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

ERIC T. SCHNEIDERMAN
Attorney General of New York
BARBARA D. UNDERWOOD
Solicitor General
STEVEN C. WU
Deputy Solicitor General
HOWARD MASTER
Senior Enforcement Counsel
LISA LANDAU
Bureau Chief, Health Care Bureau

120 Broadway, 25th Floor
New York, NY 10271
(212) 416-6312
Barbara.Underwood@ag.ny.gov

XAVIER BECERRA
Attorney General of California
EDWARD C. DUMONT
Solicitor General
JONATHAN L. WOLFF
Acting Chief Assistant Attorney General
JULIE WENG-GUTIERREZ
Senior Assistant Attorney General
KATHLEEN BOERGERS
Deputy Solicitor General
GREGORY BROWN
Deputy Attorney General
SAMUEL P. SIEGEL
Associate Deputy Solicitor General
455 Golden Gate Avenue, Suite 11000
San Francisco, CA 94102
(415) 703-2540
Edward.DuMont@doj.ca.gov

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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,

[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,

[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

[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

[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.

Dated: May 18, 2017

Respectfully submitted,

ERIC T. SCHNEIDERMAN
Attorney General of New York
BARBARA D. UNDERWOOD
Solicitor General
STEVEN C. WU
Deputy Solicitor General
HOWARD MASTER
Senior Enforcement Counsel
LISA LANDAU
Bureau Chief, Health Care Bureau

120 Broadway, 25th Floor
New York, NY 10271
(212) 416-6312
Barbara.Underwood@ag.ny.gov

XAVIER BECERRA
Attorney General of California

/s/ Edward C. DuMont
EDWARD C. DUMONT
Solicitor General
JONATHAN L. WOLFF
Acting Chief Assistant Attorney General
JULIE WENG-GUTIERREZ
Senior Assistant Attorney General
KATHLEEN BOERGERS
Deputy Solicitor General
GREGORY BROWN
Deputy Attorney General
SAMUEL P. SIEGEL
Associate Deputy Solicitor General
455 Golden Gate Avenue, Suite 11000
San Francisco, CA 94102
(415) 703-2540
Edward.DuMont@doj.ca.gov

FOR THE STATE OF CONNECTICUT

GEORGE JEPSEN
Attorney General of Connecticut
ROBERT W. CLARK
Special Counsel to the Attorney General
JOSEPH RUBIN
Associate Attorney General
55 Elm Street
Hartford, CT 06106

FOR THE STATE OF DELAWARE

MATTHEW P. DENN
Attorney General of Delaware
AARON R. GOLDSTEIN
State Solicitor
SARAH FISHMAN GONCHER
JOHN H. TAYLOR
Deputy Attorneys General
801 North French Street
Wilmington, DE 19801

FOR THE STATE OF HAWAII

DOUGLAS S. CHIN
Attorney General of Hawaii
425 Queen Street
Honolulu, HI 96813

FOR THE STATE OF ILLINOIS

LISA MADIGAN
Attorney General of Illinois
100 West Randolph Street, 12th Floor
Chicago, IL 60601

FOR THE STATE OF IOWA

THOMAS J. MILLER
Attorney General of Iowa
JEFFREY THOMPSON
Solicitor General
1305 East Walnut Street
Hoover State Office Building, Second Floor
Des Moines, IA 50319

FOR THE COMMONWEALTH OF KENTUCKY

ANDY BESHEAR
Attorney General of Kentucky
LA TASHA BUCKNER
Executive Director, Office of Civil and Environmental Law
S. TRAVIS MAYO
TAYLOR PAYNE
Assistant Attorneys General
700 Capitol Avenue
Capitol Building, Suite 118
Frankfort, Kentucky 40601

FOR THE STATE OF MARYLAND

BRIAN E. FROSH
Attorney General of Maryland
STEVEN M. SULLIVAN
Solicitor General
200 Saint Paul Place
Baltimore, MD 21202

FOR THE COMMONWEALTH OF MASSACHUSETTS

MAURA HEALEY
Attorney General of Massachusetts
ROBERT E. TOONE
MARY BECKMAN
ERIC GOLD
Assistant Attorneys General
One Ashburton Place
Boston, MA 02108

FOR THE STATE OF VERMONT

THOMAS J. DONOVAN, JR.
Attorney General of Vermont
BENJAMIN D. BATTLES
Solicitor General
109 State Street
Montpelier, Vermont 05609

FOR THE STATE OF MINNESOTA

LORI SWANSON
Attorney General of Minnesota
ALAN GILBERT
Solicitor General
JASON PLEGGENKUHLE
KATHERINE KELLY
Assistant Attorneys General
445 Minnesota Street, Suite 1100
St. Paul, MN 55101

FOR THE STATE OF WASHINGTON

ROBERT W. FERGUSON
Attorney General of Washington
JEFFREY T. SPRUNG
Assistant Attorney General
1125 Washington Street SE
P.O. Box 40100
Olympia, WA 98504

FOR THE STATE OF NEW MEXICO

HECTOR H. BALDERAS
Attorney General of New Mexico
408 Galisteo Street
Santa Fe, NM 87501

FOR THE DISTRICT OF COLUMBIA

KARL A. RACINE
Attorney General of the District of Columbia
TODD S. KIM
Solicitor General
441 4th Street, NW
Suite 600 South
Washington, D.C. 20001

FOR THE COMMONWEALTH OF PENNSYLVANIA

JOSH SHAPIRO
Attorney General of Pennsylvania
16th Floor, Strawberry Square
Harrisburg, PA 17120

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,

Ph.D., Peter H. Lindbert, Ph.D., Eric S. Maskin, Ph.D., Alan C. Monheit, Ph.D., Joseph Newhouse, Ph.D., Daniel Polsky, Ph.D., James B. Rebitzer, Ph.D., Michael Reich, Ph.D., Thomas Rice, Ph.D., Robert D. Reischauer, Ph.D., Alice Rivlin, Ph.D., Meredith Rosenthal, Ph.D., Louise Sheiner, Ph.D., Katherine Swartz, Ph.D., Kenneth Thorpe, Ph.D., Laura Tyson, Ph.D., Paul N. Van de Water, Ph.D., Justin Wolfers, Ph.D.

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 *<u>/s/ Edward C. DuMont</u>*
Edward C. DuMont

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*
Edward C. DuMont

ADDENDUM

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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

DECLARATION OF RICARDO AZZIZ, M.D.
IN SUPPORT OF THE STATES' MOTION TO INTERVENE

Dr. Ricardo Azziz, declares under penalty of perjury, pursuant to 28 U.S.C. § 1746, that the following is true and correct:

1. I am the Chief Officer of Academic Health and Hospital Affairs of the State University of New York (SUNY), the largest university system in the nation, and have been in this position since 2016. My responsibilities include providing support, strategic oversight, guidance, and advocacy for the educational, research and clinical programs within the SUNY academic health and health professions portfolio, representing over 30% of SUNY's total annual $13.3 billion budget.

2. I am offering this declaration in support of the State of New York, and its motion for leave to intervene in the lawsuit of *House v. Price*.

3. I have compiled the information in the statements set forth below through SUNY personnel who have assisted me in gathering this information from SUNY hospitals.

4. SUNY operates three state-funded hospitals: in Syracuse, Brooklyn, and Stony Brook. They were established as clinical classrooms for the growing State University and three of its four medical schools. Their mission as teaching hospitals is to educate the next generation of health care providers, care for the sickest and most financially vulnerable New Yorkers, provide the highest level of care with advanced technology, and offer safety net services to the communities they serve.

5. Health insurance coverage for patients is vital to the financial stability of SUNY hospitals. When SUNY hospitals treat uninsured patients – as they must – they are forced to absorb the costs of these patients' care. This can have an adverse impact on the ability of SUNY hospitals to fulfill their mission of serving their communities and training health care providers.

6. The three SUNY hospitals in New York have seen a sharp decline in visits from uninsured individuals since the expansion of insurance coverage under the Affordable Care Act began in early 2014. Uninsured emergency visits dropped a staggering 41% from 30,777 in 2013 to 18,184 in 2015.

7. We have seen similar positive trends in other services, which are directly attributable to the expansion of health insurance coverage in the communities we serve. Since 2013, uninsured inpatient days have declined by 31%, and for non-emergency, non-referred outpatient visits, the uninsured rate decreased by 20%.

8. SUNY hospitals depend on funding from various sources to serve their patients, including cost-sharing subsidies, Medicaid, and Disproportionate Share Hospital (DSH) payments.

9. If cost-sharing reduction subsidies were to be eliminated and the number of uninsured New Yorkers were to increase, SUNY hospitals would likely experience an uptick in the number of uninsured patients they treat. If this were to happen, SUNY hospitals could be negatively impacted financially, in particular if their

DSH payments are reduced, as has been proposed. As a result, the ability of SUNY hospitals to serve their patients and to educate the next generation of health care providers may be harmed.

Executed on this 11 day of May, 2017

Dr. Ricardo Azziz
Chief Officer of Academic Health and Hospital Affairs
State University of New York

IN THE UNITED STATES COURT OF APPEALS
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v.

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Honorable Rosemary M. Collyer

DECLARATION OF KIMBERLY S. CAMMARATA IN SUPPORT OF THE STATES' MOTION TO INTERVENE

I, Kimberly S. Cammarata, declare and say as follows:

1. I am an Assistant Attorney General and the Director of the Maryland Attorney General's Health Education and Advocacy Unit (HEAU). I have served in this position for over 6 years. The facts stated herein are of my own personal knowledge, and I could and would competently testify to them.

2. The HEAU was established to promote the interests of health consumers in the health marketplace, among other purposes. The HEAU assists Maryland residents with health insurance enrollment, enrollment denials, denials of advance premium tax credits, denials of cost-sharing reductions, denials of coverage, and disputes involving medical equipment and billing. The HEAU advocates for consumers during federal and state legislative, administrative and rulemaking proceedings and during the Maryland Insurance Administration's rate review proceedings.

3. As the Director of the HEAU, I serve as a consumer-liaison with the Maryland Health Benefit Exchange, Maryland's state-based health insurance marketplace.

4. In Maryland, as of September 2016, the Patient Protection and Affordable Care Act (ACA) ensured access to health insurance for 421,084 individuals. 142,872 individuals were covered in private insurance and 278,212 were covered under Medicaid expansion.

5. Statistics reported by the Maryland Health Benefit Exchange show that over 83,000 individuals in Maryland are projected to receive over $97 million in cost-sharing reductions in calendar year 2017.

6. The Maryland Insurance Administration is responsible for Maryland's health insurance rate review program. As part of the rate review program, the Insurance Administration reviews carriers' proposed rates in Maryland's individual and small group markets.

7. The rate review program serves a vital public purpose. All rate filings and supporting information not deemed confidential commercial information by the Administration is open to public inspection when filed and subject to public comment filing. The HEAU has filed consumer-centric comments to carrier rate filings for the last two plan years.

8. The rate review program also provides the Maryland Insurance Administration with an opportunity as a regulator of health plans to review proposed rates and announce to the public whether proposed rates are actuarially sound.

9. If the Maryland Insurance Administration finds that a proposed rate is inadequate, unfairly discriminatory or excessive, it will modify or deny the rate filing and offer the carrier a hearing.

10. For the 2018 plan year, carriers filed requests with the Maryland Insurance Administration on May 1, 2017.

11. The requirement that carriers post their proposed rates at least 7 months before they are implemented serves an important function, by allowing members of the public and consumer advocates to review the proposed rates independently, check the carriers' assumptions, and provide public comment on the proposed rates to the carriers and the Insurance Administration. The May 1 rate filing deadline also allows the rates to be reviewed and finalized within the time needed for the Maryland Health Benefit Exchange to certify health plans and to incorporate the plans on the Exchange's consumer shopping website, Maryland Health Connection, in time for open enrollment.

12. Allowing sufficient time for review by the Maryland Insurance Administration and the public is important to ensure that consumers have accurate information about their health plans' proposed rates and whether the Maryland Insurance Administration has found that the rates are supported by evidence. This information is crucial for consumers when they are evaluating their enrollment options, and comparing premiums and networks.

13. Proposed rates depend entirely on the carriers' and the Insurance Administration's assumptions about market conditions and pertinent laws and regulations that are expected to apply during the relevant rating period. If those assumptions prove incorrect, they could have serious consequences for consumers and health plans.

14. Uncertainty regarding whether the federal government will fund reimbursements for cost-sharing reductions has the potential to cause wide variations in proposed rate increases for any year in which cost-sharing reductions are not permanently funded.

15. In 2018 rate filings, Maryland carriers included language stating that requested rate increases were based on assumptions that cost-sharing reduction payments would be funded through the 2018 plan year and that any reduction in funding the subsidies may lead to supplemental filings. One carrier, Cigna Health & Life Insurance Company, stated, "any reduction in funding these subsidies may lead to a significant impairment in the adequacy of the rates developed herein."

16. By law, health plans must provide cost-sharing reductions to consumers, regardless of whether they are funded. If the federal government does not reimburse health plans for cost-sharing reductions, health plans will need to increase their premiums in order to compensate for this loss.

17. If, after the rate filing and public posting deadline has already past, the federal government announces that it will not reimburse health plans for cost-sharing reductions, the Maryland Insurance Administration will find it necessary to invite a supplemental proposed rate filing. If carriers submit supplemental rate filings, both the Insurance Administration and the public will have less time than usual to review proposed rate increases. And, the Insurance Administration would incur significantly more administrative time and expense in reviewing the supplemental filings.

18. Reducing the amount of time available to spend on the rate review program would thwart a valuable and important statutory mandate to ensure a sufficient, transparent, and public review of proposed premium increases, would cause consumer confusion about rate increases and timelines for review and comment, and would diminish the Maryland Insurance Administration's ability to conduct a thorough review.

19. If the Insurance Administration's rate review is delayed because of supplemental filings, the delay will impact the Maryland Health Benefit Exchange's plan certification timeline which currently requires final rate review templates to be submitted to the Exchange on September 17, 2017.

I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct.

Kimberly S. Cammarata

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

DECLARATION OF CHRISTOPHER CHAPPELEAR
IN SUPPORT OF THE STATES' MOTION TO INTERVENE

Christopher Chappelear declares, under penalty of perjury, pursuant to 28 U.S.C. § 1746, that the following is true and correct:

1. I am the Chief Actuary of EmblemHealth, Inc. ("EmblemHealth"). I make this declaration in support of Connecticut and New York State's Motion for Leave to intervene in the above-captioned action. As the Chief Actuary, I am responsible for the filing of our applications for approval of our rates with the appropriate state agencies for certain of our health insurance products.

2. EmblemHealth is a not-for-profit health plan that provides benefits to approximately 3million people who live and work across the New York tri-state area. EmblemHealth offers a range of commercial and government-sponsored health plans for large groups, small groups, and individuals.

3. The health insurance plans that EmblemHealth offers include Qualified Health Plans ("QHPs") for individuals and small groups and the EmblemHealth Essential Plan HMO, which is a Basic Health Plan Program (BHP) plan. These plans are offered through the New York State of Health marketplace commonly referred to as the Exchange.

4. The Exchange was established pursuant to the Patient Protection and Affordable Care Act ("ACA"), and EmblemHealth's plans offered on the Exchange meet the requirements of the ACA.

5. ConnectiCare Holding Company Inc., ("ConnectiCare") is a wholly

owned subsidiary of the EmblemHealth enterprise and through its various subsidiaries provides health insurance benefits to over 280,000 members in Connecticut and Massachusetts in the individual, small group and large group market, and to the Medicare population and retirees. Neil Kelsey is ConnectiCare's Vice President and Chief Actuary, and he is responsible for filing ConnectiCare's applications for approval of rates with the appropriate state agencies for certain ConnectiCare's health insurance products. As EmblemHealth's Chief Actuary, I am kept informed of the contents of ConnectiCare's filings and its rates for it plans.

6. Both the Connecticut and New York marketplaces for individual health insurance have been working well as a result of the strong collaboration among health plans and the states' respective insurance regulatory agencies. EmblemHealth and ConnectiCare both entered their respective exchange marketplaces at implementation of the Affordable Care Act (ACA). EmblemHealth began offering ACA-compliant individual and small group qualified health plans at all metal levels to consumers in 2014. ConnectiCare offered such plans in the individual market and not in the small group market.

7. In New York, as of February 1, 2017, 15 health plans were offering (QHPs) and (BHPs) plans with over 3.6 million New Yorkers enrolled in insurance coverage. The rate of uninsured in New York declined from 10

percent to 5 percent between 2013 and September 2016.

8. In 2017, EmblemHealth offers 23 individual QHPs through the Exchange. Three of these plans are standard silver plans with variations for each of the three Costs Sharing Reduction ("CSR") levels as required by the ACA, and three of the plans are non-standard silver plans with the same CSR features.

9. EmblemHealth, also offers the EmblemHealth Essential Plan HMO, which is New York State's Basic Health Plan. The Essential Plan was created through a waiver, as provided for under the ACA, and it is for consumers whose household income is below 200% of the federal poverty level. 25,230 individuals are enrolled in the EmblemHealth Essential Plan, which is 4% of all BHP enrollees statewide.

10. For the 2017 plan year, 17,258 individuals enrolled in an individual EmblemHealth QHP. This is 5% of QHP enrollees statewide and 7% of the QHP enrollees in EmblemHealth's service area, which is a portion of New York State.

11. In 2016, approximately 1,494 EmblemHealth enrollees received a CSR, and the total value of CSRs provided by EmblemHealth in 2016 was $251,855.

12. In 2017, approximately 1,943 EmblemHealth enrollees have received a CSR subsidy through the month of May. Assuming that enrollment remains steady for the remainder of 2017, we anticipate a CSR subsidy of $172,158.

13. In Connecticut, as of February 1, 2017, two health plans were offering QHPs, and over 100,000 Connecticut residents were enrolled in coverage. The rate of uninsured declined from 9.4 percent to 6.0 percent between 2013 and 2015.

14. In the individual market, ConnectiCare offers QHP's and has the largest individual market share in the state of Connecticut. In 2017, ConnectiCare offers seven individual QHPs through the Marketplace. Three of these plans are silver plans with variations for each of the three CSR levels as required by federal law. During the 2017 Access Health open enrollment period, 68 percent of Connecticut QHP enrollees selected a ConnectiCare plan on the Exchange. With respect to both the on Exchange and off Exchange markets, ConnectiCare covers 56 percent of the individuals purchasing such coverage.

15. In 2017, approximately 31,500 ConnectiCare enrollees have received a (CSR) subsidy through the month of March, and in 2016, approximately 24,300 ConnectiCare enrollees received a CSR. The total value of CSRs provided by ConnectiCare in 2016 is estimated to be $20.0 million.

16. If the federal government does not make CSR payments to health plans for the duration of 2017, the EmblemHealth enterprise, including ConnectiCare, will incur a significant financial liability. We expect that if CSR payments are halted, health plans will nevertheless be required to continue to make CSR

payments to providers on behalf of our covered members for the remainder of the contract year, that is 2017.

17. In sum, we are expected to make these payments under the ACA, whether or not we receive these funds from the federal government. Specifically, if the federal government refuses to reimburse ConnectiCare for CSR payments for the second half of 2017, ConnectiCare will be expected to pay approximately $13 million on behalf of its members -- payments for which it will not receive reimbursement from the federal government.

18. Additionally, if payments to EmblemHealth for such CSR payments are halted for the second half of 2017, EmblemHealth will be expected to pay approximately $172,158, again amounts for which it will not receive reimbursement from the federal government.

19. Both EmblemHealth and ConnectiCare have begun the process of preparing, filing and obtaining approval with our respective state regulatory authorities for plans and rates that we will offer on our respective Exchanges for 2018.

