In the United States District Court
FOR THE NORTHERN DISTRICT OF TEXAS

TEXAS, WISCONSIN, ALABAMA, ARKANSAS, ARIZONA, FLORIDA, GEORGIA, INDIANA, KANSAS, LOUISIANA, PAUL LEPAGE, *Governor of Maine*, GOVERNOR PHIL BRYANT OF THE STATE OF MISSISSIPPI, MISSOURI, NEBRASKA, NORTH DAKOTA, SOUTH CAROLINA, TENNESSEE, UTAH, WEST VIRGINIA, NEILL HURLEY, *and* JOHN NANTZ,

PLAINTIFFS,

v.

UNITED STATES OF AMERICA, UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, ALEX AZAR, *in his Official Capacity as* SECRETARY OF HEALTH AND HUMAN SERVICES, UNITED STATES DEPARTMENT OF REVENUE, *and* DAVID J. KAUTTER, *in his Official Capacity as Acting* COMMISSIONER OF INTERNAL REVENUE,

DEFENDANTS.

APPENDIX IN SUPPORT OF PLAINTIFF-STATES' AND INDIVIDUAL-PLAINTIFFS' APPLICATION FOR PRELIMINARY INJUNCTION

Exhibit A

IN THE UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF TEXAS
FORT WORTH DIVISION

TEXAS, WISCONSIN, ALABAMA, ARKANSAS, ARIZONA, FLORIDA, GEORGIA, INDIANA, KANSAS, LOUISIANA, PAUL LePAGE, Governor of Maine, MISSISSIPPI, by and through Governor Phil Bryant, MISSOURI, NEBRASKA, NORTH DAKOTA, SOUTH CAROLINA, SOUTH DAKOTA, TENNESSEE, UTAH, WEST VIRGINIA, NEILL HURLEY, and JOHN NANTZ,	§	CIVIL ACTION NO. 4:18-CV-00167-O
Plaintiffs,	§	
v.	§	
UNITED STATES OF AMERICA, UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, ALEX AZAR, in his Official Capacity as SECRETARY OF HEALTH AND HUMAN SERVICES, UNITED STATES INTERNAL REVENUE SERVICE, and DAVID J. KAUTTER, in his Official Capacity as Acting COMMISSIONER OF INTERNAL REVENUE,	§	
Defendants.	§	

DECLARATION OF JOHN NANTZ

I, John Nantz, do hereby declare:

1. I am a citizen of the United States and a resident of Austin, Texas.

2. I am 31 years old.

3. I am single. I have no dependents.

4. I am self-employed, and the founder of a management consulting business. I advise clients on maximizing growth potential, and develop organizational plans and digital strategic plans.

5. I am ineligible for health insurance coverage through an employer, Medicare, Medicaid, or the Children's Health Insurance Program.

6. I am ineligible to receive a subsidy from the federal government to purchase health insurance coverage.

7. I am currently covered under an individual health insurance plan that meets minimum standards mandated by the Affordable Care Act.

8. For the 2018 calendar year, I purchased health insurance from Oscar Insurance based on a recommendation from Stride Health (an individual insurance advisory company). I am enrolled in the Oscar Saver Bronze Plan, an ACA-compliant individual health insurance plan.

9. My monthly premium is $266.56. I must pay a deductible of $6,500.00 annually before my health insurance company begins to pay for covered health care services. As stated on Oscar Insurance's website, "You pay the full price for covered medical services until you spend $6,500.00. After that, Oscar pays the full amount of your covered medical care (in-network only)". The plan also includes a select set of complimentary services including an annual routine physical examination and Doctor on Demand access. The full list of complimentary services can be found at https://www.hioscar.com/benefits/preventive/.

10. I have been enrolled in an ACA-mandated plan since 2014. Before that, I was enrolled in an employer-sponsored plan offered by McKinsey & Company, which offered access to a much wider network of providers. The cost of my current plan is high given the high deductible, limited network of providers and my age and health status. I enrolled in this plan because I was required by the ACA to do so; I do not believe it provides sufficient value to warrant the cost.

11. My plan is an Exclusive Provider Organization (EPO) Plan. I am limited to using the health care providers within the network. The plan provides no out-of-network benefits.

12. I am young and in good health. I have received minimal professional medical care for years with my use of the healthcare system limited almost exclusively to seeing sports therapists and chiropractors which I have paid out-of-pocket or with my HSA. The money that I have paid for ACA-mandated health insurance premiums would have been much better spent on additional contributions to a Health Savings Account and/or basic catastrophic insurance, which would be my preferred insurance option.

13. The ACA has greatly increased my health insurance costs. My preference would be to purchase reasonably-priced insurance coverage that is consumer-driven in accordance with my actuarial risk. I would maintain health insurance coverage through a plan that offers low premiums and a high deductible priced according to my risks and lifestyle choices. This would be available to me in a consumer-driven, competitive insurance market. In this situation, I would contribute to a Health Savings Account, which I would use to pay for my health expenses.

14. The ACA's individual mandate requires me to divert resources from my business endeavors in order to obtain qualifying health insurance coverage, regardless of my own judgment as to whether maintaining such coverage is a worthwhile cost of doing business. The additional costs imposed upon me by the individual mandate place a burden on my business.

15. I value compliance with my legal obligations, and believe that following the law is the right thing to do. The repeal of the associated health insurance tax penalty did not relieve me of the requirement to purchase health insurance. I continue to maintain minimum essential health insurance coverage because I am obligated to comply with the Affordable Care Act's individual mandate, even though doing so is a burden to me.

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

Executed on this 23 day of April, 2018.

John Nantz

JOHN NANTZ

In the United States District Court
FOR THE NORTHERN DISTRICT OF TEXAS

TEXAS, WISCONSIN, ALABAMA, ARKANSAS, ARIZONA, FLORIDA, GEORGIA, INDIANA, KANSAS, LOUISIANA, PAUL LEPAGE, *Governor of Maine*, GOVERNOR PHIL BRYANT OF THE STATE OF MISSISSIPPI, MISSOURI, NEBRASKA, NORTH DAKOTA, SOUTH CAROLINA, TENNESSEE, UTAH, WEST VIRGINIA, NEILL HURLEY, *and* JOHN NANTZ,

PLAINTIFFS,

v.

UNITED STATES OF AMERICA, UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, ALEX AZAR, *in his Official Capacity as* SECRETARY OF HEALTH AND HUMAN SERVICES, UNITED STATES DEPARTMENT OF REVENUE, *and* DAVID J. KAUTTER, *in his Official Capacity as Acting* COMMISSIONER OF INTERNAL REVENUE,

DEFENDANTS.

APPENDIX IN SUPPORT OF PLAINTIFF-STATES' AND INDIVIDUAL-PLAINTIFFS' APPLICATION FOR PRELIMINARY INJUNCTION

Exhibit B

IN THE UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF TEXAS
FORT WORTH DIVISION

TEXAS, WISCONSIN, ALABAMA, ARKANSAS, ARIZONA, FLORIDA, GEORGIA, INDIANA, KANSAS, LOUISIANA, PAUL LePAGE, Governor of Maine, MISSISSIPPI, by and through Governor Phil Bryant, MISSOURI, NEBRASKA, NORTH DAKOTA, SOUTH CAROLINA, SOUTH DAKOTA, TENNESSEE, UTAH, WEST VIRGINIA, NEILL HURLEY, and JOHN NANTZ,	§	CIVIL ACTION NO. 4:18-CV-00167-O
Plaintiffs,	§	
v.	§	
UNITED STATES OF AMERICA, UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, ALEX AZAR, in his Official Capacity as SECRETARY OF HEALTH AND HUMAN SERVICES, UNITED STATES INTERNAL REVENUE SERVICE, and DAVID J. KAUTTER, in his Official Capacity as Acting COMMISSIONER OF INTERNAL REVENUE,	§	
Defendants.		

DECLARATION OF NEILL HURLEY

I, Neill Hurley, do hereby declare:

1. I am a citizen of the United States and a resident of Katy, Texas.

2. I am thirty-nine years old.

3. I am married. I have two dependent children.

4. I am self-employed, and own a consulting business. I am a technology consultant in the parking industry.

5. I am ineligible for health insurance coverage through an employer, Medicare, Medicaid, or the Children's Health Insurance Program.

6. I am ineligible to receive a subsidy from the federal government to purchase health insurance coverage.

7. I am currently covered under a family health insurance plan that meets minimum standards under the Affordable Care Act. This plan also covers my wife and our two children. My health insurance company is Community Health Choice, and we are enrolled in the HMO Bronze Plan.

8. I selected and enrolled in my health insurance plan online through www.healthcare.gov - the health insurance marketplace established by the federal government and managed by the U.S. Centers for Medicare and Medicaid Services.

9. My monthly premium is $1,081.70. I must pay a deductible of $6,000.00 annually for myself and for each covered family member or until our combined family deductible expenses meet the overall family deductible of $12,000.00 annually.

10. I first enrolled in an ACA Gold plan in 2016. I paid a monthly premium of $912.60. I renewed that plan in 2017, even though the monthly premium had increased by 17 percent to $1,071.50. In October of 2017, I received a notice from my health insurance company that my monthly premium for the same plan would increase by 49 percent to $1,594.84 if I elected to renew coverage for 2018. I had to enroll in the Bronze plan, which provides an inferior level of coverage, because I could no longer afford to pay for the Gold plan.

11. I was enrolled in a health insurance plan through my previous employer before the ACA mandated that I obtain coverage. My previous plan was widely accepted by the health care providers in our local area. I only had to pay a low co-pay for physician visits instead of meeting a high deductible before any benefits are provided. My monthly premiums under my previous plan were only $425.00.

12. I was unable to obtain a plan through the federal marketplace that was accepted by all of my and my family's health care providers. I opted to enroll in a plan that was accepted by my children's pediatrician. Our family practice physician, ENT specialist, dermatologist, urgent care facility and urologist do not accept our ACA plan, so we had to find new health care providers that we would not otherwise choose. Our new health care providers are not of the same quality as I and my family had before. Some of our new health care providers have limited the number of appointments available to patients with ACA plans, which delays my ability to timely access health care for me and my family.

13. The ACA prevents me from obtaining care from my preferred health care providers and has greatly increased my health insurance costs. I would purchase reasonably-priced insurance coverage that allowed me to access care locally from my preferred service providers, were I not limited to the plans provided through the federal health insurance marketplace.

14. The ACA's individual mandate requires me to divert resources from my business endeavors in order to obtain qualifying health insurance coverage, regardless of my own judgment as to whether maintaining such coverage is a worthwhile cost of doing business. The additional costs imposed upon me by the individual mandate place a burden on my business.

15. I value compliance with my legal obligations, and believe that following the law is the right thing to do. The repeal of the associated tax penalty did not relieve me of the requirement to purchase health insurance. I continue to maintain minimum essential health insurance coverage because I am obligated to comply with the Affordable Care Act's individual mandate.

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

Executed on this 23 day of April, 2018.

NEILL HURLEY

In the United States District Court
FOR THE NORTHERN DISTRICT OF TEXAS

TEXAS, WISCONSIN, ALABAMA, ARKANSAS, ARIZONA, FLORIDA, GEORGIA, INDIANA, KANSAS, LOUISIANA, PAUL LEPAGE, *Governor of Maine*, GOVERNOR PHIL BRYANT OF THE STATE OF MISSISSIPPI, MISSOURI, NEBRASKA, NORTH DAKOTA, SOUTH CAROLINA, TENNESSEE, UTAH, WEST VIRGINIA, NEILL HURLEY, *and* JOHN NANTZ,

PLAINTIFFS,

v.

UNITED STATES OF AMERICA, UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, ALEX AZAR, *in his Official Capacity as* SECRETARY OF HEALTH AND HUMAN SERVICES, UNITED STATES DEPARTMENT OF REVENUE, *and* DAVID J. KAUTTER, *in his Official Capacity as Acting* COMMISSIONER OF INTERNAL REVENUE,

DEFENDANTS.

APPENDIX IN SUPPORT OF PLAINTIFF-STATES' AND INDIVIDUAL-PLAINTIFFS' APPLICATION FOR PRELIMINARY INJUNCTION

Exhibit C

IN THE UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF TEXAS
FORT WORTH DIVISION

TEXAS, WISCONSIN, ALABAMA, ARKANSAS, ARIZONA, FLORIDA, GEORGIA, INDIANA, KANSAS, LOUISIANA, PAUL LePAGE, Governor of Maine, MISSISSIPPI, by and through Governor Phil Bryant, MISSOURI, NEBRASKA, NORTH DAKOTA, SOUTH CAROLINA, SOUTH DAKOTA, TENNESSEE, UTAH, and WEST VIRGINIA, Plaintiffs,	§	
v.	§	Civil Action No. 4:18-cv-00167-O
UNITED STATES OF AMERICA, UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, ALEX AZAR, in his Official Capacity as SECRETARY OF HEALTH AND HUMAN SERVICES, UNITED STATES INTERNAL REVENUE SERVICE, and DAVID J. KAUTTER, in his Official Capacity as Acting COMMISSIONER OF INTERNAL REVENUE, Defendants.	§	

DECLARATION OF BLAISE DURAN

I, Blaise Duran, am a citizen of the United States, am over the age of eighteen, and am competent to testify. The following statements are true and correct based on my personal knowledge:

1. I am the Manager for Underwriting, Data Analysis and Reporting for the Employees Retirement System of Texas ("ERS"), the agency that provides retirement and other benefit programs for Texas employees, retirees, and their dependents. As the Manager for Underwriting, Data Analysis and Reporting for ERS, my responsibilities include analyzing the financial impact to the Texas Employees Group Benefits Program ("GBP") health benefit plans related to the requirements of the Patient Protection and Affordable Care Act (ACA), including certain actions required by state laws amended by the Texas Legislature in 2011 and 2013 related to ACA requirements. I have personal knowledge of the information set forth herein. To the extent that the information herein is a statement of the financial cost or benefit to the GBP, my personal knowledge is based on information provided by ERS' GBP consulting actuaries and my review of the reasonableness of the assumptions and methodology used by the consulting actuaries to obtain the stated numbers.

2. ERS administers the GBP, which provides coverage for health, life, dental, voluntary accidental death and dismemberment, vision and short and long-term disability. One objective for offering GBP benefits is to enable the state to attract and retain competent and able employees by providing employees and their dependents with life, accident, and health benefit coverages at least equal to those commonly provided in private industry.

3. As of August 31, 2017, GBP health insurance plans cover about one of every 53 Texans.

4. As of August 31, 2017, ERS had 534,101 GBP plan participants.

5. For GBP health plan participants, ERS paid about $3.5 billion in medical and pharmacy claims for self-funded plans and premiums for fully insured plans for fiscal year ("FY") 2017, which ran from September 1, 2016 to August 31, 2017.

6. The GBP health plans have instituted plan design changes and taken additional actions, as set forth below, in connection with the ACA, including certain actions required by state laws amended by the Texas Legislature in 2011 and 2013 related to ACA requirements.

7. The ACA contains a prohibition against lifetime and annual dollar limits for essential health benefits, whether in-network or out-of-network. Prior to the ACA, the GBP contained a $1 million lifetime limit on out-of-network coverage; there was no similar limit on in-network coverage. This limit was removed effective September 1, 2010. As a result of this plan design change, the GBP has paid approximately an additional $0.3 million for FY 2011, $0.3 million for FY 2012, $0.3 million for FY 2013, $0.3 million for FY 2014, $0.3 million for FY 2015, $0.4 million for FY 2016, and $0.4 million for FY 2017. Accordingly, for the seven-year period between FY 2011 and FY 2017, the GBP has paid approximately $2.3 million in costs due to this plan design change.

8. The ACA requires provision of coverage for dependent children up to age 26, whether or not they are married. Prior to the ACA, the GBP provided coverage for eligible unmarried dependent children up to age 25. Coverage was expanded to all eligible dependent children up to age 26 effective September 1, 2011. As a result of this plan design change, the GBP has paid approximately an additional $7.6 million for FY 2012, $11.1 million for FY 2013, $12.0 million for FY 2014, $13.5 million for FY 2015, $18.3 million for FY 2016, and $19.2 million for FY 2017. Accordingly, for the six-year

period between FY 2012 and FY 2017, the GBP has paid approximately $81.7 million in costs due to this plan design change.

9. The ACA requires coverage of certain preventive care services at no cost-share (that is, no co-payment, coinsurance or deductible) to the health plan participant. Effective September 1, 2011, the GBP began providing this coverage at no cost-share. As a result of this plan design change, the GBP has paid approximately an additional $20.3 million for FY 2012, $21.8 million for FY 2013, $23.0 million for FY 2014, $24.6 million for FY 2015, $26.0 million for FY 2016, and $27.2 million for FY 2017. Accordingly, for the six-year period between FY2012 and FY2017, the GBP has paid approximately $142.9 million in costs due to this plan design change.

10. The ACA requires coverage of certain contraceptives for women at no cost share. The GBP began providing this coverage at no cost share on September 1, 2012. As a result of this plan design change, the GBP has paid approximately an additional $8.6 million for FY 2013, $8.3 million for FY 2014, $8.8 million for FY 2015, $9.3 million for FY 2016, and $8 million for FY 2017. Accordingly, for the five-year period between FY2013 and FY2017, the GBP has paid approximately $43 million in costs due to this plan design change.

11. The ACA prohibits health plan coverage waiting periods that exceed 90 days. As a result, Section 1551.1055 of the Texas Insurance Code was amended to provide that eligibility under the GBP health plans begins not later than the 90th day after the date of employment. Effective September 1, 2014, eligible new employees and their eligible dependents are now enrolled effective the first day of the month following the 60th day of employment. Prior to this ACA requirement and related amendment to the state statute,

ERS enrolled employees on the first day of the month after the 90th day of employment. Because administration of the GBP health plans provides for coverage to begin on the first day of the month following an employee's or dependent's first eligibility to participate in the plan, the waiting period was changed to 60 days to ensure compliance with the ACA's 90-day limit. As a result of this plan design change, the GBP has paid approximately an additional $19.3 million for FY 2015, $21.0 million for FY 2016, and $22.8 million for FY 2017. Accordingly, for the three-year period between FY 2015 and FY 2017, the GBP has paid approximately $63.1 million in costs due to this plan design change.

12. The ACA provides for an out-of-pocket maximum on participant cost share for in-network essential health benefits. The GBP implemented an out-of-pocket maximum on in-network medical coverage effective September 1, 2014, and implemented an out-of-pocket maximum on in-network medical and prescription drug coverage effective September 1, 2015. As a result of this plan design change, the GBP has paid approximately an additional $0.1 million for FY 2015, $0.4 million for FY 2016, and $0.4 million for FY 2017. Accordingly, for the three-year period between FY 2015 and FY 2017, the GBP has paid approximately $0.9 million in costs due to this plan design change.

13. Under the ACA, employers are required to offer minimum essential health coverage for all full-time employees and this coverage must be affordable and offer minimum value. A "full-time employee" is defined generally as a person working on average 30 hours per week. The GBP definition of an eligible full-time employee was changed from an employee working 40 hours per week to one working 30 hours per week effective

September 1, 2013. As a result of this plan design change, the GBP has paid approximately an additional $4.2 million for FY 2014, $4.4 million for FY 2015, $4.7 million for FY 2016, and $5.0 million for FY 2017. Accordingly, for the four-year period between FY 2014 and FY 2017, the GBP has paid approximately $18.3 million in costs due to this plan design change.

14. The ACA requires payment of PCOR (Patient-Centered Outcomes Research) Fees for seven years. The PCOR fees apply to plan years ending after October 1, 2012 and before October 1, 2019; i.e., in the case of the GBP, FY 2013 – FY 2019. The GBP paid approximately $0.5 million for FY 2013, $0.8 million for FY 2014, $0.9 million for FY 2015, $0.9 million for FY 2016, and $1.0 million for FY 2017. Accordingly, for the five-year period between FY 2013 and FY 2017, the GBP has paid approximately $4.1 million in costs due to this fee.

15. The ACA established the Transitional Reinsurance Program (TRP) to which health insurers and group health plans were required to contribute. The GBP contributed to this program, which was operational for calendar years 2014 – 2016. The TRP impacted GBP cost across four fiscal years: FY 2014 – FY 2017. The GBP paid approximately $18.5 million for FY 2014, $22.1 million for FY 2015, $14.5 million for FY 2016, and $4.0 million for FY 2017. Accordingly, for the four-year period between FY 2014 and FY 2017, the GBP has paid approximately $59.1 million in costs due to this program.

16. Beginning with calendar year (CY) 2014, the ACA requires payment of an annual fee by health insurance providers. The amount payable is the insurer's proportionate share of the aggregate fee for that year as statutorily defined. Certain of the GBP's fully insured health plans are subject to this fee, which can be passed through to the GBP as part of the

plans' premiums. There are moratoriums on these fees for CY 2017 and CY 2019. Thus far, these fees have impacted GBP cost across four fiscal years: FY 2014 – FY 2017. The GBP paid fees of approximately $8.9 million for FY 2014, $19.3 million for FY 2015, $22.1 million for FY 2016, and $7.5 million for FY 2017. Accordingly, for the four-year period between FY 2014 and FY 2017, the GBP has paid approximately $57.8 million due to this fee. Unless the there is a change to the requirement, ERS will continue to comply as required.

17. Although participation was not required, the GBP participated in the ACA's Early Retiree Reinsurance Program (ERRP), receiving reimbursement of certain benefit payments for coverage of its early retirees during FY 2010 and FY 2011. The GBP received reimbursements of approximately $30.2 million in FY 2011 and $40.7 million in FY 2012. Accordingly, in the two-year period FY 2011 and FY2012, the GBP received approximately $70.9 million due to this program.

18. The ACA established the Coverage Gap Discount Program (CGDP) under Medicare Part D which commenced January 1, 2011. The CGDP provides manufacturer discounts to beneficiaries in connection with prescription drug expenditures in the Part D coverage gap. The GBP provided prescription drug coverage to Medicare-eligible participants under HealthSelect until January 1, 2013, at which time such coverage was transferred to HealthSelect Medicare Rx, a self-funded Employer Group Waiver Plan under Medicare Part D. Since HealthSelect Medicare Rx participants only pay the plan copay for prescription drugs that would otherwise fall in the coverage gap, the GBP is eligible to receive the manufacturer discounts in order to offset a portion of the cost of HealthSelect Medicare Rx. The GBP received discounts in connection with prescription drugs

dispensed of approximately $15.4 million in FY 2013, $39.7 million in FY 2014, $27.7 million in FY 2015, $48.2 million in FY 2016, and $40.0 million in FY 2017. Accordingly, in the five-year period between FY 2013 and FY 2017, the GBP has received approximately $171.0 million due to this program.

19. Compliance with the ACA has imposed costs on the GBP approximating $0.3 million in FY 2011, $28.2 million for FY 2012, $42.3 million for FY 2013, $76.0 million for FY 2014, $113.3 million for FY 2015, $117.6 million for FY 2016, and $95.5 million for FY 2017. Participation in the ERRP and CGDP by the GBP has resulted for payments to the GBP approximating $30.2 million for FY 2011, $40.7 million for FY 2012, $15.4 million for FY 2013, $39.7 million for FY 2014, $27.7 million for FY 2015, $48.2 million for FY 2016, and $40.0 million for FY 2017. Accordingly, for the seven-year period between FY 2011 and FY 2017, the GBP has incurred approximately $473.2 million in costs and received approximately $241.9 million in connection with its ACA compliance.

20. The GBP has made administrative process changes in connection with its ACA compliance, such as those related to the provision of Form 1095-B's to plan participants and the Internal Revenue Service.

21. The ACA also required ERS to reduce the maximum annual contribution to the GBP flexible spending account from $5,000 to $2,500 effective September 1, 2013; i.e., for FY 2014. While this requirement does not impact GBP cost, it generates additional cost to employers due to the additional social security taxes they will pay as a result of reduced annual pre-tax contributions that employees can make to flexible spending accounts.

22. ERS' process for making a plan design or benefit change to the GBP health plans varies depending on the scope and impact of the change. Plan design and benefit changes and

changes to eligibility requirements require review by ERS staff in order to determine impact to rates, financial status of the GBP, and operations. Additionally changes may require legislative action, approval by the ERS Board of Trustees, action by the third party administrator, system changes by ERS and/or system changes by the third party administrator.

23. So long as the ACA continues to apply to coverages authorized and funded under the GBP, then ERS won't be able to make changes to the plan design that would cause the GBP to discontinue paying claims or costs as addressed in paragraphs 7, 8, 9, 10, 11, 12, 13 and 14.

