IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MARYLAND

CITY OF COLUMBUS, *et al.,* *Plaintiffs*, v. DONALD J. TRUMP, *et al.,* *Defendants*.	Civil Action No. 1:18-cv-02364-DKC

DEFENDANTS' MEMORANDUM OF LAW IN SUPPORT OF THEIR MOTION TO DISMISS

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I. INTRODUCTION

Plaintiffs, four cities (the "City Plaintiffs") and two individuals (the "Individual Plaintiffs"), bring this suit against the President of the United States, the Department of Health and Human Services ("HHS"), the Secretary of HHS, the Center for Medicare & Medicaid Services ("CMS"), and the Administrator of CMS under the Take Care Clause of the Constitution and the Administrative Procedure Act ("APA"). They seek to enjoin implementation of a final agency rule, which governs aspects of the health insurance markets for the 2019 plan year and beyond (the "2019 Rule"), as well as other agency rules and executive actions, all of which Plaintiffs argue would undermine the Affordable Care Act ("ACA"). At its core, Plaintiffs' suit is a political disagreement with the Federal Government's implementation of the ACA, which is beyond the purview of an Article III court. Despite Plaintiffs' compilation of a laundry list of alleged grievances in their 129-page Complaint, Plaintiffs have no standing to sue, and their claims, in any event, fail under the APA's deferential standard of review or are otherwise without a cause of action.

Most significantly, this Court has no jurisdiction over this lawsuit because Plaintiffs have no standing to sue. Their alleged injury is based on highly speculative claims of potential future harm, which are dependent on the independent actions of third parties not before this Court. Specifically, the Individual Plaintiffs allege that the challenged rules and executive actions will drive up the premiums for the ACA individual insurance market and decrease insurer competition in Charlottesville, Virginia, where they reside. But contrary to their dire predictions, the average premiums charged by the Individual Plaintiffs' qualified health plan, the Optima Health Plan, will decrease significantly in the 2019 plan year. Moreover, a new insurer has entered the Charlottesville market for the 2019 plan year, thereby increasing competition, which in turn should decrease or at least stabilize prices and provide the Individual Plaintiffs with expanded health insurance options. There is simply no basis for the Court to assume that the Individual Plaintiffs will experience premium increases for 2020 or beyond, given the highly variable market conditions for the ACA Exchanges across different States and the numerous unknowable facts about the future behavior of state

legislators and regulators, issuers, and consumers. Indeed, the D.C. Circuit recently rejected a nearly identical theory of standing, holding that consumers of ACA-compliant health insurance lacked standing to challenge an ACA-related agency policy based on the speculative assumption that the policy would cause rate increases for qualified health plans. *See Am. Freedom Law Ctr. v. Obama*, 821 F.3d 44, 49-50 (D.C. Cir. 2016), *cert. denied*, 137 S. Ct. 1069 (2017).

The City Plaintiffs' alleged injury is even more speculative. They speculate that premiums for qualified health plans will increase as a result of the challenged rules and executive actions because individuals will be forced to leave the ACA insurance markets or face greater difficulty in purchasing health insurance coverage; the uninsured or underinsured sicker individuals will then turn to rely on the City Plaintiffs' health clinics and other services, including ambulance services, forcing the City Plaintiffs to spend more money on such clinics and services; and the financial burden will make the four relevant cities less desirable places to live and work. But this speculative chain of possibilities is based on several flawed assumptions, which underscore that the City Plaintiffs, like the Individual Plaintiffs, have not alleged any non-speculative, non-conclusory, certainly impending harm, let alone harm traceable to the challenged rules and executive actions.

First, rather than trending toward higher premiums as Plaintiffs have speculated, monthly premiums for individual market plans offered through the 39 Exchanges that rely on the federal Exchange's eligibility and enrollment platform (the "federal platform") will generally decrease in 2019. For the second-lowest cost silver plan, average monthly premiums will drop by an average of 1.5%. Meanwhile, the Exchanges that rely on the federal platform will see an increase in individual market insurers as compared to 2018. Second, the assumption that rising premiums necessarily will force enrollees out of the ACA markets is flawed. The vast majority of the Exchange enrollees (87% in 2018) are generally insulated from the effect of premium increases because they receive subsidies that are pegged to premiums, and the remaining 13% may choose not to leave the Exchanges, particularly if they have pre-existing conditions. Third, it is speculative that individuals will leave the ACA markets because of the challenged actions, and not some other reasons, such as Congress's decision to reduce to zero the tax penalty for individuals failing to maintain the minimum health coverage required by

the ACA ("individual mandate") effective as of January 1, 2019. With the tax change, healthier and younger individuals may find it more cost-effective to have no insurance at all or to purchase cheaper alternatives to qualified health plans that discriminate on the enrollees' health and age. Their departure could then create the same type of injury Plaintiffs complain is allegedly caused by the challenged actions.

Even if Plaintiffs could overcome this jurisdictional obstacle, the Complaint still fails to state a claim upon which relief can be granted. Count I—which challenges approximately ten separate provisions of the 2019 Rule as arbitrary, capricious or otherwise not in accordance with law under the APA—fails under APA's "ultimately narrow and highly deferential" standard of review. The 2019 Rule is an amalgamation of rules that govern the functioning and stability of the ACA insurance markets, including but not limited to Federal- and State-based Exchanges, and are promulgated annually pursuant to HHS's express rulemaking authority under the ACA and the Public Health Service Act ("PHS Act"). The defendant agencies' promulgation of each of the challenged provision more than satisfies the requirement that there be a rational connection between the facts found and the choices made. As the preamble to the 2019 Rule explains, each provision is a modification or amendment of prior similar rules and reflects the defendant agencies' experience gained in operating and administering the Exchange program, as well as in implementing the ACA's federal insurance market requirements. The nearly 100-page preamble thoughtfully explains the agency's rationale for promulgating each of the challenged provisions. It also belies Plaintiffs' claim that the agencies failed to articulate an adequate response or failed to respond to comments on the proposed rule. Finally, in promulgating the 2019 Rule, the defendant agencies' interpretation of the relevant provisions of the ACA, pursuant to their delegated rulemaking authority to fill gaps in the statutory language, is entitled to deference under the framework set forth in *Chevron, U.S.A., Inc. v. Natural Resources Defense Council, Inc.*, 467 U.S. 837 (1984). Indeed, despite Plaintiffs' assertion that many of the challenged provisions are "not in accordance with" the text of the ACA, they have identified no actual violation of the ACA.

Plaintiffs' Take Care claim in Count II is on even more precarious legal footing. The claim is an apparent attempt to avoid both the legal hurdle that the President is not subject to the APA and

the practical problem that Plaintiffs cannot identify any law or regulation that Defendants have violated. But there is little doubt that the President must be dismissed from this lawsuit given the Supreme Court's longstanding precedent holding an Article III court "has no jurisdiction of a bill to enjoin the President in the performance of his official duties." *Mississippi v. Johnson*, 71 U.S. (4 Wall) 475, 501 (1866). Nor may an Article III court issue a declaratory judgment against the President in his official capacity. Aside from the Court's inability to grant the requested relief against the President, the Take Care Clause in any event does not provide a cause of action as against the President. Although the Clause mandates that "[the President] shall take care that the Laws be faithfully executed," U.S. Const., art. II, § 3, the Supreme Court has held that the President's exercise of power under that Clause is purely executive and political, and not subject to judicial direction. Indeed, the challenges in the Complaint that relate to the President—such as signing into law a bill passed by Congress and issuing an executive order directing agencies to implement his policy objectives—are quintessential discretionary actions that fall within the Executive's exclusive prerogative.

What remain of Plaintiffs' Take Care Clause claim are challenges to various agency rules and actions that may or may not have been issued or taken by the defendant agencies. But regardless of the defendant agencies' actual roles in the rules and actions challenged in Count II, the Take Care Clause cannot provide a basis for affirmative relief as against them because the Clause applies to the President alone, and not to anyone else. In any event, the challenges are either to a rulemaking not promulgated by the defendant agencies or reasonable discretionary agency actions that are unreviewable even under the APA. Plaintiffs' novel Take Care Clause claim has no legal or factual basis and must be dismissed.

II. BACKGROUND

A. Statutory Background

In 2010, Congress enacted the ACA with the aim of "increas[ing] the number of Americans covered by health insurance and decreas[ing] the cost of health care." *Nat'l Fed'n of Indep. Bus. v. Sebelius*, 567 U.S. 519, 538 (2012). The ACA established, among other things, a series of new insurance market reforms in the individual and small group markets and also imposed a number of other

requirements for plans in those markets, such as mandatory provision of essential health benefits. To facilitate a market for health insurance products that conform to its market reforms, the ACA established "Health Benefit Exchanges" or State-based virtual marketplaces where consumers can purchase qualified health plans. 42 U.S.C. § 18031. To help low-income individuals obtain such coverage in the individual market, the law provides subsidies in the form of premium tax credits, which are available only to eligible taxpayers who purchase individual health insurance coverage through an Exchange for themselves or family members. 26 U.S.C. § 36B. The amount of the premium tax credit is determined in part based on the premium charged for a benchmark plan on the Exchange—*i.e.*, the applicable second lowest cost silver plan—and depends on the eligible taxpayer's household income. *See* 26 U.S.C. § 36B. Thus, if premiums for the applicable benchmark plan increase, premium tax credits generally increase by a corresponding amount. Wu Decl. ¶ 5. As of 2018, roughly 87% of individual market consumers purchasing health insurance through an Exchange received subsidies. *Id.* These consumers are insulated from the effects of premium increases for QHPs purchased through the Exchanges.

After the Exchanges became operative in 2014, premiums for health plans sold in the individual market rose drastically. Between 2013 and 2014, individual market premiums rose an average of roughly 38%, followed by another 23% in the following year.[1] Overall, health insurance premiums, particularly for individual coverage (the markets most affected by the ACA) more than doubled in the individual market between 2013 and 2017,[2] while out-of-pocket spending has also skyrocketed.[3] As premiums rose, higher-than-expected health care claims costs also drove many

[1] *See, e.g.*, Forbes, Overwhelming Evidence that Obamacare Caused Premiums to Increase Substantially (July 28, 2016), https://www.forbes.com/sites/theapothecary/2016/07/28/overwhelming-evidence-that-obamacare-caused-premiums-to-increase-substantially/#61242bf715be (last visited Oct. 9, 2018).
[2] Assistant Secretary for Planning and Evaluation, Individual market premium changes: 2013-2017, (May 23, 2017), https://aspe.hhs.gov/system/files/pdf/256751/IndividualMarketPremiumChanges.pdf.
[3] Sawyer B, Cox C, Claxton G. An analysis of who is most at risk for high out-of-pocket health spending. Kaiser Family Foundation. Washington DC. October 4, 2017.

issuers to exit the individual health insurance markets, leaving consumers with fewer and less affordable insurance choices.[4] Since the enactment of the ACA, individual market premiums finally stabilized for the first time for the 2019 plan year. Nationwide, premiums for individual health insurance coverage through the 39 ACA Exchanges that rely on the federal platform will generally decrease in 2019. Wu Decl. at ¶¶ 9-10. Specifically, the average monthly premiums for individual market coverage will drop by an average of 1.5% for benchmark silver plans, and 1.0% for bronze plans.[5] *Id.*

Plans sold on an Exchange qualify as one of several forms of "minimum essential coverage" identified by the ACA. The ACA requires non-exempt individuals to obtain minimum essential coverage or pay a tax penalty. 26 U.S.C. § 5000A(a)-(b). In December 2017, however, Congress enacted the Tax Cuts and Jobs Act, which reduced the amount of the tax penalty to $0 beginning in 2019. *See* Budget Fiscal Year, 2018, Pub. L. No. 115-97 § 11081, 131 Stat. 2054 (2017).

On April 17, 2018, HHS issued the 2019 Rule, an annual rulemaking that governs many aspects of the ACA insurance markets and Exchanges for the 2019 plan year. *See* 83 Fed. Reg. 16930 (Apr. 17, 2018). In addition to providing certain payment and cost-sharing parameters and user fees for Federally-facilitated and State-based Exchanges, the 2019 Rule also increases the States' flexibility in operating the exchanges and enhances the States' role regarding the certification of qualified health plans. *See id.* Additionally, the Rule includes changes to the rate review program, the medical loss

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https://www.healthsystemtracker.org/brief/who-is-most-at-risk-for-high-out-of-pocket-health-spending/ (last accessed September 27, 2018).

[4] *See, e.g.*, The Brookings Institution & The Rockefeller Institute, A Study of Affordable Care Act Competitiveness in Texas (Feb. 2017), https://www.brookings.edu/wpcontent/uploads/2017/02/texas-aca-competitiveness-2-6-for-print.pdf (last visited Oct. 13, 2018).

[5] Indeed, a recent analysis of premium data by the respected, independent Kaiser Family Foundation found that nationally, the average unsubsidized premium for the lowest-cost bronze plan is decreasing by 0.3% from 2018 to 2019, the average unsubsidized lowest-cost silver premium is decreasing by 1%, and the average unsubsidized lowest-cost gold plan is decreasing by 2%. *See* Rachel Fehr, Rabah Kamal, Marco Ramirez, and Cynthia Cox, *How ACA Marketplace Premiums Are Changing by County in 2019* (Nov 20, 2018), Kaiser Family Foundation, https://www.kff.org/health-costs/issue-brief/how-aca-marketplace-premiums-are-changing-by-county-in-2019/.

ratio program, and a number of other issues related to the operation and functioning of the Exchanges and the ACA insurance markets. *See id.*

B. Factual Background

Plaintiffs are four cities, Columbus, Ohio; Cincinnati, Ohio; Chicago, Illinois; and Baltimore, Maryland, Compl., ¶¶ 16-23, and two individuals, who reside in Charlottesville, Virginia, and who are enrolled in a qualified health plan offered by Optima Health, *id.* at ¶¶ 24, 247, 250. They filed this two-count, 129-page Complaint under the APA and the Take Care Clause of the Constitution seeking injunctive and declaratory relief.

The APA Claim in Count I challenges approximately 10 aspects of the 2019 Rule issued by CMS to govern various aspects of the individual and group health insurance markets subject to the ACA for the 2019 benefit year. *See* HHS Notice of Benefit and Payment Parameters for 2019, 83 Fed. Reg. 16930 (Apr. 17, 2018). *See also* Compl., ¶ 255. Briefly summarized, those 10 aspects are:

- Amending the Advance Premium Tax Credit eligibility notification requirements in a manner that avoids violating Internal Revenue Code rules that bar disclosure of Federal tax information to third parties. *See* Compl., ¶ 255(a); *see also* 83 Fed. Reg. at 16982-16984.

- Eliminating duplicative Federal and State reviews of QHPs on Federally-Facilitated Exchanges by incorporating the results of the States' QHP reviews. *See* Compl., ¶ 255(b); *see also* 83 Fed. Reg. at 17024-17026.

- Implementing a new operational readiness review and audit approach pursuant to which health insurance agents, brokers, and insurers participating in direct enrollment may select their own independent third-party auditors for purposes of the annual operational readiness review. *See* Compl., ¶ 255(c); *see also* 83 Fed. Reg. at 16981-16982.

- Eliminating the standardized option that issuers must offer in Federally Facilitated Exchanges in an effort to encourage competition in the individual market and "to maximize innovation by issuers in designing and offering a wide range of plans to consumers." *See* Compl., ¶ 255(d); *see also* 83 Fed. Reg. at 16974-16975.

- Removing the requirement that one of the two Navigators[6] for an ACA Exchange must be a community non-profit organization and that the Navigators must maintain

[6] A "Navigator" is an individual or organization that is trained to help consumers, small businesses, or their employees search for health coverage options through the ACA Exchanges. *See* Health Care Glossary, "Navigator," https://www.healthcare.gov/glossary/navigator/ (last visited: Dec. 2, 2018).

a physical presence in the State. *See* Compl., ¶ 255(e); *see also* 83 Fed. Reg. at 16979-16980.

- Reducing regulatory burdens concerning the Small Business Health Options Program ("SHOP")—which provides health plan options for small employers in each State with an Exchange—including enhancing States' flexibility to respond to decreases in issuer participation and lower-than-expected enrollment in the federally-funded SHOPs and SHOPs operated by State-based exchanges on the federal platform. *See* Compl., ¶ 255(f); *see also* 83 Fed. Reg. at 16996-16706.

