**UNITED STATES DISTRICT COURT**
**SOUTHERN DISTRICT OF NEW YORK**

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| STATE OF NEW YORK and STATE OF MINNESOTA,<br><br>Plaintiffs,<br><br>v.<br><br>U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES; and ERIC D. HARGAN, in his official capacity as Acting Secretary of the U.S. Department of Health and Human Services,<br><br>Defendants. | CIVIL ACTION NO. 18-cv-00683<br><br>COMPLAINT FOR DECLARATORY AND INJUNCTIVE RELIEF |

## INTRODUCTION

1. The States of New York and Minnesota ("the States") file this action to challenge the Defendants' abrupt and unlawful cutoff of more than $1 billion annually in federal funding owed to the States to operate "Basic Health Programs" ("BHPs") — state-run health insurance programs authorized by federal law and primarily funded by the federal government. If allowed to continue, the Defendants' unlawful actions will inflict significant financial injury on the States by forcing them to cover this dramatic loss in federal funding to avoid jeopardizing programs that provide over 800,000 low-income people with access to affordable health care.

2. The Patient Protection and Affordable Care Act ("ACA"), Pub. L. No. 111-148, 124 Stat. 119 (2010), enacted several reforms, including the BHP, that collectively ensure that comprehensive, low-cost health insurance is available to millions of low-income Americans. One such reform involved the creation of federal and state exchanges through which consumers can buy health insurance known as "qualified health plans" ("QHPs") from private companies.

Separate ACA provisions require the federal government to provide subsidies to defray much of the consumers' costs of those plans through a combination of (a) federal premium tax credit subsidies ("PTCs") under Section 1401, which reduce the premiums that consumers pay; and (b) cost-sharing reduction subsidies ("CSRs") under Section 1402, which reduce out-of-pocket costs such as copayments and deductibles.

3. A separate ACA provision, Section 1331, directs the Secretary of Health and Human Services ("HHS") to establish a new program, the BHP, that states can elect to adopt "in lieu of" offering QHPs for certain low-income residents. 42 U.S.C. § 18051(a)(1). Under the BHP, the federal government provides funding directly to participating states, which in turn contract with private health insurance companies to make affordable health insurance plans available to certain low-income residents.

4. The ACA mandates that HHS provide federal funding every quarter to each participating BHP state according to a detailed statutory formula that requires funding at 95% of the PTC and CSR subsidies that "would have been provided" to BHP-eligible individuals if they "were allowed to enroll in qualified health plans through an Exchange." 42 U.S.C. § 18051(d)(3)(A)(i). These payments are made prospectively—i.e., they cover the anticipated costs of the BHP for the upcoming quarter.

5. HHS's implementing regulations reinforce the mandatory nature of these quarterly payments by committing both HHS and participating states to continue a BHP once it begins — unless certain narrow criteria are satisfied and detailed procedures are followed. Among other things, the regulations provide that the federal certification of a state's BHP "remains in effect" once approved, and HHS may terminate it only under two specific circumstances: (1) when an annual review reveals that the state is not complying with quality and

performance standards required by the statute; or (2) when there is "significant evidence of beneficiary harm, financial malfeasance, fraud, waste or abuse" in the state's program. 42 C.F.R. § 600.120(c)(3).

6. In reliance on these statutory and regulatory guarantees of federal funding, the States passed laws and collectively invested millions of dollars to establish qualifying BHPs. Since 2015, the States have deployed their BHPs with great success, providing comprehensive health coverage to over 800,000 low-income residents, at costs to consumers far lower than the costs of QHPs with subsidies. Indeed, some BHP enrollees do not pay *any* premiums, and, at most, enrollees pay premiums of $20 per month (in New York) and $80 per month (in Minnesota).

7. Until just a few weeks ago, HHS consistently complied with its statutory and regulatory obligations and transferred federal funding every quarter to the States according to the formula set out in the BHP statute and implementing regulations. The States used these payments to cover their BHP expenses in the following quarters.

8. On December 21, 2017, in an abrupt break from this consistent practice, HHS sent New York and Minnesota emails informing them that the agency would not be paying the $266 million due to New York and $32 million due to Minnesota for their BHP expenses in the first quarter of 2018—amounts that HHS described as the "CSR component" of the BHP payment. HHS's sole justification for reducing its BHP payments, as articulated in these emails, was the federal government's earlier decision in October 2017 to stop making CSR payments to insurers offering QHPs on exchanges. That earlier decision—which is being challenged in a separate court action—was based on HHS's conclusion that there was no congressional appropriation for CSR payments for exchange plans.

9. HHS's October 2017 announcements that it was cutting CSR payments for exchange plans made no mention of the States' BHPs. Nonetheless, within the next several weeks, HHS officials stated in separate phone conversations with the States that they were likely to adopt a similar position with respect to the BHPs—namely, to stop paying the "CSR component" of BHP funding while continuing to pay the "PTC component."

10. In response to these conversations, the States quickly submitted alternative proposals to HHS that would have preserved most of their federal funding, even without payment of the "CSR component." The States' proposals accomplished this objective by following the model that other states had adopted in response to the October 2017 cutoff of CSR payments for exchange plans. Specifically, these other states permitted insurers to increase certain premium rates to compensate for the CSR cutoff, leading to higher federal subsidies (through PTCs) that largely addressed the funding shortfall caused by the cutoff. The States' proposals replicated the marketplace experience of other states. While there is no dispute that HHS received these proposals, the agency never considered them, contrary to federal law requiring consideration of alternatives to minimize harm to the States as a result of a funding cutoff. *See, e.g.*, 2 U.S.C. § 1535(a)(1). Rather than considering and adopting the States' proposals, as they should have done, the agency's December 21 emails make no mention of them, and they provide no explanation whatsoever for why the proposals were not considered or adopted.

11. HHS's unlawful decisions to reduce BHP funding and ignore the States' reasonable proposals will deprive the States of well over $1 billion in annual BHP funding that they are entitled to receive under both federal law and HHS's own implementing regulations.

12. HHS's termination of this critical funding inflicts direct and potentially devastating injury on the States, which passed legislation and collectively invested millions of dollars to create and operate compliant BHPs for the benefit of over 800,000 people who rely on the BHPs for health coverage "in lieu of" QHPs on an exchange—only to find that the federal government does not intend to comply with federal statutes and its own payment regulations.

13. This sudden termination of more than $1 billion of critical annual BHP funding is not supported by any intervening statutory or regulatory change. To the contrary, both the ACA and HHS's regulations continue to require that the agency transfer the full amount of BHP funding to the States every quarter.

14. As set forth more fully below, each of HHS's foregoing actions violate the ACA and the Administrative Procedure Act ("APA"), and HHS must be compelled to remedy its procedurally and substantively defective actions resulting in the withholding of significant BHP funds owed to the States.

15. First, by eliminating *one-quarter* of the States' funding in the form of an email sent *the day before the deficient payment*, HHS failed to abide by the mandatory notice-and-comment process for amending an existing rule. As set forth more fully herein, HHS established BHP regulations and the operative BHP payment formula for 2018 through the APA's notice-and-comment procedures. Yet it provided no notice, and engaged in no rulemaking whatsoever, before making an administrative determination to withhold payment of the "CSR component" required by the 2018 BHP payment formula. Such decision-making effectively amends the existing payment methodology and therefore constitutes rulemaking subject to the APA's notice-and-comment process. The email through which HHS abruptly communicated its final decision to reduce BHP funding does not satisfy the APA's procedural requirements.

16. Second, HHS failed to give a reasoned explanation for abruptly reducing its BHP payments to the States by more than $1 billion annually. HHS's cursory December 21 email offered no legal analysis or reasoning relating to the BHP. Instead, the email relied solely on an opinion letter from the Department of Justice ("DOJ"), which in turn relied on a district court decision, *U.S. House of Representatives v. Burwell*, 185 F. Supp. 3d 165 (D.D.C. 2016), both of which address only CSR payments for QHPs and make no mention of the distinct statutory and regulatory framework that governs the BHP. Nor does HHS's email acknowledge, let alone reasonably consider, the significant reliance interests engendered by the agency's previous and consistently-followed position that the States would receive the full BHP payments mandated by statute and regulations, or the special solicitude accorded to states that rely on such express federal guarantees in accepting federal funds. HHS's deficient reasoning for such an enormous change to a critical health care program also violates the APA.

17. Third, HHS substantively and procedurally erred by failing to consider and adopt the States' alternative proposals. The States' proposals would adjust their BHP funding—and preserve the federal funding to which they are entitled—in a manner consistent with federal law by reflecting the marketplace experiences of other states, which accounted for the loss in CSR funding in QHPs by increasing the value of PTCs. HHS has not provided any formal acknowledgment of the States' proposals, nor has it provided any explanation or justification for its failure to consider or adopt the States' proposals, which would reduce the billion-dollar financial burden imposed on the States by HHS's sudden change in course. HHS's failure to even acknowledge, let alone respond to, the States' proposals violates the APA.

