UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MASSACHUSETTS

STATE OF CALIFORNIA, COMMONWEALTH OF MASSACHUSETTS, STATE OF NEW JERSEY, STATE OF ARIZONA, STATE OF COLORADO, STATE OF CONNECTICUT, STATE OF DELAWARE, STATE OF ILLINOIS, STATE OF MAINE, STATE OF MARYLAND, PEOPLE OF THE STATE OF MICHIGAN, STATE OF MINNESOTA, STATE OF NEW MEXICO, STATE OF NEVADA, STATE OF NEW YORK, STATE OF OREGON, JOSH SHAPIRO, *in his official capacity as Governor of the Commonwealth of Pennsylvania*, STATE OF RHODE ISLAND, STATE OF VERMONT, STATE OF WASHINGTON, STATE OF WISCONSIN,

Plaintiffs,

v.

ROBERT F. KENNEDY, JR., *in his official capacity as Secretary of Health and Human Services*, MEHMET OZ, *in his official capacity as Administrator for the Centers for Medicare and Medicaid Services*, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, U.S. CENTERS FOR MEDICARE AND MEDICAID SERVICES,

Defendants.

No. 1:25-cv-12019

PLAINTIFF STATES' MEMORANDUM OF LAW IN SUPPORT OF THEIR MOTION FOR A PRELIMINARY INJUNCTION AND STAY

TABLE OF CONTENTS

TABLE OF AUTHORITIES

CASES

STATUTES

REGULATIONS

COURT RULES

OTHER AUTHORITIES

INTRODUCTION

Congress enacted the Patient Protection and Affordable Care Act (ACA) in 2010 to increase health insurance coverage and decrease the cost of healthcare. Fifteen years later, the ACA continues to meet its twin goals. Annual enrollment on the ACA marketplaces doubled over the past five years, resulting in over 24 million people—7 million in Plaintiff States alone—selecting a health insurance plan for 2025 on the ACA exchanges, ninety percent of whom receive subsidies to make coverage affordable.[1] Now, with less than four months until open enrollment for 2026 begins, the U.S. Department of Health and Human Services (HHS) and Centers for Medicare & Medicaid Services (CMS) have issued a Final Rule that will reverse that trend. The Rule makes comprehensive and, in several instances, unprecedented changes that will impose arbitrary and unlawful costs, increase paperwork burdens, and erode the value of insurance.

Defendants admit the Rule's new barriers to enrollment will end coverage for up to 1.8 million people, reduce States' revenue, impose substantial compliance costs, and drive up the costs Plaintiff States will incur backstopping healthcare for our uninsured residents. It imposes illegal junk charges, unlawfully allows denial of coverage in violation of the ACA's "guaranteed issue" requirement, and excludes as an essential health benefit any "sex-trait modification procedure,"[2] a novel and nebulous term that encompasses treatments across multiple mandated benefit categories. Moreover, the decision to modify EHBs in this manner did not consider state-by-state

[1] Centers for Medicare & Medicaid Services, Health Insurance Exchange 2025 Open Enrollment Report, pp. 5-6, 16, https://www.cms.gov/files/document/health-insurance-exchanges-2025-open-enrollment-report.pdf

[2] As in the accompanying Complaint, *see* Compl. at 3, n.2, Plaintiff States adopt the term "sex-trait modification" to refer to the ambiguous and arbitrary set of services HHS attempts to exclude as EHB. Where appropriate, Plaintiff States may employ different terminology that best reflects the context, including "gender-affirming care," "treatment for gender dysphoria," and "medically necessary care for gender and sexual minorities."

differences in typical employer plan coverage, as required by law.

The loss of enrollees will worsen the risk pool in health insurance markets and harm overall public health. These harms are not theoretical: they are already occurring and will accelerate if the Rule's provisions become operational on the Rule's effective date, August 25, 2025. In Defendants' view, these harsh measures are urgently necessary to combat fraud. But, as countless commenters pointed out during rulemaking, the evidence shows the Rule's most harmful provisions will do little, if anything, to address that concern. Nor did Defendants consider reasonable alternatives or significant downsides, including the profound impact on the millions who will lose coverage. What's more, several of the provisions go into effect for only one year. Defendants provided no notice of that possibility during rulemaking and have not reckoned with the doubling of compliance costs states and consumers will face as a result of the sunset provision.

These changes violate the Administrative Procedure Act (APA) and are contrary to law, arbitrary and capricious, and profoundly harmful to Plaintiff States. The States bring this suit to have the challenged provisions of this unlawful and unjustified HHS regulation stayed, or preliminarily enjoined, and ultimately vacated—protecting access to affordable healthcare for millions of our residents.

BACKGROUND

I. ACA HEALTH INSURANCE MARKETPLACES

The Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010) (as amended by Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029 (2010)) is a landmark law designed to "increase the number of Americans covered by health insurance and decrease the cost of health care." *Nat'l Fed'n of Indep. Bus. v. Sebelius*, 567 U.S. 519, 538 (2012). To achieve these goals, the ACA created health insurance markets, or exchanges, in each State, allowing people to compare and purchase insurance plans. 42 U.S.C.

§ 18031; *King v. Burwell*, 576 U.S. 473, 479 (2015). Congress authorized exchanges to be operated by either a State (state-based exchanges, or SBEs), or, if a State opted not to establish an exchange, by the federal government (federally facilitated exchanges, or FFEs). 42 U.S.C. § 18041(c).

The ACA's purpose is to protect consumers' access to health insurance. The "guaranteed issue" requirement forbids insurers' pre-ACA practice of denying coverage to those with preexisting conditions, and the "guaranteed renewability" requirement ensures people remain covered after getting sick. *See* 42 U.S.C. § 300gg-1(a) (guaranteed issue); *id.* § 300gg-2(a) (guaranteed renewability). Notably, renewability is not guaranteed to those who owe past-due premiums, *id.* § 300gg-2(b)(1), but the guaranteed issue provision contains no such exception, *see id.* § 300gg-1(b).

Several provisions of the ACA operate to ensure that the risk pool is broad, with as many healthy enrollees as possible. *See* 42 U.S.C. § 18091(2)(I) (a "risk pool [with] healthy individuals . . . will lower health insurance premiums"). To promote enrollment by people who could otherwise not afford coverage, Congress appropriated billions of dollars to fund advance premium tax credits (APTCs) that reduce monthly premiums for individuals with household incomes between 100% and 400% of the federal poverty level (FPL). 26 U.S.C. § 36B(b)(3).

To qualify for sale through the Exchanges, health plans must cover a list of ten "essential health benefits" for several categories of care that were previously excludable, such as maternity care, mental health treatment, or prescription drugs. The EHBs are minimum standards for these plans, but the States are free to add "additional benefits." 42 U.S.C. § 18031(d)(3)(B). Several key ACA financial protections—including provisions that cap annual out-of-pocket costs and prohibit annual or lifetime dollar limits on care—apply only to the coverage of EHBs. As a result, insurers can cap coverage, and consumers can face unlimited out-of-pocket costs, for non-EHB items and

services. These critical financial protections apply to most private health plans, including those in individual and small group markets as well as many employer-sponsored health plans.

II. THE FINAL RULE

For the stated purpose of combating fraud and improper enrollments, on March 19, 2025, HHS proposed a series of sweeping changes to ACA eligibility and enrollment. Patient Protection and Affordable Care Act; Marketplace Integrity and Affordability, 90 Fed. Reg. 12,942 (Mar. 19, 2025) (Proposed Rule). HHS proposed wide-ranging changes to both the federal exchange and the SBEs, which, according to HHS' own estimates, would cause "750,000 to 2,000,000 individuals to lose coverage." Proposed Rule at 13,025. In the 23-day period after publication during which HHS allowed public comment, 26,396 individuals and organizations submitted feedback. Several commenters, including many of the undersigned States,[3] pointed out that the Proposed Rule did little to strike at the root of the problem of fraudulent enrollments—which occur primarily on the federal government's own healthcare platform, healthcare.gov, not on the SBEs.

HHS published its Final Rule just over three months later. *See* Patient Protection and Affordable Care Act; Marketplace Integrity & Affordability, 90 Fed. Reg. 27,074 (June 25, 2025) (Final Rule).[4] For the most part, HHS pressed forward with its original proposal. The Final Rule makes substantial changes to the rules governing ACA exchanges—many of which go into effect almost immediately. These changes place new hurdles in front of individuals who need health insurance. *See* Rule at 27,200 (HHS acknowledging that just one of the fifteen changes will cause nearly half a million people to lose subsidies). These changes narrow opportunities for enrollment,

[3] *See* State of California, Commonwealth of Massachusetts, State of New Jersey, et al., Comment Letter on Proposed Rule (Apr. 11, 2025), at 35, available at https://www.regulations.gov/comment/CMS-2025-0020-23836 (attachments) (California et al. Comment Letter).

[4] Citations to the Final Rule will take the form "Rule at ____."

hamper access to affordable plans, and impose new bureaucratic barriers, such as new eligibility verification requirements for FFEs before individuals experiencing events such as a job loss, move, or birth of a child can obtain coverage or change plans. Rule at 27,148. New barriers to coverage also include refusing to accept individuals' self-attestation of projected household income, which the Final Rule predicts will cause 488,000 people to lose subsidies. Rule at 27,200. Still other changes permit insurers to deny coverage to individuals with past-due premiums, including for previous policies, Rule at 27,084, in violation of the ACA's "guaranteed issue" requirement, 42 U.S.C. § 300gg-1(a). And the Final Rule makes methodological changes to the APTC calculation formula, Rule at 27,102 (a formula set by statute, 26 U.S.C. § 36B(b)); premium adjustments, Rule at 27,166; and actuarial value ranges for health plans, Rule at 27,174, which diminish the value of health coverage and make it less affordable. It also bars "sex-trait modification procedures" from being covered as an EHB. Rule at 27,154. Many of these changes, which are outlined in more detail below, will begin to become effective on August 25, 2025.

LEGAL STANDARD

The APA permits courts to stay "agency action" to "prevent irreparable injury" and "may issue all necessary and appropriate process to . . . preserve status or rights pending conclusion of the review proceedings." 5 U.S.C. § 705. "When assessing a request for a preliminary injunction, a district court must consider '(1) the movant's likelihood of success on the merits; (2) the likelihood of the movant suffering irreparable harm; (3) the balance of equities; and (4) whether granting the injunction is in the public interest.'" *Norris ex rel. A.M. v. Cape Elizabeth Sch. Dist.*, 969 F.3d 12, 22 (1st Cir. 2020) (quoting *Shurtleff v. City of Bos.*, 928 F.3d 166, 171 (1st Cir. 2019)). "[T]he same standard governs both forms of relief." *Mass. Fair Hous. Ctr. v. U.S. Dep't of Hous. and Urb. Dev.*, 496 F.Supp.3d 600, 609 (D. Mass. 2020). All four factors support Plaintiff

States.

ARGUMENT

I. PLAINTIFF STATES ARE LIKELY TO SUCCEED ON THE MERITS.

A. HHS's 23-Day Period for Notice and Comment Was Legally Insufficient.

By allowing only twenty-three days of public comment on a Rule that made substantial changes to complex regulatory policies and abruptly reversed prior agency decisions, HHS failed to provide a meaningful "opportunity to participate in the rulemaking through submission of written data, views, or arguments," as required by the APA. 5 U.S.C. § 553(b)-(c). Where, as here, a rule proposes substantial changes, a 30-day comment period is generally the shortest period sufficient for interested persons to meaningfully review and provide informed comment. *See Prometheus Radio Project v. FCC*, 652 F.3d 431, 453 (3d Cir. 2011) (holding 28-day comment period insufficient); *Azar v. Allina Health Servs*., 587 U.S. 566, 570 (2019) (referring to the "APA minimum of 30 days"). And even a 30-day period is atypical, and highly disfavored, especially for such substantial changes. *See Petry v. Block*, 737 F.2d 1193, 1202 (D.C. Cir. 1984) (observing that 30 days for comment "cut[s] the comment period to the bone" and 60 days is "a more reasonable *minimum* time for comment" for complex rules (quotation omitted)); *Nat'l Lifeline Ass'n v. FCC*, 921 F.3d 1102, 1117-18 (D.C. Cir. 2019) (citing *Petry*, 737 F.2d at 1201) ("When substantial rule changes are proposed, a 30-day comment period is generally the shortest time period sufficient for interested persons to meaningfully review a proposed rule and provide informed comment.").

Here, the Proposed Rule was published in the Federal Register on March 19, 2025, and comments were accepted through April 11, 2025. HHS therefore provided only 23 days to review a complicated, multifaceted rule spanning 90 pages in the Federal Register. As Plaintiff States explained to HHS when the rule was pending, the shortened comment period prejudiced Plaintiff States' ability to address certain highly technical matters; for example, SBEs could not perform a

complete analysis of the expected enrollment losses, premium impacts, and risk pool changes associated with this rule because of the truncated comment period.[5] As such, the 23-day comment period afforded by HHS is legally deficient, not only because it is less than the bare legal minimum of 30 days, *Petry*, 737 F.2d at 1202, but also because a rule of such complexity and magnitude, involving various technical issues under the ACA, requires a significantly longer comment period to ensure technical comments. *See* Parts I.B-C, *infra* (discussing substantive provisions of the Final Rule). Indeed, multiple recent prior rulemakings under the ACA typically afforded a comment period well over 30 days. *See, e.g.*, Extension of Comment Period for Rule Regarding ACA Interoperability, 84 Fed. Reg. 16,834 (Apr. 23, 2019) (extending existing comment period from 60 days to 90 days in response to public feedback); Patient Protection and Affordable Care Act; Increasing Consumer Choice Through the Sale of Individual Health Insurance Coverage Across State Lines Through Health Care Choice Compacts, 84 Fed. Reg. 8,657 (Mar. 11, 2019) (56-day comment period). As such, the Final Rule is procedurally invalid—a sufficient basis for the Final Rule to be stayed or enjoined (and ultimately vacated).[6]

[5] *E.g.*, California Department of Managed Health Care, Comment Letter on Proposed Rule (Apr. 11, 2025), at 1-2, available at https://www.regulations.gov/comment/CMS-2025-0020-23127 (attachments); Washington Health Benefit Exchange, Comment Letter on Proposed Rule (Apr. 11, 2025), at 2-3, available at https://www.regulations.gov/comment/CMS-2025-0020-24557 (attachments) (Washington HBE Comment Letter).

[6] Nor does the Final Rule include a finding of "good cause" justifying such a truncated comment period, as required by 5 U.S.C. § 553(b)(B). A rule with a comment period of less than 30 days is "generally characterized by the presence of exigent circumstances in which agency action was required in a mere matter of days." *N.C. Growers' Ass'n, Inc. v. United Farm Workers*, 702 F.3d 755, 770 (4th Cir. 2012). The Final Rule makes no such showing, instead arguing that the Proposed Rule was "displayed for public inspection" for 30 days. Rule at 27,180. But only official publication in the Federal Register is sufficient to provide legal notice of a proposed rule to the public. *See* 44 U.S.C. § 1507 (documents are "not valid" until "filed" and "made available for public inspection as provided by section 1503," which describes the publication process).

Finally, even if HHS had allowed for a legally sufficient comment period, the notice-and-comment process was still inadequate because the agency failed to notify the public that many of the Final Rule's most burdensome provisions could be adopted for 2026 only. Had HHS disclosed this possibility in the Proposed Rule, commenters could have pointed out the fundamental illogic of the agency's approach. CMS's failure to make this disclosure renders the notice-and-comment process inadequate. *See Chocolate Mfrs. Ass'n of U.S. v. Block*, 755 F.2d 1098, 1105 (4th Cir. 1985) (reversing denial of vacatur where rulemaking provided no notice of the action taken).

B. The Final Rule's Marketplace Integrity Changes Are Unlawful.

Agency actions are arbitrary and capricious if they are not "reasonable and reasonably explained." *FCC v. Prometheus Radio Project*, 592 U.S. 414, 423 (2021). An explanation is only reasonable if it is consistent with the evidence before the agency, and the agency must additionally provide "a satisfactory explanation for its action" and demonstrate "a rational connection between the facts found and the choice made." *Motor Vehicle Mfrs. Ass'n of U.S. v. State Farm Mut. Auto. Ins. Co.* (*State Farm*), 463 U.S. 29, 43 (1983) (quoting *Burlington Truck Lines v. U.S.*, 371 U.S. 156, 168 (1962)). The Court may vacate an agency action where "[s]everal points, considered together, reveal a significant mismatch between the decision . . . made and the rationale [] provided," even where "no particular step in the process stands out as inappropriate or defective." *Dep't of Com. v. New York*, 588 U.S. 752, 783 (2019).

The challenged provisions of the Final Rule do little to accomplish HHS's stated goal of combating "fraudulent and improper enrollments at scale." Rule at 27,074. As its primary evidence of such fraud, HHS points to a report finding potential indicia of improper enrollment that occurs at "far higher" rates in non-Medicaid expansion states—in particular "nine States where erroneous and improper enrollment is most noticeable (that is, Alabama, Florida, Georgia, Mississippi, North Carolina, South Carolina, Tennessee, Texas, and Utah)"—and that is "highly concentrated in

Exchanges on the Federal platform." Rule at 27,106, 27,122, 27,213. Notwithstanding this limited evidence and while acknowledging that SBEs do not have the same levels of fraudulent activity, Rule at 27,108, the Final Rule implements sweeping changes that directly impact Plaintiff States, all of which have expanded Medicaid (with one exception), none of which are among the nine States supposedly experiencing significant problems with improper enrollment, and most of which operate through SBEs. Further, HHS acknowledges that the expiration of enhanced premium tax credits at the end of 2025 "will substantially mitigate the threat of future improper enrollments," Rule at 27,075, but goes on to impose these sweeping changes in 2026 anyway—with no explanation.

Without any rational basis grounded in fraud prevention, let alone the actual fraud concern HHS has identified, the challenged provisions of the Final Rule amount to little more than unjustified administrative barriers to coverage that will swiftly throw millions of people off of the health insurance exchanges, impose substantial new administrative barriers, wrongfully deny coverage to eligible consumers, increase costs for all enrollees, and decrease the quality and availability of coverage. All of the challenged provisions are arbitrary and capricious, and many are contrary to law too.

Mandating a $5 minimum premium for auto-reenrollments is unlawful and arbitrary.[7] The Rule mandates that insurance exchanges must charge $5 monthly premiums to re-enrollees who are by law entitled to pay $0 until those enrollees confirm their re-enrollment. Rule at 27,102. This provision contravenes the plain text of the ACA and is not justified.

[7] This provision of the Final Rule applies to States utilizing the Federal Exchange; among Plaintiff States, those states are Arizona, Delaware, Michigan, Oregon, and Wisconsin.

The ACA sets forth the method for calculating the amount of APTC that an enrollee receives using a formula that considers household size, household income as a percentage of the FPL, the rate of inflation, and the "second lowest cost silver plan" available to the applicant in the applicant's geographic area. 26 U.S.C. § 36B(b). It further requires that APTC amounts "shall" be paid as directed by 26 U.S.C. § 36B. 42 U.S.C. § 18082(c)(2)(A). The use of "shall" indicates that the amount calculated under 26 U.S.C. § 36B is not discretionary. Yet the Rule commands a reduction in the amount of APTC credited to enrollees by $5, without lawful authority to do so.

HHS did not meaningfully respond to commenters who pointed out the illegality of this provision, offering only its unsupported "belie[f]" that the ACA allows the Secretary to "establish procedures" for redetermining "eligibility on a periodic basis in appropriate circumstances." Rule at 27,109; *See Mass. v. NIH*, 770 F. Supp. 3d 227, 306 (D. Mass. 2025) ("conclusory statements" do not satisfy the APA).

In addition to being unlawful, this provision of the Final Rule is arbitrary and capricious. HHS has provided no evidence to support its claim that the $5 charge would reduce improper enrollments, and no justification for choosing $5 as the amount automatic re-enrollees should owe. Nor does the Final Rule address the risk of substantial consumer confusion and harm—including the potential for disenrollment or of consumers being locked out of coverage for the remainder of the year—that is likely to result from the federal exchange imposing $5 charges on people who are by law entitled to pay $0 premiums.[8] *See* Rule at 27,103 (acknowledging but not addressing the possibility of "consumer confusion").

[8] Covered California, Comment Letter on Proposed Rule (Apr. 11, 2025), at 7, available at https://www.regulations.gov/comment/CMS-2025-0020-25629 (attachments) ($5 charge "complicates a previously clear procedure, risking lower enrollment, market destabilization, decreased long-term affordability and added administrative hurdles.").

Requiring 75% verification for triggering-event SEPs is arbitrary.[9] Consumers and small businesses seeking health coverage typically sign up during annual open enrollment periods (OEPs). But consumers who experience certain life events may be eligible for special enrollment periods (SEPs)—including events such as the loss of minimum coverage, the loss of a job, a move to a new area, or the birth of a child. The Final Rule now requires the federal platform to verify 75% of SEPs for all triggering events before a consumer's new coverage can take effect. Compl. ¶¶ 105-109.

That change is arbitrary and capricious. The Final Rule claims this requirement protects the risk pool by deterring adverse selection, Rule at 27,148, but the evidence before the agency shows the reverse: verification "may deter healthier, less motivated individuals from enrolling," Rule at 27,148. HHS estimates this change will generate 293,073 SEP verification issues that consumers will need to rectify before enrolling in coverage. Rule at 27,186. Those motivated to overcome that barrier will be those who are older and sicker—meaning younger, healthier enrollees are likely to be discouraged from maintaining coverage because of this change, harming the risk pool, a downside Defendants readily acknowledge. Rule at 27,148. Their own data, presented during rulemaking, showed that many enrollees struggle to submit documents and verify their eligibility. Compl. ¶ 115 (citing Proposed Rule at 12,983).

Moreover, HHS offers no data showing that SEP enrollees are more expensive to insure compared to non-SEP enrollees, meaning there is no justification for this change. In fact, during rulemaking, several commenters provided data showing that the aggregate risk score for SEP enrollees was the same as, or lower than, that of non-SEP enrollees. Compl. ¶ 105 (citing Covered

[9] This provision of the Final Rule applies to States utilizing the Federal Exchange; among Plaintiff States, those states are Arizona, Delaware, Michigan, Oregon, and Wisconsin.

California Comment Letter and Washington HBE Comment Letter). And Defendants sunset this provision after just one year, undermining their assertion that it is necessary to prevent adverse selection. Rule at 27,151.

Ending acceptance of self-attested projected household income is arbitrary. The Final Rule makes two arbitrary changes pertaining to income verification. First, it forbids the self-attestation of an enrollee who claims eligibility for APTC by projecting annual household income at or above 100% of the FPL if existing tax data shows a lower income. In such cases, a "data matching issue" (DMI) will be generated (the "contradictory-data DMI"). Rule at 27,121. Second, whenever there is no IRS data available, a DMI will be generated if other trusted data sources cannot corroborate the consumer's income (the "missing-data DMI"). *Id*. In either case, consumers must submit additional paperwork before they may obtain health insurance. *Id*.

HHS's rationale for these changes is to crack down on enrollees wrongly claiming APTC eligibility. *Id.* at 27,126. But nearly every Plaintiff State has expanded Medicaid, meaning adults with incomes up to 138% FPL qualify—so there is no incentive to inflate incomes. *See* Compl. ¶¶ 132-34. Rather than tailoring these new verification requirements to only those States that have not expanded Medicaid, HHS imposes these requirements on all States, effective immediately.

These changes will impose enormous financial and administrative burdens on SBEs and on low-income consumers. They will generate an estimated 2.7 million new DMIs—meaning that nearly 3 million people will need to track down and submit additional paperwork to purchase health insurance. Moreover, the vast majority of these DMIs—2.1 million—will be generated

because of *missing* IRS data (not contradictory IRS data), which may be no fault of the consumer.[10]

HHS estimates that implementing the contradictory-data DMI will cause the SBEs to spend $12.4 million to receive, review, and verify documents and to conduct outreach and communication with consumers, on top of another $14.7 million in one-time system update costs. Rule at 27,199. But thanks to the sunset provision, HHS projects that Exchanges will have to spend *another* $14.7 million to undo this change. *Id*. As for consumers, the Final Rule further acknowledges that this DMI will cost them over $13 million, and 81,000 will lose access to APTC (50,000 on the FFE and 31,000 on the SBEs). *Id*.

