U.S. COURT OF APPEALS FOR
THE SECOND CIRCUIT

UNITEDHEALTHCARE OF NEW YORK, INC.,
OXFORD HEALTH INSURANCE, INC.,

Plaintiffs-Appellants,

v.

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

Defendant-Appellee.

No. 18-2583

MEMORANDUM OF LAW IN OPPOSITION TO EMERGENCY MOTION FOR AN INJUNCTION PENDING APPEAL

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PRELIMINARY STATEMENT

In this proceeding, plaintiffs UnitedHealthcare of New York and Oxford Health Insurance seek an injunction against a New York regulation promulgated by the State's Department of Financial Services (DFS) to effect risk adjustment in New York's health insurance markets. Plaintiffs assert that the regulation is preempted by a similar federal risk adjustment program administered by the Department of Health and Human Services (HHS). The U.S. District Court for the Southern District of New York (Koeltl, J.) dismissed plaintiffs' claim and denied any relief pending appeal. This Court should also deny injunctive relief pending appeal because plaintiffs have failed to satisfy any of the stringent requirements necessary to obtain the extraordinary relief of a federal injunction against state regulatory authority.

Plaintiffs have no likelihood of success on their preemption claim. The fundamental premise of plaintiffs' preemption argument is that DFS's risk-adjustment program interferes with HHS's "exclusive responsibility" to conduct risk adjustment under the Affordable Care Act (Mot. at 3). But what this argument disregards is that HHS has repeatedly and expressly *approved* of state-law regulations such as DFS's—and,

indeed, reiterated that approval just six months ago in response to direct questions about the validity of the New York program challenged by plaintiffs here. As the district court correctly recognized, HHS's position is consistent both with the States' traditional role in regulating their own insurance markets and with provisions of federal law that expressly preserve rather than preempt state insurance regulations.

The equities also weigh heavily against an injunction. DFS's regulation is intended to redress significant distortions that the federal risk adjustment program has inflicted on New York's health insurance markets in the last several years—distortions that, among other harms, have led two insurers to exit New York altogether. HHS has recognized that state-law approaches like New York's are a critical tool to restore market stability and protect the interests of both insurers and consumers. By contrast, the payments that plaintiffs may be required to make under DFS's regulation are a mere fraction of their operating revenues and do not come close to offsetting the windfalls they have received for the past two years under the federal program. The public interest thus weighs heavily against any interim injunctive relief.

BACKGROUND

A. New York's Risk Adjustment Program

In health insurance markets, insurers will often face dramatically different costs from year to year based on unanticipated differences in the health of their insured populations. Risk adjustment programs help to reduce these disparities by requiring insurers with relatively healthier enrollees to make payments into a common fund, which can then be disbursed to insurers with relatively unhealthier enrollees. By thus reducing the costs of insuring individuals who may be sicker than the average enrollee, risk adjustment programs deter insurers from "avoiding or failing to ensure" such individuals or "avoiding or terminating coverage of persons whose health care costs are high." Second Powell Decl. ("Powell Decl."), ECF No. 40, ¶ 6 (quoting 11 N.Y.C.R.R. § 361.1(1)-(2).

In 1992, the New York Legislature granted DFS broad authority to develop a risk adjustment program in New York.[1] *See* Insurance Law

[1] DFS is authorized to create such a program in both the individual market and the small group market, which includes employers with one hundred or fewer employees. Insurance Law § 3221(h)(3).

§ 3233. DFS adopted implementing regulations that specified funding levels and formulas for risk adjustment for each year from 1993 to 2013. *See generally* 11 N.Y.C.R.R. pt. 361.

B. HHS's Endorsement of New York's Program to Address Distortions Caused by the Federal Risk Adjustment Program

In 2013, pursuant to its authority under the Affordable Care Act (ACA), HHS promulgated a federal risk adjustment program, which became operational for the 2014 benefits year. *See* 78 Fed. Reg. 15,527 (Mar. 11, 2013); 42 U.S.C. §§ 18041(a)(1)(C), 18063(b). States were given the option of administering the federal program themselves or leaving HHS to administer the federal program on their behalf. *Id.* Because DFS "concluded New York should use the federal risk adjustment program," it "suspended" New York's state-level program *See* 38 N.Y. Reg. 63, 63 (Sept. 28, 2016).

