UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

UNITEDHEALTHCARE OF NEW YORK.

and

OXFORD HEALTH INSURANCE, INC.

Plaintiffs,

-against- 17-CV-7694

MARIA T. VULLO, in her official capacity as Superintendent of Financial Services of the State of New York,

Defendant

COMBINED MEMORANDUM OF LAW IN OPPOSITION TO PLAINTIFFS' CROSS MOTION FOR SUMMARY JUDGMENT AND IN REPLY TO DEFENDANT'S MOTION TO DISMISS PURSUANT TO FRCP 12(b)(1) AND 12(b)(6)

ERIC T. SCHNEIDERMAN
Attorney General of the State of New York
Attorney for Defendant
The Capitol
Albany, New York 12224-0341

C. Harris Dague
Kelly L. Munkwitz
Assistant Attorneys General, of Counsel
Telephone: (518) 776-2621
Fax: (518) 473-1572 (Not for service of papers)

Date: February 16, 2018

Table of Contents

PRELIMINARY STATEMENT

The United States Department of Health and Human Services ("HHS") is the Federal agency responsible for administering the Affordable Care Act ("ACA"). HHS's responsibilities have included the design, creation, and operation of a risk adjustment program ("ACA-Risk Adjustment Program" or "ACA-Risk Adjustment"). The ACA-Risk Adjustment Program was established by HHS through regulations first promulgated in 2013 and updated on a yearly basis since.

By May 2016, HHS realized that its Program was having exaggerated and unintended consequences in certain states that were destabilizing the health insurance markets in those states. One of the states most disproportionately affected was New York. Rather than immediately revise the ACA-Risk Adjustment Program, HHS encouraged and authorized states – including New York – "to examine whether any local approaches, under State legal authority, are warranted to help ease this transition to new health insurance markets", and to "take temporary, reasonable measures under State authority to mitigate effects under their own authority." 81 F.R. 29152; 81 Fed. Reg. 94159 & 82 Fed. Reg. 51073.

New York did exactly what the Federal government (HHS) told it to do.

Pursuant to HHS's authorization and the existing statutory authority provided by N.Y. Insurance Law 3233, Defendant Maria T. Vullo, the New York Superintendent of Financial Services ("DFS"), promulgated a new emergency regulation – 11 NYCRR § 361.9 – to ameliorate the exaggerated and unintended consequences of the Federal Program and to help stabilize the small group health insurance market in New York (hereinafter "NY Market Stabilization Regulation" or "Emergency Regulation").

The NY Market Stabilization Regulation addresses the disproportionate consequences of

the ACA-Risk Adjustment Program in New York by authorizing the Superintendent to deploy an additional risk adjustment program separate and apart from the ACA-Risk Adjustment Program. Id. The additional risk adjustment program, however, can only be established after the ACA-Risk Adjustment Program runs its course for the 2017 plan year (which will occur in June 2018 at the earliest) and only if the Superintendent determines that an additional risk adjustment program is necessary to help stabilize the small group health insurance market in New York. Moreover, the risk adjustment program authorized by the NY Market Stabilization Regulation is limited to 30% of the magnitude of the ACA-Risk Adjustment transfers, based on New York market specific considerations.

Over a year after the NY Market Stabilization Regulation was issued, Plaintiffs filed the pending lawsuit asserting (1) Supremacy Clause/preemption claims; (2) taking/Exactions Clause; and (3) Section 1983 claims challenging the regulation[1]. See Dkt. No. 1.

On December 15, 2017, Defendant Vullo filed a motion to dismiss all counts in Plaintiffs' Complaint pursuant to FRCP 12(b)(1) and (12)(b)(6) (the "Underlying Motion"). Dkt, Nos. 31-33. Defendant's Underlying Motion raised multiple grounds for dismissal, including: (1) lack of subject matter jurisdiction over Plaintiffs' claims; (2) imposition of Burford Abstention, in the event the Court exercised jurisdiction; (3) non-justiciability of Plaintiffs' claims under the ripeness doctrine, and; (4) dismissal of Plaintiffs' causes of action for failure to state a claim. Defendant asserts that the Underlying Motion is fully dispositive of all causes of action.

On January 9, 2018, Plaintiffs' filed a Cross-Motion for Summary Judgment and submitted a combined memorandum in support of their cross-motion and in opposition to Defendant's motion

[1] Notably, half of Plaintiffs' causes of action challenge a proposed regulation that would apply to the 2018 plan year and beyond. Plaintiffs acknowledge that these challenges to the as-yet enacted, proposed regulation are plainly premature and need not be considered by this Court. See Dkt. No. 34 at 2, FN1.

to dismiss ("Cross Motion"). In accordance with the briefing schedule set by the Court on December 15, 2017, Defendant now submits this combined memorandum in opposition to Plaintiffs' Cross Motion and in Reply (and further support) of Defendant's motion to dismiss.

This Opposition and Reply Memorandum includes six parts. Part I explains why the general rule that Federal courts have jurisdiction over suits to enjoin state officials from interfering with Federal rights does not apply to Plaintiffs' Supremacy Clause causes of action (Counts I, II, VI, VII). As recognized by the Supreme Court in Armstrong v. Exceptional Child Ctr., Inc. [135 S. Ct. 1378, 1383 (U.S. 2015), the general rule does not apply where Congress has elected to provide an agency with unilateral power to enforce a Federal statue and where the statute is judicially unadministrable. The Armstrong foreclosure rule is applicable to the ACA-Risk Adjustment Program, rendering Plaintiffs' preemption claims dismissible pursuant to FRCP 12(b)(1).

Part II demonstrates why, as a matter of law, even if the Court exercises jurisdiction over Plaintiffs' preemption claims, they should be dismissed pursuant to FRCP 12(b)(6) for failure to state a claim. Even without HHS's public and private statements encouraging New York to issue the Emergency Regulation, the NY Market Stabilization program readily satisfies all elements of the express preemption, field preemption, and conflict preemption analyses. But, where, as here, the Federal government expressly and repeatedly authorizes and encourages such exact state action, it is simply not possible for the resulting action to be illegal under any preemption analysis.

Part III addresses both the ripeness and legal sufficiency of Plaintiffs' Takings/Exactions claims. Until the ACA-Risk Adjustment Program for the 2017 plan year is completed (in June 2018 at the earliest), there is no action that can even be taken pursuant to the Emergency Regulation. Of course, until action is taken pursuant to the NY Market Stabilization Regulation,

Plaintiff's claims are non-justiciable for lack of ripeness. Nevertheless, even if the claims were ripe, they should still be dismissed as matters of law. In the 1990s, New York courts already rejected identical Takings and Exaction challenges to the market stabilization regulations that were utilized in the individual and small group markets in New York prior to the ACA. Just as the Plaintiffs' receipt of money under ACA-risk adjustment does not constitute a Taking, neither would fund transfers under New York's Emergency Regulation.

Part IV explains why Plaintiffs' opposition to the application of Burford Abstention is founded on factually distinct precedent, which does not support their position. The cases relied upon by Plaintiffs do not contemplate a complex area of law that is traditionally of State concern, like the N.Y. Insurance Law and regulations at issue here. In the unlikely event this Court even finds a basis for original jurisdiction, Plaintiffs' have not offered any grounds for it to avoid application of the Burford.

Parts V responds to Plaintiffs' ill-conceived 42 U.S.C. §1983 claims. Plaintiffs' Section 1983 claims are either improperly pled or must be merged with their Takings/Exaction causes of action, as matters of well-established law.

Part VI explains why Plaintiffs cannot satisfy the standard for declaratory or permanent injunctive relief in this case.

For all of the reasons set forth herein, and in Defendant's Underlying Motion, Plaintiffs' cross motion for summary judgment must be denied and Defendant's Motion to Dismiss granted on all counts.

STATEMENT OF RELEVANT FACTS AND LEGAL BACKGROUND

Defendant's Motion to Dismiss contains a complete discussion of the Federal and State risk adjustment paradigms and the statutory history relevant to the jurisdictional and legal issues

before the Court. These facts are incorporated by reference hereto. The additional facts set forth herein are submitted in opposition to Plaintiffs' Cross Motion for Summary Judgment.

ACA-Risk Adjustment Has a Distorted Impact in New York

By all objective measures – including the data and estimates submitted by Plaintiffs – the ACA-Risk Adjustment Program has had extremely distortive impacts in New York. Powell 2d Decl. ¶ 21. There are several ways to measure the impact of the ACA-Risk Adjustment Program in New York as compared to other states. Id. ¶ 22. One measure is a comparison of the aggregate dollar amount of the transfers required under the ACA-Risk Adjustment Program that are made in New York as compared to other states. Id. This measure of the aggregate dollar amount of transfers – known as the size of a state's ACA-Risk Adjustment Pool – is a way to understand the sheer magnitude of the transfers in a particular state. Id.