The Rule estimates that the missing-data DMI will cost the SBEs $62.8 million in verification costs on top of $16.6 million in one-time system update costs. *Id.* at 27,200. Again, SBEs would incur another $16.6 million cost to undo the change at the end of 2026. *Id*. HHS estimates that this DMI will revoke APTC from 252,000 enrollees on the FFE and 155,000 enrollees on the SBEs. *Id*. In total, HHS projects that 488,000 people may lose APTC on account of these new requirements. But HHS's justifications for imposing these acknowledged harms are meritless, rendering these changes arbitrary and capricious.

First, the Final Rule "acknowledge[s] that income verification can be more challenging for lower-income tax filers due to less consistent employment," *id*., which is consistent with the evidence before the agency.[11] Despite this evidence, the Final Rule states only that "the [income verification] process does not impose a substantial burden," *id*., but that evidence-free conclusion

[10]Jason Levitis et al., Comment Letter on Proposed Rule (Apr. 11, 2025), at 20, available at https://www.regulations.gov/comment/CMS-2025-0020-25047 (attachments) (Levitis et al. Comment Letter).

[11] *Id*. at 19.

"runs counter to the evidence before the agency," *State Farm*, 463 U.S. at 43, and contradicts HHS's own conclusion that consumers and exchanges will spend hundreds of millions of dollars and hundreds of thousands of hours trying to meet these new requirements, and that almost half a million people will fail to do so. Rule at 27,199.

Second, the Final Rule claims that enough consumers "are intentionally inflating their incomes" to justify these new burdens, *id*. at 27,121, but the limited evidence cited justifies, at most, a far narrower policy change. The Government Accountability Office (GAO) recommended that HHS verify household incomes only "when attested income amounts significantly exceed income amounts reported by IRS or other third-party sources." Proposed Rule at 12,964. That recommendation at most justifies only the first DMI—based on an actual *contradiction* between self-reported income and IRS-reported income. It would not justify the missing-data DMI (which would generate more than 75% of new DMIs under this policy change). Moreover, the GAO report shows that HHS' action is grossly disproportionate to the problem it purports to solve. Every instance that the GAO identified of a mismatch between self-reported income and IRS data occurred "for individuals residing in States that did not expand Medicaid." *Id*. Again, none are Plaintiffs here (save Wisconsin), and there is no incentive to inflate incomes for APTC purposes in those States. In addition, many Medicaid-expansion States have mechanisms to ensure that Medicaid-eligible clients do not receive APTC. Defendants fail to consider an "obvious alternative"—imposing these two verification requirements only in non-expansion States—so this change is "arbitrary or capricious." *California v. EPA*, 72 F.4th 308, 317 (D.C. Cir. 2023) (citing *State Farm*, 463 U.S. at 43) (failure to rationally connect evidence to agency action is arbitrary).

Transitioning to a one-year FTR eligibility window is arbitrary. The ACA awards APTCs to enrollees based on their projected future income. 26 U.S.C. § 36B; 42 U.S.C. § 18082.

When the enrollee files income taxes with the Internal Revenue Service the following year, the amount of the APTC award that was claimed is reconciled against eligibility as shown by the tax data. Importantly, HHS does not have access to such data—only the IRS does. *See* Rule at 27,116 ("privacy concerns" prevent HHS from knowing whether an individual has failed to file and reconcile). Under existing law, an enrollee who fails to file taxes and reconcile their claimed award against their actual eligibility—known as failure to file and reconcile, or FTR—for two consecutive years loses eligibility for future APTCs. The Rule temporarily ends this policy, imposing a one-year FTR window.[12]

Reverting to a one-year FTR grace period rather than a two-year grace period is unlikely to accomplish HHS' stated goal of reducing fraud on the Exchanges, as demonstrated by the fact that many more people receive one-year FTR codes than two-year FTR codes.[13] HHS acknowledges that the availability of enhanced APTCs drove fraudulent enrollment in the first place, and further acknowledges that the eAPTCs are expiring at the end of *2025*—yet imposes this change for 2026 anyway, before reverting to a two-year window once again for 2027. Rule at 27,091-103.

Not only is this change ineffective, it is also harmful. A one-year FTR window risks eligible individuals losing access to APTCs due to administrative error or paperwork delays. HHS acknowledged during rulemaking that the FTR eligibility check needed to be suspended during

[12] Underscoring the absurdity, the recently enacted budget reconciliation bill then *re-imposes* this sunsetted FTR provision for plan years 2028 and beyond. *See* One Big Beautiful Bill Act, Pub. L. 119-21 §§ 71303(a)-(c), 139 Stat. 72, 324 (July 4, 2025) (implementing this provision of the Rule with an effective date of January 1, 2028). Thus, over the next few years, Exchanges must change to a one-year FTR window for 2026 (due to the Rule), revert to a two-year window for 2027 (due to the Rule's sunset provision), and then change *again* to a one-year window for 2028 (due to the legislation).

[13] California et al. Comment Letter, *supra* note 3, at 9.

the Covid-19 emergency "due to concerns that consumers who had filed and reconciled would lose APTC due to IRS processing delays resulting from IRS processing facility closures and a corresponding backlog of paper filings." Proposed Rule at 12,958. Far from theoretical, HHS acknowledged that the IRS backlog during the pandemic "severely impacted the IRS's ability to process tax returns for the 2019, 2020, and 2021 tax years." Rule at 27,114. That concern is especially relevant today, when the Administration may be planning to cut the IRS in half.[14] Plaintiff States pointed this out during rulemaking,[15] and HHS did not specifically respond to the concern regarding the looming cuts to IRS staffing.

Moreover, the compliance costs of this change are significant. HHS estimates one-time costs of $19.4 million borne by the SBEs to update their systems, and then another $19.4 million to revert to the two-year window that will once again be in effect for 2027. Additionally, some states, like Washington, will struggle severely to create a new one-year FTR window from scratch in a matter of months.[16] HHS is unmoved. Remarkably, HHS seems not to care that the "majority of State Exchanges expressed in comments that they *could not make the technological changes* to revert back to a 1-year FTR policy in time for OEP 2026," requiring "all Exchanges" to "impose a 1-year FTR requirement beginning for PY 2026" regardless of the Exchanges' warnings that compliance on this timeline is impossible. Rule at 27,199 (emphasis added).

HHS's changes to the premium adjustment percentage methodology are arbitrary. The Final Rule changes the premium adjustment methodology—beginning in plan year 2026—to

[14] Fatima Hussein, The IRS is drafting plans to cut as much as half of its 90,000-person workforce, AP sources say, Associated Press (Mar. 4, 2025), https://apnews.com/article/irs-doge-layoffs-tax-season-0659e4b439400bf66023273f6a532fa0 (last accessed July 16, 2025).

[15] California et al. Comment Letter, *supra* note 3, at 9.

[16] Urley Declaration (Exhibit 24), ¶¶ 24-25.

include consideration of premium changes in the individual market (in addition to premium changes in the employer market). *Id*. at 27,166-73. Including the more price-volatile individual market premiums in the measure of inflation significantly increases out-of-pocket premiums for consumers receiving APTCs. *Id*. at 27,168. As a result, the consumer's share of premiums for the APTC benchmark silver plan in 2026 will be about 4.5% higher than it would have been under the prior methodology. *Id*. This translates to an additional $313 in premiums for a family of four making $85,000.[17] These increases will cause enrollment to decline, shrinking the risk pool and likely increasing premiums further for the less-healthy enrollees who remain. *Id*. These changes to the premium adjustment percentage methodology are arbitrary and capricious for three reasons.

First, HHS improperly factored in individual market premiums from 2013. Rule at 27,166-73. Unlike group market premiums, individual market premiums were highly volatile just before the ACA went into effect in 2013, and as such, are statistical outliers that do not represent underlying trends in health coverage costs, which the premium adjustment measures.[18] Commenters noted that considering these highly volatile, pre-ACA individual market premiums artificially inflates premium growth over time. *See* Compl. ¶¶ 150-55 (discussing comments). Group market premiums, by contrast, are more stable and accurate metrics of healthcare spending trends. *Id*. That is why HHS previously considered only group market premiums when calculating the annual premium adjustment percentage. *See* Patient Protection and Affordable Care Act; HHS

[17] Gideon Lukens and Elizabeth Zhang, Proposed AZA Marketplace Rule Would Raise Health Care Costs for Millions of Families, Center on Budget and Policy Priorities (Apr. 1, 2025), https://www.cbpp.org/research/health/proposed-aca-marketplace-rule-would-raise-health-care-costs-for-millions-of (last accessed July 16, 2025).

[18] *See* Levitis et al. Comment Letter, *supra* note 10, at 3 ("Individual market premiums experienced a discrete period of volatility. . . ."); *see also* 42 U.S.C. § 18022(c)(4) (setting comparator year).

Notice of Benefit and Payment Parameters for 2015, 79 Fed. Reg. 13,744, 13,801-04 (Mar. 11, 2014) (explaining the decision to exclude individual-market premiums from the calculation).

Second, the changes to the premium adjustment percentage methodology squarely undermine Congress' twin goals of expanding access to healthcare and making it more affordable. *See Sebelius*, 567 U.S. at 538 (Congress enacted the ACA to "increase the number of Americans covered by health insurance and decrease the cost of health care."). Although this change knowingly reduces enrollment and sharply increases premiums and cost-sharing, HHS claims—remarkably—that "making coverage more accessible and affordable" is an improper "policy objective[]." Proposed Rule at 12,990. But HHS "is not free to substitute new goals in place of the statutory objectives" set by Congress without "link[ing]" those goals with the law's stated objectives. *Indep. U.S. Tanker Owners Comm. v. Dole*, 809 F.2d 847, 854 (D.C. Cir. 1987).

Third, HHS failed to "be cognizant that longstanding policies may have 'engendered serious reliance interests that must be taken into account.'" *DHS v. Regents of Univ. of Cal.*, 591 U.S. 1, 30 (2020) (quoting *Encino Motorcars, LLC v. Navarro*, 579 U.S. 211, 222 (2016)). The 24 million healthcare consumers who obtained health coverage through the exchanges this year rely on HHS to keep healthcare premiums and out-of-pocket costs from rising too quickly. This change disregards those reliance interests by imposing huge increases in premiums and cost-sharing limits.

Expanding the acceptable actuarial value ranges for health plans is arbitrary. The Final Rule widens the accepted ranges for the actuarial value (AV) of health plans, expanding the de minimis AV range for expanded bronze plans to +5/-4 percentage points and +2/-4 percentage points for standard bronze, silver, gold, and platinum. Rule at 27,175-76. Prior to the Final Rule, HHS set narrower AV ranges of +2/-2 or +2/-0 for most plans to balance transparency and affordability for consumers against flexibility for issuers. Patient Protection and Affordable Care

Act; HHS Notice of Benefit and Payment Parameters for 2023, 87 Fed. Reg. 27,208, 27,306 (May 6, 2022). By allowing less-generous plans within each metal tier, the Final Rule's expanded AV ranges undermine consumer choice, by decreasing the differences between metal tiers, and reduce affordability, by increasing out-of-pocket costs and net premiums. As a result, these expanded *de minimis* ranges will lead to higher out-of-pocket costs and less comprehensive coverage for most individuals enrolled on the exchanges. This change is arbitrary and capricious for two reasons.

First, HHS' primary justifications are conclusory and contradict the evidence before the agency. HHS claimed that the prior ranges "substantially reduce[d] issuer flexibility" and that issuers "voiced concern about their ability to continue to participate in the market generally." Rule at 27,175. But the Final Rule offers no empirical support for these assertions, and by contrast, a commenter pointed to increased issuer participation since the prior *de minimis* ranges were put into place. *See* Compl. ¶ 169 (discussing Levitis et al. Comment Letter showing an increased number of participating issuers and the expansion of service areas by existing issuers). HHS also asserts that the changes will improve the risk pool by promoting unsubsidized (and healthier) enrollee participation through lowered premiums, Rule at 27,175, but as commenters noted, lower premiums come at the expense of less-generous coverage. *See* Compl. ¶ 170. The Final Rule does not explain why less-generous plans with lower premiums will attract unsubsidized consumers, given that lower metal tier plans *already* offer these choices. HHS's justifications lack support and "run[] counter to the evidence before the agency." *State Farm,* 463 U.S. at 43.

Second, the Final Rule fails to consider that wider AV ranges may in fact increase gross premiums for unsubsidized enrollees as well, reducing unsubsidized enrollment and harming risk pools. The Final Rule acknowledges that wider AV ranges will decrease APTCs by $1.22 billion in 2026 (and more in each subsequent year) by allowing the APTC benchmark plan to undershoot

the 70% AV requirement by an additional 4 percentage points. Rule at 27,208. Because decreased APTCs lead to higher net premiums for subsidized enrollees, commenters pointed out these ranges will likely harm risk pools as healthier individuals are more likely to drop coverage, leading to an increase in gross premiums for unsubsidized enrollees as well. *See* Compl. ¶ 171 (discussing comments). HHS accepted commenters' prediction of "an initial weakening of the risk pool," caused by healthier subsidized enrollees "drop[ping] coverage when net premiums rise," Rule at 27,177, yet failed to account for the likely increase in unsubsidized enrollees' gross premiums as a result. *Id*. As such, the Final Rule arbitrarily overlooked "an important aspect of the problem," *Ohio v. EPA*, 603 U.S. 279, 294 (2024).

Allowing plans to deny coverage to those who owe past-due premiums from previous policies is unlawful and arbitrary. Enrollees who do not pay their premiums typically fall into a grace period of between one and three months, during which coverage is still available if the enrollee brings their account current. Premiums remain due during the grace period even if the consumer makes no claim and the insurer thus incurs no cost. Failure to pay outstanding premiums by the end of the grace period can result in termination of coverage. Insurers can take steps to recoup any past-due premiums, such as placing the debt into collections. But insurers may not deny coverage to new enrollees who owe past-due premiums from prior coverage, so long as the enrollee pays the new premium. This longstanding policy is commanded by the ACA's "guaranteed issue" provision, which requires that participating insurers "must accept every employer and individual in the State that applies for such coverage." 42 U.S.C. § 300gg-1(a).

HHS tries to supplant that statutory command with rulemaking, allowing insurers to deny coverage to enrollees with past-due premiums from prior coverage. This is contrary to law. The statute requires insurers to cover "every" eligible individual. *Id.* Notably, the guaranteed-

renewability provision does allow nonrenewal for past-due premiums, *see id.* § 300gg-2(b)(1); the absence of that exception from the guaranteed-issue provision makes Congress's intent clear. HHS is not free to rewrite statutes that do not align with its policy preferences.

Moreover, despite HHS's assertions that the point of this policy is to help consumers avoid "premium debt," Rule at 27,089, the Rule does not even require insurers to notify consumers of the reason for their denial—meaning a person who is denied coverage on this basis might not know *why* she was denied coverage or that the debt even exists. Nor is this change necessary: HHS found during previous rulemaking that existing debt-collection practices are sufficient to protect insurers. Patient Protection and Affordable Care Act; Health Insurance Market Rules; Rate Review, 78 Fed. Reg. 13,406, 13,416-17 (Feb. 27, 2013). The Rule's only explanation for the change in position is that HHS now believes "other forms of debt collection, such as placing the debt into collections, can be costly and time-consuming." Rule at 27,089. But surely debt-collection was just as costly and time-consuming in 2013 as in 2025.

HHS arbitrarily failed to consider reasonable alternatives. Only one of HHS's changes to the ACA rules—making it easier to remove brokers for cause—effectively addresses the issue of fraudulent broker enrollments. Plaintiff States supported,[19] and continue to support, that proposal. But it is not enough. If HHS had been serious about combating fraud, it would have seriously considered adopting the several changes Plaintiff States proposed during the comment period, such as multi-factor authentication.[20] Defendants' only response is that they "are continuing to explore additional operational solutions to further curb improper enrollments,

[19] California et al. Comment Letter, *supra* note 3, at 15.

[20] *Id.* at 16; *see also* Justin Giovannelli & Stacey Pogue, Policymakers Can Protect Against Fraud in the ACA Marketplaces Without Hiking Premiums, The Commonwealth Fund (Mar. 5, 2025), https://www.commonwealthfund.org/blog/2025/policymakers-can-protect-against-fraud-aca-marketplaces-without-hiking-premiums (last accessed July 16, 2025).

including two-factor verification." Rule at 27,147. Nowhere do Defendants acknowledge Plaintiff States' suggested solutions that would have effectively blocked improper enrollments by unscrupulous brokers without burdening innocent consumers. The Rule is arbitrary and capricious due to its failure to consider these "obvious alternative[s]." *California*, 72 F.4th at 317.

C. The Final Rule's Elimination Of "Sex-Trait Modification" As An Essential Health Benefit Is Unlawful.

1. The Final Rule Is Contrary to Law

The HHS Secretary must ensure that the scope of EHBs "is equal to the scope of benefits provided under a typical employer plan." 42 U.S.C. § 18022(b)(2)(A). To determine typicality, the ACA requires the Labor Secretary to conduct a survey of employer-sponsored coverage "to determine the benefits typically covered by employers." *Id*. This approach is well settled. In December 2011, in anticipation of the ACA's EHB provisions becoming effective in 2014, HHS determined for the first time what benefits are typically covered by employers by considering the Department of Labor (DOL) survey,[21] recommendations from the Institute of Medicine (IOM), plus public input, before issuing agency guidance.[22] Despite this well-established practice, HHS failed to conduct such a study before drafting the Final Rule that changed the scope of EHBs, violating its statutory mandate.

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[21] The Department of Labor released that survey of employer-sponsored plans, which included those of large and small employers, on April 15, 2011. *See* Selected Medical Benefits: A Report from the Department of Labor to the Department of Health and Human Services, Department of Labor (Apr. 15, 2011), https://www.bls.gov/ebs/additional-resources/selected-medical-benefits-a-report-from-dol-to-hhs.pdf (DOL Report). The survey used 2008 and 2009 National Compensation Survey data. Essential Health Benefits Bulletin, Centers for Medicare & Medicaid Services: Center for Consumer Information and Insurance Oversight, 2 (Dec. 16, 2011), https://www.cms.gov/cciio/resources/files/downloads/essential_health_benefits_bulletin. (2011 CMS Bulletin). This 2011 Department of Labor survey was the first and last completed in accordance with 42 U.S.C. §18022(b)(2).

[22] *See* 2011 CMS Bulletin.

Moreover, the ACA mandates that in "revising [EHB] the Secretary shall submit a report to the appropriate committees of Congress," presumably premised on renewed reports by DOL based on "a survey of employer-sponsored coverage." 42 U.S.C. § 18022(a)(2). Because this procedure is mandated by statute and is a well-established process, the failure of HHS to conduct a new DOL report and submit a report to Congress is contrary to law. *Perales v. Sullivan*, 948 F.2d 1348, 1354 (2d Cir. 1991); *see also New Mexico Farm & Livestock Bureau v. U.S. Dep't of Interior*, 952 F.3d 1216, 1231 (10th Cir. 2020) (holding that agency's failure to follow own regulations or offer reasoned explanation for its failure to do so is arbitrary and capricious). While CMS adhered to this rigorous and evidence-based process in first promulgating the benchmark plan process, it failed to do so in excluding "sex-trait modification" as EHB. The consideration of new DOL reports is not only statutorily required but also would provide a more accurate snapshot of the increasing coverage for services falling within the umbrella of gender-affirming care than the limited data upon which the Rule currently relies.

2. HHS's Exclusion of "Sex-Trait Modification Procedures" is Arbitrary and Capricious

The Final Rule's exclusion of any "sex-trait modification procedure" from EHBs and its finding that such care "is not typically included in employer-sponsored plans," Rule at 27,152, are also arbitrary and capricious. *First*, HHS diverges without good reason, *see FCC v. Fox*, 556 U.S. 502, 515 (2009), from its settled policy of determining on a flexible state-by-state basis what benefits are provided under a "typical" employer plan. And HHS does so without even considering and addressing the significant reliance interests of states. *See Regents of the Univ. of Cal.*, 591 U.S. at 33. *Second*, even taken on its own terms, HHS's explanation of what benefits are covered under a "typical" employer plan inexplicably "runs counter to the evidence before the agency."

State Farm, 463 U.S. at 43. *Third*, HHS departed from its past practice and statutorily required procedures in redefining EHBs, relying instead on a limited data set.

The Final Rule bars any "sex-trait modification procedure" from being treated as an EHB, defining the term as "any pharmaceutical or surgical intervention that is provided for the purpose of attempting to align an individual's physical appearance or body with an asserted identity that differs from the individual's sex either by: (1) intentionally disrupting or suppressing the normal development of natural biological functions, including primary or secondary sex-based traits; or (2) intentionally altering an individual's physical appearance or body, including amputating, minimizing or destroying primary or secondary sex-based traits such as the sexual and reproductive organs." Rule at 27,154.[23]

In excluding this care from EHBs, the Final Rule arbitrarily diverges from the longstanding approach of determining a "typical" employer plan on a state-by-state basis, instead dictating to all States a brand-new exclusion with little to no explanation for the change. Considering the established state-by-state approach to EHBs, the "typical" employer plan in Plaintiff States provides coverage for medically necessary treatment of gender dysphoria, services likely falling within the definition of "sex-trait modification".[24] The process by which each state fills in the

[23] The Final Rule adopts a novel definition of "sex-trait modification procedure," a term that does not exist in medicine or law and that HHS did not include in the Proposed Rule. HHS thus deprived Plaintiff States and other commenters, such as medical professionals and insurers, of the opportunity to comment on a definition that HHS did not propose during this rulemaking process *and* that has never before been used or defined by the federal government. By adopting an entirely new term and associated definition in the Final Rule, HHS "substantially depart[ed] from the terms or substance of the proposed rule," rendering the notice-and-comment process "inadequate." *Chocolate Mfrs. Ass'n*, 755 F.2d at 1105.

[24] Small Business Health Option Plans (SHOP) are one of the types of plans pointed to by HHS as "typical." Rule at 27,155. However, SHOP plans are fully insured, which means that they cover services treating gender dysphoria under anti-discrimination laws. Notably, the Final Rule does not even evaluate SHOP plans; rather, it uses enrollment and claims data from a variety of plans to make an assertion about SHOP plans specifically.

details of the ten statutory EHB categories has always been in the form of a benchmark plan "reflecting both the scope of services and any limits offered by a 'typical employer plan' *in that State* as required by section 1302(b)(2)(A) of the [ACA]."[25] The 2011 CMS Bulletin announced the agency's commitment to "State flexibility" and clarified that assessing the contents of a "typical employer plan" is a state-specific inquiry.[26] Consequently, HHS confirmed in its 2013 rule on EHBs that "typical employer plans differ by state." Patient Protection and Affordable Care Act; Standards Related to EHBs, Actuarial Value, and Accreditation, 78 Fed. Reg. 12,834, 12,843 (Feb. 25, 2013) (emphasis added).

The Final Rule effects this drastic change while failing to consider or address the significant reliance interests of States. *See Regents of the Univ. of Cal.*, 591 U.S. at 33. As contemplated by the ACA and HHS's regulations, states have selected their EHB benchmark plans to best reflect the coverage and benefits typical to each state's insurance market, including coverage that complies with state-based legal requirements, including nondiscrimination protections, and state-specific conditions. *See* Patient Protection and Affordable Care Act; Standards Related to EHBs, Actuarial Value, and Accreditation, 78 Fed. Reg. 12,834, 12,841 (Feb. 25, 2013) ("The benchmark plan options for each state reflect the scope of benefits and services typically offered in the employer market *in that state*." (emphasis added)). HHS's abrupt decision to exclude "sex-trait modification" from EHBs nationwide is highly disruptive and will force states to re-evaluate their benchmark plans. Five states explicitly include certain gender-affirming care in their benchmark plans. *See* Rule at 27,154 n.196 ("The EHB-benchmark plans for California, Colorado, New Mexico, Vermont, and Washington specifically include coverage of some sex-trait

[25] 2011 CMS Bulletin, *supra* note 22, at 8 (emphasis added).