- Modifying the ACA's premium tax credit eligibility income verification requirements to require an individual who attests to a household income within 100% to 400% of the federal poverty line (which would make the individual eligible for premium tax credits for purchase of ACA-complaint plans), but whose attested income is contradicted by trusted electronic data sources, to submit additional documentation supporting the attested to income. *See* Compl., ¶ 255(g); *see also* 83 Fed. Reg. at 16985-16987.

- Establishing a process for States to request a percentage reduction in the calculation of the risk adjustment transfer amounts (*i.e.*, transfers from lower-than-average risk plans to higher-than-average risk plans in the individual and small group markets) beginning with the 2020 benefit year. *See* Compl., ¶ 255(h); *see also* 83 Fed. Reg. at 16955-16960.

- Amending the ACA's rate review program regulations to, *inter alia*, (1) exempt student health insurance coverage from federal rate review, and (2) increase the federal minimum threshold that triggers an "unreasonableness" review of an issuers' proposed premium rate increase from 10% to 15%. *See* Compl., ¶¶ 95, 255(i); *see also* 83 Fed. Reg. at 16972-16973.

- Streamlining the processes governing submission and review of State requests to adjust the medical loss ratio ("MLR")[7] threshold in its individual market, and amending the requirements for issuers to report qualified improvement activity expenditures to allow issuers the option to submit either a detail, itemized report of such expenditures or to report a single, fixed quality improvement activity amount. *See* Compl., ¶¶ 101, 255(j); *see also* 83 Fed. Reg. at 17032-17036.

Count II of the Complaint asserts a claim under the Take Care Clause challenging various other actions allegedly taken by Defendants and other federal agencies, *see* Compl., ¶¶ 106, 256-258:

[7] The "medical loss ratio" is the ratio of the amounts that an insurer spends on medical claims and quality improvement activities as opposed to overhead expenses, such as marketing, profit, salaries, and other administrative costs. *See* Health Care Glossary, "medical loss ratio," https://www.healthcare.gov/glossary/medical-loss-ratio-mlr/ (last visited: Dec. 2, 2018).

- The President's issuance of Executive Order No. 13,765, 82 Fed. Reg. 8351 (Jan. 20, 2017), which directs federal agencies to "take all actions consistent with law to minimize the unwarranted economic and regulatory burdens of the [ACA]." *See* Compl., ¶ 107.

- Expanding consumer access to association health plans ("AHPs"), short-term, limited-duration insurance ("STLDI") plans, and health reimbursement arrangements ("HRAs") as alternatives to qualified health plans. *See id.* ¶ 116.

- The President's signing into law the Tax Cuts and Jobs Act of 2017, which reduced the amount of the tax penalty to $0 beginning in 2019 for individuals who fail to comply with the ACA's mandate to purchase certain minimum healthcare coverage. *See id.* ¶¶ 126, 129.

- The President's public statements that were critical of the ACA. *See id.* ¶¶ 134-35.

- Shortening (by approximately 45 days) open enrollment on Federally-Facilitated ACA Exchanges. *See id.* ¶¶ 141-42.

- Not spending enough money on open enrollment advertising. *See id.* ¶¶ 150-51, 153.

- Spending only $10 million on Navigator programs for the Federally-Facilitated Exchanges. *See id.* ¶ 168.

- Not sending HHS staff to regional enrollment events. *See id.* ¶ 171.

- Taking certain litigation positions regarding the constitutionality and enforceability of the ACA's individual mandate and two related provisions. *See id.* ¶ 174.

The Individual Plaintiffs claim that, as a result of the challenged agency and executive actions, they will face higher premiums, lower quality insurance, and less insurer competition. *See, e.g.*, *id.* ¶¶ 241, 243. The City Plaintiffs claim that they will be forced to (i) devote more money, personnel, and other resources to subsidize and provide uncompensated health care for their uninsured or underinsured residents, after they leave the ACA Exchanges due to rising insurance premiums or are otherwise prevented from enrolling in the ACA Exchanges; s*ee, e.g.*, *id.*, ¶¶ 178, 181, 183, and (ii) spend more money on ambulance services, as a sicker population without insurance will require more ambulance transports to hospitals, *see, e.g.*, *id.* ¶ 189, ultimately, making these cities less attractive places to live and work, *see, e.g.*, *id.* ¶ 214.

III. ARGUMENT

A. The Complaint Should be Dismissed for Lack of Subject Matter Jurisdiction.

1. Standard of Review

"No principle is more fundamental to the judiciary's proper role in our system of government than the constitutional limitation of federal-court jurisdiction to actual cases or controversies." *Clapper v. Amnesty Int'l USA*, 568 U.S. 398, 408 (2013) (citation omitted). One element of this constitutional limitation is that a plaintiff must establish that he has standing to sue. *Raines v. Byrd*, 521 U.S. 811, 818 (1997). The requirement is "built on separation-of-powers principles" and "serves to prevent the judicial process from being used to usurp the powers of the political branches." *Clapper*, 568 U.S. at 408. Because the relaxation of the standing inquiry "is directly related to the expansion of judicial power," that inquiry is "especially rigorous" when, like here, reaching the merits would force the judiciary "to decide whether an action taken by one of the other two branches of the Federal Government was unconstitutional." *Id.* at 408–09.

To establish "the irreducible constitutional minimum of standing" at the pleading stage, *Lujan v. Defs. of Wildlife*, 504 U.S. 555, 560 (1992), Plaintiffs bear the burden of alleging specific facts establishing that they have "(1) suffered an injury in fact, (2) that is fairly traceable to the challenged conduct of the defendant, and (3) that is likely to be redressed by a favorable judicial decision," *Spokeo, Inc. v. Robins*, 136 S. Ct. 1540, 1547 (2016). An "injury in fact" must be "'concrete and particularized' and 'actual or imminent, not conjectural or hypothetical.'" *Id.* at 1548 (quoting *Lujan*, 504 U.S. at 560). Moreover, where, as here, Plaintiffs' standing is based on alleged future injuries, the Supreme Court has "repeatedly reiterated that 'threatened injury must be *certainly impending* to constitute injury in fact,' and that 'allegations of *possible* future injury' are not sufficient." *Clapper*, 568 U.S. at 409 (quoting *Whitmore v. Arkansas*, 495 U.S. 149, 158 (1990)); *see also Lujan*, 504 U.S. at 564 n.2 (plaintiff who "alleges only an injury at some indefinite future time" has not shown an injury in fact; "the injury [must] proceed with a high degree of immediacy, so as to reduce the possibility of deciding a case in which no injury would have occurred at all"). The future injury may not be based on a "speculative chain of possibilities." *Clapper*, 568 U.S. at 410. These standing requirements ensure that legal questions are

"resolved, not in the rarified atmosphere of a debating society, but in a concrete factual context conducive to a realistic appreciation of the consequences of judicial action." *Valley Forge Christian Coll. v. Ams. United for Separation of Church & State, Inc.*, 454 U.S. 464, 472 (1982).

Moreover, to survive a motion to dismiss, the plaintiff must allege "sufficient factual matter, accepted as true, to 'state a claim to relief that is plausible on its face.' " *Ashcroft v. Iqbal*, 556 U.S. 662, 678 (2009) (quoting *Bell Atl. Corp. v. Twombly*, 550 U.S. 544, 570 (2007)); *Cioca v. Rumsfeld*, 720 F.3d 505, 508 (4th Cir. 2013). The plausibility standard is not akin to a "probability requirement," but asks for more than a sheer possibility that a defendant has acted unlawfully. *Iqbal*, 556 U.S. at 678. That is, a plaintiff must offer more than "an unadorned, the-defendant-unlawfully-harmed-me accusation" and may not rely on "mere conclusory statements" or "'naked assertion[s]' devoid of 'further factual enhancement.'" *Iqbal*, 556 U.S. at 678 (quoting *Twombly*, 550 U.S. at 557).[8]

As discussed below, Plaintiffs have failed to meet the above requirements. Not only are their allegations speculative, but their alleged future harms are conclusory and depend on the action of third parties, such as insurers, state regulators, and consumers, among others.

2. The Individual Plaintiffs lack standing because they fail to show that they will suffer any cognizable injury that is traceable to Defendants.

The Complaint alleges that as a result of Defendants' alleged attempts to undermine the ACA, the Individual Plaintiffs are harmed by rising individual market premiums (or premiums that are higher than they otherwise would be without the challenged actions) and a lack of insurer competition in Charlottesville, Virginia, where they purchased a silver plan in 2017 and then a bronze plan in 2018, both from Optima Health. Compl., ¶¶ 241, 249-51. The Individual Plaintiffs' prediction about rising individual market insurance premiums for 2019 has been proven to be incorrect. Premiums for individual health insurance coverage through the ACA Exchanges have stabilized nationwide for the

[8] Although *Twombly* and *Iqbal* set forth the standard for considering the plausibility of allegations pursuant to Rule 12(b)(6), the same standard applies in assessing the sufficiency of allegations of injury for purposes of a Rule 12(b)(1) challenge to standing. *See Reid v. Prince George's Cty. Bd. of Educ.*, 60 F. Supp. 3d 601, 605 (D. Md. 2014) (citing *Kerns v. United States*, 585 F.3d 187, 192 (4th Cir. 2009)).

first time since the ACA's enactment. Significantly, the 2019 premiums for such insurance in Albemarle County, Virginia (the county that includes the City of Charlottesville) will see dramatic decreases; average individual market premiums will *decrease* 26.1% for a silver Optima plan, while average premiums for a bronze Optima plan will *decrease* 31.7%. Wu Decl. ¶¶ 12-13.[9] Additionally, a new insurer, HealthKeepers, Inc. (affiliated with Anthem, Inc.), will enter the Charlottesville market in 2019, increasing insurer competition and thus likely stabilizing if not further decreasing premiums. *Id.* ¶ 14. Thus, any concern that the Individual Plaintiffs will experience higher premiums in 2020 is entirely speculative and far from "certainly impending." *Clapper*, 568 U.S. at 409.

Even assuming that the Individual Plaintiffs could show that some premiums in Virginia will increase in 2020 and beyond, they can do no more than speculate that *they* will be among those who pay higher premiums. Furthermore, even if they could move beyond such speculations, they still cannot show that the harm is directly tied to the challenged policies or actions. The D.C. Circuit's recent decision in *American Freedom Law Center*, 821 F.3d at 49, is illustrative. There, consumers of qualified health plans alleged that an HHS policy will "cause them to pay more for their health insurance in the future," because the policy permitted insurers to provide non-ACA compliant health plans under certain circumstances and further allowed some individuals whose policies were cancelled for noncompliance to avoid the individual mandate tax penalty. *Id.* at 49. The D.C. Circuit found Plaintiffs' claim of injury "speculative" because although the insurer's rate filings indicated that on average premiums increased due to the HHS policy at issue, they did not demonstrate that premiums for any particular plan would increase. *Id.*

[9] "In a 12(b)(1) motion, the court may consider evidence outside of the pleadings to help determine whether it has jurisdiction over the case before it," *Int'l Ass'n of Machinists & Aerospace Workers v. Werner-Masuda*, 390 F. Supp. 2d 479, 491 (D. Md. 2005) (citation omitted), "without converting the proceeding to one for summary judgment." *Gilbert v. U.S. Bureau of Alcohol, Tobacco, Firearms & Explosives*, 306 F.Supp.3d 776, 783 (D. Md. 2018) (quoting *Velasco v. Gov't of Indonesia*, 370 F.3d 392, 398 (4th Cir. 2004)); *see also Richmond, Fredericksburg & Potomac R.R. Co. v. United States*, 945 F.2d 765, 768 (4th Cir. 1991)). Moreover, the Court "may take judicial notice of publicly available records without converting a motion to dismiss to one for summary judgment." *Fusaro v. Davitt*, 327 F. Supp. 3d 907, 916–17 (D. Md. 2018) (citing *Zak v. Chelsea Therapeutics Int'l, Ltd.*, 780 F.3d 597, 607 (4th Cir. 2015) ("[C]ourts are permitted to consider facts and documents subject to judicial notice without converting the motion to dismiss into one for summary judgment.")).

Moreover, the court noted that the inherently variable nature of health care cost renders it difficult to establish the requisite causal link between the alleged increased premiums and the challenged HHS policy. As the court explained, "many factors determine the cost of health care," and changes "in any of these factors could cause costs to increase or decrease." *Id.* at 51. Thus, the court held, Plaintiffs must provide more than "mere unadorned speculation as to the existence of a relationship between the challenged government action and the third-party conduct [*i.e.*, the insurer's increase of premiums]," *id.* at 49, which they failed to do:

> According to Appellants, "basic economic principles" establish a direct link between the supposed decrease in the number of individuals in ACA-compliant risk pools allegedly caused by HHS's [] Policy and the asserted increase in the price of Appellants' health insurance plan. But . . . the effect of various factors, including the size of risk pools, on health insurance pricing is far from "basic," and Appellants have made no concrete allegations, nor provided any specific evidence, establishing that the cost of their health insurance plan is likely to increase in the future, let alone that such an increase will stem from the [] Policy. This is a major missing link in the causal chain Appellants must establish to demonstrate that HHS's [] Policy is a "substantial factor motivating" Appellants' alleged harm.

Id. at 50 (internal citations omitted).

The same is true here. Despite the many pages of their Complaint, Plaintiffs have not alleged facts demonstrating a causal connection between Defendants' actions and any alleged future higher-than-necessary premium increases. This is particularly true given that premiums are set by the insurers, who are in turn influenced by numerous factors not within Defendants' control. Because a cognizable injury "must result from the actions of the [defendant], not from the actions of a third party beyond the Court's control," *Doe v. Va. Dep't of State Police*, 713 F.3d 745, 755 (4th Cir. 2013) (quoting *Mirant Potomac River, LLC v. EPA*, 577 F.3d 223, 226 (4th Cir. 2009)), the Individual Plaintiffs cannot establish an injury in fact for this reason as well.

3. The City Plaintiffs lack standing because their alleged injury is based on speculative, contingent, and hypothetical harms.

With respect to the City Plaintiffs' alleged injury, there is an even greater number of uncertain links in the causal chain, which are either premised on invalid assumptions or are attributable to the City Plaintiffs themselves. According to the City Plaintiffs, "premiums for plans on the ACA

exchanges" are "increasing substantially" as a result of Defendants' actions, *see, e.g.*, Compl., ¶¶ 178-79, 238, 240; such "[i]ncreased premiums lead to an increase in the rate of the uninsured," *id.* ¶ 180, requiring the City Plaintiffs "to confront the many downstream effects of a population that is necessarily sicker, less productive, and less able to participate in the community and civic life," *id.* ¶ 191; *see also id.* at ¶¶ 195, 207, 218, 228; those downstream effects include the need to "to devote additional funding, personnel, and other resources to subsidizing and providing uncompensated care" for such population., ultimately harming "the City Plaintiffs' budgets, including the budgets for their public health departments, free or reduced-cost clinics, and ambulance services," *id.* ¶ 183. They also assert that the same injuries would result from agency and executive actions that allegedly make it harder for Americans to afford and purchase quality health insurance. *Id.* ¶¶ 178, 181.

