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

DEFENDANTS' SUPPLEMENTAL BRIEFING

INTRODUCTION

In response to the Court's request at the July 8 hearing, Defendants respectfully submit this supplemental brief addressing two issues: (1) The potential effect of the preliminary relief sought on individuals who have already enrolled in catastrophic coverage for 2026; and (2) the practical obstacles to directing CMS to develop a standardized plan for Plan Year 2027 at this juncture. For the reasons set forth below, the equities weigh against entering preliminary relief with respect to these provisions and, at a minimum, any such relief should be tailored to reduce burdens on consumers, insurers, and exchanges.

LEGAL STANDARD

"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). 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). The balance-of-equities and public-interest considerations "merge when the Government is the opposing party," *Nken v. Holder*, 556 U.S. 418, 435 (2009), and these factors weigh decidedly against extraordinary relief here. "In exercising their sound discretion, courts of equity should pay particular regard for the public consequences in employing the extraordinary remedy of injunction." *Winter v. Nat. Resources Def. Council, Inc.*, 555 U.S. 7, 24 (2008) (quoting *Weinberger v. Romero-Barcelo*, 456 U.S. 305, 312 (1982)).

ARGUMENT

I. If this Court were to stay the Rule's expansion of catastrophic coverage eligibility, it should appropriately limit such preliminary relief.

On September 4, 2025, CMS advised insurers and the public of a forthcoming expansion of catastrophic coverage eligibility. *See* Guidance on Hardship Exemptions for Individuals Ineligible for Advance Payment of the Premium Tax Credit or Cost-sharing Reductions Due to Income, and Streamlining Exemption Pathways to Coverage ("Guidance"), Ctrs. For Medicare & Medicaid Servs. (Sep. 4, 2025), https://perma.cc/NLQ8-TVT2. The Guidance explained that "consumers who are ineligible for [Advanced Premium Tax Credits ("APTCs")] or [cost-sharing reductions ("CSRs")] due to their projected annual household income being below 100 percent of the federal poverty level ("FPL") or above 250 percent of the FPL will be eligible for a hardship exemption and enrollment in catastrophic coverage." Guidance at 2. The Guidance further explained that "[s]tarting November 1, 2025, when the open enrollment period for plan year 2026 begins, CMS will begin streamlining the process to allow consumers to apply for a hardship exemption through the [Federal Exchange] for a catastrophic plan based on being ineligible for APTC or CSRs[.]" *Id.* at 3. The Guidance prompted some insurers to offer catastrophic coverage to the expanded eligibility pool ahead of the 2027 Payment Notice, and some consumers elected to enroll in that coverage for Plan Year 2026. Plaintiffs, however, did not challenge the Guidance until they brought this action in June 2026 challenging the 2027 Payment Notice. Plaintiffs delay further cuts against their claim for preliminary relief. *See Quince Orchard Valley Citizens Ass'n, Inc. v. Hodel,* 872 F.2d 75, 79-80 (4th Cir. 1989).

As of July 8, 2026, 20,025 consumers who were ineligible for APTCs, and thus eligible for catastrophic coverage under the revised hardship exemption, enrolled in a catastrophic plan between November 1, 2025, and January 15, 2026 in the Federal Exchange. Decl. of Jeff Wu ¶ 25

("Wu Dec."). This number does not include anyone enrolled in catastrophic coverage whose hardship exemption application was processed through CMS's eligibility support contractor, Serco..*Id*¡ Through Serco, CMS approved about 630 applications—which is inclusive of every hardship request, not just those due to ineligibility for APTCs—through the end of May.[1] *Id.*