For the 2014 plan year, New York's total ACA-Risk Adjustment pool for the small group market was $195,038,660. Id. ¶ 23. This was, by far, the largest ACA-Risk Adjustment pool in the country. Id. The state with the second highest risk adjustment pool was California whose risk adjustment pool was $42,543,626. Id. The state with the third highest risk adjustment pool was Pennsylvania whose risk adjustment pool was $31,567,964. Id. In short, New York's risk adjustment pool was materially larger relative to its population. Id.

This distortion continued. For the 2015 plan year, New York's total ACA-Risk Adjustment pool for small group was $341,996,248. Id. ¶ 24. Once again, this was, by far, the largest ACA-Risk Adjustment pool in the country. Id. The state with the second highest risk adjustment pool was California whose risk adjustment pool was $163,666,550. Id. The state with the third highest risk adjustment pool was New Jersey whose risk adjustment pool was $48,269,532. Id. In other words, insurance companies in New York in 2015 transferred over twice as much money under

the ACA Risk-Adjustment Program than any other state including California which has a far larger population and more people enrolled in small group health insurance plans that are subject to ACA Risk-Adjustment. Id. ¶ 25.

A second measure of the impact of the ACA-Risk Adjustment Program in New York as compared to other states is a comparison of the "per member per month" transfers in each state. This metric eliminates the variation in population size and enrollment size in health insurance plans subject to risk adjustment from the state to state analysis of the impact of ACA-Risk Adjustment. Id. ¶ 26.

For the 2014 plan year, only three statistically irrelevant states—Hawaii, South Dakota, and Wyoming—all of which have extremely small, small group markets – had higher per member per month transfers. Id. ¶ 27. New York's per member per month transfer in the small group market for the 2014 plan year was $23.91, as compared to California's $9.21 or Pennsylvania's $12.93 per member per month transfers. Id. New York's per member per month transfers were nearly double the average transfer ($12.73). Id.

For the 2015 plan year, the per member per month transfers provided by ACA-Risk Adjustment in New York for small group was $29.86. Id. ¶ 28. This was, by far, the largest per member per month transfer required by the ACA-Risk Adjustment pool in the county for 2014. Id. The states with the second and third largest per member per month transfers were the small markets of Alaska and Hawaii with per member per month transfers of $24.14 and $24.80 respectively. Id. In contrast, California had $14.08 per member per month transfers and New Jersey's transfers landed at $10.69 per member per month. Id. The per member per month transfers provided by ACA-Risk Adjustment in New York were disproportionately large as

compared to similarly situated states. Id. Indeed, they were more than double the average per member per month transfer ($12.60). Id.

A final relevant metric in examining ACA-Risk Adjustment is a state's Average Plan Liability Risk Score, commonly referred to simply as the state's Risk Score. In general, a risk score is a measure an individual's health status or risk based on diagnoses codes contained in claims data. Id. ¶ 29. A state's Risk Score, for ACA-Risk Adjustment purposes, is the average risk score of all of the individuals in a given insurance market as calculated by HHS. Id. Contrary to expectations, New York's Risk Score has been the highest among the fifty states in every year that ACA-Risk Adjustment has been run. Id. ¶ 30.

For the 2014 plan year New York's Risk Score was 1.643 which significantly exceeded the average state Risk Score of 1.315. It was also 7.5% higher than Oklahoma's 1.528 Risk Score which was the second highest. Id.

For the 2015 plan year New York again had the highest Risk Score at 1.803. This was again significantly higher than the average state Risk Score of 1.408. Rhode Island and Alabama ranked second and third in Risk Score with 1.693 and 1.580 respectively. New York's Risk Score was therefore over 14% higher than Alabama's. Id.

Shifting to Plaintiffs' own data, the risk adjustment transfers provided under the ACA-Risk Adjustment Program far exceeded the estimates of the transfers prepared by the actuaries at both UnitedHealthcare and Oxford. Id. ¶ 31. Under New York's "prior approval" law insurers must seek approval from DFS for their yearly rate adjustments. See N.Y. Ins. Law §§ 3231(e)(1)(E), 4308(c). Among the factors that comprise this review, insurers must include in their rate submissions a factor accounting for anticipated receipts or liabilities in ACA-Risk Adjustment. Powell 2d Decl. ¶ 32. An insurer's anticipated receipts from ACA-Risk Adjustment will decrease

its premium cost in proportion to the size of the receipts. Id. In other words, all other things being equal, the higher an insurer's anticipated receipts from ACA-Risk Adjustment, the lower the premium should be. Id. And the higher an insurer's anticipated liability from risk adjustment, the higher the premium should be. Id. Using simple math, the factor used by insurers in rate review to account for anticipated receipt or liabilities from ACA-Risk Adjustment can be used to determine the aggregate (i.e., dollar amount) that the insurer expects to receive or pay pursuant to the ACA-Risk Adjustment Program for the following plan year. Id.

In its submissions to DFS, Plaintiff Oxford consistently underestimated its ACA-Risk Adjustment receipts in the small group market. Id. ¶ 33. For 2014 rate setting, Oxford projected a receivable from ACA-Risk Adjustment of $37,526,179 for its New York business. Id. In actuality, Oxford received $145,248,014 under the ACA-Risk Adjustment Program for this year. Id. For 2015 rate setting, Oxford, after being required by DFS to project a larger receivable than first submitted for 2015 rates, estimated a receivable from ACA-Risk Adjustment of $150,574,691. Id. In actuality, Oxford received more than double the amount, or $315,374,420, under the ACA-Risk Adjustment Program for that year which was reduced to $211,846,960 but only because one of the insurers in the New York market became insolvent. Id. For 2016 rate setting, after again being required by DFS to make an upward adjustment to the estimated receivable that was first submitted for 2016 rates, Oxford projected a receivable from ACA-Risk Adjustment of $211,943,022.67. Id. In actuality, Oxford received $254,933,461 under the ACA-Risk Adjustment Program for that year. Id.

The systematic underestimation of its risk adjustment receivables has provided Oxford with a windfall. Id. ¶ 33. Because the company underestimated ACA-Risk Adjustment receipts by $211,984,542 for the years 2014 through 2016, the company was permitted to charge and it

received far higher health insurance rates than it would have been allowed had the projected risk adjustment receivable equaled the actual amounts received. Id.

Plaintiff UnitedHealthcare has also consistently underestimated its ACA-Risk Adjustment receipts in the individual market. Id. ¶ 35. For 2014 rate setting, UnitedHealthcare projected a receivable from ACA-Risk Adjustment of $1,165,248 for its New York business. Id. In actuality, UnitedHealthcare received four times that amount, or $4,787,190, under the ACA-Risk Adjustment Program for this year. Id. For 2015 rate setting, UnitedHealthcare, after being required by DFS to project a greater receivable than first submitted for 2015 rates, estimated a receivable from ACA-Risk Adjustment of $3,616,547. Id. In actuality, UnitedHealthcare received $10,564,737 under the ACA-Risk Adjustment Program for that year which was reduced to $9,306,990 but only because one of the insurers in the New York market became insolvent. Id. For 2016 rate setting, after again being required by DFS to make an upward adjustment to the estimated receivable that was first submitted for 2016 rates, UnitedHealthcare projected a receivable from the ACA-Risk Adjustment Program of $3,829,317. Id. In actuality, UnitedHealthcare received $5,932,308 under the risk adjustment program for that year. Id. Similar to Oxford, the systematic underestimation of its risk adjustment receivables has provided UnitedHealthcare with a windfall. Id. ¶ 36. Because the company underestimated ACA-Risk Adjustment receipts by $11,415,376, the company was permitted to charge and it received far higher health insurance rates than it would have been allowed had the projected risk adjustment receivable equaled the actual amounts received. Id.

In Accordance with HHS Published Rules and Guidance Directly Provided by HHS, DFS Took Action to Address the Disproportionate and Exaggerated Impact of ACA-Risk Adjustment in New York and Issues Market Stabilization Regulations

At the outset, as set forth in detail within Defendant's Underlying Motion, HHS has never

taken the position that its implementation of a risk adjustment program under the ACA on behalf of the several states forecloses state authority over market stability. Powell 2d. Decl. ¶¶ 11-15; Underlying Mot. at 9-10, 34-38. To the contrary, HHS has repeatedly acknowledged unexpected problems with ACA-Risk Adjustment and encouraged states to use pre-existing state authority to ease market instability concern. Powell 2d Decl. ¶ 18-20; 81 Fed. Reg. 29146, 29152 (May 11, 2016), 81 Fed. Reg. 94058, 94159 (Dec. 22, 2016), 82 Fed. Reg. 51052, 51073 (Nov. 2, 2017).

