UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MARYLAND

CITY OF COLUMBUS, *et al.*,

Plaintiffs,

v.

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

Defendants.

Civil Action No. 1:25-cv-2215-BAH
Leave to file in excess of page limit granted on June 18, 2026

DEFENDANTS' OPPOSITION TO PLAINTIFFS' MOTION FOR STAY OR PRELIMINARY INJUNCTION

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INTRODUCTION

Healthcare in America is oftentimes expensive and confusing. Coverage under the Affordable Care Act ("ACA") is no exception. Enrollees may find available plans are too costly or inadequate for their needs. Likewise, enrollees may inadvertently incur unexpected costs for tax credits and benefits for which they are ineligible. The Centers for Medicare & Medicaid Services ("CMS") issued its annual Notice of Benefit and Payment Parameters for 2027 ("Payment Notice" or "the Rule") to address these problems. Plaintiffs challenge twelve of the Rule's provisions, seeking to stay eight of them. Contrary to Plaintiffs' claims, however, each provision is not only squarely authorized by the statute but also reasonable and reasonably explained, justified by contemporary data and circumstances to address significant market failures. But the Court need not reach these issues to deny emergency relief because, as a threshold matter, Plaintiffs fail to show standing, much less irreparable harm.

BACKGROUND

I. The Affordable Care Act.

Enacted in 2010, the ACA "adopts a series of interlocking reforms designed to expand coverage in the individual health insurance market" and "to make insurance more affordable." *King v. Burwell*, 576 U.S. 473, 478-79 (2015); *see* Pub. L. No. 111-148, 124 Stat. 119 (2010). To "ensure that anyone can buy insurance," *King* at 493, the ACA generally prohibits health insurance issuers in individual or group markets from denying coverage to applicants because of their health (the "guaranteed availability" requirement). 42 U.S.C. § 300gg-1(a). And to promote continuous coverage, the ACA generally requires issuers to "renew or continue in force" an enrolled customer's coverage "at the option of . . . the individual," provided they pay their premiums. *Id.* § 300gg-2(a), (b)(1).

The ACA also required the creation of an "Exchange" in each State where customers can compare and purchase individual "qualified health plans" (as opposed to group or employer-sponsored coverage), which must cover certain "essential health benefits" and adhere to limits on enrollee cost sharing (*i.e.*, deductibles, coinsurance, and co-payments). *Id.* §§ 18022(a)-(c), 18031(b)(1). CMS is responsible for ensuring that the plans offered meet certain standards to ensure adequate access, including ensuring a sufficient choice of providers through their networks ("network adequacy"). *See* 42 U.S.C. § 18031(c)(1). States can elect to operate their own Exchanges ("State-based Exchanges" or "SBEs"). In States that do not do so, CMS operates a federally facilitated Exchange ("FFE").[1]

Consumers can typically enroll in Exchange plans for the upcoming plan year during an annual "open enrollment period," or for the current plan year during "special enrollment periods" that become available if a "triggering event" occurs (*e.g.*, a person loses employer-based coverage). *Id.* § 18031(c)(6). Exchange plans are categorized into different "metal tiers"—bronze, silver, gold, and platinum—based on their "level of coverage"; "silver plans," for instance, must have an actuarial value of 70%, meaning the plan is designed such that the issuer will pay, on average, 70% of covered medical expenses, and the enrollee will pay the remaining 30% of expenses through out-of-pocket spending. *Id.* § 18022(d) (setting the "level of coverage" for the other plan types). Generally speaking, the higher the level of coverage, the higher the premiums. Insurers may also offer "catastrophic coverage," which is generally a low-premium, high-deductible type of coverage that includes the ACA's ten requisite essential health benefits after the deductible is met while remaining affordable. Historically, this type of coverage has only been offered to those under the age of 30 or who meet certain income or other hardship requirements.

[1] Three States, Arkansas, Oklahoma, and Oregon, operate a State-based Exchange on the federal Exchange platform ("SBE-FP").

To help make insurance more affordable, the ACA provides subsidies to eligible Exchange enrollees in the form of "premium tax credits," which enrollees can claim on their annual federal income tax returns. *See* 26 U.S.C. § 36B. The amount of a premium tax credit ("PTC") is based on the enrollee's annual household income and the premium charged for the "benchmark" plan—*i.e.*, the second-lowest cost silver plan—in the enrollee's Exchange. *Id.* Enrollees also have the option of receiving their PTC in advance to lower their monthly insurance payments. These advance premium tax credits ("APTCs") are paid directly to an enrollee's insurer and offset premium costs. *See* 42 U.S.C. § 18082. Because APTCs are based on an enrollee's projected annual household income, however, recipients historically have been required to file a federal tax return and "reconcile" the APTCs they received with the PTC amount they ultimately qualify for based on their actual income during the applicable tax year. *See* 26 U.S.C. § 36B(f)(1).

Prior to 2021, PTCs and APTCs were available only to Exchange enrollees with household incomes between 100% and 400% of the Federal Poverty Level ("FPL"). *See id.* § 36B(c)(1)(A).[2] During the COVID-19 pandemic, Congress temporarily increased the generosity of the ACA's premium subsidies and expanded subsidy eligibility to enrollees with household incomes above 400% of the FPL via the American Rescue Plan Act of 2021, Pub. L. No. 117-2, 135 Stat. 4. The Inflation Reduction Act of 2022, Pub. L. No. 117-169, 136 Stat. 1818, extended these enhanced subsides through 2025, but they have since expired.

Since 2013, CMS has issued an annual Notice of Benefit and Payment Parameters ("Payment Notice") that sets standards for, and makes adjustments to, different facets of Exchanges and ACA coverage for the upcoming plan year. *See, e.g.*, CMS, *Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2026; and Basic Health*

[2] The ACA set the lower FPL threshold with the expectation that individuals with an income below 100% of the FPL would generally be eligible for Medicaid.

Program, 90 Fed. Reg. 4424 (Jan. 15, 2025) ("2026 Payment Notice"). The Rule at issue here is a continuation of that longstanding practice. The HHS Secretary also has broad authority under the ACA to issue regulations implementing and "setting standards for" the ACA's requirements, including those regarding the "establishment and operation of Exchanges," the "offering of qualified health plans through such Exchanges," and "such other requirements as the Secretary determines appropriate." 42 U.S.C. § 18041(a)(1). Since the ACA's enactment, CMS has accordingly engaged in numerous rulemakings to implement various aspects of the ACA. *See, e.g.*, CMS, *Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers*, 77 Fed. Reg. 18,310 (Mar. 27, 2012) ("Exchange Establishment Rule"); CMS, *Patient Protection and Affordable Care Act; Market Stabilization*, 82 Fed. Reg. 18,346 (Apr. 18, 2017) ("Market Stabilization Rule"); CMS, *Patient Protection and Affordable Care Act; Marketplace Integrity and Affordability*, 90 Fed. Reg. 27,074 (June 25, 2025) ("Marketplace Integrity and Affordability Rule"); *see also* 90 Fed. Reg. at 27,080-27,084 (summarizing past rulemakings).

II. The Notice of Benefit and Payment Parameters for 2027.

On May 20, 2026, after notice and comment on its proposed rule, 91 Fed. Reg. at 6,292 (Feb. 11, 2026), CMS issued its annual "Notice of Benefit and Payment Parameters" for 2027, 91 Fed. Reg. 29,526 (May 20, 2026). Each year, this omnibus regulation amends or refines dozens of ACA provisions. Plaintiffs seek to stay eight such provisions:

Failure to Reconcile. The Payment Notice implements Congress's ratification of the Marketplace Integrity and Affordability Rule's earlier requirement that APTC recipients who received those tax credits based on estimated income, reconcile those tax credits with their actual earned income when they file their tax return each year beginning for Plan Year 2028. *Id.* at 29,606.

In the interim, for Plan Year 2027, the Rule permits SBEs to impose an annual or biennial reconciliation requirement while the FFE and SBE-FPs will adopt an annual reconciliation requirement. *Id.* Enrollees who fail to timely reconcile their APTCs will lose access to them.

Mandatory Verification for Applicants Below 100% of the Federal Poverty Line. The Payment Notice will require Exchanges to perform further verification of an applicant's income when an applicant attests to a projected annual household income level above 100% FPL but the IRS indicates an income below 100% FPL, which creates a "data-matching issue." 91 Fed. Reg. at 29,613. Exchanges will be required to set a "reasonable threshold," no less than 10%, by which the applicant's attested income must exceed the income reported by "trusted data sources." *Id.* at 29,616-17. Applicants will have 90 days to resolve the data-matching issue after it is generated. *Id.* at 29,616. This provision will apply beginning in Plan Year 2027.

Removal of the Requirement to Accept Attestation when Tax Data is Unavailable. The Payment Notice will remove the requirement that all Exchanges automatically consider an applicant's income to be verified when the IRS does not return any data on the applicant's income, beginning in Plan Year 2027. *Id.* at 29,619.

Verification Requirements for Special Enrollment Periods. The Payment Notice will require the FFE to verify additional categories of SEPs, such as permanent move or marriage, for at least 75% of all new enrollments through special enrollment periods. *Id.* at 29,631. Prior to the Payment Notice, CMS required the FFE to verify pre-enrollment eligibility verification only for applicants seeking to enroll in an Exchange plan under the loss-of-minimum-essential-coverage ("Loss of MEC") SEP. This is in line with the eligibility verification policy that was in place between 2017 and 2022. This provision will apply to FFE and SBE-FPs beginning in Plan Year 2027. *Id.* at 29,631.

Expansion of Design Options for Bronze Plans. The Payment Notice will permit insurers to offer bronze plans in the individual market that utilize a cost-sharing design that exceeds the maximum annual limitation on cost sharing in increments of 50 dollars in order to achieve an actuarial value within the standard bronze de minimis variation, but not to exceed an amount equal to 130 percent of the annual limitation on cost sharing, if, within the same service area, the insurer offers a bronze plan that complies with existing cost-sharing and levels of coverage requirements. *Id.* at 29,690.

Expansion of Eligibility for Catastrophic Coverage. The Payment Notice will consider an individual with income below 100% FPL or above 250% FPL to have a hardship such that they are eligible to purchase "catastrophic coverage" when they experience a change in household income and become ineligible for financial assistance. *Id.* at 29,633-34.

Changes to Standards for Network Adequacy. The Payment Notice removes quantitative time and distance requirements for in-network treatment and treatment access from plans offered on SBEs and SBE-FPs to restore state flexibility. 91 Fed. Reg. at 29,645. SBEs and SBE-FPs are permitted to establish their own network adequacy standards, given each state's unique geography and healthcare needs. *Id.* FFE states will have the option to elect to conduct their own reviews, provided the state satisfies the applicable criteria for network plans and effective review. This provision will apply beginning in Plan Year 2028.

Elimination of Standardized Plans and the Non-Standardized Plans Limit. CMS will no longer differentially display existing "standardized" plans on the Healthcare.gov website, and FFE and SBE-FP insurers will no longer be required to build and offer plans that align with this CMS-determined preset benefit designs. *Id.* at 29,708. CMS also removed the accompanying numerical limit on non-standardized plans they offer and the related exceptions process. *Id.* at 29,708. The

Rule is set to take effect on July 20, 2026, *id.*at 29,526, but many of its provisions will not begin until Plan Years 2027 and later.