Both HHS and DFS subsequently discovered, however, that the federal program failed to account for certain New York-specific factors and thus led to substantial distortions in New York's health insurance markets. In 2016, HHS determined that, based on its initial review of the 2014 risk adjustment numbers, certain insurers had found themselves

owing substantially higher risk adjustment payments than expected—particularly "new, rapidly growing, and smaller insurers." 81 Fed. Reg. 29,146, 29,152 (May 11, 2016). DFS identified similar distortions, finding that under the federal program many smaller insurers would have to pay tens of millions of dollars that would "represent a significant portion of their revenue." Letter from Maria T. Vullo, Superintendent of Fin. Servs., to Sylvia M. Burwell, Secretary of HHS, at 2 (June 28, 2016), ECF No. 38-17. DFS was concerned that the federal program would be "unduly impacted" by factors other than "the actual relative health" of members and would "allow the large, established insurers to convince CMS that their members are relatively more unhealthy." *Id.* at 1-2.

These concerns proved well founded. During the first two years of the federal risk adjustment program, one New York insurer became insolvent and another voluntarily withdrew from the New York market in part because of the large unanticipated payments they were required to make under the federal program. Powell Decl. ¶ 41. Moreover, compared to other States, New York's health insurance market was disproportionately affected by the federal risk adjustment program. In 2014 and 2015, New York had by far the largest aggregate amount of

money transferred under the federal program: the nearly $200 million required to be transferred among New York insurers in 2014 was more than four times the amount transferred in California, the State with the second highest risk adjustment pool. *Id.* ¶¶ 22-25.

DFS's actuarial team determined that thirty percent of the extraordinarily large federal risk adjustment transfers in New York could be attributed to two particular factors that had a disproportionate adverse effect in this State. *Id.* ¶ 38. First, DFS determined that the federal program led to inflated risk scores—and thus inflated payment transfers—because it treats certain non-claims expenses by insurers (such as administrative expenses) as "losses." 38 N.Y. Reg. at 64-65. Under New York law, by contrast, only payments of claims are treated as losses for purposes of setting premium rates. *See* DFS Insurance Circular Letter No. 15 (Dec. 22, 2011).

Second, New York has unique rules governing the coverage of children that the federal program disregards. DFS regulations require a plan that covers *any* children to cover *all* children in a family at the same rate, without regard to their number. *See* N.Y. State Dep't of Fin. Servs., *Instructions for the Filing of 2019 Premium Rates*. (In other States, by

contrast, plans may offer different tiers that cover specific numbers of children.) The federal risk adjustment formula "exclude[s] children who do not count toward family rates or family policy premiums" when calculating a plan's number of billable members. 81 Fed. Reg. 94,058, 94,104 (Dec. 22, 2016). Thus, the federal risk adjustment rules artificially treat all New York family plans as plans that cover a single child. The federal program's treatment of plans covering children thus leads to an anomaly that causes inflated plan liability risk scores in New York. 38 N.Y. Reg. at 64-65.

Recognizing that state-specific differences such as these would have a destabilizing effect on some States' markets, HHS in May 2016 expressly "encourage[d] 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. at 94,159. HHS repeated this invitation several more times over the next two years. In December 2016, HHS again acknowledged the problem of "certain issuers, including some new, rapidly growing, and smaller issuers, ow[ing] substantial risk adjustment charges [under the federal program] that they did not anticipate," and "continue[d] to encourage States to examine whether any

local approaches, under State legal authority," could address this specific problem. *Id*. In November 2017, HHS once more "recognized some State regulators' desire to reduce the magnitude of [federal] risk adjustment charge amounts for some issuers," and again invited States to pursue "any local approaches under State legal authority" to pursue that goal. 82 Fed. Reg. 51,052, 51,072 (Nov. 2, 2017).

In response to HHS's express invitation, DFS determined that it would exercise its state-law authority under Insurance Law § 3233 to reactivate the state-run risk adjustment program for the 2017 plan year "on an emergency basis" in order to prevent "unnecessary instability in the health insurance market." 38 N.Y. Reg. at 63.

