UNITED STATES DISTRICT COURT
DISTRICT OF NORTH DAKOTA
WESTERN DIVISION

STATE OF KANSAS, *et al*., Plaintiffs, v. UNITED STATES OF AMERICA, *et al*., Defendants.	Civil Action No. 1:24-cv-150-DMT-CRH Judge Daniel M. Traynor

MOTION FOR LEAVE TO INTERVENE

Proposed Defendant-Intervenors New Jersey, Arizona, California, Colorado, Delaware, Hawai‘i, Illinois, Maryland, Attorney General Dana Nessel on Behalf of People of Michigan, Minnesota, Nevada, New Mexico, Oregon, and Vermont (collectively, “Movant States”) respectfully request that the Court grant them leave to intervene as defendants in this action as of right pursuant to Federal Rule of Civil Procedure 24(a)(2) or, in the alternative, grant permissive intervention pursuant to Federal Rule of Civil Procedure 24(b)(1)(B).

In support of this Motion, Movant States rely on and incorporate herein their Memorandum of Law, and the accompanying exhibits. Movant States have also attached as Exhibit 11 to this Motion their Proposed Answer, as required by Federal Rule of Civil Procedure 24(c).

Dated: January 15, 2025

Respectfully submitted,

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CERTIFICATE OF SERVICE

I, the undersigned, hereby certify that, on the 15th day of January, 2025, I caused the foregoing documents to be served via electronic filing on lead counsel of record.

/s/ Joshua P. Bohn
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Deputy Attorney General

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF NORTH DAKOTA
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STATE OF KANSAS, *et al*., Plaintiffs, v. UNITED STATES OF AMERICA, *et al*., Defendants.	Civil Action No. 1:24-cv-150-DMT-CRH Judge Daniel M. Traynor

MEMORANDUM OF LAW IN SUPPORT OF MOTION TO INTERVENE AS DEFENDANTS BY PROPOSED INTERVENORS NEW JERSEY, ARIZONA, CALIFORNIA, COLORADO, DELAWARE, HAWAI'I, ILLINOIS, MARYLAND, ATTORNEY GENERAL DANA NESSEL ON BEHALF OF PEOPLE OF MICHIGAN, MINNESOTA, NEVADA, NEW MEXICO, OREGON, AND VERMONT

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INTRODUCTION

This case challenges a Final Rule authorizing DACA recipients to enroll in a health plan via an ACA exchange. As this Court has recognized, a range of States welcome this Final Rule and believe it is lawful—and filed an amicus brief explaining that the ACA authorizes noncitizens who are "lawfully present," including DACA recipients, to participate in state and federal health insurance exchanges. Because federal defendants can no longer be counted on to defend Movant States' interests or to press these arguments regarding the proper scope of the ACA, and because elimination of the Final Rule would impose significant harms on Movant States and their residents, these 14 Movant States now move to intervene.[1] This Court should grant the motion.

The basis for intervention is straightforward. The challengers seek final relief that would prevent implementation of the Final Rule across the country, whether in the form of vacatur or an injunction. But granting the challengers that relief would harm Movant States in at least four ways. First, Movant States incur costs providing health care to residents without health insurance—and a court order barring DACA recipients from obtaining insurance on ACA exchanges, or stripping DACA recipients of insurance they already obtained, would increase those costs. Second, Movant States assess fees from each enrollment on their ACA exchanges—specific state revenue streams a court order would eliminate. Third, Movant States who run their own exchanges would have to expend funds to implement any court order that vacated the Final Rule, both by updating eligibility criteria and in informing DACA recipients of their loss of insurance and prospective ineligibility. And fourth, Movant States maintain an interest in the health and safety of their residents, including

[1] The Movant States seeking to intervene in this action are: New Jersey, Arizona, California, Colorado, Delaware, Hawai'i, Illinois, Maryland, Attorney General Dana Nessel on Behalf of People of Michigan, Minnesota, Nevada, New Mexico, Oregon, and Vermont.

the DACA recipients who have resided within their borders for years or decades. Reliable access to health insurance has been shown to improve residents' health outcomes, as well as to improve productivity generally, benefiting DACA recipients, their families, and their States alike.

Given the significant harms that Movant States would incur from an adverse judgment in this case, and the lack of prejudice to the parties at this early stage of the litigation, intervention is appropriate. While federal defendants previously defended the Final Rule, there is little doubt that will change: the President-Elect and Vice President-Elect criticized the Final Rule during the 2024 campaign, and the previous Trump Administration declined to defend both DACA and the ACA. Without intervention, this Court would be deprived of an adequate defense of the Final Rule. That is why, when another district court faced the same situation in the context of DACA, it permitted DACA recipients and New Jersey to participate as intervenors and provide the adequate defense the Federal Government would not. Nor is intervention belated or premature: federal defendants will only now cease their defense of the Final Rule, and DACA recipients and Movant States alike are prepared to litigate. This Court should allow them to do so.

BACKGROUND

As this Court is already aware, on May 8, 2024, the U.S. Department of Health and Human Services ("HHS") and the Centers for Medicare & Medicaid Service ("CMS") published the Final Rule, *Clarifying the Eligibility of DACA Recipients & Certain Other Noncitizens for a Qualified Health Plan through an Exchange, Advance Payments of the Premium Tax Credit, Cost-Sharing Reductions, & a Basic Health Prog.*, 89 Fed. Reg. 39,392 (May 8, 2024) ("Final Rule"). ECF 1; 89 Fed. Reg. at 39,393. The Final Rule allows recipients of deferred action pursuant to the Deferred Action for Childhood Arrivals ("DACA") policy, including the DACA recipients in Movant States, to purchase qualifying insurance via their state or federal exchanges under the Patient Protection and Affordable Care Act ("ACA").

On August 8, 2024, Plaintiff States challenged the Final Rule, ECF 1, and two days later moved for a preliminary injunction, ECF 35. Many of the Movant States submitted an amicus brief ("States' Amicus Brief") in support of the Final Rule on October 2, 2024, explaining that the Final Rule was consistent with the plain language of the ACA, and emphasizing that this Court should deny the application for a preliminary injunction. ECF 69. The Final Rule took effect on November 1, 2024, and DACA recipients across the country became eligible to purchase health insurance via the ACA exchanges—whether the federal ACA exchange or, in the States that maintain them, state ACA exchanges. *See* ECF 105. On November 4, 2024, Defendants also filed a Motion to Dismiss, arguing this Court lacked jurisdiction and that Plaintiffs failed to state a claim. In the alternative, Defendants asked the court to dismiss or transfer for improper venue. ECF 108.

On December 9, 2024, the Court granted a Preliminary Injunction, found Plaintiffs' request for a temporary restraining order moot, and denied Defendants' Motion to Dismiss. *See* ECF 117. After finding that the Plaintiff States had standing to challenge the Final Rule, the Court concluded that they were entitled to a preliminary injunction and thus enjoined Defendants from enforcing the Final Rule against the 19 Plaintiff States. *Id.* Federal defendants appealed that decision. The Eighth Circuit denied a stay pending appeal, but it expedited appellate briefing. *See* CA8 No. 5466750. Plaintiff States subsequently filed a motion with this Court seeking clarification as to whether the preliminary relief that they obtained applies nationwide. *See* ECF 134.

ARGUMENT

This Court should grant Movant States' motion to intervene. Invalidation of the Final Rule would directly injure Movant States' interests in four different ways. These threatened injuries, individually and together, entitle Movant States to intervene as of right—since federal defendants will no longer adequately represent their interests after the imminent change in administration, and

Movant States' intervention is timely. *See* Fed. R. Civ. P. 24(a)(2). Alternatively, this Court should grant Movant States permissive intervention. *See* Fed. R. Civ. P. 24(b)(1)(B).

I. MOVANT STATES ARE ENTITLED TO INTERVENE AS OF RIGHT.

Under Rule 24(a), "a court must permit anyone to intervene who, (1) on timely motion, (2) claims an interest relating to the property or transaction that is the subject of the action, and is so situated that disposing of the action may as a practical matter impair or impede the movant's ability to protect its interest, (3) unless existing parties adequately represent that interest." *Berger v. N.C. State Conf. of the NAACP*, 597 U.S. 179, 190 (2022) (cleaned up); *see N. Dakota ex rel. Stenehjem v. United States*, 787 F.3d 918, 921 (8th Cir. 2015). "Rule 24 is construed liberally," so courts "resolve all doubts in favor of the proposed intervenors," *Ctr. for Biological Diversity v. Haaland*, 341 F.R.D. 236, 239 (D. Minn. 2022) (quoting *United States v. Union Elec. Co.*, 64 F.3d 1152, 1158 (8th Cir. 1995)), and accept "as true all material allegations in the motion to intervene," *Swinton v. SquareTrade, Inc.*, 960 F.3d 1001, 1003-04 (8th Cir. 2020). Each consideration compels granting Movant States a right to intervene: this litigation threatens to impair Movant States' substantial interests; federal defendants no longer adequately represent those interests; and Movant States' motion is swift and timely. Just as another court permitted States to defend DACA absent a federal defense, intervention is proper here.

1. Movant States' interests would be significantly impeded by the invalidation of the Final Rule. To intervene as of right, a litigant must demonstrate significant "interest[s] in the resolution of this lawsuit that may be practically impaired or impeded without [their] participation." *Berger*, 597 U.S. at 191. As long as "the interest identified" is "more than peripheral or insubstantial," *Planned Parenthood of Minn., Inc. v. Citizens for Cmty. Action*, 558 F.2d 861, 869 (8th Cir. 1977), a litigant can establish such interests by demonstrating Article III injury. *See Ctr. for Biological Diversity v. U.S. Dep't of the Interior*, 640 F. Supp. 3d 59, 68 (D.D.C. 2022) ("Constitutional

standing sufficiently demonstrates … interest" under Rule 24(a)); *Jones v. Prince George's Cnty.*, 348 F.3d 1014, 1018-19 (D.C. Cir. 2003) (noting that if a movant "has suffered a cognizable injury sufficient to establish Article III standing, she also has the requisite interest under Rule 24(a)(2)"); *Mausolf v. Babbitt*, 85 F.3d 1295, 1301-02 (8th Cir. 1996) (after finding movant had demonstrated Article III injury, concluding same injuries established interests under Rule 24); *accord Utah Ass'n of Ctys. v. Clinton*, 255 F.3d 1246, 1252 n.4 (10th Cir. 2001) (same, and reasoning that "Article III standing requirements are more stringent than those for intervention under Rule 24(a)").

Movant States can easily establish standing here—and thus interests sufficient to warrant intervention—because the final relief the challengers request, including vacatur of the Final Rule or a nationwide injunction, would harm Movant States' interests in at least four ways. *See Becker v. N.D. Univ. Sys.*, 112 F.4th 592, 595 (8th Cir. 2024) (listing elements of Article III standing). First, Movant States have interests in ensuring that DACA recipients within their borders can access affordable health insurance options on the applicable state or federal ACA exchanges to avoid significant expenses for preventive and/or emergency care Movant States otherwise have to shoulder. Second, Movant States have an interest in protecting their revenue streams associated with the payment of insurance premiums—revenue they would lose for each DACA recipient that is forced to go without insurance absent the Final Rule. Third, Movant States who run exchanges will incur compliance costs if the Final Rule is eliminated. Fourth, Movant States have an interest in protecting the health of their residents—both their DACA recipients and their other residents, too. Because any court order or settlement between the current parties invalidating the Final Rule would threaten each interest, Movant States have a right to participate in this challenge.[2]

[2] That Movant States plainly have Article III standing allows them to establish interests for purposes of Rule 24(a) intervention. But to be clear, Movant States need not separately establish

a. Movant States' first three Article III injuries in this case are the direct pocketbook harms they would suffer from elimination of the Final Rule. To satisfy Article III, an asserted injury must be "concrete and particularized and actual or imminent." *Missouri v. Biden*, 52 F.4th 362, 368 (8th Cir. 2022) (quoting *Spokeo, Inc. v. Robins*, 578 U.S. 330, 339 (2016)). A State suffers an injury if the action it opposes—a court order invalidating the Final Rule—would cause the States or their instrumentalities "financial harm." *Biden v. Nebraska*, 600 U.S. 477, 490 (2023); *see also FDA v. All. for Hippocratic Med.*, 602 U.S. 367, 381 (2024) (agreeing that the "injury in fact can be a … monetary injury"); *Missouri v. Biden*, 52 F.4th at 368 (confirming that an "[e]conomic injury to a State from increased proprietary costs or reduced tax revenues can … give the State standing to sue"). These injuries suffice to demonstrate Movant States' Article III standing—and, relatedly, confirm harms to their interests sufficient to justify intervention. *See Nat'l Parks*, 759 F.3d at 976 ("economic interests in the lawsuit satisfy Rule 24(a)(2)'s recognized-interest requirement").

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standing to intervene as defendants in this Court. Because Movant States ask only that this Court refuse to grant relief on the Plaintiff States' claims, they do not have to demonstrate independent standing in this litigation. *See Va. House of Delegates v. Bethune-Hill*, 587 U.S. 658, 663 (2019) (defendant-intervenor need not establish standing since its defense of redistricting plan did not "entail[] invoking a court's jurisdiction"); *see e.g.*, *Berger*, 597 U.S. 179 (holding that legislative leaders may intervene to defend law without discussing their standing); *West Virginia v. EPA*, No. 23-32, 2023 WL 3624685, at *2 n.2 (D.N.D. Mar. 31, 2023) (observing proposed defendant intervenors were "not required to independently demonstrate Article III standing" when they are not "assert[ing] any counterclaim" and asked only that the Court refuse to grant relief on "the plaintiff states' claims"); *accord Melone v. Coit*, 100 F.4th 21, 28-29 (1st Cir. 2024) (rejecting argument that intervenor defendant has "to establish independent Article III standing" if it "simply seeks to defend the agency's position"); *GreenFirst Forest Prods. Inc. v. United States*, 577 F. Supp. 3d 1349, 1354 n.4 (Ct. Int'l Trade 2022) (same). To the extent prior Eighth Circuit decisions required putative defendant-intervenors to establish standing, *see Mausolf*, 85 F.3d at 1300; *Nat'l Parks Conservation Ass'n v. EPA*, 759 F.3d 969, 974 (8th Cir. 2014), those decisions are inconsistent with *Bethune-Hill*, which makes clear that a court should not require prospective defendant-intervenors who assert no counterclaims to establish standing. 587 U.S. at 663. This Court should follow *Bethune-Hill*.

First, invalidation of the Final Rule would impose on Movant States expenses associated with providing medical care to uninsured DACA recipients who live in their States. *See New York v. DHS*, 969 F.3d 42, 59-60 (2d Cir. 2020) (approving state standing tied to "increasing overall healthcare costs"); *City & Cty. of San Francisco v. USCIS*, 981 F.3d 742, 754 (9th Cir. 2020) (states had standing where immigrants' avoidance of federal benefits would result in "increased demand for aid supplied by the state," including "overall increase in healthcare costs … borne by public hospitals"); *Massachusetts v. HHS*, 923 F.3d 209, 223 (1st Cir. 2019) (state had standing where policy would cause more women to obtain state-funded contraceptive or prenatal care); *California v. Azar*, 911 F.3d 558, 571-72 (9th Cir. 2018). DACA recipients are over three times more likely than the general U.S. population to be uninsured. 89 Fed. Reg. at 39,395. And as the attached declarations lay out, Movant States incur costs for the care of their uninsured residents. These costs include millions annually in unreimbursed costs for the care of uninsured residents at public hospitals, *see* Ex. 1 at ¶¶ 7-9; Ex. 2 at ¶¶ 10-12, 24-26,[3] and hundreds of millions in annual subsidies to defray the cost of health care services that are provided to uninsured residents, *see* Ex. 1 at ¶¶ 7-9; Ex. 2 at ¶¶ 10-12, 19-20, 25; Ex. 5 at ¶¶ 17-19, 23-25; Ex. 6 at ¶¶ 4-11. Movant States have seen thousands of DACA recipients obtain health insurance under the Final Rule, Ex. 3 at ¶ 17; Ex. 4 at ¶ 17, and the invalidation of the Final Rule risks swiftly sending those residents back to the ranks of the uninsured, requiring Movant States to again incur these additional costs.

New Jersey's health care programs illustrate ways in which States incur costs for health care services provided to uninsured residents, including uninsured DACA recipients. For example, an uninsured resident can visit Federally Qualified Healthcare Centers ("FQHC") to obtain free or low-cost preventive health services. The State's Uncompensated Care Fund ("UCF") subsidizes

[3] "Ex. __" are to the exhibits referenced within the Table of Exhibits, filed with this motion.

these services by paying a flat rate from State funds per visit for an uninsured resident: $112 per visit for primary and dental care and $63 per visit for mental health services. New Jersey funds the UCF, so the greater the number of uninsured residents in New Jersey, the more the State spends on preventive care for those who obtain such services. Ex. 2 at ¶¶ 20-24. Similar logic applies to the New Jersey's Charity Care program (which offers annual subsidies to support free or low-cost emergency care services for uninsured residents), and its Supplemental Prenatal and Contraceptive Program (which provides prenatal and family-planning services to residents who do not qualify for Medicaid due to immigration status). For each of these programs, as detailed in the attached declarations, the greater the number of uninsured residents, the more the State spends on health care for uninsured individuals. Ex. 2 at ¶¶ 16-20; Ex. 5 at ¶¶ 10-19. The same is true of programs operated by other Movant States. *See, e.g.*, Ex. 6 at ¶¶ 4-11.

Moreover, because these state-operated programs do not defray all costs of uncompensated care, state-owned acute care hospitals in Movant States also incur significant costs in providing services to uninsured patients, even after federal or state subsidies. *See* Ex. 1 at ¶¶ 8-9 (New Jersey's University Hospital incurred $53 million in uncompensated care costs in Fiscal Year 2022, and $58 million in Fiscal Year 2023). Thousands of DACA recipients have purchased insurance plans through an exchange since open enrollment for the year 2025 began on November 1, 2024. *E.g.*, Ex. 3 at ¶ 17; Ex. 4 at ¶ 17 (over 2,000 DACA-recipient enrollees in California and New Jersey alone). Loss of eligibility would leave those individuals without health insurance and require that Movant States incur expenses when they seek preventive or emergency health care.

Second, not only would elimination of the Final Rule impose new medical expenses upon Movant States, but it would also reduce the specific revenue streams from the assessments levied on the payment of insurance premiums by many Movant States. *See, e.g.*, *Missouri v. Biden*, 52

F.4th at 368 (finding "reduced tax revenues" can support States' showing of standing); *Wyoming v. Oklahoma*, 502 U.S. 437, 448 (1992) (confirming State may demonstrate Article III standing based on "a direct injury in the form of a loss of specific tax revenues"); *New York v. U.S. Dep't of Lab.*, 363 F. Supp. 3d 109, 125 (D.D.C. 2019) (States have standing based on a financial injury from a decrease in tax revenue derived from a percentage of insurance premiums). Movant States have assessed hundreds of thousands of dollars in fees tied directly to insurance premiums paid by DACA recipients who, under the Final Rule, can access insurance via ACA exchanges. *See*, *e.g.*, Ex. 3 at ¶¶ 19-20; Ex. 4 at ¶¶ 29-30; Ex. 8 at ¶¶ 15-20. As one example, New Jersey's state-run exchange, GetCoveredNJ, generates revenue because insurance carriers pay a 3.5% fee on the total monthly premium collected for each health benefits plan sold in the individual market. *See* Ex. 3 at ¶¶ 19-20. Because over 225 DACA recipients in New Jersey have already purchased health insurance plans through GetCoveredNJ, *id.* at ¶ 17, elimination of the Final Rule would deprive New Jersey of the revenues generated by their premiums.