If this Court were to stay the Rule's expansion of catastrophic coverage eligibility and deprive certain enrollees of their catastrophic coverage, it would impose significant burdens on the Government, insurers, and consumers: (1) CMS would be required to engage in significant coordination with insurers to remove consumers from their catastrophic coverage plans, and (2) CMS would be required to communicate with and educate consumers to properly re-enroll this population into other coverage. As catastrophic coverage is intended to be a backstop to total uninsurance, many of these consumers may not have the means to obtain coverage under another more expensive plan. Similarly, many of these consumers may have already made financial planning decisions based on their enrollment in catastrophic coverage. Consumers would likely also lose the benefit of any claims amounts accumulated against deductibles as they are forced to switch plans; to those consumers, any progress toward reaching their deductible would be forfeited. In short, retroactively removing these individuals from catastrophic coverage would impose a similar kind of administrative burden and barrier to coverage of which Plaintiffs complain and could seriously imperil consumers' financial health and economic stability.

Here, where the equities and public interest merge, *see Nken v. Holder*, 556 U.S. at 435*,* the Court must consider the impact a stay or other preliminary relief could impose on consumers who presently rely on catastrophic coverage, *see Winter*, 555 U.S. at 24; *Starbucks Corp. v. McKinney*, 602 U.S. 339, 345 (2024) (explaining that "[w]hen Congress empowers courts" via

[1] As of July 7, 2026, there are 25,864 people enrolled in catastrophic coverage on the Federal Exchange, inclusive of all eligibility groups for catastrophic coverage

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"). Accordingly, Defendants respectfully request should the Court stay this provision, it permit consumers currently enrolled in these plans to remain in them for the remainder of the 2026 plan year. This would allow consumers to participate in the standard open enrollment process without navigating a sudden, unexpected loss of coverage.

II. This Court should not grant preliminary relief for the Rule's changes to standardized and non-standardized plans.

The Rule's revisions to standardized and non-standardized plan requirements includes three separate but related policies that would be affected if this Court were to order a stay of this provision: (1) the requirement that each insurer offer standardized plan options, (2) the limit on the number of non-standardized plan options offered, and (3) the corresponding exceptions process for the limit on the number of non-standardized plan options offered.

A "standardized option" is a qualified health plan ("QHP") "offered for sale through an individual market Exchange that . . . has a standardized cost-sharing structure specified by HHS in rulemaking." 45 C.F.R. § 155.20; Wu Dec. ¶ 7. Each year, CMS specifies the cost-sharing structures in its annual Notice of Benefit Payment Parameters ("Payment Notice") to ensure the standardized plan option designs continue to meet their required actuarial value ("AV") and associated payment parameters. *Id.* ¶ 8. At minimum, this required CMS to modify the maximum out-of-pocket limit ("MOOP"), deductible values, and associated payment parameters each year. *Id.* In anticipation of the 2027 Payment Notice, CMS did not design standardized plan options or begin the process to do so. *Id.* ¶ 9.

At the Court's July 8 hearing, undersigned counsel explained the impracticability of

designing standardized plan options for Plan Year 2027. To begin, CMS cannot use a "template plan" from a previous year. *Id.* ¶ 10. Several standardized plan option designs that were finalized in the 2026 Payment Notice are no longer compliant with CMS's revised 2027 AV requirements when run through the 2027 AV Calculator. Notably, the Bronze, Silver (both the 73% and 94% cost-sharing reduction plans), and Platinum metal level standardized plans would not be AV compliant, due to AV inflation. *Id.* Accordingly, CMS could not use plan designs from Plan Year 2026 for Plan Year 2027 without extensive restructuring of the underlying cost-sharing parameters. *Id.* ¶ 11. This would be no small task. Typically, CMS would issue standardized plan designs in notice-and-comment rulemaking. It would be extremely difficult, if not impossible, to complete such rulemaking before Open Enrollment begins on November 1, 2026. And even if CMS were to bypass notice-and-comment rulemaking with an interim final rule, *see* 5 U.S.C. § 553(b)(B), such a rule would still take time to draft, clear, and become effective—likely significantly past the August 12, 2026, deadline for issuers to finalize their 2027 QHP data, Wu Dec. ¶ 11.