20. As with 2017, we expect, pursuant to the ACA, that we will be required to continue to pay CSR's on behalf of our members, whether or not we receive such funds from the federal government. We are preparing our rates on the assumption, as directed by our respective regulators, that CSR funding will

continue through 2018.

21. EmblemHealth is required to submit its rate proposal to the New York State Department of Financial Services by May 15, 2017 and must make a final decision regarding participation in the individual Exchange market by May 26, 2017. Should CSRs not be funded for 2018, EmblemHealth would be compelled to increase its premium rates for its individual plans in 2018 to reflect the shortfall in CSR payments.

22. In addition, the failure to fund CSR's would also have a significant financial impact on EmblemHealth's participation in the market for the Essential Plan. As discussed above, EmblemHealth serves a large population of 25,230 New Yorkers through the state's Essential Plan.

23. There are four Essential Plan categories, two of which rely on CSR payments as part of their funding calculation. Should CSR payments be discontinued, Essential Plans 1 and 2 will be impacted. We currently serve 20,308 Essential Plan 1 and 2 members and EmblemHealth receives a total premium revenue of $120,603,000 from New York State. Included in this amount paid to EmblemHealth is an amount calculated based on CSR funding that New York State receives from HHS.

24. If funding based on CSR payments stops in June of 2017, the Essential Plans 1 and 2 would lose approximately $7.2 million for the rest of the year, and

for 2018 the shortfall would be $14.3 million.

25. With respect to ConnectiCare, if CSR funding does not continue for 2018, then ConnectiCare would be required to increase premiums for individual plans in 2018 to account for this loss of federal funding. ConnectiCare estimates that the premium increase attributable to the loss of CSR funding alone that would be required to make up for this loss would likely be in the range of 9.0 – 15.0 percent. ConnectiCare has submitted its initial rate proposal for 2018 to the Commissioner of Insurance, and has until July 1, 2018 to make a final decision on participation in the individual Exchange market.

26. The loss of CSR funding will in all likelihood result in significant rate increases in the individual market. In addition to the financial impact on health plans, the loss of this funding would have severe negative consequences for our covered members. These rate increases will cause a large number of healthy, low-risk individuals in the individual market to drop coverage. This will drive up premiums for individual products further leading to a situation where only those who are sick or have chronic illnesses buy coverage resulting in lost access to coverage and higher premium prices for consumers who can maintain coverage.

27. Failure to fund the CSRs will threaten the stability of the individual markets in both New York and Connecticut, harming the well-being of the

citizens of both Connecticut and New York. For this reason, we strongly support this motion for leave to intervene in the case of *U.S. House of Representatives v. Thomas Price, et al.*

Dated: May 10, 2017

Christopher Chappelear

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,
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Honorable Rosemary M. Collyer

DECLARATION OF JAMES DEBENEDETTI
IN SUPPORT OF THE STATES' MOTION TO INTERVENE

DECLARATION OF JAMES DEBENEDETTI

I, James DeBenedetti, declare and say as follows:

1. I am the Director of the Plan Management Division for Covered California. I have worked for Covered California for two and a half years. The facts stated herein are of my own personal knowledge, and I could and would competently testify to them.

2. As Covered California's Director of the Plan Management Division, I am responsible for overseeing all the work undertaken with Covered California's contracted health plan issuers, including annual rate negotiations, patient centered benefit design modeling, cost, quality, and accessibility of healthcare delivered to Covered California's consumers.

3. On May 1, 2017, insurers filed their initial proposed Qualified Health Plans for the 2018 Plan Year. Given the uncertainty in federal policy regarding funding of Cost Sharing Reduction payments, at Covered California's request, insurers submitted proposed premium rates that assumed Cost Sharing Reduction reimbursement payments would continue through the 2018 Plan Year. The insurers also identified the potential percentage increase to their premium rates should there be no funding for Cost Sharing Reduction reimbursement payments. The insurers further offered information on the projected impact on member enrollment should there be no funding for those payments. The proposed rates that were submitted to Covered California are confidential. Final rates will become public on July 18, 2017 after they have been filed by the health plans with the regulatory agency overseeing their plans.

I declare under the penalty of perjury under the law of the United States that the foregoing is true and correct, and that this declaration was executed on May 12, 2017, at Sacramento, California.

James DeBenedetti

AltaMed

April 28, 2017

Attorney General Xavier Becerra
Office of the Attorney General
1300 I Street
Sacramento, CA 95814-2919

Re: *House v. Price*, D.C. Circuit Case No. 16-5202

Dear Attorney General Becerra:

On behalf of AltaMed Health Services and the 300,000 patients we serve, I write today asking for your support in defending the health care system that we have built together. AltaMed has been providing quality health and human services to individuals and families in Southern California for over 48 years. Each year we serve more than 300,000 individuals and families at 46 sites in Orange and Los Angeles Counties. Our services include a full continuum of care including, complete primary care, dental care, pediatrics obstetrics, gynecology, senior care, HIV services, and youth services.

Since the implementation of the Affordable Care Act, the number of patients at AltaMed has nearly tripled. This includes a 43% increase in beneficiaries who for the first time in a long time had access to comprehensive primary care and preventive care in their local community. In addition to medical, dental, and mental healthcare, our patients now have peace of mind knowing that they will get the care they need at AltaMed, reaching over 1.2 million encounters annually.

AltaMed opened 2 Health Enrollment Resource Centers in order to assist the community in enrolling in health care insurance through the Exchange, public health programs, Medicaid, and Medicare. The AltaMed Health Enrollment Resource Centers also serve as informational centers where the community can learn about how to use their health insurance, when to go to the Emergency vs. Urgent Care, and what are all their options when it comes to health care coverage. For 3 years in a row AltaMed has been named the #1 enroller in California for our State Exchange, Covered California.

AltaMed works to get individuals enrolled in healthcare plans offered through Covered California, one of the Exchanges established by the Patient Protection and Affordable Care Act. We do so by signing up individuals for health care plans. Since 2014, we have enrolled close to 100,000 individuals in health care plans and Medi-Cal (Medicaid) offered through Covered California.

When premium rates for plans offered through the Exchanges have risen, fewer individuals choose to buy them. Some individuals choose to go without healthcare coverage instead of paying higher rates. Sometimes this is a matter of choice, but sometimes it is a matter of economic necessity—the rise in health care premiums forces some people to choose for paying for health care and paying for other necessities like food and rent.

AltaMed Health Services Corporation 2040 Camfield Avenue Los Angeles, CA 90040 Tel 323 725 8751 Fax 323 889 7399 AltaMed.org

AltaMed

Furthermore, when premiums for health care plans offered through the Exchanges rise, some individuals decide not to purchase those plans even if they are eligible for tax credits and other subsidies that would substantially reduce those premiums. Some individuals will decide not to purchase those plans even if their failure to do so means that they will pay a tax penalty.

The Affordable Care Act and Medicaid program are essential to the mission of community health centers and by extension the health of local communities. They ensure access to care for the vulnerable people and communities we both serve. We are asking you to stand up for health and healthcare today.

Sincerely,

Cástulo de la Rocha, J.D.
President & CEO

AltaMed Health Services Corporation
2040 Camfield Avenue
Los Angeles, CA 90040
Tel 323 725 8751
Fax 323 889 7399
AltaMed.org

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

DECLARATION OF JANET FOSDICK
IN SUPPORT OF THE STATES' MOTION TO INTERVENE

DECLARATION OF Janet Fosdick

I, Janet Fosdick, hereby declare:

1. I am Vice President of Marketplaces of Molina Healthcare Inc. I am the senior executive in charge of the Marketplace product for Molina. In this capacity, I am responsible for product development , provider contracting strategy, actuarial pricing, risk adjustment/ quality, medical management, distribution channel development, consumer experience and advocacy efforts. I have 20+ years of expertise in all aspects of the health insurance business, focused on the Medicare Advantage and Non-Group markets. The facts stated herein are of my own personal knowledge, and I could and would competently testify to them.

2. Molina Healthcare is a FORTUNE 500 company, providing managed health care services under the Medicaid and Medicare programs and through the state insurance marketplaces. Through our locally operated health plans in 12 states across the nation and in the Commonwealth of Puerto Rico, Molina serves more than 4.2 million members. Dr. C. David Molina founded our company in 1980 as a provider organization serving low-income families in Southern California. We continue to be

headquartered out of Long Beach, California as we pursue our mission of providing high quality and cost effective care to those who need it the most.

3. Molina Healthcare has offered health insurance plans for purchase through the Exchanges created by the Patient Protection and Affordable Care Act since November 2013. We currently provide health insurance through the Exchanges to 150,000 individuals in California, 45,000 individuals in Washington, and 1,085,000 individuals across all the nine states, including California and Washington, where we offer Exchange products.

4. Like all other carriers who offer health insurance plans through the Exchanges, we are required to cover cost-sharing reduction (CSR) payments for those individuals who are eligible to receive them. Those payments are substantial: in 2015, they totaled $70 million; in 2016, they totaled $220 million; in 2017, we are projecting total payments of approximately $340 million, and approximately 70% of our members depend on these payments.

5. Since January 2014, we have been reimbursed by the Secretary of Health and Human Services for these costs each month.

6. For the 2017 plan year, we have already received $85 million in CSR reimbursements.

7. We anticipate that we will spend an additional $255 million in CSR costs for the rest of 2017. In California, CSR payments have amounted to fifteen percent of total claims costs for us; nationally, across all our Exchange states, CSR payments have also amounted to fifteen percent of total claims costs.

8. If the district court's decision in *House v. Price* became effective during the middle of the 2017 plan year, we would still be required to cover CSR costs. It would be very difficult to recover those costs through other means.

9. That loss would make Molina Healthcare seriously re-consider whether, and to what extent, we would continue to offer plans through the Exchanges in 2018.

10. In addition, the annual instability created by the district court's decision would seriously affect whether, and to what extent, we would continue to offer plans for purchase through the Exchanges in future years.

11. We typically must make decisions of whether to participate in the Exchanges during the first half of any given year. But Congress usually does not make its appropriation decisions until October (or later).

12. Whether or not the CSR reimbursements will be paid is one of the biggest variables influencing Molina Healthcare's decision as to whether, and to what extent, it will offer plans through the Exchanges.

13. Not knowing this key piece of information when we are deciding whether to participate in the Exchanges and file rates for plan year 2018 (or future plan years) will have a significant impact on our business operations. Among other things, it will affect the number of States and counties in which we will offer plans, and given the financial impact that not being reimbursed for the CSR payments will have on our business operations, it is my belief, that we would not offer any plans through the Exchanges at all if the CSR payments are discontinued.

14. In addition, if we decided to continue offering plans through the Exchanges, we would have to raise premiums on those plans in order to cover any shortfall that would result if Congress later decided not to appropriate funds for CSR reimbursements.

15. Based on our experience offering plans through the Exchanges, when premiums rise, fewer people sign up for the plans offered through the Exchanges.

16. Moreover, based on our experience in the health care industry, we believe that eliminating the CSR payments raises the risk of "adverse selection" in the individual market. The cost increases will drive out those members who do not get Federal subsidies, and also other healthy members for whom the rising cost of insurance may be untenable. As a result, the overall quality of the risk pool, or its medical acuity, will deteriorate, as its composition will skew towards sicker enrollees. This will lead to higher costs which in turn will lead to higher prices, which will perpetuate the cycle described above.

I declare under penalty of perjury under the laws of the United States that the foregoing is true and correct, and that this declaration was executed electronically, at my request, on April _27_, 2017, while I was in Sacramento, California.

Dated: April _27_, 2017

/s/ Janet Fosdick

[Janet Fosdick]

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

DECLARATION OF DONNA FRESCATORE
IN SUPPORT OF THE STATES' MOTION TO INTERVENE

Donna Frescatore, declares under penalty of perjury, pursuant to 28 U.S.C. § 1746, that the following is true and correct:

1. I am the Executive Director of the NY State of Health, which is established within the New York State Department of Health. I make this declaration in support of New York State's Motion to Intervene in the above-captioned action.

2. The NY State of Health ("NYSoH" or "Marketplace") is New York State's official health plan Marketplace established pursuant to the Patient Protection and Affordable Care Act ("ACA").

3. New York opened the NYSoH in October 2013 so that consumers would be able to purchase health plans to ensure coverage as of January 1, 2014. The NYSoH certifies health plans, determines eligibility, and offers enrollment opportunities on-line, in-person, by phone and by mail to individuals enrolling in public and private health insurance coverage.

4. Through the NYSoH, New Yorkers can enroll in Qualified Health Plans ("QHPs") — plans that have been certified by the Marketplace and cover all required essential health benefits required by the Affordable Care Act. New Yorkers earning less than 400 percent of the federal poverty level ($47,520 for individuals and $97,200 for families of four) can qualify for advance premium tax credits to lower the cost of their premiums for QHPs through the NYSoH. Under the ACA, those earning up to 250 percent of the federal poverty level may also be eligible for additional financial assistance through "cost-sharing reductions" ("CSRs") that reduce the cost of using their health insurance coverage. The NYSoH assists New Yorkers in determining whether such financial assistance is available. New Yorkers must enroll in a plan directly through the

Marketplace if they want to qualify for and use premium tax credits and CSRs.

5. In addition, eligible New Yorkers can enroll in Medicaid, Child Health Plus, or the Essential Plan (the State's Basic Health Program that offers free or low-cost health insurance coverage to low-income residents) through the Marketplace, and the NYSoH assists applicants in determining their eligibility to enroll in these programs.

6. Through these health plan options, the NYSoH has dramatically increased New Yorkers' access to affordable and comprehensive health insurance coverage. Prior to the ACA, coverage through New York's individual insurance market was unaffordable for most, costing $1,000 or more per person per month. As a result, generally only the sickest or wealthiest individuals purchased coverage, and New York's individual insurance market risked entering into a "death spiral."

7. Since its inception in 2014, the NYSoH has transformed New York's individual insurance market, offering all New Yorkers access to affordable health insurance options, with an average Marketplace premium costing $486 excluding any subsidies enrollees may receive. New York experienced an unprecedented increase in individual health insurance enrollment, both on and off the Marketplace. In just three years — from the NYSoH opening in 2013 to 2016 — the rate of uninsured New Yorkers has declined from 10% to 5%.

COST-SHARING REDUCTIONS

8. Pursuant to Section 1402 of the ACA, certain low-income individuals are eligible for CSRs to reduce the cost of using their health insurance coverage. "Cost-sharing" refers to co-payments, co-insurance, and deductibles that individuals pay when they access care covered by their health plans. The value of the CSR that an individual or

family receives depends on income level, and the lower one's income, the higher proportion of costs that will be covered through the CSR. For example, an individual's deductible could drop from $2,000 to between $1,650 to $0 with a CSR, depending on the individual's income.

9. New Yorkers are generally eligible for CSRs if: (a) they enroll in a qualified health plan ("QHP") at the "silver" level of coverage through the Marketplace, (b) their household income is between 100 and 250 percent of the federal poverty line ("FPL"),[1] and (c) they are also eligible for premium tax credits under the ACA. Eligibility is determined based on information submitted by the applicant regarding income, family size, and availability of minimum essential coverage. New Yorkers will be prompted to provide this information when they apply for coverage through the NYSoH if they are seeking financial assistance.

10. The NYSoH coordinates with the relevant federal agencies to provide real-time data-matching on eligibility requirements such as income and immigration status, enabling NYSoH to provide applicants with immediate eligibility determinations for financial assistance so they know their true cost of coverage when they compare plans and apply for coverage.

11. Health plans will be notified by the NYSoH that an individual eligible for a CSR has enrolled in their plan, and approximately once per month NYSoH sends to the U.S. Department of Health and Human Services ("HHS") Centers for Medicare and Medicaid Services and to the health plans a list of the plans' enrollees with CSRs.

[1] It is worth noting, however, that in New York individuals are generally eligible for Medicaid if their income is below 138% of the FPL.

HEALTH PLAN OFFERINGS IN THE MARKETPLACE

12. New York's Marketplace has been an undeniable success in providing health plan choices and coverage to millions of New Yorkers.

13. Millions of New Yorkers enroll in health insurance coverage through the Marketplace each year. In 2017, more than 3.6 million people enrolled in health coverage through the Marketplace. This represented an increase of 28% from the prior year's open enrollment period. The vast majority of those who enrolled through the NYSoH in 2017 reported not having health insurance at the time that they first applied for coverage through the Marketplace.

14. In 2017, nearly 1 in 5, or 18%, of New Yorkers are covered through the NYSoH.

15. The Marketplace offers a range of choices to consumers. In 2017, 14 health insurers offered qualified health plan coverage to individuals. These insurers are required to offer plans at each metal level — platinum, gold, silver, and bronze — in every county of its Marketplace service area.

16. Of the approximately 3.6 million New Yorkers who enrolled in coverage through the NYSoH in 2017, approximately 243,000 enrolled in QHPs (both with and without financial assistance). The remainder enrolled in the Essential Plan, Medicaid, and Child Health Plus.

17. Of these QHP enrollees, over 142,000 received financial assistance (tax credits and/or cost sharing reductions) to reduce the cost of coverage.

18. Nearly 65,000 individuals benefitted from CSRs in 2017. The majority of individuals who were eligible for CSRs in 2017 enrolled in a silver plan that enabled them

to utilize the reductions, while the rest enrolled in other metal levels.

19. In addition to the many QHP offerings available through NYSoH, New York is one of two states to offer a Basic Health Program ("BHP"), called the "Essential Plan," which offers free or low-cost health insurance coverage to individuals under age 65 with household incomes between 138 and 200 percent of the FPL and for those with incomes below 138 percent of the Federal Poverty Level who are lawfully present but do not qualify for federal Medicaid due to their immigration status. The Essential Plan offers coverage with no deductible and premiums of $0 or $20. On average individuals in the Essential Plan save more than $1,000 a year as compared to the cost they would have incurred if they were enrolled in a Qualified Health Plan.

20. The Essential Plan's first full year of operation was 2016. In that year eleven health insurers offered plans and approximately 379,559 individuals enrolled as of January 31, 2016. In 2017, fourteen insurers offered plans and the number of enrollees increased significantly, with approximately 665,324 individuals enrolled in an Essential Plan as of January 31, 2017.

21. Eighty-five percent of the Essential Plan funding is from the federal government, and the remaining 15 percent is paid by the State. Approximately one-quarter of the federal funding — or nearly $900 million — is based on the value of the CSRs that would have been paid to the health plans to help cover the cost-sharing obligations of eligible individuals had they enrolled in a QHP silver plan instead of the Essential Plan. The remaining three-quarters is based on the value of the advance premium tax credits that eligible individuals would have received had they enrolled in a QHP.

22. These funds from the federal government are deposited into New York's BHP Trust Fund, which New York then uses to reimburse the insurers offering Essential Plans. Attached as Exhibit 1 is a transmittal form from HHS to New York that sets out the federal payments to New York for the BHP, including the cost-sharing component of those payments.

PROCESS FOR PLANS TO PARTICIPATE IN THE MARKETPLACE

23. In approximately April of each year, the NYSoH issues an invitation for health plans to participate in the Marketplace in the following calendar year, and includes an outline of the certification requirements for designation as a Qualified Health Plan. All plans must meet these requirements to be included in the Marketplace. The NYSoH will evaluate whether the health plans that submitted proposals meet the federal minimum participation standards, along with any New York State participation requirements. Part of this assessment includes validating that the health plan is licensed and in good financial standing with the New York State Department of Financial Services ("DFS") and New York State Department of Health ("DOH").

