revenue-could-drop-87-billion-over-10-years-because-reconciliation-bill.

[36] Page 2,976 of the Final Rule (91 FR 29526) https://www.federalregister.gov/d/2026-10050/p-2976. In the same sections, CMS claims the range is 1.2 to 2.4 percent, but this seems to be a typo. Page 2,982 of the Final Rule (91 FR 29526), https://www.federalregister.gov/d/2026-10050/p-2982 .

[37] *See* Zachary Sherman, Michael Cohen, and Lina Rashid, 2027 Proposed NBPP: Analyzing State and Consumer Impacts, Health Management Associates (March 10, 2026), https://www.healthmanagement.com/insights/briefs-reports/2027-proposed-nbppanalyzing-state-andconsumer-impacts/.

32. Second, CMS inexplicably claims that the failure to reconcile (FTR) change would eliminate advance premium tax credits (APTC) (and therefore likely end coverage) for at most 42,000 households in 2027, notwithstanding CMS data showing that the current, less stringent rule ended APTC for 199,000 households (representing 235,000 consumers) in 2025 and 366,000 households (representing 430,000 consumers) in 2026.[38] CMS gives no meaningful explanation for this immense discrepancy, as noted below in the section on FTR.

33. Taken together, just these two implausible estimates of coverage losses are understated by at least 2 million people. Adding that differential to CMS's overall estimate suggests coverage losses of 3 to 4 million people under the rule.

34. The rule is also expected to increase gross premiums overall. CMS concedes that provisions that account for most of the rule (including those at issue in this lawsuit) will increase premiums, but it understates by how much. Specifically, CMS claims that, excluding its changes to special enrollment periods and the user fee, the rule will increase premiums by 1.7 to 2.4 percent. This figure is implausibly small considering the numerous burdensome administrative barriers imposed by the rule and the substantial coverage losses that would result, as detailed below. As summarized above, there is extensive evidence that administrative burdens reduce enrollment among healthier individuals, worsen risk pools, and ultimately, substantially increase premiums.

35. Wakely highlighted similar concerns about the credibility of CMS's estimates in discussing the premium effects of last year's Marketplace Affordability and Integrity Rule,

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[38] *See* CMS Actions to Protect Consumers and Strengthen Exchange Program Integrity, CMS (Jan. 28, 2026), https://www.cms.gov/newsroom/fact-sheets/cms-actions-protect-consumers-strengthen-exchange-program-integrity. The 2025 household figure (rounded to 200,000) is also included in the Final Rule at 91 FR 29836, https://www.federalregister.gov/d/2026-10050/p-2792.

which included many of the same provisions, noting that "many pricing actuaries will likely not price into their 2026 rates…the reduction in average claims (-0.9 to -5.4 percent) HHS is projecting. Rather, we would expect these changes to increase average costs."[39] This underestimation may be related to CMS's underestimation of coverage losses, as discussed above. Because administrative burdens especially deter enrollment among healthier individuals, larger coverage losses likely mean larger premium increases.

36. CMS also errs by claiming that eliminating the special enrollment period (SEP) for those under 150 percent of the federal poverty level (FPL) will reduce premiums by 2 to 3 percent and thus reverse any premium increases from the rule's other provisions. This effect is implausible, since the One Big Beautiful Bill Act (OBBBA) eliminated PTC and CSRs for people using this SEP, rendering it useless for the low-income population eligible to use it. The population eligible for this SEP (individuals with income under $23,940 for plan year 2027) cannot afford to purchase or use coverage without PTC and CSRs. And many of them can purchase coverage with PTC and CSRs during the open enrollment period or using other SEPs. In short, as the Congressional Budget Office (CBO) noted in its analysis of OBBBA, OBBBA "effectively eliminate[d] this SEP."[40] As a result, CMS can't plausibly claim that formally eliminating it will further reduce premiums, let alone counteract the premium increases of actual policy changes.

37. After accounting for this 2 to 3 percent estimate, CMS's own estimates indicate that the provisions challenged in this rule would increase premiums, even if there is some small

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[39] Lydia Tolman and Michael Cohen, Pricing Considerations for the Program Integrity Rule, Wakely (Apr 2025), https://www.wakely.com/blog/pricing-considerations-for-the-program-integrity-rule/.

[40] Phillip L. Swagel, Re: Estimated Effects on the Number of Uninsured People in 2034 Resulting From Policies Incorporated Within CBO's Baseline Projections and H.R. 1, the One Big Beautiful Bill Act, Congressional Budget Office (June 4, 2025), https://www.cbo.gov/system/files/2025-06/Wyden-Pallone-Neal_Letter_6-4-25.pdf#page=13.

offsetting reduction due to the SEP verification changes and the smaller user fee. Combining this with more realistic estimates of premium increases due to new administrative burdens, the rule overall is likely to increase gross premiums by a substantial amount.

38. What's more, the provisions that CMS concedes would increase premiums are generally the ones that the plaintiffs in this case are asking to be stayed. Of the provisions for which a stay is requested, the only one that CMS claims would reduce premiums is verification of SEP eligibility in the federal Marketplace. That claim is inconsistent with the actual experience of Exchanges in implementing SEPs, as discussed below. But even if one were to accept CMS's claim at face value, it asserts that the SEP provision would reduce premiums by 0.5 to 0.8 percent, which is substantially less than the premium increase CMS concedes would result from the FTR, data matching issue (DMI) verification, and other provisions. As a result, it is clear from CMS's own estimates that granting the requested stay would reduce premiums.

**The Analysis in the Rule Includes Several Additional Obvious Errors, Many of Which Were Noted in Comments that CMS Ignored.**

39. Beyond its estimates of the rule's overall coverage and premium effects, CMS's analysis includes numerous major errors that are incompatible with a reasoned consideration of the facts. Many of these errors were pointed out in comments on the analysis in the proposed rule, but CMS generally excludes these comments from its comment summaries and fails to respond to them.

40. All of CMS's estimates of the effects of the rule are built from its "baseline"–its understanding of the world absent the rule. Yet CMS's baseline coverage figures are plainly implausible for years at issue here.

41. First, CMS estimates that, between 2025 and 2026, total Marketplace enrollment is set to fall by "approximately 725,000 to 1,800,000."[41] But every credible estimate shows a much larger decline over this span, due to recent policy changes like the expiration of the PTC enhancements and changes in OBBBA. CBO estimates a reduction of 5.5 million people,[42] KFF a reduction of 4.8 million people,[43] and the Urban Institute a reduction of 7.3 million people due to the expiration of the enhanced PTCs alone.[44] CMS's estimates are a third or less of these estimates. No explanation is given for this discrepancy.

42. Second, between 2026 and 2027, CMS projects that Marketplace enrollment in the baseline will *increase* slightly. This is implausible in light of baseline facts on the ground, including OBBBA eliminating eligibility for many immigrants in 2027 and the expiration of the PTC enhancements being felt more over time. Credible estimates show a substantial enrollment decline in 2027–CBO puts it at 3.8 million people.[45] Comments noted this clear error in the regulatory impact analysis (RIA) in the proposed rule,[46] but CMS neither acknowledged these concerns nor responded.

43. Since the baseline estimates are the foundation for all other estimates in the rule, these errors call into question all of CMS's estimates.

44. Many of CMS's estimates regarding the impact of particular provisions are also implausible. As discussed in more detail below, CMS's estimates regarding the impact of the two

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[41] *See* page 2,793 of the Final Rule (91 FR 29526), https://www.federalregister.gov/d/2026-10050/p-2793.
[42] Baseline Projections: Federal Subsidies for Health Insurance, Congressional Budget Office (Feb. 2026), https://www.cbo.gov/system/files/2026-02/51298-2026-02-healthinsurance.pdf.
[43] Matt McGough, Jared Ortaliza, Justin Lo, and Cynthia Cox, What We Know So Far About 2026 ACA Marketplace Enrollment, Premiums, and Deductibles, KFF (May 19, 2026), https://www.kff.org/affordable-care-act/what-we-know-so-far-about-2026-aca-marketplace-enrollment-premiums-and-deductibles/.
[44] Matthew Buettgens et al., 4.8 Million People Will Lose Coverage, *supra* note 12.
[45] *See* Baseline Projections, *supra* note 42.
[46] *See*, for example, Comment CMS-2026-0496-0989, https://www.regulations.gov/comment/CMS-2026-0496-0989.