[26] *Id.* at 8-9.

modification."). For those states that do not explicitly include medically necessary treatment for gender dysphoria in their benchmark plans, but that otherwise require coverage of this care through state law, they will be subject to defrayal costs pursuant to 45 C.F.R. § 155.170. Rule at 27,161 (states with coverage mandates are subject to defrayal costs). States could not have reasonably anticipated such a restriction in part because medically necessary treatment for gender dysphoria is not a stand-alone category of health care and rather spans more than one of the 10 mandatory categories of EHBs, including prescription drugs. Because the Rule applies the exclusion to PY 2026, states must finalize these changes in under two months. HHS was required to at least consider the states' significant reliance interests when imposing such a profound change in approach, and HHS's failure to do so is arbitrary and capricious. *Regents of the Univ. of Cal.*, 591 U.S. at 33 (where agency is "'not writing on a blank slate,' it [i]s required to assess whether there were reliance interests, determine whether they were significant, and weigh any such interests against competing policy concerns" (citation omitted)).

HHS's purported finding that a typical employer plan does not cover "sex-trait modification" is contradicted by the very evidence before the agency, rendering it arbitrary. *State Farm*, 463 U.S. at 43. In its Final Rule, HHS relied on Movement Advancement Project (MAP) data, which shows that 24 states explicitly require coverage of services falling within the umbrella of gender-affirming care in their state employee health benefit plans, which would include "sex trait modification" by insurers, as compared to 14 states that exclude coverage from such plans. In other words, of those states' plans that mention these services, 63 percent explicitly require coverage. Twelve states "do not mention or ha[ve] no clear policy" regarding coverage of gender-affirming care. Rule at 27,153. When compared to other EHBs determined by HHS, the level of coverage for these services is sufficiently "typical" to qualify as EHB even on a nationwide basis.

By way of comparison, HHS's 2011 determination of EHBs was informed by the Department of Labor's dataset, which revealed that only 27 percent of plans surveyed explicitly offered coverage for infertility treatments.[27] Yet HHS did not exclude coverage for infertility treatment services, nor did the agency suggest that these services were not part of a typical employer plan under 42 U.S.C. § 18022(b)(2)(A).

Further evidencing its untenable rationale, HHS's Final Rule disregards without meaningful explanation the evidence that undercuts its premise for the regulatory action. *See* Compl. ¶ 213 (72 percent of Fortune 500 companies cover gender-affirming care according to Corporate Equality Index); *see also* Compl. ¶ 214 (significant numbers of companies of all sizes cover gender-affirming care according to Kaiser Family Foundation's survey). The Final Rule rejects data proving that the vast majority of Fortune 500 companies, and a substantial number of companies of all sizes, cover treatment for gender dysphoria on the basis that the typicality analysis should focus solely on small employers, not large employer plans, even though the latter plans cover more Americans.[28] *See* Rule at 27,154-55.

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[27] *See* DOL Report, *supra* note 22. In order to assess employer-sponsored coverage for the report, DOL drew on data from the Bureau of Labor Statistics (BLS). *Id.* DOL not only reviewed the BLS National Compensation Survey, which captured data from approximately 36,000 employers, but also a BLS analysis of 3,900 private sector plans to assess "detailed provisions of employment-based health care benefits." *Id.* BLS analyzed plan documents requested from those 3,900 private sector plans to evaluate existing coverage for treatments for conditions like infertility; BLS found that, of all of the private sector plans, only 27 percent covered infertility treatments (meaning, covered diagnosis *and* treatment). Overall, 47 percent of assessed plan documents mentioned infertility treatments, and 60 percent of those that mentioned infertility treatments covered more than a diagnosis. *Id.*

[28] HHS tries to dismiss this data by suggesting, without evidence, that "very large employers also receive more pressure from advocacy organizations to cover sex-trait modification procedures and, therefore, likely do not represent the typical employer to the degree a portion respond to this pressure." Rule at 27,155. HHS suggests that the "voluntary participation" of employers in that survey "suggests these employers do not represent the typical employer and, instead, align with the advocacy organization's views." *Id*. HHS could have commissioned its own survey or

Once again, this approach is a sharp divergence from how HHS has approached these issues until now. HHS's 2011 analysis of Department of Labor survey data, for example, examined benefits offered by plans of all sizes,[29] and CMS's December 2011 Essential Health Benefits Bulletin explained that, in trying to define "typical," HHS "gathered benefit information on large employer plans (which account for the majority of employer plan enrollees)" as well as "small employer products (which account for the majority of employer plans), and plans offered to public employees."[30] While the Bulletin expressed that HHS's "intended approach to EHB incorporates plans typically offered by small employers," it clarified that the approach also "incorporates . . . benefits that are covered *across the current employer marketplace*" – those covered by plans of all sizes.[31] This underscores the importance of the state-by-state approach—disregarded here by HHS—which provides the most accurate picture of the benefits covered in the employer marketplace in each state.

The Final Rule also capriciously misinterprets a "limited data set" that describes levels of enrollment in certain plans and the frequency of types of claims submitted, the External Data Gathering Environment (EDGE) data, to make conclusive assertions about nationwide coverage.[32]

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analysis—as it did through an extensive process before issuing guidance in 2011. But the agency cannot use its own failure to thoroughly investigate this issue to dismiss evidence submitted by commenters that its policies are capricious.

[29] *See* DOL Report, *supra* note 22. Notably, this was the first and last DOL report on the contents of typical employer plans.

[30] 2011 CMS Bulletin at 3-4.

[31] 2011 CMS Bulletin at 8 (emphasis added).

[32] Rule at 27,153 ("The EDGE limited data set contains certain masked enrollment and claims data for on- and off- Exchange enrollees in risk adjustment covered plans in the individual and small group (including merged) markets, in States where HHS operated the risk adjustment program required by section 1343 of the ACA, and is derived from the data collected and used for the HHS-operated risk adjustment program.")

Because the number of claims for "sex-trait modification" is purportedly low,[33] the Final Rule leaps to the conclusion that gender-affirming care is infrequently utilized and therefore not typically covered by small business plans.[34] Rule at 27,155-56. But utilization rates are not a substitute for coverage rates; indeed, the fact that there were claims at all undercuts the argument that this care is not covered. Further, public and commercial insurers regularly cover healthcare services that are infrequently used. For example, heart and lung transplants are exceptionally rare,[35] but the vast majority of public and private insurance plans cover them, and transplants themselves are not excluded from EHBs.[36] Likewise, HHS has never before cited utilization as grounds for exclusion from EHB coverage, 78 Fed. Reg. at 12,844-45 (excluding as EHBs limited category of services "because they are not typically included in medical plans offered by a typical employer"). Indeed, even within the Final Rule itself, low utilization is not consistently grounds for exclusion from EHB coverage. For example, the Final Rule permits hormone therapy for the treatment of precocious puberty to be included as an EHB, even though it is less frequently utilized than hormone therapy to delay puberty to affirm an individual's gender identity.[37] It is

[33] The Final Rule does not define what claims it considered in making this assessment.

[34] As explained above, the Final Rule uses the EDGE data to make claims about SHOP coverage, specifically that "sex-trait modification" is not covered by the typical small business plan, even though EDGE data includes enrollment and claim information from plans of various sizes and SHOP plans in all Plaintiff States cover gender-affirming care.

[35] Detailed Description of Data, Health Res. and Servs. Admin., https://www.organdonor.gov/learn/organ-donation-statistics/detailed-description (last accessed July 16, 2025).

[36] Lindsey Dawson, Kaye Pestaina, & Matthew Rae, New Rule Proposes Changes to ACA Coverage of Gender-Affirming Care, Potentially Increasing Costs for Consumers, Kaiser Family Found. (Mar. 24, 2025), https://www.kff.org/private-insurance/issue-brief/new-rule-proposes-changes-to-aca-coverage-of-gender-affirming-care-potentially-increasing-costs-for-consumers/ (last accessed July 17, 2025).

[37] Precocious puberty affects 1 in 5-10,000 children, predominantly girls, whereas 1.4 percent of adolescents identify as transgender. Precocious Puberty, Rare Diseases, available at

unreasonable for HHS to maintain that services must be excluded from EHBs due to data that purportedly show infrequent utilization of "sex-trait modification" procedures.

Ultimately, because HHS failed to consider evidence and incorrectly dismissed what it dubs "sex-trait modification," as not being typically covered, the decision to exclude the services theoretically falling within this ambit from EHBs is arbitrary and capricious.

II. THE EQUITIES COMPEL PRELIMINARY RELIEF.

A. Preliminary Relief Is Needed To Avert Irreparable Harm.

Plaintiff States are "likely to suffer irreparable harm in the absence of preliminary relief." *Winter v. Natural Res. Def. Council, Inc.*, 555 U.S. 7, 20 (2008). The Final Rule results in imminent irreparable harm to Plaintiff States through: (1) costs that SBE States are incurring and will continue to incur to comply with the Final Rule by the effective date and in advance of the start of open enrollment in less than four months on November 1, 2025; (2) lost revenue derived from fees for each insurance premium sold on the SBEs that will no longer be collected; (3) increased expenses to provide medical care and other health-related services to individuals who will lose insurance coverage, and who are unable to enroll in alternative health insurance coverage after the end of the open enrollment period; and (4) increased costs resulting from adverse health outcomes that follow predictably from newly-uninsured individuals foregoing preventive or emergency health care in the absence of affordable health insurance coverage.[38]

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https://rarediseases.org/rare-diseases/precocious-puberty (last accessed July 17, 2025); Many Adults and Youth Identify as Transgender in the United States?, UCLA School of Law Williams Institute (June 2022), available at https://williamsinstitute.law.ucla.edu/publications/trans-adults-united-states/ (last accessed July 17, 2025).

[38] For the same reasons that Plaintiffs have demonstrated that they will be irreparably harmed absent an injunction, Plaintiffs have Article III standing to sue because they will suffer an "injury in fact" that is "fairly traceable" to the Final Rule and "may be redressed by" a court order enjoining its implementation. *McBreairty v. Miller*, 93 F.4th 513, 518 (1st Cir. 2024). States satisfy the Article III injury when they establish a "substantial risk" that the action will impose a "fiscal

First, the Final Rule correctly acknowledges that it will "result in costs to State Exchanges and the Federal Government to update eligibility systems in accordance with this policy." Rule at 27,193. As open enrollment for benefit year 2026 begins in less than four months, Plaintiff States that operate their own ACA exchange would immediately incur compliance costs. The changes made by the Final Rule require such States to implement changes to technology platforms, retrain their staff, update websites and publications, conduct advertising and outreach, and send notices to affected individuals.[39] The Final Rule's exclusion of treatment for gender dysphoria from essential health benefits further requires SBEs to work with carriers to review revised health plans and develop cost-defrayal mechanisms on an expedited basis.[40] Even a temporary disruption will cause irreparable harm.[41]

Second, the Final Rule will also reduce the specific revenue streams from the user fees levied on plans sold on the SBEs. As the Final Rule acknowledges, up to 1.8 million people, many of whom reside in Plaintiff States, may lose access to health insurance coverage. Rule at 27,213. Plaintiff States with SBEs and State exchanges on the federal platform receive millions of dollars in fees tied directly to insurance premiums paid by individuals who access insurance through ACA

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injury" on them. *Mass. v. HHS*, 923 F.3d 209, 222 (1st Cir. 2019); *In re Fin. Oversight & Mgmt. Bd. for P.R.*, 110 F.4th 295, 308 (1st Cir. 2024) (agreeing financial losses are "a quintessential injury in fact"). The compliance costs, lost tax revenue, and increased expenditures all qualify.

[39] *See*, *e.g.*, Altman Decl. (Exhibit 3) ¶11 (detailing over $1.5 million in compliance costs that will be incurred as a result of the Final Rule); Holahan Decl. (Exhibit 20) ¶20 (anticipating $10 million spent on staff time); Humphreys Decl. (Exhibit 21) ¶28 (projecting roughly $5.5 million in compliance costs); Michel Decl. (Exhibit 5) ¶17 (compliance requiring over 1,000 hours of staff time); Schneider Decl. (Exhibit 10) ¶18 (estimating compliance costs of more than $2 million); Woltmann Decl. (Exhibit 11) ¶8 (compliance requiring 1,500 hours of staff and vendor time).

[40] *E.g.*, Beyer Decl. (Exhibit 23) ¶¶7-8; Lang Decl. (Exhibit 22) ¶21; Zimmerman Decl. (Exhibit 18) ¶26.

[41] Huck Decl. (Exhibit 17) ¶14.

exchanges.[42] 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.[43] The Final Rule will deprive the States of the revenues generated by these premiums. Plaintiff States need relief before this extensive revenue loss occurs.

Third, the Final Rule imposes on Plaintiff States increased expenses for providing medical care to individuals who lose insurance due to these changes. State expenditures will balloon as people who lose subsidized marketplace coverage turn to publicly funded healthcare as a backstop. And for those individuals who become uninsured, Plaintiff States will incur substantial costs for their care, including millions annually in unreimbursed costs for the care of uninsured residents at public hospitals,[44] and hundreds of millions in annual subsidies to defray the cost of health care services that are provided to uninsured residents.[45] These costs include subsidies for preventive or emergency care services for uninsured residents. One example is New Jersey's Uncompensated Care Fund, which subsidizes preventive health services for uninsured residents by paying a flat rate from State funds per visit ($114 per visit for primary and dental care, and $74 per visit for mental health services).[46] For this program, and similar programs across Plaintiff States, the greater the number of uninsured residents, the more the State spends on healthcare for uninsured individuals.[47] Moreover, because these state-operated programs do not defray all costs of uncompensated care, state-owned hospitals also incur significant costs in providing services to

[42] Altman Decl. (Exhibit 3) ¶8; Eberle Decl. (Exhibit 12) ¶13; Humphreys Decl. (Exhibit 21) ¶24; Lang Decl. (Exhibit 22) ¶14; Winters Decl. (Exhibit 9) ¶10.

[43] Zimmerman Decl. (Exhibit 18) ¶18.

[44] *See* Huck Decl. (Exhibit 17) ¶12.

[45] Beyer Decl. ¶17; Holahan Decl. ¶32; Huck Decl. ¶¶12-13; Humphreys ¶31.

[46] Brown Decl. ¶24.

[47] *E.g.*, Smith Decl. ¶ 15, Altman Decl. ¶ 24.

uninsured patients.[48]

Finally, Plaintiff States face increased costs resulting from the adverse health outcomes that predictably follow from newly uninsured individuals foregoing preventive or emergency health care because they lack affordable insurance. The Rule acknowledges these harms. *See* Rule at 27,213 (acknowledging "strain on emergency departments" and a "reduction in labor productivity," among other harms); 27,171 (Rule "may increase the number of uninsured"); 27,192 (enrollees "may . . . become uninsured" and "may face higher costs for care and medical debt if care is needed."). Just a year ago, HHS acknowledged that "[i]ndividuals without health insurance are less likely to receive preventive or routine health screenings and may delay necessary medical care, incurring high costs and debts," and that such "[d]elays in care can lead to negative health outcomes including longer hospital stays and increased mortality." Rule Regarding ACA Exchanges And Basic Health Program, 89 Fed. Reg. 39,392, 39,396 (May 8, 2024). Loss of insurance can also result in increased medical debt, reduced spending power, lost work productivity, and absenteeism—as uninsured individuals, less likely to seek preventive care, are more likely to get sick and miss work. *Id*. Moreover, individuals who have recently initiated a time-sensitive course of treatment may have to decide whether to continue such treatment and pay out-of-pocket, or to interrupt treatment and risk significant adverse health consequences.[49]

B. The Balance Of Equities And Public Interest Favor Preliminary Relief

The balance of equities and public interest cut the same way. *Winter*, 555 U.S. at 20; *Does 1-6 v. Mills*, 16 F.4th 20, 37 (1st Cir. 2021) (noting these prongs "merge when the [g]overnment is the opposing party"). Plaintiff States will suffer the immediate and irreparable harms discussed

[48] Huck Decl. (Exhibit 17) ¶10 (University Hospital incurred roughly $58 million in uncompensated care costs in fiscal year 2023).

[49] *E.g.*, Holahan Decl. (Exhibit 20) ¶33.

above. And beyond these harms, the Final Rule acknowledges some of its changes "may deter enrollments among younger people at higher rates, which could worsen the risk pool and increase premiums." Rule at 27,203. For another, the Final Rule will cause up to 1.8 million people to lose insurance coverage and will increase the risk and magnitude of disease outbreaks and thus place a greater strain on hospitals due to the nature of communicable diseases.[50] And because uninsured individuals are less likely to have access to regular outpatient care—leading to greater rates of hospitalization for longer periods, *see* 89 Fed. Reg. at 39,396—smaller communities with fewer resources to address higher hospitalization rates will feel the strain most acutely.[51] In light of these imminent injuries, which cannot be cured after the Final Rule becomes effective or after the close of open enrollment, Plaintiff States will suffer irreparable harm absent a preliminary injunction.

On the other hand, Defendants suffer no harm by maintaining the status quo while this litigation proceeds. Defendants will be able to obtain complete relief at the conclusion of the litigation. Given the imminence of open enrollment for the 2026 benefit year, allowing the pre-Final Rule status quo to remain in place will avert significant disruption to the reliance interests of Plaintiff States, state-based exchanges, and our residents seeking healthcare.

[50] *E.g.*, Travis Campbell et al., Exacerbation of COVID-19 Mortality by the Fragmented United States Healthcare System, The Lancet Regional Health (May 12, 2022), available at https://pmc.ncbi.nlm.nih.gov/articles/PMC9098098/ (last accessed July 17, 2025) (finding that "insurance gaps exacerbated local COVID-19 outbreaks and resulted in more cases, hospitalization, and death than experienced by jurisdictions with better coverage.")

[51] Jennifer Tolbert et al., Key Facts About the Uninsured Population, Kaiser Family Foundation (Dec. 18, 2023) , available at https://www.kff.org/uninsured/issue-brief/key-facts-about-the-uninsured-population (last accessed July 16, 2025) ("[h]igh uninsured rates contribute to rural hospital closures and greater financial challenges for rural hospitals, leaving individuals living in rural areas at an even greater disadvantage to accessing care.")

III. THE COURT SHOULD NOT REQUIRE A BOND.

The Federal Rules of Civil Procedure ordinarily require "security in an amount the court considers proper" before a preliminary injunction may issue. Fed. R. Civ. P. 65(c). "However, the First Circuit has recognized an exception to the bond requirement in suits to enforce important federal rights or public interests, as is precisely the case here." *New York v. McMahon*, --- F.Supp.3d ---, 2025 WL 1463009, at *39 (D. Mass. May 22, 2025) (Joun, J.) (quoting *Westfield High Sch. L.I.F.E. Club v. City of Westfield*, 249 F.Supp.2d 98, 129 (D. Mass. 2003)). The Court should not require a bond.

CONCLUSION

This Court should grant the motion for a stay under Section 705 and a preliminary injunction, and stay/enjoin the challenged components of the Final Rule from taking effect in Plaintiff States.

July 17, 2025

Respectfully submitted,

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**Application for pro hac vice admission forthcoming*

LOCAL RULE 7.1 CERTIFICATE

I certify that on July 17, 2025, at 11:46 a.m., I contacted Diane Kelleher, Director, Federal Programs Branch, U.S. Department of Justice (diane.kelleher@usdoj.gov), Rayford Farquhar, Chief, Defensive Litigation, Civil Division, U.S. Attorney's Office for the District of Massachusetts (rayford.farquhar@usdoj.gov), Abraham George (abraham.george@usdoj.gov), and Brad Rosenberg (brad.rosenberg@usdoj.gov) by email in an attempt to meet and confer regarding the foregoing request for relief. Eric Beckenhauer (Eric.Beckenhauer@usdoj.gov) responded on behalf of Defendants. Plaintiffs and Defendants have met and conferred in good faith and have been unable to resolve or narrow the subject of this Motion.

/s/ *Allyson Slater*

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CERTIFICATE OF SERVICE

I, Allyson Slater, certify that this document filed through the ECF system will be sent electronically to the registered participants as identified on the Notice of Electronic Filing (NEF) and paper copies will be sent to those indicated as non-registered participants.

_/s/_____
Allyson Slater

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MASSACHUSETTS

STATE OF CALIFORNIA, et al. *Plaintiffs*, v. ROBERT F. KENNEDY, JR., et al., *Defendants.*	Civil Action No.: 25-cv-12019

DECLARATION OF ALLYSON SLATER

I, Allyson Slater, an attorney admitted to practice before this Court, do hereby state the following under penalty of perjury, pursuant to 28 U.S.C. § 1746:

1. I am the Director of the Reproductive Justice Unit in the Office of the Attorney General for the Commonwealth of Massachusetts, and I appear on behalf of the Commonwealth of Massachusetts in this action.

2. I submit this declaration in support of Plaintiff States' Memorandum of Law in Support of their Motion for a Preliminary Injunction and Stay.

3. The facts set forth herein are based upon my personal knowledge or a review of the files in my possession.

4. Attached hereto as Exhibit 1 is a true and correct copy of the Declaration of Sterling Gavette.

5. Attached hereto as Exhibit 2 is a true and correct copy of the Declaration of Jeffery Tegen.

6. Attached hereto as Exhibit 3 is a true and correct copy of the Declaration of Jessica Altman.

7. Attached hereto as Exhibit 4 is a true and correct copy of the Declaration of Michael Conway.

8. Attached hereto as Exhibit 5 is a true and correct copy of the Declaration of James Michel.

9. Attached hereto as Exhibit 6 is a true and correct copy of the Declaration of Steven M. Constantino.

10. Attached hereto as Exhibit 7 is a true and correct copy of the Declaration of Trinidad Navarro.

11. Attached hereto as Exhibit 8 is a true and correct copy of the Declaration of Jennifer Epstein.

12. Attached hereto as Exhibit 9 is a true and correct copy of the Declaration of Morgan Winters.

13. Attached hereto as Exhibit 10 is a true and correct copy of the Declaration of H. Schneider.

14. Attached hereto as Exhibit 11 is a true and correct copy of the Declaration of Marissa Woltmann.

15. Attached hereto as Exhibit 12 is a true and correct copy of the Declaration of M. Eberle.

16. Attached hereto as Exhibit 13 is a true and correct copy of the Declaration of Joseph A. Garcia.

17. Attached hereto as Exhibit 14 is a true and correct copy of the Declaration of Sarah Adelman.

18. Attached hereto as Exhibit 15 is a true and correct copy of the Declaration of Jeffrey Brown.

19. Attached hereto as Exhibit 16 is a true and correct copy of the Declaration of Elizabeth Caulum.

20. Attached hereto as Exhibit 17 is a true and correct copy of the Declaration of John Gary Huck.

21. Attached hereto as Exhibit 18 is a true and correct copy of the Declaration of Justin Zimmerman.

22. Attached hereto as Exhibit 19 is a true and correct copy of the Declaration of Colin Baillio.

23. Attached hereto as Exhibit 20 is a true and correct copy of the Declaration of Danielle Holahan.

24. Attached hereto as Exhibit 21 is a true and correct copy of the Declaration of Michael Humphreys.

25. Attached hereto as Exhibit 22 is a true and correct copy of the Declaration of Lindsay M. Lang.

26. Attached hereto as Exhibit 23 is a true and correct copy of the Declaration of Jane Beyer.

27. Attached hereto as Exhibit 24 is a true and correct copy of the Declaration of Ingird Urley.

28. Attached hereto as Exhibit 25 is a true and correct copy of the Declaration of Sarah Smith.

29. Attached hereto as Exhibit 26 is a true and correct copy of the Declaration of T.K. Keen.

30. Attached as an appendix is a list of the exhibits attached to this declaration, in chart form.

Signed under the penalties of perjury on this 17th day of July 2025 in Boston, Massachusetts.

