UNITED STATES COURT OF APPEALS
THURGOOD MARSHALL UNITED STATES COURTHOUSE
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February 19, 2019

Kelly Cleary
Chief Legal Officer
Centers for Medicare and Medicaid Services Division
U.S. Department of Health and Human Services
Office of the General Counsel
330 Independence Ave, SW, Rm 5309
Washington, DC 20201

Re: *UnitedHealthcare of N.Y., Inc. v. Vullo*, No. 18-2583-cv

Dear Ms. Cleary:

On February 8, 2019, a panel of the Second Circuit heard the case *UnitedHealthcare of N.Y., Inc. v. Vullo*, No. 18-2853-cv. UnitedHealthcare of New York ("UnitedHealthcare") argued that the Affordable Care Act and its implementing regulations preempt New York's state regulations titled "Market Stabilization Pools for the Small Group Health Insurance Market for the 2017 Plan Year," 11 N.Y.C.R.R. 361.9, and "Market Stabilization Pools for the Individual and Small Group Health Insurance Markets for Plan Years 2018 and Thereafter," 11 N.Y.C.R.R. 361.10. Because the Department of Health and Human Services ("HHS") is charged with implementing regulations concerning risk-adjustment programs and has not yet participated in the proceedings, we write to solicit a Statement of Interest.

During a 2018 notice and comment period, HHS was specifically asked whether states that elected to participate in the federal risk-adjustment program were allowed to make unilateral adjustments—that is, adjustments without HHS approval—to the federal risk-adjustment methodology. Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2019, 83 Fed. Reg. 16930-01, 16960 (Apr. 17, 2018). HHS responded that States were permitted to take "local approaches under State legal authority" to ameliorate the impact of the transition for new participants to the health insurance markets. *Id.* HHS then suggested that "the flexibility finalized" in the proposed rule for the 2019 benefit year would require HHS review because that flexibility "involve[d] a reduction to the risk adjustment transfers calculated by HHS." *Id.* Our Circuit has not previously had the occasion to address the following issues, which are central to this appeal:

(1) Whether, when a state participates in the federal risk-adjustment program, a state program that reverses a percentage of the federal risk-adjustment payments constitutes a "local approach[] under State legal authority." *Id.*

(2) Whether New York's market stabilization program constitutes a "reduction to the risk adjustment transfers calculated by HHS." *Id.*

(3) Whether the following communications constituted a determination under 42 U.S.C. § 18041(b)(2), as well as under the HHS risk-adjustment regulations (45 C.F.R. §§ 153.310, 153.320, 153.330), that New York's market-stabilization regulations implement the federal standards in New York:

   a. An August 8, 2016, phone call regarding New York's proposed market stabilization regulation between the New York State Department of Financial Services ("DFS") and staff members at HHS, specifically with Jeff Wu, Deputy Director for Policy, Center for Consumer Information and Insurance Oversight ("CCIIO"), Centers for Medicare & Medicaid Services ("CMS"), HHS. **[2d Powell Decl. at 14, ¶ 42, ECF No. 40]**

   b. A September 8, 2016, phone call regarding New York's proposed market-stabilization regulation between DFS and staff members at HHS, specifically with Jeffrey Grant, then the Director, Payment Policy & Financial Management Group, CCIIO, CMS, HHS. **[*Id.* at 15, ¶ 43]**

   c. An October 2, 2017, phone call regarding New York's proposed market stabilization regulation between DFS and staff members at HHS, specifically with Erin Sutton, Deputy Group Director, Payment Policy & Financial Management Group, CCIIO, CMS, HHS. **[*Id.* at 16, ¶ 49]**

   d. An October 19, 2017, email regarding implementation of New York's proposed market stabilization regulation from Krutika Amin, Health Insurance Specialist, Payment Policy and Financial Management Group, CCIIO, CMS, HHS. **[*Id.* at 16, ¶ 49]**

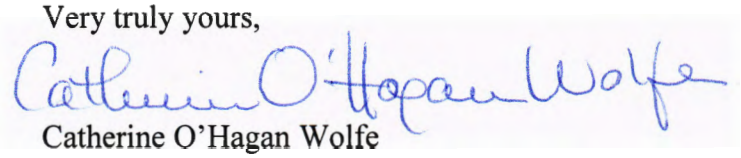
(4) Whether HHS is authorized under 42 U.S.C. § 18041(b)(2), as well as its risk-adjustment regulations (45 C.F.R. §§ 153.310, 153.320, 153.330), to make a retroactive determination that a state's market-stabilization regulations implement the federal standards, and if so, under what circumstances may HHS make such a retroactive determination.

Given the importance of these issues, the parties' differing interpretations of the statutory and regulatory language, and the above-referenced communications, as well as the policy implications for the Affordable Care Act that might result from our resolution of this case, the Court hereby solicits a Statement of Interest explaining any views HHS may have on these subjects.

To assist your preparation of a Statement of Interest, we enclose the Second Declaration of John Powell that New York submitted to the district court regarding these events. 2d Decl. of

John Powell, No. 17-cv-7694, ECF No. 40. The Clerk's Office will send by email a copy of the briefs and appendix. We would appreciate a response in the form of either a letter brief or an amicus brief of no more than thirty double-spaced pages by April 5, 2019. If an extension is necessary, we ask that HHS file a letter alerting us to a feasible response date as soon as practicable.

Very truly yours,



Catherine O'Hagan Wolfe
Clerk of Court

cc: Noel Francisco,
Solicitor General of the United States
Neal Kumar Katyal, Esq.
Matthew William Grieco,
Assistant Solicitor General of the State of New York

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