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8
 9 IN THE UNITED STATES DISTRICT COURT
 10 FOR THE NORTHERN DISTRICT OF CALIFORNIA

11 **THE STATE OF CALIFORNIA; THE STATE**
 12 **OF CONNECTICUT; THE STATE OF**
 13 **DELAWARE; THE DISTRICT OF**
 14 **COLUMBIA; THE STATE OF ILLINOIS;**
 15 **THE STATE OF IOWA; THE**
 16 **COMMONWEALTH OF KENTUCKY; THE**
 17 **STATE OF MARYLAND; THE**
 18 **COMMONWEALTH OF MASSACHUSETTS;**
 19 **THE STATE OF MINNESOTA; THE STATE**
 20 **OF NEW MEXICO; THE STATE OF NEW**
 21 **YORK; THE STATE OF NORTH CAROLINA;**
 22 **THE STATE OF OREGON; THE**
 23 **COMMONWEALTH OF PENNSYLVANIA;**
 24 **THE STATE OF RHODE ISLAND; THE**
 25 **STATE OF VERMONT; THE**
 26 **COMMONWEALTH OF VIRGINIA; and THE**
 27 **STATE OF WASHINGTON,**

Plaintiffs,

v.

22 **DONALD J. TRUMP, President of the United**
 23 **States; ERIC D. HARGAN, Acting Secretary of**
 24 **the United States Department of Health and**
 25 **Human Services; UNITED STATES**
 26 **DEPARTMENT OF HEALTH AND HUMAN**
 27 **SERVICES; STEVEN T. MNUCHIN,**
 28 **Secretary of the United States Department of**
the Treasury; UNITED STATES
DEPARTMENT OF THE TREASURY; and
DOES 1-20,

Defendants.

Case No. 4:17-cv-05895-KAW

**PLAINTIFFS' MEMORANDUM OF
 POINTS AND AUTHORITIES IN
 SUPPORT OF EX PARTE MOTION
 FOR A TEMPORARY
 RESTRAINING ORDER AND
 ORDER TO SHOW CAUSE WHY A
 PRELIMINARY INJUNCTION
 SHOULD NOT ISSUE**

RELIEF REQUESTED BY 4:00 P.M.
THURSDAY, OCTOBER 19, 2017

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INTRODUCTION

1 Pursuant to Federal Rule of Civil Procedure 65(b) and Local Civil Rule 65-1, Plaintiffs the
2 State of California; the State of Connecticut; the State of Delaware; the District of Columbia; the
3 State of Illinois; the State of Iowa; the Commonwealth of Kentucky; the State of Maryland; the
4 Commonwealth of Massachusetts; the State of Minnesota; the State of New Mexico; the State of
5 New York; the State of North Carolina; the State of Oregon; the Commonwealth of Pennsylvania;
6 the State of Rhode Island; the State of Vermont; the Commonwealth of Virginia; and the State of
7 Washington (collectively, States) seek a temporary restraining order (TRO) and order to show
8 cause why a preliminary injunction should not issue to enjoin Defendants Donald J. Trump,
9 President of the United States; Eric D. Hargan, Acting Secretary of the United States Department
10 of Health and Human Services; the United States Department of Health and Human Services;
11 Steven T. Mnuchin, Secretary of the United States Department of the Treasury; and the United
12 States Department of the Treasury (collectively, Defendants) from terminating the cost sharing
13 reduction (CSR) payments required by the Patient Protection and Affordable Care Act (ACA)
14 pending judicial resolution of this action. Because Defendants have stated that they will not make
15 the monthly CSR reimbursement payments to insurers that are due on Friday, October 20, 2017,
16 Plaintiffs ask that **a TRO issue by 4:00 p.m. Thursday, October 19, 2017** requiring that timely
17 and complete payments be made.

18
19 The requested injunctive relief, which would simply preserve the status quo pending a final
20 resolution of this case, is necessary and appropriate here. First, after full consideration the Court
21 is likely to conclude that the law requires Defendants to continue making CSR reimbursement
22 payments. Multiple provisions of the ACA require Defendants to make these payments, which
23 are an essential part of the Act's carefully integrated structure. *See* 42 U.S.C. §§ 18071(c)(3)(A);
24 18082(a)(3) & (c)(3). The cost-sharing reduction payments work hand-in-hand with the ACA's
25 premium tax credits to provide low and middle income families access to more affordable health
26 care. Understanding that these federal subsidies are integral to the ACA's success, and that they
27 must work seamlessly and predictably every year in order for the ACA to achieve its goals,
28 Congress both mandated that the payments be made and exempted them from the annual

1 appropriations process by creating a permanent appropriation for these funds. *See* 31 U.S.C.
2 § 1324(b)(2); 26 U.S.C. § 36B; 42 U.S.C. § 18071. Since the ACA’s operative provision took
3 effect in January 2014, the Secretaries of the Treasury and Health and Human Services (HHS)
4 (under both Presidents Obama and Trump) have made monthly CSR reimbursement payments
5 pursuant to this statutory authority. They have done so without interruption, and without further
6 congressional appropriations.

7 Late last week, Defendants suddenly announced that they would no longer be making these
8 payments. That announcement was made just eight days before the October 2017 monthly
9 payments are due, and less than three weeks before open enrollment for 2018 is set to begin. The
10 Administration’s abrupt reversal not only violates the ACA, but is also arbitrary and capricious in
11 violation of the Administrative Procedure Act (APA). And, under the unusual circumstances of
12 this case, it violates the President’s constitutional duty to take care that the laws be faithfully
13 executed. The President’s own statements make clear that the termination of CSR payments is
14 not based on any neutral, good faith interpretation of the statutes, but instead is deliberately
15 intended to *undermine* the proper functioning of the ACA. Since taking office, the Trump
16 Administration has engaged in a continued and sustained effort to “explode” the ACA by making
17 it more difficult and expensive for individuals to procure health insurance coverage through the
18 Act’s health insurance Exchanges.¹ His first act as President included signing the Executive
19 Order, *Minimizing the Economic Burden of the Patient Protection and Affordable Care Act*
20 *Pending Repeal*.² And after repeatedly trying, but failing, to convince Congress to repeal the
21 ACA, President Trump is now openly seeking to “dismantle[]” this landmark Act of Congress—
22 which provided affordable health insurance coverage to over 20 million Americans—through
23 sudden, unilateral, and irresponsible executive action.³ To take just one example, after abruptly
24

25 ¹ https://www.washingtonpost.com/national/health-science/affordable-care-act-remains-law-of-the-land-but-trump-vows-to-explode-it/2017/03/24/4b7a2530-10c3-11e7-ab07-07d9f521f6b5_story.html?utm_term=.9ad0a92dce44.

26 ² <https://www.whitehouse.gov/the-press-office/2017/01/2/executive-order-minimizing-economic-burden-patient-protection-and>.

27 ³ <https://twitter.com/realDonaldTrump/status/919009334016856065>.

1 ending the CSR payments, which millions of American families rely on for access to high quality
2 and affordable health care, the President declared in a Cabinet meeting that:

3 The healthcare, as you know, is moving along. I knocked out the CSRs; that was a subsidy
4 to the insurance companies ... Republicans are meeting with Democrats because of what I
5 did with the CSR, because I cut off the gravy train ... Obamacare is finished. It's dead. It's
6 gone. It's no longer—you shouldn't even mention it. It's gone. There is no such thing as
7 Obamacare anymore.⁴

8 Under these circumstances, equitable relief is necessary to preserve the status quo while the
9 court resolves the important legal questions presented by this case. Interim relief will bring some
10 modicum of stability and order to the situation and prevent irreparable harm to the plaintiff States
11 and to the millions of Americans who have access to affordable health insurance because of the
12 ACA. In contrast, allowing Defendants to stop making the CSR payments required by the Act,
13 particularly in the precipitous fashion they have proposed, will bring about chaos and uncertainty,
14 cause premium increases and insurer withdrawals from ACA markets, increase the number of
15 uninsured Americans, and increase uncompensated care costs that are ultimately borne by state
16 and local governments. And, ironically, allowing Defendants to depart from the intended
17 statutory structure by terminating the CSR payments will cost the federal government *more*
18 money in the end. These unfortunate consequences are wholly unnecessary, and should not be
19 tolerated simply because Defendants now suddenly argue that they lack the authority to make
20 CSR payments in the absence of a further specific appropriation. Notably, Defendants' current
21 stance is a complete reversal of the legal position the Executive Branch has maintained and acted
22 on for nearly four years, including for eight months under the new Administration. This Court
23 should issue an immediate TRO to preserve the status quo and permit the Court to consider the
24 merits of the Executive Branch's new position in an orderly manner.

