No. 16-5202

IN THE UNITED STATES COURT OF APPEALS
FOR THE DISTRICT OF COLUMBIA CIRCUIT

UNITED STATES HOUSE OF REPRESENTATIVES,
Plaintiff-Appellee,

v.

THOMAS E. PRICE, M.D., in his official capacity as Secretary of Health and Human Services; U.S. Department of Health and Human Services; STEVEN T. MNUCHIN, in his official capacity as Secretary of the Treasury; U.S. Department of the Treasury,

Defendants-Appellants.

On Appeal from the United States District Court
for the District of Columbia, No. 1:14-cv-01967
Honorable Rosemary M. Collyer

MOTION TO INTERVENE
OF THE STATES OF CALIFORNIA, NEW YORK, CONNECTICUT, DELAWARE, HAWAII, ILLINOIS, IOWA, KENTUCKY, MARYLAND, MASSACHUSETTS, MINNESOTA, NEW MEXICO, PENNSYLVANIA, VERMONT, AND WASHINGTON, AND THE DISTRICT OF COLUMBIA

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INTRODUCTION

In this litigation, the House of Representatives attacks a critical feature of the Patient Protection and Affordable Care Act—landmark federal legislation that has made affordable health insurance coverage available to nearly 20 million Americans, many for the first time. If successful, the suit could—to use the President's expression—"explode" the entire Act.[1] Until recently, States and their residents could rely on the Executive Branch to respond to this attack. Now, events and statements, including from the President himself, have made clear that any such reliance is misplaced. The States of California, New York, Connecticut, Delaware, Hawaii, Illinois, Iowa, Kentucky, Maryland, Massachusetts, Minnesota, New Mexico, Pennsylvania, Vermont, and Washington, and the District of Columbia move to intervene to ensure an effective defense against the claims made in this case and to protect the interests of millions of state residents affected by this appeal.

The ACA was designed to create state-based markets presenting affordable insurance choices for consumers. A central feature of that design is federal cost-

[1] Goldstein & Eilperin, *Affordable Care Act Remains 'Law of the Land,' But Trump Vows to Explode It*, Wash. Post, Mar. 24, 2017, https://www.washingtonpost.com/national/health-science/affordable-care-act-remains-law-of-the-land-but-trump-vows-to-explode-it/2017/03/24/4b7a2530-10c3-11e7-ab07-07d9f521f6b5_story.html?utm_term=.d6b97abead98.

sharing reduction subsidies backed by mandatory payment provisions, giving insurers and state regulators the stability they need to maintain functional markets. The district court's ruling would destroy this design by eliminating the permanent appropriation Congress intended for cost-sharing reduction payments. Payments would cease immediately in the absence of a specific appropriation; and any future payments would be subject to the unpredictability of the appropriations process. That would directly subvert the ACA, injuring States, consumers, and the entire healthcare system.

The States thus have a vital interest in seeking reversal or vacatur of the district court's decision. In California and New York alone, the ACA provides access to health coverage for 8.9 million people. The loss of funds and financial uncertainty threatened by this case would lead at least to higher health insurance costs for consumers, and more likely to many insurers abandoning the individual health insurance market. The number of uninsured Americans would go back up, hurting vulnerable individuals and directly burdening the States. The wrong decision could trigger the very system-wide "death spirals" that central ACA features, such as stable financing, were designed to avoid. *See King v. Burwell*, 135 S. Ct. 2480, 2493 (2015). At a minimum, the annual uncertainty created by the district court's decision would make the States' tasks in regulating and

providing health insurance to their residents more complex, unpredictable, and expensive.

These concerns are concrete and immediate. Insurers are currently deciding whether to participate in ACA Exchanges in 2018. Some have already withdrawn because of uncertainty over funding for cost-sharing reduction payments, and others are threatening to follow suit. Meanwhile, the President has increasingly made clear that he views decisions about providing access to health insurance for millions of Americans—including the decision whether to continue defending this appeal—as little more than political bargaining chips. The States and their residents cannot continue to rely on the Executive Branch to represent them in this appeal.

BACKGROUND

Congress enacted the Affordable Care Act "to increase the number of Americans covered by health insurance and decrease the cost of health care." *Nat'l Fed'n of Indep. Bus. v. Sebelius*, 132 S. Ct. 2566, 2580 (2012). The ACA adopted a "series of interlocking reforms" to achieve these goals. *King*, 135 S. Ct. at 2485. It provides for the "creation of an 'Exchange' in each State—basically, a marketplace that allows people to compare and purchase insurance plans." *Id.*[2]

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

Many States, including proposed intervenors, play an integral role in bringing plans to market through these Exchanges.