After the final ACA-Risk Adjustment results were issued by HHS for the 2014 plan year, DFS began evaluating, and initiated discussions with HHS about, the causes and consequences of the disproportionate and excessive magnitude of New York's ACA-Risk Adjustment transfers. Powell 2d Decl. ¶ 37. After review by the DFS's actuarial team, DFS determined that approximately 30% of the magnitude of the ACA-Risk Adjustment transfers could be explained by factors including New York's unique family tiering structure and the use of a statewide average premium in the calculation of the transfers that included administrative expenses, profits and claims rather than just claims. Id. ¶ 38.

Following the release of the 2015 ACA-Risk Adjustment results and after identifying the root causes of the disproportionate impact, DFS also determined that the sheer magnitude of the risk adjustment liabilities was having a destabilizing impact on the market for small group health insurance in New York. Id. ¶ 39. In accordance with HHS's guidance in the interim final rule issued on May 11, 2016, DFS began developing New York "approaches, under State legal authority, . . . to help ease this transition to new health insurance markets." Id.; 81 Fed. Reg. 29146, 29152 (May 11, 2016).

After consultation with HHS, as described in further detail below, and a review of the available data, DFS determined that use of independent Market Stabilization authority under New

York Insurance Law § 3233 was critically necessary in order to ensure market stability until HHS was able to take corrective action within the ACA-Risk Adjustment methodology to correct for the destabilizing impact. Powell 2d Decl. ¶ 40. Since the implementation of ACA-Risk Adjustment, two companies operating in New York's small group market, both of whom were required to make large payments into the ACA-Risk Adjustment pool, have left the market. Id. ¶ 39. The first went into liquidation, with ACA-Risk Adjustment liabilities playing a role in its insolvency. Id. The second voluntarily withdrew from the market citing the scale of ACA-Risk Adjustment transfers as a major cause. Id. The departure of both of these insurers has had negative and destabilizing effects on the health insurance market in New York with adverse impacts for both consumers and small businesses. Id.

At the same time, as noted above, Plaintiffs have received extremely large risk adjustment transfers and high premiums from New York consumers, receiving a large windfall from the disparate impact of ACA-risk adjustment. Id. ¶ 41. DFS therefore determined that it was necessary to take action to help stabilize New York's markets. Id. ¶ 42. DFS did so in full cooperation with HHS. Id.

On or about August 8, 2016 DFS participated in a call with HHS, including Jeff Wu, who was at the time Deputy Director for Policy, Center for Consumer Information and Insurance Oversight ("CCIIO"), Centers for Medicare & Medicaid Services ("CMS"), HHS. Id. During that call DFS relayed to HHS that New York was exploring the use of its independent state market stabilization authority to reduce the destabilizing market impact of ACA-Risk Adjustment, by reducing the magnitude of the transfers, after HHS had administered the ACA-Risk Adjustment and released the final results. Id. Deputy Director Wu expressed support for this proposed use of New York state authority and raised no objection to such a program. Id.

On or about September 8, 2016 DFS engaged in a call with HHS, including Jeffrey Grant, presently the Acting Director of Policy CCIIO/HHS, who, upon information and belief, at the time held the position of Director, Payment Policy & Financial Management Group, CCIIO, CMS, HHS. Id. ¶ 43. During that call, DFS provided HHS with a summary of the form and content of the then-draft DFS emergency regulation, how it would operate, and the state authority under which DFS was proceeding. Id. Consistent with the call on August 8, 2016, HHS raised no objection to DFS's regulation and the use of state authority to reduce the magnitude of the transfers caused by ACA-Risk Adjustment. Id.

The next day, on September 9, 2016, DFS promulgated 11 NYCRR § 361.9 as an emergency regulation ("Emergency Regulation"). Id. ¶ 44. This initial Emergency Regulation expired on December 7, 2016, and was promulgated again as an emergency regulation on that same date. 38 N.Y. Reg. 20 (Dec. 28, 2016). Id. ¶ 45. Subsequent expirations and emergency promulgations occurred in the same manner with no material changes on March 6, 2017, June 21, 2017, July 31, 2017, September 28, 2017, November 24, 2017, and January 22, 2018. Id. On December 22, 2016, months after the Emergency Regulation was first promulgated, HHS published its Notice of Benefit and Payment Parameters for 2018 as a final rule at 81 Fed. Reg. 94058. Within that final rule HHS recognized and confirmed that it supported use of independent state authority to mitigate the impact and magnitude of ACA-Risk Adjustment transfers. Powell 2d Decl. ¶ 46. HHS stated "[HHS] encouraged, and continues to encourage States to examine whether any local approaches, under State legal authority, are warranted to help ease this transition to new health insurance markets". 81 Fed. Reg. 94058, 94159 (Dec. 22, 2016).

At no time has HHS informed DFS that the Emergency Regulation is in any way contrary to Federal law. Powell 2d Decl. ¶ 47. On or about October 2, 2017, DFS had a call with Erin

Sutton – who upon information and belief was and currently is, Deputy Group Director, Payment Policy & Financial Management Group, CCIIO, CMS, HHS—and other employees of HHS. Id. ¶ 48. On that call, DFS provided a walkthrough of the structure, purpose, function, and legal basis of the regulation. Id. During this October 2 call, HHS, as it had previously privately and publicly stated, was supportive of a state-authority based solution to the deficiencies in the ACA-Risk Adjustment Program, such as the one DFS had promulgated. Id.

On or about October 19, 2017, DFS received an email from Krutika Amin—who upon information and belief was and currently is a Health Insurance Specialist with the Payment Policy and Financial Management Group, CCIIO, CMS, HHS. Id. ¶ 49. This email thanked DFS for the October 2 walkthrough and offered: "As always, please let us know if anything would be helpful on our end as you operationalize your regulation". Id.

On or about November 2, 2017, HHS released its proposed Notice of Benefit and Payment Parameters for 2019, published at 82 Fed. Reg. 51052. Consistent with the October 2 call, and with all previous guidance DFS received from HHS, the proposed Notice of Benefit and Payment Parameters for 2019 noted:

> In the 2016 Interim Final Rule, HHS recognized some State regulators' desire to reduce the magnitude of risk adjustment charge amounts for some issuers. We acknowledged that States are the primary regulators of their insurance markets, and as such, we encouraged States to examine whether any local approaches under State legal authority are warranted to help ease the transition to new health insurance markets.
> ***
> As noted above, a State that wishes to make an adjustment for the magnitude of these transfers in the individual and small group markets may take temporary, reasonable measures under State authority to mitigate effects under their own authority. 82 Fed. Reg. 51052, 51073 (Nov. 2, 2017).

HHS was fully informed of the Emergency Regulation before it was promulgated, at the time of its promulgation, and after it was promulgated, and HHS has been publicly and privately

supportive of it. Powell 2d Decl. ¶ 52. Throughout numerous conversations between DFS and HHS and various HHS publications, HHS has never even remotely suggested or cautioned that the Emergency Regulation would in in way prevent the application of the ACA-Risk Adjustment or was preempted by Federal law. Id. ¶ 53.

DFS Has Not Yet Determined Whether a Market Stabilization Pool will be Implemented for 2017

By its plain language, the Emergency Regulation dictates that the decision whether or not to implement a market stabilization pool for the 2017 plan year can only be made after the release of ACA-Risk Adjustment results, which as noted above are released annually in June for the prior plan year. Id. ¶ 55. Therefore, the risk adjustment results for the 2017 plan year will be available this June. Id.

As results for 2017 ACA-Risk Adjustment will not be released until June 2018, and in any event, have not yet been released, DFS has not, and indeed cannot, make any determination whether a market stabilization pool will be used for 2017. DFS has not made a final decision by DFS to implement a market stabilization pool under the Emergency Regulation for 2017. Indeed, the express terms of the regulation do not allow for such a determination until after ACA-Risk Adjustment results are released. Id. ¶ 56.

ARGUMENT

POINT I
PROPER APPLICATION OF ARMSTRONG PRECLUDES JURISDICTION OVER PLAINTIFFS' SUPREMACY CLAUSE CLAIMS

As a general rule, Federal courts have jurisdiction over suits to enjoin state officials from interfering with Federal rights. See, e.g., Ex Parte Young, 209 U.S. 123, 160-62 (1908). But, as set forth in the Supreme Court's decision in Armstrong v. Exceptional Child Ctr., Inc. the general rule does not apply where Congress has elected to provide an agency with unilateral power to

enforce a Federal statue. 135 S. Ct. 1378, 1383. Pursuant to Armstrong, equity jurisdiction for private enforcement of Federal rights under a statutory program ceases to exist where (1) Congress intended to foreclose equitable relief either explicitly or implicitly and (2) the statutory program is judicial unadministrable. Id. Contrary to the arguments raised in Plaintiffs' Cross Motion, the Armstrong limitation is plainly applicable in this case.

A. Armstrong Prong One: Congressional Intent to Foreclose Equitable Relief

With respect to this first element Plaintiffs contend that the primary inquiry under Armstrong is not whether the ACA provides for a private right of action, as demonstrated by Defendant [Underlying Mot. at 17-19], but instead whether it explicitly "precludes the exercise of equity jurisdiction". Cross Mot. at 18-19.

