UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF GEORGIA
BRUNSWICK DIVISION

ELEVANCE HEALTH, INC. ET AL.,	)	
	)	
Plaintiffs,	)	
	)	
v.	)	Case No. 2:26-cv-61
	)	
U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, ET AL.,	)	
	)	
Defendants.	)	

DEFENDANTS' BRIEF IN OPPOSITION TO PLAINTIFFS' MOTION FOR PRELIMINARY INJUNCTION

Nearly nine months after the Centers for Medicare & Medicaid Services announced Plaintiffs' 2026 Medicare Advantage Star Ratings, and about a month after submitting a 2027 bid that expressly incorporated those Star Ratings, Plaintiffs (collectively, "Elevance") filed this lawsuit to increase the Star Ratings assigned to five of their Medicare Advantage contracts. Elevance then moved for a preliminary injunction a week later, asserting that it is irreparably harmed by an agency action of which it has been aware for three-quarters of a year and demanding relief—in the form of a mandatory preliminary injunction that alters the status quo—to take effect within five weeks after its filing.

Elevance has failed to carry its heavy burden to demonstrate entitlement to the "extraordinary and drastic remedy" of a preliminary injunction for any of several independent reasons, any one of which is fatal to its motion. *Siegel v. LePore*, 234 F.3d 1163, 1176 (11th Cir. 2000). First, Elevance cannot establish that this Court is

the proper forum for its claims. As explained more fully in Defendants' Motion to Dismiss, *see* Doc. 34, Elevance cannot identify a single contract connected to this District that would be affected by the relief it seeks, and venue is therefore improper. Even if this Court were to reach the merits, Elevance has not carried its burden on any of the preliminary injunction factors. Its likelihood-of-success argument depends entirely on a single decision of this Court that is currently on appeal. Elevance likewise fails to establish irreparable harm. It waited nine months to file suit, undermining any claim of urgency, and in the meantime submitted a bid to CMS that expressly incorporated the very Star Ratings it now challenges. Nor has Elevance shown that the absence of preliminary relief will cause irreparable harm because CMS can implement adverse final judgments involving Medicare Advantage Star Ratings outside the bid process. Finally, the balance of equities and the public interest weigh strongly against the extraordinary relief Elevance requests. Its proposed mandatory injunction would disrupt the Medicare Advantage program by undermining the integrity and competitiveness of the bid process that determines plan pricing and benefits, while also jeopardizing the timely and accurate dissemination of information on which tens of millions of Medicare beneficiaries rely during the annual open enrollment period.

BACKGROUND

I. Medicare Advantage and Star Ratings

This case concerns Medicare Parts C and D, which are two programs under which the government contracts with health-insurance companies, known as

Medicare Advantage Organizations (MAOs), to provide insurance coverage to Medicare beneficiaries within a particular geographic area. *See* 42 U.S.C. § 1395w-21(b). Under Part C, the government pays MAOs a predetermined sum for providing the same coverage as traditional Medicare (Parts A and B) to each beneficiary, adjusted by the demographic and health characteristics of that beneficiary. *Id.* § 1395w-23(a)(1)(A), (C). Beneficiaries can then choose among the plans offered under these contracts and available where they reside. Under Part D, the government contracts with insurance companies that provide subsidized prescription drug coverage to beneficiaries. *See id.* § 1395w-101. Many insurers (including Elevance) operate plans that provide coverage under both Parts C and D.[1]

To calculate payments to MAOs, CMS first determines a "benchmark" based on the per capita cost of covering Medicare beneficiaries under Parts A and B in the relevant geographic area. *Id.* § 1395w-23(n); 42 C.F.R. § 422.258. Each MAO then submits a "bid" for each plan it will offer under its contracts indicating the payment the MAO will accept to cover a beneficiary with an average risk profile in that area. 42 C.F.R. § 422.254. If the MAO's bid is less than the benchmark, the bid becomes the MAO's "base payment"—the amount it is paid for covering a beneficiary of average risk—and the MAO receives a "rebate" calculated from the amount by which its bid is lower than the benchmark. If the MAO's bid is greater than the benchmark,

[1] This brief therefore refers generically to insurers that provide Medicare coverage under Parts C and D as MAOs. In many situations, regulations for Part C and Part D are substantively identical. *See, e.g.*, 42 C.F.R. §§ 422.164, 423.184. In those circumstances, the brief generally cites the Part C regulations.

then the benchmark becomes the insurer's base payment, and the insurer must charge beneficiaries a premium to make up the difference. *See* 42 U.S.C. §§ 1395w-23(a)(1)(B)(ii), 1395w-24(b)(2)(A).

To assist beneficiaries with choosing a Medicare Advantage plan, Congress directed CMS to issue annual ratings under a five-star rating system for each plan offered through Medicare Advantage. 42 U.S.C. § 1395w-23(o)(4). In 2010, Congress required CMS to begin using this Star Ratings system to provide additional payments to plans. *See id.* The statute reads: "The quality rating for a plan shall be determined according to a 5-star rating system (based on the data collected under section 1395w-22(e) of this title)." 42 U.S.C. § 1395w-23(o)(4)(A); *see generally* 83 Fed. Reg. 16440, 16520-25 (Apr. 16, 2018). The CMS Star Ratings system rates each plan on a 1-to-5 star scale using multiple quality measures (33 or 45 for the 2026 Star Ratings, depending on whether a plan offers Part D coverage). These measures assess health outcomes, patient experience, and care quality. Most Part C Star Ratings measures are drawn from data collected by plans as part of their statutorily required quality improvement programs. *See* 42 U.S.C. § 1322w-22(e). That provision requires plans to maintain "an ongoing quality improvement program" and "to provide for the collection, analysis, and reporting of data that permits the measurement of health outcomes and other indices of quality," but limits the data collected to "the types of data that were collected by the Secretary as of November 1, 2003."

Since 2003, CMS has collected Star Ratings data through the Consumer Assessment of Healthcare Providers and Systems (CAHPS), the Healthcare

Effectiveness Data and Information Set (HEDIS), and the Health Outcomes Survey (HOS), widely used surveys that extend beyond Medicare Advantage. *See* 69 Fed. Reg. at 46,866. CMS has also historically used its own administrative data to calculate some Star Ratings measures.

CMS determines each plan's overall rating by calculating a weighted average of the plan's Star Ratings across the individual measures. CMS publishes the Star Ratings each October for the upcoming year at the contract level, with each plan offered under that contract assigned the contract's rating. *See* 42 C.F.R. §§ 422.162(b), 422.166, 423.182(b), and 423.186.