24. Under NYS law, DFS is responsible for reviewing health plans' proposed rates and for approving policy forms. NYSoH is responsible under federal law for certifying plans to be offered on the Marketplace. Once DFS completes its review (typically in the month of August), it notifies NYSoH of the participating health plans' approved forms and rates. Health plans that meet participation requirements in the annual invitation are certified by NYSoH to be offered on the Marketplace in the next open enrollment period. Once a plan is certified, NYSoH loads information for approximately 622 product offerings, including the premium, benefits and cost sharing into its information technology

system. Starting in September, NYSoH uses this information and, with the consumers' consent, information from federal and state data sources, to begin the process of recertifying individuals' eligibility for the next calendar year, as required by federal law. Plan offerings must be publicly available on the Marketplace by November 1.

25. This rating and certification process is already in motion for the 2018 plan year. On April 18, 2017, the NYSoH issued its invitation to insurers to participate for the 2018 plan year. Insurers were required to submit their letters of interest to the NYSoH by April 25, 2017. They have until May 15, 2017 to submit their proposed rates to DFS for approval, and until May 26, 2017 to submit their participation proposals to the NYSoH. DFS will make its rate decisions by August 3, 2017, and the NYSoH will certify plans by September 28, 2017. Open enrollment for 2018 will begin on November 1, 2017.

IMPACT OF CSR APPROPRIATIONS ON THE MARKETPLACE

26. Under the Affordable Care Act, reimbursement for the Essential Plan is calculated based in part on the value of the CSRs those enrollees would have received had they instead enrolled in silver plans with CSRs. These funds are deposited by the federal government into New York's BHP Trust Fund, and New York covers approximately 85% of the cost of funding Essential Plans through these federal payments. Health insurers receive funding if they agree to participate in the program and offer an Essential Plan.

27. In 2016, the CSR component of New York's reimbursement for the Essential Plan was $597 million. In 2017, the CSR component of New York's reimbursement is estimated to be approximately $870 million.

28. If the federal government stops paying New York the value of the CSR into the BHP Trust Fund, New York will have to make up this difference and will be forced to pay

hundreds of millions of dollars to maintain this critical, and enormously successful, health insurance program for New Yorkers. If these payments stop in mid-2017, New York will have no choice but to make up for this shortfall so that hundreds of thousands of New Yorkers do not lose their health insurance coverage. Further, if these payments are either stopped or not guaranteed by 2018, New York will have to evaluate whether it is financially viable for the state to continue this successful program.

29. Even if the State is able to continue operating the Essential Plan, the loss of federal funding will likely lead to higher premium and cost-sharing contributions from consumers, which will lower enrollment and the overall number of New Yorkers who have health insurance.

30. This uncertainty over continued funding of the Essential Plan could also result in some insurers withdrawing from this program.

31. Additionally, NYSoH expects that if the federal government does not make CSR payments to health plans, it is possible some health plans may withdraw from the Marketplace and/or premiums for QHPs will increase in mid-2017 or in 2018.

32. In states that have expanded Medicaid, such as New York, the elimination of CSRs will cause premium increases not only for silver plans, but all QHPs. These increases would have the most direct impact on the approximately 225,000 people who purchase health insurance in the individual market both on and off-Marketplace and who are not eligible for tax credits.

33. The increased premiums in 2018 would have a significant impact on New York's Marketplace and the consumers who use the NYSoH to obtain affordable health insurance coverage. In our experience and evidence from the research literature, when

premiums rise, fewer people enroll in health insurance coverage.

34. Any premium increases that occur in 2018 could result in consumers either losing their coverage because they cannot afford the increased premiums or paying significantly more than they expected for the same coverage.

35. In addition to the risk of premium increases if the federal government stops making CSR payments, some insurers may exit the market altogether, as insurers have already expressed concern to the NYSoH over the discontinuation of federal funding for CSRs. This is particularly concerning for counties that have few health plan options — such as the three counties that only have two QHP issuers. While insurers cannot easily withdraw from the Marketplace or discontinue products mid-year, it is still possible for insurers do so if they face insolvency in the middle of 2017 because they will still be required to provide CSRs to their members, but will not be reimbursed by the federal government for doing so. Insurers may also exit at the start of 2018, particularly if they believe that that they are not able to raise premiums to sufficiently cover the increased expense of covering individuals who are eligible for the unreimbursed CSRs.

36. If plans withdraw from the market in the middle of 2017, their (former) members will be in the unacceptable position of having to rush to secure new coverage that meets all of their health care needs and which is financially viable, and some may find no other acceptable options and lose coverage altogether.

37. Accordingly, if the CSR payments from the federal government stop, New York will likely face increases in premiums and/or health plans dropping out of the Marketplace altogether. As a result, New Yorkers' ability to obtain low-cost health insurance will be adversely affected and enrollment in QHPs through the NYSoH will decrease.

38. Federal defunding of the CSRs jeopardizes the significant progress that New York has made to increase health insurance coverage rates for its residents, and will likely result in health coverage rates decreasing and, correspondently, rates of uncompensated care increasing.

39. NYSoH will incur other costs as well. Increased costs will include modifications to the NYSoH technology system and consumer notices. Marketplace staff will also need to develop training materials and re-train thousands of call center representatives and in-person assistors who help consumers apply for and choose coverage. In addition, NYSoH will have to invest resources in revising its consumer education materials and a consumer awareness campaign to inform consumers of these changes. Last year NYSoH Customer Service Representatives answered nearly 2 million calls during the 2017 open enrollment period — this volume can only increase as New Yorkers face the additional uncertainty and confusion that will accompany a federal defunding of CSRs.

Dated: May 17, 2017

Donna Frescatore

Donna Frescatore

EXHIBIT 1

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop N3-01-21
Baltimore, Maryland 21207-0512

DATE: December 6 2016

FROM: Christopher J. Truffer, FSA, MAAA
Deputy Director, Medicare & Medicaid Cost Estimates Group
Office of the Actuary

SUBJECT: Federal Basic Health Program Payment to New York for January – March 2017; Reconciled Payment Adjustments for April – September 2015; Payment Adjustments for Revised QHP Premiums for January – December 2016; and Payment Adjustments for Revised Enrollment Estimates for January – September 2016

This memorandum provides the amount of the federal Basic Health Program (BHP) payment to the State of New York for the months of January, February, and March 2017. The payment amount also includes 3 sets of adjustments:

1. Adjustments to reconcile payments for final enrollment for April – September 2015;
2. Adjustments to correct an error in the calculation of the second lowest cost silver plan QHP premiums for 2016 for January – December 2016;
3. Adjustments for revised enrollment estimates for January – September 2016.

The amount of the payment is **$1,073,859,016.68**. This amount is calculated as two components. The premium tax credit (PTC) component is **$810,615,201.17** and the cost-sharing reduction subsidy (CSR) component is **$263,243,815.51**. This memorandum describes the basis for the BHP payment and a description of how the payment was calculated. Along with this memorandum, we provide the estimated and final monthly payment rates for New York's BHP in 2017.

Background

Section 1331 of the Patient Protection and Affordable Care Act requires that the Secretary of the Department of Health and Human Services establish a basic health program (BHP) under which a State may enter into contracts to offer to eligible individuals, in lieu of offering such individuals coverage through an Exchange, one or more standard health plans providing at least the essential health benefits described under section 1302(b) of the Affordable Care Act.

Section 1331(d)(3) defines the amount of the Federal payment for the BHP to be equal to 95 percent of the PTC (under section 36B of the Internal Revenue Code) and CSR (under section 1402 of the Affordable Care Act) that would have been provided for the fiscal year to eligible individuals enrolled in standard health plans in the State if such eligible individuals had been allowed to enroll in qualified health plans through an Exchange.

Moreover, the payment must be determined on a per enrollee basis and must take into account all relevant factors necessary to determine the value of the premium tax credits and cost-sharing reductions that would have been provided to eligible individuals, including (i) the age and income of the enrollee, (ii) whether the enrollment is for self-only or family coverage, (iii) geographic differences in average spending for health care across rating areas, (iv) the health status of the enrollee for purposes of determining risk adjustment payments and reinsurance payments that would have been made if the enrollee had enrolled in a qualified health plan through an Exchange, and (v) whether any reconciliation of the credit or cost-sharing reductions would have occurred if the enrollee had been so enrolled.

In addition, the Chief Actuary of the Centers for Medicare & Medicaid Services (CMS) is required to certify whether the methodology used to make the determinations of the amount of payment, and such determinations, meet the requirements of this section. The Office of the Actuary of CMS has calculated the estimated and final monthly payment rates and the payment for the first quarter of 2017 for New York's BHP.

The methodology used to calculate the payment rates and the federal BHP payment are specified in CMS-2396-FN (Basic Health Program; Federal Funding Methodology for Program Year 2017 and 2018). The payment rates and the payment are calculated in two parts: the PTC component and the CSR component.

Payments are made before the start of each quarter to the state. Initially, these amounts are calculated based on estimated levels of enrollment provided by the state. After the end of each quarter, the state submits enrollment data to CMS and the payment is recalculated based on actual enrollment. To the extent that this amount differs from the initial payment, future payments to the states are increased or decreased. States may choose to develop a population health factor adjustment methodology, which would retrospectively measure the health status of BHP enrollees and Marketplace enrollees and make an adjustment to past federal BHP payments. This adjustment would account for how qualified health plan (QHP) premiums would have changed if BHP enrollees had been covered in QHPs in the Marketplace instead of BHP.

A summary of the factors used to calculate the final payment rates is available in the appendix.

Federal BHP Payment to New York (January – March 2017)

New York elected to use the 2016 QHP premium data multiplied by the premium trend factor (PTF) of 1.086 to develop the 2017 BHP payments. New York provided CMS with the requested 2016 QHP premium data for the second lowest cost silver plans and lowest cost bronze plans (New York 10 12 2016 BHP State Report for 2016 Exchange Premiums.xlsx) and estimated enrollment for January, February, and March 2017 (Final EP Projected Enrollment Jan17_Mar17.xlsx). The state provided enrollment estimates by county and income range, as agreed to by CMS. (The state provided enrollment estimates for New York City and not for each of the 5 counties in New York City. We divided the enrollment equally by county for New York City. We believe this was a reasonable adjustment, and would note that because the BHP

payment rates are very similar for these 5 counties, this adjustment likely has a negligible impact on the first quarter payment.)

To calculate the first quarter payment, we developed a weighted average payment rate across household sizes and coverage statuses (single adults and married adults) by county and income range. We assumed that there were no American Indians or Alaska Natives among the enrollees. We reviewed data from the Current Population Survey (CPS) from the Census Bureau from 2013-2015 to calculate the number of people between ages 18 and 64 and with household incomes between 100 percent and 200 percent of the federal poverty level (FPL) by household size (1 to 9) and by marital status. From this data, we calculated weights for each household size and coverage status and used these to calculate the estimated payment rates. More information and the weights are provided in the appendix.

We multiplied the estimated payment rates by the estimated number of enrollees by county and income range for each month.

The federal BHP payment to New York for January, February, and March 2017 is **$897,410,452.89**. The PTC component is **$679,054,419.81** and the cost-sharing reduction subsidy CSR component is **$218,356,033.08**.

The final and estimated monthly payment rates for BHP in New York for 2017 are provided in the attached workbook. The estimated enrollment for January, February, and March 2017 are also included with the estimated monthly payment rates.

This payment has been calculated using the methodology described in the 2017 and 2018 BHP Payment Methodology and meets the requirements of section 1331 of the Affordable Care Act.

Reconciled Federal BHP Payments for Enrollment to New York (April–September 2015)

New York provided CMS with actual enrollment for April through September 2015 in order to calculate the final, reconciled payments. Enrollment was provided by month by county, income, household size, coverage status (self-only or family), and for American Indians and Alaska Natives and non-American Indian and non-Alaska Natives. With the assistance of Mathematica Policy Research under a contract with CMS, the enrollment data has been reviewed and used to calculate the payments by quarter using the monthly BHP payment rates for 2015. (More information on the development of these payments is available by request.)

In the tables below, the initial quarterly payment, the final reconciled payments, and the differences are shown for each quarter. The sum of the quarterly differences are used to adjust this next payment to reconcile the payments for actual enrollment.

Table 1. Estimated and Reconciled Federal BHP Payment, April-June 2015

	Total	PTC Component	CSR Component
Estimated Payment	$330,711,331.79	$247,314,220.36	$83,397,111.43
Reconciled Payment	$323,042,759.99	$240,719,119.45	$82,323,640.54
Difference	–$7,668,571.80	–$6,595,100.91	–$1,073,470.89

Table 2. Estimated and Reconciled Federal BHP Payment, July-September 2015

	Total	PTC Component	CSR Component
Estimated Payment	$327,946,392.93	$245,244,317.55	$82,702,075.38
Reconciled Payment	$338,552,688.59	$252,362,054.67	$86,190,633.92
Difference	$10,606,295.66	$7,117,737.12	$3,488,558.54

Table 3. Total Reconciliation Payment Differences to Federal BHP Payments, April-September 2015

	Total	PTC Component	CSR Component
April-June 2015	–$7,668,571.80	–$6,595,100.91	–$1,073,470.89
July-September 2015	$10,606,295.66	$7,117,737.12	$3,488,558.54
Total	**$2,937,723.86**	**$522,636.21**	**$2,415,087.65**

The federal BHP payment to New York to reconcile the payments for April through September 2015 is **$2,937,723.86**. The PTC component is **$522,636.21** and the cost-sharing reduction subsidy CSR component is **$2,415,087.65**.

This portion of the payment has been calculated using the methodology described in the 2015 BHP Payment Methodology and meets the requirements of section 1331 of the Affordable Care Act.

Adjusted Federal BHP Payments for QHP Premium Revision to New York (January–December 2016)

New York provided CMS with revised QHP premium data for 2016 after identifying an error in how the second lowest cost silver plan premium was determined. This revision requires adjustments to the 2016 BHP payment rates and the previous BHP payments for all four quarters of 2016. New York provided CMS with the revised premium data (New York 10 12 2016 BHP State Report for 2016 Exchange Premiums.xlsx).

In the tables below, the initial quarterly payment, the revised payments, and the differences are shown for each quarter. The sum of the quarterly differences are used to adjust this next payment to adjust for the revised QHP premiums.

Table 4. Estimated and Adjusted Federal BHP Payment, January-March 2016

	Total	PTC Component	CSR Component
Initial Payment	$515,717,462.39	$389,395,627.31	$126,321,835.08
Revised Payment	$525,057,560.45	$396,818,353.41	$128,239,207.04
Difference	$9,340,098.06	$7,422,726.10	$1,917,371.96

Table 5. Estimated and Adjusted Federal BHP Payment, April-June 2016

	Total	PTC Component	CSR Component
Initial Payment	$559,343,580.53	$422,402,224.78	$136,941,355.75
Revised Payment	$569,629,353.92	$430,611,265.43	$139,018,088.49
Difference	$10,285,773.39	$8,209,040.65	$2,076,732.74

Table 6. Estimated and Adjusted Federal BHP Payment, July-September 2016

	Total	PTC Component	CSR Component
Initial Payment	$632,175,162.05	$476,566,551.53	$155,608,610.52
Revised Payment	$646,108,441.12	$487,705,738.94	$158,402,702.18
Difference	$13,933,279.07	$11,139,187.41	$2,794,091.66

Table 7. Estimated and Adjusted Federal BHP Payment, October-December 2016

	Total	PTC Component	CSR Component
Initial Payment	$721,659,945.86	$543,939,285.64	$177,720,660.22
Revised Payment	$737,030,649.37	$556,222,137.98	$180,808,511.39
Difference	$15,370,703.51	$12,282,852.34	$3,087,851.17

Table 8. Total Payment Differences for Revised QHP Premiums to Federal BHP Payments, January-December 2016

	Total	PTC Component	CSR Component
January-March 2016	$9,340,098.06	$7,422,726.10	$1,917,371.96
April-June 2016	$10,285,773.39	$8,209,040.65	$2,076,732.74
July-September 2016	$13,933,279.07	$11,139,187.41	$2,794,091.66
October-December 2016	$15,370,703.51	$12,282,852.34	$3,087,851.17
Total	**$48,929,854.03**	**$39,053,806.50**	**$9,876,047.53**

The federal BHP payment to New York to adjust for the revised QHP premiums for January through December 2016 is **$48,929,854.03**. The PTC component is **$39,053,806.50** and the cost-sharing reduction subsidy CSR component is **$9,876,047.53**.

This portion of the payment has been calculated using the methodology described in the 2016 BHP Payment Methodology and meets the requirements of section 1331 of the Affordable Care Act. In addition, the revised 2016 federal BHP payment rates are included with this memo.

Adjusted Federal BHP Payments for Revised Enrollment Estimates to New York (January–September 2016)

New York provided CMS with revised enrollment estimates for January through September 2016; enrollment has significantly exceeded estimated enrollment during the first year that BHP has been fully implemented in New York. This revision requires adjustments to the previous

BHP payments for the first three quarters of 2016. New York provided CMS with the revised enrollment estimates (Final Reconciliation for CMS.xlsx).

In the tables below, the quarterly payment revised for the 2016 QHP premiums (as shown in Tables 4, 5, and 6), the revised payments, and the differences are shown for each quarter. The sum of the quarterly differences are used to adjust this next payment to adjust for revised enrollment estimates.

Table 9. Estimated and Adjusted Federal BHP Payment, January-March 2016

	Total	PTC Component	CSR Component
Payment	$525,057,560.45	$396,818,353.41	$128,239,207.04
Revised Payment	$496,848,227.28	$396,818,353.41	$128,239,207.04
Difference	–$28,209,333.17	–$22,162,416.56	–$6,046,916.61

Table 10. Estimated and Adjusted Federal BHP Payment, April-June 2016

	Total	PTC Component	CSR Component
Payment	$569,629,353.92	$430,611,265.43	$139,018,088.49
Revised Payment	$644,044,458.91	$485,786,283.06	$158,258,175.85
Difference	$74,415,104.99	$55,175,017.63	$19,240,087.36

Table 11. Estimated and Adjusted Federal BHP Payment, July-September 2016

	Total	PTC Component	CSR Component
Payment	$646,108,441.12	$487,705,738.94	$158,402,702.18
Revised Payment	$724,483,655.20	$546,677,476.52	$177,806,178.68
Difference	$78,375,214.08	$58,971,737.58	$19,403,476.50

Table 12. Total Payment Differences for Revised Enrollment Estimates to Federal BHP Payments, January-September 2016

	Total	PTC Component	CSR Component
January-March 2016	–$28,209,333.17	–$22,162,416.56	–$6,046,916.61
April-June 2016	$74,415,104.99	$55,175,017.63	$19,240,087.36
July-September 2016	$78,375,214.08	$58,971,737.58	$19,403,476.50
Total	**$124,580,985.90**	**$91,984,338.65**	**$32,596,647.25**

The federal BHP payment to New York to adjust for the revised enrollment estimates for January through September 2016 is **$124,580,985.90**. The PTC component is **$91,984,338.65** and the cost-sharing reduction subsidy CSR component is **$32,596,647.25**.

This portion of the payment has been calculated using the methodology described in the 2016 BHP Payment Methodology and meets the requirements of section 1331 of the Affordable Care Act.

Total Federal BHP Payments to New York

The total of the payment for January, February, and March 2017, the reconciled payments for April through September 2015, and the adjustments for 2016 for the revised QHP premiums and enrollment estimates is **$1,073,859,016.68**. This amount is calculated as two components. The premium tax credit (PTC) component is **$810,615,201.17** and the cost-sharing reduction subsidy (CSR) component is **$263,243,815.51**. These calculations are shown in table 13.