This speculative chain of events, including the hypothesized "downstream effects," plainly is insufficient to establish that the City Plaintiffs will suffer a "certainly impending" injury, *Clapper*, 568 U.S. at 409, let alone injury that is traceable to Defendants. First, even if premiums have increased in the City Plaintiffs' geographic locations, they may decrease or stabilize in 2020 and beyond. Plaintiffs' speculation is premised in part on the idea that that there will be an "exodus of carriers," which can be expected to drive up prices. Compl., ¶ 241 (internal quotation marks omitted). But at least for 2019, the ACA Exchanges that rely on the federal platform will see an *increased* number of individual market insurers as compared to 2018; 23 more issuers in 2019 than were participating during open enrollment in 2018.[10] Wu Decl., ¶ 7. Further, 29 current individual market issuers are expanding their

[10] Indeed, the Kaiser Family Foundation recently drew the following conclusions about insurer participation in all 50 states (not just the ones that rely on the Federal platform) after analyzing data that was gathered from healthcare.gov and state-based exchange enrollment websites and insurer rate filings to state regulators: (1) insurer participation on the ACA Marketplaces will improve in 2019, with an average of 4.0 insurers participating per state, up from 3.5 in 2018; (2) the average number of companies per state in 2019 ranging from one company in five states (Alaska, Delaware, Mississippi, Nebraska, and Wyoming) to more than 10 companies in three states (California, New York and Wisconsin); (3) in 2019, 58% of enrollees (living in about 23% of counties) have a choice of three or more insurers, up from 48% of enrollees in 2018; (4) the share of Marketplace enrollees with only one insurer option (17%) will be the lowest since 2016; (5) for the first time since 2015, there are more companies entering into markets or expanding their footprints within states than there are withdrawals; (6) on average, metro-area counties have 2.3 insurers participating in 2019,

service areas into new counties that they did not serve last year in States with an Exchange that relied on the federal platform. *Id.* And major insurers Anthem, Wellmark, Molina, and Cigna also have returned to the Exchange individual markets they left in 2016 or 2017. *Id.* The number of counties with a single individual market insurer operating in the ACA Exchanges will also decrease in 2019 in States with an Exchange that relied on the federal platform. In 2019, only 39% of counties will have a single individual market issuer offering QHPs on the Exchanges that covers that county as compared to 56% in 2018. *Id.* ¶ 8. This means that only 20% of Exchange consumers will have access to only one issuer, down from 29% in 2018. *Id.* ¶ 8. Significantly, the majority of enrollees – 57% – now have access to *three or more* individual market issuers through the ACA Exchanges. *Id.* Similarly, in 2018, 10 States had only one issuer in each county offering qualified health plans on the ACA Exchanges that relied on the federal platform. *Id.* ¶ 11. But in 2019, that number will be cut in half, leaving only five States (Alaska, Delaware, Nebraska, Mississippi, and Wyoming) with only one ACA Exchange individual market issuer in each county. *Id.* Importantly, none of Plaintiffs in this action are from any of those five States. That is, Plaintiffs' speculation about 2019 is not only unfounded but contradicted by reality and there is no basis to assume that their speculation for 2020 and beyond will be any more accurate.

Second, the assumption that premium increases for qualified health plans will inevitably lead to an exodus of sufficient number of current enrollees as to burden the City Plaintiffs is highly speculative. To begin, the vast majority of Americans (approximately 92%) do not participate in the ACA individual markets but obtain their healthcare insurance through group health plans, Medicare, or Medicaid. *Id.* ¶ 3; *see also* 42 U.S.C. § 18013. Except possibly for those in the small group market,

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compared to 1.8 insurers in non-metro counties. In 2018, 87% of enrollees lived in metro counties; (5) going into 2019, 608 counties are gaining at least one insurer, while only five counties nationwide will lose an insurer; (7) in 2019, about 17% of enrollees (living in 37% of counties) have access to just one insurer on the marketplace (down from 26% of enrollees living in 52% of counties in 2018); and (8) between 2018 and 2019, the total number of insurers by State will remain at 2 in Maryland, will increase from 8 to 9 in Ohio, will increase from 4 to 5 in Illinois, and will increase from 6 to 7 in Virginia. *See* Rachel Fehr, Cynthia Cox, and Larry Levitt, Insurer Participation on ACA Marketplaces, 2014-2019 (Nov 14, 2018), https://www.kff.org/health-reform/issue-brief/insurer-participation-on-aca-marketplaces-2014-2019/.

these Americans generally are not directly affected by the rules or executive actions complained of in this lawsuit. Of the approximately 3% of the American population who receive their individual health insurance through an Exchange established under the ACA, Wu Decl. ¶ 3, 87% (as of 2018) of them receive refundable tax subsidies to help them pay for premiums. *Id.* ¶ 4. These subsidies take the form of premium tax credits, *see generally* 42 U.S.C. §§ 18021-18044; 26 U.S.C. § 36B, and the amount is determined in part based on the premium charged for a benchmark plan (*i.e.*, the applicable second lowest cost silver plan) available on the relevant Exchange, and depends on the eligible taxpayer's household income. *See* 26 U.S.C. § 36B. If premiums for the applicable benchmark plan increase, premium tax credits generally increase by a corresponding amount, thus insulating the taxpayer from the effect of the premium increase. Wu Decl. ¶ 5. In other words, 87% of those who purchase individual health insurance coverage through ACA Exchanges are insulated from premium increases. Instead, it is the Federal Government that bears the brunt of the impact of any premium increase.

Third, even if there is an exodus of enrollees, it would be difficult to determine whether that is traceable to the recent change in tax law or the actions complained of in this lawsuit. As noted before, in December 2017, Congress enacted the Tax Cuts and Jobs Act, which reduced the amount of the tax penalty to $0 beginning in 2019 for individuals who fail to comply with the individual mandate. Thus, some people may choose to go uninsured rather than purchase ACA-compliant coverage. In particular, it is possible that younger and healthier individuals may choose to purchase cheaper alternative options to qualified health plans, such as short-term limited duration insurance coverage (*see* Compl., ¶¶ 116-22), which, unlike the one-size-fits-all qualified health plans, can require underwriting and discriminate on the basis of age, pre-existing conditions, and other criteria (. The City Plaintiffs therefore have not established traceability, let alone that they necessarily will be burdened by sicker populations.

Similarly, the claim that Defendants' actions since 2017 have or will cause the premiums to increase, is suspect. As already discussed above, health insurance premiums in the individual market more than doubled between 2013 and 2017—*i.e.*, before any of the challenged actions took place. And, the individual health insurance market is inherently variable, with a slew of state-specific, market-

specific, issuer-specific and consumer-specific factors going into the determination of healthcare costs. All those factors make it impossible to determine with any degree of certainty that any market will encounter an increase in premiums for ACA-compliant health insurance, and if premiums do increase, whether and to what extent they are attributable to the challenged rules and executive actions. *See Va. Dep't of State Police*, 713 F.3d at 755 (the "traceability and redressability prongs [of standing] become problematic when third persons not party to the litigation must act in order for an injury to arise or be cured."); *Am. Freedom Law Ctr.*, 821 F.3d at 49 ("When [t]he existence of one or more of the essential elements of standing depends on the unfettered choices made by independent actors not before the courts and whose exercise of broad and legitimate discretion the courts cannot presume either to control or to predict, it becomes substantially more difficult to establish standing.") (internal citations and quotation marks omitted). Thus, even if premiums continue to rise, Plaintiffs must allege more than unadorned speculation as to the causal connection between Defendants' actions and insurers' decisions to set premium rates.

Finally, even if Plaintiffs were correct that the populations in the City Plaintiffs' jurisdictions will become uninsured or underinsured and sicker due to Defendants' actions, the City Plaintiffs still cannot acquire standing on the basis that they likely will need to increase expenditures to account for such populations. *See* Compl., ¶ 183. As an initial matter, no provision of federal law requires the City Plaintiffs to allocate any portion of their budgets to public health spending. To the contrary, they make their own political choices about budget priorities and healthcare spending, choices that are complicated and influenced by a variety of factors, including available tax revenue and the political will of the relevant decision-makers. Indeed, where, as here, "the plaintiff is not himself the object of the government action or inaction he challenges," standing "is ordinarily substantially more difficult to establish." *Lujan*, 504 U.S. at 562 (citation omitted); *see, e.g.,* Compl., ¶¶ 50-54, 255(a) (challenging the 2019 Rule's change of the notification requirement regarding individual *taxpayers'* loss of eligibility of tax credits under certain circumstances, but failing to identify the connection between such taxpayers and the City Plaintiffs' alleged harm). The City Plaintiffs are, after all, municipal cities not directly subject to the challenged provisions of the 2019 Rule.

Notably, some of Plaintiffs' challenges have nothing to do with even the City Plaintiffs' residents. For example, although the City Plaintiffs challenge the provision of the 2019 Rule that allows States to request CMS to reduce risk adjustment transfer amounts – *i.e.*, transfers from insurers with healthier-than-average enrollees to insurers with sicker-than-average enrollees, *see* Compl., ¶ 86; *see generally id.* ¶¶ 86-93, 255(h), none of the City Plaintiffs are in a State that has actually petitioned CMS for a reduction in the risk adjustment transfer payments for the 2020 benefit year, the first year that such requests are permitted under the 2019 Rule. Wu Decl., ¶ 15. The deadline for States to request such a reduction for the 2020 benefit year ended on August 1, 2018, without any such request from Illinois, Maryland, and Ohio, where the City Plaintiffs are located (or even Virginia, where the Individual Plaintiffs reside). *Id.* Plaintiffs' challenge to this aspect of the 2019 Rule, therefore, is purely academic. The same is true as to their challenge to the 2019 Rule provision that allegedly "makes it easier for states to request reduced medical loss ratio thresholds." Compl., ¶ 101. Again, none of Plaintiffs are located or reside in a State that has petitioned to reduce the medical loss ratio threshold under the 2019 Rule. Wu Decl., ¶ 16.

In sum, Plaintiffs' alleged injury depends upon multiple layers of speculation, third-party actions and tenuous causal links. It is evident that they seek to redress generalized grievances about the Executive Branch's policies by relying on their own unsubstantiated beliefs about the potential impact – primarily to others – of such policies. That is insufficient to establish Article III standing.

4. Plaintiffs' claims are not ripe.

For many of the same reasons that Plaintiffs have no standing to sue, their claims also cannot satisfy the related doctrine of ripeness. *See MedImmune, Inc. v. Genentech, Inc.*, 549 U.S. 118, 128 n.8 (2007) (recognizing that in some cases, "standing and ripeness boil down to the same question"); *Miller v. Brown*, 462 F.3d 312, 319 (4th Cir. 2006) ("Analyzing ripeness is similar to determining whether a party has standing."). "Ripeness is a justiciability doctrine designed to prevent the courts, through avoidance of premature adjudication, from entangling themselves in abstract disagreements over administrative policies, and also to protect the agencies from judicial interference until an administrative decision has been formalized and its effects felt in a concrete way by the challenging

parties." *Nat'l Park Hosp. Ass'n v. Dep't of the Interior*, 538 U.S. 803, 807-08 (2003) (quoting *Abbott Labs. v. Gardner*, 387 U.S. 136, 148–49 (1967)). Ripeness depends on "(1) the fitness of the issues for judicial decision and (2) the hardship to the parties of withholding court consideration." *Id.* at 808. A claim is not ripe for adjudication if it "'rests upon contingent future events that may not occur as anticipated, or indeed may not occur at all.'" *Andrew v. Lohr*, 445 Fed. Appx. 714, 715 (4th Cir. 2011) (quoting *Texas v. United States*, 523 U.S. 296, 300 (1998)).

Such is the case here. As shown above, the harm allegedly suffered by Plaintiffs is based on contingent events, including impact flowing from the 2019 Rule and other administrative and executive actions. In addition to the fact that it is speculative that premiums will rise in 2020 or beyond or that enrollment in qualified health plans will decrease, the impact of the challenged actions are not yet known. With minor exceptions, the challenged provisions of the 2019 Rule have yet to have any effect. *See, e.g.*, 83 Fed. Reg. at 16975 (noting that the standardized option change takes effect "for the 2019 plan year"); *id.* at 16981 (new audit standards "begin[] with the open enrollment period for the 2019 benefit year"). In fact, some will not go into effect until 2020. *See, e.g.*, 83 Fed. Reg. at 16959 (regarding provision on risk adjustment transfer amounts, "states will be permitted to request these adjustments to transfers beginning for the 2020 benefit year"). Some may not even be relevant to Plaintiffs at all. *See*, *e.g.*, 83 Fed. Reg. at 17036 (provisions modifying the submission and review process for States adjustment requests to the individual market medical loss ratio threshold will only be implicated if and when a State petitions HHS for such an adjustment, and even then, HHS will "determine the effective date for each adjustment in consultation with the respective State and based on the timing of the request submitted by the State" and after "opportunities for public comment on individual State adjustment requests").

It is also too soon to know whether the challenged rules that expand access to short-term, limited-duration insurance ("STLDI"), association health plans ("AHPs"), and health reimbursement arrangements ("HRAs") will have any concrete impact on Plaintiffs. Plaintiffs claim that such expansions of insurance options for consumers will increase premiums for qualified health plans, force individuals to leave ACA health coverage, and increase the uninsured or underinsured population in

their cities. *See* Compl., ¶¶ 116-18, 122. However, the STLDI rule change has only gone into effect on October 2, 2018, *see* 83 Fed. Reg. 38212 (Aug. 3, 2018), and the AHP rule will not be fully effective until April 1, 2019, *see* 83 Fed. Reg. 28912 (June 21, 2018).[11] And the rule change regarding HRAs is not yet final, as the Departments of the Treasury, Labor, and Health and Human Services have only recently issued a Notice of proposed rulemaking regarding HRAs, with comments due on or before December 28, 2018. *See* 83 Fed. Reg. 54420 (Oct. 29, 2018). In sum, judicial consideration of Plaintiffs' claims is premature, and the case should be dismissed as unripe.

B. The Complaint Fails to State a Claim for which Relief Can be Granted.

1. Plaintiffs' APA challenge to the 2019 Rule should be dismissed.

Even if Plaintiffs can overcome the insurmountable jurisdictional hurdle, their APA claim should be dismissed for failure to state a claim. As an initial matter, the President is not subject to the APA, *Franklin v. Massachusetts*, 505 U.S. 788, 796 (1992), and thus, this claim can only proceed as against the other defendants.

Under the APA, the Court may set aside an agency action if the Court finds that challenged action is "arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with the law." 5 U.S.C. § 706(2)(A). The Court's review is "ultimately narrow and highly deferential" and focused on "ensur[ing] that the agency has 'examine[d] the relevant data and articulate[d] a satisfactory explanation for its action.'" *Am. Whitewater v. Tidwell*, 770 F.3d 1108, 1115 (4th Cir. 2014) (internal citation). The agency need only "provide[] an explanation of its decision that includes a rational connection between the facts found and the choice made'" to have its decision sustained. *Id.* (quoting *Ohio Valley Envt'l Coal. v. Aracoma Coal Co.*, 556 F.3d 177, 192 (4th Cir. 2009)). A court "is not to substitute its judgment for that of the agency." *Motor Vehicle Mfrs. Ass'n of U.S., Inc. v. State Farm Mut. Auto. Ins. Co.*, 463 U.S. 29, 43 (1983). The agency need not "demonstrate to [the] court's satisfaction

[11] The AHP final rule establishes three "phased applicability dates." *See generally* 83 Fed. Reg. 28912 (June 21, 2018). The first date (September 1, 2018) allowed fully insured plans, such as an AHP that purchases insurance from another provider, to begin operation. *See id.* The remaining two dates, however, have not yet occurred. *See id.* Existing self-insured AHPs – those that pay out of their own assets – may begin operating under the new rule on January 1, 2019. *Id.* Meanwhile, new self-insured AHPs may begin operation on April 1, 2019. *Id.*

that the reasons for the new policy are *better* than the reasons for the old one; it suffices that the new policy is permissible under the statute, that there are good reasons for it, and that the agency *believes* it to be better, which the conscious change of course adequately indicates." *F.C.C. v. Fox Television Stations, Inc.*, 556 U.S. 502, 515 (2009).

Moreover, to the extent Plaintiffs allege that the agency action is contrary to law, the action is reviewed under the deferential framework set out in *Chevron U.S.A., Inc. v. Natural Resources Defense Council, Inc.*, 467 U.S. 837, 845 (1984). That framework is based on the presumption "'that Congress, when it left ambiguity in a statute administered by an agency, 'understood that the ambiguity would be resolved, first and foremost, by the agency, and desired the agency (rather than the courts) to possess whatever degree of discretion the ambiguity allows.'" *City of Arlington v. FCC*, 569 U.S. 290, 296 (2013) (citation omitted). Thus, if Congress has not "directly addressed the precise question at issue," *Mayo Found. for Med. Educ. & Research v. United States*, 562 U.S. 44, 52 (2011), *i.e.*, when the statute is silent or ambiguous with respect to the specific issue under consideration, then "the question for the court is whether the agency's answer is based on a permissible construction of the statute." *City of Arlington*, 569 U.S. at 296 (quoting *Chevron*, 467 U.S. at 842-43). This last analysis is coextensive with arbitrary or capricious review. *Judulang v. Holder*, 565 U.S. 42, 52 n.7 (2011).

As explained in detail below, each of the approximately 10 challenged provisions of the 2019 Rule more than satisfies this highly deferential standard.

a. The provision permitting States to request a reduction in the risk adjustment transfer amounts is not arbitrary or capricious.