Further regulatory problems abound. Under the standardized plan option requirement, issuers on the Federal Exchange, as well as State Based Exchanges on the federal platform, are required to offer these plans at *every* product network type, *every* metal level, and throughout *every* service area where they offer non-standardized plan options. 45 C.F.R. § 156.201(b); Wu Dec. ¶ 12. Less than three in five[2] standardized plan options offered in PY26 were submitted for certification in Plan Year 2027, according to data submitted for the initial QHP certification deadline. *Id.* ¶ 17.

This is an onerous process for insurers. To submit a compliant standardized plan option, whether by modifying an existing standardized plan or submitting a new one, would require the

[2] Specifically, only 796 out of 1,349, or 59%, have been submitted for certification.

insurer to first design the plan and then actuarially price it. *Id.* ¶ 13. Designing a plan is a relatively straightforward process for insurers after CMS publishes its standardized designs; however, actuarially pricing a plan is not straightforward and involves substantial data analysis and prediction. Even still, insurers would need to submit their standardized plan options for review and approval by the relevant state regulators. *Id.* This state regulatory process began as early as February in some states and concluded in the spring, prior to submission to CMS. Only after state review and approval are plans submitted to CMS for review. *Id.* CMS has multiple deadlines in this complex review process: an early deadline, a secondary submission deadline, and a final deadline. *Id.* ¶ 14. The secondary submission deadline is next week, July 15, with the final deadline on August 12. *Id.* ¶ 15. At that point, insurers should be resubmitting plans with all corrections identified by CMS addressed, which is a critical phase of the approval process. Thus, even if a design rule could be promulgated instantly, there still would not be enough time for state and CMS processes to reliably conclude before Open Enrollment begins. This could lead some insurers to simply withdraw from the market for this year. *Id.* ¶ 18.

There are also a number of operational difficulties relating to the differential display of standardized plan options on *HealthCare.gov.* To distinguish standardized from non-standardized plan options, which is one of the principal reasons for standardized plan options' existence, CMS would need to require that each applicable insurer revise and resubmit all materials with the inclusion of any novel (formerly discontinued) plans. *Id.* ¶ 19. Insurers would need to do so without a number of validation tools specific to standardized plan option designs, which ensure accuracy that CMS did not publish this year. *Id.* Likewise, CMS would need to amend its operational planning and timelines with respect to the *Healthcare.gov* website to accommodate late plan date submissions. Similarly, certain CMS-authorized brokers and private entities who operate websites

separate from the *Healthcare.gov* platform, referred to as Enhanced Direct Enrollment partners ("EDE"), will also be unexpectedly required to differentially display standardized plan options in a manner similar to the *Healthcare.gov* platform. This would require EDEs to modify their systems to correctly identify plans, but they rely on CMS for this data. *Id.* ¶ 21 Thus, EDEs' systems would need to be modified to incorporate the Plan Year 2027 data from CMS's identification of standardized plan options, and EDEs would need to continue differentially displaying standardized plan options. *Id.*

With respect to the limit on non-standardized plan options, insurers were previously limited to two non-standardized plan options per product network type, metal level, inclusion of dental or vision benefit coverage, and service area. 45 C.F.R. § 156.202(b). Prior to the introduction of the two-plan limit, the weighted average number of plan offerings available per enrollee was 114 in Plan Year 2023, while the weighted average number of plans offered per issuer was 17.3 in Plan Year 2023. *Id.* ¶ 22. After the introduction of non-standardized plan option limits, these numbers decreased to 100 and 13.7, respectively. *Id.* Accordingly, if this Court required CMS to reinstate the non-standardized plan option limit, insurers would need to discontinue at least 12-to-21 percent of plans, upsetting their market segmentation strategies and depriving consumers of additional, innovative plans. *Id.* ¶ 23.