DECLARATION UNDER PENALTY OF PERJURY

24. I, Blaise Duran, a citizen of the United States and a resident of Texas, hereby declare under penalty of perjury pursuant to 28 U.S.C. § 1746 that the foregoing Declaration is true and correct.

Respectfully submitted this 11th day of April, 2018.

Blaise Duran

In the United States District Court
FOR THE NORTHERN DISTRICT OF TEXAS

TEXAS, WISCONSIN, ALABAMA, ARKANSAS, ARIZONA, FLORIDA, GEORGIA, INDIANA, KANSAS, LOUISIANA, PAUL LEPAGE, *Governor of Maine*, GOVERNOR PHIL BRYANT OF THE STATE OF MISSISSIPPI, MISSOURI, NEBRASKA, NORTH DAKOTA, SOUTH CAROLINA, TENNESSEE, UTAH, WEST VIRGINIA, NEILL HURLEY, *and* JOHN NANTZ,

PLAINTIFFS,

v.

UNITED STATES OF AMERICA, UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, ALEX AZAR, *in his Official Capacity as* SECRETARY OF HEALTH AND HUMAN SERVICES, UNITED STATES DEPARTMENT OF REVENUE, *and* DAVID J. KAUTTER, *in his Official Capacity as Acting* COMMISSIONER OF INTERNAL REVENUE,

DEFENDANTS.

APPENDIX IN SUPPORT OF PLAINTIFF-STATES' AND INDIVIDUAL-PLAINTIFFS' APPLICATION FOR PRELIMINARY INJUNCTION

Exhibit D

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF TEXAS
FORT WORTH DIVISION

TEXAS,	§	
WISCONSIN,	§	
ALABAMA,	§	
ARKANSAS,	§	
ARIZONA,	§	
FLORIDA,	§	
GEORGIA,	§	
INDIANA,	§	
KANSAS,	§	
LOUISIANA	§	
PAUL LePAGE, Governor of	§	
Maine,	§	
MISSISSIPPI, by and through	§	
Governor Phil Bryant,	§	
MISSOURI,	§	
NEBRASKA,	§	
NORTH DAKOTA,	§	
SOUTH CAROLINA,	§	
SOUTH DAKOTA,	§	
TENNESSEE,	§	
UTAH, and	§	
WEST VIRGINIA,	§	
Plaintiffs,	§	
v.	§	Civil Action No. 4:18-cv-00167-O
	§	
UNITED STATES OF AMERICA,	§	
UNITED STATES DEPARTMENT	§	
OF HEALTH AND HUMAN	§	
SERVICES, ALEX AZAR, in his	§	
Official Capacity as SECRETARY	§	
OF HEALTH AND HUMAN	§	
SERVICES, UNITED STATES	§	
INTERNAL REVENUE SERVICE,	§	
And DAVID J. KAUTTER,	§	
In his Official Capacity as Acting	§	
COMMISSIONER OF INTERNAL	§	
REVENUE,	§	
	§	
Defendants.	§	

DECLARATION OF MICHAEL GHASEMI

My name is Michael Ghasemi and I am over the age of 18 and fully competent to make this declaration and state the following:

1. I am the Director of the Forecasting department within Financial Services for the Texas Health and Human Services Commission (HHSC). In my role as Forecasting Director, I oversee the Forecasting team and all data/reporting that we provide internally and externally. We provide HHSC client services program caseload and cost projections as well as historical data for continual budget monitoring purposes, client services appropriations requests, and many other related ad hoc or reporting purposes.
2. Effective January 1, 2014, the ACA created two additional "mandatory" populations for Medicaid programs. One of the populations is former foster care children. These are individuals under age 26 who aged out of foster care in the state and who were enrolled in federally-funded Medicaid when they aged out of foster care. Prior to the ACA, HHSC provided Medicaid to the majority of former foster care children up to age 21. The second population is children ages 6 to 18 up to and including 133 percent of the FPL. These children were eligible for the Children's Health Insurance Program (CHIP) prior to the ACA. Prior to the ACA, Medicaid required states to provide coverage for children through age 5 up to 133% of FPL and 100% of the FPL for children ages 6 to 18.

3. The ACA restricted HHSC to considering only a sole factor to determine eligibility for populations other than those who have a disability or who are elderly: Modified Adjusted Gross Income (MAGI). 42 U.S.C. § 1396a(e)(14). The tax filing rules are now the only permissible consideration used to determine income and household composition for purposes of Medicaid eligibility for those populations. Other income, such as child support and disability payments, cannot be considered. Additionally, HHSC can no longer consider deductions to income, such as dependent care or a work-related expense, when determining eligibility. HHSC also cannot consider assets such as a vehicle when evaluating eligibility for Medicaid.
4. Prior to the ACA, HHSC's policy was to allow children 6 months of continuous Medicaid coverage regardless of family income changes. Pursuant to the ACA, eligibility redeterminations for Medicaid and CHIP are now allowed no more frequently than one per 12 months, unless the enrollee volunteers to HHSC, or HHSC receives a report, that there is a change that affects eligibility. HHSC conducts periodic income checks during the 12-month certification period. For children, the periodic income check cannot impact the child's eligibility prior to the end of the continuous eligibility period (first six months). The second six months of the child's certification period has non-continuous eligibility, and income information can affect eligibility. For parents and caretaker relatives, the entire certification period for Medicaid has non-continuous eligibility, and changes in income can affect eligibility.

5. Texas's Medicaid caseload (the number of individuals enrolled in the Medicaid eligibility groups) increased from 3.01 million average monthly in State Fiscal Year (SFY) 2009 to 4.07 million average monthly in SFY 2017 (figures are rounded).
6. After the implementation of the ACA, there were increases in the Texas Medicaid caseload due to the 12-month recertification with a periodic income check for children and adults, use of MAGI (rather than income with potential disregards), and former foster care youth population, as well as increases likely due to increased focus and outreach resulting from the ACA. The overall Medicaid caseload rose above 4 million clients by September of 2014, an increase of 9.6 percent over September 2013. The following table provides estimates for ACA-related caseload additions to Medicaid, based on March 2016 forecast data:

7.

ACA-Related Caseload Additions to Medicaid - March 2016 Estimates[1]

ACA-Related Caseload Additions to Medicaid	FY 2014	FY 2015	FY 2016	FY 2017
12-Month Recertification	7,349	96,806	97,040	97,928
MAGI Changes/Eligible, Newly Enrolled	45,796	113,007	116,151	119,298
Foster Care to Age 26	562	1,722	1,816	1,846
CHIP to Medicaid (not "New" clients)	46,890	228,002	247,261	253,927
Total	**100,598**	**439,536**	**462,269**	**472,999**

8. Pursuant to 28 U.S.C. § 1746, I declare under penalty of perjury that the foregoing is true and correct.

Respectfully submitted this the 13th day of April, 2018.

Michael Ghasemi
Director of Forecasting
Texas Health and Human Services Commission

[1] All numbers are Average Monthly Recipient Months by SFY (annualized). These changes are now assumed to be in the Medicaid caseload. As such, distribution of "type" of addition to the caseload is estimated for the step-ups due to MAGI changes, 12-month recertification, and newly-enrolled clients as there is no unique identifier for impacts due to these changes. Underlying caseload data and trends are assumed as a basis for the estimates.

In the United States District Court
FOR THE NORTHERN DISTRICT OF TEXAS

TEXAS, WISCONSIN, ALABAMA, ARKANSAS, ARIZONA, FLORIDA, GEORGIA, INDIANA, KANSAS, LOUISIANA, PAUL LEPAGE, *Governor of Maine*, GOVERNOR PHIL BRYANT OF THE STATE OF MISSISSIPPI, MISSOURI, NEBRASKA, NORTH DAKOTA, SOUTH CAROLINA, TENNESSEE, UTAH, WEST VIRGINIA, NEILL HURLEY, *and* JOHN NANTZ,

PLAINTIFFS,

v.

UNITED STATES OF AMERICA, UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, ALEX AZAR, *in his Official Capacity as* SECRETARY OF HEALTH AND HUMAN SERVICES, UNITED STATES DEPARTMENT OF REVENUE, *and* DAVID J. KAUTTER, *in his Official Capacity as Acting* COMMISSIONER OF INTERNAL REVENUE,

DEFENDANTS.

APPENDIX IN SUPPORT OF PLAINTIFF-STATES' AND INDIVIDUAL-PLAINTIFFS' APPLICATION FOR PRELIMINARY INJUNCTION

Exhibit E

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF TEXAS
FORT WORTH DIVISION

TEXAS,	§	
WISCONSIN,	§	
ALABAMA,	§	
ARKANSAS,	§	
ARIZONA,	§	
FLORIDA,	§	
GEORGIA,	§	
INDIANA,	§	
KANSAS,	§	
LOUISIANA	§	
PAUL LePAGE, Governor of Maine,	§	
MISSISSIPPI, by and through Governor Phil Bryant,	§	
MISSOURI,	§	
NEBRASKA,	§	
NORTH DAKOTA,	§	
SOUTH CAROLINA,	§	
SOUTH DAKOTA,	§	
TENNESSEE,	§	
UTAH, and	§	
WEST VIRGINIA,	§	
Plaintiffs,	§	
v.	§	Civil Action No. 4:18-cv-00167-O
	§	
UNITED STATES OF AMERICA,	§	
UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, ALEX AZAR, in his Official Capacity as SECRETARY OF HEALTH AND HUMAN SERVICES, UNITED STATES INTERNAL REVENUE SERVICE, And DAVID J. KAUTTER, In his Official Capacity as Acting COMMISSIONER OF INTERNAL REVENUE,	§	
Defendants.	§	

DECLARATION OF STEPHANIE MUTH

My name is Stephanie Muth and I am over the age of 18 and fully competent to make this declaration and state the following:

1. I am the State Medicaid Director for the Texas Health and Human Services Commission (HHSC). In my role as the State Medicaid Director, I oversee Medicaid and Children's Health Insurance Program (CHIP) services across Texas.
2. Medicaid is funded by both the state and federal governments. The federal share of Medicaid funds Texas receives is based on the Federal Medical Assistance Percentage (FMAP). The FMAP is calculated annually using each state's per capita personal income in relation to the U.S. average. The Federal Fiscal Year 2018 FMAP for Texas is 56.88%, meaning the federal/state share of Medicaid funding is 56.88%/43.12% for most client services.
3. Medicaid cost is determined by the caseload—the volume or number of individuals served in each Medicaid eligibility group—and cost per client—a function of the number, type, and cost of the services a client receives, and how those services are provided.
4. The Affordable Care Act (ACA) mandates certain Medicaid benefits Texas is required to cover. Rather than allowing HHSC to make such determinations based on the needs of Texas's population, the ACA imposed a rule upon Texas that mandated reinstating birthing centers as a Medicaid provider, providing Medicaid reimbursement to providers recognized by states as licensed birth

attendants, recognizing licensed midwives as a provider type, and implementing comprehensive tobacco cessation services for pregnant women.

5. The ACA requires all Medicaid providers to revalidate their enrollment information every three to five years. 42 C.F.R. § 455.414. All durable medical equipment providers are required to revalidate enrollment information at least once every three years. All other provider types must revalidate their enrollment information at least once every five years. The ACA also requires states to collect an application fee as a condition for newly enrolling or re-enrolling institutional providers. 42 C.F.R. § 455.460.

6. As part of HHSC's implementation of the ACA's requirements, HHSC contracted with the Texas Medicaid & Healthcare Partnership (TMHP) to implement two initiatives related to the provider revalidation required by the ACA. One initiative was the ACA Provider Re-Enrollment Operations Support initiative, for which HHSC paid TMHP $17,107,072 ($12,632,677 in federal funds and $4,474,395 in state general revenue) for TMHP's work performed on this initiative from August 1, 2014 through July 31, 2017. This initiative required TMHP to perform various tasks—such as developing an enrollment application, educating the provider community about the need to re-enroll, and answering providers' questions about how to complete the application—in support of the provider revalidation required by the ACA. The second initiative was the ACA Provider Re-enrollment Quick Hits initiative in 2014-2015, for which HHSC paid TMHP $2,084,215 ($1,829,444 in federal funds and $254,771

in state general revenue). This initiative required TMHP to make several enhancements to the then-existing provider enrollment technology to support the ACA provider enrollment regulations.

7. HHSC's Medicaid operations staff spent significant amounts of time working on ACA-related issues, including the ACA provider re-enrollment. Medicaid operations had two staff members (a Project Manager and a Business Analyst) assigned full time to ACA-related work for two years. Medicaid operations also had another Program Manager and the Director working on ACA-related issues. The estimated cost to HHSC for these employees' work on the ACA was $387,082 over a two-year time period.

8. Beginning in January 2014, HHSC was required by the ACA to pay an annual excise tax to the federal government known as the Health Insurer Tax. The tax is based on the amount of health insurance premiums collected. HIT will continue to increase with premium growth. In SFY 2017, HHSC paid $112,044,306.98 in general revenue for Medicaid and $1,078,737.40 in general revenue for CHIP for the Health Insurer Tax, for a total of $113,123,044.38 in general revenue for the Health Insurer Tax.

9. Pursuant to 28 U.S.C. § 1746, I declare under penalty of perjury that the foregoing is true and correct.

Respectfully submitted this the ____ day of April, 2018.

Stephanie Muth
State Medicaid Director
Texas Health and Human Services Commission

In the United States District Court
FOR THE NORTHERN DISTRICT OF TEXAS

TEXAS, WISCONSIN, ALABAMA, ARKANSAS, ARIZONA, FLORIDA, GEORGIA, INDIANA, KANSAS, LOUISIANA, PAUL LEPAGE, *Governor of Maine*, GOVERNOR PHIL BRYANT OF THE STATE OF MISSISSIPPI, MISSOURI, NEBRASKA, NORTH DAKOTA, SOUTH CAROLINA, TENNESSEE, UTAH, WEST VIRGINIA, NEILL HURLEY, *and* JOHN NANTZ,

PLAINTIFFS,

v.

UNITED STATES OF AMERICA, UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, ALEX AZAR, *in his Official Capacity as* SECRETARY OF HEALTH AND HUMAN SERVICES, UNITED STATES DEPARTMENT OF REVENUE, *and* DAVID J. KAUTTER, *in his Official Capacity as Acting* COMMISSIONER OF INTERNAL REVENUE,

DEFENDANTS.

APPENDIX IN SUPPORT OF PLAINTIFF-STATES' AND INDIVIDUAL-PLAINTIFFS' APPLICATION FOR PRELIMINARY INJUNCTION

Exhibit F

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF TEXAS
FORT WORTH DIVISION

TEXAS,	§	
WISCONSIN,	§	
ALABAMA,	§	
ARKANSAS,	§	
ARIZONA,	§	
FLORIDA,	§	
GEORGIA,	§	
INDIANA,	§	
KANSAS,	§	
LOUISIANA	§	
PAUL LePAGE, Governor of Maine,	§	
MISSISSIPPI, by and through Governor Phil Bryant,	§	
MISSOURI,	§	
NEBRASKA,	§	
NORTH DAKOTA,	§	
SOUTH CAROLINA,	§	
SOUTH DAKOTA,	§	
TENNESSEE,	§	
UTAH, and	§	
WEST VIRGINIA,	§	
Plaintiffs,	§	
v.	§	Civil Action No. 4:18-cv-00167-O
	§	
UNITED STATES OF AMERICA, UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, ALEX AZAR, in his Official Capacity as SECRETARY OF HEALTH AND HUMAN SERVICES, UNITED STATES INTERNAL REVENUE SERVICE, And DAVID J. KAUTTER, In his Official Capacity as Acting COMMISSIONER OF INTERNAL REVENUE,	§	
Defendants.	§	

DECLARATION OF WAYNE SALTER

My name is Wayne Salter and I am over the age of 18 and fully competent to make this declaration and state the following:

1. I am the Associate Commissioner for Access and Eligibility Services for the Texas Health and Human Services Commission (HHSC). HHSC Access and Eligibility Services determines eligibility in Texas for Medicaid and the Children's Health Insurance Program (CHIP). As Associate Commissioner for Access and Eligibility Services, I oversee more than 11,000 employees responsible for delivering public assistance programs including Medicaid, Supplemental Nutrition Assistance Program, and Temporary Assistance for Needy Families, disability determination services and community-based programs and services to millions of Texans every year.
2. HHSC administers Medicaid at the state level to residents of Texas. Texas Medicaid serves: (1) low-income families, (2) children, (3) pregnant women, (4) elders, and (5) people with disabilities. The Affordable Care Act (ACA) added an additional category: former foster care youth. These are individuals under age 26 who aged out of foster care in the state and who were enrolled in federally-funded Medicaid when they aged out of foster care. 42 U.S.C.A. § 1396a(a)(10)(A)(i)(IX) (West); Affordable Care Act, Pub L 111448, 124 Stat. 865, § 2004. Were the ACA repealed, HHSC would still be required to provide Medicaid to former foster care youth up to age 21.

3. Financial eligibility for Medicaid and many other social programs is based on a family's income level as compared to Federal Poverty Level (FPL). The FPL is intended to identify the minimum amount of income a family would need to meet very basic family needs.
4. Prior to the passage of the ACA, HHSC used these factors to determine eligibility for Medicaid: (1) family income, (2) age, (3) assets, (4) other factors such as being a child, parent, or caretaker relative, a pregnant woman, or an elderly or disabled individual. HHSC reviewed eligibility criteria for Medicaid enrollees every 6 months allowing for a quick determination should anyone become ineligible for Medicaid due to no longer meeting Medicaid eligibility criteria such as household income increasing above the FPL.
5. Effective January 1, 2014, the ACA expanded Medicaid to the following populations:
    - As noted above, one of the populations is former foster care children under age 26, and Texas is required to enroll that population in Medicaid without applying a financial test. Pub. L. 111-148, 124 Stat. 271, § 2002.
    - The second population is children ages 6 to 18 up to and including 133 percent of the FPL (these children were eligible for CHIP prior to the ACA).
6. Prior to the ACA, Medicaid required states to provide coverage for children through age 5 up to 133% of FPL and 100% of the FPL for children ages 6 to

18. If the ACA were repealed, HHSC could return to using the 100% FPL limit for children ages 6 to 18.

7. The ACA restricted HHSC to considering only a sole factor to determine eligibility for populations other than those who have a disability or who are elderly: Modified Adjusted Gross Income (MAGI). 42 U.S.C. § 1396a(e)(14). The tax filing rules are now the only permissible consideration used to determine income and household composition for purposes of Medicaid eligibility for those populations. Other income, such as child support and disability payments, cannot be considered. Additionally, HHSC can no longer consider deductions to income, such as dependent care or a work-related expense, when determining eligibility. The FPL for each type of Medical assistance program was adjusted to account for the loss of deductions.

8. Under the ACA, HHSC cannot consider assets such as a vehicle or home when evaluating eligibility for Medicaid. HHSC has always exempted the homestead when evaluating eligibility for Medicaid. Were HHSC not subject to operating within the confines of the ACA, it could use pre-ACA income determination methodologies to account for considerations such as assets and alternate income that factor into a household's income status.

9. Prior to the ACA, HHSC's policy was to allow children 6 months of continuous Medicaid coverage regardless of family income changes. Pursuant to the ACA, eligibility redeterminations for Medicaid and CHIP are now allowed no more frequently than one per 12 months, unless the enrollee volunteers to HHSC, or

HHSC receives a report, that there is a change that affects eligibility. HHSC conducts periodic income checks during the 12-month certification period in which electronic income data is pulled and compared against the income currently being counted for the Medicaid recipient. For children, the periodic income check is conducted in months five through eight of the certification period and cannot impact the child's eligibility prior to the end of the continuous eligibility period (first six months). The second six months of the child's certification period has non-continuous eligibility, and income information can affect eligibility. For parents and caretaker relatives, the periodic income check is conducted in months three through eight of the certification period. The entire certification period for Medicaid for parents and caretaker relatives has non-continuous eligibility, and changes in income can affect eligibility. If the ACA were repealed, HHSC could revert back to the six month certification period for Children's Medicaid and Medicaid for Parents and Caretaker Relatives without a statutory change.

10. CHIP provides healthcare coverage for children under age 19 whose family income exceeds the Children's Medicaid income limit but is less than or equal to the applicable income limit for CHIP.[1] To qualify for CHIP, a child must, among other requirements, be uninsured for at least 90 days or claim one of

[1] Defined in Texas Works Handbook, C-131.1, Federal Poverty Income Limits (FPIL).

the good cause exemptions to this 90-day waiting period[2] as defined by Texas state statute. The ACA expanded the reasons for good cause beyond what was in the Texas state statute. The ACA also prohibits states from imposing a waiting period of longer than 90 days. 42 C.F.R. § 457.805(b)(1). Additionally, the ACA imposes strict requirements on HHSC regarding how to provide notice to applicants of eligibility determinations, including the language that must be used and the exact content of the notice. 42 C.F.R. § 457.340(e).

11. Federal rules require HHSC to track individuals determined ineligible for Medicaid or CHIP and transfer the information to the Health Insurance Marketplace for coverage. For children subject to the 90-day CHIP waiting period, HHSC sends their information to the Marketplace during the waiting period, contacts the Marketplace once the waiting period has ended, and enrolls the child in CHIP coverage. 42 C.F.R. §457.340(d)(3). HHSC is also required to determine Medicaid or CHIP eligibility for individuals who applied via the Federal Marketplace but were found potentially eligible for Medicaid or CHIP.

12. Subsidies under the ACA are available to adults starting at 100% FPL.

13. The ACA required changes regarding individuals with a Medicaid-qualifying immigration status. Prior to the ACA, a non-citizen had to provide proof that the individual had a Medicaid-qualifying immigration status before the

[2] The waiting period only applies to children who were covered by a third-party health benefits plan (private health insurance) at any time during the 90 days (3 calendar months) before the date of application for CHIP.

individual could receive Medicaid benefits. The ACA created a new mandate requiring HHSC to allow those individuals to receive Medicaid during a period of "reasonable opportunity" by simply asserting that they are non-citizens with a Medicaid-qualifying immigration status. Pursuant to the ACA, this mere assertion from an individual imposes a duty upon HHSC to provide that individual with Medicaid benefits for 90 days while the individual is given the opportunity to verify his or her immigration status. If the ACA were repealed, HHSC could revert to its pre-ACA policy requiring verification of U.S. citizenship or alien status prior to determining eligibility.

14. The ACA mandates that HHSC initially adopt a Qualified Hospital's preliminary determination of an individual's eligibility for Medicaid. 42 U.S.C. 1396(a)(47). If a Qualified Hospital determines—based upon a household's attestation of income, citizenship or immigration status, and Texas residency—that an individual is Medicaid-eligible, the ACA requires HHSC to provide the individual with Medicaid benefits during a period of "presumptive eligibility" until HHSC determines whether the individual is eligible for Medicaid or for two months, whichever is earlier. This could require HHSC to provide up to two months of Medicaid benefits to individuals that ultimately may not be determined Medicaid-eligible by HHSC. To implement the presumptive eligibility mandate, HHSC built a new website (the Presumptive Eligibility Website) and made updates to the HHSC eligibility determination system (Texas Integrated Eligibility Redesign System, or "TIERS"). Prior to

the implementation of the ACA, HHSC already provided presumptive Medicaid eligibility benefits to pregnant women and women with breast or cervical cancer who were determined presumptively eligible by Qualified Entities. If the ACA were to be repealed, HHSC could stop allowing Qualified Hospitals to determine presumptive eligibility for the following programs without a change in state law: Parent and Caretaker Relative, Pregnant Women, Children under 19, and Former Foster Care.[3]

15. The ACA requires HHSC to send tax form 1095-B out to individuals and the Internal Revenue Service. This requirement that HHSC was not subject to prior to the ACA requires HHSC to incur costs including automation systems, printing, and postage that it would not have otherwise incurred.

16. Pursuant to 28 U.S.C. § 1746, I declare under penalty of perjury that the foregoing is true and correct.

Respectfully submitted this the 13 day of April, 2018.

Wayne Salter
Assoc. Commissioner for Access and Eligibility Services
Texas Health and Human Services Commission

[3] HHSC would still be required by state law to allow Qualified Entities (such as clinics, physicians, etc.) the ability to determine presumptive eligibility for the following programs: Pregnant Women and Breast and Cervical Cancer.

In the United States District Court
FOR THE NORTHERN DISTRICT OF TEXAS

TEXAS, WISCONSIN, ALABAMA, ARKANSAS, ARIZONA, FLORIDA, GEORGIA, INDIANA, KANSAS, LOUISIANA, PAUL LEPAGE, *Governor of Maine*, GOVERNOR PHIL BRYANT OF THE STATE OF MISSISSIPPI, MISSOURI, NEBRASKA, NORTH DAKOTA, SOUTH CAROLINA, TENNESSEE, UTAH, WEST VIRGINIA, NEILL HURLEY, *and* JOHN NANTZ,

PLAINTIFFS,

v.

