IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MARYLAND

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

PLAINTIFFS' SUPPLEMENTAL BRIEF IN SUPPORT OF THEIR MOTION FOR PRELIMINARY RELIEF

INTRODUCTION

This Court has invited post-argument briefing from the parties with respect to two matters. First, Plaintiffs have sought a stay of provisions in a recent rulemaking by the Centers for Medicare & Medicaid Services (CMS), 91 Fed. Reg. 29,526 (May 20, 2026), that would expand eligibility for catastrophic plans, as well as of the agency's announcement of that expansion of eligibility in *Guidance on Hardship Exemptions for Individuals Ineligible for Advance Payment of the Premium Tax Credit or Cost-Sharing Reductions Due to Income* (Sept. 4, 2025), https://perma.cc/9QMD-RJH2 ("*Guidance on Hardship Exemptions*"). This Court has invited the parties to address whether a stay of the guidance would affect individuals who are currently enrolled in catastrophic coverage. For the reasons explained below, a stay would protect Plaintiffs from the higher costs and the burden of uncompensated care that would result next year in the absence of preliminary relief. A stay need not cause any current enrollees to lose their coverage, however. CMS may exercise its enforcement discretion to ensure that enrollees may remain in their current plans for the remainder of the calendar year, and it has exercised that discretion in similar circumstances in the past.

Second, under the agency's regulations that are currently in force, insurers are required to offer standardized plans on the Affordable Care Act's Exchanges and are subject to limits on the number of non-standardized plans that they may offer on the Exchanges. Plaintiffs seek a preliminary stay of the effective date of provisions in CMS's rulemaking that would rescind these requirements. This Court has invited the parties to address whether it would be feasible for the agency and for insurers to implement the regulations that are currently in force for the upcoming 2027 plan year. As will be explained below, it is feasible for both CMS and insurers to implement the existing requirements, and the equities weigh heavily in favor of an order requiring them to do so.

ARGUMENT

I. This Court Should Stay the Catastrophic-Plan Eligibility Provisions in the Rulemaking and in the Guidance

The Affordable Care Act (ACA) limits catastrophic plan enrollment to individuals under 30 years old or those who are certified as lacking access to affordable health coverage or as otherwise suffering a hardship. *See* 42 U.S.C. § 18022(e)(2); *see also* 26 U.S.C. § 5000A(e)(1), (5). CMS has long defined a qualifying hardship narrowly, requiring certain unexpected expenses or circumstances such as homelessness, domestic violence, bankruptcy, or a natural disaster. *See* 45 C.F.R. § 155.605. CMS's rulemaking would create a new "hardship" exemption for any individuals who attest that they project income below 100% or above 250% of the federal poverty level for the coming year. 91 Fed. Reg. at 29,633-45, 29,868 (adding 45 C.F.R. § 155.605(d)(1)(iv)). About 80% of all American adults under the age of 65 would be eligible for enrollment in a catastrophic plan under this exemption. *See* Jason Levitis et al. comment at 41 (Mar. 13, 2026), ECF 26-1 at 245.

The rule seeks to codify the agency's November 2025 guidance to the same effect. *See Guidance on Hardship Exemptions* at 2. Because the guidance was issued close to the end of last year, there was limited uptake among newly eligible enrollees for the current year. CMS estimates that about 20,000 individuals are currently enrolled in catastrophic plans who are eligible to do so because of the expansion of eligibility. Decl. of Jeffrey Wu ¶ 25, ECF 28-1. In contrast, if the rulemaking were to go into effect (or if the guidance were permitted to remain in effect) to govern 2027 enrollments, the Council of Economic Advisers calculates that about 3 million people will shift to this form of coverage. *See* Levitis comment at 43, ECF 26-1 at 247. The result would be increased costs for enrollees in metal-level coverage and an increased burden of uncompensated care for safety net providers. *See id.* at 43-44, ECF 26-1 at 247-48. Both the rulemaking and the

guidance should be stayed to ensure that CMS may not rely on either document to authorize the expansion of catastrophic plan eligibility for the 2027 plan year.

A stay need not affect individuals who are currently enrolled in catastrophic coverage, however. CMS may exercise its enforcement discretion to declare, for current enrollees, that it would not enforce the relevant provisions of the ACA or the Public Health Service Act against insurers for any actions taken in good faith reliance on the guidance before the date of any order from this Court. Such an announcement would prohibit insurers from accepting new enrollees in catastrophic plans who would be eligible for enrollment only under the guidance, or from renewing catastrophic coverage for these enrollees, but would ensure that current enrollees may retain their coverage for the remainder of the year.