III. Procedural History.

Plaintiffs in this case are four municipal governments—the City of Columbus, Ohio; the Mayor and City Council of Baltimore, Maryland; the City of Chicago, Illinois; and the County of Pima, Arizona—and two nonprofit organizations, one of which is a "national network of small businesses," and the other an advocacy organization consisting of "member physicians and medical trainees . . . in all 50 states." Compl. ¶¶ 12-13, ECF No. 1. They allege the Rule violates the APA, claiming six of its provisions are contrary to law (Count I), and that those same six provisions plus six others are arbitrary and capricious (Count II). *Id.* ¶¶ 75-82. On June 4, 2026, Plaintiffs filed a motion for preliminary relief, in which they seek a stay of the July 20, 2026 effective date of eight of the challenged Rule provisions under 5 U.S.C. § 705 or, in the alternative, a preliminary injunction. ECF No. 17; ECF No. 17-1 ("Stay Motion").

Some Plaintiffs here likewise challenged the "Marketplace Integrity and Affordability Rule," 90 Fed. Reg. 27,074 (June 25, 2025), before this Court in *City of Columbus v. Kennedy*, No. 25-cv-2114-BAH (D. Md. June 12, 2026) ("*City of Columbus II*"). While, this Court vacated four provisions in the prior case similar to those at issue here—(1) Failure to Reconcile; (2) Mandatory Verification for Applicants Below 100% FPL; (3) Removal of the Requirement to Accept Attestation of Income when Tax Data is Lacking; and (4) Verification Requirements for Special Enrollment Periods—that decision was issued after publication of the Rule here, which relies on a different record.

LEGAL STANDARD

A court "may issue all necessary and appropriate process to postpone the effective date of an agency action or to preserve status or rights pending conclusion of . . . review proceedings" where "required and to the extent necessary to prevent irreparable injury." 5 U.S.C. § 705. "The standard[] for granting" a § 705 stay is "essentially the same" as that for granting a preliminary injunction. *Am. Fed'n of State, Cnty., & Mun. Emps., AFL-CIO v. Social Sec. Admin.*, 771 F. Supp. 3d 717, 792 (D. Md. 2025); *see Casa de Maryland, Inc. v. Wolf*, 486 F. Supp. 3d 928, 950 (D. Md. 2020). Both forms of relief are "extraordinary remed[ies]" that can be granted "only if the moving party clearly establishes entitlement to the relief sought." *Di Biase v. SPX Corp.*, 872 F.3d 224, 230 (4th Cir. 2017) (quoting *Winter v. Nat. Res. Def. Council, Inc.*, 555 U.S. 7, 22 (2008)). And such relief is warranted "only if it is clear" that (1) the movant is "likely to succeed on the merits," (2) they are "likely to suffer irreparable harm in the absence of preliminary relief," (3) "the balance of the equities tips in [their] favor," and (4) "an injunction is in the public interest." *Pierce v. N.C. State Bd. of Elections*, 97 F.4th 194, 209 (4th Cir. 2024) (citation omitted).

ARGUMENT

I. Plaintiffs Lack Standing and Fail to Show Irreparable Harm.

Plaintiffs' request for a § 705 stay should be denied at the threshold because they fail to show that they have Article III standing—much less that emergency relief is needed to forestall irreparable harm they would suffer before this case is decided on the merits.

"Article III of the Constitution confines the jurisdiction of federal courts to 'Cases' and 'Controversies.'" *FDA v. All. for Hippocratic Med.*, 602 U.S. 367, 378 (2024). "For there to be a case or controversy . . . , the plaintiff must have a 'personal stake' in the case—in other words, standing." *TransUnion LLC v. Ramirez*, 594 U.S. 413, 423 (2021) (quoting *Raines v. Byrd*, 521

U.S. 811, 819 (1997)). To establish standing, "a plaintiff must demonstrate (i) that she has suffered or likely will suffer an injury in fact, (ii) that the injury likely was caused or will be caused by the defendant, and (iii) that the injury likely would be redressed by the requested judicial relief." *All. for Hippocratic Med.*, 602 U.S. at 380.

An alleged injury confers standing only if it is "concrete and particularized" and "actual or imminent, not conjectural or hypothetical." *Opiotennione v. Bozzuto Mgmt. Co.*, 130 F.4th 149, 153 (4th Cir. 2025) (quoting *Lujan v. Defs. of Wildlife*, 504 U.S. 555, 560 (1992)). And a party seeking prospective relief—as Plaintiffs do here—"must establish a sufficient likelihood of future injury." *All. for Hippocratic Med.*, 602 U.S. at 381. That is, a "threatened injury must be *certainly impending* to constitute [an] injury in fact," and "'[a]llegations of *possible* future injury' are not sufficient." *Clapper v. Amnesty Int'l USA*, 568 U.S. 398, 409 (2013) (citation omitted). The causation element of standing, moreover, requires a plaintiff to show a "causal connection" between the alleged injury and the specific "'conduct' complained of' by the plaintiff." *Md. Shall Issue, Inc. v. Hogan*, 971 F.3d 199, 212 (4th Cir. 2020) (citation omitted). The "links in th[at] chain of causation" cannot be "too speculative or too attenuated." *All. for Hippocratic Med.*, 602 U.S. at 383. A causal chain is too speculative if it is not "sufficiently predictable how third parties would react to the government action" in question or "cause downstream injury to plaintiffs." *Id.* And it is too attenuated if the challenged government action "is so far removed from its distant (even if predictable) ripple effects that the plaintiffs cannot establish Article III standing." *Id.*; *Beck v. McDonald*, 848 F.3d 262, 275 (4th Cir. 2017) (explaining that an "attenuated chain of possibilities" cannot confer standing (quoting *Clapper*, 568 U.S. at 410)).

Plaintiffs "bear[] the burden of establishing [their] standing" to seek the preliminary relief they demand here. *South Carolina v. United States*, 912 F.3d 720, 726 (4th Cir. 2019). Because

preliminary relief "may only be awarded upon a clear showing that the plaintiff is entitled to such relief," *Winter v. Nat. Res. Def. Council, Inc.*, 555 U.S. 7, 22 (2008), Plaintiffs must accordingly "make a 'clear showing'" that they are "'likely' to establish each element of standing." *Murthy v. Missouri*, 603 U.S. 43, 58 (2024); *see Lujan*, 504 U.S. at 561 ("[E]ach element [of standing] must be supported . . . with the manner and degree of evidence required at the successive stages of the litigation."). Absent that clear showing, the Court "lack[s] jurisdiction to reach the merits of" any of Plaintiffs' claims. *Murthy*, 603 U.S. at 56; *see Delmarva Fisheries Ass'n, Inc. v. Atl. States Marine Fisheries Comm'n*, 127 F.4th 509, 514 (4th Cir. 2025) (explaining that absent standing, "the federal courts lack jurisdiction to consider [a] request for a preliminary injunction").

Because they seek preliminary relief, Plaintiffs have the added burden of showing that they are "likely to suffer irreparable harm in the absence of" such relief. *Pierce*, 97 F.4th at 209 (citation omitted). It is not enough to "simply show[] some 'possibility of irreparable injury.'" *Nken v. Holder*, 556 U.S. 418, 434 (2009) (citation omitted). Rather, Plaintiffs "must make a 'clear showing' that [they] will suffer harm that is 'neither remote nor speculative, but actual and imminent.'" *Mountain Valley Pipeline, LLC v. 6.56 Acres of Land*, 915 F.3d 197, 216 (4th Cir. 2019) (citation omitted); *see Ass'n of Am. Publishers v. Frosh*, 586 F. Supp. 3d 379, 393 (D. Md. 2022) ("The harm . . . must be more than a mere possibility; it must be likely."). And preliminary relief is warranted only if the plaintiff is "likely to suffer the harm 'before a decision on the merits can be rendered.'" *M.A.B. v. Bd. of Educ. of Talbot Cnty.*, 286 F. Supp. 3d 704, 726 (D. Md. 2018) (quoting *Winter*, 555 U.S. at 22); *see Di Biase*, 872 F.3d at 230 ("A preliminary injunction is an extraordinary remedy intended to . . . prevent irreparable harm during the pendency of a lawsuit.").

None of the Plaintiffs have made the requisite showings here. They all assert that the Rule will cause them downstream economic harm, but each of their alleged injuries rests on speculative

predictions about the Rule's potential effects on a complex health insurance market and a multi-step chain of possibilities that is unlikely to materialize, much less imminently.

A. Main Street Alliance.

Plaintiff Main Street Alliance ("MSA") is a nonprofit organization that describes itself as a "national network of small businesses, with approximately 30,000 small business members throughout the United States." Compl. ¶ 13. MSA brings suit on behalf of the unknown number of its members who "rely on the Marketplace for health insurance," claiming the Rule will "create additional costs" for those members. *Id.* ¶¶ 69-70. Yet to have such associational standing to sue "as a representative of its [allegedly] harmed members," MSA must establish "that one of its members would have standing to sue in his or her own right." *Friends of the Earth, Inc. v. Gaston Copper Recycling Corp.*, 629 F.3d 387, 396-97 (4th Cir. 2011); *see Summers v. Earth Island Inst.*, 555 U.S. 488, 498 (2009) (explaining that associational standing "require[s] plaintiff-organizations to make specific allegations establishing that at least one identified member" has suffered or will suffer harm). It fails to satisfy that essential requirement here.

MSA attempts to base its associational standing on two members who own or owned small businesses in Wisconsin and are enrolled in a qualified health plan through the ACA's individual Exchange. *See* Decl. of Brooke Legler, ("Legler Decl.") ¶¶ 1-11, ECF No. 17-7; Decl. of Mike Ohlinger, ("Ohlinger Decl.") ¶¶1-10, ECF No. 17-9. Those members' theory of standing hinges on (1) the challenged Rule provisions causing cost increases in individual Exchanges generally and (2) an attendant (yet wholly indeterminate) increase in the monthly premiums the members pay post-subsidies, (3) which the members would categorically be unable to afford, (4) coupled with the existing costs to run or reopen their businesses, which are already costly for unexplained reasons, (5) ultimately making it impracticable for them to run their business because either (6a)

the member will be unable to afford the simultaneous costs or (6b) the member's employees will leave to find an employer who can offer less costly coverage. Legler Decl. ¶¶ 1-11; Ohlinger Decl. ¶¶1-10. But merely describing this attenuated chain of contingencies refutes it as an adequate basis for standing. *See Beck*, 848 F.3d at 275. For one, the members do not claim that any *specific* challenged Rule provisions would impact them directly or otherwise interfere with their eligibility to remain enrolled in their current Exchange plan. "[S]tanding is not dispensed in gross. That is, 'plaintiffs must demonstrate standing for each claim that they press' against each defendant, 'and for each form of relief that they seek.'" *Murthy*, 603 U.S. at 61 (quoting *TransUnion*, 594 U.S. at 413). Plaintiff MSA fails to do so here. Instead, the members' assertion that the Rule's impact on insurance markets more broadly will necessarily cause their or their employees' insurance premiums to increase is wholly speculative. *See All. for Hippocratic Med.*, 602 U.S. at 381 ("[T]he injury must be actual or imminent, not speculative . . ."). The members also provide no factual basis for assuming that, even if there were *some* increase in their premiums (whether caused by the Rule or not), they would necessarily forgo Exchange coverage, close their businesses, and seek insurance elsewhere, notwithstanding their satisfaction with their current Exchange plans. Plaintiff MSA has thus failed to establish that the future economic injury its members claim they will suffer as a result of the Rule is "sufficient[ly] likel[y]" to materialize, let alone imminently so. *Id.*; *see South Carolina*, 912 F.3d at 726 ("The requirement that an alleged injury be palpable and imminent ensures that the injury 'is not too speculative for Article III purposes.'" (quoting *Beck*, 848 F.3d at 271)). And MSA has certainly failed to establish that any such injury would occur before its claims could be resolved in the regular course of litigation—an essential feature of irreparable harm. *See M.A.B.*, 286 F. Supp. 3d at 726 (quoting *Winter*, 555 U.S. at 22).