18. Finally, HHS's rationale that it lacks statutory authorization to pay the "CSR component" of its BHP payments due to an alleged lack of a congressional appropriation is

meritless. Even if Congress did not appropriate money to make CSR payments *to insurers* on exchanges, HHS would still be obligated to make full BHP payments—including any "CSR component"—under the distinct statutory framework governing the BHP. HHS's concern about an available appropriation could also be fully resolved if HHS had adopted the States' alternative proposals, which would have effectively increased the "PTC component" of the States' BHP payments to address the shortfall caused by HHS's nonpayment of the "CSR component." In any event, HHS is wrong that Congress declined to appropriate money for CSRs, which are part of an integrated package of federal subsidies essential to maintaining the viability of both the exchanges and the BHPs.

19. Accordingly, the States seek a declaratory judgment that HHS is violating its statutory and regulatory obligation to make BHP payments, and declaratory and injunctive relief compelling HHS to comply with its obligations, including by considering, and then adopting, the States' proposals; or, in the alternative, declaratory and injunctive relief compelling HHS to issue a new payment methodology pursuant to the statutorily required notice-and-comment process so that the States may provide meaningful input into any changes to rules that affect them so directly.

**PARTIES**

20. The State of New York, represented by and through its Attorney General, Eric T. Schneiderman, is a sovereign State in the United States of America. The Attorney General is New York State's chief law enforcement officer, and is authorized to pursue this action pursuant to N.Y. Executive Law § 63. The New York State Department of Health ("DOH") is responsible for implementing and overseeing the BHP.

21. New York is aggrieved by the actions of the federal Defendants and has standing to bring this action because of the injuries caused to the State by the Defendants' unlawful decision to terminate more than $1 billion of federal funding for the Essential Plan, New York's BHP, and refusal to properly adjust the BHP funding formula in light of that decision. The loss of this funding deprives New York of federal payments to which it is directly entitled by the ACA. Moreover, to avoid jeopardizing health insurance coverage for over 710,000 residents who rely on this program for health coverage, New York may be compelled to cut funding from other critical programs by April 2018.

22. Plaintiff the State of Minnesota is a sovereign State of the United States of America. Attorney General Lori Swanson brings this action on behalf of Minnesota to protect the interests of Minnesota and its residents. The Attorney General's powers and duties include acting in federal court in matters of State concern. Minn. Stat. § 8.01. The Attorney General has the authority to file suit to challenge action by the federal government that threatens the public interest and welfare of Minnesota residents and to vindicate the State's sovereign and quasi-sovereign interests.

23. Minnesota is aggrieved by the actions of the federal Defendants and has standing to bring this action because of the injuries caused to the State by the Defendants' unlawful decision to terminate federal funding for MinnesotaCare, Minnesota's BHP, and refusal to properly adjust the BHP funding formula in light of that decision.

24. Defendant United States Department of Health and Human Services ("HHS") is an agency of the United States government and has responsibility for implementing and enforcing portions of the Affordable Care Act. The Centers for Medicare and Medicaid Services

("CMS") is an agency within HHS that is responsible for implementing and administering portions of the Basic Health Program.

25. Defendant Eric D. Hargan is Acting Secretary of HHS and is sued in his official capacity.

**JURISDICTION AND VENUE**

26. The Court has subject matter jurisdiction pursuant to 28 U.S.C. §§ 1331, 1361, and 2201(a). Jurisdiction is also proper under the judicial review provisions of the Administrative Procedure Act, 5 U.S.C. § 702.

27. Venue is proper in this judicial district under 28 U.S.C. § 1391(b)(2) and (e)(1). Defendants are United States agencies or officers sued in their official capacities. The State of New York is a resident of this judicial district, and a substantial part of the events or omissions giving rise to this Complaint occurred and are continuing to occur within the Southern District of New York.

**ALLEGATIONS**

**I. BACKGROUND**

28. The BHP is one of several reforms contained in the ACA to expand health insurance coverage and access to health care. Collectively, these reforms have reduced the national uninsured rate by almost 50 percent, or more than 20 million individuals.[1] This significant decrease in the uninsured rate is the result of many reforms contained in the ACA, including the ACA's prohibition against discrimination based on health status, its expansion of Medicaid, and its establishment of health insurance markets (called "exchanges") through which federally subsidized QHPs are made available to lower-income individuals. The BHP operates in

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[1] Nicholas Bakalar, N.Y. TIMES, May 22, 2017, *Nearly 20 Million Have Gained Health Insurance Since 2010*, https://www.nytimes.com/2017/05/22/health/obamacare-health-insurance-numbers-nchs.html.

lieu of subsidized QHPs for certain low-income individuals. A description of the ACA's creation of exchanges, QHPs, and related federal subsidies is set forth below.

## A. The ACA's Creation of Exchanges and Subsidies to Expand Affordable Health Insurance Coverage

### *i. State Exchanges and Qualified Health Plans*

29. The ACA's insurance exchanges can be either state-run or federally-run. 42 U.S.C. § 18041. Consumers can sign up for a range of public and private health insurance options through the exchanges. 42 U.S.C. §§ 18031, 18032, 18033. New York and Minnesota each run state exchanges.

30. Private health insurance options available through an exchange are called "qualified health plans" ("QHPs"). These health plans offer a set of minimum essential benefits that are set forth in the ACA and its implementing regulations, in addition to meeting the other consumer protection requirements set forth in the ACA. 42 U.S.C. § 18021.

31. The ACA created four levels of health insurance coverage based on the QHP's actuarial value — i.e., the approximate percentage of health care costs covered by each plan. Each level is assigned a "metal": bronze plans cover approximately 60% of health care costs; silver plans cover approximately 70%; gold plans cover approximately 80%; and platinum plans cover approximately 90%. 42 U.S.C. § 18022(d).

### *ii. Federal Subsidies Available through the Exchanges*

32. The ACA created two streams of federally funded subsidies to help ensure the affordability of QHPs: premium tax credits ("PTCs") under Section 1401 of the ACA, 26 U.S.C. § 36B; and cost-sharing reduction ("CSR") subsidies under Section 1402 of the ACA, 42 U.S.C. § 18071.

**a. Premium Tax Credits**

33. PTCs are federal tax credits that subsidize health insurance premiums for eligible individuals. Such individuals may receive these subsidies when they file their taxes, or (more commonly) through an advance-payment mechanism that sends payments to insurers to reduce monthly premiums. 26 U.S.C. § 36B. In order to provide the credits prospectively on a monthly basis, the exchange must estimate individuals' tax credits for the upcoming year; the federal government then pays that amount to the insurer to fund the premium discounts. 42 U.S.C. § 18082(b)-(c). Insurers in turn charge lower premiums to consumers.

34. PTCs are available to individuals who earn between 100% and 400% of the federal poverty level ("FPL") (400% FPL is currently $48,240 for individuals and $98,400 for families of four). 26 U.S.C. § 36B(b)(3).

35. The amount of PTCs is based on the premium for the second-lowest-price silver plan available on the exchange in an individual's geographic area. The value is then determined based on each eligible individual's income, such that those with lower incomes receive greater federal subsidies than those with higher incomes. 26 U.S.C. § 36B.

36. Since the PTC value is based on the cost of the second-lowest-cost silver plans offered on an exchange, increases in premiums for those plans lead to corresponding increases in the amounts of PTCs. However, individuals can apply their tax credits to purchase any metal-level plan available through an exchange.

**b. Cost-Sharing Reductions**

37. In addition to PTCs, the ACA provides subsidies to help lower-income individuals cover out-of-pocket costs such as copayments, coinsurance and deductibles. The ACA requires that insurance companies with QHPs on the exchanges provide CSRs to eligible

individuals. The federal government then provides CSR subsidies to reimburse health insurers for covering these costs.

38. Like the PTCs, the value of CSRs is based on a sliding scale tied to an individual's income level: a lower income means that a greater proportion of out-of-pocket costs will be covered through CSRs. 42 U.S.C. § 18071(c)(1)-(2). An individual's deductible could drop from $2,000 to as low as $0 with CSRs.

39. Individuals generally are eligible for CSRs if they: (a) enroll in a QHP at the silver level of coverage through the exchange, (b) have a household income between 100 and 250% of the FPL, and (c) are also eligible for PTCs. 42 U.S.C. § 18071(b), (f)(2).

40. While HHS is statutorily required to reimburse insurers for CSR costs, the insurers' obligation to reduce insureds' out-of-pocket costs is independent of the federal government's statutory reimbursement obligation. 42 U.S.C. §§ 18021(a)(1), 18022(a)(2), 18071(a)-(c).

## B. <u>The ACA's Establishment of the BHP and Its Payment Formula</u>

41. In addition to creating health insurance exchanges, the ACA also established the BHP in order to foster state innovation and increase access to health care.

### *i. Statutory Provisions Governing BHPs*

42. Section 1331(a) of the ACA directs HHS to establish a BHP that allows states to offer health insurance coverage for certain categories of low-income individuals — specifically those who: (a) are not eligible for Medicaid, (b) have income levels of up to 200% of the FPL, (c) are not eligible for other minimum essential coverage or other employer-sponsored coverage, and (d) are below age 65. 42 U.S.C. § 18051(e). These criteria identify a subset of the individuals who would otherwise be eligible for QHPs with PTCs and CSR subsidies. The

program is intended to increase access to health care by allowing states to offer these low-income residents coverage options that are even more affordable than QHPs with subsidies.

