Exhibit A

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF NEW MEXICO

NEW MEXICO HEALTH CONNECTIONS, Plaintiff, v. UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, *et al.*, Defendants.	:	No. 1:16-cv-00878-JB/WPL

DECLARATION OF MYJA PETERSON

I, MYJA PETERSON, being over 18 years of age and of sound mind, declare under penalty of perjury that the following statements are true and correct:

1. I make this declaration based on my personal knowledge.

2. Since January 1, 2018 I have been Senior Director, Health Plan Analytics, for True Health New Mexico. True Health New Mexico provides administrative and management support services to New Mexico Health Connections ("Health Connections"). In my current role, I am in charge of health plan analytics for Health Connections, including issues surrounding the risk adjustment program and development of premiums for Health Connections' different insurance products.

3. Between May 2015 and December 2017 I held a series of positions as a direct employee of Health Connections, in which I was responsible for health plan analytics for Health Connections, including issues surrounding the risk adjustment program and development of premiums for Health Connections' different insurance products.

4. Between January 1997 and May 2015, I held a series of positions with Blue Cross/Blue Shield of New Mexico and/or its parent company in various data analytic capacities.

5. In total, I have spent more than twenty years working in health insurance.

6. As part of my job duties at Health Connections and now True Health New Mexico, I have been tasked to work with our actuaries from a major national consulting firm to model and predict Health Connections' liabilities under the risk adjustment formula administered by HHS. It is our goal to make sure that Health Connections' premiums will be sufficient to cover our risk adjustment costs.

7. Even though HHS has published the risk adjustment formula before our rates are finalized for the relevant benefit year, Health Connections and its actuaries have been unable to accurately predict risk adjustment costs when setting premiums.

8. For example, for 2015, Health Connections predicted risk adjustment charges of roughly $4.3 million but in the end had to pay charges of roughly $14.5 million – more than three times the estimated reserve.

9. For 2016, Health Connections projected that it would receive a payment of roughly $7 million. Instead, it was assessed charges of more than $8.8 million.

10. Nor can we estimate risk adjustment liabilities even after the relevant benefit year has closed. For example, in the first quarter of 2017, Health Connections asked its actuaries for an estimate of risk adjustment exposure for 2016. By this time, Health Connections was in possession of relevant data for 2016 about its own members' medical conditions, products purchased, geographic locations, and all of the other factors that feed into Health Connections' aggregate risk score under HHS's risk adjustment formula. Moreover, Health Connections had

roughly 33% market share in 2016, so that its population would be a significant (albeit minority) component of the weighted average state risk score and the weighted average state premium, the two key inputs in the risk adjustment formula.

11. Nevertheless, Health Connections' actuaries informed us that they were unable to predict Health Connections' risk adjustment results for 2016 with any degree of certainty and offered a range of possible outcomes from Health Connections receiving a payment of $12.5 million to being charged an assessment of $8.5 million. Health Connections' actuaries provided a "baseline estimate" that Health Connections would receive a payment of $2.4 million.

12. Ultimately, rather than receive a payment, Health Connections was charged a risk adjustment assessment for 2016 of more than $8.8 million.

13. Nor have Health Connections' competitors been any better able to estimate risk adjustment. According to publicly available rate filings for 2018 premiums, three of the five carriers in New Mexico's individual insurance market (Presbyterian, Christus, and Health Connections) estimated risk adjustment liabilities of $1.9 million to $4.4 million; a fourth carrier, Blue Cross/Blue Shield, estimated a payment receivable of under $25,000; and only one carrier, Molina, estimated it would receive more than a *de minimis* payment under the risk adjustment program. In the aggregate, New Mexico's individual market insurance carriers estimated that total risk adjustment payments and charges will equal to negative $5.4 million. However, as the risk adjustment formula by its structure always sums all charges and payments to zero, this cannot be right and shows that, even several years into the program, carriers still cannot figure out how to estimate risk adjustment payments and charges.

14. The same predictive inaccuracy held true on the small group side for 2018, but in the opposite direction. There, only one of the four competitors – Health Connections –

projected it would be assessed any risk adjustment charges for 2018; the other three carriers all projected that they will have receivables under the risk adjustment program. In the aggregate, New Mexico's small group market insurance carriers estimated that total risk adjustment payments and charges will equal to roughly positive $975,000. As the risk adjustment formula's payments and charges always sum to zero, these estimates must be wrong.

15. It is my opinion that the risk adjustment formula, as structured by HHS, is inherently unpredictable. In order to project risk adjustment liabilities or payments, a carrier must understand not only its own risk profile, pricing, product mix, and geographic distribution of enrollees but also:

- The risk profile and health status of each of its competitor's insured populations, including how that information may change from year to year as new enrollees enter the market and others leave the market (for example, an individual who switches jobs or whose spouse switches jobs may transfer to the new employer's coverage).
- Each competitor's product mix and prices.
- The geographic distribution of each competitor's enrollees by rating area.
- How effective each competitor will be at capturing and mining medical diagnosis code information.

16. The risk adjustment program has also forced Health Connections to artificially raise its premiums for reasons unrelated to the health or sickness of its insured population. As a result, consumers in New Mexico have been forced by HHS's regulations to pay inflated costs for their health care.

17. Since launching in 2014, Health Connections has consistently offered the lowest or second lowest priced insurance products in each of New Mexico's rating regions. This not because Health Connections dodges sicker enrollees. On the contrary, during product development, Health Connections focuses on building a benefit plan that will support members

with chronic conditions from the perspective of overall population health management and concurrent and aggressive individual care management. As an example regarding plan product design, Health Connections provides $0 copay on drugs for chronic conditions and for outpatient mental health services.

18. Health Connections' approach has worked over time to attract more and more sick enrollees, as its reputation for quality grows in the marketplace. In 2014, as measured by HHS's risk adjustment formula, the aggregate risk score of Health Connections' population was roughly 15% below the state average. By 2016, again as measured by HHS, Health Connections' risk score was virtually identical to the state average risk score for the small group market and only 3.4% below the state average for the individual market.