Plaintiffs challenge a provision in the 2019 Rule that allows a State to request a percentage reduction in the calculation of the risk adjustment transfer amounts beginning with the 2020 benefit year. Pursuant to an express congressional delegation of authority, *see* 42 U.S.C. §§ 18041(a)(1)(C) and 18063, the Secretary previously established a risk adjustment program that permits the transfer of certain amounts "from lower risk, non-grandfathered [health insurance] plans to higher risk, non-grandfathered plans in the individual and small group markets, inside and outside [of] the Exchanges." 83 Fed. Reg. at 16939. As the Secretary explained, "[r]isk adjustment is widely used in health insurance

markets, and is recognized as a critical measure in mitigating the effects of adverse selection, ensuring financial viability of plans that enroll a higher proportion of high-risk enrollees, and fostering competitive health insurance markets." *Id.* at 16955. After numerous "discussions with issuers and State insurance regulators on ways to encourage new participation in the health insurance markets and mitigate the effects of substantial risk adjustment charge amounts," CMS promulgated the challenged rule, which "provide[s] States the flexibility" to request "certain State-specific adjustments to the HHS risk adjustment methodology" to "take into account the effect of State-specific laws and rating rules without the necessity for States to undertake operation of their own risk adjustment program." *Id.* at 16956. The challenged policy takes into account feedback from stakeholders and other interested parties that HHS's risk adjustment methodology, which is calibrated on a national dataset, may not, in some circumstances, precisely account for risk differences in their particular State. *Id.*

Plaintiffs argue that this risk adjustment provision will incentivize issuers to discriminate against individuals and families with preexisting conditions and/or deter the same from enrolling in the first instance. *See* Compl., ¶¶ 86-93. But CMS considered and rejected those concerns as unwarranted. For example, in response to comments urging CMS not to implement the provision because it could encourage risk selection by issuers, *see* 83 Fed. Reg. at 16598, CMS explained that statutory and regulatory provisions, such as "guaranteed availability, guaranteed renewability, as well as the non-discrimination provisions" exist to "protect[]" against, *inter alia*, issuers "discriminating based on health conditions, or otherwise discouraging enrollment of individuals with significant health needs." *Id.* CMS also weighed Plaintiffs' concern that allowing States to seek a reduction amount up to 50 percent is "arbitrary or too high," *see id.* at 16959, and rejected this contention, reasoning that "an adjustment of *up to* 50 percent" is an "appropriate threshold" based on CMS's "review of [risk adjustment] transfers, the potential impact of such a reduction on market premiums and the proportion of the transfers as a percent of issuers' payments." *Id.* at 16959. As CMS explained, States seeking such reductions must submit evidence and analysis of State-specific factors that justify the requested reduction amount. *Id.* at 16957-16959. The challenged provision "represents a reasonable balance" between "adjustment for actuarial risk based on a national methodology" and recognition

that such national methodology may not precisely account for actuarial risk differences attributable to unique State-specific factors. *Id.* at 16959.

Plaintiffs' assertion that CMS "failed to respond to" comments suggesting that the risk adjustment methodology "already accounts for state-specific factors," *see* Compl., ¶ 90, is incorrect. CMS explained both the limitations of the nationally-focused risk adjustment methodology and the corresponding need to "more precisely account for relative risk differences" in the State marketplace due to unique State factors. *See id.* Furthermore, Plaintiffs' assertion is belied by the language of the provision, providing that "HHS will not approve State requests for reduction to [risk adjustment] transfers based on factors in the State's individual, small group or merged market that *are addressed by the current HHS risk adjustment*." 83 Fed. Reg. at 16958 (emphasis added).

Equally meritless is Plaintiffs' assertion that CMS "provided insufficient explanation" for its decision to allow States to seek reductions in the individual market, *see* Compl., ¶ 91. To the contrary, CMS expressly acknowledged "commenters' concerns about extending the flexibility to the individual . . . market[]," but nonetheless found it appropriate to do so because it would allow consideration of "certain factors unique to the States' individual or merged market, such as State rating requirements." 83 Fed. Reg. at 16958. Nor is there any merit to Plaintiffs' claim that the challenged provision is "internally inconsistent" because it does not permit States "to *increase* risk adjustment transfers." Compl., ¶ 92. CMS explained that in instances where a State believes that an increase in risk adjustment transfers would be appropriate, State regulators "under their own State authority" could take action outside of the challenged policy to ease the transition of new entrants and/or mitigate the effects of large risk adjustment transfers. States also have the authority to operate the risk adjustment program and establish an alternative Federally-certified risk adjustment methodology. 83 Fed. Reg. at 16959; *see* also 42 U.S.C. § 18063; 45 C.F.R. § 153.310, *et. seq.* Additionally, CMS stated that such increases, in any event, likely would be unnecessary given that the current HHS methodology already compensates States' relative actuarial risk differences scaled to the average cost of the State market. *Id.* In any event, CMS's decision to focus on addressing one aspect of the problem, *i.e.,* that substantial risk adjustment payments were discouraging new issuers from participating in States'

healthcare markets and impeding competition among issuers already in the markets, *see id.* at 16956, does not render the provision arbitrary or capricious. *See, e.g., U.S. Telecomm. Ass'n v. F.C.C.*, 359 F.3d 554, 588 (D.C. Cir. 2004) (an agency has broad discretion to "defer consideration of particular issues to future proceedings" and "need not address all problems 'in one fell swoop'" (internal citation omitted)).

b. The 2019 Rule provisions amending CMS's rate review requirements are permissible interpretations of the ACA.

Plaintiffs also challenge two provisions of the 2019 Rule that amend CMS's regulations governing premium rate reviews under the ACA: 1) the provision that exempts student health insurance coverage from the federal rate review process; and 2) the provision that increases the rate increase threshold that triggers the federal rate review process. *See* Compl., ¶¶ 94-99. Both challenges fail.

As to the first provision, the exemption is not contrary to the ACA as Plaintiffs argue. *See id.* ¶ 96. Although student health insurance is a form of individual health insurance, CMS has long interpreted the ACA to exclude student health insurance plans from ACA requirements that "would have, as a practical matter, the effect of prohibiting an institution of higher education from offering a student health plan otherwise permitted under federal, state, or local law." Patient Protection and Affordable Care Act; Health Insurance Market Rules; Rate Review, 78 Fed. Reg. 13406, 13424 (Feb. 27, 2013) (interpreting 42 U.S.C. § 18118(c)). Thus, for example, student health insurance coverage is exempted from the ACA's guaranteed availability and renewability requirements to the extent that such requirements would require a student health insurance plan to accept enrollment or renew coverage of individuals who are not students or dependents of students. *See* 45 C.F.R. § 147.145(b)(1); *see also* Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2015, 79 Fed. Reg. 13744 (Mar. 11, 2014); Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2017, 81 Fed. Reg. 12204 (Mar. 8, 2016). The same is true regarding the ACA requirement that coverage be offered on a calendar year basis; student health insurance coverage generally is instead offered based on the academic calendar year. 45 C.F.R.

§ 147.145(b)(1)(ii). Moreover, student health insurance coverage is not included in the ACA's individual market risk pool in a State because issuers of student health insurance coverage typically contract with colleges and universities to issue a blanket health insurance policy based on total expected claims from which students may buy coverage. *See id.* § 147.145(b)(3).

With the 2019 Rule, CMS determined that student health insurance coverage should also be exempt from the federal rate review process under 42 U.S.C. § 300gg-94. *See* 83 Fed. Reg. at 16972. Although that provision requires both the Secretary and the States "monitor premium increases of health insurance coverage offered through an Exchange and outside of an Exchange," CMS explained that student health insurance coverage is "generally rated and administered differently" from other individual health plans; indeed, States have "allowed rating practices for student health insurance coverage to be more in line with large group pricing." 83 Fed. Reg. at 16972 (citing Final Rule, "Health Insurance Market Rules; Rate Review," 78 Fed. Reg. 13406, 13424 (Feb. 27, 2013)). As a result of these differences, CMS reasonably determined that student health insurance coverage should be exempt from federal rate review, except that CMS plans to continue to generally review their rates "[i]n States that do not have an Effective Rate Review Program to monitor the compliance of student health insurance coverage with applicable market rating reforms based on complaints and as part of targeted market conduct examinations." 83 Fed. Reg. at 16972. States maintain the flexibility to review rate increases of any size and other aspects of student health insurance coverage. *Id.* Given these explanations and safeguards, Plaintiffs' challenge to the student health insurance coverage provision fails.

Equally meritless is Plaintiffs' contention that CMS has arbitrarily and capriciously increased the threshold for federal premium rate review from 10 percent to 15 percent. *See* Compl., ¶ 98; *see also* 42 C.F.R. § 154.200. Section 300gg-94 provides that the Secretary, in conjunction with States, shall establish a process for the annual review of "unreasonable increases in premiums" for health insurance coverage, 42 U.S.C. § 300gg-94(a). Section 300gg-94, however, does not define what constitutes an "unreasonable" premium rate increase nor does it define the process that should be used for determining whether a particular increase is "unreasonable." 42 U.S.C. § 300gg-94 (requiring that a

review be conducted and a justification submitted). The statute's silence on this score is a "gap" that Congress left for CMS to fill pursuant to its rulemaking authority under the ACA. *See, e.g.*, *The Md. Dep't of Health & Mental Hygiene v. CMS*, 542 F.3d 424, 434 (4th Cir. 2008) (deferring to CMS's interpretation of the phrase "not covered under the State plan" in the Medicaid statute because "[b]y failing to define the phrase, Congress left an interpretive gap that CMS may fill"). As explained in initial rulemaking implementing 42 U.S.C. § 300gg-94, CMS regulations provide a definition of an "unreasonable" rate increase and outline the process used by HHS when reviewing rate increases to determine which rates are subject to review and among them which are "unreasonable." *See* Rate Increase Disclosure and Review; Proposed Rule, 75 Fed. Reg. 81003, 81005-81008 (Dec. 23, 2010). The federal rate review process adopted by CMS does not involve the anomaly of "pre-determining" the reasonableness of a rate before it has been reviewed. *See id.* at 81006. Instead, if a proposed rate increase equals or exceeds the defined threshold, it would be considered "subject to review." *Id.* The review process would then determine if the increase is, in fact, "unreasonable." *Id.*

In the 2019 Rule, CMS explained that its decision to increase the threshold for review under the federal rate review process was based on its "recognition of [the] significant rate increases in the past number of years." 83 Fed. Reg. at 16972. To that point, CMS reviewed all rating filings "since the inception of the review threshold" to identify those that were subject to review and ultimately determined to be "unreasonable." *Id.* at 16973. The result of CMS's analysis was that "only one filing" that fell "between the 10 to 15 percent range" over this seven year period was deemed "unreasonable" after further review. *Id.* Moreover, CMS reasoned that many States already "apply a stricter (lower threshold) standard" and thus, the 15 percent threshold would merely set "a [federal] minimum standard." *Id.*; *see also* 76 Fed. Reg. 29964, 29967 (May 23, 2011)at 29967. For these reasons, CMS rationally decided to increase the threshold for review under the federal rate review process to 15 percent. *See Am. Whitewater v. Tidwell*, 770 F.3d 1108, 1116 (4th Cir. 2014) ("so long as the agency 'provides an explanation of its decision that includes a rational connection between the facts found and the choice made,' its decision should be sustained") (citation omitted).

Plaintiffs take issue with CMS's "invo[cation]" of the States' rate review process, arguing that it is a "stopgap measure," and thus impermissible. *See* Compl., ¶ 98. But Congress expressly contemplated such reliance: it directed CMS to establish a process "in conjunction with the States" for monitoring and reviewing unreasonable premium increases. *See* 42 U.S.C. §§ 300gg-94(a)(1), 300gg-94(a)(2)(A). Also unwarranted is Plaintiffs' argument that CMS "gave short shrift" to commenters' concerns, "ignored" the deterrent purpose of the reasonableness review, and improperly made it easier for insurers to increase rates without adequate justification. *See* Compl., ¶¶ 98, 99. First, CMS's analysis of seven years of rate filings found "only one" rate filing subject to review within the 10 to 15 percent range was later deemed "unreasonable." 83 Fed. Reg. at 16973. Second, as noted, "most States" have "stricter rate review standards" to which issuers offering health insurance coverage in the single risk pool are also subject. *Id.* Third, the challenged provision represents a reasonable effort to balance the need to review and monitor unreasonable premium rate increases against CMS's interest in decreasing the regulatory burden on insurers and other interested stakeholders. *See* 83 Fed. Reg. at 16972-73. Where, as here, "the new policy is permissible under the statute, [] there [is] good reason[] for it, and [the] agency *believes* it to be better," the Court must uphold the agency's judgment. *Fox Television Stations*, 556 U.S. at 515.

c. Plaintiffs' challenge to six separate provisions of the 2019 Rule that modify certain Exchange functions and streamline the direct enrollment and eligibility verification processes also fails.

Equally unavailing is Plaintiffs' challenge to six provisions of the 2019 Rule, *see* Compl., ¶¶ 255(a), (c), (d)-(g), which modify or amend "Exchange Establishment Standards and Other Related Standards Under the Affordable Care Act," *see* 83 Fed. Reg. at 16930. CMS determined that these regulatory changes are necessary to mitigate insurers exiting the individual and small group markets, thereby causing insurance premium rates to increase in those markets and "threaten[ing] the stability of the individual and small group Exchanges in many geographic areas." *Id.* As explained in detail below, each of the challenged provisions is focused on "enhancing the role of States in these programs and providing States with additional flexibilities, reducing unnecessary regulatory burden on

stakeholders, empowering consumers, and improving affordability," *see id.* at 16930-31, all of which fall well within CMS's broad regulatory authority under the ACA.

CMS's Decision to Discontinue Standardized Options. In the 2017 health insurance benefit year, CMS "introduced standardized options (also now referred to as Simple Choice plans)," which are qualified health plans offered for sale through an individual market Exchange that have either a standardized cost-sharing structure or other specified cost-sharing structures. *Id.* at 16974. Such plans are a creation of HHS's regulation and not mandated by the ACA. With the challenged 2019 Rule, CMS has opted not to offer standardized options in an effort to encourage competition in the individual market and "to maximize innovation by issuers in designing and offering a wide range of plans to consumers." *See id.*

Although "[m]any commenters supported" the decision to discontinue standardized options, *see id.* at 16973, Plaintiffs do not, and they urge the Court to invalidate the challenged provision on two grounds. First, they argue that CMS failed to explain the basis of its decision. *See* Compl., ¶ 70. But the 2019 Rule's preamble expressly explains that CMS decided to eliminate the standardized plan option to "encourage[e] innovation," which "is especially important now, given the stresses faced by the individual market." *Id.* at 16974. The agency was also "concern[ed] that providing differential display for these plans may limit enrollment in coverage with plan designs that do not match the standardized options" but may nevertheless be a better fit for individual consumers. *Id.* For similar reasons, Plaintiffs' argument that the provision "will limit the degree to which health plans will compete on price," *see* Compl., ¶ 72, is also misguided. Again, as CMS explained, the elimination of standardized options is designed to encourage competition and innovation, which should have the effect of reducing prices.

Plaintiffs next insist that eliminating the standardized option is unlawful because CMS "has cited no data to support" its assertion that these plans stymied innovation. Compl., ¶ 70. The agency has substantial expertise in administering the Federally Facilitated Exchanges ("FFEs") and, as discussed in detail at 83 Fed. Reg. at 16975, has determined, after balancing competing concerns, that the benefits of the change outweigh the potential concerns and the proposed change is necessary to

encourage insurers to design and offer innovative health care plans in the individual market. Nothing more is required. Plaintiffs' contention that CMS failed to offer a reasonable explanation in response to commenters who believe that standardized options would encourage issuers to develop innovative plan features, *see* Compl., ¶ 70, is simply wrong. CMS considered these comments and ultimately rejected the premise, reasoning that standardized options create disincentives for issuers to innovate and that issuers are in the best position to design and offer innovative plan designs. 83 Fed. Reg. at 16975. CMS further explained that because the agency had designed standardized options "to be[] similar[] to the most popular (weighted by enrollment) QHPs in the FFEs," the plan "design features, such as annual limitations on cost sharing and deductibles, previously specified as part of standardized options are mostly available to consumers in FFEs" and, therefore, it is unnecessary to "mandate or otherwise further provide an incentive for issuers to offer plans that meet the characteristics of standardized options." *Id.*

Plaintiffs also speculate that without the ability to choose from among standardized options on the federal Exchanges, "it [will be] more difficult for consumers to select" appropriate health plans, which, in turn, will increase the risk that individuals "will go without coverage," thereby "increase[ing] the size of the underinsured and uninsured populations." Compl., ¶¶ 70-71. But as CMS explained, there are currently "other tools" to assist consumers with their health plan selection, including "HealthCare.gov plan filters." 83 Fed. Reg. at 16975. Moreover, the agency is continuing to "explore strategies to make shopping on HealthCare.gov as easy as possible, and . . . better [able to] support customers in choosing coverage that is best for them." *Id.*

Modifications to Standards for Navigator Certification. Prior to the 2019 Rule, CMS required that each Exchange have "at least two Navigator[s]," *i.e.*, entities that conduct public education and other activities aimed at increasing public awareness about QHPs and enrollment in the individual and small group market pursuant to grants awarded by each Exchange; "that one of these [two] entities [] be a community and consumer-focused nonprofit group"; and that "each Navigator entity maintain a physical presence in the Exchange service area" to facilitate "face-to-face assistance." *Id.* at 16979. CMS has now removed these requirements, while allowing the Exchanges to choose to

use their Navigator grant funds in the same manner as they did before. *Id.* CMS explained that its decision is intended "[t]o maximize the flexibility and efficiency of the Navigator program" through the Exchanges' "improved flexibility to award funding to the number and type of entities that will be most effective for the specific Exchange." *Id.* CMS stated its belief that each Exchange is best suited to determine for itself how to select Navigators, and that allowing the Exchanges the flexibility to do so would "best serve the Exchange service areas." *Id.* at 16979. After all, CMS's experience shows that Navigators "with strong relationships in their [Exchange] service areas tend to deliver the most effective outreach and enrollment results." *Id.* at 16979-80.

