No. 4:18-cv-00167-O

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

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

PLAINTIFFS,

v.

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

DEFENDANTS.

REPLY BRIEF OF PLAINTIFFS IN SUPPORT OF APPLICATION FOR PRELIMINARY INJUNCTION

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TABLE OF CONTENTS

TABLE OF AUTHORITIES

Page(s)

Cases

Statutes

Other Authorities

INTRODUCTION

The Supreme Court in *National Federation of Independent Business v. Sebelius*, 567 U.S. 519 (2012) ("*NFIB*"), accepted Plaintiff-States' central argument here: Congress attempted to enact an unconstitutional individual mandate as the core provision of the Affordable Care Act ("ACA"). The Court only upheld the ACA under a Tax Clause constitutional-avoidance rationale. But now that Congress has rendered this avoidance rationale an impossibility through the Tax Cuts and Jobs Act of 2017, Plaintiff-States (and the Individual Plaintiffs) are legally entitled to the relief sought in *NFIB*—as even the United States (partially) concedes.

Plaintiff-States' entitlement to relief follows directly from *NFIB* and the ACA's text. As *NFIB* recognized, in enacting the ACA, Congress sought to use its Commerce Clause authority to mandate that most Americans buy federally-dictated health insurance. Crucially, Congress expressly provided in the ACA's statutory text that this mandate was "essential" to the ACA's functioning, making clear that it would not have enacted the ACA without the mandate. 42 U.S.C. § 18091(2)(I). And then in the Tax Cuts and Jobs Act of 2017, Congress repealed the tax-penalty without altering the two provisions of the ACA that are the heart of this case: (1) *the mandate itself*; and (2) *the express provision that the mandate is "essential" to the ACA's operation*.

Thus, the only action left for this Court is to invalidate the ACA's mandate and follow Congress' express instruction in the "essential" provision by finding it nonseverable from the rest of the ACA.

The United States understandably adheres to its concession made at the time of the Obama Administration in *NFIB* that, given the statutory text declaring that the mandate is "essential" to several central aspects of the ACA, guaranteed-issue and community-rating must fall with the mandate. And while the United States maintains that the remaining balance of the ACA survives, the only four Justices to have considered the same arguments in *NFIB* properly rejected them, reasoning that

the entire ACA must fall if the mandate is invalid.

Meanwhile, a series of States, entities, and individuals that opposed Plaintiff-States in *NFIB*[1] repeat many of the same meritless arguments they made in 2012. On the mandate's constitutionality, they refuse to grapple with the fact that in *NFIB*, the Chief Justice *agreed* with Plaintiff-States that the most reasonable way to read the mandate is as an unconstitutional command that almost all Americans purchase health insurance. The Chief Justice only denied relief because of the Tax Clause avoidance argument, which is no longer available. As to severability, Intervenor-Defendants repeat the same atextual, policy-based arguments made in *NFIB*, when Plaintiff-States, the United States, Intervenor-Defendants, and Court-Appointed *amicus* confronted the same issue: whether, in light of Congress' provision that the mandate is "essential" to guaranteed-issue and community-rating, Congress intended those provisions to survive without the unconstitutional mandate.

In fact, in 2012, Intervenor-Defendants *expressly declined* to dispute the United States' severability concessions in *NFIB*, thereby forcing a Court-Appointed *amicus* to defend the extreme severability position that Intervenor-Defendants now espouse. Intervenor-Defendants and their *amici* also seek to confuse the issue by arguing that this Court should either invalidate the Tax Cuts and Jobs Act of 2017

[1] *See* Br. for the States of Maryland et al. on Minimum-Coverage Provision; Br. for the States of California et al. on Severability; Br. for AARP on Minimum Coverage Provision; Br. for AARP et al. on Severability; Br. for Am.'s Health Ins. Plans et al. on Severability; Br. for Am. Hosp. Ass'n et al. on Severability; Br. for Am. Pub. Health Ass'n et al. on Severability; Br. for Am. Nurses Ass'n et al. on Minimum Coverage Provision; Br. for Econ. Scholars on the Minimum Coverage Issue; Br. for Serv. Emps. Int'l Union and Change to Win on Minimum Coverage Provision; Br. for Small Bus. Majority Found., Inc. & the Main St. All. On the Minimum Coverage Provision; Br for Wash. Legal Found. and Const. L. Scholars on Minimum Coverage Provision; Br. for 104 Health L. Professors on Minimum Coverage Provision—all briefs filed in *NFIB*, 567 U.S. 519. The only party or individual *amicus* opposing Plaintiff-States here that supported Plaintiff-States in *NFIB* actually *agrees* with Plaintiff-States on the constitutional issue, disagreeing only on severability. *See* Ilya Somin, *Thoughts on the New Constitutional Case Against Obamacare*, Reason: The Volokh Conspiracy (Feb. 28, 2018, 11:35 PM), https://tinyurl.com/SominACA.

itself or presume that the 2017 Congress somehow intended to re-enact the entire ACA, just without the critical "essential" provision. But the 2017 Congress did nothing unconstitutional, as Congress can always eliminate its own taxes, and it certainly did not re-enact the ACA or repeal the "essential" provision.

Plaintiff-States are entitled to a nationwide injunction of the entire ACA based on the remaining preliminary injunction factors. Because the mandate *commands* the Individual Plaintiffs to purchase health insurance that they neither want nor need, they are irreparably injured when they follow the law and purchase ACA-compliant insurance. Similarly, Plaintiff-States are directly and irreparably harmed by the ACA because they (1) must foot the Medicaid bill when individuals comply with the individual mandate, (2) must spend significant sums of taxpayer dollars complying with the remainder of the ACA, and (3) are prevented from implementing their own laws tailored to their own specific markets and circumstances.

A nationwide injunction against the entire ACA is equitable and in the public interest given Congress's intent—embodied in the statutory text—that the ACA cannot stand without the mandate. Intervenor-Defendants' and *amici*'s policy arguments are irrelevant in light of this express congressional intent contained in the statutory text. In any event, these policy arguments are wrong. The ACA has been a disaster. Americans now pay more for health insurance premiums[2] and deductibles[3];

[2] *See, e.g.*, App.072-73, ¶7(a) (Wis.) ("In 2017, average premium rates [in Wisconsin] rose 17%, and in 2018 they increased by 42%."); App.088, ¶4(b) (Ala.) ("On March 23, 2010 . . . an individual aged 52 [in Alabama] could purchase a major medical insurance policy for $203 per month. On January 1, 2018, a comparable Obama Care policy . . . was $829."); *see also* Edmund F. Haislmaier & Doug Badger, *How Obamacare Raised Premiums*, The Heritage Found., (Mar. 5, 2018), available at https://tinyurl.com/HowObamacareRaisedPremiums (last visited Jun 25, 2018) ("Certain provisions of the ACA—including taxes and fees, essential health benefits, and actuarial value requirements—exerted discretely measurable and direct increases in premiums.").

[3] Edmund F. Haislmaier, *Obamacare's Cost Sharing Is Too High, Even for HSAs*, The Heritage Foundation (June 1, 2018), available at https://tinyurl.com/CostSharing (last visited

national expenditures on health care continue to rise[4]; Americans are forced to pay for benefits they do not need[5]; competition among providers is all but non-existent[6]; and approximately 30 million Americans (far more than predicted) are still uninsured.[7] It is in the public's interest to enjoin the ACA in its entirety.

Alternatively, if this Court adopts the United States' position and enjoins only those portions of the ACA that the United States concedes are not severable from the individual mandate, this Court can and should limit its injunction to operate only in the Plaintiff-States for the reasons explained below.

ARGUMENT

I. As the United States Concedes, the Individual Mandate is Unconstitutional after the Tax Cuts and Jobs Act of 2017.

The mandate's unconstitutionality follows from *NFIB*'s core holding. Plaintiffs' Preliminary Injunction Brief 20-21 ("Pls. PI Br."). With 26 U.S.C § 5000A(a),

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Jun 25, 2018) (noting that insurers have "changed the design of their plans, including by charging patients higher deductibles and increasing plan out-of-pocket maximums").

[4] *National Health Expenditure Projections 2017-2026*, Centers for Medicare and Medicaid Services, available at https://tinyurl.com/projections2017-2026 (last visited June 25, 2018) ("Under current law, national health spending is projected to grow at an average rate of 5.5 percent per year for 2017-26 and to reach $5.7 trillion by 2026.").

[5] *See* Richard A. Robbins, M.D. & Manoj Mathew, M.D., *Who Will Benefit and Who Will Lose from Obamacare?*, 7 Sw. J. Pulmonary & Critical Care 103, 106 (2013) ("Healthy patients will likely pay more for less care," including "people who do not need many of the preventative services" the ACA offers.).

[6] *See, e.g.*, App.132, ¶¶6-7 (Neb.) (Nebraska currently has one health insurance carrier, down from 30 carriers in 2010); App.139, ¶6 (N.D.) (only one insurance company left in North Dakota's individual exchange marketplace in 48 of the State's 53 counties for plan year 2018); *see also* Bob Bryan, *One of the Biggest Problems with Obamacare is Only Getting Worse*, Business Insider (Aug. 24, 2016, 8:14 a.m.), https://tinyurl.com/onlygettingworse ("One of the biggest drivers of increased healthcare costs is the lack of competition in some markets. . . . [T]he high-profile exits of large insurers such as Aetna, United Healthcare, and Humana have eliminated a significant amount of competition.").

[7] *See* Chris Pope, *The Individual Mandate is Unnecessary and Unfair*, Manhattan Institute 1, 7 (Oct. 2017), https://www.manhattan-institute.org/sites/default/files/IB-CP-1017.pdf (discussing current uninsured numbers and the CBO's wildly inaccurate forecasts, including predication that from 2015 to 2016, "the uninsured would fall by an additional 5 million" when it actually "fell by only 0.2 million."); *see also* Tami Luhby, *Millions More Americans Were Uninsured in 2017*, CNN Money (Jan. 16, 2018, 6:03 a.m.), https://tinyurl.com/uninsuredindex ("The uninsured rate rose 1.3 percentage points to 12.2% last year.").

Congress sought to use its Commerce Clause power to mandate most Americans to purchase health insurance—but the Supreme Court held that exercise of power unconstitutional. *NFIB*, 567 U.S. at 552 (Roberts, C.J.); *id.* at 649 (dissenting op.). However, a different Court majority saved the mandate from invalidation since it was "fairly possible," in its view, to reinterpret Section 5000A(a)'s individual mandate and Section 5000A(b)'s tax-penalty provisions as a unified tax. *NFIB*, 567 U.S. at 562-63 (Roberts, C.J.). The Court could only adopt this saving construction, it explained, because the judicially combined Section 5000A(a) and Section 5000A(b) contained "the essential feature of any tax: It produces at least some revenue for the Government." *Id.* at 563-64 (citing *United States v. Kahriger*, 345 U.S. 22, 28 n.4 (1953)). But that saving construction is now impossible under the Tax Cuts and Jobs Act of 2017 because Section 5000A(b)'s tax-penalty formula is now "Zero percent" and "$0." Pub. L. No. 115-97, § 11081, 131 Stat. 2054. With *NFIB*'s saving construction no longer available, Pls. PI Br.22-25, what remains is Section 5000A(a)'s "*most natural interpretation*": "a legal command to buy insurance," which Congress is powerless to impose, *NFIB*, 567 U.S. at 563 (Roberts, C.J.) (emphasis added); *id.* at 657 (dissenting op.).