To make healthcare more affordable, the Act provides for billions of dollars in federal funding. Section 1401 provides tax credits that reduce monthly insurance premiums for eligible individuals. 26 U.S.C. § 36B. Section 1402 provides for federal payments to insurers to fund cost-sharing reductions (CSRs) for eligible consumers, which reduce out-of-pocket costs by lowering deductibles, co-payments, and similar expenses. 42 U.S.C. § 18071. The ACA requires insurers to cover CSR costs upfront when eligible consumers receive services at reduced cost. *Id.* § 18071(a)-(c). The Secretary of Health and Human Services must "make periodic and timely payments to the [insurer] equal to the value of the reductions." *Id.* § 18071(c)(3)(A). CSR subsidies will total $9 billion in 2017, and are expected to rise to $16 billion by 2026.[3]

Since the Exchanges began operating in January 2014, the Treasury has made CSR reimbursement funds available on the authority of the permanent appropriation provided by 31 U.S.C. § 1324. *See* Exec. Branch Opening Br. 9-10. In this suit, the House argues that the ACA's permanent appropriation does not

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

extend to CSR payments, making them unconstitutional without specific later appropriations. *Id.* at 11-12. The district court held that the House had standing to maintain this suit and enjoined the Executive Branch from making CSR payments without specific appropriations, but stayed its injunction pending this appeal. *Id.* at 13-16.

The Executive Branch appealed that decision under the prior Administration, filing its opening brief on October 24, 2016. On November 21, 2016, the House moved to hold briefing in abeyance in light of the "significant possibility of a meaningful change in policy" by the new Administration. ECF No. 1647228. This Court granted that motion on December 5, 2016. On February 21, 2017, the new Administration joined a motion to continue the abeyance period, which this Court granted on March 2, 2017.

ARGUMENT

I. THE STATES ARE ENTITLED TO INTERVENE TO DEFEND CONTINUED IMPLEMENTATION OF THE AFFORDABLE CARE ACT

A party is entitled to intervene in an appeal as of right if: (1) its motion is timely; (2) it has a legally protected interest in the action; (3) the outcome of the action threatens to impair that interest; and (4) no existing party adequately represents that interest. *Crossroads Grassroots Policy Strategies v. FEC*, 788 F.3d 312, 320 (D.C. Cir. 2015). The requisite interest exists if the movant faces a potential injury sufficient to establish Article III standing. *Id.*

A. Timeliness

The States' motion is timely under the circumstances here. Until recently, the Executive Branch vigorously defended its authority to make CSR payments without any appropriation beyond that included in the ACA. Its arguments that this action should be dismissed on both standing and merits grounds reflected the positions of the States. It opposed a previous motion to intervene, by individuals concerned about possible policy changes, as "premature" and "speculat[ive]." ECF No. 1654403.

There is nothing premature or speculative about the States' motion now. President Trump has made multiple public statements threatening to abandon the positions previously advanced in this case. He has said that he will halt CSR payments if he "ever stop[s] wanting to pay the subsidies." *Transcript: Interview with Donald Trump*, The Economist, May 11, 2017.[4] Both he and his Attorney General have stated that CSR payments were "not authorized by Congress." Bender et al., *Trump Threatens to Withhold Payments to Insurers to Press Democrats on Health Bill*, Wall St. J., Apr. 12, 2017;[5] *see also* King, *Attorney General Jeff Sessions: Insurer Payments Unconstitutional*, Washington Examiner,

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[4] http://www.economist.com/Trumptranscript.

[5] https://www.wsj.com/articles/trump-threatens-to-withhold-payments-to-insurers-to-press-democrats-on-health-bill-1492029844/.

Apr. 19, 2017.[6] And the President has repeatedly threatened to stop pursuing this appeal if congressional Democrats do not "start calling [him] and negotiating," warning in April that the ACA "is dead next month if it doesn't get that money." Bender, *supra*.

These and similar statements make clear the "'potential inadequacy of [the Executive Branch's] representation'" to protect the States' interests in reversal or vacatur of the district court's decision. *Amador Cnty., Cal. v. U.S. Dep't of the Interior*, 772 F.3d 901, 904 (D.C. Cir. 2014). Moreover, imminent regulatory deadlines make the matter pressing. State insurance and health regulators face deadlines in the next few months and must make critical choices, shaping their insurance markets for the next year. *See* pp. 19-21. Many of these choices turn on whether CSR payments will continue. The States must know, at a minimum, that someone will continue to defend this appeal and prevent the district court's injunction from going into effect.