19. Yet despite having essentially the same actuarial risk as the state average (as measured by HHS), Health Connections was assessed close to $9 million in risk adjustment charges for 2016. This was because HHS scales risk adjustment transfers based not on actuarial risk, but the statewide weighted average premium. The fact that Health Connections was able to price well below the state average premium caused its risk adjustment charges, under HHS's formula, to be artificially inflated. Because Health Connections was penalized for low pricing by the risk adjustment program, it was forced to seek double-digit premium increases for 2017 and 2018, hurting consumers throughout the state.

20. These premium hikes would have been far lower but for HHS's risk adjustment scheme. This is because Health Connections can insure sicker populations far more efficiently than its competitors by proactively managing its enrollees' medical care to keep them healthier and out of the hospital. For example, in 2016 (according to data compiled and

disseminated by the New Mexico Coalition for Healthcare Value[1]), when, as noted above, Health Connections did not have a healthier population than average, Health Connections' members had only 129 emergency department visits per 1,000 members per year, far lower than its competitors Blue Cross/Blue Shield (182), United Healthcare (187), and Presbyterian (168). Cutting unnecessary emergency room utilization (and related follow on hospital admissions) based on better medical management generates significant cost savings that Health Connections has tried to funnel into lower premiums, but has been thwarted by HHS's risk adjustment formula which penalizes pricing premiums below the statewide market average.

21. Indeed, in 2016 (again according to data compiled and disseminated by the New Mexico Coalition for Healthcare Value), on average Health Connections' members had 13% fewer inpatient admissions than its competitors in New Mexico, which leads to 17% fewer inpatient days per 1,000 members per year – a significant savings in costs and improvement in the quality of enrollees' lives, who are staying healthier and out of the hospital. Again, as noted above, Health Connections' population in 2016 was no healthier than average for the state. But HHS's risk adjustment formula, by scaling transfers to the statewide average premium, has prevented Health Connections from passing on these savings to consumers.

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

Dated: April 20, 2018

Myja Peterson

[1] The largest carriers in New Mexico (Blue Cross/Blue Shield, Presbyterian, United, and Health Connections) are all members of the coalition and report their data to the coalition.

Exhibit B

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

UNITEDHEALTHCARE OF NEW YORK

and

OXFORD HEALTH INSURANCE, INC.

Plaintiffs,

-against-

MARIA T. VULLO, in her official capacity as Superintendent of Financial Services of the State of New York,

Defendant.

Second Declaration of JOHN POWELL

17-CV-7694

JOHN POWELL, pursuant to 28 U.S.C. § 1746, declares under penalty of perjury that the foregoing is true and correct to my knowledge:

1. I am the Director of Rate Review, Health Bureau of the New York State Department of Financial Services ("DFS" or the "Department"). In that role I am part of the team at DFS responsible for overseeing the regulation of the New York health insurance market and the health insurers doing business in New York State. I have held this position since 2007. I am fully familiar with the facts of this case and, in particular 11 NYCRR §361.9.
2. I submit this Declaration in opposition to Plaintiffs' Cross-Motion for Summary Judgment.

New York Market Stabilization Authority

3. In 1992 New York State enacted Chapter 501 of the Laws of 1992 in response to growing instability in the State's commercial health insurance market ("1992 Legislation"). The 1992 Legislation included new N.Y. Insurance Law § 3233 which required the Superintendent of the Insurance Department to promulgate regulations creating New York-specific risk adjustment pools.
4. Shortly after passage of the 1992 Legislation, the Superintendent of Insurance adopted regulations that created a risk adjustment pool for the individual and small group health insurance markets in New York State. See 11 NYCRR Part 361 (Insurance Regulation 146) ("Establishment and Operation of Market Stabilization Mechanisms for Certain Health Insurance Markets"). These regulations were issued on an emergency basis on December 22, 1992; final regulations were adopted on March 9, 1993.
5. Although the specific mechanisms and formulas used for market stabilization have evolved over time, as tracked by the evolution of the Department's regulations (see 11 NYCRR §§ 361.4, 361.5, and 361.6), a state risk adjustment mechanism promulgated and administrated by DFS has been a constant feature in the regulation of the commercial health insurance markets in New York since the early 1990s.
6. Since 1993, the Superintendents of Insurance and, beginning in 2011, the Superintendents of DFS, have utilized, administered, and enforced a risk adjustment pool -- referred to as a market stabilization mechanism for state law purposes -- in the individual and small group insurance markets in New York State pursuant to 11 NYCRR 361.0 et seq. (Insurance Regulation 146). The purposes of the state market stabilization mechanism are:

(1) to share among insurers and HMOs those substantive cost variations attributable to significant differences in demographic characteristics or specified medical conditions of the persons covered. The protection afforded by this sharing process will facilitate the introduction of mandated open enrollment and community rating by providing some assurance to insurers and HMOs that their business and competitive interests will be secure because they are protected from sudden or significant changes in the proportion of high cost persons they cover, and because other insurers and HMOs will not obtain a competitive advantage by avoiding or failing to insure a proportionate share of high cost persons;

(2) to promote competition among insurers and HMOs on the basis of efficient claims handling, ability to manage health care services, consumer satisfaction, and low administrative costs, and to deter competition on the basis of avoiding or terminating coverage of persons whose health care costs are high;

(3) to protect insurers and HMOs which are subject to the open enrollment and community-rating provisions of chapter 501 of the Laws of 1992 from undue variations in costs which are not related to differences in operating efficiency, the ability to manage care, or provider agreements; and

(4) to encourage insurers to enter, remain in, and compete vigorously in the small group health insurance and/or individual health insurance markets.

11 NYCRR § 361.1.

ACA-Risk Adjustment

7. The Patient Protection and Affordable Care Act ("ACA") was enacted in 2010 and became fully operational on January 1, 2014. The ACA contains a federal requirement that, beginning January 1, 2014, an ACA-Risk Adjustment program be implemented in each state, to spread financial risk across insurers providing individual or small group health insurance in the state.

8. As noted, New York State already had a risk adjustment mechanism prior to the ACA. Under the ACA, a state could meet the ACA-Risk Adjustment program requirement either by administering ACA-Risk Adjustment itself—by obtaining approval from the United States Department of Health and Human Services ("HHS") for a state-specific

ACA-Risk Adjustment methodology—or the state could opt to allow HHS to carry out ACA-Risk Adjustment on behalf of the state. New York elected to have ACA-Risk Adjustment administered by HHS on behalf of the state.