Plaintiffs contend that the provision violates the ACA because without a physical presence or a community or consumer-focused non-profit Navigator in the Exchange service area, the Navigator program "cannot adequately carry out [its] statutory duties." Compl., ¶¶ 74-75. But the ACA provision governing Navigators does not speak to the issue. *See* 42 U.S.C. § 18031(i)(2)(A) (providing only that an eligible Navigator entity must "demonstrate . . . that [it] . . . has existing relationships, or could readily establish relationships, with employers, . . . consumers . . . or self-employed individuals likely to be qualified to enroll in a qualified health plan"). Thus, it is not surprising that Plaintiffs' sole support is a *proposed* rule, *see* Compl., ¶ 74 n.79, which of course has no legal effect. In any event, "[i]t goes without saying that a proposed regulation does not represent an agency's considered interpretation of its statute and that an agency is entitled to consider alternative interpretations before settling on the view it considers most sound." *Commodity Futures Trading Comm'n v. Schor*, 478 U.S. 833, 845 (1986). "Since the proposed rule was simply a proposal, its presence meant that the Department was considering the matter; after that consideration the Department might choose to adopt the proposal or to withdraw it." *Long Island Care at Home, Ltd. v. Coke*, 551 U.S. 158, 175 (2007). In the absence of any statutory directive, the same statutory authority that allowed CMS to establish the prior standards for Navigator certification, *see* 42 U.S.C. §§ 18031(i)(4)(A), 18041(a)(1), now also allows CMS to modify those standards. Indeed, there can be no dispute that the new standard is consistent with § 18031 and CMS's regulations. 83 Fed. Reg. at 16980; *see, e.g.*, 45 C.F.R. § 155.210. And with today's technological advances, many, if not most consumer choices and certainly insurance choices are not

made after face-to-face communication. Plaintiffs' subjective beliefs about how best to implement the program cannot invalidate the agency's decision to allow more flexibility to Exchanges to control their Navigator programs, consistent with the statute.

Nor is that decision arbitrary or capricious. *See* Compl., ¶¶ 76-77. During rulemaking, CMS considered and rejected many of the same objections that Plaintiffs advance here, *see* 83 Fed. Reg. at 16980-81. In particular, in removing the physical presence requirement, CMS considered the availability of other resources (*e.g.*, agents, brokers, and direct enrollment partners) "to provide enrollment assistance or remote services to consumers," *id.* at 16981, concluding that the Exchanges are better suited to determine "the weight to give a [Navigator's] physical presence in the Exchange service area," *id.* at 16980. And in removing the requirement that each Exchange must have at least one community and consumer-focused non-profit organization, CMS examined Section 18031(i)(2)(A)'s requirement that the entity needs to only demonstrate that it has "existing relationships, or could readily establish relationships" as required under the statute, and that such an entity could include "trade, industry, and professional associations, commercial fishing industry organizations, ranching and farming organizations, . . . chambers of commerce, unions, [and] resource partners of the Small Business Administration." 42 U.S.C. § 18031(i)(2)(B). CMS also considered the concern that the Exchanges will select "conflict[ed]" Navigators, Compl., ¶ 75, concluding that the Exchanges "are able to determine the type of entity or entities that will serve their Exchange service area best" in a manner consistent with established statutory and regulatory standards and obligations. 83 Fed. Reg. at 16980. In sum, because the challenged provision is a permissible interpretation of the ACA and is neither arbitrary nor capricious, it should be upheld. *Fox Television Stations*, 556 U.S. at 515.

New Audit Standards for Entities Participating in Direct Enrollment. As part of HHS's effort to reduce regulatory burden, the 2019 Rule now provides that for purposes of the annual operational readiness review, agents, brokers, and issuers participating in direct enrollment "would select their own third-party entities for conducting audits, rather than requiring HHS to initially review and approve these entities [as was the case under CMS's prior rule]." 83 Fed. Reg. at 16981. CMS

explained that it intends "to publish technical guidance outlining the review standards and other operational details, as well as [to] provide other resources to assist third-party entities in conducting the reviews." *Id.* Moreover, third party entities will "be subject to HHS oversight" and "the agent, broker, or issuer will remain responsible for compliance with all applicable direct enrollment requirements." *Id.*

Plaintiffs speculate about a host of harms that allegedly would result from this regulatory change and accuse CMS of "fail[ing] to grapple with evidence" and to respond to comments expressing concern about this change. *See* Compl., ¶¶ 63-66. None of these arguments has merit. First, CMS considered the concern that the new provision may "increase the likelihood that consumers [will] receive inaccurate information," which in turn may decrease enrollment and increase the number of uninsured, *see id.* ¶ 66; *see also* 83 Fed. Reg. at 16982. But it concluded that such concern is addressed by established "standards" that "help promote informed consumer choice" in the individual and small group markets, including but not limited to the requirement to "display all QHP data." 83 Fed. Reg. at 16982. There is also a requirement that agents, brokers, and issuers participating in direct enrollment provide consumers with correct information. *See* 45 C.F.R. §§ 155.220(j)(2)(i) and 156.1230(b)(3). CMS also explained in the 2019 Rule that there are guidelines and processes in place to oversee the activities of agents, brokers, and issuers participating in direct enrollment; the agency also emphasized its commitment to continuous monitoring and oversight of such entities. *See* 83 Fed. Reg. at 16982.

CMS also carefully considered Plaintiffs' concern "that enrollment through a non-governmental site would occur without proper oversight and controls," including "the potential for conflicts of interest arising from relationships between the agents, brokers, and issuers and the third-party auditors they select to conduct their audits." *Id.* But again, CMS concluded that these concerns are mitigated by the requirements and processes the agency has put in place. *Id.* CMS indicated that it also intends to continue "to monitor enrollments through the direct enrollment pathway for evidence of fraud and abuse." *Id.* And, although the agency "acknowledge[d] the potential for conflicts of interest," in its view, the "required disclosures, continuous monitoring and oversight, and

standards established for third-party auditors will sufficiently mitigate these concerns." *Id.* Plaintiffs cannot invalidate CMS's decision based on their own unsubstantiated fear that there will be widespread fraud or abuse by insurance issuers, agents, or auditors. *See Am. Whitewater*, 770 F.3d at 1116 ("[T]he APA does not give us license to second-guess an agency's well-reasoned decision simply because a party disagrees with the outcome.").

Decision to Amend Exchange Eligibility Determination Processes. Similarly without merit is Plaintiffs' challenge to the provision in the 2019 Rule that amends the notification requirement regarding an individual's eligibility for advance payments of the premium tax credit. As noted before, under the ACA, certain enrollees in the individual market Exchanges are eligible to receive a premium tax credit to reduce their costs for health insurance premiums. 83 Fed. Reg. at 16930. Under CMS's regulations, an individual is ineligible to receive advance payments of the premium tax credit ("APTC") if, *inter alia*, "the tax filer or his or her spouse" fails to file an income tax return and reconcile APTC received for the individual for a previous year. 45 C.F.R. § 155.305(f)(4). Under the prior regulations, the Exchanges (Federal and State-based) could "not discontinue APTC due to [this] failure" "unless direct notification [wa]s first sent to the tax filer that his or her eligibility w[ould] be discontinued." 83 Fed. Reg. at 16982. The 2019 Rule amends this provision by "removing the direct notification requirement." *Id.*

CMS explained that it promulgated the challenged 2019 Rule provision to address concerns that Internal Revenue Service rules "generally prohibit the disclosure of FTI [federal tax information] to anyone other than the tax filer," and FTI includes "information as to whether a tax return has been filed with [the] IRS." *Id.* "To avoid unauthorized disclosure of FTI" and ensure that consumers receive appropriate APTC eligibility notification when necessary, the federal exchanges will send two notices: (1) a "combined notice," *i.e.*, written notices (electronically or via U.S. Mail), sent to consumers (FTR and non-FTR), which explains in general terms the need to address FTR but is not considered FTI, *see id.* at 16983, and (2) "warning notices" or "direct notices" to "tax filers on whose behalf APTC was being paid but for whom the FFE ha[s] information the tax filer had not met the requirement to file and reconcile." *Id.* The direct notice "unambiguously explain[s] that the tax filer has been

identified as having failed to meet the requirement to file and reconcile" and urges "the tax filers to file and reconcile to avoid losing APTC." *Id.* And, with respect to the State-based Exchanges ("SBEs"), CMS noted the "infeasib[ility]" of "upgrading their systems to be FTI compliant . . . in the short term" and their "varying capacities," and thus "encourage[d] SBEs to take a similar noticing approach [as the federal exchanges], where feasible" and offered "to provide technical assistance, as needed." *Id.* at 16984.

Plaintiffs contend that CMS's decision to amend the direct notice requirement in this manner is both contrary to 26 U.S.C. § 36B, the Internal Revenue Code ("IRC") provision authorizing the receipt of APTC for an "applicable taxpayer," and arbitrary and capricious. *See* Compl., ¶¶ 51-53. Plaintiffs are wrong on both scores. As an initial matter, the IRC provision on which Plaintiffs rely is not under the jurisdiction of CMS, and the provision does not limit CMS's authority to promulgate regulations governing the functioning of the Exchanges under Section 18041(a)(1) of the ACA, which authorizes CMS to establish the eligibility requirements for the APTC program. CMS's decision to modify the regulations governing notification of APTC eligibility is a permissible interpretation of the ACA and entitled to deference.

Moreover, Plaintiffs' argument runs afoul of the "canon against reading conflicts into statutes." *Epic Sys. Corp. v. Lewis*, 138 S. Ct. 1612, 1630 (2018). There is no conflict between the challenged provision and § 36B of the IRC because nothing in the challenged provision "deprive[s]," *see* Compl., ¶ 52, an individual from receiving APTC as long as she or he complies with the statutory and regulatory eligibility requirements, including the obligation to file a federal tax return and reconcile a prior year's APTC, if any. *See* 42 U.S.C. § 18081(a)(1), (2); *see also* 45 C.F.R. § 155.305. Again, the challenged provision simply amends the process by which the Exchanges provide written notice of APTC eligibility to ensure that the Exchanges' written notices do not run afoul of IRS rules barring the disclosure of FTI to third parties.

There is also no merit to Plaintiffs' claim that the challenged provision is arbitrary and capricious. Plaintiffs argue that CMS failed to provide "evidence" indicating that consumers are "receiving APTC improperly." Compl., ¶ 53. But CMS need not do so because its decision is a

prophylactic measure to *avoid* program integrity issues. *See, e.g.*, *F.C.C. v. Nat'l Citizens Comm. For Broad.* 436 U.S. 775, 813-14 (1975) (a "forecast of the direction in which future public interest lies necessarily involves deductions based on the expert knowledge of the agency") (citation omitted). As CMS explained, while it "is committed to ensuring consumers eligible for APTC maintain that important benefit," it "also believe[s] that *ensuring* consumers are not receiving APTC improperly is necessary for program integrity." 83 Fed. Reg. at 16984 (emphasis added). Moreover, as already discussed, CMS proffered two other bases for its decision: (1) the "importan[ce] . . . [of] reduc[ing] burden on Exchanges, which have varying capacities," and (2) the need to "[e]stablish[] a mechanism through which to notify tax filers without making an unauthorized disclosure of protected FTI." *Id.*

Finally, Plaintiffs insist that the challenged provision is arbitrary and capricious because CMS itself "recognizes the utility and importance of [direct] notifications" as evidenced by the fact that the federal exchanges will continue to provide them. Compl., ¶ 53. But as CMS explained, "the direct notices were not generated by the [Federally Facilitated Exchange] itself; rather, data was securely sent to an FTI-compliant print contractor for printing and mailing." 83 Fed. Reg. at 16983. State-based Exchanges, on the other hand, "may have fewer options available to them"; indeed, CMS has learned that some of them "are required to use only in-State contractors, which can create a significant barrier if there are not FTI-compliant contractors in the State." *Id.* CMS also emphasized that the agency "remain[s] committed to improving the clarity and effectiveness of the FTR notification process," *see id.* at 16985, and will do so "as part of broader rulemaking and guidance" on this and other issues related to program integrity, *id.* at 16986. For now, the challenged rule should be upheld because it properly balances the Exchanges' obligation to provide APTC eligibility notices, need to avoid unlawful disclosure of FTI, and the undue or "infeasible" burden on State-based Exchanges that are unable to upgrade their systems to be FTI compliant in a short order without great expense.

Revisions to the Income Verification Requirements for APTC Eligibility. Plaintiffs also challenge a provision of the 2019 Rule that requires a tax filer to submit additional documentation where he or she attests to income between 100 and 400 percent of federal poverty level—making him or her eligible for APTC—but trusted electronic data sources reflect income under 100 percent of the

federal poverty level. 83 Fed. Reg. at 16985. The prior rule required the Exchanges "to accept the [tax filer's] attestation without further verification" even when the attested income is contradicted by income data from the IRS and the Social Security Administration. *Id.* CMS explained that the new requirement is "a critical program integrity measure" and that "without proper procedures for verifying income and family sizes, the risk of providing APTC [to] individuals who do not meet the minimum income eligibility requirements—including those who may purposefully misstate their incomes in order to gain access to APTC—is increased." *Id.* at 16986.

Wholly ignoring this sound policy objective, Plaintiffs assert that it is arbitrary and capricious to require tax filers to clarify the income inconsistencies before their APTC eligibility can be determined. *See* Compl., ¶¶ 81-84. Plaintiffs first argue that CMS "does not have firm data" indicating that individuals may attempt to inflate their income to gain APTC. But lack of "firm data" does not undermine the validity of the challenged provision, which CMS implemented based on its experience and expertise that income-dependent benefits programs, such as the APTC program, may be subject to abuse. *See, e.g.*, *Huncto Pawn Holdings, LLC v. U.S. Dep't of Def.*, 240 F. Supp. 3d 206, 225 (D.D.C. 2016) (rejecting plaintiffs' argument that rule was arbitrary and capricious because agency did not "support its belief that such misuse [that is, falsifying self-certification forms] was occurring with any technical data"). And contrary to Plaintiffs' argument, *see* Compl., ¶ 82, this valid concern is not mitigated by the ACA's requirement that eligible individuals reconcile their prior year's premium tax credit with the income tax return. *See* 83 Fed. Reg. at 16986 (explaining the agency's view that this new requirement is "a critical program integrity measure, notwithstanding any liability that the tax filer may have when filing income taxes and reconciling APTC paid during the inconsistency period"). "[T]o the extent that funds paid for APTC cannot be recouped through the tax reconciliation process, it is important to ensure these funds are not paid out inappropriately in the first instance." *Id.*; *see also Stillwell v. Office of Thrift Supervision*, 569 F.3d 514, 519 (D.C. Cir. 2009) ("agencies can, of course, adopt prophylactic rules to prevent potential problems before they arise").