The House's passage of the American Health Care Act of 2017 (AHCA), H.R. 1628, 115th Cong., does not reduce the need for intervention. The Senate has yet to act on that bill, and if it does, it may make significant changes. Moreover,

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[6] http://www.washingtonexaminer.com/attorney-general-jeff-sessions-insurer-payments-unconstitutional/article/2620718; *see also* YouTube, *Jeff Sessions on ACA Lawsuit (4/19/17)*, https://www.youtube.com/watch?v=EOIY6-Abj0I (last visited May 17, 2017).

even if the AHCA were enacted in its current form, it would not repeal CSR payments until 2020. *Id.* § 131(b). Any injunction in this case would thus continue to cause concrete harm for at least several more years. If anything, the Administration's full-throated support of the AHCA—including its provision eliminating CSRs—illustrates the sharp divide between the current Administration's interests and those of the States.

B. Inadequate Representation

For the same reasons, the Executive Branch no longer adequately represents the States' interests. This requirement is "minimal," *Trbovich v. United Mine Workers of Am.*, 404 U.S. 528, 538 n.10 (1972), and intervention "'ordinarily should be allowed … unless it is clear'" that an existing party provides adequate representation. *United States v. AT&T*, 642 F.2d 1285, 1293 (D.C. Cir. 1980).

Here, the public record makes clear that the current Administration does *not* represent the States' interests. The President has stated that CSR payments have not been authorized by Congress, while the States take the opposite view. These contrasting positions strongly support intervention. Moreover, the States have unique sovereign interests—in administering their insurance markets and safeguarding their residents—that the current parties cannot represent. *See* pp. 19-21; *Fund for Animals, Inc. v. Norton*, 322 F.3d 728, 736 (D.C. Cir. 2003) (allowing intervention due to distinct sovereign interests). Because the States' interests do

not coincide with those of the House or the current Administration, neither party adequately represents them. *Fund for Animals*, 322 F.3d at 736-737.

C. Legally Protected Interests and Article III Standing

The States have a vital interest in this litigation. If the district court's injunction goes into effect, it would critically undermine the proper implementation of the ACA—just as the House, and now the President, intend. Immediate loss of CSR funding, with any future funding subject to the myriad uncertainties of the appropriations process, would harm millions of state residents and the States themselves. Those harms amply justify intervention.

1. Higher premiums, insurer withdrawals, uninsured residents, uncompensated care, and higher state costs

(a) *Increased premiums*. Insurers would react to an immediate loss of CSR payments, coupled with grave uncertainty concerning any future funding, by raising premiums for plans offered through the Exchanges. The ACA requires insurers to offer plans with CSRs and to cover those costs, even if the federal government does not reimburse them. 42 U.S.C. §§ 18021(a)(1), 18022(a)(2), 18071(a)-(c). If the district court's injunction takes effect, reimbursements for CSR payments would stop. Insurers would respond by raising premiums, to avoid a multi-billion-dollar loss. *See* Letter from America's Health Insurance Plans to

Donald Trump (Apr. 12, 2017) (AHIP Letter);[7] *see also* Kreidler Declaration ¶ 22; Frescatore Declaration ¶ 31.[8] And those increases would be significant—nearly 20% on the most popular plans in the first instance. *See* Levitt et al., *The Effects of Ending the Affordable Care Act's Cost-Sharing Reduction Payments* 1 (Apr. 2017).[9]

It is no answer that Congress could pass specific appropriations for CSR payments for particular periods, in place of the permanent appropriation included in the Act. Insurers must submit proposed premium rates, and applications to participate in Exchanges, to state regulators between April and July. *See* Wick, 2017 QHP Rate Filing—Key Dates (Apr. 18, 2016);[10] *see also* Centers for Medicare & Medicaid Services, *Bulletin* 2 (Apr. 13, 2017) (CMS Bulletin).[11] Congress, however, often does not make appropriations decisions until October or

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[7] https://www.ahip.org/wp-content/uploads/2017/04/Joint-CSR-Letter-to-President-Trump-04.12.2017.pdf.

[8] Unless otherwise noted, declarations and letters referenced in this motion can be found in the attached addendum.