Third, elimination of the Final Rule would directly impose compliance costs on Movant States that operate their own state ACA exchanges. *Cf. New Jersey v. EPA*, 989 F.3d 1038, 1046 (D.C. Cir. 2021) (recognizing "exacerbated administrative costs and burdens imposed by the Rule" upon States "constitute a concrete and particularized injury"). If this Court were to ultimately grant the challengers' request and prevent implementation of the Final Rule nationwide, Movant States that maintain state exchanges would incur compliance costs, including to implement changes to technology platforms, retrain their staff, update websites and publications, conduct advertising and outreach, and send notices to participating DACA recipients. *See, e.g.*, Ex. 4 at ¶¶ 21-27 (detailing over $600,000 in compliance costs incurred by California and describing additional costs that would be incurred if the Final Rule were invalidated); Ex. 3 at ¶¶ 23-27 (describing New Jersey's

compliance costs); Ex. 7 at ¶¶ 16-17, 20-22 (describing Illinois's compliance costs);[4] *see also* ECF 119-1 at ¶¶ 19-21 (declaration filed by federal defendants estimating that CMS will need to "spend approximately 1500 hours at a cost of about $200,000 to make the emergency update to the [Federally-facilitated Exchange] eligibility criteria due to this [Court's] injunction," incur over $14,000 in costs to notify affected DACA recipients, and incur further costs to inform agents and brokers, other consumers, and plan issuers of the relevant eligibility changes).

b. Fourth, Movant States satisfy Article III because the elimination of the Final Rule would harm their interests in the health and welfare of their residents—which would be gravely impaired if their residents lose access to federally subsidized health insurance. Courts have recognized that, in addition to the vindication of their own pocketbook injuries, "[S]tates have a variety of … quasi-sovereign interests that they validly may seek to vindicate in litigation." *Kentucky v. Biden*, 23 F.4th 585, 598 (6th Cir. 2022); *see Lynch v. Nat'l Prescription Adm'rs, Inc.*, 787 F.3d 868, 872 (8th Cir. 2015). This includes the States' "quasi-sovereign interest in the health and well-being—both physical and economic—of [their] residents in general." *Alfred L. Snapp & Son, Inc. v. Puerto Rico, ex rel., Barez*, 458 U.S. 592, 607 (1982) ("*Snapp*"); *see also, e.g.*, *Lynch*, 787 F.3d at 872 (quoting *Snapp* for its endorsement of the quasi-sovereign interest in residents' health); *Missouri*

[4] Although the United States has previously argued that the three Plaintiff States that maintain their own state exchanges lack standing based on compliance costs, their principal arguments have no applicability to Movant States' distinct harms. *See* ECF 61 at 16-19 (emphasizing that two States did not submit any actual evidence of expenditures, that the remaining State identified only costs it *previously* incurred to comply with the Final Rule and not prospective costs that could be redressed by an injunction, and that all three States' compliance costs would be offset by revenues generated by new enrollees). Here, Movant States have introduced actual evidence—in the form of declarations—spelling out their compliance costs. And these costs *are* prospective, as Movant States would incur them if this Court vacates or otherwise enjoins the Final Rule on a nationwide basis, which therefore justifies intervention in order to oppose that relief. Nor could these costs be offset by revenues generated by new enrollees, as vacatur would doubly harm Movant States by depriving them of such revenue from DACA recipients too.

v. China, 90 F.4th 930, 940 n.2 (8th Cir. 2024) (State sufficiently alleged Article III standing based in part on the health "harms [residents] suffered" from China's alleged hoarding of PPE during the COVID-19 pandemic); *New York*, 969 F.3d at 59-60 (approving of state standing based in part on "increasing overall healthcare costs, and … general economic harm" within the State's borders). Such interests also suffice to demonstrate an interest under Rule 24. *See Arizona v. California*, 460 U.S. 605, 615 (1983), *decision supplemented*, 466 U.S. 144 (1984) (permitting tribes to intervene in environmental "litigation critical to the[] welfare" of members); *Texas v. United States*, No. 18-68, 2018 WL 11226239, at *1 (S.D. Tex. June 25, 2018) (permitting New Jersey to intervene in DACA challenge in light of NJ's interests in, inter alia, "maintaining public health").[5]

Without the Final Rule, New Jersey's interest in its residents' health and welfare will be injured. Should the Final Rule be invalidated, their DACA recipient residents would lose access to federally subsidized health insurance, which for many means they cannot afford such insurance at all. *See* 89 Fed. Reg. at 39,425 (estimating that the Final Rule makes 147,000 residents eligible for coverage). As explained in the States' Amicus Brief and the declarations accompanying this motion, depriving DACA recipients of access to affordable health insurance on the exchanges will undermine short-term and long-term health outcomes—including because these residents will be less likely to seek salutary preventive care, especially the many services not covered by state programs. *See* ECF 69 at 4-5 (collecting sources, including findings in the Final Rule, confirming

[5] Although Movant States acknowledge that "[a] State does not have standing as *parens patriae* to bring an action *against* the Federal Government" based upon these interests, *Haaland v. Brackeen*, 599 U.S. 255, 295 (2023) (emphasis added) (quoting *Snapp*, 458 U.S. at 610, n.16 (in turn citing *Massachusetts v. Mellon*, 262 U.S. 447, 485-86 (1923))), the so-called "*Mellon* bar" is no obstacle to a State's assertion of standing to *defend* federal action based on its quasi-sovereign interests in the health and well-being of its residents. *Cf. Massachusetts v. EPA*, 549 U.S. 497, 520 n.17 (2007) (explaining "critical difference between allowing a State to protect her citizens from the operation of federal statutes (which is what *Mellon* prohibits) and allowing a State to assert its rights under federal law (which it has standing to do)" (citations omitted)).

that "[i]ndividuals without health insurance are less likely to receive preventive or routine health screenings and may delay necessary medical care," such as "DACA recipients who may be victims of child abuse, domestic violence, sexual assault, and human trafficking" (quoting 89 Fed. Reg. at 39,396, 39,405)); Ex. 2 at ¶¶ 41-44. And beyond the harms to their health, loss of insurance can result in increased medical debt, reduced spending power, lost work productivity, and absenteeism—since DACA recipients, now less likely to seek preventive care, would be more likely to get sick and be absent from work as a result. *See* ECF 69 at 5-6, 8 (citing *Final Rule*, 89 Fed. Reg. at 39,396); Ex. 2 at ¶ 43; Ex. 4 ¶ 31; Ex. 7 ¶¶ 26-28.

Not only would Movant States' own interests in the health and welfare of DACA recipient residents be harmed, but their interest in the health and welfare of non-DACA residents would also be impacted. For one, residents who participate in Movant States' own exchanges or in the federal exchange also benefit from the inclusion of DACA recipients in insurance pools; because DACA recipients are generally younger and healthier than the overall population who participates in the exchanges, eliminating them from insurance pools could weaken those pools and increase costs across the board. *See* ECF 69 at 7 (citing *Final Rule*, 89 Fed. Reg. at 39,398); Ex. 4 ¶¶ 32-33; Ex. 7 at ¶¶ 24-26; Ex. 8 at ¶¶ 23-24. For another, given the nature of communicable diseases, and because individuals without insurance have worse access to preventive care and are more likely to get sick, any court order that increases the number of residents in Movant States who lack insurance could increase health risks statewide. *See* ECF 69 at 6 (citing studies that communities with lower rates of insurance had exacerbated outbreaks of COVID-19); Ex. 2 at ¶ 4. And perhaps most fundamentally, "[m]ore than 250,000 children have been born in the United States with at least one parent who is a DACA recipient"—and those children, too, count on having healthy parents to care for them. *Deferred Action for Childhood Arrivals*, 87 Fed. Reg. 53,152 (Aug. 30,

2022); Ex. 5 at ¶¶ 30-32 (noting that increased access to healthcare improves child health and welfare). Elimination of the Final Rule would thus injure Movant States' quasi-sovereign health interests, another reason Movant States have standing to defend against that result. [6]

2. Because there are no longer parties likely to adequately defend Movant States' interests, this Court should allow Movant States to take their place. Potential intervenors bear "a 'minimal' burden" to show that no party is adequately protecting their interests. *National Parks*, 759 F.3d at 976; *accord Kansas Pub. Emps. Ret. Sys. v. Reimer & Koger Assocs., Inc.*, 60 F.3d 1304, 1309 (8th Cir. 1995). While this low bar is higher "when one of the existing parties is a governmental agency," *National Parks*, 759 F.3d at 976, Movant States clear it easily. After all, while federal defendants were previously defending their Final Rule on the merits, there is little doubt that will now change: the President-Elect and Vice President-Elect both criticized the Final Rule during the presidential campaign, and the prior Trump Administration declined to defend both DACA and the ACA. As to the former, at a campaign event in 2024, President-elect Trump criticized the Final Rule, albeit inaccurately, asserting that it "giv[es] Obamacare and all free government health care

[6] In addition to these four Rule 24 interests, this Court's own prior decision in this case supports a fifth interest for Movant States. This Court preliminarily accepted North Dakota's argument that if the Final Rule is vacated, some DACA recipients who currently reside in North Dakota would leave the State and thereby save North Dakota money it currently expends on those recipients. *See* ECF 117 at 9. As explained in the States' Amicus Brief, that premise is contrary to the record and to real-world experience. *See* ECF 69 at 9-11; *see also* 89 Fed. Reg. at 39,399 (observing that it is not "reasonable to conclude" that DACA recipients who have been residing in the United States for at least 17 years without access to the ACA exchanges would suddenly leave without the Final Rule). If, however, the Court believes DACA recipients will leave this country absent the Final Rule, that would harm Movant States profoundly. *Cf. DHS v. Regents of the Univ. of Cal.*, 591 U.S. 1, 31 (2020) (observing loss of DACA recipients from lawful labor force would "radiate outward" not only to the recipients' 250,000 U.S.-children but also to "the schools where DACA recipients study and teach," "the employers who have invested time and money in training them," and the state and local governments that could "could lose $1.25 billion in tax revenue each year"); *DACA*, 87 Fed. Reg. at 53,172-74 (noting that the States would suffer if they lost DACA recipients from colleges, government workplaces, and tax bases, and finding—after engaging in a cost-benefit analysis—that DACA does not impose net economic harm to any State).

to illegal aliens." Emily Baumgaertner & Margot Sanger-Katz, *Does Kamala Harris Back Free Health Care for Illegal Immigrants*, N.Y. Times (Oct. 30, 2024), https://tinyurl.com/ymb3wrs7. The Vice President-Elect likewise issued a release criticizing the Final Rule as "giv[ing] your hard-earned money away to illegal immigrants in the form of taxpayer-funded healthcare," called it a "slap in the face to every hardworking American who plays by the rules," said that "it would never happen if Donald Trump were president," and promised to "exclude DACA recipients and bar the use of any federal taxpayer dollars through ACA waivers for providing health insurance coverage for illegal aliens." *Sen. Vance Blasts Biden Admin. For Providing Taxpayer-Funded Healthcare To Illegal Immigrants*, JD Vance (May 3, 2024), https://tinyurl.com/54sxcbvw.

Nor is there a doubt that, given the incoming Administration's express hostility to the Final Rule, federal defendants will decline to defend it on the merits. When President-Elect Trump was last in office, federal defendants refused to defend against a challenge to DACA, specifically agreeing with the plaintiffs there (who overlap considerably with Plaintiff States here) that "DACA is unlawful." *Texas v. United States*, No. 18-68 (S.D. Tex.), ECF 71 (Response to PI Motion), at 1 ("The United States agrees with the State of Texas and other Plaintiffs that the policy known as [DACA] is unlawful."), 13-15 ("Plaintiffs and Federal Defendants agree—DACA is unlawful."). And they likewise refused to defend the constitutionality of the ACA, instead filing a brief at the U.S. Supreme Court contending that the ACA should be invalidated. *See California v. Texas*, No. 19-840 (U.S.), Br. of United States (May 13, 2020) at 11-13 (arguing for wholesale invalidation of the ACA). It is thus clear federal defendants will no longer argue that DACA recipients satisfy the definition of "lawful presence" under the ACA's plain text—or advance the interests the Final Rule serves in expanding access to ACA exchanges. Given this opposition to the Final Rule and the President-elect's history of declining to defend both DACA and the ACA, federal defendants—

despite "having started out as … all[ies]"—will now be Movant States' "adversar[ies]," rather than "faithful representative[s] of [Movant States'] interest in this lawsuit." *Mandan, Hidatsa & Arikara Nation v. U.S. Dep't of the Interior*, 66 F.4th 282, 285 (D.C. Cir. 2023).

Intervention provides the precise solution for this problem. This case requires parties who are willing and situated to defend the Final Rule, and to ensure appropriate adversarial presentation on the standing, venue, merits, and equities questions implicated here. Without intervention, this Court would be deprived of an adequate defense of the Final Rule—or even of Article III adversity between the parties. That is why, when another district court faced the same situation in the context of DACA, it permitted DACA recipients and New Jersey to participate as intervenors and provide the adequate defense federal defendants would not. *See Texas v. United States*, 2018 WL 11226239, at *1 (finding New Jersey's "interests are inadequately represented by the existing parties" in challenge to DACA and permitting New Jersey to intervene to defend DACA); *Texas v. United States*, 50 F.4th 498, 510-11 (5th Cir. 2022) (describing how New Jersey intervened as of right because the prior Trump Administration "determined that DACA was … unlawful"). Indeed, for six years, New Jersey has defended DACA in district court and on appeal, including for four years when federal defendants declined to do so—and continues to do so today. And similarly, because the Trump Administration "took the side of the plaintiffs" in the challenge to the ACA, the courts allowed a group of States—including California and a number of other Movant States—to "intervene[] in order to defend the Act's constitutionality." *California v. Texas*, 593 U.S. 659, 668 (2021). To ensure an adequate defense and proper adversity between the parties, this Court should likewise recognize Movant States' right to intervene here.

2. Further, Movant States' motion is timely. *See United Food & Com. Workers Union, Loc. No. 663 v. USDA*, 36 F.4th 777, 780 (8th Cir. 2022) (for "timeliness, courts consider four factors:

(1) the extent the litigation has progressed at the time of the motion to intervene; (2) the prospective intervenor's knowledge of the litigation; (3) the reason for the delay in seeking intervention; and (4) whether the delay in seeking intervention may prejudice the existing parties"); *Tweedle v. State Farm Fire & Cas. Co.*, 527 F.3d 664, 671 (8th Cir. 2008) (noting courts assess "all surrounding circumstances" in assessing timeliness, including "the reason for the delay in seeking intervention, and any possible prejudice to the parties already in the litigation"). Movant States are intervening swiftly and diligently, and their intervention will not prejudice any party.

Movant States have acted swiftly and diligently at every stage in this case. Initially, many of the Movant States indicated their interest in this litigation from the beginning, submitting an amicus brief in support of federal defendants within the first two months of this lawsuit—spelling out their view of the law and the impacts the Final Rule has on them. *Compare* ECF 1 (complaint filed August 8, 2024), *with* ECF 69 (States' Amicus Brief filed on October 2, 2024).[7] At that time, Movant States had no reason to intervene because their interest in defending the Final Rule was aligned with federal defendants' interests—which bears on the adequacy inquiry discussed above. But because that will change after Inauguration on January 20, 2025—in light of the President-Elect's hostility to the Final Rule and prior decisions not to defend DACA and the ACA, *supra* at pp. 13-15—Movant States have swiftly filed their intervention papers, so that there will be a seamless transition from one sovereign's defense of the Final Rule (federal defendants) to other sovereigns that support and benefit from it (Movant States). Since federal defendants' adequate defense of the Final Rule will cease as of Inauguration Day, "the timeliness of [Movants States']

[7] Indeed, even earlier, many of the Movant States filed a comment letter in the underlying notice-and-comment rulemaking process supporting the Final Rule on June 23, 2023. *See* Ex. 9.

motion should be assessed in relation to that point in time," when the "need to seek intervention … ar[o]se." *Cameron v. EMW Women's Surgical Ctr., P.S.C.*, 595 U.S. 267, 280 (2022).

Further, permitting Movant States' intervention would not prejudice the existing parties. Federal defendants' answer is not due until January 22, 2025, ECF 132, and Plaintiffs' motions for preliminary relief have been resolved, *see* ECF 117. Movant States' participation in the district court proceedings will also not slow the pending appeal of the preliminary injunction, which will not be fully briefed until February 19, 2025, CA8 No. 5466750, and Movant States are prepared to litigate summary judgment once those appellate proceedings have concluded. *See Kane Cnty. v. United States*, 928 F.3d 877, 896-97 (10th Cir. 2019) (approving of intervention following change in presidential or agency administration); *Pasqua Yaqui Tribe v. EPA*, No. 20-2266, 2021 WL 25776939, at *1 (D. Ariz., May 5, 2021) (same). Nor can Plaintiff States or federal defendants object that Movant States would "oppose[] [their] position" on the merits and be "unwilling to settle" the litigation on terms federal defendants may not embrace—after all, "Rule 24(a) protects precisely this ability to intervene in litigation to protect one's interests," including to prevent such settlements. *Mille Lacs Band of Chippewa Indians v. Minnesota*, 989 F.2d 994, 999 (8th Cir. 1993); *see Lopez-Aguilar v. Marion Cnty. Sheriff's Dep't.*, 924 F.3d 375, 375, 390 (7th Cir. 2019) (agreeing "burden to the parties of reopening the litigation and resuming settlement negotiations" does not constitute prejudice undermining timeliness where that alleged burden "would have been the same" had the movants been parties from the case's inception).

The timeliness of this intervention motion contrasts sharply with the cases in which States' motions to intervene to defend federal policies were denied as untimely. *See, e.g.*, *Cook Cnty. v. Texas*, 37 F.4th 1335, 1337, 1342 (7th Cir. 2022) (affirming denial of intervention motion filed over six months after district court had vacated federal regulation being challenged, four months

after President Biden took office, and two months after Biden Administration dismissed appeals defending the rule in other courts across the country); *Huisha-Huisha v. Mayorkas*, No. 22-5325, 2022 WL 19653946, at *1-2 (D.C. Cir. Dec. 16, 2022) (States not permitted to intervene in defense of federal policy where district court already vacated the policy and movants had been submitting filings in other courts for more than a year indicating they could not rely on federal defendants to defend the policy). Unlike those cases, here there is no ruling on the merits, and up until now, Movant States had reasonably relied on federal defendants to represent their interests. *Cf. Cook Cnty.*, 37 F.4th at 1342 ("States were justified in relying on DHS's continued defense of the … Rule at least through the November 2020 election"). This motion is timely, and granting it would allow Movant States to provide a fulsome defense—as they did for DACA and the ACA.[8]

II. ALTERNATIVELY, PERMISSIVE INTERVENTION IS APPROPRIATE.

Because Movant States satisfy the standard for mandatory intervention, this Court need not consider permissive intervention under Rule 24(b). But to the extent this Court reaches that issue, it should allow intervention under Rule 24(b). Such intervention is appropriate when the proposed intervenor can show "(1) an independent ground for jurisdiction, (2) timeliness of the motion, and (3) that the applicant's claim or defense and the main action have a question of law or fact in

[8] Just as Movant States have not brought this motion to intervene too late (for timeliness purposes), Movant States have also not filed too early (for adequacy purposes), because they are not required to wait until the incoming Administration in fact terminates its defense of this Final Rule. For one, Movant States acted swiftly to avoid any risk that this Court would find their motion came too late. *Compare Cook Cnty.*, 37 F.4th at 1342. For another, Movant States would likely have no formal advance notice from federal defendants that they are ceasing the defense of the Final Rule, and may learn of that development only when federal defendants and Plaintiff States settle the case—a result Movant States are intervening to avoid. *Compare id.* Finally, though Movant States may be justified in waiting to ascertain what new position federal defendants will take after the change in administration before intervening in some other cases, federal defendants' forthcoming position on the merits in *this* case—in light of the President-Elect's statements on the Final Rule and the prior nondefense of DACA and the ACA—is already clear. *See supra* at pp. 13-15.

common." *Flynt v. Lombardi*, 782 F.3d 963, 966 (8th Cir. 2015); *see also Franconia Mins. (UK) LLC v. United States*, 319 F.R.D. 261, 268 (D. Minn. 2017) (common questions of law and fact exist where a movant "seeks to uphold" the "same actions that Plaintiffs seek to overturn"). That standard is easily met here: Movant States have standing to intervene, establishing an independent ground for jurisdiction, *see supra* at pp. 4-13; the motion is timely, *see supra* at pp. 15-17; and common questions of law and fact exist because Movant States seek to defend the same agency action that the challengers here attack (the Final Rule), and their defenses will be "directly responsive" to the claims' merits. *Franconia*, 319 F.R.D. at 268. Without intervention of additional defendants, this Court would lose the benefit of adversarial presentation on the merits. As prior courts have found in adjudicating DACA and the ACA, intervention provides the solution to that problem.