CMS has exercised its enforcement discretion under similar circumstances in the past. In 2019, a federal district court vacated a Department of Labor rule that was "designed to end run the requirements of the ACA" by unlawfully expanding the category of plans that were exempt from certain ACA coverage requirements. *New York v. U.S. Dep't of Lab.*, 363 F. Supp. 3d 109, 141 (D.D.C. 2019). In response to the district court's order, CMS, together with the Department of Labor, announced that both agencies would exercise their enforcement discretion to ensure that enrollees in the unlawful plans could remain in that coverage for the remainder of the plan year. *See* U.S. Dep't of Labor, News Release, U.S. Department of Labor Statement Relating to the U.S. District Court Ruling in State of New York v. United States Department of Labor (Apr. 29, 2019), https://perma.cc/JM77-E26A; *see also* Katie Keith, *DOL Issues Additional Guidance on AHPs*, Health Affairs Forefront (May 15, 2019), https://perma.cc/634G-QL6M. A similarly time-limited announcement by CMS would be appropriate in this case to clarify that current enrollees may retain their coverage for the remainder of this year. (Any attempt by the agency to expand eligibility for catastrophic coverage for 2027 or future years under the guise of "enforcement

discretion," however, would be unlawful for the same reasons that the rule's provisions and the 2025 guidance are unlawful. *See* Pls.' Mem. in Supp of Mot. for Stay at 30-38, ECF 17-1.)

Current enrollees in catastrophic coverage would also be eligible to re-enroll in metal-level coverage under a special enrollment period. CMS's current regulations allow for a special enrollment period in cases where an individual has enrolled in a plan as "the result of the error, misrepresentation, misconduct, or inaction" of CMS or an Exchange. 45 C.F.R. § 155.420(d)(4). The regulations also permit a special enrollment period in "other exceptional circumstances as the Exchange may provide." *Id.* § 155.420(d)(9). A stay of the guidance would establish that CMS had committed an error in permitting enrollment in the catastrophic plan, thereby triggering one or both special enrollment periods. As a result, given CMS's ability to exercise targeted enforcement discretion and the availability of special enrollment periods, current enrollees would have the option to retain their current plan or to re-enroll in more generous coverage.

II. This Court Should Stay the Rulemaking's Rescission of Requirements for Standardized Plans and Non-Standardized Plans

Under CMS's regulations that are currently in effect, an insurer that participates in the federally facilitated Exchange (FFE) must offer at least one standardized plan option at every product network type, at every metal level (except the nonexpanded bronze metal level), and throughout every service area that it offers a non-standardized plan. 45 C.F.R. § 156.201(b). Issuers may offer more than one standardized plan option within the product network type, metal level, and service area, but if they do, they must ensure the plans meaningfully differ from one another. *Id*. § 156.201(c). Current regulations also impose limits on the number of "non-standardized" plans that issuers may offer on the FFE. *Id*. § 156.202(b). CMS's rulemaking would rescind these requirements, thereby permitting insurers to forgo offering standardized plans, and revoking any limitations on the number of non-standardized plans that insurers may offer. 91 Fed.

Reg. at 29,708-27. The rescission of these requirements would make the enrollment process more confusing for many enrollees, leading many individuals to enroll in less comprehensive coverage that does not meet their needs or to drop out of coverage altogether. *See* Levitis comment at 35-36, ECF 26-1 at 239-40; *see also* Community Catalyst comment at 8 (Mar. 13, 2026), ECF 26-1 at 163. The rescission of these requirements should be stayed to protect enrollees from the higher costs that would result from a degradation of the risk pool and to avoid imposing greater costs of uncompensated care on safety net providers.

CMS contends that it has not prepared for the possibility that standardized plans would be required for the 2027 plan year, and that it would face difficulties if it were to begin those preparations now. If the agency would face any difficulty in complying with an order of this Court staying the rescission of the standardized plan rules, that would be a problem of the agency's own devising. Ordinarily, CMS announces its policies for the Exchanges through annual rulemakings, which are typically completed before insurers are required to submit their plan designs to state regulators. *See* Cong. Res. Serv., *Health Insurance Exchanges and Qualified Health Plans: Overview and Policy Updates* 57-58 (May 6, 2025), https://perma.cc/TN72-L7XX. This year, however, CMS issued a proposed rule in February (including a proposal to rescind the standardized plan rules), while the annual rate-setting cycle had already begun, *see* Wu Decl. ¶ 13, and issued its final rule in May, while that cycle was well underway. In the meantime, the agency should have prepared for the possibility that commenters would persuade it to retain the standardized plan rules, or at least to delay their rescission for a year or more. (That the agency now asserts it did not do so provides an independent ground for a stay, given that the APA forbids an agency from approaching a rulemaking with an unalterably closed mind. *See Kravitz v. Dep't of Com.*, 366 F. Supp. 3d 681, 750 (D. Md. 2019).)

Equity requires clean hands, after all, and the balance of the equities weighs heavily in favor of providing relief to Plaintiffs (who moved as promptly as possible to seek relief after the final rule was published), and heavily against permitting CMS to insulate its rule from judicial review simply by delaying its issuance and failing to engage in any contingency planning. *See Novartis Consumer Health, Inc. v. Johnson & Johnson-Merck Consumer Pharms. Co.*, 290 F.3d 578, 596 (3d Cir. 2002) (weighing "the fact that the defendant brought that injury upon itself" in balancing the equities); *see also Di Biase v. SPX Corp.*, 872 F.3d 224, 235 (4th Cir. 2017); *Ramirez v. U.S. Immigr. & Customs Enf't*, 568 F. Supp. 3d 10, 34 (D.D.C. 2021).