The MSA member-declarants, in short, fail to establish their standing on multiple fronts.

Because they lack standing to challenge the Rule in their own right, it follows, then, that MSA does not have associational standing to challenge the Rule either and MSA certainly has failed to make the requisite clear showing of irreparable harm.

B. Doctors for America.

Plaintiff Doctors for America ("DFA") is a not-for-profit organization "of over 27,000 physician[] and medical trainee[]" members "in all 50 states." Decl. of Dr. Janet Krommes, ("Krommes Decl.") ¶ 3, ECF No. 17-5. Like MSA, DFA is challenging the Rule on behalf of its members. *See, e.g.*, Stay Motion at 14-15 ("DFA 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 like MSA, DFA attempts to establish its associational standing with a declaration from a single member, this one a primary care provider in a Kansas county health center. *See* Decl. or Dr. Beth Oller, ("Oller Decl.") ¶¶ 1-4, ECF No. 17-10.[3]

That member asserts that the Rule "would have a devastating effect on [her] practice and [her] community" because "many" of her roughly 800 patients would allegedly "become uninsured or underinsured" *Id.* This, she claims, would cause those newly uninsured or underinsured patients to be "more likely to opt out of critical preventative care services," which would "hinder[]" the member's ability "to provide optimal care to [her] patients" and "jeopardize[]" the patients' "long-term health," and result in her providing more uncompensated or unreimbursed care. *Id.* ¶ 7.

Yet the Rule's alleged effects on the "long-term health" of the DFA member's *patients* is largely irrelevant to whether *the member* would have standing to challenge the Rule (and, by

[3] While DFA also includes a declaration from Janet Krommes, a retired rheumatologist and member of DFA, Dr. Krommes does not at any point allege how the Rule injures her. Rather, Dr. Krommes generally describes how insurance coverage can impact patients that DFA members treat, but this falls far short of the specific showing required for associational standing. *See All. for Hippocratic Med.*, 602 U.S. at 381.

extension, whether DFA has associational standing to do so), or whether *the member* will be irreparably harmed by the Rule in some way. *See All. for Hippocratic Med.*, 602 U.S. at 381 ("[T]he injury must affect '*the plaintiff* in a personal and individual way.'" (emphasis added)); *New Mexico v. Musk*, 769 F. Supp. 3d 1, 7 (D.D.C. 2025) ("[H]arm that might befall unnamed third parties does not satisfy the irreparable harm requirement in the context of emergency injunctive relief, which must instead be connected specifically to the parties before the Court." (citation omitted)). As for the alleged increase in "uncompensated and undercompensated care," Oller Decl. ¶¶ 9-10, the member does not explain how an uninsured patient's inability to pay for certain care, or how the member providing health care services that go unreimbursed by an insurer, affects *her* compensation directly. Nor does the member attempt to explain how any increase in uncompensated care that she might encounter could reasonably be attributed to any *specific* provision of the Rule. *Murthy*, 603 U.S. at 61 ("[S]tanding is not dispensed in gross."). And to the extent the member tries to base her standing on the prospect of the alleged increase in uncompensated care being so substantial that hospitals and clinics will eventually be "force[d] . . . to close," Oller Decl. ¶ 9, such an injury is far too speculative and attenuated to confer standing, *see All. for Hippocratic Med.*, 602 U.S. at 381 ("[T]he injury must have already occurred or be likely to occur soon."); *Clapper*, 568 U.S. at 401 ("[R]espondents' theory of *future* injury is too speculative to satisfy the well-established requirement that threatened injury must be 'certainly impending.'"), and undoubtedly far too distant to constitute imminent irreparable harm.

DFA's member-declarant thus falls well short of making the requisite "clear showing" that she will be imminently and concretely harmed by the Rule. *Murthy*, 603 U.S. at 58. And that shortcoming is fatal to both DFA's claim to associational standing and its demand for preliminary relief.

C. The Municipal Plaintiffs.

That leaves the four municipal Plaintiffs—the City of Columbus, the Mayor and City Council of Baltimore, the City of Chicago, and the County of Pima, Arizona. All four contend the Rule will harm them in the same way—namely, "[b]y driving up the rate of uninsured or underinsured individuals within the municipal Plaintiffs' jurisdictions," thus "forc[ing]" the municipal Plaintiffs cover the costs of uninsured and underinsured patients as providers of last resort. Stay Motion at 48; *See* Decl. of Dr. Theresa Cullen, ("Cullen Decl.") ¶¶ 12-14, ECF No. 17-2; Decl. of Edward Johnson, ("Johnson Decl.") ¶¶ 13-15, ECF No. 17-4; Decl. of Faith Leach, ("Leach Decl.") ¶¶ 11-15, ECF No. 17-6; Decl. of Fikirte Wagaw, ("Wagaw Decl.") ¶ 14, ECF No. 17-12. And all four contend that this budgetary injury amounts to irreparable harm requiring preliminary relief. *See* Stay Motion at 44-49.

As with the two organizational plaintiffs, however, the injury in fact that the city Plaintiffs assert here "lies at the end of a 'highly attenuated chain of possibilities.'" *South Carolina*, 912 F.3d at 727. Indeed, the budgetary harms they fear could materialize only if (1) the Rule provisions Plaintiffs challenge cause a certain number of individuals currently enrolled in Exchange plans to disenroll or otherwise lose coverage, and (2) a portion of that recently uninsured group seeks medical care (3) in the municipal Plaintiffs' jurisdictions (4) specifically at municipality-run health care facilities (rather than privately operated ones) or through a municipality-funded emergency medical service and (5) receives services at such a rate that the municipalities (6) are required to increase the budgets for their respective public health departments to cover that increase in potentially uncompensated care. Such a remote harm built on "a lengthy chain of assumptions," *Chambliss v. Carefirst, Inc.*, 189 F. Supp. 3d 564, 569 (D. Md. 2016), simply "does not satisfy the requirement that threatened injury must be certainly impending" to confer standing, *Clapper*, 568

U.S. at 410. And that remote harm is certainly not imminent enough to qualify as the sort of irreparable injury that warrants extraordinary preliminary relief.

Additionally, the municipalities rely on self-inflicted injuries. But it is well-established that the incidental effects of policies do not confer standing. *See, e.g.*, *Department of Educ. v. Brown*, 600 U.S. 551, 568 (2023). If the municipalities choose to provide services to their residents, they cannot complain that federal policy causes more residents to seek those services. *See Pennsylvania v. New Jersey*, 426 U.S. 660, 662-64 (1976) (per curiam). As the Supreme Court has explained, a local government's desire to "supply social services such as healthcare," *United States v. Texas*, 599 U.S. 670, 674 (2023), is not a cognizable injury.

Finally, the municipal Plaintiffs make the additional assertion that they will be irreparably harmed by the Rule because, by purportedly making it harder for city residents to get "the medical care they need," the Rule will cause those residents to be "less healthy, less productive, and less able to participate in city life," which would "have cascading negative . . . effects on municipal Plaintiffs' programs and communities." Stay Motion at 49. Not only is this *parens patriae* standing by another name, *see Haaland v. Brackeen*, 599 U.S. 255, 295 (2023), but the "cascading negative" effects that the municipal Plaintiffs purportedly fear are just as speculative and remote as their alleged budgetary harms and thus fail to warrant preliminary relief for the same reasons. Plaintiffs also point to no legal authority suggesting that such amorphous "negative effects" can amount to a sufficiently concrete injury for standing purposes. *See All. for Hippocratic Med.*, 602 U.S. at 381 ("An injury in fact . . . must be real and not abstract."). And the city Plaintiffs' assumptions about their residents' future medical decisions and productivity also rest entirely on "guesswork as to how independent decisionmakers will exercise their judgment" in response to the Rule, which is likewise not a viable basis for standing. *Murthy*, 603 U.S. at 57 (citation omitted).

II. Plaintiffs are not Likely to Succeed on the Merits.

Plaintiffs' failure to establish standing and irreparable harm is sufficient on its own to warrant a denial of their Stay Motion. *See Maryland v. U.S. Dep't of Agric.*, 777 F. Supp. 3d 432, 452 (D. Md. 2025) (noting that "'[a] plaintiff unlikely to have standing is *ipso facto* unlikely to succeed' in its cause" for purposes of preliminary relief); *Bethel Ministries, Inc. v. Salmon*, No. 19-cv-1853, 2020 WL 292055, at *7 (D. Md. Jan. 21, 2020) ("[S]ince [the plaintiff] has not met its burden to establish irreparable harm, its Motion [for a preliminary injunction] fails on this basis alone."). But even if the Court were to conclude otherwise, Plaintiffs are not likely to succeed on the merits of any of their claims.

Plaintiffs' Stay Motion challenges eight of the Rule's provisions, claiming that six are contrary to law and that all eight are arbitrary and capricious. *See* Compl. ¶¶ 77, 81. The APA provides that a reviewing court "shall . . . hold unlawful and set aside agency action" that is "found to be . . . arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law." 5 U.S.C. § 706(2)(A). When reviewing a contrary-to-law claim, "courts must exercise independent judgment in determining the meaning of statutory provisions" and "set aside" any action that is "inconsistent with the law as they interpret it." *Loper Bright Enters. v. Raimondo*, 603 U.S. 369, 392, 394 (2024). "In determining whether agency action was arbitrary or capricious, [a] court must consider whether the agency considered the relevant factors and whether a clear error of judgment was made." *Ohio Valley Env't Coal. v. Aracoma Coal Co.*, 556 F.3d 177, 192 (4th Cir. 2009). "Review under" the arbitrary-and-capricious standard "is highly deferential, with a presumption in favor of finding the agency action valid." *Id.* A court accordingly "may not substitute its own policy judgment for that of the agency." *FCC v. Prometheus Radio Project*, 592 U.S. 414, 423 (2021). Rather, "[s]o long as the agency 'provide[s] an explanation of its decision that includes a

rational connection between the facts found and the choice made,'" its decision must be upheld. *Jimenez-Cedillo v. Sessions*, 885 F.3d 292, 297-98 (4th Cir. 2018) (citation omitted); *see Prometheus*, 592 U.S. at 423 ("A court simply ensures that the agency . . . has reasonably considered the relevant issues and reasonably explained the decision."). Agencies are also "free to change their existing policies as long as they provide a reasoned explanation for the change." *Encino Motorcars, LLC v. Navarro*, 579 U.S. 211, 221 (2016). Each of Plaintiffs' challenges fails under these standards.