Plans that earn an overall rating of 4 stars or higher receive an increased benchmark for the contract year following the ratings year (*e.g.*, the 2025 Star Ratings can increase the Medicare Advantage bidding benchmarks for contract year 2026). *See* 42 U.S.C. § 1395w-23(o)(1), (o)(3)(A)(i). This increased benchmark in turn can allow a Medicare Advantage plan to increase its bid, receive higher rebates, or lower premiums. *See id.* § 1395w-24(b)(1)(C); 42 C.F.R. § 422.260. They also receive a higher share of their rebate, which they must use to fund supplemental benefits for beneficiaries, reduce plan premiums, or reduce cost-sharing. 42 U.S.C. § 1395w-24(b)(1)(C); 42 C.F.R. § 422.260. Plans that earn an overall rating of 4.5 stars or higher receive a rebate of 70% of the amount by which their bid is lower than the benchmark, while plans that earn 3.5 or 4 stars receive a rebate of 65% of that amount, and plans that earn less than 3.5 stars are eligible for a rebate of 50% of that amount. 42 U.S.C. § 1395w-24(b)(1)(C)(v); 42 C.F.R. § 422.266(a)(2)(ii). Collectively,

the increased benchmark and increased rebates available to plans with higher Star Ratings are referred to as "quality bonus payments" or QBPs. The contract QBP rating is applied to each plan benefit package offered under the contract. 42 C.F.R. § 422.162(b)(4)(ii).

II. Notice and Comment Rulemaking, the Annual Notice, and Technical Specifications for Star Ratings

CMS has codified the overall Star Ratings framework and process for modifying measures through regulation, but the detailed technical specifications, including, for example, case-mix adjustment coefficients, are not established by regulation and are instead updated and published annually in the Part C and D Star Ratings Technical Notes.

Rulemaking: In 2018, CMS codified via rulemaking certain aspects of the Star Ratings system and its approach to future modifications. The agency listed "high level descriptions" of the measures beginning "on or after January 1, 2019" and explained that the Technical Notes document "provides detailed specifications for each measure." 83 Fed. Reg. at 16538-46. Those detailed specifications include "where appropriate, the identification of a measure's: (1) numerator, (2) denominator, (3) calculation, (4) timeframe, (5) case mix adjustment, and (6) exclusions." *Id.* at 16538. CMS took comments on the listed measures but not on the measure specifications.[2]

[2] For example, commenters on the "Controlling Blood Pressure" measure suggested that documented ambulatory and home blood pressure readings be included as part of the assessment of a clinician's treatment plan and responded that the National Committee for Quality Assurance was considering changes to the HEDIS system consistent with this proposal. 83 Fed. Reg. at 16,548.

See id. at 16,547-54. CMS also promulgated 42 C.F.R. § 422.164, which states that it will "announce potential new measures" via the Annual Notice and Rate Announcement process ("Annual Notice") described below and will propose and finalize new measures through rulemaking. *See* 42 U.S.C. § 1395w-23(b)(2); *see also* 42 C.F.R. § 422.164(c) (describing process for adding new measures).

Annual Notice: CMS makes "non-substantive" changes to measures via the Annual Notice. *See* 42 C.F.R. § 422.164(d) (non-substantive updates "include" changes that narrow the denominator, do not meaningfully impact the numerator or denominator, update clinical codes, provide additional clarifications, or add alternative data sources or expand modes of data collection). The Annual Notice is a statutory process for Part C rate setting described at 42 U.S.C. § 1395w-23(b); MAOs have an opportunity to comment on proposed changes but other interested parties do not, and neither the annual notice nor the rate announcement is published in the Federal Register.

Technical Specifications: CMS has never promulgated the detailed technical specifications for the Star Ratings measures by regulation. Instead, those specifications are published annually in a guidance document called the Technical Notes and identify the measure's metric, data source, and related technical requirements. For example, the Technical Notes specify which measures are case-mix adjusted, and the case-mix adjustment coefficients are calculated annually. *See, e.g.*, 2025-26 Technical Notes at 97-107 (case-mix coefficients) (*available at* https://www.cms.gov/files/document/2026-star-ratings-technical-notes.pdf). These

specifications also include a "measure reference," which often refers to the data source, *e.g.*, Measure C17 (Medication Reconciliation Post-Discharge) refers to the "HEDIS Measurement 2024 Year Technical Specifications Volume 2, Page 294."

III. 2026 Star Ratings Litigation

On October 9, 2025, CMS published 2025 Medicare Advantage Star Ratings on the Medicare Plan Finder. *Clover Ins. Co. v. U.S. Dep't of Health & Human Servs.*, No. 2:25-CV-142, 2026 WL 1483515, at *5 (S.D. Ga. May 27, 2026) (Wood, J.) (*Clover I*), *on reconsideration in part*, 2026 WL 1510382 (S.D. Ga. May 29, 2026). On November 7, 2025, a single MAO—Clover Insurance Company—filed suit in this Court, asserting that CMS had calculated its Star Rating using measures that were, for various reasons, unlawful. *Id.* at *6. On May 27, 2026, this Court granted partial summary judgment to Clover, holding that CMS had unlawfully applied twenty Star Ratings measures to it. *See id.* at *14, *22. Those twenty measures fell into two categories: this Court held that ten were not "based on" data collected under 42 U.S.C. § 1395w-22(e), and it held that the other ten were not promulgated by regulation as required by 42 U.S.C. § 1395hh(a)(2). *Id.* at *14, *22, *25. This Court thus set aside Clover's 2026 Star Rating and ordered CMS to recalculate that rating in a manner consistent with the Court's order. *Id.* at *25. This Court explicitly declined to issue a declaration that Defendants' use of certain measures was unlawful under the APA. *Id.* at *25 n.21.

On June 9, 2026, Clover announced in an SEC filing that CMS had, consistent with this Court's decision, recalculated its Star Rating at 4.5 Stars and instructed

Clover to submit alternate bids at 4.5 Stars.[3]

Eight days later, on June 17, 2026, CMS announced that it was "voluntarily recalculating the 2027 QBP ratings for certain Medicare Advantage (MA) contracts." CMS, HPMS Memo, Update to 2027 Quality Bonus Payment Determinations, June 17, 2026, Doc. 10 at 12-14. The memorandum referenced this Court's decision in *Clover*, but it explicitly noted that CMS's decision to recalculate "has no bearing on CMS's potential exercise of its right to appeal this decision." *Id.* at n.1. Under the memorandum, CMS recalculated Star Ratings using only measures that incorporated data collected under a statutory provision, 42 U.S.C. § 1395w-22(e), that governs quality improvement plans. *Id.* For each contract, it compared the recalculated score to the original score. Only contracts that had a rating increase that resulted in improved QBP eligibility status as a result of the recalculation could submit revised bids. *Id.*

On July 22, 2026, the government filed a notice of appeal of this Court's decision in *Clover*.