UNITED STATES OF AMERICA, UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, ALEX AZAR, *in his Official Capacity as* SECRETARY OF HEALTH AND HUMAN SERVICES, UNITED STATES DEPARTMENT OF REVENUE, *and* DAVID J. KAUTTER, *in his Official Capacity as Acting* COMMISSIONER OF INTERNAL REVENUE,

DEFENDANTS.

APPENDIX IN SUPPORT OF PLAINTIFF-STATES' AND INDIVIDUAL-PLAINTIFFS' APPLICATION FOR PRELIMINARY INJUNCTION

Exhibit G

IN THE UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF TEXAS
FORT WORTH DIVISION

TEXAS *et al.*	§	
	§	
Plaintiffs,	§	
	§	
v.	§	Civil Action No. 4:18-cv-00167-O
	§	
UNITED STATES OF AMERICA, *et al.*	§	
	§	
Defendants.	§	

DECLARATION OF JAMIE WALKER, ASSISTANT DEPUTY COMMISSIONER, FINANCIAL REGULATION DIVISION, TEXAS DEPARTMENT OF INSURANCE

Introduction

1. My name is Jamie Walker. I am over eighteen years of age, of sound mind, and am competent to testify to the matters contained in this declaration.

2. I am the Assistant Deputy Commissioner of the Financial Regulation Division at the Texas Department of Insurance (TDI). The Financial Regulation Division is responsible for financial and solvency related issues, including examinations, troubled companies, licensing, withdrawals, managed healthcare networks, and insurance company transactions. As the Assistant Deputy Commissioner, my official duties include managing Financial Regulation staff working on financial and solvency related issues and licensing of insurance market participants.

3. In October 2012, I analyzed the business plans, associated financial information, and merger activity related to entrance into the Texas market. In 2013, I oversaw the development and implementation of the navigator rules authorized under SB 1795, 83rd Legislature, Regular Session (2013).

Market Entrants

4. Insurance companies and health maintenance organizations (HMOs) are required under Insurance Code Chapter 801 to obtain certificates of authority to operate in Texas. The specific requirements for obtaining certificates of authority vary by the type of insurance or plan being offered by a carrier. Insurance Code § 841.101 requires the issuance of certificates of authority for certain domestic insurance companies, which includes health

insurance companies offering coverage affected by the Affordable Care Act, before engaging in the business of insurance, except for the lending of money. Insurance Code § 843.071 prohibits a person from organizing or operating an HMO in Texas without obtaining a certificate of authority. Insurance Code § 982.051 requires the issuance of certificates of authority for certain foreign insurance companies, which includes health insurance companies offering coverage affected by the Affordable Care Act, before engaging in the business of insurance, except for the lending of money.

5. TDI staff has done an analysis of filings made by carriers wanting to enter the individual health market. No carriers added the accident and health line of authority needed to write individual health coverage between January 1, 2009, and March 22, 2018. However, new carriers were issued certificates of authority with the intent of writing individual health coverage. A summary of the number of carriers issued accident and health certificates of authority and writing individual health coverage follows:

Calendar Year	No. of New Health Carriers
2009	-
2010	-
2011	2
2012	-
2013	-
2014	2
2015	2
2016	1
2017	-
2018 (thru 3/22)	-

Market Exits

6. An insurer, which includes health insurance companies, must file with the Commissioner a plan for orderly withdrawal under Insurance Code § 827.003 if the company reduces its total annual premium volume by 50% or more, or reduces its annual premium by 75% or more in a line of insurance in Texas. Insurance Code § 843.051 makes an HMO subject to the withdrawal and restriction plan requirements in Insurance Code Chapter 827.

7. Under Insurance Code § 827.005, the Commissioner must approve a withdrawal plan that adequately provides for meeting the requirements prescribed by Insurance Code § 827.004(3), and the Commissioner may modify restrict, or limit a withdrawal plan as necessary if the Commissioner finds that a line of insurance subject to the withdrawal plan is not offered in a quantity or manner to adequately cover the risks in Texas or to adequately protect Texans if the withdrawal plan were approved as submitted.

8. Generally, the following actions are involved when TDI receives withdrawal plans. TDI staff reviews the withdrawal plans for completeness and points out deficiencies to the filer when necessary. TDI evaluates whether the plan contents demonstrate that the insurer will be able to meet its contractual obligations, provide service to policyholders and claimants in Texas, and meet any other statutory obligations. Once TDI has concluded that the plan demonstrates those elements, TDI then considers whether, if the plan is approved, the line of insurance being withdrawn from will continue to be offered in a quantity and manner to adequately cover Texas risks.

9. TDI staff has done an analysis of withdrawal plan filings made by carriers between January 1, 2009, and March 22, 2018, affecting participation in the individual health line of business. A summary of the number of carriers filing withdrawal plans for the individual health line of business follows:

Calendar Year	No. of Health Withdrawal Filings
2009	-
2010	-
2011	-
2012	-
2013	2
2014	7
2015	2
2016	6
2017	8
2018 (thru 3/22)	-

As of March 22, 2018, there were 10 carriers offering individual health coverage in various Texas regions and one carrier offering coverage statewide.

Activities Involving Navigator Regulation

10. During the 83rd Legislature, Regular Session (2013), the Legislature passed SB 1795, which created Insurance Code Chapter 4154, Navigators for Health Benefit Exchanges. Insurance Code § 4154.001 stated the purpose of the statute as, "[s]ince the State of Texas opted out of implementing a state exchange, pursuant to the Patient Protection and Affordable Care Act as amended by the Health Care and Education Reconciliation Act of 2010, the purpose of this chapter is to provide a state solution to ensure that Texans are able to find and apply for affordable health coverage under any federally run health benefit exchange while helping consumers in this state." Under Insurance Code § 4154.051, the

Commissioner was required to determine whether the standards and qualifications for navigators provided by 42 U.S.C. § 18031 and any regulations enacted under that section were sufficient to ensure that navigators could perform the required duties. If the Commissioner determined that the federal standards were insufficient, the Commissioner was further required to make a good faith effort to work in cooperation with the United States Department of Health and Human Services (HHS) to propose improvement to those standards. If the Commissioner determined that the insufficiencies in the federal standards had not been addressed, the Commissioner was required to establish standards and qualifications by rule to ensure navigators could perform the required duties.

11. The federal regulations enacted under 42 U.S.C. § 18031 were adopted in July 2013. TDI staff evaluated the rules. In August 2013, Texas Attorney General Greg Abbott joined 12 other attorneys general in a letter addressing concerns with the federal regulations. In a September 2013, letter to the Commissioner, Governor Perry also addressed concerns with the standards for navigators set out in federal regulations. TDI sought public comment on the sufficiency of the standards in a stakeholder meeting held on September 30, 2013. TDI conducted additional investigation into the federal standards for navigators in follow-up to the stakeholder meeting by meeting or holding teleconferences with navigator entities, consumer advocates, and representatives of health care provider groups. TDI also conducted multiple conference calls with HHS regarding the federal standards. TDI posted an outline of solutions for potential insufficiencies identified during this process and invited additional public comment on the outline. TDI also held a call with HHS on December 2, 2013, to discuss the outline; HHS indicated that it would not consider revising the regulations to address the issues raised in the outline and confirmed that solutions set out in the outline did not present federal preemption concerns. HHS staff suggested that TDI proceed with its proposal of rules. In the adoption of the final TDI rules, which were effective in February 2014, the Commissioner found that insufficiencies existed in the federal standards in the following areas: applicability of federal regulations to individuals and entities providing navigator services; qualifications of individuals who serve as navigators; education requirements for navigators; privacy requirements; and accountability of navigators. In order to ensure that Texans were protected, TDI required navigators and navigator entities to register with TDI and provide evidence through the registration process that minimum standards were met.

12. SB 1795 also included Insurance Code § 4154.006 which contained an automatic expiration date. The chapter was not extended; therefore, the statute and associated rules adopted by TDI expired on September 1, 2017.

Repeal of Texas Health Insurance Pool Statute

13. The Texas Legislature passed SB 1367, 83rd Legislature, Regular Session (2013) abolishing the Texas Health Insurance Pool. The House Research Organization Bill

Analysis, dated May 15, 2013, provided in part, "[i]n 1997, the 75th Legislature made operational the Texas Health Insurance Pool to sell health insurance policies to individuals unable to get private coverage due to pre-existing health conditions. The pool, as it is known, began offering coverage in 1998, and enrolled more than 23,000 Texans as of April 2013. . . Beginning January 1, 2014, the federal Patient Protection and Affordable Care Act (ACA) will require most individuals either obtain health insurance or pay a tax penalty. Individuals purchasing insurance in a health benefit exchange, an online marketplace of private, government regulated health insurance plans, will not be denied coverage or charged more based on their health status." See Exhibit A, which is a true and correct copy of the House Research Organization Bill Analysis for SB 1367, dated May 15, 2013. In the SB 1367 Senate Research Center Bill Analysis, the Author's/Sponsor's Statement of Intent provided in part, "[c]hanges in federal law have made the Texas Health Insurance Pool (THIP) unnecessary." See Exhibit B, which is a true and correct copy of the Senate Research Center Bill Analysis for SB 1367, dated July 18, 2013.

14. Under Section 2 of the bill, the Commissioner approved the Texas Health Insurance Pool's plan of dissolution under Commissioner's Order No. 2990, dated February 10, 2014. See Exhibit C attached, which is a true and correct copy of Commissioner's Order No. 2990, dated February 10, 2014. The Commissioner acknowledged the completion of the dissolution effective September 1, 2015, by letter dated August 26, 2015. See Exhibit D attached, which is a true and correct copy of the letter discharging the Texas Health Insurance Pool Board of Directors, dated August 26, 2015.

Activity Involving Complaints

15. TDI regulates fully insured individual and group health plans. TDI's Consumer Protection Section (Consumer Protection) receives and resolves complaints. Insurance Code Chapter 521 sets out the requirements for consumer information and complaints at TDI. Insurance Code § 521.002 provides that TDI establish a program to facilitate resolution of policyholder complaints. The program applies to insurers and generally to HMOs. Further, Insurance Code § 521.051 states, in part, that TDI must maintain a toll-free telephone number to receive and aid in resolving complaints against insurers.

16. As part of the process, TDI must provide, through TDI's toll-free telephone number, information related to the number and disposition of justified, verified, and documented as valid complaints received; the rating of an insurer, if any, as published by a nationally recognized rating organization; the kinds of coverage available to a consumer through any insurer writing insurance in this state; an insurer's admitted assets-to-liabilities ratio; and other appropriate information collected and maintained by TDI as found, in part, under Insurance Code § 521.052.

17. TDI regulates the processing and settlement of claims under Insurance Code Chapter 542. Insurance Code § 542.002 provides that Subchapter A of Insurance Code Chapter 542, the Unfair Claim Settlement Practices Act, applies to a life, health, or accident insurance

company, in addition to other types of insurers. Insurance Code § 843.051(a) makes HMOs subject to the Act as well. Insurance Code § 542.005 defines a complaint as any written communication primarily expressing a grievance. Under Insurance Code § 542.008, TDI must establish a system for receiving and processing individual complaints alleging a violation of Subchapter A of Insurance Code Chapter 542.

18. In addition, Insurance Code Chapter 843 provides regulatory authority with respect to HMOs, including who a complainant is, what a complaint is, and when to submit a complaint to TDI. A complaint under Insurance Code § 843.002(6), in part, "means any dissatisfaction expressed orally or in writing by a complainant to a[n] [HMO] regarding any aspect of the [HMO's] operation." Insurance Code § 843.002(5) provides that a complainant is "an enrollee, or a physician, provider, or other person designated to act on behalf of an enrollee, who files a complaint."

19. Insurance Code § 843.282 requires TDI to accept complaints alleging certain violations of Insurance Code Chapter 843 and other laws in the Insurance Code by "[a]ny person, including a person who has attempted to resolve a complaint through [an HMO's] complaint system process and is dissatisfied with the resolution."

20. The following is based on information conveyed to me from Consumer Protection staff. Consumer Protection receives complaints from consumers and providers, such as physicians and hospitals, involving claims for healthcare services. Consumer Protection maintains a database tracking system for complaints. The system uses codes to track the type of health coverage involved in the complaint. Consumer Protection collected data on healthcare complaints for the calendar years 2010 through 2017, showing the number of complaints involving qualified health plans, under the Affordable Care Act (ACA Complaints) as summarized in the following table:

Calendar Year	No. of ACA Complaints
2010	-
2011	-
2012	-
2013	-
2014	824
2015	1,483
2016	2,117
2017	1,107

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

Executed on 24 April 2018.

Jamie Walker
Assistant Deputy Commissioner
Texas Department of Insurance

SUBJECT: Abolishing the Texas Health Insurance Pool

COMMITTEE: Insurance — committee substitute recommended

VOTE: 8 ayes — Smithee, G. Bonnen, Creighton, Morrison, Muñoz, Sheets, Taylor, C. Turner

1 nay — Eiland

SENATE VOTE: On final passage, April 9 — 31-0

WITNESSES: (*On House companion bill, HB 2791:*)
For — (*Registered, but did not testify:* Nora Belcher, Texas e-Health Alliance; Jennifer Cawley, Texas Association of Life and Health Insurers; Marisa Finley, Scott & White Center for Healthcare Policy; David Gonzales, Texas Association of Health Plans; John Hawkins, Texas Hospital Association; Patricia Kolodzey, Texas Medical Association; Katharine Ligon, Center for Public Policy Priorities; Kandice Sanaie, Texas Association of Business)

Against — (*Registered, but did not testify:* Freddy Warner, Memorial Hermann Health System)

On — Steven Browning, Texas Health Insurance Pool; Betty DeLargy, Texas Health Insurance Pool; Gary Stankowski; (*Registered, but did not testify:* Doug Danzeiser, Texas Department of Insurance; Tony Gilman, Texas Health Services Authority)

BACKGROUND: In 1997, the 75th Legislature made operational the Texas Health Insurance Pool to sell health insurance policies to individuals unable to get private coverage due to pre-existing health conditions. The "pool," as it is known, began offering coverage in 1998, and enrolled more than 23,000 Texans as of April 2013.

Insurance Code, sec. 1506.105 prohibits pool premiums from exceeding twice the standard risk rate, which is the average private market rate charged to a healthy individual for the same coverage. In practice, the pool's premiums are set at roughly this amount. In 2011, the pool began

using portions of insurers' late claims payment penalties to fund sliding scale premium reductions for enrollees with incomes below 300 percent of the federal poverty level, or about $34,000 for an individual. As of May 2012, about 3,500 pool enrollees were receiving premium subsidies.

Beginning January 1, 2014, the federal Patient Protection and Affordable Care Act (ACA) will require most individuals either obtain health insurance or pay a tax penalty. Individuals purchasing insurance in a health benefit exchange, an online marketplace of private, government regulated health insurance plans, will not be denied coverage or charged more based on their health status.

DIGEST:

CSSB 1367 would abolish the Texas Health Insurance Pool.

Dissolution. CSSB 1367 would specify that if insurance coverage in Texas' health benefit exchange becomes effective on January 1, 2014, as planned, the Texas Health Insurance Pool would issue policies no later than December 31, 2013, and would terminate its policies' coverage as of January 1.

Should the exchange be delayed, the pool would continue to issue coverage until the exchange was operational, and would terminate its policies when the commissioner of insurance determined the pool's enrollees could be expected to have obtained guaranteed issue coverage.

The bill would require that as soon as practicable, the pool's board of directors develop and submit to the commissioner of insurance for approval a plan for dissolving the board and the pool after the pool's obligations to issue and maintain health benefit coverage were to terminate.

The board's plan would also transfer to the commissioner and the Texas Department of Insurance (TDI) any assets, authority, accumulated rights, and continuing obligations of the board and the pool.

CSSB 1367 would allow the commissioner by rule to delay dissolving the Texas Health Insurance Pool and collecting and distributing its funds if the guaranteed issue of health benefit coverage, such as through the state's health benefit exchange, were delayed, or if the commissioner determined the health benefit coverage expected to be available on a guaranteed issue basis was not reasonably available to individuals eligible for pool

coverage immediately prior to this bill's enactment.

Assets. CSSB 1367 would transfer to TDI any fund or asset of the Texas Health Insurance Pool upon its dissolution and would grant TDI the authority to recover pool overpayments or other amounts, including subrogation amounts, that the pool would have been authorized to recover had it not been dissolved. Any funds collected by TDI during the dissolution process would be deposited in the Texas Treasury Safekeeping Trust Co.

The bill would extend the pool's authority to collect premium assessments on its health benefit plan issuers until the insurance commissioner determined all of the pool's financial obligations had been met. After making this determination, the commissioner either would issue a final assessment or refund any surplus monies not designated for premium assistance on a pro rata or otherwise equitable basis to the health benefit plan issuers.

CSSB 1367 would distribute $5 million from any surplus premium assistance funds to the Texas Health Services Authority (THSA). Remaining monies would support the Healthy Texas program until December 31, 2013, after which they would be used for any commissioner-authorized purpose to improve uninsured Texans' health insurance access. Any funds payable to THSA or the Healthy Texas program would be subject to audit.

Effective date. Effective January 1, 2014, CSSB 1367 would repeal statutes requiring that employers, health benefit plan issuers, HMOs, and others provide notice of potential eligibility for pool coverage to individuals as required by the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). It would also repeal limits on the amount of gross premium receipts that could be paid toward administrative costs and fees.

Effective September 1, 2015, the bill would repeal ch. 1506, Insurance Code, governing the Texas Health Insurance Pool.

This bill would take immediate effect if finally passed by a two-thirds record vote of the membership of each house. Otherwise, it would take effect September 1, 2013.

SUPPORTERS SAY:

CSSB 1367 would dissolve the Texas Health Insurance Pool in an orderly manner after it was no longer needed. It is anticipated that nearly all pool enrollees would purchase coverage in the new health benefit exchange between the start of its open enrollment period, October 1, 2013, and the date its policies became effective, January 1, 2014. The exchange is expected to offer guaranteed issue plans that have more coverage options and increased benefits, such as maternity coverage, and that are more affordable than those available in the pool.

CSSB 1367 would wind down the pool in a responsible manner, allowing the board of directors to customize a plan to dissolve the pool and transferring to TDI any needed authority to collect payments and assets and to meet residual obligations, such as unpaid claims. The three-month period for pool enrollees to purchase insurance in the exchange and avoid a gap in coverage is brief, but the pool has already conducted outreach to notify its members of this likelihood and would continue to do so. Should the exchange not be functional on January 1, the commissioner of insurance would retain the ability to continue coverage of those insured through the pool.

The bill would fairly return any insurer overpayment upon the termination of the pool and would distribute funds collected from previously assessed penalties to improve health care quality and access to care.

OPPONENTS SAY:

CSSB 1367 would not adequately ensure Texas Health Insurance Pool enrollees did not face a gap in their coverage should the Affordable Care Act's health benefit exchanges not be fully functional. The bill would be premature and should not be enacted until there is more certainty about the implementation of the Affordable Care Act's many provisions.

NOTES:

The House companion bill, HB 2791 by Smithee, was left pending in the House Insurance Committee on April 23.

CSSB 1367 differs from the Senate-passed version by more specifically defining the allocation of any remaining premium support funds from the pool.

BILL ANALYSIS

Senate Research Center

S.B. 1367
By: Duncan
State Affairs
7/18/2013
Enrolled

AUTHOR'S / SPONSOR'S STATEMENT OF INTENT

Changes in federal law have made the Texas Health Insurance Pool (THIP) unnecessary. S.B. 1376 requires the THIP board to create a plan of dissolution once THIP enrollees are able to obtain coverage in the private insurance market. The plan of dissolution must be approved by the commissioner of insurance. Once all THIP enrollees have left THIP, the administrative and financial responsibilities of THIP will transfer to the Texas Department of Insurance to complete any obligations tied to THIP. S.B. 1376 contains a provision that allows the commissioner of insurance to adjust timelines and requirements for the dissolution plan in case federal law changes or is amended.

S.B. 1367 amends current law relating to abolishing the Texas Health Insurance Pool.

RULEMAKING AUTHORITY

Rulemaking authority is expressly granted to the commissioner of insurance (commissioner) in SECTION 6 and SECTION 7 of this bill.

SECTION BY SECTION ANALYSIS

SECTION 1. DEFINITIONS. Defines "board," "commissioner," "department," "health benefit exchange," and "pool" in this Act.

SECTION 2. PLAN FOR DISSOLUTION. Requires the board of directors (board) of the Texas Health Insurance Pool (THIP), as soon as practicable after the effective date of this Act, to:

(1) develop a plan for:

(A) dissolving the board and THIP after THIP’s obligations to issue and continue health benefit coverage terminate under Sections 3 and 4 of this Act; and

(B) transferring to the commissioner of insurance (commissioner) and the Texas Department of Insurance (TDI) any continuing obligations of the board and THIP, any assets of THIP, any rights of the board or THIP that accrued before the dissolution of the board or THIP or that accrue with respect to coverage issued by THIP before THIP's dissolution, and any authority previously held by the board the continuation of which is necessary or appropriate; and

(2) submit the plan to the commissioner for the commissioner’s approval.

SECTION 3. ACCEPTANCE OF ENROLLEES. Provides that the latest date on which THIP may issue health benefit coverage is the later of:

(1) December 31, 2013; or

(2) the earliest date on which health benefit coverage is reasonably available on a guaranteed issue basis to each class of individuals eligible for health benefit coverage through THIP immediately before the effective date of this Act, as determined by the commissioner.

SECTION 4. TERMINATION OF POOL COVERAGE. Provides that health benefit coverage that is issued to an individual by THIP and that is otherwise in force terminates on the later of:

(1) January 1, 2014; or

(2) the earliest date on which the individual is enrolled in comparable health benefit coverage or could reasonably be expected to have obtained health benefit coverage on a guaranteed issue basis, as determined by the commissioner.

SECTION 5. EXERCISE OF POOL'S RECOVERY RIGHTS. Authorizes TDI to exercise any authority to recover overpayments or other amounts THIP would have been authorized to recover or collect had THIP not been dissolved, including amounts recoverable under THIP's subrogation rights.

SECTION 6. TRANSFER OF CERTAIN FUNDS; ASSESSMENT AUTHORITY CONTINUED. (a) Requires that any fund in which money belonging to THIP is kept and any other assets of THIP be transferred to TDI on dissolution of THIP. Requires that money and any other money recovered or otherwise collected by TDI under this Act on behalf of THIP be used by TDI to satisfy obligations of THIP in accordance with this Act, Chapter 1506 (Texas Health Insurance Pool), Insurance Code, as that chapter existed before its repeal by this Act, and the dissolution plan.

(b) Provides that the authority of the board to make assessments under Subchapter F (Assessments for Operation of Pool), Chapter 1506, Insurance Code, as that subchapter existed before its repeal by this Act, is continued and may be exercised by the commissioner until the commissioner determines that all financial obligations of the board and THIP have been satisfied.

(c) Requires that money collected by TDI under Subsections (a) and (b) of this section be deposited to an account in the Texas Treasury Safekeeping Trust Company to be used for the purposes described by this Act. Authorizes the money deposited to the account to be used to pay fees for the Texas Treasury Safekeeping Trust Company account. Authorizes TDI to transfer money into the treasury local operating fund to disburse the money as required by this Act.

(d) Requires the commissioner, when the commissioner determines that all financial obligations of the board and THIP have been satisfied, to make a final accounting with respect to THIP finances and:

(1) make any necessary final assessment under this section; or

(2) refund any surplus assessments or other surplus money collected on behalf of THIP, other than money described by Subsection (e) of this section, on a pro rata basis to the health benefit plan issuers that paid the assessments to the extent possible or on another equitable basis to the extent pro rata refunds are not possible.

(e) Requires that the money paid or payable under Section 83.342(m) (relating to setting forth penalty payment under this section) and Section 1301.137(l) (relating to setting forth penalty payment under this section), Insurance Code, if it is no longer necessary to finance premium discounts as prescribed by Section 1506.260 (Funding for Premium Discounts), Insurance Code, be distributed and used as follows:

(1) $5 million is required to be distributed to the corporation established under Chapter 182 (Texas Health Services Authority), Health and Safety Code, to be used for a purpose provided by that chapter; and

(2) any money available after the amount required by Subdivision (1) of this subsection has been distributed in accordance with that subdivision is required to

be distributed to the fund established under Subchapter F (Healthy Texas Small Employer Premium Stabilization Fund), Chapter 1508 (Healthy Texas Program), Insurance Code, to be used:

(A) before January 1, 2014, for a purpose provided by that subchapter; and

(B) on and after January 1, 2014, for any other purpose authorized by the commissioner by rule to improve access to health benefit coverage for individuals without coverage.

