IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

PLANNED PARENTHOOD SOUTHEAST, INC.
241 Peachtree St. NE, Suite 400
Atlanta, GA 30303; and

FEMINIST WOMEN'S HEALTH CENTER
1924 Cliff Valley Way NE
Atlanta, GA 30329;

Plaintiffs,

v.

Case No.

ALEX M. AZAR, II, in his official capacity as Secretary of Health and Human Services,
200 Independence Ave. SW
Washington, DC 20201;

UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES
200 Independence Ave. SW
Washington, DC 20201;

SEEMA VERMA, in her official capacity as Administrator of the Centers for Medicare and Medicaid Services,
7500 Security Blvd.
Baltimore, MD 21244;

CENTERS FOR MEDICARE AND MEDICAID SERVICES
7500 Security Blvd.
Baltimore, MD 21244;

STEVEN T. MNUCHIN, in his official capacity as Secretary of the Treasury,
1500 Pennsylvania Ave. NW
Washington, DC 20220;

DAVID KAUTTER, in his official capacity as Assistant Secretary for Tax Policy, United States Department of the Treasury,
1500 Pennsylvania Ave. NW
Washington, DC 20220; and the

UNITED STATES DEPARTMENT OF THE TREASURY
1500 Pennsylvania Ave. NW
Washington, DC 20220,

Defendants.

COMPLAINT FOR DECLARATORY AND INJUNCTIVE RELIEF

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Plaintiffs Planned Parenthood Southeast, Inc. and Feminist Women's Health Center hereby sue Alex M. Azar, II, in his official capacity as Secretary of Health and Human Services, the United States Department of Health and Human Services, Seema Verma, in her official capacity as Administrator of the Centers for Medicare and Medicaid Services, the Centers for Medicare and Medicaid Services, Steven T. Mnuchin, in his official capacity as Secretary of the Treasury, David Kautter, in his official capacity as Assistant Secretary for Tax Policy, United States Department of the Treasury, and the United States Department of the Treasury, and allege as follows:

1. The Patient Protection and Affordable Care Act (the "ACA"), enacted in 2010, has provided affordable, high-quality health insurance to millions of Americans over the last decade, including to millions of Americans who could not previously purchase health insurance because of preexisting health conditions or inadequate financial support. A critical part of the ACA's reforms is its Exchanges: online marketplaces where consumers can go to compare qualified health plans, obtain information about public programs for which they may be eligible, and, ultimately, enroll in the coverage that's right for them. Prior to the ACA, consumers had to go to individual insurers or brokers to survey their offerings and to purchase a plan—an arduous and time-consuming process. Now, consumers can go to an Exchange established by their state, or in states that have not established Exchanges, to healthcare.gov, which is administered by the federal government.

2. A recent decision by Defendants—amidst the COVID-19 pandemic—threatens to reverse this considerable progress in the State of Georgia. Over the course of 2019 and 2020, Georgia submitted several versions of an application for a State Innovation Waiver under Section 1332 of the ACA. *See* 42 U.S.C. § 18052. Section 1332 is intended to give states flexibility to

innovate in providing coverage to their residents. To that end, Section 1332 allows states to waive certain ACA requirements, so long as they can show that their proposed alternative would match the ACA with respect to coverage, comprehensiveness, affordability, and deficit neutrality—criteria referred to as Section 1332's "statutory guardrails." *Id.* § 18052(b)(1).

3. Georgia's plan, however, would tear a hole in the ACA—overriding Congress's considered legislative judgments and eviscerating the ACA's substantial achievements. Georgia's proposal, the euphemistically named "Georgia Access Model," does away with Georgia consumers' access to healthcare.gov. It forces them to shop through private insurance companies, agents, and brokers, rather than through a single, consolidated marketplace. In this respect, the Georgia Access Model essentially returns the health insurance shopping experience for Georgia consumers to how it stood before the ACA was enacted. Despite overwhelming public opposition to Georgia's plan, Defendants approved the final version of Georgia's application on November 1, 2020.

4. Defendants' decision is unlawful for several reasons. Most importantly, the Georgia Access Model will drastically underperform the ACA and therefore violates the statutory guardrails. As the record before Defendants demonstrated, it will decrease enrollment in Georgia by up to 100,000 consumers, violating the coverage guardrail; shift consumers to non-ACA-compliant junk plans that provide inadequate coverage, violating the comprehensiveness guardrail; and result in increased premiums that consumers must pay to receive coverage, violating the affordability and deficit neutrality guardrails. In nonetheless approving the Georgia Access Model, Defendants violated Section 1332, as well as the Administrative Procedure Act's requirements for reasoned agency decisionmaking.

5. Defendants' decision was itself based in substantial measure on a guidance document from 2018 that weakened the standards for approving waivers under Section 1332 (the "2018 Guidance"). *See State Relief and Empowerment Waivers*, 83 Fed. Reg. 53,575 (Oct. 24, 2018). The 2018 Guidance interprets Section 1332 to permit waivers that would promote non-ACA-compliant coverage, including short-term, limited-duration insurance plans and association health plans. *See, e.g.*, *id.* at 53,576-77. To that end, the 2018 Guidance interprets the "comprehensiveness" and "affordability" guardrails of Section 1332 to focus only on the "nature of coverage that is made available to state residents" by a proposed state plan, "rather than on the coverage that residents actually purchase." *Id.* at 53,576. The 2018 Guidance therefore unlawfully encourages state plans—like Georgia's—intended to drive consumers toward junk plans that are anathema to the ACA. Even under the 2018 Guidance, however, Georgia's plan still violates the coverage guardrail and is therefore unlawful.

6. Georgia's plan also suffers from several other flaws. By allowing Georgia to terminate its reliance on healthcare.gov without creating a state Exchange in its place, Defendants' decision grossly exceeds their authority under Section 1332, which allows the waiver of a discrete list of statutory requirements. Even if Defendants had the authority to grant Georgia's waiver, both Georgia and Defendants rushed Georgia's application through the approval process—again, amidst a global pandemic placing extraordinary strain on health system stakeholders—and deprived the public of adequate time to comment on Georgia's radical changes. And Georgia's application itself was deficient in numerous respects, failing to explain core elements of the state's plan and reasoning.

7. If allowed to stand, Defendants' decision to approve Georgia's waiver will harm Georgia consumers and those who serve them, including Plaintiffs. Plaintiffs Planned

Parenthood Southeast and the Feminist Women's Health Center are healthcare providers that offer reproductive health services to thousands of otherwise-underserved patients in Georgia. By dismantling Georgia's Exchange, the Georgia Access Model will make obtaining health insurance—particularly insurance that covers Plaintiffs' services—more expensive and difficult for Plaintiffs' patients. That result will strain Plaintiffs' resources by increasing demand for them to provide uncompensated care to their patient populations, by making their patients less healthy and therefore more resource-intensive to care for, and by making it more complicated for them to assist their patients in obtaining insurance coverage for their services. In each of these ways, Georgia's waiver inflicts significant, tangible injuries on Plaintiffs.

8. For these reasons, and as described more fully below, the Court should declare that Defendants' issuance of a waiver to Georgia under Section 1332 is unlawful and that the related 2018 Guidance is unlawful, set both the waiver and the Guidance aside, and enjoin Defendants from issuing the proposed waiver to Georgia or processing future waivers under the terms of the 2018 Guidance.

JURISDICTION AND VENUE

9. The Court has subject matter jurisdiction over this action under 28 U.S.C. § 1331 because this action arises under federal law.

10. Venue is proper in this district under 28 U.S.C. § 1391(e), because Defendants are officers and agencies of the United States and Defendants Alex M. Azar, II, the United States Department of Health and Human Services, Steven T. Mnuchin, David Kautter, and the United States Department of the Treasury are located in Washington, DC.

PARTIES

11. Plaintiff Planned Parenthood Southeast, Inc. ("PPSE") is a not-for-profit corporation registered in Georgia. PPSE "believes in the fundamental right of each individual,

throughout our service area, to manage his or her fertility."[1] "Based on these beliefs, and reflecting the diverse communities within which [it] operate[s], the mission of Planned Parenthood Southeast is:"

a. "to provide comprehensive reproductive and complementary health care services in settings which preserve and protect the essential privacy and rights of each individual";

b. "to advocate for public policies which guarantee these rights and ensure access to such services";

c. "to provide educational programs which enhance understanding of individual and societal implications of human sexuality"; and

d. "to participate in research that supports the advancement of reproductive health care and encourages understanding of their inherent bioethical, behavioral, and social implications."[2]

12. PPSE and its corporate predecessors have provided care in Georgia for over 50 years. PPSE operates four health centers in Georgia, located in DeKalb, Gwinnett, Cobb, and Chatham counties, and an additional three health centers in Alabama and Mississippi. PPSE provides comprehensive reproductive health care, including family planning services, testing and treatment for sexually transmitted infections ("STIs"), cancer screening and treatment, pregnancy testing, all options counseling, and abortion.

13. Plaintiff Feminist Women's Health Center ("FWHC") is a non-profit reproductive health care facility registered in the state of Georgia and located in DeKalb County. FWHC has

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[1] *Who We Are*, Planned Parenthood Southeast, https://www.plannedparenthood.org/planned-parenthood-southeast/who-we-are (last visited Jan. 13, 2021).

[2] *Id.*

been providing reproductive health care in the state since 1976. It currently provides a range of services, including abortion up to 21 weeks and 6 days from the first day of a woman's last menstrual period, contraception, annual gynecological examinations, miscarriage management, STI testing and treatment, and transgender health care, such as hormone replacement therapy. FWHC also engages in community education, grassroots organizing, public affairs, and advocacy programs to advance reproductive health, rights, and justice for all Georgians.

14. Defendant Alex M. Azar, II, is sued in his official capacity as Secretary of Health and Human Services.

15. Defendant the United States Department of Health and Human Services ("HHS") is a federal agency headquartered in Washington, DC, at 200 Independence Avenue SW, Washington, DC, 20201.

16. Defendant Seema Verma is sued in her official capacity as Administrator of the Centers for Medicare and Medicaid Services.

17. Defendant the Centers for Medicare and Medicaid Services ("CMS") is a component of Defendant HHS and is headquartered in Baltimore, Maryland, at 7500 Security Boulevard, Baltimore, MD, 21244.

18. Defendant Steven T. Mnuchin is sued in his official capacity as Secretary of the Treasury.

19. Defendant David Kautter is sued in his official capacity as Assistant Secretary for Tax Policy, United States Department of the Treasury.

20. Defendant the United States Department of the Treasury ("Treasury") is a federal agency headquartered in Washington, DC, at 1500 Pennsylvania Avenue NW, Washington, DC 20220.

FACTUAL ALLEGATIONS

I. The Affordable Care Act

A. The ACA's reforms

21. In 2010, Congress passed, and President Obama signed into law, the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010) (as amended by Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029 (2010)).

22. One of the primary objectives of the ACA is "to expand coverage in the individual health insurance market." *King v. Burwell*, 135 S. Ct. 2480, 2485 (2015); *see also Maine Cmty. Health Options v. United States*, 140 S. Ct. 1308, 1315 (2020) (explaining that the Act seeks "to improve national health-insurance markets and extend coverage to millions of people without adequate (or any) health insurance"); *Nat'l Fed'n of Indep. Bus. v. Sebelius*, 567 U.S. 519, 538 (2012) ("The Act aims to increase the number of Americans covered by health insurance and decrease the cost of health care."); *Doe #1 v. Trump*, 957 F.3d 1050, 1063 (9th Cir. 2020) (explaining that Congress aimed "[t]o incentivize the purchase of insurance plans through ACA marketplaces").

23. In enacting the ACA, Congress concluded that high uninsured and underinsured rates harm both individuals who lack adequate insurance and society as a whole. Specifically, Congress found that the uninsured suffer from "poorer health and shorter lifespan"; that the "cost of providing uncompensated care to the uninsured" is high; that "health care providers pass on the cost to private insurers, which pass on the cost to families" by "increas[ing] family premiums"; and that, because many "personal bankruptcies are caused in part by medical expenses," "significantly increasing health insurance coverage … will improve financial security for families." 42 U.S.C. § 18091(2)(E)-(G).

24. Prior to the enactment of the ACA, individual health insurance markets were dysfunctional: "premiums for these policies were increasing more than 10% a year, on average, while the policies themselves had major deficiencies," including that they "often excluded pre-existing conditions" and "charged higher premiums for people with health risks."[3]

25. As the Supreme Court has explained, many state efforts to reform the individual health insurance market in the 1990s were unsuccessful. *King*, 135 S. Ct. at 2485-86. The ACA "grew out of [this] long history of failed health insurance reform," *id.* at 2485, and aims to achieve systemic improvements in the individual health insurance market by means of certain key reforms, including:

a. ***Nondiscrimination on the basis of health status and health history.*** The ACA requires "each health insurance issuer that offers health insurance coverage in the individual … market in a State [to] accept every … individual in the State that applies for such coverage," 42 U.S.C. § 300gg-1(a), and bars insurers from charging higher premiums on the basis of a person's health, *id.* § 300gg(a).

b. ***Coverage for essential health benefits.*** Insurance for individuals and families sold on ACA Exchanges must cover "essential health benefits," *id.* § 300gg-6(a), and so-called "cost-sharing" payments—for example, deductibles and copayments—for such coverage are limited, *see id.* §§ 300gg-6(b), 18022(a)(2), (c).

[3] David Blumenthal & Sara Collins, *Where Both the ACA and AHCA Fall Short, and What the Health Insurance Market Really Needs*, Harv. Bus. Rev. (Mar. 21, 2017), https://hbr.org/2017/03/where-both-the-aca-and-ahca-fall-short-and-what-the-health-insurance-market-really-needs.

c. ***Subsidized coverage.*** The ACA "seeks to make insurance more affordable by giving refundable tax credits to individuals with household incomes between 100 percent and 400 percent of the federal poverty line." *King*, 135 S. Ct. at 2487 (citing 26 U.S.C. § 36B; 42 U.S.C. §§ 18081, 18082).

26. Through these reforms, the ACA aims to increase enrollment in affordable, high-quality health coverage. But increasing enrollment in quality health insurance coverage is not only the ACA's immediate goal; it is also key to the ACA's long-term success. "At the overall market level, enrollment must be high enough to reduce random fluctuations in claims from year to year."[4] In addition, "[b]ecause the ACA prohibits health plans from denying coverage or charging higher premiums based on pre-existing health conditions, having affordable premiums depends on enrolling enough healthy individuals over which the costs of the less-healthy individuals can be spread. Enrollment of only individuals with high health care needs … can produce unsustainable upward premium spirals."[5]

B. The ACA's Exchanges

27. To help individuals learn about and enroll in the health coverage options that are available to them, the ACA requires each State to "establish" an "Exchange" that "facilitates the purchase of qualified health plans" ("QHPs"). 42 U.S.C. § 18031(b)(1); *see also Maine Cmty. Health Options*, 140 S. Ct. at 1315 (explaining that the ACA "called for the creation of virtual health-insurance markets, or 'Health Benefit Exchanges,' in each State," to serve the "end" of increased coverage); *King*, 135 S. Ct. at 2487 (explaining that the ACA "requires the creation of

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[4] *An Evaluation of the Individual Health Insurance Market and Implications of Potential Changes*, Am. Academy of Actuaries 5 (Jan. 2017), https://www.actuary.org/files/publications/Acad_eval_indiv_mkt_011817.pdf.