DMI provisions, the SEP verification provision, the elimination of the low-income SEP, and the FTR rule are all plainly flawed in light of available evidence.

45. CMS received comments directly questioning many of these estimates and of other aspects of its regulatory impact analysis. Yet CMS generally finalized its estimates without change and fails to acknowledge these concerns in its comment summaries or address them in its responses.

**Several Challenged Provisions of the Final Rule Will Increase Administrative Obstacles and Reduce Access to Subsidies, and Therefore Are Expected to Reduce Enrollment and Increase Premiums**

46. The Final Rule includes several provisions that are expected to impose additional administrative obstacles and thus increase gross premiums, both of which are expected to decrease enrollment. This lower enrollment will impose costs on providers, and especially safety net providers.

***Denying Financial Assistance under FTR Rules***

47. The Final Rule requires Marketplaces to impose burdensome and confusing rules known as "Failure to Reconcile." Under the ACA, Marketplace enrollees can receive PTCs as "advance payments" to reduce their monthly premiums. They must then file a tax return to "reconcile" that assistance based on their actual income for the year. Individuals who fail to file and reconcile are subject to having their returns rejected and to normal tax enforcement measures like the withholding of tax refunds and liens and levies. The Final Rule requires Marketplaces to impose an additional penalty: denying financial assistance for the current year if the IRS reports that an individual has failed to file a tax return and reconcile their advance payments for one or more prior years.

48. The FTR rules impose complex administrative burdens on affected consumers. The tax forms used for reconciling advance payments are complicated, especially for consumers facing complex situations.[47] Because the fact of having filed and reconciled is considered federal tax information, that information must be protected from disclosure and handled consistently with federal tax privacy laws. As a result, the Marketplace cannot generally discuss a consumer's FTR status with that consumer–even when denying financial assistance on that basis. For the same reason, many Marketplaces cannot notify consumers that they are at risk of losing assistance due to FTR status; instead, they send vague notices indicating that the consumer is at risk of losing financial assistance for any of several potential reasons. When recipients of these vague notices ask the Marketplace to explain, it cannot do so. Consumers also face risks of FTR "false positives," where individuals who have in fact filed are still denied financial assistance. The IRS has been plagued by processing delays and errors over the years.[48] There are no data on the prevalence of errors. But in the analogous case of Marketplaces requesting tax data to verify income, state-based Marketplaces (SBMs) report that the IRS fails to return income data for some 40 percent of applicants across income levels[49]–a share much larger than the fraction of non-filers. And these concerns are exacerbated by IRS customer service shortcomings. Both the

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[47] *See* About Form 8962, Premium Tax Credit, IRS (accessed June 4, 2026), https://www.irs.gov/forms-pubs/about-form-8962 and About Publication 974, Premium Tax Credit (PTC), IRS (accessed June 4, 2026),https://www.irs.gov/forms-pubs/about-publication-974.
[48]Jessica Lucas-Judy, More Delays Ahead—Pandemic Continues to Slow Down IRS, Government Accountability Office (March 25, 2021), https://www.gao.gov/blog/more-delays-ahead-pandemic-continues-slow-down-irs; National Taxpayer Advocate, 2023 Annual Report to Congress: Most Serious Problems, IRS (2023), https://www.taxpayeradvocate.irs.gov/reports/2023-annual-report-to-congress/most-serious-problems/; and National Taxpayer Advocate, 2024 Annual Report to Congress: Most Serious Problems, IRS (2024), https://www.taxpayeradvocate.irs.gov/reports/2024-annual-report-to-congress/most-serious-problems/.
[49] New CMS Proposed Rule: ACA Marketplace Integrity, State Health and Value Strategies (Apr 1, 2025), https://www.shvs.org/wp-content/uploads/2025/04/New-CMS-Proposed-Rule-on-ACA-Marketplace-Integrity_Final.pdf#page=32.

IRS Inspector General and the IRS Taxpayer Advocate recently warned of increases in errors and customer service delays due to recent staffing reductions.[50]

49. There are two versions of the FTR rules, one stricter and one less strict. Under the stricter version, consumers are denied financial assistance if the IRS reports that they have failed to reconcile for a single year. Under the less-strict version, consumers are denied financial assistance only with two years of FTR status. The Final Rule provides that the federal Marketplace will use the one-year rules, while state Marketplaces may choose between the two for the 2027 plan year.

50. Under either approach, FTR rules create a complicated administrative obstacle for some consumers. The literature discussed above shows that even simple administrative obstacles reduce enrollment, especially by healthier people. The Kafka-esque features of FTR rules are likely to have even greater effects, reducing enrollment and worsening risk pools.

51. The FTR policy is expected to eliminate APTC and cause loss of coverage for hundreds of thousands of individuals. With the two-year rules in effect, CMS eliminated APTC for 199,000 households (representing 235,000 consumers) in 2025 and 366,000 households (representing 430,000 consumers) in 2026.[51] With the one-year rules in effect in 2027, at least in the Federally-facilitated Marketplace (FFM), APTC losses are expected to be even higher. The vast majority of these would be unable to afford the premium without APTC and so would lose

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[50] Diana M. Tengesdal, The Internal Revenue Service's Readiness for the 2026 Filing Season, Department of the Treasury (Jan. 26, 2026), https://www.oversight.gov/sites/default/files/documents/reports/2026-01/2026400002_Readiness%20Memo_Final.pdf and National Taxpayer Advocate, 2025 Annual Report to Congress, IRS (2025) https://www.taxpayeradvocate.irs.gov/wp-content/uploads/2026/01/ARC_Publication-2104_2025_Web.pdf.

[51] CMS Actions to Protect Consumers and Strengthen Exchange Program Integrity, CMS (Jan. 28, 2026), https://www.cms.gov/newsroom/fact-sheets/cms-actions-protect-consumers-strengthen-exchange-program-integrity. The 2025 household figure (rounded to 200,000) is also included in the Final Rule at 91 FR 29836, https://www.federalregister.gov/d/2026-10050/p-2792.

coverage altogether, degrading the risk pool. These coverage losses would also harm providers, as explained above.

52. CMS's projections for APTC loss due to FTR are implausibly low. Despite the clear recent history of APTC losses in the hundreds of thousands, the Final Rule projects that at most 42,000 households would lose APTC in 2027 due to FTR–and that assumes every state uses the stricter one-year rules. The only explanation given for this precipitous decline is that total Marketplace enrollment is expected to fall by 725,000 to 1.8 million in 2027. In other words, CMS projects that an enrollment decline of perhaps 5 to 10 percent will reduce APTC loss due to FTR by almost 90 percent.

***Requiring Additional Paperwork to Address DMIs***

53. The Final Rule broadens the set of circumstances where consumers must submit additional documentation to prove their eligibility for financial assistance. Under the ACA, federal tax information and other trusted data sources are used to verify eligibility for financial assistance. When a consumer's application claims income lower than shown in tax data or other administrative data sources, a "DMI" is generated, and the consumer must collect and then come back to submit additional information. Those who do not do so have their financial assistance reduced—generally to $0. Most of this group can be reasonably expected to lose coverage because they can no longer afford it.

54. The Final Rule would expand these rules to also generate a DMI when the consumer attests to income higher than is shown in tax data or other sources, and when this data is not available.

55. These provisions add additional paperwork burdens for large numbers of consumers. The IRS is currently unable to provide tax data for about 40 percent of consumers,

including many with moderate incomes who certainly file tax returns.[52] As a result, this provision would result in millions of DMIs each year. CMS estimates they would lead to 3.3 million additional DMIs per year, while the actuarial firm Wakely estimates 4.7 million per year.[53]

56. Resolving a DMI requires consumers to submit information like pay stubs, invoices, or a narrative explaining their income situation. This additional paperwork is especially burdensome for eligible low-income people, those with variable incomes, and small business owners and the self-employed, all of whom face greater challenges documenting their income.