This argument does not withstand simple analysis of Armstrong itself. The Armstrong Court did not identify any explicit preclusionary language in the Medicaid Act. Instead Armstrong relied upon language that "implicitly precludes private enforcement" to foreclose equity jurisdiction. Armstrong 135 S. Ct. at 1385 (emphasis added). That is, rather than requiring explicit preclusionary language, the court conducted an analysis of the statute and implied a preclusion based on the "complexity of enforcing" the Medicaid Act provisions in question and the act's inclusion of "an administrative remedy". Id. Thus, contrary to Plaintiffs' position, Armstrong does not require the identification of "clearly" or expressly preclusive language to foreclose equity jurisdiction, but only evidence of a "implicit" preclusion. Id.

For all material purposes the analysis of the Medicaid Act under Armstrong is indistinguishable to the ACA. The ACA implicitly precludes private enforcement of the risk adjustment provisions such that equity jurisdiction cannot be extended. Just like the Medicaid Act, the ACA contains multiple provisions which limit enforcement authority to the HHS

Superintendent exclusively. See 42 U.S.C. §18041(c)(1)(b)(ii)(II); 42 U.S.C. §18041(c)(2), 42 U.S.C. § 300gg-22. These provisions are directly analogous to the "administrative remedy" present in the Medicaid Act, which formulated part of the Supreme Court's finding of "implicit" preclusion[2]. Armstrong, 135 S. Ct. at 1385.

Plaintiffs' attempt to distinguish the cited enforcement provisions in the ACA from those relied upon by the Armstrong Court rings hollow. Cross Motion at 19. Both provisions in ACA and Medicaid Act vest enforcement authority in the Secretary of HHS, and both involve programmatic penalties against the States. Compare ACA 42 U.S.C. §18041(c)(1)(b)(ii)(II); 42 U.S.C. §18041(c)(2), 42 U.S.C. § 300gg-22 with Medicaid Act 42 U.S.C. §1396c. In this respect the ACA and Medicaid Act are actually highly analogous, and Plaintiffs claim otherwise is nothing more than linguistic semantics.

Additionally, 42 U.S.C. §18041(c)(1)(b)(ii)(II); 42 U.S.C. §18041(c)(2), 42 U.S.C. § 300gg-22 are the only enforcement provisions within the ACA. Thus, despite Plaintiffs' contention that the ACA does not foreclose private enforcement, their memorandum is completely silent regarding any provisions in the ACA or legislative history demonstrating Congressional intent for private rights of action. See generally Cross Motion at 18-21.

Plaintiffs' Cross motion also fails to address the Armstrong Court's holding that an Act's provision of an express remedy "suggests that Congress intended to preclude others". Armstrong, 135 S. Ct. at 1385, citing Alexander v. Sandoval, 532 U.S. 275 (2001). Of course, in the face of the ACA's inclusion of provisions vesting enforcement in HHS (See e.g. 42 U.S.C. §18041(c)(1)(b)(ii)(II); 42 U.S.C. §18041(c)(2)), Sandoval represents an inconvenient precedent

[2] The statutory "administrative remedy" available under the Medicaid Act that was considered by Armstrong was a provision holding that the sole remedy provided for a State's failure to comply with Medicaid's requirements is the withholding of Medicaid funds by the Secretary of Health and Human Services. See 42 U.S.C. §1396c.

for Plaintiffs. In accordance with Armstrong and Sandoval, the cited enforcement provisions in the ACA must be interpreted to preclude private rights of action; a result that necessarily forecloses the extension of equity jurisdiction here.

Finally, Plaintiffs' Complaint is itself a prime example for why ACA enforcement should be vested exclusively with HHS. HHS has previously advised New York, and other states, that the "a state that wishes to make an adjustment for the magnitude of these transfers [in the ACA-Risk Adjustment Program] in the individual and small group market may take temporary, reasonable measures under State authority to mitigate effects under their own authority." 82 Fed Reg. at 51073. DFS did exactly what the Federal government told New York that it could do. It is thus patently illogical that, by private action, Plaintiffs be permitted to undue HHS's administration of the ACA.

B. Armstrong Prong Two: Judicial Administrability

With respect to the second element of Armstrong – whereunder equity jurisdiction is foreclosed when the Federal standards in question are "judicially unadministrable" – Plaintiffs erroneously claim that this element merely asks whether the Court can determine if New York followed the ACA's "proscribed procedure before adopting its own RA formula". Cross Mot. at 20. This is not the proper inquiry under Armstrong.

In finding the Medicaid Act "judicially unadministrable" the Armstrong Court focused on provisions of the Act that conferred a "judgment-laden standard" of enforcement on the HHS Secretary. Armstrong, 135 S. Ct. at 1385. The court reasoned that the Act's clear preference for achieving enforcement in line with "the expertise, uniformity, widespread consultation, and resulting administrative guidance that can accompany agency decision-making" supported a finding of judicial unadministrability and thus no equity jurisdiction. Id. (citations omitted).

The same types of "judgment-laden standards" are evident in the ACA in two separate areas. First, as detailed in Defendant's Underlying Motion and discussed further herein [Point II], the precise balance between State and Federal involvement in risk adjustment is, generously, a delicate one. The ACA itself reflects this by providing States the option to either administer ACA risk adjustment themselves or leave administration to the Federal government. 45 C.F.R. § 153.310. HHS's regulations only further demonstrate this sensitive and difficult balance, by referring repeatedly to cooperation in partnership with the States, and by specifically encouraging States to take additional "reasonable measures under State authority to mitigate effects [of ACA-Risk Adjustment] under their own authority". 82 Fed. Reg. 51052, 51072-73 (Nov. 2, 2017). The relevant issue of judicial administrability here is thus the precise role that States can play in risk adjustment. Under the teachings of Armstrong, it is wise for policy and jurisprudential reasons to leave this sensitive question to HHS, as envisioned by the ACA, given HHS's express policy of cooperating with the States and incorporating their feedback on an ongoing basis in this area. See Powell 2d Decl. ¶¶ 18-20.

The second area that the "judgment laden" standard is evident in the ACA is in the degree to which HHS maintains discretion in the risk adjustment field. The ACA in no way prohibits HHS from encouraging and authorizing states to adopt additional risk adjustment programs to mitigate the impact of the ACA-Risk Adjustment Program. Plaintiffs neither cite to such a prohibition nor even claim that one exists. See generally Cross-Motion. While the ACA requires risk adjustment, it vests the "criteria and methods" to be employed entirely to the "expertise" and "resulting administrative guidance" of HHS. See 42 U.S.C. §18063. This is precisely the type of clear preference for agency expertise that Armstrong relied upon in determining "judicial unadministrability". Armstrong 135 S. Ct. at 1385. Nonetheless, Plaintiffs' Complaint would

have this Court upset HHS' determination that additional state-administered risk adjustment can be used to mitigate the effects of the Federal Program. Given that HHS developed and is solely responsible for administering the ACA-Risk Adjustment Program, HHS should also be solely responsible for determining the acceptability of the NY Market Stabilization Regulation.

C. Plaintiffs' Case Law is Inapposite

Finally, Plaintiffs' criticism of Defendant's application of Armstrong is also marred by an over-reliance on inapposite case law. Plaintiffs' Brief repeatedly cites to Friends of the East Hampton Airport, Inc. v. Town of East Hampton (841 F.3d 133, 145 (2d Cir. 2016)) and Entergy Nuclear Vt. Yankee, LLC v. Shumlin (733 F.3d 393 (2d Cir. 2013)) as examples of preemption cases that "mirror" the instant action. Cross Motion at 17. Both cases, however, are factually and legally dissimilar to the issues presently before this Court.

The East Hampton case deals with the Federal Airport Noise and Capacity Act ("ANCA") – a statute that the court readily acknowledged could not be "analogized to the Medicaid statute", which, as set forth above and in Defendant's Underlying Motion, is a close comparator to the ACA. 841 F.3d at 145. Most notably, ANCA's very text provides for multiple enforcement measures, including contemplation of "legal" and "injunctive" measures by the Secretary of Transportation. Id. at 145-146. Of course, as discussed above, Plaintiffs do not identify any similar provisions in the ACA – as the ACA does not contain any diverse enforcement provisions like ANCA.

Plaintiffs' reliance on the Entergy case fairs no better. Entergy actually pre-dates the Supreme Court's decision in Armstrong, and is therefore of limited value to the specific analysis presently before this Court. The Entergy court does not engage in any discussion or analysis of the court's jurisdictional mandate over the preemption claim[3]. See generally, 733 F.3d 393 (2d

[3] Interestingly, the Entergy case presents a legal analysis that actually supports Defendant's position that Plaintiffs' preemption claims must be dismissed on the merits. This argument is discussed below. See infra at Point II, FN 4.

Cir. 2013).