25 **ISSUE PRESENTED**

26 Whether the Court should issue a temporary restraining order and preliminary injunction to
27 preserve the status quo by requiring Defendants to continue making cost-sharing reduction
28 payments mandated under the ACA pending a final resolution of the merits of this lawsuit.

⁴ <https://www.whitehouse.gov/the-press-office/2017/10/16/remarks-president-trump-cabinet-meeting>.

FACTUAL BACKGROUND

1
2 The ACA is a landmark law that made affordable health coverage available to more than 20
3 million Americans and sharply reduced the number of Americans without health insurance. It
4 was designed to create local, state-based markets presenting affordable insurance choices for
5 consumers, in order to “increase the number of Americans covered by health insurance and
6 decrease the cost of health care.” *Nat’l Fed’n of Indep. Bus. v. Sebelius*, 132 S. Ct. 2566, 2580
7 (2012). The ACA adopted a “series of interlocking reforms” to achieve these goals. *King v.*
8 *Burwell*, 135 S. Ct. 2480, 2485 (2015). The three “closely intertwined” reforms implemented by
9 the Act are: (1) requiring nearly everyone to maintain insurance coverage (the individual
10 mandate); (2) mandating that insurers accept every person seeking coverage and not charge them
11 higher premiums based on their health (i.e., not discriminating based on “pre-existing
12 conditions”); and (3) providing subsidies designed to make insurance coverage more affordable.
13 *Id.* at 2486-87. To achieve these goals, the ACA created local health insurance markets (called
14 Exchanges), both state-run and federally-run, “basically, a marketplace that allows people to
15 compare and purchase insurance plans.” *Id.* at 2485.⁵ The ACA relies on both the States and
16 private insurance companies to bring those plans to market. *Id.* at 2486-87. These core principles
17 of the ACA have made health care affordable and accessible for more than 20 million Americans.

18 One critical element of the ACA is that it permanently appropriated billions of dollars in
19 federal subsidies to make health care more affordable for eligible low and moderate-income
20 Americans. Health care expenses (for those with health insurance) generally fall into two
21 categories. First, health insurance companies typically charge monthly premiums for the
22 coverage that they provide. Second, in addition to paying monthly premiums, insurance plans
23 usually require insured individuals and families to make out-of-pocket payments to health care
24 providers in the form of copayments for medical visits and prescription drugs, coinsurance, and
25
26

27 ⁵ Exchanges may be established either by a State, or, if a State does not establish an
28 Exchange, by the federal government. *King*, 135 S. Ct. at 2485.

1 deductibles (collectively known as “cost-sharing” requirements).⁶ Congress designed the ACA’s
2 subsidies to address both types of health care costs.

3 The ACA provides two forms of interrelated subsidies that reduce the cost of obtaining and
4 utilizing health care coverage for lower income individuals and their families. First, section 1401
5 provides premium tax credits that reduce monthly insurance premiums for eligible individuals.
6 26 U.S.C. § 36B. Qualified individuals are those with household incomes between 100% and
7 400% of the federal poverty level. *King*, 135 S. Ct. at 2487. For 2017, the poverty level for a
8 family of four is \$24,600.⁷ Such individuals may purchase insurance with the premium tax
9 credits—which the Treasury Secretary pays in advance directly to the individual’s health insurer.
10 *King*, 135 S. Ct. at 2487. The “tax credits are among the Act’s key reforms, involving billions of
11 dollars in spending each year and affecting the price of health insurance for millions of people.”
12 *Id.* at 2489.

13 Second, to offset individuals’ out-of-pocket costs when using their health insurance, section
14 1402 requires insurers to provide cost-sharing reductions to individuals: (1) who are eligible to
15 receive tax credits under Section 1401 and 26 U.S.C. § 36B; (2) whose household income is
16 below 250% of the federal poverty level (\$61,500 for a family of four); and (3) who are enrolled
17 in a “silver” plan on one of the Exchanges. 42 U.S.C. § 18071(b), (c)(2), (f)(2).⁸ Eligibility for a
18 premium tax credit under 26 U.S.C. § 36B is thus a statutory precondition for receipt of cost-
19 sharing reductions. 42 U.S.C. § 18071(f)(2). Insurers must reduce cost sharing for all qualified
20 individuals. *Id.* § 18071(c)(2). But while the upfront cost is thus borne by the insurers, *id.*
21 § 18071(a)-(c), the ACA requires the government to reimburse insurers for these cost-sharing
22 reductions by “mak[ing] periodic and timely payments to the [insurer] equal to the value of the

23 ⁶ See [https://www.cbo.gov/sites/default/files/110th-congress-2007-2008/reports/12-18-](https://www.cbo.gov/sites/default/files/110th-congress-2007-2008/reports/12-18-keyissues.pdf)
24 [keyissues.pdf](https://www.cbo.gov/sites/default/files/110th-congress-2007-2008/reports/12-18-keyissues.pdf), at 16-17.

25 ⁷ See <https://obamacare.net/2017-federal-poverty-level/>.

26 ⁸ The Act classifies plans offered on the Exchanges into one of four “metal levels” based
27 on their cost-sharing requirements. 42 U.S.C. § 18022(d). A “silver” plan is structured so that
28 the insurer pays 70% of the average enrollee’s health care costs, leaving the enrollee responsible
for the remaining 30% through cost sharing. *Id.* “Gold” and “platinum” plans cover a greater
portion of the insured’s average health care costs, while a “bronze” plan covers a smaller portion.
Id. Insurers on the Exchanges must offer at least one “silver” and one “gold” level plan. *Id.*
§ 18021(a)(1)(C)(ii).

1 reductions,” *id.* § 18071(c)(3)(A). Cost-sharing reductions are a major expense: in 2016 they
2 cost \$7 billion, they will total \$9 billion in 2017, and are expected to rise to \$16 billion by 2026.⁹
3 They play a crucial role in lowering out-of-pocket costs so that consumers can actually use their
4 health care. For example, in States with federally-run Exchanges, insurers on average reduced the
5 overall out-of-pocket limit for silver plans from \$6,224 to \$2,047—a reduction of over 67%—for
6 individuals with incomes between 150 and 200% of the federal poverty level.¹⁰

7 The ACA requires that “advance payments” for both tax credits and cost-sharing reductions
8 be made as part of a single, unified program. 42 U.S.C. § 18082(a). Under that unified program,
9 the Secretary of the Treasury makes monthly “advance payments of such [tax] credits or [cost
10 sharing] reductions” to the issuers of the qualified health plans in order to “reduce the premiums
11 payable by individuals eligible for such credit.” *Id.* § 18082(a)(3). These advance payments for
12 both components of the subsidy program are made directly to health insurers. *Id.* Both premium
13 tax credits and cost-sharing reductions are funded through a permanent appropriation under 31
14 U.S.C. § 1324, as amended by the ACA. Section 1324 permanently appropriates “[n]ecessary
15 amounts ... for refunding internal revenue collections as provided by law,” including “refunds
16 due ... from” specified provisions of the tax code. 31 U.S.C. § 1324(a), (b)(2). And section 1401
17 of the Act amended the list of funded provisions to include “refunds due ... from” Section 36B.
18 ACA § 1401(d)(1); 31 U.S.C. § 1324(b)(2).

19 Consistent with this statutory scheme, since January 2014, the Secretaries of Treasury and
20 HHS have paid both cost-sharing reductions and premium tax credits under the authority of the
21 permanent appropriation provided by 31 U.S.C. § 1324. Those monthly payments began under
22 the Obama Administration and were continued by the Trump Administration. On October 12,
23 2017, however, the Trump Administration abruptly announced that it would no longer make CSR
24 payments, beginning the following week. In a brief press statement, issued late in the evening,

25 ⁹ Congressional Budget Office, *Federal Subsidies for Health Insurance Coverage for*
26 *People Under Age 65: 2016 to 2026* 8 (Mar. 2016) (CBO *Federal Subsidies*),
[https://www.cbo.gov/sites/default/files/114th-congress-2015-2016/reports/
51385-healthinsurancebaseline.pdf](https://www.cbo.gov/sites/default/files/114th-congress-2015-2016/reports/51385-healthinsurancebaseline.pdf).

27 ¹⁰ See [http://www.commonwealthfund.org/publications/issue-briefs/2016/mar/cost-](http://www.commonwealthfund.org/publications/issue-briefs/2016/mar/cost-sharing-reductions)
28 [sharing-reductions](http://www.commonwealthfund.org/publications/issue-briefs/2016/mar/cost-sharing-reductions), at 7-8.