The United States concedes, as it must, that the mandate is unconstitutional. Federal Defendants' Preliminary Injunction Brief 9-11 ("Defs. PI Br."). While the United States once defended the mandate under the Commerce Clause, Br. for Fed. Gov't on Minimum Coverage Provision 21, *NFIB*, 567 U.S. 519, *NFIB* rejected that argument, *see* Defs. PI Br.11, and "Section 5000A(a) can no longer fairly be described as a tax" after the Tax Cuts and Jobs Act of 2017, Defs. PI Br.9-11. Put another way, because Congress "eliminated the linchpin of [*NFIB*'s] saving construction," leaving only the plain-text reading of Section 5000A(a)—"a command" to buy insurance—this Section now "exceed[s] Congress's enumerated powers." Defs. PI Br.11.

Intervenor-Defendants, for their part, no longer meaningfully argue that Congress can require individuals to purchase health insurance under the Commerce Clause. They instead address the Commerce Clause only in a conclusory footnote, asserting that the mandate "may *now* be sustained under the Commerce Clause" because, without "any penalty," it no longer "compels individuals to become active in commerce by purchasing a product." Intervenor-State Defendants' Preliminary Injunction Brief 18 n.17 ("Inter. PI Br.") (emphasis altered, citation omitted). But with the avoidance rationale off the table, Section 5000A(a) has only one possible meaning: it is a legal command that most Americans buy health insurance, which is what Congress had intended to impose from the beginning. *See NFIB*, 567 U.S. at 558-62 (Roberts, C.J.); *id.* at 657 (dissenting op.). In light of the elimination of the tax-penalty, Section 5000A(a) would be a complete *nullity* and *utterly meaningless* unless it imposes an independent legal requirement, as would Section 5000A(d)'s express exemptions from that legal requirement. *See* 26 U.S.C. § 5000A(d). And basic canons of statutory construction reject rendering statutory provisions as nullities. *See, e.g.*, *Yates v. United States*, 135 S. Ct. 1074, 1085 (2015).

Intervenor-Defendants then argue that although there is no more tax-penalty, the Court may somehow still interpret the mandate as a tax. Inter. PI Br.16-22. Intervenor-Defendants claim that "[t]he fact that [Section 5000A(b)] raised revenue was just one of several factors that caused it to resemble a tax"—for example, the tax-penalty was also "enforced by the IRS," "assess[ed] and collect[ed]" "in the same manner as taxes," and "based on" familiar tax factors. Inter. PI Br.17 (citations omitted). But *NFIB* made plain that these other factors were relevant only to the extent they "yield[ ] *the essential feature* of any tax": the "produc[tion of] at least some revenue for the Government." 567 U.S. at 563-64 (emphasis added). Without the generation of "some revenue," no "tax" is enforced, assessed, collected, paid, or

calculable. As *NFIB* explained, "Congress's authority under the taxing power is limited to requiring an individual *to pay money* into the Federal Treasury, no more." *Id.* at 574; *accord In re Kollock,* 165 U.S. 526, 536 (1897); *Sozinsky v. United States*, 300 U.S. 506, 511-14 (1937). Intervenor-Defendants do not cite a single case in support of its argument on this point. *See* Inter. PI Br.17-18. Quite the contrary, elsewhere in their brief, they cite caselaw strongly supporting *NFIB*'s "some revenue" requirement. *See* Inter. PI Br.19 (citing *United States v. Ross*, 458 F.2d 1144, 1145 (5th Cir 1972) ("The test of validity is whether on its face the tax operates as a revenue generating measure and the attendant regulations are in aid of a revenue purpose.")).

Amici American Medical Association *et al.*, in turn, cite *United States v. Ardoin*, 19 F.3d 177 (5th Cir. 1994). AMA PI Amicus Br.15-16 (Dkt. No. 113). But that case (which predates *NFIB* by almost 30 years), does not support the mandate's constitutionality. In *Ardoin*, the statute provided that "[t]here shall be levied . . . upon the making of a firearm a tax at the rate of $200 for each firearm made." 26 U.S.C. § 5821(a). The criminal defendant argued that this statute no longer had a "constitutional basis" under the Tax Clause because the Bureau of Alcohol, Tobacco, and Firearms ("ATF") had refused to accept tax payments for machineguns, in light of Congress' subsequent ban on those weapons. *See* 19 F.3d at 179-80. Rejecting this argument, the Fifth Circuit explained that "ATF has the *authority* to tax [the] now-illegal machineguns[,] [a]lthough it *chooses* not to allow tax payments." *Id.* at 180 (emphases added). *Ardoin*'s reliance on the tax-collecting authority Congress granted, rather than an agency's decision not to exercise that granted authority, is sensible because the constitutional question is whether *Congress* has exercised its taxing authority. Here, of course, *Congress* repealed the tax starting in 2019, so *Ardoin* is beside the point. *Ardoin*'s rationale would apply only to a hypothetical IRS decision not to collect the mandate's tax-penalty amount for *2018*, when such tax-penalty

collection is statutorily authorized; of course, the IRS has made no such decision.[8]

Finally, Intervenor-Defendants claim Congress has only "suspended collection" of the tax-penalty, but "retains the option of increasing" the penalty "in future years." Inter. PI Br.18. This misunderstands the nature of the law that Congress enacted. The Tax Cuts and Jobs Act of 2017 *permanently* reduces the mandate's tax-penalty formula to "[z]ero percent" and "$0"—there is no sunset provision. Pub. L. No. 115-97, § 11081. And while Intervenor-Defendants assert that "[t]he production of revenue *at all times* is not a constitutional requirement," Inter. PI Br.18 (emphasis added), the critical point is that for a provision to be a constitutional tax, it must be "expected to raise" "some revenue," at some point, *see NFIB*, 567 U.S. at 563-64; *accord United States v. Sanchez*, 340 U.S. 42, 44 (1950); *In re Kollock*, 165 U.S. at 447; *Sozinsky*, 300 U.S. at 556. Thus, in *NFIB*, the Court held that Section 5000A(b), with its original tax-penalty formula, "produces at least some revenue" for the United States, although the tax-penalty would not be exacted for another two years. 567 U.S. at 563-64 (Roberts, C.J.). Section 5000A(b), after the Tax Cuts and Jobs Act of 2017, cannot "be expected to raise" "some revenue" at *any* point.[9]

[8] AMA-*amici*'s claim that adhering to the "some revenue" requirement "lead[s] to bizarre results," since some taxes "*completely halt*[ ]" the taxed activity, AMA PI Amicus Br.18 (Dkt. No. 113), fails for the same reason: Congress would have *authorized* the collection of "some revenue."

[9] Intervenor-Defendants also argue that Plaintiff-States' claim is not ripe "because the shared responsibility payment will produce revenue for years to come" in the form of tax-penalty payments for Tax Year 2018, collected in 2019, and the various types of late tax-penalty payments. *See* Inter. PI Br.21 (capitalization altered). Yet the revenue Intervenor-Defendants identify is attributable to tax year 2018—and no additional revenue will be "raised" in later years. The Tax Cuts and Jobs Act of 2017 "reduc[es] to $0 the monetary exaction imposed for noncompliance with [Section 5000A(a)] for tax-years 2019 and beyond." Defs. PI Br.7. Plaintiff-States are seeking relief only starting in 2019, Pls. PI Br.40, and their harms starting on that date are numerous, *see id.* at 40-48.

II. Congress Expressly Concluded in the Statutory Text that the Mandate is "Essential" to the ACA, Resolving the Severability Question.

A. The Statutory Text Compels the United States' Concession, By Both the Obama and Trump Administrations, that the Guaranteed-Issue and Community-Rating Provisions are Inseverable From the Mandate.

Congress expressly stated in the ACA's text its intent that the community-rating and guaranteed-issue provisions are inseverable from the individual mandate. *See* 42 U.S.C. § 18091(2); *NFIB*, 567 U.S. at 586 (Roberts, C.J.) (following Congress' "explicit textual instruction" on severability). Congress explicitly provided that "[t]he [individual mandate] is *essential*" to the requirement of "health insurance products that are guaranteed issue and do not exclude coverage of pre-existing conditions." 42 U.S.C. § 18091(2)(I) (emphasis added). "[I]f there were no requirement[to buy health insurance], many individuals would wait to purchase health insurance until they needed care." *Id.* But "[b]y significantly increasing health insurance coverage, the requirement [to buy health insurance], together with the other provisions of this Act, will minimize this adverse selection and broaden the health insurance risk pool to include healthy individuals, which will lower health insurance premiums." *Id.* The Supreme Court recognized the plain import of Section 18091(2)(I) in *King v. Burwell*: "Congress found that the guaranteed issue and community rating requirements would not work without the coverage requirement," since these reforms are "closely intertwined." 135 S. Ct. 2480, 2486-87 (2015) (citing 42 U.S.C. § 18091(2)(I)).

Given that the statutory text ties the survival of community-rating and guaranteed-issue to the individual mandate, it is no surprise that the United States, both before the Supreme Court in *NFIB* and before this Court now, conceded that these provisions must fall if the mandate is invalid. Br. for Fed. Gov't on Severability 11, *NFIB*, 567 U.S. 519; Defs. PI Br.13-16. "[A]ll of the Justices in *NFIB*" recognized "the linkage between the individual mandate, guaranteed-issue, and community-

rating requirements." Defs. PI Br.14 (citing *NFIB*, 567 U.S. at 548 (Roberts, C.J.), *id.* at 597-98 (Ginsburg, J., concurring in part and dissenting in part), and *id.* at 695-96 (dissenting op.)). Further, "Congress looked to experiences from prior state experiments" with these reforms, Defs. PI Br.14-15; Br. for Fed. Gov't on Severability, *supra* at 47-51, and while such "empirical assumptions . . . may be subject to dispute," it "is indisputable . . . that *Congress* believed that these three provisions were interdependent in enacting the ACA," Defs. PI Br.15. This "conclusion is not affected by" the Tax Cuts and Jobs Act of 2017 because that Act neither repealed the individual mandate nor Section 18091(2). *See* Defs. PI Br.15.

The contrary arguments that Intervenor-Defendants raise are meritless.

First, Intervenor-Defendants repackage the same severability arguments that the Court-Appointed *amicus* presented in *NFIB* in 2012, Br. for Court-Appointed *Amicus Curiae* on Severability 31-41, 47-52, *NFIB*, 567 U.S. 519, arguing that guaranteed-issue and community-rating are severable from the mandate notwithstanding Congress' express conclusion, in Section 18091(2), that the mandate's survival is "essential" to the community-rating and guaranteed-issue provisons. Notably, in 2012, Intervenor-Defendants expressly declined to dispute the United States' argument that given the "essential" provision, guaranteed-issue and community-rating are inseverable from the mandate. *See* Br. for Amici Curiae States on Severability 3 n.2, *NFIB*, 567 U.S. 519.

Intervenor-Defendants respond to Plaintiff-States' text-based severability analysis by criticizing Plaintiff-States for "emphasi[zing]" the importance of the statutory text to the severability question. *See* Inter. PI Br.27-28. But severability is "best determined by an analysis of *the language in the statute* in question." *EEOC v. Hernando Bank, Inc.* 724 F.2d 1188, 1190 (5th Cir. 1984) (emphasis added). Because Section 18091(2) expressly provides that community-rating and guaranteed-issue are

inseverable from the individual mandate, that is Congress' controlling intent.