A. The Failure to File and Reconcile Policy is Neither Unlawful nor Arbitrary and Capricious.

The failure-to-file-and-reconcile policy ("FTR") policy serves a purpose that should be uncontroversial: When someone receives a government subsidy in advance, based on their projected income, it is only fair to require them to show, at year's end, that their actual income indeed met the eligibility requirements. *See* 26 U.S.C. § 36B(f)(1). Some version of this commonsense policy has been in place since 2015. 77 Fed. Reg. at 18,444. For nearly a decade, it was one year, albeit paused from 2020 to 2024. In 2024, it was changed to provide an extension that delayed enforcement for an additional year. CMS, Patient Protection and Affordable Care Act, HHS Notice of Benefit and Payment Parameters for 2024, 88 Fed. Reg. 25,740, 25,917 (Apr. 27, 2023). The Marketplace Integrity and Affordability rule eliminated this extension. 90 Fed. Reg. at 27,117. In establishing the FTR policy—both in its one-year form in 2015-24 and 2026 and in its two-year form in 2024-25—CMS relied on its general rulemaking authority under 42 U.S.C. § 18041(a)(1) and specific authority under 42 U.S.C. § 18082(b)(1)(B). In *City of Columbus II*, some Plaintiffs here challenged and this Court preliminarily enjoined the Marketplace Integrity and Affordability Rule's iteration of the FTR policy. *City of Columbus v. Kennedy*, 796 F. Supp. 3d

123, 161 (D. Md. 2025). But Congress addressed this very issue in the Working Families Tax Cuts Act ("WFTCA"), ratifying the Marketplace Integrity and Affordability Rule's one-tax-year FTR policy beginning in Plan Year 2028. *See* One Big Beautiful Bill Act, Pub. L. No. 119-21 § 71303, 139 Stat. 72, 323 (2025). The Rule challenged here implements that congressional ratification, requiring a one-tax-year FTR policy beginning in Plan Year 2028 and permitting Exchanges to adopt a one-year or two-year FTR policy for Plan Year 2027, to ensure a smooth transition.

Defendants appealed the Court's preliminary injunction of this provision of the Marketplace Integrity and Affordability Rule, *City of Columbus II*, Notice of Appeal, ECF No. 39, and they are considering appealing the Court's recent vacatur of the same provision, which mooted their prior appeal, *City of Columbus II*, Mem. Op., at ECF No. 73, a decision that lies with the Solicitor General, *see* 28 C.F.R. § 0.20. In the meantime, there is little reason for this Court to rush to enter extraordinary relief now: The present dispute concerns only the 2027 plan year, and the Fourth Circuit may provide guidance on this issue before that time. Accordingly, it would be most efficient for the Court to exercise its discretion to defer resolution of this issue for the time being.

If the Court decides to reach the issue now, however, it should deny preliminary relief. As Defendants have previously explained, and would argue on any appeal, HHS relied on its general rulemaking authority under 42 U.S.C. § 18041(a)(1), which it had historically relied on to issue FTR policies for more than a decade. We recognize, of course, that this Court has already rejected those arguments, so will not belabor them here, and instead respectfully incorporate them by reference. *City of Columbus II*, Defs.' Opp'n to Pls.' Mot. for Prelim. Reflief, ECF No. 28; Defs.' Cross Mot. for Summ. J. & Opp'n to Pls.' Mot. for Summ. J., ECF No. 68. But the Court need not change its mind to deny relief here because the WFTCA has changed the landscape. That Act not only ratifies the 2026 rule, beginning in 2028. *See* Pub. L. No. 119-21 § 71303, 139 Stat. at 323.

Congress's express ratification of CMS's policy judgment forecloses Plaintiffs' arbitrary and capricious challenge. And the speed with which Congress acted to affirm the FTR policy after it was challenged strongly suggests that Congress viewed this rulemaking authority as squarely within the agency's authority all along. *United States v. Bd. of Com'rs of Sheffield, Ala.*, 435 U.S. 110, 134 (1978).

B. The Mandatory Verification Policy for Applicants Below 100% FPL is not Arbitrary and Capricious.

The Rule's mandatory verification policy will require Exchanges to flag and further verify income-related information in certain circumstances when (1) a tax filer's attested projected annual household income is above 100% of the federal poverty line ("FPL") and the income amounts returned by the IRS with respect to that tax filer are less than 100% of the FPL, and (2) the attested household income exceeds IRS data by a "reasonable threshold": at least 10%, with the FFE utilizing an even higher threshold, of 50% or $12,000. 91 Fed. Reg. at 29,613-14, 29,619. As part of the process for verifying an applicant's household income for purposes of determining their eligibility for APTCs, an Exchange historically considered an applicant's tax return information and their attestation regarding their "projected annual household income." 45 C.F.R. § 155.320(c)(3)(ii). Under prior regulations, if an applicant's attestation regarding their projected annual household income reflected a higher household income than that reflected in income data provided by the IRS or certain other sources, an Exchange generally "must accept the applicant's attestation . . . without further verification." *Id.* § 155.320(c)(3)(iii)(A), (v). The Rule amends this provision by requiring an Exchange to instead further verify an applicant's household income through the above process. The applicant would then be given an opportunity to resolve the inconsistency by providing additional documentation and taking other steps to verify their

household income. *See id.* § 155.315(f)(1)-(4).

The logic behind the policy is straightforward: Because individuals with household incomes below 100% FPL are generally not eligible for PTCs or, by extension, APTCs, *see* 26 U.S.C. § 36B(a), (c)(1), an applicant who attests to having a projected household income that is equal to or above 100% of the FPL might be deemed eligible for APTCs despite income data from other sources showing otherwise. 91 Fed. Reg. at 29,613-19. And given that such a discrepancy could be a consequence of an applicant, agent, broker, or web broker overestimating the applicant's projected household income so the applicant may obtain APTCs for which he is not otherwise eligible, it is a "necessity," CMS explains, to request additional documentation verifying an applicant's actual income in such circumstances, so as to protect against overpayment of APTCs. *Id.* at 29,615 ("[W]e find that continued issues on the Exchange with accurately determining APTC eligibility . . . present ongoing risks to the financial integrity for the Exchanges and create opportunities for agent, broker, and web-broker driven improper conduct. We stated that this gives further weight to the necessity of the continuation of this income verification policy beyond 2027."). That additional verification is precisely what the Rule will require.

To be sure, this provision resembles policies issued in 2018 and 2025 that were vacated in *City of Columbus,* 523 F. Supp. 3d 731 and *City of Columbus II*, respectively. In the first case, the 2018 version was found arbitrary and capricious largely because, at the time, CMS "failed to point to any actual or anecdotal evidence" of Exchange consumers inflating their income to obtain APTCs for which they were not otherwise eligible. 523 F. Supp. 3d at 762; *see id.* (describing CMS's stated rationale of "prevent[ing] fraud in states that did not expand Medicaid" as "unfounded"). And the 2025 version was found arbitrary and capricious because CMS "failed to meaningfully address the comments pointing out potential flaws in the data contained in the

Paragon Report" and "refuse[d] to engage with commenters' reasonable concerns that the data fails to support the conclusion the agency drew from that data." *City of Columbus II*, Mem. Op. at 57. But CMS now points to a constellation of evidence, supported by internal data metrics, new and existing GAO studies, and anecdotal accounts:

Internal Data. Following recent data analysis, CMS determined that almost 80% of income data-matching issues were generated for households who worked with an agent, broker, or web-broker in Plan Year 2024. Similarly, those who worked with an agent, broker, or web-broker generated data-matching issues three times more often than those who did not work with one. 91 Fed. Reg. at 29,615. This data was previously unavailable when CMS issued the Marketplace Integrity and Affordability Rule.

GAO studies. Two GAO studies, the latest released in December 2025 after CMS issued its Marketplace Integrity and Affordability Rule, support this provision. 91 Fed. Reg. at 29,615 (citing GAO (2025 Dec.) Patient Protection and Affordable Care Act: Preliminary Results from Ongoing Review Suggest Fraud Risks in the Advance Premium Tax Credit Persist, GAO-26-108742. https://perma.cc/2SXX-WTCZ, ("GAO-26-108742")). This new, comprehensive study identified no less than 160,000 applications in Plan Year 2024 that likely had unauthorized changes without consumers' consent. GAO-26-108742 at 16. Further, GAO auditors created twenty fictitious applicants and enrolled them in plans for which they would be ineligible. By September 2025, 90% of those fictitious applicants remained undetected and improperly enrolled. *Id.* at 2, 11-12. GAO cautioned against generalizing this data to the "universe of enrollees" but emphasized its covert testing was "illustrative of potential enrollment control weaknesses" "such as identity proofing and income verification[.]" *Id.* at 3, 9.

This new GAO study both tracks and builds on similar findings in an earlier GAO study,

upon which CMS has previously relied. 91 Fed. Reg. at 29,615 (citing GAO. (2016 Nov.). Patient Protection and Affordable Care Act: Results of Enrollment Testing for the 2016 Special Enrollment Period. GAO-17-78. https://perma.cc/8AQA-TLZB ("GAO-17-78")). In that study, GAO also employed covert testing and found 75% of the fictitious applicants it created remained improperly enrolled, and only half received an income verification request. GAO-17-78.

Anecdotal Evidence. CMS received reports that agents, brokers, and web-brokers may be using artificial intelligence ("AI") to impersonate FFE and SBE-FP consumers and falsely attest to household income. 91 Fed. Reg. at 29,614. CMS was not aware of this information when it promulgated the Marketplace Integrity and Affordability Rule, and as AI continues to progress rapidly, fraud will become easier to commit and more challenging to identify.

When squared with previous studies and data from the Marketplace Integrity Affordability Rule, a through-line emerges: "some agents, brokers, web-brokers, and applicants are taking advantage of weaknesses in the Exchanges' eligibility framework to enroll consumers in coverage with APTC without their knowledge, even when consumers are not eligible." *Id.* at 29,615. Here, CMS does not assume that "enrollees must have been trying to defraud the Exchange," Stay Motion at 21, as much of the now available evidence suggests enrollees may be unwittingly enrolled into Exchange coverage with APTCs. Likewise, there is no longer a "hypothetical risk of fraud." *Id.* GAO studies acknowledge enrollment control weaknesses, internal data suggests those weaknesses are exploited, and anecdotal evidence indicates this exploitation is done with frightening technological proficiency. And unlike in the Marketplace Integrity and Affordability Rule, none of this data faces the same "potential flaws" as the previously relied upon Paragon Report. Accordingly, this constellation of evidence provides ample reasonable basis to issue the Rule, even if Plaintiffs provide an alternative interpretation of it.

CMS "examined the relevant data," "provided an explanation for its decision," and established with data a "rational connection between the facts found and the choice made." *Ohio Valley Env't Coal.*, 556 F.3d at 192 (citation omitted). That comports with the APA's arbitrary-and-capricious standard.

C. The Requirement to Accept Attestations of Household Income when Tax Data is Unavailable is not Arbitrary and Capricious.

Plaintiffs also challenge the Rule's recission of a regulation that requires an Exchange to accept an applicant's self-attestation of projected annual household income "without further verification" whenever (1) the Exchange requests tax return data from the IRS to verify the applicant's attested income, but (2) the IRS confirms that there is no such data available. *See* 91 Fed. Reg. at 29,620. The prior regulation, which was adopted in 2023, created an exception to the general requirement that an Exchange must verify an applicant's annual household income with certain trusted data sources, 45 C.F.R. § 155.320(c)(1)(ii), and otherwise follow an alternative verification process if tax return data for an applicant is unavailable, *id.* § 155.320(c)(3)(vi). The Rule simply removes this exception and requires Exchanges to follow standard verification and data-matching procedures "if the IRS does not return any tax data [for] PY 2027 and beyond." 91 Fed. Reg. at 29,620.

