IN THE UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF TEXAS
WICHITA FALLS DIVISION

TEXAS, KANSAS, LOUISIANA, INDIANA, WISCONSIN, and NEBRASKA, *Plaintiffs*, v. UNITED STATES OF AMERICA, UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, ERIC HARGAN, in his Official Capacity as ACTING SECRETARY OF HEALTH AND HUMAN SERVICES, UNITED STATES INTERNAL REVENUE SERVICE, and JOHN KOSKINEN, in his Official Capacity as COMMISSIONER OF INTERNAL REVENUE, *Defendants*.	§ §	CIVIL ACTION NO. 7:15-CV-00151-O

PLAINTIFFS' SUPPLEMENTAL BRIEF
IN SUPPORT OF SUMMARY JUDGMENT

Plaintiffs dispute that a limitations period regarding APA claims expired. The six years preceding Plaintiffs' lawsuit (filed Oct. 22, 2015) saw agency action (and inaction) that produced "legal consequences"—the controlling question—to Plaintiffs.

I. PLAINTIFFS CLAIM THAT DEFENDANTS EXCEEDED THEIR CONSTITUTIONAL AND STATUTORY AUTHORITY.

As the Court notes,

> [i]t is possible, however, to challenge a regulation after the limitations period [for a facial challenge] has expired, *provided that the ground for the challenge is that the issuing agency exceeded its constitutional or statutory authority*. To sustain such a challenge, however, the claimant must show some direct, final agency action involving the particular plaintiff within six years of filing suit.

Dunn-McCampbell Royalty Interest, Inc. v. Nat'l Park Serv., 112 F.3d 1283, 1287 (5th Cir. 1997) (emphasis added). Complaining about the application of the HIPF, ECF No. 19, Plaintiffs claim Defendants exceed constitutional and statutory authority in causing Plaintiffs to pay the HIPF, *id.*

First, the ACA forecloses the application of the HIPF on the States. Pls.' App. 45–46. Defendants' application of 42 U.S.C. § 1396b, to cause Plaintiffs to pay the HIPF, exceeds statutory authority. *See* ECF No. 54 at 29–30; ECF No. 66 at 19–20.

Second, Plaintiffs claim Defendants act unconstitutionally by delegating the power to define "actuarially sound" (as to the ACA and HIPF) to the ASB—a private entity. *See* ECF No. 54 at 35–37; ECF No. 66 at 22–23; 42 C.F.R. §§ 438.1–.6. By maintaining (applying) the post-ACA delegation regarding "actuarial soundness" to the ASB, Defendants (again) permit private parties to exercise legislative authority.

Plaintiffs also challenge not just ASOP 49, but Defendants' deference to ASOP 49 without going through notice and comment. This also means that Defendants' actions are arbitrary and capricious—another challenge to Defendants' statutory authority. This is especially so where Defendants' actions work to alter the text of Congress by placing liability for the HIPF on Plaintiffs.

II. DEFENDANTS NEWLY APPLIED THEIR RULES TO PLAINTIFFS WITHIN SIX YEARS OF PLAINTIFFS' FILING SUIT.

> [W]hen an agency *applies* a rule, the limitations period running from the rule's publication will not bar a claimant from challenging the agency's statutory authority.
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> . . .
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> [A]n agency's application of a rule to a party creates a new, six-year cause of action to challenge to the agency's constitutional or statutory authority.

Dunn-McCampbell, 112 F.3d at 1287 (emphasis in original).

The Fifth Circuit discussed "direct, final agency action involving the particular plaintiff within six years of filing suit," *id.*, though never defined "direct." "[D]irect" is from *Abbott Labs. v. Gardner*, 387 U.S. 136, 149–53 (1967). Part of that test is "whether the impact on the plaintiff is direct and immediate." *Id.* at 152; *see Dunn-McCampbell*, 112 F.3d at 1288.[1] However, whether an agency impact is "direct and immediate" is both a "'flexible' and 'pragmatic'" inquiry. *Qureshi v. Holder*, 663 F.3d 778, 781 (5th Cir. 2011) (quoting *Abbott Labs.*, 387 U.S. at 149–50).