Under the state program, DFS must review the federal risk adjustment results after they are released, with a particular focus on the New York-specific factors discussed above: namely, the treatment of non-claims expenses as losses, and the failure to account for New York's rating tiers for children. *See* 11 N.Y.C.R.R. § 361.9(b)(1), (e)(1). Based on that review, DFS must identify a percentage of New York insurers' federal risk transfer payments (up to thirty percent) that should be collected in a risk adjustment pool "to correct any one or more of the

adverse market impact factors." *Id.* § 361.9(e)(1). That pool will then be distributed to carriers that paid money into the federal risk adjustment program. *Id.* § 361.9(e)(2). This latest iteration of the state risk adjustment program will apply for the first time to the federal risk adjustment payments scheduled to be issued on or about October 22, 2018.[2]

DFS designed its emergency regulations in close consultation with HHS. Before promulgating the risk adjustment regulation for the 2017 plan year, DFS discussed its intended approach in detail with several high-level HHS officials who were supervising the federal risk adjustment program. The officials at no point objected to DFS's anticipated approach. Powell Decl. ¶¶ 42-43.

To the contrary, in April 2018, HHS endorsed New York's approach in its final rule implementing the federal risk adjustment program for 2019. As HHS observed, a "few commentators noted that New York has already taken action to reduce transfers under the State's authority"—a reference to the DFS regulations being challenged here—"and requested clarification whether other States could take steps under existing State

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[2] In July 2018, DFS promulgated a similar regulation for plan year 2018 and beyond. *See generally* 11 N.Y.C.R.R. § 361.10.

authority." 83 Fed. Reg. 16,930, 16,960 (Apr. 17, 2018). In particular, HHS noted that commenters had inquired whether States could "implement[] any State-specific adjustments" like New York's without obtaining HHS approval. *Id.* HHS responded to these inquiries by again confirming its approval of "local approaches under State legal authority" to respond to distortions caused by the federal risk adjustment program, and concluded that "States that take such action and make adjustments do not generally need HHS approval as these States are acting under their own State authority and using State resources." *Id.*

C. Procedural History

In October 2017, plaintiffs brought this action against DFS, claiming that the ACA preempts New York's 2017 and 2018 regulations. *See* Compl., ECF No. 1. In August 2018, the district court dismissed the complaint. *See* Opinion & Order (Op.), ECF No. 66.

The district court rejected plaintiffs' arguments for both express and field preemption, relying on multiple provisions of the ACA that explicitly preserve rather than displace state laws in recognition of the States' traditional authority to regulate their insurance markets. *See id.* at 17. The court also rejected plaintiffs' assertion of conflict preemption.

It held that the ACA and HHS's implementing regulations relate solely to the federal risk adjustment program, not to local state programs; and that "HHS has explicitly acknowledged that such local programs may be necessary and encouraged States to consider adopting them." *Id.* at 23. The court thus concluded that "the fact that the agencies responsible for implementing" the federal risk adjustment program "have repeatedly stated that States may turn to their own authority to adjust for unintended consequences of the [federal program] . . . is strong evidence that the ACA does not preempt" New York's program. *Id.* at 27.

In September 2018, the district court denied plaintiffs' request for an injunction, pending appeal, against enforcement of the 2017 regulation. *See* Mem. Order & Opinion (Mem. Op.), ECF No. 83. The court concluded that plaintiffs had shown "no reasonable chance of success on appeal," noting that their arguments continue to conflate the federal, HHS-run risk adjustment program with state risk adjustment programs that HHS has expressly endorsed. *Id.* at 6-8. The district court also found that preventing New York's state risk adjustment payments would be against the public interest because it would harm smaller insurance companies and destabilize the small group market. *Id.* at 6, 8-9. That

risk, the court held, far outweighed any harm to the plaintiffs, for whom even the maximum state risk adjustment payment would be a fraction of the risk adjustment payment they received in the federal program—and a minute fraction of their annual revenues. *Id.* at 5.