43. States may elect to establish a BHP for eligible low-income individuals "in lieu of offering such individuals coverage through an Exchange." 42 U.S.C. § 18051(a)(1). The BHP is thus a substitute for QHPs for such individuals: indeed, any resident eligible to enroll in a BHP plan (in a state that has elected to provide a BHP) is prohibited from buying a QHP on the state's exchange. *Id.* § 18051(e)(2). As a result, individuals eligible for a BHP plan do not receive the PTCs and CSRs that individuals who purchase plans on exchanges receive. 42 U.S.C. § 18051(a)(1), (e). Instead, states that elect to offer a BHP provide coverage at or below the QHP cost for the consumer. HHS in turn is required to prospectively provide direct federal funding to the states to cover a significant portion of those costs—including but not limited to reducing premiums and cost-sharing. *Id.* § 18051(d)(1)-(2).

44. Specifically, the ACA requires the HHS Secretary to make payments directly to BHP-participating states, providing: "If the Secretary determines that a State electing [to create a BHP] meets the requirements of the program . . . , the Secretary *shall transfer* to the State for each fiscal year for which 1 or more standard health plans are operating within the State the amount determined" by a statutory formula. 42 U.S.C. § 18051(d)(1) (emphasis added).

45. The statutory formula requires HHS to transfer funding to the States in an amount that:

> is equal to 95 percent of the premium tax credits under section 36B of title 26, and the cost-sharing reductions under 18071 of this title, that *would have been provided* for the fiscal year *to eligible individuals* enrolled in standard health plans in the State if such eligible individuals were allowed to enroll in qualified health plans through an Exchange . . .

*Id.* § 18051(d)(3)(A)(i) (emphasis added); *see also* 42 C.F.R. § 600.605(a)(1)-(2).

46. In other words, HHS's BHP payments to a state must equal 95% of the PTCs and CSRs that BHP enrollees would have received had the state not elected to create a BHP and the BHP enrollees had instead purchased QHPs on an exchange. 42 U.S.C. § 18051(d)(3)(A)(i). Critically, with respect to CSRs, the statutory formula is based on the cost-sharing reductions that *eligible individuals* would have received—that is, the actual reductions in co-payments, deductibles, and other cost-sharing that the individual would have received—not on the reimbursement subsidies that insurance companies would have been paid to cover the cost of those reductions.

47. When calculating the BHP payments, HHS must "make the determination . . . on a per enrollee basis and shall take into account all relevant factors necessary to determine the value of the premium tax credits and cost-sharing reductions that would have been provided to eligible individuals [who could have enrolled in QHPs]." *Id.* § 18051(d)(3)(A)(ii). The statute sets forth various factors HHS must consider, such as health status to ensure that the values reflect health risk. Among other factors, the statute specifically mandates that HHS consider the "experience of other States with respect to participation in an Exchange." *Id.*

48. These federal BHP payments must be "transfer[red] to the State" on a quarterly basis and placed into a segregated trust fund that the states must create and from which they can draw upon to pay health plans directly "to reduce the premiums and cost-sharing of, or to provide additional benefits for, eligible individuals" who obtain coverage through BHPs. *Id.* § 18051(d)(2); *see also* 42 C.F.R. § 600.615. The payments are prospective. 42 C.F.R. § 600.610(c)(1).

***ii. Regulatory Provisions Governing BHPs***

49. There are two sets of rules that pertain to the BHP: the BHP Final Rule and an annual Payment Methodology Rule. The BHP Final Rule sets forth all of the rules and

procedures applicable to the BHP, except for the detailed methodology for calculating BHP payments to the States, which is contained in the annual Payment Methodology Rule.

**a. BHP Final Rule**

50. On March 12, 2014, HHS issued the Final Rule implementing the BHP statute. Basic Health Program; State Administration of Basic Health Programs, 79 Fed. Reg. 14112 (Mar. 12, 2014) (to be codified at 42 C.F.R. pt. 600, 45 C.F.R. pt. 144).

51. Under these regulations, a state can opt into the BHP by submitting a "BHP Blueprint" to HHS signed by the state's governor or other state official. *See* 42 C.F.R. § 600.115. The BHP Blueprint must, among other things, demonstrate the BHP's compliance with at least fifteen separate requirements, such as providing essential health benefits, contracting through a competitive process, containing certain contract requirements, and having a particular medical loss ratio. 42 C.F.R. §§ 600.110; 600.415. A BHP Blueprint is effective when certified by the Secretary of HHS. 42 C.F.R. § 600.120(a).

52. Tracking the statutory language, the implementing regulations provide that the federal BHP payment to a state for covering a BHP enrollee is based on "the sum of the premium tax credit component . . . and the cost-sharing reduction component" for which the individual would be eligible had the individual been enrolled on an exchange. 42 C.F.R. § 600.605(a). The regulations then define the "premium tax credit component" as equaling "95 percent of the premium tax credit for which the eligible individual *would have qualified* had he or she been enrolled in a qualified health plan through an exchange in a given calendar year, adjusted by the relevant factors" set forth elsewhere in the regulations. *Id.* § 600.605(a)(1) (emphasis added). Similarly, the "cost-sharing reduction component" is defined as equaling "95 percent of the cost of the cost-sharing reductions for which the eligible individual *would have qualified* had he or she been enrolled" in a QHP on the exchange, subject to adjustment based on relevant factors.

*Id.* § 600.605(a)(2) (emphasis added). Again, this CSR component is based on the cost-sharing reductions for which individuals would have qualified, not the payments that insurers would have received to compensate them for providing those required reductions.

53. Although the Final Rule identifies various factors HHS must consider in developing its BHP payment methodology, including "[m]arketplace experience in other states with respect to Exchange participation," the rule itself does not set forth the specific calculation HHS will use to compute the amount owed to states for operating BHPs. *Id.* § 600.605(b)(7). Instead, in its Final Rule, HHS established that the Secretary must publish the following year's proposed BHP payment methodology every October in the Federal Register, with the final payment notice published in February. 42 C.F.R. § 600.610(a)-(b). It is through this process that HHS notifies the states of the formula it will use to calculate the PTC and CSR values, and, consequently, the states' BHP funding for the ensuing year.

54. Once HHS has published its final methodology, it is required to use that methodology to calculate prospective BHP payments. It may adjust that payment amount only in two limited circumstances: to adjust for actual enrollment, and to correct mathematical errors. *Id.* § 600.610(c)(2).

**b. Payment Methodology Rule**

55. On February 29, 2016, HHS published its final payment methodology for calendar years 2017 and 2018. Basic Health Program: Federal Funding Methodology for Program Years 2017 and 2018, 81 Fed. Reg. 10091 (Feb. 29, 2016) (to be codified at 42 C.F.R. pt. 600). This payment methodology sets forth the calculation that HHS has committed to using to determine the BHP funding amount, including the PTC and CSR components, for calendar years 2017 and 2018.

56. In promulgating the payment formula, HHS reiterated that its ultimate goal was to develop a methodology and calculation that would accurately reflect the amount of both PTCs and CSRs that *would have been provided* to BHP enrollees, had those individuals instead enrolled in QHPs. HHS explicitly stated: "Federal funding will be available for BHP based on the amount of [PTCs and CSRs] that BHP enrollees *would have received had they been enrolled* in [QHPs] through Exchanges." *Id*. at 10092 (emphasis added). HHS later stated that it developed values for the factors used to calculate the PTC and CSR amount "to *simulate* the values of the PTC and CSRs that BHP enrollees would have received if they had enrolled in QHPs offered through an Exchange." *Id.* at 10093-94 (emphasis added).

57. Although HHS reserved the right to promulgate changes to the methodology for 2018, *see id.* at 10094, it has never done so.

## C. <u>The States' Basic Health Programs</u>

58. As discussed, states seeking to offer their residents a BHP must submit a "BHP Blueprint" to the HHS Secretary for approval. 42 C.F.R. § 600.110. The Blueprint describes how the state's BHP will function and comply with relevant federal regulations. *Id.* The Secretary then "certifies" a Blueprint if it: (a) contains sufficient information to determine compliance with federal law and regulations, (b) demonstrates "adequate planning for the integration of BHP with other insurance affordability programs" in a seamless manner, and (c) provides a comprehensive description of the BHP operations and program design. *Id.* § 600.120(d).

59. Once certified, a BHP Blueprint "remains in effect" and both HHS and the BHP-participating state are bound to adhere to it except in narrowly defined circumstances.

60. HHS can terminate a BHP Blueprint only on its own initiative if the Secretary first "makes a finding that the BHP Blueprint no longer meets the standards for certification

based on findings in the annual review, or reports significant evidence of beneficiary harm, financial malfeasance, fraud, waste or abuse by the BHP agency or the State consistent with § 600.142." 42 C.F.R. § 600.120(c)(3). Termination may then only occur after the Secretary provides the state with notice of its findings "that the standards for certification are not met or evidence of harm or misconduct in program operations," as well as "a reasonable period for the State to address the finding (either by substantiating compliance with the standards for certification or submitting revisions to the Blueprint, or securing HHS approval of a corrective action plan)," and "an opportunity for a hearing before issuing a final finding." 42 C.F.R. § 600.142(b). HHS is further required to "make every reasonable effort to resolve proposed findings without requiring withdrawal of BHP certification and in the event of a decision to withdraw certification, [to] accept a request from the State for reconsideration." *Id.* § 600.142(c). Even then, termination is not effective for at least 120 days, with a transition plan submitted in the interim. *Id.* § 600.142(d-e).

