Exhibit A

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 JEFFREY WU

I, Jeffrey Wu, declare under penalty of perjury as follows:

1. My name is Jeffrey Wu.

2. I am the Associate Deputy Director for Policy Coordination at the Center for Consumer Information and Insurance Oversight ("CCIIO"), one of the Centers in the Centers for Medicare & Medicaid Services ("CMS"), a component agency within the U.S. Department of Health and Human Services ("HHS"). CMS is the agency charged with implementing many of the insurance market reforms of the Affordable Care Act ("ACA"). CCIIO is the Center within CMS that oversees the federally-facilitated exchanges; the federally administered reinsurance, risk adjustment, and risk corridors programs (collectively, the "3R" or "premium stabilization" programs); and the Medical Loss Ratio ("MLR") rules, among other ACA programs.

3. I graduated from Harvard College in 1992 with a bachelor's degree in economics and from Stanford Business School and Stanford Law School in 2001 with a master's degree in business administration and a juris doctor degree, respectively.

4. I previously worked as a management consultant for Oliver, Wyman & Company,

where I advised financial services institutions, and as an attorney with Covington & Burling LLP, where I advised life sciences companies in corporate and commercial transactions.

5. In 2011, I joined CCIIO, first as a health insurance specialist, then in various policy roles. In my current role, I lead CCIIO's rulemaking and policy making functions and oversee all of CCIIO's policy and regulatory activities, including policymaking with respect to the exchanges, the premium stabilization programs, and the MLR rules, among other programs. I also oversee CCIIO's communications, stakeholder outreach, and data analysis work, as well as serve as a member of the senior leadership team.

Impact of Vacatur on the Risk Adjustment Program

6. The risk adjustment program is one of three premium stabilization programs implemented by the ACA to mitigate the potential impact of adverse selection, stabilize the price of health insurance in the individual and small group markets, and ensure that premiums are not based on the health status of enrollees. Reinsurance and risk corridors were temporary programs applicable for the 2014-2016 benefit years. The risk adjustment program is a permanent program and the only premium stabilization program that continues in effect.

7. The 3R programs are each funded entirely from amounts that insurance entities pay into them. Congress did not enact separate appropriations for these provisions.

8. The risk adjustment program collects and distributes funds associated with actuarial risk among non-grandfathered plans in the individual and small group health insurance markets within a given state. Plans with lower risk enrollees (and therefore lower anticipated costs) are assessed a "charge," which are collected by CMS or an administering state and used to make payments to plans with higher risk enrollees (and therefore higher anticipated costs). These transfers are a critical part of the ACA's reforms of the individual and small group markets.

Because the ACA requires that health plans guarantee availability to all enrollees, and prohibits underwriting those enrollees or setting rates based on health status, risk adjustment is important to assure issuers that they will receive financial protections against the risk they take on.

9. Due to the absence of additional funding for the risk adjustment program, risk adjustment must balance payments and charges across plans. CMS can only make risk adjustment payments in a market in a state to the extent that it has collected amounts through risk adjustment charges. If CMS is unable to collect risk adjustment charges from plans with low-risk enrollees, it cannot make payments to plans with high-risk enrollees in the same market.

10. More than 700 health insurance issuers have participated in the federally-administered risk adjustment program in each year that it has been administered since its inception in benefit year 2014. The program has transferred billions of dollars each year from plans with less risky participants to plans with riskier participants.

11. Health insurance companies are generally required by state insurance law to set their rates for a particular benefit year several months in advance of the beginning of that benefit year. Health insurance premiums are based on an actuarial analysis that incorporates the payments or charges a plan expects to receive or pay under CMS's risk adjustment methodology. Accordingly, CMS has worked diligently since 2011 to ensure that the complete risk adjustment methodology for each benefit year is published in advance of the rate setting process so that plan actuaries can incorporate expected risk adjustment transfers into their rate setting and plan design.

12. Health insurance plans are presently in the process of submitting data to HHS for the 2017 benefit year, with risk adjustment transfers to be announced on June 29, 2018, and those amounts collected and disbursed shortly thereafter. If CMS's use of the statewide average premium is vacated on a nationwide basis, however, this process will come to a halt. CMS will

have no cost-scaling factor with which payments and charges for 2014-2018 can be calculated.