REASONS FOR DENYING PLAINTIFFS' MOTION

A party seeking a preliminary injunction against "governmental action taken in the public interest pursuant to a statutory or regulatory scheme" must show that: (1) it is likely to succeed on the merits; (2) it will suffer imminent and irreparable harm; and (3) a preliminary injunction is in the public interest. *Oneida Nation of N.Y. v. Cuomo*, 645 F.3d 154, 164 (2d Cir. 2011) (quotation marks omitted). Because the public interest is presumptively served by continued enforcement of a duly enacted state law or regulation, the State's defense of its policies is "entitled to a higher degree of deference than a private party's position would merit," and this Court "must be sure that, in all likelihood, New York has acted unlawfully" before it will issue a preliminary injunction. *Otoe-Missouria Tribe of Indians v. New York State Dep't of Fin. Servs.*, 769 F.3d 105, 111 (2d Cir. 2014) (quotation marks omitted).

Plaintiffs are thus mistaken in arguing that they can obtain an injunction merely by showing a "substantial possibility" of success on the merits, or a comparatively greater degree of hardship on a "sliding scale." Mot. at 9 (quotation marks omitted). Because plaintiffs challenge a state regulation that was duly promulgated pursuant to a state statute, they must meet "the higher standard" of showing that they are likely to win this case, even if they show a "possibly serious intrusion" on their interests. *Otoe-Missouria Tribe*, 769 F.3d at 112.

Plaintiffs' arguments, which restate the position the district court has twice found unpersuasive, fail to show a likelihood of success on appeal. In any event, the public interest strongly counsels against an injunction, and plaintiffs fail to show irreparable harm.

A. Plaintiffs Are Unlikely to Succeed on the Merits.

1. Plaintiffs' preemption claims fail in light of HHS's endorsement of New York's risk adjustment program.

As the district court correctly recognized (*see* Op. at 23-27), plaintiffs' preemption claims cannot be reconciled with HHS's specific, repeated, and recent approvals of state-law programs like New York's. HHS could not have been more direct. For more than two years, and most

recently under the current presidential administration, HHS has actively encouraged States to take action under state law—in their capacity as "the primary regulators of their insurance markets"—to mitigate "the effects of unanticipated risk adjustment charge amounts" under the federal program. 81 Fed. Reg. at 94,159; *see also* 81 Fed. Reg. at 29,152 (same). In April 2018, responding to questions about the validity of New York's program in particular, HHS reiterated its endorsement of such "local approaches under State legal authority" and concluded that "States that take such actions and make adjustments do not generally need HHS approval as these States are acting under their own State authority and using State resources." 83 Fed. Reg. at 16,960.

HHS's explicit and pointed endorsement of state-law programs like New York's removes any suggestion that such programs conflict with federal law—either because they stand as an obstacle to federal objectives, or because they impose inconsistent obligations. *See New York SMSA Ltd. P'ship v. Town of Clarkstown*, 612 F.3d 97, 104 (2d Cir. 2010). Plaintiffs make the remarkable assertion that this Court could find conflict preemption even if the relevant federal agency has found no such conflict (Mot. at 17), but that argument cannot be squared with the broad

discretion that Congress delegated to HHS to determine the parameters of the federal risk adjustment program. The ACA provides that HHS, "in consultation with States, shall establish criteria and methods to be used in carrying out" the federal risk adjustment program. 42 U.S.C. § 18063(b). This language supports what HHS did here: consulting with the States—including with New York specifically—and concluding that state-law approaches to risk adjustment were compatible with the federal risk adjustment program.

Plaintiffs are also wrong to assert that anything in the ACA or in HHS's implementing regulations expressly preempt New York's program. As the district court correctly recognized (Op. at 17), far from abrogating state programs, the ACA goes out of its way to *preserve* state laws and regulatory authority. Congress provided 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." 42 U.S.C. § 18041(d). Because States have historically been the primary regulators of insurance, state insurance laws are not preempted by conflicting federal laws "'unless a federal statute specifically requires otherwise.'" *Wadsworth v. Allied Prof'ls Ins. Co.*, 748 F.3d 100, 105 (2d Cir. 2014) (quoting *United*

States Dep't of Treasury v. Fabe, 508 U.S. 491, 507 (1993)). As the district court concluded (Op. at 16-17), the language in the ACA preserving rather than displacing state law comes nowhere close to satisfying this demanding test.