[9] http://files.kff.org/attachment/Issue-Brief-The-Effects-of-Ending-the-Affordable-Care-Acts-Cost-Sharing-Reduction-Payments.

[10] https://www.ahip.org/2017-qhp-rate-filing-key-dates/.

[11] https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Final-Revised-2017-filing-timeline-bulletin-4-13-17.pdf.

later.[12] The district court's decision would thus put insurers in a bind: those wanting to participate in Exchanges would have to commit themselves to known expenses (the CSRs), without knowing until months later if the Administration would have the legal authority to fund CSR reimbursements. Insurers have said they would respond to such uncertainty by preemptively raising premiums "in order to cover any shortfall that would result if Congress later decided not to appropriate funds for CSR reimbursements." Fosdick Declaration ¶ 14; *see also* Lopatka Declaration ¶¶ 9-10; Chappelear Declaration ¶ 21; *Q1 2017 Anthem Inc. Earnings Call – Final*, Fair Disclosure Wire, Apr. 26, 2017 (Anthem Earnings Call); Letter from Robert Spector, Vice President, Blue Shield of California (May 17, 2017) (Blue Shield Letter); Letter from Shari Westerfield, Vice President, American Academy of Actuaries, to Paul Ryan (Dec. 7, 2016) (Actuaries Letter);[13] Letter from Theodore Nickel, President, National Association of Insurance Commissioners, to Paul Ryan (Apr. 19, 2017) (Commissioners Letter).[14]

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[12] Saturno & Tollestrup, *Continuing Resolutions: Overview of Components and Recent Practices* 10 (Jan. 14, 2016), https://fas.org/sgp/crs/misc/R42647.pdf ("[R]egular appropriations were enacted after October 1 in all but four fiscal years between FY 1977 and FY 2016.").

[13] https://www.actuary.org/files/publications/HPC_letter_ACA_CSR_120716.pdf.

[14] http://www.naic.org/documents/government_relations_170419_testimony_csr_house.pdf.

Rising premiums, in turn, would force more state residents to forgo health insurance. Among those most directly affected would be the 2.1 million people who currently purchase insurance through the Exchanges but do *not* qualify for premium tax credits, and thus would pay out-of-pocket for higher premiums.[15] Increased premiums would mean many lower-income families "cannot afford to stay covered under their health insurance plan." McLeod Declaration ¶ 5; *see also* AHIP Letter. And as the States' experience confirms, "[w]hen premium rates for plans offered through the Exchanges have risen, fewer individuals choose to buy them." Letter from Cástulo de la Rocha, President & CEO, AltaMed Health Services (Apr. 28, 2017); *see also* Kreidler Declaration ¶¶ 22-26; Wadleigh Declaration ¶ 6; Tailor Declaration ¶ 6; Frigand Declaration ¶¶ 5-8; Vullo Declaration ¶ 10; Frescatore Declaration ¶ 33.

Increasing premiums would also increase the number of uninsured individuals because it would relieve more people from the Act's "shared responsibility" provision, which imposes a tax on people who do not have health insurance. *Sebelius*, 132 S. Ct. at 2580, 2585. No tax is levied if premiums exceed about 8% of household income. 26 U.S.C. § 5000A(e)(1)(A). The rise in

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

premiums triggered by the district court's decision would carry some people above this threshold. And freed from this requirement, many individuals would "wait to purchase health insurance until they need[] care." 42 U.S.C. § 18091(2)(I); *see also* Kreidler Declaration ¶¶ 27-28.

Loss of individual purchasers from Exchanges could also have a larger destabilizing effect. Healthy individuals are the most likely to stop buying insurance because of increased costs. Vullo Declaration ¶ 10; Chappelear Declaration ¶ 26. But participation by healthy individuals is "essential to creating effective health insurance markets." 42 U.S.C. § 18091(2)(I). The loss of healthy participants "destabilize[s] the individual insurance markets," and can lead to the "very 'death spirals' that Congress designed the Act to avoid." *King*, 135 S. Ct. at 2493. Industry experts confirm that subjecting CSRs to the appropriations process would make this result more likely. *See* Kreidler Declaration ¶ 31; Fosdick Declaration ¶ 16; Actuaries Letter; Blue Shield Letter; Corlette et al., *Uncertain Future for Affordable Care Act Leads Insurers to Rethink Participation, Prices* 7-8 (Jan. 2017).[16]

[16] http://www.urban.org/sites/default/files/publication/87816/2001126-uncertain-future-for-affordable-care-act-leads-insurers-to-rethink-participation-prices_1.pdf.