Table 13. Total Reconciliation Payment Differences to Federal BHP Payments, January-September 2015

	Total	PTC Component	CSR Component
January-March 2017 Payment	$897,410,452.89	$679,054,419.81	$218,356,033.08
April-September 2015 Reconciled Payments	$2,937,723.86	$522,636.21	$2,415,087.65
January-December 2016 QHP Premium Adjustments to Payment	$48,929,854.03	$39,053,806.50	$9,876,047.53
January-September 2016 Enrollment Estimate Adjustments to Payment	$124,580,985.90	$91,984,338.65	$32,596,647.25
Total	**$1,073,859,016.68**	**$810,615,201.17**	**$263,243,815.51**

APPENDIX

I. Factors used to calculate the federal BHP payment

This is a description of the factors that were used to calculate the federal BHP payment and the payment rates for 2017.

1. Reference premiums

The 2016 QHP premiums were provided by New York (10 12 2016 BHP State Report for 2016 Exchange Premiums.xlsx), as specified by CMS.

2. Premium trend factor

The premium trend factor is 1.086.

3. Population health factor

The population health factor is 1.00.

4. Federal poverty level

The 2016 federal poverty level (FPL) is calculated by the Department of Health and Human Services. (https://www.federalregister.gov/documents/2016/01/25/2016-01450/annual-update-of-the-hhs-poverty-guidelines)

5. Premium tax credit formula percentages

The premium tax credit formula percentages are specified in the Affordable Care Act and are updated annually. The 2016 premium tax credit formula percentages are used to calculate the BHP payment. (https://www.irs.gov/pub/irs-drop/rp-14-62.pdf)

6. Income reconciliation factor

The income reconciliation factor was developed by the Office of Tax Analysis in the Department of the Treasury. The factor is 100.38 percent for the 2017 BHP payment methodology.

7. Tobacco rating adjustment factor

New York does not use tobacco rating in its Exchange; therefore, the tobacco rating factor is 1.00.

8. Factor to remove administrative costs

The factor to remove administrative costs is specified by HHS for calculating the advanced CSR payments for eligible QHP enrollees. The factor is 0.80. (HHS Notice of Benefit and Payment Parameters for 2017; CMS-9937-F)

9. Actuarial value

The actuarial values for silver level and bronze level plans are specified in the Affordable Care Act. The actuarial value for a silver level plan is 70 percent and the actuarial value for a bronze level plan is 60 percent.

10. Induced utilization factor

The induced utilization factor is specified by HHS for calculating the advanced CSR payments for eligible QHP enrollees. It is equal to 1.12 for non-American Indian and non-Alaska Native enrollees receiving CSR with incomes below 200 percent FPL, and is equal to 1.15 for American Indian and Alaska Native enrollees receiving CSR with incomes below 200 percent FPL. (HHS Notice of Benefit and Payment Parameters for 2017; CMS-9937-F)

11. Change in actuarial value

The change in actuarial value is specified in the Affordable Care Act for CSR. For enrollees in a silver level (or higher metal tier) plan with household incomes below 150 percent FPL, the change in actuarial value is 0.24. For enrollees in a silver level (or higher metal tier) plan with household incomes between 150 percent FPL and 200 percent FPL, the change in actuarial value is 0.17. For American Indian and Alaska Native enrollees in bronze level plans who qualify for CSR, the change in actuarial value is 0.40.

II. Weights to calculate estimated payment rates

We reviewed data from the Current Population Survey (CPS) from the Census Bureau from 2013-2015 to calculate the number of people between ages 18 and 64 and with household incomes between 100 percent and 200 percent of the federal poverty level (FPL) by household size (1 to 9) and by marital status. The data is shown in table 1 below.

Table 1. Number of adults by household size, 1 adult and 2 adult households (age 18-64, income 100%-200% FPL), 2012-2014 (in thousands of persons)

Household Size	1 Adult	2 Adults
1	8,256	0
2	3,435	3,026
3	3,000	2,054
4	2,273	3,301
5	1,397	2,382
6	690	1,113
7	372	491
8	171	175
9	96	120

Source: United States Census Bureau, Current Population Survey 2013-2015

From this data, we calculated weights for each household size and coverage status and used these to calculate the estimated payment rates. These weights are shown in table 2 below.

Table 2. Percentage of adults by household size, 1 adult and 2 adult households (age 18-64, income 100%-200% FPL), 2012-2014

Household Size	1 Adult	2 Adults
1	25.5%	0.0%
2	10.6%	9.4%
3	9.3%	6.3%
4	7.0%	10.2%
5	4.3%	7.4%
6	2.1%	3.4%
7	1.1%	1.5%
8	0.5%	0.5%
9	0.3%	0.4%

Source: United States Census Bureau, Current Population Survey 2013-2015

We assumed that no children would be enrolled in BHP and that household sizes would be 9 or less for all enrollees for the purpose of calculating the estimated payment rates. The final BHP payment calculation does not rely on these assumptions.

IN THE UNITED STATES COURT OF APPEALS
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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

DECLARATION OF HANNAH DYER FRIGAND
IN SUPPORT OF THE STATES' MOTION TO INTERVENE

I, Hannah Dyer Frigand, hereby state the following:

1. I am the Associate Director, HelpLine, Enrollment and Education of Health Care For All (HCFA). The facts below are based on my personal knowledge and my review of documents kept in the ordinary course of business by HCFA, and are, to the best of my knowledge, true and accurate.

2. HCFA is a Massachusetts nonprofit advocacy organization that has worked for 32 years to improve the health care system through policy, advocacy and direct service to consumers. Since the passage of the Patient Protection and Affordable Care Act (ACA), HCFA has played a major role in its implementation in Massachusetts. In my role at HCFA, I oversee its consumer HelpLine that informs Massachusetts residents about their health insurance options and assists with their applications for coverage. I started working at Health Care For All in October of 2006 and have been managing the HelpLine since January of 2013. I have personally assisted thousands of callers to apply for insurance coverage, and have since 2013 supervised up to six others in the same work. HelpLine Counselors complete applications for consumers seeking coverage including Medicaid, CHIP, Qualified Health Plans with Advanced Premium Tax Credits and Cost Sharing Reduction subsidies, as well as Qualified Health Plans without subsidies. The HelpLine handles an average of 20,000 calls a year.

3. As part of my work at HCFA, I am in regular contact with dozens of other people employed by public and private agencies to assist with insurance enrollment. My experience at HCFA assisting individuals with insurance enrollment in publicly subsidized programs makes me uniquely qualified to comment on the impact of proposed changes to consumers in Massachusetts.

4. The HelpLine direct service work involves assisting individuals to enroll in healthcare plans offered through the Massachusetts Health Connector, Massachusetts' state-based exchange under the ACA. We do so by screening families for their insurance options based on household size, income and access to other insurance options, completing application as well as troubleshooting issues with coverage. We assist eligible members with shopping for private insurance options through the Health Connector if the family qualifies for marketplace coverage. Since 2015, Health Care for All's HelpLine has helped over 3,500 people apply for health care plans offered through the Health Connector and Massachusetts' Medicaid program.

5. In my experience, when premium rates for plans being offered through the Health Connector have risen, fewer people have chosen to enroll. Instead, at least some people have chosen to go without health care coverage instead of paying higher rates. Sometimes this has been a matter of choice for callers I have encountered, but often it has been a matter of economic necessity. In some cases, I have spoken with callers who have chosen to forego health insurance in order to pay for other necessities, specifically on account of increased insurance premium charges.

6. In my experience, when premiums for health care plans offered through the Health Connector have risen, I have heard from individuals that choose not to purchase those plans even if they are eligible for tax credits and other subsidies that would substantially reduce those premiums.

7. In my experience, when premiums for health care plans offered through the Health Connector have risen, at least some individuals decide not to purchase those plans even if they will pay a tax penalty.

8. Therefore, based on my experience at HCFA assisting individuals, it is my opinion that there is an inverse relation between increased premium charges and the rate of enrollment in health insurance policies issued by the Connector pursuant to the ACA.

Signed under the pains and penalties of perjury this 15th day of May, 2017.

5/15/2017

Hannah Dyer Frigand
Associate Director, HelpLine, Enrollment and Education
Health Care For All

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

DECLARATION OF LAURA HOWARD
IN SUPPORT OF THE STATES' MOTION TO INTERVENE

STATE OF DELAWARE
DELAWARE HEALTH CARE COMMISSION
MARGARET O'NEILL BUILDING
410 FEDERAL STREET, SUITE 7
DOVER, DE 19901
TELEPHONE: (302) 739-2730
FAX: (302) 739-6927
www.dhss.delaware.gov/dhcc

May 11, 2017

I, Laura Howard, declare:

1. I am the Executive Director of the Delaware Health Care Commission (DHCC). I have served at the DHCC in this position for 1.5 years, and have worked in national health care policy for over 16 years, including as a consultant to the State of Delaware during its implementation of the Affordable Care Act from 2013-2015. The facts stated herein are of my own personal knowledge, and I could and would competently testify to them.

2. Delaware utilizes a State-Federal Partnership model to administer its Health Insurance Marketplace. Delaware consumers enroll in Qualified Health Plans through HealthCare.gov, the federal enrollment platform, with the State retaining responsibility for plan management, consumer assistance, and enrollment outreach. The DHCC is the State agency that coordinates such consumer assistance and enrollment outreach. The DHCC is also responsible for the annual review and modification of the state-specific Qualified Health Plan Standards.

3. In my role, I promote policies that ensure access to quality, affordable health care for all Delawareans, ensure the coordination of consumer messaging regarding the availability of insurance through the Marketplace, promote and coordinate as needed the availability of in-person assisters throughout the state, and coordinate with other state agencies, including the Department of Insurance, on any state policy decision impacting the availability of health insurance through the Marketplace.

4. The Cost Sharing Reduction (CSR) payments have played a vital role in increasing access to insurance in Delaware. In 2016, 42.9% of Delaware's 28,256 marketplace enrollees—or 12,147 individuals—were eligible for Cost Sharing Reductions. In total, these individuals saved approximately $13,776,396 in out-of-pocket costs that year. This breaks down to an approximate per person savings of $1,134 in 2016.

5. The uncertainty surrounding 2016 Presidential Election and related discussion of the likely repeal of the Affordable Care Act (ACA) had a negative impact on consumers during the open enrollment period, which ran from November 1, 2016 to January 31, 2017. Delaware had 28,256 enrollees in 2016 and 27,584 in 2017 – a 2.4% reduction. The uncertainty of the availability of CSRs and the potential for increased premiums that would result would continue to erode the gains Delaware has made over the last several years to reduce its uninsured population from 10% in 2013 to 5.9% in 2016.

6. An increase in the number of uninsured Delawareans would negatively impact the State's budget, with Delaware already facing a $390 million shortfall for fiscal year 2018. In response to the availability of coverage through the ACA, Delaware took steps to reduce State spending on health coverage programs for the uninsured, including modifying its eligibility criteria for Public Health programs to reduce the number of individuals receiving fragmented services and increase the number who have access to comprehensive care with insurance coverage. A reversal of the trend in the state's uninsured population would provide additional strain to Delaware's budget if programs and services were redeployed.

7. The Health Insurance Marketplace in Delaware would face additional instability should the federal government cease reimbursing insurers for CSR payments due to the State's already-limited competition for Marketplace health care plans. Delaware has had a difficult time attracting additional issuers into the Marketplace due to its relatively small eligible population, compared to larger states. For 2018, Delaware will have only one issuer participating in the Marketplace. In contrast, the national average for states that use HealthCare.gov is 3.9 insurers. If the remaining issuer needs to increase premiums substantially, or need to assume additional costs that are not reimbursed, there is significant danger that they will exit the Marketplace causing extreme disruption.

Signed,

Laura Howard

Executive Director

Delaware Health Care Commission

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

DECLARATION OF MYRON BRADFORD "MIKE" KREIDLER, INSURANCE COMMISSIONER FOR THE STATE OF WASHINGTON IN SUPPORT OF THE STATES' MOTION TO INTERVENE

I, Myron Bradford "Mike" Kreidler, am over the age of eighteen years old. I make the following declaration based on first hand personal knowledge and am competent to testify to the facts set forth herein.

1. I am the elected Insurance Commissioner for the State of Washington. I was first elected to this position in 2000. I was reelected to my fifth four year term in 2016.

2. As Insurance Commissioner, I am charged with the regulation of the insurance market in Washington State through the enforcement of the Insurance Code, Title 48, Revised Code of Washington, and enforcement of applicable federal statutes that affect insurance. Wash. Rev. Code 48.02.060. I also sit as an ex officio member of the Washington Health Benefit Exchange (the Exchange) Board.

3. Since 1947, following the passage of the McCarran–Ferguson Act, 15 U.S.C. §§ 1011-1015, primary authority to regulate the business of insurance has belonged to the states. 15 U.S.C. § 1012. Only federal statutes that expressly regulate the business of insurance are considered to preempt Washington State laws, regulations, and authority concerning insurance.

4. The Patient Protection and Affordable Care Act ("Affordable Care Act") is one example of federal law that expressly addresses insurance. More specifically, it addresses how health plans must be regulated. However, it does not strip the states of their authority or responsibility to regulate health insurance carriers, health plans, or their markets. Instead, the Act, and rules implementing the Act, heavily rely on states, particularly state insurance regulators, to enforce its various provisions. 42 U.S.C.A. § 300gg-22; 45 C.F.R. § 150.201.

5. Because of my role in regulating insurance carriers and the plans they offer, my office has been at the center of implementation of the Affordable Care Act for the State of Washington since its passage in 2010. As a result, I and my office are in a unique position to

understand the harmful impact caused by the threat that the United States Department of Health and Human Services (HHS) intends to unilaterally change its position regarding its obligation and ability to continue payments to carriers for reimbursement of cost sharing reductions (CSR) required by section 1402 of the Affordable Care Act, 42.U.S.C. §18071.

6. I and my office understand that the new administration at HHS needed time to grapple with these important issues, and come to their own conclusion. However, my office can no longer wait for HHS to decide and announce its official position. As described below, carriers need guidance on how to file plans for 2018 now. Given HHS's failure to announce an official position, or provide any meaningful guidance for carriers or regulators on this issue, I am forced to assume that HHS will no longer adequately represent the interests of Washington State, or other insurance regulators in this lawsuit.

7. At its core, the business of insurance is all about accurately predicting risk. In order to set plan rates, and compete in the market, a carrier must be able to accurately estimate 1) its costs to provide promised services to all of its enrollees, and 2) the number and nature of the enrollees a carrier believes it will have for the plan year. Both pieces involve complex analysis based on numerous factors including things like provider agreements, geographic locations, enrollee demographics, regulatory limits, past experience, and how other carriers are participating in the market. Further, those calculations are performed for each service where a carrier is considering doing business. Adding uncertainty to these calculations increases the risk that carriers are taking on, and in turn, the premiums they will charge.

8. One of the most significant areas of uncertainty Washington carriers are facing now is whether the cost sharing reductions (CSR) carriers are required to provide will be reimbursed for the remainder of the 2017 plan year, and for the 2018 and future plan years. To date, there has

been no official communication from HHS to the carriers or insurance regulators as to how much longer CSR payments will be made. Carriers are required to offer the CSRs to their enrollees, whether they are reimbursed or not. Unlike other states that may allow carriers to stop selling plans in through the Exchange if CSR payments stop, Washington carriers cannot unilaterally leave the Exchange, or otherwise stop offering approved health plans mid year. Washington carriers cannot change their rates mid year. Any unreimbursed payments for 2017 will be an unanticipated loss for carriers in 2017.

9. Any failure to make payments in the 2017 plan year will cause a direct harm to the financial condition of carriers in Washington State. Because my office is also tasked with monitoring and correcting threats to carrier solvency, threats to the financial condition of Washington authorized carriers increase the workload imposed on my office. Because of the uncertainty surrounding CSR reimbursements, my office has already been forced to review which carriers may have significant solvency issues if payments are not received. That review has already taken approximately 2 days of financial examiner time. Carrier financial statements, which are filed with and monitored by my office, presently assume those payments will be made through the end of the plan year. If CSR reimbursement payments are not made through the end of 2017, my office will be obligated to closely review the financial impact any unreimbursed payments have on carriers operating in Washington State, to ensure it does not negatively impact the measures my office uses to determine the financial health of our carriers. If CSR payments are halted mid year, my office will need to conduct a careful review of all health carriers participating in the Exchange, who will be affected by this financial blow. That review is likely to take my financial examiners an additional 2 days of review.

10. The failure of HHS to provide clarity or guidance to carriers regarding CSR

payments is increasing administrative burden on my office. In the absence of HHS guidance, Washington carriers are turning to my office for guidance and instruction that should be offered by the federal government.

11. The failure of HHS to offer clarity and assistance to my office as a regulator is compounding this administrative burden. In the past, when carriers had questions about implementation of federal requirements, my office was often able to seek guidance and input from HHS staff about implementation. No such assistance is being offered by HHS concerning the critical issue of CSR payments. Between fielding questions from carriers, attempting to get some guidance from HHS, and reviewing possible options for addressing this uncertainty, my staff has spent at least 100 hours dealing with the uncertainty surrounding CSR payments.

12. The failure of HHS to provide clarity for the 2018 plan year will impose an additional burden to my office as we begin to conduct rate reviews. My office must review and approve any health plan (as that term is defined in Wash. Rev. Code 48.43.005(27)) that is submitted by a health carrier (as that term is defined in Wash. Rev. Code 48.43.005(26)) before that plan may be sold in Washington State. Wash. Rev. Code 48.18.110, 48.44.020, and RCW 48.46.060. The health plan filing deadline for plans that will be sold in 2018 is June 7, 2017.

13. The review performed by my office ensures that the forms being used by carriers (the contract between the carrier and its enrollee), and the rates they are charging consumers (also called premiums), are fully compliant with state and federal requirements. Wash. Rev. Code 48.18.110, 48.44.020, and RCW 48.46.060; Wash. Admin. Code 284-43-0140.

14. In order for my office to review rates proposed in a health plan, the carrier must file detailed data and actuarial analysis that justifies the basis for their rates with my office. Because of the complexity of this analysis, carriers need a substantial amount of time to perform it. Once

it is filed with my office, my staff need a significant amount of time to review it. Carriers are already working on the analysis that is required for the 2018 plan year.

15. After approval by my office, a plan that will be sold through the exchange must be independently certified by the Exchange as a Qualified Health Plan. The Exchange needs time to review and certify these health plans, and time to upload those plans into their system so that they are available to consumers when open enrollment begins on November 1, 2017 for the 2018 plan year. For the 2018 plan year, the Exchange has informed carriers that it intends to certify the plans my office has approved at its September 14, 2017 board meeting.

16. We have already adjusted the filing process as a result of the failure of HHS to provide clarity and guidance. My office originally informed carriers that their plan filings, which must include a detailed actuarial analysis justifying their rates, would be due May 5, 2017. However, due to the uncertainty of what actions the federal government might take affecting the Affordable Care Act, including uncertainty regarding the future of CSR payments, carriers indicated they needed more time to prepare their health plan filings. My office agreed to extend health plan filing deadline to June 7, 2017. This gives carriers more time to conduct the review and analysis they must provide with their filings. However, by pushing the filing deadline back to June 7, my office is already being negatively impacted, because this will compress the time available to review health plan filings.

17. In addition, because the threatened, but not official, change in CSR payments creates enormous uncertainty for insurance markets, it creates significant challenges to my office's ability to review the underlying assumptions developed by carriers in setting their rates. It will take more time for my actuarial staff to review assumptions related to the payment or nonpayment of CSR reimbursements. It will be more difficult for my staff to determine if these assumptions

are in fact reasonable and sound. Assumptions that appear to be extreme will be more difficult for my staff to challenge, because the uncertainty of CSR reimbursements is so significant.

