UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

UNITEDHEALTHCARE OF NEW YORK.

and

OXFORD HEALTH INSURANCE, INC.

Plaintiffs,

-against- 17-CV-7694

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

Defendant

MEMORANDUM OF LAW IN SUPPORT OF DEFENDANT'S MOTION TO DISMISS PURSUANT TO FRCP 12(b)(1) AND 12(b)(6)

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PRELIMINARY STATEMENT

This action challenges New York State's well-established right to regulate and stabilize the State's unique health insurance industry – a function that the courts and Congress have unambiguously ceded to the states. New York, like every other state, maintains broad regulatory oversight over all statewide insurance business. In New York, the regulation of the insurance industry is the duty of the Department of Financial Services ("DFS" or the "Department"), and the DFS Superintendent ("Superintendent") who possesses broad power to interpret and effectuate the provisions of the insurance law.

Twenty-five years ago, New York enacted legislation authorizing the Department of Insurance (which was merged in 2011 with the Department of Banking to become DFS) to issue regulations that provide a risk adjustment pool for the individual and small group health insurance markets in the State. Insurance Law § 3233(c)(1). In short, a risk adjustment pool is a "pooling process involving insurer contributions to, or receipts from, a fund which shall be designed to share the risk of or equalize high cost claims, claims of high cost persons, cost variations among insurers and health maintenance organizations." Id.

In 2016 and 2017, pursuant to this long standing statutory authority, the Superintendent (1) adopted an emergency regulation that provided a discretionary risk adjustment pool that could be used in the small group[1] health insurance market in New York for the 2017 plan year ("2017 Emergency Regulation") and (2) proposed a similar risk adjustment pool for the individual and small group health insurance markets for the 2018 plan ("2018 Proposed Regulation") (collectively "DFS Market Stabilization Regulations"). These regulations were promulgated and proposed, respectively, as necessary responses to the implementation of the Affordable Care Act's ("ACA")

[1]Small group health insurance market "means all policies and contracts providing hospital, medical or surgical expense insurance, other than Medicare supplement insurance, covering one to 100 employees." 11 NYCRR §361.9(b)(2)(C).

Federal Risk Adjustment Program ("F-RAP"), which applies universally to all States and does not take into account New York's particularized market realities. 42 USC §18001, et seq.

Between 2014 when the ACA became fully operational and the present day, the Department has observed how application of the generic F-RAP provisions have compromised the fair and efficient operation of the New York insurance markets; resulting in, among other problems, excessive transfers between insurers doing business in the State. 11 NYCRR § 361.9(d)(3). The DFS Market Stabilization Regulations are merely a continuation of New York's well-established market stabilization laws, which have historically been applied to protect New York's citizens by deterring "competition on the basis of avoiding or terminating coverage of persons whose health care costs are high". Id. §361.9(d)(2). These regulations and the future decisions whether to implement risk adjustment pools for the 2017 plan year and each plan year thereafter are entitled to "substantial deference." See e.g., Ling Jin Li v. Holder, 381 Fed. Appx. 111, 113 (2d Cir. 2010).

By this lawsuit Plaintiffs, UnitedHealthcare of New York, Inc. ("United") and Oxford Health Insurance, Inc. ("Oxford") (collectively "Plaintiffs"), challenge the DFS Market Stabilization Regulations based on three[2] legally insufficient grounds. First, Plaintiffs assert a cause of action under the preemption doctrine of the Supremacy clause alleging that the DFS Market Stabilization Regulations conflict with federal law and are therefore preempted. Second, Plaintiffs allege a Takings Clause/Exaction claim based on a theory that the regulations constitute an unlawful seizure of unrealized and unearned insurance offsets. Third, Plaintiffs ambiguously allege a "violation of 42 USC §1983" purportedly sounding under unspecified Fifth/Fourteenth

[2] Plaintiffs' Complaint actually lists ten (10) separate causes of action, but due to redundancy [i.e. restating each identical claim for both the 2017 Emergency and 2018 Proposed regulations] for purposes of this Motion and in the interest of brevity the causes can ultimately be treated/addressed as three (3) separate claims only.

Amendment violations.

Defendant Maria T. Vullo, as Superintendent of DFS, now moves to dismiss the Complaint pursuant to FRCP 12(b)(1) and 12(b)(6) based on four separate, yet equally dispositive grounds.

First, this court lacks subject matter jurisdiction over Plaintiff's preemption claims because there is no independent federal cause of action under the Supremacy Clause. As neither the ACA nor the Declaratory Judgment Act ("DJA") confer a private right of action, Plaintiffs' preemption claims fail as a matter of well-established law. Plaintiffs should have filed their preemption challenge to the Market Stabilization Regulations in New York State Supreme Court, the only court of first instance that would have subject matter jurisdiction over the preemption claims and, if they ever become ripe, the other claims asserted in Plaintiffs' Complaint.

Second, Plaintiffs' Takings/Exaction and 42 USC §1983 claims are not justiciable as failing the ripeness doctrine. The 2017 Emergency Regulation has not yet been implemented and the 2018 Proposed Regulation has no force of law whatsoever as it remains a legal nullity in its proposed state. As such, Plaintiffs have not suffered any articulable injury by the DFS Market Stabilization Regulations, and thus cannot state a justiciable case or controversy for a governmental taking before this Court.

Third, even if this Court had subject matter jurisdiction over Plaintiffs' causes of actions, this Court should abstain from the exercise of federal jurisdiction in order to permit adjudication of the claims in a New York State Court venue. The DFS Market Stabilization Regulations strictly contemplate an area of comprehensive State regulation that is subject to deferential regulation by the Superintendent and that is central to the State's particularized interests in stabilizing New York's health insurance markets. The Burfurd abstention doctrine should therefore be applied in this case.

Fourth, even if this Court both had subject matter jurisdiction and chose to exercise its jurisdiction, each of Plaintiffs' causes of action should be dismissed pursuant to Fed. R. Civ. P. 12(b)(6). As a matter of law, the DFS Market Stabilization Regulations are not preempted by any federal law. In fact, the Federal Government has expressly encouraged states to use existing state law to make adjustments to F-RAP:

> We acknowledged that States are the primary regulators of their insurance markets, and as such, we encouraged States to examine whether any local approaches under State legal authority are warranted to help ease the transition to new health insurance markets.
> ***
> [A] State that wishes to make an adjustment for the magnitude of these transfers in the individual and small group markets may take temporary, reasonable measures under State authority to mitigate effects under their own authority. 82 Fed. Reg. 51072-73 (Nov. 2, 2017)

In addition to this express authority to issue the DFS Market Stabilization Regulations, both the clear mandate of the ACA and the interplay between the State and federal laws in question preclude Plaintiffs from every prevailing on their preemption theory. Next, Plaintiffs' Takings/Exactions Clause claims fail as there is no legally cognizable property interest at stake in an inchoate, heavily regulated risk adjustment value. Finally, Plaintiffs have improperly pled their 42 USC §1983 claims as assuming an independent federal right under the act that does not exist.

In light of these four grounds, Plaintiffs' attempt to disrupt New York's long-standing, regulatory obligation to stabilize its own insurance markets should be denied. Defendant respectfully requests an order dismissing the Complaint in its entirety pursuant to FRCP 12(b)(1) and 12(b)(6).

STATEMENT OF RELEVANT FACTS AND LEGAL BACKGROUND

A. New York's Risk Adjustment Statute

In 1992, nearly twenty-years before the ACA became law, New York State enacted Chapter 501 of the Laws of 1992 in response to the State's growing health insurance problems (hereinafter "1992 Legislation"). See New York State Health Maintenance Organization Conference v. Curiale, 64 F.3d 794, 795 (2d Cir. 1995). As is pertinent to this case, the 1992 Legislation made three changes to the New York Insurance Law.

First, the 1992 Legislation required that all individual and small group health insurance policies issued by commercial insurers be "community rated," which requires the same premium to be charged by an insurer for the entire pool of risks of all individuals and small groups covered by the insurer without regard to age, sex, health status, tobacco usage, or occupation. See N.Y. Insurance Law §§ 3231(a)(1), 4317(a)(1).

Second, the 1992 Legislation required that all commercial insurers accept every person or group that applied for coverage irrespective of whether the person or group was a good (i.e. low cost) or bad (i.e. high cost) risk. Id. at §§ 3231(a)(2); 4317(a)(2). This mandated acceptance rule is commonly referred to as "open enrollment" or "guaranteed issue".

Third, the 1992 Legislation required the Superintendent of the Insurance Department to promulgate regulations creating New York-specific risk adjustment pools. Id. at §3233. Specifically, relevant to this case, the 1992 Legislation required the Superintendent to issue regulations that included:

> [A] pooling process involving insurer contributions to, or receipts from, a fund which shall be designed to share the risk of or equalize high cost claims, claims of high cost persons, cost variations among insurers and health maintenance organizations …Such regulations may also include other mechanisms designed to share risks or prevent undue variations in insurer claim costs which are not related

> to expected differences in insurer costs based upon competition, innovation and efficiency of operation. Id. at § 3233(c)(1).