CONCLUSION

This Court should grant Movant States' motion to intervene as defendants.

Dated: January 15, 2025

Respectfully submitted,

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UNITED STATES DISTRICT COURT
DISTRICT OF NORTH DAKOTA
WESTERN DIVISION

STATE OF KANSAS, *et al.*,

Plaintiffs,

v.

UNITED STATES OF AMERICA, *et al.*,

Defendants.

Civil Action No.
1:24-cv-150-DMT-CRH

Judge Daniel M. Traynor

[PROPOSED] ORDER GRANTING PROPOSED DEFENDANT-INTERVENORS' MOTION TO INTERVENE

The motion to intervene by New Jersey, Arizona, California, Colorado, Delaware, Hawai'i, Illinois, Maryland, Attorney General Dana Nessel on Behalf of People of Michigan, Minnesota, Nevada, New Mexico, Oregon, and Vermont (Docket Entry No. _____) having come before this Court, and the Court having considered the papers submitted in connection with said motion, and such other relevant information and evidence as was presented to this Court, and good cause appearing, IT IS HEREBY ORDERED that:

(1) Movants' Motion to Intervene is GRANTED;

(2) Movants shall be entered as Defendants-Intervenors and shall be served with all relevant papers in the above-captioned action; and

(3) The Clerk of Court shall docket Movants' Answer to Plaintiffs' Complaint, attached to Movant's Motion to Intervene as Exhibit 11.

IT IS SO ORDERED on this _____ day of _____, 2025.

_____
HON. DANIEL M. TRAYNOR, U.S.D.J.

UNITED STATES DISTRICT COURT
DISTRICT OF NORTH DAKOTA
WESTERN DIVISION

STATE OF KANSAS, *et al*.,

Plaintiffs,

v.

UNITED STATES OF AMERICA, *et al*.,

Defendants.

Civil Action No. 1:24-cv-150-DMT-CRH
Judge Daniel M. Traynor

TABLE OF EXHIBITS

Exhibit	**Description**
1	Declaration of John Gary Huck
2	Declaration of Kaitlan Baston
3	Declaration of Justin Zimmerman
4	Declaration of Doug McKeever
5	Declaration of Sarah Adelman
6	Declaration of Maureen Sharp
7	Declaration of Morgan Winters
8	Declaration of Trinidad Navarro
9	June 23, 2023 Comment Letter to U.S. Department of Health and Human Services
10	Declaration of Elizabeth Caulum
11	Proposed Answer

Respectfully submitted,

MATTHEW J. PLATKIN
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CERTIFICATE OF SERVICE

I certify that a true and correct copy of the foregoing was filed with the Court's CM/ECF system, which provides notice to all parties, on this 15th day of January 2025.

*/s/ Joshua P. Bohn*__
Joshua P. Bohn
Deputy Attorney General

EXHIBIT 1

Declaration of John Gary Huck

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF NORTH DAKOTA
WESTERN DIVISION

STATE OF KANSAS, *et al.*, Plaintiffs, v. UNITED STATES OF AMERICA, *et al.*, Defendants.	Civil Action No. 1:24-cv-150-DMT-CRH Judge Daniel M. Traynor

DECLARATION OF JOHN GARY HUCK

I, John Gary Huck, pursuant to 28 U.S.C. § 1746, hereby declare that the following is true and correct:

1. I am the Chief Financial Officer of University Hospital, a position I have held since 2020. As Chief Financial Officer, I am responsible for overseeing the financial health of University Hospital. Prior to holding this position, I held the position of Interim Chief Financial Officer of the hospital. Prior to holding that position, I was the Director of Managed Care and Reimbursement of the hospital for approximately 18 years.
2. I submit this Declaration in support of the Final Rule, 89 Fed. Reg. 39,392, issued by the U.S. Department of Health and Human Services and Center for Medicaid Services permitting Deferred Action Childhood Arrivals ("DACA") recipients to enroll in a qualifying health plan through an exchange pursuant to the Affordable Care Act ("ACA"). I have compiled the information in the statements set forth below through University Hospital personnel who have assisted me in gathering this information from our hospital. I have also familiarized myself

with the Final Rule in order to understand its immediate impact on University Hospital. The Final Rule benefits the State and New Jersey residents.

3. University Hospital is New Jersey's only public hospital. Located at 150 Bergen Street, Newark, New Jersey 07103, University Hospital is an independent and state-owned teaching hospital. It is certified by the American College of Surgeons and is a state-designated Level 1 Trauma Center.

4. University Hospital is an acute care hospital, specializing in active but short-term treatments for severe injuries, episodes of illness, urgent medical conditions, and recovery from surgery, as opposed to longer-term and chronic care. University Hospital is the only state-owned acute care hospital in New Jersey.

5. As an instrumentality of the State of New Jersey, University Hospital sometimes treats uninsured patients and/or patients that cannot afford the full cost of urgent and/or acute care treatments, services, and procedures.

6. In some cases, the State subsidizes some of these costs to hospitals like University Hospital through its Charity Care program. This program is only available for patients receiving inpatient and outpatient services at acute care hospitals.

7. Although the State subsidizes some of these costs, it does not fully cover the cost to acute care hospitals of providing care to uninsured individuals who cannot afford to pay out of pocket for that care.

8. For example, University Hospital provided care to approximately 42,000 uninsured individuals in FY 2022, at cost to the hospital of approximately $116,000,000.00. Of this amount, approximately $63,000,000.00 was reimbursed by Charity Care, leaving approximately $53,000,000.00 in unreimbursed costs.

9. University Hospital provided care to approximately 46,000 uninsured individuals in FY 2023, at a cost to the hospital of approximately $121,000,000. Of this amount, approximately $63,000,000.00 was reimbursed by Charity Care, leaving approximately $58,000,000.00 in unreimbursed costs.
10. University Hospital provides care to patients without regard to immigration status.
11. More uninsured individuals receiving treatment at University Hospital who cannot afford to pay for their care translates to higher costs to the Hospital, and, ultimately, to the State.

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

Executed this 13 day of January, 2025, in Newark, New Jersey.

John Gary Huck, Chief Financial Officer
University Hospital

EXHIBIT 2

Declaration of Kaitlan Baston

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF NORTH DAKOTA
WESTERN DIVISION

STATE OF KANSAS, *et al.*, Plaintiffs, v. UNITED STATES OF AMERICA, *et al.*, Defendants.	Civil Action No. 1:24-cv-150-DMT-CRH Judge Daniel M. Traynor

DECLARATION OF KAITLAN BASTON, MD, MSc, DFASAM

I, Kaitlan Baston, MD, MSc, DFASAM, pursuant to 28 U.S.C. § 1746, hereby declare the following:

1. I am the Commissioner of the New Jersey Department of Health ("NJDOH") and have been employed as the Commissioner since August of 2023. I am dual boarded in Family Medicine and Addiction Medicine, obtained a master's degree in Neuroscience from Kings College, London, and graduated from Jefferson Medical College in Philadelphia, Pennsylvania. Prior to becoming NJDOH's Commissioner, I built and led the Cooper Center for Healing, an integrated pain, addiction, and behavioral health center and was an Associate Professor of Medicine at Cooper Medical School of Rowan University. Prior to my position with Cooper, my work ranged from public health projects in Rwanda, to public maternity and trauma hospitals in the Dominican Republic, to providing full spectrum family planning services and working in a bilingual community health center in Seattle, Washington.

2. I submit this Declaration in support of the Final Rule, 89 Fed. Reg. 39,392, issued by the U.S. Department of Health and Human Services and Center for Medicaid Services permitting Deferred Action Childhood Arrivals ("DACA") recipients to enroll in a qualifying health plan through an exchange pursuant to the Affordable Care Act ("ACA"). The below information in the statements set forth below were complied through personal knowledge, through NJDOH personnel who have assisted in gathering this information from our agency, on the basis of documents that have been provided to me.

The New Jersey Department of Health

3. The mission of the NJDOH is to protect the public's health, promote healthy communities, and continue to improve the quality of health care in New Jersey. To that end, NJDOH's three primary branches—Public Health Services, Health Systems, and Integrated Health—all work collaboratively to improve health by strengthening New Jersey's health system.
4. NJDOH provides essential services and implements comprehensive measures to prioritize public health, including: preventing the spread of infectious diseases, educating the public to promote healthy lifestyles, preparing for emergencies and disasters, licensing and regulating health care facilities and professionals, collecting and analyzing data, and addressing health disparities.
5. Data collection is the foundation of effective public health planning. NJDOH collects and analyzes health data to identify trends, assess community health needs, and inform policy decisions. By maintaining vital records, conducting health surveys, and producing reports, NJDOH is able to shape public health programs and initiatives.

6. The Center for Health Statistics & Informatics ("CHSI") is a program within NJDOH's Office of Health Care Quality and Informatics. CHSI is responsible for compiling and releasing statistical information on the health of New Jersey residents. CHSI publishes official reports on births, deaths, chronic illnesses, injuries, and behavioral risk factors, among other types of information. CHSI provides analytical support to state and other governmental agencies to support population health initiatives. The New Jersey State Health Assessment Data System is maintained by CHSI and provides on-demand access to public health datasets, statistics, and information on the health status of New Jerseyans.

7. Via the New Jersey Hospital Discharge Data Collection System, New Jersey collects and manages data on emergency room visits as part of the State's efforts to monitor health outcomes and public health trends.

8. Health Care Quality Assessment is an office of NJDOH. The Office of Health Care Quality Assessment collects data on the quality of health care services in New Jersey and uses the information to produce reports which can help consumers, health care providers, policy makers, and regulators to make informed decision.

Charity Care

9. In New Jersey, "[n]o hospital shall deny any admission or appropriate service to a patient on the basis of that patient's ability to pay or source of payment." N.J.S.A. 26:2H-18.64.

10. The chart below sets forth the number and uninsured status of patients who presented in an emergency department at a New Jersey hospital between 2021 and 2023, along with the overall total costs of services (before subsidies) that such hospitals have incurred for uninsured patients who have presented in an emergency department during the same period:

	2021	2022	2023
Total Patients	2,690,532	2,923,102	3,106,320

Uninsured Patients	246,826	247,171	231,164
Total Costs of Services for Uninsured Patients	$63,226,640.86	$72,764,116.66	$92,063,158.04

11. The State offsets some of the costs that eligible hospitals sustain as a result of treating uninsured patients through the New Jersey Hospital Care Payment Assistance Program, commonly known as Charity Care, administered by NJDOH. *See* Health Care Cost Reduction Act, N.J.S.A. 26:2H-18.50 (1992).

12. Charity Care provides eligible hospitals with financial support in the form of a yearly subsidy that is administered by NJDOH. N.J.S.A. 26:2H-18.51. Charity Care relies on intergovernmental funding; the State and federal government contribute equally to the program. Charity Care does not reimburse individual claims made by individual patients.

13. From the patient's perspective, Charity Care offers free or reduced-charge care to patients who receive inpatient and outpatient services at acute care hospitals throughout the State. Hospital assistance and reduced charge care are available only for medically necessary hospital care.

14. A New Jersey resident is eligible to receive free or reduced-charge services through Charity Care if (a) they meet specific income and asset–eligibility criteria, (b) are ineligible for any private or government-sponsored coverage (such as Medicaid), and (c) have no health coverage or coverage that pays only for part of the bill. N.J.A.C. 10:52-11.10(a) (assets eligibility); N.J.A.C. 10:52-11.8(c) (income eligibility). A New Jersey resident may be eligible for Charity Care services without regard to immigration status.

15. The Hospital Services Manual Rules, N.J.A.C. 10:52, govern Charity Care eligibility and coverage. When a patient who is underinsured or uninsured receives medical care from an acute care hospital and seeks financial assistance to cover the cost of the care received, the hospital is required to screen the patient for Charity Care eligibility. N.J.A.C. 10:52-11.5. If

the patient meets the eligibility requirements, then the patient's medically necessary hospital services are fully or partially covered by Charity Care, with certain exemptions discussed further below. *See* N.J.A.C. 10:52-1.6.

16. The funding source for Charity Care is the Health Care Subsidy Fund, which is dedicated for use by the State to distribute Charity Care subsidy payments to eligible hospitals. N.J.S.A. 26:2H-18.58(a).

17. The New Jersey Legislature appropriates the total amount available for the Charity Care subsidy in each year's State Appropriations Act. In determining the precise amount of appropriations, the Legislature may consider data concerning the utilization of Charity Care subsidies, among other factors.

18. Once appropriated, NJDOH allocates the Charity Care subsidy in accordance with a statutory formula and any instructions mandated in the State fiscal year's Appropriations Act.

19. The statutory formula governing appropriation of the Charity Care subsidy among hospitals allocates the subsidy based on "the amount of hospital-specific gross revenue for charity care patients [divided] by the hospital's total gross revenue for all patients." N.J.S.A. 26:2H-18.59i.

20. In State Fiscal Year 2025, the New Jersey Legislature appropriated $137.2 million for Charity Care. In State Fiscal Year 2024, the Legislature appropriated $342 million for Charity Care.

Uncompensated Care Fund

21. In addition to funding Charity Care, the Health Care Subsidy Fund also funds the Federally Qualified Health Center Expansion, commonly known as the Uncompensated Care Fund. *See* N.J.S.A. 26:2H-18.58(a), (d). Through the Uncompensated Care Fund, the State is able to offer free or subsidized primary care, dental care, and mental health services to uninsured and

underinsured New Jersey residents who are otherwise ineligible for Medicaid and have an income at or below 250% of the federal poverty level.

22. Federally Qualified Health Centers are a "one-stop" health center model with co-located services (medical, dental, and behavioral health) that makes health care more accessible for eligible New Jersey residents. By comparison, the acute care hospitals covered by Charity Care provide emergency medicine to individuals experiencing acute medical conditions.

23. In New Jersey, there are twenty-three Federally Qualified Health Centers and two "look-alike" centers, which function as Federally Qualified Health Centers for purposes of the Uncompensated Care Fund.

24. The Uncompensated Care Fund is funded exclusively by the State. Through the program, the State pays Federally Qualified Health Centers a flat rate for uninsured and underinsured patient visits: $114 per visit for primary and dental care, and $74 per visit for mental health services.

25. In State Fiscal Years 2022, 2023, and 2024, New Jersey spent $26,030,696, $28,701,063, and $32,163,822, in payments to Federally Qualified Health Centers. The chart below breaks down this data by total number of unique patients and total visits:

	State Fiscal Year 2022 7/1/2021 to 6/30/2022	**State Fiscal Year 2023** 7/1/2022 to 6/30/2023	**State Fiscal Year 2024** 7/1/2023 to 6/30/2024
Total Unique Patients	111,824	102,600*	107,179
Total Visits	251,114	263,913	283,005
Cost	$26,030,696	$28,701,063	$32,163,822
* The unique patient count for State Fiscal Year 2023 is an estimate due to a data conversion issue.			

26. DACA recipients have accessed health care services through the Uncompensated Care Fund.

Impacts of Health Insurance on Public Health

27. The Final Rule issued by the U.S. Department of Health and Human Services expanding access to affordable and adequate health insurance coverage to Deferred Action for Childhood Arrivals ("DACA") recipients, *see* 89 Fed. Reg. 39392, benefits the State and New Jersey residents.

28. Before the Final Rule, uninsured DACA recipients relied on Charity Care and the Uncompensated Care Fund for their medical needs. While both programs allow DACA recipients to access health care (preventive care through the Uncompensated Care Fund and acute hospital care through Charity Care), each program has limitations on which services they cover and where they cover those services.

29. The Uncompensated Care Fund only covers primary care, dental care, and behavioral health services. It does not cover specialist services (like cardiology or oncology), and does not cover the cost of prescription medications. Additionally, health care under the Uncompensated Care Fund can only be accessed at a Federally Qualified Health Center rather than any doctor of the patient's choosing. So, an uninsured individual who does not qualify for Medicaid, like a DACA recipient, and who cannot pay out of pocket for a prescription or specialist visit, would be unable to get those medical services under the Uncompensated Care Fund.

30. Charity Care only covers services provided at acute care hospitals, and it does not cover any service that is not provided through the hospital directly, but rather are contracted out. Such services may include physician services, anesthesiology services, radiology interpretation, and outpatient prescriptions. This is because only those services directly provided by a hospital are covered by the State's mandate that hospitals provide appropriate services to all patients regardless of ability to pay. *See* N.J.S.A. 26:2H-18.64; *see also* N.J.A.C. 10:52-1.8(a)(10) (excluding vendor services from Charity Care coverage).

31. So, while Charity Care and the Uncompensated Care Fund allow uninsured individuals, including DACA recipients, in New Jersey to access some degree of State-funded health care, there remain gaps in access.

32. For example, an uninsured DACA recipient may have difficulty accessing a Federally Qualified Health Center for preventive care based on its location or hours. Even if she can access preventive care at a Federally Qualified Health Center, she may not be able to access all the affordable care she needs. Federally Qualified Health Centers, like individual hospitals participating in Charity Care, offer a limited subset of providers, as compared to providers that accept insurance. So, a DACA recipient may have less choice in the provider she sees.

33. If, for example, a DACA recipient needs to see a specialist for a cancer screening, or if she needs prescription medication to treat high blood pressure, neither would be covered by the Uncompensated Care Fund. Thus, without the Final Rule, if she cannot pay out of pocket for those services, she cannot receive that care.

34. A DACA recipient failing to access such preventative care increases the risk that she will need emergency care services, such as to treat a heart attack, which the State would pay for in part through Charity Care.

35. Especially in light of these continuing gaps in access, NJDOH has found that increased access to health insurance both improves public health and reduces the costs of uncompensated care to the State.