Intervenor-Defendants then seek to cast doubt on this statutory text, claiming that Section 18091(2) expresses only Congress' opinion that the mandate is constitutional under the Commerce Clause, Inter. PI Br.37—the same argument that the Court-Appointed *amicus* articulated in 2012, Br. for Court-Appointed *Amicus Curiae* on Severability 31-32, *NFIB*, 567 U.S. 519. While Subsection 18091(2)*(A)* does state that the mandate "regulates activity that is commercial and economic in nature," Subsections (B) through (J) explicitly discuss how "[t]he requirement is essential" to guaranteed-issue community-rating. This is why the United States interpreted Section 18091(2) as an inseverability clause, Br. for Fed. Gov't on Severability 11, *NFIB*, 567 U.S. 519—which Intervenor-Defendants expressly declined to dispute in *NFIB*, Br. for Amici Curiae States on Severability 3 n.2, *NFIB*, 567 U.S. 519—and why the Supreme Court in *King* cited Section 18091(2) for the proposition that "Congress found that the guaranteed issue and community rating requirements would not work without the coverage requirement," 135 S. Ct. at 2487.

Intervenor-Defendants next argue that Section 18091(2) is a historical relic because the "concern[s] about adverse selection" causing the 2010 Congress to tie the mandate to community rating and guaranteed issue are "not well founded in 2018." Inter. PI Br.39-43. But this ignores that Congress has never altered the express statutory provisions providing its clear intent that the mandate cannot be severed from other parts of the ACA: Congress expressly found, *with no time qualification*, that "if there were no requirement [to buy insurance], many individuals would wait to purchase health insurance until they needed care." 42 U.S.C. § 18091(2)(I). So if at any time that requirement was declared invalid, Congress believed these "many individuals" would once again "wait to purchase health insurance until they needed care." *Id.*; *King*, 135 S. Ct. at 2487 (stating in 2015 that "the guaranteed issue and

community rating requirements *would not work* without the coverage requirement" (emphasis added)). And while it is true that Section 18091(2)(I) also states that the three provisions are necessary when "'*creating* effective health insurance markets,'" Inter. PI Br.40 (quoting 42 U.S.C. § 18091(2)(I)), Congress also believed they were needed to *sustain* these markets, given the market problems experienced by "several States" without all three reforms, *King*, 135 S. Ct. at 2485-86; *see also* Defs. PI Br.15.

More generally, Intervenor-Defendants claim that Congress would have enacted guaranteed-issue and community-rating without the mandate because those provisions further the goals of "ensur[ing] that everyone has access to affordable health insurance regardless of their health status" and "reduc[ing] administrative costs and lower[ing] premiums." Inter. PI Br.34-36. But Congress' own statutory text expressly links the achievement of these goals *to the mandate*. *See* 42 U.S.C. § 18091(2)(I). Without it, the ACA could not "creat[e] effective health insurance markets in which improved health insurance products that are *guaranteed issue* and *do not exclude coverage of pre-existing conditions* can be sold." *Id.* (emphases added). As the United States conceded both now and in 2012, the "enforcement of [community-rating and guaranteed-issue] provisions without a minimum coverage provision would *restrict* the availability of health insurance and make it *less* affordable—the opposite of Congress's goals in enacting the Affordable Care Act." Br. for Fed. Gov't on Severability 44-45, *NFIB*, 567 U.S. 519; Defs. PI Br.13-14.

Intervenor-Defendants argue that finding inseverability here would be "unprecedented," Inter. PI Br.25, but that is plainly wrong. The Supreme Court in *Murphy v. NCAA*, 138 S. Ct. 1461 (2018), just invalidated the *entire* Professional and Amateur Sports Protection Act under traditional severability analysis, *id.* at 1482-85, even though it was practically possible to save the constitutional provisions, *id.* at 1488-89 (Ginsburg, J., dissenting). Relatedly, Intervenor-Defendants quote the

Eleventh Circuit's 2011 ACA decision (that was overruled in part by *NFIB*) in support of their claim that severability doctrine erects a "strong presumption" of severability. Inter. PI Br.26 & n.22. But *Murphy* made no mention of a presumption—strong, modest, or otherwise. 138 S. Ct. at 1482. As the only four Justices who reached the severability question in *NFIB* explained, "uncritical severance[ ] assumes the legislative function" and "can be a more extreme exercise of the judicial power than striking the whole statute." 567 U.S. at 692 (dissenting op.). Notably, that Eleventh Circuit decision adopted such an extreme position on the severability of the individual mandate that neither the United States, Br. for Fed. Gov't on Severability 22, *NFIB*, 567 U.S. 519, nor Intervenor-Defendants, Br. for Amici Curiae States on Severability 3 n.2, *NFIB*, 567 U.S. 519, defended it before the Supreme Court.[10]

Second, Intervenor-Defendants take an entirely different tack, arguing that if the mandate is invalid, then the proper remedy is to re-impose the repealed tax. Inter. PI Br.22-24. But it is crystal clear that Congress intended to eliminate this tax in the Tax Cuts and Jobs Act of 2017, and it is wholly constitutional for Congress to repeal this tax. *Frost v. Corporation Commission*, 278 U.S. 515 (1929), is not to the contrary. In *Frost*, the constitutionally offending legislation that the plaintiff challenged was *the subsequent amendment* to pre-existing law (this amendment created a distinction in a licensing statute in violation of the Equal Protection Clause). *Id.* at 517, 522-25. It was sensible for the Court to invalidate that amendment's unconstitutional

[10] Intervenor-Defendants' other criticisms of Plaintiff-States' framing of the severability doctrine are likewise unpersuasive. *Cf.* Inter. PI Br.26 n.22. Plaintiff-States' description of the severability analysis as proceeding along two steps comes directly from *Alaska Airlines* and the opinion of the four Justices who addressed severability in *NFIB*. Pls. PI Br.27-28 (quoting *Alaska Airlines Inc. v. Brock*, 480 U.S. 678, 684-85 (1987), and citing *NFIB*, 567 U.S. at 692-94 (dissenting op.)). This is also consistent with *Murphy*, which itself favorably cites *Alaska Airlines*. *Murphy*, 138 S. Ct. at 1482. Intervenor-Defendants also mistakenly assert that the States have argued that "the lack of a severability clause" creates a presumption in favor of inseverability. Inter. PI Br.27-28. On the contrary, the Plaintiff-States argue that textual instructions by Congress on severability *when present* should answer the severability question. Pls. PI Br.28-29; *supra* 9-10.

distinction, while leaving the pre-existing licensing legislation intact. *Id.* at 517, 526-28; *see also United States v. Tufti*, 542 F.2d 1046, 1047 (9th Cir. 1976) (per curiam) (enjoining only amendment to criminal statute, not statute itself, which drew distinctions based on nationality); *Texas v. Standard Oil Co.*, 107 S.W.2d 550, 557 (Tex. 1937) (similar for amendment to antitrust law, which irrationally exempted some businesses). But here, the Tax Cuts and Jobs Act of 2017—unlike the amendment in *Frost*—is *constitutional*, as Congress has plenary authority to repeal its own taxes. *See generally Brushaber v. Union Pac. R.R. Co.*, 240 U.S. 1, 12 (1916). The unconstitutional provision that Plaintiff-States challenge is Section *5000A(a)*'s individual mandate, which the 2017 Congress did not enact. The 2017 Congress's valid amendment to the ACA to repeal this tax does have the consequence of rending the *NFIB* constitutional-avoidance reading impossible. But this does not mean the 2017 tax cut is invalid, rather it leaves only Congress' intent all along: to enact an unconstitutional mandate under its Commerce Clause authority. *See supra* at 5-6.

Intervenor-Defendant's suggestion that this Court should nevertheless strike the valid Tax Cuts and Jobs Act of 2017—which no party has challenged—to save the otherwise unconstitutional individual mandate turns the concept of constitutional avoidance on its head. Again, as the Chief Justice explained in *NFIB*, Congress never intended for the individual mandate in Section 5000A(a) to be a tax. 567 U.S. at 562 (Roberts, C.J.). The Tax Power issue only came into play as a matter of constitutional avoidance, in an effort *to save Congress' handiwork from invalidation*. *Id.* at 562-63. Now, Congress has repealed the tax, but not the mandate. Constitutional avoidance does not authorize striking down an entirely valid law (the tax cut), to save an otherwise unconstitutional law (the individual mandate).

Third, advocating yet *another* approach to the severability analysis, Intervenor-Defendants (and some *amici*) argue that even if this Court invalidates the

individual mandate, and even if the United States is correct that the 2010 Congress would not have enacted guaranteed-issue and community-rating without the mandate, this Court should leave the rest of the ACA in place to honor the intent of the *2017 Congress*. Inter. PI Br.28-30 & n.23; AMA PI Amicus Br.20-22 (Dkt. No. 113); Professors' PI Amicus Br.8-10 (Dkt. No. 121). This argument fails for much the same reasons that Intervenor-Defendants' *Frost* argument fails: *the 2017 Congress enacted only a constitutional tax cut, not the unconstitutional mandate, and it is only the judicial invalidation of the mandate that necessitates a severability analysis*.

While Intervenor-Defendants do not explain the jurisprudential or statutory source of their only-look-to-2017-Congress'-intent thesis, it appears to rest upon an unstated and frankly bizarre premise: that because the 2017 Congress repealed the tax penalty, and not the rest of the ACA, it thereby intended to re-enact the entire ACA, except (conveniently) for the "essential" statutory provision that ties the survival of (at least the) guaranteed-issue and community-rating provisions to the survival for the mandate. But any suggestion that the 2017 Congress intended to re-enact the ACA (except for 42 U.S.C. § 18091(2)) is baseless: the ACA only passed in 2010 by a razor-thin margin when the party supporting it was in power in both Houses of Congress and the White House. *See, e.g.*, Robert Pear, *Senate Passes Health Care Overhaul on Party-Line Vote*, N.Y. Times, Dec. 24, 2009, https://tinyurl.com/SenPassesHealthCare. There is no real-world analysis under which the 2017 Congress would have enacted, and this President would have signed, the ACA. As the United States accurately explains, the law that Congress enacted in 2017 was just a tax cut, enacted under "the restrictive reconciliation process, which limits congressional action to generally fiscal matters," Defs. PI Br.16 n.4.[11]

[11] That the 2017 Congress enacted a tax cut, not a wholesale re-enactment of the ACA without the "essential" provision, also demonstrates why Intervenor-Defendants' reliance on

And, taking a step back, this argument must be wrong under any serious inquiry into congressional intent. If the United States is correct that Congress in 2010 would never have enacted community-rating and guaranteed-issue without the mandate (and it surely is right about that), and given that the 2017 Congress would never have enacted the ACA (sans 42 U.S.C. § 18091(2)), it makes no sense under the Supreme Court's intent-based severability analysis to conclude that *any* Congress—however one defines that body temporally—intended to enact community-rating and guaranteed-issue without the mandate.