[5] *Id.*

an 'Exchange' in each State where people can shop for insurance, usually online"). "ACA exchanges are virtual marketplaces in which consumers and small businesses can shop for and purchase private health insurance coverage and, where applicable, be connected to public health insurance programs."[6]

28. Prior to the enactment of the ACA, individuals generally had to purchase insurance through private insurers, agents, and brokers, rather than through a consolidated marketplace. Those "individual and small group health insurance markets … suffered from adverse selection and high administrative costs, resulting in low value for consumers."[7] In 2006, however, Massachusetts created the first successful health insurance marketplace—an exchange referred to as the "Connector"—which then served as a model for the ACA's Exchanges.[8]

29. The Exchanges have therefore been described as the "centerpiece,"[9] a "central feature,"[10] and "the major national innovation"[11] of the ACA's reforms. As President Obama explained in signing the ACA, "Once this reform is implemented, health insurance exchanges

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[6] Vanessa C. Forsberg, Cong. Res. Serv., R44065, *Overview of Health Insurance Exchanges* 1 (June 20, 2018), https://fas.org/sgp/crs/misc/R44065.pdf.

[7] *Initial Guidance to States on Exchanges*, CMS, https://www.cms.gov/CCIIO/Resources/Files/guidance_to_states_on_exchanges (last visited Jan. 13, 2021).

[8] William P. Brandon & Keith Carnes, *Federal Health Insurance Reform and "Exchanges": Recent History*, 25 J. of Health Care for the Poor & Underserved, at xxxii, xli (Feb. 2014), https://www.researchgate.net/publication/260130007_Federal_Health_Insurance_Reform_and_Exchanges_Recent_History.

[9] Timothy Stoltzfus Jost, *Health Insurance Exchanges and the Affordable Care Act: Key Policy Issues*, The Commonwealth Fund, at v (July 2010), https://www.commonwealthfund.org/sites/default/files/documents/___media_files_publications_fund_report_2010_jul_1426_jost_hlt_insurance_exchanges_aca.pdf.

[10] Sharon Silow-Carroll et al., *Health Insurance Exchanges: State Roles in Selecting Health Plans and Avoiding Adverse Selection*, The Commonwealth Fund, https://www.commonwealthfund.org/publications/newsletter-article/health-insurance-exchanges-state-roles-selecting-health-plans-and (last visited Jan. 13, 2021).

[11] Brandon & Carnes, *supra* note 8, at xxxii.

will be created, a competitive marketplace where uninsured people and small businesses will finally be able to purchase affordable, quality insurance."[12]

30. The Exchanges "are intended to provide a seamless, single point of access for individuals to enroll into private health plans, apply for income-based financial subsidies established under the law, and, as applicable, obtain an eligibility determination for other health coverage programs, such as Medicaid or the State Children's Health Insurance Program (CHIP)."[13] The ACA's Exchanges are grounded in substantial scholarship from health economists and policy scholars finding that competitive, well-managed marketplaces "reward quality, efficiency, and value among insurers and plans."[14]

31. To that end, the ACA's Exchanges "are designed to streamline enrollment and help ensure affordability for a range of consumers. Exchanges must offer centralized, online mechanisms for plan enrollment[,] … are responsible for determining purchasers' eligibility for plans and subsidies," and "must coordinate with other federal institutions, including [CMS] and [Treasury], to ensure that consumers receive the maximum possible assistance in the form of tax credits and/or cost-sharing subsidies."[15]

32. Exchanges must also play an active role in helping consumers obtain coverage. Specifically, "Exchanges have a number of responsibilities related to assisting consumers in accessing and obtaining coverage, including providing tools to help consumers access the

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[12] *Statement by President of the United States; Statement by President Barack Obama Upon Signing H.R. 3590*, 2010 U.S.C.C.A.N. S6.

[13] U.S. Gov't Accountability Off., GAO-13-601, *Status of CMS Efforts to Establish Federally Facilitated Health Insurance Exchanges* 2 (June 2013), https://www.gao.gov/assets/660/655291.pdf.

[14] Margo M. Hoyler et al., *Insurance Exchanges Under the Affordable Care Act: How Will They Affect Surgical Care?*, Bull. of the Am. Coll. of Surgeons (May 1, 2013), https://bulletin.facs.org/2013/05/insurance-exchanges/.

[15] *Id.*

exchange, helping consumers determine which plan or program to enroll in, and helping consumers determine their potential financial responsibility for a QHP offered through an exchange."[16]

33. As CMS put it in its first Exchange-related rule, the Exchanges "will offer Americans competition, choice, and clout. Insurance companies will compete for business on a level playing field, driving down costs. Consumers will have a choice of health plans to fit their needs, and Exchanges will give individuals and small businesses the same purchasing clout as big businesses."[17]

34. Indeed, CMS again recognized just over a month ago that

> [o]ne of the primary advantages of th[e] [Exchange] design is that consumers can access one-stop shopping for all QHPs offered through an Exchange and can access relevant details on such plans in a standardized format. Before Exchanges existed, consumers shopping for individual market health insurance who tried to search for this information would have to contact multiple issuers or visit multiple websites, and the information would often be presented inconsistently, preventing true apples-to-apples comparison shopping. Exchange-run application and enrollment websites also help to manage churn between private health insurance coverage and public programs such as Medicaid and CHIP by offering connections to those public programs for individuals who may qualify for participation.

Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2022 and Pharmacy Benefit Manager Standards; Updates To State Innovation Waiver (Section 1332 Waiver) Implementing Regulations, 85 Fed. Reg. 78,572, 78,618 (Dec. 4, 2020).

35. Exchanges may offer only quality health insurance plans, referred to as "qualified health plans" or "QHPs" under the Act. 42 U.S.C. § 18031(b)(1), (c); *see id*. § 18021(a). QHPs

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[16] Bernadette Fernandez & Annie L. Mach, Cong. Res. Serv., R42663, *Health Insurance Exchanges Under the Patient Protection and Affordable Care Act (ACA)* 14 (Aug. 15, 2012), https://www.ncsl.org/documents/health/CRS-ExchgRpt81512.pdf.

[17] *Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers*, 77 Fed. Reg. 18,310, 18,311 (Mar. 27, 2012).

must cover preexisting conditions and essential health benefits and cannot impose annual or lifetime-dollar limits on core coverage. *See*, *e.g.*, *id*. §§ 300gg-3(a), -6(a), -11, 18022. For ease of comparison, the ACA differentiates plans along four standard metallic tiers—Bronze, Silver, Gold, and Platinum, from least to most generous—according to how they apportion costs between individuals and issuers. *Id.* § 18022(d).

36. An Exchange may be established by the state in which it operates or, in states that have elected not to establish Exchanges, by the federal government. *See King*, 135 S. Ct. at 2487 (citing 42 U.S.C. §§ 18031(b)(1), 18041(c)(1)); 45 C.F.R. § 155.105(f).[18] As of 2021, fifteen states operated "state-based exchanges" or "SBEs" (operating their own websites rather than using the federally run healthcare.gov), thirty states relied principally on the federal government to run their "federally facilitated exchanges" or "FFEs" using healthcare.gov, and six states had hybrid exchanges that assume some, but not all, exchange functions.[19]

37. Since the effective date of the ACA's Exchange provisions and, as of the filing of this lawsuit, Georgia has had a federally facilitated Exchange.[20]

C. The ACA's substantial achievements

38. When faithfully implemented, the ACA's reforms, including the Exchanges, successfully met Congress's goal of enabling more individuals—specifically, 20 million more individuals—to enroll in health insurance coverage. At the time the ACA was adopted, 46.5

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[18] *See* Forsberg, *supra* note 6, at 2.

[19] *State Health Insurance Marketplace Types, 2021*, Kaiser Family Found., https://www.kff.org/health-reform/state-indicator/state-health-insurance-marketplace-types/ (last visited Jan. 13, 2021).

[20] *See* Louise Norris, *Georgia Health Insurance Marketplace: History and News of the State's Exchange*, Healthinsurance.org (Dec. 16, 2020), https://www.healthinsurance.org/georgia-state-health-insurance-exchange/.

million non-elderly Americans, 17.8% of the population, lacked health coverage.[21] By 2016, the ACA had driven the uninsured rate down dramatically, to 26.7 million and 10%.[22] Millions of those individuals obtained health insurance through the ACA's Exchanges. These coverage gains have also been witnessed in Georgia, where the uninsured rate declined by 5.8 percentage points from 2010 to 2015, a coverage gain of 581,000 people.[23]

39. These national coverage gains have been "widely shared":

> As the ACA took effect, uninsured rates fell by a third or more for low-income households (mostly due to Medicaid expansion), moderate-income households (mostly due to subsidies), and middle- and upper-income households (mostly due to market reforms, including the individual mandate). They fell for people of all ages (especially sharply for young adults), of all racial/ethnic backgrounds, and at all education levels. Other data show uninsured rates also fell dramatically for both urban and rural households and for both healthy and sick people.[24]

40. The ACA's individual market reforms were particularly successful in reducing the uninsured rate among individuals with preexisting conditions.[25] That is because the ACA "put in place crucial protections for the more than 50 million non-elderly Americans with pre-existing health conditions," preventing health insurers from continuing to "deny coverage or charge exorbitant premiums based on health status."[26]

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[21] Jennifer Tolbert et al., *Key Facts about the Uninsured Population*, Kaiser Family Found. (Nov. 6, 2020), https://www.kff.org/uninsured/issue-brief/key-facts-about-the-uninsured-population/.

[22] *Id.*

[23] Off. of the Ass't Sec'y for Planning & Evaluation, *Compilation of State Data on the Affordable Care Act*, HHS, https://aspe.hhs.gov/compilation-state-data-affordable-care-act (last visited Jan. 13, 2021) ("Compilation of State Data on the Affordable Care Act" spreadsheet).

[24] *Chart Book: Accomplishments of Affordable Care Act*, Ctr. for Budget & Pol'y Priorities (Mar. 19, 2019), https://www.cbpp.org/research/health/chart-book-accomplishments-of-affordable-care-act.

[25] Off. of the Ass't Sec'y for Planning & Evaluation, *Health Insurance Coverage for Americans with Pre-Existing Conditions: The Impact of the Affordable Care Act*, HHS 1 (Jan. 5, 2017), https://aspe.hhs.gov/system/files/pdf/255396/Pre-ExistingConditions.pdf.

[26] *See Chart Book*, *supra* note 24.

41. These coverage expansions are generally understood to have improved access to care, health outcomes, and financial security, and reduced the level of income inequality in the United States.[27]

42. Moreover, health coverage for women of reproductive age is at an all-time high. The ACA's guarantee of preventive services without cost-sharing has accounted for massive gains[28] in access to lifesaving care and cost savings, particularly for women of color.[29] Since the ACA was passed, the proportion of Black and Hispanic women of reproductive age without health insurance fell by 36 percent and 31 percent, respectively.[30]

43. Enrollment on the Exchanges remains robust. During 2020 open enrollment, preliminary numbers show that over 8.2 million consumers purchased insurance on healthcare.gov, an increase of 6.6% over 2019, with over 517,000 in Georgia, an increase of roughly 11%.[31]

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[27] *See, e.g.*, *id.*; *The Economic Record of the Obama Administration: Reforming the Health Care System*, Council of Econ. Advisers 27-36 (Dec. 2016), https://obamawhitehouse.archives.gov/sites/default/files/page/files/20161213_cea_record_health_care_reform.pdf.

[28] Usha Ranji et al., *Overview: 2017 Kaiser Women's Health Survey*, Kaiser Family Found., (March 2018), https://www.kff.org/report-section/executive-summary-2017-kaiser-womens-health-survey/.

[29] Marcela Howell & Ann M. Starrs, *For Women of Color, Access to Vital Health Services Is Threatened*, The Hill (July 26, 2017), https://thehill.com/blogs/pundits-blog/healthcare/343996-for-women-of-color-access-to-vital-health-services-is.

[30] *Id.*

[31] *2021 Federal Health Insurance Exchange Weekly Enrollment Snapshot: Final Snapshot*, CMS (Jan. 12, 2021), https://www.cms.gov/newsroom/fact-sheets/2021-federal-health-insurance-exchange-weekly-enrollment-snapshot-final-snapshot; Joshua Peck, *Week 6: HealthCare.gov Enrollment Grows Due to COVID-19—Underscoring the ACA's Critical Role in the Safety Net*, Medium (Dec. 18, 2020), https://medium.com/get-america-covered/week-6-healthcare-gov-6cb216b6a238.

44. Indeed, as of 2020, Georgia's Exchange appears to be functioning well. "After several years of insurer exits and fairly substantial rate increases, Georgia's individual insurance market appears to be stabilizing. The average rate increase for 2019 was less than 4 percent, and average rates decreased slightly for 2020. … For 2021, all six insurers are continuing to offer coverage, and average rates are increasing by less than 5 percent."[32]

II. Defendants' efforts to undermine the ACA

45. The Affordable Care Act remains a binding, duly enacted law—one that, as explained above, has provided coverage to tens of millions of Americans.

46. Since the beginning of the Trump Administration, however, Defendants have "follow[ed] a long-established pattern … to weaken and discourage enrollees to the ACA at nearly every turn possible" in an effort to sabotage the law.[33]

47. President Trump and his advisors repeatedly promised to undermine the Affordable Care Act as a substitute for repealing it legislatively. To take just a few examples:

a. On January 25, 2017, President Trump stated, "[T]he best thing we could do is nothing for two years, let [the ACA] explode. And then we'll go in and we'll do a new plan and—and the Democrats will vote for it. Believe me. … So let it all come [due] because that's what's happening. It's all coming [due] in '17. We're gonna have an explosion. And to do it right,

[32] Norris, *supra* note 20.

[33] Katelyn Burns, *Trump Could Have Reopened Enrollment for the Affordable Care Act for Coronavirus. He Chose Not to.*, Vox (Apr. 1, 2020), https://www.vox.com/policy-and-politics/2020/4/1/21202841/trump-enrollment-affordable-care-act-coronavirus.

sit back, let it explode and let the Democrats come begging us to help them because it's on them."[34]

b. After Congress declined to repeal the Affordable Care Act on July 28, 2017, President Trump tweeted, "3 Republicans and 48 Democrats let the American people down. As I said from the beginning, let ObamaCare implode, then deal. Watch!"[35]

c. On October 13, 2017, President Trump stated, "We're taking a little different route than we had hoped, because getting Congress—they forgot what their pledges were. … So we're going a little different route. But you know what? In the end, it's going to be just as effective, and maybe it'll even be better."[36]

d. In late April 2018, at a rally in Michigan, President Trump bragged, "Essentially, we are getting rid of Obamacare[.] … Some people would say, essentially, we have gotten rid of it."[37]

e. In signing a bill unrelated to the ACA on May 30, 2018, President Trump stated: "For the most part, we will have gotten rid of a majority of

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[34] *Transcript: ABC News Anchor David Muir Interviews President Trump*, ABC News (Jan. 25, 2017), http://abcnews.go.com/Politics/transcript-abc-news-anchor-david-muir-interviews-president/story?id=45047602.