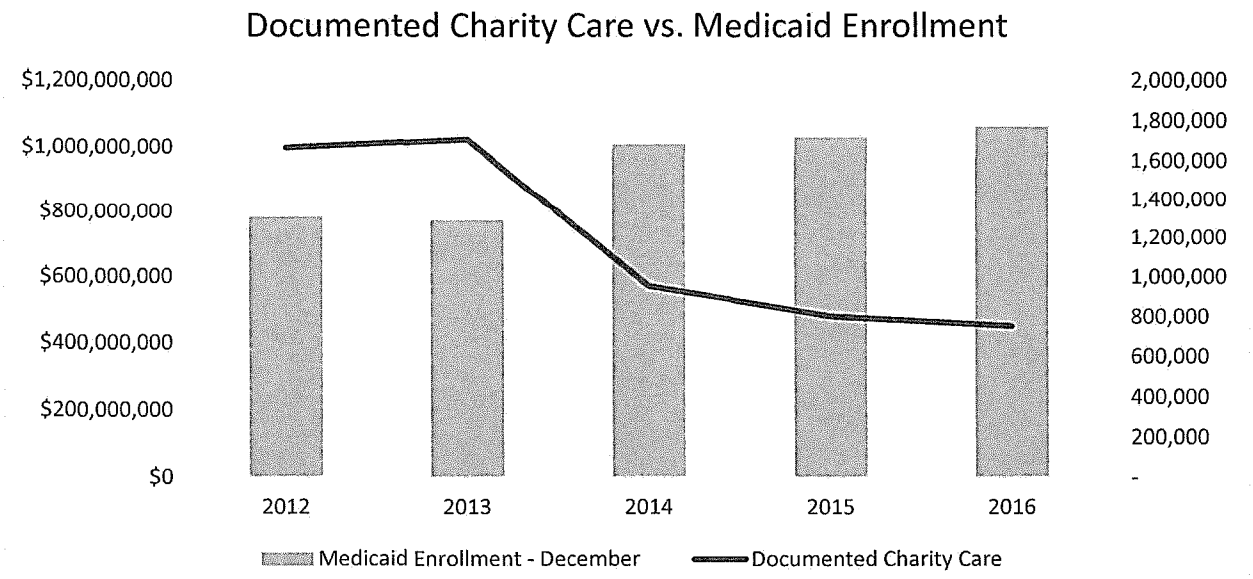
36. New Jersey's experience with Medicaid Expansion is an example of how increased access to health insurance can reduce the costs of uncompensated care.

37. New Jersey's Medicaid expansion began in 2014. With more individuals eligible for Medicaid, costs of providing health care to uninsured or underinsured individuals shifted from State-funded Charity Care to federally-funded Medicaid.

38. Documented Charity Care for a particular hospital is the dollar amount of Charity Care provided by the hospital, as verified by NJDOH audit, and valued at the same rate paid to that hospital by the Medicaid program. *See* N.J.S.A. 26:2H-18.59e(a).

39. As Medicaid enrollment increased each year, Documented Charity Care costs decreased from 2013 (over $1 billion), beginning in 2014 ($570.2 million) and continuing into 2015 ($479.6 million) and 2016 ($450.6 million). This decrease is likely associated with New Jersey's Medicaid expansion.

40. The chart below illustrates this relationship by comparing Documented Charity Care costs with Medicaid enrollment figures from 2012 to 2016. The data shows a strong negative correlation between Documented Charity Care costs and Medicaid enrollment.



41. Generally speaking, uninsured individuals are less likely to seek preventive care or attend routine health screenings, and may further delay necessary medical care due to prohibitive costs. Crucial preventive services include cardiovascular, cancer, and diabetes screenings. Foregoing such services can result in negative health outcomes, such as emergency medical care with longer hospital stays and increased mortality rates, and ultimately result in increased costs to the State through uncompensated hospital emergency costs.

42. Increased access to health insurance results in both better health outcomes for New Jersey residents as well as reduced costs for the State. As noted, when New Jersey residents are uninsured or underinsured they are less likely to access all the preventive care services they need, resulting in worse health outcomes. Conversely, an individual without adequate insurance is more likely experiencing a health issue that could have been caught at a routine screening but has now evolved into an emergency medical issue. In that example, the State would assist with the uncompensated emergency medical costs through Charity Care.

43. The lack of insurance and resulting deleterious health outcomes could also result in downstream consequences. These include, for example, increased absenteeism in the workplace, ultimately leading to an increased reliance on unemployment insurance.

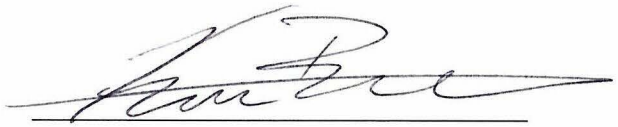
44. Similarly, decreased access to adequate and affordable health insurance could mean that infectious diseases, like the novel coronavirus, spread more widely and rapidly in New Jersey because uninsured and underinsured individuals are less likely to access vaccines or seek care at the early onset of symptoms.

45. By expanding access to affordable and adequate health insurance coverage to DACA recipients, the Final Rule would lower the uncompensated care costs New Jersey incurs

through the Uncompensated Care Fund and Charity Care and would benefit the State's overall public health by enabling its residents to live healthier lives.

I declare under penalty of perjury under the laws of the United States of America that I am authorized to sign this certification, that there is no single official or employee of the NJDOH who has personal knowledge of all such matters; that the facts stated above have been assembled by employees of the NJDOH, and I am informed that the information set forth above are in accordance with the information available to me and records maintained by the NJDOH and are true and accurate. I am aware that if any of the foregoing statements made by me are willfully false, I am subject to punishment.

Executed this 14th day of January, 2025, in Trenton, New Jersey.



Kaitlan Baston, MD, MSc, DFASAM
Commissioner, NJDOH

EXHIBIT 3

Declaration of Justin Zimmerman

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF NORTH DAKOTA
WESTERN DIVISION

STATE OF KANSAS, *et al.*, Plaintiffs, v. UNITED STATES OF AMERICA, *et al.*, Defendants.	Civil Action No. 1:24-cv-150-DMT-CRH Judge Daniel M. Traynor

DECLARATION OF JUSTIN ZIMMERMAN

I, Justin Zimmerman, pursuant to 28 U.S.C. § 1746, hereby declare that the following is true and correct:

1. I am Commissioner of the New Jersey Department of Banking and Insurance ("the Department").
2. I submit this Declaration in support of the Final Rule, 89 Fed. Reg. 39,392, issued by the U.S. Department of Health and Human Services and Center for Medicare and Medicaid Services permitting Deferred Action Childhood Arrivals ("DACA") recipients to enroll in a qualifying health plan through an exchange pursuant to the Patient Protection and Affordable Care Act ("ACA"). I have compiled the information in the statements set forth below through personal knowledge, Department personnel who have assisted me in gathering information, and on the basis of documents that have been provided to and/or reviewed by me. I have also familiarized myself with the Final Rule in order to understand its immediate impact on the Department. The Final Rule benefits the State and New Jersey residents.

3. By establishing that DACA recipients are eligible for subsidies on the official state health insurance marketplace, the Final Rule ensures that more New Jersey residents will have access to quality affordable health insurance coverage. The Department established and operates Get Covered New Jersey the State's Official Health Insurance Marketplace and, as laid out in this declaration, can explain how increased access to quality affordable health insurance benefits both the State and its residents.

4. By contrast, as laid out in this declaration, a decision from a court invalidating the Final Rule on a nationwide basis would impose a series of other harms on the State of New Jersey, from residents losing coverage, to the loss of revenue tied to the payment of the exchange user fee.

The New Jersey Department of Banking and Insurance

5. Among other functions, the Department operates Get Covered New Jersey ("GetCoveredNJ"), the State's official health insurance marketplace under P.L.2019, c.141 and the ACA, 42 U.S.C. § 180001 et seq., which includes, among other things, operating a technology platform and consumer assistance center consistent with the requirements of State and Federal law.

GetCoveredNJ

6. GetCoveredNJ, New Jersey's ACA exchange, was established under P.L.2019, c. 141 (codified at N.J.S.A. 17B:27A-57 to -59). GetCoveredNJ is a source of quality affordable health insurance for New Jersey residents who do not have health coverage from their employers or access to other health care programs. Financial assistance to lower the cost of premiums and out-of-pocket expenses is available for eligible residents.

7. GetCoveredNJ provides access to high-quality, affordable health coverage for New Jersey residents. GetCoveredNJ is where individuals and families who do not have health insurance through an employer or other program, such as Medicaid or Medicare, can easily shop for and

buy quality, affordable health insurance. Hundreds of thousands of New Jersey residents have signed up for health insurance through GetCoveredNJ. During the 2024 Open Enrollment Period, plan selections increased over 61% since the Murphy Administration took over the marketplace's operations from the federal government in 2020.

8. Over 480,000 New Jersey residents have signed up for a 2025 health insurance plan through GetCoveredNJ in the first nine weeks of the state's open enrollment period. This is an increase from the 366,986 residents who had selected plans by this time last year. At the end of the last Open Enrollment Period on January 31, 2024, a total of 397,942 consumers overall had signed up for 2024 health coverage with Get Covered New Jersey.
9. Health plans offered through GetCoveredNJ cover preventative services, emergency services, prescription drugs, prenatal and pediatric care, as well as other services. No one can be denied coverage due to a pre-existing condition.
10. Financial assistance under GetCoveredNJ takes several forms: federal advance premium tax credits, cost-sharing reductions, and New Jersey Health Plan Savings offered under N.J.S.A.17B:27A-67 (a state subsidy). Premium tax credits and the state subsidy help lower monthly premium payments. Cost-sharing reductions help lower out-of-pocket costs like deductibles and co-pays for doctor visits.
11. The American Rescue Plan Act of 2021 and the Inflation Reduction Act of 2022 allowed more people to qualify for more financial help. Previously, premium tax credits were only available up to certain income levels. As a result of the federal savings available, no one pays more than 8.5 percent of their income for health insurance (for a benchmark plan) through Get Covered New Jersey. Consumers with annual incomes up to 600% of the federal poverty level are also eligible for state subsidies, known as New Jersey Health Plan Savings. An individual with an

income of up to $90,360 and a family of four who makes up to $187,200 can receive state subsidies to lower the costs of health coverage.

12. To be eligible for GetCoveredNJ, under 45 C.F.R. § 155.305, New Jersey residents:

    a. Must live in the United States and have a primary residence in New Jersey;

    b. Must be considered a resident of the United States and New Jersey for tax purposes;

    c. Must be a United States citizen or national or be lawfully present; and

    d. Cannot be currently incarcerated.

13. Prior to the Final Rule, DACA recipients were excluded from the definition of "lawfully present" for purposes of Exchange eligibility under federal rules. Under this Final Rule, DACA recipients are no longer excluded from the definition of "lawfully present" and are therefore eligible for coverage through GetCoveredNJ.

State Revenue Derived from Insurance Purchased Through GetCoveredNJ

14. To fund its operations, pursuant to N.J.S.A.17B:27A-57, GetCoveredNJ collects a 3.5% user fee on "the total monthly premium collected by a [health insurance] carrier for each health benefits plan" sold in the individual market.

15. Because health insurance carriers receive a monthly premium payment for each individual enrolled in their insurance plans, the total monthly premium collected by a health insurance carrier decreases as the number of enrollees decreases. And the total user fee collected by New Jersey correspondingly decreases as the number of enrollees decreases.

16. Thus, for each individual who ceases to be enrolled in a health benefits plan in New Jersey, including plans sold on GetCoveredNJ, the State loses user fee revenue.

17. As of January 9, 2024, it is estimated that over 225 DACA recipients have enrolled in a plan offered on GetCoveredNJ.

18. Nine in 10 individuals enrolling in GetCoveredNJ qualify for financial help that reduce the costs of their monthly premium. Record levels of financial help through federal tax credits and state subsidies are available for New Jersey residents. Many consumers can find a plan for $10 a month or less. Indeed, 91% of individuals who purchase insurance on GetCoveredNJ receive state or federal subsidies. Thus, for many enrollees, losing access to GetCoveredNJ means not being able to afford private health insurance at all.

19. If a court issues an order rendering those DACA recipients who have enrolled in plans offered on GetCoveredNJ now ineligible for participation in ACA exchanges, the State would lose revenue based on insurance premiums under those plans no longer being collected, and thus carriers no longer being assessed a 3.5% user fee based on those premiums.

20. Using the average 2025 projected premium in the individual market and the estimated DACA population enrolled in 2025 plans, the projected loss of exchange user fees if these enrollees were excluded from the market is estimated to be $68,584 for 2025.

Impact of Final Rule on New Jersey

21. The Final Rule allows more New Jersey residents to access the state exchange, reducing the numbers of uninsured individuals in the State.

22. Beyond improving health outcomes, increased access to health insurance also results in financial benefits for DACA recipients. Access to quality affordable health care results in lower-cost preventative care and a decrease in high-cost emergency care, reducing the financial strain of costly medical bills.

Compliance Costs Related to the Final Rule

23. Many GetCoveredNJ operations, as well as health insurance carrier operations, have been modified to accommodate the Final Rule on DACA recipients.

24. The GetCoveredNJ website has been updated to explain that coverage for DACA recipients is available under the Final Rule. The technology platform system logic has been altered to handle any DACA immigration responses appropriately and manage referrals from Medicaid. The Department has trained consumer assistance center staff, coordinated with carriers, assisters, brokers and navigators to ensure awareness of the Final Rule and accurate communication with consumers.

25. The total costs incurred to ensure GetCoveredNJ's compliance with the Final Rule are approximately $28,800 for technical implementation and $4,400 dollars in marketing costs.

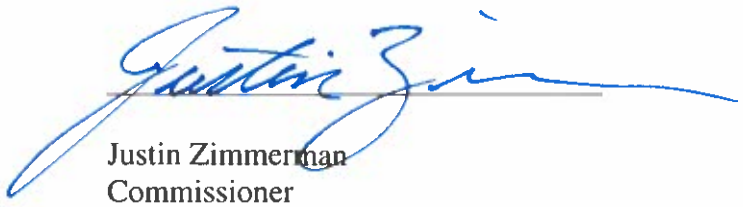
26. Invalidating the Final Rule will not only require the Department to reverse system changes to GetCoveredNJ, but will also require close coordination with consumer assistance center staff, carriers, assisters, and brokers, and navigators.

27. The total estimated costs that the Department would incur if the Final Rule were invalidated are approximately $9,900.

28. Invalidating the Final Rule would also cause confusion and uncertainty in the insurance marketplace. To the extent that DACA recipients have scheduled medical appointments with network providers, these appointments may need to be cancelled or modified due to lack of insurance coverage.

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

Executed this 14th day of January, 2025, in Mercer County.



Justin Zimmerman
Commissioner
New Jersey Department of Banking and Insurance

EXHIBIT 4

Declaration of Doug McKeever

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF NORTH DAKOTA
WESTERN DIVISION

STATE OF KANSAS, *et al*., Plaintiffs, v. UNITED STATES OF AMERICA, *et al*., Defendants.	Civil Action No. 1:24-cv-150-DMT-CRH Judge Daniel M. Traynor

DOUG McKEEVER

I, Doug McKeever, hereby declare that the following is true and correct:

1. I am the Chief Deputy Executive Director, Program, of Covered California, the State of California's health insurance marketplace exchange. I have held this position since 2017. The facts stated herein are of my own personal knowledge, and I could and would competently testify to them. I submit this declaration in my capacity as Chief Deputy Executive Director, Program, of Covered California, a non-party, in supporter of proposed intervenor, the State of California.
2. I submit this Declaration in support of the Final Rule, Clarifying the Eligibility of Deferred Action for Childhood Arrivals (DACA) Recipients and Certain Other Noncitizens for a Qualified Health Plan through an Exchange, Advance Payments of the Premium Tax Credit, Cost-Sharing Reductions, and a Basic Health Program, 89 Fed. Reg. 39,392 (May 8, 2024), issued by the U.S. Department of Health and Human Services and Centers for Medicare and

Medicaid Services ("CMS") permitting Deferred Action for Childhood Arrivals ("DACA") recipients to enroll in a qualifying health plan through an exchange pursuant to the Affordable Care Act ("ACA").

3. By making DACA recipients eligible for subsidies on Covered California, the Final Rule ensures that more California residents have access to affordable health insurance coverage.

4. Increased access to affordable and adequate health insurance benefits both the State and its residents.

5. Vacatur of the Final Rule on a nationwide basis would harm Covered California and the State of California by causing loss of revenue streams tied to the payment of insurance premiums as well as compliance costs relating to our management of this marketplace.

Covered California

6. Covered California is the state agency that was created pursuant to the ACA to administer a Health Benefit Exchange in California.

7. California built its own state-based exchange, Covered California, for the individual and small group markets. Through Covered California, the public can find affordable, high quality insurance plans from private insurance companies or apply for programs such as Medicaid. With over 1.8 million members, Covered California is the largest state-based health insurance Marketplace.

8. Enrollment of eligible Californians into coverage is central to Covered California's mission. Since passage of the ACA, California has experienced a historic decrease in the number of uninsured residents—the uninsured rate dropped from 17 percent in 2013 to 6.4 percent in 2023— predominantly attributable to the expansion of eligibility in the Medi-Cal program and

the availability of health coverage through Covered California made more affordable through federal premium tax credits and cost-sharing assistance.

9. Covered California has always recognized the need to tailor outreach and education efforts to ensure they meet the needs of eligible immigrants in California. To meet this goal, Covered California has invested substantial financial and administrative resources into targeted marketing campaigns designed to educate communities with high populations of eligible immigrants about the benefits of enrolling in health insurance coverage, including Spanish-speaking and Asian communities. In addition to our robust state-wide marketing campaigns, these targeted campaigns have bolstered eligible immigrant enrollment and built a culture of trust between hard-to-reach populations and Covered California.
10. As the State's official ACA health insurance marketplace, Covered California operates a technology platform and consumer service center consistent with the requirements of State and Federal law.
11. Health plans offered through Covered California cover preventative services, emergency services, prescription drugs, prenatal and pediatric care, as well as other services. No one can be denied coverage due to a pre-existing condition.
12. Financial assistance under Covered California takes several forms, including Advance Premium Tax Credits and cost-sharing reductions. The Premium Tax Credit helps lower monthly premium payments. Cost-sharing reductions help lower out-of-pocket costs like deductibles and co-pays for doctor visits.
13. To be eligible to enroll in Covered California plans, state residents:
    a. Must live in the United States and have a primary residence in California;
    b. Must be considered a resident of the United States and California for tax purposes;

c. Must be a United States citizen or national or be lawfully present; and

d. Cannot be currently incarcerated.

14. Covered California generates roughly $455.8 million in operating revenue annually, including participation fee revenue from the individual and small business markets. These revenues are generated through a participation fee charged to participating exchange carriers. Participation fee revenue is a function of enrollment, gross premiums, and Covered California's participation fee rate. The participation fee rate for the individual market was lowered from 3.25% to 2.25% starting in plan year 2025.

Impact of Final Rule

15. Prior to the Final Rule, DACA recipients were not considered lawfully present for purposes of Covered California subsidies. Under the Final Rule, DACA recipients are considered lawfully present for purposes of Covered California subsidies.

16. Covered California welcomed the Final Rule because it created an opportunity to further reduce the rate of uninsured individuals in our state. As the Final Rule indicates, an estimated 40,000 of remaining uninsured Californians are DACA recipients who, thanks to the Final Rule, now qualify for subsidies through Covered California. 89 Fed. Reg. at 39,428-29.

17. As of January 11, 2025, a total of 1,868 DACA recipients had enrolled in a Covered California plan. Covered California anticipates that these numbers will increase as the option becomes more widely known and more enrollees effectuate coverage.

18. Between December 2024 and December 2025, Covered California will generate approximately $413,382 in additional operating revenue attributable to the enrollment of DACA recipients for this time period. For the plan year 2025, which includes only 12 months, additional

operating revenue attributable to the enrollment of DACA recipients is forecast to be approximately $409,151.

19. The 1,868 individual DACA recipients who had coverage as of January 11, 2025, had an average gross monthly premium of $437. This premium amount is lower than that of Covered California's overall enrolled population, reflecting the younger relative age of DACA recipients compared to Covered California risk pools generally.

20. The Final Rule allows more California residents to access the state exchange, reducing the number of uninsured individuals in the State.

Invalidation of the Final Rule Would Cause Harm

21. Covered California has incurred significant costs specifically to implement the Final Rule. The Final Rule required technological updates to the California Healthcare Eligibility, Enrollment, and Retention System (CalHEERS) in order to build a new configuration to treat DACA recipients as lawfully present, and to allow electronic verification of lawful presence for these individuals.

22. Implementing these changes to CalHEERS have cost state agencies approximately $550,000 to date. These costs are split between Covered California and the California Department of Health Care Services, according to a CMS-approved cost allocation plan.