9. The federal regulations require a state that chooses to have ACA-Risk Adjustment administered by HHS to "forgo implementation of all State functions **in this subpart**, and HHS will carry out all of the **provisions of this subpart** on behalf of the State." 45 C.F.R. § 153.310 (emphasis added). As such, New York has and continues to "forgo implementation of all state functions" of ACA-Risk Adjustment, those functions being specifically laid out in Subpart D of Part 153--Standards Related To Reinsurance, Risk Corridors, And Risk Adjustment Under The Affordable Care Act, and including functions such as data collection and data validation.
10. Importantly, the ACA explicitly preserves the state as the primary regulator of insurance and expressly preserves state law from preemption unless it "prevent[s] the application" of the ACA, in line with consistent federal policy to preserve that traditional state role of primary regulator of insurance.

New York Market Stabilization after the ACA

11. The state market stabilization mechanism, contained in 11 NYCRR 361.0 et seq. (Insurance Regulation 146), remains in force today, and DFS has never repealed the regulation, nor has anyone ever challenged its legality.
12. During the first three years after the ACA-Risk Adjustment mandate took effect – plan years 2014, 2015, and 2016—DFS opted to forgo application of an additional state market stabilization pool for the individual and small group markets that were subject to ACA-Risk Adjustment.

13. N.Y. Insurance Law § 3233, which is the statutory mandate for the state market stabilization regulation, has also remained in place and unchanged.

14. Neither DFS nor any other state or federal agency has ever taken the position that the ACA preempted section 3233 or the State's independent market stabilization authority. Nor has HHS taken this position either before or after the enactment of the ACA.

15. DFS never "expressly suspended" Insurance Regulation 146, and DFS has presided over market stabilization mechanisms, for example in the Medicare supplemental insurance market, in every year since the ACA was passed.

Imperfections in the ACA-Risk Adjustment Program Have Led to Unintended Consequences and HHS has Encouraged States to Take Corrective Action

16. Risk adjustment models look at a specified period of time. For the ACA-Risk Adjustment, the statute calls for an annual risk adjustment and HHS has determined to perform this adjustment based on the calendar year.

17. HHS releases annual ACA-Risk Adjustment results in June of each year for the prior plan year. For example, in June 2015, HHS released the annual ACA-Risk Adjustment results for the 2014 plan year. In June 2016, HHS released the annual ACA-Risk Adjustment results for the 2015 plan year. And in June 2017, HHS released the annual ACA-Risk Adjustment results for the 2016 plan year.

18. As noted, HHS has never taken the position that its implementation of a risk-adjustment program on behalf of a states preempted state authority over market stability. Quite the contrary, on or about May 11, 2016, a month prior to releasing its results for 2015, HHS recognized unexpected issues with the ACA-Risk Adjustment program and encouraged states to use pre-existing state authority to help ease the unintended instability caused by

these issues with the ACA-Risk Adjustment program. In its interim final rule published at 81 F.R. 29152 on May 11, 2016, HHS stated:

> Based on our experience operating the 2014 benefit year risk adjustment program, HHS has become aware that certain issuers, including some new, rapidly growing, and smaller issuers, owed substantial risk adjustment charges that they did not anticipate. HHS has had a number of discussions with issuers and State regulators on ways to help ease issuers' transition to the new health insurance markets and the effects of unanticipated risk adjustment charge amounts.
> ***
> *However, we are sympathetic to these concerns and recognize that States are the primary regulators of their insurance markets. We encourage States to examine whether any local approaches, under State legal authority, are warranted to help ease this transition to new health insurance markets.* (emphasis added.)

19. In December 2016, after completing the risk adjustment process for the 2015 policy period and witnessing the same problems that states had identified for the 2014 policy period, HHS issued a final rule modifying the federal risk adjustment program. Just as it had with the interim rule in May 2016, the December 2016 final rule identified problems caused by the federal program and encouraged states to take action under existing state law:

> Based on our experience operating the 2014 and 2015 benefit years risk adjustment program, HHS is aware that certain issuers, including some new, rapidly growing, and smaller issuers, owed substantial risk adjustment charges that they did not anticipate. HHS has had, and continues to have discussions with issuers and State regulators on ways to help ease issuers' transition to the new health insurance markets and the effects of unanticipated risk adjustment charge amounts. HHS believes that a robust risk adjustment program that addresses new market dynamics due to rating reforms and guaranteed issue requirements is critical to the proper functioning of these new markets. *However, we are sympathetic to these concerns and recognize that States are the primary regulators of their insurance markets. As such, we encouraged, and continue to encourage States to examine whether any local approaches, under State legal authority, are warranted to help ease this transition to new health insurance markets.* (emphasis added.)

Federal Register / Vol. 81, No. 246, at 94159.

20. Through the present day, HHS has continued to encourage states to take independent action to address the deficiencies in the ACA-Risk Adjustment Program. Indeed, on November 2, 2017, HHS published a proposed rule that encouraged and explicitly authorized states to use their existing state authority to take temporary, reasonable measures under State authority to mitigate the effects of the ACA- Risk Adjustment Program:

> The HHS risk adjustment payment transfer formula generally transfers amounts from issuers with lower than average actuarial risk to those with higher than average actuarial risk. Such risk adjustment transfers are widely used in health insurance markets and recognized as critical in mitigating the effects of adverse selection, ensuring financial viability of plans that enroll a higher proportion of high-risk enrollees, and thus, fostering competitive health insurance markets. The HHS risk adjustment program transfers are scaled with the Statewide average premium in the applicable State market. In the 2018 Payment Notice, we noted that compared to other scaling factors, such as, plans' own premiums, our analyses found Statewide average premium proves to be a more accurate means of scaling the transfers for differences in relative actuarial risk, particularly in the context of a budget-neutral system. We also finalized in the 2018 Payment Notice an administrative cost adjustment to the statewide average premium to remove a portion of administrative costs that did not vary based on claims differences from the Statewide average premium and base the transfers on the portion of the premiums that vary with claims. Nevertheless, we acknowledge that, for some States that deviate significantly from the national dataset used, a further adjustment to the Statewide average premium may more precisely account for differences between the plan premium estimate reflecting adverse selection and the plan premium estimate not reflecting selection in the respective State market risk pools.
>
> *In the 2016 Interim Final Rule, HHS recognized some State regulators' desire to reduce the magnitude of risk adjustment charge amounts for some issuers. We acknowledged that States are the primary regulators of their insurance markets, and as such, we encouraged States to examine whether any local approaches under State legal authority are warranted to help ease the transition to new health insurance markets*
> ***

> *As noted above, a State that wishes to make an adjustment for the magnitude of these transfers in the individual and small group markets may take temporary, reasonable measures under State authority to mitigate effects under their own authority.*

Federal Register / Vol. 82, No. 211, at 51072-73 (emphasis added).