1 the White House stated that “[b]ased on guidance from the Department of Justice, the Department
2 of Health and Human Services has concluded that there is no appropriation for cost-sharing
3 reduction payments to insurance companies under [the ACA]. In light of this analysis, the
4 Government cannot lawfully make the cost-sharing reduction payments.”¹¹ The next morning,
5 the U.S. Department of Justice attached a copy of a new, four-page opinion from the Attorney
6 General providing the purported legal basis for the Administration’s action to a court filing in a
7 related case. *See United States House of Representatives v. Hargan*, D.C. Circuit Case No. 16-
8 5202, ECF No.1698827.

9 That same morning (October 13, 2017), President Trump tweeted “The Democrats
10 ObamaCare is imploding. Massive subsidy payments to their pet insurance companies has
11 stopped. Dems should call me to fix!”¹² Later that day, he tweeted that the ACA “is being
12 dismantled, but in the meantime, premiums & deductibles are way up!”¹³ The next day, he
13 celebrated the plunge of health insurance stocks as the result of his Executive action.¹⁴ And
14 during a cabinet meeting on Monday, October 16, 2017, President Trump bragged that he had
15 “knocked out the CSRs” and pronounced the ACA “dead,” “finished,” and “gone.”¹⁵

16 LEGAL STANDARD

17 To obtain a preliminary injunction, a plaintiff “must establish that he is likely to succeed on
18 the merits, that he is likely to suffer irreparable harm in the absence of preliminary relief, that the
19 balance of equities tips in his favor, and that an injunction is in the public interest.” *Winter v.*
20 *Nat’l Res. Def. Council, Inc.*, 555 U.S. 7, 20 (2008). The Ninth Circuit applies a “sliding scale
21 approach under which a preliminary injunction could issue where the likelihood of success is
22 such that ‘serious questions going to the merits were raised and the balance of hardships tips
23 sharply in plaintiff’s favor.’” *Alliance for the Wild Rockies v. Cottrell*, 632 F.3d 1127, 1131 (9th
24 Cir. 2010) (quoting *Clear Channel Outdoor, Inc. v. City of Los Angeles*, 340 F.3d 810, 813 (9th

25
26 ¹¹ <http://thehill.com/policy/healthcare/355258-trump-to-cut-off-key-obamacare-payments>.

¹² <https://twitter.com/realDonaldTrump/status/918772522983874561>.

¹³ <https://twitter.com/realDonaldTrump/status/919009334016856065>.

¹⁴ <https://twitter.com/realDonaldTrump/status/919160558712172544>.

¹⁵ <https://www.whitehouse.gov/the-press-office/2017/10/16/remarks-president-trump-cabinet-meeting>.

1 Cir. 2003)). The purpose of interim injunctive relief is “not to conclusively determine the rights
2 of the parties,” but instead to “balance the equities as litigation moves forward.” *Trump v. Int’l*
3 *Refugee Assistance Project*, 137 S. Ct. 2080, 2087 (2017). Crafting an injunction is an “exercise
4 of discretion and judgment, often dependent as much on the equities of a given case as the
5 substance of the legal issues it presents.” *Id.* (citing *Winter*, 555 U.S. at 20, 24). Courts must
6 “also ‘consider the overall public interest.’” *Id.* (alterations and citations omitted).

7 The States seek a nationwide injunction, which is appropriate when the legal violation is
8 nationwide in scope. “[T]he scope of injunctive relief is dictated by the extent of the violation
9 established, not by the geographical extent of the plaintiff.” *Califano v. Yamaski*, 442 U.S. 682,
10 702 (1979); see also *Washington v. Trump*, 847 F.3d 1151, 1166-67 (9th Cir. 2017) (affirming
11 nationwide injunction against executive branch travel ban order).

12 ARGUMENT

13 I. THE STATES ARE LIKELY TO SUCCEED ON THE MERITS OF THEIR CLAIM THAT THE 14 EXECUTIVE BRANCH IS REQUIRED TO MAKE THE ACA’S MANDATORY COST- SHARING REDUCTION PAYMENTS

15 The States are likely to succeed on the merits of their claim that the Administration’s
16 decision to stop making CSR payments is unlawful. The APA provides that a person suffering a
17 legal wrong because of agency action or adversely affected or aggrieved by agency action is
18 entitled to judicial review. 5 U.S.C. § 702. A final agency action for which there is no other
19 adequate remedy in a court is subject to judicial review. *Id.* § 704. A reviewing court shall:
20 “(1) compel agency action unlawfully withheld or unreasonably delayed; and (2) hold unlawful
21 and set aside agency action, findings, and conclusions found to be ... arbitrary, capricious, an
22 abuse of discretion, otherwise not in accordance with law; [or] without observance of procedure
23 required by law.” *Id.* § 706. The APA defines “agency action” to include “the whole or a part of
24 an agency rule, order, license, sanction, relief, or the equivalent or denial thereof, or failure to
25 act.” *Id.* § 551(13); see *id.* § 551(6) (defining “order” to mean “the whole or a part of a final
26 disposition, whether affirmative, negative, injunctive, or declaratory in form, of an agency in a
27 matter other than rule making but including licensing”).
28

1 The ACA requires the Executive Branch to make timely and regular cost-sharing reduction
2 payments to insurers to ensure coverage of out-of-pocket health care expenses for beneficiaries,
3 and provides a permanent appropriation of the funds necessary to make those payments. These
4 cost-sharing reductions are a core component of the ACA, and are essential to the ACA’s central
5 goal of providing access to affordable health care coverage. The federal government’s sudden
6 refusal to make these payments is both “arbitrary, capricious” and “not in accordance with law,”
7 and therefore violates both the ACA and the APA. 5 U.S.C. § 706; *see Safe Air for Everyone v.*
8 *U.S.E.P.A.*, 488 F.3d 1088, 1101 (9th Cir. 2007) (agency decision based on legally erroneous
9 interpretation of statute is “arbitrary, capricious, or otherwise not in accordance with law”).

10 **A. The ACA Requires the Secretaries of the Treasury and HHS to Make**
11 **Cost-Sharing Reduction Reimbursement Payments**

12 **1. The text of the ACA mandates cost-sharing reduction reimbursement**
13 **payments**

14 The text, structure, and design of the ACA establish the mandatory nature of cost-sharing
15 reduction payments, for which Congress permanently appropriated funds. First, the Act’s text
16 expressly requires—many times over—the Treasury Secretary to make these payments. The
17 statute first states that “[a]n issuer of a qualified health plan making reductions under this
18 subsection shall notify the Secretary of such reductions and the Secretary *shall make* periodic and
19 timely payments to the issuer equal to the value of the reductions.” 42 U.S.C. § 18071(c)(3)(A)
20 (emphasis added). The ACA subsequently requires the Secretary of HHS to establish a program
21 under which “the Secretary of the Treasury *makes* advance payments of such credit or reductions
22 to the issuers of the qualified health plans in order to reduce the premiums payable by individuals
23 eligible for such credit.” *Id.* § 18082(a)(3) (emphasis added). And the Secretary of the Treasury
24 “*shall make*” an “advance payment of the cost-sharing reductions” in the amount specified by the
25 Secretary of HHS. *Id.* at (c)(3) (emphasis added). Payment for cost-sharing reductions has even
26 been codified by federal regulation. *See* 42 C.F.R. § 156.430. The ACA’s text leaves no
27 ambiguity regarding the mandatory nature of these payments.
28

1 **2. The text, structure and design of the ACA demonstrate that Congress**
2 **permanently appropriated funds for cost-sharing reduction**
3 **payments**

4 The text, structure, and design of the ACA also demonstrate that Congress permanently
5 appropriated funds for cost-sharing reduction payments. As discussed above, 31 U.S.C.
6 § 1324(b)(2) provides a permanent appropriation for “refunds due” from various “credit
7 provisions” of the Internal Revenue Code. The ACA amended this list to include refunds due
8 from 26 U.S.C. § 36B. Section 36B provides that “applicable taxpayers” are entitled to a credit
9 against the “tax imposed by this subtitle” in “an amount equal to the premium assistance credit
10 amount.” 26 U.S.C. § 36B(a). But this credit is not paid or credited directly to the individuals
11 who are entitled to the premium subsidy; rather, it is paid to their insurers, so that the beneficiary
12 never has to pay the up-front cost of the premium in the first place. *See* 42 C.F.R. § 156.430. In
13 just the same way, the ACA also provides that a subset of the individuals eligible to receive
14 premium tax credits under Section 36B are also entitled to have their insurance carrier “reduce
15 the[ir] cost-sharing” expenditures in amounts that vary by income—and the insurer is entitled to
16 have the government reimburse it for that subsidy, just as the government pays the premium
17 subsidy credit directly to the insurer. 42 U.S.C. § 18071(c)(2), (c)(3), (f)(2).¹⁶ The two
18 components of the ACA’s subsidy program work in exactly the same way. And when Congress
19 amended Section 1324 to include a permanent appropriation for “refunds due” from Section 36B,
20 it created a permanent appropriation for whatever amounts proved necessary to fund both. *See*
21 *also United States House of Representatives v. Hargan*, 2016 WL 6216355, at *46-53 (Brief of
22 the Executive Branch in related litigation in the D.C. Circuit explaining how the ACA’s
23 permanent appropriation covers cost-sharing reduction payments).