As of 1981, Medicaid MCO capitation rates must be "actuarially sound." 42 U.S.C. § 1396b(m)(2)(A). "Actuarially sound capitation rates means capitation rates that . . . [h]ave been certified, as meeting the requirements of this paragraph (c), by actuaries who meet the qualification standards established by the American Academy of Actuaries and follow the practice standards established by the Actuarial Standards Board." 42 C.F.R. § 438.6(c)(1)(i)(C) (June 14, 2002), 67 Fed. Reg. 41095. Before the ACA, "actuarial soundness" was discretionary, as there was no hard rule as to what was "actuarially sound" in any given circumstance.[2] Since the ACA,

[1] The newer standard from *U.S. Army Corps of Engineers v. Hawkes Co., Inc.*, 136 S. Ct. 1807 (2016), and its application herein, is addressed in the following section.

[2] The ASB described "actuarial soundness" as a phrase that "has different meanings in different contexts and might be dictated or imposed by an outside entity. In rendering actuarial services, if the actuary identifies the process or result as 'actuarially sound,' the actuary should define the meaning of 'actuarially sound' in that context." ASB, ASOP No. 1 at § 2.3 (Mar. 2013), *available at* http://www.actuarialstandardsboard.org/wp-content/uploads/2013/10/asop001_170.pdf.

Defendants cling to the illusion of discretion, contending they merely "continue[] to apply a longstanding provision of the federal Medicaid statute providing that states' contracts with Medicaid MCOs will not be approved unless the contractual capitation rates are actuarially sound." ECF No. 63 at 39. Not so.

This "longstanding provision" is now being *applied* in a different way—a way devoid of discretion. And the following chronological series of events articulates myriad such applications within the six year period preceding this lawsuit:

(1) The original ASOP 1, promulgated in 1990, made "tax rates" just one of over thirteen different "contract factors" or "anticipated experience factors" that *could* factor into an actuary's "sound professional judgment."[3]

(2) The ACA, which includes the HIPF, became law on March 23 2010.

(3) On November 29, 2013, IRS issued its rule making the HIPF a non-deductible excise tax. Health Insurance Providers Fee, 78 Fed. Reg. 71476 (Nov. 29, 2013); 26 C.F.R. § 57.8. Clarifying the Congressional exemption for a "governmental entity," IRS extended "governmental entity" to include "[a]ny agency or instrumentality" of a "governmental entity." 26 C.F.R. § 57.2(b)(2)(ii)(D). However, IRS excluded from the definition of "agency or instrumentality" an entity "if it engages in the business of providing insurance on the commercial market on a continuing and regular basis." 78 Fed. Reg. 71479–80. Thus, though contracted by Plaintiffs for Medicaid, Plaintiffs' MCOs are excluded from IRS's definition of "governmental entity."[4] This cuts against the uniform expert testimony. *See* ECF No. 54 at 13–14, 14 n.40, 19, 23.

(4) In October 2014, Defendants released an "FAQ" document falsely contending

[3] ASB, ASOP No. 1 § 5.5 (1990), *available at* http://www.actuarialstandardsboard.org/wp-content/uploads/2014/07/asop001_020.pdf.

[4] IRS cloaks this discretionary decision in past legal precedent. 78 Fed. Reg. 71480. Yet, regardless of whether this decision is consistent, or not, with prior decisions, it remains a "legal consequence" for how MCOs will be treated regarding a brand new legal mechanism—the HIPF.

that "[s]tates and their actuaries have flexibility in incorporating the Health Insurance Providers Fee into the state's managed care capitation rates" and that "[s]tates have the flexibility to account for the Health Insurance Providers Fee on a prospective or retroactive basis."[5]

(5) ASOP 49 was promulgated in March 2015. ASOP 49, contrasted against ASOP 1, is not discretionary. Rather, "the actuary should include an adjustment for any taxes, assessments, or fees that the MCOs are required to payout of the capitation rates."[6]

(6) Plaintiffs implemented ASOP 49. On May 1, 2015, Texas issued Rev. 2.14 of its Uniform Managed Care Terms & Conditions.[7] Section 10.19 provides that "[i]n order to satisfy the requirement for actuarial soundness set forth in 42 C.F.R. § 438.6(c) with respect to amounts paid by HHSC under this Agreement, the parties agree that HHSC will make a retroactive adjustment to capitation to the MCO for the full amount of the HIP Fee allocable to this Agreement . . . ." Pls.' App. 577–78. Revision 2.14 was "approved" by the federal government. Pls.' App. at 513–14.[8]

(7) In September 2015, Defendants released their 2016 Medicaid Managed Care Rate Development Guide addressing, in part, the HIPF. Significantly, this Guide points to ASOP 49 as controlling law, to wit:

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[5] Pls.' App. 85, 101, 112, 993–96, 1104, 1149–52; U.S. DEP'T OF HEALTH AND HUMAN SERVS., CTRS. FOR MEDICARE & MEDICAID SERVS., MEDICAID AND CHIP FAQS: HEALTH INSURANCE PROVIDERS FEE FOR MEDICAID MANAGED CARE PLANS (Oct. 2014).