61. A BHP-participating state's ability to terminate the BHP is also curtailed. A state must meet a series of requirements before terminating a BHP Blueprint, including submitting a transition plan at least 120 days before the proposed termination date, obtaining HHS's approval of the transition plan, resolving any "concerns" HHS may have, and notifying all BHP plan offerors and enrollees. 42 C.F.R. §§ 600.120(c)(2), 600.140. A BHP Blueprint can only be changed if "revisions [are] submitted by the State" and certified by HHS. 42 C.F.R. § 600.120(c)(1).

62. To date, two states, New York and Minnesota, have submitted Blueprints, and HHS approved both states to operate BHPs. Both states relied upon the federal government's statutory guarantee of federal funding in deciding to implement and operationalize their

respective BHPs and have received the federal funding via quarterly prospective payments since HHS granted approval to the States to operate the programs. The States continue to rely on this statutory guarantee of federal funds to operate their BHPs. Their respective programs are described below.

***i. New York's Essential Plan***

63. In March 2014, New York passed legislation, effective April 1, 2015, authorizing the New York State Department of Health ("DOH") to establish a BHP, which is known as the Essential Plan. NY Soc. Serv. L. § 369-gg. In establishing its BHP, the state determined that the Essential Plan would enable New York to provide more affordable coverage for its low-income residents and improve affordability for residents whose incomes fluctuate above and below Medicaid levels and who would, absent the BHP, have been enrolled in a QHP with higher premiums and cost-sharing levels. The Essential Plan offers eligible individuals insurance through private insurers who contract with the state.

64. On February 23, 2015, DOH submitted its Blueprint to HHS, and on March 27, 2015, New York received federal certification to establish its BHP.

65. The federal certification, a copy of which is attached hereto as Attachment 1, specifically authorizes New York "to establish a BHP and *receive federal funds in its BHP trust fund*, with coverage beginning April 1, 2015." (emphasis added). The certification commended New York for the "thorough planning" reflected in its Blueprint. *Id.*

66. Consistent with federal law and regulations, the Essential Plan is available to residents under age 65 who are not eligible for Medicaid, who do not have access to minimum essential coverage, and whose incomes are at or below 200% of the FPL ($24,120 for a household of one; $49,200 for a household of four). It covers all essential health benefits, which include inpatient and outpatient care, physician services, diagnostic services and prescription

drugs, with no annual deductible and low out-of-pocket costs. Preventive care has no out-of-pocket costs for enrollees.

67. The Essential Plan offers enrollees significant cost savings, with either no monthly premiums or premiums of only $20, depending on income. These premiums are significantly less than what BHP enrollees would pay for a QHP offered through New York's exchange, even after PTCs and CSR subsidies are applied: on average, individuals in the Essential Plan are estimated to save more than *$1,100* a year compared to what they would spend if they enrolled in a QHP. Currently, if an Essential Plan enrollee had to enroll in a silver-level QHP with PTCs, their monthly premiums would be $127— more than *six times* the current monthly premium of $20. Further, individuals can enroll in the Essential Plan at any time—in contrast to QHPs, where enrollment is generally limited to a brief annual open enrollment period.

68. Because of the Essential Plan's low cost and comprehensive coverage options, the Essential Plan has helped significantly decrease the uninsured rate in New York. Since its inception, the Essential Plan's enrollment has nearly doubled, from 379,559 individuals enrolled as of January 31, 2016, to 716,000 individuals as of December 15, 2017. Of those deemed eligible for the Essential Plan, 93% ultimately enroll—compared to 73% of those deemed eligible for QHPs. Through the BHP and other ACA innovations, New York has dramatically increased access to affordable and comprehensive health insurance coverage. In just four years — from 2013 to the present — the rate of uninsured New Yorkers has declined from 10% to 4.7%.

69. In or around April of each year, DOH sends out an invitation to health insurers for participation in ACA programs, including the Essential Plan. For the 2018 plan year, insurers had until May 26 to submit their proposals, and DOH certified the plans for participation in the

Essential Plan by September 28, 2017. Thus, months before HHS gave its first indication that it would not pay the "CSR component" of the BHP funding, New York had committed to offering the Essential Plan for 2018 in reliance on HHS's published 2018 funding formula. Fifteen insurers committed to offering insurance to individuals through the Essential Plan.

***ii. Minnesota's Establishment of MinnesotaCare***

70. Minnesota's BHP is called MinnesotaCare. Currently, there are approximately 87,000 individuals enrolled in the BHP.

71. MinnesotaCare was originally created in 1992 to provide health insurance coverage to low- and moderate-income Minnesotans who were not eligible for Medicaid or other public programs, did not have employer-sponsored health insurance, and could not afford private insurance coverage. MinnesotaCare is administered by the Minnesota Department of Human Services ("MDHS")—through contracted insurers—and historically operated as a federal Medicaid waiver program. This program existed before the ACA under the authority of a Medicaid 1115 waiver, but was converted to a Basic Health Program effective January 1, 2015. Minnesota was required to sunset its Medicaid 1115 waiver in conjunction with the implementation of the ACA. The only option to continue the program with federal funding was through the Basic Health Program authority. In reliance on the ACA and under guidance from CMS, MDHS modified MinnesotaCare's income and eligibility rules and benefit set to meet the ACA's BHP requirements. The ACA also requires that states desiring to create a BHP must "establish a competitive process for entering into contracts with standard health plans" to cover BHP enrollees. 42 U.S.C. § 18051(c)(1). In 2013, state law required the Commissioner of MDHS to establish a competitive process for entering into contracts with health plans to offer MinnesotaCare plans, consistent with federal law. See Minn. Laws 2013, ch. 108, art. 1, § 61.

72. In December 2014, MDHS submitted its final Blueprint to HHS, and on December 15, 2014, Minnesota received federal certification to establish its BHP. Minnesota expended significant resources converting MinnesotaCare into a BHP, in reliance on the ACA and CMS's guidance.

73. The federal certification, a copy of which is attached as Attachment 2, specifically authorizes Minnesota "to establish a BHP and *receive federal funds in its BHP trust fund*, with coverage beginning January 1, 2015." (emphasis added). MinnesotaCare began operating as a BHP on January 1, 2015.

74. MinnesotaCare currently covers, in general, Minnesota residents under the age of 65 who have a gross income between 133% and 200% of the federal poverty guidelines and are not eligible for Medicaid and do not have access to minimum essential coverage. Enrollees pay monthly premiums on a sliding scale, with a maximum monthly premium of $80. These premiums are significantly less than what BHP enrollees would pay for a QHP offered through Minnesota's exchange, even after PTCs and CSR subsidies are applied: MDHS estimates that a person in a household of one purchasing individual coverage on the BHP would save between $340 and $570 per year in premiums compared to what he or she would spend if enrolled in a QHP (depending on income level).

## D. Federal BHP Payments to the States Prior to December 2017

### *i. Federal BHP Payments to New York State Prior to December 2017*

75. Since March 2015, the Centers for Medicare and Medicaid Services ("CMS"), an agency within HHS, has routinely issued the full BHP payments owed to New York, calculated according to HHS's regulations and published payment methodology rule, and deposited the funds in the state's BHP trust fund prospectively on a quarterly basis.

76. Approximately one month before the end of each calendar quarter, CMS has sent DOH a letter setting forth the BHP payment for the upcoming quarter. The letter divides the payment into two components: the part based on PTCs and the part based on CSRs.[2]

77. As recently as September 20, 2017, CMS deposited the full amount owed to New York — $906,514,960 — into the BHP trust fund to prospectively cover the majority of New York's BHP expenses for the last quarter of 2017. Of that amount, the CSR-based portion comprised $214,397,109, or approximately 25%, of the total, with the remainder based on the PTC. CMS sent a letter in advance of the payment explaining the methodology used to derive this quarterly payment, a copy of which is attached hereto as Attachment 3.

78. Prior to November 2017, New York received no formal indication that HHS would deviate from its published 2018 payment methodology rule in 2018, and at no time before or since then have any laws, regulations, or published guidance been issued that would affect HHS's obligations to reimburse New York for its operation of the Essential Plan.

***ii. Federal BHP Payments to Minnesota Prior to December 2017***

79. Since the establishment of MinnesotaCare as the State's BHP, CMS routinely issued the full payments owed to Minnesota, calculated according to HHS's regulations and published payment formula, and deposited the funds in the state's BHP Trust Fund on a quarterly basis.

80. Each quarter, MDHS sends CMS enrollee information so CMS can calculate that quarter's BHP payment. Prior to Minnesota receiving its quarterly BHP payment, CMS has

[2] Additionally, in some quarters, there is a third component to account for reconciliation based on actual enrollment data for prior quarters. DOH sends that data to CMS on a quarterly basis. *See* 42 C.F.R. § 600.610(c)(2)(i).

typically sent MDHS a letter setting forth the BHP payment for the upcoming quarter. The letter divided the payment into two components: the part based on PTCs and the part based on CSRs.[3]

81. As recently as September 21, 2017, CMS deposited the full amount owed – $130,273,985 – into the BHP Trust Fund to prospectively cover the majority of Minnesota's BHP expenses for the last quarter of 2017. Of that amount, the CSR portion comprised $30,980,583, or approximately 24%, of the total, with the remainder based on the PTC. CMS sent a letter in advance of the payment explaining the methodology used to derive this quarterly payment, a copy of which is attached hereto as Attachment 4.