For much the same reasons, Professor-*amici* are wrong to argue that the 2017 Congress implicitly repealed the textual, "essential" provision tying the individual mandate to the community-rating and guaranteed-issue provisions because it repealed the associated tax-penalty. Professors' PI Amicus Br.6-8. Repeals by implications are "not favored," *Nat'l Ass'n of Home Builders v. Defenders. of Wildlife*, 551 U.S. 644, 662 (2007), and Professor-*amici* come nowhere close to sustaining a repeal-by-implication holding here. While Professor-*amici* seem to believe that the mandate without the tax penalty is meaningless, Professors' PI Amicus Br.6-7, Congress disagreed. The "essential" provision unambiguously ties the mandate itself, not the tax-penalty, to community-rating and guaranteed-issue. 42 U.S.C. § 18091(2). What is more, at the time that Congress enacted the "essential" text, it specifically exempted many Americans from the tax penalty, but not the mandate, 26 U.S.C. § 5000A(e)(1)-(5)—while exempting others from the mandate entirely, *id.* § 5000A(d)(2)-(4); *id.* § 1402(g)(1). Then, in 2017, it increased the category of those exempted from the tax penalty but subject to the mandate, while leaving the category of those exempt from the mandate in place. This is a powerful, text-based indication

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the statements of four Senators from the 2017 Congress does not support their argument. Inter. PI Br.29-30. The Tax Cuts and Jobs Act of 2017, after all, simply eliminated a tax. *See id.* at 29-30 (quoting floor statements).

that Congress believes subjecting individuals to the mandate itself is significant.

Thus, this Court should not inquire into the 2017 Congress' subjective intent because that Congress did not re-enact the ACA or repeal the "essential" provision linking the mandate to community-rating or guaranteed-issue. But even if the Court were to engage in that atextual inquiry, it should adhere to the principle that the 2017 Congress intended the "natural and probable consequences of [its] acts." *United States v. Falstaff Brewing Corp.*, 410 U.S. 526, 570 n.22 (1973). When Congress enacted the Tax Cuts and Jobs Act of 2017, it knew that: (1) *NFIB* only upheld the mandate as a tax-penalty; (2) the United States conceded in that case that, in light of the "essential" provision, community-rating and guaranteed-issue were inseverable from the mandate; and (3) the only four Justices to opine on severability concluded that the rest of the ACA was inseverable from the mandate. Knowing this, Congress repealed the penalty, while leaving the "essential" provision as the law, rendering the mandate unconstitutional and leaving the rest of the ACA subject to either the United States' or the *NFIB* dissent's severability approach. *See generally* James F. Blumstein, *How to End ObamaCare in Two Pages*, Wall Street J., (Sept. 18, 2017, 6:49 PM), https://tinyurl.com/howtoendobamacare (explaining in Sept. 2017 how disavowing the Tax Clause power would render the ACA unconstitutional).[12]

B. Congress Did Not Intend for the ACA's Remaining Provisions to Remain in Effect Without the Mandate.

All the other major and minor provisions of the ACA are inseverable from the mandate. Pls. PI Br.35-40. While the United States[13] and Intervenor-Defendants

[12] Intervenor-Defendants have also appealed to the "estimated 70" unsuccessful attempts of "some members of Congress" to repeal the ACA. Inter. PI Br.30. But the intent of Congress is expressed through the laws it passes, not through unsuccessful bills proposed by some members of Congress. *See Pension Benefit Guar. Corp. v. LTV Corp.*, 496 U.S. 633, 650 (1990); *United States v. Wise*, 370 U.S. 405, 411, 414 (1962).

[13] The United States claims in a footnote that Plaintiff-States "may only seek to invalidate statutory provisions as inseverable if those provisions themselves injure them."

disagree, their briefs largely fail to address Plaintiff-States' arguments.

Insurance Regulations and Taxes. The ACA's insurance regulations and taxes include the "essential health benefits" requirements, limits on "cost-sharing," and the elimination of coverage limits. *Id.* at 36. Congress designed the mandate and the forced Medicaid expansion to offset these regulations' costs. *NFIB*, 567 U.S. at 698 (dissenting op.). Retaining them "would impose significant risks and real uncertainties" on "all other major actors in the system," "undermin[ing] Congress' scheme of 'shared responsibility.'" *Id.* at 698-99. (quoting 26 U.S.C. § 4980I); *compare Alaska Airlines*, 480 U.S. at 685.

The United States fails to address meaningfully any of these provisions, instead asserting that "various insurance regulations" "can independently operate consistent with Congress' basic objectives." Defs. PI Br.16 (internal quotation marks omitted). Further, it mistakenly claims that Section 18091(2) shows that these provisions are severable. *Id.* at 17. But that text specifically states that "*the other provisions of the Act*" work "together with" the "individual responsibility requirement" to achieve the ACA's goals. 42 U.S.C. § 18091(1)-(2) (emphasis added). The mandate, "*together with the other provisions of th[e] [ACA]*, will significantly reduce [health care's] economic cost," "lower health insurance premiums," and "reduce administrative costs." *Id.* § 18091(2)(E), (F), & (J) (emphasis added). Those statements are unqualified and so encompass *all provisions* of the ACA.

Intervenor-Defendants, in turn, claim that it is "inconceivable" that Congress "would have wished to nullify" these other ACA provisions without the mandate because they had prior implementation dates. Inter. PI Br.31. But the fact that

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Defs. PI Br.12 n.3. To the extent that "an argument can be made that those portions of the Act that none of the parties has standing to challenge cannot be held nonseverable," the "response . . . is that [the Court's] cases do not support it." *NFIB*, 567 U.S. at 696-97 (dissenting op.) (citing *Williams v. Standard Oil Co.*, 278 U.S. 235, 242-44 (1929)).

Congress wanted a provision to be effective *before* the mandate became effective communicates nothing about its desire to have that provision exist *independently in perpetuity*. Intervenor-Defendants made the same exact argument in *NFIB*, Br. for Intervenor-Defendants on Severability 24-27, 567 U.S. 519, and it failed to persuade the four Justices who reached the severability question.

Reductions In Reimbursements To Hospitals And Other Reductions In Medicare Expenditures. The ACA reduced federal Medicare and Medicaid payments to hospitals, with the understanding that they would be "offset" by the mandate. *NFIB*, 567 U.S. at 699 (dissenting op.). So without the mandate, these reductions would "distort[ ]" "shared responsibility." *Id.*; *compare Alaska Airlines*, 480 U.S. at 685. Intervenor-Defendants again assert that it is "inconceivable" that the Congress would have wished to "unwind" "completed [ ] payments," Inter. PI Br.31, but no "unwind[ing]" need occur, since an injunction would be prospective only.

Health Insurance Exchanges And Their Federal Subsidies. The ACA originally "require[d] each State" to establish exchanges, with individual policies offset by federal subsidies valued in relation to premium costs. *NFIB*, 567 U.S. at 701 (dissenting op.). Congress designed the mandate, community-rating, and guaranteed-issue provisions to check the cost of these premiums. *Id.* Without them, the subsidies would increase unchecked, "break[ing] down" the "shared responsibility" between the "[insurance] industry and the federal budget," *id.* at 702; *see King*, 135 S. Ct. at 2493-94; thus, these provisions are inseverable, *Williams*, 278 U.S. at 238, 243. Here again, both the United States and Intervenor-Defendants respond with general claims of Congressional intent without analyzing how these specific provisions could operate without the mandate. *See* Defs. PI Br.16-17; Inter. PI Br.29-30.

Employer-Responsibility Provisions. The ACA requires employers to make an employer-responsibility payment if an employee buys insurance on an exchange with

a federal subsidy. *NFIB*, 567 U.S. at 703 (dissenting op.). Absent the exchanges and subsidies, "nothing [would] trigger" this payment, and the payment requirement standing alone "would upset" "shared responsibility," so these provisions are inseverable. *Id.*; *compare Alaska Airlines*, 480 U.S. at 685; *see also Minnesota v. Mille Lacs Band of Chippewa Indians*, 526 U.S. 172, 191 (1999). Neither the United States nor Intervenor-Defendants offer a specific response.

Medicaid Expansion. The ACA substantially expanded Medicaid, and while such expansion could not be forced, *NFIB*, 567 U.S. at 575-80, 587-88 (Roberts, C.J.), the provisions allowing optional expansion must nevertheless fall with the mandate to respect Congress' intent, *Alaska Airlines*, 480 U.S. at 685. Medicaid expansion, absent the ACA's major regulations, would directly upset the "shared responsibility" intention. *Accord NFIB*, 567 U.S. at 703 (similar conclusion for employer-responsibility payment). Namely, Congress designed this to "offset the [ACA's] cost to the insurance industry." *Id.* at 689-90 (dissenting op.). If the ACA's provisions imposing costs on the insurance industry are inseverable and removed, *supra* at 18-19, this Medicaid expansion would not offset those costs, but instead benefit one group at the expense of another, in direct conflict with Congress' intent. *NFIB*, 567 U.S. at 694; *compare Alaska Airlines*, 480 U.S. at 685.

The United States responds that "Congress has repeatedly expanded [ ] Medicaid" before, and so the ACA's expansion should not fall with the mandate. Defs. PI Br.17. But prior Medicaid expansions give no indication of Congress' intent with *the ACA's* expansion. *This* expansion was part of Congress' goals of "shar[ing] responsibility" and "balanc[ing] the costs and benefits" among all regulated parties. *NFIB*, 567 U.S. at 694, 705 (dissenting op.). Without the offsetting provisions, this expansion is not in accord with congressional intent.

The ACA's Minor Provisions. The ACA's minor provisions include

miscellaneous tax increases, lingering administrative measures, and other miscellaneous regulations. *See* Pls. PI Br.39-40. Every one of these minor provisions are inseverable because they would not properly function without the major ACA provisions, since they were part of Congress' "balance" of "shared responsibility," *NFIB*, 567 U.S. at 694, 705 (dissenting op.); because they would serve no meaningful purpose, *Williams*, 278 U.S. at 243; or because they would not have been enacted at all, given that many were "benefits to the State of a particular legislator" to secure the ACA's passage, *NFIB*, 567 U.S. at 704 (dissenting op.).

Only the United States has a (partial) response. It claims that "these 'minor' provisions serve purposes far removed" from the ACA's core. Defs. PI Br.18. But that core is to provide near-universal, affordable health-insurance. *NFIB*, 567 U.S. at 694, 696 (dissenting op.). Thus, "there is no reason to believe Congress would have enacted [the minor provisions] independently," *id.* at 705, given that they are "mere adjuncts of the [main] provisions," *Williams*, 278 U.S. at 243. And while the United States claims that Plaintiff-States inappropriately rely on "parliamentary probabilities," Defs. PI Br.19, severability asks whether "Congress *would have enacted*" a particular provision—and as the four dissenting Justices concluded, recognizing that "a minor provision [was] the price paid for support of a major provision" is relevant to that analysis, *NFIB*, 567 U.S. at 704-05 (dissenting op.) (emphasis added).

III. This Court Should Preliminarily Enjoin the Inseverable ACA on a Nationwide Basis.

A. The Entire ACA Irreparably Harms Plaintiffs.

1. The individual mandate will irreparably harm the Individual Plaintiffs absent an injunction.

Intervenor-Defendants wrongly assert that the ACA's affirmative mandate to buy insurance will not harm the Individual Plaintiffs because they can choose not to purchase insurance and instead "pay" a tax of "$0." Inter. PI Br.43. First off, a person

can never "pay" a $0 tax. Moreover, this contention misunderstands the nature of the mandate. As of January 1, 2019, *NFIB*'s saving construction is unavailable, and the mandate must be "read[ ]. . . as a *command* to buy insurance," which is what Congress intended all along. *NFIB*, 567 U.S. at 574 (Roberts, C.J.) (emphasis added). That legal command carries the force of law; it is an affirmative command to obtain insurance, not a requirement to "pay" a $0 tax. Because the Individual Plaintiffs must comply with the mandate, they will suffer irreparable harm. *See* App.004, ¶¶13, 15 (Nantz); App.008, ¶¶13, 14 (Hurley).