18. Some carriers have indicated that they are considering filing two versions of each health plan they intend to offer for the 2018 plan year: one that assumes the CSR reimbursement, and one that assumes no CSR reimbursement. This kind of dual filing will double the work my office has to do in reviewing and approving the assumptions related to CSR payments, and any exhibits or supporting materials impacted by these assumptions. In my judgment, that review will increase the workload for my actuarial staff by at least an additional 30%.

19. The burden imposed by our compressed review schedule and additional rate review work will ripple through my office. Because the actuarial review done by my office is highly specialized, I cannot easily hire additional staff or outside consultants to perform this work. In order to accommodate the additional work in less time, trained staff must be pulled from other projects. Pulling staff from review of other types of insurance products means review of those products will be delayed, thus delaying when carriers can begin selling them. Even for health plans, staff will not have as much time to work with carriers to correct filings with significant errors or problems. This could mean that more plans do not make it through the review process in time to be certified by the Exchange. That could mean fewer options in the individual market.

20. In addition to the administrative burdens this uncertainty is imposing on my office, the possibility that HHS will determine that CSR reimbursements will not be funded presents a real threat to the existence of a stable, fair, robust, and competitive insurance market in Washington State, and all the benefits that come with it.

21. For the last 17 years, I have worked with carriers, constituents, and lawmakers to rebuild the individual insurance market in Washington State. We have fully implemented the

requirements of the Affordable Care Act with great success. Our uninsured rate has dropped from 13.9% in 2012 to 5.8% in 2017. The average rate increases that have been approved each year have dropped from 13.1%, prior to passage of the Affordable Care Act, to 3.9 % in 2016. And the percentage of uncompensated care our state hospitals and health care providers have had to shoulder has dropped from $2.35 billion in 2013 to $1.20 billion in 2014, when the Exchange became operational and premium subsidies and CSRs became effective.

22. The uncertainty surrounding CSR payments threatens to unravel these benefits. First, we anticipate that failure to fund CSRs will result in a dramatic premium increase for Washington consumers. If carriers only raise premiums sufficiently to offset the loss of CSR reimbursements, we calculate that would necessitate an increase of 6-20%, depending on the carrier, and the area where that carrier is offering plans.

23. As a result, all Washington consumers (even those who do not qualify for CSRs individually) will be harmed by the increasing premiums that provide no additional benefit to them. Some may choose to purchase off the Exchange from a carrier whose plans are not directly affected by the CSR uncertainty. However, those individuals whose incomes fall between 250 – 400% of the federal poverty level, who are eligible for premium subsidies, can only receive subsidies through plans sold through the Exchange.

24. Because the premium subsidies are established based on the second lowest cost silver plan available, individuals receiving premium subsidies who purchase anything other than the second lowest silver plan, are likely to be paying more out of pocket in premiums.

25. Although a premium increase will impact all consumers in the individual market, for individuals who are not eligible for tax credits or CSRs, the impact is even more profound. Because carriers have to use the same risk pool as the basis for all of their health plans, both inside

and outside of the Exchange, it is not only silver level plans, and not only Exchange plans whose rates are likely to increase. As a result, consumers who will not receive CSRs, or increased premium subsidies, will receive no benefit from a premium increase designed to capture CSR payments.

26. Our own state's history and experience demonstrates that, as premiums increase, fewer people purchase insurance. This is even more likely in light of the federal government's decision to relax (or eliminate) enforcement of the individual mandate in the Affordable Care Act.

27. Further, the Affordable Care Act exempts individuals from the obligation to purchase coverage if the least expensive plan available in their area is more than 8.13% of their income. As premiums rise, more people qualify for this exemption, which leads to a further reduction of enrollment in the risk pool.

28. Our state has seen that when premiums increase, the people who continue to purchase coverage are generally those with significant health risks and health costs, who can't afford to go without it. With a smaller and sicker risk pool, premiums will likely continue to rise, creating smaller and sicker risk pools, and even higher premiums.

29. Our market has already demonstrated that carriers will not simply continue to raise premiums indefinitely. Each carrier has a point at which the administrative costs of running a health plan, and the risk associated with a small and costly pool of enrollees is no longer a financially viable option for the carrier. If premiums have to be raised too much, carriers are likely to simply stop selling health plans in the Exchange where CSRs are required.

30. Even for carriers that continue to sell in the Exchange, they are likely to look at other options for reducing their costs, such as eliminating service areas. My office is particularly concerned that rural counties, where the cost of providing services is higher, are particularly

vulnerable if CSR reimbursements are not made. Some of our rural counties have some of the highest percentages of individuals enrolled in qualified health plans receiving CSRs.

31. My concern that non-payment of CSRs will erode the individual market is not merely a speculative parade of horribles. This has been the actual experience of the State of Washington. When I took office in 2000, our individual insurance market had been devastated. In the early 1990s, Washington state enacted health insurance reforms that provided meaningful but expensive benefits to enrollees, with market controls that provided stability needed by carriers (an individual mandate). In 1995, the stabilizing provisions were eliminated by lawmakers, but the rich benefits were not. Rates went up, pricing healthy people out of the market. The risk pool got smaller and sicker, and rates went up again. Over the course of a few years, this "death spiral" resulted in the complete collapse of our individual market. For two years, Washington consumers could not buy an individual or family health insurance policy in Washington State. Requiring carriers to continue to offer CSRs, without the reimbursements that stabilize this benefit, has the potential to similarly devastate the individual market in Washington State.

32. There is also a very real possibility that some carriers may choose to simply stop selling plans for the 2018 plan year in the Exchange all together. My office recently received a letter from Molina Health Plan of Washington indicating that their company, which has 50,000 enrollees through the Exchange, is seriously considering not participating in the Exchange market at all for the 2018 plan year, due to the uncertainty of whether they will receive CSR reimbursements. Attached as Exhibit A is a copy of the letter I received from Peter Adler, President, Molina Healthcare of Washington, on May 05, 2017.

33. The uncertainty facing carriers like Molina will not be eliminated simply by a statement that CSRs will be paid for this year and 2018. Assuming the Affordable Care Act

remains the law of the land, carriers will continue to have to file their plans in May or June in Washington State. Congress does not typically pass its operating budgets until September. Until this issue is clarified, this uncertainty will resurface every summer. Only a permanent answer to the payment of CSRs will eliminate the uncertainty and administrative burden faced by my office and insurance regulators across the country.

34. More importantly, only a decision aligned with the position taken by HHS in its opening brief will alleviate the potential harm to Washington State's insurance market. 42.U.S.C. §18071 plainly requires HHS to reimburse carriers for the CSRs they provide to enrollees. Only a decision finding that Congress has in fact made a permanent appropriation for CSR reimbursements, will prevent the spiraling premium increases that devastated our individual market in the 1990s. Without clear alignment on this issue, I do not believe that HHS can adequately represent Washington State's position.

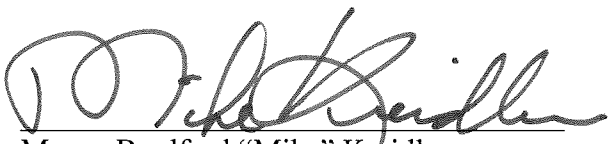
35. Had HHS announced via a proposed rule or an official statement that it intends to impose a completely opposite interpretation of the funding provisions affecting CSR reimbursements, a broad interpretive and policy change affecting virtually every Washington carrier participating in the Exchange, regulators and carriers could have provided input and taken steps to address the impact this change in course would have. However, HHS has not taken steps to clearly communicate its change in position to regulators and carriers through official channels. Therefore, there has not been an opportunity to address this broad change in policy through an administrative action.

36. In fact, even in the course of this litigation, HHS has not officially clarified its position to date. However, should HHS change its position in this appeal, the underlying decision by the district court would likely be used by HHS as justification for refusing CSR reimbursements

in the near future. Because the harm that change in position would cause to our individual market would be substantial, I and the State of Washington cannot risk allowing that decision to be implemented without a meaningful and truly adversarial challenge.

I declare, under the penalty of perjury, the foregoing is true and correct.

DATED this 9th day of May 2017, at Olympia, Washington.



Myron Bradford "Mike" Kreidler
Washington State Insurance Commissioner

EXHIBIT A

Peter Adler
President
Molina Healthcare of Washington, Inc.
Direct: 425-398-2642
Peter.Adler@MolinaHealthcare.com

May 01, 2017

Mike Kreidler
Insurance Commissioner, State of Washington
Office of the Insurance Commissioner
Insurance Building
302 Sid Snyder Ave SW, Suite 200
PO Box 40258
Olympia, WA 98504

Dear Commissioner Kreidler,

For over 37 years, Molina Healthcare has fulfilled its mission by serving vulnerable populations, with a focus on low income individuals and families. Nationally, Molina serves over 3.6 million Medicaid and Medicare members. Our deep commitment to lower income Americans is further reflected in our 2014 decision to enter and make a major commitment to the ACA Marketplaces. Today, that decision has manifested in an additional one million Marketplace members across 9 states, bringing Molina's total national membership to over 4.6 million. In Washington State, in addition to being the largest Medicaid Managed Care Organization with over 730,000 Medicaid members, Molina is honored to also be the State's largest Marketplace carrier, with nearly 50,000 members.

Molina's strategic decision to actively participate on the Washington Health Benefit Exchange was based on our Mission and 22 year history in the state's Medicaid market, and was made knowing that there were higher actuarial risks and volatility in the anticipated Exchange population due to the uncertainty of their healthcare needs and trends of a previously uninsured population. Those risks and the volatility associated with the newly insured Marketplace population were openly acknowledged in the ACA and by the Washington Health Benefit Exchange. To attract carriers to take those risks, and to attract eligible, low income individuals to seek and retain coverage on the Exchange, certain explicit commitments were provided in the ACA to participating carriers to mitigate some of those risks. Specifically, Molina offered multiple insurance products on the Washington Health Benefit Exchange based on the explicit commitment provided in the ACA by the Federal Government to fund the ACA-defined Cost Savings Reduction (CSR) payments to health plans for eligible members. Without the CSR mechanism and payments, the ACA Marketplaces would have posed too much financial volatility and uncertainty, and Molina would not have entered or participated on any Exchange in any state, including Washington.

The CSR mechanism is the means by which eligible individuals receive reductions in their out-of-pocket costs (copays, deductibles, co-insurance, etc.) so as to make Exchange-based health plans more affordable. Greater affordability is required not only to make health insurance more accessible for eligible individuals, but also to reduce insurance volatility and to maintain actuarial stability in the Exchange insurance risk pools. Reduced volatility and greater predictability in the insurance world translates into lower premiums and increased ability for carriers to price products appropriately. Hence, the very stability of Marketplace offerings on the Exchange for both members and carriers depend on the existence and continuation of the CSRs.

As you know, Congress and the new Administration in Washington DC are threatening to cease and/or reduce CSR funding – a reneging on a fundamental commitment upon which carriers and members entered the Exchanges. The uncertainty generated by these threats has already caused a number of carriers to withdraw from the Exchanges, including in Washington State. Molina does not want to withdraw from the Exchange in Washington State; however, if the Federal government's full CSR funding commitments are in jeopardy, we believe that the viability of the Exchange market is in immediate jeopardy of failing. That risk, if not remedied by Congress or the Administration in advance of June 7 (the Washington State 2018 filing deadline), will present a major challenge for Molina to financially sustain the costs or risks associated with the ensuing instability of the Exchange Marketplaces. This uncertainty, coupled with any further undermining of the individual mandate, which ensures that insurance pools continue to include younger and healthier people along with those with high healthcare needs, places the Washington Exchange market in general - and Molina's participation in specific - in serious jeopardy.

To date, Molina's commitment to offering insurance coverage on the Washington Health Benefit Exchange has been unwavering. We expanded, not contracted, the number of counties we served in 2017, and offered some of the lowest average cost increases to consumers in comparison to other carriers in both 2016 and 2017. We wish to continue our commitment to Washingtonians who select the Exchange for their health coverage. However, to do so, we need the Federal Government to keep its commitment to continue and fully fund the promised CSR payments from May 1 through December 31, 2017, and we need an equally firm commitment that the CSRs will be fully funded throughout the entirety of calendar year 2018. Without those commitments, Molina will have to very seriously consider its ability to remain on the Exchange. We continue to intend to make good on our commitments as long as the Federal Government makes good on theirs. We appreciate your ongoing leadership and support in seeing that Washington State Health Benefit Exchange and the individual insurance market remain stable, viable and accessible to the hundreds of thousands of Washingtonians who now look to the Washington Health Benefit Exchange for their healthcare coverage.

Please do not hesitate to contact me if you desire additional information or wish to discuss further.

Sincerely,

Peter Adler
President, Molina Healthcare of Washington

CC: Joseph White, Interim CEO, Molina Healthcare, Inc.

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

DECLARATION OF PETER LOPATKA
IN SUPPORT OF THE STATES' MOTION TO INTERVENE

Peter Lopatka, declares under penalty of perjury, pursuant to 28 U.S.C. § 1746, that the following is true and correct:

1. I am the Vice President--Actuary at Healthfirst. I make this declaration in support of New York State's Motion to Intervene in the above-captioned action.

2. Healthfirst is a provider-sponsored health insurance company that serves more than 1.2 million members in New York State. In addition to many other health plan offerings, such as Medicaid and Child Health Plus plans, Healthfirst offers Qualified Health Plans ("QHPs" — plans that have been certified by the Marketplace and cover all required essential health benefits required by the Affordable Care Act) and the Essential Plan through the New York State of Health ("NYSoH" or "Marketplace"), New York State's official health plan Marketplace established pursuant to the Patient Protection and Affordable Care Act ("ACA").

3. Upon information and belief, since the opening of the Marketplace in 2013 (for coverage starting in January 2014) with significant insurer participation and a broad range of plan offerings, the rate of uninsured declined from 10 percent to 5 percent between 2013 and September 2015. Upon information and belief, over 2.8 million New Yorkers were enrolled in plans as of January 2016.

4. Healthfirst launched QHP products in 2014 enrolling 5,500 members in the first year. Our enrollment increased to 33,000 in 2015. Enrollment decreased to 14,000 in 2016 as some members moved into New York's Basic Health Plan (called the "Essential Plan").

5. In 2017, Healthfirst offered nine QHPs through the Marketplace. As required by

law, one of these plans is a standard silver plan with variations for each of the cost reduction subsidy ("CSR") levels.

6. During the 2017 NYSoH open enrollment period, Healthfirst enrolled 31,000 people in a Healthfirst QHP plan (representing 24% of the QHP enrollees in Healthfirst's service area and 15% statewide) and 124,000 people in a Healthfirst Essential Plan (representing 26% of EP enrollees in Healthfirst's service area and 20% statewide).

7. In 2017, approximately 650 Healthfirst QHP enrollees received a CSR, and in 2016 approximately 1,900 Healthfirst QHP enrollees received a CSR. The total value of CSRs provided by Healthfirst in 2016 was $560,000.

8. If the federal government does not make CSR payments to health plans for the duration of 2017, Healthfirst will incur a financial loss. This is because even if these federal payments to health plans stop, Healthfirst will continue to be required to provide CSRs to its members throughout 2017. The federal government's refusal to reimburse Healthfirst for such CSR payments for the second half of 2017 would cost Healthfirst approximately $200,000.

9. Further, if the federal government cannot guarantee continued funding of the CSRs to health plans throughout 2018, then Healthfirst will likely need to increase its premium rates for all relevant members in 2018 to account for the possibility that it will lose such funding at some point during the year. Healthfirst is required to submit its rate proposal to the New York State Department of Financial Services by May 15, 2017, and DFS will make its rate decisions by August 3, 2017.

10. Approximately 24,800 of enrollees – those not receiving tax credits or CSRs – would be directly affected by this premium increase in 2018, and we expect that some

CSR recipients will instead enroll in less expensive health plans, such as the bronze plans, due to the increased premium expense. Others may simply drop out of health plan coverage because of the higher costs.

11. Other anticipated impacts on Healthfirst if the federal government stops reimbursing health plans for CSRs include the potential elimination or re-structuring of the Essential Plan. The Essential Plan is a critical component of New York's healthcare market, providing stability by reducing enrollment "churn" and significantly contributing to New York's lower than national average uninsured rate. If the Essential Plan is eliminated, the influx of a portion of the former Essential Plan members into the QHP markets could cause material disruption to the QHP market for several years.

Dated: May 12, 2017

Peter Lopatka

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

DECLARATION OF PAM MACEWAN
IN SUPPORT OF THE STATES' MOTION TO INTERVENE

I, Pam MacEwan, am over the age of 18 years of age, competent to testify to the matters below, and declare based upon personal knowledge:

1. I am the chief executive officer of the Washington Health Benefit Exchange (WAHBE or the Exchange). I have held this position since 2015, before which I was chief of staff. I have 24 years of experience in the healthcare management.

2. WAHBE is Washington State's health insurance exchange, or insurance marketplace. WAHBE was established in 2011 under the Patient Protection and Affordable Care Act (ACA) and state legislation, Wash. Rev. Code 43.71. WAHBE is a self-sustaining, public-private partnership governed by an 11-member bipartisan board. WAHBE serves more than 1.7 million Medicaid and commercial insurance customers through its website, www.wahealthplanfinder.org.

3. The ACA contains provisions designed to make health insurance coverage more affordable. These include the individual advanced premium tax credits, and cost sharing reduction (CSR) payments made by the federal government to health insurance carriers in the exchange markets. When passed through to the provider, the CSR payments lower the cost-sharing for qualified health plan enrollees under 250 percent of the federal poverty

level. The CSR also increases the actuarial value of silver-level qualified health plans offered through the exchanges. The actuarial value refers to the percentage of medical costs covered by carriers.

4. WAHBE enrollment data for 2016 show that nearly 70,000 qualified health plan enrollees received an annual average CSR of $928 per enrollee, worth almost $65 million. Attach. A.

5. As explained below, the uncertainty about whether CSR payments will continue to be paid to carriers will have a negative impact on Washington consumers, carriers and the sustainability of WAHBE.

6. Washington's average premium increases have been relatively low, 13 percent, for plans offered inside the Exchange. Should CSR payments cease, carriers will likely cover the loss through premium increases which could be up to 20 percent, based on sources that we typically rely on such as the Kaiser Family Foundation. Qualified health plan enrollment in Washington State has steadily increased from 140,000 in 2014 to 204,000 in 2017. This positive trend may reverse, however, as plans become unaffordable and consumers drop coverage, particularly for those not receiving CSRs or premium tax credits, which currently represent 40 percent of the Exchange's enrollment.

7. The impact on carriers is also substantial. Carriers in this state are currently making business decisions about whether or not to participate in our state's insurance market. For 2018 plans, carriers must file their products and pricing information with the Office of the Insurance Commissioner by June 7, 2017. The lack of certainty about CSR payments could cause some carriers to withdraw from the market. For example, on May 1, 2017, Molina Healthcare of Washington, Inc. sent a letter to Mike Kreidler, Washington State Insurance Commissioner, stating that if CSRs are not funded Molina will have to assess its ability to remain a carrier in the Washington Exchange. *See* Declaration of Myron Bradford "Mike" Kreidler, Insurance Commissioner for the State of Washington, In Support of the States' Motion to Intervene, at ¶ 32 and Ex. A.

8. Between 2016 and 2017, Washington saw a reduction from 13 to nine carriers offering qualified health plans, along with a reduction in plan offerings. Two statewide insurers withdrew from Washington State entirely. Two other statewide insurers reduced the number of counties where they offer plans in 2017. The loss of more carriers in 2018 will reduce competition and consumer choice.