57. Consistent with the literature above, this sort of burden leads to substantially reduced enrollment. This coverage loss will disproportionately affect healthy consumers, worsening risk pools. Indeed, CMS has long underscored that coverage losses associated with DMIs are concentrated among the young.[54]

58. This expanded paperwork burden is expected to reduce Marketplace enrollment by about 2.3 million people, according to the actuarial firm Wakely.[55]

59. CMS claims a much smaller impact: that 488,000 people will lose financial assistance. Comments noted that CMS's analysis "greatly understates the expected impact" of these provisions and suggested likely methodological errors.[56] But CMS's summaries of comments[57] on the estimates make no reference to these comments, and its responses[58] do not

[52] New CMS Proposed Rule: ACA Marketplace Integrity, *supra* note 49.
[53] Sherman et al., *supra* note 37.
[54] Strengthening the Marketplace – Actions to Improve the Risk Pool, CMS (Jun 8, 2016), https://www.cms.gov/newsroom/fact-sheets/strengthening-marketplace-actions-improve-risk-pool.
[55] Sherman et al., *supra* note 37.
[56] *See*, for example, Comment CMS-2026-0496-0989, https://www.regulations.gov/comment/CMS-2026-0496-0989.
[57] Pages 2,800 and 2,807 of the Final Rule (91 FR 29526), https://www.federalregister.gov/d/2026-10050/p-2800.
[58] Pages 2,801 and 2,808 of the Final Rule (91 FR 29526), https://www.federalregister.gov/d/2026-10050/p-2801.

address them, instead focusing exclusively on commenters' substantive concerns about the provisions.[59]

60. In addition, CMS's estimate of coverage losses from requiring a DMI when there is no applicant tax data seems too low relative to CMS's estimates for the same provision in the proposed Marketplace Integrity Rule.[60] CMS's estimate of the number of DMIs created increased from 2.1 million to 2.8 million. But the same number of people (407,000) are projected to lose APTC. It is unclear how–and no explanation is given–a 30 percent increase in DMIs would lead to no increase in coverage loss. Comments noted this disparity,[61] but CMS's comment summaries and responses make no reference to these comments.

***Requiring Additional Paperwork for SEPs***

61. The ACA requires consumers to enroll during the year-end open enrollment period, unless they qualify for one of several SEPs based on circumstances like a change in family composition or loss of coverage. The Final Rule expands the set of circumstances where a consumer seeking to enroll during a SEP must submit specific documentation to the FFE to demonstrate that they are eligible.

62. Affected individuals must obtain some specific document (like a letter from their former employer about the loss of employer-based coverage or a marriage certificate) and upload or mail that information. This is in addition to the information described above that all applicants for coverage must provide. Consumers are unlikely to have this information on hand and will need to set aside time to collect it. This will generally make it impossible for consumers to

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[59] *See*, for example, Comment CMS-2026-0496-0989, https://www.regulations.gov/comment/CMS-2026-0496-0989.

[60] *See* page 617 of the Proposed Marketplace Integrity Rule https://www.federalregister.gov/d/2025-04083/p-617.

[61] *See*, for example, Comment CMS-2026-0496-0989, https://www.regulations.gov/comment/CMS-2026-0496-0989.

complete the application process in a single sitting, substantially increasing the likelihood that they will not complete it at all. Consistent with the literature above, this will decrease enrollment, especially among healthier individuals.

63. CMS estimates that this provision would require an additional 293,000 consumers to submit documentation, resulting in about 40,000 failing to enroll.[62]

64. CMS asserts that expanding SEP verification will reduce premiums by 0.5 to 0.8 percent, explaining that the "positive impact on program integrity by verifying eligibility for SEPs" would decrease premiums.[63] This is inconsistent with available evidence about those who enroll through a SEP.

65. For example, actuarial data from the Massachusetts Connector[64] show that their population with the most SEP eligibility generally has lower risk than other enrollees and that consumers enrolling through an SEP tend to be slightly younger than those enrolling through an open enrollment period (OEP).

66. Data from Covered California suggest that SEP enrollees do not generally worsen the risk pool. Data about the prospective risk scores of SEP and OEP enrollees indicate that the overall health profile of SEP enrollees is consistently slightly better than that of those enrolling during the OEP.[65]

67. The actuarial firm Wakely has found that SEP eligibility supports a stable insurance market, since "members joining via SEP have a similar loss ratio (claims/premium) as

[62] Page 2,822 of the Final Rule (91 FR 29526), https://www.federalregister.gov/d/2026-10050/p-2822.
[63] Page 2,821 of the Final Rule (91 FR 29526), https://www.federalregister.gov/d/2026-10050/p-2821.
[64] Gary D. Anderson, Report Of The Merged Market Advisory Council, (2022) https://www.mass.gov/doc/final-report-of-the-merged-market-advisory-council/download.
[65] Data Snapshot: Covered California Open and Special Enrollment Periods, Covered California (Apr. 3, 2025), https://hbex.coveredca.com/data-research/library/CoveredCA_OE_SEP_Data_Snapshot_20250403.pdf.

those who joined during the open enrollment period in 2022" and the current rule creates a "bigger pool to spread risk and administrative costs."[66] Moreover, the tighter rules are self-defeating, since "prospective joiners who are sicker will be more likely to gain coverage even under tightened rules compared to healthier prospective joiners."[67]

68. 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 indicate that the likely effect of eliminating the low-income SEP and creating an additional verification burden would be to worsen risk pools.[68]

69. Comments raised concerns about CMS's analysis in the proposed rule, but the Final Rule did not acknowledge or respond to these comments. Commenters noted that "CMS…seemingly overstates the premium benefit of its proposal to require more paperwork for individuals enrolling through a SEP, while failing to explain its methods [and ignoring] available evidence about those who enroll through a SEP."[69] Yet CMS finalized its analysis without change, and its comment summary[70] and response[71] focused exclusively on substantive concerns about the provisions and on estimates regarding state Marketplace implementation costs.

***Eliminating Standardized Plans and Limits on Non-Standardized Plans***

70. The ACA includes several requirements, such as metal level tiers, to help consumers select a Marketplace plan that fits their health needs and their budget. Even with these

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[66] Tolman and Cohen, *supra* note 39.
[67] Tolman and Cohen, *supra* note 39.
[68] To the extent this policy reduced the share of enrollment attributable to low-income people, gross silver plan premiums would likely fall, separate from any risk pool effects, but this would not translate to consumers facing lower costs as described above.
[69] Comment CMS-2026-0496-0989, https://www.regulations.gov/comment/CMS-2026-0496-0989.
[70] Page 2,826 of the Final Rule (91 FR 29526), https://www.federalregister.gov/d/2026-10050/p-2826.
[71] Page 2,827 of the Final Rule (91 FR 29526),https://www.federalregister.gov/d/2026-10050/p-2827.

minimum standards in place, health insurance is complex, and it remains difficult for consumers to assess and meaningfully compare their plan options.[72]

71. Comparing plans is especially daunting in the face of many complex options. "Choice overload"—where consumers presented with more choices make lower-quality decisions—is a well-documented phenomenon in the behavioral economics literature.[73]

72. Choice overload is especially concerning in the context of health insurance, where the products themselves are so complicated and the stakes so high. Whether for Marketplace, Medicare, or job-based coverage, choice overload has led consumers to select a plan that does not meet their needs—or to not enroll in coverage at all.[74] In a review of the extensive literature, choice overload was found to cause worse enrollment decisions due to the difficulty consumers face in processing complex health insurance information.[75] Choice overload has a particularly

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[72] *See* Rayna Wallace, Meghan Salaga, Michelle Long, and Kaye Pestaina, Navigating the Maze: A Look at Patient Cost-Sharing Complexities and Consumer Protections, KFF (Mar. 28, 2025), https://www.kff.org/private-insurance/navigating-the-maze-a-look-at-patient-cost-sharing-complexities-and-consumer-protections/.

[73] *See, e.g.*, Barry Schwartz, The Paradox of Choice (2004).