Plaintiffs' objection appears to be that CMS did not adequately consider the policy's potential burden on consumers' access to subsidized coverage on Exchanges. *See* Stay Motion at 22-23. But CMS did, in fact, consider commenters' concerns about the burden that extra verification steps might place on applicants. *See* 91 Fed. Reg. at 29,619-20. Contrary to Plaintiffs' arguments, this provision is designed to protect consumers from significant tax liability, not force them off Exchanges. "Under section 71305 of the WFTCA, repayment caps on excess APTC

payments will discontinue starting in [Plan Year] 2026." *Id.* at 29,620. Prior to 2026 and the WFTCA legislation, there was "a repayment cap on the maximum amount of excess APTC taxpayers with household income below 400[%] of the FPL were responsible for paying back when filing their Federal income tax for the year of coverage." *Id.* at 29,621. But starting in 2026, "tax filers whose APTC continues uninterrupted and whose actual household income is higher than their projected household income may have excess PTC and, if so, must pay back the full difference between their APTC and PTC, regardless of their income level." *Id.*

Consumers now could inadvertently subject themselves to significant tax liability, which this provision seeks to mitigate as it would help ensure enrollees receive the appropriate APTCs for their income level at the outset. Similarly, consumers could be inadvertently and fraudulently enrolled into APTCs for which they are ineligible by an unscrupulous agent, broker, or web-broker who, intentionally or unintentionally misrepresents the consumer's annual household income on their application so the consumer receives maximum APTC subsidies, again subjecting the consumer to significant tax liability. This provision would mitigate that tax liability.[4] Ultimately, CMS determined that mitigation of consumers' significant tax burdens justified the verification requirements imposed in this provision. *Id.* at 29,622 ("We believe eligible applicants would likely have documentation to verify their household income. . . . [W]e do not anticipate this burden would deter many eligible people from enrolling as there are a multitude of documents that can verify income, and additionally, the Exchanges on the Federal platform have provided an extensive guide to verifying income with resources for households that struggle to obtain documentation.").

[4] CMS adopted a process for the FFE and SBE-FPs that allows consumers to report an unauthorized enrollment, which allows them to avoid tax liabilities, but this is a back-end solution that requires a consumer to be aware of the improper enrollment and take actions to correct it. Similarly, CMS also permits issuers insurers to report improper FFE and SBE-FP enrollments to HHS, which effectively allows the consumer to avoid tax liability for an enrollment they were unaware of and did not authorize, but this, too, is a back-end solution. *See* 91 Fed. Reg. at 29,621. This provision offers a prophylactic approach, which would mitigate the imposition of significant tax liability and back-end consumer complications.

Plaintiffs do not address the WFTCA or this reasoning whatsoever in their Motion to Stay.

CMS also cited genuine program integrity concerns. The prior "policy may have helped contribute to the weakening of the Exchange eligibility system, which some agents, brokers, and web-brokers took advantage of by enrolling consumers in fully-subsidized plans they may not have been eligible for, oftentimes without those consumers' knowledge." *Id.* at 29,619. As noted earlier, *supra* p. 22, CMS determined that almost 80% of income data-matching issues were generated for households who worked with an agent, broker, or web-broker in Plan Year 2024. Similarly, those who worked with an agent, broker, or web-broker generated data-matching issues three times more often than those who did not work with one. 91 Fed. Reg. at 29,615. This provision would mitigate improper enrollments by agents, brokers, and web-brokers who do not have consumers' permission to enroll in APTCs and accordingly lack those consumers' detailed income information.

Thus, CMS has identified a "*nexus*" between enrollment control vulnerabilities, such as the one this Rule seeks to fix, and fraudulent and improper enrollments. *See City of Columbus II*, Mem. Op. at 59. CMS in short, provided the very sort of "reasoned explanation" for its policy change that the APA requires, *Encino Motorcars*, 579 U.S. at 221 (citation omitted), and Plaintiffs' conclusory arguments to the contrary are meritless.

D. The Verification Requirements Policy for Special Enrollment Periods is Not Arbitrary and Capricious.

Plaintiffs separately challenge two changes to the eligibility verification procedures that apply to Exchange enrollment via SEPs. Under prior regulations, the FFE and SBE-FPs were required to conduct pre-enrollment eligibility verification only for applicants seeking to enroll in an Exchange plan under the loss-of-minimum-essential-coverage ("Loss of MEC") SEP; they were not permitted to conduct such pre-enrollment eligibility verification in conjunction with any other

category of SEP. *See* 45 C.F.R. § 155.420(g). Under the Rule, the FFE and SBE-FPs will instead be required to conduct pre-enrollment eligibility verification for other categories of SEPs as well (*e.g.*, permanent move, marriage, etc.), which is in line with the eligibility verification policy that was in place between 2017 and 2022 and set forth in the 2025 Marketplace Integrity and Affordability Rule. *See* 91 Fed. Reg. at 29,631. The Rule further requires the FFE and SBE-FPs to conduct pre-enrollment eligibility verification "for at least 75 percent of new enrollments" through SEPs. *Id.* at 29,631-32.[5] Unlike the 2025 iteration of this provision, it will not sunset. *Id.* at 29,631.

Plaintiffs argue that the Rule's changes to the eligibility verification procedures for SEP enrollment are arbitrary and capricious because, in their view, CMS "fail[ed] to consider obvious alternative actions" and its "chosen solution [was] unmoored from the problem it [sought] to address." Stay Motion at 25 (citations omitted). But CMS identified critical enrollment control vulnerabilities for SEPs, which this provision is specifically designed to address. In recent data analysis, CMS discovered a troubling pattern in which a disproportionate number of consumers enrolled through SEPs without verification requirements. *See* 91 Fed. Reg. at 29,632. After the Loss of MEC SEP's verification requirements resumed after the Covid-19 pandemic, consumers moved away from it in droves: previously, the Loss of MEC SEP accounted for 48% of all SEP enrollment, but it now only accounts for 27%. Similarly, other SEPs that did not require verification saw a remarkable surge in overall enrollments: the Permanent Move SEP ballooned from 1% of all SEP enrollments to 21%, and the Medicaid/CHIP denial SEP increased from 8% of all SEP enrollments to 24%. *Id.* While CMS acknowledges that consumers may qualify for multiple SEPs and are directed to the one that is most suitable for them, "the substantial shift

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

cannot be explained by that logic alone as these trends do not match any of [CMS's] historical SEP enrollment data." *Id.* This data corresponds with an earlier 2016 GAO study that identified enrollment control vulnerabilities in SEPs. *Id.* at 29,631 (citing GAO-17-18).

CMS also explained that any burdens imposed by these verification requirements would be minimal and justified. When CMS implemented a similar verification policy in 2017, it reviewed consumer-submitted documents within one to three days on average. *Id.* Over 90% of all applicants who were required to submit verification documents were successfully enrolled in SEPs. *Id.* Similarly for plan years through 2021, 73% of SEP applicants successfully submitted verification documents within 14 days of an SEP verification issue being generated, and 86% of all SEP applicants resolved their verification issue within 30 days of the issue being generated. *Id.*

Ultimately, these provisions improve verification to address apparent gamesmanship of SEP opportunities and enrollment control vulnerabilities while imposing minimal burdens. CMS's thorough explanation of its reasoning and the reasons for its ultimate decision put to rest Plaintiffs' contention that the agency's "chosen solution [was] unmoored from the problem it sought to address[.]" Stay Motion at 25. Though Plaintiffs "may disagree with" CMS's "policy balance," that by no means renders the requirements arbitrary or capricious. *Owner-Operator Indep. Drivers Ass'n v. Fed. Motor Carrier Safety Admin.*, 494 F.3d 188, 211 (D.C. Cir. 2007).

E. The Expansion of Design Options for Bronze Plans is Neither Unlawful nor Arbitrary and Capricious.

Plaintiffs challenge a provision of the Rule that provides some flexibility to insurers that choose to offer bronze plans on Exchanges. Specifically, when insurers offer at least one traditional bronze plan with the standard maximum out-out-pocket limit (MOOP), as calculated using the cost-sharing provision in 42 U.S.C. § 18022(c)(1), and that complies with the applicable levels of

coverage requirements, the Rule provides these insurers the option to also offer, within the same service area, individual market bronze plans with a MOOP of up to 130% of the standard MOOP, when doing so is needed to achieve the actuarial value of a bronze plan. If an insurer exercises this option, consumers get the benefit of being able to choose from a wider range of affordable plans within the bronze tier. Plaintiffs argue this regulatory provision is contrary to the ACA and is arbitrary and capricious. Stay Motion at 27. To the contrary, the rule harmonizes two competing ACA mandates in a manner that best effectuates congressional intent, and the preamble sets forth a reasoned explanation for CMS's regulatory approach.

The Rule addresses a problem that arises from competing ACA requirements on insurers to adhere to the cost-sharing limits described in 42 U.S.C. § 18022(c) and to meet the actuarial value (AV) levels of plans established by 42 U.S.C. § 18022(d)). Specifically, § 18022(c)(1) limits the annual cost sharing incurred under a health plan to the maximum annual limitation, which is calculated using a provided formula. Meanwhile, 42 U.S.C. § 18022(d) sets out four tiers of issuable plans, which are defined by their AV, which roughly means the percentage of total average costs for essential health benefits (EHB) costs that a given plan covers. As specified in 42 U.S.C. § 18022(d), a bronze plan generally must have an AV of 60%, while the AVs of silver, gold and platinum plans are set at 70%, 80%, and 90%, respectively. In turn, AV is calculated using the CMS AV Calculator, which comprises three interrelated components that have changed at different speeds: worsening health in the standard population increases EHB costs, which push the AV up, while increases to the MOOP limit pushes the AV down—but not enough to offset the other two components. 91 Fed. Reg. at 29,693-96; 42 U.S.C. § 18022(d)(2)(A).

As the Rule explains, CMS has assessed that the structural mismatch between how AV is calculated and the cost sharing formula set out in § 18022(c)(1) will eventually make compliant

bronze plans "mathematically impossible" to design. 91 Fed. Reg. 29,691. Indeed, CMS believes that traditional bronze plans are "barely still viable in 2027." *Id.* at 29,698. Furthermore, of the "metal plans," bronze plans are the most susceptible to AV increase because they have the lowest AV (60%), and the highest maximum annual limitation on cost sharing typically requires insurers to cover more than 60% of allowed claims. *Id.* at 29,695. As such, insurers have fewer options to adjust the cost sharing for bronze plans, compared to other metal level plans, and are increasingly designing "non-expanded" standard bronze plans with an AV below 62% to have a deductible near or equal to the maximum annual limitation on cost sharing, which risks collapsing the distinction between bronze and catastrophic plans (catastrophic plans offer no coverage, besides three primary care visits, before the MOOP limit is reached) and undermining the metal tier system set out in § 18022(d)(1). This reality also risks eliminating an important affordable coverage option for consumers. Because this actuarial problem will eventually impact the other metal plans (i.e., silver, gold, and platinum), the rule is an incremental step toward addressing the growing tension between the statutory mandates in §§ 18022(c)(1) and 18022(d). 91 Fed. Reg. 29,695-97. It does so by treating the specific requirement that a bronze plan must meet a 60% AV as the more specific statutory requirement because that requirement applies only to "a defined subset of plans in the individual and small groups markets," over the more general provision of the MOOP cap, which applies "broadly across all plan types and markets." *Id.* at 29,696 (noting that the Affordable Care Act's statutory language must be read in context and in light of the statute's structure and purpose) *see also id.* (explaining that statutes should be interpreted as a "'symmetrical and coherent regulatory scheme'' (citing *FDA v. Brown & Williamson Tobacco Corp.,* 529 U.S. 120, 133 (2000))). Consequently, under this provision, insurers are granted more flexibility in designing bronze plans, which keeps the bronze tier intact. And, because standard bronze plans are still

viable, albeit barely, in 2027, the rule's incremental approach allows insurers to offer higher-MOOP bronze plans *only* alongside at least one standard bronze plan in the same service area. *Id.* This regulatory approach honors congressional intent by preserving the distinctness of the metal plans, while improving consumer choice through a wider range of plan options, stabilizing risk pools by attracting healthier enrollees, and lowering premiums. As such, the Rule strikes a balance between actuarial reality and statutory fidelity and adopts an incremental and targeted approach to a technical problem that, at the regulatory level, CMS is uniquely qualified to address.