[35] Donald J. Trump (@realDonaldTrump), Twitter (July 28, 2017, 2:25 AM), https://twitter.com/realDonaldTrump/status/890820505330212864. Now that President Trump has been suspended from Twitter, his account is no longer viewable; however, this tweet can be viewed at the "Trump Twitter Archive" at https://www.thetrumparchive.com/?searchbox=%22%5C%223+Republicans+and+48+Democrats+let+the+American+people+down.%5C%22%22.

[36] *President Trump Addresses Values Voters Summit*, CNN (Oct. 13, 2017), http://www.cnn.com/TRANSCRIPTS/1710/13/cnr.04.html.

[37] Alan Rappeport, *Trump Says He Got Rid of Obamacare. The I.R.S. Doesn't Agree.*, N.Y. Times (May 6, 2018), https://www.nytimes.com/2018/05/06/business/trump-obamacare-irs.html.

Obamacare."[38] He went on to confirm that his Administration's objective is to achieve by executive action alone what Congress has refused to do: "Could have had it done a little bit easier, but somebody decided not to vote for it, so it's one of those things."[39]

f. At a rally on June 23, 2018, according to an observer, President Trump complained about Congress's decision not to repeal the ACA and told audience members that "it doesn't matter. We gutted it anyway."[40]

g. On August 1, 2018, President Trump returned to the same theme, stating that, even though Congress declined to repeal the ACA, "I have just about ended Obamacare," but "we're doing it a different way. We have to go a different route."[41]

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[38] *Remarks by President Trump at S.204, "Right to Try" Bill Signing*, The White House (May 30, 2018), https://www.whitehouse.gov/briefings-statements/remarks-president-trump-s-204-right-try-bill-signing/.

[39] *Id*.

[40] Laura Litvan (@LauraLitvan), Twitter (June 23, 2018, 4:04 PM), https://twitter.com/LauraLitvan/status/1010614472946352128; *see also* Jake Sherman et al., *Overheard at the DSCC Retreat on Martha's Vineyard*, Politico (June 24, 2018), https://www.politico.com/newsletters/playbook/2018/06/24/overheard-at-the-dscc-retreat-on-marthas-vineyard-281247.

[41] *President Trump Calls the Show!*, The Rush Limbaugh Show (Aug. 1, 2018), https://www.rushlimbaugh.com/daily/2018/08/01/president-trump-calls-the-show/amp/ (emphasis added).

h. On November 2, 2018, President Trump boasted that his Administration is "decimating [the ACA] strike by strike"[42]; "we've decimated Obamacare."[43]

i. On May 6, 2020, during a press availability in the Oval Office, President Trump declared that his Administration would continue arguing to invalidate the ACA, stating that "Obamacare is a disaster," that "[w]hat we want to do is terminate it," and that his Administration had "already pretty much killed it."[44]

j. On May 26, 2020, President Trump claimed that "essentially we got rid of Obamacare, if you want to know the truth. You can say that in the truest form."[45]

48. President Trump and his Administration have made good on their threats to undermine the ACA through executive action, although the ACA has continued to function and—again—remains the law of the land.

49. Hours after he was sworn in, President Trump signed Executive Order No. 13,765, *Minimizing the Economic Burden of the Patient Protection and Affordable Care Act Pending Repeal*, 82 Fed. Reg. 8,351 (Jan. 20, 2017). The Order turned what had been candidate

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[42] *Speech: Donald Trump Holds a Political Rally in Huntington, West Virginia – November 2, 2018*, Factbase, https://factba.se/transcript/donald-trump-speech-maga-rally-huntington-wv-november-2-2018.

[43] Jim Acosta (@Acosta), Twitter (Nov. 2, 2018, 8:19 PM), https://twitter.com/acosta/status/1058514065595777024?s=21.

[44] Nikki Carvajal, *Trump Says Administration Will Continue Legal Fight to Eliminate Obamacare*, CNN (May 6, 2020), https://www.cnn.com/2020/05/06/politics/trump-obamacare/index.html.

[45] *Remarks by President Trump on Protecting Seniors with Diabetes*, The White House (May 26, 2020), https://www.whitehouse.gov/briefings-statements/remarks-president-trump-protecting-seniors-diabetes/.

Trump's promises to repeal the ACA into President Trump's official policy. *Id.* § 1 ("It is the policy of my Administration to seek the prompt repeal of the Patient Protection and Affordable Care Act … ."). "[P]ending such repeal," the Order directs Administration officials to "take all actions consistent with law to minimize the unwarranted economic and regulatory burdens of the Act." *Id.*; *see id.* §§ 2-4.

50. In particular, the Trump Administration has taken steps to promote so-called "junk plans" that do not provide the coverage the ACA guarantees. On October 12, 2017, President Trump signed Executive Order No. 13,813, *Promoting Healthcare Choice and Competition Across the United States*, 82 Fed. Reg. 48,385 (Oct. 12, 2017). The Order directs the Administration to "prioritize three areas for improvement in the near term: association health plans (AHPs), short-term, limited-duration insurance (STLDI), and health reimbursement arrangements (HRAs)." *Id.* § 1(b). All three forms of coverage fail to comply with the ACA's requirements. In keeping with Executive Order No. 13,813's directive, the Administration has issued rules expanding access to AHPs,[46] STLDI,[47] and HRAs.[48]

51. In an effort to further destabilize the ACA's Exchanges, the Trump Administration shortened the period for open enrollment, cutting the open enrollment period for 2018 plans in half compared to prior years.[49] The Administration provided a similarly short

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[46] *See Definition of "Employer" Under Section 3(5) of ERISA—Association Health Plans*, 83 Fed. Reg. 28,912 (June 21, 2018).

[47] *See Short-Term, Limited-Duration Insurance*, 83 Fed. Reg. 38,212 (Aug. 3, 2018).

[48] *See Health Reimbursement Arrangements and Other Account-Based Group Health Plans*, 84 Fed. Reg. 28,888 (June 20, 2019).

[49] *Patient Protection and Affordable Care Act; Market Stabilization*, 82 Fed. Reg. 18,346, 18,353-54 (Apr. 18, 2017); *see* 45 C.F.R. § 155.410(e).

period for open enrollment in 2019 and 2020.[50] The Administration has also repeatedly slashed funding for outreach and advertising for open enrollment,[51] even though evidence known to HHS demonstrates that robust advertising is critical to fulfilling the ACA's goal of increasing enrollment.[52] And, finally, the Administration has slashed funding for navigators, groups which assist individuals in the enrollment process.[53]

III. Defendants' use of State Innovation Waivers

52. The Trump Administration has also sought to sabotage the ACA through its approach to waivers of the ACA's requirements, including waivers under Section 1332 of the ACA—so-called "State Innovation Waivers." 42 U.S.C. § 18052; *see also* 31 C.F.R. § 33.100 *et seq.*; 45 C.F.R. § 155.1300 *et seq.* (implementing regulations).

53. Section 1332 allows a state to apply "for the waiver" of certain individual market requirements "for plan years beginning on or after January 1, 2017." 42 U.S.C. § 18052(a)(1). State Innovation Waivers are intended to allow states to "pursue innovative strategies for

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[50] Clary Estes, *We Are Midway Through ACA's 2020 Enrollment Period, but The Trump Administration Is Hoping You Won't Notice*, Forbes (Nov. 23, 2019), https://www.forbes.com/sites/claryestes/2019/11/23/we-are-midway-through-acas-2020-enrollment-period-but-the-trump-administration-is-hoping-you-wont-notice/#45ab958f6bb1.

[51] Paul Demko, *Trump White House Abruptly Halts Obamacare Ads*, Politico (Jan. 26, 2017), http://www.politico.com/story/2017/01/trump-white-house-obamacare-ads-234245; *Policies Related to the Navigator Program and Enrollment Education for the Upcoming Enrollment Period*, CMS 1 (Aug. 31, 2017), https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces/Downloads/Policies-Related-Navigator-Program-Enrollment-Education-8-31-2017.pdf.

[52] *See id.*

[53] U.S. Gov't Accountability Off., GAO-18-567, *Health Insurance Exchanges: HHS Should Enhance Its Management of Open Enrollment Performance* 24 (July 2018), https://www.gao.gov/assets/700/693362.pdf.

providing their residents with access to high quality, affordable health insurance while retaining the basic protections of the ACA."[54]

54. Under Section 1332, a state may seek to waive requirements only under Part A of the ACA (the definition of "qualified health plans," scope of "essential health benefits," and limits on cost-sharing), Part B of the ACA (the establishment of Exchanges, risk pool requirements, and enrollment), Section 18071 of Title 42 (cost-sharing reductions), or Sections 36B (premium tax credits), 4980H (payments by employers who don't offer coverage), or 5000A (the individual mandate) of Title 26. 42 U.S.C. § 18052(a)(2).

55. If the state seeks to waive requirements under Sections 36B, 4980H, or 5000A of Title 26, the Secretary of the Treasury must review the waiver; the others are reviewed by the HHS Secretary. *Id.* § 18052(a)(6)(B). In practice, however, HHS and Treasury generally collaborate in reviewing waivers.

56. Neither official may "waive under this section any Federal law or requirement that is not within [their] authority." *Id.* § 18052(c)(2).

57. State Innovation Waivers also allow states to receive the amount of funding that would have otherwise been paid to participants in the state's Exchange for the purpose of implementing the state's plan. *Id.* § 18052(a)(3).

58. To ensure that State Innovation Waivers further, rather than undermine, the goals of the ACA, Section 1332 and its implementing regulations impose several significant requirements. Most importantly, the Secretaries must determine that the state plan will meet

[54] *Section 1332: State Innovation Waivers*, CMS, https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Section_1332_State_Innovation_Waivers- (last visited Jan. 13, 2021).

Section 1332's "statutory guardrails"—*i.e.*, that it will match or outperform the ACA in certain respects. The Secretaries must conclude that the plan:

> (A) will provide coverage that is at least as comprehensive [with respect to essential health benefits] as certified by [the] Office of the Actuary of the Centers for Medicare & Medicaid Services based on sufficient data from the State and from comparable States … ;
>
> (B) will provide coverage and cost sharing protections against excessive out-of-pocket spending that are at least as affordable as the provisions of this title would provide;
>
> (C) will provide coverage to at least a comparable number of its residents as the provisions of this title would provide; and
>
> (D) will not increase the Federal deficit.

Id. § 18052(b)(1). Section 1332's implementing regulations provide further detail concerning the information and analyses that states must submit to demonstrate that their requests comply with the statutory guardrails. *See, e.g.*, 45 C.F.R. § 155.1308.

59. Section 1332 also imposes a variety of procedural requirements designed to ensure that both the state and federal governments thoroughly scrutinize the state's plan and allow the public to comment on the plan.

60. ***Application Requirements.*** A state's application "shall … contain such information as the Secretary may require, including

> (i) a comprehensive description of the State legislation and program to implement a plan meeting the requirements for a waiver under this section; and
>
> (ii) a 10-year budget plan for such plan that is budget neutral for the Federal Government.

42 U.S.C. § 18052(a)(1)(B). It must also "provide an assurance that the State has enacted" a law, *id.* § 18052(a)(1)(C), "that provides for State actions under a waiver under this section, including the implementation of the State plan," *id.* § 18052(b)(2)(A).

61. After submission, "[e]ach application for a section 1332 waiver will be subject to a preliminary review by the Secretary and the Secretary of the Treasury, as applicable, who will make a preliminary determination that the application is complete." 45 C.F.R. § 155.1308(b). However, "[t]he preliminary determination that an application is complete does not preclude a finding … that a necessary element of the application is missing or insufficient." *Id.* § 155.1308(c)(3).

62. ***Process for Approval.*** Prior to even being submitted, the proposed waiver must undergo "a process for public notice and comment at the State level, including public hearings, sufficient to ensure a meaningful level of public input" 45 U.S.C. § 18052(a)(4)(B)(i). Similarly, after submission, the waiver must undergo a federal "process for providing public notice and comment … that is sufficient to ensure a meaningful level of public input and that does not impose requirements that are in addition to, or duplicative of, requirements imposed under the Administrative Procedures Act, or requirements that are unreasonable or unnecessarily burdensome with respect to State compliance." *Id.* § 18052(a)(4)(B)(iii).

63. HHS and Treasury must promulgate, and have promulgated, regulations providing for state and federal notice and comment procedures. *See, e.g.*, 45 C.F.R. §§ 155.1312, .1316. In issuing those regulations, they opined that, "[t]o the extent that a proposal is particularly wide-ranging, the proposed regulations will support a longer State public notice and comment period." *Application, Review, and Reporting Process for Waivers for State Innovation*, 77 Fed. Reg. 11,700, 11,706 (Feb. 27, 2012). The same is true of the federal notice and comment period. *Id.* at 11,708.

64. Ultimately, the Secretaries must make a decision on the application within 180 days from deeming the application complete and submitted. 42 U.S.C. § 18052(d)(1). If the

waiver is granted, the Secretaries "shall notify the State involved of such determination and the terms and effectiveness of such waiver." *Id.* § 18052(d)(2)(A).

65. HHS and Treasury must also promulgate regulations providing a process for submitting "periodic reports by the State concerning the implementation of the program under the waiver"; and "for the periodic evaluation by the Secretary of the program under the waiver," *id.* §§ 18052(a)(4)(B)(iv), (v), which they have, *see, e.g.*, 45 C.F.R. § 155.1320, .1324, 1328.

66. ***Term of Waiver.*** A waiver lasts no longer than five years unless the state applies for a continuance, which is deemed granted if HHS fails to respond in 90 days. 42 U.S.C. § 18052(e). However, Defendants have stated that the "Secretaries reserve the right to suspend or terminate a waiver, in whole or in part, any time before the date of expiration, if the Secretaries determine that the state materially failed to comply with the terms and conditions of the waiver." 83 Fed. Reg. at 53,577.

67. Through these requirements, Section 1332 maintains a careful balance between offering states flexibility to manage their insurance markets while ensuring that the ACA's protections remain in place.

68. Prior to Georgia's application, twenty-two states had applied for State Innovation Waivers; fifteen of those applications had been approved.[55] Fourteen of those fifteen approvals, however, were for state reinsurance programs, which are relatively uncontroversial programs in which a third party acts as an insurer for the insurer, protecting them against high medical

[55] *Section 1332: State Innovation Waivers*, *supra* note 54.

claims.[56] Indeed, the ACA itself established a transitional reinsurance program during the first few years of its implementation.[57]

69. In 2015, HHS and Treasury issued guidance clarifying how they would apply Section 1332's statutory guardrails (the "2015 Guidance"). In accord with the ACA's fundamental purpose, the agencies explained that they would "take[] into account the effects" of any state plan "across different groups of state residents, and, in particular, vulnerable residents, including low-income individuals, elderly individuals, and those with serious health issues or who have a greater risk of developing serious health issues." *Waivers for State Innovation*, 80 Fed. Reg. 78,131, 78,132 (Dec. 16, 2015).