Lastly, chronic and high-cost condition plans offered through the non-standardized plan option limit exceptions process will face additional administrative hurdles prior to approval. With the discontinuation of the non-standardized plan option limit, insurers can offer these plans without submitting a justification and actuarial memorandum to CMS, which is part of the exceptions process. *Id.* ¶ 24. If this Court were to order a stay of the Rule's changes to standardized and non-

standardized plan requirements, insurers would be required to submit these materials for chronic and high-cost condition plans to be available. *Id.*

Accordingly, staying the Rule's changes to standardized and non-standardized plans would not only inappropriately tread on Executive Branch prerogatives, *see Am. Fed'n. of Teachers v. Bessent*, No. 25-1282, 2025 WL 1023638, at *3 (4th Cir. Apr. 7, 2025) (Agee, J., concurring) ("[j]udicial management of agency operations offends the Executive Branch's exclusive authority to enforce federal law."); *see also Abbott v. Perez*, 585 U.S. 579, 602 n.17 (2018), but as a practical matter would likely reduce the number of affordable plans available to consumers. To the extent that this Court does grant Plaintiffs' request for preliminary relief, it should not impose requirements on Defendants that would be impossible or grossly impracticable to comply with, *see Am. Hosp. Ass'n v. Price*, 867 F.3d 160 (D.C. Cir. 2017) ("In sum, it was an abuse of discretion to tailor the mandamus relief without tackling the Secretary's claims that lawful compliance would be impossible."), to the detriment of consumers.

CONCLUSION

For the forgoing reasons, the Court should deny Plaintiffs' Motion for Stay or Preliminary Injunction or limit such relief as the equities warrant.

Dated: July 9, 2026

Respectfully submitted,

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UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MARYLAND

CITY OF COLUMBUS, *et al.*, Plaintiffs, v. ROBERT F. KENNEDY, JR., in his official capacity as Secretary of the United States Department of Health and Human Services, *et al.*, Defendants.	Civil Action No. 1:26-cv-02215-BAH

DECLARATION OF JEFF WU

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

1. I am the Deputy Director for Policy at the Center for Consumer Information and Insurance Oversight ("CCIIO"), one of the centers within the Centers for Medicare & Medicaid Services ("CMS"), a component of HHS. CCIIO is charged with operating HealthCare.gov, including the Federally-facilitated Exchanges and certain State-based exchanges that use the federal HealthCare.gov infrastructure, as well as overseeing State-based Exchanges to ensure they comply with federal requirements. As part of that work, CCIIO is also responsible for administering consumer enrollment in qualified health plans (QHPs) offered through the Federally-facilitated Exchanges and State-based Exchanges on the federal platform, including eligibility for advance payment of the premium tax credit (APTC) and cost-sharing reductions

(CSRs) under the Patient Protection and Affordable Care Act ("ACA"). In addition, CCIIO enforces federal health insurance regulations covering the individual, small group, and fully-insured large group health insurance markets, and non-federal governmental plans.

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

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

4. My role at CCIIO encompasses policy matters pertaining to the recently promulgated final rule entitled "Patient Protection and Affordable Care Act, HHS Notice of Benefit and Payment Parameters for 2027; and Basic Health Program" 90 Fed. Reg. 27,526 (May 20, 2026) (the 2026 NBPP), which contains the policies disputed in *Columbus*.

5. I also understand that the District Court in this case has recently asked for briefing on the impact of issuing a preliminary injunction under 5 U.S.C. § 705, prohibiting CMS from implementing a number of provisions of the 2026 NBPP final rule pending a final ruling on the merits of the case. In particular, I understand that the Court asked for briefing on the potential impacts of a stay on policies related to standardized plan options, non-standardized plan option limits, and exceptions to the non-standardized plan option limits.

6. For the reasons detailed below, it would be impracticable for CMS to implement standardized plan requirements along the lines that petitioners seek.

Standardized Plan Options

7. 45 C.F.R. § 155.20 defines a "standardized option" as a "QHP [qualified health plan] offered through an individual market Exchange that …[h]as a standardized cost-sharing structure specified by HHS **in rulemaking**." (emphasis added).