ACA-Risk Adjustment Has a Distorted Impact in New York

21. By all objective measures – including the data and estimates submitted by Plaintiffs UnitedHealthcare of New York ("UnitedHealthcare") and Oxford Health Insurance, Inc. ("Oxford") – the ACA-Risk Adjustment Program has had extremely distortive impacts in New York.

22. There are several ways to measure the impact of the ACA-Risk Adjustment program in New York as compared to other states. One measure is a comparison of the aggregate dollar amount of the transfers required under the ACA-Risk Adjustment Program that are made in New York as compared to other states. This measure of the aggregate dollar amount of transfers – known as the size of a state's ACA-Risk Adjustment Pool – is a way to understand the sheer magnitude of the transfers in a particular state.

23. For the 2014 plan year, New York's total ACA-Risk Adjustment Pool for the small group market was $195,038,660. This was, by far, the largest ACA-Risk Adjustment Pool in the country. The state with the second highest risk adjustment pool was California whose risk adjustment pool was $42,543,626. The state with the third highest risk adjustment pool was Pennsylvania whose risk adjustment pool was $31,567,964. In short, New York's risk adjustment pool was materially larger relative to its population.

24. This distortion continued. For the 2015 plan year, New York's total ACA-Risk Adjustment Pool for the small group market was $341,996,248. Once again, this was, by

far, the largest ACA-Risk Adjustment Pool in the country. The state with the second highest risk adjustment pool was California whose risk adjustment pool was $163,666,550. The state with the third highest risk adjustment pool was New Jersey whose risk adjustment pool was $48,269,532.

25. In other words, insurance companies in New York in 2015 transferred over twice as much money under the ACA risk-adjustment program than any other state including California which has a far larger population and more people enrolled in small group health insurance plans that are subject to ACA-Risk Adjustment.

26. A second measure of the impact of the ACA-Risk Adjustment program in New York as compared to other states is a comparison of the "per member per month" transfers in each state. This metric eliminates the variation in population size and enrollment size in health insurance plans subject to risk adjustment from the state to state analysis of the impact of ACA-Risk Adjustment.

27. For the 2014 plan year, only three statistically irrelevant states—Hawaii, South Dakota, and Wyoming—all of which have extremely small, small group markets – had higher per member per month transfers. New York's per member per month transfer in the small group market for the 2014 plan year was $23.91, as compared to California's $9.21 or Pennsylvania's $12.93 per member per month transfers. New York's per member per month transfers were nearly double the average transfer ($12.73).

28. For the 2015 plan year, the per member per month transfers provided by ACA-Risk Adjustment in New York for the small group market was $29.86. This was, by far, the largest per member per month transfer required by the ACA-Risk Adjustment Pool in the county for 2014. The states with the second and third largest per member per month

transfers were the small markets of Alaska and Hawaii with per member per month transfers of $24.14 and $24.80 respectively. In contrast, California had $14.08 per member per month transfers and New Jersey's transfers landed at $10.69 per member per month. The per member per month transfers provided by ACA-Risk Adjustment in New York were disproportionately large as compared to similarly situated states. Indeed they were more than double the average per member per month transfer ($12.60).

29. A final relevant metric in examining ACA-Risk Adjustment is a state's Average Plan Liability Risk Score, commonly referred to simply as the state's Risk Score. In general, a risk score is a measure an individual's health status or risk based on diagnoses codes contained in claims data. A state's Risk Score, for ACA-Risk Adjustment purposes, is the average risk score of all of the individuals in a given insurance market as calculated by HHS.

30. Contrary to expectations, New York's Risk Score has been the highest among the fifty states in every year that ACA-Risk Adjustment has been run. For the 2014 plan year New York's Risk Score was 1.643 which significantly exceeded the average state Risk Score of 1.315. It was also 7.5% higher than Oklahoma's 1.528 Risk Score which was the second highest. For the 2015 plan year New York again had the highest Risk Score at 1.803. This was again significantly higher than the average state Risk Score of 1.408. Rhode Island and Alabama ranked second and third in Risk Score with 1.693 and 1.580 respectively. New York's Risk Score was therefore over 14% higher than Alabama's.

31. Shifting to Plaintiffs' own data, the risk adjustment transfers provided under the ACA-Risk Adjustment Program far exceeded the estimates of the transfers prepared by the actuaries at both UnitedHealthcare and Oxford.

32. Under New York's "prior approval" law insurers must seek approval from DFS for their yearly rate adjustments. See N.Y. Ins. Law §§ 3231(e)(1)(E), 4308(c). Among the factors that comprise this review, insurers must include in their rate submissions a factor accounting for anticipated receipts or liabilities in ACA-Risk Adjustment. An insurer's anticipated receipts from ACA-Risk Adjustment will decrease its premium cost in proportion to the size of the receipts. In other words, all other things being equal, the higher an insurer's anticipated receipts from ACA-Risk Adjustment, the lower the premium should be. And the higher an insurer's anticipated liability from risk adjustment, the higher the premium should be. Using simple math, the factor used by insurers in rate review to account for anticipated receipt or liabilities from ACA-Risk Adjustment can be used to determine the aggregate (i.e., dollar amount) that the insurer expects to receive or pay pursuant to the ACA-Risk Adjustment program for the following plan year.

33. In its submissions to DFS, Plaintiff Oxford consistently underestimated its ACA-Risk Adjustment receipts in the small group market. For 2014 rate setting, Oxford projected a receivable from ACA-Risk Adjustment of $37,526,179 for its New York business. In actuality, Oxford received $145,248,014 under the risk adjustment program for this year. For 2015 rate setting, Oxford, after being required by DFS to project a larger receivable than first submitted for 2015 rates, estimated a receivable from ACA-Risk Adjustment of $150,574,691. In actuality, Oxford received more than double the amount, or $315,374,420, under the risk adjustment program for that year which was reduced to $211,846,960 but only because one of the insurers in the New York market became insolvent thereby reducing the overall payments into the ACA-Risk Adjustment pool.