In any event, CMS is incorrect in claiming that it would be impossible for it to implement the regulations that are currently in force. Its assertion on this score seems to turn on its claim that CMS would be required to begin a new rulemaking process to designate standardized plans for the 2027 plan year. *See* Wu Decl. ¶ 7. This is not so. CMS's regulations specify that a standardized plan must have either "a standardized cost-sharing structure specified by HHS in rulemaking," or such a structure "that is modified only to the extent necessary" to align with Internal Revenue Code requirements or with "the applicable annual limitation on cost sharing and HHS actuarial value requirements." 45 C.F.R. § 155.20. CMS has already specified the cost-sharing structure for standardized plans through rulemaking. *See, e.g.*, 90 Fed. Reg. 4424, 4494 tbl. 1 (Jan. 15, 2025) (specifying parameters for 2026 standardized plans); *see also id.* at 4493 (clarifying that CMS made "minor updates" to standardized plan options from the previous year because "maintaining a high degree of continuity will reduce the risk of disruption for all involved interested parties"). The only modifications to this structure that the agency claims would be required are updates to account for cost sharing and actuarial value requirements. *See* Wu Decl. ¶¶ 9-11. Under 45 C.F.R. § 155.20, these updates may be announced through sub-regulatory guidance.

It would be a relatively straightforward task for CMS to perform these updates through the use of its AV Calculator, and the agency could complete and publish most of the required updates within a matter of days, and all of the required updates within several weeks. *See* Decl. of Jeffrey Grant ¶¶ 20. This would leave the agency sufficient time to permit insurers to revise their plan offerings and to submit plans for final approval well in advance of the commencement of the open enrollment period on November 1. Indeed, CMS has succeeded in permitting late-arising adjustments to plan offerings, either in response to a judicial ruling or a change in Executive Branch policy, over schedules that were much more compressed than what would be needed here. *See id.* ¶¶ 10-17 (providing three examples where "CMS, issuers, and states were able to offer guidance, adapt timelines, and adjust plan pricing ahead of the open enrollment period" with "far less time ahead of the open enrollment period than stakeholders have now to respond to any ruling from this Court.").

CMS asserts that it would be difficult for it to design software that would permit it to display standardized plans more prominently on Exchange websites, as is required under the standardized plan rules that are currently in force. *See* Wu Decl. ¶ 20. But the FFE *already* provides for that differential display, and it would not be a particularly complicated task for the agency to maintain the software that is currently in use to permit the same format of plan displays to continue for next year's offerings. Even in the absence of relief from this Court, that software would need to remain in place even after the commencement of the next open enrollment period on November 1 in order to support enrollments under special enrollment periods in the current year's standardized plan offerings. *See* Grant Decl. ¶ 31.

The agency also speculates that it would be difficult for insurers to prepare standardized plans afresh this late in the annual rate-setting cycle. *See* Wu Decl. ¶ 16. But the agency concedes that about 59% of last year's standardized plans have already been submitted for regulatory

approval. *See id.* ¶ 17. And insurers almost certainly had been preparing, at least up until May, for the possibility that the standardized plan rules would not be rescinded (or that their rescission would be delayed). If the standardized plan rules remain in place, insurers would not need to design new plans in order to comply with the requirement to offer standardized plans; they would only need to determine how to price their standardized plan offerings, and they almost certainly could so quickly. *See* Grant Decl. ¶¶ 24-26. And there is no reason to believe that insurers would drop out of the market if the standardized plan requirements, which have been in effect since the 2023 plan year, were to continue in force. *See id.* ¶¶ 9, 36.

At all events, CMS offers no justification for lifting the limit on the number of non-standardized plan offerings. The agency asserts that insurers may need to revisit "strategic decisions" regarding the pricing of the plans that are offered in a market where the number of plan offerings is capped. *See* Wu Decl. ¶ 23. But those calculations can be readily performed, and, as noted, insurers almost certainly have already engaged in contingency planning for the possibility that the limits on non-standardized plan offerings would remain in effect. *See* Grant Decl. ¶ 35. While insurers may need to submit actuarial memoranda to seek exceptions to offer certain types of plans, *see* Wu Decl. ¶ 24, those insurers would be aware that those memoranda are required under the regulations that are currently in force, and there is no reason to believe that insurers would find it particularly burdensome to comply with those existing rules. *See* Grant Decl. ¶ 35.

In sum, CMS's claim of impossibility rests on its misapprehension that a new round of notice-and-comment rulemaking would be required to retain standardized plan options for 2027. *See Am. Hosp. Ass'n v. Price*, 867 F.3d 160, 168 (D.C. Cir. 2017) (noting that the government bears a heavy burden to demonstrate the existence of impossibility that is not met by showing "mere difficulty or inconvenience"). No such rulemaking is required, and it is feasible for the agency and for insurers to perform the work necessary to ensure compliance with existing law for

the coming plan year. That task may occur over a shorter timeline than would have been the case if CMS had made appropriate plans to comply with its existing rules at the start of this year, but that is a problem of the agency's own creation, and cannot weigh against equitable relief.