(f) Provides that money paid or payable under Section 843.342(m) and Section 1301.137(l), Insurance Code, is subject to audit by the State Auditor's Office.

SECTION 7. DELAYED IMPLEMENTATION. Authorizes the commissioner by rule to delay the implementation of any part of Sections 1-6 of this Act or the THIP dissolution plan established under this Act if:

(1) the guaranteed issue of health benefit coverage is delayed;

(2) the operation of a health benefit exchange in this state is delayed; or

(3) the commissioner determines that health benefit coverage expected to be available on a guaranteed issue basis to a class of individuals eligible for coverage under Chapter 1506, Insurance Code, immediately before the effective date of this Act, is not reasonably available to those individuals in this state.

SECTION 8. REPEALER. (a) Repealers, effective January 1, 2014: Sections 1506.007(a-1) (relating to requiring a health benefit plan issuer, employer, or other person who is required to provide notice to an individual of the individual's ability to continue coverage in accordance with COBRA to also provide notice to the individual of the availability of coverage under THIP at a certain time) and (a-2) (relating to requiring a health benefit plan issuer who is providing coverage to an individual in accordance with COBRA to notify the individual of the availability of coverage under THIP not later than the 45th day before the date that coverage expires), Sections 1506.205(b) (relating to prohibiting the total amount of administrative costs and fees paid in a calendar year to all THIP administrators from exceeding 12.5 percent of the gross premium receipts of THIP for the calendar year) and (c) (relating to authorizing the commissioner to approve payment of a higher amount, not to exceed 15 percent of the gross premium receipts of THIP for the calendar year, under certain conditions), Section 1251.255(b) (relating to requiring an insurer to notify and provide certain information), and Section 1271.305 (Notification of Risk Pool Eligibility), Insurance Code.

(b) Repealer, effective September 1, 2015: Chapter 1506 (Texas Health Insurance Pool), Insurance Code.

SECTION 9. EFFECTIVE DATE. Effective date: upon passage or September 1, 2013.

No. 2990

Official Order
of the
Texas Commissioner of Insurance

Date: FEB 10 2014

Subject Considered:

Texas Health Insurance Pool of Dissolution

The commissioner of insurance considers the Plan of Dissolution submitted by the Board of Directors of the Texas Health Insurance Pool on December 10, 2013, under §2 of SB 1367, Act of June 14, 2013, 83rd Legislature, Regular Session.

FINDINGS OF FACT

1. The Board of Directors of the Texas Health Insurance Pool submitted a Plan of Dissolution to the commissioner for the commissioner's approval on December 10, 2013, under §2 of SB 1367, Act of June 14, 2013, 83rd Legislature, Regular Session.

2. The attached Plan of Dissolution contains the matters required by §2(1) of SB 1367.

CONCLUSIONS OF LAW

1. The commissioner has jurisdiction over this matter under §2 of SB 1367 and Insurance Code §§31.021 and 1506.201.

2. The Plan of Dissolution satisfies the requirements for approval by the commissioner.

ACTION

The commissioner approves the Plan of Dissolution submitted for approval by the Board of Directors of the Texas Health Insurance Pool on December 10, 2013, under §2 of SB 1367, Act of June 14, 2013, 83rd Legislature, Regular Session. The commissioner further directs the Board to submit quarterly dissolution progress reports through its Executive Director to the commissioner by the last day of the month following the end

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of each calendar quarter until the Pool and Board are dissolved. The commissioner reserves the right to issue further instructions and orders regarding the dissolution of the Pool and Board.

Julia Rathgeber
Commissioner of Insurance

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TEXAS
Health Insurance Pool

December 10, 2013

Via Courier Delivery

Ms. Amy Einhorn
Director of Research and Policy Initiatives
Texas Department of Insurance
333 Guadalupe, Tower 1
Austin, TX 78701

Re: Texas Health Insurance Pool Dissolution Plan

Dear Amy:

I have enclosed the Board's formal Plan of Dissolution, for commissioner review and approval, if acceptable. This final version incorporates all of the revisions previously discussed. In addition, we have included some additional clarifying edits, as well as the following more substantive changes: 1) inserted a more specific legal action deadline in Item #5 of the Plan; and 2) inserted a reminder date in the Timeline for the assessment activity in 2016.

Please let me know if the commissioner has any questions about the Plan. Thanks again to you and the others at the Department for the very helpful assistance with this challenging project—I think the final product will be a useful reference for all of us as we move forward.

Sincerely,

Steven Browning
Executive Director

Enclosure

TEXAS
Health Insurance Pool

TEXAS HEALTH INSURANCE POOL

PLAN OF DISSOLUTION

In accordance with Senate Bill 1367 (83R), the Board of Directors of the Texas Health Insurance Pool (the Pool) hereby submits to the Commissioner of Insurance (the Commissioner) a Plan of Dissolution (the Plan). As directed by state law, this Plan provides for: 1) the dissolution of the Board and Pool after the Pool's obligations to issue and continue coverage terminate; and 2) the transfer to the Commissioner and Department of any continuing obligations and assets of the Pool, as well as all rights and authority.

Effective December 1, 2013, the Commissioner adopted Title 28, Texas Administrative Code §3.3615 on an emergency basis, extending the termination date of the Pool until March 31, 2014, in accordance with Senate Bill 1367 (83R). This Plan summarizes the Board's understanding of the Pool's future responsibilities and lists the essential tasks the Pool proposes to complete prior to such dissolution and transfer.

The Pool Board approved the initial Plan on September 24, 2013; revisions to the Plan were approved by the Pool Board on December 4, 2013. By resolution, the Pool Board has designated the Pool Executive Director, Mr. Steven Browning, to act as its representative to implement the Plan, and perform all necessary duties required to dissolve the Pool.

This Plan is submitted to the Texas Commissioner of Insurance for review and approval.

Submitted this 10th day of December, 2013.

Steven Browning, Executive Director
Texas Health Insurance Pool

Exhibits:

I. Timeline of Important Dates
II. S.B. No. 1367 (83R)

1701 Directors Blvd., Suite 120 • Austin, TX 78744 • 512/441-7665 Phone • 512/441-7690 Fax • txhealthpool.org

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TEXAS HEALTH INSURANCE POOL
PLAN OF DISSOLUTION

1. **Discontinuation of New Enrollment.** The Pool will stop issuing new health benefit coverage after December 31, 2013, unless extended by the Commissioner.

2. **Termination of Pool Coverage.** The Pool will terminate in-force health benefit coverage at 11:59 P.M. on March 31, 2014, unless further delayed by the Commissioner.

3. **Adjudication of Claims.** Claims for Pool benefits must be submitted to the Pool within one year of the date of service. The Pool will process all timely filed claims for medical and outpatient prescription benefits.

4. **Appeals Management.** The Pool will process all appeals received. If any appeals are pending when the Pool is dissolved, the Pool will provide the Department with a summary of any such appeals and will transfer all appeal files. In addition, the Pool will provide the Department with a comprehensive, searchable database of all complaints and appeals processed by the Pool since inception.

5. **Litigation Management.** Legal actions against the Pool must be brought within two years of the date the cause of action arises. It is possible that a legal action could be filed up to April 1, 2017, or later if the Commissioner further delays termination of in-force coverage. If any legal actions are pending against the Pool at the time of Pool dissolution, the Pool will provide the Department with a summary of any such actions, and will transfer any litigation files.

6. **Board Action Summary.** The Pool will continue to maintain a complete log of all board actions. At dissolution, the Pool will provide the Department with a searchable file that summarizes every Pool Board action since inception.

7. **Unclaimed Property.** The Pool will deliver to the State Comptroller all eligible unclaimed funds for which Pool checks were issued, including those issued to agents, claimants or vendors. In addition, all required unclaimed property reports will be filed with the Comptroller. Any unclaimed payments not yet eligible for delivery to the Comptroller at time of dissolution will be documented and the funds transferred to the Department.

8. **Termination/Assignment of Contracts.** The Pool will summarize all in-force administrative and vendor contracts and will, in consultation with Department staff, assign any contracts to the Department that survive dissolution.

9. **Pool Bank Accounts.** All Pool bank accounts will be closed and any remaining funds will be transferred to the Department on the dissolution date.

10. **Recovery Rights.** Upon dissolution, the Pool will notify all contractors, including the Pool's subrogation recovery vendor, that all future recoveries of overpayments or other funds owed to the Pool should be redirected to the Department.

11. **Transfer of rights and obligations.** On or before dissolution, the Pool will transfer to the commissioner and the department:

(i) any remaining and continuing obligations of the Board and the Pool;

(ii) any fund in which money belonging to the Pool is kept and any remaining assets of the Pool;

(iii) any remaining rights of the Board or the Pool that accrued before the dissolution of the Board or the Pool or that accrue with respect to coverage issued by the Pool before the Pool's dissolution; and

(iv) any authority previously held by the Board the continuation of which is necessary or appropriate.

12. **Pool Office Closure.** Prior to dissolution, the Pool office will be closed and any remaining furniture and equipment will be transferred to the Department or otherwise disposed of, as directed by the Department.

13. **Pool Employees.** At dissolution, employment of remaining Pool staff will end, as will all employee benefit programs.

14. **Computer Files.** At dissolution, the Pool will transfer all necessary computer files to the Department.

15. **Pool Website.** At dissolution, the Pool will deactivate all remaining website content other than a home page that contains contact information for the Department. Domain ownership will be transferred to the Department, and all necessary domain documentation will be transferred.

16. **Final Audits/Accounting.** In 2015, the Pool's outside auditor will conduct an audit of the Pool's December 31, 2014 financial data. After dissolution, any subsequent audits will be managed by the Department. At dissolution, the Pool will provide all historical financial reports and general ledger files needed by the Department.

17. **Final Assessment.** In 2015, the Pool will process the reconciliation of the 2014 Regular Assessment and generate invoices for the 2015 Interim Assessment, if needed to cover any estimated 2015 expenses. After that assessment is processed, the Pool will provide the Department with all documentation and data needed to process subsequent assessments, including the 2015 Regular Assessment in 2016.

18. **Federal Grant Funds Reporting.** All grant fund disbursements and associated reporting should be completed in 2014. It is not anticipated that the Department will be required to administer any aspects of the federal grant program for state risk pools after dissolution, but a complete accounting of all Pool federal grants will be provided to the Department.

19. **Premium Subsidy Fund.** The Pool will continue to collect penalties pursuant to Sections 843.342 and 1301.137, Texas Insurance Code. The Pool will distribute monies from this Fund as directed by the Commissioner. At dissolution, the remaining Fund balance will be transferred to the Department, and all HMOs and Insurers will be instructed to remit subsequent penalty payments to the Department rather than to the Pool.

20. **Annual Report to the Governor.** The Board shall prepare and adopt the 2014 annual report, in accordance with Sec. 1506.057, Texas Insurance Code, which must be submitted to the Governor, et. al., by June 1, 2015. The Department shall prepare any subsequent reports, if necessary.

21. **Tax Returns.** The Pool will file the Y2014 Form 990 by the May 15, 2015 filing deadline. Subsequent annual filings, if required, will be managed by the Department.

22. **TDI Reporting.** The Pool will file the Y2014 Annual Statement with the Department by the March 1, 2015 deadline. Responsibility for preparation of the Y2015 Quarterly Statements will be determined based upon the official date of dissolution.

23. **Retention and Destruction of Records.** Prior to dissolution, records eligible for destruction will be destroyed, in accordance with industry document retention standards. At dissolution, the Pool will provide the Department with an inventory of all records securely stored at the Pool's off-site storage facility, and the Pool's agreement with the facility will be transferred to the Department. If requested by the Department, all Pool records will be transferred to the Department's storage facility.

24. **Contingency Plans.** In the event guaranteed issue coverage is not reasonably available on April 1, 2014 and the Commissioner elects to delay termination of in-force Pool coverage, the dates for all affected transition activities will be adjusted accordingly.

25. **Discharge of Board.** Upon the Pool's completion of the obligations set forth in this Plan of Dissolution, the Board of Directors will apply to the Commissioner for discharge of the Board.

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Exhibit I
Timeline of Important Dates

January/February 2014: Supplemental assessment processed in connection with extension of coverage termination date
February 2014: Y2013 assessment reporting forms released to insurers
March 1, 2014: Deadline to file the Y2013 annual financial report with TDI
March 31, 2014 (11:59 P.M.): All in-force Pool coverage to end, unless extended by Commissioner
April 30, 2014: Final reports due to federal government for risk pool grant programs
May 2014: Y2013 audited financial statement report received from outside audit firm
May 2014: Pool Board Meeting. Earlier and subsequent board meetings will be scheduled based upon status of outstanding issues.
May 15, 2014: Deadline to file the 1Q 2014 quarterly financial report with TDI
May 15, 2014: Filing deadline for Y2013 IRS Form 990
May 31, 2014: Pool Executive Director's Office lease agreement expires. Short-term renewal may be negotiated, depending upon determination of need.
June 1, 2014: Due date for Y2013 Annual Report to the Governor.
July/August/September 2014: Y2013 Regular Assessment reconciliation finalized and Y2014 Interim Assessment invoiced, if needed
August 15, 2014: Deadline to file the 2Q 2014 quarterly financial report with TDI
November 15, 2014: Deadline to file the 3Q 2014 quarterly financial report with TDI

March 31, 2015: Last possible date for claims to be timely filed by with the Pool, unless coverage cancellation date was further extended by Commissioner beyond 11:59 P.M., March 31, 2014
February 2015: Y2014 assessment reporting forms released to insurers
March 1, 2015: Deadline to file the Y2014 annual financial report
May 15, 2015: Deadline to file the 1Q 2015 quarterly financial report, if still required
May 15, 2015: Filing deadline for Y2014 IRS Form 990
June 1, 2015: Due date for statutory Y2014 Annual Report to the Governor
July/August 2015: Y2014 Regular Assessment reconciliation finalized and Y2015 Interim Assessment invoiced, if needed
August 15, 2015: Deadline to file the 2Q 2015 quarterly financial report, if still required
September 1, 2015: Chapter 1506, Texas Insurance Code (Pool statute), is repealed, pursuant to SB 1367 (83R)
December 31, 2015: Expiration date of the Pool's Run Off Period administrative services agreements with Blue Cross Blue Shield Texas and Medco/Express Scripts.

July/August 2016: Y2015 Regular Assessment finalized and Y2016 Interim Assessment invoiced, if needed.

March 2017: Deadline for filing of litigation associated with denied claims, unless coverage cancellation date was further extended by Commissioner beyond March 31, 2014

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Exhibit II

S.B. No. 1367

AN ACT

relating to abolishing the Texas Health Insurance Pool.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF TEXAS:

SECTION 1. DEFINITIONS. In this Act:

(1) "Board" means the board of directors of the pool.

(2) "Commissioner" means the commissioner of insurance.

(3) "Department" means the Texas Department of Insurance.

(4) "Health benefit exchange" has the meaning assigned by Section 1369.201, Insurance Code.

(5) "Pool" means the Texas Health Insurance Pool established under Chapter 1506, Insurance Code, as that chapter existed before its repeal by this Act.

SECTION 2. PLAN FOR DISSOLUTION. As soon as practicable after the effective date of this Act, the board shall:

(1) develop a plan for:

(A) dissolving the board and the pool after the pool's obligations to issue and continue health benefit coverage terminate under Sections 3 and 4 of this Act; and

(B) transferring to the commissioner and the department:

(i) any continuing obligations of the board and the pool;

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(ii) any assets of the pool;

(iii) any rights of the board or the pool that accrued before the dissolution of the board or the pool or that accrue with respect to coverage issued by the pool before the pool's dissolution; and

(iv) any authority previously held by the board the continuation of which is necessary or appropriate; and

(2) submit the plan to the commissioner for the commissioner's approval.

SECTION 3. ACCEPTANCE OF ENROLLEES. The latest date on which the pool may issue health benefit coverage is the later of:

(1) December 31, 2013; or

(2) the earliest date on which health benefit coverage is reasonably available on a guaranteed issue basis to each class of individuals eligible for health benefit coverage through the pool immediately before the effective date of this Act, as determined by the commissioner.

SECTION 4. TERMINATION OF POOL COVERAGE. Health benefit coverage that is issued to an individual by the pool and that is otherwise in force terminates on the later of:

(1) January 1, 2014; or

(2) the earliest date on which the individual:

(A) is enrolled in comparable health benefit coverage; or

(B) could reasonably be expected to have obtained health benefit coverage on a guaranteed issue basis, as determined by the commissioner.

SECTION 5. EXERCISE OF POOL'S RECOVERY RIGHTS. The department may exercise any authority to recover overpayments or other amounts the pool would have been authorized to recover or collect had the pool not been dissolved, including amounts recoverable under the pool's subrogation rights.

SECTION 6. TRANSFER OF CERTAIN FUNDS; ASSESSMENT AUTHORITY CONTINUED. (a) Any fund in which money belonging to the pool is kept and any other assets of the pool shall be transferred to the department on dissolution of the pool. That money and any other money recovered or otherwise collected by the department under this Act on behalf of the pool shall be used by the department to satisfy obligations of the pool in accordance with this Act, Chapter 1506, Insurance Code, as that chapter existed before its repeal by this Act, and the dissolution plan.

(b) The authority of the board to make assessments under Subchapter F, Chapter 1506, Insurance Code, as that subchapter existed before its repeal by this Act, is continued and may be exercised by the commissioner until the commissioner determines that all financial obligations of the board and the pool have been satisfied.

(c) Money collected by the department under Subsections (a) and (b) of this section shall be deposited to an account in the Texas Treasury Safekeeping Trust Company to be used for the purposes described by this Act. The money deposited to the account may be used to pay fees for the Texas Treasury Safekeeping Trust Company account. The department may transfer money into the treasury local operating fund to disburse the money as required by this Act.

(d) When the commissioner determines that all financial obligations of the board and the pool have been satisfied, the commissioner shall make a final accounting with respect to pool finances and:

(1) make any necessary final assessment under this section; or

(2) refund any surplus assessments or other surplus money collected on behalf of the pool, other than money described by Subsection (e) of this section:

(A) on a pro rata basis to the health benefit plan issuers that paid the assessments to the extent possible; or

(B) on another equitable basis to the extent pro rata refunds are not possible.

(e) If money paid or payable under Subsection (m), Section 843.342 and Subsection (l), Section 1301.137, Insurance Code, is no longer necessary to finance premium discounts as prescribed by Section 1506.260, Insurance Code, as that section existed immediately before the effective date of this Act, the money shall be distributed and used as follows:

(1) $5 million shall be distributed to the corporation established under Chapter 182, Health and Safety Code, to be used for a purpose provided by that chapter; and

(2) any money available after the amount required by Subdivision (1) of this subsection has been distributed in accordance with that subdivision shall be distributed to the fund established under Subchapter F, Chapter 1508, Insurance Code, to be used:

(A) before January 1, 2014, for a purpose provided by that subchapter; and

(B) on and after January 1, 2014, for any other purpose authorized by the commissioner by rule to improve access to health benefit coverage for individuals without coverage.

(f) Money paid or payable under Subsection (m), Section 843.342 and Subsection (l), Section 1301.137, Insurance Code, is subject to audit by the State Auditor's Office.

SECTION 7. DELAYED IMPLEMENTATION. The commissioner by rule may delay the implementation of any part of Sections 1 through 6 of this Act or the pool dissolution plan established under this Act if:

(1) the guaranteed issue of health benefit coverage is delayed;

(2) the operation of a health benefit exchange in this state is delayed; or

(3) the commissioner determines that health benefit coverage expected to be available on a guaranteed issue basis to a class of individuals eligible for coverage under Chapter 1506, Insurance Code, immediately before the effective date of this Act, is not reasonably available to those individuals in this state.

SECTION 8. REPEALER. (a) Effective January 1, 2014, the following laws are repealed:

(1) Subsections (a-1) and (a-2), Section 1506.007, Insurance Code;

(2) Subsections (b) and (c), Section 1506.205, Insurance Code;

(3) Subsection (b), Section 1251.255, Insurance Code; and

(4) Section 1271.305, Insurance Code.

(b) Effective September 1, 2015, Chapter 1506, Insurance Code, is repealed.

SECTION 9. EFFECTIVE DATE. This Act takes effect immediately if it receives a vote of two-thirds of all the members elected to each house, as provided by Section 39, Article III, Texas Constitution. If this Act does not receive the vote necessary for immediate effect, this Act takes effect September 1, 2013.

President of the Senate Speaker of the House

I hereby certify that S.B. No. 1367 passed the Senate on April 9, 2013, by the following vote: Yeas 31, Nays 0; and that the Senate concurred in House amendment on May 21, 2013, by the following vote: Yeas 31, Nays 0.

Secretary of the Senate

I hereby certify that S.B. No. 1367 passed the House, with amendment, on May 16, 2013, by the following vote: Yeas 126, Nays 1, two present not voting.

Chief Clerk of the House

Approved:

Date

Governor

TEXAS DEPARTMENT OF INSURANCE
Commissioner of Insurance (113-1C)
333 Guadalupe, Austin, Texas 78701 ★ PO Box 149104, Austin, Texas 78714-9104
(512) 676-6020 | F: (512) 490-1045 | (800) 578-4677 | TDI.texas.gov | @TexasTDI

August 26, 2015

Steven Browning
Executive Director
Texas Health Insurance Pool
9211 Broadway Street #17463
San Antonio TX 78217

Re: Discharge of Texas Health Insurance Pool Board of Directors

Dear Mr. Browning:

Senate Bill 1367 (83R) provides for the dissolution of the Pool and the Board and repeals the Pool's governing statute, Texas Insurance Code 1506, effective September 1, 2015. Therefore, pursuant to the Pool's Plan of Dissolution and Order No. 2990, I discharge the Board from further service, effective September 1, 2015.

Thank you and the Board for your service, helping to make health insurance available to those who would not otherwise have been able to secure it.

Sincerely,

David C. Mattax
Commissioner of Insurance

In the United States District Court
FOR THE NORTHERN DISTRICT OF TEXAS

TEXAS, WISCONSIN, ALABAMA, ARKANSAS, ARIZONA, FLORIDA, GEORGIA, INDIANA, KANSAS, LOUISIANA, PAUL LEPAGE, *Governor of Maine*, GOVERNOR PHIL BRYANT OF THE STATE OF MISSISSIPPI, MISSOURI, NEBRASKA, NORTH DAKOTA, SOUTH CAROLINA, TENNESSEE, UTAH, WEST VIRGINIA, NEILL HURLEY, *and* JOHN NANTZ,

PLAINTIFFS,

v.

UNITED STATES OF AMERICA, UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, ALEX AZAR, *in his Official Capacity as* SECRETARY OF HEALTH AND HUMAN SERVICES, UNITED STATES DEPARTMENT OF REVENUE, *and* DAVID J. KAUTTER, *in his Official Capacity as Acting* COMMISSIONER OF INTERNAL REVENUE,

DEFENDANTS.

APPENDIX IN SUPPORT OF PLAINTIFF-STATES' AND INDIVIDUAL-PLAINTIFFS' APPLICATION FOR PRELIMINARY INJUNCTION

Exhibit H

IN THE UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF TEXAS
FORT WORTH DIVISION

TEXAS, WISCONSIN, *et al.*	§	
	§	
Plaintiffs,	§	
	§	
v.	§	Civil Action No. 4:18-cv-00167-O
	§	
UNITED STATES OF AMERICA, UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, ALEX AZAR, in his Official Capacity as SECRETARY OF HEALTH AND HUMAN SERVICES, UNITED STATES INTERNAL REVENUE SERVICE, and DAVID J. KAUTTER, in his Official Capacity as Acting COMMISSIONER OF INTERNAL REVENUE	§	
Defendants.	§	

DECLARATION OF THEODORE K. NICKEL, COMMISSIONER, WISCONSIN OFFICE OF THE COMMISSIONER OF INSURANCE, PURSUANT TO 28 U.S.C. § 1746

INTRODUCTION

1. My name is Ted Nickel, I am the Commissioner of the Wisconsin Office of the Commissioner of Insurance ("OCI").

2. OCI is responsible for regulating the Wisconsin health-insurance market and protecting consumers of this market. Overall, OCI performs a variety of tasks to protect insurance consumers and ensure a competitive insurance environment, including:

a. Reviewing insurance policies that are sold in Wisconsin to make sure they meet the requirements set forth in Wisconsin law;

b. Conducting examinations of domestic and foreign insurers to ensure compliance with Wisconsin laws and rules;

c. Monitoring the financial solvency of licensed companies to make sure that consumers have the insurance coverage they expect when they need it;

d. Issuing licenses to the various parties involved in selling and marketing insurance products;

e. Assisting insurance consumers with their insurance problems;

f. Researching special insurance issues to understand and assess their impact on Wisconsin;

g. Providing technical assistance on legislation and promulgating administrative rules to interpret insurance laws;

h. Creating and distributing public information and consumer education pieces to educate people about insurance; and

i. Operating a state life insurance fund, a property fund for the property owned by local units of government, and a patients compensation fund insuring health care providers for medical malpractice.