[74] *See* Rose C. Chu et al., Facilitating Consumer Choice: Standardized Plans in Health Insurance Marketplaces (Assistant Secretary for Planning and Evaluation Office of Health Policy, HP-2021-29, 2021) http://resource.nlm.nih.gov/9918538381606676 (reviewing the research literature on how standardized plans affect consumers and insurance markets); *see also* J. Michael McWilliams et al., Complex Medicare Advantage Choices May Overwhelm Seniors—Especially Those With Impaired Decision Making, 30 *Health Affairs* 1786 (2011), https://doi.org/10.1377/hlthaff.2011.0132; Keith M. Marzilli Ericson and Amanda Starc, How Product Standardization Affects Choice: Evidence from the Massachusetts Health Insurance Exchange, 50 *J. Health Econ*. 71 (2016), https://doi.org/10.1016/j.jhealeco.2016.09.005; *see* also Saurabh Bhargava et al., Do Individuals Make Sensible Health Insurance Decisions? Evidence from a Menu with Dominated Options, NBER Working Paper No. 21160, (2015), https://www.nber.org/papers/w21160; M. Kate Bundorf et al., Are Prescription Drug Insurance Choices Consistent with Expected Utility Theory?, 32 *Health Psych.* 986 (Sept.. 2013), https://doi.org/10.1037/a0033517; M. Kate Bundorf and Helena Szrek, Choice Set Size and Decision Making: The Case of Medicare Part D Prescription Drug Plans, 30 *Med. Decision Making* 582 (Mar. 2010), https://doi.org/10.1177/0272989X09357793; Yaniv Hanoch et al., How Much Choice Is Too Much? The Case of the Medicare Prescription Drug Benefit, 44 *Health Servs. Res.* 1157 (Aug. 2009), https://doi.org/10.1111/j.1475-6773.2009.00981.x; and Yaniv Hanoch et al., Choosing the Right Medicare Prescription Drug Plan: The Effect of Age, Strategy Selection and Choice Set Size, 30 *Health Psych*. 719 (Nov. 2011), https://doi.org/10.1037/a0023951.

[75] Erin Audrey Taylor et al., Consumer Decisionmaking in the Health Care Marketplace, Rand (2016), https://www.rand.org/pubs/research_reports/RR1567.html.

negative impact on low-income applicants, many of whom have limited time to undertake the enrollment process, as well as lower levels of health insurance literacy.[76]

73. To mitigate these well-known challenges, state Marketplaces[77] and the federal government[78] have required health insurers to offer standardized plan options and limited the number of non-standardized plan options. Standardized plans offer an additional level of comparability through consistent cost sharing and benefit design within a metal-level tier. By requiring consistent cost sharing, standardized plans enable consumers to compare plans based on key metrics such as premiums, provider networks, and quality.[79] Standardized plans are paired with Marketplace choice architecture, such as preferential display, to further increase the likelihood that consumers purchase coverage that best meets their needs.[80]

74. Standardized plans, preferential display, and limits on non-standardized plans simplify the plan selection process and improve the consumer experience.[81] For instance, a 2026 evaluation recently found that Colorado's standardized plans "made it easier for consumers to understand what benefits they get from their plans, what they will pay out of pocket, and compare across plans— especially for common services."[82] Standardized plans also improve affordability and lower consumer costs. Standardized plans have had to waive the deductible or

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[76] *See*, e.g., Rose C. Chu et al., *supra* note 74.
[77] *See*, e.g., Rose C. Chu et al., *supra* note 74.
[78] *See*, e.g., Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2023, 87 Fed. Reg. 27,208, 27,310 (May 6, 2022); Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2017, 81 Fed. Reg. 12,204, 12,330 (Mar. 8, 2016).
[79] *See, e.g.*, Sabrina Corlette, Sandy Ahn, Kevin Lucia, and Hannah Ellison, Missed Opportunities: State-Based Marketplaces Fail to Meet Stated Policy Goals of Standardized Benefit Designs. Urban Institute (July 2016), https://www.urban.org/research/publication/missed-opportunities-state-based-marketplaces-fail-meet-stated-policy-goals-standardized-benefit-designs-0.
[80] *See*, e.g., Rose C. Chu et al., *supra* note 74.
[81] *See*, e.g., Rose C. Chu et al., *supra* note 74.
[82] R. Vincent Pohl et al., Analysis of the Colorado Option, pursuant to § 10-16-1310, C.R.S.: Final Report, Colorado Division of Insurance (Jan. 16, 2026), https://doi.colorado.gov/sites/doi/files/documents/CO-Option-10-16-1304-Report.pdf.

charge a fixed-dollar copay for a core set of high-value services, including primary care, behavioral health services, urgent care visits, and generic drugs.[83]

75. In addition to helping consumers understand their plan options, standardized plan requirements force health insurers to compete based on price and thus help hold down health Marketplace premiums. For instance, the introduction of standardized plans through the FFM was shown to reduce premiums across metal levels.[84] By ensuring a level playing field across plans, health insurers compete more directly on premiums and quality instead of through benefit design that attempts to cherry-pick healthier, lower-risk consumers.[85]

76. Given these benefits, eliminating standardized plans, preferential display, and limits on non-standardized plans is expected to worsen consumer decisionmaking and outcomes, leading to more uninsured and underinsured people. Without these tools, consumers can no longer rely on the "standard" plan designation, making it even more challenging to understand and compare plan options.

77. In the absence of standardized cost sharing across plans, consumers will be asked to understand and account for countless new plan features, in the form of copays and coinsurance, that vary across multiple benefit categories. Consumers will be forced to consider this complex cost sharing information alongside information about premiums, provider networks, and quality. This complexity, in turn, will increase the cognitive burden of selecting a

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[83] Karen Pollitz, Justin Lo, and Rayna Wallace, Standardized Plans in the Health Care Marketplace: Changing Requirements, KFF (May 8, 2026), https://www.kff.org/private-insurance/standardized-plans-in-the-health-care-marketplace-changing-requirements/.

[84] Ben Hopkins and Sean Lyons, The effect of offering standardized "Simple Choice" plans on premiums in the Federally Facilitated ACA marketplaces, *Journal of Health Economics* (July 2026), https://doi.org/10.1016/j.jhealeco.2026.103142.

[85] *See*, e.g., Rose C. Chu et al., *supra* note 74.

Marketplace plan for millions of consumers who could see their standardized plans discontinued beginning with the 2027 plan year.[86]

78. Consumers who cannot overcome these barriers might not complete the enrollment process at all. Others might enroll in coverage but select a suboptimal plan that leaves them with higher health care costs than if standardized plans were still required and identified by the Marketplace. For instance, a consumer might select a plan with the same premium but less generous coverage than a standardized plan if the plan has higher cost sharing, out-of-network providers, or off-formulary drugs.[87] Some consumers in suboptimal plans will pay higher out-of-pocket costs while others might choose to drop the coverage because it is too costly and does not meet their needs.

79. Removing standardized plans, preferential display, and limits on non-standardized plans will also reduce incentives for insurers to compete based on price. Instead, plans will be able to vary cost sharing levels and even actuarial value levels in ways that obscure meaningful plan differences and lead to more consumers being enrolled in a suboptimal plan.

**Effects of Expanding Availability of Lower-Quality Plans**

80. Economic theory and empirical evidence show that expanding the availability of lower-quality coverage has several effects.[88]

81. Lower-quality products are cheaper, for two reasons. First, their lower quality (higher cost-sharing, smaller network, etc.) makes them a cheaper product for a given enrollee.

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[86] About one-third of all federal Marketplace enrollees selected a standardized plan for 2025. Page 2,787 of the Final Rule (91 FR 29526), https://www.federalregister.gov/d/2026-10050/p-1787.
[87] *See*, e.g., Rose C. Chu et al., *supra* note 74.
[88] For discussions of these dynamics, *see*, e.g., Michael Geruso, Timothy J. Layton, Grace McCormack, and Mark Shepard, The Two-Margin Problem in Insurance Markets, *The Review of Economics and Statistics* (2023) 105 (2): 237–257, https://doi.org/10.1162/rest_a_01070; Michael Geruso, Timothy Layton, and Daniel Prinz, Screening in Contract Design: Evidence from the ACA Health Insurance Exchanges, *American Economic Journal: Economic Policy* vol. 11, no. 2 (May 2019), https://doi.org/10.1257/pol.20170014.