9. The current uncertainty about CSRs threatens WAHBE's sustainability. Any loss of enrollees will lower WAHBE's revenues because WAHBE's operations are mostly financed through fees paid by carriers. Federal and state law authorize user fees on carriers that offer plans on the Exchange. 45 C.F.R. §§ 155.160, 156.50; Wash. Rev. Code 43.71.080, 48.14.020(2)(b), 48.14.0201(5)(b). Carriers are taxed two percent on the value of premiums paid, and also charged a flat per-member per-month assessment for enrollees on the Exchange. These premium taxes and assessments are deposited in the state treasurer's health benefit exchange account. Wash. Rev. Code 43.71.060(2).

10. For state fiscal year 2017 (July 2016 to June 2017), expected WAHBE revenues related to qualified health plan premiums and assessments are $29.7 million, and projected revenues for state fiscal year 2018 (July 2018 to June 2019) are $32.3 million. A 20 percent reduction in qualified health plan enrollment would decrease state fiscal year 2018 revenues by $6.5 million, while a 40 percent reduction in enrollment would decrease revenues by $13 million. Some enrollment decline due to the loss of CSR funding can safely be predicted, even if the exact amount cannot precisely calculated. *Any* decline in enrollment will reduce WAHBE revenue.

11. An additional impact of the loss of CSR funding is the need for more state general fund dollars to support Medicaid. WAHBE administers enrollment in the state Medicaid program through its on-line portal, www.wahealthplanfinder.org. Therefore, the potential effects to Washington's qualified health plan market through the loss of CSR funding, described above, and the ensuing loss of premium tax revenues, also impacts Medicaid financing. Medicaid is a cooperative federal-state program that requires state matching funds to be expended in order to draw down federal funds. In Washington, premium taxes paid by carriers participating in the Exchange are used as state Medicaid match necessary for the receipt of federal Medicaid funds. If premium tax funds are not available as state Medicaid match, state general fund dollars must replace those funds to support WAHBE's costs for enrolling Medicaid applicants through the on-line "healthplanfinder".

I affirm under penalty of perjury that the foregoing is true and correct to the best of my knowledge and belief.

DATED this 9th day of May 2017, at Olympia, Washington.

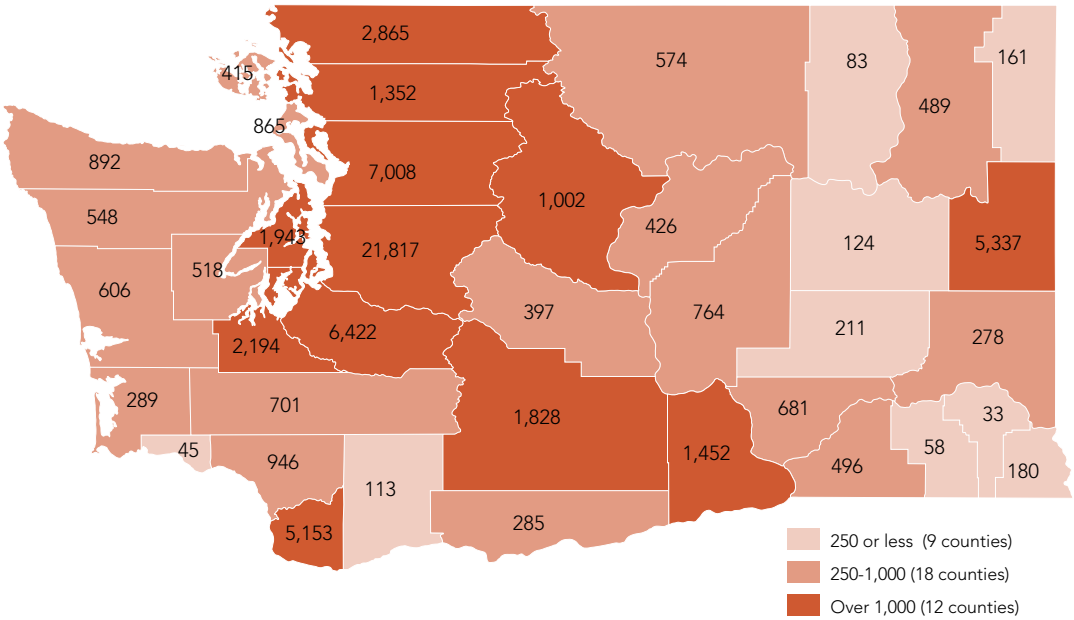
Pam MacEwan

PAM MACEWAN

ATTACHMENT A

1 in 4 WASHINGTON

Residents Receiving Cost-Sharing Reductions (CSR) through Washington Healthplanfinder in 2016*

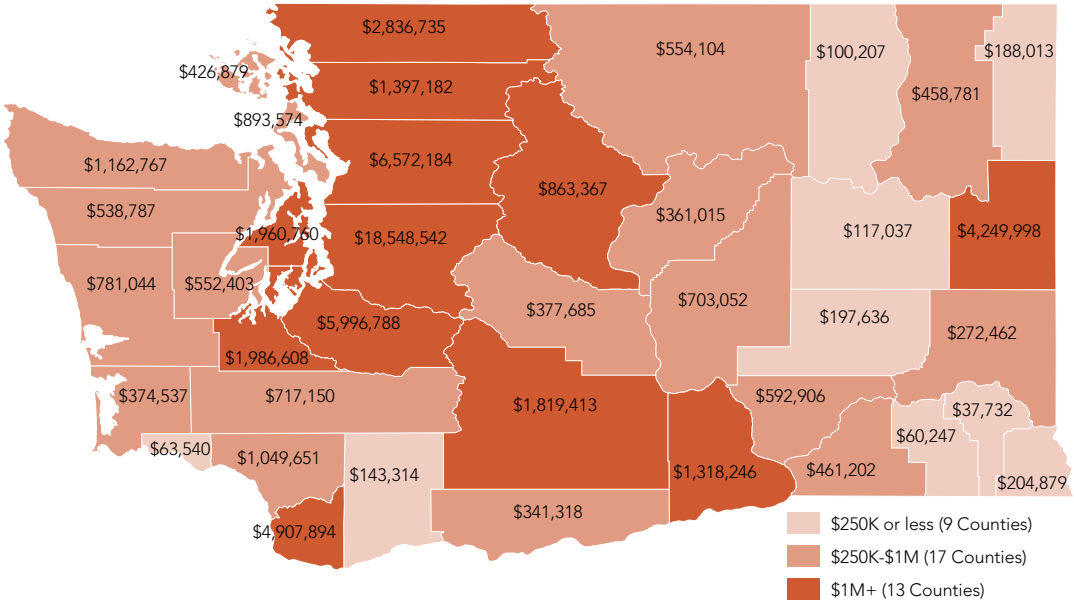


Top 10

KING	21,817
SNOHOMISH	7,008
PIERCE	6,422
SPOKANE	5,337
CLARK	5,153
WHATCOM	2,895
THURSTON	2,194
KITSAP	1,943
YAKIMA	1,828
BENTON	1,452
TOTAL	69,582

*CSRs are federal subsidies lower out-of-pocket costs for low and middle-income *Washington Healthplanfinder* consumers. Data as of November 2016.

Total Amount of Cost-Sharing Reductions (CSR) in 2016*



Top 10

KING	$18,548,542
SNOHOMISH	$6,572,184
PIERCE	$5,996,788
CLARK	$4,907,894
SPOKANE	$4,249,998
WHATCOM	$2,836,735
THURSTON	$1,986,608
KITSAP	$1,960,760
YAKIMA	$1,819,413
SKAGIT	$1,397,182
TOTAL	$64,192,879

*CSRs are federal subsidies that lower the amount low and middle-income consumers have pay for deductibles, copayments, and coinsurance. Consumers must enroll through *Washington Healthplanfinder* in a Silver plan to get these extra savings. Data as of November 2016.

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

DECLARATION OF ANNE MCLEOD, CALIFORNIA HOSPITAL ASSOCIATION, IN SUPPORT OF THE STATES' MOTION TO INTERVENE

DECLARATION OF Anne McLeod

I, Anne McLeod, declare:

1. I am the Senior Vice President, Health Policy and Innovation, with the California Hospital Association (CHA). I have served at CHA in this, and similar positions, for more than 10 years. In my role, I provide leadership for developing policy objectives that support the implementation of health care reforms and the transformation of health care in the future. I have worked on health policy and financing issues in support of former state governor's health care reform efforts, including the implementation of provisions of the Affordable Care Act, such as development and design of health insurance coverage products offered by Covered California, the state's health benefit exchange.

2. Cost-sharing reductions (CSR's) are subsidies that make health care coverage more affordable for qualifying consumers. CSR's are used to reduce out-of-pocket costs including copayments, coinsurance, deductibles and out-of-pocket maximums. Eligible consumers that purchase a silver-level plan will automatically receive these CSR's through an enhanced silver plan. About 1.4 million Californians purchase their health coverage through Covered California. Health insurers received cost-sharing reductions for over half of Covered California's plan enrollees.

3. Consumers that benefit from CSR's are income-eligible individuals or families with children that rely on hospitals for the care they need when they need it. In working with hospitals and Covered California, I know that a report of the hospital care provided to enrollees, including those benefiting from CSR's, for a specific period, includes: 65,000 emergency room visits; 5,000 babies delivered; 500 infants being treated in a neonatal intensive care unit; more

than 10,000 cancer treatments; 700 joint replacements; 3,800 broken bones fixed; and, nearly 100 transplants performed.

4. An estimated $800 million a year in CSRs is paid to insurers in CA. If funding for CSR's is not stabilized and continued, health plans would be forced to raise the premiums for the enhanced silver plans to pay for the value that the richer (enhanced) coverage consumers receive. One report by PriceWaterhouseCoopers, April 27, 2017 for Covered California, (http://hbex.coveredca.com/data-research/library/CoveredCA_Impact_to_CA_ind_market_4-27-17%20(1).pdf) estimates that silver plan premiums would need to increase by 16.6 percent. Further, the report states that across all enrollees in all metal tiers, the loss of CSR funding would result in an additional 11 percent increase in premiums.

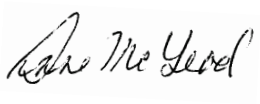
5. Increased premiums for lower-income working families will mean that many cannot afford to stay covered under their health insurance plan. California moved its uninsured rate down to a low of 9 percent down from 17 percent. Families that drop their coverage will become uninsured, driving up the state's uninsured rate and the overall cost of providing care to all Californians. Having health care coverage helps individuals get the appropriate care when needed, including preventive services and primary care. Getting the proper level of treatment in a timely manner helps reduce health care costs for everyone. If coverage is dropped, payments to providers like hospitals and physicians will decline. When that happens, services also decline or may become unavailable – and that will impact all Californians. Further, when kids and families receive necessary preventive care they have better attendance in school and their parents are better able to work.

6. California hospitals have worked hard to reduce costs through delivery system reform, care coordination and clinical efficiencies. These innovations mean patients often recover quicker and can return to work and home sooner. Lower utilization results in lower costs. When individuals and families don't have health care coverage, they also lose access to care. Providers don't get paid to treat uninsured individuals. When patients can't be seen by a primary care doctor, they often turn to hospital emergency rooms as a last resort. More uninsured individuals will seek care in hospital emergency rooms – the most expensive place to be treated – if funding for CSR's is lost. Preserving emergency rooms for those truly needing emergency care ensures life-saving treatment is there when needed for everyone.

7. Caring for patients in the appropriate setting can lower costs and improve patient well-being. Sometimes the hospital is not the appropriate level of care for patients. But when a patient is uninsured, other providers such as nursing home, rehabilitative services or other post-acute care settings are not willing to accept hospital patients unless there is a form of payment guaranteed. This means the uninsured can stay in the hospital longer than what is needed, increasing costs for the entire health care system. Patients recover quicker when they receive timely and appropriate care in the appropriate setting. And, the proper level of treatment is often less costly.

8. A loss of CSR's will result in an increase in the number of Californians without health care coverage. Higher uninsured rates increase the cost of health care for all Californians. Uninsured individuals and families are often forced to seek care in the most expensive or inappropriate settings. Higher uncompensated costs will result in a loss of access and services for every Californian.

I declare under penalty of perjury under the laws of the United States that the foregoing is true and correct, and that this declaration was executed on May _15_, 2017, in __Sacramento_____, California.



Dated: May _15___, 2017

Anne McLeod

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

DECLARATION OF TRINIDAD NAVARRO
IN SUPPORT OF THE STATES' MOTION TO INTERVENE

Trinidad Navarro
Commissioner

Delaware Department of Insurance

DECLARATION OF TRINIDAD NAVARRO, DELAWARE INSURANCE COMMISSIONER

I, Trinidad Navarro, declare and say as follows:

1. I am Commissioner for the Delaware Department of Insurance ("DOI"), a Delaware state agency. I have served in this position since January 3, 2017. The facts stated herein are of my own personal knowledge, and I could and would competently testify to them.

2. As the Insurance Commissioner, I am responsible for the DOI's rate review process, which is a statutory obligation of the DOI. As part of the rate review process, the DOI reviews health insurance plans' (health plans) proposed rate increases in Delaware's markets. The DOI's responsibility to review all rates includes rates submitted by insurers offering plans in Delaware through the federal health care marketplace.

3. Delaware utilizes a State-Partnership Marketplace with the federal government. Delaware consumers access marketplace health insurance plans through Healthcare.gov, the federal marketplace platform, with the State retaining responsibility for rate review, consumer assistance, and enrollment outreach.

4. The rate review process serves a vital public purpose. It provides the DOI with an opportunity as a regulator of health plans to review proposed rate increases and announce to the public whether proposed rate increases are actuarially sound.

5. If the DOI finds that a proposed rate increase fails to meet statutory requirements, it issues an order specifying in what respects it finds that such filing fails to meet such requirements.

6. No rate increase may become effective unless filed with the DOI at least 30 days in advance of the proposed effective date of such proposed increase. Such a filing will be deemed to meet statutory requirements unless disapproved by the DOI within 30 days after the rate increase request is filed, subject to the DOI's ability to extend the time of review to up to 90 days from the date of the filing. Proposed rates for health plans participating in the federal health care marketplace must be filed no later than June 21st, in order to comply with federal filing requirements for health plans offered through the federal marketplace. The DOI has requested that the insurers file their proposed rate increases by June 9th.

7. The DOI publishes the proposed rates for health plans participating in the marketplace on the DOI website after they are filed. The DOI also holds public information sessions where the insurers explain to the public how they arrived at their rate filings and to allow for public comment on the effects of those proposed rate increases.

8. The DOI's public posting of the marketplace-related proposed rate increases, in conjunction with the public information sessions, serves an important function by allowing members of the public to be informed of the proposed increases and provide public comment on the proposed increases to the health plans and the DOI, including the effect that those proposed increases will have on the public in general.

9. Allowing sufficient time for the DOI's review is important to ensuring that the DOI has sufficient evidence to make a determination that the rate files are supported by evidence and statutorily compliant. Making the proposed rate increases publicly available is crucial for consumers when they are evaluating their enrollment options, and comparing premiums and networks.

10. Proposed rate increases are driven largely by the plans' and the DOI's assumptions about market conditions and rules during the relevant rating period. If those assumptions prove incorrect, they could have serious consequences for consumers and health plans.

11. While setting rates is always a matter of judgment, the level of uncertainty regarding the continuation of the cost sharing reductions and amount of funding that is potentially affected is unprecedented. Uncertainty regarding whether the federal government will fund reimbursements for cost sharing reductions has the potential to cause wide variations in health plans' proposed rate increases for any year in which it is anticipated that cost sharing reductions will not be permanently funded.

12. By law, health plans provided through the marketplace must provide cost sharing reductions to consumers, regardless of whether they are funded by the federal government. If the federal government does not reimburse health plans for cost sharing reductions, it is expected that health plans will need to increase their premiums in order to compensate for this loss. This premium increase would be in addition to the rate increases the DOI anticipates the plans filing based on prior years' experience.

13. Delaware currently has only three insurers, Highmark BCBSD Inc. ("Highmark"), Aetna Health, Inc. and Aetna Life Insurance Company, providing health plans through the federal health care marketplace, leaving its citizens particularly vulnerable to significantly increased premiums or the loss of any of these insurers from the federal marketplace for Delaware. In 2016, the DOI approved average premium increases of 32.4%, 23.6% and

22.8%, respectively, for the 2017 plan year to avoid having any plans exit the federal marketplace for Delaware.

14. On May 10, 2017, I was notified that two of the current insurers, Aetna Health, Inc. and Aetna Life Insurance Company, are withdrawing from Delaware's individual market. This will leave one insurer in the Delaware marketplace for policy year 2018. In notifying the DOI of its intention to withdraw from the market, Aetna cited the continued financial unsustainability of the plans and the current political turmoil surrounding the Affordable Care Act, including the uncertainty regarding the reimbursements of the cost sharing reduction payments. Prior to notifying the DOI of its intention to withdraw, Aetna had informed the DOI that it would have needed a premium rate increase of at least 55% to continue in the market; however, the fluctuating legislative landscape has resulted in the ultimate determination to withdraw completely from the market. Such a withdrawal may present statutory barriers to Aetna's reentering the market within a certain timeframe as provided under Delaware law.

15. If federal government reimbursement for cost sharing reductions were discontinued, the sole insurer remaining on the Delaware marketplace may have to seek to file alternative rates. The DOI would consider accommodating alternative filings to ensure that it is not locked into rates that would be inadequate under the statutory standard. Failing to accommodate the insurer in this way and the concomitant losses could have significant negative consequences, including no longer having an insurer participating in the Delaware marketplace in future years.

16. There are at least two ways the DOI could accommodate alternative rate filings: (1) the DOI could invite the remaining insurer to file and post two proposed rate increases, one assuming cost sharing reductions will be reimbursed, and the other assuming they will not; or (2) it could permit the insurer to file supplemental proposed rate increases after the initial proposed rate increases are filed.

17. If two proposed rate increases are filed with the DOI, or if the DOI invites a supplemental rate filing, the DOI would need to review both sets of proposed increases. This duplicative workload would result in a need for significant additional hours from our external actuarial vendor.

18. Publicly posting two sets of rates also would be confusing to the public because it would be unclear on what proposed rates members of the public should focus their comments.

19. Additionally, if the DOI invites a supplemental proposed rate increase filing after the June 21st rate filing deadline because it does not become clear until after the deadline that the

federal government will not reimburse health plans for cost sharing reductions, the DOI will have less time to review proposed rate increases for statutory compliance. It would be unclear year to year how much time the DOI would have to review proposed rates.

20. Reducing the amount of time spent on the rate review process as a result of supplemental filings would thwart a valuable and important statutory mandate to ensure a sufficient review of proposed premium increases, would cause consumer confusion about rate increases and timelines for comment, and would impact the DOI's ability to conduct a timely, thorough review as contemplated by statute.

By: Trinidad Navarro
Trinidad Navarro
Delaware Insurance Commissioner
Date: May 10, 2017

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

DECLARATION OF KARYL T. RATTAY, MD, MS
IN SUPPORT OF THE STATES' MOTION TO INTERVENE

DELAWARE HEALTH
AND SOCIAL SERVICES
DIVISION OF PUBLIC HEALTH

OFFICE OF THE DIRECTOR

May 10, 2017

I, Karyl T. Rattay MD, MS, declare:

I am the Director of the Delaware Division of Public Health (DPH) within the Department of Health and Social Services. I have served as the Delaware's State Health Officer since May 2, 2009, and in similar positions for more than 16 years. I attest based on personal knowledge:

1. DPH's mission is "to improve the quality of life for Delaware's citizens by promoting health and well-being, fostering self-sufficiency, and protecting vulnerable populations." In addition to regulating and overseeing public health in Delaware, DPH also provides direct health care through 18 medical and dental clinics statewide; as well as laboratory services; Child Development Watch; HIV/AIDS case management; maternal child health programming; emergency preparedness planning and response; and chronic and communicable disease prevention, screening, recognition and treatment (depending upon the illness), among other services. The clinic programs offered are adult and child health screenings, family planning, sexually transmitted disease and Tuberculosis testing and treatment, and Smart Start / Healthy Families of America. In addition to these programs, DPH also provides seasonal flu and pneumonia vaccinations. Working with providers, DPH also operates the Delaware Cancer Treatment Program (DCTP).