In accordance with this legislative mandate, the Superintendent of Insurance adopted regulations that created a risk adjustment pool for the individual and small group health insurance markets in New York State. See 11 NYCRR Part 361 (Insurance Regulation 146) ("Establishment and Operation of Market Stabilization Mechanisms for Certain Health Insurance Markets"). These regulations were issued on an emergency basis on December 22, 1992; final regulations were adopted on March 9, 1993. Id.

The preamble to Part 361 includes a detailed explanation of the purpose and effect of New York's long standing risk adjustment regulations:

> (b) Prior to enactment of sections 3231 and 4317 of the Insurance Law there was some concern that the open enrollment process would expose insurers and HMOs to financial losses due to the enrollment of persons for coverage who are very ill or have a history of poor health…In order to avoid those results the Legislature enacted section 3233 of the Insurance Law which explicitly requires that these regulations include market stability and other provisions designed to encourage insurers to remain in or enter those markets, and to protect all insurers and HMOs in those markets from extreme losses due to open enrollment
> ***
> (d) The purpose of this regulation is to establish a market stabilization process. 11 NYCRR § 361.1.

From 1993 through 2013, the Superintendents of Insurance and DFS utilized, administered, and enforced a risk adjustment pool in the individual and small group insurance markets in New York. See Insurance Law §3231, et seq.; See also Declaration of John Powell executed December 15, 2017 ("Powel Decl.) ¶4. Similarly, from 2002 through the present day, the Superintendents have administered and enforced a risk adjustment pool in the Medicare Supplemental market in New York. 11 NYCRR § 361.1 et seq. Although the specific mechanisms and formulas used for risk adjustment have evolved between 1993 and the present day (see 11 NYCRR §§ 361.4, 361.5,

and 361.6) a risk adjustment mechanism promulgated and administrated by DFS has been a constant feature in the regulation of the commercial health insurance markets in New York since the early 1990s. See N.Y. Ins. Law § 3233; 11 NYCRR § 361.1 et seq.; See also Powell Decl. ¶5.

Under New York's system of risk adjustment, as in any such system, certain insurers – those with comparatively healthier enrollees, and thus lower claims costs – pay into the risk pool ("payors") and some – those with comparatively sicker enrollees, and thus higher claims costs – receive distributions from the pool ("receivers"). See e.g., 42 U.S.C. § 18063; 11 NYCRR § 361.6(e). Risk adjustment payors under the New York program challenged the validity of 11 NYCRR Part 361 after it was first issued. Both the New York Appellate Division for the Second Department and the Second Circuit rejected these challenges and upheld the validity of the regulations. See New York State Health Maintenance Organization Conference 64 F.3d. at 794; See also Colonial Life Ins. Co. of America v. Curiale, 205 A.D.2d 58 (2d Dept. 1994) ("[C]onsidering the statute as a whole and keeping in mind its objective of stabilizing health insurance premiums, we find that Supreme Court correctly found that the Legislature intended to create a mandatory pooling system").

B. The Affordable Care Act Includes a Risk Adjustment Requirement

The ACA was enacted in 2010 and became fully operational on January 1, 2014. 42 USC §18001, et seq. Like New York's 1992 Legislation, the ACA required that all individual and small group health insurance policies issued by commercial insurers be community rated and required that all commercial insurers accept every person or group that applied for coverage. Id. To alleviate the negative market consequences of these restrictions, the ACA also required each state to adopt a risk adjustment program. Id. at § 18063, et seq.

The purpose of the risk adjustment program was to spread "financial risk across insurers

providing individual or small group health insurance in a state" and "protect consumers' access to a range of robust coverage options by reducing the incentive for insurance companies to seek only to insure healthy individuals." Complaint ("Compl.") ¶ 27. "Risk adjustment was designed to encourage insurers to compete for enrollees' business based on the value and efficiency of an insurer's particular health insurance plan, rather than competing only for the healthiest enrollees". Id.

To comply with the risk adjustment program mandate in the ACA, a State that operated its own health plan exchange[3] could either: (1) elect to administer a risk adjustment program approved by the U.S. Department of Health and Human Services ("HHS") or (2) have HHS carry out the state's risk adjustment obligations on behalf of the state (F-RAP"). 45 CFR §153.310. Either way, the risk adjustment mandated by the ACA was a state-specific requirement.

To satisfy the risk adjustment program mandate in the ACA, New York, like every other state, except Massachusetts[4], elected to allow HHS to carry out the State's risk adjustment obligations by undertaking the F-RAP. Compl. ¶ 45.

The risk adjustment required by the ACA was intended to operate on a state-by-state basis, taking into consideration the market differences which exist within each state. See 42 U.S.C. 18063. The statutory language commands that "each State" will put in place a risk adjustment program under criteria established by "the Secretary, in consultation with the States[,]" and that such program is to apply to all insurance issuers that provide "coverage in the individual or small group market within the State". 42 U.S.C. 18063. In other words, risk adjustment under the ACA is not a state pool versus a federal pool. It is always state specific. Id.

As noted above, the purpose of risk adjustment is to encourage plans to compete for

[3] The New York exchange is known as the New York State of Health.
[4] Massachusetts elected to administer its own Risk Adjustment Program. 78 Fed. Reg. at 15,415.

enrollees regardless of their potential risk – in other words to compete for enrollees business regardless of health status. See 82 Fed. Reg. 51052 (Nov. 2, 2017). The statutory scheme accomplishes this by looking at the experience of health plans within each state and transferring premium revenue from those plans who have comparatively healthier lives and thus pay out lower claims (called in statute "Low actuarial risk plans") to those plans with comparatively sicker lives who thus have paid more in claims (called "High actuarial risk plans"). 42 USC §18063(a). In this manner risk adjustment discourages any attempt to circumvent bars to medical underwriting and the cherry-picking of only healthy lives. Under the ACA whether a plan is a low or high actuarial risk is based on the experience of the plans in each individual state. Id. (basing the low/high determination on "the average actuarial risk of all enrollees in all plans or coverage in such State").

Though the ACA and HHS in its implementing regulations recognize the state-centric nature of risk adjustment, the F-RAP failed to appropriately take into account the state specific deviations in the markets, instead relying on a national database and making uniform adjustments to it in attempting to reflect market differences. See 82 Fed. Reg. 51072 (Nov. 2, 2017). ("Nevertheless, we acknowledge that, for some States that deviate significantly from the national dataset used, a further adjustment to the statewide average premium may more precisely account for differences between the plan premium estimate reflecting adverse selection and the plan premium estimate not reflecting selection in the respective State market risk pools."). It is just such a deviation which necessitated DFS action. See 11 NYCRR §361.9.

C. HHS Repeatedly Acknowledges the States' Collaborative Role in Risk Adjustment

In early 2016, after completing risk adjustment for the 2014 policy period, HHS recognized that its administration of F-RAP was causing problems in certain health insurance markets with

new health insurers. See 81 Fed. Reg. 29152 (May 11, 2016). As there was no restriction in the ACA or any other federal statute or regulations that prohibited a state from adopting a risk adjustment program in addition or supplement to the program required by the ACA, HHS began encouraging states to use existing state laws to address the issues caused by the federal administration of risk adjustment in the various states. Id.

In May 2016, the Department of Health and Human Services published an interim final rule – which had the force of law – explicitly encouraging the states to take action:

> Based on our experience operating the 2014 benefit year risk adjustment program, HHS has become aware that certain issuers, including some new, rapidly growing, and smaller issuers, owed substantial risk adjustment charges that they did not anticipate. HHS has had a number of discussions with issuers and State regulators on ways to help ease issuers' transition to the new health insurance markets and the effects of unanticipated risk adjustment charge amounts. We believe that a robust risk adjustment program that addresses new market dynamics due to rating reforms and guaranteed issue is critical to the proper functioning of these new markets.
> ***
> However, we are sympathetic to these concerns and recognize that States are the primary regulators of their insurance markets. We encourage States to examine whether any local approaches, under State legal authority, are warranted to help ease this transition to new health insurance markets. Id.

In December 2016, after completing the risk adjustment process for the 2015 policy period and witnessing the same problems that states had identified for the 2014 policy period, HHS issued a final rule modifying the F-RAP. Just as it had with the interim rule in May 2016, the December 2016 final rule identified the problems caused by the federal program and encouraged states to take action under existing state law. See 81 Fed. Reg. 94159 (Dec. 22, 2016) ("We encourage States to examine whether any local approaches, under State legal authority, are warranted to help ease this transition to new health insurance markets").

Through the present day, HHS in the new administration continues to encourage states to take unilateral action to address the deficiencies in the federal risk adjustment program. 82 Fed. Reg. 211 (Oct. 27, 2017). On October 27, 2017, HHS published a proposed rule that encouraged and explicitly authorized states to use their existing state authority to take temporary, reasonable measures under State authority to mitigate the effects of the federal risk adjustment program:

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

D. New York's Emergency Regulation for the 2017 Plan Year

New York was one of the states that contacted HHS in late 2015 and early 2016 regarding issues with the application of the federal risk adjustment program in New York. 11 NYCRR § 361.9.