Likewise, nothing in HHS's implementing regulations expressly preempts New York's program. As the district court correctly understood, HHS's regulations give States "two options for addressing any unintended negative impacts of the [federal risk adjustment program] in their local markets: (1) take action and make adjustments pursuant to state authority; or (2) request an adjustment to the federal risk adjustment transfers from HHS." Op. at 27. Plaintiffs' argument that HHS's regulations prohibit state-law risk adjustments rests on a "misleading conflation" of these two options, as the district court explained in denying an injunction pending appeal. Mem. Op. at 8.

All of the regulatory language that plaintiffs cite—about States obtaining "HHS review" (Mot. at 18 (quotation marks omitted)) or "forgo[ing] implementation of all State functions" (*id.* at 14 (quotation marks omitted))—concerns only state involvement with the *federal* risk adjustment methodology. The regulations are unambiguous on this score.

HHS may approve a State "to operate risk adjustment *under a particular Federally certified* risk adjustment methodology." 45 C.F.R. § 153.310(d)(1) (emphasis added). If a State does not obtain approval to operate the federal risk adjustment methodology, then it "will forgo implementation of all State functions *in this subpart*, and HHS will carry out all of the provisions *of this subpart* on behalf of the State." *Id.* § 153.310(a)(2), (3), (4) (emphasis added). The emphasized language plainly refers only to HHS's administration of the *federal* program.

None of this language applies to risk adjustments made by States "under their own State authority and using State resources," which HHS has expressly said are separate from the federal risk adjustment program and thus "do not generally need HHS approval." 83 Fed. Reg. at 16,960. As discussed (see *supra* at 8-9), New York chose to adopt this state-law approach for the 2017 and 2018 plan years, exercising its authority under a nearly thirty-year-old state program to order transfers that account for the "unique aspects of the small group health insurance market in New York." 38 N.Y. Reg. at 64.

While HHS has continued to engage "in consultation with States" to improve the "criteria and methods" used in the federal risk adjustment

program, 42 U.S.C. § 18063(b), plaintiffs are wrong in asserting that any feature of that ongoing collaborative process precludes state-law risk adjustments. In particular, HHS has announced that, "[b]eginning with the 2020 benefit year," a State may request reductions to transfers under the federal risk adjustment program, including to account for local circumstances. 45 C.F.R. § 153.320(d). Contrary to plaintiffs' argument (Mot. at 18), that new process applies only to adjustments to the *federal* risk adjustment methodology, as HHS itself made clear: in announcing this new process, HHS continued to adhere to its long-standing position that reductions "under State legal authority are warranted to help ease the transition for new participants to the health insurance markets" and that such measures do not require HHS approval. 83 Fed. Reg. at 16,960.

Contrary to plaintiffs' argument (*see* Mot. at 18-19), there is nothing irrational about HHS's promulgation of detailed procedures for States to obtain federal approval for risk-adjustment reductions while continuing to recognize the States' prerogative to make such reductions under their own state-law authority. Given the States' concrete experience and traditional authority in regulating their own insurance markets, it makes sense for HHS to continue deferring to the States' views on

tailoring risk adjustment to local circumstances. That respect for state experience and regulation in an area of traditional state authority is a core attribute of cooperative federalism, and a familiar feature not only in the ACA but across a number of federal regulatory schemes. *See, e.g.*, *King v. Burwell*, 135 S. Ct. 2480, 2487 (2015) (ACA health care exchanges); *EPA v. EME Homer City Generation, L.P.*, 134 S. Ct. 1584, 1594 (2014) (Clean Air Act programs).