70. In 2018, Defendants revoked the 2015 Guidance concerning State Innovation Waivers and replaced it with the 2018 Guidance. *See* 83 Fed. Reg. 53,575. One commentator noted that, "[a]s the name change from 'Innovation' to 'Relief and Empowerment' implies, the administration views the waiver as a way to 'relieve' states from the statute's requirements, and shifts the aim from novel experiments to simply giving states greater authority to work around the federal regulations."[58]

71. The 2018 Guidance expressly invokes President Trump's 2017 Executive Order instructing agencies to waive the ACA's requirements "to the maximum extent permitted by law." *Id.* at 53,584. In announcing the Guidance, Administrator Verma made plain that its

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[56] Jack Pitsor & Samantha Scotti, *State Roles Using 1332 Health Waivers*, Nat'l Conf. of St. Legislatures (Nov. 3, 2020), https://www.ncsl.org/research/health/state-roles-using-1332-health-waivers.aspx.

[57] *The Transitional Reinsurance Program - Reinsurance Contributions*, CMS, https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/The-Transitional-Reinsurance-Program/Reinsurance-Contributions (last visited Jan. 13, 2021).

[58] Elizabeth Y. McCuskey, *Big Waiver Under Statutory Sabotage*, 45 Ohio N.U. L. Rev. 213, 235 (2019).

purpose was to restore "a state's traditional regulatory role over health insurance," and to address the ACA's purported "negative impact on state insurance markets."[59]

72. In relevant part, the 2018 Guidance interprets Section 1332 to permit waivers that would promote non-ACA-compliant coverage, including short-term, limited-duration insurance plans and association health plans. *See, e.g.*, *id.* at 53,576-77.

73. To that end, the 2018 Guidance interprets the "comprehensiveness" and "affordability" guardrails to focus only on the "nature of coverage that is made available to state residents" by a proposed state plan, "rather than on the coverage that residents actually purchase." *Id.* at 53,576. Under the 2018 Guidance, a proposed state plan must still cover the same number of state residents, but it can allow those residents to have less affordable or less comprehensive coverage, so long as comparably affordable or comprehensive coverage remains theoretically available on the market.[60] In other words, a proposed state plan would meet the statutory guardrails under this interpretation if it, for example, pushed 100% of the state's residents on to non-ACA-compliant insurance products, so long as they could theoretically buy comprehensive ACA-compliant insurance on the market.

74. That interpretation violates the Affordable Care Act for several reasons. Much like Section 1332 requires that a state's waiver "*provide* coverage to at least a comparable

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[59] Letter from CMS Admin. Seema Verma to State Governors 1 (Oct. 22, 2018), https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Downloads/SignedSREWaiverDearGovLetter.pdf.

[60] Individuals tend to choose plans based on multiple factors, including the individual's health status. Young, healthy individuals are more likely to purchase a cheaper, non-ACA-compliant plan, believing that they are unlikely to use the plan in the near future. In contrast, an older individual with preexisting conditions is likely to choose a more expensive plan that guarantees full coverage. As explained further below, however, this sorting effect means that the risk pool for ACA-compliant insurance becomes filled with higher risk individuals, driving up the cost for ACA-compliant coverage.

number of its residents," the waiver must also "*provide* coverage that is at least as comprehensive" and "affordable" to the state's residents. 42 U.S.C. § 18052(b)(1) (emphasis added). Thus, a state waiver may be approved only "where the state shows that at least as many of its residents would actually have coverage—not merely have access to coverage—that is as affordable and comprehensive as what those residents would have under the ACA."[61] Defendants' contrary interpretation also renders meaningless the statute's requirement that the state provide "an actuarial analysis, based on real data, comparing the scope of coverage that state residents would receive under the waiver to that they would receive without a waiver."[62] And finally, it is predicated on an expansive definition of coverage that includes short-term, limited-duration insurance plans not found in the ACA itself.[63] Any waiver predicated on the 2018 Guidance, including Georgia's waiver, therefore violates the ACA as well.

75. A month after issuing the 2018 Guidance, CMS issued a "discussion paper" "intended to foster discussion with states by illustrating how states might take advantage of new flexibilities provided in recently released guidance." CMS reiterated its commitment to "empowering states to innovate" with Section 1332 waivers, and encouraged states to "reach out to the Departments promptly for assistance in formulating an approach that meets the requirements of section 1332."[64] Among the options highlighted by CMS was an option for

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[61] Joel McElvain, *The Administration's Recent Guidance on State Innovation Waivers under the Affordable Care Act Likely Violates the Act's Statutory Guardrails*, Yale J. on Reg.: Notice & Comment (Dec. 11, 2018), https://www.yalejreg.com/nc/the-administrations-recent-guidance-on-state-innovation-waivers-under-the-affordable-care-act-likely-violates-the-acts-statutory-guardrails-by-joel-mcelvain/.

[62] *Id.*

[63] *Id.*

[64] Ctr. for Consumer Info. & Ins. Oversight, *Discussion Paper, Section 1332 State Relief and Empowerment Waiver Concepts*, CMS 3-4 (Nov. 29, 2018), https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Downloads/Waiver-Concepts-Guidance.PDF.

states to provide subsidies for consumers to enroll in non-ACA-compliant plans through mechanisms other than a consolidated Exchange platform.[65]

76. More recently, Defendants issued an interim final rule that allows them to modify public notice and comment requirements to expedite decisions under Section 1332, and that modifies the post-award public participation requirements as well. *See Additional Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency*, 85 Fed. Reg. 71,142, 71,144-45 (Nov. 6, 2020). Although these changes were published on November 6, 2020, and therefore did not affect the approval of Georgia's waiver, which was granted on November 1, the interim final rule further illustrates Defendants' intent to rush through State Innovation Waivers that would undermine the ACA's fundamental goals.[66]

IV. Georgia's waiver applications

77. Georgia has prepared four separate iterations of the waiver application at issue here. Each time, it has consisted of two parts: "Part I," involving an uncontroversial reinsurance program, and "Part II," a program called the "Georgia Access Model" that would make sweeping changes to Georgia's individual health market, including by eliminating Georgia's reliance on healthcare.gov without creating an Exchange in its place. This case is concerned primarily with Part II of Georgia's application.

78. The first two iterations of Part II—a draft prepared in November 2019, and a revised application submitted to HHS in December 2019—would have made even more drastic

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[65] *Id.* at 13-15.

[66] Similarly, Defendants recently proposed to codify the 2018 Guidance as a formal rule and to allow states to request approval to pursue models similar to Georgia's without seeking a waiver under Section 1332. *See* 85 Fed Reg. at 78,572. While these potential changes, if finalized, would also be unlawful, they again have no bearing on the manner in which Georgia's waiver was approved.

changes to the state's insurance market.[67] Those proposed waivers "would have converted the ACA's open-ended premium tax credit into a capped, state-administered financial assistance program that would place consumers on a waitlist when funding ran out."[68] The first iteration also "proposed allowing the sale of individual market health plans that did not offer all of the ACA's mandated Essential Health Benefits," while the second left benefit requirements unchanged but permitted the sale of plans that impose excessive cost-sharing.[69]

79. After Georgia's plan received substantial public criticism, and it became clear that it could not lawfully be approved,[70] Georgia asked CMS on February 5, 2020, to bifurcate its review of Parts I and II, and to pause its review of Part II pending the completion of CMS's review of Part I.[71] CMS agreed to do so the next day, and asked Georgia to provide additional data concerning Part II.[72]

80. Georgia again asked CMS to pause its review of Part II on July 8 while the state solicited a new round of notice and comment, lasting only fifteen days, on a proposed third iteration of its Part II application.[73] That third iteration focuses solely on implementing the

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[67] *Georgia Section 1332 State Empowerment and Relief Waiver Application*, Ga. Off. of the Gov. (Dec. 23, 2019), https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Section_1332_State_Innovation_Waivers-.

[68] Christen Linke Young & Jason Levitis, *Georgia's Latest 1332 Proposal Continues to Violate the ACA*, Brookings (Sept. 1, 2020), https://www.brookings.edu/research/georgias-latest-1332-proposal-continues-to-violate-the-aca/.

[69] *Id.*

[70] *Id.*

[71] Letter from Ga. Gov. Brian P. Kemp to CMS Admin. Seema Verma (Feb. 5, 2020), https://www.cms.gov/files/document/25-cms-1332-letter-georgia.pdf.

[72] Letter from Randy Pate, Dir., Ctr. for Consumer Info. & Ins. Oversight, to Ga. Gov. Brian P. Kemp 1-2 (Feb. 6, 2020), https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Downloads/1332-GA-Completeness-Letter.pdf.

[73] Letter from Ga. Gov. Brian P. Kemp to CMS Admin. Seema Verma (July 8, 2020), https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Downloads/1332-GA-Governor-July8-Letter.pdf.

Georgia Access Model, as described above, eliminating the first and second iteration's changes to what plans may be sold.

81. Despite the unreasonably short period for comment, Georgia received over 600 detailed comments from the public.[74]

82. Georgia formally submitted the third iteration of its Part II application to CMS on July 31, 2020.[75]

83. CMS preliminarily declared Georgia's revised Part II application complete on August 17, initiating a thirty-day federal notice and comment period lasting until September 16.[76] That period was subsequently extended to September 23 because of a computer error that prevented individuals from commenting for an unknown amount of time during the original comment period.[77]

84. During that comment period, Defendants received approximately 1,826 total comments. Those comments comprised 75 comments from organizations, of which 72 were opposed to the Georgia Access Model, and 1,751 comments from individuals, of which 1,746

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[74] *Georgia Section 1332 State Empowerment and Relief Waiver Application*, Ga. Off. of the Gov. 29-30 (July 31, 2020), https://medicaid.georgia.gov/document/document/georgia1332waiverapplicationfinal07312020vfpdf/download.

[75] *Id.*

[76] Letter from Randy Pate, Dir., Ctr. for Consumer Info. & Ins. Oversight, to Ga. Gov. Brian P. Kemp (Aug. 17, 2020), https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Downloads/1332-GA-Completeness-Letter-Modified-Application.pdf.

[77] Ariel Hart, *Public Comment Window Extended on Kemp Plan to Block ACA Shopping Site*, Atlanta J.-Const. (Sept. 18, 2020), https://www.ajc.com/news/georgia-news/public-comment-window-extended-on-kemp-plan-to-block-aca-shopping-site/LN3SMSGOSRBPHDRZAMB4P2GUGY/.

were opposed.[78] In other words, only *eight* comments supported the model, or less than half of one percent of the total.

85. After the notice and comment period closed, Georgia submitted a fourth iteration of its waiver application on October 9, purportedly in response to comments it received during the federal comment period.[79] That application retains the essential features of the third iteration of Georgia's plan, but includes additional details about how the state plans to approach certain subjects. According to the Internet Wayback Machine, that application was not made publicly available on the CMS website until November 1, the same day Georgia's waiver was approved.[80] Nor did Defendants provide the public with any opportunity to comment on the October application.

86. While the July and October submissions abandon Georgia's proposed changes to essential health benefits, cost-sharing, and financial assistance, the state continues to seek to "waive certain exchange requirements and … transition its individual market from the FFE to the new Georgia Access Model."[81]

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[78] Letter from CMS Admin. Seema Verma to Ga. Gov. Brian P. Kemp 15-16 (Nov. 1, 2020), https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Section_1332_State_Innovation_Waivers-/1332-GA-Approval-Letter-STCs.pdf (the "Approval Letter").

[79] *Georgia Section 1332 State Empowerment and Relief Waiver Application*, Ga. Off. of the Gov. 4 (dated July 31, 2020, revised Oct. 9, 2020), https://medicaid.georgia.gov/document/document/modified-1332-waiver/download ("Georgia's Application").

[80] *Section 1332: State Innovation Waivers*, Wayback Machine, https://web.archive.org/web/2020*/https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Section_1332_State_Innovation_Waivers- (last visited Jan. 13, 2021). To see the change, click the calendar entry for November 1. The application does not appear on prior calendar entries.

[81] Georgia's Application, *supra* note 79, at 4.

87. Specifically, Georgia requested a "five-year partial waiver" of 42 U.S.C. § 18031—a lengthy statutory provision containing dozens of subsections and requirements—but "only to the extent that it is inconsistent with the operation of the Georgia Access Model."[82] The state asserts that it "will remain in full compliance with sections of [the ACA] not waived."[83]

88. Under the Georgia Access Model, "the private sector provides the front-end consumer shopping experience and operations"—*i.e.*, the virtual store fronts at which individuals shop for plans—while the state performs functions like "validating eligibility information and determining if an applicant is eligible for [advance premium tax credits]; transmitting the eligibility determination to CMS … ; sending information annually to enrollees … ; and sending information to the IRS."[84] "The State will transition responsibility for the front-end functions of consumer outreach, customer service, plan shopping, selection, and enrollment from the FFE to the commercial market."[85] All that would remain of those functions is a website where "the State will provide a list of approved carriers and web-brokers that will participate in Georgia Access."[86]

89. As a practical matter, that means that, "[i]nstead of selecting and enrolling in plans through the FFE, consumers will enroll through private web-brokers or directly with carriers"[87]—as they were essentially required to do prior to the enactment of the ACA.

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82 *Id.*

83 *Id.* at 29.

84 *Id.* at 4.

85 *Id.* at 17.

86 *Id.* at 18-19.

87 *Id.* at 25.

"Georgia's unprecedented proposal would force consumers to navigate the type of fragmented insurance system of brokers and insurers the ACA was intended to remedy."[88]

90. The state nonetheless claims that "[t]he Georgia Access Model expands consumer access by allowing individuals to shop for and compare available plans using the platform of their choice."[89] The state asserts that the Georgia Access Model will "increase affordability and spur innovation in the individual market while maintaining access to QHPs and ensuring consumer protections for individuals with pre-existing conditions."[90]

91. In its revised October application, the state "decided to move the implementation date for Georgia Access to [Plan Year] 2023" in response to concerns about "migrating during a national pandemic."[91] The state also provided additional details about how it will offer "auto-reenrollment" for current consumers; "streamline the referral process for Medicaid-eligible individuals and incentivize agents and brokers to provide support for consumers"; provide "consumer protections" against inappropriate steering to non-ACA-compliant plans; and assist "vulnerable individuals."[92]

92. Despite significant public resistance to Georgia's extraordinary waiver, Defendants approved the waiver on November 1, 2020, just weeks after the federal notice and

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88 Tara Straw, *Tens of Thousands Could Lose Coverage Under Georgia's 1332 Waiver Proposal*, Ctr. on Budget & Pol'y Priorities (Sept. 1, 2020), https://www.cbpp.org/research/health/tens-of-thousands-could-lose-coverage-under-georgias-1332-waiver-proposal.

89 Georgia's Application, *supra* note 79, at 17.

90 *Id.*

91 *Id.* at 180.