82. Prior to October 2017, MDHS received no formal indication that HHS would deviate from its published 2018 payment formula in 2018, and at no time before or since then have any laws, regulations, or published guidance been issued that would affect HHS's obligations to reimburse Minnesota for its operation of MinnesotaCare.

## II. HHS'S UNLAWFUL DECISION TO STOP PAYING MANDATED BHP FUNDING

### A. The Current Administration's Defunding of CSR Reimbursements and the States' Responses

83. In reducing the States' BHP funding, HHS relied on its earlier determination, in October 2017, that it would no longer reimburse insurance companies for the cost of CSRs they are required to incur when offering QHPs on exchanges. Accordingly, a brief description of HHS's defunding of CSRs, and the states' responses to that defunding, is below.

84. The current administration has sought since its inception to repeal the ACA or, failing that, to undermine its successful operation at every turn. After efforts at statutory repeal were largely unsuccessful during the summer of 2017, the administration then looked for other

[3] Additionally, in some quarters, there is a third component to account for reconciliation based on actual enrollment data for prior quarters, based on enrollment data that MDHS sends to CMS on a quarterly basis. *See* 42 C.F.R. § 600.610(c)(2)(i).

ways to impede the ACA. These include: using federal funds to produce nearly 20 testimonial videos asserting that the ACA has harmed individuals;[4] cutting funding for "navigators" who help individuals enroll in insurance coverage;[5] and cutting the federal exchange open enrollment period in half.[6]

85. Along the same lines, on October 12, 2017, less than a month before the start of open enrollment, HHS announced that it would immediately stop making the CSR payments to insurers that are mandated by Section 1402 of the ACA, 42 U.S.C. § 18071. HHS based its October 12 decision on a Department of Justice ("DOJ") letter, issued just a day earlier, that reversed DOJ's and HHS's longstanding view that Congress had appropriated funds to cover CSR reimbursements for QHPs.[7]

86. The DOJ letter effectively endorsed the reasoning of a district court decision, *U.S. House of Representatives v. Burwell*, 185 F. Supp. 3d 165 (D.D.C. 2016), which had held that there was no appropriation authorizing the CSR payments required by Section 1402, and accordingly issued a permanent injunction preventing such payments.[8]

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[4] Audrey Carlsen et al., N.Y. TIMES, *The Same Agency That Runs Obamacare Is Using Taxpayer Money to Undermine It,* Sept. 4, 2017, https://www.nytimes.com/interactive/2017/09/04/us/hhs-anti-obamacare-campaign.html; *see also, e.g.*, U.S. Dep't of Health & Human Servs., YOUTUBE, *Marjorie Weer and Montgomery Weer of Mount Pleasant, South Carolina*, June 30, 2017, https://www.youtube.com/watch?v=oBItUJ8Q_HE.

[5] Juliet Eilperin et al., WASH. POST, *HHS Slashes Funding to Groups Helping ACA Consumers Enroll by up to 92 Percent*, Sept. 14, 2017, https://www.washingtonpost.com/national/health-science/hhs-slashes-funding-to-some-aca-navigator-groups-by-more-than-60-percent/2017/09/14/729c394c-9957-11e7-b569-3360011663b4_story.html?utm_term=.404176885694.

[6] Healthcare.gov, HEALTHCARE.GOV BLOG (Dec. 7, 2017), https://www.healthcare.gov/blog/december-15-deadline-almost-here/ (reflecting deadline for 2018 open enrollment as December 15, 2017) (last visited Jan. 24, 2018); Healthcare.gov, HEALTHCARE.GOV BLOG (Jan. 13, 2017), https://www.healthcare.gov/blog/avoid-2017-health-insurance-deadline/ (reflecting deadline for 2017 open enrollment as January 31, 2017) (last visited Jan. 24, 2018).

[7] *See Trump Administration Takes Action to Abide by the Law and Constitution, Discontinue CSR Payments*, U.S. DEP'T OF HEALTH & HUMAN SERVS. (Oct. 12, 2017), https://www.hhs.gov/about/news/2017/10/12/trump-administration-takes-action-abide-law-constitution-discontinue-csr-payments.html.

[8] The district court stayed its injunction pending the federal government's appeal. Subsequently, the D.C. Circuit granted intervention to several states (including New York and Minnesota) to defend the legality of those payments. *See* Order Granting Motion for Leave to Intervene, *U.S. House of Representatives v. Thomas E. Price*, No. 16-5202

87. Neither the DOJ letter nor the district court decision on which it relied makes any mention of the BHP (which is authorized by a separate section of the ACA, Section 1331), or of the detailed regulations that implement the BHP and confirm its funding formula.

88. HHS's cut-off of CSR payments for QHPs threatened to deprive insurers of critical federal funding that was essential to their ability to continue providing affordable health insurance on the exchanges. To limit the impact of this financial injury, many states authorized insurers to charge higher 2018 premiums for silver plans available on their exchanges, including for the second-lowest-cost silver plans. Because the second-lowest-cost silver plan premiums serve as the benchmark by which federal subsidies for PTCs are calculated, *see supra* ¶¶ 35-36, the effect of raising those premiums was to increase federal funding through higher PTCs in order to make up for the loss of federal funding through CSR payments. This practice has become known colloquially as "silver loading."

89. "Silver loading" has meant significant premium increases for silver plans. One analysis performed by the Kaiser Family Foundation found that, of the 32 states and the District of Columbia that published detailed data concerning 2018 premiums rates, "among those insurers that specify the surcharge on silver plans for the discontinuation of CSR payments, the amount of the surcharge ranges from 7.1% to 38%."[9] For example, in Pennsylvania, all

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(D.C. Cir. filed Aug. 1, 2017). The parties recently moved for the D.C. Circuit to remand the case back to the district court to vacate the permanent injunction and resolve that litigation. *See* Joint Motion for Remand, *U.S. House of Representatives v. Thomas E. Price*, No. 16-5202 (D.C. Cir. filed Jan. 19, 2018). If the D.C. Circuit grants the motion, the parties have agreed that "the district court's holding on the merits should not in any way control the resolution of the same or similar issues should they arise in other litigation, and hereby waive any right to argue that the judgment of the district court or any of the district court's orders or opinions in this case have any preclusive effect in any other litigation." *See* Joint Status Report, Exh. A, *U.S. House of Representatives v. Thomas E. Price*, No. 16-5202 (D.C. Cir. filed Dec. 15, 2017).

[9] Rahah Kamal et al., Kaiser Family Foundation, How the Loss of Cost-Sharing Subsidy Payments is Affecting 2018 Premiums, Oct. 27, 2017, https://www.kff.org/health-reform/issue-brief/how-the-loss-of-cost-sharing-subsidy-payments-is-affecting-2018-premiums/.

exchange silver plans experienced increases of 34.29% to account for CSR defunding, and in California, there was an average "CSR surcharge" on premiums for exchange silver plans of 12.4% (with at least one plan increasing premiums by 27%).[10] Federal expenditures on PTCs increased accordingly, and without limitation.

90. HHS has raised no objection to the states' adoption of "silver loading"—and the concomitant increase on federal subsidies for PTCs—to make up for the loss of CSR payments for QHPs. On the contrary, through DOJ, HHS has expressly relied on "silver loading" to defend itself against a legal challenge to its cut-off of CSR payments. In October 2017, a coalition of states, which included New York and Minnesota, sued HHS and other federal defendants in the United States District Court for the Northern District of California seeking to compel the federal government to make CSR payments to insurers offering QHPs on exchanges. The plaintiff States also moved for a preliminary injunction. In opposing the preliminary injunction, DOJ expressly endorsed "silver loading," arguing that no harm had been caused by ending CSR payments for QHPs "given that premium tax credits will rise with a rise in premiums on silver plans," and submitting a sworn declaration from an Associate Deputy Director at CMS similarly approving of the fact that "many Exchange enrollees will have greater purchasing power as a result of increases in the premium tax credits." Defendants' Opposition to Plaintiffs' Motion for a Temporary Restraining Order ("DOJ PI Br.") at 26–27, *California v. Trump*, No. 17-cv-05895-VC (N.D. Cal. filed Oct. 13, 2017).

91. On October 25, 2017, the district court (Chhabria, J.) denied the preliminary injunction in part based on its agreement with DOJ's assertion that "silver loading" appeared to

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[10] *Id*; Covered California, October 11, 2017, Covered California Keeps Premiums Stable by Adding Cost-Sharing Reduction Surcharge Only to Silver Plans to Limit Consumer Impact, https://www.coveredca.com/news/.

have blunted the impact of HHS's October 12 CSR cut-off decision by essentially swapping one federal funding stream for another, leaving many consumers who receive subsidies through the exchanges no worse off than they were before the cut-off decision. *California v. Trump*, 17-cv-05895-VC, 2017 WL 4805588 (N.D. Cal. 2017).[11]

### B. HHS Refuses to Fund New York's BHP in Contravention of its Statutory and Regulatory Obligations

92. On October 17, 2017, DOH submitted to HHS, along with its estimated enrollment data, its "Silver Plan Data Table B," which reflects the premiums that HHS should use to determine New York's quarterly BHP payments for 2018.