CONCLUSION

For these reasons, the Court should grant Plaintiffs' motion for preliminary relief, including Plaintiffs' requests to stay the revisions by rulemaking and guidance to rule governing catastrophic plan eligibility and to stay the rescission of the rules currently in effect governing the requirements to offer standardized plans and the limits on non-standardized plan offerings.

Dated: July 13, 2026

Respectfully submitted,

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DECLARATION OF JEFFREY GRANT

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

1. The facts contained in this declaration are known to me personally and, if called as a witness, I could and would testify competently thereto under oath. I submit this sworn declaration in support of Plaintiffs' motion for preliminary relief with respect to certain provisions in the 2027 Notice of Benefit and Payment Parameters Final Rule (Final Rule).

2. I am Founder and President of Schedule F Healthcare Strategies. Before March of 2025, I spent nearly thirty years as a career employee at the Centers for Medicare and Medicaid Services (CMS), including almost fifteen in senior roles at the Center on Consumer Information and Insurance Oversight (CCIIO), which oversees Affordable Care Act (ACA) policy and runs the federal Marketplace. I served as acting Director of CCIIO for six months and as Deputy Director for Operations for seven and a half years, and before that served in senior policy positions. My full curriculum vitae, including a list of publications, appears as an Appendix to this declaration.

Summary of Observations

3. It is feasible for the government, health insurance issuers, and state regulators to take the necessary steps to have the standardized plan provisions in effect in plan year 2027 without undue risk of disruption.

4. Indeed, CMS under President Trump has implemented similar late-breaking federal rule changes at least twice, including last year, without serious disruptions.

5. Consumers will face disruption and more difficulty comparing plan options if standardized plans and related rules are not restored. The loss of standardized plan options will lead confused consumers to be more likely to select a plan that does not provide the coverage they need, or to drop out of the enrollment process altogether.

It is Feasible for Plans to Comply with Standardized Plan and Related Rules for Plan Year 2027, Suggesting Little Risk of Serious Disruption.

6. In my view it is feasible for CMS, states, and issuers to work together over the next several months to take the steps necessary to have standardized plan rules in effect in Plan Year 2027. Doing so is critical to, first, ensure continuity for millions of consumers who enrolled in standardized plans and, second, make it easier for all consumers to more easily compare plans across issuers.

7. To maintain standardized plan requirements, CMS must communicate to issuers the parameters for standardized options; re-incorporate into the qualified health plan (QHP) certification process procedures for ensuring QHP issuers are satisfying requirements related to offering standardized and non-standardized plans; and continue providing preferential display of standardized options through the Federally-facilitated Exchange, as well as direct enrollment pathways.

8. It is critical to note that not all plans will require changes: issuers will only be required to offer standardized plans where they have not already opted to do so. According to CMS, issuers have already submitted 59% of standardized plan options from plan year 2026 for certification for plan year 2027. And CMS acknowledges that designing a standardized plan "is a relatively straightforward process for insurers" so long as issuers have the requisite guidance from CMS. Defendants' Supplemental Briefing at 6.

9. I am not aware of any issuer that has suggested that it would leave the Marketplace due to a requirement to resume offering standardized plans and limits on non-standardized plans. Issuers generally notify state and federal regulators of these actions far in advance to minimize disruption and do not proceed with the QHP certification process if they intend not to offer coverage, so any issuer that intends to withdraw from the Marketplace would have likely announced any such plans by now. Insurers are sophisticated participants in this market, and they almost certainly would have been preparing throughout the first half of this year for multiple contingencies, including the possibility that CMS would not finalize its proposal to rescind the standardized plan requirements. It is not plausible to believe that insurers would now respond to the reinstatement of those requirements by dropping out of the market.

Experience with Similar Late-Breaking Policy Changes Shows No Serious Disruption Occurred

10. CMS, issuers, and states have a long history of working together to respond to late-breaking developments with the potential for disruption to the Marketplaces. In doing so, federal and state regulators have repeatedly permitted issuers to adjust plan offerings and have avoided serious disruptions for consumers. This has been the case even where CMS has raised concerns about severe market disruption and issuer withdrawal, concerns that have proved unfounded.

11. For example, on October 12, 2017, federal officials announced that they would no longer reimburse issuers for cost-sharing reduction (CSR) payments,[1] a decision expected to cut payments to issuers by $7 billion.[2] This change was expected to "roil individual markets"[3] and was characterized as "a dramatic move"[4] and an "Obamacare bombshell."[5] On October 13, President Trump himself asserted that "Obamacare is imploding" after CSR payments were stopped.[6]

12. The announcement came after that year's deadline of September 27 for issuers to finalize their Marketplace plan offerings for 2018.[7] Despite much-anticipated disruption to the Marketplaces, these dramatic consequences did not come to pass.

13. Instead, issuers, CMS, and states worked together to quickly revise filings and update premiums in response to the announcement. Federal and state officials offered flexibility so issuers could make changes not previously contemplated under the prior certification timeline.