The statutory program in this case is far more analogous to the Medicaid Act at issue Armstrong than the statues at issue in Entergy and East Hampton. The textual considerations in the Medicaid Act analyzed by the court in reaching its conclusion not to extend equity jurisdiction in Armstrong, should guide this Court in its analysis of the ACA. Plaintiffs' Cross Motion fails to demonstrate any basis for this Court to diverge from the holding in Armstrong. As such, for the reasons set forth in Defendant's Underlying Motion, Plaintiffs' preemption claims must be dismissed on jurisdictional grounds pursuant to FRCP 12(b)(1).

POINT II
PLAINTIFFS ARE NOT ENTITLED TO SUMMARY JUDGMENT ON THEIR PREEMPTION CLAIMS: THE PREEMPTION CLAIMS FAIL AS A MATTER OF LAW AND SHOULD BE DISMISSED PURSUANT TO RULE 12(B)(6)

In their Memorandum, Plaintiffs assert that "preemption arises where: (1) the Federal law or regulation expressly forbids state regulation; (2) the Federal government has occupied the field; (3) state and Federal law directly conflict in which case stat law must give way; or (4) the state law stands as an obstacle to the achievement of Federal goals and objectives." Plaintiffs' Memo at 25 (quotations and citations omitted). This recitation of the legal standard is the only accurate aspect of Plaintiffs' preemption analysis.

As set forth in Defendant's Underlying Motion and discussed further below, Plaintiffs do not satisfy any element of this preemption test. All of their claims under the Supremacy Clause should therefore be dismissed pursuant to FRCP 12(b)(6), irrespective of the jurisdictional bars to the claims.

A. The Emergency Regulation is Not Expressly Preempted

Simply put, not one of the Federal statutes and regulation cited in Plaintiffs' Cross Motion expressly preempt the New York Market Stabilization Regulation.

The first statute cited by Plaintiffs – 42 U.S.C. § 18041(d) – is titled "No Interference with State Regulatory Authority" and provides that "[n]othing in this title shall be construed to preempt any State law that does not prevent the application of the provisions of this title." Id. Section 18041(d) is not a statute that provides for express preemption. In fact, just the opposite. Section 18041(d) is a non-preemption statute that expressly authorizes states to retain all of their existing authority to regulate their insurance markets provided only that the State does not prevent the application of the provisions of the ACA. This Congressional statement of no-preemption is not surprising in light of the well-established preference for State regulation and control of the insurance industry (as set forth in both case law and the McCarron-Ferguson Act -- See Underlying Motion at 27-29).

The operative legal question under §18041(d), therefore, is whether the New York Market Stabilization Regulation expressly prevents the application of the provisions of the ACA. It does not. By intentional design, the New York Market Stabilization Regulation does not in any way interfere with, interact with, intersect with, enhance, impair, or otherwise "touch" the ACA-Risk Adjustment Program. The New York specific risk adjustment authorized by the Emergency Regulation only applies **after** all aspects of the ACA-Risk Adjustment Program have been completed. 11 NYCRR § 361.9. As a matter of law, the New York Market Stabilization Regulation therefore does not impede application of the ACA-Risk Adjustment Program or any other provision in Title 42 of the United States Code or the related Federal regulations. As such, §18041(d) does not expressly preempt the New York Market Stabilization Regulation.

It is important to note that rather than provide the true quotation of §18041(d), Plaintiffs' Memo attempts to recast the provision using a forced and inaccurate quotation of the statute. Plaintiffs' version of §18041(d) states that the ACA "preempt[s] any State law that … prevents

(sic) the application of this title". Cross Motion at 26. In short, §18041(d) does not state what Plaintiffs' badly contorted version claims. Re-stating something in the negative, as Plaintiffs' attempt to do, and then claiming your version is accurate does not make it so. Id. at 26-27.

The second statute cited by Plaintiffs to establish express preemption – 42 U.S.C. §300gg-23(a)(1) – is also quoted by Plaintiffs in a misleading manner. Cross Mot. at 26. Similar to §18041(d), §300(gg)-23(a)(1) is a non-preemption statute titled "[c]ontinued applicability of State law with respect to health insurance issuers". Section 300(gg)-23(a)(1) expressly allows states to retain all of their existing authority to regulate health insurance issuers within their State:

> (a) Continued applicability of State law with respect to health insurance issuers
> (1) In general:
> ... this part shall not be construed to supersede any provision of State law which establishes, implements, or continues in effect any standard or requirement solely relating to health insurance issuers in connection with individual or group health insurance coverage except to the extent that such standard or requirement prevents the application of a requirement of this part.

The operative legal question under §300gg-23(a)(1) is whether the New York Market Stabilization Regulation expressly prevents the application of the provisions of the ACA. Because the Emergency Regulation does not interfere with the ACA-Risk Adjustment Program, it does not prevent the application of the ACA or any other provision in Title 42 of the United States Code or the related Federal regulations and does not expressly preempt.

Finally, Plaintiffs' reliance on 45 C.F.R. §§153.310(a)(3), and (4) to advance their express preemption claim also fails. Cross Mot. at 26. First, §§153.310(a)(3) and (4) are not preemption provisions. Rather they are rules which require HHS to implement the Federal ACA-Risk Adjustment Program. There is no credible claim that either of these two provisions expressly prohibit a state from operating a risk adjustment program separate and apart from the ACA-Risk Adjustment Program. Second, DFS has not taken any action to implement the ACA-Risk

Adjustment Program. Because the New York Market Stabilization Regulation does not implement any function related to the ACA-risk adjustment, the Emergency Regulation is not contrary to, prohibited by, or in any way inconsistent with 45 C.F.R. 153.310(a)(3), and (4).

As a matter of law, there is no Federal statute or regulation that expressly preempts the New York Market Stabilization Regulation.

B. Field Preemption is Inapplicable to the Affordable Care Act and the ACA-Risk Adjustment Program

Plaintiffs' second argument in favor of preemption relies on the so called doctrine of "field preemption." Cross Mot. at 27-29. Field preemption will only be found where Congress "has designed a pervasive scheme of regulation that leaves no room for the state to supplement, or where it legislates in 'a field in which the Federal interest is so dominant that the Federal system will be assumed to preclude enforcement of state law on the same subject.'" Affordable Hous. Found., Inc. v. Silva, 469 F.3d 219, 240 (2d Cir. 2006). Field preemption is inapplicable here for at least three distinct reasons.

First, the plain text of the ACA expressly reserves state authority to continue to regulate the insurance markets within their respective states. Both §18041(d) and §300(gg)-23(a)(1), discussed at length above, reserve a state's authority to enact legislation and regulations with respect to the business of health insurance. §18041(d) ("Nothing in this title shall be construed to preempt any State law …"). Based on these two statutes, field preemption is simply inapplicable in the ACA context, as a matter of basic statutory interpretation.

Second, the McCarran-Ferguson Act, 15 U.S.C. § 1011, et seq. precludes the application of field preemption in any insurance business unless there is clear explicit preemption language in the Federal law. Underlying Motion at 27-29. McCarran-Ferguson states that "Congress hereby declares that the continued regulation and taxation by the several states of the business of insurance

is in the public interest, and that silence on the part of the Congress shall not be construed to impose any barrier to the regulation or taxation of [insurance] by the several states". Id. The Act unambiguously acknowledges Congress' recognition that insurance administration and regulation constitute an important State concern that must be left to the exclusive jurisdiction and control of the various States absent express Congressional statement to the contrary. See, e.g. United States Dep't of Treasury v. Fabe, 508 U.S. 491, 506 (1993) ("state laws enacted for the purpose of regulating the business of insurance do not yield to conflicting Federal statutes unless a Federal statute specifically requires otherwise."); Lander v. Hartford Life & Annuity Ins. Co., 251 F.3d 101, 115 (2d Cir. 2001) (describing this principle as creating a "clear-statement rule").

Third, as set forth in detail within Defendant's Underlying Motion [at 9-10, 34-38], HHS – the Federal agency responsible for administering the ACA including all aspects of the ACA-Risk Adjustment Program – has on multiple occasions expressly stated that a State may use its legal authority to apply additional risk adjustment programs to their individual and small group health insurance markets.

- On or about May 11, 2016, a month prior to releasing its results for 2015, HHS recognized unexpected issues with the ACA-Risk Adjustment Program and encouraged states to use pre-existing state authority to help ease the unintended instability caused by these issues with the ACA-Risk Adjustment Program. See Federal Register / Vol. 81, No. 091, at 29152.

- Again, in December 2016, after completing the risk adjustment process for the 2015 policy period and witnessing the same problems that states had identified for the 2014 policy period, HHS issued a final rule modifying the ACA-Risk Adjustment Program. The December 2016 final rule also encouraged states to take action under existing state law in light of problems caused by ACA-Risk Adjustment. See Federal Register / Vol. 81, No. 246, at 94159.