After the interim final rule that encouraged states to use any existing state authority to ameliorate the effects of the federal program was published by HHS in May 2016, New York adopted, on an emergency basis, a new regulation using the authority provided by New York Insurance Law § 3233 – the risk adjustment pool statute enacted with the 1992 Legislation. See 11 NYCRR §361.9.

This emergency regulation ("2017 Emergency Regulation") was first promulgated on September 9, 2016 by publication in the New York State Register on September 28, 2016. See 38 N.Y. Reg. 63 (Sept. 28, 2016). That Emergency Regulation expired on December 7, 2016, and

was promulgated again as an Emergency Regulation on that same date. See 38 N.Y. Reg. 20 (Dec. 28, 2016). Subsequent expirations and emergency promulgations occurred in the same manner on March 6, 2017, June 21, 2017, July 31, 2017, September 28, 2017, and November 24, 2017. See e.g., Notice of Emergency Rule Making, DFS-18-17-00020-E, NYS Register at 11 (October 18, 2017).

As discussed above, New York Insurance Law §3233 authorizes DFS to deploy a risk adjustment pool in the individual and small group markets. The 2017 Emergency Regulation utilizes DFS's existing statutory authority under Insurance Law §3233 to protect the small group health insurance market in New York from instability. 11 NYCRR §361.9.

There are several key features of the 2017 Emergency Regulation. First, the 2017 Emergency Regulation only grants the Superintendent discretionary authority to deploy a State risk adjustment pool if the "superintendent determines that the federal risk adjustment program has adversely impacted the small group health insurance market in the State and that amelioration is necessary." 11 NYCRR § 361.9(b)(2). That is the 2017 Emergency Regulation does not automatically mandate that a state risk adjustment pool be used for the 2017 plan year. Id. §3619(e). Thus, it remains uncertain today whether a state risk adjustment pool will be used for the 2017 plan year and, if so, what the magnitude of the adjustments required by the pool will be. Id.; See also Powell Decl. ¶¶ 9-12.

Second, the Emergency Regulation allows a state risk adjustment pool to only be used to ameliorate the disproportionate impact that F-RAP may have on carriers, to address the unique aspects of the small group health insurance market in this State, and to prevent unnecessary instability for carriers participating in the small group health insurance market in this State, other than for Medicare supplement insurance. 11 NYCRR § 361.9(b)(2). In other words, the regulation

limits the magnitude of the state risk adjustment program to the adjustment necessary to correct the adverse impacts of the federal program. Id. at § 361.9(b)(1).

Examples of these adverse impacts are identified in the 2017 Emergency Regulation as:

> (i) the federal risk adjustment program results in inflated risk scores and payment transfers in this State because the calculation is based in part upon a medical loss ratio computation that includes administrative expenses, profits and claims rather than only using claims; and
>
> (ii) the federal risk adjustment program results in inflated risk scores and payment transfers in this State because the program does not appropriately address this State's rating tier structure…Id.

Third, the 2017 Emergency Regulation limits the maximum amount of the adjustments to the results of F-RAP to 30% of any carrier's receipts or obligations under the federal program. Id. at§ 361.9(e)(1).

E. New York's Proposed Regulation for the 2018 Plan Year and Beyond

The 2017 Emergency Regulation is limited to the 2017 plan year and is further limited to only the small group market. See 11 NYCRR §361.9. On May 3, 2017, the Department published a proposed regulation that would authorize the use of state risk adjustment pools in the 2018 plan year and all future plan years ("2018 Proposed Regulation"). See Notice of Proposed Rule Making, DFS-18-17-00020-P, 38 N.Y. Reg. at 11 (May 3, 2017). The 2018 Proposed Regulation remains just that – a proposed regulation. It has not been adopted as either a final regulation or an emergency regulation and no final agency action has been taken with regard to the subject matter of the regulation. Powell Decl. ¶¶ 9-12.

If adopted at some point in the future, the 2018 Proposed Regulation would have very similar features to the 2017 Emergency Regulation. First, the regulation would authorize the Superintendent to deploy a state risk adjustment pool in a plan year only if the superintendent first

determined that the federal risk adjustment program had adversely impacted the small group health insurance market in the State and that amelioration is necessary. See 2018 Proposed Regulation at § 361.10(b)(2).

Second, the 2018 Proposed Regulation would allow a state risk adjustment pool to only offset the disproportionate impact of the federal risk adjustment program in the specific plan year and would limit the amount of state risk adjustment to the adjustment necessary to correct the adverse impact caused by the federal program. Id. at § 361.9(b)(2), and (3).

Third, the 2018 Proposed Regulation would limit the maximum amount of the adjustments to the results of the federal risk adjustment program to be 40% of any carrier's receipts or obligations under the federal program for the 2018 plan year. 2018 Proposed Regulation at § 361.10(g)(1).

Fourth, the 2018 Proposed Regulation would not automatically mandate that a state risk adjustment pool be used in any plan year. Rather, the regulation would provide that a state risk adjustment pool could only be used if, after reviewing the results of the federal risk adjustment program for a plan year, the Superintendent determined that a market stabilization mechanism is a necessary amelioration. Id. at § 361.10 (g).

In addition to the differences in maximum adjustment, the primary difference between the 2017 Emergency Regulation and the 2018 Proposed Regulation is that the proposed regulation would apply to both the individual and small group markets in New York, whereas the emergency regulation only applies to the small group market. Compare 11 NYCRR § 361.9(b)(1) with Proposed Regulation at § 361.10(b)(1), (b)(2).

F. UnitedHealthcare's Complaint

UnitedHealthcare, which is currently ranked 6th on the Fortune 500 list, reported operating

revenues of $184,840,000,000 in 2016, taking in $144,118,000,000 in premium dollars alone. In New York, United companies collected over $14 billion in premium in 2016 according to their most recent filings with the National Association of Insurance Commissioners ("NAIC"). www.unitedhealthgroup.com/~/media/5D60EEEE258F4D2FA4BA765727C41D5C.ashx (last accessed Dec. 15. 2017).

On October 6, 2017, UnitedHealthcare filed the pending Complaint raising identical challenges to the 2017 Emergency Regulation and the 2018 Proposed Regulation. Compl (Dkt. No. 1). As of the date of this filing Plaintiffs have not availed themselves to any State administrative or legal processes to challenge 11 NYCRR §361.9. See generally Complaint. Despite the availability of a CPLR Article 7803 special proceeding to challenge any action by the Superintendent as arbitrary, capricious or contrary to law, or the ability of the Plaintiffs to commence a declaratory judgment action in New York Supreme Court, Plaintiffs never raised these claims prior to instituting this federal action. Instead Plaintiffs seek to fully circumvent the long-standing State court processes for challenging regulations issued by New York State agencies. Id.

ARGUMENT

LEGAL STANDARD

The standards regarding adjudication of FRCP 12(b)(1) and 12(b)(6) motions are well-established in the Second Circuit. See, Goldman v. Belden, 754 F.2d 1059, 1065 (2d Cir. 1985); See also, Carter v. HealthPort Techs., LLC, 822 F.3d 47, 54-55 (2d Cir. 2016).

POINT I
THIS COURT HAS NO JURISDICTION OVER PLAINTIFFS' CLAIMS UNDER THE SUPREMACY CLAUSE

Plaintiffs' challenge the 2017 Emergency Regulation and the 2018 Proposed Regulation

under the preemption doctrine of the Supremacy Clause. See Compl. ¶¶ 94-104, 122-133. Importantly, however, in asserting these claims Plaintiffs neither cite to nor rely on a federal statute or other provision of federal law that establishes a cause of action to assert their preemption challenge. Id. Because there is no federal right of action under the ACA for an insurer to challenge a state action as preempted, this Court does not have jurisdiction and Plaintiffs' Supreme Clause claims must be dismissed.

It is well-established that the Supremacy Clause is not a "source of any federal rights" and does not create a cognizable cause of action. Armstrong v. Exceptional Child Ctr., Inc., 135 S. Ct. 1378, 1383 (U.S. 2015), citing, Golden State Transit Corp. v. Los Angeles, 493 U.S. 103, 107 (1989); see also Amaker v. Schiraldi, 2017 U.S. Dist. LEXIS 166294, at *21 (E.D.N.Y. Sept. 29, 2017) ("the Supremacy Clause does not create a private cause of action to settle conflicts between federal and state law"). The Supremacy Clause only creates "a rule of decision by which courts are to resolve conflicts between state and federal laws and leaves the substantive federal law to confer a private right of action". Id.

Plaintiffs disregard this well-defined limitation and improperly allege causes of action for preemption under the Supremacy Clause, where no such private rights of action exist. See Compl. ¶¶ 94-104, 122-133. Even a comprehensive review of the Complaint illustrates that Plaintiffs preemption claims arise exclusively under the Supremacy Clause, with no attempt to identify an independent basis for their claim. Id.