AMA-*amici* latch onto Intervenor-Defendants' irreparable-harm argument and recast it as a standing argument, but to no avail. It still suffers from the same fatal flaw of ignoring that, as the law now stands, the *only* permissible reading of the individual mandate is as an affirmative mandate to buy insurance. Individual Plaintiffs' injury from complying with that mandate is thus directly traceable to the challenged provision. AMA-*amici* resist that point only by denying the only statutory interpretation available after the Tax Cuts and Jobs Act of 2017. For instance, AMA-*amici* argue that Congress "ordinarily provides a relatively clear indication of its intent" if it wishes to alter a "settled [statutory] construction"—such as *NFIB*'s construction of the mandate as a choice between purchasing insurance and paying a tax. AMA PI Amicus Br.8 (Dkt. No. 113) (quoting *TC Heartland LLC v. Kraft Foods Grp. Brands LLC*, 137 S. Ct. 1514, 1520 (2017)). But asking whether Congress clearly indicated an intent to alter the *NFIB* saving construction makes no sense. *NFIB* adopted the saving construction "only because [the Court had] a duty to construe [the] statute to save it, *if fairly possible*." *NFIB*, 567 U.S. at 574 (Roberts, C.J.) (emphasis added). Because that construction is no longer "fairly possible"—and, in fact, was never Congress's intent, as five Justices explained in *NFIB*—the individual mandate must be read, consistent with its "most natural" meaning, as a requirement to

purchase health insurance. And that irreparably harms the Individual Plaintiffs.[14]

2. The individual mandate will irreparably harm the Plaintiff-States absent an injunction.

Intervenor-Defendants make the same mistake when they argue that no injunction should issue because "none of [the Plaintiff-States'] purported injuries are caused by the requirement that most *individuals* maintain insurance coverage." Inter. PI. Br.44.[15] But the mandate *commands* individuals to buy insurance, and, as of January 1, 2019, many individuals can only satisfy the command by enrolling in Medicaid at the State's expense. *See* Pls. PI Br.42. So although the mandate applies to individuals, it irreparably harms the Plaintiff-States by forcing individuals to take actions that will drain the Plaintiff-States of their resources. *See* CBO, *Repealing the Individual Health Insurance Mandate: An Updated Estimate*, at 1 (Nov. 8, 2017), *available at* https://tinyurl.com/CBO2017Report ("2017 Report") (noting that some individuals will obtain health insurance "solely because of a willingness to comply with the law"); *see also* App.027 ¶¶2-3 (Tex.) ("Medicaid cost is determined [in part] by the caseload," and is paid by "both the state and federal governments").

AMA-*amici*'s decision to recast these arguments under the Article III framework does not make them viable. Like Intervenor-Defendants, AMA-*amici*

[14] AMA-*amici* appear to believe that because the Individual Plaintiffs could choose to disobey the mandate without facing a monetary penalty, their injury is self-inflicted and cannot support standing. AMA PI Amicus Br.9 (Dkt. No. 113). But none of the cases they cite support this argument, as none involved a mandate that the plaintiffs do something that caused them injury. For example, AMA-*amici* rely heavily on *Clapper v. Amnesty International USA*, 568 U.S. 398, 416 (2013), even though the issue presented there—whether expenditures motivated by fear of the law can create standing—has nothing to do with the issue presented here: whether expenditures *required by law* establish standing. Indeed, it would be absurd and contradictory to say that an injury from purchasing insurance is *voluntarily* incurred when the law specifically *commands* that purchase.

[15] The Intervenor Defendants also argue that Plaintiff-States have not identified harms flowing "from [z]eroing [o]ut the [s]hared [r]esponsibility [p]ayment." Inter. PI Br.44. That is beside the point. No harms need to flow from "zeroing out" the tax penalty because Plaintiff-States are not challenging or seeking to enjoin that amendment, but are challenging the unconstitutional mandate.

contend that the individual mandate will not cause the Plaintiff-States any harm because it "provides covered individuals with a *choice* whether to obtain minimum essential coverage" and thus a choice whether to injure the Plaintiff-States. AMA PI Amicus Br.10 (Dkt. No. 113). But the Supreme Court has made clear that a party has standing when it suffers an "injury produced by determinative or coercive effect upon the action of someone else." *Bennett v. Spear*, 520 U.S. 154, 169 (1997). That is this case. Federal law commands individuals to obtain insurance with determinative or coercive effect, since "[i]t is the *duty* of all citizens to obey the law whether they agree with it or not." *United States v. Grumka*, 728 F.2d 794, 797 (6th Cir. 1984) (per curiam) (emphasis added); *see also Montero v. City of Yonkers, New York*, 890 F.3d 386, 396 (2d Cir. 2018) (recognizing "obligation as a citizen to obey the law"); *cf. United States ex rel. Simoneaux v. E.I. duPont de Nemours & Co.*, 843 F.3d 1033, 1037 (5th Cir. 2016) (reciting United States' argument that "[a] statute enforceable through an unassessed monetary penalty . . . creates an obligation to obey the law").

3. The remainder of the ACA will irreparably harm the Plaintiff-States absent an injunction.

Plaintiff-States have also shown irreparable injury from enforcement of the rest of the ACA, which is inseverable from the mandate. In disagreeing, Intervenor-Defendants argue that the "harm allegedly caused by other, non-challenged provisions has no legal relevance." Inter. PI Br.44-45. That is incorrect, as courts entering a remedy after finding inseverability *must* address the other inseverable provisions. *See, e.g.*, *Murphy*, 138 S. Ct. at 1482-85. Plaintiff-States ask this Court to enjoin all inseverable ACA provisions, so the Court must consider the harms those provision would impose if not enjoined. *See Winter v. Nat. Res. Def. Council, Inc.*, 555 U.S. 7, 20 (2008). Intervenor-Defendants' claim to the contrary is, in effect, an argument that inseverable provisions can never be preliminarily enjoined—a position for which they cite no authority. It is this Court's obligation to craft a remedy that

respects Congress' intent. *See*, *e.g.*, *New York v. United States*, 505 U.S. 144, 186 (1992) ("Having determined that the take title provision exceeds the powers of Congress, we must consider whether it is severable from the rest of the Act.").

The inseverable provisions undoubtedly cause the Plaintiff-States irreparable harm. The fact that these provisions prevent Plaintiff-States from enforcing their own laws and policies is more than enough irreparable injury, on its own, for this Court to enjoin the entire ACA. *See* Pls. PI Br.44-46. Intervenor-Defendants have no real response to this, and instead bury in a footnote an argument that the Plaintiff-States' sovereignty is not harmed because federal law is supreme to state law. *See* Inter. PI Br.44 n.42. But Plaintiff-States' entire point is that the ACA is *not* valid federal law because it is inseverable from the unconstitutional mandate. So long as the invalid federal law unconstitutionally encroaches upon state sovereignty, including by preempting state laws, the Plaintiff-States suffer severe and irreparable injury. *See Abbott v. Perez*, No. 17-586, slip op. at 21 n.17 (June 25, 2018) ("[T]he inability to enforce its duly enacted [laws] clearly inflicts irreparable harm on the State.").

Intervenor-Defendants also argue that the Plaintiff-States will not, in fact, be financially harmed by the ACA because they "mischaracterize[d] the nature and extent of their costs." Inter. PI Br.45-46. That is incorrect. The main evidence in support of Intervenor-Defendants' allegation is the exceedingly unremarkable fact that the Plaintiff-States have, to different extents, made use of federal dollars available under the ACA. Inter. PI Br.45. But the Plaintiff-States have never disputed that fact. Indeed, when explaining that Texas spent $473.2 million on the ACA in fiscal years 2011 through 2017, the Plaintiff-States noted that Texas received $241.9 million in offsetting benefits, leaving Texas holding the bag to the tune of roughly $231 million. Pls. PI Br.43 (citing App.017, ¶19 (Tex.)). Intervenor-Defendants' argument that the Plaintiff-States failed to account for the prevention of

future medical costs and increased physical well-being is also misplaced. *See* Inter. PI Br.47. Even assuming the ACA accomplishes these goals in a meaningful way—a highly dubious assumption—that speculative premise would in no way come close to eliminating the pecuniary harm to the Plaintiff-States.[16] *Cf. Texas v. United States*, 787 F.3d 733, 750 (5th Cir. 2015) (holding, in context of standing, that offsetting benefits must be of the same character as harm to offset that harm). Intervenor-Defendants' arguments picking at the margin of harm misunderstand that the Plaintiff-States plead for an injunction, not a specific amount of damages.

There is no need for the Plaintiff-States to provide hundreds of pages detailing every element of their ACA compliance choices when the bottom line, established with ample evidence, is that the ACA is a financial drain on the Plaintiff-States both as sovereigns and employers. *See* Pls. PI Br.41-44 (discussing evidence).[17]

B. The Balance of Equities and Public Interest Favor an Injunction Preventing Nationwide Enforcement of the ACA.

1. Enjoining the entire ACA is equitable and in the public interest.

Intervenor-Defendants are wrong that "the harm that would occur from enjoining the ACA far outstrips the purported injury to" the Plaintiff-States. Inter. PI Br.48. The ACA harms not only the Plaintiff-States, but the American people. Insurers have stopped offering coverage in the individual market. *See, e.g.*, App.072-

[16] For example, there is no suggestion that the $10.7 million Missouri spent between 2012 and 2017 complying with the ACA legal mandate to insure dependents until the age of twenty-six is offset in any meaningful way by health benefits. *See* App.121, ¶¶15-16 (Mo.).

[17] Although the Intervenor-Defendants suggest that "self-insured plans, such as Texas' Health Select, may exempt themselves from the ACA's minimum coverage requirement," Inter. PI Br.47 n.49 (citing 42 U.S.C. § 300gg-21(a)(2)), they never dispute that Texas as an employer was required to increase its coverage due to the ACA, as Blaise Duran explains in her affidavit, *see* App.012 (Duran). This is because, while the statutory provision that the Intervenor-Defendants cite allows certain non-federal governmental plans to elect to opt out of certain parts of the ACA, that "election . . . shall not be available with respect to the provisions of subparts I and II"—the subparts that contain core requirements such as discrimination based on health status, 42 U.S.C. § 300gg-21, prohibition of preexisting condition exclusions, *id.* § 300gg-3, and extension of dependent coverage, *id.* § 300gg-14.

73, ¶7 (Wis.); App.093, ¶6 (Ark.); App.132, ¶¶6-7 (Neb.); App.139, ¶6 (N.D.). At the same time, "[p]remiums have consistently risen since the ACA was enacted. In 2017, average premium rates rose 17%, and in 2018 they increased by 42%," App.072-73, ¶7(a) (Wis.), largely because Americans are paying for benefits that they do not need, *see supra* at 3-4 & nn.2-5. In short, the ACA has not been good for the average American.

Regardless, Intervenor-Defendants' attempt to litigate the merits and policy implications of an immensely complicated law misunderstands this Court's role in balancing the equities and weighing the public interest. On the equitable question of whether to enjoin the individual mandate, there can be little doubt: "[I]t is always in the public interest to prevent the violation of a party's constitutional rights." *Awad v. Ziriax*, 670 F.3d 1111, 1132 (10th Cir. 2012) (citation omitted) (cited with approval by *Jackson Women's Health Org. v. Currier*, 760 F.3d 448, 458 n.9 (5th Cir. 2014)); *see also NFIB*, 567 U.S. at 535 (Roberts, C.J.) (noting that the Constitution is, in effect, a bill of rights). Moreover, enjoining the mandate would alleviate the financial burden on the Plaintiff-States by allowing their citizens to opt-out, without harming Intervenor-Defendants or individuals who *want* to purchase qualifying plans.