Dated: July 17, 2025
Boston, MA

/s/ Allyson Slater
Allyson Slater
Director, Reproductive Justice Unit
Office of the Attorney General

APPENDIX

Exhibit No.	Description
1.	Declaration of S. Gavette Arizona Department of Insurance and Financial Institutions
2.	Declaration of J. Tegen Arizona HealthCare Cost Containment System Administration
3.	Declaration of J. Altman Covered California
4.	Declaration of M. Conway Colorado Division of Insurance
5.	Declaration of J. Michel Connecticut Health Insurance Exchange dba Access Health CT
6.	Declaration of S. Costantino Delaware Department of Health and Social Services
7.	Declaration of T. Navarro Delaware Department of Insurance
8.	Declaration of J. Epstein Illinois Department of Public Health
9.	Declaration of M. Winters Illinois Department of Insurance
10.	Declaration of H. Schneider Maine Department of Health and Human Services
11.	Declaration of M. Woltmann Massachusetts Health Connector
12.	Declaration of M. Eberle Maryland Health Benefit Exchange
13.	Declaration of J. Garcia Michigan Department of Insurance and Financial Services
14.	Declaration of S. Adelman New Jersey Department of Human Services
15.	Declaration of J. Brown New Jersey Department of Health
16.	Declaration of E. Caulum MNsure
17.	Declaration of J. Huck University Hospital of Newark, New Jersey
18.	Declaration of J. Zimmerman New Jersey Department of Banking and Insurance
19.	Declaration of C. Baillio New Mexico Health Care Authority
20.	Declaration of D. Holahan New York State of Health
21.	Declaration of M. Humphreys

	Pennsylvania Insurance Department
22.	Declaration of L. Lang HealthSource of Rhode Island
23.	Declaration of J. Beyer Washington State Office of the Insurance Commissioner
24.	Declaration of I. Urley Washington Health Benefit Exchange
25.	Declaration of S. Smith Wisconsin Office of the Commissioner of Insurance
26.	Declaration of T. Keen Oregon Dept. of Insurance

CERTIFICATE OF SERVICE

I, Allyson Slater, certify that counsel for or on behalf of plaintiffs have submitted the foregoing document with the clerk of court for the District of Massachusetts, using the electronic case filing system of the Court. Counsel for Plaintiffs hereby certify that they have served all parties electronically or by another manner authorized by Fed. R. Civ. P. 5(b)(2).

/s/ *Allyson Slater*
Allyson Slater
Director, Reproductive Justice Unit
Office of the Attorney General

EXHIBIT 1

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MASSACHUSETTS

STATE OF CALIFORNIA, et al. *Plaintiffs*, v. ROBERT F. KENNEDY, JR., et al., *Defendants.*	Civil Action No.: 25-12019

DECLARATION OF STERLING GAVETTE

I, Sterling Gavette, declare under the penalty of perjury pursuant to 28 U.S.C. § 1746 that the foregoing is true and correct to the best of my knowledge:

1. I am the Life and Health Oversight Manager at the Arizona Department of Insurance and Financial Institutions ("DIFI"). I have been employed as the Life and Health Oversight Manager since July 2022.

2. DIFI administers Arizona's laws protecting insurance consumers by regulating the insurance and financial services industries. DIFI licenses, monitors, and investigates regulated entities. It collects state taxes from insurance providers, resolves consumer complaints against insurance entities, and acts in response to violations of the law. DIFI also combats insurance fraud by issuing public awareness campaigns and funding law enforcement.

3. Arizona does not operate its own health insurance exchange. Rather, consumers in Arizona enroll in health coverage using healthcare.gov, which is operated and maintained by the U.S. Department of Health and Human Services.

4. I am familiar with the information in the statements set forth below through personal knowledge and from documents and information that have been provided to and reviewed by me.

5. I submit this Declaration in support of the States' Motion for a Preliminary Injunction.

Risk Pool and Tax Impacts

6. DIFI regulates health care services organizations, which are entities that "conduct one or more health care plans." A.R.S. § 20-1051(6). Health care plans are agreements "to provide directly or to arrange for all or a portion of contractually covered health care services and to pay or make reimbursement for any remaining portion of the health care services on a prepaid basis through insurance or otherwise." *Id.* § 20-1051(4). DIFI collects a tax of 2% "of net charges received from enrollees." *Id.* § 20-1060(A).

7. DIFI regulates corporations that operate "nonprofit hospital service or medical or dental or optometric service plans," which allow public subscribers to obtain hospital, medical, or dental services. *Id.* § 20-822. DIFI collects a 2% tax on "net premiums that are received to effect or maintain the corporation's subscription contracts." *Id.* § 20-837(A).

8. Health care services organizations and corporations offering nonprofit hospital services, medical, dental, or optometric service plans sell Arizona subscribers healthcare insurance through the federally facilitated Affordable Care Act exchange.

9. Arizona tax revenues increase when any regulated entity sells insurance to Arizonans through the federally facilitated exchange because DIFI collects a tax of 2% of each insurance premium.

10. Accordingly, attrition in enrollment in the Federally-facilitated Exchange will cause Arizona to lose tax revenue.

11. In addition, removing a pool of relatively young and healthy individuals from the risk pool of insureds participating in health coverage in Arizona will likely increase costs to all insured individuals in Arizona.

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

Executed this 15th day of July, 2025, in Phoenix, Arizona

Sterling Gavette

Sterling Gavette

Life and Health Oversight Manager
Arizona Department of Insurance & Financial Institutions
Paper document bears an original signature

EXHIBIT 2

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MASSACHUSETTS

STATE OF CALIFORNIA, et al. *Plaintiffs,* v. ROBERT F. KENNEDY, JR., et al., *Defendants.*	Civil Action No.: 25-12019

DECLARATION OF JEFFERY TEGEN

I, Jeffery Tegen, declare under the penalty of perjury pursuant to 28 U.S.C. § 1746 that the foregoing is true and correct to the best of my knowledge:

1. I am the Fiscal Integrity Program Review and Reform Administrator at the Arizona Health Care Cost Containment System (AHCCCS) Administration located in Arizona.

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

3. AHCCCS is the largest insurer in Arizona, covering approximately 1,971,678 individuals. It uses federal, state, county, and other funds to provide health care coverage to the State's Medicaid population.

4. I am familiar with the information in the statements set forth below through personal knowledge and from documents and information that have been provided to and reviewed by me.

5. I submit this Declaration in support of the States' Motion for a Preliminary Injunction.

Increased Costs to the State and Worsening Public Health Outcomes

6. The Final Rule acknowledges that the changes it makes will result in a decrease in enrollment in the Affordable Care Act ("ACA") marketplace exchanges of up to 1.8 million people nationwide. *See* 90 Fed. Reg. 27212.

7. Decreased enrollment under the Final Rule could cause enrollment in Arizona's Medicaid program to increase, thereby increasing costs to the state to administer this program and provide health coverage.

8. In Arizona, all hospitals are required to treat patients presenting in their emergency departments, regardless of the patient's ability to pay. *See, e.g.*, A.R.S. § 20-2803(C); *Thompson v. Sun City Comm. Hosp., Inc.*, 141 Ariz. 597, 602 (1984) ("[A]s a matter of public policy, licensed hospitals in this state are required to accept and render emergency care to all patients who present themselves in need of such care."). Arizona offsets some of the costs that eligible hospitals sustain as a result of this requirement through Disproportionate Share Hospital (DSH) payments, administered by AHCCCS, and funded through intergovernmental agreements with state and local governments and entities. *See* A.R.S. § 36-2903.01(O). Any decrease in marketplace enrollment will cause an increase in unrecovered costs and thereby increase state and local expenses.

9. The Final Rule is also detrimental to Arizona's public health. Uninsured individuals who lack access to affordable, adequate health insurance are less likely to seek preventive care or attend routine health screenings, and may delay necessary medical care due to prohibitive costs.

10. Decreased access to adequate and affordable health care could mean infectious diseases spread more widely and rapidly with those affected not seeking care due to being uninsured or underinsured.

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

Executed this 15th day of July 2025, in Phoenix, Arizona.

Jeffery Tegen

Jeffery Tegen
Fiscal Integrity Program Review and Reform Administrator
AHCCCS
Paper document bears an original signature

EXHIBIT 3

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MASSACHUSETTS

STATE OF CALIFORNIA, et al., *Plaintiffs*, v. ROBERT F. KENNEDY, JR., in his official capacity as Secretary of Health and Human Services, et al., *Defendants*.	Civil Action No. 25-12019

Declaration of Jessica Altman in Support of Plaintiffs' Motion for a Preliminary Injunction

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

1. I am the Executive Director of Covered California. I am familiar with the information in the statements set forth below either through personal knowledge or from documents that have been provided to and reviewed by me.

2. I submit this Declaration in support of the States' Motion for a Preliminary Injunction.

Professional Background

3. I, Jessica Altman, have served as the Executive Director for Covered California since 2022. In this role, I oversee all aspects of the organization's operations, strategy and policy implementation to ensure Covered California fulfills its mission of expanding access to health care, driving affordability, promoting equity, and improving outcomes for consumers across the state. Covered California provides coverage to over 1.9 million Californians annually and operates as a competitive health insurance marketplace that promotes choice and accountability among health plans.

4. Prior to joining Covered California, I served as Pennsylvania's Insurance Commissioner, where I led efforts to protect consumers, regulate insurance carriers, and advance health care reform. I also served as the founding board chair of Pennsylvania's state-based exchange, Pennie, which began offering health coverage at the start of 2021. I hold a Master of Public Policy from Harvard University and a Bachelor of Science in Policy and Management from Cornell University. My education and experience in regulatory policy, marketplace operations, and consumer protection give me a comprehensive understanding of the challenges exchanges, and particularly state-based exchanges, face and the consequences federal regulations can have on their ability to serve consumers effectively.

State-based Exchange (SBE) Background

5. Covered California was established in 2011 and began its first open enrollment period (OEP) in 2013 for coverage starting in the 2014 plan year. Following the recent OEP for the 2025 plan year, 1,979,504 residents were enrolled in health insurance through Covered California. Since our SBE was established, California's uninsured rate has dropped from 17.2 percent to 6.4 percent in 2023.[1] Through innovation and careful stewardship, our SBE has established a competitive market and a robust risk pool, and currently includes 12 health insurance plan issuers, five dental plan issuers, and 116 qualified health and dental plan options (a "plan option" is a unique carrier, network, and metal tier combination) for the 2025 plan year to ensure that all our residents have access to high quality and affordable health coverage. Moreover, Covered California has consistently cultivated a stable and healthier risk pool compared to the federally-facilitated exchange (FFE), as demonstrated by CMS's annual risk adjustment data, even when accounting for market-specific differences.

6. The flexibility that CMS has afforded SBEs in operating our unique marketplaces has allowed us to implement innovative policies which make it easier for consumers to enroll in more generous plans at low or no cost. While CMS imposes rules to ensure a baseline level of

[1] Jessica Altman, Comment Letter on the Marketplace Integrity and Affordability Proposed Rule (Apr. 11, 2025), https://www.regulations.gov/comment/CMS-2025-0020-25629

performance across marketplaces, it also permits states to innovate and tailor policies to meet their unique needs. For example, Covered California has maintained a longer OEP, running from November 1 through January 31, which strengthens our risk pool by enrolling healthier and younger individuals who are more likely to sign up later in the period. Our special enrollment period (SEP) strategies have also been uniquely designed to meet California's needs, ensuring continuous coverage and minimizing enrollment barriers while maintaining a healthy risk pool. Moreover, our robust fraud oversight standards have ensured that consumer enrollments are conducted with the highest integrity, effectively safeguarding against improper enrollments with negligible instances of fraud. These flexibilities allow states like California to address local conditions while upholding program integrity and consumer protections.

7. Covered California has had very few instances of fraud. In fact, a robust review of consumer complaints and enrollment partner activity in recent years revealed that improper enrollments are exceedingly rare, thanks to the tailored oversight measures we have implemented, such as requiring agents to verify consumer consent through secure methods like three-way calls, one-time passcodes, or direct consumer portal updates. For the few instances reported, Covered California has taken swift and decisive corrective actions, including investigations, monitoring, warnings, suspensions, and, if necessary, decertifying agents. These measures have enabled us to uphold program integrity while simultaneously reducing financial and administrative barriers to obtaining coverage for those who need it most.

8. To fund our operations, Covered California collects a user fee of 2.25 percent of the total monthly premiums collected by an issuer for each plan purchased through our individual exchange and a 5.2 percent fee for each plan sold through our small business exchange. (Cal. Gov't Code, § 100503, subd. (n).) Therefore, policies which decrease enrollment in Covered California result in less revenue for Covered California to operate our state-run exchange.

9. Covered California develops annual standard benefit designs well in advance of the upcoming plan year to allow health plan issuers to finalize plan submissions and calculate upcoming rates. Beginning in late 2024, Covered California worked to develop 2026 standard

benefit designs with significant input from interested parties. Finalized benefit designs were adopted by Covered California's board of directors on February 20, 2025. Issuers submitted plan filings to Covered California and to their state regulators that incorporated the finalized benefit designs by April 30, 2025, as part of the plan year 2026 certification process. The Final Rule increases the maximum limitation on cost sharing beyond the value used to finalize Covered California's benefit designs. This change will require reconfiguration of the adopted benefit design for catastrophic plans and resubmission and review of issuer plan filings.

10. The Final Rule will make it difficult for consumers to enroll in coverage and significantly increase consumers' health insurance premiums and out-of-pocket costs. It will greatly increase financial costs, administrative burdens, and instability for Covered California while eliminating state flexibility to tailor our exchange to local needs.

11. We estimate that the numerous changes in the Final Rule will require us to spend more than $1.5 million and 12,500 hours of staff time updating our information technology (IT) systems alone. Additionally, the rule will require an unquantifiable amount of staff time to implement its requirements and impose significant operational challenges on our SBE. Moreover, some of the technical changes to our IT systems cannot be completed in time for the 2026 plan year. Specifically, the new income verification requirements—such as requiring documentation when tax data shows income under 100 percent of the federal poverty level (FPL) and requiring documentation when no tax data is available through the federal data services hub—are impossible to timely implement within our existing system infrastructure. Implementing these rules would necessitate new system programming and additional manual processes, which would compromise the efficiency of our automated systems. This, in turn, would lead to higher operational costs, greater challenges for consumers, and added strain on critical resources. Specifically, it would impact the accuracy and timeliness of consumer notices, increase the volume and complexity of mailings, require expanded enrollee outreach efforts to address potential confusion, and place additional demands on service center operations,

including longer wait times and increased staffing needs to handle the influx of inquiries and support requests.

12. The Final Rule's exclusion of medically necessary treatments for transgender individuals from the definition of an Essential Health Benefit (EHB) is also detrimental. This medical care is necessary for some transgender individuals. In addition, a typical employer plan in California covers the treatments commonly provided for treating gender dysphoria, and therefore it is improper to exclude such care from the EHB definition. Furthermore, singling out this one treatment for exclusion as an EHB marks a sharp departure from CMS's longstanding practice of increasing state flexibility in defining the scope of EHBs to keep pace with the diverse and evolving needs of states' residents. CMS has never before excluded benefits that are traditionally embedded within a health plan (as opposed to "excepted benefits" like dental benefits).

13. The timing of the Final Rule is deeply problematic for another reason. Enhanced premium tax credits are scheduled to expire on December 31, 2025, unless Congress extends them. The expiration of those enhanced federal subsidies will drastically lower enrollment in the exchanges and increase consumer costs. The Congressional Budget Office (CBO) estimates that the expiration of these enhanced subsidies will increase the number of people without health insurance by 4.2 million by 2034. Our internal estimates are that the expiration of enhanced premium tax credits will cause an average premium increase of 66 percent for Covered California enrollees and result in, on average, 346,000 to 522,000 fewer monthly enrollees through July 2031.[2] When factoring in the many harmful impacts of the Final Rule layered on top of the expiring subsidies, the result could be serious instability and volatility in both the federal and state-based exchanges.

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[2] Covered California, *The Impact of Expiring Enhanced Tax Credits on Californians and Communities in Need*, HBEX.COVEREDCA.COM, https://hbex.coveredca.com/data-research/library/Brief%201%20IRA%20ACA%20Premium%20Impacts%202025.pdf (last visited Jun. 12, 2025); Covered California Board of Directors, *Policy and Action Items at the May 15, 2025 Board Meeting,* p. 9-10, BOARD.COVEREDCA.COM (May 15, 2025), https://board.coveredca.com/meetings/2025/May%2015,%202025/2025.05.15_Policy_and_Action.pdf

14. Beyond the impact of the expiring enhanced premium tax credits, the cumulative effect of the Final Rule will inflict immediate and significant harm on our SBE and the consumers we serve, with lasting consequences that will be challenging to reverse if implemented. Covered California's historical success will be undone under the Final Rule, leading to an increase in California's uninsured rate and triggering broader macroeconomic challenges as a result. Covered California will be forced to divert more than $1.5 million and potentially hundreds of thousands of staff hours towards changing our IT systems and helping consumers meet unnecessary and burdensome eligibility and verification requirements. Moreover, the Final Rule carries multi-year implications that threaten to undermine marketplace competitiveness over time, as smaller plans may struggle to withstand the prolonged volatility caused by substantial changes to the risk pool.

15. We estimate that the Final Rule will cause total Covered California enrollment to decrease by a range of 58,000 to 144,000 (8 percent), and the risk pool will significantly worsen, thereby causing premiums to rise.[3] As such, the Final Rule poses a profound threat not only to Covered California's stability and success but also to the broader healthcare landscape, undermining affordability, access, and marketplace competitiveness.

[3] Based on national 2025 Open Enrollment data, California represents approximately 8 percent of Marketplace plan selections. Using this methodology, we estimate potential coverage loss of 58,000 to 144,000 Covered California enrollees, applying 8 percent to CMS's updated projection of 725,000 to 1,800,000 fewer individuals enrolling in Qualified Health Plan (QHP) coverage nationwide due to the Final Rule.

Denying Advanced Premium Tax Credits (APTC) for Individuals Who Fail to File and Reconcile Their Income Data After Only One Year

16. The ACA provides APTCs to individuals whose projected household income qualifies them for assistance with paying their healthcare premiums. Because those APTC awards are based on a consumer's projected income, the recipient must later reconcile their APTC award against the allowed premium tax credit based on their actual income, as shown in their tax filings with the Internal Revenue Service (IRS). If the enrollee received more APTC during the benefit year than allowed, the enrollee then owes the difference as a tax liability when they file taxes for that year. This requirement ensures that consumers cannot claim and retain credits to which they are not entitled. When an individual fails to file taxes and reconcile the amount of credit allowed with the APTC award received, they lose eligibility for future APTCs and owe the prior period's excess APTC as a tax liability. This is known as failure to file and reconcile, or FTR. The Final Rule temporarily shortens the failure-to-file period to one year for plan year 2026, meaning consumers will lose APTC credit eligibility and incur a corresponding tax liability after just one FTR year, rather than after two consecutive FTR years (which was the previous policy).

17. Reverting to a one-year FTR rule increases the risk of eligible individuals losing access to APTCs due to administrative complexities or processing delays, especially IRS processing delays (or outright errors) that are not the fault of the consumer. Many more people receive one-year FTR codes than two-year FTR codes (because the former fix the issue before year two comes around). In California, 220,000 enrollees renewing for January 2025 coverage received a one-year FTR code, while 47,000 received a two-year code.

18. Moreover, even in a world where the IRS processes all returns perfectly and on time, there are legitimate reasons why a consumer might knowingly accrue (and pay) a higher tax liability after two years rather than one. For some consumers, maintaining health coverage over a two-year span, even at the costs of a higher tax liability at the end, might be a rational tradeoff. And, either way, whether after one year or two years, the consumer must pay the federal government back for any APTC that was higher than it should have been based on the

consumer's income. Thus, there is no reason for shortening the FTR period to force a reconciliation after just one year.

19. Implementing this new FTR rule will likely cause consumer confusion because SBEs will be required to deny APTC much more frequently than under the current system, often based on IRS processing delays or mistakes. As the U.S. Office of the National Taxpayer Advocate highlighted in its 2024 annual report to Congress, the IRS continues to experience ongoing challenges stemming from persistent paper processing delays, correspondence issues, and data errors in monitoring reports and tax return handling.[4] Further, added barriers to marketplace enrollment discourage healthier individuals from enrolling, deteriorate the risk pool, and lead to higher premiums for those who remain insured.

Ending Acceptance of Self-Attestation of Projected Annual Household Income At or Above 100 Percent of the FPL

20. Prior to the Final Rule, exchange plans accepted the self-attestation of an enrollee who claimed eligibility by projecting annual household income at or above 100 percent of the FPL. This policy is distinct from the FTR rules, discussed above, which still ensure that an enrollee who over-claims APTC eligibility must repay the overpayment via tax liability or else lose APTC eligibility. This self-attestation policy was designed to ensure that the lowest-income enrollees, who are often younger and healthier, are not discouraged from entering the risk pool due to paperwork burdens. The prior policy also recognized the challenges that low-income individuals face in accurately estimating their annual income. Many low-income individuals experience significant fluctuations in their earnings over the course of the year.

21. The Final Rule changed this policy in two ways. First, anytime IRS data shows that a consumer has income below 100 percent of the FPL, a "data matching issue" (DMI) will be generated. Second, in the absence of IRS data, a DMI will be generated. Whenever a DMI is generated, consumers will be required to track down and submit the necessary paperwork in

[4] National Taxpayer Advocate, *Annual Report to Congress 2024*. https://www.taxpayeradvocate.irs.gov/reports/2024-annual-report-to-congress/full-report/

order to purchase health insurance. DMIs also create administrative burdens on SBEs, which are required to receive, process, and determine whether the newly submitted paperwork adequately addresses the issue.

22. These changes impose a heavy burden on SBEs. I estimate that Covered California will need to spend over 52,000 hours to receive, process, and review documents generated by these new DMIs, costing over $2.5 million. This cost includes conducting outreach and determining DMI outcomes for applicants whose tax return data is unavailable. Updating our eligibility systems and performing technical updates relating to this change will cost approximately $1,250,000. This change represents yet another administrative barrier to enrollment that will likely cause younger and healthier consumers to drop out of the marketplace. That, in turn, will worsen the risk pool and increase premiums for both subsidized and unsubsidized consumers.

Changing the Premium Adjustment Calculation Method

23. Exchange plans set a maximum annual limit on cost-sharing, such as copays, coinsurance, and out-of-pocket maxima due from the enrollee over the plan year. Those annual limits are adjusted in reference to a measure of premium inflation called the annual premium adjustment percentage, set by the HHS Secretary each year. In addition, the IRS uses the premium adjustment percentage when determining individuals' expected contributions and thus the amount of APTC the enrollee will receive. Accordingly, even small changes in the way the premium adjustment percentage is calculated can have large effects on both out-of-pocket costs and the amount of APTC an enrollee is entitled to receive.

24. Prior to the Final Rule, CMS policy recognized that the premium adjustment methodology needed to be price-stable to reduce volatility and keep premiums from spiking. Under that prior policy, the adjustment methodology looked to a biannual measure of premium inflation that is based on the employer-sponsored insurance (ESI) market, rather than the individual market, which is much more price-volatile. It is important to highlight that a reduction in marketplace enrollment directly contributes to a rise in the uninsured rate, which in turn increases the burden of uncompensated care on the healthcare system. This uncompensated care

ultimately impacts negotiated rates in the ESI market. The ESI market is already likely to face rising costs as a result of this Final Rule, further exacerbating premium inflation under the current methodology. Regardless, including the more price-volatile individual market in the measure of inflation increases out-of-pocket costs to consumers.

25. The Final Rule changes the premium adjustment methodology to include consideration of inflation in the volatile individual market. That will directly harm consumers by significantly increasing premium contributions (including for the 160 million Americans with employer-based insurance).

26. First, this change will directly cause premiums to rise. By including consideration of inflation in the individual market, the premium adjustment percentage in 2026 will be about 4.5 percent higher than under the previous methodology. That means that the premium for a benchmark silver plan in 2026 will be about 4.5 percent higher than it was in 2025 on account of this change. That is a hefty increase, given the cost of health insurance, and the impact could be further compounded if the enhanced premium tax credits expire at the end of 2025. In 2023, for example, an average on-exchange plan in the individual market cost $590.08 per member per month (PMPM), for an annual premium of $7,080.96 per member. A 4.5 percent increase in that premium is an additional $318.64 annually. For an average annual premium of $25,572 for family coverage, a 4.5 percent increase is an extra $1,150.74 per year.

Expanding the Actuarial Value Ranges for Health Plans

27. Plans sold on the exchanges fall into Bronze, Silver, Gold, and Platinum tiers based on how much of an average consumer's expected medical cost will be paid by the plan. Bronze plans must cover 60 percent of the expected cost; Silver plans, 70 percent; Gold plans, 80 percent; and Platinum plans, 90 percent. Higher-tier plans, meaning richer benefits, typically have higher premiums and lower out-of-pocket costs. Lower-tier plans have the opposite: lower premiums and higher out-of-pocket costs. Issuers on the exchanges must offer plans that meet these targets within some range of accepted *de minimis* variation. These ranges are presently small—most plans must fall within +2/-2, or +2/- 0, percentage points. This narrow range

encourages transparency and diminishes consumer confusion in the marketplace, because a plan that claims to be Silver but undershoots its target by five percentage might only offer Bronze-level value and should be priced accordingly. Keeping the bands narrow promotes that policy goal.