(b) *Insurer withdrawals*. The district court's injunction would also lead to more uninsured by causing some insurers to exit the Exchanges altogether. Molina Healthcare, which provides Exchange coverage to more than one million people in nine states, has stated that it would "not offer any plans through the Exchanges at all if the CSR payments are discontinued." Fosdick Declaration ¶¶ 3, 13. Anthem has similarly warned that it will consider "exiting certain individual [Exchanges] altogether" if CSR payments are not guaranteed. Anthem Earnings Call. *See also* Wade Declaration ¶ 19. That Congress might ultimately fund some CSR payments does not fix this problem: just as some insurers would preemptively raise premiums in response to uncertainty over possible appropriations, others would withdraw from the Exchanges entirely. *See* Fosdick Declaration ¶¶ 10-13; Kreidler Declaration ¶¶ 29, 32-33; Wadleigh Declaration ¶ 10; Frescatore Declaration ¶ 31; Vullo Declaration ¶ 11; Actuaries Letter; Commissioners Letter; Corlette, *supra*, at 7. Indeed, Aetna recently announced that it will stop offering plans through the Exchange in Delaware, and represented to the Delaware Department of Insurance that its decision was based in part on the uncertainty over CSR reimbursements. Navarro Declaration ¶ 14.

Fewer insurers would lead to fewer affordable coverage choices and ultimately more uninsured residents. This is most apparent in counties where only a single insurer currently offers coverage on an Exchange, as is true in at least one

county in each of 25 States. *See* Sanger-Katz, *Bare Market: What Happens if Places Have No Obamacare Insurers?*, N.Y. Times, Apr. 18, 2017.[17] Withdrawal of that insurer would be devastating. Qualified residents in those counties would have no ability to take advantage of premium tax credits and CSRs to afford insurance. *King*, 135 S. Ct. at 2487. And while some might have other options, such as purchasing a non-Exchange individual plan, most would not: "There are no 'good' options for addressing what would be a 'bare county.'" Covered California, *Options for Addressing Counties that Have No Individual Market Qualified Health Plan for 2018* 1 (Apr. 14, 2017);[18] *see also* Howard Declaration ¶¶ 6-7. Even in counties where insurers continue to offer plans, the loss of some insurers would lead to more uninsured. Fewer insurers decreases competition and drives up premiums. MacEwan Declaration ¶ 8; Vullo Declaration ¶ 11; Navarro Declaration ¶¶ 13-15. Higher premiums force more people to forgo insurance.[19]

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[17] https://www.nytimes.com/2017/04/18/upshot/bare-market-what-happens-if-places-have-no-obamacare-insurers.html.

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

[19] Two analyses confirm that a loss of CSR payments would lead to premium increases, but conclude that the number of insured could also increase (although many individuals would face higher out-of-pocket costs, because they would purchase health plans with higher deductibles). Blumberg & Buettgens, *The Implications of a Finding for the Plaintiffs in* House v. Burwell (Jan. 2016), http://www.urban.org/sites/default/files/publication/77111/2000590-The-Implications-of-a-Finding-for-the-Plaintiffs-in-House-v-Burwell.pdf;

(continued...)

(c) *Uncompensated care and rising state costs*. Apart from the human costs imposed on residents deprived of insurance, the increase in uninsured residents resulting from the district court's injunction would cause a direct increase in healthcare costs for the States. States ultimately must cover the costs of care when the uninsured seek treatment at state-funded facilities. Under federal law, state-funded hospitals must provide emergency care, regardless of a patient's insurance status or ability to pay. 42 U.S.C. § 1395dd. State law typically imposes similar mandates. *See, e.g.*, Cal. Welf. & Inst. Code §§ 17000, 17600; N.Y. Public Health Law § 2807-k. As the number of uninsured goes up, then, so does state healthcare spending.

The States' experience demonstrates this cause and effect. In California, adoption of the ACA led to "a reduction in the number of uninsured [residents] who rely on county indigent health care programs," which "reduc[ed] counties' costs of serving the indigent population." Taylor, *The Uncertain Affordable Care*

(…continued)
Yin & Domurat, *Evaluating the Potential Consequences of Terminating Direct Federal Cost-Sharing Reduction (CSR) Funding* (Jan. 26, 2017), http://www.coveredca.com/news/pdfs/CoveredCA_Consequences_of_Terminating_CSR.pdf. Both reports assume, however, that insurers would have sufficient time to adjust premiums before CSR payments stop, and would not exit the Exchanges. As discussed, those assumptions are unwarranted.