92 *Id.* at 180-81.

comment period closed and Georgia submitted the governing version of its application.[93] That decision constitutes the final agency action regarding Defendants' review of Georgia's waiver.

93. Georgia's waiver was approved for a period lasting from January 1, 2022 to December 31, 2026.[94]

94. In approving the waiver, Defendants concluded that it "satisfies the statutory guardrails" set forth in Section 1332, and that "implementation of … the Georgia Access Model will lower individual market premiums in the state."[95]

95. Although Defendants purported to assess whether Georgia's waiver, taken as a whole, complied with Section 1332's statutory guardrails, it is clear from Georgia's application that the two parts of the waiver were designed to operate independently. To that end, Georgia repeatedly requested that Defendants evaluate the two parts of the waiver separately, explained why it thought each part complied with the guardrails,[96] and structured its waiver so that the two parts take effect in the 2022 and 2023 plan years, respectively.[97] Moreover, Defendants separately considered the effects of Parts I and II on the statutory guardrails, assessing, for example, the coverage effects of the reinsurance program and the Georgia Access Model in isolation.[98] Regardless, Defendants' decision to approve Georgia's waiver is unlawful, both with respect to the waiver as a whole and as to Part II in particular.

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93 Approval Letter, *supra* note 78.

94 *Id.* at 1.

95 *Id.* at 1-2.

96 Georgia's Application, *supra* note 79, at 8-9, 30-31.

97 *Id.* at 1.

98 Approval Letter, *supra* note 78, at 9-14.

V. Defendants' approval of Georgia's waiver is unlawful.

96. Defendants' hasty approval of Georgia's waiver will cause immense damage to Georgia's health insurance market, resulting in thousands of individuals losing coverage and thousands more losing coverage appropriate for them, including public programs like Medicaid and private health insurance plans adequate to their needs.

97. Defendants' decision is unlawful in three overarching ways. ***First***, Georgia's waiver violates Section 1332's statutory guardrails, which are critical safeguards designed to ensure that a state's plan does not undermine the ACA's goals—and, for similar reasons, is arbitrary and capricious and unsupported by the record. Defendants' contrary conclusion is predicated in large part on the 2018 Guidance, which is unlawful as well. ***Second***, Part II of Georgia's waiver is so radical and sweeping that it conflicts with provisions of the ACA that cannot be waived under Section 1332. And ***third***, Georgia's incomplete plan was rushed through the process without adequate time for public comment and without adequate clarification of how the state intends to approach key issues, as required by the Administrative Procedure Act and Section 1332. Plaintiffs summarize these shortcomings below.[99]

A. Defendants' decision violates Section 1332's guardrails.

98. To start, Defendants' decision violates all four of Section 1332's statutory guardrails: the Georgia Access Model will result in fewer Georgians with insurance coverage, *see* 42 U.S.C. § 18052(b)(1)(C); fewer Georgians with comprehensive coverage, as opposed to

[99] For ease of reference, Plaintiffs cite to two informative publications regarding Georgia's waiver: Young & Levitis, *supra* note 68, and Straw, *Tens of Thousands*, *supra* note 88. Many of the organizational comments on Georgia's waiver, including the comments submitted by PPSE and FWHC, echo these points. While an administrative record has not yet been produced in this matter, those comments are available at https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Downloads/1332-GA-Federal-Comments-Organization-Letters.pdf.

non-ACA-compliant junk plans, *see id.* § 18052(b)(1)(A); and more expensive coverage, which will also potentially expand the federal deficit, *see id.* § 18052(b)(1)(B), (D). It is therefore contrary to law. *See* 5 U.S.C. § 706(2)(A). Defendants also failed to adequately consider these matters and other significant comments and concerns—including alternatives like expanding Medicaid or adopting a reinsurance-only model—and their decision is therefore arbitrary and capricious and unsupported by substantial evidence. *See id.* § 706(2)(A), (E), (F).

1. Coverage

99. The Georgia Access Model will result in fewer Georgians with insurance coverage. 42 U.S.C. § 18052(b)(1)(C). Although Georgia estimates that the Georgia Access Model will increase enrollment by 33,000, with approximately 8,000 consumers losing coverage, thereby yielding net enrollment growth of 25,000,[100] these figures rest on fatally flawed assumptions and modeling.

100. According to the state, "[t]he Georgia Access Model expands consumer access by allowing individuals to shop for and compare available plans using the platform of their choice."[101] But insurance companies, as well as agents and brokers, are *already* allowed to sell plans directly to consumers, through a process called direct enrollment.[102] In the past year, "at least 16 insurers and web-brokers offered these services in Georgia," and even Georgia's application itself "notes these options are widely available."[103] Despite the wide availability of direct enrollment options in Georgia, 79 percent of Georgians who enroll on the individual market choose to find and purchase their health coverage using healthcare.gov, with only 21

[100] Georgia's Application, *supra* note 79, at 56.
[101] *Id.* at 17.
[102] Young & Levitis, *supra* note 68.
[103] Straw, *Tens of Thousands*, *supra* note 88.

percent opting for direct enrollment.[104] Rather than expanding consumer access, Georgia's plan thus *eliminates* the easiest and most common way for consumers to shop for insurance plans—healthcare.gov.

101. As a fallback, the state argues that "[c]arriers have an additional incentive to invest in marketing to attract new business and retain their current FFE consumers."[105] Again, however, "to the extent private entities face 'market incentives' to drum up new enrollment, those incentives *already exist*, and nothing in the application creates new incentives that could plausibly bring in new business."[106]

102. In support of its numbers, Georgia's application notes that the share of enrollments that happen through private vendors has grown by "an average of 4 percentage points … over the past two years."[107] Thus, "[a]ssuming this trend continues," private enrollment will "increase by 33,658."[108] But there are two flaws in this analysis. First, it conflates the share of enrollment and the total amount of enrollment; obviously, if healthcare.gov is eliminated, the share of private enrollment will be 100%, regardless of how much enrollment there is. And second, if the private share of enrollment is *already* increasing by 4% each year, then those increases in enrollment cannot be attributed to the waiver.[109]

103. On the other side of the ledger, Georgia's enrollment losses from eliminating healthcare.gov will be far higher than the 8,000 estimated by the state. The state's "analysis entirely ignores countervailing threats to enrollment posed by dismantling the enrollment and

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[104] Georgia's Application, *supra* note 79, at 77.
[105] *Id.* at 18.
[106] Young & Levitis, *supra* note 68.
[107] Georgia's Application, *supra* note 79, at 77.
[108] *Id.*
[109] Young & Levitis, *supra* note 68.

consumer support system that roughly 400,000 people use." [110] Given that "only 21 percent of marketplace enrollees opted for direct enrollment or enhanced direct enrollment in 2020," "[a]bandoning HealthCare.gov would leave the other 79 percent of enrollees without their platform of choice, almost certainly reducing enrollment significantly."[111]

104. Specifically, abolishing healthcare.gov in the state would require customers to identify private vendors, shop through them, and complete new enrollment processes, resulting in enrollment losses in at least several ways.

105. New enrollees and active re-enrollees would need to navigate new administrative barriers that would likely cause some of them to drop out of the enrollment process, or to lose coverage later as a result of such barriers.[112] Consumers would have to navigate multiple private vendors and additional types of insurance plans on their own, rather than shopping for plans on one, consolidated website. "Fragmenting the insurance market would confuse and discourage consumers, hindering enrollment."[113] Indeed, studies show that administrative barriers are one of the most common reasons people decline to participate in health and other programs.[114]

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[110] Straw, *Tens of Thousands*, *supra* note 88.

[111] *Id.*

[112] Young & Levitis, *supra* note 68.

[113] Straw, *Tens of Thousands*, *supra* note 88.

[114] *See, e.g.*, Samantha Artiga & Olivia Pham, *Recent Medicaid/CHIP Enrollment Declines and Barriers to Maintaining Coverage*, Kaiser Family Found. (Sept. 24, 2019), https://www.kff.org/medicaid/issue-brief/recent-medicaid-chip-enrollment-declines-and-barriers-to-maintaining-coverage/; Pamela Herd, *How Administrative Burdens Are Preventing Access to Critical Income Supports for Older Adults: The Case of the Supplemental Nutrition Assistance Program*, 25 Pub. Pol'y & Aging Rep. 52 (Spring 2015), https://academic.oup.com/ppar/article/25/2/52/1501759; Sheila Hoag et al., *CHIPRA Mandated Evaluation of Express Lane Eligibility: Final Findings*, Mathematica Pol'y Res. (Dec. 2013), https://www.mathematica.org/our-publications-and-findings/publications/chipra-mandated-evaluation-of-express-lane-eligibility-final-findings; Jennifer Maier Snow, *Overcoming Barriers to Enrollment: A 50-State Assessment of Outreach and Enrollment Simplification Strategies for the State Children's Health Insurance Program (SCHIP)*, 9 J. of Pub. Aff. Educ. 63 (Jan. 2003),

106. Moreover, more than 80,000 Georgia enrollees opted to automatically reenroll in coverage—meaning that they were automatically re-enrolled in the same or a comparable plan and did not make an active choice during open enrollment. [115] Because an insurer may no longer offer a consumer's specific plan, the auto-reenrollment process sometimes involves "mapping" or "crosswalking" enrollees to similar plans offered by the insurer. [116] However, the latest version of Georgia's waiver was the first to provide even an abbreviated account of how the state will carry out and fund auto-reenrollment. And because the public was not permitted to comment on those revisions, they were not permitted to articulate the significant challenges Georgia will face in designing a system for auto-reenrollment while simultaneously shifting all enrollment to private vendors. In the past, states transitioning to state-based marketplaces have experienced substantial difficulty in porting over and using previous enrollment information to facilitate auto-reenrollment. In nonetheless approving Georgia's waiver, Defendants simply rubberstamped its assertions about auto-reenrollment.

107. Georgia's waiver will also allow private vendors to direct Medicaid-eligible consumers to less affordable insurance. Under the "no wrong door" requirement, healthcare.gov automatically redirects individuals who may be Medicaid-eligible to the state Medicaid agency. [117] However, private vendors, who are incentivized by commissions and profits, have no incentive to direct consumers to Medicaid, and may actively mislead consumers to deter them

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https://mpa.unc.edu/sites/default/files/MPA%20Capstone%20Paper%20Snow_0.pdf. *See generally* Eldar Shafir & Sendhil Mullainathan, *Scarcity: Why Having Too Little Means So Much* (2013).

[115] Straw, *Tens of Thousands*, *supra* note 88.

[116] Louise Norris, *How to Avoid the Surprise of Health Plan 'Mapping,'* Healthinsurance.org (Jan. 9, 2021), https://www.healthinsurance.org/obamacare/how-to-avoid-the-surprise-of-health-plan-mapping/.

[117] Straw, *Tens of Thousands*, *supra* note 88.

and their families from enrolling in Medicaid.[118] For example, a 2019 report revealed that, in exchange for commissions, some direct enrollment entities were deliberately steering consumers away from Medicaid and instead promoting plans which cost hundreds of dollars more per month than Medicaid, and that many were not presenting information about the Medicaid enrollment process.[119]

108. Additionally, following the initial transition, Georgia will not be assuming any of healthcare.gov's extensive outreach and support functions to assist consumers in navigating the enrollment process. There is little reason to assume that private vendors will pick up the slack.[120] And Georgia will be required to construct a new administrative apparatus to provide all of the "back-end" functions it has never before provided, which it appears to have inadequately funded.[121] Thus, the Georgia Access Model may lead to still more enrollment losses.

109. Experts have therefore calculated that the Georgia Access Model is likely to lead to significant net enrollment losses, the scale of which will depend on the extent of these effects, as displayed below.[122]

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[118] Young & Levitis, *supra* note 68.

[119] Tara Straw, *"Direct Enrollment" in Marketplace Coverage Lacks Protections for Consumers, Exposes Them to Harm*, Ctr. on Budget & Pol'y Priorities (Mar. 15, 2019), https://www.cbpp.org/research/health/direct-enrollment-in-marketplace-coverage-lacks-protections-for-consumers-exposes.

[120] Straw, *Tens of Thousands*, *supra* note 88.

[121] Young & Levitis, *supra* note 68; Straw, *Tens of Thousands*, *supra* note 88.

[122] *Id.*

Figure 1: Coverage losses from Georgia waiver under various assumptions

Scenario	Active Re-Enrollee Loss	Automatic Re-enrollee Loss	Medicaid Enrollee Loss	Total Coverage Loss
Minimal coverage losses: retain 97% active re-enrollees, 70% automatic re-enrollees, 90% Medicaid enrollees	7,243	24,029	3,807	35,078
Moderate coverage losses: retain 95% active re-enrollees, 50% automatic re-enrollees, 75% Medicaid enrollees	12,072	40,048	9,517	61,636
Large coverage losses: retain 90% active re-enrollees, 30% automatic re-enrollees, 50% Medicaid enrollees	24,144	56,067	19,034	99,244

Source: Authors' calculations based on CMS 2020 Marketplace Open Enrollment Period Public Use Files

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110. Finally, even if Georgia and Defendants were roughly in the ballpark on gains and losses, it makes errors in the timing of the enrollment effects. To satisfy the coverage guardrail, a state's plan must not result in fewer individuals with coverage in any given year. 83 Fed. Reg. at 53,579. The state assumes that enrollment will rise on net by 25,000 in the first year of the Georgia Access Model, while remaining relatively constant moving forward.[123] But any gains are likely to phase in over time, as Georgia estimates that web-brokers enroll a slightly larger fraction of the market each year, while any losses are likely to occur immediately for the reasons explained above.[124] Thus, if one instead assumes that the 33,000 gain phases in linearly over the first five years of the waiver, then losses will actually exceed gains in the first year of the waiver—violating the coverage guardrail.[125]

111. For these reasons, the Georgia Access Model will decrease, rather than increase, overall enrollment, violating the coverage guardrail even under the standards of the 2018

[123] Georgia's Application, *supra* note 79, at 56.

[124] Young & Levitis, *supra* note 68.

[125] *Id.*; *see also* Straw, *Tens of Thousands*, *supra* note 88.

Guidance. In nonetheless concluding that "the waiver plan meets the coverage guardrail,"[126] Defendants simply rubberstamped Georgia's wildly unrealistic assumptions and estimates in a manner that is unreasoned, contrary to the record, and contrary to the ACA's legal requirements.

2. Comprehensiveness

112. The Georgia Access Model will also result in consumers enrolling in less comprehensive, non-ACA-compliant insurance products, to the extent they are able to enroll at all. Georgia's plan therefore violates the comprehensiveness guardrail as well.

113. Non-ACA-compliant plans, including short-term, limited-duration insurance plans, association health plans, and others, generally represent a bad deal for the consumer. They often have discriminatory gaps that can leave consumers (or providers) exposed to high costs,[127] especially as compared to the affordable, comprehensive, and non-discriminatory coverage of the ACA. Some individuals may be turned down by insurers based on their prior health status, while others will face benefit exclusions based on prior health care needs.[128] These plans are also generally subject to other conditions that limit their value, like large amounts of cost-sharing, annual or lifetime limits on coverage, limitations on services, or limitations on the amount the plan will pay per medical visit.[129]

114. For example, "[o]ne review of the most popular short-term plan in Atlanta found that although it had lower premiums, its deductible and maximum out-of-pocket costs were

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[126] Approval Letter, *supra* note 78, at 10.