28. The Final Rule significantly widens the accepted ranges for the actuarial value of health plans. For expanded bronze plans, the proposed range is +5/-4 percentage points. For all other plans, the proposed range is +2/-4 percentage points. By allowing all plans to undershoot their claimed targets by four percentage points, this proposal is certain to decrease the level of coverage provided to consumers, while charging those consumers the same price for their premiums that they would otherwise be charged (which includes annual increases). This change to actuarial value de minimis variation will reduce affordability by increasing premiums and out-of-pocket costs for consumers. It will also reduce APTC because APTC is keyed off the second lowest cost silver plan in the market, and plans with lower actuarial values will generally have lower premiums.

29. CMS claims that issuers need this flexibility to remain in the marketplace. However, California's experience demonstrates that such flexibility is unnecessary for fostering a thriving and stable market. Covered California utilizes standard plans, ensuring there is no variation in actuarial value ranges within our marketplace. With this consistency, issuer participation in our SBE has grown from 10 issuers in 2015 to 12 issuers today, with two expanding their service areas across the state. These results illustrate that a marketplace can succeed, grow, and provide stability for both consumers and issuers without relying on actuarial value range flexibility. Furthermore, we are not aware of any empirical evidence suggesting that rigid actuarial value requirements are prompting issuers to exit Covered California or threatening their participation. On the contrary, the success of our marketplace underscores how standard plans with consistent actuarial value requirements can enhance consumer confidence while encouraging sustained issuer engagement.

Prohibiting Coverage for Treating Gender Dysphoria

30. The ACA mandates that certain individual and small group health plans cover a set of Essential Health Benefits (EHBs) which must be equal to the scope of benefits provided under a typical employer plan and may not have any annual or lifetime dollar limit under state plans.

31. Per HHS, the items and services covered must come from the following ten benefit categories: (1) ambulatory patient services; (2) emergency services; (3) hospitalization; (4) maternity and newborn care; (5) mental health and substance use disorder services including behavioral health treatment; (6) prescription drugs; (7) rehabilitative and habilitative services and devices; (8) laboratory services; (9) preventive and wellness services and chronic disease management; and (10) pediatric services, including oral and vision care.

32. The ACA and its effectuating regulations permit latitude to the states in determining how EHBs are defined. Accordingly, states submit their "benchmark" plans to HHS for approval. EHBs are a minimum standard, and benchmark plans can choose to offer additional health benefits.

33. Each state maintains a benchmark plan on file with HHS, against which private insurers must compare plans to ensure compliance with the standards set forth therein. Further, if a state has not updated its benchmark plan to match federal requirements, private insurers must also review plans for compliance with federal EHB mandates.

34. California's EHB benchmark plan is based on the Kaiser Foundation Health Plan Small Group Health Maintenance Organization (HMO) 30 plan,[5] supplemented with pediatric oral benefits from the former Children's Health Insurance Program (CHIP) and pediatric vision benefits from the Federal Employees Dental and Vision Insurance Program (FEDVIP). California also defined habilitative services as medically necessary care to assist in acquiring or improving skills, covered under the same terms as rehabilitative services. This benchmark plan ensures compliance with the ten federally required EHB categories, including coverage for

[5] California Health & Safety Code § 1367.005; Insurance Code § 10112.27

medically necessary basic health care services. California has retained this benchmark plan since 2014, submitting it to the federal Centers for Medicare & Medicaid Services (CMS) as required, with no changes to its scope of benefits.

35. California's longstanding nondiscrimination laws prohibit coverage exclusions based on an enrollee's sex, including gender identity, ensuring equitable access to healthcare for transgender individuals.[6] These protections apply to all state-regulated employer-sponsored coverage and are embedded in California's EHB benchmark plan, which aligns with the ACA's requirement to reflect the scope of benefits provided under a typical employer plan.[7]

36. "Gender-affirming care" services fall within many categories of EHBs, such as surgeries, prescription medications, and mental health treatment. QHP issuers, like all plans in California, must make these services available to all enrollees when medically necessary, in a nondiscriminatory manner.

37. Requiring states to exclude these otherwise-covered services from EHB definitions would raise the defrayal cost borne by California. This is because premium amounts that would otherwise be attributed to EHB services and covered by carriers in response to the state coverage mandate would be put back on states. At estimated 2026 enrollment levels, assuming that enhanced premium tax credits are not extended, Covered California estimates it will cost roughly $15 million to defray the cost of gender-affirming care for enrollees in the individual market, plus more for those enrolled in small group coverage.

38. With respect to providing essential health benefits for gender-affirming care, the Final Rule will force Covered California to examine carrier submissions to ensure the appropriate amounts have been excluded from federal cost-sharing. Covered California estimates it will cost $200,000 for related information technology changes. Covered California will need to implement technical assistance on the back end to ensure this is done consistently across the market in California. This will take up valuable time and resources. In addition, insurance carriers in

[6] Cal. Health & Safety Code § 1365.5; Cal. Ins. Code § 10140
[7] 42 U.S.C. § 18022(b); 45 C.F.R. § 156.100

California do not all maintain their data in the same way. This means that conducting targeted assessments will be necessary to ensure that gender-affirming care services, which can take many different forms, have been excluded from coverage as EHBs. These targeted assessments would require additional time on part of marketplaces.

/s/ Jessica Altman

Jessica Altman

Paper document bears an original signature.

Date: July 16, 2025

EXHIBIT 4

UNITED STATES DISTRICT COURT

FOR THE DISTRICT OF MASSACHUSETTS

STATE OF CALIFORNIA, et al. *Plaintiffs*, v. ROBERT F. KENNEDY, JR., et al., *Defendants*.	Civil Action No.: 25-12019

DECLARATION OF MICHAEL CONWAY

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

1. I am the Commissioner of Insurance at the Colorado Division of Insurance located in Denver, Colorado. I have been employed at the Colorado Division of Insurance since March of 2016.

2. Pursuant to section 10-1-103(1), C.R.S., the Division of Insurance is charged with the execution of the laws relating to insurance and has a supervising authority over the business of insurance in Colorado. The Division of Insurance's supervising authority includes enforcing the requirements of article 16 of title 10 of the Colorado Revised Statutes, also known as the "Colorado Health-Care Coverage Act."

3. I am familiar with the information in the statements set forth below through personal knowledge and from documents and information that have been provided to and reviewed by me.

4. I submit this Declaration in support of the States' Motion for a Preliminary Injunction.

5. The ACA mandates that certain individual and small group health plans cover a set of Essential Health Benefits (EHBs) which must be equal to the scope of benefits provided under a typical employer plan and may not have any annual or lifetime dollar limit.

6. Per the ACA, the items and services covered must come from the following ten benefit categories: (1) ambulatory patient services; (2) emergency services; (3) hospitalization; (4) maternity and newborn care; (5) mental health and substance use disorder services including behavioral health treatment; (6) prescription drugs; (7) rehabilitative and habilitative services and devices; (8) laboratory services; (9) preventive and wellness services and chronic disease management; and (10) pediatric services, including oral and vision care.

7. The ACA and its effectuating regulations permit latitude to the states in determining how EHBs are defined. Accordingly, states submit their "benchmark" plans to HHS for approval. EHBs are a minimum standard, and benchmark plans can choose to offer additional health benefits, like vision, dental, and medical management programs (e.g., weight loss).

8. Each state maintains a benchmark plan on file with HHS, against which private insurers must compare plans to ensure compliance with the standards set forth therein. Further, if a state has not updated its benchmark plan to match federal requirements, private insurers must also review plans for compliance with federal EHB mandates.

9. Since 2023, Colorado's Benchmark plan has included coverage for gender-affirming care. The 2023 Benchmark plan was submitted to HHS for approval on May 7, 2021 and was approved on October 21, 2021.

10. On May 23, 2025, House Bill 25-1309 was signed into Colorado law, which provides that all health benefit plans issued or renewed in the state shall provide coverage for gender-affirming health care. Further, Colorado Insurance Regulation 4-2-62 provides that carriers shall not engage

in unfair discrimination due to sexual orientation or gender identity between individuals of the same class in benefits payable under such policy and any other manner that may be perceived as discriminatory.

11. Colorado's EHB Benchmark plan requires insurers to provide the following medically-necessary treatment, including treatment for gender dysphoria and, at a minimum, the following gender-affirming care services:

a. Blepharoplasty (eye and lid modification)

b. Face/forehead and/or neck tightening

c. Facial bone remodeling for facial feminization

d. Genioplasty (chin width reduction)

e. Rhytidectomy (cheek, chin, and neck)

f. Cheek, chin, and nose implants

g. Lip lift/augmentation

h. Mandibular angle augmentation/creation/reduction (jaw)

i. Orbital recontouring

j. Rhinoplasty (nose reshaping)

k. Laser or electrolysis hair removal

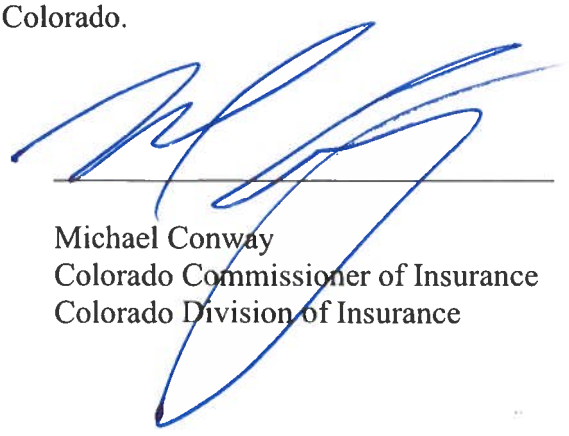
l. Breast/Chest Augmentation, Reduction, Construction

12. In 2020, the Division requested carriers provide information to determine whether carriers were covering gender-affirming care services. The responses indicated that all carriers in the small group market were covering gender-affirming care services. *See Attachment A, Fall 2020 Summary of Colorado Small Group Carrier Coverage of Hormone Therapy and Surgical Genital Procedures*.

13. HHS approved Colorado's EHB Benchmark Plan most recently in 2024 and specifically approved coverage of gender-affirming care services as EHB in 2021 beginning with the 2023 plan year. HHS has not rescinded its approval of these benchmark plans, which are the standardized set of essential health benefits that must be met by a qualified health plan in Colorado. Pursuant to 45 C.F.R. § 155.170, gender-affirming care services are essential health benefits covered in Colorado's EHB-benchmark plan that do not require defrayal. As noted above, the Colorado General Assembly passed House Bill 25-1309, which requires carriers to cover gender-affirming healthcare. Based on then-current law and policy, including HHS' approval of gender-affirming care as EHB in Colorado, state fiscal analysis of House Bill 25-1309 from June 11, 2025, assumed that gender-affirming care did not require defrayal. However, the Final Rule states that CMS would enforce defrayal obligations. If this statement is correct and it is ultimately determined that HHS' Final Rule requires states to defray the costs of gender-affirming healthcare when state anti-discrimination law requires gender-affirming care to be covered by carriers, a state has a previously approved benchmark plan that includes gender-affirming care as EHB, and a mandate to cover gender-affirming healthcare that was signed into state law prior to the adoption of HHS' Final Rule, the estimated defrayal costs borne by Colorado would be substantial.

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

Executed this 16th day of July 2025, in Denver, Colorado.



Michael Conway
Colorado Commissioner of Insurance
Colorado Division of Insurance

EXHIBIT 5

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MASSACHUSETTS

STATE OF CALIFORNIA, et al. *Plaintiffs*, v. ROBERT F. KENNEDY, JR., et al., *Defendants.*	Civil Action No.: 25-12019

DECLARATION OF JAMES MICHEL

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

1. I am the Chief Executive Officer (CEO) at the Connecticut Health Insurance Exchange dba Access Health CT (AHCT) located in Connecticut. I have a Masters of Business Administration (MBA) in Management, Finance and Accounting and a background in management, finance and audit. I have been employed as the CEO since 2018 and have worked at Access Health CT in various roles in Operations and Finance since 2013.

2. Access Health CT (AHCT), Connecticut's official health insurance marketplace established in 2011, supports health reform efforts at the state and national levels. AHCT provides Connecticut residents with resources for better health, and an enhanced and more coordinated healthcare experience, which results in healthier people, healthier communities and a healthier Connecticut. AHCT's mission is to decrease the number of uninsured residents, improve the quality of healthcare, and reduce health disparities through an innovative, competitive marketplace that empowers consumers to choose the health coverage that gives them the best value. Connecticut residents and small business owners can compare and enroll in healthcare coverage and apply for

tax credits for individuals through AHCT. AHCT also partners with the Dept. of Social Services for eligibility and enrollment for state Medicaid Insurance and Children's Health Insurance Programs.

3. I am familiar with the information in the statements set forth below through personal knowledge and from documents and information that have been provided to and reviewed by me.

Introduction

4. When AHCT first began enrolling consumers in health insurance coverage in 2013, our state's uninsured rate was 9.2%. As of 2025, our state's uninsured rate has dropped to 5.2%.

5. Through AHCT, Connecticut has established a competitive market and a robust risk pool, which currently includes 3 health insurance plan issuers and 2 dental plan issuers.

6. AHCT is funded through a market assessment.

7. The flexibility that the U.S. Department of Health and Human Services (HHS) and the Centers from Medicare and Medicaid Services (CMS) have afforded SBEs in operating our unique marketplaces has allowed AHCT and the State of Connecticut to implement innovative policies which make it easier for consumers to enroll in more generous plans at low or no cost. In 2021, the State of Connecticut created the Covered CT program enabling low-income adults who are above the income threshold for Medicaid to enroll in a qualified health plan (QHP) through AHCT with no consumer cost for premiums or cost-sharing. Eligible Connecticut residents with income above the income threshold for Medicaid and up to 175% of the federal poverty limit (FPL) enroll in a Silver-level QHP utilizing the full premium tax credit they are eligible to receive and in the appropriate level cost-sharing reduction (CSR) plan, and the State of Connecticut pays the consumer portion of premium and cost-sharing amounts. The State of Connecticut was granted a Section 1115 waiver for the 5-year demonstration period for the program. There are currently over 48,000 consumers enrolled in the program.

8. Our special enrollment period (SEP) strategies have also been uniquely designed to meet Connecticut's needs, ensuring continuous coverage and minimizing enrollment barriers.

Lack of enrollment fraud

9. AHCT has had very few instances of fraudulent enrollment. A review of consumer complaints and enrollment partner activity in recent years revealed that improper enrollments are exceedingly rare, thanks to the tailored oversight measures we have implemented, such as using the remote identity proofing (RIDP) service available through the Federal Data Services Hub (FDSH); requiring a two-way process for brokers to connect with consumers in the AHCT enrollment system ensuring that the consumer approves the connection before a broker may take any actions on behalf of the consumer; having a Compliance and Disciplinary Policy for Certified Independent Brokers in place since 2015 to govern broker/agents actions within the AHCT system and with AHCT consumers; and, conducting pre-enrollment verification for most applications for Special Enrollment eligibility including proof of permanent move to Connecticut.

10. For the few instances reported, AHCT has taken swift and decisive corrective actions, including investigations, monitoring, warnings, suspensions, and, if necessary, decertifying agents/brokers pursuant to AHCT Compliance and Disciplinary Policy for Certified Independent Brokers.

11. Connecticut's integrated eligibility and enrollment system verifies applicants for both Medicaid, the Children's Health Insurance Program (CHIP) and marketplace coverage, further limiting any potential for fraudulent enrollments.

12. Our data does not show any significant amount of fraud stemming from this low-income SEP. Because of AHCT's tailored program integrity measures, including oversight of enrollment partners and enforcement mechanisms, reports of any improper enrollments within AHCT remain very low.

Lost enrollment revenue

13. We estimate that the Final Rule and other federal policy changes will cause total enrollment in AHCT to decrease by 30-35% by 2034, which is between 46,000 and 54,000 consumers based on AHCT's current enrollment of over 155,000.

14. One direct consequence of this anticipated decrease in enrollment is a loss of assessment revenues. To fund operations, AHCT collects a market assessment currently set at 1.85% percent of the total monthly premiums collected by an issuer for fully insured individual and small group medical and dental plan sold in Connecticut. C.G.S. § 38a-1083(7) authorizes AHCT to "charge assessments or user fees to health carriers that are capable of offering a qualified to health plan through the exchange . . ." and §38a-1083(a) directs AHCT to interpret its powers broadly effectuate its purposes. In 2013, the Board of Directors adopted its Policy: Acquiring Operating Funding authorizing AHCT to determine the amount of the assessment rate as part of the annual budget approval process.

15. If our estimates are accurate, then decreased enrollment due to the Final Rule and other federal policy changes will result in decreases of approximately $4M in assessment revenue per year as enrollment begins to decrease, as premiums will no longer be paid by individuals and small employers who are no longer enrolled in plans in Connecticut.

16. Examples of currently enrolled individuals who we anticipate will enroll in significantly lower numbers under the Final Rule include all consumers receiving financial assistance as there will be more administrative burdens placed on consumers to receive assistance, and the amount of assistance will be smaller, as well as younger consumers who historically enroll in the January during the current Open Enrollment period term, and also low-income consumers generally due to provisions in the Final Rule impacting premium payment thresholds and allowing issuers to require payment of past-due premiums from any prior year before effectuation in a new coverage year.

Compliance costs, including as to Gender Affirming Care

17. We estimate that the numerous changes in the Final Rule will require us to spend at least $300,000 and over 1,000 hours of staff time updating our information technology (IT) systems. Additionally, the rule will require a substantial amount of staff time to implement its requirements and impose significant operational challenges on AHCT.

18. If the comment period for the Proposed Rule had been longer than 23 days, AHCT could have provided CMS with a robust analysis of the fiscal and administrative impact of the Final Rule's changes before they were finalized.

19. Some of the technical changes to our IT systems may be challenging to be completed in time for the 2026 plan year. Specifically, the new income verification requirements—such as requiring documentation when tax data shows income under 100 percent of the FPL and requiring documentation when no tax data is available through the federal data services hub—are impossible to implement without changes our existing system infrastructure.

20. Further, if we are required to implement these changes for 2026 plan year, we will be forced to remove or delay other items currently in scope and budget for our Open Enrollment IT system release that is already scheduled, scoped and budgeted.

21. Implementing these rules would necessitate new system programming and additional manual processes, which would compromise the efficiency of our automated systems. This, in turn, would lead to higher operational costs, greater challenges for consumers, and added strain on critical resources. Specifically, it would impact the accuracy and timeliness of consumer notices, increase the volume and complexity of mailings, require expanded enrollee outreach efforts to address potential confusion, and place additional demands on service center operations, including longer wait times and increased staffing needs to handle inquiries and support requests.

22. Moreover, AHCT on average experiences a high amount of traffic during the OEP. As a result, AHCT requires internal teams and external partners to minimize technical changes during this period of time to prevent any unintended disruptions to consumers' ability to enroll by the deadline.

23. Prior to the Final Rule, exchanges accepted the self-attestation of an enrollee who claimed eligibility by projecting annual household income at or above 100% of the FPL in some cases. The Final Rule changes this policy in two ways. First, anytime IRS data shows that a consumer has income below 100% of the FPL, a "data matching issue" (DMI) will be generated. Second, in the absence of IRS data, a DMI will be generated. Whenever a DMI is generated,

consumers will be required to track down and submit the necessary paperwork in order to purchase health insurance. DMIs also create administrative burdens on SBEs, which are required to receive, process, and determine whether the newly submitted paperwork adequately addresses the issue. These changes impose a heavy burden on SBEs. It is estimated that the volume of DMI for annual income will increase significantly and AHCT will need to spend greatly increased hours to generate and mail numerous DMI notices to consumers, and to receive, process, and review documents generated by these new DMIs, greatly increasing AHCT's operational costs. Updating our eligibility systems and performing technical updates relating to this change will cost approximately over $200,000.

Increased healthcare costs to states

24. The Final Rule acknowledges that the changes it makes will result in a decrease in enrollment in the ACA marketplace exchanges of up to 1.8 million people nationwide.

25. A direct consequence of this decreased enrollment under the Final Rule is a higher rate of uninsured residents in Connecticut, and a corresponding higher amount of costs incurred by Connecticut both in funding programs that pay for certain types of care offered to uninsured residents and costs for providing care that is uncompensated by such programs.

26. In addition, in Connecticut all hospitals are required to treat patients presenting in their emergency departments with acute emergency conditions, regardless of the patient's ability to pay. See Conn. Agency Regs., § 19-13-D3 (j).

Public Health Impacts

27. The Final Rule is detrimental to Connecticut's public health. With increased access to affordable health insurance via AHCT, individuals are more likely to seek preventive care, have better health outcomes and avoid costly emergency room visits. Without access to affordable health insurance, individuals are more likely delay or fail to seek preventive care, resulting in more serious

health outcomes and disease, and incurring costly emergency room visits, and requiring the State of Connecticut to cover costs for uninsured individuals.

28. Increased access to health insurance also improves public health. Uninsured individuals who lack access to affordable, adequate health insurance are less likely to seek preventive care or attend routine health screenings, and may delay necessary medical care due to prohibitive costs.

29. In 2021, AHCT conducted a study of the negative consequences to public health resulting from a lack of access to health insurance along with the disparities that exist in health status and healthcare delivered to lower income people. These factors lead to increased burdens from disease and risk of premature death. Reducing the uninsured rate along with reducing the health disparities that exist is key to improving public health. One of the outcomes of the Study was the creation of the Broker Academy program, designed to increase the number of licensed brokers in targeted communities around the state.

30. Lack of insurance and resulting negative health outcomes also result in downstream consequences, including, absenteeism in the workplace and increased reliance on unemployment insurance, which relies on State funding.

31. Decreased access to adequate and affordable health care could mean infectious diseases spread more widely and rapidly with those affected not seeking care due to being uninsured or underinsured.

Gender-Affirming Care EHBs

32. The ACA mandates that certain individual and small group health plans cover a set of Essential Health Benefits (EHBs) which must be equal to the scope of benefits provided under a typical employer plan and may not have any annual or lifetime dollar limit under state plans.

33. Per HHS, the items and services covered must come from the following ten benefit categories: (1) ambulatory patient services; (2) emergency services; (3) hospitalization; (4) maternity and newborn care; (5) mental health and substance use disorder services including

behavioral health treatment; (6) prescription drugs; (7) rehabilitative and habilitative services and devices; (8) laboratory services; (9) preventive and wellness services and chronic disease management; and (10) pediatric services, including oral and vision care.

34. The ACA and its effectuating regulations permit latitude to the states in determining how EHBs are defined. Accordingly, states submit their "benchmark" plans to HHS for approval. EHBs are a minimum standard, and benchmark plans can choose to offer additional health benefits, like vision, dental, and medical management programs (e.g., weight loss).

35. Each state maintains a benchmark plan on file with HHS, against which private insurers must compare plans to ensure compliance with the standards set forth therein. Further, if a state has not updated its benchmark plan to match federal requirements, private insurers must also review plans for compliance with federal EHB mandates.

36. Connecticut's current benchmark plan is available at: https://www.cms.gov/files/document/ct-bmp-summary-py2025-2027.pdf.

37. Connecticut's statutes requiring mental health parity compliance, C.G.S. § 38a-488a and 38a-514, include parity and coverage for services for the diagnosis and treatment of "mental or nervous conditions" which are defined as those mental disorders in the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM-5-TR). Gender dysphoria is a diagnosis listed in the DSM-5-TR. Connecticut Public Act 11-55 specifically prohibits discrimination on the basis of gender identity or expression with regard to health insurance practices as well as in other areas. Connecticut Insurance Dept. Bulletin IC-34 confirms gender identity nondiscrimination requirements for health insurance coverage. Further, Connecticut S.B. 1380, 2025 prohibits discrimination on the basis of gender identity in the provision of healthcare.

38. QHPs offered through AHCT offer coverage for gender affirming care. Premium for these services will be required to be separated as non-EHB portion of premium by issuers.

39. Although "gender affirming care" is not its own category of EHB, different types of services for gender affirming care are covered through the ten EHB categories: hospitalization; mental health and substance use disorder services including behavioral health treatment;

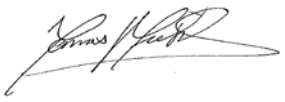
prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services.

40. Even in states like Connecticut, where gender-affirming care is not listed as its own category of EHB in the state's benchmark plan, many services that fall within "gender-affirming care", such as surgeries, hospitalizations, prescription medications, and mental health treatment, are treated as EHBs by state marketplaces.