Act Landscape: What It Means for California 18 (Feb. 2017).[20] In New York, the ACA led to a steep reduction in hospital visits from uninsured individuals—between 2013 and 2015, uninsured emergency visits dropped by 23% and outpatient visits by 17%. Wynn Declaration ¶¶ 7-9. State University of New York hospitals saw an even sharper decline, with a 41% drop in emergency services. Azziz Declaration ¶ 6. As a result, New York hospitals' uncompensated care costs fell by 15%. Wynn Declaration ¶ 10. Other States have had similar experiences. *See* Wadleigh Declaration ¶ 11; Kreidler Declaration ¶ 21; Rattay Declaration ¶¶ 4-7; Department of Legislative Services, *Assessing the Impact of Health Care Reform in Maryland* viii (Jan. 2017).[21] If the number of uninsured goes back up, this trend would reverse. *See* Taylor, *supra*, at 21; Wadleigh Declaration ¶ 11; Rattay Declaration ¶ 5; Wynn Declaration ¶¶ 11-12.

(d) *Loss of direct federal funding*. New York and Minnesota also risk losing hundreds of millions of dollars in direct federal funds if the federal government stops making CSR payments. As authorized by the ACA, both States operate Basic Health Programs (BHPs), which provide alternative health coverage

[20] http://www.lao.ca.gov/reports/2017/3569/ACA-Landscape-021717.pdf.

[21] http://mgaleg.maryland.gov/Pubs/LegisLegal/2017-Impact-Health-Care-Reform.pdf.

options to certain low-income individuals. *See* 42 U.S.C. § 18051.[22] New York's BHP covers nearly 675,000 people; Minnesota's, 85,000. Vullo Declaration ¶ 9; Zimmerman Declaration ¶ 6.

The federal government provides funds directly to these States to subsidize the cost of insurance offered through BHPs. That funding is expressly pegged to the CSR payments at issue here: the States receive 95% of the CSRs that would have been provided to insurers had the individuals purchased non-BHP plans on an Exchange. 42 U.S.C. § 18051(d)(3)(A)(i). These federal payments are "transfer[red] to the State" and placed into a segregated fund that the State can draw upon "to reduce the premiums and cost-sharing" for eligible individuals who purchase coverage through BHPs. *Id.* § 18051(d).

The district court's injunction threatens these funds. If allowed to take effect, the injunction would put at risk approximately $870 million of annual funding to New York, and $120 million to Minnesota. Vullo Declaration ¶ 9; Zimmerman Declaration ¶ 7. This potential loss further supports the States' intervention. *See Clinton v. City of N.Y.*, 524 U.S. 417, 430-431 (1998).

[22] *See also* Medicaid.gov, *Basic Health Program*, https://www.medicaid.gov/basic-health-program/index.html (last visited May 17, 2017).

2. Annual uncertainty and state administrative costs

The district court's decision would also directly affect and substantially complicate the States' efforts to administer their Exchanges. Indeed, the uncertainty created by this litigation is already imposing that harm on the States.

The States play a critical role in delivering plans offered through the Exchanges. State regulators review proposed premium rates to evaluate whether they are "actuarially sound," Cal. Health & Safety Code § 1385.06(a), and whether proposed rate increases are "unjustified," *id.* § 1385.11(a), or not "excessive, inadequate, unfairly discriminatory, destructive of competition or detrimental to the solvency of insurers," N.Y. Insurance Law § 2303. *See also* 18 Del. Code § 2503; Md. Code, Ins. § 11-603(c)(2)(i). Similarly, the ACA relies on regulators in most States to annually review "unreasonable increases in premiums" and compel insurers to justify such increases before they go into effect. 42 U.S.C. § 300gg-94(a)(1); 45 C.F.R. §§ 154.200-154.230, 154.301. And States review plans offered on their Exchanges (and through BHPs) to determine, among other things, whether they meet requirements such as covering essential health benefits and paying CSRs for eligible individuals. 42 U.S.C. § 18031(b)-(e); 45 C.F.R. §§ 155.1000-155.1010, 156.20, 156.200.