3. As Commissioner, I am the head of OCI and the chief regulator of insurance in Wisconsin. Generally, my official duties include supervising the entire agency, serving as final adjudicator of all administrative actions, and serving on various councils and committees in a variety of capacities.

4. Additionally, my official duties with OCI include studying the impact of the Affordable Care Act (hereinafter "the ACA," or "the Act") on Wisconsin's insurance market, ensuring Wisconsin's compliance with the Act, advising the Wisconsin Governor's Office on the ACA, and developing strategies for Wisconsin to mitigate the numerous harms the Act has inflicted on Wisconsin health-insurance markets.

5. A member of my office has testified in front of Congress about the negative

effects of the Affordable Care Act on Wisconsin's health-insurance market.[1] Briefly, this testimony explained that Wisconsin had competitive individual and small group health-insurance markets before the ACA, which were significantly harmed by the ACA.

HARMS CAUSED BY THE AFFORDABLE CARE ACT

6. The Affordable Care Act inflicts numerous harms on Wisconsin and its citizens, as detailed below. Specifically, the Act inflicts harms on Wisconsin as a regulator of the health-insurance market.

7. The Act inflicts harms on Wisconsin because, as a result of the Act's individual-market reforms many failings, Wisconsin was forced to enact state-level individual-market reforms to stabilize this market.

a. Because of the ACA's burdensome regulations, many insurers in Wisconsin have left the individual market, scaled back their offerings in the individual market, or otherwise limited their exposure in the individual market. For those insurers still selling in the individual market, their products have become much more expensive. Premiums have consistently risen since the ACA was enacted. In 2017, average premium rates rose 17%, and in 2018 they increased by 42%.

b. As a result, the Wisconsin Legislature passed a reinsurance program in February 2018 to stabilize the individual market. *See* Wisconsin State Legislature, Senate Bill 770;[2] Governor Scott Walker, Press Release, Governor Walker Proposes Health Care Stability Plan to Stabilize Premiums for Wisconsinites on Obamacare (Jan 21, 2018);[3] Governor Scott

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[1] This testimony may be found at http://docs.house.gov/meetings/IF/IF14/20170202/105506/HHRG-115-IF14-Wstate-WieskeJ-20170202.pdf.

[2] https://docs.legis.wisconsin.gov/2017/proposals/reg/sen/bill/sb770.

[3] https://walker.wi.gov/press-releases/governor-walker-proposes-health-care-stability-plan-stabilize-premiums-wisconsinites.

Walker, Memo Accompanying Jan. 21, 2018 Press Release;[4] Bob Lang, Legislative Fiscal Bureau Memo Accompanying Assembly Bill 885/Senate Bill 770 (Feb. 12, 2018).[5]

c. Wisconsin's reinsurance program is necessary because the ACA's regulations of the individual market have caused health-insurance premiums to rise substantially. Without Wisconsin's intervention, plans in the individual market would either not be offered, or would be prohibitively expensive.

d. This reinsurance program proposal costs an estimated $200 million, split between state and federal funds.

e. The reinsurance plan cannot be implemented without federal approval through a Section 1332 State Innovation Waiver; a process involving drafting of the application, staff travel, and presentation preparation for required public hearings, OCI funds to support actuarial analysis required for inclusion in the application, and administrative expenses necessary to operate the program.

8. As mentioned above, the Act forced Wisconsin insurers out of the individual market and/or all health-insurance markets.

a. For example, a major Wisconsin health insurer, Assurant Health, ceased its Wisconsin operations because of the ACA. *See, e.g.*, Guy Boulton, *Milwaukee-based Assurant Health to be sold off or shut down*, Milwaukee Journal Sentinel (Apr. 28, 2015).[6] This cost Wisconsin 1,200 jobs. *Id.*

b. This contributes to the harms to the individual market, as mentioned

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[4] https://jwyjh41vxje2rqecx3efy4kf-wpengine.netdna-ssl.com/wp-content/uploads/2018/01/180120Overview.pdf.

[5] http://docs.legis.wisconsin.gov/misc/lfb/bill_summaries/2017_19/0885_ab_885_wisconsin_healthcare_stability_plan_and_medical_assistance_lapse_2_12_18.pdf

[6] http://archive.jsonline.com/business/assurant-considering-sale-of-milwaukee-based-assurant-health-b99490422z1-301614251.html.

above. As some health insurers have stopped using agents to sell individual health insurance products and have left the market altogether, therefore no longer needing agents, the ACA has also resulted in OCI collecting less revenue in health insurance-related agent licensing fees. Agents licensed to sell insurance in Wisconsin must pay an initial fee of $75.00 along with an application fee of $10.00. *See* Wis. Stat. § 628.04(1)(a); Wis. Admin. Code Ins. § 6.59 ("Licensing of individuals as agents, reinsurance intermediaries, or managing general agents"). A licensing fee of $100 and a biennial license renewal fee of $35.00 also applies to some firms. *See* Wis. Stat. § 628.04(1)(a); Wis. Admin. Code Ins. § 6.58(3), (5).

9. The Act creates an unsustainable insurance market, which will ultimately raise Medicaid reimbursement rates.

a. As the ACA causes insurers to leave the marketplace, more individuals will be unable to obtain insurance coverage.

b. These individuals will ultimately receive uncompensated medical care via hospital emergency rooms. *See generally* 42 U.S.C. § 18091(2)(A), (F), (I) (describing this problem).

c. To compensate for this uncompensated care, health-care providers will raise their rates on compensated services, thus requiring the State to reimburse more money for Medicaid-paid services.

10. The Act harms Wisconsin because it preempted Wisconsin law, preventing Wisconsin from regulating the Wisconsin health-insurance market in the manner it sees fit. Relatedly, Wisconsin repealed statutes and regulations related to its high risk pool, a safety net for individuals with high health care needs. *See infra*, ¶ 10.a. Without the ACA, Wisconsin could enforce these preempted laws and rules to return stability to the health-insurance market.

a. The ACA resulted in the repeal of Wisconsin's high-risk pool, the Health Insurance Risk-Sharing Plan, which effectively managed the

health-insurance needs of high-risk individuals before the full implementation of the ACA. Wis. Stat. §§ 149.10–.53 (2011–12) (statutory framework for Wisconsin Health Insurance Risk-Sharing Plan), *repealed by* 2013 Wis. Act 20, § 1900n; *see generally* Wisconsin Legislative Audit Bureau, Report 14-7 Health Insurance Risk-Sharing Plan Authority at 1 (June 2014) (describing history of Wisconsin's Health Insurance Risk-Sharing Plan, including dissolution and repeal).[7]

b. The ACA preempted Wisconsin law relating to coverage for preventive services. Wisconsin insurance law allows for cost-sharing for preventative services. *See* OCI, Bulletin, September 3, 2010, Patient Protection and Affordable Care Act of 2009 (hereinafter "OCI Bulletin");[8] Wis. Stat. § 632.895 (describing Wisconsin coverage mandates, which Wisconsin had interpreted to permit cost-sharing). The ACA does not allow such cost sharing. *See* 42 U.S.C. § 300gg-13.

c. The ACA preempted Wisconsin law on the treatment of preexisting conditions. Under Wisconsin insurance law, preexisting condition exclusions were permitted for a 12-month period. *See* OCI Bulletin; Wis. Stat. § 632.76(2)(ac). The ACA's conflicting rules on preexisting conditions increase the cost of health insurance.

d. The ACA preempted Wisconsin fraud rules. Under Wisconsin insurance law, rescission in cases of fraudulent misrepresentation, including negligent misrepresentations, was permitted. *See* OCI Bulletin; Wis. Stat. § 632.76(1). The ACA allows rescission only when fraudulent misrepresentation is intentional. *See* OCI Bulletin; 42 U.S.C. § 300gg-12.

11. The ACA imposes other costs, burdens, and requirements on OCI:

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[7] http://legis.wisconsin.gov/lab/reports/14-7full.pdf.

[8] https://oci.wi.gov/Pages/Regulation/Bulletin20100903PPACA.aspx.

a. The Act forces OCI to expend significant amounts of money on compliance and education costs. For example, in 2013 OCI spent a significant amount of resources on state-wide information-sharing town halls for the public.

b. In preparation to comply with the ACA for the 2018 plan year, OCI held multiple calls with insurers to provide direction on the filing of their rates. With congressional uncertainty and ultimately a decision resulting in the federal government no longer funding cost sharing reduction subsidies (CSRs), OCI had to revise timelines and expectations around rate filings and communicate those expectations verbally and in writing.

12. Finally, without the ACA, OCI could allow insurers to operate under a set of rules that creates certainty and stability for market growth while protecting consumers and offering them affordable access to individual health insurance coverage. Under the ACA, OCI has limited flexibility in regulating the individual market and is forced to react to the implications federal rules have on the Wisconsin market. As mentioned earlier, an example of that reaction is addressing a destabilizing market with between $30–50 million general purpose revenue to support a $200 million state based reinsurance plan.

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

Executed on 3 April 2018,

Signed,

Theodore K. Nickel
Commissioner,
Wisconsin Office of the Commissioner of Insurance

In the United States District Court
FOR THE NORTHERN DISTRICT OF TEXAS

TEXAS, WISCONSIN, ALABAMA, ARKANSAS, ARIZONA, FLORIDA, GEORGIA, INDIANA, KANSAS, LOUISIANA, PAUL LEPAGE, *Governor of Maine*, GOVERNOR PHIL BRYANT OF THE STATE OF MISSISSIPPI, MISSOURI, NEBRASKA, NORTH DAKOTA, SOUTH CAROLINA, TENNESSEE, UTAH, WEST VIRGINIA, NEILL HURLEY, *and* JOHN NANTZ,

PLAINTIFFS,

v.

UNITED STATES OF AMERICA, UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, ALEX AZAR, *in his Official Capacity as* SECRETARY OF HEALTH AND HUMAN SERVICES, UNITED STATES DEPARTMENT OF REVENUE, *and* DAVID J. KAUTTER, *in his Official Capacity as Acting* COMMISSIONER OF INTERNAL REVENUE,

DEFENDANTS.

APPENDIX IN SUPPORT OF PLAINTIFF-STATES' AND INDIVIDUAL-PLAINTIFFS' APPLICATION FOR PRELIMINARY INJUNCTION

Exhibit I

IN THE UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF TEXAS
FORT WORTH DIVISION

TEXAS, WISCONSIN, *et al.*	§	
	§	
Plaintiffs,	§	
	§	
v.	§	Civil Action No. 4:18-cv-00167-O
	§	
UNITED STATES OF AMERICA, UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, ALEX AZAR, in his Official Capacity as SECRETARY OF HEALTH AND HUMAN SERVICES, UNITED STATES INTERNAL REVENUE SERVICE, and DAVID J. KAUTTER, in his Official Capacity as Acting COMMISSIONER OF INTERNAL REVENUE,	§	
Defendants.	§	

DECLARATION OF ARLENE LARSON, MANAGER OF FEDERAL HEALTH PROGRAMS & POLICY AT WISCONSIN EMPLOYEE TRUST FUNDS, PURSUANT TO 28 U.S.C. § 1746

INTRODUCTION

1. My name is Arlene Larson, I am the Manager of Federal Health Programs and Policy at the Wisconsin Department of Employee Trust Funds ("ETF"). My duties generally include health insurance policy and contract analysis and implementation.

2. ETF is responsible for administering retirement, insurance, and other benefit programs for State and participating Local government employees and retirees of the Wisconsin Retirement System. ETF performs a variety of tasks to satisfy this responsibility. The Group Insurance Board ("Board") enters into contracts to provide the State Group Health Insurance Program.

3. Additionally, my official duties with ETF include ensuring the State's group health insurance program complies with the Patient Protection and Affordable Care Act (hereinafter "the ACA," or "the Act").

WISCONSIN'S STATE-EMPLOYEE HEALTH INSURANCE PLANS AND THE AFFORDABLE CARE ACT'S EFFECTS

4. Below is basic information about the State's employee group health insurance program:

a. There are an estimated 167,500 state employees (and their family members) enrolled in the State's group health insurance program. The employee contribution amount appears in the grid, below. It varies between regular State employees and University of Wisconsin (UW) graduate assistants. It further varies based upon the benefit selected by the employee. Most employees choose a vendor that offers the "It's Your Choice Health Plan."

	It's Your Choice **Health Plan**	It's Your Choice **Access Plan**	It's Your Choice **High Deductible Health Plan (HDHP)**	It's Your Choice **Access High Deductible Health Plan (HDHP)**
Monthly Payment (Premium)				
Individual / Family	$85 / $211	$263 / $656	$30 / $74	$208 / $519
UW Grad Assistant Individual / Family	$42.50 / $105.50	$131.50 / $328	Not eligible	Not eligible

b. For 2017, ETF estimates that the State spent the amounts below on the state-employee group health insurance program.

Employer Estimate	Employee Estimate	Total
$998,003,809.42	$132,613,004.50	$1,130,616,813.92

c. Additionally, there are administrative tasks performed by State employees to enroll each employee in the group health insurance program.

5. The Act required the Board to modify the State's group health insurance program to State employees:

a. The Board enhanced an existing health-care benefit for State employees to comply with the essential-health-benefits requirements. Preventive care is required to be paid at 100% under the ACA.

b. The Act lowered limits on employee flexible health spending accounts. I am aware that every year ETF reviews the limits to be certain we comply with requirements.

6. The ACA's Market Share Fee, ACA § 9010, may have a financial impact on the State's group health insurance program in the future.

a. Beginning in 2015, ETF and the Board began an intensive investigation into moving from a fully insured model to a self–insurance model for the State group health insurance program. This investigation included working with the Board's consulting actuary, Segal Consulting (Segal), which issued reports to the Board. To date, Segal is the Board's consulting actuary and former benefit consultant.

b. This investigation was motivated in part to find a means to avoid the Act's Market Share fees of approximately 2% of health premiums, per Segal's March 25, 2015 report to the Board. Segal's reports are publicly available on ETF's website. I am aware that in 2015, Congress approved a moratorium on collecting insurer taxes for 2017. The moratorium was set to expire in 2018. During annual health plan negotiations regarding 2018 rates, participating health plans were limited in their 2017 administrative fee increases. Per Segal's August 30, 2017 report to the Board, no consideration was given to additional ACA fees currently projected for 2018. The State group health insurance program ultimately did not change to self-insurance, and instead the Board explored cost reductions in other areas.

7. The ACA's 40% excise tax, 26 U.S.C. § 4980I, may have a financial impact on the State's group health insurance program if enacted. This tax is triggered when the cost of plans offered by an employer exceeds a certain value.

a. The Segal reports to the Board, referenced above, also addressed the potential effect of the ACA's excise tax on the State's group health insurance program.

b. The federal government has delayed the enforcement of the excise tax for specific years, but the State's group health insurance program may be liable to pay the 40% tax if it is imposed as written.

c. If the 40% excise tax is enforced, ETF and the Board will dedicate time and resources during its annual process to review options to avoid or minimize the impact of the excise tax.

d. Segal annually provides benefit alternative calculation estimates to ETF and the Board. If the 40% excise tax is enforced, Segal will provide calculations for options to the State's group health insurance program to minimize or avoid the tax.

8. The ACA imposes other costs and requirements on ETF:

a. The ACA has required ETF to comply with the requirements surrounding IRS Form 1095-C for some retirees in the State's group health insurance program administered by ETF. In 2017, ETF hired a vendor to issue 343 Form 1095-Cs.

b. ETF has had to dedicate some agency resources to studying the ACA and ensuring the State's compliance with the ACA. For example, ETF coordinated with other state agencies and local government municipalities to discuss the potential impact of the employer shared responsibility penalty. These discussions focused primarily on the possibility of employers failing to offer health insurance premium contributions to full-time employees prior to the 91st day after the employee's hire date.

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

Executed on 4-20-18,

Signed,

Arlene Larson
Manager of Federal Health Programs and Policy
Wisconsin Employee Trust Funds

In the United States District Court
FOR THE NORTHERN DISTRICT OF TEXAS

TEXAS, WISCONSIN, ALABAMA, ARKANSAS, ARIZONA, FLORIDA, GEORGIA, INDIANA, KANSAS, LOUISIANA, PAUL LEPAGE, *Governor of Maine*, GOVERNOR PHIL BRYANT OF THE STATE OF MISSISSIPPI, MISSOURI, NEBRASKA, NORTH DAKOTA, SOUTH CAROLINA, TENNESSEE, UTAH, WEST VIRGINIA, NEILL HURLEY, *and* JOHN NANTZ,

PLAINTIFFS,

v.

UNITED STATES OF AMERICA, UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, ALEX AZAR, *in his Official Capacity as* SECRETARY OF HEALTH AND HUMAN SERVICES, UNITED STATES DEPARTMENT OF REVENUE, *and* DAVID J. KAUTTER, *in his Official Capacity as Acting* COMMISSIONER OF INTERNAL REVENUE,

DEFENDANTS.

APPENDIX IN SUPPORT OF PLAINTIFF-STATES' AND INDIVIDUAL-PLAINTIFFS' APPLICATION FOR PRELIMINARY INJUNCTION

Exhibit J

IN THE UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF TEXAS
FORT WORTH DIVISION

TEXAS,
WISCONSIN,
ALABAMA,
ARKANSAS,
ARIZONA,
FLORIDA,
GEORGIA,
INDIANA,
KANSAS,
LOUISIANA,
PAUL LePAGE, Governor of Maine,
MISSISSIPPI, by and through
Governor Phil Bryant,
MISSOURI,
NEBRASKA,
NORTH DAKOTA,
SOUTH CAROLINA,
SOUTH DAKOTA,
TENNESSEE,
UTAH, and
WEST VIRGINIA,
Plaintiffs,

v.

UNITED STATES OF AMERICA,
UNITED STATES DEPARTMENT
OF HEALTH AND HUMAN
SERVICES, ALEX AZAR,
in his Official Capacity as
SECRETARY OF HEALTH AND
HUMAN SERVICES, UNITED
STATES INTERNAL REVENUE
SERVICE, and DAVID J. KAUTTER,
in his Official Capacity as Acting
COMMISSIONER OF INTERNAL
REVENUE,
Defendants.

Civil Action No. 4:18-cv-00167-O

DECLARATION OF JIM L. RIDLING, ALABAMA COMMISSIONER OF INSURANCE

My name is Jim L. Ridling and I am over the age of 18 and fully competent to make this declaration and state the following:

1. I am Commissioner of the Alabama Department of Insurance (ALDOI). I have served as Commissioner of ALDOI for over nine (9) years. As Commissioner, I am the head of the ALDOI and the chief insurance regulator for the state of Alabama. Generally, my official duties include supervising the entire agency, serving as final adjudicator of all administrative actions, and serving on various commissions, councils, and committees in a variety of capacities.

2. ALDOI is responsible for regulating the business of insurance in the state of Alabama. As a part of these responsibilities, ALDOI performs a variety of tasks that are designed to protect insurance consumers while ensuring a competitive insurance environment. Included among the duties and responsibilities are the following:

a. Licensing insurance companies and conducting regular examinations of domestic insurers, and as necessary foreign insurers, to ensure compliance with Alabama laws and rules.

b. Monitoring the financial solvency of licensed insurers to make sure that consumers will be provided the insurance coverage they have paid for when they need it.

c. Reviewing and approving all insurance policies to make sure they meet the requirements of Alabama law.

d. Licensing the insurance producers and various other representatives of the insurers.

e. Assisting insurance consumers with any problems they may experience with their insurance policies.

f. Providing technical assistance on legislation and adopting administrative rules to implement and interpret insurance laws.

3. Included within all the duties and responsibilities is the regulation of the health insurance market, and in particular the impact of the Affordable Care Act (ACA) on Alabama's health insurance market, ensuring compliance of the ACA in Alabama, advising the Alabama Governor's office on the ACA, and to generally develop strategies for the State of Alabama to mitigate the numerous harms the ACA has inflicted on the health insurance markets in the State of Alabama.

4. In particular, the ACA has inflicted numerous harms on Alabama and its citizens, as follows:

a. First, a stated goal of the ACA was to increase competition, as expressed by President Obama in an address to Congress on September 9, 2009, where he said Alabama lacked competition because one carrier had almost 90% of the market.[1] Because of the ACA's burdensome regulations, many insurers in Alabama have left the insurance market or scaled backed their exposure so that there is actually less competition for the individuals within the health insurance market to choose from. Instead of fostering competition, Alabama has seen the exact opposite within its borders when it

[1] http://blog.al.com/live/2009/09/obama_cited_lack_of_competitiv.html

comes to the ACA's effect on the insurance market. After four years of the ACA, that one company had 100% of the individual health insurance market.

b. Another stated goal of the ACA was to reduce the rates paid for health insurance. The embedded mandates through the essential health benefits requirement in the ACA have added to the health insurer costs in the market, putting upward premium pressure on insurers in the Alabama market for policies in this State. On March 23, 2010 when President Obama signed the ACA into law, an individual aged 52 could purchase a major medical insurance policy for $203 per month. On January 1, 2018, a comparable Obama Care policy for a 52 year old was $829, an increase of 308%, or 19% per year.

c. The ACA has had a disastrous effect on the number of insurers within the state regarding the federal risk adjustment within the individual and small group markets. The stated goal again was to increase competition by stabilizing premiums. Here are the results of the risk adjustments for the first three years under ACA:

2014: One insurer collected $2,544,517, four other insurers collected a total of $246,858, and six insurers paid a total of $2,791,376.[2]

2015: One insurer collected $15,326,641, two other insurers collected a total of $104,889, and seven insurers paid a total of $15,431,531.[3]

[2] https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/RI-RA-Report-REVISED-9-17-15.pdf

2016: One insurer collected $27,243,856 and seven insurers paid a total of $27,243,856, (including default payments).[4]

2017: The report for 2017 is due this summer. It is anticipated the transfers will be sharply reduced due to the fact that only one insurer remains in the individual market.

d. Finally, the ACA harms Alabama because it preempted Alabama law, thus preventing Alabama from regulating the Alabama health insurance market in the manner it deems most appropriate to the Alabama situation. Without the ACA, Alabama could again enforce preempted laws and rules to return stability to the health insurance market.

5. Pursuant to 28 U.S.C. § 1746, I declare under penalty of perjury that the foregoing is true and correct.

Respectfully submitted this the 24th day of April, 2018.

Jim L. Ridling
Alabama Commissioner of Insurance

[3] https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/June-30-2016-RA-and-RI-Summary-Report-5CR-063016.pdf
[4] https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/Summary-Reinsurance-Payments-Risk-2016.pdf

In the United States District Court
FOR THE NORTHERN DISTRICT OF TEXAS

TEXAS, WISCONSIN, ALABAMA, ARKANSAS, ARIZONA, FLORIDA, GEORGIA, INDIANA, KANSAS, LOUISIANA, PAUL LEPAGE, *Governor of Maine*, GOVERNOR PHIL BRYANT OF THE STATE OF MISSISSIPPI, MISSOURI, NEBRASKA, NORTH DAKOTA, SOUTH CAROLINA, TENNESSEE, UTAH, WEST VIRGINIA, NEILL HURLEY, *and* JOHN NANTZ,

PLAINTIFFS,

v.

UNITED STATES OF AMERICA, UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, ALEX AZAR, *in his Official Capacity as* SECRETARY OF HEALTH AND HUMAN SERVICES, UNITED STATES DEPARTMENT OF REVENUE, *and* DAVID J. KAUTTER, *in his Official Capacity as Acting* COMMISSIONER OF INTERNAL REVENUE,

DEFENDANTS.