2. DPH provides direct programming and clinic services regardless of insurance status. If an individual does not have insurance, DPH provides the necessary care with state resources. DPH provides funding for cancer treatment through DCTP.

3. Cost-sharing reductions (CSRs) are subsidies that make health care coverage more affordable for qualifying consumers. CSR's are used to reduce out-of-pocket costs including copayments, coinsurance, deductibles and out-of-pocket maximums. Eligible consumers that purchase a silver-level plan will automatically receive these CSR's through an enhanced silver plan. Consumers that benefit from CSRs are income-eligible individuals or families with children. Without CSRs, health insurance would likely be prohibitively expensive for many Delawareans.

4. Based on available data starting in 2012, our uncompensated care amounts for clinic services dropped from approximately $800,000 to $530,000 in 2016. From 2014 through 2016, we observed uncompensated care averaged approximately $550,000 annually. We do believe that these amounts would have been higher without the implementation of the ACA. In addition, the spending trend for the DCTP has decreased significantly based on enrollment. In 2011, the cost of treatment services was over $8 million and it decreased to around $2 million in 2016.

JESSE S. COOPER BUILDING • FEDERAL STREET • DOVER • DELAWARE
MAILING ADDRESS: 417 FEDERAL STREET • DOVER • DELAWARE • 19901
TELEPHONE: (302) 744-4700 • FAX: (302) 739-6659

5. If the CSRs are no longer federally reimbursed, DPH anticipates a direct increase in the number of uninsured Delawareans who can no longer afford health insurance through the Health Insurance Marketplace. Consequently, DPH also anticipates a direct increase in the amount of state funds that would have to be used to pay for the individuals without insurance seeking care from DPH.

6. Individuals without insurance frequently defer needed care, which can result in more serious health issues as time progresses. Preventive care or care at the beginning of an illness is almost always less costly than treating a full blown or advanced health problem. Thus, should the rate of individuals without insurance in Delaware increase due to the loss of the federal CSR funding, DPH expects those individuals who seek care from the state to be sicker and more in need of costly services. This would further compound the additional health care costs borne by the state.

7. A loss of CSRs will result in an increase in the number of Delawareans without health care coverage. DPH, as a state agency, will see an increase in costs resulting from uncompensated care, and consequently be directly harmed by the loss of federal funding for CSRs.

Karyl T. Rattay, MD, MS
Director

blue of california

May 17, 2017

Xavier Becerra
Attorney General
State of California
1300 I Street
Sacramento, CA 95814

RE: Cost Sharing Reduction Payments

We are writing with regard to the cost-sharing reduction (CSR) plans and subsidies that are provided for by the Affordable Care Act (ACA), and to explain the importance of those subsidies to our members and the impact on premium rates if the subsidies are not paid as provided by the statute.

Blue Shield of California, an independent member of the Blue Cross Blue Shield Association, is a nonprofit health plan with 4 million members, 6,800 employees and more than $17 billion in annual revenue. Founded in 1939 and headquartered in San Francisco, Blue Shield of California and its affiliates provide health, dental, vision, Medicaid and Medicare health care service plans in California. The company's mission is to ensure that all Californians have access to high-quality care at an affordable price.

Blue Shield of California has offered health insurance plans for purchase through the Exchanges created by the Patient Protection and Affordable Care Act since October, 2013 We currently provide health insurance through the Exchanges in every county of the state, to approximately 389,000 individuals in California. In 2016, we had 30.8 percent of the market share of plans sold through Covered California.

Like all other carriers who offer health insurance plans through the Exchanges, we are required to provide plans with reduced cost-sharing for those individuals who are eligible to receive them. We are then reimbursed for the cost of these plans by the federal government. Those payments are substantial: for 2015 they totaled $122 million; for 2016 the anticipated amount is $141 million.

We anticipate that we will spend $133 million in CSR costs for 2017.

If the District Court's decision in *House v. Price* were to become effective at any point during the 2017 plan year, and if Congress did not then appropriate funds to reimburse us for our CSR payments, we would still be required by law to cover the costs of providing reduced cost-sharing plans. We do not know of any way to recover those costs through other means. Carriers like Blue Shield participating in Covered California would therefore take a financial loss if CSRs were not paid, with the magnitude of the loss tied to how soon before the end of the plan year the payments stop.

blue of california

Moreover, additional certainty for the 2018 plan year is critical at this point in the rate setting process. Carriers in California are currently negotiating rates with Covered California, but we do not know if CSRs will or will not be paid during the plan year. If we do not have assurance that we will receive reimbursement for our CSR costs for plan year 2018, we would have to raise premium rates on our plans in the individual insurance market in order to cover any shortfall that would result. Covered California has estimated that on average, premiums would have to increase 11 percent across all enrollees in all metal tiers to account for that shortfall.

Moreover, based on our experience in the health care industry, we believe that eliminating the CSR payments raises the risk of "adverse selection" in the individual market. We would expect that this increase in premium rates would cause some people to be unable to afford health insurance, and as a result, fewer people would sign up for the plans offered through the Exchange. Healthier people will be less likely to purchase coverage if premiums rise, while sicker people will do what they can to maintain coverage. This adverse selection would cause premium rates to rise more and faster in the future than they would have otherwise if the CSR payments continued.

Sincerely,

Robert Spector
Area Vice President – Covered California Health Insurance Exchange
Blue Shield of California

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

DECLARATION OF PRAYUS TAILOR, MD
IN SUPPORT OF THE STATES' MOTION TO INTERVENE

MSD

LEADING THE WAY TO A HEALTHY DELAWARE

May 8, 2017

I, Prayus Tailor, declare:

1. I am the President of the Medical Society of Delaware (MSD). I am a practicing physician at Nephrology Associates PA in Wilmington, DE. I have practiced medicine for 11 years. I have served at the MSD in this, and similar positions, for more than 3 years. In my role, I am the elected leader of the Society, which is one of the oldest professional associations of physicians in the country, founded in 1776. I lead our efforts in advocacy, representation, public service, and education. The facts stated herein are of my own personal knowledge, and I could and would competently testify to them.

2. The MSD is the primary industry representation and advocacy organization for Delaware physicians. The MSD is the voice of the medical profession in Delaware, regardless of specialty, practice type, age, gender, background, geography, or professional affiliation. We are comprised of over 1,500 physicians who work to further the MSD's mission to promote the practice and the profession of medicine to enhance the health of Delaware's communities.

3. Cost-sharing reductions (CSR's) are subsidies that make health care coverage and use of that coverage more affordable for qualifying patients. CSR's are used to reduce out-of-pocket costs including copayments, coinsurance, deductibles and out-of-pocket maximums. Eligible patients who purchase a silver-level plan will automatically receive these CSR's through an enhanced silver plan. Patients that benefit from CSR's are income-eligible individuals or families with children that need access to health care for preventative as well as acute care.

4. In 2016, 12,147, or 42.9% of Delaware enrollees subsequently served by Delaware physicians receive CSR assistance with their insurance through the health care marketplace. These are patients below 250 percent of the federal poverty level, who, before coverage and CSR, would routinely forgo care due to the out-of-pocket cost. They now have coverage for care and routinely access the health care system through physician services.

5. According to CMS, the second-lowest cost silver plan premium for a 27-year-old in Delaware in 2016 was $292. In 2017, it went up 19% to $347. The Kaiser Family Foundation estimates that to offset the removal of CSR payments that premiums would have to be raised even further, which does not take into account valuation for other risk factors for the removal of CSR's. Part of that unaccounted-for valuation is the risk that insurer's simply are unable to participate in the marketplace due to annual budget uncertainty.

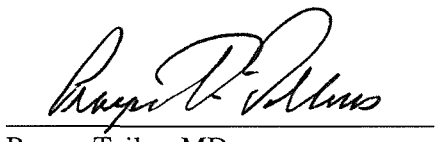
6. It has been the experience of Delaware physicians that increased premiums for lower-income working families will mean that many cannot afford to stay covered under their health insurance plan. Families that drop their coverage will become uninsured, disrupting their continuity of care and halting all variety of care from simple check-ups to important chronic disease management. Getting the proper level of treatment in a timely manner, especially outside of the emergency department, helps reduce health care costs for everyone. If coverage is dropped, access to services declines or may become unavailable altogether, which will impact tens of thousands of Delawareans and their families.

7. As a result of the availability of health insurance through the health care marketplace, Delaware physicians have been able to deliver care to all segments of the Delaware population. In America's 2015 Health Rankings, Delaware was ranked 32nd healthiest state. According to the Delaware Department of Health and Social Services' 2015 Primary Care Health Needs Assessment study, this lower ranking is in part due to the primary care access which is 114.3 per 100,000 persons, although we rank among the best for health insurance coverage. A critical piece of insurance coverage is the ACA; 52% of Delawareans eligible for the Marketplace enrolled in 2015.

8. When individuals and families don't have health care coverage, they also lose access to care. When patients can't be seen by a primary care doctor, they often turn to hospital emergency rooms as a last resort. More uninsured individuals will seek care in hospital emergency rooms – the most expensive place to be treated – if funding for CSR's is lost. Preserving emergency rooms for those truly needing emergency care ensures life-saving treatment is there when needed for everyone.

9. Access to care needs to be available outside of hospitals and physician offices as well. While physicians are critical for diagnosing and treating, continuity of care often includes partners in other care settings. For instance, nursing homes, psychiatric services, addiction services, rehabilitative services or other post-acute care settings. However, these settings also require insurance coverage. Patients recover quicker when they receive timely and appropriate care in the appropriate setting. And, the proper level of treatment is often less costly.

10. A loss of CSR's will result in an increase in the number of Delawareans without health care coverage. Higher uninsured rates increase the cost of health care for all Delawareans. Uninsured individuals and families are often forced to seek care in the most expensive or inappropriate settings. Higher uncompensated costs will result in a loss of access and services for every Delawarean.



Prayus Tailor, MD
President
Medical Society of Delaware
Nephrology Associates PA
4923 Ogletown-Stanton Road, Suite 200
Newark, DE 19713

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

DECLARATION OF WAYNE THOMAS
IN SUPPORT OF THE STATES' MOTION TO INTERVENE

DECLARATION OF Wayne Thomas

I, Wayne Thomas, hereby declare:

1. I am the Chief Actuary for the Department of Managed Health Care (DMHC), a California state department. I have served in this position for six and a half years. The facts stated herein are of my own personal knowledge, and I could and would competently testify to them.

2. As the DMHC's Chief Actuary, I am responsible for the DMHC's rate review program, which is a statutory obligation of the DMHC. As part of the rate review program, the DMHC reviews health care services plans' (health plans) proposed rate increases in California's individual and small group markets.

3. The rate review program serves a vital public purpose. It provides the DMHC with an opportunity as a regulator of health plans to review proposed rate increases and announce to the public whether proposed rate increases are actuarially sound.

4. If the DMHC finds that a proposed rate increase is unreasonable or unjustified, it posts a notice of this finding on its web site.

5. Health plans are required by law to file their proposed individual rate increases with the DMHC at least 100 days before the start of the annual open enrollment period, and must publicly post these proposed increases at least 120 days before they are implemented.

6. The requirement that health plans post their proposed rate increases at least 120 days before they are implemented serves an important function, allowing members of the public to

review the proposed increases independently, check the health plans' assumptions, and provide public comment on the proposed increases to the health plans and the DMHC.

7. Allowing sufficient time for the DMHC's and the public's review is important to ensuring that consumers have accurate information about their health plans' proposed rate increases and whether the DMHC has found that they are supported by evidence. This information is crucial for consumers when they are evaluating their enrollment options, and comparing premiums and networks.

8. Proposed rate increases depend entirely on the plans' and the DMHC's assumptions about market conditions and rules during the relevant rating period. If those assumptions prove incorrect, they could have serious consequences for consumers and health plans.

9. Uncertainty regarding whether the federal government will fund reimbursements for cost sharing reductions has the potential to cause wide variations in proposed rate increases for any year in which cost sharing reductions are not permanently funded.

10. By some estimates, not reimbursing cost sharing reductions would result in a loss of $700 million for California's health plans in Plan Year 2017.

11. By law, health plans must provide cost sharing reductions to consumers, regardless of whether they are funded. If the federal government does not reimburse health plans for cost sharing reductions, health plans will need to increase their premiums in order to compensate for this loss.

12. If reimbursement for cost sharing reductions were discontinued, health plans may have to seek to file alternative rates. The DMHC would accommodate alternative filings to ensure that

health plans are not locked into rates that would cause them to incur large losses because cost sharing reductions are not reimbursed. Failing to accommodate health plans in this way and the concomitant losses could have significant negative consequences, including potential future market exits.

13. There are at least two ways the DMHC could accommodate alternative rate filings: (1) the DMHC could invite health plans to file and post two proposed rate increases, one assuming cost sharing reductions will be reimbursed, and the other assuming they will not; or (2) it could permit health plans to file supplemental proposed rate increases after the initial proposed rate increases are filed.

14. If health plans file two proposed rate increases with the DMHC, or if the DMHC invites a supplemental rate filing, the DMHC would need to review both sets of proposed increases. This duplicative workload would result in additional 125 staff hours from our internal actuarial staff and $13,000 spent on our external actuarial vendor.

15. Publicly posting two sets of rates also would be confusing to the public. It would be unclear what proposed rates members of the public should focus their comment on.

16. Additionally, if the DMHC invites a supplemental proposed rate increase filing after the rate filing and public posting deadline because it does not become clear until after the deadline that the federal government will not reimburse health plans for cost sharing reductions, both the DMHC and the public will have less time to review proposed rate increases for reasonableness. It would be unclear year to year how much time the DMHC and the public would have to review and comment on proposed rates.

17. Reducing the amount of time spent on the rate review program would thwart a valuable and important statutory mandate to ensure a sufficient, transparent, and public review of proposed premium increases, would cause consumer confusion about rate increases and timelines for review and comment, and would diminish the DMHC's ability to conduct a thorough review.

I declare under penalty of perjury under the laws of the United States that the foregoing is true and correct, and that this declaration was executed electronically, at my request, on May 4, 2017, while I was in Los Angeles, California.

Dated: May 4, 2017

[Wayne Thomas]

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

DECLARATION OF SUPERINTENDENT MARIA T. VULLO
IN SUPPORT OF THE STATES' MOTION TO INTERVENE

MARIA T. VULLO, declares under penalty of perjury, pursuant to 28 U.S.C. § 1746, that the following is true and correct:

1. I am the Superintendent of the New York Department of Financial Services (DFS) and have been in this position since 2016. My responsibilities include reviewing and approving health insurance plan filings and premium rates. I submit this declaration in support of the State of New York's motion for leave to intervene in the lawsuit of *House v. Price*.

2. The New York State Department of Financial Services (DFS), among other responsibilities, regulates commercial accident and health insurers, non-profit health services corporations, and health maintenance organizations (collectively referred to as "Health Plans") and ensures their compliance with New York law and federal law including the applicable provisions of the Patient Protection and Affordable Care Act ("ACA"). Some of DFS' most important responsibilities include overseeing the solvency of Health Plans, reviewing and approving health insurance plan premium rates and adjustments, and ensuring that Health Plans pay consumer claims for covered benefits as they become due.

3. Health Plans offer a variety of products in New York, including Qualified Health Plans ("QHPs") and Basic Health Program ("BHP") plans through the New York State of Health ("NYSoH" or "Marketplace"), New York State's Official Health Plan Marketplace established pursuant to the ACA.

4. In just six years, the ACA has succeeded in providing lower cost, higher quality coverage to millions of individuals and businesses in New York. Since the ACA's implementation, New York's uninsured rate has dropped by approximately 50%, reducing the number of uninsured New Yorkers from approximately 10% to 5%. Under the ACA, approximately 3.4 million New Yorkers have received new coverage through our Marketplace. In addition, commercial health insurance premiums for individuals remain over 50% less costly in 2017 than they would have been without the ACA. Federal tax credits further reduce the cost of coverage to consumers. And the ACA's Cost Share Reduction (CSR) provisions reduce out-of-pocket expenses, such as deductibles and copayments, to make coverage even more affordable to the consumer which helps to make the market competitive and robust. New York's individual and group markets remain competitive and robust. For the 2017 plan year, 16 insurers offer coverage in our individual market and 21 insurers offer coverage in our small group market.

5. On a yearly basis, all New York Health Plans must apply for and receive prior approval from DFS of premium rates for all commercial individual and small group insurance policies, as well as community rated large group policies. DFS carefully reviews the Health Plan's rate applications and underlying calculations, including the cost of medical care, member utilization of medical services, administrative expenses and profit. Under the law, DFS may disapprove or modify

an insurer's request for a premium rate increase if it is unreasonable, excessive, inadequate, or unfairly discriminatory.

6. Health Plans' proposed rates are based, in part, on actuarial assumptions about market conditions and third party funding sources during the relevant rating period. If the third party funding sources change after proposed rate increases are submitted by Health Plans and reviewed by DFS, the underlying actuarial assumptions will likely be incorrect. The consequences of incorrect underlying actuarial assumptions can be serious for consumers and Health Plans.

7. One important actuarial assumption regarding expected third party funding sources impacting Health Plan rates rests on the amount of CSR payments that QHPs will receive. CSRs decrease out-of-pocket costs such as deductibles and co-payments for individuals who enroll in silver level Marketplace plans and have household incomes below 250% of the federal poverty level. By law, Health Plans must provide CSRs to their members, regardless of whether the CSRs are ultimately funded by the federal government. All CSR payments have been made through 2016.

8. If the federal government does not reimburse Health Plans for CSRs, Health Plans' rates will be inadequate and cause substantial financial loss. In New York, 65,000 individuals in 2017 received CSRs through QHPs, reducing New Yorkers' collective cost-sharing responsibilities by approximately $13,500,000.

9. New York also has 675,000 people with health coverage under the Essential Plan, New York's Basic Health Program (BHP) plan. The BHP Plan also receives federal funding calculated from CSR payments, which is expected to total $870 million for 2017. If the funding for BHP plans is discontinued, New York State must either make up the lost CSR payments – finding another source of funding for the $870 million – or, in the alternative, discontinue the BHP and direct BHP enrollees to find other coverage.

10. The termination of CSR payments will cause an increase in premium rates which will, in turn, lead to more New Yorkers losing their health insurance as the insurance becomes unaffordable. Healthy individuals will be more likely to forego coverage, compared to sick individuals. If healthy individuals leave the market, the remaining unhealthy individuals will be a larger portion of the insured population. The disproportionate share of expensive, unhealthy individuals will further cause premiums to increase.

11. It is well documented that Health Plans may withdraw from the Marketplace due in part to the uncertainty created since January 2017 as to the future of the ACA. Fewer Health Plans in the New York marketplace will reduce competition, which could lead to higher premiums. Fewer Health Plans and higher premiums will reduce consumer choice and the availability of health insurance to New Yorkers.

12. Health Plans withdrawing from the market or discontinuing their products will have a significant regulatory impact on DFS operations, as withdrawals and discontinuances necessitate considerable additional staff time to ensure that the procedural requirements in New York's insurance law and insurance regulations are met. DFS has been expending significant staff resources already to manage the uncertainty about the future of CSR payments.