24 Numerous provisions in the ACA reinforce the conclusion that Congress intended to treat
25 premium tax credits and cost-sharing reduction payments as interrelated components of a single,
26 integrated, and permanently appropriated subsidy program. For starters, eligibility for premium
27 tax credits and cost-sharing reductions are determined at the same time, through the same process,

28 ¹⁶ *See also* <https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/CMS-Guidance-on-CSR-Reconciliation.pdf>.

1 and by the same person. The Secretary of HHS determines, in advance, the income eligibility of
 2 individuals “for the premium tax credit allowable under section 36B of Title 26 *and* the cost-
 3 sharing reductions under section 18071 of this title.” 42 U.S.C. § 18082(a)(1) (emphasis added).
 4 The Secretary uses the same information and verification process for both eligibility
 5 determinations. *Id.* § 18082(a), (b)(3), (c)(3), (e)(2). And both subsidies are directly linked by
 6 the fact that cost-sharing reductions are *only* available for a subset of tax credit recipients. *Id.*
 7 § 18071(c)(2), (f)(2). One cannot qualify for cost-sharing reductions without first being eligible
 8 for premium tax credits. *Id.*

9 Furthermore, payments for both premium tax credits and cost-sharing reductions occur at
 10 the same time, through the same process, and are paid by the same person and to the same
 11 entities. Under the statutory scheme, the Treasury Secretary makes “advance payments” on a
 12 monthly basis directly to insurers—payments that expressly cover both tax credits and cost-
 13 sharing reduction payments. 42 U.S.C. § 18082(c)(2)-(3).¹⁷ Congress created an integrated
 14 scheme to pay insurers at the same time and in the same manner for both types of subsidies,
 15 which further demonstrates that Section 1324’s permanent appropriation applies to both premium
 16 tax credits and cost-sharing reduction payments. 42 U.S.C. § 18082(c)(2)-(3). Any other reading
 17 of the statutory scheme would be “untenable in light of the statute as a whole.” *King*, 135 S. Ct.
 18 at 2495.

19 All told, no fewer than 45 provisions in the ACA link premium tax credits and cost-sharing
 20 reductions.¹⁸ From streamlining enrollment procedures for the ACA’s Exchanges, to authorizing
 21 the IRS to disclose tax return information, to clarifying that eligibility for premium tax credits and
 22 cost-sharing reduction subsidies does not affect eligibility for other public benefits, the ACA

23 ¹⁷ Though paid at the same time and in the same manner, premium tax credit payments are
 24 prospective, whereas CSR reimbursement payments are retroactive because insurers have already
 made those payments on behalf of covered beneficiaries.

25 ¹⁸ See 42 U.S.C. § 18083(e)(1); 26 U.S.C. § 6103(l)(21)(A); *id.* § 36B(f)(3)(B), (C); *id.*
 26 § 6055(b)(1)(B)(iii)(II); 29 U.S.C. § 218b(a)(2); 42 U.S.C. § 18084(2); *id.* § 18054(c)(3)(A); 26
 27 U.S.C. § 4980H(a)(2), (b)(1)(B), (c)(3), (d)(3); 42 U.S.C. § 300gg-4(l)(3)(A)(ii); *id.*
 28 § 1397ee(d)(3)(B); *id.* § 18023(b)(2)(A)(i)-(ii), (b)(2)(B)(i)(I); *id.* § 18031(c)(5)(B), (d)(4)(G),
 (i)(3)(B); *id.* § 18032(e)(2); *id.* § 18033(a)(6)(A); *id.* § 18051(a)(2), (d)(3)(A)(i), (d)(3)(A)(ii); *id.*
 § 18052(a)(3); *id.* § 18071(f)(2); *id.* § 18081(a)(1), (a)(2), (a)(2)(B), (b)(3), (b)(4), (c)(3),
 (e)(2)(A)(i), (e)(4)(B)(ii), (e)(4)(B)(iii), (g)(1), (g)(2)(A); *id.* § 18082(a)(1), (a)(2)(B), (a)(3), (c),
 (d), (e).

1 consistently and repeatedly treats premium tax credits and cost-sharing reduction payments as
2 part and parcel of a single, fully funded subsidy program. Indeed, if cost-sharing reduction
3 payments did not always go hand-in-hand with premium tax credit payments, “these provisions
4 would make little sense.” *King*, 135 S. Ct. at 2492. As the Supreme Court recently instructed in
5 *King*, “[a] fair reading of legislation demands a fair understanding of the legislative plan.” *Id.* at
6 2496. The text, structure, and design of the ACA conclusively demonstrate that Congress
7 permanently appropriated funds for both premium tax credits and cost-sharing reductions.

8 **3. Eliminating CSR reimbursement payments would have the perverse**
9 **effect of increasing the federal government’s net expenditures**
10 **because it would increase premium tax credits**

11 There is yet another reason why Congress could not possibly have intended for CSR
12 reimbursement payments not to be permanently funded. If the government stops making these
13 payments, insurers are still mandated to make the payments and therefore will make up the
14 difference by increasing premiums for “silver” plans (the only plans eligible for cost-sharing
15 reductions). Eyles Decl. ¶ 8. This in turn raises costs for the federal government. Premium tax
16 credits are calculated based on the premiums for silver plans, and thus an increase in premiums
17 for silver plans will trigger a commensurate increase in the amount of premium tax credits
18 available for *all* individuals eligible for such tax credits. *See* 26 U.S.C. § 36B(b)(2)(B).

19 Both the Federal Department of Health and Human Services and the Congressional Budget
20 Office have explained that if CSR reimbursement payments are terminated, the resulting increase
21 in premium tax credit expenditures will cost the federal government billions of dollars *more* than
22 paying CSR reimbursements. *See* Office of the Assistant Sec’y for Planning & Evaluation,
23 Department of Health & Human Services, *ASPE Issue Brief: Potential Fiscal Consequences of*
24 *Not Providing CSR Reimbursements* at 4 (2015) (federal deficits would be “billions of dollars
25 higher annually than it otherwise would be” if cost-sharing reduction payments are not made)¹⁹;
26 Congressional Budget Office, *The Effects of Terminating Payments for Cost-Sharing Reductions*,
27 August 2017 (CBO Report) at 2 (federal deficit would increase by \$194 billion over a 10 year

28 ¹⁹ *See* https://aspe.hhs.gov/system/files/pdf/156571/ASPE_IB_Cost-sharing_reductions.pdf.

1 window without cost-sharing reduction payments).²⁰ For 2018 alone, terminating CSR payments
 2 would result in a net increase in federal costs of \$2.3 billion. Reyes Decl. ¶ 5. Congress surely
 3 did not intend to increase the federal deficit by nearly \$200 billion dollars over a decade by
 4 permanently funding only one of the ACA’s two interrelated subsidies. As the Supreme Court
 5 did in interpreting the ACA in *King*, this Court should conclude that “[i]t is implausible that
 6 Congress meant the Act to operate in this manner.” *King*, 135 S. Ct. 2494.

7 **B. The Executive Branch’s Sudden Decision to Terminate CSR Payments is**
 8 **“Arbitrary and Capricious” Under the APA**

9 The Executive Branch’s sudden decision to terminate CSR payments is not only
 10 substantively impermissible, but the process by which it was reached and announced is also
 11 arbitrary and capricious under the APA. 5 U.S.C. § 706. As the President’s own statements
 12 make clear (and as discussed further below), this decision is motivated by his desire to “finish”
 13 the ACA through unilateral executive action in light of Congress’s failure to repeal it. *See infra*,
 14 Part II. That explains the timing of the President’s abrupt change in position after his
 15 administration had relied on Section 1324’s permanent appropriation to make CSR payments for
 16 the first eight months of this year. But suddenly refusing to carry out a statutory mandate because
 17 Congress was unwilling to repeal that mandate—and creating chaos for millions of Americans in
 18 the process—undermines the rule of law and our democratic system of governance. The States
 19 are likely to prevail on their claim that this unlawful executive action is arbitrary and capricious
 20 under the APA.