93. On November 21, 2017, DOH held a routine call with CMS to discuss the BHP. During this call, CMS advised New York that it was not intending to pay the CSR component in the next regularly scheduled BHP payment covering the first quarter of 2018. While HHS had informally indicated that this was a possibility during a phone call in mid-October, the November 21 phone call was the first time CMS stated its intention to not pay New York the "CSR component" of the BHP payment.

94. One day later, on November 22, 2017, DOH sent CMS an email proposing alternative premium rates that CMS should use to compute the PTC component of the next quarterly payment. The alternative premiums reflect the rates that insurers would have charged enrollees in the individual market had every BHP enrollee been enrolled in a QHP. To calculate the alternative premiums rates, DOH determined the number of Essential Plan enrollees at each

[11] New York and Minnesota are parties to the litigation in the Northern District of California because they continue to operate exchanges through which insurers are entitled to receive CSR subsidies. The States' BHPs, however, are not part of that litigation, which was filed before HHS's subsequent decision to cut off BHP funding. Moreover, in opposing a preliminary injunction, DOJ specifically noted that New York and Minnesota might have standing to challenge any reduction in BHP payments, but asserted that venue would not lie in the Northern District of California if New York and Minnesota were to challenge any such reduction. DOJ PI Br. at 13 n.9.

CSR plan variation, calculated the premium adjustment for each variation based on its respective actuarial value and then computed a weighted average silver premium increase across all Essential Plan enrollees. This incremental percentage was then added to the previously authorized silver level premium increase, which did not include Essential Plan enrollees, to arrive at the alternative premium rates.

95. In effect, these alternative premium rates reflect what BHP enrollees "would have been paid" in PTC subsidies if, like the vast majority of other states, New York had authorized health plans to engage in "silver loading" to account for the loss of CSR subsidies for all of these individuals. These revised figures thus represented the type of hypothetical calculation mandated by the BHP statute and regulations, which require HHS to simulate what would have happened in the marketplace if BHP enrollees instead enrolled in QHPs through an exchange, 42 U.S.C. § 18051(d)(3), taking into account the "[m]arketplace experience in other states with respect to Exchange participation." 42 C.F.R. § 600.605(b)(7). DOH's November 22 email requested that CMS use the adjusted premiums to calculate its next quarterly payment to the state for the first quarter of calendar year 2018. A true and correct copy of DOH's November 22, 2017 email is attached hereto as Attachment 5.

96. DOH's revised premium rates are an accurate reflection of the premium rates New York would have approved if the then-682,000 BHP enrollees in New York had purchased QHPs on the state's exchange in 2018. Because BHP covers individuals up to 200% of the FPL, and CSRs are available for individuals with incomes up to 250% of the FPL, by definition, all of New York's BHP enrollees would have been eligible for CSR subsidies. Simply put, putting all BHP enrollees in QHPs on the exchange would mean hundreds of thousands of additional individuals receiving CSR subsidies for which (because of the federal government's October

2017 decision) insurers would not be reimbursed. To make up for this loss of federal funding, New York would have authorized premium increases on silver plans available on its exchange so those plans could cover the increased costs of unreimbursed CSRs. New York did, in fact, allow such increases in 2018 for the relatively small number of individuals eligible for CSRs in New York on QHPs (approximately 65,000), but given the small number of such individuals, those increases were minor. The revised figures submitted to CMS reflect the far larger amount of "silver loading" necessary to make up for the loss of CSR funding if the entire population of 682,000 BHP enrollees were to purchase QHPs instead. New York's proposal accordingly incorporates the same change that other states made to silver plan rates to reflect the new marketplace reality, and that DOJ expressly cited as a permissible means of avoiding the harm of a CSR cut-off in successfully opposing a preliminary injunction in the Northern District of California. *See supra* ¶ 90.

97. As a result of the increased silver plan premiums that would have been charged by insurers and authorized by New York, the PTCs provided to those 682,000 BHP enrollees also would have increased substantially. New York's proposed adjustment thus would have led to a higher PTC component for its BHP payment because it would account for the higher PTCs "that would have been provided . . . if such eligible individuals were allowed to enroll" in QHPs subject to "silver loading." 42 U.S.C. § 18051(d)(3)(A)(i).

98. CMS acknowledged receipt of New York's November 22 email, but at no point did it offer a substantive response. Instead, on December 21, 2017, CMS sent New York an email notifying it that the funding to be paid for the first quarter of 2018 would not contain the "CSR component." The email did not mention or consider—let alone reflect—the state's

proposed adjustments. A true and correct copy of CMS's email is attached hereto as Attachment 6.

99. In this email, CMS noted that the CSR component of New York's BHP payment was calculated to be $265,931,411. However, CMS continued to state that it would "deliver only the PTC portion of the BHP payment" because of the administration's October 2017 determination that the CSRs were not appropriated. The email stated that, as a result of this determination, "CMS does not have appropriated funds to make pass-through payments" for the CSR component of the BHP payment, and it would not remit the $266 million due to New York for the first quarter of 2018.

100. CMS's email also stated that it calculated the PTC component of the next quarter's payment to be $833,521,555, and it deposited this amount in New York's BHP Trust Fund the following day. This amount was based on the original premium rates DOH submitted to HHS, and not the revised premiums DOH had asked HHS to use in November 2017.

101. Not only did HHS decline to use New York's proposed adjustment to calculate the PTC component, it provided no indication that the proposal received any consideration, and no explanation as to why the adjustment was not used.

102. HHS's cut amounts to a loss of over $1 billion in federal funding over the course of one year.

### C. HHS Refuses to Fund Minnesota's BHP in Contravention of its Statutory and Regulatory Obligations

103. In mid-October 2017, MDHS was informally told in a telephone call that Minnesota's BHP payments would be affected by the federal government's determination that CSR payments were not appropriated for QHPs.

104. Due to the possibility of losing the CSR component in future BHP payments, MDHS sent CMS an email on November 28, 2017, attaching a proposed payment methodology and requested that CMS use the proposed methodology to calculate its next quarterly BHP payment in the event CMS eliminated the CSR component.[12] A true and correct copy of this email is attached as Attachment 7.

105. The payment methodology proposed by MDHS included an adjustment to silver level premiums for what would have occurred if Minnesota's BHP population had been in the individual market and on a QHP. Premiums for Minnesota silver plans on the exchange increased between approximately 0 and 1.2% to account for the increased CSR cost that plans would incur. This increase was relatively small compared to other states because most CSR-eligible individuals in Minnesota are enrolled in MinnesotaCare. The revised payment methodology reflected an adjustment to the reference premium to account for benchmark premium increases that would have occurred in Minnesota's market if the BHP population were in the market, as evidenced by the experience in other states. If the full BHP population enrolled in QHPs in Minnesota, the premiums on the second-lowest-cost silver plan would have been significantly higher in 2018 (which is the rate used to calculate PTCs). In effect, the proposed payment methodology reflects what these individuals would have been paid in PTC subsidies if, like the vast majority of other states, Minnesota had authorized health plans to engage in "silver loading" to account for the loss of CSR subsidies for all of these individuals. The revised methodology thus represented the type of hypothetical calculation mandated by the BHP statute, while also properly taking into account the "[m]arketplace experience in other states with respect

[12] When MDHS initially sent CMS the data to calculate its BHP payment for the first quarter of 2018, MDHS had not been formally notified that it would lose the CSR component of its payment. The data it sent to CMS therefore did not take into account any change to the payment methodology.

to Exchange participation." 42 C.F.R. § 600.605(b)(7). The proposed methodology reflected Minnesota's market expectations that the silver premiums would have required a 20.2% increase on average to reflect the loss of CSRs.

106. Because the low-income thresholds for the BHP are lower than the thresholds to receive CSR subsidies on the exchange, all of Minnesota's BHP enrollees would have been eligible for CSR subsidies. If those CSR payments were no longer being made, then to make up for this loss of federal funding, Minnesota would have authorized premium increases on the second-lowest price silver plans available on its exchange so plans could cover the increased costs of unreimbursed CSRs, just as Minnesota allowed in 2018 for the relatively minor premium increases to account for CSR defunding. This is the same change that other states made to silver plan rates to reflect the new marketplace reality, and that DOJ expressly cited as a permissible means of avoiding the harm of a CSR cut-off in successfully opposing a preliminary injunction in the Northern District of California. *See supra* ¶¶ 88-90.

107. As a result of the increased premiums that would have been authorized by Minnesota, the PTCs provided to those 87,000 BHP enrollees also would have increased substantially. Minnesota's proposed adjustment thus would have led to a higher PTC component for its BHP payment because it would account for the increased value of PTCs "that would have been provided . . . if such eligible individuals were allowed to enroll" in QHPs subject to "silver loading." 42 U.S.C. § 18051(d)(3)(A)(i).

108. CMS acknowledged receipt of Minnesota's November 28 email, but at no point did it offer a substantive response. Instead, on December 21, 2017, CMS sent Minnesota an email notifying it that the funding to be paid for the first quarter of 2018 would not contain the

"CSR component." The email did not mention—let alone reflect—the State's proposed adjustments. A true and correct copy of CMS's email is attached hereto as Attachment 8.