41. Even in states that do not have a mandate for insurers to cover gender-affirming care, the Rule will reduce the amount of premium eligible for APTCs, which will increase premiums for consumers.

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 July, 2025, in Hartford, Connecticut.



James Michel
Chief Executive Officer
Access Health CT

EXHIBIT 6

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MASSACHUSETTS

STATE OF CALIFORNIA, et al.,

Plaintiffs,

v.

ROBERT F. KENNEDY, JR., in his official capacity as Secretary of Health and Human Services, et al.,

Defendants.

Civil Action No.: 25-12019

DECLARATION OF STEVEN M. COSTANTINO

I, Steven M. Costantino, declare under the penalty of perjury pursuant to 28 U.S.C. § 1746 that the foregoing is true and correct:

1. I am the Director of Health Care Reform and Associate Deputy Secretary at the Delaware Department of Health and Social Services (DHSS). I oversee the Delaware Medicaid program, Public Health, Health Care Quality, and all payment reform models across DHSS. I have been employed in this position since May 2017. I have previously served as Commissioner of the Department of Vermont Health Access and Medicaid Director, and as Secretary of the Executive Office of Health and Human Services in Rhode Island. I have a Master's degree in Health Care Delivery Science from Dartmouth College and a BA in Psychology from Providence College.

2. The DHSS mission is to improve the quality of life for Delaware's citizens by promoting health and well-being, fostering self-sufficiency, and protecting vulnerable populations. DHSS is a consolidated agency comprised of multiple divisions that provide services and funding to support low-income families and vulnerable populations. DHSS is responsible for administering a wide range of health and social service programs, including Medicaid, Delaware Healthy Children's Program (CHIP), Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for

Needy Families (TANF), and other state programs designed to assist individuals, including children, with access to healthcare, food benefits and cash assistance. These programs are crucial to ensure wellness and quality of life at all levels. DHSS also runs the Delaware Psychiatric Hospital and the Delaware Hospital for the Chronically Ill.

3. Delaware does not operate its own health insurance exchange. Rather, consumers in Delaware enroll in health coverage using healthcare.gov, which is operated and maintained by the U.S. Department of Health and Human Services.

4. I am familiar with the information in the statements set forth below through personal knowledge and from documents and information that have been provided to and reviewed by me.

5. I submit this Declaration in support of the States' Motion for a Preliminary Injunction.

6. The Final Rule is detrimental to Delaware's public health and is likely to lead to increased costs to the Delaware state budget.

7. By limiting access to affordable health insurance through the Health Insurance Marketplace, the rule is expected to result in a higher number of uninsured individuals in Delaware.

8. Increased access to affordable health insurance has been a critical mechanism in improving health outcomes for individuals and communities. Access to affordable health care coverage is essential to reducing disparities, promoting early intervention, and improving the overall health status of the population.

9. Insurance coverage facilitates access to preventive services such as immunizations, cancer screenings, chronic disease management, and behavioral health care, services that reduce the burden of illness and prevent complications that often lead to costly emergency department visits and hospitalizations. Individuals who are uninsured or underinsured are significantly less likely to access preventive services or participate in routine health screenings, such as mammograms, blood pressure checks, and vaccinations. These delays can lead to more advanced disease, poorer health outcomes, and higher treatment costs when care is eventually sought.

10. Lack of preventative care often leads to a greater reliance on state-funded programs, such as Medicaid and other safety net services, resulting in increased public expenditures. In addition,

the rule may place further strain on state-run hospitals and long-term care facilities, which may face increased demand from individuals with complex health needs who lack regular access to primary or preventive care.

11. DHSS expects that decreased enrollment in ACA marketplace plans, as a result of the Final Rule, will lead to increased costs to the state in the form of emergency room visits, preventable hospitalizations, and other healthcare expenditures associated with treating uninsured residents. These costs include both direct medical care and broader public health expenses related to managing outbreaks, emergency care surges, and follow-up interventions. The financial impact on state-supported health infrastructure is expected to be substantial and unsustainable over time.

12. DHSS's Public Health Division provides limited coverage, typically restricted to emergency services, and does not cover essential preventive, diagnostic, or specialty care services. These programs often have narrow eligibility criteria and limited provider participation. As a result, uninsured individuals who do not qualify for Medicaid and cannot afford private insurance or out-of-pocket payments are left without a viable option for receiving necessary care. This gap disproportionately affects vulnerable populations and increases reliance on emergency services, which are not designed to manage long-term or preventive health needs.

13. The lack of health insurance and the resulting negative health outcomes that would result if the Final Rule were to go into effect would extend beyond individual health and place broader social and economic pressures on the state. Without consistent access to preventive care, immunizations, and routine screenings, uninsured individuals face a significantly higher risk of untreated chronic conditions, delayed diagnoses, and preventable illnesses. This includes the undetected or unmanaged spread of communicable diseases such as sexually transmitted infections (STIs) and tuberculosis (TB), which pose serious public health threats if not identified and treated early. The consequences of these gaps in care not only compromise long-term health outcomes for individuals but also contribute to avoidable emergency room visits, increased disease transmission, and higher healthcare costs borne by public systems in Delaware.

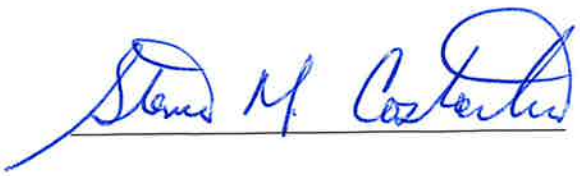
14. Lack of insurance and resulting negative health outcomes also result in downstream consequences, including, absenteeism in the workplace and increased reliance on unemployment insurance, which relies on state funding.

15. Decreased access to adequate and affordable healthcare coverage also heightens the risk of public health emergencies. Uninsured individuals may avoid seeking care for infectious diseases such as influenza, COVID-19, tuberculosis, or sexually transmitted infections due to cost barriers. This delay or avoidance can lead to undetected transmission, larger outbreaks, and increased burden on public health response systems. Ensuring coverage helps enable timely detection, treatment, and containment of communicable diseases, which protects not only individuals but the community at large.

16. As explained above, should the Final Rule go into effect, Delaware and its residents will experience irreparable harm.

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 July, 2025, in New Castle, Delaware.



Steven M. Costantino
Director of Health Care Reform and
Associate Deputy Secretary
Delaware Department of Health and Social Services

EXHIBIT 7

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MASSACHUSETTS

STATE OF CALIFORNIA, et al., *Plaintiffs,* v. ROBERT F. KENNEDY, JR., et al., *Defendants.*	Civil Action No.: 25-12019

DECLARATION OF TRINIDAD NAVARRO

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

1. I am the Commissioner of the Delaware Department of Insurance ("DDOI"). I have served in this role since January 2017.

2. 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.

3. Delaware operates a federally-facilitated exchange through 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.

4. I am familiar with the information in the statements set forth below through personal knowledge and from documents and information that have been provided to and reviewed by me.

5. I submit this Declaration in support of the States' Motion for a Preliminary Injunction.

6. The Final Rule would increase costs to Delaware by removing a group of relatively young and healthy individuals from the pool of insureds participating in health coverage in our State. Over 20% of the current marketplace enrollees in Delaware are aged 25 and younger. In 2024, 31% of Delaware enrollees were 55 years of age or older. Whereas younger, healthier enrollees may opt to be uninsured, these participants will likely remain, creating adverse selection in the marketplace.

7. The Final Rule makes several changes that adversely impact Delaware's risk pool, including, but not limited to, the following.

8. The Final Rule requires the Federal marketplace to conduct pre-enrollment eligibility verification for at least 75% of new enrollments through the SEPs, including the SEPs that can be triggered by events such as a move to a new geographical area or the birth of a child. Compared to verification of SEPs triggered by the loss of minimum coverage, which was required by the prior policy, verification of other SEPs often cannot employ electronic data sources for auto-verification to the same extent, and therefore rely on consumers to submit supporting documentation. As a result, verification of all SEPs is likely to discourage younger, healthier individuals—who are less likely to navigate complex paperwork requirements successfully during life changes—from enrolling, undermining the stability of the risk pool and driving up costs for everyone.

9. The Final Rule requires the Federal marketplace to impose a $5 monthly charge on a subset of automatically reenrolled consumers: those who have $0 premiums because of the APTC that they qualified for. That charge would be levied until the consumer actively re-enrolls in coverage. This provision will pose an unjustified and duplicative reporting burden on consumers in our State who do not have changes to their account. In Delaware, 9,539 of our consumers have sufficient APTC to reduce their premiums to $10 or below. In DDOI's experience, a substantial fraction of those enrollees has sufficient APTC to reduce their premiums to $0. Under the Final Rule, automatic re-enrollees with such fully subsidized premiums would be charged $5 until they undertook an affirmative action to confirm their re-enrollment. The imposition of this unexpected

premium, when the consumer is accustomed to paying $0 out-of-pocket premiums, will cause attrition and lead to lower enrollment in Delaware. Imposing an unnecessary administrative hurdle will cause many of these consumers to lose coverage and is likely to worsen the risk pool by disproportionately causing younger and healthier consumers to lose coverage, which would lead to higher premiums for both subsidized and unsubsidized enrollees.

10. Prior to the Final Rule, exchange plans accepted the self-attestation of an enrollee who claimed eligibility by projecting annual household income at or above 100% of the FPL. This self-attestation policy was designed to ensure that the lowest-income enrollees, who are often younger and healthier, are not discouraged from entering the risk pool due to paperwork burdens. The prior policy also recognized the challenges that low-income individuals, who may have seasonal employment, be independent contractors, or participate in the gig economy, face in accurately estimating their annual income. Many low-income individuals experience significant fluctuations in their earnings over the course of the year. The Final Rule's elimination of this practice is an administrative barrier to enrollment that will likely cause younger and healthier consumers to drop out of the marketplace. That, in turn, will worsen the risk pool and increase premiums for both subsidized and unsubsidized consumers.

11. The *de minimis* thresholds in the Final Rule limit Delaware's ability to be the primary enforcer of plan generosity and metal-rating provisions. This will affect Delaware's federally-approved 1332 Waiver by shifting the metal levels of local plans and could reduce or eliminate the 15.3% in premium savings predicted by CMS. We have already seen carriers filing rates that reflect much smaller premium savings for next year than were anticipated.

12. The Final Rule acknowledges that the changes it makes will result in a decrease in enrollment in the ACA marketplace exchanges of up to 1.8 million people nationwide.

13. 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."

14. Because health insurance carriers receive a monthly premium payment for each individual enrolled in their insurance plans, the total monthly premium collected by a 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.

15. Thus, for each individual who ceases to be enrolled in a health benefit 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.

16. The ACA mandates that certain individual and small group health plans cover a set of Essential Health Benefits (EHBs) which must be equal to the scope of benefits provided under a typical employer plan and may not have any annual or lifetime dollar limit under state plans.

17. Per HHS, the items and services covered must come from the following ten benefit categories: (1) ambulatory patient services; (2) emergency services; (3) hospitalization; (4) maternity and newborn care; (5) mental health and substance use disorder services including behavioral health treatment; (6) prescription drugs; (7) rehabilitative and habilitative services and devices; (8) laboratory services; (9) preventive and wellness services and chronic disease management; and (10) pediatric services, including oral and vision care.

18. Gender dysphoria is a specific diagnosis with relevant criteria and standards of care. Certain treatments for a gender dysphoria diagnosis fall into the above benefit categories.

19. The ACA and its effectuating regulations permit latitude to the states in determining how EHBs are defined. Accordingly, states submit their "benchmark" plans to HHS for approval. EHBs are a minimum standard, and benchmark plans can choose to offer additional health benefits, like vision, dental, and medical management programs (e.g., weight loss).

20. Each state maintains a benchmark plan on file with HHS, against which private insurers must compare plans to ensure compliance with the standards set forth therein. Further, if a state

has not updated its benchmark plan to match federal requirements, private insurers must also review plans for compliance with federal EHB mandates.

21. Delaware's EHB benchmark plan can be found here: https://www.cms.gov/marketplace/resources/data/essential-health-benefits#Delaware. An EHB benchmark plan may not necessarily contain all voluntary coverages offered by carriers, or all mandated coverages required by a state.

22. Delaware's Gender Identity Nondiscrimination Act of 2013 (the "Gender Identity Nondiscrimination Act") prohibits discrimination based on gender identity in employment, housing, public accommodations, and insurance.

23. The Gender Identity Nondiscrimination Act added nondiscrimination protections to two provisions of the Delaware Insurance Code. When these laws are read together, they unequivocally prohibit the denial, cancellation, termination, limitation, refusal to issue or renew, or restriction, of insurance coverage or benefits thereunder on the basis of a person's gender identity or transgender status, or because the person is undergoing gender transition.

24. Private insurance plans offered in Delaware generally cover gender-affirming care. Because of that, marketplace plans offered in Delaware also cover gender-affirming care. Their plans for 2026 including such care have already begun review processes according to federally-set timelines.

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

Executed this 16th day of July, 2025, in Lewes, Delaware.

Trinidad Navarro
Insurance Commissioner
Delaware Department of Insurance

EXHIBIT 8

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MASSACHUSETTS

STATE OF CALIFORNIA, et al. *Plaintiffs*, v. ROBERT F. KENNEDY, JR., et al., *Defendants.*

Civil Action No.: 25-12019

DECLARATION OF JENNIFER EPSTEIN

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

1. I am the Deputy Director of the Office of Policy, Planning, and Statistics (OPPS) at the Illinois Department of Public Health (IDPH). I have a Master of Science in Urban and Regional Planning from the University of Wisconsin-Madison, with a concentration in community development, and a Bachelor of Arts from Macalester College in St. Paul, MN. I have been employed as the Deputy Director for OPPS since October 2022. I have over 15 years of experience in public health and a professional background that includes roles in both the nonprofit and public sectors in international and domestic settings.

2. IDPH is an advocate for and partner with the people of Illinois to re-envision health policy and promote health equity, prevent and protect against disease and injury, and prepare for health emergencies. IDPH plays a vital role in supporting hospitals and advancing healthcare access. OPPS's mission is to collect, analyze, and evaluate information on health status, needs, and disease occurrence in Illinois; conduct epidemiologic studies; support health assessments and

planning; and identify future needs for health care facilities, services, and personnel. OPPS preserves the state's records on births, deaths, marriages, civil unions, and dissolutions.

3. I am familiar with the information in the statements set forth below through personal knowledge and from documents and information that have been provided to and reviewed by me, in my professional capacity.

4. I submit this Declaration in support of the States' Motion for a Preliminary Injunction.

5. Prior to the passage of the Affordable Care Act (ACA), 17% of Illinois residents under age 65 had no health insurance. Following the passage of the ACA, that rate dropped by more than half and is now 8%.

6. The 2025 Marketplace Integrity and Affordability Final Rule (Final Rule), issued by CMS on June 25, 2025, acknowledges that the changes it makes will decrease enrollment in the ACA marketplace exchanges by about 1.8 million people nationwide. Final Rule, Table 16. I understand that the Illinois Department of Insurance estimates this will mean about 14,000 Illinoisians lose their ACA exchange-based insurance. (Winters Declaration dated 7-11-25 at ¶ 9).

7. A direct consequence of this decreased enrollment under the Final Rule is a higher rate of uninsured in Illinois, and a corresponding higher amount of costs incurred by Illinois and its hospitals.

8. In Illinois, all hospitals are required to treat patients who present to their emergency departments, regardless of any patient's ability to pay. 210 ILCS 70/1; 210 ILCS 80/1; 42 U.S.C. § 1395dd.

9. Many hospitals operate as "community hospitals," also known as "safety net" hospitals. A safety net hospital or health system provides a significant level of care to low-income, uninsured, and vulnerable populations. Safety net hospitals are not necessarily distinguished from other hospitals by ownership. Some are publicly owned and operated by local or state governments, and others are non-profit entities.

10. In Illinois, a hospital is designated a "safety net hospital" if it meets specific criteria. That includes being licensed by IDPH as a general acute care or pediatric hospital; qualifying as a Medicaid "Disproportionate Share" hospital per federal law (Section 1923 of the federal Social Security Act, 42 U.S.C. §1396-r4) and either having a Medicaid inpatient utilization rate (MIUR),[1] of at least 40%, and a charity percent[2] of at least 4%; or having a MIUR of at least 50%. 305 ILCS 5/5-5e.1. Some hospitals also are grandfathered into this status, based on their historic MIUR and charity rates. *Id.*; 305 ILCS 5/5-5e.1(c) and (c-5). In Illinois, approximately 34 hospitals meet the statutory definition of safety net hospital.

11. In addition, Illinois also has approximately 58 critical access hospitals. A "critical access hospital" is a Medicare-certified rural hospital, at least 35 miles drive away from any other hospital, offering 24-hour, 7-day-a-week emergency care. Critical access hospitals have no more than 25 inpatient beds and maintain an annual average length of stay of no more than 96 hours for acute inpatient care.

12. Many Illinois hospitals, especially those in rural communities and traditionally underserved areas of metropolitan areas, are already at or near a financial breaking point. Most

[1] MIUR is the percentage of a hospital's inpatient stay days used by Medicaid-eligible patients. 305 ILCS 5/5-5e.1(b)(2).
[2] Charity percent means the percentage of hospital charges that are for services provided to patients without health insurance or another source of coverage. 305 ILCS 5/5-5e.1(b)(1).

facilities that care for the uninsured or underinsured are operating at very low profit margins, with no financial buffer to absorb an increase in uninsured patients. Far above the 4% charity percent qualifier for a safety net hospital (depending on the qualification method), 40% of inpatients at Illinois hospitals are categorized and served as charity care patients, meaning patients without insurance or ability to pay.

13. The Final Rule, in increasing the population of uninsured Illinois residents, would reduce the revenue and thus operation of its hospitals, particularly its safety net and critical access hospitals. Increasing the number of uninsured Illinois residents likely would cause many of the safety net and critical access hospitals with lower profit margins to severely reduce the level of services they currently provide or cause such facilities to close altogether. The closure or severe reduction of services by safety net and critical access hospitals will ultimately affect other hospitals, as they will have no choice but to absorb uninsured patients.

14. A reduction of access to health services through safety net hospitals, particularly preventative and screening services, will result in an increase in poor health outcomes for vulnerable populations with historically poor track records. This in turn increases costs when those same people, now much sicker than they were initially, finally seek care. Decreased access to adequate and affordable health care also contributes to infectious diseases spreading more widely and rapidly, where those affected do not seek care due to being uninsured or underinsured.

15. If there is an increase in the uninsured population, Illinois patients utilizing safety net hospitals will face even longer delays receiving healthcare than they already do. Illinois patients may need to travel farther to receive services, which will again impact health outcomes, as many individuals will forgo preventative care where distance or a lack of transportation create barriers.

16. The potential loss of safety net hospitals would create financial instability far beyond the healthcare services lost by the individual closure of a safety net hospital. Hospitals are important to the economy as major employers, particularly in rural areas. The inevitable reduction in services would lead to an adverse impact on the workforce of the facility and the surrounding areas. The loss of employment would likely result in even more individuals becoming uninsured yet still needing healthcare, further impacting the local economy. Lack of insurance and resulting negative health outcomes also result in other downstream consequences, including absenteeism in the workplace and increased reliance on unemployment insurance, which relies on State funding.

17. Illinois residents recognize the adverse effects of reducing access to affordable healthcare on the broader community. For example, in connection with a now-pending application for a safety net hospital in Ottawa, Illinois to close its obstetric and intensive care operations and redirect patients to another location about a 30-minute drive away, local businesses and regional chambers of commerce are organizing against this outcome. Ahead of a state board vote, those community members have come together in significant numbers to emphasize the importance of access to comprehensive healthcare services in maintaining a community's economic vitality.

18. If safety net and critical access hospitals are forced to close or are unable to provide services to a larger uninsured population, the state will be very limited in its ability to fill in the gaps. Even if the state legislature were to enact new laws to address these gaps, a considerable amount of time and resources would be needed to implement a functioning system. In the meantime, residents of the affected areas would still face all the above issues.

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

Executed this 15 day of July, 2025, in Chicago, Illinois.

Jennifer Epstein

JENNIFER EPSTEIN
Deputy Director
Office of Policy, Planning and Statistics
Illinois Department of Public Health
Paper document bears an original signature

EXHIBIT 9

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MASSACHUSETTS

STATE OF CALIFORNIA, *et al.*, *Plaintiffs*, v. ROBERT F. KENNEDY, JR., in his official capacity as Secretary of Health and Human Services, *et al.*, *Defendants.*	Civil Action No.: 25-12019

DECLARATION OF MORGAN WINTERS

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

1. I am the Marketplace Director at the Illinois Department of Insurance. 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 am familiar with the information in the statements set forth below through personal knowledge and from documents and information that have been provided to and reviewed by me.

5. I submit this Declaration in support of the States' Motion for a Preliminary Injunction.

Illinois' Health Insurance Marketplace

6. Get Covered Illinois ("GCI") is the state's official health insurance marketplace, located within the Illinois Department of Insurance. GCI is currently operating in its first year as a State-based Marketplace on the Federal Platform ("SBM-FP"). That means GCI fulfills certain functions of a State-based Marketplace—such as administering a navigator program, managing marketing and outreach, maintaining a public website and toll-free number that provide general information about the Affordable Care Act to Illinois residents, and certifying Qualified Health Plans—while utilizing the federal marketplace platform at Healthcare.gov to support eligibility and enrollment functions and provide customer service. GCI is awaiting approval from the Centers for Medicare & Medicaid Services to operate GCI as a fully independent State-based Marketplace for the upcoming open enrollment period beginning November 1, 2025.

7. GCI has established a competitive market, a robust risk pool, and currently includes 11 health insurance issuers of medical plans and 8 issuers of dental plans.

8. GCI is funded through a combination of establishment funding from the state for initial implementation of the marketplace and user fee collection from the GCI health insurance issuers, which supports ongoing operations. In Fiscal Year 2024, Illinois paid $1.25 million to maintain the program.

Impact of Final Rule on Enrollment Revenue

9. Based on the Congressional Budget Office's estimate[1] of a 0.9 million increase in uninsured for the proposed version of the CMS "Marketplace Integrity and Affordability Rule"[2] and CMS' estimate[3] of 24 million ACA Marketplace enrollees nationwide, the proposed version of the rule would have caused a national decrease in enrollment of 3.75%. Because some provisions of the proposed rule that would have had negative enrollment impacts were not adopted in the Final Rule,[4] and lacking an updated estimate from the CBO about the Final Rule, we estimate that the Final Rule will cause total enrollment in GCI to decrease by 3% and will also cause the risk pool to significantly worsen, thereby causing premiums to rise. Based on the CMS state-level data on Illinois exchange participants for Plan Year 2025,[5] a 3% drop would mean about 14,000 people in Illinois would lose their health insurance access.

10. One direct consequence of this anticipated decrease in enrollment is a loss of State revenues. To fund operations, GCI collects a user fee of 0.5% as a State-based Marketplace on the Federal Platform and will, as a State-based Marketplace starting with Plan Year 2026, collect 2.75% of the total monthly premiums collected by an issuer for each medical or dental plan

[1] Congressional Budget Office. "Re: Estimated Effects on the Number of Uninsured People in 2034 Resulting From Policies Incorporated Within CBO's Baseline Projections and H.R. 1, the One Big Beautiful Bill Act" (Jun. 4, 2025). *Available at:* https://www.cbo.gov/system/files/2025-06/Wyden-Pallone-Neal_Letter_6-4-25.pdf.
[2] 90 Fed. Reg. 12542 (Mar. 19, 2025). *Available at*: https://www.federalregister.gov/documents/2025/03/19/2025-04083/patient-protection-and-affordable-care-act-marketplace-integrity-and-affordability.
[3] Centers for Medicare and Medicaid Services. Press Release (Jan. 17, 2025). *Available at:* https://www.cms.gov/newsroom/press-releases/over-24-million-consumers-selected-affordable-health-coverage-aca-marketplace-2025.
[4] 90 Fed. Reg. 27074 (Jun. 25, 2025). *Available at*: https://www.federalregister.gov/documents/2025/06/25/2025-11606/patient-protection-and-affordable-care-act-marketplace-integrity-and-affordability.
[5] Centers for Medicare and Medicaid Services. 2025 Marketplace Open Enrollment Period Public Use Files. *Available at:* https://www.cms.gov/data-research/statistics-trends-reports/marketplace-products/2025-marketplace-open-enrollment-period-public-use-files.

purchased through our individual exchange pursuant to 215 ILCS 122/5-21.[6] Since January 2025, GCI has collected $7,967,139.99 in user fees at the 0.5% rate.