Second, they attract healthier consumers, since sicker people do not generally enroll, and healthier consumers are generally quite price-sensitive and so are drawn to these lower-quality plans.[89]

82. When permitted to offer lower-quality products, insurers consistently do so, since it permits them to attract healthier consumers.[90]

83. Healthier consumers within the market are more likely to enroll in these plans. This disproportionately decreases the premium revenue in the risk pool from healthy enrollees, reducing risk sharing across the single risk pool.

84. As a result, expanding the availability of lower-quality plans results in splitting the risk pool and increasing premiums for the higher-quality products that sicker consumers want and need.

85. Within the individual market, the ACA includes several provisions to mitigate this dynamic. It limits variation in plan quality by imposing minimum standards on benefits, cost-

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[89] *See*, for example, Edward Kong, Timothy Layton, and Mark Shepard, Adverse Selection and (un)Natural Monopoly in Insurance Markets, *NBER Working Paper* (Nov. 2024), https://www.nber.org/papers/w33187. Consumers' price sensitivity can also be seen in this year's open enrollment results so far. As a result of out-of-pocket premium increases due to the expiration of the PTC enhancements, consumers have shifted to lower-premium plans (generally bronze plans), resulting in average ACA Marketplace deductibles increasing by 37 percent (or $1,027 per person). Matt McGough, Jared Ortaliza, Justin Lo, and Cynthia Cox, What We Know So Far About 2026 ACA Marketplace Enrollment, Premiums, and Deductibles, KFF (May 19, 2026), https://www.kff.org/affordable-care-act/what-we-know-so-far-about-2026-aca-marketplace-enrollment-premiums-and-deductibles/.

[90] For example, CMS data shows that, when insurers were permitted to offer silver plans with lower actuarial values, "approximately 87 percent of counties across 23 States ha[d] an SLCSP that is below 70 percent AV." Page 2,109 of the Notice of Benefit and Payment Parameters for 2023 (87 FR 27208), https://www.federalregister.gov/d/2022-09438/p-2109. Another example can be found in the proliferation of non-ACA-compliant coverage. Notwithstanding ACA insurance regulations, federal and state regulators have carved out several exceptions for less-regulated coverage. Insurance companies and others have jumped into these opportunities, offering a wide proliferation of non-ACA-compliant plans to try to skim the best risk. *See*, e.g., Christen Linke Young, Taking a broader view of "junk insurance", Brookings (July 6, 2020), https://www.brookings.edu/articles/taking-a-broader-view-of-junk-insurance/; Amy Killelea and JoAnn Volk, The Peddling Of "Junk Plans" To Consumers Facing Higher Insurance Premiums, Center on Health Insurance Reforms (Feb. 27, 2026), https://chir.georgetown.edu/the-peddling-of-junk-plans-to-consumers-facing-higher-insurance-premiums/; John Dicken, Private Health Coverage: Information on Farm Bureau Health Plans, Health Care Sharing Ministries, and Fixed Indemnity Plans, Government Accountability Office (July 26, 2023), https://www.gao.gov/assets/gao-23-106034.pdf

sharing, and networks. Lower-quality plans like catastrophic plans are available only in limited situations and without financial assistance. It also includes a risk adjustment program that transfers premium dollars from insurers with healthier enrollees to those with sicker enrollees. However, this program does not work perfectly. And catastrophic coverage is separately risk adjusted, effectively creating a separate risk pool.

86. Expanded enrollment in lower-quality plans with higher cost-sharing also leads to lower provider revenue and more uncompensated care, since consumers are unable to afford to pay thousands of dollars in cost sharing. As a result, enrollment in lower-quality plans hurts providers. This is especially true of safety net providers, who are more likely to serve consumers who have trouble paying their bills.[91]

87. The Final Rule includes several provisions that expand the availability of lower-quality plans. These provisions are expected to have the effects described above: attracting healthier consumers to these lower-quality plans, resulting in higher gross premiums for other coverage and higher cost-sharing overall, which in turn will increase providers' uncompensated care costs.

**Several Challenged Provisions of the Final Rule Expand Availability of Lower-Quality Plans and thus Are Expected to Raise Premiums for Higher-Quality Coverage and Increase Uncompensated Care**

***Expanded Eligibility for Catastrophic Plans***

88. The Final Rule greatly expands eligibility for catastrophic coverage. Because catastrophic coverage is lower-quality and less expensive, it is expected to attract enrollment

[91] In December 2018, 28 percent of community health center visits were covered by private/Marketplace coverage in nonexpansion states and 12 percent in expansion states. Anne E. Larson et al., Private/marketplace insurance in community health centers 5 years post-affordable care act in Medicaid expansion and non-expansion states, 141 *Preventive Medicine* (2020), https://doi.org/10.1016/j.ypmed.2020.106271. *See* also Benedic Ippolito, Erin Trish, Erin L Duffy, and Boris Vabson, Patient Repayment of US Hospital Bills From 2018 to 2024, 6 *JAMA Health Forum* 8 (2025), https://doi.org/10.1001/jamahealthforum.2025.2284.

among healthier consumers. This is especially a concern since catastrophic plans are separately risk adjusted, so metal-level plans are not compensated when catastrophic plans siphon off the healthier risk. Therefore, this change will increase gross premiums for metal-level plans.

89. In addition, shifting more people into lower-quality, higher-deductible coverage will result in higher uncompensated care costs for providers.

90. The ACA carefully limits access to catastrophic plans to avoid this dynamic. Specifically, eligibility is limited only to individuals under age 30, those without access to affordable coverage (meaning coverage costs more than 8 percent [indexed] of income), and those who face a hardship in accessing coverage.

91. The rule upends this structure by providing a categorical hardship exemption to individuals with incomes under 100 percent FPL and over 250 percent FPL: a group that includes roughly 80 percent of adults.[92] This includes individuals with very high incomes who can easily afford to purchase health insurance and have high rates of coverage.

92. CMS claims it did not receive any comments on its analysis of this proposal,[93] but this is not true. Comments noted that "the RIA omits important information that could help stakeholders evaluate the proposal," that CMS "fails to consider the potential harms to consumers," that CMS "has not provided the evidence to support" its claim that the proposal will improve affordability, that a recent study "strongly suggests the exemption is too broad to achieve its stated goal," that CMS "fails to take into consideration potential increased costs associated with the proposal, [including] increase[d] premiums."[94]

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[92] Urban Institute analysis of the 2024 American Community Survey Data.
[93] Page 2,841 of the Final Rule (91 FR 29526), https://www.federalregister.gov/d/2026-10050/p-2841.
[94] Comment CMS-2026-0496-0989, https://www.regulations.gov/comment/CMS-2026-0496-0989.

***Higher Maximum Out-of-Pocket Spending Limits for Bronze Plans***

93. The Final Rule allows insurers to offer bronze plans with maximum out-of-pocket spending limits, or MOOPs, that exceed statutory limits by 30 percent. While higher deductibles mechanically reduce premiums for a particular plan, they expose consumers to very high out-of-pocket costs.

94. According to KFF, the weighted average deductible for a bronze plan is $7,476 for 2026.[95] If bronze deductibles were 30 percent higher, that would be an increase of $2,243, to an average deductible of almost $10,000. Such higher cost-sharing requirements mean greater uncompensated care, since many consumers are unable to afford to pay their cost sharing. As explained above, this is especially harmful to safety net providers, who are more likely to serve consumers who have trouble paying their bills.[96]

95. Despite CMS's assertions otherwise, there is no doubt that insurers will offer plans with higher maximum out-of-pocket limits if they are permitted to do so. As explained above, when insurers have the option to offer lower-priced coverage, they will do so, even at the expense of quality. In a similar setting, when insurers were permitted to offer silver plans with actuarial values below 70%, there was widespread adoption. According to data from CMS, "approximately 87 percent of counties across 23 States ha[d] an SLCSP [Second-Lowest-Cost Silver Plan] that is below 70." [97] Similarly, insurers will offer these plans with MOOPs that exceed statutory limits as they compete over premium costs for consumer enrollments, according to data from CMS.