Plaintiffs nonetheless contend that CMS "ignores" that it could adjust the AV components in future years to address issues that may arise in the design of bronze plans. Stay Motion at 28. But CMS considered this approach, directly addressed it, and explained in the Rule why the possibility of continuing to adjust AV components as a way to keep bronze plans viable was not feasible. 91 Fed. Reg. at 29,694. In fact, after having identified this problem years ago, and in an effort to maintain bronze tier viability, CMS already modified the methodology by which insurers calculate AV. *Id.* However, as CMS explained, modifications made to ensure that plans at a certain metal tier remain viable "do not carry the level of fidelity to AV calculation that may be justified by generally accepted actuarial principles and methodologies." *Id.* at 29,694. And, as CMS determined, the agency has "reached a point at which further modifications would undermine the integrity of AV calculation" and would threaten the agency's ability to implement § 18022(d) "in such a compliant manner." *Id*.

Plaintiffs accuse CMS of being "insouciant about the negative effects of its policy on financially vulnerable consumers and their providers." Stay Motion at 28. To the contrary, CMS carefully considered and responded to comments concerning affordability, including concerns about potential higher out-of-pocket costs, increased medical debt, and increased uncompensated

care. 91 Fed. Reg. at 29,699. CMS stated that these concerns can be mitigated by consumers selecting a bronze plan with a standard annual limitation on cost sharing or selecting a plan offered at a different metal tier that offers more covered care. *Id.* at 29,700. Indeed, the Rule makes clear that higher-MOOP bronze plans do not displace traditional bronze plans and, instead, widen the range of options for consumers. *Id.* And, because higher-MOOP plans are expected to attract healthier consumers, the Rule is expected to stabilize risk pools and generally benefit consumers, especially unsubsidized or uninsured consumers, by lowering premiums. *Id.* Thus, Plaintiff's contention that "[CMS] does not have authority to permit private actors . . . to violate the clear terms of a statute, much less in a way that would increase negative outcomes for consumers" is doubly misplaced. Stay Motion at 29. CMS not only properly harmonized the statute's competing provisions, but did so to the benefit of consumers.

Finally, Plaintiffs challenge the reasonableness of the decision to impose the 130% cost-sharing limitation on higher-MOOP bronze plans, arguing that the agency principally relies on a similar 130% limitation for catastrophic plans as the basis for capping bronze plan cost-sharing at 130%. *Id.* Not so. While consistency with the catastrophic plan multiplication factor is one reason for setting the same limitation for bronze plans, there are additional, independent justifications. *Id*. For instance, CMS chose the specific 130% multiplier after considering lower multipliers but concluded that a lower ceiling "would not provide issuers with adequate flexibility to design bronze plans with meaningfully lower deductibles and more pre-deductible coverage." 91 Fed. Reg. at 29,700. Further, the 130% cap protects consumers by allowing insurers to shift cost-sharing structure in a way that is actuarially meaningful and enables lower deductibles without exposing consumers to unlimited or unconstrained out-of-pocket liability. *Id.*

Thus, while Plaintiffs may disagree with the agency's ultimate policy decision to allow insurers to offer higher-MOOP bronze plans in certain limited circumstances and, in the future, require issuers to offer catastrophic plans utilizing a higher MOOP limit than the metal tier plans are permitted, CMS nonetheless provided an explanation of its decision that included a rational connection between the facts found and the choice made. *See Ohio Valley Env't Coal.*, 556 F.3d at 192.

F. The Expansion of Eligibility for Catastrophic Coverage is Lawful and not Arbitrary and Capricious.

Plaintiffs also challenge a provision of the Rule that considers individuals who are ineligible for APTCs and Cost-Sharing Reductions (CSRs), due to projected household income below 100% or above 250% of the federal poverty line (FPL), to qualify for a hardship exemption that allows them to enroll in catastrophic coverage. This provision intends to improve access to affordable coverage options and offers a safety net to individuals against becoming uninsured. 91 Fed. Reg. at 29,635. Contrary to Plaintiffs' contentions, it fits squarely within CMS's broad discretion under 42 U.S.C. § 18031(d)(4)(H) to determine the scope of hardship exemptions, and the agency provided a thorough explanation for its chosen approach to combatting a market-wide affordability crisis.

This provision addresses the structural affordability barriers caused by sustained premium increases that have far outpaced income and wage growth. 91 Fed. Reg. at 29,634. From 2013 to 2025, average monthly premiums on the individual market jumped by 219%, with premiums increasing by 26% in 2026 alone. *Id.* at 29,634-35. As a result, consumers face serious financial challenges to obtaining coverage, especially if they do not qualify for financial assistance through APTCs and CSRs. *Id.* To address these challenges, the expanded hardship exemption provides a

pathway for a greater number of individuals who experience financial hardship, including those aged 30 and above, to qualify for a catastrophic plan. It does so by providing hardship exemption eligibility to individuals, regardless of age, whose projected annual household income makes them ineligible for APTCs or CSRs because their income falls either below 100% or above 250% of the FPL. These individuals become eligible to enroll in catastrophic plan coverage, although they are not required to do so. But if an individual chooses to take advantage of the hardship exemption to enroll in a catastrophic plan, the individual must first either attest to their projected household income when applying for coverage through the Exchange or submit an application attesting that they are no longer eligible for financial assistance. *Id.* at 29,636.

Plaintiffs claim this provision is a "broad, categorical, income-based, and automatic 'hardship' exemption'" that is incompatible with § 5000A(e)(5). Not so. Expansion of catastrophic plan eligibility via the hardship exemption is well grounded in the ACA and this application of the hardship authority does not threaten the integrity of the affordability exemption provision. Section 5000A(e)(5) of the Internal Revenue Code, which was added by § 1501(b) of the ACA, defines a hardship exemption as a situation in which an individual is determined by CMS to have suffered a hardship with respect to their capability to obtain coverage under a qualified health plan. 26 U.S.C. § 5000A(e)(5) and 42 U.S.C. § 18031(d)(4)(H). These statutory provisions grant broad authority to CMS to determine the nature and scope of qualifying hardships; they also provide a distinct and independent pathway from the affordability exemption in 26 U.S.C. § 5000A(e)(1). 91 Fed. Reg. at 29,635-36. Indeed, the ACA "does not establish a hierarchy between these two pathways, nor does it provide that the hardship pathway is constrained by the criteria Congress established for the separate affordability exemption." *Id.* The hardship provision instead grants CMS the authority to define the circumstances that constitute a qualifying hardship. *Id.*

Importantly, Congress did not enumerate or limit those circumstances, nor did it require that the hardship exemption be unavailable to individuals who also fail to qualify for the affordability exemption. *Id.*

The provision reflects the exercise of the CMS's broad discretion to determine that a projected household income either below 100% or above 250% FPL qualifies as a hardship for purposes of the exemption. And CMS fully explained its rationale for this provision. Individuals with a projected household income below 100% FPL are generally ineligible for APTC because they are assumed to be eligible for Medicaid; however, not all such individuals are actually eligible for or enrolled in Medicaid. For these individuals, "the hardship exemption under section 5000A(e)(5) addresses a distinct structural barrier—the gap between assumed and actual coverage access," which the affordability exemption framework would not resolve. *Id.* In contrast, individuals who make over 250% FPL are ineligible for CSRs, which would otherwise substantially reduce deductibles, copayments, and out-of-pocket maximums. Thus, even though plaintiffs dismiss the notion that individuals with income over 250% FPL should qualify for this type of coverage due to lack of need, CMS explains how such individuals may bear the full cost-sharing burden of metal-level plans that, as practical matter, renders coverage financially inaccessible. Stay Motion at 32; 91 Fed. Reg. at 29,636-37.

Plaintiffs also mischaracterize the Rule as establishing a categorical exemption. Even if the scope of the exemption is informed by income-related structural barriers, it nonetheless remains rooted in an individualized process for determining eligibility for exemptions that is consistent with the existing statutory and regulatory framework. Indeed, when applying for the hardship exemption, individuals are required to either attest to their income or attest they are no longer eligible for financial assistance. 91 Fed. Reg. at 29,636. The application process itself is inherently

individualized, and attestations of income reflect the individual circumstances of each individual applicant.

Plaintiffs further contend that CMS failed to sufficiently address comments about potentially negative consequences of eligibility expansion. These arguments all boil down to policy disagreements with the agency, which in no way render the provision arbitrary and capricious. *See Pub. Citizen, Inc. v. Nat'l Highway Traffic Safety Admin.*, 374 F.3d 1251, 1263 (D.C. Cir. 2004).

To start, Plaintiffs assert that CMS failed to provide evidence that increased access to catastrophic plans would increase *net* affordability of medical care for consumers compared to bronze plans, contending that this is an important aspect of the problem that was overlooked. Stay Motion at 36. But this argument misses the mark. The agency repeatedly acknowledged that catastrophic plans have "very high deductibles[,]" are intended as a safety-net against total uninsurance, and are "not . . . a preferred coverage option for individuals with serious illness, complex conditions, or ongoing health care needs." 91 Fed. Reg. at 29,635. Furthermore, the agency stated that "consumers who qualify for PTC or CSR should compare bronze and silver plans, as those plans may be a better value." *Id.* So, even if a particular bronze plan is a better value option for a particular consumer, a possibility the agency explicitly recognizes, it doesn't undercut the logic that more consumers should have access to catastrophic plans as a backstop to total uninsurance, especially in an environment with sustained premium increases that have far outpaced income and wage growth and at a time when consumers face serious financial challenges to obtaining coverage.

Next, Plaintiffs claim that expanded eligibility for catastrophic coverage risks creation of a parallel market that would compete with metal-level plans. Stay Motion at 36-37. But the

provision does no such thing. CMS designed the hardship exemption as a limited and individualized pathway for enrollees to obtain insurance coverage. For starters, catastrophic plans have been available in the individual market alongside metal-level plans for eligible consumers, so they hardly amount to a new or separate market. The provision adopted in the Rule similarly does not create a new, separate market—catastrophic plans remain part of the individual market. 91 Fed. Reg. at 29,634; 42 U.S.C. § 18022(e)(3); *see also* 45 C.F.R. § 156.155(a). Further, CMS data shows that expansion of access to catastrophic plans that resulted from its 2025 Guidance did not create a meaningful competitive distortion in the market. 91 Fed. Reg. at 29,634. While more consumers may qualify for the broader hardship exemption, they continue to be free to choose any individual market plan, including a non-catastrophic metal-level plan. Furthermore, catastrophic plans continue to remain part of the individual market for purposes of the single risk pool and premium rating, as well as the application of the federal market reforms, and no changes have been made to how catastrophic plans are risk-adjusted relative to metal plans. *See* 91 Fed. Reg. at 29,634-45. At bottom, Plaintiffs' complaints about the expansion of catastrophic coverage are mere policy disagreements, and they fall well short of showing that this provision exceeds the agency's broad authority or is arbitrary and capricious.