For 2016 rate setting, after again being required by DFS to make an upward adjustment to the estimated receivable that was first submitted for 2016 rates, Oxford projected a receivable from ACA-Risk Adjustment of $211,943,022.67. In actuality, Oxford received $254,933,461 under the ACA-Risk Adjustment program for that year.

34. The systematic underestimation of its risk adjustment receivables has provided Oxford with a windfall. Because the company underestimated ACA-Risk Adjustment receipts by $211,984,542 for the years 2014 through 2016, the company was permitted to charge and it received far higher health insurance rates than it would have been allowed had the projected risk adjustment receivable equaled the actual amounts received.

35. Plaintiff UnitedHealthcare has also consistently underestimated its ACA-Risk Adjustment receipts in the individual market. For 2014 rate setting, UnitedHealthcare projected a receivable from ACA-Risk Adjustment of $1,165,248 for its New York business. In actuality, UnitedHealthcare received four times that amount, or $4,787,190, under the risk adjustment program for this year. For 2015 rate setting, UnitedHealthcare, after being required by DFS to project a greater receivable than first submitted for 2015 rates, estimated a receivable from ACA-Risk Adjustment of $3,616,547. In actuality, UnitedHealthcare received $10,564,737 under the risk adjustment program for that year which was reduced to $9,306,990 but only because one of the insurers in the New York market became insolvent thereby reducing the overall payments into the ACA-Risk Adjustment pool. For 2016 rate setting, after again being required by DFS to make an upward adjustment to the estimated receivable that was first submitted for 2016 rates, UnitedHealthcare projected a receivable from ACA-Risk Adjustment of $3,829,317. In

actuality, UnitedHealthcare received $5,932,308 under the risk adjustment program for that year.

36. Similar to Oxford, the systematic underestimation of its risk adjustment receivables has provided UnitedHealthcare with a windfall. Because the company underestimated ACA-Risk Adjustment receipts by $11,415,376 , the company was permitted to charge and it received far higher health insurance rates than it would have been allowed had the projected risk adjustment receivable equaled the actual amounts received.

In Accordance with HHS Published Rules and Guidance Directly Provided by HHS, DFS Took Action to Address the Disproportionate and Exaggerated Impact of ACA-Risk Adjustment in New York and Issues Market Stabilization Regulations

37. After the final ACA-Risk Adjustment results were issued by HHS for the 2014 plan year, DFS began evaluating and initiated discussions with HHS about the causes and consequences of the disproportionate and excessive magnitude of New York's ACA-Risk Adjustment transfers.

38. After review by the DFS's actuarial team, DFS determined that approximately 30% of the magnitude of the ACA-Risk Adjustment transfers could be explained by factors including New York's unique family tiering structure and the use of a statewide average premium in the calculation of the transfers that included administrative expenses, profits and claims rather than just claims.

39. Following the release of the 2015 ACA-Risk Adjustment results and after identifying root causes of the disproportionate impact, DFS also determined that the sheer magnitude of the ACA-Risk Adjustment liabilities was having a destabilizing impact on the market for small group health insurance in New York. In accordance with HHS's guidance in the interim final rule issued on May 11, 2016, DFS began developing New York

"approaches, under State legal authority, . . . to help ease this transition to new health insurance markets."

40. After consultation with HHS, as described in further detail below, and a review of the available data, DFS determined that use of independent Market Stabilization authority under New York Insurance Law § 3233 was critically necessary to ensure market stability until HHS was able to take action within the ACA-Risk Adjustment methodology to correct for the destabilizing impact.

41. Since the implementation of ACA-Risk Adjustment, two companies operating in New York's small group market, both of whom were required to make large payments into the ACA-Risk Adjustment pool, have left the market. The first went into liquidation, with ACA-Risk Adjustment liabilities playing a role in its insolvency. The second voluntarily withdrew from the market citing the scale of ACA-Risk Adjustment transfers as a major cause of its decision to withdraw. The departure of both of these insurers has had negative and destabilizing effects on the health insurance market in New York with adverse impacts for both consumers and small businesses. At the same time, as noted above, Plaintiffs have received extremely large risk adjustment transfers and high premiums from New York consumers, receiving a large windfall from the disparate impact of the HHS-administered risk adjustment program in New York.

42. DFS therefore determined that it was necessary to take action to help stabilize New York's markets. DFS did so in full cooperation with HHS. On or about August 8, 2016 DFS participated in a call with HHS, including Jeff Wu, who was at the time Deputy Director for Policy, Center for Consumer Information and Insurance Oversight ("CCIIO"), Centers for Medicare & Medicaid Services ("CMS"), HHS. During that call

DFS relayed to HHS that New York was exploring the use of its independent state market stabilization authority to reduce the destabilizing market impact of ACA-Risk Adjustment, by reducing the magnitude of the transfers, after HHS had administered the ACA-Risk Adjustment and released the final results. Deputy Director Wu expressed support for this proposed use of New York state authority and raised no objection to such a program.

43. On or about September 8, 2016 DFS engaged in a call with HHS, including Jeffrey Grant, presently the Acting Director of Policy CCIIO/HHS, who, upon information and belief, at the time held the position of Director, Payment Policy & Financial Management Group, CCIIO, CMS, HHS. During that call, DFS provided HHS with a summary of the form and content of the then-draft DFS emergency regulation, how it would operate, and the state authority under which DFS was proceeding. Consistent with the call on August 8, 2016, HHS raised no objection to DFS's regulation and the use of state authority to reduce the magnitude of the transfers caused by ACA-Risk Adjustment.

44. The next day, on September 9, 2016, DFS promulgated 11 NYCRR § 361.9 as an emergency regulation ("Emergency Regulation").

45. That initial Emergency Regulation expired on December 7, 2016, and was promulgated again as an emergency regulation on that same date. 38 N.Y. Reg. 20 (Dec. 28, 2016). Subsequent expirations and emergency promulgations occurred in the same manner with no material changes on March 6, 2017, June 21, 2017, July 31, 2017, September 28, 2017, November 24, 2017, and January 22, 2018.