8. When this policy was in place, HHS implemented it by specifying the precise cost-sharing structures it required in the various standardized plan options at each metal level and plan variation each year through notice and comment rulemaking in the Notice of Benefits and Payment Parameters (NBPP). These specifications were updated each year to ensure that the standardized options continue to satisfy the required actuarial value (AV) and associated payment parameters each plan year and to ensure that insurance companies were in fact implementing these structures in a consistent manner – the point of the policy.

9. However, this year, because the policy had been discontinued, HHS did not create or specify such plan designs in the 2027 NBPP. In order to develop new such plan designs for 2027, HHS would need additional time to collect and analyze the most common cost-sharing structures available in the market, and then subject them to actuarial value analysis. Promulgation of these plan designs through rulemaking would require many additional months as well.

10. It would be impracticable to attempt to use last year's plan designs as the standardized plans for this year. For example, several of the standardized plan options used in the 2026 NBPP have actuarial values that do not comply with 2027 rules under the current AV calculator. A plan's actuarial value is calculated pursuant to the actuarial methods specified in regulation at 45 C.F.R. § 156.135. Specifically, unless an exception applies pursuant to 45 C.F.R § 156.135(b), issuers must use an AV Calculator tool developed and made available by HHS for

a given benefit year to calculate a plan's actuarial value. In particular, the plan year (PY) 26 SPO plan designs for the the Bronze, Silver 73% CSR, Silver 94% CSR, and Platinum metal SPO would not be compliant with the 2027 calculator due to AV inflation.

11. Thus, in order to import plan year (PY) 26 plan designs into the PY 27 plan landscape, HHS would need to thoughtfully restructure the cost-sharing parameters for 2027. It would be very challenging to issue a new standardized plan requirement via either notice-and-comment rulemaking or an interim final rule in time for issuers to rely on it. Any such rule would only be drafted, cleared, and become effective well past the stated deadline.

Regulatory Approvals of Standardized Plan Options

12. 45 C.F.R. § 156.201(b) requires the Federally-facilitated Exchanges (FFE) and state-based Exchanges on the Federal Platform (SBE-FF) to offer standardized plans at "every product network type… at every metal level… throughout every service area where they offer non-standardized QHP options."

13. To submit a compliant standardized plan option (SPO), whether by modifying an existing SPO or submitting a new plan, an issuer must design a plan, actuarially price it, create provider networks and prescription drug formularies, and then submit it for review and approval by the state regulator. This process begins annually early in February in some states, and concludes in the spring.

14. Following state review and approval, plans need to be submitted to CMS for review. This review has a number of deadlines in a complex review process, consisting of an early submission, secondary submission, and final deadline.

15. The initial submission deadline was June 10, 2026. The secondary submission deadline is next week on July 12, 2026, and final submissions are due August 12, 2026. Open

enrollment begins on November 1, 2026.

16. Between an issuer's initial submission of a plan and the final deadline, CMS provides feedback on those plan designs, and issuers make corrections following back and forth discussions with CMS, all by the August 12 date. The August 12 deadline is in place so that CMS has sufficient time to do final reviews and analysis and ready the Healthcare.gov website in time for open enrollment beginning November 1. While CMS has been required to push this deadline back by a few weeks in the past, doing so raises significant risk of operational errors, which can lead to plans being blocked because data is not ready, or enrollments cancelled. Bringing a plan online late or after open enrollment has serious business consequences for the issuers of those plans because the large bulk of consumer enrollments occurs during open enrollment. Cancelling a plan that has been made available because of errors discovered later in the process leads to challenging communications and operational processes in which consumers must be informed of the cancellation (which can take extensive effort in some cases) and, sometimes through extensive manual work, enrolled in another plan.

17. Only 796 of the 1,349 (59 percent) standardized plan options offered for plan year 2026 were submitted for certification in plan year 2027.