G. Changes to Network Adequacy Standards are not Arbitrary and Capricious

In the Rule, CMS defers reviews of provider access, or "network adequacy," to FFE states, including those performing plan management, provided the state elects to conduct such reviews, and demonstrates sufficient authority and technical capacity to conduct network adequacy reviews by satisfying the applicable criteria for having an Effective Provider Access Review Program under CMS regulations at 45 C.F.R. § 155.1050(d)(2)-(d)(4). 91 Fed. Reg. at 29,727. It similarly allows qualifying FFE states to conduct their own Essential Community Provider (ECP) certification

reviews when they satisfy the criteria for having an Effective ECP Review Program. 91 Fed. Reg. at 29,747. CMS also removed the quantitative time and distance requirements for in-network treatment and treatment access from plans offered on SBEs and SBE-FPs and permits SBEs and SBE-FPs to establish their own standards, if certain conditions are met, to meet the state's unique geography and healthcare needs. *Id.* at 29,645. Plaintiffs challenge as arbitrary and capricious CMS's decision to revert to a framework in which certain FFE states are permitted to conduct network adequacy reviews, including ECP reviews. Stay Motion at 39-40. These CMS decisions, however, readily pass muster under the deferential arbitrary-and-capricious standard because CMS provided a thorough explanation that includes a rational connection between the facts found and the choice made. *Jimenez-Cedillo v. Sessions*, 885 F.3d 292, 297-98 (4th Cir. 2018); *see also Prometheus*, 592 U.S. at 423. Agencies are also "free to change their existing policies as long as they provide a reasoned explanation for the change." *Encino Motorcars, LLC*, 579 U.S. at 221.

CMS exercised its authority under the ACA to re-establish a framework that defers review of network adequacy to states, when states elect to conduct such reviews and demonstrate they have sufficient authority and technical capacity to do so. 91 Fed. Reg. at 29,727. These reviews stem from the requirement that CMS establish, by regulation, "criteria for the certification of health plans as qualified health plans." 42 U.S.C. § 18031(c)(1). To receive certification, a plan must, among other requirements, "ensure a sufficient choice of providers" and "include within health insurance plan networks those essential community providers, where available, that serve predominately low-income, medically-underserved individuals;" in other words, plans must be certified for network adequacy. *Id.* § 18031(c)(1). Insurers submit network data for review, and certification of network adequacy is evaluated under the criteria set forth by CMS in 45 C.F.R. § 156.230 and § 156.235, as applicable.

The CMS policy of deferring review of network adequacy to states, when certain conditions are met, is not a new one. Indeed, CMS first deferred review of network adequacy of QHPs in its 2017 Market Stabilization Final Rule, which deferred review to states that possessed sufficient authority to enforce network adequacy standards that were at least equal to the reasonable access standard defined in CMS regulations and that had the means to assess the adequacy of plans' provider networks. 91 Fed. Reg. at 29,727; 82 Fed. Reg. at 18,346-47. This approach was adopted again in the 2019 Payment Notice. 91 Fed. Reg. at 29,727 (citing Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2019, 83 Fed. Reg. 16,930 (Apr. 17, 2018)). When some Plaintiffs here challenged the 2019 Payment Notice, this Court found that outsourcing network adequacy reviews to states was consistent with the ACA. *City of Columbus*, 523 F. Supp. at 750 (vacating the provision as arbitrary and capricious on grounds that the agency did not sufficiently respond to public comments). Similarly, removal of the federal minimum quantitative time and distance network standards for SBEs and SBE-FPs restores a pre-2025 policy. Patient Protection and Affordable Care Act, HHS Notice of Benefit and Payment Parameters for 2025; Updating Section 1332 Waiver Public Notice Procedures; Medicaid; Consumer Operated and Oriented Plan (CO-OP) Program; and Basic Health Program, 89 Fed. Reg. 26,218 (Apr. 15, 2024). Prior to the 2025 Payment Notice, the core requirement for SBEs and SBE-FPs was a qualitative "sufficient access" standard without a mandatory federal quantitative floor (such as specific time and distance metrics). *See*, *e.g.*, 87 Fed. Reg. at 27,208. As explained by CMS, this policy had been in place from the early years of the ACA through the 2024 Payment Notice.

Plaintiffs argue that CMS did not provide a detailed justification for its decision that states, rather than CMS, could conduct network adequacy reviews, and that the agency failed to provide

"any data of the sort it would have considered if it had considered [the issue] in any meaningful way." Stay Motion at 39 (quoting *Nat'l Treasury Emps.Union v. Horner*, 854 F.2d 490, 499 (D.C. Cir. 1988)). Not so. CMS explained that it conducted reviews of QHP issuer provider network adequacy and analyzed the data submitted by insurers from Plan Year 2023 to 2026. The agency was also informed by discussions with states, insurers and other stakeholders. Data and information gathered from these various sources demonstrated to CMS that "a one-size-fits all approach to provider network adequacy review is not satisfactory." 91 Fed. Reg. at 29,728. For instance, insurers reported persistent challenges locating and contracting with enough providers of various specialties in remote or difficult to access areas. *Id.* at 29,728-29. States also reported that "various geographic constraints" can impact an insurer's ability to satisfy time and distance requirements; in some cases, such as with bodies of water or mountainous terrain, these constraints are insurmountable. Furthermore, CMS highlighted the innovative abilities of states performing plan management to conduct network adequacy reviews in a manner responsive to the unique conditions and capacity in the state. For instance, CMS noted some states assess network adequacy based on access to service rather than provider types. Thus, the agency concluded that states "are often best positioned to evaluate local provider networks and market conditions and tailor adequacy standards in a more nuanced way" than federal requirements. *Id.* CMS similarly explained that states possess unique knowledge of local factors related to ECP reviews (such as market conditions, geographic constraints, areas in the state with limited economic resources, provider shortages, workforce issues, and population demographics) and assessed that states' knowledge of these unique factors could strengthen ECP certification review, which often involves identifying low-income areas and geographic areas with health professional shortages. *Id.* at 29,748.

Next, Plaintiffs argue that CMS did not adequately respond to comments expressing concern with the consequences of entrusting states to conduct network adequacy reviews, including states' supposed inability to perform these reviews, as well as the removal of FFE network adequacy standards as the minimum requirements for SBEs and SBE-FPs. Stay Motion at 39-40. But CMS did explain how the Rule's framework, which allows but does not require state review, provides consumer protections and backstops that would mitigate commenters' concerns.

As CMS explained, FFE states are not automatically given authority to conduct network adequacy or ECP reviews: a state must first elect to conduct reviews and then demonstrate that it has sufficient authority and technical capacity to do so, which requires a determination that the state has an effective program. 91 Fed. Reg. at 29, 535, 29,727-40. For instance, under the Effective Provider Access Review Program, a state must show sufficient legal authority (i.e., having standards in statute/regulations); technical capacity; measurable, enforceable standards consistent with certain federal standards (e.g., *id.* § 156.230(a)(1)(ii) and (iii)); and processes for compliance monitoring, data collection, and public reporting. *Id.* §§ 155.1050(d)(2)-(d)(4). Until a state makes this demonstration, CMS remains responsible for conducting these reviews. Similarly, CMS did not blindly restore network adequacy review authority back to the SBEs and SBE-FPs. Instead, these states will be required to ensure that each QHP applying for certification provides a sufficient choice of providers in a manner that meets applicable standards specified in § 156.230(a)(1)(ii) and (iii). 91 Fed. Reg. at 29,788.

Furthermore, as CMS explained, the agency will provide support to states that choose to conduct reviews. For instance, CMS will continue to collect and analyze various forms of network adequacy data, including time and distance and appointment wait time data, and make it available in a standardized format to effective program states, to assist them in their network adequacy

analysis. *Id.* at 29,732. CMS will also engage in other consumer protection activities, such as utilizing the collected data to research and address consumer or other complaints. *Id.* Also, consistent with routine practice, the agency will monitor implementation and may adjust these policies in the future in response to new data or information, as well as market dynamic changes.

Finally, contrary to Plaintiffs' assertions, CMS addressed commenter concerns regarding removal of the FFE network adequacy standards as the minimum requirements for SBEs and SBE-FPs and the agency's decision to rely on the standards set out in the Effective Provider Access Review Program. Plaintiffs point to comments regarding potential impact on rural communities and consumer access to specialty care, but the agency also addressed those concerns. *Id.* at 29,647-48. For instance, as CMS explained, states will be better positioned to proactively adapt their Exchange standards to meet specific market needs, which will enable them to better consider the needs of their enrollee population related to factors such as provider supply shortages and topography. *Id*. Accordingly, SBEs and SBE-FPs will be able to review local markets and tailor standards to better fit the specific needs of their population. This policy is thus reasonable and reasonably explained, and Plaintiffs' arbitrary and capricious challenge fails.

H. Eliminating Standardized Plans and Removing the Limits on Non-Standardized Plans is not Arbitrary and Capricious.

Finally, Plaintiffs challenge the Rule's discontinuation of the requirement that issuers in the FFE and SBE-FP offer standardized plan options, as well as the accompanying removal of the numerical limit on non-standardized plans offered by issuers and the related exceptions process. Plaintiffs contend that this provision is arbitrary and capricious because CMS did not provide a reasoned explanation for these policies. Stay Motion at 42-44. On the contrary, CMS provided detailed explanations that are rooted in empirical analysis.

Standardized plans were first introduced by CMS as an option for issuers in Plan Year 2017. The stated goal of offering "standardized options," which are plans with a specific design and cost-sharing structure designated by CMS, was to simplify the consumer shopping experience by making it easier to compare plans offered by different issuers within a metal tier. Then, CMS introduced the differential display of standardized options on HealthCare.gov in the 2018 Payment Notice, which allowed consumers to filter available plan options to differentiate the standardized options. Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2018; Amendments to Special Enrollment Periods and the Consumer Operated and Oriented Plan Program, 81 Fed. Reg. 94,058, 94,118 (Dec. 22, 2016). Standardized plan options were discontinued by the 2019 Payment Notice. 83 Fed. Reg. at 16,974-75. The policy change was challenged and, in 2021, another judge of this Court found the discontinuation of such plans to be arbitrary, faulting the agency for insufficiently explaining its view that standardized options hampered innovation. *City of Columbus II*, 523 F. Supp. 3d at 754. Following that decision in 2022, CMS reintroduced standardized plan options, again with the stated goal of enhancing consumer experience, increasing consumer understanding, simplifying plan selection process, and combating discriminatory benefit designs. 91 Fed. Reg. at 29,709 (citing Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2023, 87 Fed. Reg. 27,208, 27,313 (May 6, 2022) ("2023 Payment Notice")).

Since the re-introduction of standardized plan options, CMS has benefited from over four years of additional experience implementing the approach. *Id.* at 29,726. The agency is, thus, equipped with new information to evaluate and "weigh[] both the advantages and disadvantages of requiring FFE and SBE–FP QHP issuers to offer standardized plan options," and to assess "whether this strategy aligns with [the] originally articulated objectives with standardized plan

option policies, and whether this strategy has yielded the intended results." *Id*. at 29,711. After conducting a review of Plan Year (PY) 2023–2026 data, CMS concluded that the plan standardization polices have "failed to achieve the originally articulated objectives" set forth in the 2023 Payment Notice. *Id.* at 29,715.

Plaintiffs contend that the initially projected benefits of standardized options used to justify the original policy, show that this provision is arbitrary. Stay Motion at 42.