46. On December 22, 2016, months after the Emergency Regulation was first promulgated, HHS published its Notice of Benefit and Payment Parameters for 2018 as a final rule at

81 FR 94058. Within that final rule HHS recognized and confirmed that it supported use of independent state authority to mitigate the impact and magnitude of ACA-Risk Adjustment transfers. HHS stated "[HHS] encouraged, and continues to encourage States to examine whether any local approaches, under State legal authority, are warranted to help ease this transition to new health insurance markets."

47. At no time has HHS informed DFS that the Emergency Regulation is in any way contrary to federal law.

48. On or about October 2, 2017, DFS had a call with Erin Sutton – who upon information and belief was and currently is, Deputy Group Director, Payment Policy & Financial Management Group, CCIIO, CMS, HHS—and other employees of HHS. On that call, DFS provided a walkthrough of the structure, purpose, function, and legal basis of the regulation. During this October 2 call, HHS, as it had previously privately and publicly stated, was supportive of a state-authority based solution to the deficiencies in the ACA-Risk Adjustment program, such as the one DFS had promulgated.

49. On or about October 19, 2017, DFS received an email from Krutika Amin—who upon information and belief was and currently is a Health Insurance Specialist with the Payment Policy and Financial Management Group, CCIIO, CMS, HHS. This email thanked DFS for the October 2 walkthrough and offered: "As always, please let us know if anything would be helpful on our end as you operationalize your regulation."

50. On or about October 27, 2017, HHS released its proposed Notice of Benefit and Payment Parameters for 2019, published at 82 FR 51052.

51. Consistent with the October 2 call and with all previous guidance DFS received from HHS, the proposed Notice of Benefit and Payment Parameters for 2019 noted:

> In the 2016 Interim Final Rule, HHS recognized some State regulators' desire to reduce the magnitude of risk adjustment charge amounts for some issuers. We acknowledged that States are the primary regulators of their insurance markets, and as such, we encouraged States to examine whether any local approaches under State legal authority are warranted to help ease the transition to new health insurance markets.
> ***
> As noted above, a State that wishes to make an adjustment for the magnitude of these transfers in the individual and small group markets may take temporary, reasonable measures under State authority to mitigate effects under their own authority.

52. HHS was fully informed of the Emergency Regulation before it was promulgated, at the time of its promulgation, and after it was promulgated, and HHS has been publicly and privately supportive of it.

53. Throughout numerous conversations between DFS and HHS and various HHS publications, HHS has never even remotely suggested or cautioned that the Emergency Regulation would in in way prevent the application of the ACA-Risk Adjustment or was preempted by federal law.

DFS Has Not Yet Determined Whether a Market Stabilization Pool will be Implemented for 2017

54. The Emergency Regulation provides the following procedures for the Superintendent's determination as to whether to implement a market stabilization pool for the 2017 plan year:

> (d) Following the annual release of the federal risk adjustment results for the 2017 plan year, the superintendent shall review the impact of the federal risk adjustment program established pursuant to 42 U.S.C. section 18063 on the small group health insurance market in this State for that plan year.
>
> (e) If, after reviewing the impact of the federal risk adjustment program on the small group health insurance market in this State for the 2017 plan year, including payment transfers, the statewide average premiums, and the ratio of claims to premiums, the superintendent determines that a market stabilization mechanism is a

necessary amelioration, the superintendent shall implement a market stabilization pool in such market ...

11 NYCRR § 361.9(d),(e).

55. By its plain language, the Emergency Regulation dictates that the decision whether or not to implement a market stabilization pool for the 2017 plan year can only be made after the release of ACA-Risk Adjustment results, which as noted above are released annually in June for the prior plan year. Therefore, the risk adjustment results for the 2017 plan year will be available this June.

56. As results for 2017 ACA-Risk Adjustment will not be released until June 2018, DFS has not, and indeed cannot, make any determination whether a market stabilization pool will be used for 2017.

57. DFS has not made a final decision by DFS to implement a market stabilization pool under the Emergency Regulation for 2017. Indeed, the express terms of the regulation do not allow for such a determination until after ACA-Risk Adjustment results are released.

Dated: Albany, New York
February 16, 2018

John Powell

Exhibit C

Return Date: November 22, 2016

KATHARINE L. WADE, INSURANCE COMMISSIONER OF THE STATE OF CONNECTICUT Plaintiff,	:	SUPERIOR COURT JUDICIAL DISTRICT OF HARTFORD AT HARTFORD
v.	:	
HEALTHYCT, INC. Defendant.	:	 NOVEMBER 1, 2016

PETITION FOR ORDER OF REHABILITATION AND APPOINTMENT OF STATE INSURANCE COMMISSIONER AS REHABILITATOR OF HEALTHYCT, INC.

To the Superior Court to be held in Hartford, within and for the Judicial District of Hartford, comes the plaintiff Katharine L. Wade, Insurance Commissioner of the State of Connecticut (the "Commissioner"), petitioning, pursuant to Conn. Gen. Stat. § 38a-914, for an order of rehabilitation appointing her as Rehabilitator of the defendant HealthyCT, Inc. ("HealthyCT"), a domestic insurance company, and in support she represents as follows:

I. PARTIES

1. The Commissioner is the duly appointed Insurance Commissioner of the State of Connecticut, and as such is charged with the duty of administering and enforcing the provisions of Title 38a of the Connecticut General Statutes, the insurance laws of the State of Connecticut.

2. HealthyCT was formed in 2013 as a Connecticut-domiciled health insurer incorporated and licensed to transact insurance business in Connecticut pursuant to Chapter 698 of the Connecticut General Statutes. HealthyCT's principal office is located at 35 Thorpe Avenue, Suite 104, Wallingford, CT 06492.

II. JURSIDICTION, VENUE AND STANDING

3. HealthyCT is subject to the provisions of the Insurers Rehabilitation and Liquidation Act, Conn. Gen. Stat. §§ 38a-903 to 38a-961, ("the Act").

11. On September 20, 2015, HealthyCT and CMS executed an amendment to the start-up loan that converted the balance of the start-up loan ($21,011,768) to a surplus note which increased the balance of the solvency loan from $106,969,000 to $127,980,768.