11. Therefore, when enrollment in GCI decreases, the issuer no longer receives those premiums and thus no longer pays a portion of them to the State of Illinois. Based on our estimates, the decreased enrollment in GCI in Illinois because of the Final Rule will result in approximately $1.8 million in lost user fee revenue for 2026.

12. According to CMS data, 418,039 Illinois consumers receive APTCs for Plan Year 2025 to make their coverage more affordable.[7] The Inflation Reduction Act of 2022 enhanced these subsidies through the end of 2025 and the average tax credit among Illinoisans enrolled in Marketplace coverage is $540.[8] With the anticipated end of these subsidy enhancements after 2025 leading to higher monthly premiums, the Final Rule will compound the effect on Marketplace enrollees by allowing QHP issuers to deny new coverage for individuals with past-due premiums. This alarming rise in premium costs would lead to potentially thousands of Illinois residents losing health insurance.

Impact of Final Rule on Compliance Costs

13. Prior to the Final Rule, exchange plans accepted the self-attestation of an enrollee who claimed eligibility by projecting annual household income at or above 100% of the FPL. The Final Rule changes this policy in two ways. First, anytime IRS data shows that a consumer has income below 100% of the FPL, a "data matching issue" (DMI) will be generated. Second, in the absence of IRS data, a DMI will be generated. Whenever a DMI is generated, consumers will be required to track down and submit the necessary paperwork to purchase health insurance. DMIs

[6] Statutorily, the user fee is the same for plans purchased through Illinois's small business exchange, but currently that exchange is not operational because issuers are not offering and have not proposed to offer plans through the small business exchange.
[7] *See* n.5, *supra*.
[8] *Id.*

also create administrative burdens on State Based Exchanges ("SBEs"), which are required to receive, process, and determine whether the newly submitted paperwork adequately addresses the issue.

14. These changes impose a burden on SBEs. GCI and its contractor will need to spend additional staff time analyzing the rule, confirm the information technology updates are correctly implemented, and create communications and content. This may cost in the tens of thousands of dollars. Also, the need to prioritize these updates has created risk and opportunity cost because our user acceptance testing contractor has had to prioritize the changes from the Final Rule, which diverted our contractor's focus away from other time-sensitive tasks related to Illinois' transition to a full State-based Marketplace for Plan Year 2026.

15. With respect to providing essential health benefits for gender-affirming care, the Final Rule will force GCI to examine carrier submissions to ensure the appropriate amounts have been excluded from federal cost-sharing. GCI will need to implement technical assistance on the back end to ensure this is done consistently across the market in Illinois. This will take up valuable time and resources. In addition, insurance carriers in Illinois do not all maintain their data in the same way. This means that conducting targeted assessments will be necessary to ensure that gender-affirming care services, which can take many different forms, have been excluded from coverage as EHBs. These targeted assessments would require additional time on part of marketplaces.

Impact of Final Rule on Risk Pool

16. The Final Rule would increase costs to Illinois by removing a pool of relatively young and healthy individuals from the pool of insureds participating in state-based exchanges.

17. The Final Rule makes several changes that adversely impact GCI's risk pool, including, but not limited to, the following.

18. The Final Rule shortens the annual Open Enrollment Period ("OEP") for the Federally Facilitated Exchange ("FFE") from 76 to 45 days, and it prohibits the SBEs from having an OEP that ends later than December 31. Since Plan Year 2022, Illinois has had an OEP from November 1 through January 15. Having an OEP of 76 days, or approximately two and a half months, has allowed our Exchange to increase enrollment and strengthen our risk pool by encouraging younger and healthier consumers to enroll. Even with a much longer OEP than the 45 days permitted by the Final Rule, our enrollment partners experience overwhelming demand and work long hours to renew their existing customers and enroll new ones. Reducing the OEP to just 45 days, or six weeks, would severely strain our enrollment partner workforce and likely hinder their ability to reach and enroll qualifying individuals, which would likely degrade the risk pool. CMS claims that a longer OEP does not boost enrollment and contributes to adverse selection; however, our data and experience show otherwise. The longer OEP has strengthened our risk pool and enhanced market stability.

19. The Final Rule also denies consumers Advance Premium Tax Credit ("APTC") eligibility and imposes a tax liability where an individual fails to file taxes and reconcile the projected household income that qualified them for APTC after one year, rather than after two consecutive years, which was the previous policy. This added barrier to marketplace enrollment will discourage healthier individuals from enrolling, deteriorate the risk pool, and lead to higher premiums for those who remain insured.

20. The Final Rule requires all FFEs and SBM-FPs to impose a $5 monthly charge on a subset of automatically reenrolled consumers: those who have $0 premiums because of the APTC for which they are qualified.[9] That charge would be levied until the consumer affirmatively re-

[9] In Illinois, all premiums are at least $1 per month. This paragraph is included in the event CMS applies this provision to any Illinois SBM-FP plans.

enrolls in coverage. This provision will pose an unjustified and duplicative reporting and financial burden on consumers who do not have changes to their account. Imposing an unnecessary administrative hurdle will cause many of these consumers to lose coverage and is likely to worsen the risk pool by disproportionately causing younger and healthier consumers to lose coverage, which would lead to higher premiums for both subsidized and unsubsidized enrollees.

21. Prior to the Final Rule, exchange plans accepted the self-attestation of an enrollee who claimed eligibility by projecting annual household income at or above 100% of the FPL. This self-attestation policy was designed to ensure that the lowest-income enrollees, who are often younger and healthier, are not discouraged from entering the risk pool due to paperwork burdens. The prior policy also recognized the challenges that low-income individuals face in accurately estimating their annual income. Many low-income individuals experience significant fluctuations in their earnings over the course of the year. The Final Rule's elimination of this practice is an administrative barrier to enrollment that will likely cause younger and healthier consumers to drop out of the marketplace. That, in turn, will worsen the risk pool and increase premiums for both subsidized and unsubsidized consumers.

Impact of Final Rule's Prohibition on Designating Gender-Affirming Care as an Essential Health Benefit

22. The ACA mandates that certain individual and small group health plans cover a set of Essential Health Benefits (EHBs) which must be equal to the scope of benefits provided under a typical employer plan and may not have any annual or lifetime dollar limit under state plans.

23. Per HHS, the items and services covered must come from the following ten benefit categories: (1) ambulatory patient services; (2) emergency services; (3) hospitalization; (4) maternity and newborn care; (5) mental health and substance use disorder services including behavioral health treatment; (6) prescription drugs; (7) rehabilitative and habilitative services and

devices; (8) laboratory services; (9) preventive and wellness services and chronic disease management; and (10) pediatric services, including oral and vision care.

24. The ACA and its effectuating regulations permit latitude to the states in determining how EHBs are defined. Accordingly, states submit their "benchmark" plans to HHS for approval. EHBs are a minimum standard, and benchmark plans can choose to offer additional health benefits, like vision, dental, and medical management programs (e.g., weight loss).

25. Each state maintains a benchmark plan on file with HHS, against which private insurers must compare plans to ensure compliance with the standards set forth therein. Further, if a state has not updated its benchmark plan to match federal requirements, private insurers also must review plans for compliance with federal EHB mandates.

26. Illinois most recently updated the Illinois EHB Benchmark Plan effective for the 2020 Plan Year and onward.

27. State laws in Illinois prohibit discrimination in healthcare coverage. In Illinois, this includes discriminating on the basis of an insured's or prospective insured's actual or perceived gender identity, or on the basis that the insured or prospective insured is a transgender person. For example, health insurance coverage offered in Illinois must not contain discriminatory exclusionary clauses; limit, charge a higher rate for, or deny a claim for coverage of hospital and medical benefits for gender dysphoria if the benefits are provided for other medical conditions; cancel, limit, or refuse to issue or renew an insurance policy on the basis of an insured's or prospective insured's actual or perceived gender identity, or for the reason that the insured or prospective insured is a transgender person, or because the insured or prospective insured has undergone, or is in the process of undergoing, gender transition; exclude from, limit, charge a higher rate for, or deny a claim for coverage for the surgical treatments for gender dysphoria; deny or limit coverage relating to health care services that are ordinarily available to individuals of one

sex based on the fact that an individual's sex assigned at birth, actual or perceived gender identity, or gender otherwise recorded is different from the one to which such services are ordinarily available; or, subject to medical necessity under generally accepted standards of care, deny or limit coverage for covered services relating to gender transition based on a categorical age limitation. 50 Ill. Adm. Code 2603.35.

28. Even in states like Illinois, where gender-affirming care is not listed as its own category of EHB in the state's benchmark plan, many services that fall within "gender-affirming care," such as surgeries, prescription medications, and mental health treatment, are treated as EHBs by state marketplaces. The Illinois EHB Benchmark Plan covers surgeries on an outpatient and inpatient hospital basis, prescription medications, and mental health treatment, and it has no exclusions that conflict with Illinois' prohibitions on gender identity discrimination listed above.

29. To the extent that the Rule may override the Illinois EHB Benchmark Plan by determining gender-affirming care not to be EHB, the Rule will reduce the amount of premium eligible for APTCs, which will increase premiums for consumers. Based on data submitted by health insurance issuers seeking certification of qualified health plans for Plan Year 2026, APTCs may decrease up to 0.4% as a result of switching these forms of gender-affirming care from EHB to non-EHB status.

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

Executed this 11 day of July 2025, in Chicago, Illinois.

Morgan Winters

MORGAN WINTERS
Marketplace Director
Illinois Department of Insurance
Paper document bears an original signature

EXHIBIT 10

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MASSACHUSETTS

STATE OF CALIFORNIA, et al. *Plaintiffs*, v. ROBERT F. KENNEDY, JR., et al., *Defendants.*	Civil Action No.: 25-12019

DECLARATION OF HILARY SCHNEIDER

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

1. I am the Director at the Office of the Health Insurance Marketplace, Maine Department of Health and Human Services, located in Maine. I have a Master in Public Policy from Harvard Kennedy School of Government and a Bachelor of Arts in Economics from Bates College. I have been employed as the Director of Maine's State-Based Marketplace since September 2023. Previously, I served as a government relations director for the American Cancer Society Cancer Action Network for more than a decade, and have also held professional positions in economic and management consulting, market research, and consumer marketing. I have worked in roles conducting policy research and analysis related to Maine's health coverage landscape for nearly twenty years.

2. The Office of the Health Insurance Marketplace (OHIM) is an office within the State of Maine Department of Health and Human Services (Maine DHHS). OHIM administers the State of Maine's State-Based Health Insurance Exchange (SBE), which operates as CoverME.gov. OHIM is responsible for consumer enrollment into qualified health and dental plans and eligibility

for advance premium tax credits. OHIM oversees training and certification of brokers and Maine Enrollment Assisters, who are eligible to enroll Maine consumers in CoverME.gov health insurance coverage. OHIM has contracts with vendors who provide the following services: development, maintenance and operations of the eligibility and enrollment platform, consumer assistance center (call center and live chat) operations, marketing services, and consumer outreach and navigation.

3. I am familiar with the information in the statements set forth below through personal knowledge and from documents and information that have been provided to and reviewed by me.

4. I submit this Declaration in support of the States' Motion for a Preliminary Injunction.

Introduction

5. CoverME.gov was established in 2020 through a hybrid model, where the federal marketplace was used as the enrollment platform and then transitioned to a full state-based marketplace in 2021 for the Plan Year 2022 Open Enrollment Period. Currently, CoverME.gov provides health coverage to more than 62,000 Maine residents. During the last Open Enrollment Period (November 1, 2024-January 15, 2025), 64,678 Maine residents enrolled in health coverage through CoverME.gov, including 11,285 new consumers. Eighty-five percent of consumers enrolled in coverage with Advance Premium Tax Credits ("APTC"), which helped lower their monthly premium costs. Maine's SBE provides coverage to individuals and families that were previously uninsured, and the plans sold through our marketplace provide coverage for gender-affirming care, as required by state law.

6. When CoverME.gov was established in 2020, Maine's uninsured rate was approximately 8 percent. As of 2025, Maine's uninsured rate has dropped to approximately 6 percent.

7. Maine's SBE has established a competitive market, a robust risk pool, and currently includes four health insurance plan issuers and two dental plan issuers.

8. CoverME.gov is primarily funded through an assessment on health and dental plan issuers equivalent to 3% of premiums charged for plans sold through marketplace. The SBE is also funded by federal Medicaid matching funds for eligible expenditures and some grant funding. In Fiscal Year 2024, Maine's SBE had operating expenditures of $13.8 million.

9. The flexibility that the U.S. Department of Health and Human Services (HHS) and the Centers from Medicare and Medicaid Services (CMS) have afforded SBEs in operating our unique marketplaces has allowed us to implement innovative policies which make it easier for consumers to enroll in more generous plans at low or no cost. For example, when determining coverage and/or premium tax credit eligibility, CoverME.gov allows self-attestation to verify certain eligibility criteria, including household income, residency, tribal membership, and family size changes. This flexibility provides consumers with the ability to prove eligibility in situations where documentation is unavailable or overly burdensome to obtain. Additionally, it has allowed CoverME.gov to successfully design qualified health plans that comply with Maine laws and develop targeted outreach and marketing campaigns utilizing Maine-specific data that best engage our state's residents, and leverage agency relationships and areas of opportunity. Close relationships and partnerships with our state's Medicaid offices and Bureau of Insurance (BOI) allow us to investigate, respond to, and resolve complaints and enrollment issues quickly.

10. Our special enrollment period (SEP) strategies have also been uniquely designed to meet Maine's needs, ensuring continuous coverage and minimizing enrollment barriers.

Lack of Enrollment Fraud

11. CoverME.gov has had very few instances of fraudulent enrollment. In fact, I am not aware of any fraudulent enrollment since the state transitioned to an SBE. A review of consumer complaints and enrollment partner activity in recent years revealed that improper enrollments are exceedingly rare, thanks to the tailored oversight measures we have implemented, such as requiring agents to be assigned to consumer accounts through verified consumer consent using secure methods like consumer action either in the portal or by calling the call center. If a broker calls the call-center on behalf of a client without such verification, a three-way call with the consumer is required before proceeding. In addition, CoverME.gov's close partnership with the BOI allows us to coordinate efforts in documenting, investigating, and taking any necessary action in response to consumer complaints or evidence brought to our attention through other means related to inappropriate broker or Enrollment Assister conduct. These actions can include written warnings, required retraining, and/or removal of SBE certification or loss of professional licensure. Brokers and Enrollment Assisters are required to complete annual training and certification and enter into binding legal agreements with the SBE, in addition to the BOI's professional licensure requirements. CoverME.gov's team meets monthly by video with brokers and navigators to elicit feedback, answer questions, and present updated information. A quarterly email newsletter is sent to brokers and enrollment assisters, with interim email updates provided as needed and as capacity allows. These regular methods of communication provide opportunities to distribute user guides, reminders and other updates, including addressing areas of concern identified through recent consumer case escalations.

12. For the few instances reported, CoverME.gov has taken swift and decisive corrective actions, including investigations, monitoring, required retraining, and warnings. To date, I am not aware of any instances that have required suspensions or decertifying agents, but those options are available if the actions are determined to be in violation of law or regulation. BOI has the authority to revoke licensure if an agent has lost their license in another state. While I am not aware of instances where this has happened with agents certified by CoverME.gov, BOI has taken such action with insurance agents that work outside of the SBE.

13. Although Maine does not have an integrated eligibility and enrollment system, CoverME.gov does screen applicants for Medicaid and SBE eligibility and Maine DHHS has an account transfer process between CoverME.gov and the Maine DHHS Office of Family Independence, which is responsible for final determinations on Medicaid eligibility. In addition, two members of the CoverME.gov team have access to the Medicaid eligibility and enrollment system and can look up individuals and households within that system. The close partnership between the two offices further limits any potential for fraudulent enrollment.

Lost Enrollment Revenue

14. OHIM estimates that the Final Rule will cause total enrollment in CoverME.gov to decrease by 10-15%, and will also cause the risk pool to worsen, resulting in a rise in premiums.

15. One direct consequence of this anticipated decrease in enrollment is a loss of Maine revenues. To fund operations, CoverME.gov collects a user fee of 3 percent of the total monthly premiums collected by an issuer for each plan purchased through our individual exchange, pursuant to 22 M.R.S. § 5406.

16. Based on current assessments, decreased enrollment due to the Final Rule will result in approximately $200,000 or more in revenue lost from fees no longer collected on premiums no longer paid by individuals who are no longer enrolled in plans via CoverME.gov.

17. Examples of currently enrolled individuals who we anticipate will enroll in significantly lower numbers under the Final Rule include younger, healthy individuals, individuals who are older or live in rural parts of the state, individuals with low- or variable incomes, and immigrants who are lawfully present immigrants.

Compliance Costs

18. OHIM estimates that the numerous changes in the Final Rule will require us to spend more than $2 million and more than 500 hours of staff time updating our information technology (IT) systems. Additionally, the rule will require a substantial amount of staff time to implement its requirements and impose significant operational challenges on our SBE. With all available resources currently focused on preparing for Open Enrollment, OHIM's capacity to take on additional work is extremely limited. The anticipated system and operational changes require hundreds of hours of system testing, rewriting consumer, broker, and assister guides, updating website content and scripts, and developing training materials for stakeholders. Given the compressed timeline – where any system changes could not be deployed until just before renewals begin – there is a high risk of disrupting critical support functions and compromising the overall success of this year's open enrollment period. Implementing technology changes without proper lead time can result in the introduction of bugs in the system, which can lead to system outages, as well as improper enrollments and security vulnerabilities.

19. If the comment period for Proposed Rule had been longer than 23 days, OHIM could have provided CMS with a robust analysis of the fiscal and administrative impact of the Final Rule's changes before they were finalized.

20. Some of the technical changes to our IT systems cannot be completed in time for the 2026 plan year. Specifically, new income verification requirements—such as requiring documentation when tax data shows income under 100 percent of the FPL, requiring documentation when no tax data is available through the federal data services hub and eliminating the additional 60-day window to verify household income—are impossible to implement within our existing system infrastructure.

21. Implementing these rules would necessitate new system programming and additional manual processes, which would compromise the efficiency of our automated systems. This, in turn, would lead to higher operational costs, greater challenges for consumers, and added strain on critical resources. Specifically, it would impact the accuracy and timeliness of consumer notices, increase the volume and complexity of mailings, require expanded enrollee outreach efforts to address potential confusion, and place additional demands on service center operations, including longer wait times and increased staffing needs to handle inquiries and support requests.

22. Moreover, CoverME.gov on average experiences a high amount of traffic during the OEP. As a result, OHIM requires that its internal teams and external partners minimize technical changes during this period of time to prevent any unintended disruptions to consumers' ability to enroll by the deadline.

23. Prior to the Final Rule, exchange plans accepted the self-attestation of an enrollee who claimed eligibility by projecting annual household income at or above 100% of the FPL. The Final Rule changes this policy in two ways. First, anytime IRS data shows that a consumer has

income below 100% of the FPL, a "data matching issue" (DMI) will be generated. Second, in the absence of IRS data, a DMI will be generated. Whenever a DMI is generated, consumers will be required to track down and submit the necessary paperwork in order to purchase health insurance. DMIs also create administrative burdens on SBEs, which are required to receive, process, and determine whether the newly submitted paperwork adequately addresses the issue. These changes impose a heavy burden on SBEs. OHIM estimates that CoverME.gov will need to spend over 2,000 hours to receive, process, and review documents generated by these new DMIs, costing over $120,000.00. This cost includes conducting outreach and determining DMI outcomes for applicants whose tax return data is unavailable. Updating our eligibility systems and performing technical updates relating to this change will cost approximately $600,000.00.

Risk Pool Impacts

24. CoverME.gov has consistently cultivated a stable and healthier risk pool since transitioning to an SBE. This is reflected in the individual Plan Liability Risk Score (PLRS) scores, designed to be a measure of liability risk present within a healthcare plan, which have gone down from a range of 1.363-1.476 when Maine operated on the FFE to 1.215-1.289 since transitioning to an SBE (excluding the COVID year in 2020).

Increased Healthcare Costs to States and Uncompensated Care

25. The Final Rule acknowledges that the changes it makes will result in a decrease in enrollment in the ACA marketplace exchanges of up to 1.8 million people nationwide.

26. A direct consequence of this decreased enrollment under the Final Rule is a higher rate of uninsured in Maine, and a corresponding higher amount of costs incurred by Maine both in funding programs that pay for certain types of care offered to uninsured residents and costs for providing care that is uncompensated by such programs.

27. In accordance with the federal Emergency Medical Treatment and Labor Act (EMTALA), 42 U.S.C. § 1395dd, and the Centers for Medicare and Medicaid Services regulations at 42 C.F.R. § 489.24, all Medicare certified hospitals are required to provide an appropriate medical screening exam and necessary medical treatment to stabilize an emergency medical condition In Maine, P.L. 2025, ch. 488, § 3 (to be codified at 22 M.R.S. § 1716-A) and 22 M.R.S. § 1715 require hospitals and certain medical facilities providing outpatient (non-emergency) medical care and diagnostic tests to meet certain charity care requirements.

28. As an instrumentality of Maine, Riverview Psychiatric Center (RPC) and Dorothea Dix Psychiatric Center (DDPC) treat uninsured patients and/or patients that cannot afford the full cost of urgent and/or acute care treatments, services, and procedures, the costs of which are often not fully covered. More uninsured individuals receiving treatment at RPC and DDPC who cannot afford to pay for their care translate to higher costs to the Hospital, and ultimately, to Maine.

Public Health Impacts

29. The Final Rule is detrimental to Maine's public health. With increased access to affordable health insurance via CoverME.gov, individuals are more likely to seek preventive care and avoid costly emergency room visits. Without individuals having access to affordable health insurance, they are more likely to delay or avoid preventive care, incur costly emergency room visits, and require Maine to cover costs for uninsured individuals.

30. Maine estimates that the decreased enrollment in the ACA insurance market resulting from the Final Rule would significantly increase the cost to Maine for preventive care, emergency room visits, and other expenses associated with funding care provided to uninsured residents.

31. Increased access to health insurance also improves public health. Uninsured individuals who lack access to affordable, adequate health insurance are less likely to seek preventive care or attend routine health screenings, and may delay necessary medical care due to prohibitive costs.

32. Lack of insurance and resulting negative health outcomes also result in downstream consequences, including absenteeism in the workplace and increased reliance on unemployment insurance, which relies on State funding.

33. Decreased access to adequate and affordable health care could mean infectious diseases spread more widely and rapidly with those affected not seeking care due to being uninsured or underinsured.

Gender-Affirming Care EHBs

34. The ACA mandates that certain individual and small group health plans cover a set of Essential Health Benefits (EHBs) which must be equal to the scope of benefits provided under a typical employer plan and may not have any annual or lifetime dollar limit under state plans.

35. Per HHS, the items and services covered must come from the following ten benefit categories: (1) ambulatory patient services; (2) emergency services; (3) hospitalization; (4) maternity and newborn care; (5) mental health and substance use disorder services including behavioral health treatment; (6) prescription drugs; (7) rehabilitative and habilitative services and devices; (8) laboratory services; (9) preventive and wellness services and chronic disease management; and (10) pediatric services, including oral and vision care.

36. The ACA and its effectuating regulations permit latitude to the states in determining how EHBs are defined. Accordingly, states submit their "benchmark" plans to HHS for approval.

EHBs are a minimum standard, and benchmark plans can choose to offer additional health benefits, like vision, dental, and medical management programs (e.g., weight loss).

37. Each state maintains a benchmark plan on file with HHS, against which private insurers must compare plans to ensure compliance with the standards set forth therein. Further, if a state has not updated its benchmark plan to match federal requirements, private insurers must also review plans for compliance with federal EHB mandates.

38. The current EHB-Benchmark Plan is the Small Group Market PPO Off-Exchange Blue Choice $30.00 $2,500 Deductible Plan offered by Anthem Health Plans of Maine. This EHB-Benchmark Plan was set for plan year 2017 and has remained unchanged through plan year 2027. The current EHB-Benchmark Plan does not specifically mention coverage for gender-affirming care, though many aspects of gender-affirming care are covered under other areas including surgical services, prescriptions medications, and mental and behavioral health services. Coverage under Maine's EHB-Benchmark Plan does not include cosmetic surgical services intended solely to change or improve appearance, or to treat emotional, psychiatric or psychological conditions.