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[1] U.S. Dep't of Health & Hum. Servs., Memorandum on Discontinuance of Cost-Sharing Reduction Payments (Oct. 12, 2017), https://www.hhs.gov/sites/default/files/csr-payment-memo.pdf.

[2] Alison Kodjak, Halt in Subsidies for Health Insurers Expected to Drive Up Costs for Middle Class, NPR (Oct. 13, 2017), https://www.npr.org/sections/health-shots/2017/10/13/557541856/halt-in-subsidies-for-health-insurersexpected-to-drive-up-costs-for-middle-clas.

[3] Timothy Jost, Administration's Ending of Cost-Sharing Reduction Payments Likely to Roil Individual Markets, Health Affairs Forefront (Oct. 13, 2017), https://www.healthaffairs.org/do/10.1377/forefront.20171022.459832/

[4] Kevin Liptak, Tami Luhby & Phil Mattingly, CNN, Trump Will End Health Care Cost-Sharing Subsidies (Oct. 12, 2017), https://www.cnn.com/2017/10/12/politics/obamacare-subsidies

[5] Dan Mangan, Obamacare Bombshell: Trump Kills Key Payments to Health Insurers, CNBC (Oct. 12, 2017), https://www.cnbc.com/2017/10/12/obamacare-bombshell-trump-kills-key-payments-to-health-insurers.html

[6] Kevin Liptak, Tami Luhby and Phil Mattingly, CNN, Trump Will End Health Care Cost-Sharing Subsidies (Oct. 12, 2017), https://www.cnn.com/2017/10/12/politics/obamacare-subsidies

[7] Rabah Kamal, Ashley Semanskee, Michelle Long, Gary Claxton & Larry Levitt, How the Loss of Cost-Sharing Subsidy Payments Is Affecting 2018 Premiums, KFF (Oct. 27, 2017), https://www.kff.org/private-insurance/issuebrief/how-the-loss-of-cost-sharing-subsidy-payments-is-affecting-2018-premiums/

This effort was successful: issuers made the necessary changes by late October,[8] and open enrollment began on November 1, 2017 as planned. All of this careful work by dedicated staff at CMS, state insurance regulators, and issuers took place within the 19 days following the Trump administration's announcement. I am not aware of any issuers that stopped offering metal level Marketplace coverage as a result of these events. As has been the case of Marketplace operations in every year before and since, every county was served by at least one Marketplace issuer in 2018.

14. More recently, CMS implemented two policy changes in late 2025 year that required refilings for 2026 plans after the normal timing. First, on September 5, 2025,[9] CMS issued guidance that allowed issuers to revise their QHP applications and rates to comply with this Court's stay of rulemaking provisions that would have expanded the range of permissible so-called "*de minimis*" variations in actuarial values of plans on the Exchanges in *City of Columbus v. Kennedy*. Specifically, CMS allowed issuers to revise plan deductibles, cost-sharing, and premiums to be consistent with narrower *de minimis* ranges. CMS predicted dire consequences from the Court's stay, suggesting that about 80 percent of plans would need to be revised[10] and "a sudden and severe disruption to the Exchange marketplace [that] could have a devastating effect on the availability of Exchange coverage."[11] These "devastating effect[s]" did not come to pass, and the open enrollment plan began as planned on November 1, 2025.

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[8] Rabah Kamal, Ashley Semanskee, Michelle Long, Gary Claxton & Larry Levitt, How the Loss of Cost-Sharing Subsidy Payments Is Affecting 2018 Premiums, KFF (Oct. 27, 2017), https://www.kff.org/private-insurance/issuebrief/how-the-loss-of-cost-sharing-subsidy-payments-is-affecting-2018-premiums/

[9] https://www.cms.gov/files/document/qhp-certification-updates.pdf-0

[10] Declaration of Jeff Wu at 24. City-of-Columbus_2025.08.29._DEFENDANTS-MOTION-AND-MEMORANDUM-FOR-STAY-PENDING-APPEAL.pdf

[11] Defendants' Motion for a Stay Pending Appeal, https://litigationtracker.law.georgetown.edu/wp-content/uploads/2025/07/City-of-Columbus_2025.08.29._DEFENDANTS-MOTION-AND-MEMORANDUM-FOR-STAY-PENDING-APPEAL.pdf

15. Second, on September 4, 2025, CMS issued guidance that expanded eligibility for catastrophic plans in 2026 in all but four states; this guidance and its codification have been challenged by the Plaintiffs in this case.[12] By allowing many more people to newly qualify for catastrophic coverage, CMS's new guidance significantly altered issuer expectations about who might enroll in catastrophic coverage (versus metal level coverage). On September 23, 2025, CMS allowed issuers to revise and refile their rates to account for this new policy, with a deadline of October 1, 2025.[13]

16. In all of these instances, CMS, issuers, and states were able to offer guidance, adapt timelines, and adjust plan pricing ahead of the open enrollment period. These changes did not result in meaningful disruption for consumers or undue costs to CMS.