IV. Elevance's Challenge

Elevance registered no dispute with any of its contracts' Star Ratings, either during the plan preview periods or after CMS published the ratings. When Elevance submitted its 2027 bids to CMS, it incorporated its Star Ratings for all contracts as they appeared in the October 2025 data release.

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[3] This SEC filing is available at https://www.sec.gov/Archives/edgar/data/1801170/000180117026000137/clov-20260609.htm.

Nevertheless, about a month after submitting those bids relying on its Star Ratings as calculated in October 2025, Elevance filed this suit on July 1, 2026. It includes three counts: a claim that CMS arbitrarily and capriciously treated Clover differently from Elevance, a claim that CMS unlawfully included measures incorporating data outside of that described in 42 U.S.C. § 1395w-22(e) in calculating Elevance's Star Rating, and a claim that CMS failed to codify by regulation other measures in violation of 42 U.S.C. § 1395hh(a)(2). Elevance's litigation strategy confirms that this case is not about the legality of CMS's policies in the abstract. Elevance challenges CMS's actions only as to the five contracts for which it believes a favorable ruling would increase federal payments. *See* Doc. 1, ¶ 18. It does not seek relief with respect to other contracts for which it believes it would derive no comparable benefit.

Elevance moved for a preliminary injunction on July 7, 2026.

STANDARD OF REVIEW

"A preliminary injunction is an extraordinary remedy never awarded as of right." *Winter v. Nat. Res. Def. Council, Inc.*, 555 U.S. 7, 24 (2008). Because it is an extraordinary and drastic remedy, "its grant is the exception rather than the rule." *United States v. Lambert*, 695 F.2d 536, 539 (11th Cir. 1983). "The purpose of a preliminary injunction is merely to preserve the relative positions of the parties until a trial on the merits can be held." *Univ. of Texas v. Camenisch*, 451 U.S. 390, 395 (1981); *see also Ne. Fla. Chapter of Ass'n of Gen. Contractors of Am. v. City of Jacksonville, Fla.*, 896 F.2d 1283, 1284 (11th Cir. 1990) (noting that the chief function

of a preliminary injunction is "to preserve the status quo until the merits of the controversy can be fully and fairly adjudicated.").

The moving party bears the burden to establish the need for a preliminary injunction. To grand such "extraordinary relief," the court must find that the movant has established four essential elements: "(1) a likelihood of success on the merits of the overall case; (2) irreparable injury; (3) the threatened injury outweighs the harm the preliminary injunction would cause the other litigants; and (4) the preliminary injunction would not be averse to the public interest." *Benavides v. Gartland*, No. 5:20-cv-46, 2020 WL 3839938, at *4 (S.D. Ga. July 8, 2020) (Wood, J.). A preliminary injunction should not be granted "unless the movant clearly established the burden of persuasion as to all four elements." *Horton v. City of Augustine, Fla.*, 272 F.3d 1318, 1326 (11th Cir. 2001) (quotation marks omitted). However, "where the government is the party opposing the preliminary injunction, its interest and harm merge with the public interest." *Swain v. Junior*, 958 F.3d 1081, 1091 (11th Cir. 2020).

When a party seeks to change the status quo through an injunction, the injunction is a mandatory injunction. *See, e.g., Meghrig v. KFC W., Inc.*, 516 U.S. 479, 484(1996) (outlining difference between mandatory and "prohibitory" injunctions). Mandatory injunctions are "particularly disfavored, and should not be issued unless the facts and law clearly favor the moving party." *Martinez v. Mathews*, 544 F.2d 1233, 1243 (5th Cir. 1976); *see also Fox v. City of W. Palm Beach*, 383 F.2d 189, 194 (5th Cir. 1967) ("There is no question but that mandatory injunctions are to be sparingly issued and upon a strong showing of necessity and upon equitable grounds

which are clearly apparent."); *Wachovia Ins. Servs., Inc. v. Paddison*, No. 4:06-cv-83, 2006 WL 8435308, at *2 (S.D. Ga. Apr. 6, 2006) (Edenfield, J.) (noting that mandatory injunctions are subject to heightened scrutiny). Here, this Court should construe Elevance's Motion as seeking a mandatory injunction, since Elevance seeks a change in the current status quo of its Star Rating and bid status, and it should therefore give that request heightened scrutiny and require it to meet that burden.

ARGUMENT

I. Elevance is unlikely to succeed on the merits of its claim.

A. Venue is improper.

Elevance cannot establish that this Court is the proper forum for this action. Defendants have already filed a motion to dismiss this case under Federal Rules of Procedure Rule 12(b)(1) and 12(b)(3). Doc. 34. Elevance's only asserted basis for venue is one Medicare Advantage contract (H4036) serving beneficiaries in this District. Doc. 1, ¶ 11. But H4036 would not receive a higher Star Rating even if Elevance prevailed on the merits. As Defendants explain in their motion to dismiss, H4036 would receive no benefit from the relief Elevance seeks and should be dismissed from this action. Doc. 34. The remaining contracts concededly lack any connection to this District, Doc. 1, ¶ 18, Ex. A., and even under this Court's *Clover* order on venue, *Clover Ins. Co., v. U.S. Dept. of Health and Human Services*, No. 2:25-cv-142, 2026 WL 2165252 (S.D. Ga. Mar. 18, 2026) (Wood, J.) (*Clover II*), venue is improper.

Defendants further submit that venue would not be proper here even if the Georgia contract were not dismissed; the federal-officer venue statute requires more

than the possibility that the effects of a decision made outside of this District will be felt here. Doc. 34. Because venue is improper in this Court, Plaintiffs are unlikely to succeed on the merits and their motion for a preliminary injunction should be denied.

B. Elevance is not similarly situated to Clover and was treated the same as all other MAOs who did not receive a court judgment.

Elevance's contention that CMS failed to treat like cases alike rests on a faulty premise. It depends on treating this Court's *Clover* judgment as though it granted universal relief. It did not.