23. Covered California has also invested approximately $140,000 to date in advertising and outreach in order to publicize the availability of coverage for DACA recipients under the Final Rule.

24. Invalidating the Final Rule would require Covered California to turn off those technological system changes in which these substantial investments have already been made, and would interfere with existing plans to further modify CalHEERS. It would also require close

coordination with consumer service center staff, carriers, assisters, agents, brokers, navigators, and other community partners in order to mitigate confusion for DACA recipients.

25. If the Final Rule were invalidated, Covered California would likely need to send two additional notices to DACA recipients already enrolled in Covered California plans, first informing them of prospective termination, and then notifying them of their eligibility redetermination. For an estimated 1,000 individual enrollees, the total cost of sending these notices would be $2,200. As more DACA recipients enroll in Covered California plans in 2025, those numbers will increase.

26. If the Final Rule were invalidated, the total overall estimated agency costs to Covered California and the Department of Health Care Services, including communication with impacted individuals and loss of the value of prior technological and advertising investments, would be approximately $692,200.

27. Covered California would incur additional costs in changes to its website, staff training, and community outreach and engagement efforts that cannot be separated from ongoing program administrative budgets, but that would nevertheless divert time and resources from Covered California's core mission of increasing Californians' access to healthcare.

28. Invalidating the Final Rule would likely cause confusion and uncertainty, undercutting Covered California's efforts to promote continued enrollment of all eligible individuals into health insurance coverage.

29. Invalidation of the Final Rule would also cause loss to Covered California's operating budget and harm to the State marketplace. Because Covered California plans receive a monthly premium payment for each individual enrolled, the total monthly premium collected decreases as the number of enrollees decreases. And the total user fee collected by Covered California

correspondingly decreases as the number of enrollees decreases. Thus, for each individual who ceases to be enrolled in a Covered California plan, the State loses user fee revenue.

30. If a court issues an order rendering those DACA recipients who have enrolled in Covered California plans ineligible for participation in ACA exchanges, the State would lose revenue based on insurance premiums under those plans no longer being collected, and carriers no longer being assessed a 2.25% user fee based on those premiums. As described above, this would result in a loss of approximately $409,151 in revenue for plan year 2025.

31. Most often, individuals who purchase insurance on Covered California do so to access subsidies that enable them to afford health insurance coverage that they otherwise could not afford. Indeed, nearly 90% of individuals who purchase insurance on Covered California receive some sort of financial help. For many of those enrollees, losing access to Covered California means not being able to afford private health insurance at all.

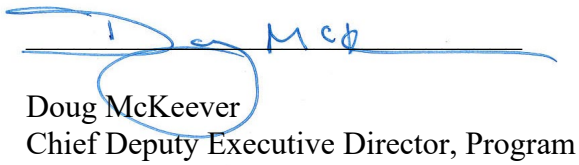
32. Furthermore, when noncitizens drop out of coverage, it hurts everyone in the market for individual insurance. Insurance markets ensure efficient protections by pooling risk. While individual medical treatment—especially for those who experience severe health conditions or who need emergency services—can sometimes be costly, the greater the number of healthy enrollees in the insurance market, the more diffuse the costs, which are generally spread out via insurance premium payments.

33. Based on an analysis of hospital discharges and emergency room visits, Covered California estimates that noncitizens are 10 percent less costly to insure compared to the overall population. Having these healthier enrollees in the market (who are less likely to require expensive medical treatments) helps to lower premiums for all Californians.

34. Enrollees must pay the first month's insurance premium before coverage can start. Therefore, to the extent that premiums have already been paid by DACA recipients who have enrolled in plans on Covered California, they will need to be returned. To the extent that DACA recipients have scheduled medical appointments with network providers, these appointments may need to be cancelled or modified due to lack of insurance coverage.

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

Executed this 13th day of January, 2025, in Sacramento, California.



Doug McKeever
Chief Deputy Executive Director, Program
Covered California

EXHIBIT 5

Declaration of Sarah Adelman

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF NORTH DAKOTA
WESTERN DIVISION

STATE OF KANSAS, *et al.*, Plaintiffs, v. UNITED STATES OF AMERICA, *et al.*, Defendants.	Civil Action No. 1:24-cv-150-DMT-CRH Judge Daniel M. Traynor

DECLARATION OF SARAH ADELMAN

I, Sarah Adelman, pursuant to 28 U.S.C. § 1746, hereby declare that the following is true and correct:

1. I am the Commissioner of the New Jersey Department of Human Services ("DHS"). I have been employed as Commissioner since January 2021.
2. I submit this Declaration in support of the Final Rule, 89 Fed. Reg. 39,392, issued by the U.S. Department of Health and Human Services and Center for Medicaid Services permitting Deferred Action Childhood Arrivals ("DACA") recipients to enroll in a qualifying health plan through an exchange pursuant to the Affordable Care Act ("ACA"). I have compiled the information in the statements set forth below through personal knowledge, through DHS personnel who have assisted me in gathering this information from our agency, and on the basis of documents that have been provided to and/or reviewed by me. I have also familiarized myself with the Final Rule in order to understand its immediate impact on DHS and New Jersey.

The New Jersey Department of Human Services

3. DHS is New Jersey's largest agency, serving approximately 2.1 million New Jersey residents. DHS serves many people in New Jersey including but not limited to older residents, individuals, and families with low incomes; people with developmental disabilities, or late-onset disabilities; people who are blind, visually impaired, deaf, hard of hearing, or deaf-blind; parents needing child care services, child support and/or healthcare for children; people who are dealing with addiction and mental health issues; and families facing catastrophic medical expenses for their children. Through DHS's eight divisions, the agency provides numerous programs and services designed to give eligible individuals and families assistance with economic and health challenges. These programs include publicly funded health insurance through NJ FamilyCare, which includes New Jersey's Children's Health Insurance Program, Medicaid, and Medicaid expansion populations. New Jersey residents of any age who qualify for NJ FamilyCare may be eligible for free or low-cost healthcare coverage that covers doctor visits, prescriptions, vision, dental care, mental health and substance use services, and hospitalization.

4. The Office of New Americans within DHS supports new Americans through outreach and education, and works on priorities to build trust, improve access to social services, workforce development and employment services, and assists with legal services for immigrants. The Office of New Americans seeks to increase accessibility to State programs available to new Americans, including those who speak languages other than English. The Office of New Americans also serves as a resource for other state agencies to amplify education and outreach on state initiatives and programs to ensure they reach all new American communities in our state.

5. The Final Rule states that DACA recipients are, on average, "younger than the general [ACA] Exchange population." 89 Fed. Reg. 39396, 39400. This is true in New Jersey, where the average age of DACA recipients is 33, but the average age of the general population is 40.

NJ FamilyCare and Related Healthcare Programs

NJ FamilyCare

6. NJ FamilyCare is a federal- and state-funded health insurance program created to help qualified New Jersey residents of any age access affordable health insurance.
7. NJ FamilyCare includes, but is not limited to, the following programs funded by both the federal government and the State: Medicaid and the Children's Health Insurance Program ("CHIP").
8. With limited exceptions, DACA recipients are generally not eligible for Medicaid or CHIP, see 89 Fed. Reg. 39,393; 42 C.F.R. 435 (Medicaid eligibility); 42 C.F.R. 457 (CHIP eligibility); N.J.A.C. 10:78 (NJ FamilyCare eligibility), and so they face barriers in accessing these components of NJ FamilyCare.
9. To help address these barriers, New Jersey operates programs specifically directed at individuals who cannot access these components of NJ FamilyCare, including the Supplemental Prenatal and Contraceptive Program and the Medical Emergency Payment Program, among others.

New Jersey Supplemental Prenatal and Contraceptive Program

10. New Jersey's Supplemental Prenatal and Contraceptive Program ("NJSPCP") is operated by DHS and is a limited-benefit program. It provides prenatal and family-planning services to women who do not qualify for NJ FamilyCare due to their immigration status. However,

NJSPCP does not provide complete healthcare coverage, such as hospital visits or labor and delivery.

11. Emergency medical services for pregnant women who do not qualify for NJ FamilyCare due to immigration status are covered through the Medical Emergency Payment Program, which is discussed below.

12. NJSPCP covers outpatient prenatal and family planning services for women including, but not limited to: prenatal care, prenatal-related services, birth control, pregnancy tests, family-planning counseling, and family-planning lab tests.

13. To be eligible for NJSPCP, a patient must meet all criteria below, N.J.A.C. 10:72-3.10:

    a. Women age 19-64;

    b. New Jersey resident;

    c. Income-eligibility criteria under NJ FamilyCare; and

    d. Ineligible for NJ FamilyCare due to immigration status.

14. If they meet the above criteria, DACA recipients may be eligible for NJSPCP.

15. DACA recipients have accessed health care services through NJSPCP.

16. Patients can apply for NJSPCP by seeing a medical provider at a hospital, outpatient clinic, Federally Qualified Health Center, or Family Planning Center. If the provider participates in the NJSPCP program, they will provide application assistance. Patients can receive NJSPCP benefits at any hospital, clinic, Federally Qualified Health Center, or Family Planning Center that accepts fee-for-service Medicaid. Patients can also have their prescriptions filled at most pharmacies. NJSPCP coverage terminates at the end of each fiscal year and eligible individuals must reapply after July 1st of each year to renew their benefits.

17. If a patient is eligible for NJSPCP, then the services covered through the program are of no cost to the patient. The State pays providers directly for the covered services—the provider submits claims to the State to be reimbursed by fee-for-service Medicaid payment.
18. NJSPCP is funded exclusively by the State of New Jersey.
19. In Federal Fiscal Year 2024, the period from October 2023 through September 2024, New Jersey spent $36 million on the NJSPCP program.

Medical Emergency Payment Program

20. New Jersey's Medical Emergency Payment Program covers emergency services, including labor and delivery, for New Jersey residents age 19 and older who do not qualify for NJ FamilyCare due to immigration status. The Medical Emergency Payment Program does not provide complete healthcare coverage, but only treatment that is provided at an acute care hospital for an emergency medical condition and labor and delivery of a baby in any setting. Regarding treatment for an emergency medical condition, the condition must have severe symptoms (including severe pain) that would place the patient's health in serious danger, seriously damage the patient's bodily functions, or seriously damage a body part or organ.
21. Under 42 C.F.R. 435.406, New Jersey residents are eligible for the Medical Emergency Payment Program, without regard to immigration status. Therefore, individuals may access the Medical Emergency Payment Program even if, for example, they are undocumented or do not qualify for NJ FamilyCare due to immigration status.
22. The Medical Emergency Payment Program is also subject to income-eligibility criteria based on the federal poverty level. *See* 42 U.S.C. § 1396b(v) (allowing states to pay for emergency medical services for individuals who do not otherwise meet the immigration requirements for Medicaid).

23. Given these criteria, DACA recipients may be eligible for the Medical Emergency Payment Program.

24. Pregnant DACA recipients who rely on NJSPCP benefits would need to access the Medical Emergency Payment Program to obtain coverage for labor and delivery services.

25. During Federal Fiscal Year 2024, New Jersey spent over $67 million on the Medical Emergency Payment Program.

Impacts of Health Insurance on Public Health

26. Increased access to health insurance provides significant benefits to public health. The expansion of access to health insurance under New Jersey's Cover All Kids initiative is an illustrative example.

27. In January 2023, through the Cover All Kids initiative, New Jersey expanded health insurance coverage to income-eligible children whose immigration status would otherwise prevent them from qualifying for NJ FamilyCare.

28. There are currently over 44,000 children accessing NJ FamilyCare coverage through this expansion.

29. Cover All Kids is funded exclusively by the State. In Federal Fiscal Year 2024, New Jersey spent over $134 million on the Cover All Kids program.

30. Access to healthcare, particularly to primary care, makes children healthier and communities stronger, and it is a fiscally responsible investment in the future of New Jersey children. Through Cover All Kids, income eligible children, regardless of immigration status, can access the same NJ FamilyCare coverage as any other child within the State.

31. The increased enrollment of immigrant children in the State expansion of NJ FamilyCare via the Cover All Kids initiative has had a positive impact on public health in the state. Children

with access to health insurance are more likely to receive preventive care services and families are not left with medical bills that they are unable to pay.

32. An increase in insurance coverage for immigrant children also results in decreased emergency room visits for preventable illness, (because children are being seen before treatable medical issues become an emergency).

33. The Final Rule—which expands access to affordable health insurance coverage on the state insurance marketplace to DACA recipients, *see* 89 Fed. Reg. 39392—likewise benefits New Jersey. With increased access to affordable health insurance via the state insurance marketplace, DACA recipients are more likely to seek preventive care and avoid costly emergency room visits.

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

Executed this 15th day of January, 2025, in Trenton, New Jersey.

Sarah Adelman
Commissioner
New Jersey Department of Human Services

EXHIBIT 6
Declaration of Maureen Sharp

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF NORTH DAKOTA
WESTERN DIVISION

STATE OF KANSAS, *et al.*, Plaintiffs, v. UNITED STATES OF AMERICA, *et al.*, Defendants.	Civil Action No. 1:24-cv-150-DMT-CRH Judge Daniel M. Traynor

DECLARATION OF MAUREEN SHARP

I, Maureen Sharp, pursuant to 28 U.S.C. § 1746, hereby declare that the following is true and correct:

1. I am the Chief Analytics Officer at the Arizona Health Care Cost Containment System ("AHCCCS") Administration, which is Arizona's Medicaid agency.
2. My educational background includes a Bachelor of Science in Business Administration and a Masters of Public Health. I have been employed as Chief Analytics Officer since March 6, 2023.
3. I submit this Declaration regarding the Final Rule, 89 Fed. Reg. 39,392, issued by the U.S. Department of Health and Human Services and Centers for Medicare and Medicaid Services permitting Deferred Action Childhood Arrivals ("DACA") recipients to enroll in a qualifying health plan through an exchange pursuant to the Affordable Care Act ("ACA"). I have compiled the information in the statements set forth below through personal knowledge, through AHCCCS personnel who have assisted me in gathering this information from our agency, and on the basis of documents that have been provided to and/or reviewed by me.

AHCCCS

4. AHCCCS is Arizona's Medicaid agency that offers health care programs to serve Arizona residents who meet certain income and other requirements. AHCCCS' mission is to help Arizonans live healthier lives by ensuring access to quality healthcare across all Arizona communities.

5. AHCCCS is the largest insurer in Arizona, covering more than 2,033,720 individuals. It uses federal, state, county, and other funds to provide health care coverage to the State's Medicaid population. It also provides certain emergency health care services to uninsured individuals through the Federal Emergency Services Program ("FESP").

6. Data collection allows AHCCCS to effectively administer its programs and assist in public health planning. AHCCCS collects and analyzes data regarding the utilization of its various programs, including the FESP, to identify trends, assess community health needs, and inform policy decisions.

Federal Emergency Services Program

7. AHCCCS provides certain emergency medical and behavioral health care services through the FESP for uninsured qualified and nonqualified aliens, as specified in 8 USC § 1611 *et seq.* who meet all requirements for Title XIX eligibility as specified in the State Plan except for citizenship. *See also* A.R.S. § 36-2903.03. Uninsured DACA residents are eligible for FESP emergency care services.

8. The FESP covers emergency medical or behavioral health conditions, meaning a medical condition or a behavioral health condition, including labor and delivery, manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in:

a. Placing the member's health in serious jeopardy;

b. Serious impairment to bodily functions;

c. Serious dysfunction of any bodily organ or part; or

d. Serious physical harm to self or another person.

See A.A.C. § R9-22-217.

9. In SFY2024, 519 DACA recipients in Arizona received emergency medical or behavioral health care services through the FESP. The care provided to these 519 individuals resulted in a total cost of $1,849,758. At the time these expenditures were made, the State share of this cost was $501,411 and the federal share of this cost was $1,348,347.

10. Individuals receiving FESP services are not enrolled in health plans. AHCCCS does not pay for FESP services for DACA residents in Arizona that obtain health insurance through the ACA. Thus, if more DACA residents in Arizona obtained health insurance, including through the ACA, AHCCCS would likely be able to reduce its financial costs for emergency care services spent on those individuals via the FESP.

11. By expanding access to affordable and adequate health insurance coverage through the ACA to DACA recipients, the Final Rule would likely lower the emergency care costs AHCCCS incurs through the FESP.

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

Executed this 14th day of January, 2025, in Phoenix, Arizona.

Maureen.Sharp Digitally signed by Maureen.Sharp Date: 2025.01.14 15:37:36 -07'00'

Maureen Sharp
Chief Analytics Officer
Arizona Health Care Cost Containment System Administration

EXHIBIT 7

Declaration of Morgan Winters

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF NORTH DAKOTA
WESTERN DIVISION

STATE OF KANSAS, *et al*., Plaintiffs, v. UNITED STATES OF AMERICA, *et al*., Defendants.	Civil Action No. 1:24-cv-150-DMT-CRH Judge Daniel M. Traynor

DECLARATION OF MORGAN WINTERS

I, Morgan Winters, pursuant to 28 U.S.C. § 1746, hereby declare that the following is true and correct:

1. I am the Acting Marketplace Director of the Illinois Health Benefits Exchange at the Illinois Department of Insurance ("IDOI") located in Chicago, Illinois. I have been employed as Marketplace Director since March 25, 2024.
2. Prior to joining IDOI, I was with MNsure, the state of Minnesota's Health Benefits Exchange, for over a decade, where I served in various roles, most recently as MNsure's Chief Operating Officer.
3. My educational background includes a Master's Degree in Public Policy from the Humphrey School of Public Affairs at the University of Minnesota.
4. I submit this Declaration in support of the Final Rule, 89 Fed. Reg. 39,392, issued by the U.S. Department of Health and Human Services and Centers for Medicare and Medicaid Services permitting Deferred Action Childhood Arrivals ("DACA") recipients to enroll in a qualified

health plan through an exchange pursuant to the Affordable Care Act ("ACA"). I have compiled the information in the statements set forth below through personal knowledge and through IDOI personnel who have assisted me in gathering this information. I have also familiarized myself with the Final Rule in order to understand its immediate impact on IDOI and the State of Illinois.

Illinois Demographic Data

5. Illinois has an estimated population of 12,710,158 individuals, as of July 1, 2024.

6. Per the United States Citizenship and Immigration Services, as of September 30, 2023, there were 28,610 active DACA recipients in the State of Illinois (available at https://www.uscis.gov/sites/default/files/document/data/active_daca_recipients_fy23_q4.pdf, p.5).

Background about Illinois Department of Insurance

7. IDOI operates the Illinois Health Benefits Exchange. IDOI also administers and enforces insurance-related laws and public pension laws in the State of Illinois.

8. Illinois currently operates the Illinois Health Benefits Exchange as a State-based Exchange on the Federal Platform.

9. As an insurance regulator, IDOI conducts investigations, regulatory examinations, administrative hearings, complaints' reviews, and reviews of regulatory filings to ensure that regulated persons and businesses transacting insurance-related business in Illinois comply with applicable financial solvency standards, licensure requirements, and standards of market conduct toward applicants, policyholders, and beneficiaries of insurance and insurance-related products. IDOI has jurisdiction over health insurance lines of business in the State, as well as property, casualty, and life and annuities insurance lines of business.