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[95] Deductibles in ACA Marketplace Plans, 2014-2026, KFF (Nov. 6, 2025), https://www.kff.org/affordable-care-act/deductibles-in-aca-marketplace-plans/.
[96] Ippolito et al., *supra* note 91.
[97] Page 2,109 of the Notice of Benefit and Payment Parameters for 2023 (87 FR 27208), https://www.federalregister.gov/d/2022-09438/p-2109.

96. It is also clear that healthier consumers within the market will be more likely to enroll in these higher-deductible bronze plans. This will disproportionately decrease the premium revenue in the risk pool from healthy enrollees. And given that risk adjustment only imperfectly compensates insurers for sicker risk, this will increase gross premiums for higher-quality plans.

97. This proposal is perplexing, because CMS concedes that the new bronze plans violate statutory requirements. CMS claims this departure is necessary to preserve the existence of bronze plans. But CMS also concedes that it is quite possible for bronze plans to satisfy statutory rules. Indeed, CMS conditions an insurer's right to offer these extra-statutory bronze plans on its also offering a bronze plan that complies with the statutory rules.

98. It is also not the case that insurers are in any imminent danger of being unable to design bronze plans that satisfy the statute. As Matthew Fiedler of the Brookings Institution explained in his comment on the proposed rule, designing bronze plans that comply with the statute is possible today, will remain possible for years to come, and may never become impossible.[98] CMS does not contest these claims.

***Weaker Network Adequacy Standards***

99. The ACA charges the Secretary of Health and Human Services with establishing standards to ensure Marketplace plans have adequate provider networks, which must include essential community providers.[99] Marketplaces must ensure that Marketplace plans meet these standards.[100]

100. Consistent with this statutory charge, CMS has developed specific standards for network adequacy for FFM plans, including specific numeric time and distance standards for

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[98] Comment CMS-2026-0496-1027, https://www.regulations.gov/comment/CMS-2026-0496-1027.
[99] ACA section 1311(c)(1)(B) and (C).
[100] ACA section 1311(d)(4).

many types of providers that adjust at the county level to reflect a given area's population size and density (e.g., CMS applies different standards for metro counties and rural counties to reflect the differences between them).[101] SBMs have generally been permitted to establish their own network adequacy standards so long as they are at least as strict as the federal baseline requirements. These standards are generally enforced by the Marketplace or state insurance regulators in each state.

101. The Final Rule undermines this structure in several ways. It eliminates the obligation for SBMs and SBMs on the federal platform to apply standards that are as stringent as the federal baseline. It also permits states that use the FFM to opt out of federal quantitative review requirements and use weaker standards, including with respect to essential community providers.

102. These changes will have little effect in some states. For example, some states have long had network adequacy rules more rigorous than the federal standards.

103. But in other states, including Wisconsin and Ohio, CMS's standards through the FFM are more robust than the state's network adequacy review processes for other health insurance. Reverting to these states' rules will permit insurers to offer narrower-network plans at lower premiums.

104. While narrower networks may decrease gross premiums for some consumers, they would be expected to increase costs for consumers receiving financial assistance who want to maintain the same size network. This is because Marketplace financial assistance is based on the price of the second-lowest-cost silver plan available to the consumer. If narrow-network

[101] 2023 Final Letter to Issuers in the Federally-facilitated Exchanges, CMS (Apr. 28, 2022), https://www.cms.gov/sites/default/files/2022-04/Final-2023-Letter-to-Issuers_0.pdf.

options are newly permitted to be sold, it will drive down financial assistance and increase costs for the higher-quality plans. This cost increase for subsidized consumers to maintain comparable coverage may deter some from seeking coverage. Narrower networks will also increase consumers' out-of-pocket costs, resulting in larger uncompensated care burdens for providers. Inadequate networks may also make it more difficult for enrollees to obtain care.

105. Plans with narrow networks will also disproportionately appeal to healthier consumers. This will disproportionately decrease the premium revenue in the risk pool from healthy enrollees. And given that risk adjustment only imperfectly compensates insurers for sicker risk, this will increase gross premiums for plans with adequate networks.

**Conclusion**

106. The challenged provisions of the Final Rule each operate to impose administrative burdens, worsen Marketplace risk pools, increase gross or net premiums, or some combination of those effects. The result will be lower-quality coverage at greater expense for both enrollees in the Marketplace, whether those enrollees are subsidized or not. They are expected to decrease Marketplace enrollment and increase the number of uninsured or underinsured persons. When more people are uninsured or underinsured, safety net providers will incur greater costs in the form of uncompensated care for these people.

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.

*Signature on following page.*

Dated: June 4, 2026

Washington, D.C.

JASON LEVITIS

# APPENDIX

# JASON A. LEVITIS


## CONTACT INFORMATION

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C/o Urban Institute
500 L'Enfant Plaza SW
Washington, DC 20024
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## SUMMARY


Jason Levitis is a leading expert on the Affordable Care Act (ACA) and the intersections of health and tax policy and law. He is currently a senior fellow in the Health Policy Division at the Urban Institute and a nonresident senior fellow at Yale Law School's Solomon Center for Health Law and Policy. He publishes research and provides technical assistance to federal and state health policymakers and advocates on the financing and regulation of private health coverage, health insurance subsidies, Section 1332 waivers, federal and state tax policy, programmatic operations, and approaches to minimizing consumers' administrative burdens. He provides technical assistance to state officials through State Health and Value Strategies, a project of the Robert Wood Johnson Foundation.

Levitis served at the US Treasury Department from 2009 to 2017. He represented the Treasury on the interagency team that helped craft and then implemented the ACA, and he led Treasury's ACA implementation as counselor to the assistant secretary for tax policy. He also co-chaired the interagency working group that stood up the Section 1332 waiver program.

Levitis earned a BA in mathematics from Wesleyan University and a JD from Yale Law School, where he was co–editor in chief of the Yale Journal of Health Policy, Law, and Ethics.


## PROFESSIONAL EXPERIENCE

2022-Present Senior Fellow, Urban Institute

2017-Present Senior Fellow (Nonresident) and Distinguished Visiting Scholar, Yale Law School Solomon Center for Health Law and Policy

2017-2022 Principal, Levitis Strategies LLC. Clients include State Health and Value Strategies, Massachusetts Health Connector, Brookings Institution, Urban Institute, and Yale Law School Solomon Center for Health Law and Policy

2017-2022 Nonresident Fellow, Economic Studies, Brookings Institution

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|---|---|
| 2012-2017 | Counselor and ACA Implementation Lead (previously Senior Advisor for ACA Implementation), Office of Tax Policy, U.S. Treasury Department |
| 2010-2012 | Senior Advisor to the Assistant Secretary for Tax Policy, U.S. Treasury Department |
| 2009-2010 | Senior Advisor to the Counselor to the Secretary, U.S. Treasury Department |
| 2008-2008 | Economics and International Trade Group, Obama Presidential Transition |
| 2005-2009 | Senior Analyst and Counsel (previously Policy Analyst), Center on Budget and Policy Priorities |
| 2002-2004 | Founding Director of Legal Intern Program, Connecticut Voices for Children |
| 2003-2004 | Co-Editor-in-Chief, Yale Journal of Health Policy, Law, & Ethics |
| 2003 | Legal Intern, Senate Democratic Policy Committee |
| 2002 | Legal Intern, Georgetown Federal Legislation Clinic |
| 1998-2001 | Senior Analyst (Previously Economic Analyst), Greater New York Hospital Association |
| 1997-1998 | Teaching Fellow in Math and Computer Science, The Taft School |
| 1996-1997 | Cabinet Shop Manager, Habitat for Humanity of Wake County, NC |

**EDUCATION**

| | |
|---|---|
| 2005 | J.D., Yale Law School |
| 1996 | B.A., Mathematics, Wesleyan University |

**BAR ADMISSIONS**

Maryland

**HONORS**

U.S. Treasury Department: The Treasury Medal, 2017
Yale Law School: Stephen J. Massey Prize, 2004
Wesleyan University

- Rice Prize in mathematics, 1996
- Phi Beta Kappa, 1995
- CRC Award in chemistry, 1993
- Sherman Prize in mathematics, 1993

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“How Much Would a State Earned Income Tax Credit Cost in 2008?” (with Sloane Kuney and David Super), CBPP, Feb. 8, 2007.