Moreover, neither the ACA nor the Declaratory Judgment Act ("DJA") confer private rights of action that would give this Court jurisdiction over the preemption claims[5]. One of the

[5] Similarly, Plaintiffs cannot succeed in claiming that their ambiguously plead 42 USC §1983 claim serves as a private right of action under which the Court can access its Supremacy Clause claims. As discussed infra at Point IV, 42 USC §1983 itself creates no substantive rights; it provides only a procedure for redress for the deprivation of rights established elsewhere. See Thomas v. Roach, 165 F.3d 137, 142 (2d Cir. Jan. 7, 1999). That is, one cannot assert a

few courts to address private rights of action under the ACA found that Congress established no such right by the act.

> The Affordable Care Act imposed new requirements on plans offered on state health insurance exchanges. It expressly left enforcement of these requirements to the states and the Secretary of Health and Human Services, not individuals. And if Congress had meant to provide a private right of action, then it could have done so as it has with insurance plans subject to ERISA. This implies that there is no private right of action to enforce certain insurance plan requirements imposed by the Affordable Care Act.

Marlena Mills v. Bluecross Blueshield of Tenn., Inc., 2017 U.S. Dist. LEXIS 2730 (E.D. Tenn. 2017).

Nor does the DJA confer any private right of action:

> The Court also may not exercise original jurisdiction under the [DJA]…The [DJA] is a procedural statute that, alone, does not confer jurisdiction upon a district court…Rather, the [DJA] provides an additional remedy in cases with an independent basis of jurisdiction…Thus, the Court must have before it a properly pled claim over which it has an independent basis for exercising original jurisdiction before it may act pursuant to the [DJA].

Clear Sky Car Wash, LLC v. City of Chesapeake, 910 F. Supp. 2d 861, 871 (E.D. Va. 2012).

In light of the Supreme Court's finding that no private right of action exists under the Supremacy Clause and the similar lack of a private rights under either the ACA or the DJA, this Court does not have jurisdiction over Plaintiffs' preemption/Supremacy Clause challenges. As such, Plaintiffs' First, Second, Sixth and Seventh causes of action must be dismissed pursuant to FRCP 12(b)(1).

Any attempt by Plaintiffs to request that this case proceed as a claim in equity fails for identical reasons. Courts in equity "can no more disregard statutory and constitutional

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Supremacy Clause claim under 42 USC §1983, as 1983 "creates a cause of action only for violations of federal laws that manifest an unambiguous intent to confer individual rights…Federal laws…that do not create specific rights for individuals [like the Supremacy Clause see above], are not enforceable by a civil action under § 1983". Davis v. Shah, 821 F.3d 231, 244 (2d Cir. 2016).

requirements and provisions than can courts of law." Armstrong 135 S. Ct. at 1385. Where a statute "implicitly precludes private enforcement" a plaintiff "cannot, by invoking our equitable powers, circumvent Congress's exclusion of private enforcement." Id. Thus, when analyzing a court's power to proceed in equity over a claim of preemption, courts look to the enforcement provisions of the underlying statute as the primary indicator. See Id.; see also Friends of the E. Hampton Airport, Inc. v. Town of E. Hampton, 841 F.3d 133, 145 (2d Cir. 2016).

In Armstrong the Supreme Court declined an invocation of equity jurisdiction based upon a finding that the underlying statute in question precluded private enforcement. Id. Armstrong dealt with the federal Medicaid Act, and the court's decision ultimately turned on the enforcement remedies delineated therein. Id. In sum, because the Medicaid Act limited the remedy for a State's non-compliance to the withholding of Medicaid funding by the Secretary of HHS, the Armstrong court determined that Congress did not intend to permit private claims. Id. This analysis is highly analogous here where review of the ACA illustrates similarly rigid limitations on available remedies.

The ACA limits enforcement authority to the HHS Secretary exclusively – and does not contemplate private actions by insurance companies as a mechanism of enforcement. See 42 USC §18001, et seq. Specifically, pursuant to ACA §18041(c)(1)(b)(ii)(II), where a State fails to implement the required exchanges under the Act, the pronounced remedy is for the Secretary of HHS to "establish and operate Exchanges within the State" and take necessary steps to implement the purpose of the ACA. Id. Moreover, enforcement authority is further vested in the HHS Secretary under ACA §18041(c)(2), which cross-references and applies Section 2736(b) of the Public Health Services Act ("PHSA") for enforcement. 42 USCS § 300gg-22. The PHSA specifically contemplates only HHS "Secretarial enforcement authority". Id.

This vesting of enforcement with the HHS Secretary exclusively under the ACA is a preclusion of private remedies, such as private actions by insurance companies in equity. See Alexander v. Sandoval, 532 U.S. 275, 290, 121 S. Ct. 1511, 149 L. Ed. 2d 517 (2001) (The "express provision of one method of enforcing a substantive rule suggests that Congress intended to preclude others"). Thus, consistent with Armstrong, Plaintiffs' Supremacy Clause claim should not proceed in equity either.

Plaintiffs' Supremacy Clause claims fail to enunciate an appropriate cause of action upon which the Court can exercise jurisdiction and adjudicate the claims. As such, all of Plaintiffs' Supremacy Clause causes of action must be dismissed under FRCP 12(b)(1) or alternatively 12(b)(6).

POINT II
PLAINTIFFS' TAKINGS CLAUSE CLAIMS ARE NOT RIPE FOR REVIEW: PLAINTIFFS HAVE NOT SUFFERED ANY INJURY AS THE 2017 EMERGENCY REGULATION HAS NOT BEEN IMPLEMENTED AND THE 2018 PROPOSED REGULATION HAS NO FORCE OF LAW

Plaintiffs' Takings/Exaction claims suffer from a host of threshold deficiencies that render them non-justiciable by this Court. In light of these defects, this Court lacks subject matter jurisdiction over all of these claims and must dismiss them accordingly.

Although alleging a governmental taking under the Fifth Amendment, Plaintiffs have not actually been subjected to any loss. This undeniable fact renders Plaintiffs' Third, Fourth, Fifth, Eighth, Ninth and Tenth causes of action[6] dismissible under both FRCP 12(b)(1) or 12(b)(6).

The existence of a justiciable case or controversy is necessary to warrant invocation of

[6] Plaintiffs' Takings/Exaction Clause claims are set forth in the Complaint as Causes of Action 3 (¶¶105-113), 4 (¶¶114-117), 8 (¶¶134-142), and 9 (¶¶143-146). Additionally, as set forth below (infra Point V and FN 7), Plaintiffs' 42 USC §1983 claims are improperly pled as independent causes of action and are generously interpreted as attempts to plead Takings/Exaction claims. These claims are set forth in the Complaint as Causes of Action 5 (¶¶118-121), and 10 (¶¶147-150).

federal-court jurisdiction and justify exercise of the court's remedial powers. See Amarin Pharma, Inc. v. United States FDA, 119 F. Supp. 3d 196, 220 (S.D.N.Y. 2015). As such, federal courts may adjudicate only those "real and substantial controvers[ies] admitting of specific relief . . . as distinguished from an opinion advising what the law would be upon a hypothetical state of facts." Auerbach v. Board of Educ., 136 F.3d 104, 108-109 (2d Cir. 1998). When the "events alleged in a plaintiff's cause of action have not yet occurred, a federal court is precluded from exercising subject matter jurisdiction because a real case or controversy does not exist for purposes of Article III". See Cargill, Inc. v. Charles Kowsky Resources, Inc., 949 F.2d 51, 56 (2d Cir. 1991).

Thus, to be justiciable a cause of action must be ripe—it must present "a real, substantial controversy, not a mere hypothetical question." Nat'l Org. for Marriage, Inc. v. Walsh, 714 F.3d 682, 687 (2d Cir. 2013). A claim is not ripe if it depends upon "contingent future events that may not occur as anticipated, or indeed may not occur at all". Id. Plaintiffs' Takings/Exaction Clause and 42 USC §1983 claims[7] are decidedly not ripe for adjudication, and must be dismissed pursuant to FRCP 12(b)(1).

A Fifth Amendment Takings claim "is premature until it is clear that the Government has both taken property and denied just compensation." Horne v. Dep't of Agric., 569 US 513 (2013); see also Sherman v. Town of Chester, 752 F.3d 554, 561 (2d Cir. 2014) ("For the claim to be ripe, the plaintiff must show that (1) the state regulatory entity has rendered a final decision on the matter, and (2) the plaintiff has sought just compensation by means of an available state procedure") (internal quotations and citation omitted). Similarly, any claim under 42 USC §1983,

[7] As discussed infra in Point IV(C), Plaintiffs' 42 USC §1983 is improperly pled as stating an independent cause of action under §1983 that does not exist. For purposes of the ripeness discussion, it is assumed that by their 42 USC §1983 claims Plaintiffs are inartfully attempting to assert their Fifth and Fourteenth Amendment Takings/Exaction clause claims through the prism of 42 USC §1983. As such, these claims must either be dismissed for the reasons set forth within Point II or in Point (IV)(C).

including a Takings claim, is not ripe for judicial review unless and until the plaintiff actually endures the injuries it claims. See Marone v. Greene County Prob. Dep't, 2008 U.S. Dist. LEXIS 119413, at *8 (N.D.N.Y. Sept. 26, 2008).