10. As the operator of the Illinois Health Benefits Exchange, IDOI facilitates the offering of qualified health plans through a platform that allows qualified individuals in Illinois to compare plans from different health insurance issuers in a standardized, consumer-friendly format, to directly enroll in qualified health plans that are subject to enhanced standards of coverage, to apply for federal premium tax credits and cost-sharing reductions based on household income and other factors, to automatically receive eligibility determinations for Medicaid based on information provided in an application, and to receive consumer assistance in their local communities from trained personnel who are certified by the exchange. IDOI ensures that its exchange meets operational requirements under the ACA, which are enforced by the U.S. Department of Health and Human Services. Qualified health plans are offered through the Illinois Health Benefits Exchange in every county of the State.
11. The Illinois Health Benefits Exchange enables residents who are uninsured and underinsured to access affordable coverage to protect their health. Health plans offered through the Illinois Health Benefits Exchange cover a variety of services including preventative services, emergency services, prescription drugs, and prenatal and pediatric care. No one can be denied coverage due to a pre-existing condition.
12. 398,814 Illinois residents signed up for a 2024 qualified health plan through the exchange in Illinois during the open enrollment period from November 1, 2023 through January 15, 2024.
13. As of January 10, 2025, IDOI estimates that 449,553 Illinois residents have signed up for a 2025 qualified health plan through the Illinois Health Benefits Exchange since November 1, 2024.
14. Illinois intends to transition to a fully State-based Exchange beginning with Plan Year 2026.

15. Because the new definition of "lawfully present" allows DACA recipients to be "qualified individuals" under the Final Rule, 89 Fed. Reg. 39,392, IDOI has a responsibility to ensure that DACA recipients have access to the full range of protections and benefits available to qualified individuals under the ACA, including enrollment in qualified health plans and access to federal tax credits and cost-sharing reductions when eligible.

Compliance with Final Rule

16. IDOI spent approximately $10,000 to ensure compliance with the Final Rule. This included, but was not limited to, direct outreach by our marketing vendor to inform DACA recipients of the Final rule and their eligibility for ACA health insurance, including advertising and updating IDOI's website. This amount also includes money IDOI spent in support of educational and enrollment outreach events such as webinars and educational materials conducted by the Get Covered Illinois Navigator Network to inform residents of the impacts of the Final Rule.
17. IDOI also used its limited resources to amend its State administrative rules governing the health insurance exchange to accurately reflect the Final Rule.
18. Beginning with the January 2025 benefit month, IDOI will receive exchange user fees, the amount of which is based on applying a set rate, 0.5%, to the monthly premiums charged by health insurance issuers for every policy issued under qualified health plans, to the extent the enrollment is through the Illinois exchange. 215 ILCS 122/5-21(a). The fees will directly fund IDOI's operation of the Illinois Health Benefits Exchange.
19. Separately, health insurance issuers in the State of Illinois must pay an annual privilege tax, the amount of which is based on a set rate, 0.4%, applied to the amount of insurance premiums written by the issuer. 215 ILCS 5/409.

20. If the Final Rule were vacated and DACA recipients became ineligible to enroll in health insurance via the Illinois Health Benefits Exchange, IDOI would lose potential tax and user fee revenue necessary to fund its forthcoming State-based Exchange.

21. Additionally, IDOI would have to revise its website, marketing materials, and any other documents and materials to explain the consequences of vacatur to consumers, promulgate new guidance for third parties assisting consumers in obtaining insurance, and expend resources to reverse State administrative rules implementing the Final Rule.

22. IDOI also would experience the opportunity cost of devoting development hours to rolling back existing functionality instead of developing new functionality to better support State residents.

23. Impact of Final Rule on Public Health

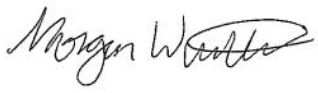
24. The Final Rule will likely benefit Illinois, beyond just from the benefits received by its DACA recipients, by introducing a pool of young, healthy individuals to the State's individual health insurance market. A health insurance risk pool is a group of individuals whose medical costs are combined to calculate premiums. Pooling risks together allows the higher costs of the less healthy to be offset by the relatively lower costs of healthier individuals. Because the largest component of health insurance premiums is the medical spending paid on behalf of enrollees, premiums reflect the expected health care costs of the risk pool. Therefore, when risk pools become healthier, the entire market benefits.

25. The Final Rule states that there is a slight positive effect on the exchange risk pools by the introduction of DACA recipients to the individual market, because DACA recipients represent a pool of relatively young, healthy adults who are younger than the general exchange population. *See* 89 Fed. Reg. 39,396.

26. The Final Rule benefits Illinois by allowing more Illinois residents to access health insurance on the exchange, thereby reducing the number of uninsured individuals in the State. Increased access to health insurance improves public health and results in financial benefits for insured individuals.
27. Uninsured individuals who lack access to affordable, adequate health insurance are less likely to seek preventive care or attend routine health screenings, and may further delay necessary medical care due to prohibitive costs.
28. With increased access to affordable, adequate health insurance via the exchange, DACA recipients are more likely to detect emerging health conditions early through routine screenings, seek lower-cost preventive care, and avoid high-cost emergency room visits, thereby reducing the financial strain of costly medical bills.

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

Executed this 13th day of January, 2025 in Chicago, Illinois.



Morgan Winters
Marketplace Director
Illinois Department of Insurance
115 S. LaSalle St., Fl. 13
Chicago, Illinois 60603

EXHIBIT 8

Declaration of Trinidad Navarro

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF NORTH DAKOTA
WESTERN DIVISION

STATE OF KANSAS, *et al.*, Plaintiffs, v. UNITED STATES OF AMERICA, *et al.*, Defendants.	Civil Action No. 1:24-cv-150-DMT-CRH Judge Daniel M. Traynor

DECLARATION OF TRINIDAD NAVARRO

I, Trinidad Navarro, pursuant to 28 U.S.C. § 1746, hereby declare that the following is true and correct:

1. I am Commissioner of the Delaware Department of Insurance ("DDOI").
2. I submit this Declaration in support of the Final Rule, 89 Fed. Reg. 39,392, issued by the U.S. Department of Health and Human Services and Center for Medicaid Services permitting Deferred Action Childhood Arrivals ("DACA") recipients to enroll in a qualifying health plan through an exchange pursuant to the Affordable Care Act ("ACA"). I have compiled the information in the statements set forth below through DDOI personnel who have assisted me in gathering this information from our agency. I have also familiarized myself with the Final Rule in order to understand its immediate impact on DDOI. The Final Rule benefits the State and Delaware residents.
3. By making DACA recipients eligible for subsidies on Delaware's health insurance marketplace, the Final Rule ensures that more Delaware residents will have access to

affordable health insurance coverage. DDOI, as laid out in this declaration, can explain how increased access to affordable and adequate health insurance benefits both the State and its residents.

4. By contrast, as laid out in this declaration, a decision from a court invalidating the Final Rule on a nationwide basis would impose a series of other harms on the State of Delaware, including loss of revenue streams tied to the payment of insurance premiums.

The Delaware Department of Insurance

5. DDOI administers the laws of Delaware as they pertain to the protection of the insurance consumer through the regulation of the insurance industry. The work of DDOI includes: monitoring financial solvency; licensing insurance companies and producers; reviewing and approving rates and forms; overseeing the takeover and liquidation of insolvent insurance companies and the rehabilitation of financially troubled companies; and investigating and enforcing state laws and regulations pertaining to insurance.

6. Delaware operates a federally-facilitated exchange through www.HealthCare.gov in partnership with the federal government. Under this model, Delaware is responsible for plan management, stakeholder outreach and consumer assistance functionality for the marketplace.

The Health Insurance Marketplace

7. The federal health insurance marketplace (the "Marketplace"), operated through www.HealthCare.gov, was established under the authority of the Patient Protection and Affordable Care Act. The Marketplace is a source of affordable health insurance for Delaware residents who do not have health coverage from their employers or access to other health care programs. Financial assistance to lower the cost of premiums and out-of-pocket expenses is available for eligible residents.

8. The Marketplace improves access to high-quality, affordable health coverage for Delaware residents. The program enables residents who are uninsured or underinsured to access affordable coverage to protect their health. During plan year 2024, Delaware's Marketplace served roughly 45,000 residents, a 29% year-over-year increase from 2023 plans and nearly 54% increase from 2018.
9. As of January 4, 2025, more than 51,000 Delaware residents have signed up for a 2025 health insurance plan through the Marketplace. This is an increase from the 44,842 residents who had selected plans by this time last year.
10. Delaware health plans offered through the Marketplace cover preventative services, emergency services, prescription drugs, prenatal and pediatric care, as well as other services. No one can be denied coverage due to a pre-existing condition.
11. Financial assistance under the Marketplace takes several forms, including advance premium tax credits and cost-sharing reductions. Premium tax credits help lower monthly premium payments. Cost-sharing reductions help lower out-of-pocket costs like deductibles and co-pays for doctor visits.
12. Due to the federal American Rescue Plan Act of 2021 and the federal Inflation Reduction Act of 2022, eligible Delaware residents are also able to receive expanded financial help from the federal government via additional subsidies and advance premium tax credits.
13. To be eligible for the Marketplace in Delaware, Delaware residents:
    a. Must live in the United States and have a primary residence in Delaware;
    b. Must be considered a resident of the United States and Delaware for tax purposes;
    c. Must be a United States citizen or national or be lawfully present; and
    d. Cannot be currently incarcerated.

14. Prior to the Final Rule, DACA recipients were not considered lawfully present for purposes of eligibility through the Marketplace. Under the Final Rule, DACA recipients are considered lawfully present for purposes of Marketplace eligibility.

State Revenue Derived from Insurance Purchased Through the Marketplace

15. As part of its efforts to make health insurance more affordable, Delaware has implemented, pursuant to 16 *Del. C.* § 9903(g), a state-based and state-administered reinsurance program. To fund the operation of the reinsurance program, pursuant to 18 *Del. C.* § 8703(b), DDOI collects from carriers a 2.75% assessment on "all amounts used to calculate the [carrier's] premium tax liability or the amount of the [carrier's] premium tax exemption value for the previous calendar year."

16. Because health insurance carriers receive a monthly premium payment for each individual enrolled in their insurance plans, the total monthly premium collected by a health insurance carrier, which is used to calculate their premium tax liability, decreases as the number of enrollees decreases. And the total reassessment collected by Delaware correspondingly decreases as the number of enrollees decreases.

17. Thus, for each individual who ceases to be enrolled in a health benefits plan in Delaware, including plans sold on the Marketplace, the State loses revenue, whether through premium tax or through the value of the assessment collected under the reinsurance program.

18. According to U.S. Citizenship and Immigration Services, as of September 30, 2024 there were 1,140 active DACA recipients living in Delaware that may benefit from the Final Rule.

19. Most often, Delawareans who purchase insurance on the Marketplace do so to access subsidies that enable them to afford health insurance coverage that they otherwise could not afford. Indeed, more than 62% of Delawareans who purchase insurance on the Marketplace for plan

year 2024 had a household income of less than 250% of the federal poverty level, and over 90% received subsidies. Thus, for most enrollees, losing access to the Marketplace means not being able to afford private health insurance at all.

20. If a court issues an order rendering those DACA recipients who may have enrolled in Delaware plans offered on the Marketplace now ineligible for participation in ACA exchanges, the State would lose revenue based on insurance premiums under those plans no longer being collected, and thus carriers no longer being assessed the 2.75% reinsurance assessment based on those premiums. This would result a loss of revenue to the State.

Impact of Final Rule on Delaware

21. The Final Rule allows more Delaware residents to access the Marketplace, reducing the numbers of uninsured individuals in the State.

22. Beyond improving health outcomes, increased access to health insurance also results in financial benefits for DACA recipients. Access to affordable and adequate health care results in lower-cost preventative care and a decrease in high-cost emergency care, reducing the financial strain of costly medical bills.

23. The Final Rule states that there a slight positive effect on exchange risk pools by introducing DACA recipients to the individual market, because DACA recipients represent a pool of relatively young, healthy adults that are younger than the general exchange population. *See* 89 Fed. Reg. 39,396.

24. The Final Rule will likely benefit Delaware by introducing a pool of young, healthy individuals to the state's individual health insurance market. A health insurance risk pool is a group of individuals whose medical costs are combined to calculate premiums. Pooling risks together allows the higher costs of the less healthy to be offset by the relatively lower costs of the more

healthy. Because the largest component of health insurance premiums is the medical spending paid on behalf of enrollees, premiums reflect the expected health care costs of the risk pool. Therefore, when risk pools become healthier the entire market benefits.

25. Invalidating the Final Rule would also cause significant confusion and uncertainty in the insurance marketplace. Enrollees must pay the first month's insurance premium before coverage can start. Therefore, to the extent that premiums have already been paid by DACA recipients who have enrolled in plans on the Marketplace, they will need to be returned. To the extent that DACA recipients have scheduled medical appointments with network providers, these appointments may need to be cancelled or modified due to lack of insurance coverage.

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

Executed this 13th day of January, 2025, in Dover, DE.

Trinidad Navarro, Commissioner
Delaware Department of Insurance

EXHIBIT 9

June 23, 2023 Comment Letter to U.S. Department of Health and Human Services

THE STATE OF NEW JERSEY
OFFICE OF THE ATTORNEY GENERAL

June 23, 2023

Via Regulations.gov

The Honorable Xavier Becerra
Secretary
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

RE: **Notice of Proposed Rulemaking, *Clarifying Eligibility for a Qualified Health Plan Through an Exchange, Advance Payments of the Premium Tax Credit, Cost-Sharing Reductions, a Basic Health Program, and for Some Medicaid and Children's Health Insurance Programs*, 88 Fed. Reg. 25,313 (April 26, 2023).**

Dear Secretary Becerra:

We write on behalf of the States of New Jersey, California, Connecticut, Delaware, Hawai'i, Illinois, Maine, Massachusetts, Michigan, Minnesota, Nevada, New Mexico, New York, Oregon, Pennsylvania, Rhode Island, Vermont, Washington, and the District of Columbia ("the States"), in support of the proposed rulemaking by the U.S. Department of Health and Human Services and Centers for Medicare & Medicaid Services (collectively, "Department") reducing barriers to healthcare access for individuals receiving deferred action pursuant to the Deferred Action for Childhood Arrivals ("DACA") policy. *See Clarifying Eligibility for a Qualified Health Plan Through an Exchange, Advance Payments of the Premium Tax Credit, Cost-Sharing Reductions, a Basic Health Program, and for Some Medicaid and Children's Health Insurance Programs*, 88 Fed. Reg. 25,313 (Apr. 26, 2023) (to be codified at 42 C.F.R. Parts 435, 457, and 600, and 45 C.F.R. Parts 152 and 155) (the "Proposed Rule"). The Proposed Rule remedies a discrepancy in the current regulatory scheme, under which DACA recipients are the only type of deferred action recipients not eligible to enroll in and receive subsidies for health insurance plans on the exchanges established by the Affordable Care Act ("ACA"), or to enroll in Medicaid and the Children's Health Insurance Program ("CHIP") in states that have elected to cover non-citizens

who are lawfully present under Department rules, as well as Basic Health Programs in states that have created such programs under the ACA.[1]

DACA protects from removal and, due to longstanding regulations, extends work authorization to more than 580,000 active recipients—including 165,090 in California, 30,740 in Illinois, 23,780 in New York, 14,430 in New Jersey, 14,310 in Washington, 11,270 in Nevada, 8,430 in Oregon, 4,930 in New Mexico, 4,880 in Massachusetts, 4,690 in Michigan, 4,560 in Minnesota, 4,060 in Pennsylvania, 3,170 in Connecticut, 1,200 in Delaware, 800 in Rhode Island, 520 in the District of Columbia, 340 in Hawai'i, 60 in Maine, and 40 in Vermont—who grew up in this country; most of these individuals have known no home other than the United States.[2] DACA has allowed recipients to live, study, and work in the States (and throughout the country) as contributors and leaders in their communities. DACA recipients attend public and private universities and are employed by companies, nonprofit organizations, and governmental agencies and institutions, all of which benefit from their skills and productivity. DACA recipients provide critical financial support to their families, many of which include United States citizens and lawful permanent residents. DACA recipients also help to grow the economy, and contribute significantly to State and local revenues and tax bases. DACA enables recipients to open bank accounts, obtain credit cards, start businesses, purchase homes and cars, and participate in other aspects of daily life. And DACA has improved public health by allowing DACA recipients access to employer-sponsored health insurance. These positive effects have rippled throughout the States' economies.

However, under existing Department rules, DACA recipients are unable to obtain affordable health insurance through any means other than an employer-sponsored health plan. The federal government has a long history of deferred action, including 17 different deferred action policies that existed prior to DACA, and none of the recipients of those other programs were or are categorically denied access to government health insurance affordability programs. In contrast, the Department's current rules contain an exception that carves out DACA recipients alone from

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[1] Basic Health Programs cover citizens and lawfully present non-citizens whose incomes are too high to qualify for Medicaid, but are no more than 200% of the Federal Poverty Line. New York and Minnesota have created such programs. *See Basic Health Program*, Center for Medicaid & Medicare Services, https://www.medicaid.gov/basic-health-program/index.html (last visited June 20, 2023).

[2] *See Count of Active DACA Recipients By State or Territory As of December 31, 2022*, U.S. Citizenship and Immigr. Servs., https://www.uscis.gov/sites/default/files/document/data/Active_DACA_Recipients_Dec_FY23_qtr1.pdf.

eligibility, effectively locking recipients out of the government health insurance programs their tax dollars help fund. This means that unless a DACA recipient's employer provides health insurance benefits for employees, the recipient will likely be unable to secure insurance coverage for themselves or their children. This barrier to insurance coverage translates to high uninsured rates among the DACA population and results in economic and health precarity that is felt by recipients' families, communities, and the States.[3]

As state Attorneys General, we support the Department's Proposed Rule because it will provide health and economic benefits for DACA recipients residing in our territories and support the communities in which they live. A substantial portion, 34 percent, of DACA recipients are uninsured, and access to coverage through the Proposed Rule would provide substantial health and financial benefits to the recipients and their communities.[4] The Proposed Rule is substantively valid and advances public health and societal interests by giving DACA recipients the opportunity to procure health insurance for themselves and their dependents, regardless of whether their employer provides health insurance coverage. Because such a rule would be consistent with the public interest, and would help the States in their efforts to protect the health, safety, and well-being of their residents, we strongly support the Department's Proposed Rule.

I. The Proposed Rule is Substantively Valid

The Proposed Rule is a lawful exercise of the Department's authority under the ACA and better effectuates the statute's purposes than the current regulatory scheme. The ACA uses the phrase "lawfully present" as an eligibility criterion in numerous provisions.[5] In doing so, Congress conveyed a clear policy directive: individuals who are lawfully present, and only those lawfully present, would receive access to the ACA's benefits.[6] Although the ACA does not define "lawfully present," the phrase is also used in 8 U.S.C. § 1611(b)(2), which predates the ACA, as an eligibility

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[3] *See* Comment Letter of 24 State Attorneys General, in response to proposed rule, *Deferred Action for Childhood Arrivals*, 86 Fed. Reg. 53,736 (November 19, 2021), at 3-4, https://www.nj.gov/oag/newsreleases21/DACA-NPRM-Multistate-Comment-2021-1119.pdf.

[4] *See* 88 Fed. Reg. at 25,315-16.

[5] *See* 42 U.S.C. § 18032(f)(3) (eligibility to enroll in a health plan on the exchange); 26 U.S.C. § 36B(e) (eligibility for refundable premium tax credits); 42 U.S.C. § 18071(e) (eligibility for cost sharing); 42 U.S.C. 18081(c) (process by which lawful presence will be verified); 42 U.S.C. § 18082(d) (advanced payment of credits or cost sharing).