17. These experiences demonstrate that it will be feasible for CMS, issuers, and states to offer and price standardized plans and to comply with related provisions before this year's open enrollment period. In all three instances described above, these actions were taken with far less time ahead of the open enrollment period than stakeholders have now to respond to any ruling from this Court.

CMS Can Rely on Prior Parameters for Standardized Plans with Minimal Adjustments

18. Under CMS regulations, a standardized option includes a QHP that "has a standardized cost-sharing structure specified by HHS in rulemaking that is modified only to the extent necessary to align with high deductible health plan requirements under section 223 of the Internal Revenue Code of 1986, as amended, or the applicable annual limitation on cost sharing and HHS actuarial value requirements."

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[12] https://www.cms.gov/files/document/guidance-hardship-exemptions.pdf
[13] https://www.cms.gov/files/document/additional-guidance-qualified-health-plan-certification-city-columbus-v-kennedy.pdf

19. Contrary to the assertion in Jeffrey Wu's Declaration, CMS does not have to collect and analyze the most common cost-sharing structures available in the market to develop standardized plan designs. While this might be a best practice that the agency has sometimes used in prior years to inform revisions to standardized options, this step is not required by statute or regulation. As noted below, CMS has performed annual updates to standardized plan parameters without doing an updated market analysis.

20. In my view, it would be both feasible and sound policy to utilize the standardized plan designs for 2026 to serve as the basis for standardized plan designs for plan year 2027. Consistent with existing regulations, CMS would modify the 2026 designs only to the extent necessary to align with high deductible health plan requirements under section 223 of the Internal Revenue Code of 1986, as amended, or the applicable annual limitation on cost sharing and HHS actuarial value requirements, and then make any necessary cost-sharing adjustments to align the plans with the appropriate actuarial values. These updates would be straightforward for CCIIO to make using the AV calculator, and the agency could perform most of these updates within a matter of days, and all of the updates within several weeks.

21. Because the 2026 designs were specified in the preamble to the Notice of Benefit and Payment Parameters for 2026 and the only changes would be to align with the requirements under section 223 and the 2027 actuarial value requirements, these 2027 designs could be published in sub-regulatory guidance.

22. This minimalist approach would allow issuers simply to price the new plan options similar to the pricing changes they made in the examples discussed below. Furthermore, this approach is consistent with CMS's most recent regulatory revisions to the cost-sharing structure for standardized options, and therefore is aligned with contingency planning that issuers were

likely engaged in due to uncertainty regarding whether CMS would eliminate standardized plans in the final rule.

23. For plan years 2024, 2025, and 2026, CMS adopted minimal changes to the cost-sharing structure for standardized options, with CMS favoring targeted changes to ensure plans continue to have actuarial values within the permissible ranges for each metal level. In adopting these targeted changes in prior years, CMS explained that this approach enables issuers to "continue to be able to utilize many existing benefit packages, networks, and formularies" including by using those paired with standardized plan options from prior years. (90 Fed. Reg. 4424, 4533 (Jan. 15, 2025)).

24. If CMS provides parameters for standardized options that update the 2026 standards to meet 2027 AV standards, I believe issuers will be able to quickly update their plan offerings and offer the standardized plans that they offered for plan year 2026, updated to comply with the 2027 AV Calculator.

25. Because the Final Rule was not released until May 20, 2026, QHP issuers did not have certainty regarding whether CMS would finalize its proposal to eliminate standardized options until most issuers' plan benefit design cycles were already underway. Furthermore, the current litigation commenced quickly after the rule was finalized, reinforcing for issuers that there was ongoing uncertainty regarding whether standardized plans would be required in the Federally-facilitated Exchanges. Therefore, I believe most issuers likely engaged in contingency planning in case CMS did not finalize the proposal, and have continued such contingency planning given the uncertainty around this litigation.

26. Updating benefit offerings to comply with the following year's AV Calculator is an action insurance companies must do for *all* plans that they are continuing in the individual

market. This is neither a new requirement nor an unfamiliar exercise to issuers. And, as noted above, 59% of standardized plan options from plan year 2026 were submitted for certification for plan year 2027 and will already have been updated to comply with the 2027 AV Calculator.

There is Ample Time to Certify Standardized and Non-Standardized Plans

27. Just as it is feasible to establish the parameters for standardized options for plan year 2027, there is no reason to believe that CMS and states could not include the requirements regarding offering standardized and non-standardized plan options as part of the QHP certification process for plan year 2027. The QHP certification process has included processes for reviewing and certifying standardized plans for years. In addition, CMS has QHP certification processes for reviewing non-standardized plans and for granting exceptions to the limits on non-standardized plan offerings. CMS and states can apply these established processes for plan year 2027.

28. If it needed to do so, CMS could extend the QHP certification timelines, as it has in the past, without significant risk of operational errors. As noted above, CMS has repeatedly extended the QHP certification deadline to accommodate significant policy changes that have presented novel circumstances for CMS, QHP issuers, and states - including as recently as last fall in response to adjustments to plans that were required as a result of this Court's stay of provisions in last year's rulemaking.