Plaintiffs' Takings/Exaction claims are not ripe, as no decision has been made to employ a discretionary risk adjustment pool authorized by the DFS Market Stabilization Regulations in question and Plaintiffs have not transferred any funds to the Superintendent consequent to the regulations. This point is implicitly conceded, as Plaintiffs' Complaint is silent as to any payment of any funds into the established risk pool and no demand for payment has been made by the Superintendent. See generally Complaint.

Plaintiffs have not transferred any funds into the risk pool established by 11 NYCRR § 361.9 because:

> (a) The 2017 Emergency Regulation only gives the Superintendent the authority to exercise risk adjustment and establish the risk pool – but the adjustment itself has not yet been implemented and is not scheduled for implementation until the Fall of 2018. Powell Decl. ¶¶9-12, and
>
> (b) The 2018 Proposes Regulation is not yet even enacted – and thus by definition has not been implemented or enforced. Id. ¶¶ 13-14.

Without any indicia of payments made by Plaintiffs, it simply cannot be said that Defendant has "taken property and denied just compensation" from Plaintiffs. Horne, 569 US at 513. Likewise, with no implementation of the 2017 Emergency Regulation scheduled until Fall of 2018, the requisite final decision by the state regulatory entity required to establish ripeness is not present. See Sherman, 752 F.3d at 561; See also Powell Decl. ¶ 12.

For similarly intuitive reasons, all of Plaintiffs' claims against the 2018 Proposed Regulation must be dismissed as unripe, as well. It is undisputed that the Proposed 2018

Regulation is not yet adopted. See generally Compl. (referring to 2018 Regulation as "proposed" regulation); Powell Decl. ¶¶ 13-14. Of course, a legal challenge to proposed legislation is, by definition, not ripe for judicial review, as not presenting an actual case or controversy for the Court to consider. See Priests for Life v. Sebelius, 2013 U.S. Dist. LEXIS 55082, at *6 (E.D.N.Y. April 2013); See also NY v. Army Corp of Engineers, 896 F. Supp. 2d 180, *38-40 (E.D.N.Y. Sept. 2012).

Simply put, Plaintiffs' various causes of action under the Takings/Exaction Clause are unripe at this juncture. Accordingly, this Court must decline jurisdiction over these claims.

POINT III
THE COURT SHOULD DECLINE TO EXERCISE JURISDICTION UNDER THE DOCTRINE OF ABSTENTION

For the reasons discussed in Points I and II above, all of Plaintiffs' claims should be dismissed on jurisdictional grounds. In the alternative, however, should the Court not dismiss these claims based on the stark justiciability deficiencies, then the Court should abstain from exercising its jurisdiction.

Although divided into a variety of separate doctrines the well-developed law of federal abstention generally creates an exception to the exercise of original federal jurisdiction where important countervailing State interests are at stake. See generally, Volvo Const. Equip. N. Am, LLC. v. Clyde/West, Inc., 26 F. Supp. 3d 1033, 1036 (W.D. WA 2014). Courts in this Circuit consider a "motion to dismiss based on the abstention doctrine . . . as a motion made pursuant to Rule 12(b)(1)". Global Tech Indus. Grp., Inc. v. Go Fun Grp. Holdings, Ltd., 2017 U.S. Dist. LEXIS 182019, at 86 (S.D.N.Y. Nov. 2, 2017); See also Burford, 219 US at 334 (dismissal of action appropriate remedy upon finding of Abstention).

Abstention is appropriate here because Plaintiffs' case concerns New York's complex

insurance regulation paradigm, which is both central to the State's ability to manage and stabilize its uniquely situated markets, and is an area for which considerable deference is accorded to the Superintendent of DFS. Plaintiffs' attempt to disrupt New York State's authority to regulate its own health insurance markets, and deny New York State Courts an opportunity to weigh in on this issue of primary State concern, presents a textbook basis for the application of the Abstention Doctrine.

The most applicable of the various abstention doctrines in the instant case is that announced by the Supreme Court in Burford v. Sun Oil Co., 319 U.S. 315 (1943). In pertinent part, the Burford Abstention doctrine maintains that where "timely and adequate state-court review is available, a federal court sitting in equity must decline to interfere with the proceedings"

> [w]here the exercise of federal review of the question in a case and in similar cases would be disruptive of state efforts to establish a coherent policy with respect to a matter of substantial public concern. New Orleans Pub. Serv., Inc. v. Council of City of New Orleans[8], 491 U.S. 350, 361 (1989) (cited shorthand as "NOPSI"); citing, Burford, 319 U.S. 315.

Thus, under this ground for Burford Abstention it has been held that:

> [w]here a state creates a complex regulatory scheme, supervised by the state court and central to state interests, abstention will be appropriate if federal jurisdiction deals primarily with state law issues and will disrupt a state's efforts to establish a coherent policy with respect to a matter of substantial public concern. Lac D'Amiante Du Quebec, Ltee v. American Home Assur. Co, 864 F.2d 1033 (3d Cir. 1988).

The Second Circuit has identified three factors to aid courts in determining whether federal interference constitutes a disruption of a state's goal of establishing a coherent public policy

[8] NOPSI is part of the progeny of cases following Burford. NOPSI further "distilled" Burford and is widely considered to have announced a more workable definition of the doctrine. See Liberty Mut. Ins. Co. v. Hurlbut, 585 F.3d 639, 650 (2d Cir. 2009). NOPSI sets forth two separate grounds for abstention, only the second ground is discussed herein.

concerning a public interest. See Liberty Mut. Ins. Co. v. Hurlbut, 585 F.3d 639, 650 (2d Cir. 2009); citing Bethphage Lutheran Serv., Inc. v. Weicker, 965 F.2d 1239, 1244-45 (2d Cir. 1992). The Bethpage factors are: "(1) the degree of specificity of the state regulatory scheme; (2) the need to give one or another debatable construction to a state statute; and (3) whether the subject matter of the litigation is traditionally one of state concern." Id. Each of these factors cuts in favor of Defendant and clearly support a finding of abstention under the second Burford ground, as articulated in NOPSI.

A. Specificity of Regulatory Scheme

There is no clearer example of a specified regulatory scheme created to address an issue of statewide public concern, than both New York's Insurance Law, and more specifically, the DFS Market Stabilization Regulations. Initially, it is well established that New York's Insurance Law as a whole constitutes a complex, nuanced and reticulated field. Alliance of American Insurers v. Cuomo, 854 F.2d 591, 600 (2d Cir. 1988) (New York has a "comprehensive and complex insurance scheme"); Peckham v. Continental Casualty Ins. Co., 895 F.2d 830, 837 (1st Cir. 1990) ("Insurance is a complicated subject and the industry, over time, has developed a patina of custom and usage. Arcana abound").

The DFS Market Stabilization Regulations are similarly complex and highly specialized. The enabling legislation for the regulations at issue was enacted in 1992 in response to the State's growing health insurance problems and was specifically enacted to stabilize the insurance market by reallocating resources and risks among insurers. See New York State Health Maintenance Org. Conference v. Curiale, 64 F.3d 794, 795-97 (2d Cir. 1995); See also N.Y. Insurance Law §§ 3231(a)(1), 4317(a)(1).

The specific regulations in question were conceived following the imposition of general

ACA regulations, which impact New York differently than the 49 other States. As noted in the regulations, application of the generic F-RAP provisions has created a market imbalance in New York, and resulted in "money transfers among carriers in this State under [FRAP]" being "among the largest in the nation". 11 NYCRR Pt. 361.9(a)(3). The regulations were derived in a State specific manner in order to stabilize New York's own health insurance markets based on a number of State specific factors and exposures. See e.g. 11 NYCRR §§ 361.9(a)(3)-(4) ("[F-RAP] as applied in this State does not yet adequately address the impact of administrative costs and profit of the carriers and how this State counts children in certain calculations").

11 NYCRR §361.9 permits the Superintendent of DFS, in her discretion, to create a risk pool if she determines that the federal risk adjustment payments adversely impacted the State's small group health insurance market. Id. at § 361.9(b)(2). If the Superintendent deems it necessary to rectify disproportionate impacts on New York carriers (based on several State specific criteria including statewide average premiums) she has authority to implement a stabilization pool that operates to offset adverse market impact factors unique within New York's marketplace. Id. at §361.9(b)(2)(E). The primary mechanism for ameliorating market inequalities is the payment transfer between carriers. Id. at §361.9(b)(2)(E)(1). This is accomplished pursuant to a calculation and based on "adverse market impact factors" set forth in the regulation. Id.