[6] *See id.*

criterion for Social Security. That section grants authority to the Attorney General (now the Secretary of Homeland Security) to define who is lawfully present.[7]

Since passage of the ACA in 2010, Centers for Medicare & Medicaid Services ("CMS") has promulgated regulations to effectuate Congress's purpose with respect to lawful presence. However, CMS has not been consistent in its treatment of recipients of deferred action, nor has the federal government been consistent in its definition of the phrase across agencies and programs. As explained in the Notice of Proposed Rulemaking, CMS first codified a definition of "lawfully present" in 2010. Under that definition, codified at 45 C.F.R. § 152.2, all recipients of deferred action were considered lawfully present. In reaching that conclusion, CMS drew on two sources: a guidance letter to state health officials ("2010 SHO")[8] and a Department of Homeland Security ("DHS") regulation defining the phrase for purposes of Social Security. Both of these sources defined "lawfully present" to include all recipients of deferred action.[9]

But in August 2012, CMS abruptly changed course after DACA was announced: CMS modified the definition of "lawfully present" in 45 C.F.R. § 152.2 to explicitly carve out DACA recipients from eligibility for qualified health plans, despite maintaining eligibility for other types of deferred action recipients.[10] The 2012 changes also excluded DACA recipients from the definition of "lawfully present" for purposes of Section 214 of the Children's Health Insurance Program Reauthorization Act of 2009 ("CHIPRA"), under which states may elect to expand Medicaid and CHIP to lawfully present pregnant individuals and/or children.[11] DHS did not change the definition of "lawfully present" as it is used in the Social Security regulation at 8 C.F.R. § 1.3. The result for the past decade has been that DACA recipients are incongruously considered "lawfully present" for purposes of Social Security benefits, but not for several federal health programs.[12]

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[7] *See* 8 U.S.C. § 1103(a)(1).

[8] Medicaid Coverage of "Lawfully Residing" Children and Pregnant Women, Center for Medicaid, CHIP and Survey Certification (July 1, 2010), at 3, 8, 10-11, https://downloads.cms.gov/cmsgov/archived-downloads/smdl/downloads/sho10006.pdf.

[9] 8 C.F.R. § 1.3; 88 Fed. Reg. 25,315.

[10] 88 Fed. Reg. 25,315.

[11] *Id.* at 25,314-15; *see also* Medicaid and CHIP Coverage of Lawfully Residing Children and Pregnant Individuals (May 4, 2023), https://www.medicaid.gov/medicaid/enrollment-strategies/medicaid-and-chip-coverage-lawfully-residing-children-pregnant-individuals.

[12] *See* 88 Fed. Reg. 25,316-17.

The incongruity of this status quo is further demonstrated by how DHS treats DACA recipients for the purposes of immigration law. Although DACA (and deferred action generally) is not a form of "lawful status," the agency does not consider those subject to a grant of deferred action to be *un*lawfully present in the U.S. as long as the deferred action is in effect.[13] Unlawful presence has serious ramifications: a person who accrues unlawful presence in the U.S. and leaves the country and tries to reenter may be barred and deemed inadmissible for 3 or 10 years, depending on the length of unlawful stay.[14] DACA recipients do not accrue that unlawful presence time, so long as their individualized grant of their DACA requests and renewals remains valid.[15] Furthermore, DACA recipients and other recipients of deferred action are, due to decades-old DHS regulations, eligible for work authorization.[16] Taken as a whole, for the past decade, current DACA recipients have been eligible to live and work in the U.S. and have been eligible to receive benefits like Social Security, but they *cannot* access crucial aspects of the healthcare system—at least not with public assistance. This is despite the fact that according to one estimate, as of 2021, DACA recipients and their households pay $6.2 billion in annual federal taxes and about $3.3 billion in annual State and local taxes—meaning that DACA recipients are paying into the very same benefits from which they are barred.[17]

The Proposed Rule appropriately corrects that longstanding error. It would revise the definition of "lawfully present" in 45 C.F.R. 152.2 and related provisions[18] and thereby harmonize the definition of a single statutory phrase across agencies and applications, following the lead of

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[13] *See What is Deferred Action for Childhood Arrivals?*, U.S. Citizenship and Immigr. Servs., https://www.uscis.gov/humanitarian/consideration-of-deferred-action-for-childhood-arrivals-daca/frequently-asked-questions (last updated May 30, 2023).

[14] Immigration and Nationality Act (INA), 8 U.S.C. § 1182(a)(9)(B)(i)(1). *See also Unlawful Presence and Inadmissibility*, U.S. Citizenship and Immigr. Servs., https://www.uscis.gov/laws-and-policy/other-resources/unlawful-presence-and-inadmissibilityhttps://www.uscis.gov/laws-and-policy/other-resources/unlawful-presence-and-inadmissibility (last updated June 24, 2022).

[15] *See What is Deferred Action for Childhood Arrivals?*, *supra* note 13.

[16] 8 C.F.R. §§ 274a.12, 274a.13.

[17] Nicole Prchal Svajlenka & Trinh Q. Truong, *The Demographic and Economic Impacts of DACA Recipients: Fall 2021 Edition*, Center for American Progress (Nov. 24, 2021), https://www.americanprogress.org/article/the-demographic-and-economic-impacts-of-daca-recipients-fall-2021-edition/.

[18] The Proposed Rule would also make changes to 42 C.F.R. §§ 435.4, 457.320(c), 600.5 and 45 C.F.R. §§ 152.2, 155.20.

the federal agency best suited to make immigration determinations—DHS. The Proposed Rule also better effectuates the purpose of the ACA by ensuring that a class of individuals considered "lawfully present" for other federal programs and purposes receives access to the ACA's benefits. And it corrects a fundamental error of CMS's 2012 regulation, which treated DACA recipients as a *sui generis* class of deferred action recipients when, in fact, DACA is just one in a long line of deferred action programs in the nation's history.[19]

II. The Proposed Rule is Needed and Timely

The Proposed Rule is urgently necessary for two interrelated reasons: (1) the high rates of uninsured among DACA recipients; and (2) the aging DACA population's increasing need for coverage.

As mentioned earlier, a 2021 survey indicated that 34% of DACA recipients do not possess health insurance.[20] This number is even greater when expanded to include individuals who likely would have been eligible for DACA; the Kaiser Family Foundation estimates that approximately 47% of such individuals are uninsured.[21] Moreover, recent events such as the COVID-19 pandemic have had a negative impact on health insurance coverage among DACA recipients; an estimated 18% of DACA recipients lost their employer-provided health insurance during the COVID-19 pandemic.[22]

The uncertainty DACA recipients face in relation to health insurance coverage has created additional obstacles to accessing critical healthcare—obstacles that extend to DACA recipients as well as their children and other family members who rely on them. In a 2021 survey of over 1,000

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[19] *See* Ben Harrington, An Overview of Discretionary Reprieves from Removal: Deferred Action, DACA, TPS, and Others, Congressional Research Service (April 10, 2018), https://sgp.fas.org/crs/homesec/R45158.pdf.

[20] *See* 88 Fed. Reg. 25,315-16.

[21] *Key Facts on Deferred Action for Childhood Arrivals,* Kaiser Family Foundation https://www.kff.org/racial-equity-and-health-policy/fact-sheet/key-facts-on-deferred-action-for-childhood-arrivals-daca/ (April 26, 2023). DHS is currently bound by an injunction that permits it to continue to renew deferred action for current DACA recipients but precludes it from granting any new DACA requests. *See Texas v. United States*, No. 1:18-CV-00068, 2021 WL 3022434 (S.D. Tex. July 16, 2021).

[22] Nat'l Immigr. Law Center, *Tracking DACA Recipients' Access to Health Care*, at 2 (June 1, 2022), https://www.nilc.org/wp-content/uploads/2022/06/NILC_DACA-Report_060122.pdf.

DACA recipients, 61% of recipients surveyed identified their immigration status as a "significant barrier" to receiving health insurance and healthcare, while 50% reported that they were unaware of any affordable care or coverage available to them.[23] Additionally, 47% of respondents reported delaying medical care due to their immigration status, while 67% indicated that they or a family member were unable to pay medical bills or expenses.[24] In short, a significant number of DACA recipients either lack health insurance or face significant barriers to accessing health care. The Proposed Rule helps to ameliorate these issues by expanding access to the ACA exchanges, Medicaid, and CHIP. In California alone, by one estimate, approximately 40,000 uninsured DACA recipients would qualify for ACA subsidies under the Proposed Rule.[25]

Additionally, the DACA population is aging and having increasing numbers of children, further exacerbating these healthcare access and coverage issues. The average age of DACA recipients at the time of their arrival to the United States was 7 years old, with recipients having arrived on average in 1999.[26] The same demographic data gathered in 2021 indicated that the average age across 590,070 DACA recipients was 26 years old.[27] As the DACA population ages, it will face new and different health challenges requiring insurance coverage.

Critically, the percentage of DACA recipients with children has more than doubled over the last ten years; in 2012, an estimated 22% of DACA recipients had children, while an estimated 48% had children in 2021.[28] There is also great need among the DACA population for public health care options. In New York, roughly two-thirds of DACA recipients have an income below 100% of the Federal Poverty Line (FPL) and nearly a third have an income between 100-138% FPL.[29]

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[23] *Id.* at 2.

[24] *Id.*

[25] Miranda Dietz et. al, *Extending Covered California Subsidies to DACA Recipients Would Fill Coverage Gap for 40,000 Californians*, UC Berkeley Labor Center (June 6, 2023), https://laborcenter.berkeley.edu/extending-covered-california-subsidies-to-daca-recipients-would-fill-coverage-gap-for-40000-californians/.

[26] Nicole Prchal Svajlenka & Trinh Q. Truong, *The Demographic and Economic Impacts of DACA Recipients: Fall 2021 Edition*, Ctr. for Am. Progress (Nov. 24, 2021), https://www.americanprogress.org/article/the-demographic-and-economic-impacts-of-daca-recipients-fall-2021-edition/.

[27] *Id*.

[28] *DACA 11 Years Later*, FWD.us (June 12, 2023), https://www.fwd.us/news/daca-anniversary/.

[29] Information provided by New York State Dep't of Health (NYSDOH).

Allowing DACA recipients to purchase Marketplace plans and access Medicaid and CHIP for children and pregnant individuals will benefit families and expand health insurance coverage for children. For instance, one study found that children living in states with expanded health benefits for all individuals regardless of immigration status experienced lower uninsured rates, and fewer of them had forgone medical, dental, and preventative care.[30] And although U.S.-born children of DACA recipients are eligible to participate in Medicaid and CHIP, increased fear and uncertainty causes decreased enrollment for children in these programs relative to U.S.-citizen children with U.S.-born parents.[31]

In 2021, DACA recipients had more than 250,000 U.S.-born children, who depend on their parents for insurance coverage.[32] For DACA recipients who do not receive employer-based insurance and who do not meet the income eligibility criteria for Medicaid and CHIP coverage, the Proposed Rule will allow them to purchase affordable insurance coverage in the Marketplace to cover themselves and their dependent children.

III. The Proposed Rule's Benefits Will Redound to DACA Recipients' States

The expansion of healthcare coverage in the Proposed Rule will benefit not just DACA recipients themselves, but also the communities in which they live. Access to health insurance improves public health.[33] A large body of research has documented the economic benefits of Medicaid expansion under the ACA, including a per-person reduction in medical debt of more than $1,100, improved access to credit, greater labor mobility, and a drop in uncompensated

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[30] Julia Rosenberg et al, *Insurance and Health Care Outcomes in Regions Where Undocumented Children are Medicaid-Eligible*, 150(3) Pediatrics (Sept. 2022), available at https://publications.aap.org/pediatrics/article-abstract/150/3/e2022057034/189211/Insurance-and-Health-Care-Outcomes-in-Regions.

[31] Samantha Artiga & Anthony Damico, *Nearly 20 Million Children Live in Immigrant Families that Could Be Affected by Evolving Immigration Policies*, Kaiser Family Foundation (Apr. 18, 2018), https://www.kff.org/racial-equity-and-health-policy/issue-brief/nearly-20-million-children-live-in-immigrant-families-that-could-be-affected-by-evolving-immigration-policies.

[32] *See* Svajlenka & Truong, *supra* note 26.

[33] *See The Importance of Health Coverage*, Am. Hospital Ass'n (Oct. 2019), https://www.aha.org/system/files/media/file/2019/10/report-importance-of-health-coverage_1.pdf.

medical care, which improved hospital budgets.[34] States that participated in Medicaid expansion also saw greater utilization of preventative care and improved health outcomes, including fewer premature deaths, with at least 19,000 lives saved from 2014 to 2017 alone, and greater utilization of care for mental illness and addiction, including for opioid use disorders.[35] In fact, Medicaid expansion is associated with lower opioid overdose rates compared to states that have not expanded.[36] Medicaid expansion is also an effective form of economic stimulus, with one study finding that every $100,000 of additional federal Medicaid spending would result in 3.8 net job-years (i.e., one job that lasts one year).[37] Another study estimated that if the remaining non-expansion states expanded Medicaid, it would create more than 1 million jobs nationwide.[38] Medicaid expansion was also associated with greater food and housing security, increased child support payments, and even reductions in violent crime.[39] Children who became Medicaid-eligible (or whose mothers gained Medicaid while they were *in utero*) experienced fewer hospital visits and hospitalizations later in life, and higher graduation rates.[40]

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[34] Center on Budget and Policy Priorities, *The Far-Reaching Benefits of the Affordable Care Act's Medicaid Expansion*, at 2, 13, 16-17, https://www.cbpp.org/sites/default/files/atoms/files/10-2-18health.pdf (updated Oct. 21, 2020); *see also* Kyle J. Caswell, Timothy A. Waidmann, *The Affordable Care Act Medicaid Expansions and Personal Finance*, 76(5) Med Care Research and Review. 538-571 (Sept. 16, 2017), https://journals.sagepub.com/doi/10.1177/1077558717725164.

[35] *The Far-Reaching Benefits of the Affordable Care Act's Medicaid Expansion*, *supra* note 34 at 2, 10.

[36] Nicole Kravitz-Wirtz et al., *Association of Medicaid Expansion with Opioid Overdose Mortality in the United States*, JAMA (Jan. 10, 2020), https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2758476.

[37] Gabriel Chodorow-Reich et al., *Does State Fiscal Relief During Recessions Increase Employment? Evidence from the American Recovery and Reinvestment Act*, 4(3) Am. Econ. J.: Econ. Pol'y 121 (2012), https://www.aeaweb.org/articles?id=10.1257/pol.4.3.118.

[38] Leighton Ku and Erin Brantley, *The Economic and Employment Effects of Medicaid Expansion Under the American Rescue Plan*, The Commonwealth Fund (May 20, 2021), https://www.commonwealthfund.org/publications/issue-briefs/2021/may/economic-employment-effects-medicaid-expansion-under-arp.

[39] The White House, *The Effects of Earlier Medicaid Expansions, A Literature Review* (June 22, 2021), https://www.whitehouse.gov/cea/written-materials/2021/06/22/the-effects-of-earlier-medicaid-expansions-a-literature-review/.

[40] *Id.*

Similarly, research has found that creation of the ACA insurance marketplace has had health and financial benefits. The marketplace is particularly beneficial for small businesses and self-employed individuals, resulting in lower healthcare costs for the former and dramatically reduced uninsured rates for the latter.[41] Similar to Medicaid expansion, increased access to private insurance is associated with fewer bankruptcy filings and an average reduction in total debt of over one thousand dollars per person.[42]

Further, research indicates that increased eligibility for Medicaid is associated with uptake among the DACA population. One study found that after New York and California extended eligibility for their state Medicaid programs to DACA recipients, DACA-eligible immigrants were 4% more likely to report insurance coverage in those states than in other states that did not extend Medicaid coverage to low-income DACA recipients. [43, 44] In New York alone, more than 13,000 DACA recipients have enrolled in Medicaid, aided by specially trained enrollment assistors in numerous languages.[45] And in 2023, New Jersey expanded Medicaid and CHIP to children under

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[41] *See Marketplace Coverage and Economic Benefits: Key Issues and Evidence*, U.S. Dep't of Health and Human Servs., Assistant Sec'y for Planning and Evaluation, Office of Health Policy (July 20, 2022), https://aspe.hhs.gov/sites/default/files/documents/36e5e989516728adcc63e398b3e3d23d/aspe-marketplace-coverage-economic-benefits.pdf.

[42] *Id.* at 5. *See also* Bhashkar Mazumder & Sarah Miller, *The Effects of the Mass. Health Reform on Household Fin. Distress,* 8(3) Am. Econ. J.: Econ. Pol'y 285-286, 305 (Aug. 2016), https://www.aeaweb.org/articles?id=10.1257/pol.20150045; Caswell & Waidmann, *supra* note 34.

[43] California has extended its Medicaid program, Medi-Cal, to all adults who are income eligible regardless of immigration status, using state funds. *See also State Spotlight: California's Landmark Coverage Expansion for Immigrant Populations*, Manatt Health (Nov. 2022), https://www.shvs.org/wp-content/uploads/2022/11/SHVS-State-Spotlight-Californias-Landmark-Coverage-Expansion-for-Immigrant-Populations.pdf.

[44] Osea Giuntella & Jakub Lonsky, *The Effects of DACA on Health Insurance, Access to Care, and Health Outcomes*, IZA Institute of Labor Economics (April 2018), at 10, https://repec.iza.org/dp11469.pdf.

[45] Information provided by NYSDOH; *see also Fast Facts on Health Insurance for Immigrants*, NYSDOH (Sept. 2015), https://info.nystateofhealth.ny.gov/sites/default/files/Immigrants%20Fact%20Sheet_3.pdf.

19 whose families meet income and eligibility requirements regardless of immigration status.[46] Within the first six months of this expansion, 17,896 children who did not previously qualify due to immigration status had enrolled.

DACA itself is also associated with improved healthcare utilization. After 2012, DACA-eligible individuals were 20% less likely to delay care because of financial constraints, and in California, DACA increased the likelihood of having a primary care doctor by 13%.[47] DACA recipients in California were also more likely to receive mental healthcare services, though there was no evidence of increased doctor or ER visits.[48] This data indicates that, should the Department finalize the Proposed Rule, DACA recipients will enroll in health insurance coverage and it will serve as an important safety net, safeguarding their financial and overall wellness.

This overwhelming body of evidence as to the health and economic benefits of the ACA and access to affordable health insurance strongly suggests that should the Proposed Rule be implemented, not only will DACA recipients themselves see improved health and financial outcomes, but states and communities with large DACA populations will see reductions in uncompensated care expenses and increased economic growth. And indeed, the proposed rule (to the extent it impacts eligibility for Medicaid and CHIP) only impacts States that affirmatively choose to extend Medicaid and CHIP to lawfully present pregnant individuals and/or children, a choice current law does not require them to make. For these reasons, the Signatory States strongly support the proposed rule.

CONCLUSION

DACA recipients in the States are small-business owners, employees, students, healthcare workers, and, perhaps most importantly, valued community members, friends, and family. Their presence, and the presence of DACA-eligible individuals, has enriched the States in countless ways. The States urge the Department to finalize regulations expanding access to the insurance Marketplace, Medicaid, and CHIP to DACA recipients. The Department's Proposed Rule is not only a valid exercise of regulatory authority, it would also increase health and wellbeing among a vulnerable population and allow DACA recipients to better support themselves and their communities.

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[46] *See Governor Highlights Expanded Eligibility for NJ FamilyCare Health Care Coverage as Administration Continues Efforts to Cover All Kids*, N.J. Dep't of Human Servs. (Jan. 18, 2023), https://www.nj.gov/humanservices/news/pressreleases/2023/approved/20230118.shtml.

[47] *State Spotlight: California's Landmark Coverage Expansion for Immigrant Populations*, *supra* note 43 at 11.

[48] *Id.* at 11 and 30.

Sincerely,

Matthew J. Platkin

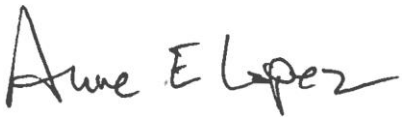
New Jersey Attorney General

Brian L. Schwalb

District of Columbia Attorney General

Rob Bonta

California Attorney General



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Oregon Attorney General

Michelle A. Henry

Pennsylvania Attorney General

Peter F. Neronha

Rhode Island Attorney General

Charity R. Clark

Vermont Attorney General

Bob Ferguson

Washington Attorney General

EXHIBIT 10

Declaration of Elizabeth Caulum

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF NORTH DAKOTA
WESTERN DIVISION

STATE OF KANSAS, *et al.*,

Case No. 24-cv-150-DMT-CRH

Plaintiffs,

vs.