The APA requires agencies to treat similarly situated parties similarly. But a party that has obtained a judgment is not similarly situated to a party that has not. *See Kansas v. United States Dep't of Labor*, 749 F. Supp. 3d 1363, 1381 (S.D. Ga. 2024) (Wood, J.) ("Providing party-specific relief comports with a federal court's Article III authority to decide cases and controversies for the parties to the litigation, not for any party anywhere."). This court has explained, "'when a federal court finds a remedy merited, it provides party-specific relief . . . . If the courts remedial order affects nonparties, it does so only incidentally.'" *Id.* (quoting *United States v. Texas*, 599 U.S. 670, 693 (2023) (Gorsuch, J., concurring)). That principle controls here.

This Court's order in *Clover* was expressly party-specific. It "set aside" the "2026 Star Rating for Clover" and "ordered [defendants] to recalculate *that rating* in a manner consistent with this Order." *Clover I*, 2026 WL 1483515, at *25 (emphasis added), *see also id.* at n.21 (noting that "courts should, where possible, leave it to administrative agencies to determine in the first instance how best to implement a judicial decision that alters the relevant legal framework"). It said nothing about any

other MAO's Star Rating, nor could it have. Courts generally lack authority to issue injunctions that give relief to non-parties. *Trump v. CASA, Inc.*, 606 U.S. 831, 841-47 (2025).

CMS promptly implemented this Court's decision. As Plaintiffs have acknowledged, on June 9, 2026, Clover filed an SEC Form 8-K stating that "consistent with the Court's order, [CMS] has recalculated Clover's 2026 Star Rating as 4.5 Stars." https://www.sec.gov/Archives/edgar/data/1801170/000180117026000137/clov-20260609.htm. More than a week after recalculating Clover's Star Rating as required by this Court's order, CMS issued a memorandum announcing that it would *voluntarily* recalculate QBP ratings "only using data collected under 42 U.S.C. 1395w-22(e) as of November 1, 2003, specifically Part C measures using Healthcare Effectiveness Data and Information Set (HEDIS), Consumer Assessment of Healthcare Providers and Systems (CAHPS), and Health Outcomes Survey (HOS) data." Doc. 10 at 12. That memorandum established uniform criteria applicable to all MAOs. Contracts whose recalculated ratings increased their benchmark or rebate amounts were permitted to submit revised bids. Contracts whose ratings remained unchanged or decreased retained their existing ratings. *Id.*[4] None of the Elevance contracts at issue received a different Star Rating as a result of this recalculation.

[4] CMS did something very similar following two district court decisions in 2024 regarding Tukey outlier deletion and guardrails. https://www.cms.gov/files/document/updateto2025qualitybonuspaymentdeterminations.pdf. It explicitly reserved the possibility of appealing the adverse decision, recalculated all MAOs' Star Ratings under a specified methodology, and allowed contracts that would receive a higher Star Rating under the revised methodology to re-bid while stating that a "contract's QBP rating will not be decreased by CMS as a result of this recalculation." *Id.*

CMS therefore treated Elevance exactly the same as it treated every other MAO that had not obtained a court order governing recalculation of Star Ratings. The only contract treated differently was Clover's, and only because this Court required CMS to recalculate that contract's Star Rating after excluding the measures this Court held unlawful as applied to Clover. *See Clover*, 2026 WL 1483515, at *8, *22 (listing measures).[5]

Elevance responds that "[s]urely the disparate treatment cannot be explained by the fact that Clover obtained a judgment." Doc. 7 at 17. This is plainly mistaken. After all, a party that has obtained a judgment is unlike a party that has not in one dispositive way: it may ask the district court that issued the judgment to enforce it. *See* Fed. R. Civ. P. 65, 70. Meanwhile, a nonparty to a judgment may enforce that judgment only "[w]hen an order grants relief for a nonparty"—something that plainly is not the case here. Fed. R. Civ. P. 71; *see Clover I*, 2026 WL 1483515, at *25.

Elevance's position—that it is similarly situated to Clover despite the fact that Clover filed a lawsuit in November 2025 and obtained a judgment in its favor in that suit—would erase the distinction between party-specific relief and universal relief. Under its view, every MAO would automatically acquire the benefit of a judgment entered in litigation to which it is not a party. That is not what this Court ordered and is not what Article III permits. *See CASA*, 606 U.S. at 847 ("Because the universal

[5] If this Court's order is reversed or modified on appeal, CMS would not be legally obligated to recalculate Clover's Star Rating to exclude any measures subject to the reversal or modification and could recalculate Clover's Star Rating consistent with a revised instruction from the Eleventh Circuit or this Court.

injunction lacks a historical pedigree, it falls outside the bounds of a federal court's equitable authority under the Judiciary Act."); *see also id.* at 852 ("As a matter of law, the injunction's protection extends only to the suing plaintiff—as evidenced by the fact that only the plaintiff can enforce the judgment against the defendant responsible for the nuisance."). Elevance was not a party to this Court's decision in favor of Clover and cannot assert any right to enforce that decision. CMS therefore did not act arbitrarily and capriciously, or fail to treat like cases alike, by enforcing this Court's order according to its terms.

C. This Court's *Clover* decision may be reversed on appeal, which would defeat all of Plaintiffs' claims.

Elevance does not attempt to establish a likelihood of success on either claim except by relying on this Court's decision in *Clover*. That decision, however, is currently pending appeal, and Defendants preserve their disagreement with it here.

First, the Medicare rulemaking statute, 42 U.S.C. § 1395hh(a)(2), does not apply to QBPs because an MAO's Star Rating does not "govern . . . the payment for services." QBPs are not "payments for services" because, under the Medicare statute, insurance coverage is not a Medicare service. Medicare Advantage plans provide "benefits under the original medicare fee-for-service program option." 42 U.S.C. § 1395w-22(a)(1)(A). "Benefits" are distinct from "services." *See, e.g.*, 42 U.S.C. § 1395hh(a)(2) (requiring a "rule, requirement, or other statement of policy . . . that establishes or changes a substantive legal standard governing the scope of benefits, the payment for services, *or* the eligibility of individuals, entities, or organizations to furnish or receive services *or* benefits" to be promulgated by regulation) (emphasis

added). "Payments for services" are payments to the providers who (e.g., doctors, hospitals, skilled nursing facilities) who *perform* services, and the Medicare statute defines various types of "service" at 42 U.S.C. § 1395x. None of these includes "insurance." MAOs provide *insurance coverage*, which includes paying providers for services—but insurance coverage itself is not a Medicare service. *See, e.g.*, 42 U.S.C. §§ 1395d, 1395k. "Regardless of how much money an MAO receives in quality bonus payments or in rebates because of its Star Rating, its obligation to pay providers of services remains the same. Thus, the Star Ratings do not affect 'payment for services.'" *Humana Inc. v. U.S. Dep't of Health & Hum. Servs.*, 806 F. Supp. 3d 642, 648 (N.D. Tex. 2025), *appeal docketed*, No. 25-11302 (5th Cir.).