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“The Impact of Hawaii's Income Tax on Low-Income Families: An Update” (with Nicholas Johnson), CBPP, May 4, 2006.

“A Dubious Honor for Hawaii” (with Nicholas Johnson), CBPP, Updated Apr. 17, 2006.

“The Impact of State Income Taxes on Low-Income Families in 2005” (with Nicholas Johnson), CBPP, Feb. 22, 2006.

“How Much Would a State Earned Income Tax Credit Cost?” CBPP, Feb. 1, 2006.

**IN THE UNITED STATES DISTRICT COURT**
**FOR THE DISTRICT OF MARYLAND**

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|---|---|
| CITY OF COLUMBUS, *et al.*,<br><br>*Plaintiffs*,<br><br>v.<br><br>ROBERT F. KENNEDY, JR., *et al.*,<br><br>*Defendants*. | Case No. 1:26-cv-2215 |

## DECLARATION OF MIKE OHLINGER

I, Mike Ohlinger, 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, HHS Notice of Benefit and Payment Parameters for 2027; and Basic Health Program," would have on my family and 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 Neenah, Wisconsin.

4. I currently co-own OhmCo, a carwash marketing agency, with my wife Mel Ohlinger. I am also the Director of Operations and Organizational Development of the company. My wife and I have been running our small business for over seven years.

5. As a small business owner, my wife and I depend on our six employees, and we want to be able to provide them with quality healthcare. We have attempted to sponsor our employees'

healthcare before, but the cost was too high. In 2023, we offered insurance coverage to our employees under Blue Cross Blue Shield. But the coverage would have cost them $1,500 a person out of pocket, with OhmCO paying a portion of the monthly costs. As a result, our employees turned to the Affordable Care Act (ACA) marketplace or their spouse's insurance, where they were able to get a better rate. Providing affordable healthcare for our employees now would likely bankrupt our business that is already being squeezed in every direction.

6. I understand that the new CMS rule will increase the cost of health insurance and limit coverage options. This will result in a higher number of uninsured and underinsured individuals. Our employees that depend on the ACA will be forced to look for other options or may forgo health insurance all together. Despite wanting to support them, we will be unable to afford employer-sponsored health insurance.

7. My family struggles to afford health insurance as it is. My children and I are on a NetworkHealth plan through the ACA. (My wife is a veteran and has separate insurance through Veteran Affairs.) This plan offers coverage at the bronze level of coverage. In 2026, my family premiums went up by a little over $200. As a result, our healthcare costs are as much as our monthly mortgage payments. At the same time, student loan interest rates have increased, and our student loan payment amounts have increased, right as we prepare to send our daughter to college this fall. These price hikes are troubling and make it even more improbable that my wife and I could afford to sponsor our employees' health insurance.

8. My family income is above 400% of the federal poverty level and will likely still be next year. Our monthly premium used to be subsidized, but when Congress did not extend ACA subsidies in December 2025, our coverage became unsubsidized. We anticipate that we will continue to be ineligible for subsidies next year, but we will need to maintain the same amount of coverage. Going forward, anything that increases the cost of coverage will result in an increase

in what I already pay for insurance. My family needs healthcare, and we will continue to pay for it, but we have no affordable options.

9. We wish to maintain the same level of comprehensive insurance coverage for our family next year, even if CMS's policy changes make that coverage more expensive. If CMS permits the sale of cheaper, but less comprehensive plans, we would not wish to purchase that coverage.

10. If the ACA becomes unaffordable for our employees, they will likely leave our business and look for alternative employment to sponsor their healthcare. The loss of our employees and the inability to sponsor future employees could force my wife and I to shut down our company. Without our business, we will lose our primary source of income, and we will be entirely unable to keep up with the rising costs of healthcare coverage.

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

*(Signature on the following page.)*

Executed on June 03, 2026 in Appleton, Wisconsin.

Michael Ohlinger

**IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MARYLAND**

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| CITY OF COLUMBUS, *et al.*,<br>*Plaintiffs*,<br>v.<br>ROBERT F. KENNEDY, JR., *et al.*,<br>*Defendants*. | Case No. 1:26-cv-2215 |

**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, HHS Notice of Benefit and Payment Parameters for 2027; and Basic Health Program," 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 Doctors for America (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 and gender affirming care.

4. For more than a decade, I ran a small private practice that served Rooks County, Kansas. Practicing as a family medicine physician in a rural community like Rooks County means seeing many patients who are on Medicare, Medicaid, Affordable Care Act (ACA) plans, or who are 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 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,

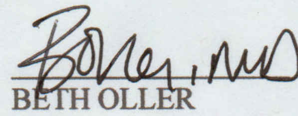
especially in rural areas like mine.

10. With an increase in uninsured patients, I will have to provide even more uncompensated care, at the expense of my private practice and the Rooks County Health Center. Overtime, this financial burden will lead to a decrease in my total compensation. I and other doctors in my position will likely look for new employment in non-rural areas with a higher insured population. This would require me to stop serving the population of Rooks County, Kansas. Leaving my current role with Rooks County Health Center would be the second time I left a job because practicing medicine became impracticable in light of insurance coverage issues. The departure of doctors like myself could have detrimental impacts on the health of rural residents who could lose proximate access to critical care.

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 on June 3, 2026 in Douglas County, Kansas.



BETH OLLER

**IN THE UNITED STATES DISTRICT COURT**
**FOR THE DISTRICT OF MARYLAND**

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|---|---|
| CITY OF COLUMBUS, *et al.*,<br><br>*Plaintiffs*,<br><br>v.<br><br>ROBERT F. KENNEDY, JR., *et al.*,<br><br>*Defendants*. | Case No. 1:26-cv-2215 |

**DECLARATION OF SHAWN PHETTEPLACE**

I, Shawn Phetteplace, declare as follows:

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

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

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

4. Those members will be negatively impacted by the new Centers for Medicare & Medicaid Services (CMS) rule, "Patient Protection and Affordable Care Act, HHS Notice of Benefit and Payment Parameters for 2027; and Basic Health Program," which will increase the cost of health insurance and limit insurance coverage. The financial and health impact of the rule will cause direct harm to MSA members, their families, and their businesses.

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

6. MSA's founding was directly focused on the passage of the Affordable Care Act, and the organization has remained focused on the subsequent strengthening of the law over the past 16 years. The new CMS rule undermines the hard-fought legislative victories that MSA helped to secure.

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

*Signature on following page.*

Executed on June 02, 2026 in Fitchburg, Wisconsin.

SHAWN PHETTEPLACE

**IN THE UNITED STATES DISTRICT COURT**
**FOR THE DISTRICT OF MARYLAND**

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|---|---|
| CITY OF COLUMBUS *et al.*,<br><br>*Plaintiffs*,<br><br>v.<br><br>ROBERT F. KENNEDY JR. *et al.*,<br><br>*Defendants.* | No. 26-cv-02215 |

**DECLARATION OF FIKIRTE WAGAW, MPH**

I, Fikirte Wagaw, MPH, declare under penalty of perjury as prescribed in 28 U.S.C. § 1746:

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

2. I currently serve as the Acting Commissioner of the Chicago Department of Public Health ("CDPH"). I have held this position since May 2026. I also served as the Acting Commissioner from August 2023 to December 2023. Before becoming Acting Commissioner, I served as the First Deputy Commissioner for CDPH. In that role, I acted as the Chief Operating Officer for CDPH, conducting direct executive-level oversight of strategic planning, financial operations, facilities management, human resources, labor relationships, contracts, and cross-departmental initiatives. Previously, I served as the Director of Special Projects for the Alliance of Chicago Community Health Services, now known as "AllianceChicago," where I led strategic initiatives advancing research and public health integration for Federally Qualified Health Centers

(FQHCs) who were members of this health center controlled network. And from 1997 to 2009, I served in various roles for CDPH's Division of STD/HIV/AIDS.

3. I have a Bachelor of Arts in Psychology from the University of Michigan. I received Master of Public Health degree in Health Policy and Administration from the University of Illinois at Chicago.