This market correction, if deemed necessary by the DFS Superintendent, is based on a complex methodology and rooted in the realities of New York's market. See 11 NYCRR §361.1, et. seq. The Superintendent's discretion to employ risk adjustment will be based upon multiple considerations relating to New York's health insurance market and any adverse impacts that F-RAP have caused in New York including, without limitation:

> (i) [F-RAP] results in inflated risk scores and payment transfers in this State because the calculation is based in part upon a medical

> loss ratio computation that includes administrative expenses, profits and claims rather than only using claims; and
>
> (ii) [F-RAP] results in inflated risk scores and payment transfers in this State because the program does not appropriately address this State's rating tier structure. For this State, the federal risk adjustment program alters the definition of billable member months to include a maximum of one child per contract in the billable member month count. This understatement of billable member month counts: (a) lowers the denominator of the calculation used to determine the statewide average premium and plan liability risk scores; (b) results in the artificial inflation of both the statewide average premium and plan liability risk scores; and (c) further results in inflated payments transfers through the federal risk adjustment program. Id. at § 361.9(b)(1).

Certainly, New York's market stabilization regulation is a highly specific, integrated and complex regulatory scheme created to achieve the overarching goal of carrier equality.

In addition to the specificity of the actual regulatory scheme in question, this first Bethpage factor also focuses on the extent "to which the federal claim requires the federal court to meddle in a complex state scheme". Hachamovitch v. Debuono, 159 F.3d 687, 697 (2d Cir. 1998). This proposition is satisfied on the face of Plaintiffs' Complaint alone, where they ask the Court to nullify New York's independent effort to respond, in a State-specific manner, to general provisions of the ACA. Plaintiffs ask the federal court to divest New York of its well-established right to regulate and protect its own insurance markets – leaving New York on even par with 49 other states, despite the profound differences between the states' diverse market realities, sizes and economies of scale. See generally Compl. Plaintiffs' request demands the highest degree of "meddling" by a federal court in a State system – the nullification of the system all-together.

B. Debatable Construction

The second Bethpage factor asks whether an exercise of federal jurisdiction would put this Court "into the business of interpreting the state regulatory regime". Hachamovitch, 159 F.3d at

698. To answer this inquiry, the Court must determine whether the law in question contains terms "that properly should be interpreted by a state agency and the experts in a particular field". Bethpage, 965 F.2d at 1243.

11 NYCRR §361.9 presents a purely discretionary mechanism for risk adjustment. See §361(b)(2). That is, pursuant to the plain terms of the regulation "if…the Superintendent determines that [F-RAP] has adversely impacted the small group health insurance market in the State and that amelioration is necessary," then in her discretion, based on the complex factors discussed supra [Point I(A)(i)(1)], she may implement the risk adjustment protocols under the regulation. Id. This discretion, however, does not end at the Superintendent's decision to implement risk adjustment, it continues throughout the actual implementation of the risk adjustment protocol, and includes the Superintendent's discretion in the percentage a carrier must remit to the pool. Id. §361.9(e), et. seq.

It is, of course, well settled that "the Superintendent's interpretation of the Insurance Law provisions is entitled to great deference because of [her] special competence and expertise with respect to the insurance industry. Colonial Life Ins. Co. of Am. v. Curiale, 205 A.D.2d at 61-62.

Substantive resolution of Plaintiffs' claims in this lawsuit would undoubtedly require this Court to interpret the regulatory scheme and, by doing so, encroach on discretionary interpretations at the heart of the regulation that require the expertise of the Superintendent of DFS. For these reasons Plaintiffs fail the second Bethpage factor.

C. Subject Matter of Regulations Traditionally of State Concern

The final Bethpage factor – whether the subject matter at issue is traditionally one of State concern – clearly weighs in Defendant's favor. First, federal courts of appeal, including the Second Circuit, routinely recognize that insurance regulation constitutes a substantial public

concern in which the states have a paramount and primary interest in regulating. See e.g. Wadsworth v. Allied Prf'sl Ins. Co., 748 F.3d 100, 105-106 (2d Cir. 2014) (Recognizing the existence of a "general presumption...that insurance regulation is generally left to the states"); Levy v. Lewis, 635 F.2d 960, 963 (2d Cir. 1980) ("New York has a complex administrative and judicial system for regulating and liquidating domestic insurance companies"); Silicon Spring Hotel, LLC v. Century Svc. Co., 781 F.3d 1233, 1239 (10th Cir. 2015) ("States have a particularly strong interest in insurance regulation"); Arkansas Project v. Shaw, 756 F.3d 801, 812 (5th Cir. 2014) ("Courts have recognized a strong state interest in, among other areas, utilities, train service and insurance regulation"); Millipore Corp. v. Travelers Indem. Co., 115 F.3d 21, 29 (1st Cir. 1997) ("New Jersey has a strong interest in the integrity of its insurance regulatory process").

In fact, this general principle is so axiomatic that Congress specifically codified it in the McCarran-Ferguson Act. See 15 U.S.C. § 1011, et seq. The McCarran-Ferguson Act states that "Congress hereby declares that the continued regulation and taxation by the several states of the business of insurance is in the public interest, and that silence on the part of the Congress shall not be construed to impose any barrier to the regulation or taxation of [insurance] by the several states". Id. The McCarran-Ferguson Act unambiguously acknowledges Congress' recognition that insurance administration and regulation constitute an important State concern that must be left to the exclusive jurisdiction and control of the various States. Id.

Simply put, there is no credible argument in Plaintiffs' favor regarding the third Bethpage factor – regulation of insurance matters is clearly a substantial State concern for which they enjoy regulatory primacy. As all three of the Second Circuit's Bethpage factors turn decidedly in Defendant's favor, the second basis for Burford abstention – whether federal interference would constitute a disruption of a State's goal of establishing a coherent public policy concerning a public

interest – must be answered in the affirmative. As such, this Court should decline jurisdiction and dismiss the matter.

D. Availability of State Judicial Process

While resolution in Defendant's favor of the three Bethpage factors alone should result in a finding of abstention by the Court, there are various other considerations relevant to a Burford analysis that also cut in favor of federal abstention.

Another factor analyzed in application of Buford is the availability of State process to resolve dispositive issues of State law. To that end, under Burford a district court may abstain jurisdiction to "avoid a decision of a federal constitutional question where the case may be disposed of on questions of state law". Bethpage, 965 F.2d at 1242. Such is exactly the situation here, where ample State process exists to determine this issue of substantial State concern.

Despite Plaintiffs' creative efforts to cast this case as presenting a federal question, at its core it is the type of challenge to a New York State regulation that should be venued in a State court special proceeding under CPLR 7803. This action is not a constitutional challenge to 11 NYCRR §361.9 at all. Instead it is a routine claim to Superintendent Vullo's, as yet unmade [Powell Decl. ¶¶ 8-12], discretionary determination to employ risk adjustment, to what extent, and based on what specific factors. As such, at the very most, Plaintiffs present an unripe CPLR 7803 challenge to the DFS Superintendent's wholly discretionary implementation of 11 NYCRR §361.9. Such a challenge is regularly adjudicated under CPLR Article 78's arbitrary and capricious/contrary to established law standard and does not constitute a federal constitutional issue requiring an exercise of federal jurisdiction. The existence of an available CPLR Article 78 process and remedy has been held by the Second Circuit as sufficient State process to invoke Burford Abstention. See Carey 727 F.2d at 245.

It is clear that New York courts have not had an opportunity to weigh in on the DFS Market Stabilization Regulations or speak to the viability of the regulation's proposed methodology, despite the State-centric nature of the regulations. Analysis of 11 NYCRR §361.9 and the Superintendent's exercise of her discretionary authority to deploy a State risk reduction pool will turn on the State specific factors and should be left to New York's State courts in the first instance. See Naylor v. Case & McGrath, Inc., 585 F.2d 557, 564 (2d Cir. 1978) ("[A]bstention is appropriate where an unconstrued state statute is susceptible of a construction by the state judiciary").

While Plaintiffs may wish to raise their federal preemption claim under the Supremacy Clause as a basis to avoid abstention, such an argument is misplaced. As an initial matter, Plaintiffs' Supremacy Clause claim is facially improper and must be dismissed as failing to announce an actionable private right of action. Discussed supra at Point I.

Further, regardless of this threshold impropriety, it has been held that preemption alone is not a valid basis upon which to avoid Burford abstention. See Fleet Bank, N.A. v. Burke, 160 F.3d 883, 892 (2d Cir. 1998). The Second Circuit made this point clear in Fleet Bank where it declined a plaintiff's attempt to avoid abstention based on a preemption claim. Id. The court held "though…plaintiff, may invoke federal question jurisdiction to adjudicate an unadorned claim of federal preemption…it should not be accorded the opportunity to use a preemption claim as a way to force a state to adjudicate in a federal court the meaning of a state regulatory statute". Id.; see also Hi Tech Trans, LC v. New Jersey, 382 F.3d 295, 306 (3d Cir. 2004) ("We are, of course, mindful that there is no absolute rule prohibiting abstention whenever a preemption claim is asserted").