Elevance's second statutory claim likewise depends entirely on this Court's earlier decision in *Clover*. Defendants continue to submit that the better reading of 42 U.S.C. § 1395w-22(e) is that the phrase "based on" does not require exclusive reliance on the data sources identified in that provision. "'Nothing about the plan and ordinary meaning of the phrase 'based on' connotes exclusivity,' and 'nothing about it implies the list that follows is exhaustive." *Advance Trust & Life Escrow Services v. Protective Life Ins. Co.*, 93 F.4th 1315, 1326 (11th Cir. 2024) (discussing life insurance policy) (quoting *Slam Dunk v. Conn. Gen. Life Ins. Co.*, 853 F. App'x 451, 455 (11th Cir. 2021)). "'[B]ased on' does not mean 'exclusively on' or 'solely on.' " *Id.* at 1333. This follows from dictionary definitions of the word "base." *Id.*[6] Given that the

[6] By offering these arguments above, Defendants do not waive and expressly reserve any other arguments they may make on appeal or in a subsequent cross-motion for summary

Eleventh Circuit has squarely considered the "plain and ordinary meaning" of the phrase "based on" twice in recent years, Defendants respectfully submit that this Court erred in *Clover*.

II. Plaintiffs cannot demonstrate imminent irreparable harm.

Elevance cannot establish irreparable harm. "A showing of irreparable harm is the sine qua non of injunctive relief." *Northeastern Florida Chapter of Ass'n of General Contractors of America*, 896 F.2d at 1285 (internal quotation marks omitted). "A plaintiff seeking a preliminary injunction must establish . . . that he is likely to suffer irreparable harm *in the absence of preliminary relief*." *Winter*, 555 U.S. at 20 (emphasis added). In applying that standard here, this Court should look first to the preliminary relief that Elevance requests:

> Elevance Health respectfully requests that this Court preliminarily enjoin Defendants from refusing to recalculate Elevance Health's 2026 Star Ratings consistent with this Court's holding in *Clover*. *The requested injunction does not seek to alter the Star Ratings of any other MAO.* Elevance Health asks only that Defendants be required to do something this Court has already once ordered with respect to another MAO: to recalculate Elevance Health's 2026 Star Ratings consistent with this Court's holding in *Clover* that the same 20 challenged measures were unlawfully adopted and should not have been relied upon.

Doc. 7 at 23-24 (emphasis added).

Elevance has also stated that it "needs relief from this Court in time to resubmit bids with the benefit of knowing it, too, will realize higher 2027 QBP ratings that will result in increased rebates and QBPs across a number of its contracts." *Id.*

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judgment. Defendants preserve in this matter any arguments the government may make in the appeal of this Court's *Clover* decision.

at 6. Elevance cannot show that it will suffer irreparable harm in the absence of the remedy it requests: an order identical to this Court's *Clover* order requiring recalculation of its 2026 Star Rating without 20 challenged measures that does not alter any other MAO's Star Rating and is issued in time to resubmit bids.

Given that Elevance's requested injunction consists of an order "this Court has already once ordered with respect to another MAO," Doc. 7 at 24, Elevance's nearly nine-month delay in bringing this action undermines its allegation of irreparable harm. Elevance forthrightly acknowledges that this Court's *Clover* order did not apply to it and that it was not a party to *Clover*. *Id.* Nor does Elevance ever explain why, if it wants to be treated exactly like Clover, it did not file its own lawsuit or seek to join Clover's. It cannot demonstrate imminent irreparable harm from CMS's alleged errors in calculating its original Star Rating. "[T]he very idea of a *preliminary* injunction is premised on the need for speedy and urgent action to protect a plaintiff's rights before a case can be resolved on its merits." *Wreal, LLC v. Amazon.com, Inc.*, 840 F.3d 1244, 1248 (11th Cir. 2016). "[A] party's failure to act with speed or urgency in moving for a preliminary injunction necessarily undermines a finding of irreparable harm." *Id.* (finding delay of five months undermined claim of urgency). Elevance learned what its 2026 Star Ratings would be and then waited nearly *nine months* before filing its complaint. At all times, the statutory arguments that Elevance now presses were readily apparent from the face of the statute. During the period that Elevance waited to file suit, Clover filed a complaint, obtained a favorable decision in opposition to a motion to dismiss, fully briefed a summary judgment

motion, and obtained a judgment on the merits from this Court—all while Elevance was deciding whether to file at all.[7] This Court's *Clover* decision conclusively demonstrates that a Elevance could have had its case "resolved on the merits" had it filed a timely challenge. But it cannot now demand this Court give it immediate, preliminary relief when the urgency it claims results entirely from its own inaction. Plaintiffs do not even attempt to argue otherwise.[8]

Here, Plaintiffs have made it clear that the injunctive relief they request consists of 1) this Court applying its *Clover* order to them, 2) in time for Elevance to re-bid for 2027. Doc. 7 at 6, 23–24. *Winter* requires this Court to determine whether they are likely to suffer irreparable harm in the absence of that relief. And because Elevance asks this Court to apply its *Clover* order, Elevance must explain why its nine-month delay in seeking relief *identical to Clover* does not "necessarily undermine[] a finding of irreparable harm," *Wreal*, 840 F.3d at 1248. It has not done so, particularly where Elevance submitted a bid incorporating its original Star Rating just weeks ago and still waited to file its lawsuit until after both the original and extended bid deadlines had passed.

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[7] Had Elevance wanted to ensure that it would receive the same judgment as Clover, it could have filed a motion to intervene in this Court's *Clover* matter. *See* Fed. R. Civ. P. 24(b)(1)(B).