APPENDIX IN SUPPORT OF PLAINTIFF-STATES' AND INDIVIDUAL-PLAINTIFFS' APPLICATION FOR PRELIMINARY INJUNCTION

Exhibit K

IN THE UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF TEXAS
FORT WORTH DIVISION

TEXAS, WISCONSIN, ALABAMA, ARKANSAS, ARIZONA, FLORIDA, GEORGIA, INDIANA, KANSAS, LOUISIANA, PAUL LePAGE, Governor of Maine, MISSISSIPPI, by and through Governor Phil Bryant, MISSOURI, NEBRASKA, NORTH DAKOTA, SOUTH CAROLINA, SOUTH DAKOTA, TENNESSEE, UTAH, and WEST VIRGINIA, Plaintiffs,	§	
v.	§	Civil Action No. 4:18-cv-00167-O
UNITED STATES OF AMERICA, UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, ALEX AZAR, in his Official Capacity as SECRETARY OF HEALTH AND HUMAN SERVICES, UNITED STATES INTERNAL REVENUE SERVICE, and DAVID J. KAUTTER, in his Official Capacity as Acting COMMISSIONER OF INTERNAL REVENUE, Defendants.	§	

DECLARATION OF ALLEN KERR

INTRODUCTION

1. My name is Allen Kerr, I am the Commissioner of the Arkansas Insurance Department ("AID").

2. AID is responsible for regulating the Arkansas health-insurance market and protecting consumers of the market. Overall, AID performs a variety of tasks

to protect insurance consumers and ensure a competitive insurance environment, including:

a. Reviewing insurance policies that are sold in Arkansas to make sure they meet the requirements set forth in Arkansas law;

b. Conducting examinations of domestic and foreign insurers to ensure compliance with Arkansas laws and rules;

c. Monitoring the financial solvency of licensed companies to make sure that consumers have the insurance coverage they expect when they need it;

d. Issuing licenses to the various parties involved in selling and marketing insurance products;

e. Assisting insurance consumers with their insurance problems;

f. Researching special insurance issues to understand and assess their impact on Arkansas;

g. Providing technical assistance on legislation and promulgating administrative rules to interpret insurance laws; and

h. Creating and distributing public information and consumer education pieces to educate people about insurance.

3. As Commissioner, I am the head of AID and the chief regulator of insurance in Arkansas. Generally, my official duties include supervising the entire Department, serving as final adjudicator of all administrative actions, and serving on various councils and committees in a variety of capacities.

4. Additionally, my official duties with AID include reviewing the impact of the Affordable Care Act (herein after "the ACA," or "the Act") on Arkansas' insurance market, ensuring Arkansas' compliance with the Act, advising the Arkansas Governor on the ACA, and developing strategies for Arkansas to mitigate the adverse impact the Act has inflicted on the Arkansas health-insurance market.

HARMS CAUSED BY THE AFFORDABLE CARE ACT

5. The embedded mandates through essential health benefits requirements in the ACA have added to health insurer costs in this market putting upward

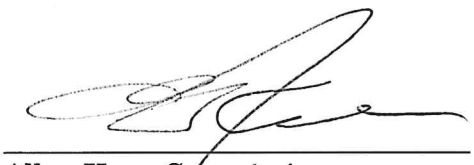
premium pressure on insurers in the Arkansas market for issuers offering individual and small group policies in this State. We estimate that since the inception of the Arkansas health insurance exchange in 2014, the percentage increase in premium in the individual market from the first year of the Exchange to today is approximately 24%.

6. The Act adds costs to health insurers in benefit requirements, underwriting and in reporting, and this negatively impacts the number of issuers in the health insurance exchange we provide for individual and small group policies. For example, as a result of the ACA costs, several years ago, United Health Care withdrew from participation in the Arkansas exchange, thereby reducing competition and the number of insurers offering individual policies in this State.

7. Finally, the Act harms Arkansas because it has preempted Arkansas law, preventing Arkansas from regulating health insurance in the manner it sees fit.

8. Pursuant to 28 U.S.C. § 1746, I declare under penalty of perjury that the foregoing is true and correct.

Executed on this 19th day of April, 2018.



Allen Kerr, Commissioner
Arkansas Department of Insurance

In the United States District Court
FOR THE NORTHERN DISTRICT OF TEXAS

TEXAS, WISCONSIN, ALABAMA, ARKANSAS, ARIZONA, FLORIDA, GEORGIA, INDIANA, KANSAS, LOUISIANA, PAUL LEPAGE, *Governor of Maine*, GOVERNOR PHIL BRYANT OF THE STATE OF MISSISSIPPI, MISSOURI, NEBRASKA, NORTH DAKOTA, SOUTH CAROLINA, TENNESSEE, UTAH, WEST VIRGINIA, NEILL HURLEY, *and* JOHN NANTZ,

PLAINTIFFS,

v.

UNITED STATES OF AMERICA, UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, ALEX AZAR, *in his Official Capacity as* SECRETARY OF HEALTH AND HUMAN SERVICES, UNITED STATES DEPARTMENT OF REVENUE, *and* DAVID J. KAUTTER, *in his Official Capacity as Acting* COMMISSIONER OF INTERNAL REVENUE,

DEFENDANTS.

APPENDIX IN SUPPORT OF PLAINTIFF-STATES' AND INDIVIDUAL-PLAINTIFFS' APPLICATION FOR PRELIMINARY INJUNCTION

Exhibit L

IN THE UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF TEXAS
FORT WORTH DIVISION

TEXAS,
WISCONSIN,
ALABAMA,
ARKANSAS,
ARIZONA,
FLORIDA,
GEORGIA,
INDIANA,
KANSAS,
LOUISIANA,
PAUL LePAGE, Governor of Maine,
MISSISSIPPI, by and through
Governor Phil Bryant,
MISSOURI,
NEBRASKA,
NORTH DAKOTA,
SOUTH CAROLINA,
SOUTH DAKOTA,
TENNESSEE,
UTAH, and
WEST VIRGINIA,

Plaintiffs,

v.

UNITED STATES OF AMERICA,
UNITED STATES DEPARTMENT
OF HEALTH AND HUMAN
SERVICES, ALEX AZAR,
in his Official Capacity as
SECRETARY OF HEALTH AND
HUMAN SERVICES, UNITED
STATES INTERNAL REVENUE
SERVICE, and DAVID J. KAUTTER,
in his Official Capacity as Acting
COMMISSIONER OF INTERNAL
REVENUE,

Defendants.

Civil Action No. 4:18-cv-00167-O

DECLARATION OF MIKE MICHAEL

My name is Mike Michael and I am over the age of 18 and fully competent to make this declaration and state the following:

1. I am the Director of the Kansas State Employee Health Plan (SEHP). SEHP administers the various insurance plans available to Kansas state employees and participating non-state entities (such as school districts, cities or counties). SEHP is part of the Division of Health Care Finance, a division within the Kansas Department of Health and Environment. I have served with SEHP for over 10 years.
2. I am particularly familiar with the SEHP changes in costs, plans, and policies required to comply with requirements of the Affordable Care Act (ACA).
3. At my direction, SEHP staff have prepared the attached spreadsheet that answers questions posed to SEHP concerning the impact of ACA.
4. As the spreadsheet details, I estimate that the overall impact of ACA on SEHP operations to be additional costs of $44,410,997 spread over the years of 2013 to 2018 inclusive.
5. The three largest categories of ACA costs are:
    a. Plan changes to cover out-of-pocket maximums - $14,006,000;
    b. Plan changes to cover individual mandate - $10,559,000; and
    c. ACA fees for transitional reinsurance - $9,520,452.
6. SEHP is currently in its design stage for the 2019 Plan year. If ACA were to be eliminated, this would affect the 2019 Plan by decreasing costs for compliance. This could potentially affect the insurance rates charged to SEHP participants.

7. Pursuant to 28 U.S.C. § 1746, I declare under penalty of perjury that the foregoing is true and correct.

Respectfully submitted this the 24 day of April, 2018.

Mike Michael
Director
Kansas State Employee Health Plan

i. What impact has the ACA had on each agency's budgeting?

· How does it break down, particularly, what costs were "one time" and what costs are ongoing?

Type of Cost	2013	2014	2015	2016	2017	2018	Grand Total
One Time Fees							
Design of Software for 1094/1095 Forms			$33,750				$33,750
Ongoing costs by year							
Plan Changes							
1. Preventive				$1,031,000	$963,000	$1,017,000	$3,011,000
2. Age 26				$1,391,000	$1,289,000	$1,362,000	$4,042,000
3. Removal of Dollar Limit on DME		$290,818	$290,818	$579,000	$521,000	$550,000	$2,231,637
4. Individual Mandate		$2,110,000	$2,420,000	$2,076,000	$1,922,000	$2,031,000	$10,559,000
5. Out of Pocket Maximum		$4,940,000	$5,280,000	$1,277,000	$1,220,000	$1,289,000	$14,006,000
Total Ongoing Cost		$7,340,818	$7,990,818	$6,354,000	$5,915,000	$6,249,000	$33,849,637
ACA FEES							
Transitional Reinsurance		$4,482,107	$3,089,585	$1,948,760			$9,520,452
Patient-Centered Outcomes Research Institute	$90,591	$178,882	$154,456	$156,623	$163,294	$163,294	$907,140
Total ACA Fees							$10,427,592
Form 1094/1095 Reporting				$18,774	$43,198	$38,048	$100,019
Grand Total							$44,410,997

ii. How would a complete repeal of ACA tomorrow affect how policy and other decisions are made for next year?

This would allow the plan to discuss preventive, age 26, DME limits, out of pocket limits and etc. to potentially modify to meet the needs of the state. This would also eliminate additional costs such as PCORI fees and tax reporting of 1094/1095.

*** "In other words: are you currently making plans regarding benefits/policy for next year and , if so, what impact would repeal of the ACA have on the decision-making that is currently happening?**

We are currently in discussions about plan design for 2019. If repealed sooner would allow discussions for plan design and potentially lower the plan costs.

*** Would repeal of the ACA now allow your agencies to be more flexible in the decisions it makes for next year?**

This would allow us to discuss options about preventive, age 26 removing DME limits and out of pocket maximums. If repealed sooner would allow discussions for 2019 versus 2020.

***Would it grant your agencies greater authority in making decisions regarding benefits and health care than it currently has?**

Yes

***What benefit would it be to your agencies (especially to its ability to make plans regarding budget, policy, etc.) to have the ACA appealed now as opposed to much later in the year or even next year?**

It would allow discussions of greater options and be able to potentially reduce costs such as PCORI fees and 1094/1095 reporting.

iii. How does your spending/budgeting under ACA compare to prior to the implementation of the ACA?

Because of the increase in cost for ACA, it has required more revenue by the employer and employee to cover the increased costs.

In the United States District Court
FOR THE NORTHERN DISTRICT OF TEXAS

TEXAS, WISCONSIN, ALABAMA, ARKANSAS, ARIZONA, FLORIDA, GEORGIA, INDIANA, KANSAS, LOUISIANA, PAUL LEPAGE, *Governor of Maine*, GOVERNOR PHIL BRYANT OF THE STATE OF MISSISSIPPI, MISSOURI, NEBRASKA, NORTH DAKOTA, SOUTH CAROLINA, TENNESSEE, UTAH, WEST VIRGINIA, NEILL HURLEY, *and* JOHN NANTZ,

PLAINTIFFS,

v.

UNITED STATES OF AMERICA, UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, ALEX AZAR, *in his Official Capacity as* SECRETARY OF HEALTH AND HUMAN SERVICES, UNITED STATES DEPARTMENT OF REVENUE, *and* DAVID J. KAUTTER, *in his Official Capacity as Acting* COMMISSIONER OF INTERNAL REVENUE,

DEFENDANTS.

APPENDIX IN SUPPORT OF PLAINTIFF-STATES' AND INDIVIDUAL-PLAINTIFFS' APPLICATION FOR PRELIMINARY INJUNCTION

Exhibit M

IN THE UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF TEXAS
FORT WORTH DIVISION

TEXAS,
WISCONSIN,
ALABAMA,
ARKANSAS,
ARIZONA,
FLORIDA,
GEORGIA,
INDIANA,
KANSAS,
LOUISIANA,
PAUL LePAGE, Governor of Maine,
MISSISSIPPI, by and through
Governor Phil Bryant,
MISSOURI,
NEBRASKA,
NORTH DAKOTA,
SOUTH CAROLINA,
SOUTH DAKOTA,
TENNESSEE,
UTAH, and
WEST VIRGINIA,
Plaintiffs,

v.

Civil Action No. 4:18-cv-00167-O

UNITED STATES OF AMERICA,
UNITED STATES DEPARTMENT
OF HEALTH AND HUMAN
SERVICES, ALEX AZAR,
in his Official Capacity as
SECRETARY OF HEALTH AND
HUMAN SERVICES, UNITED
STATES INTERNAL REVENUE
SERVICE, and DAVID J. KAUTTER,
in his Official Capacity as Acting
COMMISSIONER OF INTERNAL
REVENUE,
Defendants.

DECLARATION OF DREW L. SNYDER

My name is Drew L. Snyder and I am over the age of 18 and fully competent to make this declaration and state the following:

1. I am the Executive Director for the Mississippi Division of Medicaid (DOM). DOM administers Medicaid at the state level to residents of Mississippi. Mississippi Medicaid serves: (1) Low-income families; (2) Children; (3) Pregnant women; (4) Elders; and (5) People with disabilities. As result of the ACA, an additional category was added to this list to include individuals under age 26, who aged out of foster care in the state and who were enrolled in Medicaid while in foster care. 42 U.S.C.A. § 1396a(a)(10)(A)(i)(IX) (West); Affordable Care Act, Pub. L. 111-148, 124 Stat. 865, § 2004
2. Financial eligibility for Medicaid and many other social programs is based on a family's income level as compared to the Federal Poverty Level (FPL). The FPL is intended to identify the minimum amount of income a family would need to meet very basic family needs.
3. Medicaid is funded by both the state and federal governments. The federal share of Medicaid funds Mississippi receives is based on the Federal Medical Assistance Percentage (FMAP). The FMAP is calculated annually using each state's per capita personal income in relation to the U.S. average. Generally, Mississippi receives an FMAP of approximately 75%, meaning the federal/state share of Medicaid funding is around 75/25 for most client services.

4. With the passing of the Affordable Care Act ("ACA") in 2010, DOM's ability to manage Medicaid coverage to Mississippi residents has been significantly restricted. The regulations imposed by the ACA result in substantial burden to DOM both administratively and financially.

Administrative & Policy Burdens Under the ACA

5. Prior to the passing of the ACA, DOM used several factors to determine eligibility for Medicaid for families and children including: (1) Family income; (2) age; (3) relationship; (4) other categorical factors, such as being pregnant or disabled.[1] Prior to the ACA DOM had the option to review eligibility criteria for adult enrollees more frequently than 12 months.

6. With the passing of the ACA, DOM was no longer given the flexibility to verify a Mississippi resident's eligibility based on these factors. Instead, the ACA expanded "mandatory" populations for Medicaid programs, wherein Mississippi was required to provide them Medicaid regardless of actual financial status. *See* Pub. L. 111-148, 124 Stat. 271, § 2002. Specifically, in Mississippi the coverage for former foster children was raised from 21 years old to 26 years old. The ACA also mandated DOM use Modified Adjusted Gross Income (MAGI) to determine eligibility.[2] 42 U.S.C.A. § 1396a(e)(14) (West). In other words, the tax filing rules are now

[1] Individuals receiving SSI cash assistance were and still are automatically eligible for Medicaid.
[2] MAGI applies to pregnant women, children and families, but does not apply to individuals who are elderly or who have disabilities

the primary consideration used to determine income and household composition for purposes of Medicaid eligibility. Income that is not taxable cannot be considered.

7. The restrictions placed upon DOM when it evaluates eligibility for Medicaid means that DOM is forced to ignore many factors relevant to an individual's ability to obtain health insurance for himself or herself. As a result, the ACA caused a rise in the number of Mississippi residents enrolled in Medicaid.

8. The ACA also imposed changes to the Medicaid and CHIP renewal process. Pursuant to the ACA, eligibility redeterminations are now allowed no more frequently than once per 12 months, unless the enrollee volunteers to DOM that there is a change that affects eligibility. This change mandated by the ACA restrains the frequency with which DOM can identify persons no longer eligible for Medicaid and remove them from the rolls, thus limiting the ability of the agency to fully review whether an adult continues to be eligible. The ACA's individual mandate contributed to the expansion of the Medicaid population in Mississippi as well. As a result of the individual mandate, Mississippi residents were required to seek health care coverage, on penalty of paying a fine to the federal government. Efforts to avoid imposition of the fine likely prompted more individuals to seek Medicaid from DOM.

9. Although it is difficult to quantify the exact number of Medicaid enrollees that can be attributed to the individual mandate, I am confident that the individual mandate played a substantial role in the increase in the number of Medicaid recipients since 2011. This assertion is based on my experience with DOM and the research I have participated in to prepare reports to the Mississippi legislature.

10. New requirements pursuant to the ACA regarding non-Mississippi residents and illegal aliens also increased the number of persons receiving Medicaid benefits in Mississippi. While non-residents and illegal aliens are not (and have never been) required to be provided full Medicaid benefits by DOM, the ACA did create a new mandate requiring that DOM allow them to apply for Medicaid by simply asserting that they are in a qualified alien status and qualified to receive benefits. Pursuant to the ACA, this mere assertion from an individual imposes a duty upon DOM to provide him or her benefits for up to 90 days while he or she is given the opportunity to verify their citizenship or alien status. This imposition by the ACA resulted in an increase of persons covered by Medicaid through DOM.

11. The ACA also forced DOM to expand Medicaid coverage by mandating that DOM initially accept a hospital's determination of a person's eligibility for Medicaid. 42 U.S.C. 1396a(a)(47). If a hospital concludes that an individual is eligible for Medicaid, the ACA requires DOM to

provide him or her Medicaid for two months while DOM makes its own eligibility determination. This increased the number of persons receiving Medicaid benefits through DOM at any given time by forcing DOM to provide two months of benefits to many individuals who would not have been approved by DOM as an original matter. In addition to this numerical increase imposed by the ACA, this mandate also required DOM to build new systems to accommodate this requirement. These efforts required the investment of administrative resources, time, and money that could have been spent in other ways that benefitted the state.

12. The ACA also mandates the specific Medicaid services Mississippi is required to cover. Rather than allowing DOM to make such determinations based on the needs of Mississippi's population, the ACA imposed a "one-size-fits-all" rule upon Mississippi governing the provision of inpatient hospital services, outpatient hospital services, family planning services and supplies, federally qualified health centers, nurse midwife services, certified pediatric and family nurse practitioner services, home health care services, medical transportation services, nursing facility services for individuals 21 or over, rural health clinic services, and other significant and complex medical services and systems.

13. The ACA expands Medicaid coverage for adults under age 65 (up to 133% FPL, or rather up to 138% FPL with a 5% income disregard). 42 U.S.C.A.

§ 1396a(a)(10)(A)(i)(VIII); (e)(14)(I)(i) (West). However, subsidies are available to adults through the Exchange beginning at 100% FPL.

14. As a cumulative result of these mandates, rules, and restrictions imposed by the ACA, DOM's Medicaid caseload has increased since implementation of the ACA. Since the ACA's implementation in 2014, Mississippi has expanded its Medicaid recipients from 2013 year end enrollment of 715,979 to a current enrollment of 739,082 in March 2018.

Costs Incurred Under the ACA

15. Medicaid Cost is determined by the Caseload – the volume or number of individuals served in each category - and Cost per Client - a function of the number, type, and cost of the services a client receives, and how those services are provided.

16. Given the increase in caseloads as a direct result of the ACA's enactment, state spending on Medicaid has increased dramatically following the ACA's implementation.

17. Beginning in January 2014, DOM was required to pay an annual excise tax to the federal government known as the Heath Insurer Tax. *See* Affordable Care Act, Pub. L. 111-148, 124 Stat. 865, § 9010. The tax is based on the amount of health insurance premiums collected. HIT will continue to increase with premium growth. In the FY 2017, DOM paid a total of $43,504,254 in this tax.

18. Pursuant to 28 U.S.C. § 1746, I declare under penalty of perjury that the foregoing is true and correct.

Respectfully submitted this the 20th day of April, 2018.

Drew L. Snyder, J.D.
Executive Director
Mississippi Division of Medicaid

STATE OF MISSISSIPPI

COUNTY OF HINDS

THIS DAY personally came and appeared before me, the undersigned authority, in and for the aforesaid jurisdiction, the within named, **Drew L. Snyder**, in his official capacity as the duly appointed **Executive Director of the Division of Medicaid in the Office of the Governor**, an administrative agency of the State of Mississippi, who acknowledged to me, being first duly authorized by said agency that he signed and delivered the above and foregoing written **Declaration of Drew L. Snyder** for and on behalf of said agency and as its official act and deed on the day and year therein mention.

GIVEN under my hand and official seal of office on this the 20th day of April, A.D., 2018.

NOTARY PUBLIC

My Commission Expires:

In the United States District Court
FOR THE NORTHERN DISTRICT OF TEXAS

TEXAS, WISCONSIN, ALABAMA, ARKANSAS, ARIZONA, FLORIDA, GEORGIA, INDIANA, KANSAS, LOUISIANA, PAUL LEPAGE, *Governor of Maine*, GOVERNOR PHIL BRYANT OF THE STATE OF MISSISSIPPI, MISSOURI, NEBRASKA, NORTH DAKOTA, SOUTH CAROLINA, TENNESSEE, UTAH, WEST VIRGINIA, NEILL HURLEY, *and* JOHN NANTZ,

PLAINTIFFS,

v.

UNITED STATES OF AMERICA, UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, ALEX AZAR, *in his Official Capacity as* SECRETARY OF HEALTH AND HUMAN SERVICES, UNITED STATES DEPARTMENT OF REVENUE, *and* DAVID J. KAUTTER, *in his Official Capacity as Acting* COMMISSIONER OF INTERNAL REVENUE,

DEFENDANTS.

APPENDIX IN SUPPORT OF PLAINTIFF-STATES' AND INDIVIDUAL-PLAINTIFFS' APPLICATION FOR PRELIMINARY INJUNCTION

Exhibit N

IN THE UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF Texas
FORT WORTH DIVISION

WISCONSIN, ALABAMA, ARKANSAS, ARIZONA, FLORIDA, GEORGIA, INDIANA, KANSAS, LOUISIANA, PAUL LePAGE, Governor of Maine, MISSISSIPPI, by and through Governor Phil Bryant, MISSOURI, NEBRASKA, NORTH DAKOTA, SOUTH CAROLINA, SOUTH DAKOTA, TENNESSEE, UTAH, and WEST VIRGINIA, Plaintiffs, v. UNITED STATES OF AMERICA, UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, ALEX AZAR, in his Official Capacity as SECRETARY OF HEALTH AND HUMAN SERVICES, UNITED STATES INTERNAL REVENUE SERVICE, and DAVID J. KAUTTER, in his Official Capacity as Acting COMMISSIONER OF INTERNAL REVENUE, Defendants.	§	Civil Action No. 4:18-cv-00167-O

DECLARATION OF Jennifer R. Tidball

My name is Jennifer R. Tidball and I am over the age of 18 and fully competent to make this declaration and state the following:

1. I am the Deputy Director for the Missouri Department of Social Services. I have served as Deputy Director since August, 2014. I have served with the Department for 23 years.
2. I am familiar with the business of the Department. As Deputy Director I have been made aware of changes related to the enactment of the ACA by staff that inform the Deputy Director
3. I have personal knowledge of the matters and information set forth herein.

Missouri Department of Social Services

4. The Missouri Department of Social Services administers Medicaid at the state level to residents of Missouri.
5. Financial eligibility for Medicaid and other social programs is based on a household's income level as compared to the Federal Poverty Level (FPL). Missouri uses multiple FPL percentages for different Medicaid coverage types, dependent upon the program.
6. Medicaid is funded by both the state and federal governments. The federal share of Medicaid funds Missouri receives is based on the Federal Medical Assistance Percentage (FMAP). The FMAP is calculated annually using each state's per capita personal income in relation to the U.S. average. Generally, Missouri receives an FMAP of 64.61%, meaning the federal/state share of Medicaid funding is around 65/35 for most medical services for FFY 2018.

7. Missouri did not adopt the full Medicaid expansion, the regulations imposed by the ACA result in substantial burden to Missouri Department of Social Services both administratively and financially.
8. Missouri's Medicaid caseload (the number of individuals enrolled in the Medicaid eligibility groups) increased from 881,719 for January 2013 to 969,049 for March 2018.