The severability analysis then controls whether the remainder of the ACA should be enjoined. There is no need to engage in a free-standing analysis of the ACA's policy outcomes because, if any provision of the ACA is inseverable from the mandate (as *every* provision is), Congress has already determined that it is in the public interest *not* to have that provision operate without the individual mandate. As the United States explained in 2012, keeping inseverable portions of the ACA—and specifically, guaranteed-issue and community-rating—would "drive up costs and reduce coverage." Br. for Fed. Gov't on Severability 26, *NFIB*, 567 U.S. 519. While Intervenor-Defendants argue that this is no longer true, their *post hoc* policy arguments are irrelevant to the severability analysis.

Moreover, even if Congress's intent did not control, the balance of the equities and the public interest favor an injunction because of the severe harm to every State's sovereignty. The ACA's extensive regulatory structure prevents States from enforcing their own laws and policies, often through preemption, and thereby robs them of their sovereignty. *See Tex. Office of Pub. Util. Counsel v. F.C.C.*, 183 F.3d 393, 449 (5th Cir. 1999); *Ill. Dep't of Transp. v. Hinson*, 122 F.3d 370, 372 (7th Cir. 1997). Whatever the tip of the monetary balance, this massive infringement on state sovereignty alone makes an injunction equitable and in the public interest.

2. The preliminary injunction should apply to defendants' unlawful enforcement nationwide.

Intervenor-Defendants argue that "[a] sweeping, nationwide injunction is not warranted when precisely two individuals subjected to [the individual mandate] have sued." Inter. PI Br.50. That rhetoric seriously distorts the facts. Twenty states, with populations of over 120 million people, filed this suit seeking to enjoin not only the individual mandate but the entire ACA because it causes them irreparable harm. And even though an injunction limited to the individual mandate and its most closely related provisions—the guaranteed-issue and community-rating requirements—can logically and equitably be limited to the Plaintiff-States and those living and operating within their boundaries, *see infra* at 29-30, an injunction against the entire ACA must operate on a nationwide basis. Enjoining the entire ACA on a more limited geographic scope would force citizens from the Plaintiff-States to heavily subsidize non-Plaintiff-States with their general tax dollars. Texas citizens and entities, for example, would still have their tax dollars collected and spent in accordance with ACA programs such as the Prevention and Public Health Fund, *see* 42 U.S.C. § 300u-11, and the Community Health Center Fund, *see id.* § 254b-2—only none of those funds would be spent in Texas. An injunction that effectively allows a transfer of hundreds of millions of dollars from the Plaintiff-States to the non-Plaintiff-States

would be fundamentally inequitable. A nationwide injunction is therefore required.

3. A preliminary injunction should issue promptly, or, at least, before January 1, 2019.

The United States argues that "the injury imposed by the individual mandate is not sufficiently imminent to warrant preliminary injunctive relief, especially where final adjudication would be possible before that injury occurs." Defs. PI Br.20. Not so. Contrary to the United States' suggestion, *see id.*, it would be a remarkable feat of expediency for this Court to resolve all issues in this case and enter final judgment before January 1, 2019. Not only are the issues in this case particularly complex and important, but not all issues are currently presented to this Court: Plaintiffs' preliminary-injunction application does not address the their Due Process Clause, Tenth Amendment, or APA claims. *See* Pls. 2d Am. Compl. ¶¶61-83. Because issuing a final judgment on every issue and claim raised in this suit prior to January 1, 2019—the day that the irreparable harm to the plaintiffs begins—is unlikely, this preliminary injunction application is the *only* way for the Plaintiffs to obtain relief. *See Winter*, 55 U.S. at 22 (preliminary relief is appropriate when "applicant is likely to suffer irreparable harm before a decision on the merits can be rendered").

IV. While the Plaintiff-States Strongly Believe That No Portion of the ACA Is Severable, If the Court Agrees with the United States' Position on Severability, the Court Should Enter a Preliminary Injunction as to Only the 20 Plaintiff-States.

For the reasons stated above, no portion of the ACA is severable from the individual mandate, and thus the Court should preliminarily enjoin the ACA in its entirety. However, if this Court were inclined to enjoin only the portions of the ACA that the United States concedes are not severable from the individual mandate, this Court can and should limit its injunction to operate only in the Plaintiff-States.

Such a limited injunction would not plausibly harm the Intervenor-Defendants. It is up to each State to regulate health insurance offerings within its

borders, 15 U.S.C. § 6701(b) (persons "engag[ing] in the business of insurance in a State" must be "licensed . . . by the . . . State"), which is why health insurance cannot be sold across state lines without the approval of each State's regulatory authority. Accordingly, if the portions of the ACA that the United States says are non-severable are enjoined in the Plaintiff-States, those provisions will continue to apply in States not subject to the preliminary injunction.

At the same time, a geographically-limited injunction would afford the Plaintiff-States full relief from the individual mandate and the portions of the ACA that the United States concedes are not severable from the individual mandate. With these federal requirements enjoined, each Plaintiff-State, as regulator of its local insurance market, will be able to work with insurers to improve the mix of products on the market and promote consumer choice. This means that Plaintiff-States will once again be able to provide the right mix of coverage options for their citizens, including offering protections and requirements that target the same concerns as the ACA but in more tailored ways. *See, e.g.*, App.075, ¶10(a) (Wis.) (citing Wisconsin law protecting those with preexisting conditions repealed only because of the ACA).[18] And because the portions of the ACA that the United States concedes are not severable do not involve the payment of federal funds, a geographically-limited injunction would not have the perverse interstate funding impacts discussed above. *See supra* at 28-29.

CONCLUSION

The Court should issue preliminary relief, as of January 1, 2019, enjoining the ACA and its associated regulations nationwide. Alternatively, if this Court enjoins only the portions of the ACA that the United States concedes are not severable from the mandate, the Court should limit its injunction to operate in the Plaintiff-States.

[18] Moreover, such an injunction would not affect ACA funding, and thus the Plaintiff-States would continue to pay into and receive benefits from the ACA.

Dated, July 5, 2018

Respectfully Submitted,

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No. 4:18-cv-00167-O

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

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

PLAINTIFFS,

v.

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

DEFENDANTS.

SUPPLEMENTAL APPENDIX IN SUPPORT OF PLAINTIFFS' APPLICATION FOR PRELIMINARY INJUNCTION

TABLE OF CONTENTS

In the United States District Court
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v.

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

DEFENDANTS.

SUPPLEMENTAL APPENDIX IN SUPPORT OF PLAINTIFFS' APPLICATION FOR PRELIMINARY INJUNCTION

Exhibit T

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

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

Plaintiffs,

v.

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

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

Defendants.

DECLARATION OF BLAKE FULENWIDER

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

1. I am Deputy Commissioner and Chief of the Division of Medical Assistance Plans for the Georgia Department of Community Health (DCH). DCH's Division of Medical Assistance Plans administers Georgia Medicaid and the Children's Health Insurance Program (CHIP), known as PeachCare for Kids®.
2. Georgia Medicaid serves: (1) Low-income families; (2) Children; (3) Pregnant women; (4) Aged residents; (5) Blind persons; and (5) individuals with disabilities. PeachCare for Kids® serves children and youth from birth to age 19 who are members of a household with income above Georgia Medicaid income eligibility criteria up to 252% of the Federal Poverty Level (FPL). As a result of the Affordable Care Act (ACA), an additional category of people eligible for Georgia Medicaid as added to this list: individuals under age 26 who aged out of foster care in the state and who were enrolled in Medicaid while in foster care. 42 U.S.C.A. § 1396a(a)(10)(A)(i)(IX); Affordable Care Act, Pub. L. 111-148, 124 Stat. 865, § 2004.
3. Financial eligibility for Medicaid, CHIP, and many other social programs is based on a household's income level as compared to the Federal Poverty Level (FPL). The FPL is intended to identify the minimum amount of income a household would need to meet very basic needs and is established annually by the U.S. Department of Health and Human Services.
4. Both the state and federal governments fund Medicaid. The federal share of Medicaid funds Georgia receives is based on the Federal Medical

Assistance Percentage (FMAP). The FMAP is calculated annually using each state's per capita personal income in relation to the U.S. average. Currently (FFY2018), Georgia receives FMAP of 68.50%, meaning the federal/state share of Medicaid funding is around 70/30 for medical benefit expenditures. Generally, administrative expenses are matched 50/50 between the state and federal government.

5. DCH uses several factors to determine eligibility for Medicaid including: (1) Household income; (2) age; (3) assets; and (4) other factors including but not limited to eligibility for other non-DCH administered benefits such as Temporary Assistance for Needy Families (TANF) or Supplemental Security Income (SSI).

6. Household income often varies over time and is a key factor for Medicaid eligibility. Before the ACA was passed, DCH would review eligibility criteria for Medicaid enrollees every 6 months to allow for timely disenrollment when a person no longer qualified for Medicaid.

7. The ACA imposed changes to the Medicaid eligibility renewal process. Pursuant to the ACA, eligibility redeterminations are now allowed no more frequently than once per 12 months[1], unless the enrollee volunteers to DCH that his or her household income has changed in a way that makes the beneficiary ineligible. This change mandated by the ACA restrains the frequency with which DCH can identify persons no longer eligible for

[1] 42 CFR Sec. 435.916(a)

Medicaid and remove them from the program, thus increasing the number of persons eligible for Medicaid services at any given time. This restriction has caused some ineligible enrollees to receive benefits for a period of time that exceeds their period of eligibility, despite DCH's desire to remove enrollees from the program promptly upon becoming ineligible for continued enrollment.

8. The ACA also required states to adopt a new measure of household income, Modified Adjusted Gross Income (MAGI) of a Non-Elderly, Non-Disabled household, for the purpose of determining eligibility for state Medicaid and CHIP programs. Adoption of MAGI standards required Georgia to marginally[2] increase income thresholds for affected categories of eligibility when Georgia's MAGI Conversion Plan was approved by the federal government in 2014.

9. The ACA's individual mandate contributed to the expansion of the Medicaid population in Georgia as well. As a result of the individual mandate, Georgia residents were necessarily required to secure health care coverage or pay a fine to the federal government. Even individuals who qualified for the federal "Hardship Exemption" sought qualified coverage through available sources, including Medicaid. Efforts to avoid imposition of the fine likely prompted more individuals to secure Medicaid from DCH.

[2] https://www.medicaid.gov/medicaid/program-information/medicaid-and-chip-and-the-marketplace/downloads/ga-converted-thresholds-03jul2013.pdf (MAGI conversion results).

10. Although it is difficult to quantify the exact number of Medicaid enrollees that can be attributed to the individual mandate, I believe that the individual mandate played a substantial role in the increase in the number of Medicaid recipients since 2011. This assertion is based on my experience with DCH and the Governor's Office of Planning and Budget (OPB), as well as research I have participated in to prepare policy analyses and budget projections since the ACA was enacted into law.

11. The ACA requires Georgia's Integrated Eligibility System (IES), known as "Georgia Gateway," to electronically interface with the Federally-Facilitated Exchange (FFE) systems in order to receive Medicaid applications that the FFE has *assessed* as Medicaid-eligible. It is the obligation of DCH, as the Single State Agency for Medicaid, to conduct a full eligibility *determination* based upon information received by the FFE.