The district court's injunction would directly affect these state regulatory decisions. While rate review and plan selection takes place between May and

October, *see* Wick, *supra*; CMS Bulletin 2-4, Congress typically does not make appropriations decisions until October or later. The district court's decision would require regulators to evaluate proposed premiums, and select plans for inclusion in Exchanges, without knowing whether insurers would receive federal CSR payments. That would make it "more difficult and onerous" for regulators to determine appropriate premiums and to ensure adequate insurer participation on Exchanges. *West Virginia v. EPA*, 362 F.3d 861, 868 (D.C. Cir. 2004). *See* Kreidler Declaration ¶¶ 12-19; Wade Declaration ¶¶ 3-16; Navarro Declaration ¶¶ 4-9, 15-20; Thomas Declaration ¶¶ 3-7, 14-17; Vullo Declaration ¶¶ 5-7; Cammarata Declaration ¶¶ 6-19.

At the very least, the district court's decision would increase States' administrative burdens. Regulators typically review only one proposed premium rate per plan year. Thomas Declaration ¶¶ 12-13. If the district court's injunction goes into effect, regulators would either have to review two premium proposals or Exchange applications—one assuming CSRs will be reimbursed and one not—or establish processes for modifying premiums or changing participation after the review and selection process has begun. In either scenario, the States would spend more. *See* Kreidler Declaration ¶¶ 13-19; Wade Declaration ¶¶ 3-16; Thomas Declaration ¶¶ 11-17; Vullo Declaration ¶¶ 14-17; Frescatore Declaration ¶ 39; Cammarata Declaration ¶¶ 14-17.

Indeed, even though the district court's injunction has so far been stayed, the uncertainty caused by this case is already interfering with States' regulatory decisions. Insurers and health plans in California have submitted multiple proposed premium rates for 2018, including one that assumes that CSRs will not be funded. DeBenedetti Declaration ¶ 3. Regulators will soon begin reviewing these multiple proposals, and incurring additional costs. Thomas Declaration ¶¶ 14-17. Other States have similarly altered their regulatory programs, and begun spending additional tax dollars, in an effort to accommodate the uncertainty created by this lawsuit. *See* Kreidler Declaration ¶¶ 9-19; Wade Declaration ¶ 12; Vullo Declaration ¶¶ 13-14. These actions foreshadow the kinds of responses that States would be forced to engineer each year should the district court's injunction take effect.

3. Protectable interests and Article III standing

This appeal will determine whether the district court's injunction is reversed, vacated, or sustained. Affirmance of the district court's decision would harm the States and their residents (including some of the most vulnerable) by imposing regulatory burdens, creating uncertainty, disrupting insurance markets, preventing proper operation of the ACA, and forcing States to spend more on administration and on care for the uninsured. Two States would also risk losing direct federal funding. Those harms would stem directly from improperly allowing the House to

maintain this lawsuit and the district court's improper interpretation of the ACA. And the harms would be redressed by a decision from this Court either vacating or reversing the decision below. The States thus have both a legally protectable interest in the outcome of this appeal and Article III standing to intervene. *See Crossroads*, 788 F.3d at 320 (equating standing and legally protected interest); *see also Ass'n of Private Sector Colls. and Univs. v. Duncan*, 681 F.3d 427, 458 (D.C. Cir. 2012) (standing where regulation would impose "'greater compliance costs,'" even though costs would not be "'significant'"); *Kansas v. United States*, 16 F.3d 436, 439 (D.C. Cir. 1994) (standing to challenge federal limit on direct flights to airport where state employees "occasionally" flew to city, and more flights to airport 12 miles closer to town would permit transfers from airport to city that "presumably would take less time and cost Kansas somewhat less"). This conclusion has particular force in light of the "special solicitude" to which States are entitled "for the purposes of invoking federal jurisdiction." *Massachusetts v. EPA*, 549 U.S. 497, 518, 520 (2007).

Principles of *parens patriae* standing also support intervention. Allowing the district court's ruling to go into effect would substantially injure the States' quasi-sovereign interest in the health and well-being of their residents. *Alfred L. Snapp & Son, Inc. v. Puerto Rico, ex rel., Barez*, 458 U.S. 592, 600, 607-608 (1982). And while the law generally disfavors *parens patriae* standing in suits that seek "'to

protect [state] citizens from the operation of federal statutes,'" *Massachusetts*, 549 U.S. at 520 n.17, this is not such a case. The States instead seek to *defend* a federal statute and thereby "'vindicate the Congressional will.'" *Abrams v. Heckler*, 582 F. Supp. 1155, 1159 (S.D.N.Y. 1984).