Plaintiffs next fault CMS for failing to sufficiently answer commenters' concern that low-income individuals may have difficulty complying with the additional documentation requirement. *See*

Compl., ¶ 82. In the 2019 Rule's preamble, CMS expressly acknowledged this potential problem and outlined the available resources to assist such individuals. 83 Fed. Reg. at 16986 (citing the "modified" calculator used by HHS "to handle instances where income fluctuates, or is seasonal in nature"; the "consumer guide to households to help them provide correct documentation"; and "a worksheet for households to help verify their attested income"). Indeed, not only have these resources significantly improved the income verification process since the launch of the APTC program, CMS further emphasized its intent to "explor[e] strategies to promote more timely and accurate reporting of changes in circumstances by consumers." *Id.* In light of these current and future resources, Plaintiffs' various conjectures about the possible negative effects of the rule, *see* Compl., ¶¶ 83-84, are insufficient to call into doubt CMS's new verification requirement.

Modifications to the Small Business Health Options Program. The ACA requires each State to establish an Exchange that provides for the establishment of a Small Health Options Program ("SHOP") that is designed to assist qualified employers in the State who are small employers in facilitating the enrollment of their employees in QHPs offered in the small group market in the State. *See* 42 U.S.C. § 18031(b)(1)(B). CMS previously promulgated regulations establishing standards and processes governing SHOP operations. *See, e.g.,* 78 Fed. Reg. 15410, 15413 (Mar. 11, 2013) (Final Rule, "Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2014"). Those regulations required all SHOPs to determine employer and employee eligibility for SHOP plans and to provide certain enrollment functions, including premium aggregation functions. 83 Fed. Reg. at 16996. The 2019 Rule has removed some of those regulatory burdens on SHOPs, including verifying employee eligibility, premium aggregation, and online enrollment functionality. *Id.*

As CMS explained, it decided to remove those burdens because of "the significant decreases in SHOP QHP issuer participation and enrollment for plan year 2018," and the "lower than expected enrollment" in the Federally-Facilitated SHOPs and State-based Exchanges on the federal platform for SHOP. *Id.* According to CMS, it is no longer "cost effective for the Federal government to continue to maintain certain Federally-Facilitated SHOP functionalities, collect significantly reduced user fees on a monthly basis, maintain the technologies required to maintain a Federally-Facilitated

SHOP website and payment platform, generate enrollment and payment transaction files, and perform enrollment reconciliation." *Id.* Although CMS decided to remove many of these regulatory requirements, it made clear that "SHOPs that opt to operate in a leaner fashion, such as the Federally-Facilitated SHOPs, will still assist qualified employers . . . in facilitating the enrollment of their employees in QHPs offered in the small group market in the State." *Id.* at 16997. In CMS's view, that would be consistent with the ACA's provisions governing SHOPs, "because the basic functionalities of an Exchange will still be provided." CMS also clarified that "State Exchanges will continue to have the flexibility to operate their SHOPs as they choose, in accordance with applicable Federal and State law." *Id.* at 16996.

Plaintiffs seek to invalidate the challenged provision on two grounds. First, Plaintiffs argue that CMS's decision to "allow SHOPs to operate in a leaner fashion," *id.* at 16996, violates the ACA. *See* Compl., ¶¶ 78-9. But there is no provision in the ACA (or elsewhere) requiring SHOPs to perform the functions removed by the new rule. To the contrary, as CMS explained, all SHOPs will continue to provide ACA-mandated "basic [SHOP] functionalities," including certifying plans for sale, providing small employers the option to offer a choice of plans, and providing eligibility determinations for small employers. 83 Fed. Reg. at 16997; *see also id.* at 16996 (reiterating that the decision to remove certain functionality "that is not expressly required by the [ACA]" does not affect the "appropriate implementation of statutorily required functions of the SHOP").

There is also no merit to Plaintiffs' assertion that the decision to scale back SHOP functionality in response to reduced utilization is arbitrary and capricious. Plaintiffs complain that "making SHOPs even less functional and less user friendly" will exacerbate "declining enrollment in SHOPs," ultimately increasing the uninsured population. Compl., ¶¶ 79-80. Setting aside the entirely speculative nature of their argument, "[t]he primary purpose of these regulatory changes was not to increase the attractiveness of SHOPs to small employers, but to remove the regulatory burden on SHOPs to give Exchanges the flexibility to operate their SHOPs in a cost-effective way that best meets the needs of their State's small group market." 83 Fed. Reg. at 16998. As CMS reiterated, "SHOPs will continue to offer a centralized system that will provide certain free and impartial information to

small employers looking for coverage." *Id.* CMS's decision to remove costly and under-utilized functionality requirements while maintaining the core statutory functions of SHOPs is neither arbitrary nor capricious but a reasoned response to decreased utilization, and as explained in the preamble to the 2019 Rule, consistent with the ACA's requirements.

d. CMS's decision to continue its prior qualified health plan certification standards for network adequacy and essential community providers for the 2019 plan year is a permissible interpretation of the ACA and is neither arbitrary nor capricious.

In addition to promulgating regulations that modify certain functions of, and remove regulatory burdens imposed on, the Exchanges, the 2019 Rule builds on efforts established in a prior rule governing the qualified health plan ("QHP") certification processes. *See* 83 Fed. Reg. at 16935, 17024-26. Starting in the 2018 plan year, HHS began relying on State reviews of QHP certification standards in States with Federally-Facilitated Exchanges ("FFEs"). For those States with FFEs that perform plan management functions in partnership with HHS, HHS relied on State plan data review for QHP certification. *Id.* at 17024. And for those States with FFEs that did not perform plan management functions, HHS continued to review QHP data, but relied on State review for licensure and good standing and for network adequacy. *Id.* "[CMS] made these changes to streamline the QHP certification process and avoid duplicative Federal and State efforts." *Id.*

Specifically, the Federal QHP certification process incorporated "the States' [network adequacy] reviews in States in which a FFE is operating," provided that CMS determines that "the State has a sufficient network adequacy review process." *Id.* at 17025. And "[i]n States that do not have the authority and means to conduct sufficient network adequacy reviews," the Federal QHP certification review process will instead "rely on an issuer's accreditation (commercial, Medicaid, or Exchange) from an HHS-recognized accrediting entity." *Id.* Another area incorporated into the QHP certification process concerns access to essential community providers, which means that an "issuer that uses a provider network must include in its provider network a sufficient number and geographic distribution of essential community providers (ECPs), where available, to ensure reasonable and timely

access to a broad range of such providers for low-income individuals" and medically underserved individuals. 45 C.F.R. § 156.235(a)(1); *see* 83 Fed. Reg. at 17025.

The challenged 2019 Rule provision is simply a continuation of the processes utilized under the 2018 rule. *See id.* ("We proposed to extend for the 2019 benefit year and beyond [rules] related to QHP certification standards for network adequacy . . . and essential community providers that we had finalized in [a] . . . final rule for only plan year 2018."). As CMS determined, these are areas in which "States are already performing reviews that are duplicative of the Federal QHP certification process," and therefore, it makes sense from a regulatory burden perspective to "incorporat[e] these reviews into the QHP certification process." *Id.*

Plaintiffs fault CMS for extending the 2018 rule into the 2019 plan year. They first argue that the challenged provisions violate the ACA's directive in 42 U.S.C. § 18031(d)(4)(A) that an Exchange "at a minimum, implement procedures for the certification, recertification, and decertification, [consistent with guidelines developed by the Secretary] . . . of health plans as qualified health plans." *See* Compl., ¶ 58 (emphasis omitted). But by its plain terms, Section 18031(d)(4) does not require CMS, as the administrator of the FFEs, to conduct the QHP certification process or assess network adequacy itself. And the challenged provision does what § 18031(d)(4) requires: implementing a procedure for FFE QHP certification—albeit one that relies on States' processes for the same in an effort to avoid duplicative Federal and State efforts. *See* 83 Fed. Reg. at 17024.

Moreover, contrary to Plaintiffs' argument, the challenged 2019 provision falls well within CMS's authority to promulgate regulations that "establish criteria for the certification of health plans as qualified health plans," *see* 42 U.S.C. § 18031(c)(1), just as it did in 2018. According to Plaintiffs, relying on the States' QHP certification and network adequacy reviews will result in "inadequate" provider networks. Compl. ¶ 61. But that is an entirely speculative harm, and one that was not borne out when FFEs relied on the States' QHP certification process in the 2018 plan year. Nor is this purported harm likely to occur, given CMS's explicit commitment to "monitor enrollee complaints for access concerns." *Id.* Finally, notwithstanding Plaintiffs' contrary argument, CMS fully justified its decision to extend the policy of relying on States' QHP certification process and network adequacy

assessment: the purpose is to "allow States and issuers greater flexibility in facilitating the certification of plans best suited to their markets, while avoiding duplicative State and Federal [QHP certification] activities." *Id.* at 17025.

Plaintiffs are also wrong to accuse CMS of "offer[ing] virtually no response" to commenters who claimed that the States' review processes are inadequate. *See* Compl., ¶ 60. CMS actually has explained that it has "relied on State[s] . . . for this review in the past, and believe[s] they provide appropriate review because both typically have requirements in place that specifically address access to adequate networks." *See* 83 Fed. Reg. at 17025. CMS further explained that "[m]any States already address issuer network adequacy in State-specific regulation." *Id.* And, Plaintiffs' related argument that CMS failed to consider "how an exchange operator may be uniquely positioned to assess plan adequacy," *see* Compl., ¶ 60, is belied by CMS's explicit determination that States' review of plan adequacy is "duplicative of the Federal QHP certification process" and review. 83 Fed. Reg. at 17025. Finally, Plaintiffs argue that CMS failed to provide evidence to buttress its conclusion that State procedures are sufficient to guarantee adequacy. *See* Compl., ¶ 60. But this assertion ignores CMS's prior experience implementing this policy in the 2018 plan year, including the agency's experience in "monitor[ing] enrollee complaints for access concerns." 83 Fed. Reg. at 17025.

e. The options to allow issuers to report quality improvement activity as a single fixed percentage and to allow States to request an adjustment of the medical loss ratio standard are permissible under the ACA.

Plaintiffs' remaining challenges to the 2019 Rule focus on issuers' reporting of quality improvement activity ("QIA") expenditures and States' ability to request adjustments to the medical loss ratio ("MLR") standard for their individual markets. *See* Compl., ¶¶ 100-05. Both challenges fail.

As to the former, the 2019 Rule grants issuers the option to report QIA expenses as a single, fixed percentage in connection with the issuers' statutory obligation to report MLR, *i.e.*, "[a] ratio of the incurred loss (or incurred claims) plus the loss adjustment expense (or change in contract reserves) to earned premiums." 42 U.S.C. § 300gg-18(a); *see also* 83 Fed. Reg. at 17032-34. As CMS explained in its initial rulemaking implementing the MLR standard, the ACA requires health plan issuers "in the

group or individual market, including grandfathered health plans, to provide an annual rebate to enrollees, if the issuer's MLR fails to meet minimum requirements," which generally is "85 percent in the large group market and 80 percent in the small group or individual market." 75 Fed. Reg. 74864, 74865 (Dec. 1, 2010). The purpose of this requirement is to "provide consumers with information needed to better understand how much of the premium paid to the issuer is used to reimburse providers for covered services, to improve health care quality, and to pay for the 'non-claims,' or administrative expenses, incurred by the issuer." *Id.* at 74866.

The ACA specifies the items that an issuer must include in its MLR report, including, as relevant here, expenses "for activities that improve health care quality." 42 U.S.C. § 300gg-18(a)(2). CMS regulations then identify five separate categories of QIA that are eligible expenditures for purposes of calculating MLR, *see id.* § 300gg-18(b)(3); 45 C.F.R. §§ 158.150(b)(1)(i)-(iv), 158.150(b)(2)(i)-(v), and also note those activities that do not qualify as QIA, *see id.* § 158.150(c). Issuers are required to report QIA expenditures in alignment with the five specified types. 83 Fed. Reg. at 17032; 45 C.F.R § 158.150(b)(2)(i)-(v). Issuers are also required "to use and disclose specific allocation methods to report expenses, including QIA expenditures." 83 Fed. Reg. at 17032 (citing 45 C.F.R. § 158.170).

In the course of conducting MLR audits, "HHS observed that the current MLR regulations require a substantial effort by issuers to accurately identify, track[,] and report QIA expenses." *Id.* HHS has also observed that "between 2011 and 2015, issuers that did report QIA expenses have reported spending, on average, a consistent percentage of premium on total QIA: approximately 0.7 percent in 2011, and 0.8 percent in 2012 through 2015." *Id.* In order to address the "significant burden associated with identifying, tracking[,] and reporting [QIA] expenditures," CMS adopted the provision of the 2019 Rule that allows issuers the "option to report on their MLR reporting form a single QIA amount equal to 0.8 percent of earned premium in the relevant State and market, in lieu of tracking and reporting the issuer's actual expenditures for QIA." *Id.* The challenged rule also states that issuers that expend more than 0.8 percent of earned premium on QIA "have the option to report

the total actual, higher amount spent and, if choosing this option, . . . [must] report QIA in the five categories described in" the MLR regulations governing the allocation of expenses. *Id.* at 17032.

Plaintiffs argue that CMS's decision to permit issuers the option of reporting a single QIA expenditure amount is contrary to Section 300gg-18(a)(2), which requires insurers to report "how much they *actually* spend on reimbursement claims." Compl., ¶ 102. This is wrong. Section 300gg-18(a)(2) directs insurers to report "the percentage of total premium revenue, after accounting for collections or receipts for risk adjustment and risk corridors and payments of reinsurance, that such coverage expends . . . for activities that improve health care quality." 42 U.S.C. § 300gg-18(a). By its express terms, the statute does not require issuers to provide an itemized list of each QIA expenditure that contributes to the calculation of the MLR. Also without merit is Plaintiffs' argument that it is "arbitrary and capricious" for CMS to give issuers the option of reporting a single, fixed QIA expense for purposes of their MLR calculations. *See* Compl., ¶103. CMS explained that based on its experience over several years of conducting audits of issuers' MLR reports, the existing requirements that mandated detailed reporting of individual QIA expenditures by category was costly and burdensome and that allowing issuers to claim a standard QIA cost of 0.8 percent was reflective of what most health plan issuers would claim under the itemized method. 83 Fed. Reg. at 17032 - 17033.

Finally, Plaintiffs argue that CMS did not meaningfully account for comments that suggested that the challenged rule "would disincentivize issuers from making" quality improvement investments. Compl., ¶ 103. This argument ignores "that issuers also have financial incentives to improve the health of their enrollees because healthier populations incur lower medical costs, and reducing the administrative burden associated with tracking QIA will free up funds that issuers can invest in QIA." 83 Fed. Reg. at 17033. As the foregoing demonstrates, the standardized QIA reporting option is a considered and reasonable response to the "burden[s]" associated with "analyzing, documenting, tracking, allocating, and reporting QIA expenses." *Id.*

Plaintiffs also challenge the 2019 provision allowing States to ask CMS to adjust the 80 percent individual market MLR standard. This challenge by the Plaintiffs, however, fails to recognize that the process outlined in CMS regulations is based on express statutory authority provided to the Secretary

to adjust the individual market MLR. More specifically, 42 U.S.C. § 300gg-18(d) provides that "[t]he Secretary may adjust the rates described in (b) [*i.e.*, the large market's 85% premium rate threshold and the small group and individual markets' corresponding 80% threshold] if the Secretary determines appropriate on account of the volatility of the individual market due to the establishment of State Exchanges." 42 U.S.C. § 300gg-18(d). *See also* 42 U.S.C. § 300gg-18(b)(1)(A)(ii) (permitting the Secretary to adjust the MLR threshold "with respect to a State if the Secretary determines the application of such 80 percent may destabilize the individual market in such State"). Pursuant to this authority, CMS established the initial framework in which States could request an adjustment of the MLR standard, including the process and criteria for the Secretary to determine whether to grant a State's request. 75 Fed. Reg. 74864 (Dec. 1, 2010). This prior regulatory framework specified that the adjustment request must be initiated by the State and that the adjustment may be granted for up to 3 years at a time. *Id.* at 17034. Moreover, it also identified the information that the State must provide to support its request, and the criteria that CMS would consider in making its determination. *Id.* As noted above, in addition to amending its MLR regulations to provide issuers an option to report a single, fixed QIA expense, the 2019 Rule also amended the CMS regulations governing the adjustment of the MLR standard in the individual market.