109. In this email, CMS noted that the CSR component of Minnesota's quarterly BHP payment was $32,083,849. However, CMS stated that it would "deliver only the PTC component of the BHP payment" because of the administration's October 2017 determination that the CSRs are not appropriated. The email stated that, as a result of this determination, "CMS does not have appropriated funds to make pass-through payments" for the CSR component of the BHP payment, and it would not remit the $32 million due to Minnesota for the first quarter of 2018.

110. CMS's email also stated that it calculated the PTC component of the next quarter's payment to be $97,670,055, and it deposited this amount in Minnesota's BHP Trust Fund the following day. This amount was not based on the proposed payment methodology submitted by MDHS.

111. Not only did HHS decline to use Minnesota's proposed payment methodology to calculate the PTC component, it provided no indication that the proposal received any consideration, and no explanation as to why the adjustment was not used. In a phone call between CMS and MDHS on December 21, CMS stated that it was not required to make or consider any adjustments.

112. For Minnesota, this decreased payment amounts to approximately $32 million lost in federal funding for the first quarter of 2018 for MinnesotaCare. Minnesota projects that it will lose nearly $130 million in federal funding for 2018 attributable to the loss of the CSR component.

**D. <u>HHS's Payment Cutoff Is Unjustified</u>**

113. HHS's abrupt refusal to pay more than $1 billion of mandatory BHP funding is both procedurally and substantively flawed.

114. HHS's decision to stop paying this portion of the BHP funding was made hastily, improperly, and without adequate justification. HHS announced its decision in emails to the States' health regulators just one day before the BHP payments for the first quarter of 2018 were due. Even though both States' BHPs are governed by elaborate and duly promulgated federal regulations, including detailed payment formulas, HHS has made no effort to rescind or otherwise amend those regulations, and dramatically altered its funding without undergoing mandatory notice-and-comment rulemaking. And while HHS's BHP regulations contain procedures by which the Secretary may terminate a state's BHP under certain specific circumstances (none of which is relevant here), nothing in those regulations authorizes HHS to unilaterally modify or disregard its payment obligations. *See, e.g.* 42 C.F.R. §§ 600.140, 600.142, 600.120(c)(3).

115. In so abruptly reducing the States' BHP reimbursement by approximately 25%, HHS unlawfully refused to consider, or explain why it did not adopt, the States' proposals for adjusting the current BHP payment methodology to make up for HHS's refusal to pay the "CSR component" of BHP funding. As explained above, *see supra* ¶¶ 88–89, these proposals would have aligned the States here with other states responding to HHS's termination of CSR payments for QHPs, by increasing the "PTC component" of BHP funding to make up for any shortfall in the "CSR component." These proposals are consistent with both the BHP statute and HHS's own regulations, and, if adopted, would avoid the significant financial injury threatened by HHS's precipitous decision to withhold more than $1 billion of funding for the States. HHS unlawfully failed even to acknowledge these proposals, let alone seriously engage with them.

116. Further, the rationale that CMS gave to the States for significantly reducing their BHP funding was woefully inadequate. HHS's cursory emails relied exclusively on the federal government's earlier October 2017 decision to cut off CSR payments to insurers for QHPs on exchanges, and cited the DOJ letter that purported to provide a legal basis to withhold that funding. However, neither the DOJ letter, nor the district court decision that it effectively endorsed, even mentioned the BHP, let alone analyzed the BHP's distinct statute and regulations. Further, HHS's emails failed to consider the States' reliance on the BHP and on the federal government's formal commitment to continue payment—commitments that have special force in a program between sovereign states and the federal government. There is simply nothing in HHS's emails to the States or in the materials they reference that contain a legal justification specific to the BHP that would support its decision to withhold approximately one-quarter of the funding owed to the States for a major health insurance program for low-income residents.

117. HHS's stated reason for ceasing payment of the "CSR component" of BHP funding was the alleged absence of an appropriation to make payments for CSRs. This justification is inadequate to support HHS's decision, as Congress has appropriated money for the BHP. Specifically, Congress enacted a permanent appropriation in 31 U.S.C. § 1324 to fund federal subsidies for QHPs. Congress then required HHS to "transfer" funds from that appropriation as necessary to satisfy its BHP payment obligations.

118. HHS's position that the § 1324 appropriation covers only PTCs and not CSRs—and that it can accordingly only transfer funding to cover the "PTC component" of BHP funding—is meritless, for at least two reasons. First, the BHP is a single program under which HHS provides a single stream of quarterly payments to the States—a single stream of funding in exchange for which the States undertook a series of substantial legislative, financial, and

administrative obligations to provide health insurance to their residents. Rather than funding this single stream by cobbling together multiple appropriations, Congress instead directed HHS to a particular source of funds—the permanent appropriation in § 1324—and required HHS to draw the funding necessary to satisfy its BHP payment obligations. It is implausible that Congress, in a statute that on its face provides a single stream of required federal funding in exchange for States undertaking a series of substantial health insurance obligations, instead rendered nugatory one-quarter of the multi-billion-dollar federal funding formula for which participating States bargained.

119. Second, in any event, HHS is wrong to interpret the § 1324 appropriation as being limited to PTCs. CSR payments are federal subsidies that are available only to individuals who are eligible for PTCs, and in practice they are combined into a single advance payment that the Secretary of the Treasury makes to insurers. 42 U.S.C. § 18082(a), (c). It thus make sense to interpret the § 1324 appropriation as necessarily encompassing CSRs, which are simply a component of federal funding that Congress intended to provide to certain PTC-eligible individuals.

120. Finally, the purported lack of appropriations for CSRs cannot justify HHS's failure to adopt the States' alternative proposals, which are expressly premised on the increase in PTCs in other states that occurred in response to the administration's incorrect determination that the CSRs are not appropriated.

121. HHS has for more than two years interpreted the ACA to provide a full appropriation to make all necessary BHP payments to the States, issuing binding rules and methodologies through notice and comment and setting forth precisely how a state's BHP payment would be calculated. HHS's asserted basis for abruptly reversing course and cutting off

the CSR component is invalid and should not serve as a basis for the agency withholding statutorily-required federal funding upon which the States rely to operate their BHPs.

## III. HHS'S REFUSAL TO PAY THE FULL BHP AMOUNT OWED UNDER THE ACA HARMS THE STATES AND THEIR RESIDENTS

### A. HHS's Refusal To Transfer BHP Funds to New York State Financially Harms the State and Jeopardizes the Essential Plan

122. The viability of New York's Essential Plan depends on the federal government's compliance with its statutory and regulatory payment obligations.

123. On an annual basis, HHS's decreased payment amounts to more than $1 billion in lost federal funding for New York alone, jeopardizing the existence of the program and placing health insurance coverage for approximately 716,000 low-income individuals at risk. This action may force the state to irrevocably reduce funds to other vital programs and services funded by New York State in order to fill the shortfall created by HHS's last-minute decision.

124. New York already is obligated by its own law to maintain the Essential Plan in 2018. Premiums have been set according to state statute, the state has signed contracts with participating health plans, and individuals have enrolled in those plans. Moreover, the alternative — precipitously ending the Essential Plan for the more than 710,000 New Yorkers who rely on it — would have potentially irrevocable effects on those who are covered by it and is beyond impracticable at this late date, with the 2018 plan year already begun.

125. To maintain access to affordable health care for more than 710,000 New Yorkers, the state will have to pass a budget by April 2018 — the start of New York's fiscal year — and divert $1 billion of its already strained budget to meet financial obligations to health plans participating in the Essential Plan—obligations that should have been met by the federal government as required by law.

126. Individuals with incomes at BHP eligibility levels are extremely price sensitive, and therefore raising premiums or costs for accessing health care is not a viable option, as it will almost certainly result in more uninsured New Yorkers.

127. A study by the Urban Institute found that an increase in monthly consumer premium for the lowest income group (up to 150% of federal poverty level) from $0 to just $20 would result in a projected 6% to 12.5% of enrollees dropping coverage. An increase in monthly premium for eligible Essential Plan enrollees with higher incomes from $20 to $30 would result in projected 2% to 6% of enrollees dropping coverage.

128. The consequences of being uninsured are well-documented. Without insurance, people live sicker, die sooner, and forego necessary care because of the cost. Further, uninsured individuals who end up using medical care that they cannot afford results in increased medical debt for consumers and uncompensated care for health care providers.

**B. <u>HHS's Refusal To Transfer BHP Funds to Minnesota Financially Harms the State and Jeopardizes MinnesotaCare</u>**

129. In 2017, the federal government provided over 90% of MinnesotaCare funding for BHP enrollees, and Minnesota pays the remaining amount out of its state funds, including enrollee paid premiums.

130. Approximately 24% of the 2017 annual federal funding – or over $130 million – was based on the value of the CSRs that would have been paid to the health plans to help cover the cost-sharing obligations of eligible individuals had they enrolled in silver plans instead of MinnesotaCare. MDHS projects that it will lose nearly $130 million in federal funding attributable to the CSR component for 2018.

131. Minnesota is committed to maintaining MinnesotaCare and preserving this low-cost health insurance program for the approximately 87,000 Minnesotans who rely on it.