[6] Pls.' App. 65; ASB, ASOP No. 49 § 3.2.12(d) (Mar. 2015).

[7] The most recent version of the Texas Uniform Managed Care Terms & Conditions is 2.24, effective September 1, 2017, *available at* https://hhs.texas.gov/sites/default/files/documents/services/health/medicaid-chip/programs/contracts/uniform-managed-care-contract.pdf. Version 2.16 is included in Plaintiffs' Appendix at pp. 515–941. All versions subsequent to Rev. 2.14 are amenable for usage by the Court as the changes regarding the HIPF, implemented in Rev. 2.14, have not changed.

[8] This change in the managed care contract is not unique to Texas. All Plaintiffs adjusted their relationships with MCOs to account for the HIPF. *See, e.g.*, Pls.' App. 159, 166 ("Therefore, a [HIPF] adjustment to the capitation rate range to cover the expected cost of the fee is included as part of the capitation rate development"), 421.

> Actuaries are required to follow all Actuarial Standards of Practice; particularly relevant are . . . ASOP 49 (Medicaid Managed Care Capitation Rate Development and Certification). ASOP 49, which will become effective on August 1, 2015, is especially relevant because it focuses on the development of Medicaid managed care rates and the requirements under 42 CFR §438.6.[9]

(8) On November 7, 2016, Defendants again embraced and adopted ASOP 49.[10]

(9) Post-ACA, on multiple occasions, HHS formally amended the delegation to AAA and ASB, originally codified at 42 C.F.R. § 438.6(c)(1)(i)(C) (2002).[11] Four amendments came after ASOP 49. The effect of these amendments ("applications"), as it pertains to the issues here, did nothing to alleviate the application of the HIPF to Plaintiffs. Rather, these changes merely disbursed Plaintiffs' responsibility for the HIPF across multiple regulations. *See* 42 C.F.R. §§ 438.1–.6.

(10) Post-ACA, HHS acted to ensure that Plaintiffs paid the HIPF. Notably, in the May 16, 2016 updates to the regulations, HHS responded to multiple commenters that the updated regulations maintained consistency with

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[9] *See* U.S. DEP'T OF HEALTH AND HUMAN SERVS., CTRS. FOR MEDICARE & MEDICAID SERVS., 2016 MEDICAID MANAGED CARE RATE DEVELOPMENT GUIDE (Sept. 2015), *available at* https://www.medicaid.gov/medicaid/managed-care/downloads/2016-medicaid-rate-guide.pdf.

[10] U.S. DEP'T OF HEALTH AND HUMAN SERVS., CTRS. FOR MEDICARE & MEDICAID SERVS., 2017 MEDICAID MANAGED CARE RATE DEVELOPMENT GUIDE (Nov. 7, 2016), *available at* https://www.medicaid.gov/medicaid/managed-care/downloads/guidance/rate-development-guide-training.pdf.

[11] *See* Medicaid Program; Payment Adjustment for Provider-Preventable Conditions Including Health Care-Acquired Conditions, 76 Fed. Reg. 32816, 32837 (June 6, 2011); Medicare and Medicaid Program; Regulatory Provisions to Promote Program Efficiency, Transparency, and Burden Reduction, 77 Fed. Reg. 29002, 29028 (May 16, 2012); Medicaid Program; Payments for Services Furnished by Certain Primary Care Physicians and Charges for Vaccine Administration Under the Vaccines for Children Program, 77 Fed. Reg. 66670, 66699 (Nov. 6, 2012); Medicaid and Children's Health Insurance Programs; Mental Health Parity and Addiction Equity Act of 2008; the Application of Mental Health Parity Requirements to Coverage Offered by Medicaid Managed Care Organizations, the Children's Health Insurance Program (CHIP), and Alternative Benefit Plans, 81 Fed. Reg. 18390, 18436 (Mar. 30, 2016); Medicaid and Children's Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, and Revisions Related to Third Party Liability, 81 Fed. Reg. 27498, 27853 (May 16, 2016); Medicaid and Children's Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, and Revisions Related to Third Party Liability; Corrections, 82 Fed. Reg. 37, 39 (Jan. 3, 2017); Medicaid Program; The Use of New or Increased Pass-Through Payments in Medicaid Managed Care Delivery Systems, 82 Fed. Reg. 5415, 5428 (Jan. 18, 2017).