More specifically, the 2019 Rule amended the prior framework to "allow for adjustments to the individual market MLR standard in any State that demonstrates that a lower MLR standard could help stabilize its individual market." *Id.* CMS explained that this modification will also "streamline the process for applying for such adjustments" in a manner that will "reduce burdens for States and HHS." *Id.*

Plaintiffs argue that the challenged provision is "[an] impermissible effort to lift burdens on insurers at the expense of consumers." Compl., ¶ 104. But as CMS explained, the purpose of the challenged provision is to stabilize the individual markets and reduce the burdens for States and HHS, *id.*, which is consistent with CMS's objective to "provide States the flexibility to innovate and pursue the best solutions for their markets." 83 Fed. Reg. at 17036. It is also consistent with the statute. *See* 42 U.S.C. § 300gg-18(b)(1)(A)(ii) and (d). The new rule also eliminates or allows CMS to eliminate

burdens that may have made the individual market less attractive to issuers, leading to lessened competition and fewer consumer options. *See* 83 Fed. Reg. at 17036.

There is also no merit to Plaintiffs' assertion that CMS "failed to weigh the importance of a robust MLR system, and the importance of each individual requirement." Compl., ¶ 104. To the contrary, CMS expressly considered the comments "highlighting the benefits of the current MLR rule," but nevertheless determined that it is also important to "provide [the] States the flexibility" to respond to changes in the individual market "to improve" market stability. 83 Fed. Reg. at 17036. And, in response to commenters' concerns that the challenged provision could "undermine one of the few consumer protections and lead to higher premiums," CMS emphasized that its regulatory amendments "are not intended to reduce the overall burden of proof on States applying for adjustments" and that "there will be opportunities for public comment on individual State adjustment requests." *Id.* Put another way, based on the processes and criteria that govern a State's request to adjust the MLR standard, Plaintiffs' claims that the challenged provision "will increase the rate of the uninsured and underinsured" and "cause consumers to pay more for worse insurance," *see* Compl., ¶ 105, are entirely speculative.

* * *

In short, as it has done every year since the ACA's enactment, CMS exercised its broad authority under the ACA to promulgate policies that govern the functioning and stability of the ACA insurance markets, including the Federal and State-Based Exchanges, the entities through which qualified individuals and qualified employers can purchase health insurance coverage. It did so based on actual experience from State-based Exchanges and CMS's own experience with the FFEs, as well as CMS and State experience in the ACA insurance market requirements. The challenged policies are a direct response to changes in the individual and group markets, and serve to achieve CMS's objectives to decrease the regulatory and administrative burdens on stakeholders, empower consumers, and improve affordability. Accordingly, Plaintiffs have failed to state a claim as to their challenges to the 2019 Rule.

2. Plaintiffs fail to state a claim under the Take Care Clause.

Plaintiffs' Take Care Clause claim in Count II similarly must be dismissed. Count II of the Complaint seeks a declaration that Defendants have failed to "take care to faithfully execute the Affordable Care Act," Compl., ¶ 258, and an injunction requiring Defendants to comply with the ACA, *id.* at p. 127. As discussed below, the Take Care Clause does not provide a cause of action as against the President or any other Defendant, and this Court, in any event, has no jurisdiction to issue declaratory or injunctive relief against the President in his official capacity. Moreover, even if the Clause could furnish a basis for affirmative relief, Plaintiffs seek to rely on violations of purported duties that are found nowhere in the ACA itself, but rather, are based on Plaintiffs' subjective views about how to best implement and administer the ACA. Accordingly, Count II should be dismissed.

a. The President is not a proper defendant in this lawsuit.

As an initial matter, this Court may not issue the requested declaratory and injunctive relief against the President whether under the Take Care Clause or otherwise. In *Mississippi v. Johnson*, 71 U.S. 475 (1866) the Supreme Court held that it had "no jurisdiction of a bill to enjoin the President in the performance of his official duties." *Id.* at 501. In that case, the State of Mississippi sought to enjoin President Andrew Johnson from executing the Reconstruction Acts, which Mississippi claimed were unconstitutional. *See id.* at 497. In barring injunctive relief against the President, the Court reasoned that when presidential action requires "the exercise of judgment," "general principles . . . forbid judicial interference with the exercise of Executive discretion." *Id.* at 499. Just as courts cannot enjoin Congress in exercising its legislative function, the Court reasoned, they cannot enjoin the President in exercising the executive function. *Id.* at 500 ("Neither can be restrained in its action by the judicial department[.]").

Thereafter, a majority of the Justices in *Franklin v. Massachusetts*, 505 U.S. 788 (1992), reaffirmed that "in general, '[the] court has no jurisdiction of a bill to enjoin the President in the performance of

his official duties.'"[12] *Id.* at 802–03 (quoting *Mississippi*, 71 U.S. at 501). In *Franklin*, the district court issued an injunction requiring the President to take certain actions related to the census. *See Franklin*, 505 U.S. at 791. The plurality observed that "the District Court's grant of injunctive relief against the President himself [was] extraordinary, and should have raised judicial eyebrows." *Id.* at 802 (citation omitted). "At the threshold," the plurality said, "the District Court should have evaluated whether injunctive relief against the President was available, and, if not, whether appellees' injuries were nonetheless redressable." *Id.* at 803.

Concurring in *Franklin*, Justice Scalia opined that courts may impose neither injunctive nor declaratory relief against the President in his official capacity. *Id.* at 827-28 ("Many of the reasons [the Court] gave in *Nixon v. Fitzgerald* [457 U.S. 731, 749 (1982)], for acknowledging an absolute Presidential immunity from civil damages for official acts apply with equal, if not greater, force to requests for declaratory or injunctive relief in official-capacity suits that challenge the President's performance of executive functions."). Justice Scalia reasoned that the principle that the President "may not be ordered to perform particular executive . . . acts at the behest of the Judiciary" is "implicit in the separation of powers" and is supported by Supreme Court precedent. *Id.* at 827–28. "Permitting declaratory or injunctive relief against the President personally would not only distract him from his constitutional responsibility to 'take Care that the Laws be faithfully executed,'" but also "would produce needless head-on confrontations between district judges and the Chief Executive." *Id.* at 828 (quoting U.S. Const., art. II, § 3). Based on these separation-of-powers concerns, Justice Scalia

[12] The Supreme Court in *Franklin* "left open the question whether the President might be subject to a judicial injunction requiring the performance of a purely 'ministerial' duty." *Franklin*, 505 U.S. at 802 (quoting *Mississippi*, 71 U.S. at 498-99). A ministerial duty is "a simple, definite duty" that is "imposed by law" where "nothing is left to discretion." *Mississippi*, 71 U.S. at 498; *see also Swan v. Clinton*, 100 F.3d 973, 977 (D.C. Cir. 1996) ("A ministerial duty is one that admits of no discretion, so that the official in question has no authority to determine whether to perform the duty." (citing *Mississippi*, 71 U.S. at 498)). In contrast, "a duty is discretionary if it involves judgment, planning, or policy decisions." *Beatty v. Wash. Metro. Area Transit Auth.*, 860 F.2d 1117, 1127 (D.C. Cir. 1988) (citation omitted). There can be no question here that Plaintiffs seek to enjoin the President from performing a discretionary duty that goes to the heart of his authority as Chief Executive.

concluded that "[u]nless the other branches are to be entirely subordinated to the Judiciary, [the courts] cannot direct the President to take a specified executive act." *Id.* at 829.

In line with *Mississippi* and *Franklin*, courts have rejected plaintiffs' requests for declaratory or injunctive relief against the President.[13] For example, in a recent Fourth Circuit case that has since been vacated as moot, *International Refugee Assistance Project v. Trump*, the district court issued an injunction against several federal defendants and the President preliminarily enjoining the implementation of the President's Executive Order. 857 F.3d 554, 557, 573, 579, 605 (4th Cir. 2017) (en banc), *vacated as moot*, 138 S. Ct. 353 (2017). The Fourth Circuit found "that the district court erred in issuing an injunction against the President himself," "[i]n light of the Supreme Court's clear warning [in *Mississippi* and in *Franklin*] that such relief should be ordered only in the rarest of circumstances." *Id.* The Court thus "lift[ed] the [preliminary] injunction as to the President only." *Id.*; *see also Int'l Refugee Assistance Project v. Trump*, 265 F. Supp. 3d 570, 633 (D. Md. 2017) (preliminary injunction issued regarding another Executive Order against "[a]ll Defendants with the exception of the President of the United States"), *cert. granted, judgment vacated*, 138 S. Ct. 2710 (2018).

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[13] *See, e.g.*, *Hawaii v. Trump*, 859 F.3d 741, 788 (9th Cir.), *vacated and remanded on other grounds*, 138 S. Ct. 377 (2017); *Newdow v. Roberts*, 603 F.3d 1002, 1013 (D.C. Cir. 2010) ("With regard to the President, courts do not have jurisdiction to enjoin him and have never submitted the President to declaratory relief." (internal citation omitted)); *Swan*, 100 F.3d at 976 n.1 (stating that "similar considerations regarding a court's power to issue [injunctive] relief against the President himself apply to [the] request for a declaratory judgment"); *Doe 2 v. Trump*, 319 F. Supp. 3d 539, 541-44 (D.D.C. 2018); *Cty. of Santa Clara v. Trump*, 250 F. Supp. 3d 497, 539–40 (N.D. Cal. 2017), *denying reconsideration*, 267 F. Supp. 3d 1201 (N.D. Cal. 2017); *Settle v. Obama*, No. 15-cv-365, 2015 WL 7283105, at *6 (E.D. Tenn. Nov. 17, 2015), *dismissing appeal*, (6th Cir. Aug. 30, 2016); *Day v. Obama*, No. 15-cv-00671, 2015 WL 2122289, *1 (D.D.C. May 1, 2015), *aff'd*, 860 F.3d 686 (D.C. Cir. 2017); *Willis v. Dep't of Health & Human Servs.*, 38 F. Supp. 3d 1274, 1277 (W.D. Okla. 2014) (finding that "[l]ongstanding legal authority establishes that the judiciary does not possess the power to issue an injunction against the President" and dismissing the complaint as to the President); *McMeans v. Obama*, No. 11-cv-891, 2011 WL 6046634, at *3 (D. Del. Dec. 1, 2011); *Shreeve v. Obama*, No. 10-cv-71, 2010 WL 4628177, at *5 (E.D. Tenn. Nov. 4, 2010); *Anderson v. Obama*, No. CIV. PJM 10-17, 2010 WL 3000765, at *2 (D. Md. July 28, 2010); *Carlson v. Bush*, No. 6:07-cv-1129-ORL-19UAM, 2007 WL 3047138, at *3 (M.D. Fla. Oct. 18, 2007); *Comm. to Establish the Gold Standard v. United States*, 392 F. Supp. 504, 506 (S.D.N.Y. 1975); *Nat'l Ass'n of Internal Revenue Emps. v. Nixon*, 349 F. Supp. 18, 21–22 (D.D.C. 1972); *Reese v. Nixon*, 347 F. Supp. 314, 316–17 (C.D. Cal. 1972); *S.F. Redevelopment Agency v. Nixon*, 329 F. Supp. 672, 672 (N.D. Cal. 1971); *Suskin v. Nixon*, 304 F. Supp. 71, 72 (N.D. Ill. 1969).

The overwhelming precedent compels the conclusion that the President should be dismissed as a defendant in this case. *See, e.g.*, *Doe 2 v. Trump*, 319 F. Supp. 3d 539, 541-44 (D.D.C. 2018) (dismissing the President from suit challenging a presidential policy because "[s]ound separation-of-power principles counsel the Court against granting [declaratory and injunctive] relief against the President directly"). Indeed, "[i]n most cases, any conflict between the desire to avoid confronting the elected head of a coequal branch of government and to ensure the rule of law can be successfully bypassed, because the injury at issue can be rectified by injunctive relief against subordinate officials." *Swan*, 100 F.3d at 978–79 (citing *Franklin*, 505 U.S. at 803; *Chamber of Commerce v. Reich*, 74 F.3d 1322, 1331 n. 4 (D.C. Cir. 1996); *Harlow v. Fitzgerald*, 457 U.S. 800, 811 n.17 (1982)). Plaintiffs have named as defendants such subordinate officials as the Secretary of HHS and the Administrator of CMS. Plaintiffs could obtain relief for their alleged injuries through injunctive relief against those Defendants if they are entitled to such relief. Accordingly, the President should be dismissed as a defendant.

b. The Take Care Clause of the Constitution does not provide a private right of action.

i. The President's discretionary, political acts cannot be enjoined by a federal court under the Take Care Clause.

The Take Care Clause furnishes no basis for affirmative relief against the President. The Constitution assigns the responsibility to "take Care that the Laws be faithfully executed" to the President, not the courts. U.S. Const. art. II, § 3, Cl. 5. As the Supreme Court has recognized, the duty of the President in the exercise of the power to see that the laws are faithfully executed is "purely executive and political," and not subject to judicial direction. *Mississippi*, 71 U.S. at 499; *Marbury* v. *Madison*, 5 U.S. (1 Cranch) 137, 165-166 (1803) ("the President is invested with certain important political powers, in the exercise of which he is to use his own discretion, and is accountable only to his country in his political character"). To hold otherwise would upset our constitutional scheme of separation of powers and allow judicial superintendence over the exercise of Executive power that the Clause commits to the President alone. *Baker* v. *Carr*, 369 U.S. 186, 217 (1962) (courts lack jurisdiction over a claim where there is "a textually demonstrable constitutional commitment of the issue to a

coordinate political department"). Accordingly, no court has ever taken the step to supervise the President's discretionary decisions as to how to execute the laws, and there is no basis for entering those uncharted constitutional waters here. *See Dalton* v. *Specter*, 511 U.S. 462, 474-475 (1994) (judicial review of discretionary Presidential decisions "is not available"); *Chi. & S. Air Lines, Inc.* v. *Waterman S. S. Corp.*, 333 U.S. 103, 114 (1948) (refusing to review President's decision that "embod[ied] Presidential discretion as to political matters beyond the competence of the courts to adjudicate"); *Mississippi*, 71 U.S. at 499.

The Executive actions challenged in this case underscore the significant separation of powers constraint on this Court's review: they are all discretionary political decisions that the President is entitled to make as the Chief Executive of this Nation. For example, Plaintiffs fault the President for making statements critical of the ACA, which allegedly "[d]estabilize" or "[w]eaken [p]ublic [c]onfidence" in the ACA Exchanges, *see* Compl., ¶¶ 111-115, 125, 129, 134-137; for issuing Executive Order No. 13,765, which directs federal agencies to "take all actions consistent with law to minimize the unwarranted economic and regulatory burden[] of the [ACA]," *see id.*, ¶¶ 107-110, 123; and for signing into law the Tax Cuts and Jobs Act, which as noted before, among many other tax reforms, reduced the tax penalty for violating the individual mandate to zero, *see* Compl., ¶¶ 125-26. But it is hard to imagine more quintessential Executive actions. Surely, the Judiciary has no role in superintending the Executive's political statements, policy directives, and the signing of a bill presented by Congress into law. In the absence of any statutory violations, Plaintiffs' challenges are no more than political disagreements with the President's policy decisions, and are beyond the purview of Article III courts.

Plaintiffs also fault the Executive Branch for not defending the ACA's individual mandate (on grounds of unconstitutionality once the penalty for violating the mandate is reduced to zero on January 1, 2019) as well as two other inseverable ACA provisions in *Texas, et al. v. United States, et al.*, No. 4:18-cv-00167-O (N.D. Tex.). *See* Compl., ¶¶ 173-75. But the decision not to defend an Act of Congress on grounds of unconstitutionality has long been exercised by the Executive Branch and is indeed a part of the Executive Branch's duty to uphold the Constitution. *See* 28 U.S.C.A. § 530D (setting forth

process for Attorney General notification to Congress under certain circumstances when the Attorney General has determined an act of Congress to be unconstitutional); *see, e.g.*, Department of Justice Letters Submitted to Congress Pursuant to 28 U.S.C. § 530D, https://www.justice.gov/oip/letters-submitted-congress-pursuant-28-usc-§-530d.