Moreover, MinnesotaCare is already in place for 2018 – rates have been set, the state has signed contracts with participating health plans to provide coverage for enrollees through the end of 2018, and individuals have enrolled in those plans.

132. If the federal government continues to withhold the CSR component without adjusting the PTC component, Minnesota may be forced, in the future, to reduce benefits or increase out-of-pocket costs for its enrollees.

## FIRST CAUSE OF ACTION

### (Administrative Procedure Act — Not in Accordance With Law and Beyond Statutory Authority)

133. The States reallege and incorporate by reference the allegations set forth in Paragraphs 1 through 132.

134. Under the APA, 5 U.S.C. §§ 701-706, courts must "compel agency action unlawfully withheld or unreasonably delayed," and "hold unlawful and set aside" agency action that is "arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law," or that is "in excess of statutory jurisdiction, authority, or limitations, or short of statutory right." 5 U.S.C. § 706(1)-(2).

135. The Department of Health and Human Services is an "agency" under the APA. 5 U.S.C. § 551(1).

136. The Defendants' (a) refusal to pay the States for the CSR component of the BHP payment, and (b) refusal to use New York's revised premium rates or Minnesota's proposed revision to the rate calculation, are subject to review under the APA. 5 U.S.C. §§ 551(13), 704.

137. Through each of those actions, HHS has not acted in accordance with its statutory and regulatory obligation to make BHP payments and has acted beyond its statutory authority, in violation of the APA.

138. First, HHS's refusal to use New York's revised premium rates and Minnesota's revised methodology in its most recent payment is contrary to the ACA's statutory calculation for determining the BHP funding. The ACA mandates that HHS pay the amount of PTCs and CSRs "*that would have been provided*" had the BHP population enrolled in QHPs. 42 U.S.C. § 18051(d)(3)(A)(i). As set forth herein, the revised premiums submitted by New York or the proposed payment methodology submitted by Minnesota must be used to simulate the subsidies that would have been provided in 2018, in light of the administration's decision to not fund the CSRs. HHS's refusal to use those revised premiums for New York and the proposed payment methodology for Minnesota to calculate accurately the statutorily-required BHP payment amount is contrary to law and exceeds HHS's statutory authority.

139. Second, HHS's refusal to pay the CSR component of the BHP payment is not in accordance with law because the ACA directs HHS to transfer funds to states that operate BHPs after being certified by HHS. 42 U.S.C. § 18051(d)(1). HHS's payment calculation, as reflected in its December 21 email does not comport with the ACA's statutory calculation for determining the BHP funding amount, which mandates that HHS pay the amount of PTCs and CSRs "*that would have been provided*" had the BHP population enrolled in QHPs. 42 U.S.C. § 18051(d)(3)(A)(i). As set forth above, HHS's December 21 payment methodology fails to reflect HHS's obligations, set forth in statute and regulation, to pay the CSR component of its BHP payment obligation.

140. Defendants' violation causes ongoing harm to New York, Minnesota, and their residents.

**SECOND CAUSE OF ACTION**
**(Administrative Procedure Act – Arbitrary and Capricious)**

141. The States reallege and incorporate by reference the allegations set forth in Paragraphs 1 through 132.

142. The Administrative Procedure Act, 5 U.S.C. § 706(2), sets forth that federal agency action be held unlawful and set aside if the agency action is arbitrary and capricious.

143. In deciding to: (a) stop paying the CSR component of the BHP payment to the States, and (b) not use New York's revised premiums or Minnesota's proposed payment methodology, the Defendants have acted arbitrarily and capriciously, in violation of the APA.

144. Defendants have failed to comply with the legal requirement that they articulate a satisfactory explanation for any of these actions. To the contrary, to the extent Defendants have proffered any justification for not paying the CSR component, that justification is based on a mistaken interpretation of the relevant law, and, moreover, fails to take into account the significant reliance interests its continuous funding of the BHPs has engendered.

145. Further, the Defendants' emails notifying the States of their next payment amount did not even acknowledge the States' proposals, much less attempt to provide any justification or explanation for why the proposals were not adopted.

146. The Defendants' decisions are therefore "arbitrary and capricious," in violation of 5 U.S.C. § 706(2).

147. Defendants' violation causes ongoing harm to New York, Minnesota, and their residents.

**THIRD CAUSE OF ACTION**
**(Administrative Procedure Act – Notice and Comment)**

148. The States reallege and incorporate by reference the allegations set forth in Paragraphs 1 through 132.

149. The BHP payment methodology that dictates, and therefore lets states know in advance, how much federal funding they will receive to fund their BHPs is established through publication of the proposed methodology in the Federal Register, and then a final payment methodology published several months later. On December 21, 2017, however, HHS radically deviated from this final payment methodology by merely sending an email advising of a drastic change in the federal funding amount, without even acknowledging the States' proposed alternatives.

150. Through its issuance of this email advising of a dramatically different funding amount than previously paid under the exact same payment methodology, HHS effectively amended its existing rule while bypassing the notice and comment process that resulted in the rule's issuance, resulting in a tremendous loss of funds for the recipient states. 81 Fed. Reg. 10091 (Feb. 29, 2016). Amending a rule that was passed through notice and comment must also go through the notice and comment process, and HHS's failure to do so violates the APA. 5 U.S.C. § 553; 5 U.S.C. § 706.

151. Further, as a result of Defendants' failure to proceed through the required notice and comment process, Defendants plainly circumvented congressionally-designed procedures "to curb the practice of imposing unfunded mandates on States and local governments" when

proposing regulations. Unfunded Mandates Reform Act of 1995, Pub. L. No. 104-4, 109 Stat. 48 (March 22, 1995) ("UMRA").

152. The UMRA applies to rulemaking that results in decreased funding to existing federal entitlement programs that spend more than $500 million annually. The BHP is a multi-billion-dollar program that fits within this definition. Had HHS gone through the required notice and comment process instead of precipitously amending the BHP methodology to impose a billion-dollar unfunded mandate through an email, the States would have been entitled to substantial procedural and substantive protections set forth in UMRA, including consideration of their proposed alternative methods of funding. *See* 2 U.S.C. §§ 658(5), 1532.

153. Defendants' violation causes ongoing harm to New York, Minnesota, and their residents.

**FOURTH CAUSE OF ACTION**
**(Administrative Procedure Act — Compelling Unlawfully Withheld or Unreasonably Delayed Agency Action)**

154. The States reallege and incorporate by reference the allegations set forth in Paragraphs 1 through 132.

155. Under the APA, 5 U.S.C. § 706(1), courts must "compel agency action unlawfully withheld or unreasonably delayed."

156. HHS has refused to consider the States' alternative proposals, thereby unlawfully withholding and unreasonably delaying agency action. The States submitted their alternative proposals — proposals that would ensure HHS's funding remained consistent with federal law — soon after HHS advised of its intent to withhold the CSR component of the BHP payment. HHS then had approximately *one month* to review those proposals and provide the States with a response, including a reasoned explanation and legally-supportable justification for any

determination not to adopt the proposals. HHS never provided any such response, nor is there any indication that it meaningfully considered those proposals.

157. Accordingly, HHS should be compelled to review — and then adopt — the States' proposals.

158. Defendants' violation causes ongoing harm to New York, Minnesota, and their residents.

**PRAYER FOR RELIEF**

WHEREFORE, Plaintiffs respectfully request that this Court:

1. Declare, pursuant to 28 U.S.C. § 2201(a), that HHS's refusal to use New York's revised premium rates and Minnesota's proposed payment methodology to recalculate the BHP payments is not in accordance with law, is beyond statutory authority, and is arbitrary and capricious, in violation of the Administrative Procedure Act, 5 U.S.C. § 706, and compel HHS to consider and then use New York's revised rates and Minnesota's proposed payment methodology to calculate their BHP payments for so long as HHS determines it will not pay the CSR component of the BHP payment;

2. In the alternative, declare that HHS's payment determination as reflected in its December 21 email is void for failing to comply with the notice and comment requirements of the Administrative Procedure Act, and (a) grant a permanent injunction prohibiting implementation of that payment determination and (b) compel HHS to follow the notice and comment process set forth in 5 U.S.C. § 553 to issue a payment methodology consistent with the ACA, which shall include the required assessment under UMRA, 2 U.S.C. § 1532;

3. In the second alternative, declare that: (a) the Secretary has the authority and obligation to pay the CSR component of the Basic Health Program payment to the States under

31 U.S.C. § 1324, 26 U.S.C. § 36B, and 42 U.S.C. § 18051, and (b) the failure to pay the CSR component of the BHP payment is not in accordance with law, is beyond statutory authority, and is arbitrary and capricious, in violation of the Administrative Procedure Act, 5 U.S.C. § 706; and order the Secretary, his officers, agents, employees, and all persons who are in active concert or participation with them to make the required BHP payments under 31 U.S.C. § 1324, 26 U.S.C. § 36B, and 42 U.S.C. § 18051 immediately, and on quarterly basis going forward;

4. Award to Plaintiffs their costs of litigation including, but not limited to, reasonable attorneys' fees, as permitted by applicable law; and

5. Order such other and further relief as this Court deems just and appropriate.

DATED January 26, 2018

Respectfully submitted,

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