ASOP 49.[12] Additionally, applying the HIPF, HHS is consistent with ASOP 49 that the HIPF is a non-negotiable addition to Plaintiffs' capitation rates:

> Comment: Several commenters requested that CMS clarify that the Health Insurance Provider Fee established by section 9010 of the Affordable Care Act would be included in this definition and to address the non-deductibility of that fee. Commenters recommended that the final rule specify that these components should be included in rates in a timely manner to when Medicaid managed care plans incur these costs.
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> Response: The Health Insurance Providers Fee established by section 9010 of the Affordable Care Act is a regulatory fee that should be accounted for in the non-benefit component of the capitation rate as provided at § 438.5(e). Our previous guidance on the Health Insurer Fee issued in October 2014 acknowledged that the non-deductibility of the fee may be taken into account when developing the non-benefit component of the capitation rate. See http://www.medicaid.gov/Federal-Policy-Guidance/Downloads/FAQ-10-06-2014.pdf. That guidance also explained that the state could take the Health Insurer Providers Fee into account during the data or fee year. We decline to set forth explicit rules for the Health Insurance Providers Fee in this regulation as the existing guidance remains available.

Id. at 27576.

Before the ACA and ASOP 49, the "actuarially sound" requirement of federal law, 42 U.S.C. § 1396b(m)(2)(A), did not create a *mandatory* adjustment for any such "contract factor" or "anticipated experience factor."[13] Now, the "actuarially sound" requirement, which HHS chooses to maintain delegated to ASB for all circumstances, is *applied* to Plaintiffs to mandate that the HIPF be accounted for with an "adjustment." The "actuarially sound" requirement, once grounded in actuarial discretion, is now a federal mandate. Until ASOP 49, there was no requirement that the HIPF, or any tax, in its entirety, *must* be added as an "adjustment" to a contracting State's capitation rate. Now, Defendants have multiple "agency statement[s]" (5 U.S.C. § 551(4)) regarding not only the maintenance of its delegation to ASB, but the mandatory nature of the HIPF as it pertains to Plaintiffs. This is

[12] Medicaid Managed Care, CHIP Delivered in Managed Care, and Revisions Related to Third Party Liability, 81 Fed. Reg. 27498, 27537, 27564–65, 27569, 27571–74, 27596. (May 16, 2016).

[13] *See* ASB, ASOP No. 1 § 5.5 (1990), *available at* http://www.actuarialstandardsboard.org/wp-content/uploads/2014/07/asop001_020.pdf.

clearly a new *application* of the "actuarial soundness" standard to Plaintiffs.

In *Texas v. United States*, the Fifth Circuit recognized that "administrative rules and regulations are capable of *continuing application*." 749 F.2d 1144, 1146 (5th Cir. 1985) (quotation omitted) (emphasis added). In *Texas*, the federal government "cited no case indicating that such a restrictive standard applies to judicial review of an agency rule when later sought to be applied to a particular situation. Indeed, the cases suggest the opposite, especially when the contention is that the rule lacks statutory authorization." *Id*. at 1146 (citations omitted). "When an agency applies a previously adopted rule in a particular case, the [statute of limitations] does not bar later judicial review of the substantial statutory authority for their enactment or of their applicability to a particular situation." *Id*. (citation omitted).

Here, Plaintiffs seek "judicial review of an agency rule when *later* sought to be applied to a particular situation." *Id*. (emphasis added). Defendants acted and applied regulations, and ASOP 49, to ensure that Plaintiffs pay the HIPF. Defendants say they "merely clarified" things, ECF No. 64 at 41, but each "clairifi[cation]" is nonetheless a new application that triggers a new statute of limitations.