Administrative Changes to Medicaid Eligibility Under the ACA

9. Missouri Medicaid serves: (1) Low-income families; (2) Children; (3) Pregnant women; (4) Elderly; and (5) Persons with disabilities. As a result of the ACA, an additional category was added to this list to include individuals under age 26, who aged out of foster care in the state and who were enrolled in Medicaid while in foster care. 42 U.S.C.A. § 1396a(a)(10)(A)(i)(IX) ; Affordable Care Act, Pub. L. 111-148, 124 Stat. 865, § 2004.
10. Before the ACA, Missouri did not offer Medicaid to this full group of former foster care children under age 26.
11. Prior to the ACA, the Missouri Department of Social Services used several factors to determine eligibility for Medicaid including: (1) Family income; (2) age; (3) assets; (4) other factors such as being pregnant or disabled.[1]

[1] Individuals receiving SSI cash assistance were and still are automatically eligible for Medicaid.

12. ACA restricted the Missouri Department of Social Services to consider only a sole financial factor to determine eligibility: Modified Adjusted Gross Income (MAGI).[2] 42 U.S.C.A. § 1396a(e)(14). In other words, IRS tax filing rules are now the only permissible consideration used to determine income and household composition for purposes of Medicaid eligibility. Other income, such as child support and Social Security income for children whose total income falls below an IRS determined threshold, is not considered. Because the ACA left no choice to states but to accept these new criteria, Missouri approved the use of MAGI by SB 127 (2013) beginning in January 2014.

13. The change to MAGI complicated the administration of the program because the eligibility criteria differ from those used for other social service programs. Under the ACA, Missouri built a new eligibility system to process MAGI Medicaid, which was costly and complicated.

Under ACA, open enrollment is once per year. During the open enrollment period the Department receives an additional 10,000 to 15,000 applications per month.

[2] MAGI applies to pregnant women, children and families, but does not apply to individuals who are elderly or who have disabilities.

The ACA's individual mandate increased Missouri's Medicaid enrollment

14. The ACA also included an individual mandate. Missouri residents were required to seek health care coverage or pay a penalty to the federal government.

15. Although it is difficult to quantify the exact number of Medicaid enrollees that can be attributed to the ACA, during the time period the ACA was implemented the Medicaid caseload increased, see numbers above.

16. The ACA also mandates the specific Medicaid services Missouri is required to cover.

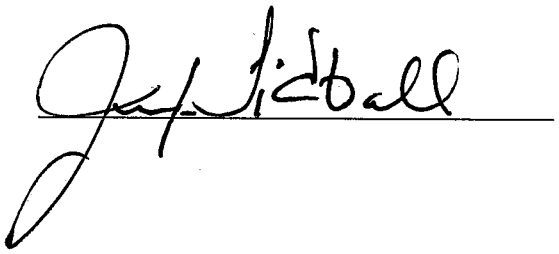
Costs Incurred Under the ACA

17. Medicaid Cost is determined by the Caseload – the volume or number of individuals served in each category - and Cost per Client - a function of the number, type, and cost of the services a client receives, and how those services are provided.

18. Given the increase in caseloads state spending on Medicaid has increased following the ACA's implementation. With the increase in caseload, the combined state share of Medicaid Administration and Assistance increased from $3,516,957,427 in FFY 2013 to $3,851,597,485 in FFY 2017.

19. Pursuant to 28 U.S.C. § 1746, I declare under penalty of perjury that the foregoing is true and correct.

Respectfully submitted this the 18th day of April, 2018.



In the United States District Court
FOR THE NORTHERN DISTRICT OF TEXAS

TEXAS, WISCONSIN, ALABAMA, ARKANSAS, ARIZONA, FLORIDA, GEORGIA, INDIANA, KANSAS, LOUISIANA, PAUL LEPAGE, *Governor of Maine*, GOVERNOR PHIL BRYANT OF THE STATE OF MISSISSIPPI, MISSOURI, NEBRASKA, NORTH DAKOTA, SOUTH CAROLINA, TENNESSEE, UTAH, WEST VIRGINIA, NEILL HURLEY, *and* JOHN NANTZ,

PLAINTIFFS,

v.

UNITED STATES OF AMERICA, UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, ALEX AZAR, *in his Official Capacity as* SECRETARY OF HEALTH AND HUMAN SERVICES, UNITED STATES DEPARTMENT OF REVENUE, *and* DAVID J. KAUTTER, *in his Official Capacity as Acting* COMMISSIONER OF INTERNAL REVENUE,

DEFENDANTS.

APPENDIX IN SUPPORT OF PLAINTIFF-STATES' AND INDIVIDUAL-PLAINTIFFS' APPLICATION FOR PRELIMINARY INJUNCTION

Exhibit O

IN THE UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF TEXAS
FORT WORTH DIVISION

TEXAS,
WISCONSIN,
ALABAMA,
ARKANSAS,
ARIZONA,
FLORIDA,
GEORGIA,
INDIANA,
KANSAS,
LOUISIANA,
PAUL LePAGE, Governor of Maine,
MISSISSIPPI, by and through
Governor Phil Bryant,
MISSOURI,
NEBRASKA,
NORTH DAKOTA,
SOUTH CAROLINA,
SOUTH DAKOTA,
TENNESSEE,
UTAH, and
WEST VIRGINIA,
Plaintiffs,

v.

UNITED STATES OF AMERICA,
UNITED STATES DEPARTMENT
OF HEALTH AND HUMAN
SERVICES, ALEX AZAR,
in his Official Capacity as
SECRETARY OF HEALTH AND
HUMAN SERVICES, UNITED
STATES INTERNAL REVENUE
SERVICE, and DAVID J. KAUTTER,
in his Official Capacity as Acting
COMMISSIONER OF INTERNAL
REVENUE,
Defendants.

Civil Action No. 4:18-cv-00167-O

DECLARATION OF JUDITH MUCK

My name is Judith Muck and I am over the age of 18 and fully competent to make this declaration and state the following:

1. I am the Executive Director of the Missouri Consolidated Health Care Plan (MCHCP). I have served as Executive Director with Missouri Consolidated Health Care Plan for 5 years.
2. As the Executive Director for Missouri Consolidated Health Care Plan, I am responsible for the day-to-day operations of the health plan.
3. I am familiar with the business of MCHCP, with the storage of records in the MCHCP and with changes in costs, plans and policies related to the enactment of the ACA.
4. I have personal knowledge of the matters and information set forth herein except where noted.

The Missouri Consolidated Health Care Plan

5. The Missouri Consolidated Health Care Plan is a non-federal governmental health plan which provides insurance coverage for most state employees as specified in Chapter 10 of the Revised Statutes of Missouri. Missouri statutes grants to the MCHCP Board of Trustees (the Board) the general administration and the responsibility for the proper operation of the plan. 103.008 RSMo.
6. Under Section 103.014, the Board appoints an Executive Director who has charge of the offices, records and employees of the plan, subject to the discretion of the board.
7. The Board, upon recommendations of the Executive Director of the MCHCP, sets benefits and premiums each year for the next plan year. Taken into

consideration when designing the coverage are benefits and limits that are mandated by law, both federal and state.

8. Per 103.100 RSMo, every year MCHCP actuarially estimates the cost based on the plan design chosen by the Board and sends an overall cost to provide benefits to the Office of Administration. The governor makes a recommendation and the legislature passes the funding at the level it approves. MCHCP's budget is contained in the Office of Administration's budget as an employee benefit.

Financial Costs Associated with ACA Regulations

9. With the passing of the ACA, Missouri Consolidated Health Care Plan has been affected with new administrative and financial requirements.

10. These requirements are described in the attached chart that was used by the MCHCP which was prepared by our employees shortly after state FY 2017, and updated as needed to summarize the historical and projected impact of the ACA on the MCHCP. This chart was made and kept in the ordinary course of business. This chart was made by assembling the data available to MCHCP in its computerized accounting system, data warehouse, actuarial analysis and contractual terms. This chart was found in the ordinary course of business and it was not prepared for purposes of litigation. The exhibit is a true copy of this chart. All fiscal years reference the state fiscal year. The state fiscal year runs from July 1, through June 30 of the subsequent year.

Lifetime Maximum Benefit

11. At the time of passage and implementation of the ACA, MCHCP did not have a lifetime maximum benefit. "Lifetime maximum benefit" is the maximum dollar amount a health insurance plan will pay in benefits to an insured person during that person's lifetime. The ACA prohibited insurance contracts nationwide from including any lifetime maximum benefit. The ACA thus eliminated Missouri Consolidated Health Care Plan's ability to choose to impose lifetime maximum benefits for essential health benefits in the future. 42 U.S.C. § 300-gg-11.

Young Adult Dependents

12. Prior to the implementation of the ACA on January 1, 2010, Missouri Consolidated Health Care Plan provided coverage for unemancipated dependents up to age 25 and unemancipated disabled children over age 25 who are permanently and totally disabled when first eligible or covered before age 25.. But the ACA requires that all health insurance coverage nationwide provide continuing coverage for all dependents until the age of 26. 42 U.S.C. § 300-gg-14.

13. Providing continuing health insurance coverage for adult dependents until the age of twenty-six puts costs upon Missouri Consolidated Health Care Plan because each individual insured by the Missouri Consolidated Health Care Plan constitutes expenses for the system.

14. Specifically, Missouri Consolidated Health Care Plan had costs of $316,382 in FY 2011, $ 1,080.559 in FY 2012, $1,319,790 in FY 2013, $1,574,090 in FY 2014, $1,726,080 in FY 2015, $2,336,735 in FY 2016, $ 2,333,801 in FY 2017.

15. Accordingly, in the six-year period between 2012 and 2017, compliance with the ACA legal mandate to insure dependents until the age of twenty-six imposed a cost of approximately $10,687,437.

16. Exact additional costs for 2018 are not yet available, but compliance with the ACA will require Missouri Consolidated Health Care Plan to indefinitely continue paying these additional costs because the dependent age requirement mandated by the ACA remains 26, which is higher than the age that Missouri Consolidated Health Care Plan had adopted prior to the implantation of the ACA.

17. MCHCP estimates that these costs will be $2,203,014 in FY 2018, $2,395,552 in FY 2019, $2,553,658 in FY 2020, and $2,722,200 in FY 2021.

Preventive Services

18. Prior to adoption of the ACA on January 1, 2010, Missouri Consolidated Health Care Plan required insured persons to pay deductible, co-insurance and/or co-payments for some preventive care that are now disallowed because the ACA requires that preventive care be covered at 100%. 42 U.S.C. § 300gg-13. Prior to this provision, MCHCP covered almost all recommended preventive services with no cost share. Examples of services not previously covered at 100% include over-the-counter tobacco cessation products with a prescription,

vitamin D with a prescription, aspirin with a prescription in certain situations, folic acid with a prescription in certain situations, routine prenatal care, and breast feeding support and services. Because so few services were not already covered, an actuary determined that this requirement did not impact MCHCP premiums. MCHCP lost the flexibility to choose not to offer these services in the future or to offer them subject to cost sharing requirements.

Clinical Trials.

19. Effective January 1, 2013, the ACA requires coverage for routine patient care costs incurred as the result of a Phase I, II, III or IV clinical trial that is conducted in relation to the prevention, detection or treatment of cancer or other life-threatening disease or condition. Prior to this provision, MCHCP covered routine patient care costs incurred as the result of Phase II, III or IV clinical trials for cancer in accordance with Missouri law. The actuary thus determined that this requirement did not impact MCHCP premiums. MCHCP lost the flexibility to choose not to cover the expanded trial requirements in the future.

Patient-Centered Outcomes Research Institute (PCORI) Fee.

20. The ACA requires Missouri Consolidated Health Care Plan to pay a Patient-Centered Outcomes Research Institute (PCORI) fee. 26 U.S.C. § 9511. The fee applies to issuers of specified health insurance policies and plan sponsors of applicable self-insured health plans to help fund the Patient-Centered Outcomes Research Institute. The fee is based on the average number of lives

covered under the plan. The fee applies to plan years ending on or after Oct. 1, 2012, and before Oct. 1, 2019. MCHCP makes payment in July of each year.

21. Missouri Consolidated Health Care Plan paid the following for its persons enrolled in a health insurance plan: in FY 2014, $87,002; in FY 2015, $173,432; in FY 2016, $181,018; in FY 2017, $187,783. It projects to pay, assuming a 4% trend over current fee of $2.08, $194,640 in FY 2018; $203,106 in FY 2019; $211,230 in FY 2020; and $211,230 in FY 2021.

Transitional Reinsurance Program Fee.

22. The ACA requires Missouri Consolidated Health Care Plan to pay the Transitional Reinsurance Program fee. 42 U.S.C. § 18061. Section 1341 of the ACA established a Transitional Reinsurance Program to help stabilize premiums for coverage in the individual market during the years 2014 through 2016. If this requirement had not been in place, Missouri Consolidated Health Care Plan would have saved approximately $3,878,420 in FY 2015; $3,185,756 in FY 2016; $2,358,259 in FY 2017; and $388,725 in FY 2018.

Employer Shared Responsibility.

23. Prior to the ACA, a full-time employee was defined as an employee who is employed at least 40 hours per week; the ACA altered that number to 30 hours per week. 26 U.S.C.A. § 4980H; Pub. L. 111-148, 124 Stat. 865, § 4980H(d)(4)(A).

24. This change impacted Missouri Consolidated Health Care Plan by increasing the number of persons the State of Missouri must insure, thus increasing the total cost of providing insurance.

25. Under the ACA, any employer with 100 (decreases to 50 in 2016) or more full-time equivalents (FTEs) is subject to a penalty if the employer fails to offer access to minimum essential coverage and if any FTE receives a tax credit or if the coverage does not meet minimum value and affordability requirements.

26. MCHCP coverage meets minimum value and affordability requirements. MCHCP offers coverage to all FTEs that are benefit-eligible. Effective January 1, 2015, MCHCP began offering coverage to certain variable hour employees who are not benefit-eligible but who worked on average more than 30 hours per week during the standard measurement period. These individuals are considered an FTE employee for the purpose of the ACA.

27. In FY 2016, this cost $112,833 and in FY 2017, $137,790. Projected costs include $268,242 in FY 2018; $290,897 in FY 2019; $310,096 in FY 2020; and $330,562 in FY 2021. Estimated costs reflect MCHCP's contribution to the premium for variable hour employees.

Excise or Cadillac Tax.

28. Under the ACA, a 40 percent excise tax will be assessed, beginning in 2022, on the cost of coverage for health plans that exceed a certain annual limit ($10,200 for individual coverage and $27,500 for self and spouse or family coverage. Limits for retiree coverage are higher.) Estimates are subject to further

guidance through regulations not yet available. Issues that can impact the potential amount owed include rate blending, age and demographic distributions, HSA/FSA contributions as well as other issues.

29. This excise tax was estimated in December 2015, to be $2.0M-$2.5M in FY 2022. The lower amount of the range is estimated based on rate blending with the higher amount reflecting no rate blending. The estimate given also does not include the impact of any future benefit design changes should they occur after the estimate was made.

IRS Reporting Requirements.

30. Under the ACA, MCHCP is required to report who has coverage to the Internal Revenue Service (IRS) annually. MCHCP has contracted for the printing and mailing of 1094B and 1095B reporting.

31. Form 1094-B is for the Transmittal of Health Coverage Information Returns. Form 1095-B is used to report certain information to the IRS and to taxpayers about individuals who are covered by minimum essential coverage and therefore are not liable for the individual shared responsibility payment.

32. These costs are $185,061 in FY 2016 and $57,699 in FY 2017. They are projected to be $47,000 in FY 2018; $47,300 in FY 2019; $49,200 in FY 2010; and $51,200 in FY 2021.

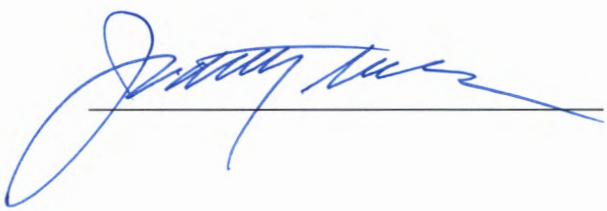
Administrative Requirements Associated with ACA Regulations

33. Missouri Consolidated Health Care Plan is currently structuring the benefits and policies for the 2019 plan year and bases its activities on knowledge of whether the ACA is still federal law in order.

34. Without the expenses described above, Missouri Consolidated Health Care Plan would possibly gain back nearly $3 million in funding. This is based on $2,395,552 for its line item on young adult dependents, $203,106 saved on the PCORI fee, $290,897 on the employer shared responsibility payments, and $47,300 on IRS reporting requirements.

35. Pursuant to 28 U.S.C. § 1746, I declare under penalty of perjury that the foregoing is true and correct.

Respectfully submitted this the 16 day of April 2018.



Affordable Care Act (ACA) Provisions for Large Groups (101+) with potential cost impact to MCHCP	MCHCP Actual Costs							MCHCP Estimated Costs			
	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021
Young adult dependents - Covered up to age 26. Effective 01/01/2010. Prior to this provision, MCHCP covered young adult dependents up to age 25 if unmarried and if lived at parent home or attended school. Estimated costs reflect MCHCP's contribution to the	$316,382	$1,080,559	$1,319,790	$1,574,090	$1,726,080	$2,336,735	$2,333,801	$2,203,014	$2,395,552	$2,553,658	$2,722,200
Preventive Services - Recommended preventive services must be covered at 100% when delivered in-network. Effective 01/01/2010. Prior to this provision - MCHCP covered almost all recommended preventive services with no cost share. Examples of services not previously covered at 100% include over-the-counter tobacco cessation products with a prescription vitamin D with a prescription, aspririn with a prescription in certain situations, folic acid with a prescription in certain situations. The actuary determined that this requirement did not impact MCHCP	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Women's Preventive Services - Includes additional recommended preventive services specific to women. Effective 01/01/2013 Prior to this provision, MCHCP covered almost all recommended preventive services at 100%. Examples of services not previously covered at 100% included routine prenatal care and breast feeding support and services. The actuary determined that this requirement did not impact MCHCP premiums.	N/A	N/A	N/A	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Clinical Trials - Coverage for routine patient care costs incurred as the result of a Phase I, II, III or IV clinical trial that is conducted in relation to the prevention, detection or treatment of cancer or other life-threatening disease or condition. Effective 01/01/2013 Prior to this provision, MCHCP covered routine patient care costs incurred as the result of Phase II, III or IV clinical trials for cancer. The actuary determined that this requirement did not impact MCHCP premiums.	N/A	N/A	N/A	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Patient-Centered Outcomes Research Institute (PCORI) Fee - A fee on issuers of specified health insurance policies and plan sponsors of applicable self-insured health plans to help fund the Patient-Centered Outcomes Research Institute. The fee is based on the average number of lives covered under the policy or plan. The fee applies to plan years ending on or after Oct. 1, 2012, and before Oct. 1, 2019. Payment made in July of each year. Assumed a 4% trend over current fee of $2.08.	N/A	N/A	N/A	$87,002	$173,432	$181,018	$187,783	$194,640	$203,106	$211,230	$211,230
Transitional Reinsurance - Section 1341 of the ACA established a Transitional Reinsurance Program to help stabilize premiums for coverage in the individual market during the years 2014 through	N/A	N/A	N/A	N/A	$3,878,420	$3,185,756	$2,358,259	$388,725	N/A	N/A	N/A

Employer Shared Responsibility - Any employer with 100 (decreases to 50 in 2016) or more full-time equivalents (FTEs) is subject to a penalty if the employer fails to offer access to minimum essential coverage and if any FTE receives a tax credit or if the coverage does not meet minimum value and affordability requirements. MCHCP coverage meets minimum value and affordability requirements. MCHCP offers coverage to all FTEs that are benefit-eligible. Effective 01/01/2015, MCHCP began offering coverage to certain variable hour employees who are not benefit-eligible but who worked on average more than 30 hours per week during the standard mearsurement period. These individuals are considered an FTE employee for the purpose of this law. Estimated costs	N/A	N/A	N/A	N/A	N/A	$112,833	$137,790	$268,242	$290,897	$310,096	$330,562
Excise Tax - On January 22, 2018, Congress passed and the President signed into law a two year delay on the Affordable Care Act's 40 percent excise tax on high-value health care plans. The 40 percent excise tax will take effect, beginning in 2022, on the cost of coverage for health plans that exceed a certain annual limit ($10,200 for individual coverage and $27,500 for self and spouse or family coverage. Limits for retiree coverage are higher.) Estimates are subject to further guidance through regulations which are not yet available. Issues that can impact the potential amount owed include rate blending, age and demographic distributions, HSA/FSA contributions as well as others. Although no payments would be due through FY 2021, an actuarial estimate completed in Dec. 2015 estimated the excise tax owed in 2022 to be $2M-$5M. The lower amount of the range is estimated based on rate blending with the higher amount reflecting no rate blending. The estimate given also does not include the impact of any future benefit design changes should they occur after the analysis was completed.	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Auto-Enrollment - Employers with >200 employees must auto-enroll employees into coverage if a new employee fails to enroll or waive coverage. Implementing regulations have not been issued and this provision will not be effective until such time. Have not estimated costs for this provision.	N/A	N/A	N/A	N/A	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
IRS Reporting Requirements - Contracted services for printing and mailing of 1094B and 1095B reporting	N/A	N/A	N/A	N/A	N/A	$185,061	$57,699	$47,000	$47,300	$49,200	$51,200

In the United States District Court
FOR THE NORTHERN DISTRICT OF TEXAS

TEXAS, WISCONSIN, ALABAMA, ARKANSAS, ARIZONA, FLORIDA, GEORGIA, INDIANA, KANSAS, LOUISIANA, PAUL LEPAGE, *Governor of Maine*, GOVERNOR PHIL BRYANT OF THE STATE OF MISSISSIPPI, MISSOURI, NEBRASKA, NORTH DAKOTA, SOUTH CAROLINA, TENNESSEE, UTAH, WEST VIRGINIA, NEILL HURLEY, *and* JOHN NANTZ,

PLAINTIFFS,

v.

UNITED STATES OF AMERICA, UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, ALEX AZAR, *in his Official Capacity as* SECRETARY OF HEALTH AND HUMAN SERVICES, UNITED STATES DEPARTMENT OF REVENUE, *and* DAVID J. KAUTTER, *in his Official Capacity as Acting* COMMISSIONER OF INTERNAL REVENUE,

DEFENDANTS.

APPENDIX IN SUPPORT OF PLAINTIFF-STATES' AND INDIVIDUAL-PLAINTIFFS' APPLICATION FOR PRELIMINARY INJUNCTION

Exhibit P

IN THE UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF TEXAS
FORT WORTH DIVISION

TEXAS, NEBRASKA, *et al.* Plaintiffs, v. UNITED STATES OF AMERICA, UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, ALEX AZAR, in his Official Capacity as SECRETARY OF HEALTH AND HUMAN SERVICES, UNITED STATES INTERNAL REVENUE SERVICE, and DAVID J. KAUTTER, in his Official Capacity as Acting COMMISSIONER OF INTERNAL REVENUE Defendants.	)	Civil Action No. 4:18-cv-00167-O

DECLARATION OF BRUCE R. RAMGE, DIRECTOR, NEBRASKA DEPARTMENT OF INSURANCE, PURSUANT TO 28 U.S.C. § 1746

INTRODUCTION

1. My name is Bruce Ramge and I am the Director of the Nebraska Department of Insurance ("NDOI").

2. NDOI is responsible for regulating the Nebraska health insurance market and protecting consumers of this market. Overall, NDOI performs a variety of tasks to protect insurance consumers and ensure a competitive insurance market environment, including:

a. Reviewing insurance policies sold in Nebraska to ensure compliance with Nebraska and federal law;

b. Conducting examinations of foreign and domestic insurers doing business in Nebraska to ensure compliance with Nebraska laws and rules;

c. Monitoring the financial solvency of licensed companies to make sure that consumers have the insurance coverage they expect when they need it;

d. Issuing licenses to agents, brokers, consultants, and other entities that sell and market insurance products;

e. Researching special insurance issues to understand and assess their impact on Nebraskans;

f. Providing technical assistance on legislation and promulgating rules and regulations to interpret insurance laws;

g. Creating and distributing public information and consumer education about all types of insurance; and

h. When insurance companies are in financially hazardous condition or have become insolvent, working with the guaranty associations made up of insurance companies, which by statute must step in and pay policyholder claims when an insurer, for example CoOportunity, fails.

3. As Director, I am the head of NDOI and the chief regulator of insurance in Nebraska. Generally, my official duties include supervising the entire agency, serving as final adjudicator of all administrative actions, and serving on various councils and committees in a variety of capacities.

4. Additionally, my official duties with NDOI include studying the impact of the Affordable Care Act ("ACA") on Nebraska's insurance market, ensuring Nebraska's compliance with the ACA, advising the Nebraska Governor on the ACA, and developing strategies for Nebraska to mitigate the numerous harms the ACA has inflicted on Nebraska's health insurance markets.