29. Further, CMS and issuers have years of experience implementing standardized options, posing fewer operational risks.

CMS Can Easily Resume Differential Display of Standardized Plans on HealthCare.gov

30. Similarly, I believe CMS could operationalize differential display of standardized plans in time for open enrollment without significant risk. CMS has operated preferential display of standardized plans continuously since plan year 2023.

31. Providing preferential display of standardized options for plan year 2027 will not require CMS to start from scratch and would in fact allow CMS to cease working on development of alternate functionality to implement the final rule. CMS already has deployed the necessary functionalities, guidance, data templates and validation tools. It merely needs to maintain the current functionality of healthcare.gov. Because some Marketplace consumers enroll in coverage effective December 1 using a special enrollment period, CMS normally keeps in place its systems to enroll for the current plan year even after the November 1 start of the open enrollment period for the following year. As a result, during open enrollment for 2027, CMS will be maintaining two different versions of healthcare.gov functionality, one for the 2026 plan enrollments and one for plan enrollments in 2027. Maintaining differential display for 2027 should simplify CMS's task as CMS would not need to deploy the alternate display functionality for 2027.

32. While CMS is right that distinguishing standardized plans would require issuers to resubmit data templates, the template with this additional field already exists and otherwise requires the same information. And CMS can employ the same validation tools it has used in the past to validate compliance with standardized plan requirements. Plans will be required to provide justifications and actuarial memoranda for exceptions due to chronic and high-cost condition plans, but that is not a new requirement, and the issuers who offer these types of plans have experience with these justifications and memoranda.

33. CMS also requires direct enrollment partners to differentially display standardized options. Because direct enrollment partners have been required to comply with these rules in past years, they already have this functionality in place and will not need to update their functionality to incorporate the final rule provisions nor maintain two different plan shopping experiences.

34. The need to develop plan crosswalks–algorithms for shifting enrollees to new plans when their existing plans are discontinued–will be substantially reduced through the continuation of existing standardized plans for all issuers who discontinued them. For issuers that submitted plan designs that kept their standardized plans in place, nothing should change within their crosswalks.

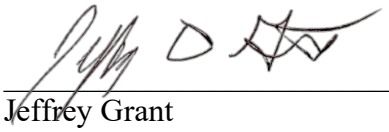
35. Insurers would not face significant operational difficulties if they remain subject to the limits on the number of non-standardized plans that they may offer. Those issuers who increased their plan offerings in response to the lifting of limits would need to comply with the limits and potentially recalculate prices for the plans that they offer, but they would be able to do so quickly. Some insurers may need to submit written justifications if they seek exceptions to the non-standardized plan limits, but the requirement for these submissions is in place under the current regulations and issuers that offer plans under these limited exceptions have experience with these justifications.

Conclusion

36. In my view, there is at most a minimal risk that issuers would be unable to conform their plan offerings to the standardized plan and related rules that were in place for the 2026 plan year, or that issuers would withdraw from the Marketplace. I am not aware of any issuer that has indicated it would exit the Marketplaces because of the possibility that issuers must resume offering standardized plans or limits on non-standardized plan options.

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

Executed on July 13, 2026 in Silver Spring, Maryland.



Jeffrey Grant

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Summary

Entrepreneurial healthcare leader with over 30 years' experience in health policy, operations, data and information systems. Veteran Chief Operating Officer, overseeing operations for a 600-person component. Implementation and quality improvement expert with proven record of providing innovative, simplified solutions to complex operational and policy problems. Leader of major national program implementations from ground up, including Medicare Advantage (MA) risk adjustment, Medicare Prescription Drug Benefit (Part D) payment, Affordable Care Act (ACA) Marketplace enrollment and payment, and the No Surprises Act.

Experience

Schedule F Healthcare Strategies

February 2025 – Present: President and Founder

Established a healthcare consultancy with two principal purposes:

- Provide strategic consulting on ACA Marketplace operations, policy and systems and No Surprises Act, including Independent Dispute Resolution (IDR); MA and Part D; risk adjustment; health information technology; operations; government relations; and federal contracting.
- Assist recently displaced CMS employees in identifying and landing new employment opportunities, while providing information to and public advocacy for all wrongfully terminated federal employees.

Centers for Medicare & Medicaid Services (CMS)/Center for Consumer Information and Insurance Oversight (CCIIO), Bethesda, MD

October 2017 – February 2025: Deputy Director for Operations

Led operations for a 600 person Center, running internal operations including budget, acquisitions, personnel, and space planning and management. Oversaw CCIIO major externally facing operations and information technology systems, including HealthCare.gov, ACA payments, and No Surprises Act.