But the agency provided ample explanation for the discontinuation of a policy that proved "ineffective" at achieving the initially stated goals. 91 Fed. Reg. at 29,711. And it used data from Plan Years 2023–2026 to justify its decision. For instance, contrary to the policy's intended goals and projected benefits, CMS found that instituting standardized plan options did not, in fact, meaningfully reduce the number of plans and, thus, did not lessen consumer choice overload. Instead, looking at Plan Year 2023-2026 data, CMS found that plan proliferation (measured by the weighted average total number of plans offered per issuer) increased from 16.9 in Plan Year 2022 to 17.3 in Plan Year 2023. Similarly, CMS found that plan proliferation (measured by the weighted average total number of plans available per enrollee) increased from 108 in Plan Year 2022 to 114 in Plan Year 2023. *Id*. CMS also looked at data for Plan Years 2024 and 2025 and found that even layering more stringent requirements onto standardized plans, in the form of non-standardized plan option limits, did not meaningfully decrease the number of plan options "despite the substantially increased regulatory complexity" of this framework. *Id*. Indeed, in weighing the advantages and disadvantages of this policy, CMS decided that the marginal benefits did not "warrant imposing additional burden on issuers or impeding issuer innovation in plan design choice." *Id*. While Plaintiffs may disagree with this conclusion, the Court may not substitute its judgment for that of the agency. *Prometheus*, 592 U.S. at 423. CMS examined the relevant data and articulated a

rational explanation for its action, including a rational connection between the facts found and the choice made. *See Motor Vehicle Mfrs. Ass'n of the U.S., Inc. v. State Farm Mut. Auto. Ins. Co.,* 463 U.S. 29, 43 (1983).

Similarly, CMS discussed the policy's original goal of reducing decision complexity for consumers, which the standardized options requirement also did not accomplish. Indeed, rather than simplifying decision-making, the agency found that "in practice, [deciphering] whether a particular plan offering was a standardized or non-standardized plan option served as yet another variable that consumers" must navigate, "adding an additional layer of complication" to the plan selection process. 91 Fed. Reg. at 29,712. Furthermore, the agency found that "when consumers are faced with a large number of heterogeneous plan options, they continue to rely primarily on premiums, networks, and issuer brand" rather than on standardized cost sharing parameters, which "fail[] to meaningfully reduce decision complexity for consumers." *Id.*

As Plaintiffs note, CMS also pointed to the "comparatively low uptake of standardized plan options relative to corresponding non-standardized plan options." 91 Fed. Reg. at 29,715; Stay Motion at 43. As CMS explained, its data shows that only 20% of total enrollment in the FFE and SBE–FPs was in standardized plan options in Plan Year 2023, 33% in Plan Year 2024, and 33% in Plan Year 2025. *Id*. Plaintiffs criticize CMS for describing the numbers as "comparatively low," noting that 8 million individuals were enrolled in standardized plans last year. Stay Motion at 43. But CMS never suggested that the number of enrollees was, in absolute terms, low or insignificant—just that the number is low *compared* to the number of enrollees in non-standardized plans. Further, CMS considered the comparatively low number of enrollees against the disadvantages of continuing to require standardized options. 91 Fed. Reg. at 29,713. Here again, Plaintiffs may not agree with how the agency weighed competing factors, but the Court cannot

substitute its judgment for the agency's. *Prometheus*, 592 U.S. at 423. CMS examined the relevant data and articulated a satisfactory explanation for its action, including a rational connection between the facts found and the choice made. *See State Farm*, 463 U.S. at 43.

In a similar vein, Plaintiffs argue that CMS's failure to adopt a similar predetermined plan option prior to discontinuation of standardized plans shows unreasoned decision-making. Stay Motion at 43. But, while CMS considered specific alternatives, including those suggested by commenters, it explained why a prescriptive mandate is unnecessary to achieve the desired outcomes. For instance, CMS pointed to other approaches to simplifying the plan selection process that it believes are better suited, more effective and better support informed consumer choice, including enhancements to plan display, choice architecture, decision-support tools, and other forms of consumer assistance on HealthCare.gov. These less burdensome tools may simplify the plan selection process and address consumer choice overload without increasing burden on insurers, inhibiting innovation, constraining consumer choice, and disrupting the market. 91 Fed. Reg. at 29,720. Furthermore, as CMS explained, a one-size-fits-all prescriptive approach to standardized plans is not feasible, particularly given their "limited efficacy" as "there is a significant degree of heterogeneity on the FFEs and . . . it is impractical to design a standardized plan option offering that issuers must conform to regardless of the market dynamics in a given location." *Id*. at 29,712. Thus, given the agency's thorough explanation for its chosen regulatory approach, CMS carried its burden under the deferential arbitrary-and-capricious standard of review. *See FERC v. Elec. Power Supply Ass'n*, 577 U.S. 260, 292 (2016) (explaining that arbitrary-and-capricious review does not require a court ask whether a regulatory decision is the best one possible or even whether it is better than the alternatives).

Finally, Plaintiffs challenge as arbitrary the removal of limits on the number of non-standardized plans, claiming that CMS is "prioritize[ing] insurers' interests over the need to protect consumers." *Id*. To the contrary, CMS explained that, for the same reasons that applied to standardization plan options, non-standardization limits were largely ineffective at combatting plan proliferation or meaningfully differentiating plans, as exhibited by the number of enrollees in non-standardized plans compared to standardized plans. 91 Fed. Reg. at 29,722. And, as with standardization plan options, non-standardized plan limits yielded only marginal benefits of the sort identified by Plaintiffs while placing substantial burden on issuers and constraining the degree of consumer choice. In weighing the advantages and additional disadvantages of non-standardized plan limits, such as plan discontinuations, market disruptions and constrained innovation, the agency made a policy determination that the disadvantages of this discretionary policy outweighed the advantages. *Id*. at 29,723–26. Moreover, the decision to remove non-standardized plan limits does not signal the prioritization of insurer interests over consumers protections; to the contrary, CMS assessed that consumer protection was better addressed by enhancing choice architecture and plan display rather than through limits on non-standardized plans. *Id*. at 29,726–27. This choice, too, was both reasonable and reasonably explained, and readily survives arbitrary and capricious review.

IV. The Equities and Public Interest Weigh Against Preliminary Relief.

The balance-of-equities and public-interest considerations "merge when the Government is the opposing party," *Nken*, 556 U.S. at 435, and these factors weigh decidedly against extraordinary relief here. As explained above, Plaintiffs fail to clearly show that they will "imminent[ly]" suffer irreparable harm absent the stay they seek. *Mountain Valley Pipeline*, 915 F.3d at 216. Additionally, Plaintiffs' assertion that Defendants "cannot suffer harm from an

injunction that merely ends an unlawful practice," Stay Motion at 50 (citation omitted), is just a repackaged version of their unsuccessful merits arguments and cannot serve as an independent basis for relief. *Cf. Archdiocese of Wash. v. Wash. Metro. Area Transit Auth.*, 897 F.3d 314, 335 (D.C. Cir. 2018) ("[T]he strength of [the plaintiff's] showing on public interest rises and falls with the strength of its showing on likelihood of success on the merits."). That Plaintiffs' concerns about the Rule's potential impact on current Exchange enrollees do not clearly outweigh the Government's equally weighty concerns about the overall integrity of Exchanges and the public fisc only further tips the balance against granting preliminary relief. *See Real Time Med. Sys., Inc. v. PointClickCare Techs., Inc.*, 131 F.4th 205, 223 (4th Cir. 2025) ("*[P]laintiffs* bear the burden of demonstrating each of the four preliminary-injunction elements . . . ." (emphasis added)).

Meanwhile, staying the effective date of the Rule would hamstring Defendants' efforts to address legitimate concerns about improper enrollments in Exchange plans that are subsidized by taxpayers, as well as interfere with Defendants' lawful implementation of their policy priorities. Such "[j]udicial management of agency operations offends the Executive Branch's exclusive authority to enforce federal law." *Am. Fed'n. of Teachers v. Bessent*, No. 25-1282, 2025 WL 1023638, at *3 (4th Cir. Apr. 7, 2025) (Agee, J., concurring). And relatedly, when a law is stayed, "the inability to enforce its duly enacted plans clearly inflicts irreparable harm on" the government that enacted it. *Abbott v. Perez*, 585 U.S. 579, 602 n.17 (2018). Staying the Rule would inflict that very harm on the federal government here.

V. Any Relief Should Be Appropriately Limited.

For the reasons explained above, Plaintiffs are not entitled to the extraordinary preliminary relief they request. But in the event the Court were to conclude otherwise, any relief it grants should be appropriately limited, consistent with Article III and equitable constraints on the Court's

remedial authority.

As Plaintiffs agree, any relief should be limited to the challenged provisions of the Rule. *See* ECF No. 17-1. Any relief should therefore encompass only the offending portions of the Rule and leave the remainder intact. Further, any preliminary injunction or stay should be no broader than necessary to afford relief to those Plaintiffs who have established standing and irreparable harm. *See TransUnion*, 594 at 431 ("Article III does not give federal courts the power to order relief to any uninjured plaintiff . . . ."). Plaintiffs seek a stay under 5 U.S.C. § 705. By authorizing relief only "to the extent necessary to prevent irreparable injury" and "to preserve status or rights pending conclusion of the review proceedings," that provision explicitly incorporates traditional equitable principles. 5 U.S.C. § 705. And one such principle of "equity jurisprudence" is that any court-ordered relief "should be no more burdensome to the defendant than necessary to provide complete relief *to the plaintiffs*." *Califano v. Yamasaki*, 442 U.S. 682, 702 (1979) (emphasis added); *Starbucks Corp. v. McKinney*, 602 U.S. 339, 345 (2024) (explaining that "[w]hen Congress empowers courts" via statute "to grant equitable relief, there is a strong presumption that courts will exercise that authority in a manner consistent with traditional principles of equity"). Any preliminary relief granted to Plaintiffs here should accord with that clear command. *See Casa de Maryland*, 486 F. Supp. 3d at 971-72 (explaining that courts are "bound to draw . . . preliminary relief, even in the APA context, narrowly" and limiting a § 705 to the plaintiffs that had demonstrated standing).

VI. The Court Should Require Plaintiffs to Submit a Bond as Security.

Finally, to the extent the Court issues any preliminary injunctive relief, it should also order Plaintiffs to "give[] security in an amount that the [C]ourt considers proper to pay the costs and damages" that Defendants would sustain as a result. Fed. R. Civ. P. 65(c). As the Fourth Circuit

has directed, "[i]n fixing the amount of an injunction bond, the district court should be guided by the purpose underlying Rule 65(c), which is to provide a mechanism for reimbursing an enjoined party for harm it suffers as a result of an improvidently issued injunction or restraining order." *Hoechst Diafoil Co. v. Nan Ya Plastics Corp.*, 174 F.3d 411, 421 n.3 (4th Cir. 1999). "[I]njunction bonds are generally required," *Nat'l Treasury Emps. Union v. Trump*, No. 25-5157, 2025 WL 1441563, at *3 n.4 (D.C. Cir. May 16, 2025) (per curiam), and "[t]he amount of the bond . . . ordinarily depends on the gravity of the potential harm to the enjoined party." *Hoechst*, 174 F.3d at 421 n.3. Here, Plaintiffs are asking the Court to preliminarily stay a Rule that CMS estimates will reduce federal expenditures on APTCs by $15.7-$31.5 billion in the next five years. 91 Fed. Reg. at 29,856. Plaintiffs should therefore be required to post a bond that reflects the gravity of their demand.

CONCLUSION

For the forgoing reasons, the Court should deny Plaintiffs' Motion for Stay or Preliminary Injunction.

Dated: June 22, 2026

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