21 **II. THE STATES ARE LIKELY TO PREVAIL ON THE MERITS OF THEIR TAKE CARE**
 22 **CLAUSE CLAIM**

23 Cost-sharing reduction reimbursement payments are mandatory and permanently
 24 appropriated by the ACA. *See supra*, Part I. The Executive Branch, therefore, cannot decline to
 25 follow the law by ending these mandatory payments. “Under Article II of the Constitution and
 26 relevant Supreme Court precedents, the President must follow statutory *mandates* so long as there
 27

28 ²⁰ *See* <https://www.cbo.gov/system/files/115th-congress-2017-2018/reports/53009-costsharingreductions.pdf>.

1 is appropriated money available and the President has no constitutional objection to the statute.”
2 *In re Aiken County*, 725 F.3d 255, 259 (D.C. Cir. 2013) (emphasis original). *In re Aiken County*,
3 like this case, “raise[d] significant questions about the scope of the Executive’s authority to
4 disregard federal statutes.” 725 F.3d at 257. In that case, the federal Nuclear Regulatory
5 Commission “declined to continue the statutorily mandated Yucca Mountain licensing process.”
6 *Id.* at 259. A federal statute provided that the Commission “shall consider” the Department of
7 Energy’s license application to store nuclear waste at Yucca Mountain and “shall issue a final
8 decision approving or disapproving” the application within three years of its submission. *Id.* at
9 257. Yet the Commission had “no current intention of complying with the law” and refused to
10 process the licensing application because the Commission, as a policy matter, did not wish to
11 pursue Yucca Mountain as a storage site for nuclear waste (among other reasons). *Id.* at 258-60.

12 The Court squarely rejected that contention, explaining that “Congress sets the policy, not
13 the Commission. And policy disagreement with Congress’s decision about nuclear waste storage
14 is not a lawful ground for the Commission to decline to continue the congressionally mandated
15 licensing process.” *In re Aiken County*, 725 F.3d at 260. The Court emphasized that “the
16 President and federal agencies may not ignore statutory mandates or prohibitions merely because
17 of policy disagreement with Congress.” *Id.* These are “settled, bedrock principles of
18 constitutional law.” *Id.* at 259; see also *Utility Air Regulatory Group v. E.P.A.*, 134 S. Ct. 2427,
19 2445 (2014) (holding that “[a]n agency has no power to ‘tailor’ legislation to bureaucratic policy
20 goals by rewriting unambiguous statutory terms”).

21 Like *In Re Aiken*, this case has “serious implications for our constitutional structure. It is
22 no overstatement to say that our constitutional system of separation of powers would be
23 significantly altered if we were to allow executive and independent agencies to disregard federal
24 law,” 725 F.3d at 267, and not pay the cost-sharing subsidies expressly required by multiple
25 provisions of the ACA, see 42 U.S.C. § 18071(c)(3)(A); *id.* § 18082(a)(3) & (c)(3); see also 31
26 U.S.C. § 1324(b)(2) (permanently appropriating funds for these mandatory payments). This case
27 is arguably more egregious than *In re Aiken* because here the President has made clear that his
28 specific intent is to undermine the proper functioning of the ACA so that this landmark

1 legislation—which brought affordable health insurance to over 20 million Americans—will be
2 “dismantled.”²¹ To allow the Executive Branch to undermine an Act of Congress in this way
3 would “deal a severe blow to the Constitution’s separation of powers.” *Utility Air Regulatory*
4 *Group*, 134 S. Ct. at 2446. It would also violate the Executive Branch’s constitutional obligation
5 under the Take Care Clause to “faithfully execute” the law. U.S. Const., Art. II, § 3.

6 Although the President has been characteristically frank, the other Defendants have at least
7 sought to portray the Administration’s change of position as the result of a legal analysis—despite
8 the fact that it represents a complete reversal of positions previously (and correctly) advanced by
9 the Executive Branch in the courts. *See* Executive Branch Opening Br., *Price*, 2016 WL
10 6216355, at *46-53. Under the extraordinary circumstances here, however, that portrayal lacks
11 the credibility it might normally have when presented in the form of a formal opinion by the
12 Attorney General. Instead, the events of the last several months make it regrettably clear that last
13 week’s sudden decision to stop CSR payments is just the latest and perhaps most drastic step in a
14 coordinated, politically-driven strategy to undermine the ACA because the current Administration
15 does not agree with its structure or objectives. For example, during his October 16, 2017 Cabinet
16 meeting, President Trump stated that “Republicans are meeting with Democrats because of what I
17 did with CSR[s], because I cut off the gravy train” and declared that “Obamacare is finished. It’s
18 dead. It’s gone. It’s no longer—you shouldn’t even mention. It’s gone. There is no such thing
19 as Obamacare anymore.”²² It is painfully apparent that terminating CSRs was not based on a
20 good faith legal analysis, but was instead intended to gut the ACA and force Democrats to
21 negotiate a replacement.

22 Indeed, for the past several months, and long before the Attorney General’s recent legal
23 opinion was formulated, the President has threatened to cut off CSR payments.²³ Those
24 statements created substantial market uncertainty, which led several insurers to withdraw from the
25 Exchanges and many others to raise premiums. *See infra*, Part III. And even setting aside CSR

26 ²¹ <https://twitter.com/realDonaldTrump/status/919009334016856065>.

27 ²² *See* <https://www.whitehouse.gov/the-press-office/2017/10/16/remarks-president-trump-cabinet-meeting>.

28 ²³ *See, e.g.*, <https://www.wsj.com/articles/trump-threatens-to-withhold-payments-to-insurers-to-press-democrats-on-health-bill-1492029844>.

1 payments, the President has taken numerous other steps to undermine the ACA, including: (1)
 2 expanding access to “association health plans” that are not required to include coverage for the
 3 minimum suite of essential health benefits; (2) actively discouraging individuals from signing up
 4 for health care through the Exchanges by cutting the enrollment period in half and shutting down
 5 *HealthCare.gov* for nearly 12 hours every Sunday; and (3) eliminating nearly all advertising and
 6 outreach funding to encourage consumer signups on the Exchanges.²⁴ Through these and other
 7 efforts, the Trump Administration has made its intentions clear: it wants the ACA to fail, no
 8 matter how many millions of Americans stand to lose access to health care benefits and services
 9 as a result. Far from “faithfully execut[ing]” the nation’s laws, the President and his
 10 Administration are now actively working to undermine them.

11 **III. THE STATES AND THEIR RESIDENTS WILL SUFFER IRREPARABLE HARM IN THE** 12 **ABSENCE OF PRELIMINARY RELIEF**

13 In addition to being likely to succeed on the merits, the Plaintiff States and their residents
 14 will also suffer irreparable harm in the absence of preliminary relief. *Winter*, 555 U.S. at 20. The
 15 discontinuation of federal funds can cause irreparable harm. *See United States v. North Carolina*,
 16 192 F. Supp. 3d 620, 629 (M.D.N.C. 2016) (finding irreparable harm where the unavailability of
 17 federal funds was “likely to have an immediate impact on [the state’s] ability to provide critical
 18 resources to the public, causing damage that would persist regardless of whether funding [was]
 19 subsequently reinstated”); *County of Santa Clara v. Trump*, 2017 WL 1459081 at *27 (N.D. Cal.
 20 April 25, 2017) (holding that “the risk of losing millions of dollars in federal funding” constitutes
 21 irreparable harm).²⁵ And so can administrative (or, more accurately, political) actions designed
 22 not to uphold the law or provide for the orderly conduct of government, but rather to sow
 23

24 _____
 25 ²⁴ For example, earlier this year the Trump Administration cut the outreach budget from
 \$5 million to \$0 in the final two weeks of open enrollment. As a result, only 400,000 signed up
 during this time when normally approximately 700,000 would have been expected.

26 ²⁵ Furthermore, “[i]t is well established that the deprivation of constitutional rights
 27 ‘unquestionably constitutes irreparable injury.’” *Melendres v. Arpaio*, 695 F.3d 990, 1002 (9th
 Cir. 2012) (quoting *Elrod v. Burns*, 427 U.S. 347, 373 (1976)); *see also Goldie’s Bookstore, Inc.*
 28 *v. Superior Court*, 739 F.2d 466, 472 (9th Cir. 1984) (recognizing that “[a]n alleged constitutional
 infringement will often alone constitute irreparable harm”).