II. PERMISSIVE INTERVENTION

For the same reasons, the States satisfy the criteria for permissive intervention. They have "claim[s] or defense[s] that share[] with the main action a common issue of law or fact," Fed. R. Civ. P. 24(b)(1)(B)—that the House lacks standing to seek the injunction entered below, and that the Executive Branch has the statutory authority to make CSR payments without congressional appropriations beyond what the Act provides. And intervention would not "unduly delay or prejudice the adjudication of the original parties' rights." Fed. R. Civ. P. 24(b)(3). To the contrary—the States may be the only parties interested in providing the robust adversary presentation necessary to proper resolution of this appeal.

III. INTERVENTION IS ESPECIALLY WARRANTED HERE

The need for state intervention is underscored by the exceptional nature of this appeal. The district court's injunction was obtained by a plaintiff whose Article III standing is deeply questionable. It threatens catastrophic harm to the States themselves, to the health insurance markets they regulate and administer, and to their residents who rely on those markets to obtain affordable insurance vital

to their continued health and well-being. And because of an intervening presidential election, the current parties appear ready to agree to allow the injunction to stand, without giving this Court the opportunity to determine whether the district court had either jurisdiction to enter it or a legal basis to enjoin the permanent appropriation that Congress intended to provide.

At minimum, these extraordinary circumstances require this Court to review for itself the jurisdictional basis and validity of the order and injunction, even if the existing parties urge the Court to allow the decision below to stand. *FW/PBS, Inc. v. City of Dallas*, 493 U.S. 215, 231 (1990) (federal courts have an "independent obligation to examine their own jurisdiction"). The States' intervention would give this Court a set of parties willing and able to present a competing view on the important legal issues that require this Court's review. In analogous circumstances, the Supreme Court has recognized that an intervenor may provide the court with a "sharp adversarial presentation of the issues" when "the principal parties agree" on the invalidity of a federal law—an important perspective for any court to consider before ruling on deeply contested legal issues that implicate the "[r]ights and privileges of hundreds of thousands of persons." *United States v. Windsor*, 133 S. Ct. 2675, 2687-2688 (2013). The States' commitment to defending the provision of CSR payments under current law, in the absence of a current party reliably willing to do so, strongly supports their intervention.

CONCLUSION

The motion to intervene should be granted.

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Respectfully submitted,

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CERTIFICATE OF PARTIES AND AMICI

Pursuant to D.C. Circuit Rules 27(a)(4) and 28(a)(1), movants certify that: Except for the following, all parties and amici appearing before the district court and in this court are listed in the Brief for Defendants-Appellants.

Amicus briefs or notices of intent to file an amicus brief were also filed in this court by the following groups:

Organizations: Families USA, Asian & Pacific Islander American Health Forum, Community Catalyst, Inc., National Health Law Program, National Partnership for Women & Families, National Women's Law Center, America's Health Insurance Plans, Blue Cross Blue Shield Association, American Hospital Association, Federation of American Hospitals, the Catholic Health Association of the United States, Association of American Medical Colleges, Center for Constitutional Jurisprudence, Cato Institute.

Professors: Walter Dellinger, William N. Eskridge, Jr., David A. Strauss.

Economic and health policy scholars: Kenneth J. Arrow, Ph.D., Susan Athey, Ph.D., Jeremy Barofsky, Sc.D., Barry Bosworth, Ph.D., Gary Burtless, Ph.D., Phillip J. Cook, Ph.D., Amitabh Chandra, Ph.D., Janet Currie, Ph.D., Karen Davis, Ph.D., Peter Diamond, Ph.D., Mark Duggan, Ph.D., Ezekiel Emanuel, M.D., Ph.D., Austin Frakt, Ph.D., Claudia Goldin, Ph.D., Vivian Ho, Ph.D., Jill Horwitz, Ph.D., Lawrence Katz, Ph.D., Genevieve M. Kenney, Ph.D., Frank Levy,

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May 18, 2017 */s/ Edward C. DuMont*
Edward C. DuMont

CERTIFICATE OF COMPLIANCE

I hereby certify that this brief complies with the requirements of Federal Rule of Appellate Procedure 27(d)(2), because it contains 5,065 words, according to the count of Microsoft Word. I further certify that this brief complies with typeface requirements of Rule 27(d)(1)(E) because it has been prepared in 14-point Times New Roman font.

May 18, 2017 */s/ Edward C. DuMont*
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CERTIFICATE OF SERVICE

I certify that on May 18, 2017, the foregoing Motion to Intervene was served electronically via the Court's CM/ECF system upon all counsel of record.

May 18, 2017 */s/ Edward C. DuMont*
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