18. Even if CMS promulgates a design rule instantly (which would also not be practically feasible), there would not be sufficient time for the state and CMS processes to reliably conclude before November 1, 2026. Some issuers might withdraw from the market rather than go through an abbreviated submission and certification process.

19. There are also significant operational difficulties with displaying SPOs on Healthcare.gov. To distinguish between SPOs and non SPOs, we would need to require each issuer to revise and resubmit detailed data templates for all of their plans. They would need to do

so without the benefit of validation tools that HHS typically publishes to ensure accuracy.

20. In addition, continuing SPOs would require CMS to maintain functions on Healthcare.gov to differentially display SPOs. CMS had not planned to maintain or continue this function, and re-initiating this work would likely require extensive operational planning as well as interruption of a number of other bodies of technical work – both maintenance and improvement – relating to healthcare.gov. Technical changes for a complex technical site like Healthcare.gov are planned many months in advance and require careful coordination of hundreds of staff and contractors.

21. Similarly, Enhanced Direct Enrollment Partners (EDE) must display SPOs in a different manner to distinguish them from non-SPE's. Changing this display on their platform would require them to modify their systems in order to correctly identify plans; and their systems would be required to incorporate the PY 2027 data from CMS.

Impact on Non-Standardized Plan Options Limits (NSPOL)

22. CMS previously limited issuers to two Non-Standardized Plan Options (NSPO) per "product network type…metal level…inclusion of adult dental benefit coverage, pediatric dental coverage, and adult vision benefit coverage…in any service area." 45 C.F.R. § 156.202(b). Prior to the introduction of this limit, the weighted average number of plan offerings per enrollee was 114 in PY2023, while the weighted average of plans offered per issuer was 17.3 in PY2023. After the introduction of the NSPO limits, the weighted average number of plan offerings per enrollee decreased to 100 and the weighted average number of plans offered per issuer was 17.3 in PY2025. 45 C.F.R. § 156.202(b).

23. If HHS is required to reinstate this limit, issuers would need to discontinue at least 12 to 21 percent of plans offered through the exchanges, which would significantly change many

issuers' strategic decisions around the number and types of products they are choosing to market.

24. With the discontinuation of the NSPOL requirement, issuers were able to offer chronic and high-cost condition plans that did not fit any required standardized plan option structure without being required to submit the justifications and actuarial memoranda which were previously part of the exceptions process. 45 C.F.R. § 156.202(e). However, if this Court stayed the discontinuation of the NSPOL requirements, issuers would have to submit the justificatios and memoranda. 45 C.F.R. § 156.202(e). Imposing such a requirement at this late stage would disrupt the marketplace for such plans.

Hardship Exemption Numbers

25. As of July 9, 2026, the date on which HHS has the most recent confirmed numbers, 20,025 consumers enrolled in a catastrophic plan in Federally-facilitated Exchanges, between November 1, 2025, and July 9, 2026, that were eligible for the exemption due to being ineligible for APTCs. These numbers do not include anyone enrolled in a catastrophic plan after being approved through for the exemption through our Eligibility Support Contractor, Serco due to being newly ineligible for CSRs, or anyone enrolled in a catastrophic plan in State-based Exchanges. HHS has only approved 630 total hardship requests (including those due to consumers being ineligible for APTC and CSRs) from January 16, 2026 through the end of May 2026. This number is inclusive of all consumers requesting a hardship exemption through our Eligibility Support Contractor, Serco, in Federally-facilitated Exchanges and State-based Exchanges, except for California, Connecticut, Maryland, or the District of Columbia.

I declare under penalty of perjury that the foregoing is true and correct to the best of my knowledge and belief. Executed this 9th day of July, 2026.

JEFFREY C. WU -S
Digitally signed by JEFFREY C. WU -S
Date: 2026.07.09 18:31:59 -04'00'

JEFF WU