[127] *See* Christen Linke Young, *Taking a Broader View of "Junk Insurance"*, Brookings (July 6, 2020), https://www.brookings.edu/research/taking-a-broader-view-of-junk-insurance/.

[128] *See* Karen Pollitz et al., *Understanding Short-Term Limited Duration Health Insurance*, Kaiser Family Found. (Apr. 23, 2018), https://www.kff.org/health-reform/issue-brief/understanding-short-term-limited-duration-health-insurance/.

[129] *See* Sarah Lueck, *Key Flaws of Short-Term Health Plans Pose Risks to Consumers*, Ctr. on Budget & Pol'y Priorities (Sept. 20, 2018), https://www.cbpp.org/research/health/key-flaws-of-short-term-health-plans-pose-risks-to-consumers.

nearly three times higher than the most popular bronze ACA plan, and it offered no coverage of prescription drugs, mental health services, or maternity care."[130]

115. Nevertheless, "[a]n explicit goal of the waiver is to increase access to coverage that doesn't meet ACA standards"[131] by allowing consumers to access "the full range of health plans licensed and in good standing in the State that are available to them today but sold through channels outside the FFE."[132] It does so by shifting all enrollment to private vendors who, unlike healthcare.gov, can offer non-ACA-compliant plans next to ACA-compliant plans.

116. Moreover, private vendors have an incentive to steer consumers toward non-ACA-compliant products. For brokers, such products generally pay higher commissions—up to ten times as much as ACA-compliant plans.[133] For insurers, such products generally have better margins because they are not required to meet medical loss ratio standards.[134]

117. "Experience with enhanced direct enrollment programs shows that these incentives sometimes give rise to 'steering,' in which web-brokers screen applicants before sending them down the official enrollment pathway and divert some toward substandard plans that pay higher commissions but leave enrollees exposed to catastrophic costs if they get sick."[135] Studies have repeatedly shown that private vendors tend to redirect consumers toward

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[130] Straw, *Tens of Thousands*, *supra* note 88.

[131] *Id.*

[132] Georgia's Application, *supra* note 79, at 4; *see also id.* at 26, 31.

[133] *Shortchanged: How the Trump Administration's Expansion of Junk Short-Term Health Insurance Plans is Putting Americans at Risk*, U.S. House of Reps. Comm. on Energy & Commerce 43 (June 2020), https://degette.house.gov/sites/degette.house.gov/files/STLDI%20Report%2006%2025%2020%20FINAL_.pdf.

[134] Straw, *Tens of Thousands*, *supra* note 88.

[135] *Id.*

such plans.[136] Even under current law, "[r]oughly one in four marketplace enrollees who were helped by a broker or commercial health plan representative said they were offered a non-ACA-compliant policy as an alternative or supplement to a marketplace policy."[137]

118. Georgia's plan would also allow additional room for deceptive or aggressive marketing tactics that healthcare.gov does not permit. "One recent study, for example, showed that most brokers gave ambiguous, misleading, or demonstrably false information regarding short-term plan coverage for COVID-related illnesses."[138]

119. Thus, the Georgia Access Model is likely to shift individuals from ACA-compliant plans to less comprehensive, non-ACA-compliant junk plans. Perhaps that is why, in the letter approving Georgia's waiver, Defendants did not refer to the requisite certification of comprehensiveness by the "Office of the Actuary of the Centers for Medicare & Medicaid Services based on sufficient data from the State and from comparable States about their experience with programs created by this Act and the provisions of this Act that would be waived." 42 U.S.C. § 18052. For that reason alone, Defendants failed to comply with the comprehensiveness guardrail.

120. Because Defendants and Georgia did not, and cannot, show that the Georgia Access Model would actually provide state residents with equally comprehensive coverage, Defendants' approval of Georgia's plan is necessarily predicated on CMS's 2018 Guidance that a plan complies with the comprehensiveness guardrail so long as equally comprehensive coverage remains available on the market. That much is clear from Defendants' approval letter:

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[136] *See, e.g.*, Straw, *"Direct Enrollment," supra* note 119; *Shortchanged*, *supra* note 133.

[137] Karen Pollitz et al., *Consumer Assistance in Health Insurance: Evidence of Impact and Unmet Need*, Kaiser Family Found. (Aug. 7, 2020), https://www.kff.org/health-reform/issue-brief/consumer-assistance-in-health-insurance-evidence-of-impact-and-unmet-need/.

[138] Straw, *Tens of Thousands*, *supra* note 88.

in approving Georgia's waiver, Defendants concluded that "consumers will have *access* under the state's waiver plan to the same metal level plans and catastrophic plans that are available today and include EHB benefits," and so "consumers will have *access* to coverage that is at least as comprehensive as the without waiver baseline scenario."[139]

121. As noted above, however, the 2018 Guidance rests on an incorrect interpretation of Section 1332. *See supra* ¶¶ 71-75. These flaws in the Guidance therefore doom Georgia's waiver as well. Put simply, Defendants did not conclude, and Georgia did not show, that an equal number of consumers would *possess* comprehensive insurance coverage as a result of the Georgia Access Model—only that equally comprehensive coverage would remain theoretically available on the market.

122. Moreover, Part II of Georgia's waiver fails even under the lenient standards of the 2018 Guidance. The 2018 Guidance evaluates whether consumers have "*access* to coverage that is as affordable and comprehensive as coverage" that would have been available prior to the waiver. 83 Fed. Reg. at 53,578 (emphasis added). But given the Georgia Access Model's failure to include protections against inappropriate steering and marketing of non-ACA-compliant plans, consumers do not have meaningful access to ACA-compliant plans. If the 2018 Guidance's conception of "access" requires only that a plan be theoretically available somewhere in the marketplace, then that is simply another reason why the 2018 Guidance is inconsistent with the text and purpose of Section 1332.

123. Defendants therefore failed to ensure that Georgia's plan meets the comprehensiveness guardrail and acted in an unreasoned manner and one that is contrary to the agency record.

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[139] Approval Letter, *supra* note 78, at 12-13 (emphasis added).

3. Affordability and deficit neutrality

124. For many of the same reasons and others, the Georgia Access Model will also increase premiums, violating the affordability guardrail. Indeed, Georgia's affordability estimates are, in substantial measure, premised on its incorrect assumption of increased enrollment.[140] *See supra* ¶¶ 100-12.

125. The Georgia Access Model will also decrease affordability by baking additional costs into the premiums that consumers pay. Insurers generally pay private agents and brokers a commission for directing consumers on to their health plans. "Transitioning all enrollment to private vendors (most of whom are commission-supported) is likely to meaningfully increase the total volume of broker commissions paid in Georgia, which will in turn increase premiums."[141] Alternatively, if consumers transition to enrolling directly through insurers, those insurers must pay to support the enrollment infrastructure. But those costs, too, are naturally incorporated into the premiums that consumers pay.[142] Georgia's application did not adequately account for either of these dynamics, instead offering only that the state "does not expect increased commissions to increase premiums by more than 0.25 percentage points on average."[143]

126. As explained above, Georgia's waiver will also lead to greater enrollment in non-ACA-compliant plans, which typically involve higher cost-sharing. Because premiums for those plans are generally cheaper for young, healthy enrollees, these consumers will tend to select them—distorting the risk pool and thereby increasing premiums for comprehensive, ACA-compliant insurance products.[144] "It is not possible to promote underwritten and non-compliant

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[140] Straw, *Tens of Thousands*, *supra* note 88.

[141] Young & Levitis, *supra* note 68.

[142] *Id.*

[143] Approval Letter, *supra* note 78, at 11.

[144] Young, *Taking a Broader View*, *supra* note 127.

plans that the state believes some consumers will prefer without 'eroding' the regulated market—if healthy enrollees can receive lower premiums from underwritten plans, that will, axiomatically, worsen the ACA risk pool and increase premiums."[145] It is also backed by the evidence: "in states that took advantage of the Administration's expansion of short-term plans—like Georgia, which has few restrictions—premiums for comprehensive coverage went up by about 4 percent."[146] By making it even easier for insurers and brokers to push relatively healthier and cheaper consumers on to short-term plans, Georgia's plan will only exacerbate these effects.

127. Georgia's analysis also makes assumptions that are not supported by the record about the risk profile of those who will lose coverage due to the elimination of healthcare.gov. In general, young, healthy people are less likely than older people to attempt to overcome administrative barriers, meaning that young people are proportionally more likely to lose coverage.[147] That shift will further weaken the ACA-compliant risk pool in the state and drive up premiums.[148] By the same token, it makes unfounded and unsupported assumptions about those who will *gain* coverage, assuming that they will tend to be the sort of young, healthy consumers who are, in fact, most likely to drop out of the enrollment process.

128. Finally, Georgia's plan will reduce competition by causing insurers, particularly smaller insurers, to exit the market rather than devote additional resources to creating enrollment

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[145] Young & Levitis, *supra* note 68.

[146] Straw, *Tens of Thousands*, *supra* note 88.

[147] *See, e.g.*, Stan Dorn, *Helping Special Enrollment Periods Work Under the Affordable Care Act*, Urban Inst. 5-8 (June 2016), https://www.urban.org/sites/default/files/publication/81806/2000834-Helping-Special-Enrollment-Periods-Work-Under-the-Affordable-Care-Act.pdf; *Strengthening the Marketplace – Actions to Improve the Risk Pool*, CMS (June 8, 2016), https://www.cms.gov/newsroom/fact-sheets/strengthening-marketplace-actions-improve-risk-pool.

[148] Young & Levitis, *supra* note 68.

infrastructure.[149] Even where such insurers remain in the market, they may not be able to compete with larger insurers in the absence of healthcare.gov. And "[t]he lack of a single, unbiased source of comparative plan data could also directly reduce competition."[150]

129. These effects also potentially violate the deficit neutrality guardrail because advance premium tax credits are pegged to the premiums in a given market, putting the federal government on the hook for higher payments, depending on the size of the coverage losses that Georgia's plan will cause.

130. Separately, Georgia's plan also threatens to expand the deficit because Georgia miscalculates the impact of the state losing user fees for healthcare.gov. "Some HealthCare.gov functions entail fixed costs, and so the absence of HealthCare.gov user fees from Georgia will not be fully offset by reduced operating costs. The federal government is clear that such costs must be accounted for in deficit neutrality calculations, and the state fails to do so."[151]

131. Thus, Defendants' decision violates the affordability guardrail and, by extension, potentially the deficit neutrality guardrail, and is unreasoned and contrary to the record.

B. Defendants' decision exceeds the scope of Section 1332.

132. Even if Defendants' decision complied with the statutory guardrails, it exceeds their statutory authority by waiving provisions that cannot be waived under Section 1332.

133. Section 1332 does not allow Defendants to nullify any and all ACA provisions; it limits their authority to specific, enumerated statutory requirements. *See* 42 U.S.C. § 18052. To that end, Georgia's application was limited to waiving provisions of 42 U.S.C. § 18031, and the

[149] Straw, *Tens of Thousands*, *supra* note 88.

[150] *Id.*

[151] Young & Levitis, *supra* note 68.

state recognizes that it must "remain in full compliance with sections of [the ACA] not waived."[152]

134. By ending the state's reliance on healthcare.gov without creating a state Exchange or a hybrid model in its place, however, Part II of Georgia's waiver is so radical that it rips a hole in the ACA—grossly exceeding the scope of authority provided by Section 1332.

135. Most importantly, Section 1321, which is not in the list of provisions that are waivable under Section 1332, mandates that, if a state does not create an Exchange, "the Secretary shall (directly or through agreement with a not-for-profit entity) establish and operate such Exchange within the State and the Secretary shall take such actions as are necessary to implement such other requirements." 42 U.S.C. § 18041(c)(1). If the state does create an Exchange, it must meet the standards established by the Secretary. *Id.* § 18041(e). Federal regulations further define an Exchange as "a governmental agency or non-profit entity that meets the applicable standards of this part and makes QHPs available to qualified individuals and/or qualified employers." 45 C.F.R. § 155.20. Georgia's plan obviously does not create an Exchange; instead, it leaves the state's consumers without a central, impartial marketplace for purchasing insurance plans, as was the case prior to the existence of the ACA.

136. The ACA also contains many provisions that presuppose the existence of an Exchange, but that are not included within the provisions that may be waived under Section 1332. *See, e.g.*, 42 U.S.C. §§ 300u-12 (public health campaign to explain preventive services offered by Exchange plans), 300gg-94(b)(1)(B) (state to make recommendations to Exchange to exclude insurers from participation), 1396a(e)(14)(K) (notify lottery winners who lose Medicaid eligibility of opportunity to enroll in Exchange), 1396w-3 (Medicaid's version of the "no wrong

[152] Georgia's Application, *supra* note 79, at 29.

door" provision), 1397ee(a)(1) (Exchange coverage to cover shortfalls in CHIP funding), 1397gg (incorporating "no wrong door" for CHIP), 18081(b) (Exchange collects and transmits information on eligibility), 18082(a) (Exchange determines eligibility for advance premium tax credits), 18083 (the Exchange version of the "no wrong door" provision), 18092 (notification of non-enrollment includes information on services offered in Exchanges).

137. Even if Defendants could waive these requirements, Georgia's application is limited to provisions of 42 U.S.C. § 18031, and thus both expressly disavows any request for a waiver of other statutory provisions and promises that the state will comply with all non-waived provisions.

138. By eliminating the exchange in Georgia entirely, Part II of Georgia's waiver prevents these other, non-waivable statutory provisions from operating, in violation of Section 1332. To take one example, an Exchange cannot provide information or determine eligibility if there is no Exchange in the first place. Of course, states retain the flexibility to experiment with different models of Exchange management. But deciding to eliminate the Exchange entirely—one of the ACA's signature achievements and statutory cornerstones—is not a choice that Section 1332 permits.

C. Defendants' decision was procedurally improper.

139. Finally, Defendants' decision to approve Georgia's waiver was procedurally deficient in several important ways, including the manner in which Defendants and the state allowed for notice and comment and the contents of the state's application.

140. Before granting a waiver under Section 1332, both the state and federal governments "must provide a public notice and comment period sufficient to ensure a meaningful level of public input." 42 U.S.C. § 18052(a)(4)(B)(i), (iii). Defendants have opined that, "[t]o the extent that a proposal is particularly wide-ranging, the proposed regulations will

support a longer State public notice and comment period." 77 Fed. Reg. at 11,706; *see also id.* at 11,708 (same for the federal notice and comment period).

141. However, Georgia offered only 15 days for comment on the third version of its proposal—the final version made public before approval. That was wholly inadequate given the scale of the changes Georgia's waiver makes to the state's insurance market and that the comment period took place during a global pandemic. Every other state to seek a waiver has allowed at least 29 days for comment, and those waivers were generally far less significant than what Georgia has proposed. And Georgia cannot rely on its comment period for the second version, which involved an "entirely different proposal that affected [essential health benefits] and financial assistance, and would not be reflective of stakeholder concerns or feedback on the current set of ideas."[153]

142. Similarly, Defendants only offered thirty days for notice and comment, with a seven-day extension because of issues with its website portal. That amount of time is likewise insufficient for the public to fully comment on a waiver of this scope.