UNITED STATES OF AMERICA, *et al.*,

DECLARATION OF ELIZABETH CAULUM

Defendants.

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

1. I am the chief executive officer of MNsure, Minnesota's health insurance marketplace established pursuant to the Patient Protection and Affordable Care Act ("ACA"), 42 U.S.C. § 18051 *et seq.* and Minnesota law, Minnesota Statutes, chapter 62V. I have held this position since May 3, 2023. Before that I served as both MNsure's interim CEO and senior director for public affairs.

2. MNsure is Minnesota's health insurance marketplace where individuals and families can shop, compare, and choose health insurance coverage that meets their needs. Individuals can apply for financial help to lower the cost of their monthly insurance premiums and out-of-pocket costs through MNsure. MNsure also offers low-cost and free health insurance options provided through government-sponsored health insurance programs, Medical Assistance and MinnesotaCare, which are managed through the Minnesota Department of Human Services, to individuals who qualify. MNsure has a statutory premium withhold (PWH) that is 3.5% of the premium. See Minn. Stat. § 62V.05, subd. 2. For Fiscal Year 2024, MNsure's entire PWH was approximately $25,418,000.

3. According to a recent visit to the United States Citizenship and Immigration Services (USCIS)'s website, as of September 30, 2024, there are 4,330 Deferred Action for Childhood Arrivals ("DACA") recipients residing in the State of Minnesota.[1]

4. As of the date of this declaration, there are fewer than 10 DACA recipients enrolled through MNsure.

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

DATED: January 14, 2025

Elizabeth Caulum
MNsure CEO

[1] U.S. Citizenship and Immigration Services, *Active DACA Recipients – (Fiscal Year 2024, Quarter 4)*, available at https://www.uscis.gov/tools/reports-and-studies/immigration-and-citizenship-data (last visited January 13, 2025).

EXHIBIT 11

Proposed Answer

UNITED STATES DISTRICT COURT
DISTRICT OF NORTH DAKOTA
WESTERN DIVISION

STATE OF KANSAS, *et al.*, Plaintiffs, v. UNITED STATES OF AMERICA, *et al.*, Defendants.	Civil Action No. 1:24-cv-150-DMT-CRH Judge Daniel M. Traynor **[PROPOSED] ANSWER TO PLAINTIFFS' COMPLAINT FOR DECLARATORY AND INJUNCTIVE RELIEF**

Proposed Defendant-Intervenors New Jersey, Arizona, California, Colorado, Delaware, Hawai'i, Illinois, Maryland, Attorney General Dana Nessel on Behalf of People of Michigan, Minnesota, Nevada, New Mexico, Oregon, and Vermont, answer the First Amended Complaint ("Complaint") of Plaintiffs the State of Kansas, the State of North Dakota, the State of Alabama, the State of Arkansas, the State of Florida, the State of Idaho, the State of Indiana, the State of Iowa, the Commonwealth of Kentucky, the State of Missouri, the State of Montana, the State of Nebraska, the State of New Hampshire, the State of Ohio, the State of South Carolina, the State of South Dakota, the State of Tennessee, the State of Texas, and the Commonwealth of Virginia (collectively, "Plaintiffs") as follows:

1. The allegations contained in Paragraph 1 of the Complaint state legal conclusions, to which no responsive pleading is required; however, to the extent a responsive pleading is necessary, Defendant-Intervenors state that the Final Rule speaks for itself. Defendant-Intervenors admit that Plaintiffs bring suit against Defendants United States of America and Center for Medicaid Services under the Administrative Procedure Act.

2. The allegation contained in Paragraph 2 of the Complaint states a legal conclusion, to which no responsive pleading is required.

3. The allegation contained in Paragraph 3 of the Complaint states a legal conclusion, to which no responsive pleading is required

4. The allegation contained in Paragraph 4 of the Complaint states a legal conclusion, to which no responsive pleading is required.

5. The allegation contained in Paragraph 5 of the Complaint states a legal conclusion, to which no responsive pleading is required.

6. The allegation contained in Paragraph 6 of the Complaint states a legal conclusion, to which no responsive pleading is required; however, to the extent a responsive pleading is necessary, it is denied.

7. The allegations contained in Paragraph 7 of the Complaint state legal conclusions, to which no responsive pleading is required; however, to the extent a responsive pleading is necessary, the DACA Memorandum speaks for itself.

8. Admitted.

9. The allegation contained in Paragraph 9 of the Complaint states a legal conclusion, to which no responsive pleading is required; however, to the extent a responsive pleading is necessary, Defendant-Intervenors state that the Final Rule speaks for itself.

10. The allegations contained in Paragraph 10 of the Complaint state legal conclusions, to which no responsive pleading is required; however, to the extent a responsive pleading is necessary, Defendant-Intervenors state that the Final Rule speaks for itself.

11. Denied.

II. THE PARTIES

12. Defendant-Intervenors admit that Plaintiffs are sovereign states of the United States of America. Defendant-Intervenors lack knowledge or information sufficient to form a belief as to the truth of the remaining allegations contained in Paragraph 12.

13. Defendant-Intervenors admit that state attorneys general have authority to represent their states in federal court. Defendant-Intervenors lack knowledge or information sufficient to form a belief as to the truth of the remaining allegations contained in Paragraph 13.

14. Admitted.

15. Admitted.

16. The allegation contained in Paragraph 16 of the Complaint states a legal conclusion to which no responsive pleading is required.

17. The allegation contained in Paragraph 17 of the Complaint states a legal conclusion to which no responsive pleading is required.

III. JURISDICTION AND VENUE

18. Admitted.

19. Admitted.

20. The allegations contained in Paragraph 20 of the Complaint state a legal conclusion to which no responsive pleading is required.

21. The allegations contained in Paragraph 21 of the Complaint state legal conclusions to which no responsive pleading is required; however, to the extent a responsive pleading is necessary, they are denied.

22. The allegations contained in Paragraph 22 of the Complaint state legal conclusions to which no responsive pleading is required.

IV. BACKGROUND

A. Statutory and Regulatory Framework

23. The allegations contained in Paragraph 23 of the Complaint state legal conclusions to which no responsive pleading is required.

24. The allegations contained in Paragraph 24 of the Complaint state legal conclusions to which no responsive pleading is required.

25. The allegations contained in Paragraph 25 of the Complaint state legal conclusions to which no responsive pleading is required.

26. The allegations contained in Paragraph 26 of the Complaint state legal conclusions to which no responsive pleading is required.

27. The allegations contained in Paragraph 27 of the Complaint state legal conclusions to which no responsive pleading is required.

28. The allegation contained in Paragraph 28 states a legal conclusion to which no responsive pleading is required; however, to the extent a responsive pleading is necessary, Defendant-Intervenors lack knowledge or information sufficient to form a belief as to the truth of the allegation contained in Paragraph 18.

29. The allegations contained in Paragraph 29 state legal conclusions to which no responsive pleading is required; however, to the extent a responsive pleading is necessary, the referenced rule, 77 Fed. Reg. 52,614, speaks for itself.

30. The allegations contained in Paragraph 30 state legal conclusions to which no responsive pleading is required; however, to the extent a responsive pleading is necessary, the referenced rule speaks for itself.

31. The allegations contained in Paragraph 31 of the Complaint state legal conclusions to which no responsive pleading is required; however, to the extent a responsive pleading is required Defendant-Intervenors deny that DACA recipients are not considered "lawfully present" for purposes of the referenced programs under the Final Rule.

B. The Final Rule

32. The allegations contained in Paragraph 32 of the Complaint state legal conclusions to which no responsive pleading is required; however, to the extent a responsive pleading is necessary, Defendant-Intervenors state that the Final Rule speaks for itself.

33. The allegations contained in Paragraph 33 of the Complaint state legal conclusions to which no responsive pleading is required; however, to the extent a responsive pleading is necessary, Defendant-Intervenors state that the Final Rule speaks for itself.

34. The allegations contained in Paragraph 34 of the Complaint state legal conclusions to which no responsive pleading is required; however, to the extent a responsive pleading is necessary, Defendant-Intervenors state that the Final Rule speaks for itself.

35. The allegations contained in Paragraph 35 of the Complaint state legal conclusions to which no responsive pleading is required; however, to the extent a responsive pleading is necessary, Defendant-Intervenors state that the Final Rule speaks for itself.

36. The allegations contained in Paragraph 36 of the Complaint state legal conclusions to which no responsive pleading is required; however, to the extent a responsive pleading is necessary, Defendant-Intervenors state that the Final Rule speaks for itself.

37. The allegations contained in Paragraph 37 of the Complaint state legal conclusions to which no responsive pleading is required.

38. The allegations contained in Paragraph 38 of the Complaint state legal conclusions to which no responsive pleading is required; however, to the extent a responsive pleading is necessary, Defendant-Intervenors state that the Final Rule speaks for itself.

39. The allegations contained in Paragraph 39 of the Complaint state legal conclusions to which no responsive pleading is required; however, to the extent a responsive pleading is necessary, Defendant-Intervenors state that the Final Rule speaks for itself.

40. The allegations contained in Paragraph 40 of the Complaint state legal conclusions to which no responsive pleading is required; however, to the extent a responsive pleading is necessary, Defendant-Intervenors state that the Final Rule speaks for itself.

41. The allegations contained in Paragraph 41 of the Complaint state legal conclusions to which no responsive pleading is required; however, to the extent a responsive pleading is necessary, Defendant-Intervenors state that the Final Rule speaks for itself.

42. The allegations contained in Paragraph 42 of the Complaint state legal conclusions to which no responsive pleading is required; however, to the extent a responsive pleading is necessary, Defendant-Intervenors state that the Final Rule speaks for itself.

V. IRREPARABLE HARM

43. Denied. Defendant-Intervenors state that the referenced proposed rule, 88 Fed. Reg. 25,313, speaks for itself.

44. Defendant-Intervenors lack knowledge or information sufficient to form a belief as to the truth of the allegations in Paragraph 44 of the Complaint; however, to the extent a response is required, Defendant-Intervenors state that the cited U.S. Citizenship and Immigration Services data speaks for itself.

45. Defendant-Intervenors lack knowledge or information sufficient to form a belief as to the truth of the allegations in Paragraph 45 of the Complaint; however, to the extent a response is required, Defendant-Intervenors state that the cited USCIS data speaks for itself.

46. Defendant-Intervenors lack knowledge or information sufficient to form a belief as to the truth of the allegation in Paragraph 46 of the Complaint.

47. Defendant-Intervenors lack knowledge or information sufficient to form a belief as to the truth of the allegation in Paragraph 47 of the Complaint.

48. Defendant-Intervenors lack knowledge or information sufficient to form a belief as to the truth of the allegation in Paragraph 48 of the Complaint.

49. Defendant-Intervenors lack knowledge or information sufficient to form a belief as to the truth of the allegation in Paragraph 49 of the Complaint with respect to the Plaintiff states.

50. Defendant-Intervenors lack knowledge or information sufficient to form a belief as to the truth of the allegations in Paragraph 50. Defendant-Intervenors further state that the cited sources speak for themselves.

51. Defendant-Intervenors lack knowledge or information sufficient to form a belief as to the truth of the allegations in Paragraph 51 of the Complaint. Defendant-Intervenors further state that the cited sources speak for themselves.

52. Defendant-Intervenors lack knowledge or information sufficient to form a belief as to the truth of the allegation in Paragraph 52 of the Complaint.

53. Defendant-Intervenors lack knowledge or information sufficient to form a belief as to the truth of the allegations in Paragraph 53 of the Complaint.

54. Defendant-Intervenors lack knowledge or information sufficient to form a belief as to the truth of the allegations in Paragraph 54 of the Complaint.

55. Denied.

56. Denied as to the allegations that the Final Rule creates incentives to remain in Plaintiff States. Defendant-Intervenors lack knowledge or information sufficient to form a belief as to the truth of the remaining allegations in Paragraph 56.

57. The allegations contained in Paragraph 57 of the Complaint state legal conclusions to which no responsive pleading is required.

58. Defendant-Intervenors lack knowledge or information sufficient to form a belief as to the truth of the allegation in Paragraph 58 of the Complaint.

59. The allegations contained in Paragraph 59 of the Complaint state legal conclusions to which no responsive pleading is required. Defendant-Intervenors further state they lack knowledge or information sufficient to form a belief as to the truth of the allegations concerning the costs incurred by Plaintiff States.

60. The allegations contained in Paragraph 60 of the Complaint state legal conclusions to which no responsive pleading is required. Defendant-Intervenors further state they lack knowledge or information sufficient to form a belief as to the truth of the allegations concerning the costs incurred by Plaintiff States.

61. Defendant-Intervenors lack knowledge or information sufficient to form a belief as to the truth of the allegations in Paragraph 61.

62. Defendant-Intervenors lack knowledge or information sufficient to form a belief as to the truth of the allegations in Paragraph 62.

63. Defendant-Intervenors lack knowledge or information sufficient to form a belief as to the truth of the allegations in Paragraph 63.

64. Defendant-Intervenors lack knowledge or information sufficient to form a belief as to the truth of the allegations in Paragraph 64.

65. Defendant-Intervenors lack knowledge or information sufficient to form a belief as to the truth of the allegations in Paragraph 65.

66. Denied.

67. Defendant-Intervenors lack knowledge or information sufficient to form a belief as to the truth of the allegations in Paragraph 67.

68. Defendant-Intervenors lack knowledge or information sufficient to form a belief as to the truth of the allegations in Paragraph 68.

69. Defendant-Intervenors lack knowledge or information sufficient to form a belief as to the truth of the allegations in Paragraph 69.

70. Defendant-Intervenors lack knowledge or information sufficient to form a belief as to the truth of the allegations in Paragraph 70.

71. Defendant-Intervenors lack knowledge or information sufficient to form a belief as to the truth of the allegations in Paragraph 71.

72. Defendant-Intervenors lack knowledge or information sufficient to form a belief as to the truth of the allegations in Paragraph 72.

73. Defendant-Intervenors lack knowledge or information sufficient to form a belief as to the truth of the allegations in Paragraph 73.

74. Defendant-Intervenors lack knowledge or information sufficient to form a belief as to the truth of the allegations in Paragraph 74.

75. Defendant-Intervenors lack knowledge or information sufficient to form a belief as to the truth of the allegations in Paragraph 75.

76. Defendant-Intervenors lack knowledge or information sufficient to form a belief as to the truth of the allegations in Paragraph 76.

77. Defendant-Intervenors lack knowledge or information sufficient to form a belief as to the truth of the allegations in Paragraph 77.

78. Defendant-Intervenors lack knowledge or information sufficient to form a belief as to the truth of the allegations in Paragraph 78.

79. Defendant-Intervenors lack knowledge or information sufficient to form a belief as to the truth of the allegations in Paragraph 79.

80. Defendant-Intervenors lack knowledge or information sufficient to form a belief as to the truth of the allegations in Paragraph 80.

81. Defendant-Intervenors lack knowledge or information sufficient to form a belief as to the truth of the allegations in Paragraph 81.

82. Defendant-Intervenors lack knowledge or information sufficient to form a belief as to the truth of the allegations in Paragraph 82.

83. Defendant-Intervenors lack knowledge or information sufficient to form a belief as to the truth of the allegations in Paragraph 83.

84. Defendant-Intervenors lack knowledge or information sufficient to form a belief as to the truth of the allegations in Paragraph 84.

85. Defendant-Intervenors lack knowledge or information sufficient to form a belief as to the truth of the allegations in Paragraph 85.

VI. CLAIMS FOR RELIEF

COUNT I

Administrative Procedure Act – Agency Action Not in Accordance with the Law

86. Defendant-Intervenors hereby repeat and reassert their answers to the previous paragraphs as if set forth fully herein.

87. The allegations contained in Paragraph 87 of the Complaint state legal conclusions to which no responsive pleading is required.

88. Denied.

89. Denied that the Final Rule violates the PRWORA. The remaining allegations contained in Paragraph 89 of the Complaint state legal conclusions to which no responsive pleading is required; however, to the extent a responsive pleading is necessary, they are denied.

90. The allegation contained in Paragraph 90 of the Complaint states a legal conclusion to which no responsive pleading is required.

91. The allegation contained in Paragraph 91 of the Complaint states a legal conclusion to which no responsive pleading is required.

92. The allegations contained in Paragraph 92 of the Complaint state legal conclusions to which no responsive pleading is required.

93. Denied that DACA recipients are statutorily ineligible for ACA benefits. The remaining allegations contained in Paragraph 93 of the Complaint state legal conclusions to which no responsive pleading is required; however, to the extent a responsive pleading is necessary, they are denied.

94. The allegations contained in Paragraph 94 of the Complaint state legal conclusions to which no responsive pleading is required; however, to the extent a responsive pleading is necessary, they are denied.

95. Denied that the Final Rule violates the ACA. The remaining allegations contained in Paragraph 95 of the Complaint state legal conclusions to which no responsive pleading is required; however, to the extent a responsive pleading is necessary, they are denied.

96. The allegations contained in Paragraph 96 of the Complaint states a legal conclusion, to which no responsive pleading is required; however, to the extent a responsive pleading is necessary, they are denied.

97. Denied.

98. The allegations contained in Paragraph 98 of the Complaint state legal conclusions to which no responsive pleading is required however, to the extent a responsive pleading is necessary, they are denied.

99. Denied.

COUNT II

APA – Arbitrary and Capricious

100. Defendant-Intervenors hereby repeat and reassert their answers to the previous paragraphs as if set forth fully herein.

101. The allegations contained in Paragraph 101 of the Complaint state legal conclusions to which no responsive pleading is required.

102. The allegations contained in Paragraph 102 of the Complaint state legal conclusions to which no responsive pleading is required.

103. Denied.

104. The allegations contained in Paragraph 104 of the Complaint state legal conclusions to which no responsive pleading is required; however, to the extent a responsive pleading is necessary, they are denied.

105. The allegations contained in Paragraph 105 of the Complaint state legal conclusions to which no responsive pleading is required.

106. The allegations contained in Paragraph 106 of the Complaint state legal conclusions to which no responsive pleading is required.

107. Denied.

108. Denied that CMS acted arbitrarily and capriciously by failing to take into account States' reliance interests on the previous definitions. Defendant-Intervenors lack sufficient information or knowledge to form a belief as to the truth of the remaining allegations in Paragraph 108 with respect to the Plaintiff states.

109. Defendant-Intervenors lack sufficient information or knowledge to form a belief as to the truth of the allegations in Paragraph 109.

110. Denied.

AFFIRMATIVE DEFENSES

As and for their affirmative defenses to all causes of action purported to be set forth by Plaintiffs in the Complaint, Defendant-Intervenors allege as follows, subject to their right to amend and assert such other affirmative defenses as may become available during discovery in this action:

FIRST AFFIRMATIVE DEFENSE: FAILURE TO STATE A CAUSE OF ACTION

Plaintiffs' claims fail to state facts sufficient to state a claim upon which relief may be granted.

SECOND AFFIRMATIVE DEFENSE: NO INJUNCTIVE RELIEF

Plaintiffs' claims, as set forth in the First Amended Complaint, fail to state facts sufficient to constitute a cause of action against defendants for injunctive relief because the requirements for granting injunctive relief cannot be satisfied.

WHEREFORE, Defendant-Intervenors respectfully request:

1. That Plaintiffs' First Amended Complaint and each cause of action therein be dismissed with prejudice;
2. That Plaintiffs' take nothing by way of the Complaint;
3. That the Court order such other and further relief for Defendant-Intervenors as the Court may deem appropriate.

Dated: January 15, 2025

Respectfully submitted,

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* *Pro hac vice motion forthcoming*