[8] This is not to say that CMS cannot implement an adverse final judgment against Elevance. CMS has consistently maintained, across numerous Star Ratings matters filed over the years, that it will implement any final adverse judgment. For cases that have been decided in the government's favor and subsequently appealed, it would not be possible to use a re-bidding process to implement a hypothetical adverse judgment by an appellate court during or even after the plan year at issue. *See, e.g. HMO La. v. HHS*, 179 F.4th 62 (D.C. Cir. 2026); *Alignment Healthcare Inc. v. HHS*, No. 25-5239, 2026 WL 2023554, at *1 (D.C. Cir. July 14, 2026); *Humana Inc. v. U.S. Dep't of Health & Hum. Servs.*, No. 25-11302 (5th Cir.). CMS would nonetheless implement any adverse judgment, though it would presumably not do so via a re-bid if a re-bid were a chronological impossibility.

Elevance's unexplained delay is a sufficient basis on its own for denial of its requested preliminary injunction. But its attempt to show irreparable harm fails for a separate reason. Its attempt to analogize competitive harms caused by the wrongful acts of other market players to its situation is legally infirm. Elevance asserts that "[c]ourts in this Circuit consistently recognize competitive harm as irreparable and thus a basis to grant preliminary injunctive relief." Doc. 7 at 21. But each of the cases it cites involves an injunction against a competitor causing the movant competitive harm. *Id.* at 22; *see United Parcel Serv., Inc. v. Mercado*, 799 F. Supp. 3d 1281, 1295 (N.D. Ga. 2025) (former employee sharing knowledge that provides "information and strategic advantage that cannot be unwound); *Bee Warehouse, LLC v. Blazer*, 671 F. Supp. 3d 1347, 1362 (N.D. Ala. 2023) (competitor's complaint resulted in removal of movant's product from Amazon, and "could lead to the loss" of movant's account); *C.B. Fleet Co., Inc. v. Unico Holdings, Inc.*, 510 F. Supp. 2d 1078, 1083 (S.D. Fla. 2007) (presuming irreparable harm in copyright case where fair use was not raised as a defense and finding competitor's use of infringed copyright to offer lower price caused irreparable harm). None of these cases involves a claim against a government agency alleging that it has caused non-specific competitive harms.

Elevance devotes its discussion of irreparable harm to describing an alleged competitive injury versus "[c]ompeting MAOs that benefitted from the June 17 HPMS memorandum Star Ratings recalculation methodology." Doc. 7 at 20; *see generally id.* at 19-22. But the source of this alleged harm is the June 17 HPMS memorandum, *which Elevance does not challenge at all*. Indeed, Elevance affirmatively states that

its "requested injunction does not seek to alter the Star Ratings of any other MAO." *Id.* at 24. *Winter* requires Elevance to demonstrate irreparable harm in the absence of preliminary relief, and the preliminary relief it seeks does not involve a set-aside or any modification of the June 17 HPMS memorandum. Any harm it alleges as a result of that memorandum is thus irrelevant to this Court's preliminary injunction analysis, because it has not challenged the underlying agency action or requested an injunction to remedy it.

Elevance's nine-month delay is a sufficient basis, without more, for this Court to conclude that it is not entitled to preliminary relief. But its allegations are defective in other ways, and this Court should therefore conclude that Elevance cannot establish the "the sine qua non of injunctive relief," *see Northeastern Florida Chapter of Ass'n of General Contractors of America*, 896 F.2d at 1285 (quotation marks omitted), and deny Elevance's request for a preliminary injunction.

III. Elevance's requested mandatory injunction would undermine the public interest in an orderly Medicare open enrollment.

The remaining preliminary injunction factors likewise favor Defendants. Elevance has not demonstrated that "the balance of equities tips in their favor," and that "an injunction is in the public interest." *See Winter*, 555 U.S. at 20. The balance of equities and the public interest factors "merge when the Government is the opposing party." *Nken v. Holder*, 556 U.S. 418, 435 (2009).

The injunction Elevance seeks would require CMS, months after the bid deadlines have passed, to permit a single MAO to revise bids it has already submitted. That relief would undermine the integrity of the Medicare Advantage bid

process and disrupt the timely dissemination of information on which millions of Medicare beneficiaries rely during the annual open enrollment period. Those public harms substantially outweigh Elevance's asserted private interest in revised bids.

First, Elevance's revised bid would occur after the release of public information revealing what their competitors have bid, giving Elevance a competitive advantage and depriving Medicare Advantage beneficiaries of the most competitively priced plan. *See* Exhibit 1, Lazio Declaration ("Lazio Dec."), ¶ 8. Plan sponsors must make competitive decisions about the level of benefits and premium to offer and how much gain/loss margin to retain in the initial bid submission, all without knowing what their competitors are bidding. *Id.* Once the national average monthly bid amount is released at the end of July, plan sponsors have much more information about their bid relative to competitor bids, allowing them to make different strategic decisions about the plan benefits, premiums, and the gain/loss margin to retain to either (i) make the plan more attractive to beneficiaries relative to competitor plans or (ii) retain more gain/loss margin as profit. *Id.* Competitors of such a plan sponsor would not have the option to make different strategic decisions after the national average monthly bid amount is known. *Id.*

Most of the bids submitted are for Medicare Advantage plans, like Elevance, that include Part D prescription drug benefits. Lazio Dec. ¶ 5. In its bid submission, an Medicare Advantage Part D plan sponsor submits the benefit and premium structure of a plan and the allocation of Medicare Advantage rebates (the amount by which a plan's bid is lower than the per capita cost of covering beneficiaries) to reach

a target Part D base premium. *Id.* at ¶ 3. When bids are submitted by the bid submission deadline, plans do not know the Part D basic premium. *Id.*

After bids are submitted, CMS is required to compute the monthly base beneficiary premium for prescription drug plans. 42 U.S.C. 1395w-113(a); *see also* 42 C.F.R. 423.286 (setting out the calculation methodology for monthly beneficiary premiums for Part D plans). On July 28, 2026, consistent with its practice in previous years, CMS released the Part D base beneficiary premium and information underlying that calculation. Lazio Dec. ¶ 7. The Calendar Year 2027 Part D national average monthly bid amount of $296.05. *Id.* Following its formula, CMS further concluded that the Part D base beneficiary premium is $41.33. Because this information was predicated on bids from other Medicare Advantage organizations that were then unknown to Elevance, it did not know the Part D base beneficiary premium amount. The plan-specific Part D basic premium is calculated as the sum of the base beneficiary premium and the difference between the plan's monthly bid and the national average monthly bid amount. *Id.*

Once these data are released, CMS opens a rebate reallocation period. Laxio Dec. ¶ 7. Rebate reallocation provides an opportunity for a plan sponsor to reallocate the Medicare Advantage rebates to return to the target Part D basic premium specified in the initial bid submission. *Id.* To protect the integrity of the competitive bidding process, bid changes for rebate reallocation are limited, as specified in guidance. *Id.* Once the national average monthly bid amount is released, plan sponsors have new information about their bid relative to other bids from competitor

plans. *Id.* at ¶ 8. Plan sponsors must balance the level of benefits and premium with how much profit to retain. *Id.* Critically, if CMS were to allow plans to resubmit bids after the national average monthly bid amount has been publicly released, Elevance could use the new information to make different strategic decisions about the plan benefits, premiums, and the gain/loss margin to retain to make the plan more attractive to beneficiaries relative to competitor plans. *Id.* Consequently, beneficiaries will not receive the most competitively priced plan.