4. As Acting Commissioner of CDPH, I make strategic decisions, in collaboration with the Mayor's Office and stakeholders across the City, to manage public health threats; design and deliver disease control services; and protect the food, air, and environment for 2.7 million Chicago residents.[1] I serve as a liaison and subject matter expert on all related policy matters and use of authorities and resources to promote and protect public health. I have built and currently manage an executive team of ten professionals, a budget of $335M, and approximately 600 employees, with a dedication to sustaining a strong public health workforce and capacity.

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

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[1] U.S. Census Bureau QuickFacts (V2025). https://www.census.gov/quickfacts/fact/table/chicagocityillinois/HSG010224.

underinsured City residents and support the City's safety net for health-related services. Each of these clinics faces greater demand when there is an increase in either the health needs of Chicago residents or in the number of uninsured or underinsured individuals who cannot obtain those services or other forms of health care elsewhere.

6. I am deeply concerned with CMS's final rule titled "Patient Protection and Affordable Care Act, HHS Notice of Benefit and Payment Parameters for 2027; and Basic Health Program" and its harmful impacts on our residents. In Chicago, nearly one in ten residents is uninsured.[2] The Rule would significantly increase barriers to coverage and the number of uninsured residents, increase health care costs for residents, and further burden the City's health care safety net. Under the guise of increased "integrity" and "affordability," the Rule would implement exactly the opposite. For example, the Rule imposes paperwork barriers on individuals enrolling in the Affordable Care Act Marketplaces by cutting off eligibility for subsidies for individuals with old tax debts, requiring audits of low-income enrollees or of enrollees for whom the IRS fails to report relevant tax data, and imposing new verification requirements for enrollees in monthly Special Enrollment Periods. This will make affordable insurance harder to obtain for many Chicago residents. The monthly Special Enrollment Periods in particular are a safeguard for people and families who experience unexpected life events.

7. Per our Department's analysis of CMS data, 103,513 Chicagoans are enrolled in Marketplace coverage, and the overwhelming majority (approximately 90,024 residents) receive premium tax credits, or subsidies from the federal government, to make their coverage more affordable.[3] The Inflation Reduction Act of 2022 enhanced these subsidies through the end of 2025

[2] Chicago Health Atlas. Uninsured rate. https://chicagohealthatlas.org/indicators/UNS?tab=map.

[3] Centers for Medicare and Medicaid Services. 2026 Marketplace Open Enrollment Period Public Use Files. CMS.gov. https://www.cms.gov/data-research/statistics-trends-reports/marketplace-products/2026-marketplace-open-enrollment-period-public-use-files.

and the average tax credit among Chicagoans enrolled in Marketplace coverage is $426.[4] With the end of these subsidy enhancements after 2025 leading to higher monthly premiums, the Rule will compound the effect on Marketplace enrollees by driving younger and healthier people out of coverage and worsening the risk pool for those who remain in coverage. This alarming rise in premium costs would lead to potentially thousands of Chicago residents losing health insurance, and thus losing access to preventative services to keep them out of the hospital, primary care, mental health services, and medications, in addition to causing unnecessary and unsafe disruption to residents undergoing active treatment.

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

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

[4] *Id.* 2025 Marketplace Open Enrollment Period Public Use Files. 2025 OEP ZIP Code-Level Public Use File. CMS.gov. Accessed on June 1, 2026 from https://www.cms.gov/data-research/statistics-trends-reports/marketplace-products/2025-marketplace-open-enrollment-period-public-use-files.

City to coordinate essential resources and services across agencies and sectors to ensure that the hardest-to-reach communities receive care.

10. The Department also partners with all hospitals and healthcare organizations in the City through the Hospital Preparedness Program, which supports the Chicago Health System Coalition for Preparedness and Response. This program includes coordination of all thirty-four (34) acute care and specialty hospitals, 136 long term care facilities, 75 dialysis centers, all Federally Qualified Health Centers, and other organizations that provide health care services within the City.

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

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

13. The Chicago Fire Department provides ambulance transportation services to its residents, including its uninsured and underinsured residents, and regardless of income and insurance status. Chicago generally seeks reimbursement for ambulance services from the patient or, if applicable, the patient's insurer. However, Chicago usually does not receive full reimbursement for ambulance services from its uninsured and underinsured residents. For example, based on our review of Chicago Fire Department ambulance records, in 2024, the City provided 56,556 ambulance transports to Chicago residents for whom no insurance was identified. The

City's net charges for these patients were $173,672,181, but the City collected just $5,647,941 – a loss of over $168 million. The Rule would only exacerbate this loss further, and other big cities and jurisdictions will also likely experience similar shortfalls.

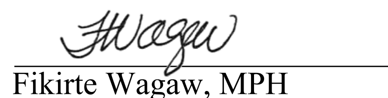
14. In Chicago's experience, the uninsured and underinsured disproportionately rely on ambulance services for transport to the emergency department. Such individuals, for instance, are more likely to wait until their conditions become more severe and then use ambulance services to receive necessary care.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

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

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

Dated: June 4, 2026

Chicago, Illinois



Fikirte Wagaw, MPH

**IN THE UNITED STATES DISTRICT COURT**
**FOR THE DISTRICT OF MARYLAND**

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|---|---|
| CITY OF COLUMBUS, *et al.*,<br><br>*Plaintiffs*,<br><br>v.<br><br>ROBERT F. KENNEDY, JR., *et al.*,<br><br>*Defendants*. | Case No. 1:26-cv-2215 |

**[PROPOSED] ORDER GRANTING STAY OF EFFECTIVE DATE UNDER 5 U.S.C. § 705 AND PRELIMINARY INJUNCTION**

Upon consideration of Plaintiffs' Motion for Stay or Preliminary Injunction, and the parties' briefing thereon, it is hereby

**ORDERED** that the motion is **GRANTED**; and it is further

**ORDERED** that the effective dates of the following provisions of the final rule entitled "Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2027; and Basic Health Program," 91 Fed. Reg. 29,256 (May 20, 2026), are **STAYED** pursuant to 5 U.S.C. § 705 pending a final ruling on the merits of this case:

1. The failure to reconcile policy in the rule's amendment of 45 C.F.R. § 155.305(f)(4), along with the previously version of 45 C.F.R. § 155.305(f)(4);
2. The mandatory verification policy for low-income enrollees in the rule's revisions to 45 C.F.R. § 155.320(c)(3)(iii)(A) and (c)(3)(vi)(C)(2);
3. The revocation of the option for enrollees to attest to their income in the rule's rescission of 45 C.F.R. § 155.320(c)(5);
4. The imposition of special enrollment period verification in the rule's revision to 45 C.F.R. § 155.420(g);

5. The expansion of maximum out-of-pocket limits in the rule's revision of 45 C.F.R. § 156.130(a)(2), addition of 45 C.F.R. § 156.136, and revision of 45 C.F.R. § 156.155(a)(3);
6. The expansion of eligibility for catastrophic plans in the rule's addition of 45 C.F.R. § 155.605(d)(1)(iv), along with the announcement of that expansion of eligibility in CMS, *Guidance on Hardship Exemptions for Individuals Ineligible for Advance Payment of the Premium Tax Credit or Cost-Sharing Reductions Due to Income* (Sept. 4, 2025);
7. The relaxation of network adequacy standards in the rule's revisions of 45 C.F.R. § 155.1050(a)(1) and (a)(2), addition of 45 C.F.R. §§ 155.1050(d) and 155.1051, revisions of 45 C.F.R. §§ 156.230 and 156.235, addition of 45 C.F.R. § 156.236, and revisions of 45 C.F.R. § 156.275(c)(2)(iv) and 45 C.F.R. § 156.810(a)(8); and
8. The elimination of the requirement to offer standardized plans and of the limitations on non-standardized plans in the rule's revisions of 45 C.F.R. §§ 155.20 and 155.205(b)(1) and rescission of 45 C.F.R. §§ 155.220(c)(3)(i)(H), 156.201, 156.202, and 156.265(b)(3)(iv); and it is further

**ORDERED** that the Defendants are preliminarily enjoined from implementing or enforcing the aforementioned policies, or any materially similar policy, pending a final ruling on the merits of this case.

**SO ORDERED**.

________________, 2026

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U.S. DISTRICT JUDGE