143. Even more troubling, neither the state nor Defendants offered any opportunity for notice and comment following the state's October 9, 2020 revisions to its application, including revisions regarding important subjects like auto-reenrollment and inappropriate steering. *See supra* ¶¶ 92-93.

144. Finally, Part II of Georgia's waiver was incomplete and vague, in violation of Section 1332 and its implementing regulations. The incompleteness of the state's application also exacerbated the public's inability to fully weigh in on the state's proposal.

[153] Young & Levitis, *supra* note 68.

a. The application fails to provide "[a] comprehensive description of the State legislation and program to implement a plan," 45 C.F.R. § 155.1308(f)(3)(i); *see also* 42 U.S.C. § 18052(a)(4)(B)(ii)(II), because it says little about how the program would operate, how the state will fund or conduct functions previously performed by the federal exchange, or how the state intends to transition over to the new plan.

b. Georgia has not enacted "State legislation that provides the State with authority to implement the proposed waiver," 45 C.F.R. § 155.1308(f)(3)(ii), because it has only enacted legislation allowing the state to apply for a waiver in a general sense rather than authorizing the Georgia Access Model.

c. The application fails to provide an adequate "list of the provisions of law that the State seeks to waive," *id.* § 155.1308(f)(3)(iii); *see also* 42 U.S.C. § 18052(a)(4)(B)(ii)(I). It says only that the state would waive relevant subsections of Section 1311, which is "a massive and multifaceted provision with over 100 subsections, paragraphs, and clauses," ranging from "extensive standards for Marketplaces" to "rules on CMS responsibilities, plan certification, navigators, quality improvement, and mental health parity."[154]

d. The application lacks "analyses, actuarial certifications, data, assumptions, analysis, targets and other information … sufficient to provide … the necessary data to determine that the State's proposed waiver" meets the

[154] *Id.*

> statutory guardrails. 45 C.F.R. § 155.1308(f)(3)(iv). As explained above, "the state makes entirely unsupported (and unsupportable) claims about coverage gains and losses, neglects to consider important and obvious factors that will raise premiums in the state and makes other related errors."[155]

145. In sum, Part II of Georgia's waiver is both procedurally and substantively deficient—a reflection of the haste with which the state and Defendants rammed through the application and the lack of any basis for it.

VI. Defendants' unlawful decision will result in significant harm to Plaintiffs.

146. For many of the same reasons, Plaintiffs will be harmed by Defendants' unlawful approval of Georgia's waiver. Georgia's waiver dramatically destabilizes the manner in which Georgians are able to obtain health insurance, harming, among others, providers of health care and organizations that assist with the insurance process. By the same token, Plaintiffs are injured by the 2018 Guidance, upon which Georgia's waiver is predicated.

147. Planned Parenthood Southeast provides health care to people throughout Georgia through its four health centers and other service offerings that treated over 13,000 patients in 2020. Similarly, the Feminist Women's Health Center provides health care to thousands of patients in Georgia, with a particular focus on underserved communities.

148. Both Plaintiffs serve Georgians with a wide variety of abilities to pay for care, including individuals with private insurance that covers some or all the range of health services offered by Plaintiffs; individuals who lack adequate insurance to pay for the services provided by

[155] *Id.*

Plaintiffs but can nonetheless "self-pay" to cover the costs of their care; and individuals who lack both insurance and the resources to self-pay.

149. Plaintiffs will face at least three forms of injury from Defendants' decision to approve Georgia's waiver: the waiver will strain Plaintiffs' resources and force them to divert those limited resources from other critical aspects of their missions, including research, community outreach, and education, to continue to provide health care to its patients who need that care but are increasingly unable to afford it; it will make Plaintiffs' patients less healthy, with more complex treatment needs; and it will require Plaintiffs to expend their already limited resources to assist its patients in managing a more complex insurance marketplace.

A. Defendants' decision will strain Plaintiffs' resources by making healthcare less affordable for their patients.

150. On the whole, Plaintiffs' patient bases are less financially secure and more vulnerable than the average Georgian, with a disproportionate share of their patients relying on Medicaid or lacking adequate insurance entirely. For example, in 2019, over 80 percent of PPSE's patients lived below 200% of the federal poverty line, as compared to 32 percent for Georgia as a whole.[156]

151. Many of PPSE's patients in Georgia are "self-pay" patients, who lack insurance coverage for PPSE's services and pay for their care entirely out of pocket. PPSE provides these patients care at rates below market reimbursement rates for insured care. For some of these

[156] *Distribution of the Total Population by Federal Poverty Level (Above and Below 200% FPL)*, Kaiser Family Found. (2019), https://www.kff.org/other/state-indicator/population-up-to-200-fpl/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.

patients who are unable to pay PPSE's discounted rates, PPSE has some limited capacity to provide that care at a reduced rate, to the degree its budget allows.[157]

152. Similarly, the majority of FWHC's patients seeking abortion-related services lack insurance coverage, while the majority of FWHC's patients seeking wellness services are able to take advantage of insurance coverage for at least some part of their care.

153. Both Plaintiffs can expect to pay more to provide care to their patient bases if Georgia's plan goes into effect. The waiver will increase the population of individuals who lack health insurance altogether, or whose insurance is insufficiently comprehensive to cover reproductive healthcare, likely increasing the number of patients seeking uncompensated (or partially compensated) care from Plaintiffs. Many of Plaintiffs' existing patients will have reduced ability to pay for their care, and as individual Georgians lose coverage, they may also choose to leave their existing reproductive healthcare providers and seek care through Plaintiffs instead.

154. Indeed, there is a close relationship between the amount of uncompensated or reduced-fee care provided by care providers and the uninsured and underinsured rates in a given area. For example, research has shown that as the ACA increased access to coverage, provider uncompensated care decreased. Between 2013 and 2015, total hospital charity care and bad debt decreased by $8.6 billion nationwide.[158] In some states, uncompensated care dropped by as much

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[157] *Payment and Insurance Information*, Planned Parenthood Southeast, https://www.plannedparenthood.org/planned-parenthood-southeast/patient-resources/copy-payment-insurance-info (last visited Jan. 13, 2021).

[158] *Report to Congress on Medicaid and CHIP*, Medicaid & CHIP Payment & Access Comm'n (Mar. 2018), https://www.macpac.gov/wp-content/uploads/2018/03/Report-to-Congress-on-Medicaid-and-CHIP-March-2018.pdf.

as 64%.[159] The share of hospital operating expenses consumed by uncompensated care dropped 30% nationally, from 4.4% in 2013 to 3.1% in 2015. [160]

155. Thus, Plaintiffs expect the number of patients who lack the resources or coverage to compensate them for their care to increase substantially once Georgia implements the Georgia Access Model. Defendants' decision to approve Georgia's waiver will cause a predictable strain on Plaintiffs' resources and will require them to divert their limited resources from other needed programs into direct patient care as well as the fundraising necessary to increase available funds for that care. Defendants' decision therefore harms Plaintiffs' core missions of providing comprehensive reproductive care to their patient populations by either forcing them to turn away patients in need (endangering their ability to provide care to patients without regard to their ability to pay for them) or to instead redirect their resources to those patients, limiting their capacity to engage in other parts of their missions, including education.

B. Defendants' decision will lead to less healthy patients with more complex treatment needs.

156. Plaintiffs provide a range of reproductive health services to their communities, including contraception (including birth control pills, long-acting reversible contraceptives, and emergency contraception), sexually transmitted infection testing and treatment, pregnancy testing, breast and cervical cancer screening, and safe and legal abortion.

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[159] *Id*. at 70.

[160] *Id*.; Jessica Schubel & Matt Broaddus, *Uncompensated Care Costs Fell in Nearly Every State as ACA's Major Coverage Provisions Took Effect*, Ctr. on Budget & Pol'y Priorities (May 23, 2018), https://www.cbpp.org/research/health/uncompensated-care-costs-fell-in-nearly-every-state-as-acas-major-coverage. Uncompensated care costs rose slightly in 2017 due to the Trump Administration's efforts to weaken the ACA, but remained much lower than they were before the enactment of the ACA. *See* Matt Broaddus, *Uncompensated Care Costs Well Down in ACA Medicaid Expansion States*, Ctr. on Budget & Pol'y Priorities (Oct. 21, 2020), https://www.cbpp.org/blog/uncompensated-care-costs-well-down-in-aca-medicaid-expansion-states.

157. Many of the services Plaintiffs provide are intended to be preventive, empowering and enabling patients to receive low-intervention care that can prevent the need for higher-intervention care later.

158. For example, patients with ready access to safe and effective contraception are less likely to face an unintended pregnancy. Even among patients with some access to contraception, patients' abilities to access the most-desired and effective forms of contraception for them (for example, patients who prefer to rely on a long-acting reversible contraceptive rather than condoms or birth control pills) can substantially affect the likelihood of an unintended pregnancy. Contraceptive services not only help to avoid unintended pregnancies and promote healthy birth spacing, resulting in improved maternal, child, and family health, but also provide preventive health benefits to some patients, such as reduced menstrual bleeding and pain and decreased risk of endometrial and ovarian cancer.

159. Similarly, widespread and regular sexually transmitted infection testing can help lower the chances of an outbreak in a community, reducing the likelihood that patients will ultimately need treatment. And availability of cancer screening is crucial to patient well-being and ensuring access to timely care if needed.

160. A large body of evidence, from both before and after implementation of the ACA, demonstrates that adequate health insurance coverage is associated with a greater likelihood that individuals will seek and receive needed care, like the preventive care described above. Significant research indicates that uninsured individuals are more likely to delay or forgo care because of costs and less likely to have reliable access to the health care system, as compared to those with comprehensive forms of health insurance coverage. Analysis of results from the

National Health Interview Survey[161] administered by the Centers for Disease Control and Prevention ("CDC") demonstrates that, in 2019, uninsured adults were over five times more likely to report that they had gone without health care "because of costs" in the previous twelve months (30.4% versus 5.4%).[162] When including individuals who delayed care, and not just those who avoided it altogether, that figure rises to 36.5% of the uninsured (compared to only 7% of the insured).[163] That is, in the relatively recent past more than a quarter of uninsured adults reported that costs had affected their ability to seek care in a twelve month period.

161. Uninsured individuals are also far less likely to report having a usual source of care compared to insured people, meaning that treatable conditions may be detected later and when treatment is more expensive. National Health Interview Survey data reflect that in 2017, half (50%) of uninsured people reported that they did not have a place that they would "usually go to if [they were] sick and need health care," compared to just 11% of the privately insured.[164] In the wake of the ACA's implementation, researchers also found that 39% of the newly insured,

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[161] *National Health Interview Survey*, CDC, https://www.cdc.gov/nchs/nhis/index.htm (last updated Dec. 3, 2020).

[162] Krutika Amin et al., *How Does Cost Affect Access to Care?*, Health System Tracker (Jan. 5, 2021), https://www.healthsystemtracker.org/chart-collection/cost-affect-access-care. For survey question wording, see *NHIS Data, Questionnaires and Related Documentation*, CDC, https://www.cdc.gov/nchs/nhis/data-questionnaires-documentation.htm (last updated Sept. 22, 2020).

[163] Gary Claxton et al., *How Does Cost Affect Access to Care?*, Kaiser Family Found. (Jan. 22, 2019), https://www.healthsystemtracker.org/chart-collection/cost-affect-access-care.

[164] Rachel Garfield et al., *The Uninsured and the ACA: A Primer*, Kaiser Family Found. (Jan. 25, 2019), https://www.kff.org/report-section/the-uninsured-and-the-aca-a-primer-key-facts-about-health-insurance-and-the-uninsured-amidst-changes-to-the-affordable-care-act-how-does-lack-of-insurance-affect-access-to-care/; *NHIS Data, Questionnaires and Related Documentation*, *supra* note 162; *see also, e.g.*, Claxton et al., *supra* note 163; Catherine Hoffman & Julia Paradise, *Health Insurance and Access to Health Care in the United States*, 1136 Annals of the N.Y. Acad. of Scis. 149 (2008), https://nyaspubs.onlinelibrary.wiley.com/doi/full/10.1196/annals.1425.007; *Summary Health Statistics for U.S. Adults: National Health Interview Survey, 2006*, CDC 12-13 (Dec. 2007), https://www.cdc.gov/nchs/data/series/sr_10/sr10_235.pdf.

compared to 57% of those who remained uninsured, did not have a regular source of health care services.[165]

162. While Plaintiffs will continue to try to provide affordable care to all who need it, under Georgia's plan, many patients will have to pay more out of pocket for care. Some of these patients will have to ration care, delay care, or even go without it—allowing otherwise preventable conditions to worsen or become more difficult to treat or manage.

163. Specifically, research has shown that as the cost of family-planning services for patients increases, patients shift away from medium- and high-efficacy methods of contraception and toward less effective means (or no birth control at all).[166] This shift away from high- and medium-efficacy contraception leads to an increase in unwanted pregnancies.[167] For example, a study in California showed that two pregnancies were averted for every seven women who received contraceptives.[168] For these reasons, as Plaintiffs' patients lose healthcare coverage, the number of unintended pregnancies among Plaintiffs' patient bases will increase, resulting both in more risky pregnancies for Plaintiffs' patient bases as well as more abortions.

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[165] Rachel Garfield et al., *Access to Care for the Insured and Remaining Uninsured: A Look at California During Year One of ACA Implementation*, Kaiser Family Found., at fig. 1 (May 28, 2015), https://www.kff.org/report-section/access-to-care-for-the-insured-and-remaining-uninsured-issue-brief/.

[166] M. Antonia Biggs et al., *Findings from the 2012 Family PACT Client Exit Interviews*, Bixby Ctr. for Global Reprod. Health, U. of Cal., S.F. 53-54 (2014), https://bixbycenter.ucsf.edu/sites/bixbycenter.ucsf.edu/files/3.%20CEI%20Report_ADA.pdf.

[167] *See*, *e.g.*, *Unintended Pregnancies and Abortions Averted by Planned Parenthood, 2015*, Guttmacher Inst. (June 13, 2017), https://www.guttmacher.org/infographic/2017/unintended-pregnancies-and-abortions-averted-planned-parenthood-2015# (estimating that in 2015, Planned Parenthood's provision of contraceptive services averted approximately 430,000 unintended pregnancies nationwide).