- Indeed, through the present day, HHS continues to encourage states to take independent action to address the deficiencies in the Federal Program. On October 27, 2017, HHS published a proposed rule that encouraged and explicitly authorized states to use their existing state authority to take measures under State authority to mitigate the effects of ACA risk adjustment. Federal Register / Vol. 82, No. 211,

at 51072-73.

Plaintiffs' attempt to dismiss these multiple, repeat statements from HHS inviting State action as mere "preamble" is unavailing. Cross Motion at 28-29. Plaintiffs' distinction between language in preamble and regulation text is of no moment here. HHS' unambiguous and repeated recognition of the States' continuing role in risk adjustment, even in preamble, necessarily informs any court's interpretation of the scope of the regulation itself. Halo v. Yale Health Plan, 819 F.3d 42, 52-53 (2d. Cir. 2015) ("[I]t does not make sense to interpret the text of a regulation independently from its preamble").

In addition to these unambiguous public statements, HHS has also supported the New York Market Stabilization Regulation and has never taken or threatened any action against the regulation. See Powell 2d Decl. ¶¶ 42-43, 47-49, 52-53 ("HHS was fully informed of the Emergency Regulation before it was promulgated, at the time of its promulgation, and after it was promulgated, and HHS has been publicly and privately supportive of it").

As a matter of simple logic, this Court cannot find field preemption where the Federal agency in charge of the regulatory field actually invites State activity. Such an invitation, by definition, illustrates that the field is not intended to be closed or preempted.

Based upon these three reasons[4], as a matter of law, there is simply no basis to apply field

[4] Plaintiffs' repeated reliance on the Entergy case as precedent for field preemption is fundamentally off base. Cross Mot. at 27. The Entergy court's finding of field preemption was based exclusively on the fact that the State law in question did not contemplate areas of State concern for which the State could regulate. 733 F.3d at 414-422. Unlike here, where the record unquestionably reflects New York's long-standing, and well-recognized interest in stabilizing the insurance market. Interestingly, the Entergy court reached its decision only after analyzing a far more analogous case where field preemption was declined by the Supreme Court. In Pacific Gas & Electric Co. v. State En. Res. Conservation & Dev. Comm'n, the Court conducted a preemption analysis of a California State energy statute against the Federal Atomic Energy Act. 461 U.S. 190 (1983). The issue at hand was whether the California law infringed on the nuclear waste safety standards, which were deemed to be under exclusive Federal authority under the AEA. While the California statute was found by the Supreme Court to encroach on the nuclear safety issues covered under the AEA, the court did not find field preemption. Id. at 214. Instead the Court held that despite the AEA's province over nuclear safety, the state maintained authority over other traditional State concerns in the nuclear power realm. Id. at 211-212.

preemption to the risk adjustment provisions of the ACA.

C. There is No Conflict with Federal Law or Obstacle to Federal Objective Presented by the New York Market Stabilization Regulation

Plaintiffs' assert two separate theories of conflict preemption which they also reiterate as "obstacles to Federal objectives". Cross Mot. at 29-32. Under their first theory, Plaintiffs claim that by failing to apply for and obtain HHS's approval for the New York Market Stabilization Regulation pursuant to 45 C.F.R. §153.310(a)(3)-(4), the regulation presents an invalid conflict with the ACA. Cross Mot. at 29-31. Pursuant to its second theory, Plaintiffs claim that because the Emergency Regulation "openly seeks to alter" the amounts transferred under the ACA-Risk Adjustment Program by up to 30%, it presents a conflict with the ACA. Id. at 31-32. Neither theory has merit.

Before analyzing Plaintiffs' two theories it is important to highlight Plaintiffs' burden of proof on this point. "[B]ecause of Federalism concerns, [a court] must interpret Congress's intent strictly, beginning with the presumption that Congress did not intend to displace state law. Accordingly, [a court] will not find preemption unless that was the clear and manifest purpose of Congress." Greater N.Y. Metro. Food Council, Inc. v. Giuliani, 195 F.3d 100, 105 (2d Cir. 1999) (citations and quotations omitted). "Indeed, in cases like this one, where Federal law is said to bar state action in fields of traditional state regulation," the U.S. Supreme Court has "worked on the assumption that the historic police powers of the States were not to be superseded by the Federal Act . . . " New York State Conf. of Blue Cross & Blue Shield Plans v. Travelers Ins. Co., 514 U.S. 645 (1995) (upholding a New York state law regarding the charging of hospital surcharges against a preemption challenge).

1. The New York Market Stabilization Regulation is in Addition to and Not a Substitute for the ACA-Risk Adjustment Program

Plaintiffs contend that the Emergency Regulation conflicts with the ACA insofar as the State regulation was not approved under CFR §§153.310(a)(3)-(4). Cross Motion at 29. This argument misapprehends the very nature of Emergency Regulation – which was definitively not codified to substitute for the ACA-Risk Adjustment Program. The New York Market Stabilization Regulation was not issued pursuant to any authority in the ACA, as it was never intended to satisfy the risk adjustment requirements of 18 U.S.C. § 18063 or 45 C.F.R. §153.310(a)(3)-(4); but only to add state specific protections in light of market instabilities.

New York State has consistently acknowledged that it relies upon HHS to satisfy New York's compliance with the ACA-Risk Adjustment Program. Powell 2d Decl. ¶¶ 8-9; Landrigan Decl. Ex. 12. Similarly, the State has never taken any action to implement any function required under the ACA-Risk Adjustment Program – and has roundly acknowledged that these functions are exclusively the function of HHS. Powell 2d Decl. ¶¶ 8-9; Landrigan Decl. Ex. 12.

Rather, the New York Market Stabilization Regulation is an additional risk adjustment program that New York may (or may not) deploy in the state's small group market for the 2017 plan year to address the disproportionate and exaggerated impact of ACA-Risk Adjustment Program in New York. Powell 2d Decl. ¶¶38-42. These impacts are set forth in stark detail in the accompanying Declaration of John Powell. The New York Market Stabilization Regulation is thus not a substitute for ACA-Risk Adjustment, as contemplated by Plaintiffs' argument, but an independent and additional risk adjustment program managed exclusively by the Superintendent pursuant to NY Insurance Law § 3233 (legal authority wholly unrelated to the ACA that has been on the books for over 25 years).

As a result, Plaintiffs' claim that the Emergency Regulation was adopted wholly outside of

the ACA-Risk Adjustment Program is completely accurate. Landrigan Decl. Ex. 12. But, such fact does not give rise to a conflict preemption claim as there is no inborn conflict between the two programs. That is, there is no provision in the ACA or any other area of Federal law that expresses a "clear and manifest purpose of Congress" to preempt a state that avails itself to ACA-Risk Adjustment from also deploying an additional market stabilization program to remedy any disproportionate and exaggerated impact to the State from ACA-Risk Adjustment. Plaintiffs' first conflict argument is thus built on the false premise that ACA-Risk Adjustment and the Emergency Regulation are competing paradigms – and not complementary to one another – and thus fails.

2. Application of the Emergency Regulation Does Not Improperly Conflict with ACA-Risk Adjustment Payments

Plaintiff's second theory of conflict preemption argues that the Emergency Regulation conflicts with the ACA insofar as it "alters" the amount of ACA-Risk Adjustment payments and receipts deemed appropriate by HHS. Cross Mot. at 31. This argument overlooks the simple, irrefutable fact that the same agency that is responsible for calculating payments and receipts under the ACA-Risk Adjustment Program – HHS – has also repeatedly and publicly encouraged New York and other states to take action under State law to remediate the unintended consequences of the ACA-Risk Adjustment Program. Powell 2d Decl. ¶¶ 16-20; 81 Fed. Reg. 29146, 29152 (May 11, 2016), 81 Fed. Reg. 94058, 94159 (Dec. 22, 2016), 82 Fed. Reg. 51052, 51073 (Nov. 2, 2017).

HHS's most recent statement on this issue is unequivocal:

> In the 2016 Interim Final Rule, HHS recognized some State regulators' desire to reduce the magnitude of risk adjustment charge amounts for some issuers. We acknowledged that States are the primary regulators of their insurance markets, and as such, we encouraged States to examine whether any local approaches under State legal authority are warranted to help ease the transition to new health insurance markets
>
> ***
>
> As noted above, a State that wishes to make an adjustment for the magnitude of these transfers in the individual and small group markets may take temporary,

> reasonable measures under State authority to mitigate effects under their own authority. 82 Fed. Reg. at 51073 (emphasis added).

In other words, Plaintiffs' second conflict preemption theory hinges on the illogical assumption that the Federal government – the entity that would presumably benefit from the application of preemption in this case and has the most stake in protecting risk adjustment payments and receipts – would go against its own interests and explicitly authorized New York to adopt measures that conflict with its HHS's authority. Cross Mot. at 31. Clearly this does nto make logical sense. This argument also fails to reflect the absence of any Federal statute that prohibits a state from enacting a state risk adjustment program in addition to the ACA-Risk Adjustment Program. To the contrary, 42 U.S.C. § 18063 delegates to HHS all administration of the ACA-Risk Adjustment Program. The fact that HHS has encouraged and authorized states to make an adjustment to the magnitude of the transfers under the ACA-Risk Adjustment Program through temporary, reasonable measures under State authority [See 82 Fed Reg. 51052, 51073], precludes a finding that a state action made in accordance with the HHS's directive is conflict preempted.