13. DFS will soon be reviewing premium rates for calendar year 2018. In preparation of this rate review, DFS has provided instructions to Health Plans regarding their upcoming rate filings, including deadlines that must be adhered to in order for plans to be ready to offer products on the Marketplace for 2018. Open enrollment for 2018 individual policies begins on November 1, 2017.

14. DFS is being forced to evaluate and make decisions regarding proposed premium rates without knowing a key piece of information – whether Health Plans can reasonably expect to receive CSR payments. Likewise, Health Plans are making decisions about whether to participate in the New York Marketplace (and, if so, whether their premiums will be adequate) without any guarantee of an essential and necessary piece of information – whether they will receive the CSR payments.

15. The later in the rate approval process that DFS learns of a discontinuation of CSR payments, the more serious the impact will be. If CSR payments stop after

Health Plans submit their premium rate applications for the 2018 plan year but before plan rates are finalized, DFS staff will need to make adjustments to the previously submitted rate requests of every insurer currently receiving CSR payments. Moreover, if CSR payments are terminated after DFS issues its rate decisions, DFS may be unable to adjust rates to account for the lost CSR payments to Health Plans. Even if possible, the process to amend the rates will become extraordinarily cumbersome and time-consuming, and may require consideration of mid-year rate increases in the individual market which would involve significant staff time. In addition, DFS will have to reevaluate the financial solvency of Health Plans in light of the non-payment of CSR funding.

16. If CSR payments stop in the middle of a plan year (after insurance becomes effective), the consequences will be even more significant for Health Plans, markets, consumers, and DFS, as there may be no mechanism for the CSR funding to be replaced.

17. DFS's regulatory burden will increase under any scenario in which CSR payments are terminated. This increased burden will require hundreds of additional hours of work from state employees.

18. CSRs are an important component of the ACA's integrated requirements to ensure that all New Yorkers, including those with limited means, can purchase health insurance. The loss of CSR payments will result in an unnecessary disruption to the highly functioning and successful NYSoH, and to the New York insurance market overall. New York has enjoyed unquestionable success with the NYSoH Marketplace. In 2016, more than 2.8 million New Yorkers -- about 15 percent of the State's population -- were enrolled in comprehensive and affordable coverage through the Marketplace. The rate of uninsured New Yorkers has dropped to 5 percent, its lowest point in decades.

19. I declare under penalty of perjury that the foregoing is true and correct.

Executed on May 11, 2017

Maria T. Vullo,
Superintendent of Financial Services

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

DECLARATION OF KATHARINE L. WADE
IN SUPPORT OF THE STATES' MOTION TO INTERVENE

State of Connecticut

KATHARINE L. WADE
INSURANCE COMMISSIONER

P.O. Box 816
HARTFORD, CT 06142-0816

Hartford

I, Katharine L. Wade, declare and say as follows:

1. I am Insurance Commissioner at the Connecticut Insurance Department, a Connecticut state department. I have served in this position for two years. The facts stated herein are of my own personal knowledge, and I could and would competently testify to them.
2. As the Commissioner, I am responsible for the Connecticut Insurance Department's rate review program, which is a statutory obligation of the Connecticut Insurance Department, Conn. Gen. Stat. §§ 38a - 481. As part of the rate review program, the Connecticut Insurance Department reviews proposed rates in Connecticut's individual and small group health insurance markets from insurers and health care centers (HMOs), also know as health plans.
3. The rate review program serves a vital public purpose. It provides the Connecticut Insurance Department with an opportunity as a regulator of health plans to review proposed rate increases and announce to the public whether proposed rate increases are actuarially sound.
4. The Connecticut Insurance Department conducts public rate hearings on a selection of rates filed with the Connecticut Insurance Department. These rate hearings are called by the commissioner voluntarily under Conn. Gen. Stat. § 38a-481 and conducted pursuant to time frames for notice and decisions set by the Connecticut Insurance Department's agency rules of practice. See, Regulations of Connecticut State Agencies 38a-8-1 et seq.
5. In cases of both public hearings and rates filed with the Connecticut Insurance Department that do not go hearing the Connecticut Insurance Department allows for public comment to be made. Once the Connecticut Insurance Department has concluded its review, all final dispositions are posted for public access on its web site.
6. Health plans are required by law to file their proposed individual rate increases with the Connecticut Insurance Department at least 90 days before they are intended to be marketed, and plans that are subject to the Affordable Care Act (ACA) are required to file by a date annually prescribed by the Commissioner. This year carriers were required to file rates by May 1, 2017.
7. Allowing sufficient time for the Connecticut Insurance Department's review and the public to make comments is important to ensuring that consumers have accurate

information about their health plans' proposed rate increases and whether the Connecticut Insurance Department has found that rate increases are supported by evidence that they are not excessive, inadequate, or unfairly discriminatory. This information is crucial for consumers when they are evaluating their enrollment options, and comparing premiums and networks.

8. Proposed rate increases depend entirely on assumptions about market conditions and rules during the relevant rating period by health plans and the Connecticut Insurance Department's review of their assumptions. If those assumptions prove incorrect, that could have serious consequences for consumers and health plans.
9. Uncertainty regarding whether the federal government will fund reimbursements for cost sharing reductions (CSRs) has the potential to cause wide variations in proposed rate increases for any year in which cost sharing reductions are not permanently funded.
10. By law, health plans must provide cost sharing reductions to consumers, regardless of whether they are funded. If the federal government does not reimburse health plans for cost sharing reductions, health plans will need to increase their premiums in order to compensate for this loss to remain solvent.
11. If reimbursement for cost sharing reductions were discontinued, health plans may have to seek to file additional increased rates to make up for the loss of those anticipated reimbursements. The Connecticut Insurance Department would accommodate alternative filings to ensure that health plans are not locked into rates that would cause them to incur large losses because cost sharing reductions are not reimbursed. Failing to accommodate health plans in this way and the concomitant losses could have significant negative consequences, including potential future market exits.
12. As the filing date of May 1, 2017 has passed, the Connecticut Insurance Department would permit health plans to file supplemental proposed rate increases to the initial proposed rate increases already filed. This would be done at the direction of Connecticut Insurance Department after May 15, 2017.
13. Reviewing supplemental proposed rate increases will impose additional burdens in terms of resources and staff upon the Connecticut Insurance Department.
14. Additionally, if the Connecticut Insurance Department invites a supplemental proposed rate increase filing after the rate filing and public posting deadline because it does not become clear until after the deadline that the federal government will not reimburse health plans for cost sharing reductions, the Connecticut Insurance Department will have less time to review proposed rate increases for reasonableness. It would be unclear year to year how much time the Connecticut Insurance Department and the public would have to review and comment on proposed rates.
15. Carriers have already filed initial rates for the 2018 plan year as of May 1, 2017. Those rate filings did not include an assumption of a reduction in CSR funding.
16. The Connecticut Insurance Department is slated to conduct rate hearings in June 2017. Any changes to the CSR reimbursement to be paid to consumers will have an influence

on these rate hearings. Uncertainty relating to existence of CSR or amount of CSR makes it impossible for the Connecticut Insurance Department to determine if health insurance rates filed are excessive, inadequate, or unfairly discriminatory.

17. Cost-sharing reductions (CSRs) are subsidies that make health care coverage more affordable for qualifying consumers. CSRs are used to reduce out-of-pocket costs including copayments, coinsurance, deductibles and out-of-pocket maximums. Eligible consumers that purchase a silver-level plan will automatically receive these CSRs through an enhanced silver plan.
18. Carriers have already notified the Connecticut Insurance Department that the uncertainty surrounding the funding for the CSR will create market volatility and jeopardize their ability to set adequate rates responsibly. Carriers indicated that rates could rise 20% over and above current proposed rates due to increase in medical costs, if CSR funding is cut.
19. In addition to uncertainty regarding rates, carriers have indicated to the Department and the Health Insurance Exchange in Connecticut that reducing or cutting funding for CSR will cause some carriers to exit the Connecticut market. At present, there are only two carriers on the exchange.
20. The Connecticut Insurance Department has already received correspondence from several health insurance carriers in the individual market indicating their intent to exit the individual market effective 1/1/18. These exits from Connecticut's individual insurance market could leave consumers with few or no choices for carriers in 2018.

I declare under penalty of perjury under the laws of the United States that the foregoing is true and correct, and that is declaration was executed on May 9, 2017.

Katharine L. Wade

Katharine L. Wade
Connecticut Insurance Commissioner

Subscribed and sworn to before me this 9th day of May, 2017.

Patricia A. Butler

Notary Public

PATRICIA A. BUTLER
NOTARY PUBLIC
MY COMMISSION EXPIRES Sept. 30, 2018

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

DECLARATION OF JAMES R. WADLEIGH, JR.
IN SUPPORT OF THE STATES' MOTION TO INTERVENE

access health CT

AFFIDAVIT OF JAMES R. WADLEIGH

The undersigned, James R. Wadleigh, Jr. being first duly sworn, deposes and says:

1. That I am more than eighteen years of age and believe in the obligations of an oath.

2. That I am the Chief Executive Officer (CEO) of the Connecticut Health Insurance Exchange d/b/a Access Health CT (the "Exchange"). I have been employed by the Exchange since 2012, serving first as the Chief Information Officer, and then as the CEO since 2014. I am responsible for management of all aspects of the operation of the Exchange. The facts stated herein are of my own personal knowledge, and I could and would competently testify to them.

3. The Exchange serves the residents of the State of Connecticut by offering enrollment in qualified health plans pursuant to the Affordable Care Act (ACA), financial assistance through advance payments of the premium tax credit (APTCs) to help pay health insurance premiums, and cost-sharing reductions (CSRs) that reduce the amount of out-of-pocket costs that eligible consumers are required to pay for health care expenses during the year. Cost-sharing reduction payments are made by the health insurance carriers to providers, and the U.S. Department of Health and Human Services (HHS) reimburses health insurance carriers for these amounts.

4. For the 2017 plan year, the Exchange estimates that carriers participating through the Exchange will receive reimbursement payments of over $55 million in payments from HHS for CSRs to eligible enrollees. For the 2017 plan year, over 47% of the Exchange's members are enrolled in CSR plans: 14% in the 94% CSR plan, 17% in the 87% CSR plan and 11% in the 73% CSR plan. The carriers are required to continue to offer these plans throughout 2017, so the financial impact of the uncertainty surrounding CSR reimbursement payments for the carriers from HHS has a strong negative impact on the market.

5. The financial assistance provided by CSRs is an important subsidy to eligible recipients who are low-income adults and children. For example, a 94% CSR plan may require a consumer to pay a $30 co-payment for a covered provider or service, while a non-CSR silver plan may require a consumer to pay a $50 co-payment for the same covered provider or service. The differences in deductibles and out-of-pocket maximums between the standard silver plan and the 94% CSR plan is substantial.

6. The Exchange conducts member surveys each year, tracking satisfaction rates, and consumer reasons for terminating coverage through the Exchange, among other things. The majority of members who enroll in qualified health insurance plans through the Exchange rate cost as their number one concern, for both subsidized and unsubsidized enrollees. A lack of affordable health insurance plans is cited by consumers as the number one reason for dissatisfaction for continuing enrollees and those who terminate their coverage through the Exchange. Therefore, potential premium increases have a significant negative impact on enrollment in health insurance plans, both on and off the Exchange.

7. The Exchange experienced carrier attrition from the 2016 plan year to the 2017 plan year. UnitedHealthcare decided to stop offering plans in the Individual and Small Employer Health Options (SHOP) marketplaces in Connecticut for 2017. Healthy CT was not permitted to sell health insurance plans starting July 1, 2016 due to an Order of Supervision by The Connecticut Insurance Department (CID).

8. The reduction in the number of health insurance carriers offering plans through the Exchange from 2016 to 2017 impacted over 11,000 enrollees. Thirty-three (33%) percent of these enrollees did not renew their coverage though a qualified health plan through a plan offered on the Exchange.

9. The Exchange currently has two (2) carriers offering qualified health plans through the Exchange for the 2017 plan year for the Individual marketplace, and one (1) carrier offering plans through the Exchange for the 2017 plan year for the SHOP marketplace. The Exchange is currently engaged in the carrier certification process for the 2018 Plan Year. Two carriers have filed their Non-Binding Notice of Intent with the Exchange to participate for the 2018 plan year, and both carriers have filed their rate and form filings for approval with the CID. Both carriers have requested significant rate increases for 2018.

10. I am currently engaged in active conversations with both carriers regarding their participation in the Exchange for the 2018 plan year. The carriers have indicated that uncertainty concerning CSR reimbursement payments from HHS and the outcome of *House v. Price* make it difficult for them to price their health insurance plans, and to determine whether they will participate in the Exchange for 2018.

11. Since 2014, the uninsured rate in Connecticut has been dramatically reduced due to the qualified health plans and the financial assistance offered through the Exchange and the expansion of Medicaid for low-income adults. The market insecurity caused by the current national environment in health insurance makes it difficult for the Exchange to determine how best to serve the residents of the State of Connecticut and maintain the greatly reduced uninsured rate that has been achieved in the State in recent years. Increases in the uninsured rates will harm the residents of the State of Connecticut, and will shift financial burdens to states, hospitals and other providers.

12. I declare under penalty of perjury under the laws of the United States that the foregoing is true and correct.

JAMES R. WADLEIGH, JR.
CEO
Connecticut Health Insurance Exchange
dba Access Health CT

Subscribed and sworn before me
this 9th day of May, 2017

Susan Rich-Bye
Commissioner of the Superior Court
Connecticut Juris No. 405996

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

DECLARATION OF ELISABETH R. WYNN
IN SUPPORT OF THE STATES' MOTION TO INTERVENE

Elisabeth R. Wynn, declares under penalty of perjury, pursuant to 28 U.S.C. § 1746, that the following is true and correct:

1. I am the Senior Vice President of Health Economics and Finance at the Greater New York Hospital Association (GNYHA) and have been in this position since 1999. My responsibilities with respect to Federal issues include policy development and technical expertise on Medicare and Medicaid payment policy, including implementation of the Affordable Care Act (ACA).

2. I am offering this declaration in support of the State of New York, and its motion for leave to intervene in the lawsuit of *House v. Price*.

3. Founded in 1904, GNYHA is a trade association representing more than 160 member hospitals and health systems in New York, New Jersey, Connecticut, and Rhode Island. In New York, GNYHA represents approximately 139 hospitals across the state.

4. GNYHA and its member hospitals and health systems have collaborated with other health care providers, State and local agencies and insurers to implement the ACA in New York with the goal of increasing health care coverage to as many New Yorkers as possible. There has been enormous success in reaching that goal: 11% of New Yorkers were uninsured in 2013, and as of 2016, only 5.4% remained without healthcare coverage.

5. Individuals with health insurance coverage have more timely access to health care that is affordable. They are less likely to delay needed services or experience financial burdens associated with medical care. Insurance coverage also reduces hospitals' burden of uncompensated care, improving their financial stability.

6. Hospitals for decades have provided care to their communities, notwithstanding that patients have not always been insured. The federal Emergency Medical Treatment and Labor Act (EMTALA) requires hospitals to provide emergency care to stabilize the patient, regardless of a patient's insurance status or ability to pay. 42 U.S.C. § 1395dd. When the uninsured seek care in a hospital emergency room, hospitals must treat the patient and cover the costs.

7. Hospitals in New York have seen a deep drop in visits from uninsured individuals since the roll out of the ACA. From 2013-2015, the number of emergency visits by the uninsured dropped by 23%, with a 12% mean annual reduction. In 2013, the year before the New York State of Health Marketplace began enrolling New Yorkers, 1,057,800 uninsured individuals were admitted to the emergency room. By 2015, the number decreased significantly to 813,976.

8. Other outpatient care saw similar trends. For all non-emergency outpatient visits, services provided to uninsured individuals dropped 17% from 2013-2015, with a mean annual drop of 9%.

9. The number of inpatient discharges for uninsured patients at all hospitals in New York State dropped even more sharply. From 2013-2015, the number of discharges dropped 38%.

10. As a result of the reductions in the number of uninsured individuals requiring services, New York hospitals' uncompensated care costs (bad debt and charity care) dropped. As a share of hospital operating expenses, uncompensated care fell 15% in New York in just one year, from 2013-2014. (Medicaid and CHIP Payment Advisory Commission, March 2017).

11. There are 27 non-public hospitals throughout New York State on a Department of Health "Watch List" for being at high-risk of closure because they have less than 15 days cash on hand, as well as other indicators of poor financial condition. These hospitals are receiving $450 million in State operating subsidies to prevent unplanned closures, while the facilities transform into more sustainable operating models and transition payment methodologies with payers that are value-based.

12. Several other hospitals in New York State have unstable finances and are at-risk of being placed on the State Watch List. Any further decline in their financial condition from higher uncompensated care costs would require increased state subsidies to prevent unplanned hospital closures and preserve access to care for their communities.

13. I declare under penalty of perjury that the foregoing is true and correct.

Dated: May 1, 2017

Elisabeth R. Wynn

Elisabeth R. Wynn

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

DECLARATION OF MARIE ZIMMERMAN
IN SUPPORT OF THE STATES' MOTION TO INTERVENE

Marie Zimmerman declares under penalty of perjury, pursuant to 28 U.S.C. § 1746, that the following is true and correct:

1. I make the following declaration based on first hand personal knowledge and am competent to testify to the facts set forth herein.

2. I am the Medicaid Director for the Minnesota Department of Human Services ("DHS") in the Health Care Administration. I have served in this position for two and a half years.

3. As the Medicaid Director, I am knowledgeable regarding Minnesota's Basic Health Program, called MinnesotaCare. MinnesotaCare provides comprehensive low-cost health insurance to Minnesota residents who do not have access to affordable coverage. MinnesotaCare is provided by Minnesota itself—through contracted insurers—and generally covers Minnesota residents age 19 and older who have a gross income between 133 percent and 200 percent of the federal poverty guidelines and who are not otherwise eligible for the State's Medical Assistance program.

4. Under the Patient Protection and Affordable Care Act ("ACA"), 42 U.S.C. § 18051, *et seq.*, states may operate a Basic Health Program and receive subsidies from the federal government in the amount of 95% of the tax credits and cost-sharing reductions the Basic Health Program's enrollees would have received had they purchased a silver-level plan on a health-care exchange under the ACA. Approximately 25% of MinnesotaCare's federal Basic Health Program funding is tied to what enrollees would have received in cost-sharing reductions under the ACA.

5. Minnesota received federal approval to operate MinnesotaCare as a Basic Health Program under the ACA on December 15, 2014. On January 1, 2015, Minnesota began

operating MinnesotaCare as a Basic Health Program. In 2016, 92,138 Minnesota residents were covered by MinnesotaCare. During 2016, Minnesota received $103 million in federal funds tied to what MinnesotaCare's enrollees would have been eligible to receive in cost-sharing reductions under the ACA.

6. As of April 2017, 84,594 Minnesota residents were enrolled in MinnesotaCare.

7. In 2017, the State of Minnesota is projected to receive a total of approximately $120 million in federal funds pegged to what MinnesotaCare enrollees would have been eligible to receive in cost-sharing reductions under the ACA. For 2018, this amount is estimated to rise to approximately $130 million.

8. The loss of these federal funds related to the cost-sharing reductions under the ACA would directly and substantially harm the State and its ability to fund coverage to enrollees of MinnesotaCare. Indeed, if allowed to take effect, the injunction in the above-captioned case would annually deprive the State of over $100 million in ACA-authorized Basic Health Program federal funds, which would otherwise be available to pay for MinnesotaCare.

Dated: 5/16/2017

Marie Zimmerman, DHS Medicaid Director