1 confusion and instability, and to actively undermine the proper functioning of a critically
2 important and complex nationwide program.

3 The D.C. Circuit recently recognized the harm to California (and other States) that would
4 flow from cost-sharing reduction payments being halted. That Court granted a motion for leave
5 to intervene filed by California, New York, 16 other States, and the District of Columbia in the
6 *United States House of Representatives v. Hargan* appeal, Case No. 16-5202. In its August 1,
7 2017 Order permitting intervention, the D.C. Circuit recognized that termination of cost-sharing
8 reduction payments “would lead directly and imminently to an increase in insurance prices, which
9 in turn will increase the number of uninsured individuals for whom States will have to provide
10 health care.” *House v. Hargan*, 2017 WL 3271445, at *1. The Court also explained that “state-
11 funded hospitals will suffer financially when they are unable to recoup costs from uninsured,
12 indigent patients for whom federal law requires them to provide medical care.” *Id.* The Court
13 described the “causal linkage” between cost-sharing reduction payments being cutoff and the
14 consequent harm to the States as “plausible, directly foreseeable, [and] imminent upon the grant
15 of the House’s requested relief.” *Id.* As shown below, terminating cost-sharing reduction
16 payments will cause large premium increases, destabilize the individual markets, increase the
17 number of uninsured residents in Plaintiff States, and significantly raise uncompensated care costs
18 that are ultimately borne by the States and their taxpayers.

19 **A. Ending Cost-Sharing Reduction Payments Will Destabilize the Individual**
20 **Markets by Increasing Premiums, Decreasing Plan Choices, and**
21 **Suppressing Market Participation**

22 The Administration’s precipitous decision to stop making cost-sharing reduction payments
23 will destabilize the individual markets by increasing premiums, decreasing plan choices offered in
24 the market, and suppressing market participation, which could, in the words of President Trump,
25 “explode,” “dismantle[,]” or “finish” the ACA. As a preliminary matter, CSR payments directly
26 benefit millions of Americans, and therefore terminating them would have an immediate and far
27 reaching impact on our nation’s health care system. Nationwide, approximately 7 million
28

1 individuals—58% of all marketplace enrollees—receive cost-sharing reductions²⁶ estimated to be
 2 \$9 billion in 2017.²⁷ In California, over 673,000 residents receive cost-sharing reductions—
 3 nearly half of all Covered California enrollees.²⁸ *See also* Reyes Decl. ¶ 3; McLeod Decl. ¶ 2.
 4 And it is estimated that—for September through December of 2017—failing to pay CSRs will
 5 result in a loss of \$250 million for California insurers. Thomas Decl. ¶ 10.

6 If the Administration’s decision to halt CSRs is allowed to take effect, insurers will not be
 7 able to absorb these multi-million dollar losses. Instead, they would be forced to raise premiums
 8 to cover the shortfall, and would strongly reconsider participating in the Exchanges in future
 9 years, making future years’ market viability uncertain at best. McLeod Decl. ¶¶ 2, 5; Thomas
 10 Decl. ¶ 11; Reyes Decl. ¶ 10; Frescatore Decl. ¶ 23; Wade Decl. ¶ 15. And the premium hike
 11 would be large. In California, it is estimated that premiums will increase (on average) by 12.4%
 12 in 2018, with some premiums rising by as much as 27%.²⁹ And other States will witness even
 13 larger increases. In Pennsylvania, “silver” plan insurance premiums sold on the exchange will
 14 increase by an average of 30.6% in 2018 because of the Executive Branch’s decision to terminate
 15 CSR reimbursements.³⁰ Mendelsohn Decl. ¶ 14; *see also* Kreidler Decl. ¶ 14 (up to 27.3%
 16 increase in premiums in Washington). Overall, the CBO estimates that premiums for the most
 17 popular “silver plans” will rise by an average of 20%. *See* CBO Report 1.

18 Rising premiums, in turn, will cause more state residents to forgo health insurance
 19 coverage.³¹ Among those most directly affected are the nearly 2.1 million people who currently
 20 purchase insurance through the Exchanges but do not qualify for premium tax credits because of

21 ²⁶ <http://www.commonwealthfund.org/publications/explainers/2017/apr/cost-sharing-reductions/#/11>.

22 ²⁷ CBO *Federal Subsidies* at 8.

23 ²⁸ <http://www.kff.org/health-reform/state-indicator/total-marketplace-enrollment-and-financial-assistance/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>.

24 ²⁹ http://www.coveredca.com/news/pdfs/CoveredCA_CL_2018_Rates-HHSLetter.pdf.

25 ³⁰ <http://thehill.com/policy/healthcare/health-insurance/355708-pennsylvania-obamacare-plans-to-see-massive-premium-spike>.

26 ³¹ In addition, some enrollees that are not eligible for tax credits will respond to higher
 27 premiums by switching to lower tiered plans with higher cost sharing. Reyes Decl. ¶ 6; Wadleigh
 28 Decl. ¶ 13. And research shows that higher out-of-pocket costs often result in patients avoiding
 necessary medical care until their condition becomes dire, at which point it is more expensive to
 treat. *Id.* And that increases overall health care costs. *Id.*

1 their incomes.³² Absent injunctive relief, many will be forced to pay for the increase in premiums
 2 triggered by the Administration’s decision out of their own pockets. Wadleigh Decl. ¶¶ 10-11.
 3 And higher premiums will mean that many families “cannot afford to stay covered under their
 4 health insurance plan.” McLeod Dec. ¶ 6. Not surprisingly, as the States’ experience with the
 5 ACA confirms, “[w]hen premium rates for plans offered through the Exchanges have risen, fewer
 6 individuals choose to buy them.” de la Rocha Letter 1-2; *see also* Kreidler Decl. ¶¶ 16, 20-23;
 7 Frigand Decl. ¶¶ 5-7; Vullo Decl. ¶ 8; Frescatore Decl. ¶¶ 24, 27, 30; Wadleigh Decl. ¶ 14.
 8 Hundreds of thousands of the States’ residents may lose their health insurance coverage as a
 9 result of rising premiums. Eyles Decl. ¶¶ 14-15; McLeod Decl. ¶ 7 (California); Brown Decl.
 10 ¶ 11 (Kentucky); Gustafson Decl. ¶¶ 6-7 (Vermont); Keen Decl. ¶ 5 (Oregon); Busz Decl. ¶ 6; *see*
 11 *also* CBO Report 7 (estimating that one million more Americans will be uninsured in 2018 if
 12 CSRs stop).

13 The termination of cost-sharing reduction payments will likely cause many insurers to exit
 14 the Exchanges, and that will further destabilize the individual markets. Reyes Decl. ¶ 10; Eyles
 15 Decl. ¶¶ 9, 17. One analyst predicts that insurers will “rapid[ly] exit” the Exchanges now that
 16 the Administration has stopped CSR payments. Corlette Decl. ¶ 6. Other industry experts
 17 similarly forecast that the Administration’s decision makes it “likely” that insurers will withdraw
 18 from the Exchanges. Eyles Decl. ¶ 17; *see also* Jones Decl. ¶ 10; Kreidler Decl. ¶¶ 25-26.
 19 Indeed, a survey of insurers conducted before the Administration’s decision found that if CSRs
 20 cease, “[m]ost insurers believed that they would be forced to exit the marketplaces or the entire
 21 individual market as quickly as state or federal law would allow”³³ That is unsurprising, as
 22 most insurers view cost-sharing reduction payments as “integral to the sustainability of the
 23 individual health insurance market” and predicted that stopping them would “lead[] to a death
 24 spiral in the market.”³⁴

25 ³² *See* Centers for Medicare & Medicaid Services, *Health Insurance Marketplaces 2017*
 26 *Open Enrollment Period Final Enrollment Report: November 1, 2016 – January 31, 2017* (Mar.
 27 15, 2017), [https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/
 2017-Fact-Sheet-items/2017-03-15.html](https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2017-Fact-Sheet-items/2017-03-15.html).

27 ³³ [https://www.urban.org/sites/default/files/publication/87816/2001126-uncertain-future-
 28 for-affordable-care-act-leads-insurers-to-rethink-participation-prices_1.pdf](https://www.urban.org/sites/default/files/publication/87816/2001126-uncertain-future-for-affordable-care-act-leads-insurers-to-rethink-participation-prices_1.pdf) at 2.