12. Georgia has not expanded Medicaid to cover childless adults from 0% FPL up to 138% FPL. However, the FFE has and continues to assess individuals who fall within the above range as eligible for Medicaid and transmits this assessment to DCH for an eligibility determination. DCH continues to receive thousands of such applications from the FFE each year, creating a significantly increased workload on Medicaid eligibility staff whose resources are limited.

13. The ACA also mandates the specific Medicaid services Georgia is required to cover. Rather than allowing DCH to make such determinations based on

the needs of Georgia's population, the ACA imposed a "one-size-fits-all" rule upon Georgia, thereby governing the provision of inpatient hospital services, outpatient hospital services, family planning services and supplies, federally qualified health centers, nurse midwife services, certified pediatric and family nurse practitioner services, home health care services, medical transportation services, nursing facility services for individuals 21 or over, rural health clinic services, and other significant and complex medical services and systems.

14. From January 2014 – March 2018, Georgia's Medicaid enrollment has grown from 1.829 million to 2.074 million individuals.

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

Respectfully submitted this the 14th day of May, 2018.

Blake T. Fulenwider
Deputy Commissioner
Chief, Medical Assistance Plans
Georgia Department of Community Health

County of Fulton
State of Georgia

Sworn and subscribed before me
this 14 day of May, 2018.

R RENEE ROBINSON NOTARY PUBLIC DEKALB COUNTY EXPIRES GEORGIA OCT. 30, 2020

Notary Public
My Commission Expires: 10.30.20

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

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

PLAINTIFFS,

v.

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

DEFENDANTS.

SUPPLEMENTAL APPENDIX IN SUPPORT OF PLAINTIFFS' APPLICATION FOR PRELIMINARY INJUNCTION

Exhibit U

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

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

DECLARATION OF TERESA MACCARTNEY

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

1. I am the Chief Financial Officer of the State of Georgia and the Director of the Governor's Office of Planning and Budget ("OPB"). I have served as the state's CFO and the Director of OPB for five and a half years. As the CFO of the State of Georgia and the Director of OPB, I am responsible for overseeing the fiscal affairs of the state and developing financial policies and plans for each of its public departments, agencies, and institutions. As a part of these responsibilities, I monitor agency expenditures and develop budget recommendations to suit the state's policy goals. I am particularly familiar with changes in costs, plans, and policies related to the enactment of the Affordable Care Act ("ACA") because I oversee the budgets for the Georgia Department of Community Health ("DCH"), the University System of Georgia Board of Regents ("BOR") and the State Accounting Office ("SAO"). I have personal knowledge of the matters and information set forth herein.
2. DCH administers the state Medicaid and PeachCare for Kids programs and the State Health Benefit Plan ("SHBP"). PeachCare for Kids is a comprehensive health care program for uninsured children living in Georgia. SHBP provides health insurance coverage to state employees, retirees, and their dependents.
3. BOR administers the University System of Georgia Healthcare Plan which provides health insurance coverage to University System of Georgia employees, retirees, and their dependents.

4. SAO is responsible for facilitating the completion of federal reports to the Internal Revenue Service and insured employees and retirees.

Provider Costs Associated with ACA Regulations

5. With the passing of the Affordable Care Act, DCH and BOR have suffered and continue to suffer financial burdens because the ACA replaced the flexibility they previously had to provide health insurance plans tailored to needs of Georgia's population with federal policies. Across all programs and agencies, compliance with the ACA has cost the State of Georgia an estimated net cumulative $514 million after discounting offsets from increased employer premiums and federal funding. Moreover, because most of the relevant ACA mandates are permanent, the State of Georgia will continue to pay additional costs indefinitely.

6. Prior to the implementation of the ACA, DCH provided coverage for unmarried dependents up to age 25 who are enrolled as a full-time student at least five months during the year or are eligible to enroll but are prevented due to illness or injury to remain on their parents' insurance OR requires that a health services plan or health insurer exempt dependent children incapable of self-sustaining employment due to disability from dependent age limits. But the ACA requires health insurance coverage to provide continuing coverage for all dependents until the age of 26. Continuing health insurance coverage for adult dependents until the age of 26 imposes significant costs upon DCH because each individual insured by a DCH plan constitutes expenses for the

system. Had DCH been permitted to continue providing dependent coverage that met pre-ACA requirements, these costs would not have been imposed upon DCH. Compliance with the ACA will require DCH to indefinitely continue paying these additional costs because the dependent age requirement mandated by the ACA remains 26.

7. Prior to adoption of the ACA, DCH required insured persons to pay co-insurance and/or co-pays for preventative care that are now disallowed because the ACA requires that preventative care be covered at 100%. Covering 100% of preventative care costs more than covering less than 100% of preventative care. Thus, if DCH could have continued to provide its prior coverage plan for preventative care, it would have saved substantial sums. Compliance with the ACA will require DCH to indefinitely continue paying these additional costs.
8. Prior to implementation of the ACA, DCH provided insurance coverage for contraceptive drugs at a rate below 100%. The ACA, however, requires contraceptives to be covered at 100%. Covering drugs at 100% of cost is more expensive for DCH than covering drugs at less than 100%. If DCH could have maintained its prior coverage plan for contraceptives, therefore, it would have saved significant monies. Compliance with the ACA will require DCH to indefinitely continue paying these additional costs.
9. The ACA requires DCH to pay a Patient-Centered Outcomes Research Institute ("PCORI") fee. The fee increases yearly. If the PCORI fee had not been required under the ACA, DCH would not have paid it and would therefore

have not seen an increase in cost. This fee is imposed currently for plans that end before October 1, 2019, and therefore, will continue to be paid into 2020 under the ACA.

10. The ACA required DCH to pay a Transitional Reinsurance Program fee. If this requirement had not been in place, DCH would not have paid the fee and would have saved substantial sums.

11. The ACA requires limits for consumer spending on in-network essential health benefits ("EHB"s) covered under most health plans. Once a person has reached the limit, the plan must cover 100% of all medical expenses. Prior to the ACA, DCH had no such limit. Covering 100% of medical expenses cost more than covering less than 100% of medical expenses. Thus, the imposition of this regulation has required DCH to spend significant funds. This is a permanent requirement under the ACA, thus the costs to DCH as a result will continue indefinitely.

12. After the implementation of the ACA's individual mandate, DCH experienced a substantial increase in employee elections to obtain health insurance. Because SHBP incurs additional costs for each additional employee who elects to obtain health insurance, the increased number of elections resulted in substantial costs to SHBP.

13. The aforementioned ACA provisions also impact the University System of Georgia Healthcare plan. Like SHBP, BOR was and continues to be impacted by ACA mandates that differ from its pre-ACA policies. Such ACA mandates

include eliminating lifetime maximums, changing coverage requirements for preventative care and out-of-pocket maximums, and instituting reoccurring fees. All of these provisions as well as increased health benefit elections have increased BOR's health plan costs.

14. As a result of the ACA, DCH and BOR increased employee premiums and participated in the Early Retiree Reinsurance Program established by the ACA to offset the cost of the law's mandates and fees. Employee premiums are paid by state employees. Thus, although DCH's costs were offset by raising employee premiums, state employee wages were negatively affected. Furthermore, when these revenue adjustments are taken into account, the net cost of the ACA to SHBP and BOR are still an estimated $442.1 million and $44.1 million, respectively, and those amounts will continue to increase each year due to the permanent and otherwise continuing mandates of the ACA.

Medicaid Costs Associated with ACA Regulations

15. With the passing of the ACA, DCH has been financially harmed and will continue to be financially harmed by the burdens imposed on it related to Medicaid and CHIP programs. To date, Medicaid and CHIP program changes as a result of the ACA have cost DCH an estimated net $24.3 million after discounting increased rebates for CMO coverage and an increased Enhanced Federal Medical Assistance Percentage. These costs will continue year after year because the relevant ACA provisions are permanent.

16. Prior to the ACA, Georgia assessed the eligibility of Medicaid recipients every six months. To comply with the ACA, Georgia now reviews the eligibility of Medicaid recipients no more frequently than every 12 months. Less-frequent eligibility assessments result in a greater number of Medicaid recipients. Each additional Medicaid recipient represents additional costs to DCH. Thus, were it not for the implementation of this regulation, DCH would have saved substantial costs. This is a permanent requirement under the ACA, so the costs to DCH as a result will continue indefinitely.

17. The ACA imposes a fee on all for-profit entities involved in the business of providing health insurance. This fee applies to Care Management Organizations (CMOs) providing health insurance coverage to Medicaid beneficiaries. DCH is required to reimburse CMOs for the cost of the fee. If DCH was not required to pay the fee, DCH would have saved substantial sums. Compliance with the ACA will require DCH to indefinitely continue paying these growing costs.

18. The ACA allowed hospitals to determine presumptive eligibility for increased populations to include low income Medicaid categories of eligibility. It also prevents entities conducting presumptive eligibility determination from requiring proof of status. Once a qualifying hospital determines a person is presumptively eligible for Medicaid, the person can receive services for a period of 60 days. Even if the person is later found to be ineligible for Medicaid, Medicaid must pay for services rendered during the period of presumptive

eligibility. This provision of the ACA has imposed substantial costs on DCH through Medicaid match requirements. This is a permanent provision of the ACA, thus the costs to DCH as a result will continue indefinitely.

19. The ACA required the state Medicaid program to increase primary care provider (PCP) reimbursement rates to 100% of Medicare reimbursement rates between January 1, 2013 and December 31, 2014. This provision required CMOs to adjust capitation rates to account for higher reimbursement rates for primary care providers, which resulted in an increase in the Health Insurance Provider Fees paid by the CMOs and was then passed onto the state through CMO capitation rates.

20. The net cost of the ACA to DCH's Medicaid programs is estimated to be $24.3 million when the costs of eligibility review requirements, presumptive eligibility requirements, Health Insurer Provider Fee, and expansion of State Children's Insurance Plan (CHIP) coverage are offset by savings from the ACA's policy of increasing rebates for CMO coverage and its 23% increase to the Enhanced Federal Medical Assistance Percentage for CHIP beneficiaries.

Administrative Costs Associated with ACA Regulations

21. With the passing of the Affordable Care Act, SAO, DCH, and BOR have had to comply with reporting requirements that would not have otherwise been required. The cost to these agencies of compliance with the ACA's reporting requirements is an estimated net $3.6 million to date after discounting the new Enhanced Federal Medical Assistance Percentage. Since reporting

requirements are a permanent provision of the ACA, reporting costs will continue indefinitely.

22. Under the ACA, SAO is required to report coverage annually. This is a permanent provision of the ACA, thus the costs to SAO as a result will continue indefinitely.

23. Under the ACA, DCH is required to provide Medicaid and PeachCare beneficiaries with coverage information on IRS 1095-B forms. This is a permanent provision of the ACA, thus the costs to DCH as a result will continue indefinitely.

24. After the implementation of the ACA, DCH experienced increased enrollment of individuals already eligible for Medicaid benefits under pre-ACA eligibility standards. The enrollment increase required DCH to enhance its Medicaid Management Information System to process additional Medicaid applications. Enhancing its Medicaid Management Information System was very costly.

25. The total administrative costs associated with the ACA are estimated to total $11.2 million. These costs were partially offset by the ACA's increasing the Enhanced Federal Medical Assistance Percentage from 77% to 100% which reduced administrative expenditures by an estimated $7.7 million. The net cost increase for administrative programs is estimated to be $3.6 million.