Similarly, the existence of Plaintiffs' 42 USC §1983 claim does not dissuade imposition of

Burford abstention. First, for the reasons set forth below [see infra. Point (IV)(C)], Plaintiffs' 42 USC §1983 claim is facially improper and must be dismissed as a matter of law. It therefore has no impact on the abstention analysis here. Second, as State and Federal courts possess "concurrent jurisdiction over claims under §1983" the application of Burford is wholly unaffected by the existence of even a properly pled §1983 claim. See Curiale, 871 F. Supp at 210.

E. Presumption in Favor of State Regulation Favors Abstention

Additionally, in the context of analyzing the applicability of Burford, the impact of Congress' codification of the McCarran-Ferguson Act – a policy explicitly favoring State regulation of insurance – cannot be overstated. In areas where Congress has previously articulated a presumption in favor of State regulation Burford abstention has been readily applied. See e.g., Capitol Indem. Corp. v. Curiale, 871 F. Supp. 205, 208 (S.D.N.Y. 1994) (Sprizzo, J.) (Abstaining under Burford upon a finding that "by enacting the McCarren-Ferguson Act...Congress provided states with exclusive jurisdiction over insurance administration and regulation, thereby creating an important state interest"); See also, Levy v. Lewis, 635 F.2d 960, 963 (2d Cir. 1980) (Abstaining under Burford noting that "it is also highly significant that ...Congress mandated that regulation of the insurance industry be left to the individual states."); New York State Ass'n for Retarded Children, Inc. v. Carey, 727 F.2d 240, 245 (2d Cir. 1984) ("Although the federal government has retained some control over Medicaid regulation it has left the administration and fiscal responsibilities to the individual states. . . .Thus, the principles that compelled abstention in (Southern Railway and Burford) apply to this case, and the district court properly abstained").

These cases are highly instructive to the application of Burford Abstention in this matter. For example, in Curiale, a 42 USC §1983 suit against the New York State Superintendent of Insurance, the plaintiff sought recovery of certain funds managed and distributed by the

Superintendent in his role as liquidator of insolvent insurance companies pursuant to his obligations under New York Insurance Law. See supra 871 F. Supp. at 206-208. Based upon the State's substantial interest in administering and regulating insurance issues and the existence of New York's "complex regulatory scheme" concerning insurance, the Curiale court abstained from exercising its jurisdiction pursuant to Burford. Id. at 208.

While the Curiale case involved only the liquidation aspects of New York Insurance Law, that court's decision to abstain was not limited to those provisions of law exclusively. To the contrary, the court's holding was based upon the State's general interest in regulating insurance issues and the existence of the entire insurance regulatory scheme, not just liquidation regulations. The very same considerations and basis for abstention in Curiale therefore apply to Plaintiffs' instant challenge to the market stabilization regulations.

Similarly, the Second Circuit's decision in the Carey case is highly germane to the issue of abstention. See supra727 F.2d 240. Carey is particularly relevant as it involved Medicaid regulation – an area of law that implicates simultaneous federal and State regulatory oversight, tantamount to the joint regulation of health insurance under the ACA and State Insurance Law at issue here. Id. at 245. In Carey the Second Circuit abstained under Burford despite the fact that the federal government maintains a distinct role in regulating Medicaid. Id. The Circuit Court found that notwithstanding the continuing federal regulatory presence, the State's role in administering the Medicaid program compelled abstention. Id.

The interplay between federal and State regulation related to health insurance at issue here is comparable to that discussed in Carey. The ACA dictates policy and the federal government maintains some regulatory control, but the State administers the programs' health care exchanges and New York Insurance Law regulates the State's markets. See 11 NYCRR §361, et seq. In fact,

federal deference to State regulatory control can be found right in the text of the ACA which unambiguously states: "No Interference with State regulatory authority. Nothing in this title shall be construed to preempt any State law that does not prevent the application of the provisions of this title". 42 USC §18041(d).

The clear and substantial State interest in stabilizing insurance markets, the well-developed, specific State regulatory scheme in issue, the federally codified presumption of State primacy over insurance issues, and the availability of a State judicial process to resolve this issue of State law, satisfies the requirements for Burford abstention. This Court should follow its decision in Curiale and the Second Circuit's guidance in Carey and abstain from exercising jurisdiction, dismiss this matter, and permit the claims to be decided by New York's system of review.

POINT IV

EACH OF PLAINTIFFS' CAUSES OF ACTION SHOULD BE DISMISSED PURSUANT TO FED. R. CIV. P. 12(b)(6)

In addition to the fully dispositive, jurisdictional bases for dismissal set forth in Points I, II and III above, each of Plaintiffs' claims should also be dismissed as failing to state a viable claim. Specifically, as discussed below: (1) Plaintiffs' preemption claims fail as 11 NYCRR §361.9 does not conflict with its ACA counterpart; (2) Plaintiffs' Takings/Exaction claims do not contemplate a recognized property interest, and; (3) Plaintiffs' 42 USC §1983 claims are improperly pled.

A. The DFS Market Stabilization Regulation Does Not Conflict with Federal F-RAP

Even if Plaintiffs' Supremacy Clause claims were properly before this Court (and they are not see infra Point I), the causes of action still fail pursuant to Fed. R. Civ. P. 12(b)(6) as 11 NYCRR §361.9 does not conflict with the ACA, as a matter of law. Based on the plain text of the

ACA, the interplay between the federal and State laws and available federal guidance on these issues, Plaintiffs fail to state a viable claim for preemption.

Pursuant to the Supremacy Clause of the United States Constitution, Congress may preempt state law through federal legislation. Oneok, Inc. v. Learjet, Inc., 135 S. Ct. 1591, 1595 (2015); see also U.S. Const. art VI, cl. 2 ("the Laws of the United States . . . shall be the supreme Law of the Land"). The Second Circuit maintains that Congress may preempt state law "expressly or it may preempt state law implicitly in circumstances where it is clear that Congress intended to occupy the entire regulatory field, where state law stands as an obstacle to the objectives of Congress, or where compliance with both federal and state law is impossible." Galper v. JP Morgan Chase Bank N.A., 802 F.3d 437, 443 (2d Cir. 2015). In line with Galper, this Court has articulated three scenarios in which federal law preempts state or local law: "(1) where Congress expressly states its intent to preempt; (2) where Congress's scheme of federal regulation is sufficiently comprehensive to give rise to a reasonable inference it leaves no room for the state to act; and (3) where state law actually conflicts with federal law". In re Fosamax Prods. Liab. Litig., 742 F. Supp. 2d 460, 475 (S.D.N.Y. 2010). The Market Stabilization Regulations do not fall under any element of the tripartite test.

The first scenario is inapplicable on the face of the ACA. Congress did not expressly state an intent to preempt under the ACA – in fact, it did the opposite. The text of the ACA unambiguously states "[n]othing in this title shall be construed to preempt any State law that does not prevent the application of the provisions of this title". 42 USC §18041(d). Furthermore, "state laws enacted for the purpose of regulating the business of insurance do not yield to conflicting federal statutes unless a federal statute specifically requires otherwise." United States Dep't of Treasury v. Fabe, 508 U.S. 491, 507 (1993); See also Lander v. Hartford Life & Annuity Ins. Co.,

251 F.3d 101, 115 (2d Cir. 2001) (describing this principle as creating a "clear-statement rule"). The HHS – the agency responsible for enforcing the ACA – has regularly recognized that the states remain the primary regulators of the health insurance markets, even under the ACA. See 81 Fed. Reg. 91 (May 11, 2016); See also, 81 Fed. Reg. 246 (Dec. 22, 2016); 82 Fed. Reg. 211 (Oct. 27, 2017). As set forth, the ACA does not expressly state preemption.

Turning next to the second scenario, the ACA F-RAP provisions do not present a wholly comprehensive scheme of regulation that leaves no room for the state action. HHS itself recognized this very point in discussing risk adjustment protocols under the ACA. In the May 11, 2016 Federal Register, HHS stated that:

> HHS has had, and continues to have discussions with issuers and state regulators on ways to help ease issuers' transition to the new health insurance markets and the effects of anticipated risk adjustment charge amounts…[HHS is] sympathetic to these concerns and recognize that states are the primary regulators of their insurance markets. As such, we encouraged, and continue to encourage States to examine whether any local approaches, under State legal authority, are warranted to help ease this transition to new health insurance markets. 81 Fed. Reg. 91 (May 11, 2016) (emphasis added).

Likewise, in the Federal Register of December 22, 2016, HHS wrote that: "we encouraged, and continue to encourage States to examine whether any local approaches, under State legal authority, are warranted to help ease this transition to new health insurance markets". 81 Fed. Reg. 246 (Dec. 22, 2016).

Finally, beyond the clarity of the unambiguous Federal Register provisions, in October 2017, HHS drove the point home in publishing a proposed rule that explicitly authorized states to use their existing State authority to apply State law to mitigate the effects of F-RAP. HHS stated in pertinent part, "a State that wishes to make an adjustment for the magnitude of these transfers … may take temporary, reasonable measures under State authority to mitigate effects under their

own authority". 82 Fed. Reg. 211 (Oct. 27, 2017).