Second, allowing bids to be submitted following the close of the bid cycle creates risk that CMS will publish printed materials containing information that conflicts with materials published online, generating confusion and undermining trust in the information CMS publishes regarding the Medicare Advantage program. Exhibit 2, Goldstein Declaration ("Goldstein Dec."), ¶ 5.

The *Medicare & You* handbook is mailed to over 65 million beneficiaries each year and serves as a comprehensive reference that helps current and prospective Medicare enrollees understand their coverage options, rights, and benefits under the Medicare program. Goldstein Dec. ¶ 2. Submission of new bids in mid-August would not provide sufficient time to review the new bid and include any changes in the Medicare & You Handbook that is statutorily required to be sent in September. *See* 42 U.S.C. 1395w-21(d)(2).

If the handbook, which often serves as beneficiaries' primary reference, contains different benefit or premium information than what appears in the online Plan Finder, beneficiaries are left with no definitive source of information. Goldstein

Dec. ¶ 5. Seniors who carefully reviewed their printed handbooks may arrive at Plan Finder only to find conflicting information, leaving them uncertain about which source to trust and whether the plan they selected is truly what they expected. *Id.* This inconsistency is especially harmful for beneficiaries who lack internet access and depend solely on the printed handbook, as they may be making decisions based on outdated or inaccurate information without even knowing it. *Id.* Data accuracy and consistency across all CMS communication channels is important to protecting the integrity of the Medicare Open Enrollment process.

These public interests substantially outweigh Elevance's request to submit revised bids after the close of the statutory bidding process. Because the requested injunction would confer a competitive advantage on a single insurer while disrupting CMS's administration of the Medicare Advantage program and impairing the information available to millions of beneficiaries, the balance of equities and the public interest weigh decisively against preliminary relief.

CONCLUSION

This Court should deny Elevance's motion for a preliminary injunction.

Respectfully submitted,

MARGARET E. HEAP
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UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF GEORGIA
BRUNSWICK DIVISION

ELEVANCE HEALTH, INC. ET AL.,	)	
	)	
Plaintiffs,	)	
	)	
v.	)	Case No. 2:26-cv-061
	)	
U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, ET AL.,	)	
	)	
Defendants.	)	

DECLARATION OF JENNIFER LAZIO

I, Jennifer Lazio, declare pursuant to 28 U.S.C. § 1746 as follows:

1. I am the Director of the Parts C & D Actuarial Group (PCDAG) within the Office of the Actuary in the Centers for Medicare & Medicaid Services ("CMS") of the United States Department of Health and Human Services. I have held this position since December 2014. In my role, I oversee the actuarial aspects of the Medicare Part C program, which includes Medicare Advantage (MA), and the Medicare outpatient prescription drug benefit program (Part D). I manage a team of professional staff who conduct the Group's work. PCDAG develops Excel forms (called bid pricing tools) and associated instructions for submission of MA and Part D bid pricing by plan sponsors, reviews and audits MA and PD bid pricing submissions, develops the MA benchmark rates, and prepares enrollment and expenditure projections for Parts C and D under current law and under proposed modifications to current law. The statements made in this declaration are based on my personal knowledge, information contained in agency files, and information furnished to me in the course of my official duties.

2. The process by which Medicare Advantage Organizations (MAOs) submit bids for their plans and CMS reviews and approves these bids in time for the Medicare fall enrollment period beginning on October 15th is complex and multi-layered. For bid submission, each commercial insurer that would like to offer a Medicare Advantage plan submits a plan-specific bid (an amount covering the expected costs of a standard benefit package for an average risk beneficiary) to CMS by the first Monday in June of the preceding year (bid submission deadline). This bid, which must also be accompanied by projected enrollment in the counties covered by the plan, is measured against county-level benchmark rates set by CMS. The benchmark is a bidding target. The Medicare Advantage benchmark rates are determined under statutory formulas whereby county-level rates vary depending on average fee-for-service spending per Medicare beneficiary. Medicare Advantage plans with star ratings of 4.0, 4.5, or 5.0 receive a Quality Bonus Percentage (QBP) increase in the calculation of the county benchmark rates.

3. CMS receives 11,000-12,000 Medicare Advantage and Part D bids each year from 200-300 MAOs. The bids are used to determine a plan-specific bid payment from Medicare and the associated premium charged to beneficiaries. If a plan bids above the benchmark, the enrollee pays a premium equal to the difference between the standardized benchmark and the standardized bid. In addition to the bid payment, plans that bid below the benchmark also receive payment from Medicare in the form of a "rebate." The rebate is a fixed percentage of the difference between the plan's actual bid (not standardized) and its risk-adjusted benchmark. The fixed percentages are 50, 65, and 70 percent, depending on a plan's star rating. A plan that receives a rebate must "return" the rebate to its enrollees in the form of supplemental benefits, reduced plan premiums, or reduced cost-sharing. The plan can apply any premium savings to the Part B premium (in which case the government retains the amount for that use), to the Part D premium, or to the premium for the total

package that may include supplemental benefits. The lower a plan bids below the benchmark, the higher the rebate.

4. The bids must be reviewed by the end of July in order for the bids to be approved and contracts executed in time for the fall enrollment period. The review of the bid pricing includes an examination of the extensive documentation that supports the entries in the bid pricing tool to confirm that the data, methods, and actuarial assumptions are appropriate, meet actuarial standards of practice, and meet program requirements. When the documentation is insufficient to reach a conclusion about the reasonableness of the bid pricing, questions are sent to the plan sponsor and certifying actuary. This can be an iterative process with multiple rounds of questions and responses until resolution is reached. Resolution may involve the certifying actuary providing additional supporting documentation. In some cases, resolution may require changes to actuarial assumptions, data sources, or methods, that affect the plan bid, so that the bid is appropriately supported.