Ultimately all three of Plaintiffs' theories for preemption are based on a fundamental misunderstanding of the interplay between the ACA-Risk Adjustment Program and New York's Market Stabilization efforts. This misunderstanding is founded on a gross oversimplification of risk adjustment as being a single program that cannot simultaneously exist at the State and Federal levels. There is simply no support for this simplistic construct of risk adjustment – but there is overwhelming evidence to the contrary.

To sustain its conflict preemption claims Plaintiffs, have the burden of showing that the "the clear and manifest purpose of Congress" was to preclude the co-existence of state and Federal risk adjustment programs. Greater N.Y. Metro. Food Council, Inc., 195 F.3d at 105. As a matter

of law Plaintiffs cannot sustain this burden and these claims should be dismissed pursuant to FRCP 12(b)(6).

POINT III

PLAINTIFFS' TAKINGS AND EXACTION CLAIMS MUST BE DISMISSED

Plaintiffs' Cross Motion attempts to rebut the ripeness problems inherent with their Fifth Amendment Taking/Exaction and 42 U.S.C. §1983 claims[5], while simultaneously moving for summary judgment over such claims. Cross Mot. at 33-36. Neither such argument is convincing.

Plaintiffs refute the ripeness problems with their claims based upon hypothetical "threatened action" of the State. Cross Motion at 21. In making this argument Plaintiffs necessarily concede that no regulatory action has been taken against them to date, and instead rely on the possibility of "future injury" to satisfy the jurisdictional "case and controversy" requirement for ripeness. Id. 21-22.

What this argument fails to address, however, is the factual reality that no State action under the Emergency Regulation can even be contemplated until after operation of ACA-Risk Adjustment in June of 2018 for the 2017 plan year. Powell 2d Decl. ¶¶ 54-57. That is, depending on the results of ACA-Risk Adjustment Program announced in June 2017, DFS may or may not implement the Emergency Regulation to create a risk adjustment pool – and the magnitude of such pool, if implemented, could be anywhere from 0% to 30%. See 11 NYCRR § 361.9; Powell 2d Decl. ¶¶ 54-57; See also Underlying Motion - Powell Decl. ¶¶ 9-12.

Stated even more succinctly, DFS' action under the Emergency Regulation is not a substantial certainty, and even should implementation come to pass at some point in the future, the

[5] See Point V infra. for discussion of Plaintiffs' improperly pled 42 USC §1983 claims.

extent of any action could be relatively minor. Such uncertainties and hypothetical outcomes do not present a justiciable ripe cause of action for this Court to decide. Nat'l Org. for Marriage, Inc. v. Walsh, 714 F.3d 682, 687 (2d Cir. 2013); Roman Catholic Archdiocese of NY v. Sebelius, 907 F.Supp. 2d 310, 327 ("A plaintiff should not be able to manufacture standing by merely asserting a need to prepare for uncertain future harms…such reasoning would gut the standing doctrine").

Even if the Takings and Exaction causes of action were ripe (and they are not), the claims should be dismissed as a matter of law. Plaintiffs' substantive argument for a Fifth Amendment Taking is that "the ACA and its implementing regulations leave no authority for the [DFS] Superintendent to seize" funds through risk adjustment. Id. at 35. This argument, however, is simply a restatement of their failed preemption theories, i.e. the ACA preempts New York's regulatory adjustment to stabilize its own market after ACA-risk adjustment. Id. As discussed above, the ACA does not preempt New York's Market Stabilization Regulations – to the contrary, the overwhelming Federal authority and HHS guidance underscore the State's authority and discretion to regulate its markets in the precise manner challenged by this lawsuit. See supra Point II; see also Underlying Motion at 33-38.

Plaintiffs' Takings and Exaction causes of action fail primarily because of the State's discretion and authority for on-going regulation of its carriers. Where such on-going, discretionary regulation exists, there can be no protected property interest that is subject to a Takings challenge. Senape, 936 F.2d at 690; R.R. Vill. Ass'n v. Denver Sewer Corp., 826 F.2d 1197, 1202-1203 (2d Cir. 1987) (denying protected property interest over prospective sewer rates because such rates were subject to on-going regulation "involving the exercise of judgment and discretion" by the municipality"). In the 1990s, New York courts already rejected identical Takings and Exaction challenges to the market stabilization regulations that were utilized in the individual and small

group markets in New York prior to the ACA. See Colonial Life Ins. Co. of America v. Curiale, 205 A.D.2d 58 (2d Dept. 1994). There are no material differences between the regulations at issue in Colonial Life and the New York Market Stabilization Regulations at issue in this case.

The hypocrisy of Plaintiffs' Takings and Exaction causes of action should not be overlooked. Plaintiffs have received hundreds of millions of dollars under the ACA-Risk Adjustment Program. Powell 2d Decl. ¶¶ 31-36. These risk adjustment payments were financed exclusively by other health insurers operating in the New York markets. See 18 U.S.C. § 18063. Plaintiffs' assertion that their receipt of proceeds from other insurers under the ACA-Risk Adjustment Program is legally acceptable while their potential obligation to pay a fraction of that amount to other insurers under New York's Market Stabilization Regulations constitutes a Fifth Amendment Taking, does not pass the straight face test. Just as operation of the ACA-Risk Adjustment Program does not constitute an illegal Taking, operation of the Emergency Regulation would not either.

POINT IV

BURFORD ABSTENTION APPLIES

Even if this Court had jurisdiction over Plaintiffs' claims, the Court should decline such an exercise of jurisdiction pursuant to the Burford abstention doctrine. The applicable legal standard and grounds for abstention are detailed in detail in Defendant's Motion to Dismiss. Underlying Motion at 22-33.

To rebut application of Burford here, Plaintiffs argue that abstention is improper because they "raise only Federal claims" in their challenge to "the State scheme" and not "a collateral attack on a final [DFS] determination". Cross-Motion at 39. As evidence of this position they claim that "no inquiry beyond the four corners of the Emergency Regulation is needed to determine

whether the Emergency Regulation is facially pre-empted". Id. at 40. Such a position is untenable, but not surprising coming from Plaintiffs, as consideration of all applicable factors demonstrates that Federal jurisdiction would disrupt New York's efforts to establish a coherent policy to stabilize its insurance markets. See New Orleans Pub. Serv., Inc. v. Council of City of New Orleans, 491 U.S. 350, 361 (1989).

Plaintiffs' desire to limit inquiry to just the "four corners" of the Emergency Regulation necessarily excludes the Court's consideration of integral factors relevant to a Burford analysis, such as:

(1) The proposed Federal rules codified in the Federal Register setting forth HHS' invitation to states to apply state law fixes to alleviate problems with ACA-Risk Adjustment. [81 Fed. Reg. 29146, 29152 (May 11, 2016), 81 Fed. Reg. 94058, 94159 (Dec. 22, 2016), 82 Fed. Reg. 51052, 51073 (Nov. 2, 2017).].

(2) HHS' guidance provided directly to DFS supporting a state-authority based solution to the deficiencies in the ACA-Risk Adjustment Program [Powell 2d Decl. ¶¶ 16-20,37-53].

(3) The McCarron-Ferguson Act's codification of deference to the States on issues of insurance regulation.

(4) The complexities of New York's small group health insurance market and the state-specific market stabilization problems created by operation of ACA-Risk Adjustment [Powell 2d Decl.¶¶ 21-36].

(5) The specificity and judgment-laden nature of New York's Market Stabilization Regulations [Underlying Mot. 17-19], and

(6) The breadth and operation of the pre-ACA State Insurance Law market stabilization provisions [Underlying Mot. 5-7].

As detailed in Defendant's Motion to Dismiss, all of these considerations must be accounted for in a proper Burford analysis, and all readily favor jurisdictional abstention here. Underlying Motion at 22-33, citing, Bethphage Lutheran Serv., Inc. v. Weicker, 965 F.2d 1239, 1244-45 (2d Cir. 1992). Plaintiffs are not able to adequately square these, and other relevant

factors, in the context of abstention.

Plaintiffs cite to three primary cases to support their proposition that abstention is unnecessary because questions of State law and policy are irrelevant to their preemption claim – Planned Parenthood of Dutchess-Ulster, Inc. v. Steinhaus; Petrosurance, Inc. v. Nat'l Ass'n of Ins. Comm'rs, and; Orozco v. Sobol. Cross Motion at 40. All three cases are easily distinguishable, as none of them involve "state efforts to maintain a coherent policy in an area of comprehensive regulation or administration" akin to New York's Market Stabilization efforts. Bethphage Lutheran Serv., Inc. v. Weicker, 965 F.2d 1239, 1244-45 (2d Cir. 1992).