2. Plaintiffs have no private right of action under federal law to challenge DFS's regulations.

Plaintiffs also face an independent barrier to obtaining federal relief: they lack any private right of action under federal law to invalidate DFS's regulations. The ACA's risk-adjustment provisions do not expressly confer any private right of action; to the contrary, the only express remedy under the ACA is for HHS to intervene if a State does not comply with the ACA's risk-adjustment requirements. *See* 42 U.S.C. § 18041(c)(1)(B)(ii)(I). When a statute provides no express private right of action to enforce a requirement, and simultaneously gives a federal agency a specific tool to enforce that same requirement, Congress has "indicated that [it] intended to foreclose a private equitable remedy for

violation of that provision." *Davis v. Shah*, 821 F.3d 231, 245 (2d Cir. 2016) (citing *Armstrong v. Exceptional Child Ctr.*, 135 S.Ct. 1378, 1385 (2015)).

Neither of the sources identified in plaintiffs' preemption cause of action—the Supremacy Clause and 42 U.S.C. § 1983 (*see* Compl. at 32-43)—gives them a right to sue. The Supremacy Clause does not provide a right of action in itself, *see Davis*, 821 F.3d at 245, and § 1983 provides a cause of action only for violations of federal law that unambiguously create individual rights, *see id.* at 244. Because the ACA's risk-adjustment provisions describe the States' duties, not the entitlements of individuals (or individual providers), they lack "the type of rights-creating language" that would allow a § 1983 suit. *Id.*

Contrary to the district court's view (*see* Op. at 13-14), it is immaterial that the ACA provides HHS with multiple ways to secure state compliance, whereas the statute at issue in *Armstrong* provided HHS with the single option of cutting off funding. The dispositive question instead is whether federal law envisions agency action as the principal means of enforcing its substantive terms; if so, that administrative remedy implicitly forecloses private remedies. *See* 135

S.Ct. at 1385. Moreover, the district court was mistaken in suggesting that the statute gives a court sufficient guidance to administer risk adjustment in place of HHS (*see* Op. at 14-15). The ACA leaves the question of how best to administer risk adjustment to HHS "in consultation with States," 42 U.S.C. § 18063(b), and "[e]xplicitly conferring enforcement of this judgment-laden standard upon the Secretary" shows that Congress intended to preclude private enforcement through the courts, *Armstrong*, 135 S.Ct. at 1385.

B. The Public Interest Strongly Favors Denying an Injunction and Outweighs Any Harm to Plaintiffs, Which Is Not Irreparable in Any Event.

The relative harms to the parties and the public strongly favor denying an injunction pending appeal. The harm alleged by plaintiffs is purely monetary, and consists of an amount that plaintiffs do not claim would materially affect their business. *See* Pls.' Mem. of Law in Supp. of Inj. at 14, ECF No. 71 (representing that plaintiffs have "more than ample resources" at hand). As the district court noted, the maximum sum potentially at issue—$65 million—is a fraction of UnitedHealthcare's federal risk adjustment payment and a minute fraction of its overall revenue. Mem. Op. at 5. Moreover, DFS could very well determine that a

smaller payment than the authorized maximum is sufficient to address any risk adjustment distortion; if so, then plaintiffs' injuries would be even more slight.

Plaintiffs argue that this alleged monetary harm is nonetheless irreparable because the Eleventh Amendment would bar them from seeking damages against the State if they are required to make a state risk adjustment payment. But a party cannot make a showing of irreparable harm based on the asserted loss of a windfall it had no right to expect. *See Population Inst. v. McPherson*, 797 F.2d 1062, 1082 (D.C. Cir. 1986). Because of New York-specific flaws in the federal program's calculation of risk adjustment payments, plaintiffs have received tens or hundreds of millions of dollars in unreasonably large transfer payments over the past years. Plaintiffs have no legitimate entitlement to continue to receive or retain yet another windfall payment. Indeed, while plaintiffs challenge the legality of New York's risk adjustment program, they do not contest the array of objective metrics showing that they have been the beneficiaries of abnormally large and market-distorting federal transfer payments in New York over the past years. *See infra* at 23, 25.

Plaintiff Oxford Health Insurance in particular has received a windfall, as shown by the amount of money it has received above what New York law would otherwise entitle it to retain. New York law requires insurers in the small group market to meet a minimum loss ratio of 82 percent—meaning that at least 82 percent of all premiums and risk adjustment income must be spent on actual medical claims, leaving no more than 18 percent for administrative and other non-claim expenses or for profit. *See* Insurance Law §§ 3231(e)(1)(B), 4308(c)(3). For the small group market in 2017, however, Oxford received a windfall of $177.7 million above what they would have been entitled to earn under New York's 82/18 rule, in part because of massive federal risk adjustment transfers.