5. Most of the bids submitted are for Medicare Advantage plans that include Part D prescription drug benefits. When bids are submitted by the bid submission deadline, a plan's Part D basic premium is unknown. Specifically, the plan-specific Part D basic premium is calculated as the sum of the base beneficiary premium and the difference between the plan's monthly bid and the national average monthly bid amount. The base beneficiary premium is calculated according to a statutory formula, using a percentage of the average bid amount and estimates of reinsurance costs submitted by certain Part D plans for the basic benefit, although the Inflation Reduction Act included a provision to cap the annual increase through 2029.

6. In its bid submission, an MA-PD plan sponsor submits the benefit and premium structure of a plan and the allocation of MA rebates to reach a target Part D basic premium. At the

bid submission deadline, the Part D basic premium after application of the Medicare Advantage rebates to buy down the premium is considered a target because the plan's Part D basic premium will not be known until the national average monthly bid amount is released.

7. At the end of July each year, CMS releases information to all plan sponsors showing the national average monthly bid amount, which allows plan sponsors to calculate plan-specific Part D basic premiums. CMS released this information for the 2027 bid cycle on July 28, 2026 (https://www.cms.gov/files/document/july-28-2026-parts-c-d-announcement.pdf). Once this information is released, CMS opens a rebate reallocation period. Rebate reallocation provides an opportunity for a plan sponsor to reallocate the MA rebates to return to the target Part D basic premium specified in the initial bid submission. To protect the integrity of the competitive bidding process, bid changes for rebate reallocation are limited, as specified in the rebate reallocation guidelines contained in Appendix E of the Instructions for Completing the Medicare Advantage Bid Pricing Tools (https://www.cms.gov/files/zip/cy-2027-bid-tools-instructions.zip).

8. Plan sponsors must make competitive decisions about the level of benefits and premium and how much gain/loss margin to retain in the initial bid submission, when they do not know what their competitors are bidding. Once the national average monthly bid amount is released, plan sponsors have much more information about their bid relative to competitor bids. The ability for plan sponsors to change their strategic approach at this point is therefore kept extremely limited by CMS. If CMS were to allow a plan sponsor to resubmit bids after the national average monthly bid amount is known (outside of the limited changes specified in the rebate reallocation guidelines), the plan sponsor could use the new information to make different strategic decisions about the plan benefits, premiums, and the gain/loss margin to retain to either (i) make the plan more attractive to beneficiaries relative to competitor plans or (ii) retain more gain/loss

margin as profit, whereby beneficiaries do not receive the most competitively priced plan. Competitors of such a plan sponsor would not have the option to make different strategic decisions after the national average monthly bid amount is known.

In accordance with 28 U.S.C. § 1746, I hereby declare under penalty of perjury that the foregoing is true and correct to the best of my knowledge.

Executed this 30th day of July, 2026, in Pasadena, California.

Jennifer Lazio

Jennifer Lazio

UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF GEORGIA
BRUNSWICK DIVISION

ELEVANCE HEALTH, INC. ET AL.,	)	
	)	
Plaintiffs,	)	
	)	
v.	)	Case No. 2:26-cv-061
	)	
U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, ET AL.,	)	
	)	
Defendants.	)	

DECLARATION OF ELIZABETH GOLDSTEIN IN SUPPORT OF DEFENDANTS' OPPOSITION TO PLAINTIFFS' MOTION FOR PRELIMINARY INJUNCTION

I, Elizabeth Goldstein, declare pursuant to 28 U.S.C. § 1746 as follows:

1. I am the Director of the Division of Consumer Assessment and Plan Performance, Medicare Drug Benefit and C & D Data Group at the Centers for Medicare & Medicaid Services (CMS) within the Department of Health and Human Services (HHS). I have held this position since October 2000, and I have been employed by CMS since 1993. Statements made in this declaration are based on my personal knowledge, information contained in agency files, and information furnished to me in the course of my official duties.

2. Medicare enrollees rely on multiple tools and publications to make their enrollment decisions, most notably the *Medicare & You* Handbook, that is statutorily required to be sent in September, *see* 42 U.S.C. 1395w-21(d)(2), and the Medicare Plan Finder on Medicare.gov.

3. The *Medicare & You* handbook is the official annual guide published by CMS for Medicare beneficiaries. It is mailed to over 65 million beneficiaries each year and serves as a comprehensive reference that helps current and prospective Medicare enrollees understand their coverage options, rights, and benefits under the Medicare program. CMS mails it to all Medicare

households in September each year prior to open enrollment. It has information about Medicare benefits, costs, rights, and protections; health and drug plans; and answers to common questions. The *Medicare & You* handbook includes a plan-specific section that provides localized and personalized information about the health and drug plans available in a beneficiary's area, including plan-specific premium and cost-sharing details to help beneficiaries compare options during open enrollment.

4. The Health Plan Management System (HPMS) team will send the final *Medicare & You* handbook dataset to the Office of Communications (OC) on Friday, August 14, 2026 so OC can get the handbook to their print contractor. This mid-August transmission from the HPMS team to OC has been standard practice for many years.

5. Submission of new bids in mid-August would not provide sufficient time to review the new bid and include any changes in the Medicare & You Handbook. Even if a Medicare Advantage plan were to change its benefits and premiums to be more generous during this period, it would still create significant confusion and concern for beneficiaries, particularly when that updated information is not consistently reflected across all CMS resources. An MAO submitting a new or revised bid in mid-August would create downstream consequences that cannot be remediated within the required timeframes. A mid-August bid submission would not allow sufficient time for CMS to review the revised bid and have benefit and premium information ready to populate the *Medicare & You* handbook and Medicare Plan Finder, all of which enrollees depend on to make informed coverage decisions during the Annual Enrollment Period.

6. If the handbook, which often serves as beneficiaries' primary reference, contains different benefit or premium information than what appears in the online Plan Finder, beneficiaries will be unsure which is the definitive source of information. A senior who carefully reviewed their

handbook may arrive at Plan Finder only to find conflicting information, leaving them uncertain about which source to trust and whether the plan they selected is truly what they expected. This inconsistency is especially concerning for beneficiaries who lack internet access and depend solely on the printed handbook, as they may be making decisions based on outdated or inaccurate information without even knowing it. Data accuracy and consistency across all CMS communication channels is important to protecting the integrity of the Medicare Open Enrollment process.

Executed this 31st day of July, 2026, in Baltimore, Maryland.

_____

Elizabeth Goldstein