12. The ACA provides three risk spreading mechanisms to address risk pool issues by limiting the amount an insurance company can lose by participating in the marketplace. These risk spreading mechanisms are risk corridors, risk adjustment and reinsurance (the "Three R's").

13. The risk adjustment program is a permanent program that redistributes funds from those health insurance plans with a greater preponderance of "lower-risk" (i.e., healthier) enrollees to plans with a greater preponderance of "higher-risk" (i.e., sicker) enrollees. The reinsurance program is a temporary three-year (2014-2016) program that provides reinsurance funded by federal monies for plans that enroll higher-cost individuals. The risk corridor program is also a temporary three-year (2014-2016) program that limits an insurer's losses and gains beyond an allowable range. All three of these programs are administered by CMS.

14. On December 13, 2014, Congress adopted the Consolidated and Further Continuing Appropriations Act of 2015. A provision of that act placed in jeopardy the projected risk corridor receivables from CMS to HealthyCT. CMS has withheld payments for the risk corridor program totaling $20,341,593 due to HealthyCT as of June 30, 2016.

15. On June 30, 2016, CMS announced in its Risk Adjustment Report for the Benefit Year 2015 that HealthyCT would be required to pay $13,372,492 to CMS pursuant to the Risk Adjustment program. As of September 30, 2016, HealthyCT satisfied such obligation to CMS.

16. On July 1, 2016, the Commissioner, pursuant to Conn. Gen. Stat. § 38a-962b, placed HealthyCT under an order of administrative supervision having determined that the imposition of

the 2015 risk adjustment by CMS placed HealthyCT in a financial condition such that the continuance of its business would be hazardous to the public or to its insureds.

17. HealthyCT is in such condition that the further transaction of its business would be hazardous, financially, to its policyholders, creditors or the public, based on the following:

a. HealthyCT reported a statement of its financial conditions to the Commissioner as of August 31, 2016, that reflected admitted assets of $79,414,000, liabilities of $34,620,000 and a surplus of $(3,522,606).

b. As of August 31, 2016, HealthyCT's reported capital and surplus is $(3,522,606), which is below Connecticut's minimum surplus requirement of $1,000,000. See Conn. Gen. Stat § 38a-72. Standing alone, HealthyCT's statutorily inadequate surplus places the company in hazardous financial condition and warrants rehabilitation.

c. Current assets and future reserves are projected by HealthyCT to be inadequate to cover all contractual obligations.

d. HealthyCT's reported net loss during the period of January 1, 2016 to August 31, 2016, is $19,285,400.

e. HealthyCT's reported capital and surplus as of December 31, 2015, was $36,127,344, but decreased to $(3,522,606) as of August 31, 2016.

f. HealthyCT has no realistic access to additional capital to improve its financial condition because: (a) it has already received from CMS the entire loan amount awarded by the federal government; and (b) HealthyCT is organized as a CO-OP, which precludes it from selling stock to raise capital. Therefore, the above circumstances evidencing the company's hazardous financial condition cannot be abated by an infusion of additional capital.

Exhibit D

Application for Conversion of a Nonprofit Health Maintenance Organization

Evergreen Health, Inc. ("Evergreen Health") seeks to convert to a for-profit entity under Title 6.5 of the State Government Article, and submits this Application to the Insurance Commissioner of the State of Maryland pursuant to § 6.5-201 of the State Government Article.

Item 1 Name of the Transferor.

The transferor is Evergreen Health, a Maryland nonprofit corporation licensed as a health maintenance organization with the Maryland Insurance Administration.

Item 2 Name of the Transferee.

The acquisition under § 6.5-101 of the State Government Article is the conversion of Evergreen Health from a nonprofit to a for-profit entity. Therefore, the transferee as a result of the conversion will be Evergreen Health, which will exist as a for-profit entity. After the conversion, the for-profit Evergreen Health entity will be acquired pursuant to § 7-304 of the Insurance Article by JARS Health Investments, LLC ("JARS"), Anne Arundel Health System, Inc. ("AAHS"), and LBH Evergreen Holdings, LLC ("LifeBridge").

Item 3 Names of Any Other Parties to the Acquisition Agreement.

None.

Item 4 Terms of the Acquisition, Including the Sale Price.

A. Background to the Acquisition

Evergreen Health was founded in 2012 by a reform-minded group of experts in health and medicine with the vision of providing affordable, high-quality health care at a reasonable cost to Maryland individuals and small businesses. In September 2012, the Centers for Medicare and Medicaid Services ("CMS") entered into an agreement with Evergreen Health to become a Consumer Operated and Oriented Plan ("CO-OP") under the Federal Patient Protection and Affordable Care Act of 2010 ("Affordable Care Act"). Evergreen Health is a Maryland nonstock corporation and was licensed in 2013 by the Maryland Insurance Administration as a non-profit health maintenance organization ("HMO"). Under the CO-OP program and pursuant to a loan agreement with CMS, Evergreen Health received loan amounts of approximately $65 million over four years to start its operations and maintain its solvency through its initial years of existence (the loan is hereafter referred to as the "CMS Surplus Note").

Evergreen Health approached the open enrollment period for the 2014 plan year with an array of product offerings for individuals and small groups both on and off the

Maryland Health Benefit Exchange. IT failures on the Maryland Health Connections site of the Maryland Health Benefit Exchange significantly hampered Evergreen Health's entrance into the Maryland marketplace. With fewer individual members than anticipated, Evergreen Health focused on the small group market in 2014, gaining respectable market share for a start-up carrier by the end of the year. 2015 was a year of tremendous growth, with membership growing from 11,694 members at the end of 2014 to 29,679 members at the end of 2015, including a small number of large group members. That growth continued in 2016 with total membership of 38,673 at year-end. Evergreen Health was fulfilling its mission of providing high quality health insurance and expert customer service to Marylanders.

On June 30, 2016, CMS announced that Evergreen Health was required to pay $24.6 million in risk adjustment transfers, wiping out all of Evergreen Health's financial gains over the prior two-and-a-half years. The risk adjustment program is one of three programs under the Affordable Care Act designed to redistribute funds from plans with lower-risk enrollees to plans with higher-risk enrollees. The rules established by CMS for this program had the effect, however, of disadvantaging small, start-up carriers (those with little data on their enrollees) and rewarding carriers with long-standing enrollees (those with multiple years of data on their enrollees). Evergreen Health had expected to receive a risk adjustment transfer assessment of $4.5 million; however a transfer assessment of $24.2 million put Evergreen Health in immediate financial peril.