Although not relevant to the merits of Plaintiffs' claim, the Executive's litigation position on the ACA cannot cause Plaintiffs any harm because the correctness of the Department of Justice's litigation position will be determined by independent Article III courts. Indeed, even after the district court in the *Texas* litigation declared the entire ACA invalid on December 14, 2018, HHS has unequivocally assured the public that it will continue administering and enforcing all aspects of the ACA until there is a final decision or other judicial order directing otherwise.[14] The White House also has publicly stated that, pending the appeal process, the ACA remains in place. And contrary to Plaintiffs' assertion that the proper functioning of the adversary system is inhibited by the Executive's litigation position in the *Texas* litigation, *see* Compl., at ¶ 175, the ACA is being vigorously defended by 16 States and the District of Columbia, including Illinois (the home state of Plaintiff Chicago) and Virginia (the home state of the Individual Plaintiffs). Plaintiffs' claim is frivolous as a matter of both law and fact.

ii. The agencies' discretionary actions cannot give rise to a claim under the Take Care Clause.

Nor does the Take Care Clause provide a basis to review the actions of subordinate Executive officials. The Clause speaks to only the President, not to his subordinates, and ensures that the President is principally responsible for the actions of the Executive Branch and directly accountable to the people through the political process. *See Free Enter. Fund* v. *Pub. Co. Accounting Bd.*, 561 U.S. 477, 492-93 (2010) ("It is *his* responsibility to take care that the laws be faithfully executed."); *id.* at 495-97; *Printz* v. *United States*, 521 U.S. 898, 922 (1997)z; *Morrison* v. *Olson*, 487 U.S. 654, 689-90 (1988); *Clinton* v. *Jones*, 520 U.S. 681, 712-13 (1997) (Breyer, J., concurring). A subordinate Executive officer

[14] *See* Press release, https://www.hhs.gov/about/news/2018/12/17/statement-from-the-department-of-health-and-human-services-on-texas-v-azar.html.

cannot violate the President's duty to faithfully execute the laws. To the extent Plaintiffs seek to challenge the other federal defendants' alleged attempt to undermine the ACA, they cannot do so through the Take Care Clause, but must do so, if at all, through the APA, as Plaintiffs already do with respect to the 2019 Rule.

It is not surprising that beyond the 2019 Rule, Plaintiffs do not challenge the agency and executive actions identified in Count II under the APA. This is because they cannot identify any provision of the ACA that HHS allegedly violated through those actions; rather, all Plaintiffs have alleged are their own subjective views of how they would have exercised the discretion differently in implementing and administering various aspects of the ACA. The Take Care Clause is not an avenue for advancing such views. For example, Plaintiffs allege that HHS has inconsistently processed requests from States seeking waivers of some of the ACA's requirements. *See* Compl., ¶¶ 130-33. But whether to grant a waiver to a State is clearly within the agency's discretion and Plaintiffs have cited nothing in the ACA that says the contrary. The same is true with respect to HHS's decision to spend less money than budgeted by Congress on various advertising and Navigator activities, *see id.*, ¶¶ 147-70, a discretionary budgetary decision made by the agency based on its experience and expertise in operating the Navigator program. Plaintiffs also would prefer that HHS participates in more education and outreach activities and sends staff to regional enrollment events. *See id.*, ¶¶ 171-72. And Plaintiffs disagreed with the decision to shorten the open enrollment period from approximately 90 days to the current 45 days, *see id.*, ¶¶ 140-46, even though the decision is committed by statute to the HHS Secretary's sound discretion, *see* 42 U.S.C. § 18031(c)(6)(B) ("The Secretary shall require an Exchange to provide for . . . annual open enrollment periods, *as determined by the Secretary*." (emphasis added)). But the Secretary reasonably could determine that longer enrollment periods would contribute to the problem of "adverse selection"—i.e., consumers waiting until they get sick to purchase insurance, *King v. Burwell*, 135 S. Ct. 2480, 2485 (2015). Indeed, it was in part for that reason HHS first proposed shortening the open enrollment to the current 45 days in 2016. *See* 81 Fed. Reg. 12204, 12206, 12274 (Mar. 8, 2016).

iii. The Executive Branch's decision to implement rules promoting AHP, STLDI, and HRA is a valid exercise of discretion and does not give rise to a claim under the Take Care Clause.

Plaintiffs also challenge the Executive Branch's regulatory reforms in three areas—association health plans ("AHP"), short-term, limited duration insurance ("STLDI"), and health reimbursement arrangements ("HRA")—which were identified in the President's Executive Order as priorities to lessen regulatory burdens and increase healthcare options for consumers. *See* Compl., ¶¶ 116-122. In Plaintiffs' view, promoting these three options undermines the ACA because they provide allegedly "bare-bones coverage[] that does not need to comply with the ACA's requirements." *Id.* ¶ 116. But that is a policy disagreement about which this Court has no authority to review. The Executive Branch reasonably could determine that it is more beneficial for consumers to have those alternative options..

The AHP rule, for example, expands access to affordable, quality healthcare for employees of some small businesses and some self-employed individuals by clarifying the definition of "employer" for purposes of sponsoring a single multiple-employer "employee welfare benefit plan" or "group health plan" under the Employee Retirement Income Security Act ("ERISA"). *See* 83 Fed. Reg. 28912, 28961-63 (June 21, 2018). The STLDI rule, on the other hand, governs plans that provide temporary health insurance for individuals who encounter gaps in their coverage (such as those who have lost their jobs, graduated from college, missed an enrollment deadline, or been priced out of more comprehensive coverage). *See, e.g.,* 83 Fed. Reg. 38212, 38213 (Aug. 3, 2018). And HRAs are "employer-funded group health plans from which employees are reimbursed tax-free for qualified medical expenses up to a fixed dollar amount per year."[15] Similar to a health savings account ("HSA"), an HRA can be used as a supplemental source of funding for a person's medical needs. *See, e.g.*, 75 Fed. Reg. at 37190-91 (describing how HRAs can be "integrated with other coverage as [a] part of a group health plan").

Moreover, none of these options is new. The AHP rule adheres to the Department of Labor's longstanding interpretation of ERISA to permit employers to join together as a single association to

[15] *See* HealthCare.gov Glossary, "Health Reimbursement Account," https://www.healthcare.gov/glossary/health-reimbursement-account-hra/ (last visited: Dec. 4, 2018).

offer health benefits to their employees, while clarifying the term "employer." The STLDI rule largely restores the definition of STLDI that existed under HHS's regulations from 1997 until 2017 by changing the permissible initial term of such coverage from less than three months (first instituted in a rulemaking finalized in 2016) to any period of less than one year, consistent with HHS's 1997 regulations. And HRAs have generally been permitted since 2002 by the Internal Revenue Service as a tool to help consumers fund medical expenses. *See* I.R.S. Notice 2002-45 (June 26, 2002), https://www.irs.gov/pub/irs-drop/n-02-45.pdf (last accessed: Dec. 4, 2018); *see also* I.R.S. Notice 2013-54 (Sept. 13, 2013) (guidance regarding tax treatment of HRAs under the ACA), https://www.irs.gov/pub/irs-drop/n-13-54.pdf (last accessed: Dec. 4, 2018). It is imminently reasonable for the Executive Branch to make these options more readily available to consumers.

Again, to the extent Plaintiffs believe that the Executive Branch's revisions to any of these options violates any statute or regulations or is arbitrary or capricious, they need to challenge them, if at all, under the APA, as other litigants have done. *See, e.g.*, *State of New York, et al. v. United States Dep't of Labor, et al.*, Civ. No. 1:18-cv-1747 (D.D.C.) (suit challenging the AHP rule); *Association for Community Affiliated Plans v. Dep't of Treasury, et. al.*, Civ. No. 1:18-cv-2133 (D.D.C.) (suit challenging the STLDI rule). They must also sue the federal agencies that promulgated the challenged rule. For example, the AHP rule was promulgated by the U.S. Department of Labor, a non-party to this case. *See* 83 Fed. Reg. at 28912. And, they must wait for final agency action before proceeding with such a lawsuit. For example, the HRA rule is in the midst of rulemaking, *see* 83 Fed. Reg. 54420 (Oct. 29, 2018), and as noted before, the AHP rule will not be fully effective until April 2019. Neither the Take Care Clause nor the APA allows Plaintiffs to lump these rules together and challenge them wholesale on the basis of Plaintiffs' own subjective views that they undermined the ACA as a whole.

IV. CONCLUSION

For the foregoing reasons, this Court should grant Defendants' motion to dismiss.

Dated: December 24, 2018

Respectfully submitted,

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CERTIFICATE OF SERVICE

The undersigned counsel certifies that on December 24, 2018, a true and accurate copy of the foregoing was electronically filed with the CM / ECF system, which will send a Notice of Electronic Filing to all counsel of record in this matter.

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IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MARYLAND

CITY OF COLUMBUS, *et al.*, *Plaintiffs*, v. DONALD J. TRUMP, *et al.*, *Defendants*.	Civil Action No. 1:18-cv-02364-DKC

DECLARATION OF JEFF WU
IN SUPPORT OF DEFENDANTS' MOTION TO DISMISS

Pursuant to 28 U.S.C. § 1146, I, Jeff Wu, make the following declaration based on personal knowledge, on information I have reviewed in the records of the U.S. Department of Health and Human Services ("HHS") and its subsidiary agencies, or on information provided to me by HHS employees and contractors:

1. I am the Deputy Director for Policy for the Center for Consumer Information and Insurance Oversight ("CCIIO"), one of the centers in the Centers for Medicare & Medicaid Services ("CMS"), a component agency within HHS. CCIIO is charged with administering many of the responsibilities assigned to the Secretary of Health and Human Services with respect to the private insurance market requirements established under the Patient Protection and Affordable Care Act ("ACA").
2. I graduated from Harvard College in 1992 with a bachelor's degree in economics, and from Stanford Business School and Stanford Law School in 2001 with a master's degree in business administration and a juris doctor degree, respectively. In 2011, I joined CCIIO as a health insurance specialist, and I have served in various policy roles at CCIIO since then. I am currently the senior member of the career staff responsible for overseeing CCIIO's

policy and regulatory activities, including policymaking with respect to the ACA's market reforms.

3. In 2017, the most recent year for which census data is available, approximately 92% of the American population received their health insurance from group plans, Medicare, or Medicaid. In 2017, approximately 3% of the American population received their individual health insurance through an American Health Benefit Exchange established under the ACA ("Exchange").

4. Section 1401 of the ACA amended the Internal Revenue Code by adding 26 U.S.C. § 36B, which provides a tax credit for applicable taxpayers with household incomes between 100% and 400% of the federal poverty level ("FPL") for individual health insurance coverage purchased through an Exchange. Because the section 36B tax credit is refundable, it can subsidize individual market insurance purchased by individuals who have no income tax liability. The vast majority of individuals who buy individual health insurance coverage on an Exchange elect to receive an advance payment of this tax credit ("APTC"), which may be applied to reduce the individual's monthly premium. In 2018, 87% of all Exchange enrollees received APTC. *See* CMS, Early 2018 Effectuated Enrollment Snapshot (July 2, 2018), p. 2, *available at*: https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces/Downloads/2018-07-02-Trends-Report-1.pdf (last visited: Nov. 26, 2018).

5. The amount of the premium tax credit generally is determined by the individual's annual household income and the cost of the applicable second-lowest cost silver plan on the relevant Exchange. The premium tax credit helps ensure that the amount the individual pays for health insurance relative to household income remains relatively consistent, even as premiums rise. For instance, for 2018, an applicable taxpayer with household income equal to 100% of the FPL ($12,140 in 2018), will pay no more than 2.01% of their monthly

household income for their monthly premium ($20.33) after the tax credits are taken into account, if the individual were to purchase the applicable second-lowest cost silver plan, regardless of the total cost of that plan. Because premium tax credits limit a recipient's health insurance premium costs for the second-lowest cost silver plan at a percentage of household income, these tax credits insulate those who receive them from the impact of rising premiums. This is generally true for all 87% of Exchange enrollees who receive an APTC nationwide. The impact of the increase is instead generally borne by the federal government.

6. The premium tax credit is available only for individual market plans purchased through an Exchange. Consequently, in order to take advantage of these subsidies, an eligible consumer must purchase a "qualified health plan" or "QHP," 42 U.S.C. § 18021, through the relevant Exchange. QHPs are generally the only type of health plan that may be sold through an Exchange, per 42 U.S.C. § 18031(d)(2)(B)(i).

7. In 2019, the Exchanges that rely on the federal Exchange's eligibility and enrollment platform (the "federal platform") will see an increase in individual market insurers as compared to 2018. There will be 23 more issuers in 2019 than were participating during open enrollment in 2018. Further, 29 current individual market issuers are expanding their service area into new counties that they did not serve last year. Major insurers Anthem, Wellmark, Molina, and Cigna have returned to the on-Exchange individual markets that they left in 2016 or 2017.

8. The number of counties with a single individual market issuer offering coverage on Exchanges that rely on the federal platform will also decrease in 2019. In 2019, only 39% of counties in Exchanges that rely on the federal platform will have a single individual market issuer compared to 56% in 2018. This means that only 20% of individual market consumers

in Exchanges that rely on the federal platform will have access to only one issuer, down from 29% in 2018. The majority of consumers in states with Exchanges that rely on the federal platform – 57% – will have access to three or more individual market issuers through the Exchange.

9. In 2019, monthly premiums for individual market plans offered through the 39 Exchanges that rely on the federal platform will generally decrease. For the second-lowest cost silver plan, average monthly premiums will drop by an average of 1.5%. This information is publicly available via a CMS-administered website at: CMS Press Release, Premiums for the Federally-facilitated Exchanges drop in 2019 (Oct. 11, 2018), https://www.cms.gov/newsroom/press-releases/premiums-federally-facilitated-exchanges-drop-2019 (last visited Nov. 11, 2018).

10. Similarly, in 2019, monthly individual market premiums on Exchanges that rely on the federal platform will decline for lowest cost plans by an average of 1.0%. This information is publicly-available via a CMS-administered website at: Average Monthly Premium for Second-Lowest Cost Silver Plan and Lowest Cost Plan for States Using the HealthCare.gov Platform, 2016-2019, https://www.cms.gov/sites/drupal/files/2018-10/10-11-18%20Average%20Monthly%20Premiums%20for%20SLCSP%20and%20LCP%202016-2019_0.pdf (last visited Nov. 11, 2018).

11. In 2018, of the states with an Exchange that relied on the federal platform, 10 states had only one individual market issuer offering coverage in each county. But in 2019, that number will be cut in half, leaving only five states (Alaska, Delaware, Nebraska, Mississippi, and Wyoming) with one individual market issuer in each county.

12. In 2019, the average individual market monthly premiums charged in the City of Charlottesville and Albemarle County (the Virginia county surrounding the City of

Charlottesville), for both bronze and silver plans issued by the Optima Health Plan, will decrease, as shown in the following charts:

Optima Bronze						
Year	Age 21	Age 27	Age 30	Age 40	Age 50	Age 60
2018	$634.85	$665.32	$720.55	$811.33	$1,133.83	$1,722.97
2019	$433.56	$454.37	$492.09	$554.09	$774.34	$1,176.68
Percent	-31.7%	-31.7%	-31.7%	-31.7%	-31.7%	-31.7%

Optima Silver						
Year	Age 21	Age 27	Age 30	Age 40	Age 50	Age 60
2018	$806.03	$844.72	$914.84	$1,030.10	$1,439.56	$2,187.55
2019	$595.27	$623.85	$675.64	$760.76	$1,063.16	$1,615.58
Percent	-26.1%	-26.1%	-26.1%	-26.1%	-26.1%	-26.1%

13. The information contained in the above charts can be calculated from data reported publicly as Health Insurance Exchange Public Use Files (Exchange PUFs) available on a government website administered by CMS and available here: https://www.cms.gov/CCIIO/Resources/Data-Resources/marketplace-puf.html (last accessed: Nov. 26, 2018). The specific files located at the link above necessary for the calculations are the Rate PUF, the Service Area PUF, and the Plan Attributes PUF.

14. In 2019, a new health insurance issuer, HealthKeepers, Inc. (affiliated with Anthem, Inc.) will enter the individual on-Exchange insurance market in Albemarle County, Virginia. This issuer will be in addition to the current issuer, Optima Health Plan (affiliated with Sentara Health Management Group), which will continue to operate in the same county.

15. As of the date of this Declaration, neither Illinois, Maryland, Ohio, nor Virginia have submitted a request to CMS for a reduction to risk adjustment transfer amounts for the 2020 benefit year. Further, the deadline for these states to submit such a request for the 2020 benefit year expired on August 1, 2018.

16. As of the date of this Declaration, neither Illinois, Maryland, Ohio, nor Virginia have submitted a request to CMS to adjust the individual market medical loss ratio threshold.

Executed on December 26, 2018 at Bethesda, MD.

Jeff Wu