III. THE SUPREME COURT'S RULING IN *HAWKES* CONTROLS WHETHER THERE IS FINAL AGENCY ACTION.

Dunn-McCampbell recognizes four factors regarding final agency action, though *Hawkes* notes only two. *Hawkes* did not change the law, as the Supreme Court clarified its two-part test just two months before *Dunn-McCampbell*.[14]

> As a general matter, two conditions must be satisfied for agency action to be "final": First, the action must mark the 'consummation' of the agency's decisionmaking process, *Chi. & S. Air Lines, Inc. v. Waterman S.S. Corp.*, 333 U.S. 103, 113 (1948)—it must not be of a merely tentative or interlocutory nature. And second, the action must be one by which "rights or obligations have been determined," or from which "legal consequences will flow," *Port of Bos. Marine Terminal Ass'n v.*

[14] As the Court may recall, unlike today, the prevalence of Westlaw and instant access to every new Supreme Court opinion was hardly mainstream in 1997. This may explain why the *Dunn-McCampbell* opinion maintained fidelity to *Abbott Labs.* and makes no mention of *Bennett*.

Rederiaktiebolaget Transatlantic, 400 U.S. 62, 71 (1970).

Bennett v. Spear, 520 U.S. 154, 177–78 (1997). *Hawkes* reaffirmed this two-part test.

There is no argument or dispute regarding the consummation of the agency's decisionmaking process. Thus, whether actionable final agency action exists turns on whether the agency actions at issue create "legal consequences." The Fifth Circuit has acknowledged the importance of *Hawkes*. *See, e.g.*, *La. State v. U.S. Army Corps of Eng'rs*, 834 F.3d 574, 581 (5th Cir. 2016). And the Fifth Circuit recently remanded another case to reconsider a final agency action question in light of *Hawkes*. *See Texas v. EEOC*, 827 F.3d 372, 376 (5th Cir. 2016) (*EEOC I*), *reh'g en banc granted, opinion withdrawn*, 838 F.3d 511 (5th Cir. 2016) (*EEOC II*).

Defendants' actions, collectively and individually, produce "legal consequences" as Plaintiffs are objects of those actions. "Whether someone is in fact an object of a regulation is a flexible inquiry rooted in common sense." *Contender Farms LLP v. U.S. Dep't of Agric.*, 779 F.3d 258, 265 (5th Cir. 2015). Moreover, it takes little agency action to produce a "legal consequence." In *Hawkes*, the Supreme Court discussed *Frozen Food Express v. United States*, 351 U.S. 40 (1956). *Frozen Food* "considered the finality of an order specifying which commodities the [ICC] *believed* were exempt by statute from regulation, and which it believed were not." *Hawkes*, 136 S. Ct. at 1815 (emphasis added). Though the order "'had no authority except to give notice of how the Commission interpreted' the relevant statute, and 'would have effect only if and when a particular action was brought against a particular carrier,' we held that the order was nonetheless immediately reviewable." *Id*. (quoting *Frozen Food*, 351 U.S. at 44–45). Thus, the ICC's order "'warns every carrier, who does not have authority from the Commission to transport those commodities, that it does so at the risk of incurring criminal penalties.'" *Id*. (quoting *Frozen Food*, 351 U.S. at 44). "So too here, while no administrative or criminal proceeding can be brought for failure to conform to the approved [jurisdictional

determination] itself, that final agency determination not only deprives respondents of a five-year safe harbor from liability under the Act, but *warns* that if they discharge pollutants onto their property without obtaining a permit from the Corps, they do so at the risk of significant criminal and civil penalties." *Id.* (emphasis added).

This analysis is apt to this case. The question for this Court is whether Defendants produced "legal consequences" to Plaintiffs within six years of filing suit. They did. Looking at Defendants' post-ACA actions applying the HIPF to Plaintiffs, *supra*, each action is, at the very minimum, an expression of what Defendants *believed*. For example, the numerous comments and responses published in 2016 regarding ASOP 49 all demonstrate Defendants' *belief* in the virtue of ASOP 49 as a properly controlling authority. In like manner, the FAQ document from October 2014 shows Defendants' belief regarding what is and is not lawful..[15] Since every action by Defendants demonstrates their *belief*, every action is an actionable "legal consequence" within the six-year statute of limitations window.