Evergreen Health realized in July 2016 that it would need access to capital to help it survive and thrive in the Maryland marketplace and began exploring opportunities to convert from non-profit to for-profit and to be acquired. During this time, the Maryland Insurance Administration closely monitored the financial condition of Evergreen Health.

Evergreen Health has decided to convert to a for-profit corporation so that it may be acquired by JARS, LifeBridge and AAHS (collectively the "Purchasers"). The Purchasers desire to acquire Evergreen Health in order to enable Evergreen Health to carry on its mission to provide high quality and affordable health insurance to all Marylanders. Evergreen Health and the Purchasers expect and intend that the acquisition of Evergreen Health will (i) be in the best interest of the Maryland public; (ii) ensure the survival of Evergreen Health; (iii) provide competition to a shrinking number of health insurers offering coverage in the Maryland health insurance marketplace; (iv) provide continuing and expanding employment opportunities consistent with Evergreen Health's evolving and growing business requirements; (v) create a collective enterprise which provides additional financial strength for policyholders and Evergreen Health; and (vi) carry on and expand Evergreen Health's mission.

B. The Terms of the Acquisition

The acquisition is the conversion of Evergreen Health to a for-profit entity. The conversion will be performed as a condition to the closing on a transaction with the Purchasers as described in greater detail below.

Evergreen Health and the Purchasers have entered into agreements pursuant to which (i) the Purchasers have loaned funds to Evergreen Health in exchange for the issuance by Evergreen Health of surplus promissory notes (the "Surplus Notes"), and (ii) following conversion, the Purchasers will acquire a 100% equity interest in Evergreen Health at which time the Surplus Notes will be deemed repaid in full and Evergreen Health's obligation will be extinguished.

Evergreen Health spent five months negotiating with CMS to end its involvement in the CO-OP program. In January 2017, Evergreen Health and CMS reached a settlement regarding full and final payment of all debts owed by Evergreen Health to CMS under the CMS Surplus Note. Beginning in January 2017, the Purchasers agreed to make loans from time-to-time to Evergreen Health to support its financial condition while the Purchasers undertook extensive due diligence on Evergreen Health. The first loan of $6,000,000 was made on January 17, 2017. Evergreen Health used a portion of these proceeds to repay the CMS Surplus Note at a discounted rate. Pursuant to the settlement with CMS, Evergreen Health ceased to be a part of the CO-OP program under the Affordable Care Act and remains a nonstock, non-profit health maintenance organization under Maryland law. The Purchasers loaned an additional $3,000,000 to Evergreen Health on April 3, 2017. A final $3,000,000 is to be loaned simultaneously with the execution and delivery of the Stock Purchase Agreement between Evergreen Health and the Purchasers on or before May 1, 2017 (the "Stock Purchase Agreement").

Pursuant to the Stock Purchase Agreement, Evergreen Health will convert to for-profit status and will sell and issue to the Purchasers shares of stock representing a 100% equity interest in Evergreen Health. The aggregate purchase price is equal to the sum of (i) the outstanding principal amount, together with all accrued but unpaid interest thereon, of the Surplus Notes and (ii) the amount of capital necessary to ensure that Evergreen Health has no less than 71% risk-based capital ("RBC") at the time of such closing (which amount Evergreen Health anticipates will be approximately $9,940,000). Thus, the total of the loans plus the consideration at closing is estimated at $21,940,000. The Purchasers agree that the entire amount owed to them under the Surplus Notes is being tendered to Evergreen Health in exchange for the applicable shares of Evergreen Health stock, and the Surplus Notes shall be deemed repaid in full and terminated. The Maryland Insurance Commissioner's approval of the repayment of the Surplus Notes (with interest) is a condition to closing.

The Stock Purchase Agreement requires the Purchasers to use commercially reasonable efforts to cause Evergreen Health's RBC level to be at least equal to 200% as of December 31, 2018. The Purchasers further agree that they will be prepared to provide additional growth capital to Evergreen Health after the closing, as needed and agreed upon. The Purchasers have established this measured, well-paced RBC path in recognition that it may require multiple additional investments in Evergreen Health to restore its financial foundation on the way to sound financial health.

Item 5 Copy of the Acquisition Agreement.

The Stock Purchase Agreement (without exhibits) is attached hereto as Exhibit 1.

Item 6 Financial and Community Impact Analysis Report.

The Financial and Community Impact Analysis Report obtained by Evergreen Health from an independent consultant is attached hereto as Exhibit 2.

Item 7 Independent Valuation

An independent valuation obtained by Evergreen Health is attached hereto as Exhibit 3.

Item 8 Antitrust Analysis

An antitrust analysis prepared by an appropriate expert is attached hereto as Exhibit 4.

Item 9 Other Documents Related to the Acquisition.

Also attached as Exhibits to this Application are the following documents:

1. Articles of Amendment and Restatement for Evergreen Health immediately following its conversion to a for-profit entity are attached hereto as Exhibit 5.

2. Board Minutes and Resolutions from Evergreen Health's April 4, 2017 and April 25, 2017 Board meetings approving the conversion and acquisition are attached as Exhibit 6.

Signatures on Next Page

SIGNATURE

Pursuant to the requirements of Title 6.5, Subtitle 2 of the State Government Article, Evergreen Health, Inc. has caused this application to be duly signed on its behalf in the City of Baltimore, and the State of Maryland, on this 1st day of May, 2017.

Attest:

signature on original

Name: Jacob Petrini
Title: Executive Coordinator

Evergreen Health, Inc.

signature on original

By: _____ (SEAL)
Peter Beilenson, M.D., M.P.H.
President & Chief Executive Officer

CERTIFICATION

The undersigned deposes and says that he has duly executed the attached application dated May 1, 2017 for and on behalf of Evergreen Health, Inc., that he is the President and Chief Executive Officer of such company, and that he is authorized to execute and file such instrument. Deponent further says that he is familiar with such instrument and the contents thereof, and that the facts therein set forth are true and to the best of his knowledge, information and belief.

signature on original

Peter Beilenson, M.D., M.P.H.