- Oversaw modernization efforts and implementation of policy changes on HealthCare.gov that more than doubled the size of the federal Marketplace, ultimately resulting in over 24 million consumers enrolled in health insurance coverage in 2025.
- Led an effort to reduce an IDR backlog that averaged 8 months, speaking with every IDR entity's leadership team, analyzing their operations, and recommending improvements as needed. Every entity improved its performance and most hit the target of reducing to a 90 day maximum backlog within one year.
- Conceived of and led a strategy to improve the consumer experience while reducing operating costs. CCIIO reduced Marketplace budgets by $100 million per year for 3 consecutive years while reducing the number of consumer calls and laborious offline consumer eligibility processes. The ultimate result was an increase in the rate of enrollment uptake and the elimination of net attrition within a benefit year.
- Led a CMS-wide policy and operational effort to combat a growing fraud and abuse problem in federal marketplace enrollments, principally driven by agents, brokers, and web brokers. This effort resulted in the suspension of nearly 1,000 agents and brokers and the termination of two web brokers.

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CMS/CCIIO/Payment Policy and Financial Management Group (PPFMG), Bethesda, MD

December 2015 – October 2017: Director, PPFMG
July 2010 – December 2015: Deputy Director and Senior Advisor to the Director, PPFMG

Lead policy, operations, system development, internal controls and audit programs for Marketplace and private insurance market payment programs, including premium tax credits, cost sharing reductions, risk adjustment, reinsurance, and risk corridors.

- As first staff member, built PPFMG by creating the organizational structure, staffing plan, budget, and acquisition strategy, aiming at and achieving long-term viability. Recruited workforce with diverse skills, including policy, health economics, operations, information systems, accounting, and data analysis.
- Business architect for ACA financial programs, including the systems specifications, operational design, acquisition planning, internal controls, and audit strategy. As a direct result of sound programmatic design and execution, CCIIO passed all audits of Marketplace programs every year since implementation.
- Conceived of and led implementation of an innovative distributed data processing strategy for reinsurance and risk adjustment, allowing standard processing to occur on 750 remote EDGE servers at insurance issuers. Under tight timeframes, completed first year processing on time with exceptional reliability.
- As Lean Champion for CCIIO, oversaw the completion of 19 Rapid Process Improvement Workshops that saved 150,000 operational hours across CCIIO while graduating six individuals as Six Sigma Green Belts. Reduced PPFMG operating budgets by double digits each year while expanding operational capacity.

Health Risk Partners, Richmond, VA

September 2008 – July 2010: Senior Vice President, Client Services

Ensured on-time and successful delivery of all HRP services to clients and provided strategic financial analysis and consulting to our clients' executive leadership. Services supported Medicare Advantage (MA) risk adjustment programs, Part D payment reconciliation, and enrollment reconciliation for MA and Part D.

- Developed a new line of business to improve clients results on CMS risk adjustment audits, leveraging HRP data and systems to deliver a comprehensive solution that supported retrieval, review and submission of relevant medical records and extrapolated the financial impact of the audits for our clients.
- Developed a marketing strategy of using short-term contracts to demonstrate HRP's superior capabilities. Led projects that landed two "top five" MA plans as clients, more than doubling HRP's annual revenue.

Centers for Medicare & Medicaid Services/Center for Beneficiary Choices

October 2004 – September 2008: Director, Division of Payment Reconciliation

Led the implementation of health plan payment programs in support of the Medicare Modernization Act, including staffing, budgeting, contracting, and development of policies, operations and systems.

- With no previous prescription drug experience, developed the initial policies to reconcile Part D payments within two months and finalized detailed specifications and operating instructions in 9 months.
- Conceived of and led groundbreaking user acceptance testing effort for the Medicare Advantage and Prescription Drug System payment processes, ensuring CMS passed financial audits with no findings.
- Completed an on-time payment reconciliation of the first year of the Part D benefit with no major audit findings. Developed and implemented a re-opening process, successfully closing out payments for Year 1.

Centers for Medicare & Medicaid Services

July 1993 – October 2004: Various positions

- Led rapid development and deployment of a streamlined data collection process for risk adjustment, significantly reducing burden on MA health plans while maintaining project schedule.
- Led effort to convert risk adjustment process from offline factor calculation to full automation, providing more reliable, auditable results and facilitating the implementation of Part D risk adjustment.

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- As Center Budget Officer, developed and executed a $100+ million administrative budget, leading all aspects of process from the initial request to Congress through acquisition planning and delivery.

United States Naval Reserve

February 1982 – February 2004: Maintenance Department Senior Chief (highest position)

Managed two aviation maintenance departments of over 100 enlisted personnel. Ensured squadron aircraft mission readiness to meet operational mission requirements, including support for Operation Iraqi Freedom.

Education

1993 The George Washington University, Washington, DC, Master of Public Administration

1991 University of Michigan, Ann Arbor, MI, B.A. in History, High Honors and Highest Distinction

Awards/Honors

Ike Skelton Public Service Award, Harry S Truman Scholarship Foundation, 2024
Presidential Meritorious Rank Award, 2022
HHS Secretary's Distinguished Service Award, 2018
CMS Senior Executive of the Year, 2017
Baltimore Federal Executive Board, Outstanding Executive of the Year (Silver), 2016
CMS Administrator's Citation, 2008
CMS Administrator's Achievement Award, 2003, 2007 (2), 2008, 2015
Navy Commendation Medal, 2004
Navy Achievement Medal 1991, 1994, 1996
Harry S Truman Scholar, 1989

References

Available upon request