Through these express statements HHS actually invites states to exercise their existing legal authority over insurance regulation to ease the application of F-RAP in the state's markets. If the ACA left no room for state action, as alleged by Plaintiffs, HHS would not encourage, invite, and affirmatively seek such regulatory help from the states.

Finally, the third scenario – requiring a demonstration of actual conflict between the federal and state law – is not satisfied here. The touchstone of this scenario "is conflict, actual or potential, between two systems which regulate" a substantive area. Christ the King Regional High School v. Culvert, 815 F.2d 219, 222 (2d Cir. 1987). Where there is no conflict, "no real preemption problem exists". Id. Thus, it has been held that there is no preemption "unless clear damage to federal goals would result". Coalition for Competitive Elec. v. Zibelman, 2017 U.S. Dist. LEXIS 116140 (S.D.N.Y. July 25, 2017) (Caproni, J.). Where federal and State law operate in a complementary fashion, there is no preemption. In re Fosamax Prods. Liab. Litig., 742 F. Supp. 2d 460, 475 (S.D.N.Y. 2010).

As discussed throughout this Memorandum, the DFS Market Stabilization Regulation was conceived as a State-specific response to the generic, one-sized-fits-all F-RAP process under the ACA. See 11 NYCRR § 361.9(a)(1)-(5). F-RAP does not take into account certain New York State specific factors and has an adverse impact in the New York markets, and, as a result, created "unintended consequences" to New York's specific carriers and markets. Id. §361.9(a)(2). The impact of F-RAP on New York's markets resulted in the need for the DFS Market Stabilization Regulations which ameliorate the adverse impacts on the State's small group health insurance carriers based on a State-centric methodology and calculation. Id. at §361.9(b)(1)-(2).

The Market Stabilization Regulations do not operate to frustrate the purpose of the ACA's

F-RAP, but instead work in conjunction with F-RAP to apply the rate adjustment protocol in a manner consistent with New York's specific market realities. Far from creating a conflict with federal law, this cooperative approach in bridging issues between the ACA's F-RAP and state-specific adjustment issues is actually preferred by CMS, and outwardly discussed in 11 NYCRR §361.9. See 81 Fed. Reg. 246 (Dec. 22, 2016); See also §361.9(a)(2) ("The department has been working cooperatively with … CMS on risk adjustment").

Indeed, finding anything other than a complimentary relationship between the ACA and 11 NYCRR §361.9, as Plaintiffs ask the Court to do, actually undermines the stated purpose of the ACA. Handcuffing the State by precluding it from addressing specific market conditions would result in a de-stabilization of the small group health and individual insurance markets. Such de-stabilization would necessarily undermine implementation of the ACA's risk adjustment function by de-incentivizing New York's carriers from insuring sicker consumers as to do so would affect their competitive market position in the State. Moreover, de-stabilization would also threaten the States' ability to provide "access to a robust range of coverage options" – in direct contravention to the ACA's stated goal. See "The Three Rs: An Overview" (Oct. 1, 2015), available at https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2015-Fact-sheets-items/2015-10-01.html (last accessed Dec. 7, 2017).

So apparent is the cooperative relationship between the two regulatory regimes, that HHS expressly articulated its expectation that States will engage in state-specific adjustments to offset unintended consequences of F-RAP. 82 Fed. Reg. 211 (Oct. 27, 2017). On October 27, 2017, HHS published a proposed rule that encouraged and explicitly authorized states to use their existing state authority to take temporary, reasonable measures under State authority to mitigate the effects of the federal risk adjustment program. Id. In pertinent part the proposed rulemaking

states:

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

Thus, even if the Court reaches the merits of Plaintiffs' Supremacy Clause claims, there is no basis to find that the ACA actually preempts New York's Market Stabilization Regulations. The overwhelming statutory, regulatory and secondary evidence supports a finding that the ACA and New York's Market Stabilization Regulations work symbiotically by design – not in a competing or conflicting manner. As such, Plaintiffs' First, Second, Sixth and Seventh causes of action must be dismissed under FRCP 12(b)(6).

B. Plaintiffs' Takings Claims Fail as There is No Vested Property Interest in Issue

While Plaintiffs' Takings/Exaction Clause claims are decidedly unripe as not yet implemented (see supra Point II), even if DFS had actually effected the transfer of monies into a risk pool, this would not constitute a regulatory taking as a matter of well-established law.

To demonstrate the existence of a regulatory taking a plaintiff must initially show the existence of "a property interest protected by the Fifth Amendment". Ganci v. N.Y.C. Transit Auth., 420 F. Supp. 2d 190, 195 (S.D.N.Y. 2005), aff'd 163 F. App'x 7 (2d Cir. 2005). That is, as with ripeness, Plaintiff must show an actual deprivation of an interest to sustain a claim for Takings. Id. The claimed property interest must be realized, not speculative or inchoate. Sanitation & Recycling Indus. v. City of New York, 928 F. Supp. 407, 417 (S.D.N.Y. June 26,

1996). For this very reason, it is widely held that there is no recognized property interest in reimbursements in the face of regulatory "provisions that retain for the state significant discretionary authority over the bestowal or continuation of a government benefit". Senape v. Constantino, 936 F.2d 687, 690 (2d Cir. 1991); See also Oberlander v. Perales, 740 F.2d 116, 120 (2d Cir. 1984).

By this action Plaintiffs are claiming a property interest in a risk adjustment value after only one half of a regulatory process has been completed, while the other half of the process is pending and unfinished. That is, Plaintiffs' Takings Clause claim asserts a property interest over insurance adjustments made following F-RAP, but prior to application of any State risk adjustment under 11 NYCRR § 361.9. See generally Compl. While Plaintiffs assert a unilateral expectation of certain funds as a result of F-RAP, they have no legitimate claim of entitlement to any adjustments as the primary regulator of State Insurance maintains regulatory authority over any such adjustments[9].

Plaintiffs' assertion of a property interest in a specific adjustment amount completely disregards the State's discretion and authority for on-going insurance regulation of carriers. Where such on-going, discretionary regulation exists, there can be no protected property interest. Senape, 936 F.2d at 690; R.R. Vill. Ass'n v. Denver Sewer Corp., 826 F.2d 1197, 1202-1203 (2d Cir. 1987) (denying protected property interest over prospective sewer rates because such rates were subject to on-going regulation "involving the exercise of judgment and discretion" by the municipality").

Plaintiffs' argument is directly analogous to Medicaid rate cases – where providers claim property interest in future Medicaid reimbursements and specific rates. Such claims have been declined in this Circuit, upon a finding that there can be no expectation of property in the heavily

[9] Discussed supra at Point (IV)(A).

regulated Medicaid area where future rate setting, and even on-going participation in the program, is subject to regulation. See Cutie v. Sheehan, 645 Fed. Appx. 93, 95 (2d Cir. 2016); See also Concerned Home Care Providers, Inc. v. Cuomo, 783 F.3d 77, 91-92 (2d Cir. 2015).

As Plaintiffs' will not suffer any cognizable loss of property should any risk adjustment be implemented in the future, their Takings/Exaction clause and 42 USC §1983 claims must be dismissed pursuant to FRCP 12(b)(6).

C. Plaintiffs' 42 USC §1983 Claims are Legally Flawed as Pled

Plaintiffs Fifth and Tenth causes of action alleging "violation of 42 USC §1983" must also be dismissed pursuant to Fed. R. Civ. P. 12(b)(6). Compl. at pgs. 37,43.

It is hornbook law that "Section 1983 is not itself a source of substantive rights." Patterson v. County of Oneida, 375 F.3d 206, 225 (2d Cir. 2004). Stated differently, there is no independent federal right conferred under 42 USC §1983. Vill. of Freeport v. Barrella, 814 F.3d 594, 600 (2d Cir. 2016). The law merely provides "a method for vindicating federal rights elsewhere conferred". Patterson, 375 F.3d at 225. As such, it is facially improper to claim a "violation of 42 USC §1983", as Plaintiffs do by their Complaint. Compl. at pgs. 37, 43.

Plaintiffs' §1983 claims ambiguously reference "Fifth and Fourteenth Amendment" rights, but fail to set forth the nature of the violation claimed. Compl. ¶¶ 119, 148. For purposes of this Memorandum it is assumed that Plaintiffs meant to bring their Takings/Exaction claims under the rubric of 42 USC §1983, and that these causes of action should be combined and ultimately dismissed [see supra Points II, (IV)(B)]. But, to the extent Plaintiffs intended to separately allege violations of 42 USC §1983, as they have pled, then these claims must be dismissed as failing to state a viable cause of action.

CONCLUSION

For the reasons set forth herein, Plaintiffs' Complaint must be dismissed in its entirety under FRCP 12(b)(1) and 12(b)(6).

Dated: Albany, New York
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