13. For 2017 and 2018, this means that CMS will not be able to invoice issuers, collect charges, or make billions of dollars of disbursements in risk adjustment payments. Hundreds of insurance companies that took on risky enrollees in 2017 and 2018, and who factored the expectation of risk adjustment payments into their rate-setting will not receive the critical funding they expected, causing an immediate economic impact on these issuers.

14. For benefit years for which charges have already been collected from plans with less risky enrollees and distributed to plans with riskier enrollees (2014-2016), vacatur raises questions about the legal status of these already-administered payments and charges while CMS engages in the additional rulemaking necessitated by the Court's decision.

15. The uncertainty about payments and charges for five years of health insurance business, as well as the immediate detrimental impact of not receiving millions of dollars of expected payments, affects health insurance companies at a time when they are setting rates and establishing benefit parameters for the 2019 benefit year. Such uncertainty could create strong financial incentives for insurance companies to raise their rates, avoid sick enrollees, or otherwise attempt to insulate themselves against the financial uncertainty of riskier enrollees.

Impact of Vacatur on the Risk Corridors Program and MLR Reporting

16. HHS's inability to calculate risk adjustment transfers would also impact the administration of two other ACA programs—the risk corridors program and the MLR rules—with potential effects for hundreds of health insurance plans and millions of enrollees.

17. The risk corridors program established by section 1342 of the ACA, 42 U.S.C. § 18062, was a premium stabilization program that reduced pricing risk for certain plans sold on ACA exchanges for the 2014-2016 benefit years. Approximately 450 unique issuers participated

in the program over the three years in which the program was in effect.

18. The statutory formula for calculating risk corridors payments and charges incorporates risk adjustment transfers as a component of "allowable costs." *See* 42 U.S.C. § 18062(c)(1)(B). An increase in risk adjustment payments or a reduction in risk adjustment charges reduces an issuer's "allowable costs," and translates into a lower risk corridors payment or an increased risk corridors charge. A reduced risk adjustment payment or an increased risk adjustment charge would do the opposite.

19. If the risk adjustment methodology is vacated on a nationwide basis for benefit years 2014-2016, insurance companies subject to both the risk corridors program and the risk adjustment program in those years may need to revise their risk corridors calculations, as well as any financial reporting impacted by those calculations. Those revisions would likely need to be revised yet again after HHS engages in additional rulemaking proceedings to re-promulgate a cost-scaling factor for the risk adjustment formula. These revisions would impact billions of dollars of risk corridors calculations, further disrupt settled expectations, and impose a massive administrative burden on health insurance plans.

20. Similarly, payments and charges under both the risk corridors and risk adjustment programs are factored into the calculations that establish MLR rebates for enrollees. *See* 42 U.S.C. §300gg-18(a)-(b). The MLR rules require health insurance issuers to spend at least 80% or 85% of premium dollars on medical care and to submit data regarding the proportion of premium revenues spent on clinical services and quality improvement each year. If a plan fails to meet the applicable MLR standard in any given year, it must provide a rebate to its enrollees.

21. Because both risk adjustment and risk corridors amounts impact an issuer's MLR reporting, if the Court's vacatur were applied on a nationwide basis, the hundreds of issuers subject

to this requirement may need to revise their MLR reports, affecting millions of dollars in MLR rebates owed to more than two million enrollees and resulting in some issuers owing new and unexpected rebates to enrollees for prior years. Those new liabilities would not only be unanticipated, they would be difficult and burdensome to calculate and disburse given that some may apply to enrollees that have moved on to other plans. Additionally, such calculations would need to be revised a second time after HHS completes any additional rulemaking necessitated by the Court's judgment, potentially imposing a second round of additional administrative revisions on health plans and raising questions about the status of the rebates that flow from such reporting. Moreover, in addition to revising the MLR reports for the states and markets where issuers had risk adjustment or risk corridors transfers, many issuers would also have to revise their data for other states and markets because changes to risk adjustment transfers are likely to impact their allocation methods for other expenses.

22. All of this uncertainty and administrative burden coincides with health insurance issuers' annual process for rate setting and plan design for the 2019 benefit year, and could influence those decisions in the form of increased premiums, thus harming policyholders.

Executed this 28th day of March, 2018 in Bethesda, Maryland.

Jeffrey Wu