³⁴ *Id.* at 8.

1 Indeed, even before the Administration announced that it would no longer make CSR
2 payments, insurers in several States had decided not to offer plans through the Exchanges in
3 2018, at least in part because of uncertainty over whether the payments would be made. Anthem,
4 for example, cited CSR uncertainty in explaining its decision to withdraw entirely from the
5 Exchanges in Wisconsin, Indiana, and Ohio, and to stop offering plans in 16 of California's 19
6 insurance regions.³⁵ Similarly, two Aetna insurers decided to withdraw from Delaware's
7 Exchange based in part on uncertainty about CSR reimbursements being made in 2018. Navarro
8 Decl. ¶ 13. Delaware has just a single insurer participating in its marketplace next year, *id.* ¶ 14,
9 and the decision to stop CSR payments could lead it to withdraw from that State's Exchanges for
10 the 2018 plan year, Kempinski Decl. ¶ 7.

11 Further insurer withdrawals will be devastating for the States and their residents. They are
12 likely to lead to "bare" counties—counties in which no insurer intends to offer a plan through the
13 Exchanges in 2018. *See* Corlette Decl. ¶ 9; Navarro Decl. ¶ 17; *see also* CBO Report at 1
14 (decision to stop CSR payments will leave 5% of nation's residents in bare counties). According
15 to the Centers for Medicare and Medicaid Services, approximately 1,472 counties—covering over
16 2.6 million enrollees on the Exchanges—were slated to have just a single health insurer in 2018
17 before the Executive Branch's decision to terminate CSR reimbursement payments.³⁶ Ending
18 CSRs could easily prompt the lone insurer in these counties to withdraw from the Exchanges.
19 Navarro Decl. ¶ 17. If that occurs, millions of qualified residents in those "bare" counties will be
20 unable to take advantage of premium tax credits and CSRs during 2018. *King*, 135 S. Ct. at 2487.
21 And although some may be able to procure health insurance through other means, most will not:
22 "There are no 'good' options for addressing what would be a 'bare county.'" ³⁷ *See also* Corlette
23 Decl. ¶ 10; Eyles Decl. ¶ 18. Even in counties where insurers continue to offer plans, the
24 dwindling number of insurers will lead to more uninsured. Fewer insurers decreases competition,

25 ³⁵ *See* Bartolone, et al. *Anthem's Retreat Leaves Californians with Fewer Choices, More*
26 *Worries*, Kaiser Health News, Aug. 2, 2017; Mangan & Coombs, *Anthem pulls out of Obamacare*
Markets in Wisconsin and Indiana for 2018, CNBC, June 21, 2017.

27 ³⁶ *See* [https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-](https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces/Downloads/2017-09-13-Issuer-County-Map.pdf)
[Marketplaces/Downloads/2017-09-13-Issuer-County-Map.pdf](https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces/Downloads/2017-09-13-Issuer-County-Map.pdf).

28 ³⁷ [http://hbex.coveredca.com/data-research/library/PolicyOptions-CountiesWithNO-](http://hbex.coveredca.com/data-research/library/PolicyOptions-CountiesWithNO-QHPCoverage--04-14-17%20Final.pdf)
[QHPCoverage--04-14-17%20Final.pdf](http://hbex.coveredca.com/data-research/library/PolicyOptions-CountiesWithNO-QHPCoverage--04-14-17%20Final.pdf).

1 which drives up premiums. MacEwan Decl. ¶¶ 7, 13; Vullo Decl. ¶ 8; Navarro Decl. ¶¶ 15-17;
 2 Reyes Decl. ¶ 10; Wadleigh Decl. ¶ 14. Higher premiums force more people to forgo insurance.
 3 Wadleigh Decl. ¶ 15. Fewer insurers will also reduce consumer's options, and may mean that the
 4 only plans available to residents are ones that do not best fit their health care needs. Corlette
 5 Decl. ¶ 11.

6 **B. Ending Cost-Sharing Reduction Payments Will Increase the Number of**
 7 **Uninsured Individuals and Increase Uncompensated Care Costs Paid for**
 8 **by the States and Counties**

9 Ending cost-sharing reduction payments will increase the number of uninsured individuals
 10 nationwide, and that directly increases the uncompensated care costs that are ultimately borne by
 11 the States and counties which pay the bill when individuals without health insurance receive
 12 medical treatment. McLeod Decl. ¶¶ 7-9; Wadleigh Decl. ¶ 16; Rattay Decl. ¶¶ 4-6; de la Rocha
 13 Letter 1-2; CBO Report 7.³⁸ There is a direct relationship between the number of uninsured State
 14 residents and the cost of publicly funded uncompensated care, as demonstrated by data drawn
 15 from before and after California's implementation of the ACA.

16 Due to implementation of the ACA, California, for example, has substantially reduced the
 17 number of uninsured residents in the State. Cantwell Decl. ¶ 2. Over 6 million Californians were
 18 uninsured in 2013, prior to full implementation of the Act. *Id.* By 2015, approximately half of
 19 that population gained health insurance, leaving around 3 million Californians remaining without
 20 coverage. *Id.* Other States have witnessed similar decreases. Billups Decl. ¶ 4; Busz Decl. ¶ 4;
 21 Wynn Decl. ¶ 4; Kreidler Decl. ¶ 19. And decreasing the ranks of the uninsured reduces
 22 uncompensated care costs. Cantwell Decl. ¶ 2. For example, according to data collected and
 23 published by the Office of Statewide Health Planning and Development (OSHPD), California
 24 hospitals incurred uncompensated care costs totaling approximately \$5.2 billion in 2013, which
 25 was reduced to \$1.9 billion by 2015 (a 64% decrease). Cantwell Dec. ¶ 3. An increase in the
 26 number of uninsured individuals in California will inevitably increase the amount of
 27 uncompensated care costs again. *Id.* And that would reintroduce the same type of financial strain

28 ³⁸ Both federal and state law require state-funded hospitals to provide emergency care, regardless of a patient's insurance status or ability to pay. *See, e.g.*, 42 U.S.C. § 1395dd; Cal. Welf. & Inst. Code § 17000 et seq; Wynn Decl. ¶ 6.

1 on state, local, and private health systems and programs that the ACA was intended to relieve.
 2 Cantwell Decl. ¶ 3; Reyes Decl. ¶ 9; Billups Decl. ¶4; Keen Decl. ¶ 5.

3 **C. Ending Cost-Sharing Reduction Payments Now Will Cause Substantial**
 4 **Consumer Confusion and Force Insurers to Absorb Multi-Million**
 5 **Dollar Losses, Further Destabilizing the Individual Market**

6 The timing of the Administration's announcement to end CSR reimbursement payments is
 7 particularly harmful. Open enrollment for plans offered through the Exchanges will begin on
 8 November 1, 2017. In anticipation of that deadline, States and insurers finalized premium rates
 9 for the 2018 plan year over the past several weeks. Redmer Decl. ¶ 9; Gasteier Decl. ¶ 14. Those
 10 rates have been reviewed by state regulators, gone through a statutorily-required public comment
 11 period, and have been communicated to consumers. Redmer Decl. ¶¶4-10; Jones Decl. ¶ 3;
 12 Gasteier Decl. ¶ 11; Cammarata Decl. ¶¶ 11-17; Frescatore Decl. ¶ 21.

13 The Administration's sudden announcement that CSRs will not be paid has thrown this
 14 intricate planning process into disarray. Kempinski Decl. ¶ 8; Redmer Decl. ¶¶ 10-18; Eyles Decl.
 15 ¶ 10; Gasteier Decl. ¶¶ 15-17. Because they anticipated that CSRs would be paid next year, many
 16 regulators approved lower premium rates than they otherwise would have. Redmer Decl. ¶ 9;
 17 Eyles Decl. ¶ 12; Cammarata Decl. ¶¶ 13, 19; Maranjian Decl. ¶¶ 7-10. Now, just a few weeks
 18 before open enrollment is set to begin, regulators in these States either have or are considering
 19 allowing insurers to raise premiums. Redmer Decl. ¶ 13; Eyles Decl. ¶ 12; MacEwan Decl. ¶¶ 7-
 20 10; Cammarata Decl. ¶ 20; Maranjian Decl. ¶¶ 11-12.³⁹ That rise in rates will force residents to
 21 forgo health insurance entirely, or to buy less comprehensive, but cheaper, plans. Reyes Decl.
 22 ¶ 6; McLeod Decl. ¶¶ 7-9; MacEwan Decl. ¶ 12. It will also create substantial confusion among
 23 consumers, many of whom began shopping for insurance weeks ago and were informed that they
 24 would be able to buy insurance for 2018 at the lower premium rates. Redmer Decl. ¶¶ 10-15;
 25 McLeod Decl. ¶¶ 5-6; Kempinski Decl. ¶ 6; Jones Decl. ¶ 3; Cammarata Decl. ¶ 22; Frescatore
 26 Decl. ¶¶ 21, 33. That confusion increases the risk that residents will choose to forgo health

27 ³⁹ The alternative would be much worse. Refusing to allow insurers to set higher rates
 28 means that they will lose tens, if not hundreds, of millions of dollars during 2018. Greene Decl.
 ¶ 5; Burrell Decl. ¶ 7; Gasteier Decl. ¶ 17. That could lead insurers to withdraw, which would
 destabilize the markets even further. Greene Decl. ¶ 5; Burrell Decl. ¶¶ 7-9; Eyles Decl. ¶12.