But Defendants did more than just share their beliefs. They increased Plaintiffs' regulatory burden. Plaintiffs are continually assessing and determining the impact of the HIPF, as demonstrated by the expert testimony from each Plaintiff. Plaintiffs also amended their managed care agreements to account for the HIPF, and made efforts to account for the HIPF in their budgets. This was no small task, as Plaintiffs are required to significantly speculate and project the impact of the HIPF for purposes of budgeting. *See, e.g.*, Decl. of Ursula Parks (Pls.' App. 1167–74).

IV. DEFENDANTS' ACTIONS THAT DID NOT GO THROUGH NOTICE AND COMMENT ARE NONETHELESS LEGISLATIVE RULES THAT COMPRISE FINAL AGENCY ACTION AND, THUS, ARE RIPE FOR REVIEW.

As provided by *Hawkes*, final agency action need not be the product of a formal

[15] That expert actuaries of both Plaintiffs and Defendants are aware of this document and citing it within or attaching it to their expert reports as authoritative is also evidence of its power as a legislative rule that did not go through notice and comment. The same is true of other publications of Defendants enumerated in this brief. *See* Pls.' App. 112

rule or enforcement action. Nonetheless, Defendants' non-formal publications meet the standard of a legislative rule, thus making them final agency action.

Agencies must provide notice of proposed rules in the *Federal Register*. 5 U.S.C. §§ 553(b)–(c). The items promulgated by Defendants are rules because: (1) they grant rights while also imposing significant obligations; (2) they amend prior legislative rules or longstanding agency practice; and (3) they bind the agencies and regulated entities. First, agency rules that affect rights and obligations are legislative. *Chrysler Corp. v. Brown*, 441 U.S. 281, 302 (1979). Here, Defendants clearly affect the rights and obligations of Plaintiffs, and contrary to what Congress said.

Second, the Fifth Circuit requires notice and comment for regulatory instruments that conflict with existing rules, *Phillips Petroleum Co. v. Johnson*, 22 F.3d 616 (5th Cir. 1994), add conditions to them, *Davidson v. Glickman*, 169 F.3d 996 (5th Cir. 1999), or depart from established and consistent agency practice, *Shell Offshore Inc. v. Babbitt*, 238 F.3d 622 (5th Cir. 2001). Defendants' regulations never previously incorporated into capitation rates taxes or fees unrelated to Medicaid. Now, Defendants' regulations bilk Plaintiffs' taxpayers for an *unrelated* program.

Third, an agency rule is legislative "if it either appears on its face to be binding, or is applied by the agency in a way that indicates it is binding." *Gen. Elec. Co. v. EPA*, 290 F.3d 377, 383 (D.C. Cir. 2001) (citation omitted). Defendants' various regulatory instruments meet both criteria. From beginning to end, each document fosters compliance with a predetermined end—the application of ASOP 49 to Plaintiffs such that they will be responsible for paying the HIPF.

Respectfully submitted this the 13th day of November 2017,

DEREK SCHMIDT
Attorney General of Kansas

JEFF LANDRY
Attorney General of Louisiana

CURTIS HILL
Attorney General of Indiana

BRAD SCHIMEL
Attorney General of Wisconsin

DOUG PETERSON
Attorney General of Nebraska

KEN PAXTON
Attorney General of Texas

JEFFREY C. MATEER
First Assistant Attorney General

BRANTLEY D. STARR
Deputy First Assistant Attorney General

MICHEL C. TOTH
Special Counsel to the First Assistant Attorney General

ANDREW D. LEONIE
Associate Deputy Attorney General

/s/ Austin R. Nimocks
AUSTIN R. NIMOCKS
Associate Deputy Attorney General
Texas Bar No. 24002695
austin.nimocks@oag.texas.gov

ANGELA V. COLMENERO
Division Chief – General Litigation

THOMAS A. ALBRIGHT
Assistant Attorney General

ANDREW B. STEPHENS
Assistant Attorney General

DAVID J. HACKER
Senior Counsel

Office of Special Litigation
ATTORNEY GENERAL OF TEXAS
P.O. Box 12548, Mail Code 009
Austin, Texas 78711-2548
Tel: 512-936-1414

ATTORNEYS FOR PLAINTIFFS

CERTIFICATE OF SERVICE

I certify that on the 13th day of November, 2017, the foregoing was electronically filed with the Clerk of Court using the CM/ECF system, which will send notification of such filing to all counsel of record.

/s/ Austin R. Nimocks
AUSTIN R. NIMOCKS