For example, in Planned Parenthood the Second Circuit declined to abstain from exercising jurisdiction upon a finding that the State regulation in issue (NY Gen. Mun. L § 104-b), a provision guarding against improprieties in dealing with taxpayer dollars, was "not sufficiently complex" to warrant abstention. 60 F.3d 122, 127 (2d Cir. 1995). The court compared the regulation in question to the "Medicaid scheme" at issue in Bethpage and the "administrative system … for the regulation, administration and conservation of Texas's oil and natural gas industry" at issue in Burford, and declared that "it does not rise to the requisite level of complexity". Id. As demonstrated in Defendant's Underlying Motion, New York's Market Stabilization Regulations and the complex economic considerations of New York's insurance markets are comparable to those considered in Bethpage and Burford. Underlying Motion at 24-27.

The courts' analyses in Petrosurance and Orozco are similar, and for the exact same reasons, inapplicable to the present case. Both cases did not involve any state laws. In Petrosurance the court declined abstention because the party plaintiff was "pursuing only Federal RICO claims that do not hinge in any way on difficult questions of Ohio law". 888 F. Supp. 2d 491, 500 (S.D.N.Y 2012). Further, the court noted that "to the extent state law is relevant at all

…the parties largely seem to agree on its application". Id.

Orozco was not even a Federal preemption claim and does not contemplate the interpretation of a complex State regulatory scheme whatsoever. Orozco v. Sobol, 703 F. Supp. 1113 (S.D.N.Y 1989). To the contrary, the case was a Fourteenth Amendment Procedural Due Process challenge to a school board's decision to deny a homeless child admission to school. Id. The court was not faced with any question of State law in adjudicating the 42 U.S.C. § 1983 claim. Id. Plaintiffs' case is clearly all about state law – Insurance Law §3233 and the New York Market Stabilization Regulation.

In the event the Court finds jurisdiction proper over Plaintiffs' Supremacy Clause claims, the Superintendent has adequately established the circumstances and prerequisites justifying and favoring this Court's application of Burford Abstention.

POINT V

PLAINTIFFS' 42 U.S.C. § 1983 CLAIM REMAINS AMBIGIUOUSLY PLED

Plaintiffs' Brief fails to clarify the substantive basis of their improperly pled 42 U.S.C. §1983 claims [Counts V and X]. Cross Motion at 36-37. As presently composed Plaintiffs' § 1983 causes of action are improperly pled as claiming just a "violation of 42 U.S.C. §1983". Underlying Motion at 40. Section 1983 provides a remedy for the deprivation of constitutional rights and is not itself a "source of substantive rights". Patterson v. County of Oneida, 375 F.3d 206, 225 (2d Cir. 2004). Plaintiffs' merely assert that their § 1983 claims are based on the Fifth and Fourteenth Amendment without further explanation. Cross Mot. at 37. It is unclear whether these purported "Fifth and Fourteenth Amendment" violations are the same as Plaintiffs' Takings/Exaction claims alleged in Counts III, IV, VIII and IX; or if they are alleging a separate and distinct theory of due process violation.

What is clear, however, is that if these are distinct claims, then Plaintiffs' Takings/Exaction causes of action (Counts III, IV, VIII, IX) are themselves improperly pled as the Fifth/Fourteenth Amendments alone do not state a private cause of action without 42 U.S.C. §1983. See Livadas v. Bradshaw, 512 U.S. 107, 132 (1994) ("Section 1983 provides a Federal cause of action for the deprivation, under color of law, of a citizen's rights, privileges, or immunities secured by the Constitution and laws of the United States").

Thus, either Plaintiffs' Section 1983 claims (Counts V, X) must be merged with the substantive causes of action, or Plaintiffs' Takings/Exaction causes (Counts III, IV, VIII, IX) must be dismissed pursuant to FRCP 12(b)(6) for failure to state a claim.

POINT VI

NEITHER DECLARATORY NOR PERMANENT INJUNCTIVE RELIEF IS WARRANTED

In Section VI of their memorandum, Plaintiffs claim they are entitled to declaratory and permanent injunctive relief to prevent implementation of the Emergency Regulation. Cross Motion at 42-45. Such relief is not warranted in this case.

Initially, Plaintiffs request for declaratory relief must be denied based upon all of the grounds set forth within Defendant's Underlying Motion and this Opposition and Reply Memorandum. Likewise, Plaintiffs are not entitled to a permanent injunction as they cannot demonstrate any of the elements required for imposition of such relief.

Plaintiffs' brief misstates the standard for the entry of the "extraordinary remedy" of injunctive relief. In Entergy Nuclear Vt. Yankee, LLC v. Shumlin, which Plaintiffs' cite for the applicable standard, the court makes clear the burden is much greater than the Plaintiffs attempt to assert.

A plaintiff seeking a permanent injunction must demonstrate: (1) that it has suffered

> an irreparable injury; (2) that remedies available at law, such as monetary damages, are inadequate to compensate for that injury; (3) that, considering the balance of hardships between the plaintiff and defendant, a remedy in equity is warranted; and (4) that the public interest would not be disserved by a permanent injunction." Entergy, 733 F.3d 393.

Plaintiffs have clearly failed to satisfy any, let alone all, of these factors.

First, for all of the reasons set forth in Defendant's Underlying Motion and herein, Plaintiffs have not and cannot establish success on the merits of their claims. See Winter v. NRDC, Inc., 555 U.S. 7, 32 (2008) (quoting Amoco Prod. Co. v. Vill. of Gambell, 480 U.S. 531 (1987) (the standard for issuance of a permanent injunction is the same as that for a preliminary injunction except that a permanent injunction requires actual success on the merits).

Second, Plaintiffs' claim of irreparable harm is specious. Plaintiffs' sole measure of damages is pecuniary in nature – the deprivation "of Federal RA payments to which" Plaintiffs claim entitlement over. Cross Motion at 44. The only way pecuniary damages can ever constitute irreparable harm is where such losses "cannot be recovered in an action at law". Id. at 43. Plaintiffs have not met this standard as a remedy at law may lie in either the New York State Court of Claims (NY CLS Ct C Act §8) or New York State Supreme Court under CPLR Article 78. Garten v. Hochman, 2009 U.S. Dist. LEXIS 7737, at *13 (S.D.N.Y. Jan. 28, 2009) ("Money damages are recoverable in Article 78 proceedings if they are incidental to the primary relief sought").

Third, the balance of the hardships overwhelmingly tips in favor of Defendant. As discussed in Defendant's Underlying Motion and detailed in the annexed Second Declaration of John Powell, the Market Stabilization Regulations are integral to the sustained viability of the State's unique small group health insurance markets. Powell 2d Decl. ¶ 39-40. The challenged regulations were carefully designed, to among other things, correct carrier inequities from the

ACA-Risk Adjustment Program's non-State specific approach, which have previously impacted solvency and continued participation of market participants. Id. Again, the sole hardship alleged by Plaintiffs is their hypothetical future pecuniary loss, which must clearly give way when weighed against the continued strength and viability of New York's insurance markets.

Finally, the public interest would in fact be disserved if an injunction were to issue. It is in the public interest to maintain a stable, diverse, and well-functioning small group insurance market properly regulated by the state as the primary regulator of insurance. This was the judgment of the New York State Legislature when it empowered and entrusted the Defendant with the responsibility of creating and overseeing the market stabilization mechanism. N.Y. Ins. Law § 3233; Powell 2d Decl. ¶¶ 3-6. This was the judgment of Congress when it passed the McCarren-Ferguson Act. 15 U.S.C. § 1011 ("The Congress hereby declares that the continued regulation and taxation by the several States of the business of insurance is in the public interest.") (emphasis added). This was also the judgment of the Federal authority responsible for the ACA-Risk Adjustment Program – HHS – when it encouraged and authorized states to use "local approaches, under State legal authority" to stabilize markets. See Powell 2d Decl. ¶ 18-20. And this was the determination of the DFS when it promulgated the New York Market Stabilization Regulation. Id. This Court should not ignore the unified determinations of all these entities that state action pursuant to state market stabilization authority is in the public interest.

Plaintiffs have not established entitlement to permanent injunctive relief.

CONCLUSION

For the reasons set forth herein, Plaintiffs' Cross Motion for Summary Judgment must be denied and the Complaint should be dismissed in its entirety under FRCP 12(b)(1) and 12(b)(6)

Dated: Albany, New York
February 16, 2018

ERIC T. SCHNEIDERMAN
Attorney General of the State of New York
Attorneys for Defendants
The Capitol
Albany, New York 12224-0341
By: s/ C. Harris Dague
C. Harris Dague
Assistant Attorney General, of Counsel

To: Plaintiffs' Counsel (via CM/CF)