[168] M. Antonia Biggs et al., *Cost-Benefit Analysis of the California Family PACT Program for Calendar Year 2007*, Bixby Ctr. for Global Reprod. Health, U. of Cal., S.F. 16 (Apr. 2010), https://www.ansirh.org/sites/default/files/publications/files/familypactcost-benefitanalysis2007_2010apr_featured.pdf

164. Similarly, lost or diminished healthcare will lead some of Plaintiffs' patients to forgo or delay regular STI testing, ultimately only turning to Plaintiffs for treatment in the event they experience symptoms of an STI, at great risk to themselves and their partners. A decrease in regular testing will also cause an increase in community STI rates, and consequent demand for STI treatment.[169] And lost or diminished access to cancer screening will result in undiagnosed cancer or cancers diagnosed later, again at great risk to patient health.[170]

165. By increasing the number of patients in Plaintiffs' communities that lack access to insurance coverage at all, or lack access to insurance coverage that covers Plaintiffs' preventive care, the Georgia Access Model is likely to make it more expensive for Plaintiffs to treat their patients. Georgia's plan will cause Plaintiffs' patients to forgo straightforward preventive care and turn to Plaintiffs for more complex treatment instead, while also likely increasing the number of patients with a need for STI testing and/or treatment in Plaintiffs' patient communities.

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[169] *See*, *e.g.*, Jennifer J. Frost et al., *Return on Investment: A Fuller Assessment of the Benefits and Cost Savings of the US Publicly Funded Family Planning Program*, 92 Milbank Q. 667, 696 (2014) (estimating that STI and HIV screening during family planning visits had saved public healthcare funds an estimated $123 million in 2010 by avoiding complications from infections, avoiding care for patients who contracted HIV from partners who unknowingly transmitted it, and avoiding costs and complications from HPV treatment through early detection or vaccination).

[170] *See*, *e.g.*, *id.* at 695 (estimating that in the absence of publicly-funded family planning services, an estimated 2.3 million women would have forgone or postponed cervical cancer testing in 2010; such testing identified 3,600 potential cancer cases before the cancer developed and averted 2,090 cervical cancer deaths).

166. Moreover, the consequences of the waiver will be disproportionately felt by Plaintiffs' low-income patients and patients of color—those who already face serious barriers to obtaining comprehensive, high-quality reproductive health care.[171]

C. Defendants' decision will require Plaintiffs to expend additional resources to manage a more complex insurance market for themselves and their patients.

167. Both Plaintiffs expend considerable resources to assist their patients in obtaining and/or using their insurance to access coverage.

168. PPSE provides a wide variety of services to ensure that as many members of its community have health coverage as possible, both to maximize the health of its community and to preserve its limited resources to serve patients who cannot otherwise access health coverage.

169. To that end, PPSE helps patients "enroll in programs like Medicaid or … options under the Affordable Care Act."[172] PPSE trains its phone intake staff to discuss patients' financial needs and resources with them, including understanding the scope of their health insurance coverage (if any) and considering options for obtaining health insurance coverage that would cover the care that PPSE provides (including purchasing coverage on an ACA exchange).

170. Similarly, the staff on-site at PPSE's health centers are trained to discuss payment and insurance options with patients to ensure that they receive the broadest coverage possible. Health center staff also work with patients to ensure as far as possible that PPSE's outgoing referrals for ongoing care are to providers covered by patients' plans.

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[171] *See generally Healthy People 2020: An Opportunity to Address Societal Determinants of Health in the U.S.*, Sec'y's Advisory Comm. on Nat'l Health Promotion & Disease Prevention Objectives for 2020 (July 26, 2010), https://www.healthypeople.gov/sites/default/files/SocietalDeterminantsHealth.pdf.

[172] *Payment and Insurance Information*, *supra* note 157.

171. PPSE also directs patients to resources provided by Planned Parenthood's nationwide entity, including a website which informs patients about how they can enroll in health insurance on healthcare.gov.[173]

172. In a similar vein, the staff of both Plaintiffs assist patients in ensuring that they are able to receive the reimbursements they are eligible for from their insurance providers. Plaintiffs file claims on patients' behalf for reimbursement of treatment and, in the event of denial, undertake the appeals process on their behalf, requiring significant staff time to be devoted to helping patients with insurance-related matters.

173. In order to maximize the insurance coverage its patients can receive for PPSE services, PPSE recently contracted with an expert health insurance consultant to manage its contracting efforts with insurers, to ensure as much as possible that PPSE is treated as an in-network provider of reproductive health services.

174. Finally, PPSE conducts broader outreach to its local community during open enrollment. Such efforts have in the past included paid door-to-door canvassing to discuss the ACA, as well as manning tables at public outreach events in order to discuss health coverage and PPSE's services with community members.

175. Similarly, FWHC undertakes substantial efforts to obtain the credentials needed to accept a variety of insurance plans, and to adjust to changing requirements and coverage by insurers.

176. Defendants' approval of Georgia's 1332 waiver application will force PPSE to divert resources from other programs to support its enrollment assistance efforts. Georgia's plan

[173] *See Health Insurance Questions and Answers*, Planned Parenthood, https://www.plannedparenthood.org/get-care/health-insurance (last visited Jan. 13, 2021).

will introduce a substantial overhaul to the consumer-facing process of choosing insurance plans, moving consumers from a centralized, regulated healthcare exchange to a fragmented series of interactions with individual insurers. This new process is likely to be far more complex and confusing for patients, and, in turn, PPSE staff assisting them. In order for PPSE staff to continue to assist its patients in this way, it will be forced to expend resources to understand the new, more fragmented insurance shopping experience, and train its staff to work through this shopping experience with patients. And because purchasing insurance will be more complex, PPSE will both have more people to assist and will need to devote additional time to each consumer interaction.

177. Similarly, Georgia's plan will force both Plaintiffs' staff to spend a larger portion of their time on efforts to obtain coverage on their patients' behalf when claims are denied by making the range of plans that their patients may carry more varied, complex, and likely to exclude coverage for the services they provide.

178. Georgia's approach is also likely to substantially alter the range of plans purchased by Georgians, particularly by facilitating insurers' promotion of non-ACA-compliant junk insurance plans with bare-bones coverage. Such plans are particularly unlikely to cover the reproductive services offered by Plaintiffs, among others. These plans often have blanket exclusions for basic health care services such as birth control, maternity services, and gender-transition related services, and frequently fail to provide coverage for preventive care such as birth control, cancer screenings, and well-woman exams without out-of-pocket costs to patients.

179. This overhaul in the state's insurance options is therefore likely to render far less useful the substantial resources PPSE already poured into rationalizing its relationships with payors, likely requiring that PPSE undertake another expensive effort to negotiate access to its

services from payors newly incentivized to encourage the purchase of a slew of new limited-coverage plans. FWHC will similarly need to undertake renewed and expanded efforts to negotiate insurers' changing credential requirements to make sure its patients can obtain covered care from FWHC as the mix of plans available in Georgia transforms as a result of Georgia's plan.

180. In sum, Georgia's plan will disrupt the manner in which Georgia consumers obtain coverage, and by extension, the manner in which Georgia providers offer care to their patients. It is both harmful and unlawful.

CLAIMS FOR RELIEF

Count One
(Contrary to Law – Violates Section 1332's Guardrails, 5 U.S.C. § 706(2)(A), 42 U.S.C. § 18052)

181. Plaintiffs repeat and incorporate by reference each of the foregoing allegations as if fully set forth herein.

182. Under the Administrative Procedure Act, a "reviewing court shall … hold unlawful and set aside agency action … found to be … not in accordance with law." 5 U.S.C. § 706(2)(A).

183. Defendants' decision to grant Georgia's waiver is contrary to law because the waiver, evaluated both as a whole and with respect to Part II specifically, fails to meet Section 1332's statutory guardrails. Specifically, Georgia's plan will not provide coverage to a comparable number of state residents, it will not provide coverage that is at least as comprehensive or affordable to state residents, and it will increase the federal deficit. *See* 42 U.S.C. § 18052(b)(1).

184. Defendants' decision to approve Georgia's waiver in whole or in part is therefore unlawful and must be set aside.

Count Two
(Contrary to Law – The 2018 Guidance, 5 U.S.C. § 706(2)(A), 42 U.S.C. § 18052)

185. Plaintiffs repeat and incorporate by reference each of the foregoing allegations as if fully set forth herein.

186. Under the Administrative Procedure Act, a "reviewing court shall … hold unlawful and set aside agency action … found to be … not in accordance with law." 5 U.S.C. § 706(2)(A).

187. Defendants' decision to grant Georgia's waiver is contrary to law because it was predicated on the 2018 Guidance, which is itself unlawful. Specifically, the 2018 Guidance erroneously interprets Section 1332 to mean that a state's waiver request meets the statutory guardrails so long as equally comprehensive and affordable coverage would remain available under the state's plan, even if fewer state residents obtain such coverage. *See* 83 Fed. Reg. at 53,578. Because Georgia's waiver would result in fewer state residents with comprehensive and affordable coverage, even though such coverage would remain theoretically available on the market, Georgia's waiver cannot be sustained if the 2018 Guidance is unlawful.

188. Both the 2018 Guidance and Defendants' decision to approve Georgia's waiver in whole or in part are therefore unlawful and must be set aside.

Count Three
(Contrary to Law / Exceeds Jurisdiction – Exceeds Scope of Authority Under Section 1332, 5 U.S.C. § 706(2)(A), (C), 42 U.S.C. § 18052)

189. Plaintiffs repeat and incorporate by reference each of the foregoing allegations as if fully set forth herein.

190. Under the Administrative Procedure Act, a "reviewing court shall … hold unlawful and set aside agency action … found to be … not in accordance with law." 5 U.S.C. § 706(2)(A).

191. Defendants' decision to grant Georgia's waiver is contrary to law because it exceeds their authority under Section 1332. Georgia's plan is so radical and sweeping in character that it requires the waiver of provisions that are not waivable under Section 1332. By eliminating Georgia's reliance on the federal Exchange without establishing a state Exchange in its place, Georgia's plan fails to comply with numerous ACA requirements that mandate or presuppose the existence of an Exchange and that are not included among the provisions that Section 1332 allows Defendants to waive. *See* 42 U.S.C. § 18052(a)(2).

192. Defendants' decision to approve Georgia's waiver in whole or in part is therefore unlawful and must be set aside.

Count Four
(Arbitrary and Capricious, 5 U.S.C. § 706(2)(A))

193. Plaintiffs repeat and incorporate by reference each of the foregoing allegations as if fully set forth herein.

194. Under the Administrative Procedure Act, a "reviewing court shall … hold unlawful and set aside agency action … found to be … arbitrary [or] capricious." 5 U.S.C. § 706(2)(A).

195. In approving Georgia's waiver, Defendants "relied on factors which Congress has not intended [them] to consider, entirely failed to consider an important aspect of the problem, [and] offered an explanation for [their] decision that runs counter to the evidence before [them]," and their decision was "so implausible that it could not be ascribed to a difference in view or the product of agency expertise." *Motor Vehicle Mfrs. Ass'n of U.S., Inc. v. State Farm Mut. Auto. Ins. Co.*, 463 U.S. 29, 43 (1983).

196. Defendants' decision to approve Georgia's waiver in whole or in part is therefore arbitrary and capricious and must be set aside.

Count Five
(Insufficient Evidence, 5 U.S.C. § 706(2)(E), (F))

197. Plaintiffs repeat and incorporate by reference each of the foregoing allegations as if fully set forth herein.

198. Under the Administrative Procedure Act, in certain circumstances, a "reviewing court shall … hold unlawful and set aside agency action … found to be … unsupported by substantial evidence … or unwarranted by the facts." 5 U.S.C. § 706(2)(E), (F).

199. Defendants were obliged to, but did not, produce substantial evidence for their factual findings in approving Georgia's waiver, and their decision was unwarranted by the facts.

200. Defendants' decision to approve Georgia's waiver in whole or in part is therefore backed by insufficient evidence and must be set aside.

Count Six
(Procedurally Deficient – State Notice and Comment, 5 U.S.C. § 706(2)(D))

201. Plaintiffs repeat and incorporate by reference each of the foregoing allegations as if fully set forth herein.

202. Under the Administrative Procedure Act, a "reviewing court shall … hold unlawful and set aside agency action … found to be … without observance of procedure required by law." 5 U.S.C. § 706(2)(D).

203. Defendants' decision to approve Georgia's waiver was procedurally deficient because the state failed to "provide a public notice and comment period sufficient to ensure a meaningful level of public input for the application for a section 1332 waiver." 45 C.F.R. § 155.1312(a)(1).

204. Defendants' decision to approve Georgia's waiver in whole or in part was therefore issued without observance of procedure required by law and must be set aside.

Count Seven
(Procedurally Deficient – Federal Notice and Comment, 5 U.S.C. § 706(2)(D))

205. Plaintiffs repeat and incorporate by reference each of the foregoing allegations as if fully set forth herein.

206. Under the Administrative Procedure Act, a "reviewing court shall … hold unlawful and set aside agency action … found to be … without observance of procedure required by law." 5 U.S.C. § 706(2)(D).

207. Defendants' decision to approve Georgia's waiver was procedurally deficient because Defendants failed to provide a sufficient period for notice and comment. 45 C.F.R. § 155.1316(b); *see also* 42 U.S.C. § 18052(a)(4)(B)(iii).

208. Defendants' decision to approve Georgia's waiver in whole or in part was therefore issued without observance of procedure required by law and must be set aside.

Count Eight
(Procedurally Deficient – Incomplete Application, 5 U.S.C. § 706(2)(D))

209. Plaintiffs repeat and incorporate by reference each of the foregoing allegations as if fully set forth herein.

210. Under the Administrative Procedure Act, a "reviewing court shall … hold unlawful and set aside agency action … found to be … without observance of procedure required by law." 5 U.S.C. § 706(2)(D).

211. Defendants' decision to approve Georgia's waiver was procedurally deficient because Part II of Georgia's waiver application was incomplete and vague. Among other things, it lacked "[a] comprehensive description of the State legislation and program to implement a plan," 45 C.F.R. § 155.1308(f)(3)(i); *see also* 42 U.S.C. § 18052(a)(4)(B)(ii)(II); failed to show that the State had enacted "legislation that provides the State with authority to implement the proposed waiver," 45 C.F.R. § 155.1308(f)(3)(ii); failed to provide an adequate "list of the

provisions of law that the State seeks to waive," *id.* § 155.1308(f)(3)(iii); *see also* 42 U.S.C. § 18052(a)(4)(B)(ii)(I); and lacked "analyses, actuarial certifications, data, assumptions, analysis, targets and other information … sufficient to provide … the necessary data to determine that the State's proposed waiver" meets the statutory guardrails. 45 C.F.R. § 155.1308(f)(3)(iv).

212. Defendants' decision to approve Georgia's waiver in whole or in part was therefore issued without observance of procedure required by law and must be set aside.

REQUEST FOR RELIEF

WHEREFORE, Plaintiffs request that this Court:

1. declare that Defendants' decision to approve Georgia's waiver under Section 1332 is unlawful in whole or in part;

2. declare that the 2018 Guidance is unlawful;

3. vacate and set aside Defendants' decision to approve Georgia's waiver in whole or in part;

4. vacate and set aside the 2018 Guidance;

5. enjoin Defendants from issuing the proposed waiver to Georgia;

6. enjoin Defendants from processing future waivers under the terms of the 2018 Guidance;

7. award Plaintiffs their costs, attorneys' fees, and other disbursements for this action; and

8. grant any other relief this Court deems appropriate.

Dated: January 14, 2021

Respectfully submitted,

/s/ John T. Lewis
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