HARMS CAUSED BY THE AFFORDABLE CARE ACT

5. The ACA has wrought havoc on the health insurance market in Nebraska and imposed significant burdens on NDOI as regulator of Nebraska's insurance market.

6. Prior to enactment of the ACA, Nebraska's individual major medical market offered more choices for consumers. For example, in 2010, approximately thirty carriers offered coverage in Nebraska's individual market. The ACA's effect on insurers' participation in the market is demonstrated by the numbers: three carriers in 2014, four carriers in 2015 and 2016, two carriers in 2017, and one remaining carrier in 2018.

7. In 2017, two major carriers exited Nebraska's individual market. Aetna announced its withdrawal from Nebraska's individual market in May 2017, citing an expected loss of $200 million for 2017 in the four states Aetna sold individual coverage. In June 2017, Blue Cross and Blue Shield of Nebraska also announced its withdrawal from Nebraska's individual market, citing an expected loss of $12 million for 2017, in addition to the approximately $150 million loss the company experienced selling ACA plans in Nebraska from 2014 to 2016. In the wake of these companies' departures, only a single insurer, Medica, remains in Nebraska's individual market. Nebraskans are left to hope that Medica—which raised premiums 31% for plan year 2018—remains in the individual market for plan year 2019.

8. Premiums are predicted to keep rising. The Congressional Budget Office's April 2018 "Budget and Economic Outlook: 2018 to 2028" estimates that, under current law, federal outlays for health insurance subsidies and related spending will rise by about 60 percent over the projection period, increasing from $58 billion in 2018 to $91 billion by 2028. (cbo.gov/publication/53651). These rising premiums have a significant negative impact on middle-class Nebraskans.

9. The State of Nebraska itself has borne significant new costs as a result of the ACA. For example, the State of Nebraska, like other States, must offer non-full time employees (*i.e.*, employees working 30-39 hours per week) health insurance plans with premiums identical to those offered to full time employees.

10. The Nebraska Department of Insurance, as the primary enforcer of insurance laws, has spent the past six years reading and enforcing thousands of pages of federal regulations, guidance, and other sub-regulatory guidance related to the ACA, completely revised its insurance policy review standards for health insurance products, educated the public on changes in the law, and fielded consumer complaints expressing confusion and frustration about the limited, expensive choices that remain in the Nebraska individual market.

11. Additionally, the ACA harms Nebraska because it has preempted Nebraska law, preventing Nebraska from regulating health insurance in the manner it sees fit.

12. The ACA forced insurers to issue policies to all qualified applicants, regardless of their health condition, and the ACA does not allow insurers to charge higher premiums to people who, because of pre-existing conditions, have higher anticipated medical costs. The ACA forced insurers to pay for pre-existing conditions, which in turn

drove up premiums. The ACA forcing insurers to charge the same rate regardless of health condition forced healthy people to pay higher premiums. While sick people's premiums became lower, as discussed below, a mechanism already existed in Nebraska law to provide coverage for high-cost individuals.

13. A recent study confirmed that the top one percent of insureds in Nebraska's individual market are responsible for 40 percent of the medical costs. Nebraska law creates a high-risk pool, which operated as an insurer of last resort for people when private insurers refused to issue coverage to them due to expensive anticipated medical costs. Because the ACA makes private insurance available and "affordable" regardless of a purchaser's health condition, Nebraska's high risk pool cannot operate as it did prior to 2014, to keep high-cost individuals from driving up premiums for insurance purchasers of average or good health.

14. Finally, the ACA harmed the Nebraska health insurance market by creating health insurance co-ops. CoOportunity Health, which operated in Iowa and Nebraska, was the first co-op to go insolvent. Co-ops were conceived in the ACA as an alternative to commercial insurance, to create competition and drive down premiums. The premiums CoOportunity charged were insufficient to cover rising health costs, despite large enrollment numbers (120,000 insureds in Nebraska and Iowa combined) and $147 million in loans from the federal government, in addition to members' premiums. Under Nebraska law, other health insurers were required to step in with funds to pay the claims of the more than 80,000 Nebraskans insured by CoOportunity. In summary, CoOportunity "created competition" by taking customers from the private market, went insolvent, then looked to its competitors to pay those customers' claims. CoOportunity was put into

liquidation in early 2015, and the CoOportunity liquidator filed suit against the federal government, which attempted to put itself, as creditor, ahead of policyholders when the time came to disburse what funds remained in CoOportunity's possession. The ACA's co-op program, nationwide, has cost taxpayers more than $1.8 billion in funds that may never be recovered. Of the original 23 co-ops, only six remain.

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

Executed on April 16, 2018.

Signed,

Bruce R. Ramge

Bruce R. Ramge, Director
Nebraska Department of Insurance

In the United States District Court
FOR THE NORTHERN DISTRICT OF TEXAS

TEXAS, WISCONSIN, ALABAMA, ARKANSAS, ARIZONA, FLORIDA, GEORGIA, INDIANA, KANSAS, LOUISIANA, PAUL LEPAGE, *Governor of Maine*, GOVERNOR PHIL BRYANT OF THE STATE OF MISSISSIPPI, MISSOURI, NEBRASKA, NORTH DAKOTA, SOUTH CAROLINA, TENNESSEE, UTAH, WEST VIRGINIA, NEILL HURLEY, *and* JOHN NANTZ,

PLAINTIFFS,

v.

UNITED STATES OF AMERICA, UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, ALEX AZAR, *in his Official Capacity as* SECRETARY OF HEALTH AND HUMAN SERVICES, UNITED STATES DEPARTMENT OF REVENUE, *and* DAVID J. KAUTTER, *in his Official Capacity as Acting* COMMISSIONER OF INTERNAL REVENUE,

DEFENDANTS.

APPENDIX IN SUPPORT OF PLAINTIFF-STATES' AND INDIVIDUAL-PLAINTIFFS' APPLICATION FOR PRELIMINARY INJUNCTION

Exhibit Q

IN THE UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF TEXAS
FORTH WORTH DIVISION

TESAS, NEBRASKA, *et al.* Plaintiffs, v. UNITED STATES OF AMERICA, UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES ALEX AZAR, in his Official Capacity as SECRETARY OF HEALTH AND HUMAN SERVICES, UNITED STATES INTERNAL REVENUE SERVICE, and DAVID J. KAUTTER, in his Official Capacity as Acting COMMISSIONER OF INTERNAL REVENUE Defendants.	)	Civil Action No. 4:18-cv-00167-O **DECLARATION OF JON GODFREAD, COMMISSIONER, NORTH DAKOTA INSURANCE DEPARTMENT**

Jon Godfread, being first duly sworn on oath, deposes and states as follows:

1. My name is Jon Godfread and I am the Commissioner of the North Dakota Insurance Department ("NDID").
2. NDID is responsible for regulating the North Dakota health insurance market and protecting the consumers of this market. Overall, NDID performs a variety of tasks to protect insurance consumers and endure a competitive insurance market environment, including:
    a. Reviewing all insurance policies offered for sale in North Dakota to ensure compliance with North Dakota law;
    b. Conducting examinations of foreign and domestic insurers doing business in North Dakota to ensure compliance with North Dakota laws and rules;

c. Monitoring the financial solvency of licensed companies to make sure that consumers have the insurance coverage they expect when they need it;

d. Issuing licenses to individuals who are qualified to serve as agents or consultants and other entities that sell and market insurance products;

e. Reviewing and approving rates for health insurance plans prior to being offered for sale in North Dakota;

f. Creating and distributing public information and consumer education about all types of insurance; and

g. Providing input and assistance on legislation and rules and regulations affecting insurance.

3. As Commissioner, I am the head of the NDID and the chief regulator of insurance in North Dakota.

4. My official duties include studying the impact of the Affordable Care Act ('ACA") on North Dakota's insurance market and developing strategies for North Dakota to mitigate the negative consequences the ACA has inflicted on North Dakota's health insurance markets.

5. North Dakota's health insurance market was not broken prior to enactment of the ACA. North Dakota had meaningful competition in its marketplace, a highly successful state high risk pool which offered a rich benefit plan, and the state had a low percentage of uninsured individuals. Prior to implementation of the ACA eight to ten percent of North Dakotans had no health insurance. After the implementation of the ACA eight to ten percent of North Dakotans have no health

insurance. The ACA attempted to fix something, which was not broken and has resulted in many negative consequences to North Dakota.

6. In 2017, one major carrier completely exited North Dakota's individual health exchange marketplace due to continued expected financial losses. Another major carrier exited North Dakota's individual exchange marketplace in 48 of the state's 53 counties, citing the same concerns. This left only one insurance company to sell on North Dakota's individual exchange marketplace in 48 of the state's 53 counties for plan year 2018.
7. Premiums are predicted to keep rising. These rising premiums have a significant negative impact on North Dakotans who are self-employed and do not qualify for a subsidy on the federal exchange, as these North Dakotans have been forced to take on the full weight of every rate increase over the years without assistance.
8. The NDID has spent the past eight years reading and enforcing thousands of pages of federal regulations and other regulatory guidance related to the ACA, spent countless hours on calls with federal officials in an attempt to learn how these laws and rules impact North Dakota's health insurance market and our consumers, completely revised its insurance policy review standards for health insurance products, and fielded consumer complaints expressing confusion and frustration about the limited, expensive choice that remain in North Dakota's individual market.
9. The ACA harms North Dakota because it has preempted North Dakota law, preventing North Dakota from regulating health insurance in the manner it sees fit.

10. The ACA forced insurers to issue policies to all qualified applicants, regardless of their health condition, and the ACA does not allow insurers to charge higher premium to people who, because of pre-existing conditions, have higher anticipated medical costs. The ACA forced insures to pay for pre-existing conditions, which in turn drove up premiums. The ACA forcing insurers to charge the same rate regardless of health condition has forced individuals without pre-existing conditions to pay much higher premiums and in many cases, the end result has been that these individuals cannot afford to have health insurance coverage.

11. North Dakota law creates a high risk pool, which prior to the enactment of the ACA operated as an insurer of last resort for people when private insurers declined to issue coverage to them due to expensive anticipated medical costs. Since the ACA makes private insurance available regardless of a purchaser's health condition, North Dakota's high risk pool cannot operate as it did prior to 2014, to keep high-cost individuals from driving up premiums for individuals of average or good health.

Further your affiant sayeth not.

Dated this 19th day of April, 2018.

By: _____
Jon Godfread
North Dakota Insurance Commissioner

Subscribed and sworn to before me this
19th day of April, 2018.

_____
Notary Public

LAURA HELBLING
Notary Public
State of North Dakota
My Commission Expires Jul 4, 2023

In the United States District Court
FOR THE NORTHERN DISTRICT OF TEXAS

TEXAS, WISCONSIN, ALABAMA, ARKANSAS, ARIZONA, FLORIDA, GEORGIA, INDIANA, KANSAS, LOUISIANA, PAUL LEPAGE, *Governor of Maine*, GOVERNOR PHIL BRYANT OF THE STATE OF MISSISSIPPI, MISSOURI, NEBRASKA, NORTH DAKOTA, SOUTH CAROLINA, TENNESSEE, UTAH, WEST VIRGINIA, NEILL HURLEY, *and* JOHN NANTZ,

PLAINTIFFS,

v.

UNITED STATES OF AMERICA, UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, ALEX AZAR, *in his Official Capacity as* SECRETARY OF HEALTH AND HUMAN SERVICES, UNITED STATES DEPARTMENT OF REVENUE, *and* DAVID J. KAUTTER, *in his Official Capacity as Acting* COMMISSIONER OF INTERNAL REVENUE,

DEFENDANTS.

APPENDIX IN SUPPORT OF PLAINTIFF-STATES' AND INDIVIDUAL-PLAINTIFFS' APPLICATION FOR PRELIMINARY INJUNCTION

Exhibit R

STATE OF SOUTH CAROLINA)
) AFFIDAVIT
COUNTY OF RICHLAND)

PERSONALLY APPEARED before me, Robin Tester, who being duly sworn, attests to the following:

1. I am the Insurance Policy Director of the Public Employee Benefit Authority, which administers the Group Health Benefits Plan of the Employees of the State of South Carolina, the public school districts, and participating entities (typically referenced as the "State Health Plan").

2. I am familiar with the Patient Protection and Affordable Care Act, P.L. 111-148, as amended by the Health Care and Education Reconciliation Act of 2010, P.L. 111-152 (ACA).

3. State Health Plan participants include state officers as well as employees of:

   - State agencies (pursuant to S.C. Code Ann. § 1-11-710)
   - Public school districts (pursuant to § 1-11-710)
   - Other participating entities/local subdivisions that elect to participate pursuant to § 1-11-720

   Participants also include retirees of these employers as defined in § 1-11-730 of the Code of Laws and the eligible spouses and eligible children of employees and retirees.

4. Since January 1, 2011, the State Health Plan has complied with the following ACA-prescribed benefits that were not previously provided under the Plan:

   - No preexisting condition exclusion for individuals younger than 19
   - No preexisting condition exclusion for individuals older than 19 (1/1/2014)

- No lifetime limits on essential benefits
- Restricted annual limits on essential benefits
- Prohibition on rescission of coverage
- Dependent coverage of children younger than 26

5. The net material measureable direct financial impact of the ACA on the State Health Plan totals $29,230,152 during the period from 2011 through 2017:

Reinsurance/PCORI Fees (2013-2017)	-$45,291,815
Early Retirement Reinsurance Fund (2012)	+$27,142,502
Lifetime Medical Claims over $2M	-$11,080,839
Net total	$29,230,252

Notes on calculation: The $2 million lifetime maximum in force prior to January 1, 2011 was only applied to medical expense, not to pharmacy, so pharmacy is not included in the calculation. Furthermore, the mandated addition of adult children up to age 26 and the addition of non-permanent employees was addressed through actuarial adjustment of contributions. The MUSC Health Plan was not included in the calculation because it was created voluntarily as an ACA non-grandfathered plan with the understanding of mandatory ACA coverage requirements.

FURTHER THE AFFIANT SAITH NOT.

Robin Tester

SWORN TO before me this 15th

day of March, 2018

NOTARY PUBLIC FOR SOUTH CAROLINA
My Commission Expires: 6/16/27

In the United States District Court
FOR THE NORTHERN DISTRICT OF TEXAS

TEXAS, WISCONSIN, ALABAMA, ARKANSAS, ARIZONA, FLORIDA, GEORGIA, INDIANA, KANSAS, LOUISIANA, PAUL LEPAGE, *Governor of Maine*, GOVERNOR PHIL BRYANT OF THE STATE OF MISSISSIPPI, MISSOURI, NEBRASKA, NORTH DAKOTA, SOUTH CAROLINA, TENNESSEE, UTAH, WEST VIRGINIA, NEILL HURLEY, *and* JOHN NANTZ,

PLAINTIFFS,

v.

UNITED STATES OF AMERICA, UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, ALEX AZAR, *in his Official Capacity as* SECRETARY OF HEALTH AND HUMAN SERVICES, UNITED STATES DEPARTMENT OF REVENUE, *and* DAVID J. KAUTTER, *in his Official Capacity as Acting* COMMISSIONER OF INTERNAL REVENUE,

DEFENDANTS.

APPENDIX IN SUPPORT OF PLAINTIFF-STATES' AND INDIVIDUAL-PLAINTIFFS' APPLICATION FOR PRELIMINARY INJUNCTION

Exhibit S

IN THE UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF TEXAS
FORT WORTH DIVISION

TEXAS,
WISCONSIN,
ALABAMA,
ARKANSAS,
ARIZONA,
FLORIDA,
GEORGIA,
INDIANA,
KANSAS,
LOUISIANA,
PAUL LePAGE, Governor of Maine,
MISSISSIPPI, by and through
Governor Phil Bryant,
MISSOURI,
NEBRASKA,
NORTH DAKOTA,
SOUTH CAROLINA,
SOUTH DAKOTA,
TENNESSEE,
UTAH, and
WEST VIRGINIA,

Plaintiffs,

v.

Civil Action No. 4:18-cv-00167-O

UNITED STATES OF AMERICA,
UNITED STATES DEPARTMENT
OF HEALTH AND HUMAN
SERVICES, ALEX AZAR,
in his Official Capacity as
SECRETARY OF HEALTH AND
HUMAN SERVICES, UNITED
STATES INTERNAL REVENUE
SERVICE, and DAVID J. KAUTTER,
in his Official Capacity as Acting
COMMISSIONER OF INTERNAL
REVENUE,

Defendants.

DECLARATION OF THOMAS STECKEL

My name is Thomas Steckel and I am over the age of 18 and fully competent to make this declaration and state the following:

1. I am the Director of the Division of Employee Benefits within the South Dakota Bureau of Human Resources ("Bureau"). I have served with the Bureau for 4 years. As the Director of the Division of Employee Benefits ("Division"), I am responsible for developing and implementing the State's health plan for state employees, including flexible benefits such as a vision and dental plan. As a part of these responsibilities, I recommend policy for the State's health plan, administer the health plan, and monitor and balance the health plan's financials. I am particularly familiar with changes in costs, plans, and policies related to the enactment of the ACA because of my role as the Director of the Division. I have personal knowledge of the matters and information set forth herein.
2. The Bureau serves four main roles for the State of South Dakota, each role having its own division within the Bureau. The first role is the Bureau provides human resource services to each agency and bureau under the purview of the Governor of South Dakota. These services include the processing of payroll, maintaining personnel files, and utilizing Human Resource Managers to assist agencies in hiring, developing, and the disciplining of employees. The second role is the Bureau provides employee and organizational development through services such as employee training, leadership development, and 360 and engagement surveys. The third role is the Bureau lies in classification and compensation. The Bureau establishes and administers a compensation structure for executive branch employees

and classifies each position based upon the position's job duties. The fourth major role of the Bureau is the establishment and administration of the benefits for state employees, which includes the State's health plan, the flexible benefits available to state employees, and workers' compensation program for state employees.

3. With the passing of the ACA, the Bureau has suffered both administrative and financial burdens that it otherwise would not have. The ACA deprived the Bureau of the flexibility it previously had to provide health insurance plans tailored to the needs of its population.

Financial Costs Associated with ACA Regulations

4. The individual mandate caused the following estimated financial burdens to the Bureau:

   a. IRO Review of denied appeals: $10,400.00 ongoing costs;

   b. Elimination of lifetime maximum: $19,140,252.00 ongoing costs;

   c. Pre-existing conditions exclusion prohibited by ACA: unable to accurately estimate the ongoing costs of this mandate;

   d. Expanded eligibility for adult dependent children to age 26: unable to accurately estimate the ongoing costs of this mandate;

   e. Expanded preventive services paid only by the plan: $4,575,200.00 ongoing costs;

   f. Transitional Reinsurance Program fee: 3,202,942.00 one-time costs;

g. Patient Centered Outcomes Research Institute fee: $172,141.00 ongoing costs;

h. Expanded health plan eligibility for part-time employees who did not meet the State's health plan's pre-ACA eligibility definition: $1,514,205.00 ongoing costs; and

i. Form 1095-C administration: $100,000.00 ongoing costs.

5. "Lifetime maximum benefit" is the maximum dollar amount a health insurance plan will pay in benefits to an insured person during that person's lifetime. The ACA banned insurance contracts nationwide from including any lifetime maximum benefit. The ACA thus eliminated the Bureau's ability to impose lifetime maximum benefits for essential health benefits. 42 U.S.C. § 300-gg-11 (West). Prior to the implementation of the ACA, the Bureau maintained a lifetime annual maximum of $2,000,000. Since the implementation of the ACA, the Bureau has been liable to pay, and has paid, substantial costs that would not have been payable had the pre-ACA lifetime maximum benefits still been in place. In the seven-year period between 2011 and 2017, the Bureau has paid approximately $19,140,252 in costs that would not have been due had the ACA not eliminated its ability to apply a lifetime maximum benefit. Compliance with the ACA will require the Bureau to indefinitely continue paying these additional costs.

6. Prior to adoption of the ACA, the Bureau required insured persons to pay co-insurance and/or co-pays for preventative care that are now disallowed

because the ACA requires that preventative care be covered at 100%. 42 U.S.C. § 300gg-13 (West). The change to 100% funding of preventative care has cost the Bureau substantial sums. During the six-year period from 2012 to 2017, therefore, the 100% funding for preventative care mandated by the ACA has imposed costs upon the Bureau approximating $4,575,200. 100% funding for preventative care is a permanent requirement pursuant to the ACA, so these costs to the Bureau as a result will continue indefinitely.

7. Prior to implementation of the ACA, the Bureau provided insurance coverage for contraceptive drugs at a rate below 100%. The ACA, however, requires contraceptives to be covered at 100%. 42 U.S.C. § 300gg-13(a)(4) (West); 77 Fed.Reg. 8725 (Feb. 2012). Covering a class of drugs at 100% of cost is more expensive for the Bureau than covering a drug at less than 100% of cost. If the Bureau could have maintained its prior coverage plan for contraceptives, therefore, it would have saved significant monies. Specifically, the Bureau would have saved approximately $672,780 during the five-year period from FY 2013 through 2017. The 100% funding for contraceptives mandate is permanent pursuant to the ACA, so these costs to the Bureau continue.

8. The ACA requires the Bureau to pay a Patient-Centered Outcomes Research Institute (PCORI) fee. 26 U.S.C. § 9511. The fee was started under the ACA for advancements in comparative clinical effectiveness research. The fee increases yearly and is based on per average number of lives that are covered by the plan or policy. In the last fiscal year, the Bureau paid $2.26 per person

enrolled in a health insurance plan. If the PCORI fee had not been required under the ACA, the Bureau would have saved approximately $172,141 for FY 2014 to 2018. This fee is imposed currently for plans that end before October 1, 2019 and, therefore, will continue to be paid into 2020 under the ACA.

9. The ACA requires the Agency to pay the Transitional Reinsurance Program fee. 42 U.S.C. § 18061. This fee is collected by the federal government to fund reinsurance payments to issuers of non-grandfathered reinsurance-eligible individual market plans, the administrative costs of operating the reinsurance program, and the General Fund of the U.S. Treasury for the 2014, 2015, and 2016 benefit years. If this requirement had not been in place, the Bureau would have saved approximately $2,622,787 in FY 2015 and FY 2016.

10. Prior to the ACA, a full-time employee was defined as an employee who is employed at least 40 hours per week; the ACA altered that number to 30 hours per week. 26 U.S.C.A. § 4980H (West); Pub. L. 111-148, 124 Stat. 865, § 4980H(d)(4)(A). This change impacted the Bureau by increasing the number of persons the Bureau must insure, thus increasing the total cost of providing insurance. The change required the Bureau to provide insurance coverage to seasonal or temporary employees who meet the ACA definition of eligible employee. The ACA change in definition of eligible employee would have reduced the cost to the Bureau of providing health insurance coverage to all "full-time" and eligible permanent part-time employees by approximately

$1,514,205 for FY 2014 to FY 2018 YTD as of 3/31/18. The 30-hour "full-time employee" rule is a permanent requirement under the ACA and, thus, these costs to the Bureau as a result will continue.

11. Given the facts summarized in ¶¶ 4-10 above, compliance with mandatory provisions of the ACA has imposed costs upon the Bureau approximating $28,715,140.00 dollars in FY 2012-2017 in order to comply with the federal government's requirements under the ACA. These impositions of costs upon the Bureau will continue indefinitely because the mandates imposed by the ACA are generally permanent.

Administrative Burdens Associated with ACA Regulations

12. The individual mandate caused significant administrative burdens and expenses to program our IT system to track and report ACA eligible employees and complete mandatory IRS Form 1095 annual reports.

13. The ACA mandates constrain our flexibility in plan design decisions, and the continued uncertainty as to the potential changes in the law, including partial repeal of certain provisions, make long term strategic planning more complicated than it would be absent the ACA.

14. The Bureau recently made changes to the State employee health plan for the FY 2019 and those changes assumed the ACA is still federal law. Repeal of the ACA is necessary now, as opposed to in future months or years, because the confines of the law that the Bureau is forced to operate within create a significant obstacle to solving current budgetary concerns. Without the

expenses described above in ¶¶ 4-13, the Bureau would gain back approximately $5.1 million in funding. If the ACA is not repealed now, however, this funding would not be available to the Bureau in time to plan for the FY 2019. Thus, the Bureau, its enrollees and the taxpayers of South Dakota would be significantly burdened if the ACA remained law pending this suit.

15. Pursuant to 28 U.S.C. § 1746, I declare under penalty of perjury that the foregoing is true and correct.

Respectfully submitted this the 24th day of April, 2018.

Thomas Steckel, Director
Division of Employee Benefits
South Dakota Bureau of Human Resources