1 insurance next year. Jones Decl. ¶ 5; Gasteier Decl. ¶¶ 21-22.

2 Finally, the Administration’s decision will irreparably injure insurers. As noted, insurers
3 must cover CSR costs, even if the federal government does not reimburse them. *See* 42 U.S.C. §§
4 18021(a)(1), 18022(a)(2), 18071(a)-(c). As a result of the Administration’s abrupt about-face,
5 insurers will lose \$1.8 billion in unreimbursed CSR costs for the 2017 plan year. Eyles Decl. ¶ 9;
6 *see also* Keen Decl. ¶ 4; White Decl. ¶ 9; Wo Decl. ¶ 3; Vullo Decl. ¶ 11; Maranjian Decl. ¶ 5.

7 **IV. THE BALANCE OF EQUITIES TIPS SHARPLY IN FAVOR OF THE PLAINTIFF STATES**
8 **AND A PRELIMINARY INJUNCTION IS IN THE PUBLIC INTEREST AND WILL PRESERVE**
9 **THE STATUS QUO**

10 Lastly, a preliminary injunction is appropriate where: (1) the balance of equities tips in
11 favor of the applicants; and (2) an injunction is in the public interest. *Winter*, 555 U.S. at 20.
12 When the federal government is a party, these last two factors merge. *Nken v. Holder*, 556 U.S.
13 418, 435 (2009); *Drakes Bay Oyster Co. v. Jewell*, 747 F.3d 1073, 1092 (9th Cir. 2014). When
14 evaluating the balance of hardships, “a court must consider the impact granting or denying a
15 motion for a preliminary injunction will have on the respective enterprises.” *Int’l Jensen, Inc. v.*
16 *Metrosound U.S.A., Inc.*, 4 F.3d 819, 827 (9th Cir. 1993). Among other things, “by establishing a
17 likelihood” of a constitutional violation, a plaintiff “establish[es] that both the public interest and
18 the balance of the equities favor a preliminary injunction.” *Ariz. Dream Act Coal. v. Brewer*, 757
19 F.3d 1053, 1069 (9th Cir. 2014). As the Supreme Court recently emphasized, “the purpose of
20 such interim equitable relief is not to conclusively determine the rights of the parties, but to
21 balance the equities as the litigation moved forward.” *Trump v. Int’l Refugee Assistance Project*,
22 137 S. Ct. 2080, 2087 (2017).

23 Furthermore, “[t]he basic function of a preliminary injunction is to preserve the status quo
24 pending a determination of the action on the merits.” *Chalk v. U.S. Dist. Court Cent. Dist. Cal.*,
25 840 F.2d 701, 704 (9th Cir. 1988); *see also Leigh v. Salazar*, 677 F.3d 892, 902 (9th Cir. 2012)
26 (“Preliminary injunctions normally serve to prevent irreparable harm by preserving the status quo
27 pending a trial or other determination of the action on the merits.”).

28 Here, the balance of equities tips sharply in favor of preserving the status quo by
temporarily enjoining the Executive Branch from abruptly halting cost-sharing reduction

1 payments. As outlined above, terminating cost-sharing reduction payments will cause large
2 premium increases, destabilize the individual market, increase the number of uninsured, and
3 significantly raise uncompensated care costs that are ultimately paid from the public fisc.
4 McLeod Decl. ¶¶ 5-9; Thomas Decl. ¶ 11; de la Rocha Letter 1-2; Cantwell Decl. ¶¶ 2-3.
5 Granting preliminary relief would preserve critical reimbursements to insurers, thereby
6 preventing a hasty exodus of insurers from the marketplaces, skyrocketing premiums, and other
7 negative impacts that would be hard—if not impossible—to reverse later. It is manifestly in the
8 public interest to prevent this widespread harm from occurring while the Court evaluates the
9 merits of the case. Put differently, the public interest is best served if the Court continues cost-
10 sharing reduction payments while it determines the legality of ending them. Otherwise, a harmful
11 chain of potentially irreversible events could result.

12 Further, a preliminary injunction will not harm the federal government. The government
13 has willingly made cost-sharing reduction payments on behalf of beneficiaries for nearly four
14 years running, including for eight months under the current administration. Requiring cost-
15 sharing reduction payments to continue for a few more months will not cause any significant
16 harm to the Executive Branch. Moreover, permanently maintaining cost-sharing reduction
17 payments will actually *save* the federal government \$194 billion dollars over ten years if the ACA
18 is properly interpreted as Plaintiffs contend (and as the Executive Branch itself contended until
19 last Thursday). CBO Report at 2 (federal deficit would increase by \$194 billion over 10 years
20 without cost-sharing reduction payments). And even if this Court ultimately concludes otherwise,
21 every month in which payments are made while that issue is litigated will produce savings, not
22 costs, for the federal fisc. Maintaining these payments is thus in the financial self-interest of the
23 federal government, in addition to being statutorily mandated. The balance of the equities and the
24 public interest strongly support the issuance of a TRO and preliminary injunction.

25 **V. A NATIONWIDE INJUNCTION IS NECESSARY AND APPROPRIATE**

26 Because the unlawful halting of mandatory cost-sharing reduction payments is nationwide
27 in scope, this Court should issue a TRO and preliminary injunction that applies nationwide. *See*
28 *Califano v. Yamaski*, 442 U.S. 682, 702 (1979) (“[T]he scope of injunctive relief is dictated by the

1 extent of the violation established, not by the geographical extent of the plaintiff.”). Courts
2 routinely grant nationwide relief under such circumstances. *See, e.g., Washington v. Trump*, 847
3 F.3d 1151, 1166-67 (affirming nationwide injunction against executive branch travel ban order);
4 *Texas v. United States*, 809 F.3d 134, 187-88 (5th Cir. 2015) (affirming nationwide preliminary
5 injunction preventing implementation of the DACA program); *Bresgal v. Brock*, 843 F.2d 1163,
6 1170-71 (9th Cir. 1987). In this case, millions of Americans across the country enjoy affordable,
7 high quality health care because cost-sharing reductions lower their out-of-pocket costs.
8 Individuals and insurers in every State will be adversely affected if the Trump Administration is
9 permitted to abruptly halt these critical payments. Accordingly, a nationwide injunction is
10 necessary and appropriate here.

11 **VI. NO SECURITY SHOULD BE REQUIRED AS A CONDITION FOR GRANTING THE TRO** 12 **OR PRELIMINARY INJUNCTION**

13 Federal Rule of Civil Procedure 65(c) provides that the “court may issue a preliminary
14 injunction or a temporary restraining order only if the movant gives security in an amount that the
15 court considers proper to pay the costs and damages sustained by any party found to have been
16 wrongfully enjoined or restrained.” In the Ninth Circuit, the district court “retains discretion” to
17 waive this requirement. *Diaz v. Brewer*, 656 F.3d 1008, 1015 (9th Cir. 2011). The Court should
18 not require California to provide a monetary security deposit because the relief sought will not
19 cause defendants to suffer any damages. As outlined above, defendants have made cost-sharing
20 reduction payments consistently for nearly four years, and the requested injunction would actually
21 *save* the federal government billions of dollars. CBO Report 2. Under these circumstances, the
22 Court should exercise its discretion and decline to require California to provide a security deposit.

23 **CONCLUSION**

24 For the foregoing reasons, the States respectfully request that the Court grant the
25 application for a temporary restraining order and order to show cause why a preliminary
26 injunction should not issue requiring the Secretaries of the Treasury and Health and Human
27 Services to continue making complete and timely cost-sharing reduction payments as required by
28 the ACA.

1 Dated: October 18, 2017

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