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

Respectfully submitted this the ___ day of May, 2018.

Teresa A. MacCartney
State Chief Financial Officer
Director,
Office of Planning and Budget

State of Georgia

County of Fulton

On this, the 14th *day of* May, 20 18, *before me a notary public, the undersigned officer, personally appeared Teresa A. MacCartney, known to me (or satisfactorily proven) to be the person whose name is subscribed to the within instrument, and acknowledged that he executed the same for the purposes therein contained.*

In witness hereof, I hereunto set my hand and official seal.

FELICIA A LOWE NOTARY PUBLIC HENRY COUNTY, GA MY COMMISSION EXPIRES

Notary Public exp 5/29/2018

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

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

PLAINTIFFS,

v.

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

DEFENDANTS.

SUPPLEMENTAL APPENDIX IN SUPPORT OF PLAINTIFFS' APPLICATION FOR PRELIMINARY INJUNCTION

Exhibit V

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF TEXAS
FORT WORTH DIVISION

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

DECLARATION OF JAMES J. DONELON,
LOUISIANA COMMISSIONER OF INSURANCE,
PURSUANT to 28 U.S.C. § 1746

INTRODUCTION

1. My name is James J. Donelon and I am the Louisiana Commissioner of Insurance.
2. As Commissioner, I am the head of the Louisiana Department of Insurance ("LDI") and the chief regulator of insurance in Louisiana pursuant to Article IV, Section 11 of the Louisiana Constitution.
3. The LDI is responsible for regulating the Louisiana health insurance market and protecting consumers in this market. The LDI performs a variety of tasks to protect insurance consumers and to ensure a competitive health insurance market environment, including:
    a. Licensing insurance companies and monitoring their financial solvency to make sure that consumers have the insurance coverage they expect when they need it;
    b. Conducting examinations of foreign and domestic insurers doing business in Louisiana to ensure compliance with Louisiana laws, rules and regulations;

c. Reviewing insurance policies to be sold in Louisiana to ensure compliance with Louisiana and federal law;

d. Issuing licenses to producers, brokers, third party administrators, and other entities that sell, market and administer insurance products;

e. Investigating consumer complaints against insurance companies, producers, and other entities involved in the business of insurance doing business in Louisiana;

f. Researching special insurance issues to understand and assess their impact on the citizens of Louisiana;

g. Providing technical assistance on legislation and promulgating rules and regulations in accordance with the Louisiana Insurance Code;

h. Creating and distributing consumer education materials and public information for many types of insurance;

i. Taking administrative action including fines, license suspension, and/or license revocation against entities found to be in violation of the provisions of the Louisiana Insurance Code;

j. Taking action to initiate rehabilitation, conservation, or liquidation proceedings of companies determined to be in financially hazardous condition or determined to be insolvent;

4. As the Louisiana Commissioner of Insurance, my duties include monitoring the impact of the Affordable Care Act ("ACA") on Louisiana's insurance market, ensuring Louisiana's compliance with the ACA, advising the Louisiana Governor and legislature on the ACA, and developing strategies for Louisiana to mitigate the numerous harms the ACA has inflicted on Louisiana's health insurance markets.

HARMS CAUSED BY THE AFFORDABLE CARE ACT

5. Title 1 of the ACA included market reforms that guaranteed minimum coverage of certain health care services, prohibited lifetime and annual limits, limited the ability of insurers to charge premiums based on gender, age, and health, as well as other lesser reforms that had an impact on pricing. The major reforms went into effect in 2014.
6. Louisiana has been very adversely affected by the market reforms of the ACA. Loss ratios for insurers operating in Louisiana skyrocketed and those sustained losses by insurers has led to market withdrawls, decreased competition, fewer product choices and higher premiums.
7. In 2013, prior to the effective date of the major provisions of the ACA, there were sixteen (16) insurance companies writing major medical insurance policies in the individual market in Louisiana. As their profits dwindled and losses mounted, companies began exiting the individual market. In 2018 there are essentially only two insurers writing individual major medical policies in Louisiana.
8. In 2013, prior to the effective date of the major provisions of the ACA, premiums increased an average of 3.7 percent (3.7%) in the Louisiana individual market. In 2014, due to the

mandates of the ACA, premiums increased by fifty-three percent (53%) and have continued to increase by double digits every year. The average rate increase in the individual market was seventeen percent (17%) in 2015, fourteen percent (14%) in 2016, thirty-three percent (33%) in 2017, and eighteen and one half percent (18.5%) in 2018. Additionally, total market enrollment is down significantly as premiums continue to rise. The viability and continued existence of the individual market in Louisiana is threatened by rising premiums and reduced enrollment.

9. Health insurance premiums are predicted to continue to rise. The Congressional Budget Office's April 2018 "Budget and Economic Outlook: 2018 to 2028" estimates that, under current law, Federal outlays for health insurance subsidies and related spending will rise by about sixty percent (60%) over the projection period, increasing from $58 billion in 2018 to $91 billion by 2028. (cbo.gov/publication/53651). These rising premiums have a significant negative impact on Louisiana's middle-class as fewer employers offer health insurance coverage due to increasing premiums.

10. The LDI, as the primary enforcer of insurance laws, has spent the past six years reading, studying, interpreting, and enforcing federal regulations and additional guidance related to the ACA. The LDI completely revised its insurance policy review standards for health insurance products, educated the public on changes in the law, and handled consumer complaints expressing confusion and frustration about the limited, expensive choices that remain in the Louisiana individual market.

11. Additionally, Louisiana has been harmed by the ACA because it has preempted Louisiana law, preventing the Louisiana Department of Insurance from regulating health insurance in the manner it deems best for consumers.

12. Finally, the ACA has harmed the Louisiana health insurance market by providing for the establishment of the Consumer Operated and Oriented Plan (Co-op) Program. The program was intended to foster the creation of nonprofit health insurance issuers to offer health plans in the individual and small group markets as an alternative to commercial insurance to create competition and drive down premiums. The onerous restrictions placed on the Co-ops as well as inadequate funding contributed to the downfall of the vast majority of the original twenty-three (23) Co-ops created nationwide. Almost every Co-op has been financially troubled and most have failed, including Louisiana's Co-op, Louisiana Health Cooperative ("LAHC"). LAHC was placed in Rehabilitation by a Louisiana court on September 1, 2015 and the LDI has spent considerable resources overseeing the Rehabilitation of LAHC to protect the consumers and healthcare providers affected by the failure of the Co-op. The ACA's Co-op Program has cost taxpayers nationwide more than $1.8 billion to date.

I DECLARE UNDER PENALTY OF PERJURY THAT THE FOREGOING IS TRUE AND CORRECT.

Executed in Baton Rouge, Louisiana, this 2nd day of MAY, 2018.

James J. Donelon
Commissioner of Insurance
State of Louisiana

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

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

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SUPPLEMENTAL APPENDIX IN SUPPORT OF PLAINTIFFS' APPLICATION FOR PRELIMINARY INJUNCTION

Exhibit W

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

STATE OF TEXAS, PAUL LePAGE, Governor of Maine, *et al.* Plantiffs	)	Civil Action No. 4:18-cv-00167-O
v.	)	
UNITED STATES OF AMERICA, *et al.*, Defendants	)	

DECLARATION OF ERIC A. CIOPPA
MAINE SUPERINTENDENT OF INSURANCE
PURSUANT TO 28 U.S.C. § 1746

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1. My name is Eric Cioppa. I am the Superintendent of Insurance for the State of Maine.

2. As Superintendent of Insurance, I am the head of the Bureau of Insurance within the Maine Department of Professional and Financial Regulation. Generally, my official duties include supervising the agency, serving as final adjudicator of all administrative actions, and serving on various councils and committees. As a member of the State Employee Health Commission, I have first-hand experience with the management and operations of a large self-insured health plan.

3. The duties of the Maine Bureau of Insurance include:

   a. Assisting insurance consumers with their insurance problems;

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

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

d. Reviewing insurance policies sold in Maine to ensure compliance with Maine and federal law;

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

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

g. Providing technical assistance on legislation, adopting rules to implement insurance laws, and issuing bulletins and other interpretive guidance;

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

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

4. In addition to the implementation and enforcement of the Maine Insurance Code, my duties include the implementation and enforcement of other state and federal statutes to the extent that they provide for administration or enforcement by the Superintendent. Federal law mandates that I enforce those provisions enacted by HIPAA and the ACA that have been codified in the federal Public Health Service Act.

5. In 1993, Maine mandated guaranteed issuance of coverage and modified community rating in its individual health insurance market without any mandate to purchase coverage.

6. As explained in Pages 30 and 31 of the Plaintiffs' Brief in Support of their Motion for Preliminary Injunction, the government argued in *NFIB v. Sebelius* that without an individual

mandate, guaranteed issue and community rating "would drive up costs and reduce coverage," leading to "a marketwide adverse-selection death spiral," and "the market will blow up."

7. That is precisely what happened in Maine. Under Maine's guaranteed-issue law, coverage became increasingly unaffordable, even for consumers willing to purchase plans with per-person deductibles as high as $20,000. By 2010, there was only one carrier offering comprehensive health plans. Only 30,000 Mainers were enrolled in the individual market, while 110,000 were uninsured.

8. The ACA implementation has led to a lack of choices in coverage, and failed to live up to its promise of affordability. Consumers with one of the most widely purchased plans in 2013, the Anthem HealthChoice 15000 plan, were mapped by Anthem into the ACA-compliant Bronze Guided Access plan for 2014. The resulting premium increase for consumers aged 30 to 60 ranged from 48.1% to 122.7%, depending on age and geographic area. Outside Rating Area 1 (which includes Portland) the smallest increase for the other three rating areas was 78.5%.

9. Premiums under the ACA continue to rise. Carriers' average individual rate increases in Maine ranged from 18.0% to 25.5% in 2017, and ranged from 19.6% to 39.7% in 2018.

10. The cost of insurance is particularly burdensome for consumers who earn more than 400% of the Federal Poverty Level ("400 % FPL") and are not eligible for premium subsidies. This year, the unsubsidized premium for a 45-year-old nonsmoking couple with two young children ranges from $16,978.80 to $25,094.40 for the lowest-priced Silver plan, depending on which county they live in. These plans are not offered on the Exchange, so the price is not artificially increased by the cost of the Cost-Sharing reductions. Even if this family were to buy

a Catastrophic plan, the annual premium for the lowest-priced plan would range from $9909.84 to $14,409.12, depending on geography.

11. Even for consumers who are eligible for subsidies, the cost of ACA-compliant insurance is often out of reach. Under the ACA, subsidies are only available if the price of the second-lowest-cost Silver plan (the "baseline" plan) exceeds a specified percentage of income. When subsidies are available, they are calculated so that the consumer must pay that percentage of their income as the premium for the baseline plan, and must also pay the applicable deductible and other cost sharing. For example; for consumers making between 300% and 400% FPL, the subsidized premium for the baseline plan is equal to 9.56% of their household income in premium. This year, for a family of four, 400% of the Federal Poverty Level ("400 % FPL") is $100,400 and 300% FPL is $75,300. This makes their subsidized premium $7,198.68 per year at 300% FPL and $9,598.24 at 400% FPL.

I declare under penalty of perjury that the foregoing is true and correct, based on my personal knowledge and on information contained within the records of the Maine Bureau of Insurance, Department of Professional and Financial Regulation.

April 30, 2018

ERIC A. CIOPPA
Superintendent of Insurance, State of Maine