In any event, plaintiffs have not shown that they would lack a state-court remedy to recover the funds transferred under the New York program if they were to prevail in this Court. While this Court has held that the availability of state-court relief does not "make injunctive relief unavailable" as a categorical matter to plaintiffs in a federal proceeding, *United States v. New York*, 708 F.2d 92, 93 (2d Cir. 1983), this Court need not ignore the existence of adequate state-court relief altogether in

determining whether the equities favor granting the extraordinary relief of an injunction against a duly promulgated state regulation. The practical "amount of irreparable injury plaintiff will suffer absent the stay" would plainly be minimal given the presence of state court remedies. *See Thapa v. Gonzales*, 460 F.3d 323, 334 (2d Cir. 2006) (quotation marks omitted).

The relatively slight burden to plaintiffs of possibly having to file a state-court lawsuit to recover any improperly transferred funds is easily outweighed by the potentially grave harms to the parties and the public if this Court were to grant an injunction pending appeal. By delaying the payments DFS has deemed necessary to stabilize the small group health insurance market, the injunction would perpetuate continued disruption of that market, harming both insurers and consumers in New York.

Indeed, it had been clear for years that the one-size-fits-all federal risk adjustment payment methodology had failed to account for certain unique aspects of the New York insurance market, leading to hundreds of millions of dollars in unanticipated transfer payments that significantly destabilized the small group market. Powell Decl. ¶¶ 22-25, 37-38. The effect was severe enough that two insurers stopped selling

insurance plans in New York. *Id.* ¶ 41. Meanwhile, other insurers, including plaintiffs, consistently underestimated the federal transfer amounts they would receive—by tens or hundreds of millions of dollars (up to four times the amounts they had estimated)—and charged higher premiums to consumers based on this mistaken estimation. *Id.* ¶¶ 33-36, 41. DFS's regulations are designed to address these market distortions and the specific circumstances of New York's small group market that the federal program ignores. *See* 11 N.Y.C.R.R. § 361.9(a)(4) (explaining that the factors not adequately addressed by the federal program "are identifiable, quantifiable and remediable for the 2017 plan year").

Granting an injunction would allow these distortions to continue unabated. Plaintiffs would again receive large payments in the immediate future. And other insurers—in particular smaller entities and newer entrants—would not receive the state-law protections that HHS itself recognized would be appropriate to insulate them from the strain of large and unanticipated transfer obligations under the federal program. As the district court correctly observed, "[d]elayed enforcement" of DFS's regulations "would harm the smaller entities not adequately accounted for under the" federal risk adjustment program. Mem. Op. at 6.

Because these small companies are the least equipped to weather ongoing regulatory uncertainties and the withholding of funds they had anticipated receiving, the longer that DFS is prevented from implementing its risk adjustment program, the greater the harms to precisely those insurers whose position in the marketplace is the most tenuous. And a delay of even several months is significant because insurance products change on an annual basis, and insurance companies are constantly making decisions about how and whether to participate in New York's marketplace. The harms of delay would thus affect the over one million New York consumers in the small group health insurance market that depend on vigorous competition and multiple options to best serve their healthcare needs.

Finally, much of the urgency of plaintiffs' emergency request to this Court is the result of their own litigation strategy. This action has been pending for nearly a year. Plaintiffs have never sought preliminary injunctive relief or a temporary restraining order. Indeed, the challenged regulation was promulgated in September 2016 without any party seeking to preliminarily or temporarily enjoin its enforcement. Having failed to ask for interim or preliminary relief at any point during the

pendency of the action below, plaintiffs now attempt to force this Court's hand at nearly the last possible moment by demanding immediate action to delay the enforcement of a lawful state regulation. Plaintiffs' delay weighs heavily against their request for extraordinary equitable relief.

CONCLUSION

The motion for an injunction pending appeal should be denied.

Dated: New York, New York
October 4, 2018

Respectfully submitted,

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CERTIFICATE OF COMPLIANCE

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/s/ Will Sager