39. The Maine Human Rights Act (5 M.R.S. Chapter 337) prohibits discrimination based on gender identity, which includes gender expression, and this prohibition includes discrimination in healthcare coverage. Maine's Health Plan Improvement Act, 24-A M.R.S. § 4301 et seq., enacted in 2019, prohibits an individual from being subjected to discrimination under a fully-insured health plan on the basis of demographic characteristics including sexual orientation or gender identity. The nondiscrimination prohibitions mean a carrier may not:

- Deny or limit coverage or a claim or impose additional cost sharing or other limitations or restrictions on coverage for any health services that are ordinarily or exclusively available to individuals of one sex to a transgender;

- Have or implement a categorical coverage exclusion or limitation for all health services related to gender transition; or
- Otherwise deny or limit coverage or a claim or impose additional cost sharing or other limitations or restrictions on coverage for specific health services related to gender transition if such denial, limitation or restriction results in discrimination against a transgender individual. (24-A M.R.S. Section § 4320-L(1)(C)-(E).

40. The employer plans offered in Maine cover gender-affirming care to the extent that it is required as equal treatment under the Maine Human Rights Act and constitutes nondiscrimination under the Maine Health Plan Improvement Act.

41. Even in states like Maine, where gender-affirming care is not listed as its own category of EHB in the state's benchmark plan, many services that fall within "gender-affirming care", such as surgeries, prescription medications, and mental health treatment, are treated as EHBs by state marketplaces.

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 July, 2025, in Portland, Maine.

Hilary Schneider
Director
Office of the Health Insurance Marketplace, Maine Department of Health and Human Services

EXHIBIT 11

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MASSACHUSETTS

STATE OF CALIFORNIA, et al. ***Plaintiffs*,** **v.** **ROBERT F. KENNEDY, JR., et al.,** ***Defendants.***	**Civil Action No.: 25-12019**

DECLARATION OF MARISSA WOLTMANN

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

1. I am the Chief of Policy at the Massachusetts Health Connector located in Massachusetts. I hold a Master's degree in Public Policy from the Heller School for Social Policy and Management at Brandeis University. I have been employed as the Chief of Policy and Plan Management since April 2023. Prior to that, I held multiple roles on the Health Connector's Policy team from 2013 to 2023 and on its Legal team from 2008 to 2013.

2. The Health Connector is the ACA marketplace for Massachusetts, providing insurance coverage to 375,000 state residents through individual market coverage. These individuals receive high-quality coverage through Qualified Health Plans (QHPs) certified by the Health Connector. The Health Connector is responsible for the design and implementation of a state subsidy program called ConnectorCare that supplements federal subsidies under the Affordable Care Act with state-funded premium and cost sharing subsidies.

3. I am familiar with the information in the statements set forth below through personal knowledge and from documents and information that have been provided to and reviewed by me.

4. I submit this Declaration in support of the States' Motion for a Preliminary Injunction.

1. When the Health Connector was established in 2006, our state's uninsured rate was approximately 10%. As of 2023, our state's uninsured rate has dropped to 2.6%.

2. Our SBE has established a competitive market, a stable risk pool, and currently includes 8 health insurance plan issuers and 2 dental plan issuers.

3. The Health Connector is funded through user fees assessed on plans sold through the Health Connector as well as through the Commonwealth Care Trust Fund, a state fund designated to support the Health Connector's work.

4. The flexibility that the U.S. Department of Health and Human Services (HHS) and the Centers from Medicare and Medicaid Services (CMS) have historically afforded SBEs in operating our unique marketplaces has allowed us to implement innovative policies which make it easier for consumers to enroll in more generous plans at low or no cost. Beginning in 2014, the Health Connector's ConnectorCare program carried forward the Commonwealth's commitment to universal coverage and served as the successor program of the Commonwealth Care program created by state health reform in 2006, which formed the model for the Affordable Care Act. ConnectorCare has provided access to more affordable premiums and cost sharing for low- and moderate-income Massachusetts residents by supplementing federal subsidies under the Affordable Care Act with state dollars. ConnectorCare historically served individuals eligible for federal subsidies with income up to 300 percent of the federal poverty level (FPL).

5. Our special enrollment period (SEP) strategies have also been uniquely designed to meet Massachusetts's needs, ensuring continuous coverage and minimizing enrollment barriers for eligible individuals.

6. The Health Connector engages in robust program integrity activities to prevent improper enrollment and to ensure people meet eligibility requirements for the coverage in which they enroll. The Health Connector does not experience those challenges that CMS describes as occurring within the FFE. The Health Connector prioritizes program integrity to ensure that member data is secure and that health insurance eligibility and associated premium tax credits are awarded correctly. In particular, the Health Connector does not use brokers or web-brokers for individual coverage or allow enhanced direct enrollment websites to enroll residents; such brokers are the primary source of fraudulent enrollment within the FFE. Certified Assisters and Health Connector call center agents undergo robust and continuous training to assist individuals and only act with explicit individual consent.

7. To date, out of the more than 1,266,000 people who have enrolled in Health Connector coverage since 2014, the Health Connector has received zero complaints about fraudulent or unauthorized activity by Assisters, or that members were unaware of their coverage and suspected fraudulent enrollment.

8. We estimate that the numerous changes in the Final Rule will require us to spend more than $150,000 and 1,500 hours of staff and vendor time updating our information technology (IT) systems. Additionally, the rule will require a substantial amount of staff time to implement its requirements and impose operational challenges on our SBE.

9. Some of the technical changes to our IT systems will be difficult to complete in time for the 2026 plan year. Specifically, the new income verification requirements—such as requiring documentation when tax data shows income under 100 percent of the FPL and requiring documentation when no tax data is available through the federal data services hub—are challenging to implement within our existing system infrastructure and complete testing in advance of Open Enrollment and pre-Open Enrollment activities to ensure system integrity.

10. Implementing these rules would necessitate new system programming and additional manual processes. This, in turn, would lead to higher operational costs, greater challenges for consumers, and added strain on critical resources. Specifically, it would increase the volume and complexity of mailings, require expanded enrollee outreach efforts to address potential confusion, and place additional demands on service center operations, including potentially longer wait times and increased staffing needs to handle inquiries and support requests.

11. Other costs that have been and would be required of the Health Connector to comply with the Final Rule include, but are not limited to, the following.

12. Prior to the Final Rule, Exchanges accepted the self-attestation of an enrollee who claimed eligibility by projecting annual household income at or above 100% of the FPL. The Final Rule changes this policy in two ways. First, anytime IRS data shows that a consumer has income below 100% of the FPL, a "data matching issue" (DMI) will be generated. Second, in the absence of IRS data, a DMI will be generated. Whenever a DMI is generated, consumers will be required to track

down and submit the necessary paperwork in order to purchase health insurance. DMIs also create administrative burdens on SBEs, which are required to receive, process, and determine whether the newly submitted paperwork adequately addresses the issue. Impacts to the Health Connector are still being assessed.

13. With respect to providing essential health benefits for gender-affirming care, the Final Rule will force the Health Connector to examine carrier submissions to ensure the appropriate amounts have been excluded from data outlining the portion of premiums allocable to Essential Health Benefits. The Health Connector will need to provide technical assistance in conjunction with the Division of Insurance to ensure this is done consistently across the market in Massachusetts and verify carriers have submitted materials consistent with such guidance. This will take up valuable time and resources.

14. The ACA mandates that certain individual and small group health plans cover a set of Essential Health Benefits (EHBs) which must be equal to the scope of benefits provided under a typical employer plan and may not have any annual or lifetime dollar limit under state plans.

15. Per HHS, the items and services covered must come from the following ten benefit categories: (1) ambulatory patient services; (2) emergency services; (3) hospitalization; (4) maternity and newborn care; (5) mental health and substance use disorder services including behavioral health treatment; (6) prescription drugs; (7) rehabilitative and habilitative services and devices; (8) laboratory services; (9) preventive and wellness services and chronic disease management; and (10) pediatric services, including oral and vision care.

16. The ACA and its effectuating regulations permit latitude to the states in determining how EHBs are defined. Accordingly, states submit their "benchmark" plans to HHS for approval. EHBs are a minimum standard, and benchmark plans can choose to offer additional health benefits, like vision, dental, and medical management programs (e.g., weight loss).

17. Each state maintains a benchmark plan on file with HHS, against which private insurers must compare plans to ensure compliance with the standards set forth therein. Further, if a state

has not updated its benchmark plan to match federal requirements, private insurers must also review plans for compliance with federal EHB mandates.

18. Pursuant to Section 1302 of the Affordable Care Act and federal rule 45 CFR 156.100, the Commonwealth of Massachusetts has selected the base-benchmark plan for coverage year 2017 and years thereafter. The EHB Benchmark Plan defines the EHBs to be included in all small group and individual plans (merged market plans) offered in the state, both within and outside of the Health Connector. For the 2017 plan year and years thereafter, Massachusetts has selected the HMO Blue New England $2000 Deductible Plan ("HMO Blue New England") offered by Blue Cross Blue Shield of Massachusetts HMO Blue, Inc. as its base-benchmark Plan.

19. State laws in Massachusetts prohibit discrimination in healthcare coverage. The Commonwealth of Massachusetts considers gender-affirming care a legally protected health activity and shields those in the Commonwealth who access, provide, and/or assist with the provision of such care from civil or criminal penalties by out-of-state jurisdictions that criminalize it.[1] Massachusetts covers gender-affirming care through MassHealth, the Commonwealth's Medicaid program, and prohibits state-regulated health insurance plans from refusing enrollment, unenrolling, or withholding coverage from individuals based on their gender identity or gender dysphoria.[2] Additionally, Massachusetts prohibits differential treatment by providers when caring for transgender residents.[3]

20. The fully-insured healthcare plans offered in Massachusetts all cover gender-affirming care. Because of that, marketplace plans offered in Massachusetts also cover gender-affirming care.

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[1] Mass. Gen. Laws c. 12, § 11 I ½(b), (c), & (d); Mass. Gen. Laws ch. 147, § 63; Mass. Gen. Laws ch. 276, § 13.

[2] Mass. Gen. Laws c. 272, §§ 92A, 98; ; Mass. Division of Insurance Bulletins 2021-11 and 2014-03, available online at https://www.mass.gov/lists/doi-bulletins; R.I. Health Insur. Bull. 2015-03, available online at https://ohic.ri.gov/sites/g/files/xkgbur736/files/bulletins/Bulletin-2015-3-Guidance-Regarding-Prohibited-Discrimination.pdf.

[3] Mass. Gen. Laws c. 272, §§ 92A, 98; Massachusetts Board of Registration in Medicine Policy 16-01: Policy on Gender Identity and the Physician Profile Program, available online at https://www.mass.gov/lists/physician-regulations-policies-and-guidelines; 130 CMR 450.202(B); MA Board of Registration in Nursing: 244 Code Mass. Reg. § 9.03(13).

21. Even in states like Massachusetts, where gender-affirming care is not listed as its own category of EHB in the state's benchmark plan, many services that fall within "gender-affirming care", such as surgeries, prescription medications, and mental health treatment, are treated as EHBs by state marketplaces.

22. ConnectorCare provides state subsidies to support the portion of premium and out of pocket costs left after federal subsidies are applied. Because gender-affirming care will no longer qualify for Advance Premium Tax Credits, more premium may be paid for by the state.

[Signature Page]

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 July, 2025, in Boston, Massachusetts.

Marissa Woltmann
Chief of Policy
Massachusetts Health Connector

EXHIBIT 12

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MASSACHUSETTS

STATE OF CALIFORNIA, et al. *Plaintiffs*, v. ROBERT F. KENNEDY, JR., et al., *Defendants*.	Civil Action No.: 25-12019

DECLARATION OF MICHELE EBERLE

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

1. I am the Executive Director at Maryland Health Benefit Exchange (MHBE), (the Exchange) located in Baltimore, Maryland. I hold a Bachelor of Science (B.S.) in Management and Computer Science and Religious Studies from Nazareth University as well as a Master of Business Administration (MBA) from Southern New Hampshire University. I have been employed as Executive Director since December 2017. Prior to serving as Executive Director of the Exchange, I was Chief Operating Officer of the Exchange from 2015 through 2017; as Executive Director of the Maryland Health Insurance Plan (MHIP) from 2013 through 2015 I served concurrently as the Acting Director for Plan and Partner Management for the Exchange.

2. The Exchange was established as a public corporation and independent unit of state government in 2011 in accordance with the 2010 Patient Protection and Affordable Care Act (ACA). The purpose of the Exchange is to reduce the number of uninsured in Maryland; facilitate

the purchase and sale of qualified health plans in the individual market in Maryland by providing a transparent marketplace; assist qualified employers in Maryland in facilitating the enrollment of their employees in qualified health plans in the small group market in Maryland and in accessing small business tax credits; assist individuals in accessing public programs (including the Maryland Medical Assistance Program (Medicaid)), premium tax credits, and cost-sharing reductions; and supplement the individual and small group insurance markets outside of the Exchange. The Exchange is responsible for the administration of Maryland Health Connection, the state's health insurance marketplace, under the ACA.

3. I am familiar with the information in the statements set forth below through personal knowledge and from documents and information that have been provided to and reviewed by me.

4. I submit this Declaration in support of the States' Motion for a Preliminary Injunction.

Introduction

5. When the Exchange was established in 2011, Maryland's uninsured rate was approximately 12%. As of 2025, our state's uninsured rate has dropped to 6%.

6. Our Exchange has established a competitive market, a robust risk pool, and currently includes 5 health insurance plan issuers and 4 dental plan issuers.

7. The Exchange is funded through Federal reimbursement (Medicaid and the 1332 Waiver Grant) and State Special and General Funds. In Fiscal Year 2024, Maryland paid $ 600,332,612 to run the Exchange and fund Maryland's reinsurance program.

8. The flexibility that the U.S. Department of Health and Human Services (HHS) and the Centers from Medicare and Medicaid Services (CMS) have afforded the Exchanges in operating our unique marketplace has allowed us to implement innovative policies which make it easier for consumers to enroll in more generous plans at low or no cost. Some examples include operating

Maryland's State Reinsurance Program which reduced individual market premiums by over 30% in the first four years of the program since 2019, with average rates still down more than 20% compared to 2018, enacting the Easy Enrollment Program to allow uninsured individuals to get connected to health coverage by checking a box on their state tax return or unemployment claim, and administering a state premium assistance program for young adults which provides an additional state subsidy that pairs with federal premium subsidies to further reduce premiums costs on a sliding scale for this population.

9. Our special enrollment period (SEP) strategies have also been uniquely designed to meet Maryland's needs, minimizing enrollment barriers and making it easier for Marylanders to maintain continuous coverage.

Lack of enrollment fraud

10. MHBE has had few instances of fraudulent enrollment. A review of consumer complaints and enrollment partner activity in recent years revealed that improper enrollments are rare, thanks to the tailored oversight measures we have implemented, such as requiring agents to verify consumer consent through secure methods like three-way calls, one-time passcodes, and robotic process automation to verify consumer documents for data accuracy.

11. For the few instances reported, the Exchange has taken swift and decisive corrective actions, including investigations, monitoring, warnings, suspensions, and, if necessary, decertifying agents.

Lost enrollment revenue caused by Final Rule

12. The requirement that MHBE request additional income documentation for individuals for which there is no IRS tax data to verify income could lead to up to 14% of on-exchange enrollees (34,000 individuals) losing coverage due to the additional burden.

13. One direct consequence of this anticipated decrease in enrollment is a loss of Maryland revenues. Health insurance companies in Maryland are subject to a 2% premium tax, of which a portion of the revenue generated is distributed to MHBE to fund the operations and administration of MHBE. Md. Code Ann., Ins. § 6–103.2.

14. If our estimates are accurate, then decreased enrollment due to the Final Rule could result in approximately $4 million in revenue lost from the premium tax that would have been generated by the approximately 34,000 individuals who are no longer enrolled in plans via the Exchange.

Compliance costs caused by Final Rule

15. We estimate that the numerous changes in the Final Rule will require us to spend a substantial number of hours of staff time updating our information technology (IT) systems, at significant cost. Additionally, the rule will require a substantial amount of staff time to implement its requirements and will impose significant operational challenges for the Exchange. One example of necessary changes concerns individuals who we anticipate could enroll in significantly lower numbers under the Final Rule include individuals who have had recent changes to their household for reasons such as marriage, birth, death, and divorce. The IRS does not return income tax data to the Exchange to verify income if a tax filer's status has changed, for example due to marriage or divorce, or if their household size has changed. These individuals will be required to provide additional income documentation under the Final Rule, necessitating additional work to verify such documentation.

16. If the comment period for the Proposed Rule had been longer than 23 days, the Exchange could have provided CMS with a robust analysis of the fiscal and administrative impact of the Final Rule's changes before they were finalized.

17. Some of the technical changes to our IT systems would likely not be possible to implement in time for the 2026 plan year. Implementing these rules, particularly the new income verification requirements—such as requiring documentation when tax data shows income under 100 percent of the Federal Poverty Level (FPL) and requiring documentation when no tax data is available through the federal data services hub, would necessitate new system programming and additional manual processes, which would compromise the efficiency of our automated systems. This, in turn, would lead to higher operational costs, greater challenges for consumers, and added strain on critical resources. Specifically, it would impact the accuracy and timeliness of consumer notices, increase the volume and complexity of mailings, require expanded enrollee outreach efforts to address potential confusion, and place additional demands on service center operations, including longer wait times and increased staffing needs to handle inquiries and support requests.

18. Moreover, the Exchange on average experiences a high amount of traffic during the OEP. As a result, Maryland requires the Exchange's internal teams and external partners to minimize technical changes during this period of time to prevent any unintended disruptions to consumers' ability to enroll by the deadline.

19. MHBE's process to verify enrollee income begins with a request to the federal data services hub for IRS data. If no IRS data is returned, MHBE then requests Maryland Department of Labor quarterly wage data. If projected income is lower than the income data in these trusted data sources by a threshold within the CMS-designated range, we require the applicant to submit documentation to verify their projected income. Depending on the document type, the document

is verified either by a caseworker or via robotic process automation. If no federal or state data is available, MHBE generates a data matching issue (DMI) requesting that the enrollee provide attestation to verify their income.

20. However, the Final Rule requires Exchanges to verify income by generating a DMI that requires enrollees to provide verification documentation when tax data from the IRS is unavailable. It also requires Exchanges to generate a DMI that requires enrollees to provide verification documentation when an enrollee's attested household income is less than 100% of the FPL but IRS data shows income of more than 100% FPL. Generating DMIs that impose documentation requirements rather than allowing Exchanges to use their own processes which work for their markets creates a significant burden for enrollees and for MHBE. Whenever a DMI is generated, consumers will be required to track down and submit the necessary paperwork in order to purchase health insurance, discouraging enrollment. The Exchange is then required to receive, process, and determine whether the newly submitted paperwork adequately addresses the issue. I estimate that the Exchange will need to spend over 1,280 hours to receive, process, and review documents generated by these new DMIs, adding significant cost. This cost includes conducting outreach and determining DMI outcomes for applicants whose tax return data is unavailable. Updating our eligibility systems and performing technical updates relating to this change alone will cost approximately $152,064. This does not include costs for handling increased manual verifications, which we are not able to quantify at this time.

Risk pool impacts caused by Final Rule

21. The Exchange has consistently cultivated a stable and healthy risk pool.

22. Final Rule would result in relatively younger and healthier individuals disproportionately dropping coverage due to a more burdensome enrollment process, which will negatively impact the overall health of the risk pool. Maryland estimates the Final Rule could result in a loss of approximately 34,000 such individuals.

23. Any differences between attested and actual income that result in over or underpayments of premium tax credits are reconciled during the individuals' federal tax filing. Maryland's self-attestation policy was designed to ensure that younger and healthier enrollees are not discouraged from entering the risk pool due to paperwork burdens. In particular, lower-income individuals face challenges in accurately estimating their annual income and experience significant fluctuations in their earnings over the course of the year; increased requirements will likely cause these individuals to drop coverage. Additional verification requirements will likely cause younger and healthier consumers to drop out of the marketplace. That, in turn, will worsen the risk pool and increase premiums for both subsidized and unsubsidized consumers.

Increased healthcare costs to Maryland Caused by Final Rule

24. The Final Rule acknowledges that the changes it makes will result in a decrease in enrollment in the ACA marketplace exchanges of up to 1.8 million people nationwide.

25. A direct consequence of this decreased enrollment under the Final Rule is a higher rate of uninsured in Maryland, and a corresponding higher amount of costs incurred by Maryland both in funding programs that pay for certain types of care offered to uninsured residents and costs for providing care that is uncompensated by such programs.

26. Federal law requires all hospitals to treat patients presenting in their emergency departments, regardless of the patient's ability to pay and even if the patient's condition is not an emergency medical condition. *See* the Emergency Medical Treatment and Labor Act (EMTALA), 42 U. S. C. § 1395dd. In Maryland, hospitals are required to cover these associated uncompensated care (UCC) costs, which are built into the state's unique All-Payer Model hospital rate setting structure under the model's UCC policy. The All-Payer Model is administered by the Maryland Health Services Cost Review Commission (HSCRC) and ensures that all payers are charged the same rate for the same service at any given hospital. In 2024 the determined UCC amount to be built into rates for Maryland hospitals was 4.29 percent (HSCRC RY 2024 UCC Report). Increased UCC costs are therefore shouldered by all payers and health insurance purchasers in the state, including publicly funded programs and payers that impact the state budget like Maryland Medicaid, the state employee health plan, etc.

Public Health Impact to Maryland from Final Rule

27. The Final Rule is detrimental to Maryland's public health. With increased access to affordable health insurance via the Exchange, individuals are more likely to seek preventive care and avoid costly emergency room visits. But the Final Rule causes the inverse: without access to affordable health insurance, individuals are more likely to not seek preventative care, and will instead incur costly emergency room visits, and require Maryland to cover costs for uninsured individuals.

28. Maryland estimates that the decreased enrollment in the ACA insurance market resulting from the Final Rule would increase costs in Maryland for preventive care, emergency room visits, and other expenses associated with funding care provided to uninsured residents.

29. Increased access to health insurance also improves public health. By contrast, uninsured individuals who lack access to affordable, adequate health insurance are less likely to seek preventive care or attend routine health screenings, and may delay necessary medical care due to prohibitive costs.

30. Lack of insurance and resulting negative health outcomes also result in downstream consequences, including, absenteeism in the workplace and increased reliance on unemployment insurance, which relies on State funding.

31. Decreased access to adequate and affordable health care also increases the risk that infectious diseases spread more widely and rapidly, with those affected not seeking care due to being uninsured or underinsured.

Gender-Affirming Care EHBs Effects of the Final Rule

32. The ACA mandates that certain individual and small group health plans cover a set of Essential Health Benefits (EHBs) which must be equal to the scope of benefits provided under a typical employer plan and may not have any annual or lifetime dollar limit under state plans.

33. Per HHS, the items and services covered must come from the following ten benefit categories: (1) ambulatory patient services; (2) emergency services; (3) hospitalization; (4) maternity and newborn care; (5) mental health and substance use disorder services including behavioral health treatment; (6) prescription drugs; (7) rehabilitative and habilitative services and devices; (8) laboratory services; (9) preventive and wellness services and chronic disease management; and (10) pediatric services, including oral and vision care.

34. The ACA and its effectuating regulations permit latitude to the states in determining how EHBs are defined. Accordingly, states submit their "benchmark" plans to HHS for approval. EHBs are a minimum standard, and benchmark plans can choose to offer additional health benefits, like vision, dental, and medical management programs (e.g., weight loss).

35. Each state maintains a benchmark plan on file with HHS, against which private insurers must compare plans to ensure compliance with the standards set forth therein. Further, if a state has not updated its benchmark plan to match federal requirements, private insurers must also review plans for compliance with federal EHB mandates.

36. Maryland's EHB Benchmark Plan for 2025-2027, Blue Choice HMO HSA-HRA, is a small group market plan issued by CareFirst BlueChoice, Inc. This has been Maryland's benchmark plan since 2017 and it covers the ten items and services required under the ACA.

37. State laws in Maryland prohibit discrimination in healthcare coverage. In Maryland, this includes prohibiting differential treatment for care for transgender residents. Maryland law

requires that Medical Assistance provide gender-affirming care in a non-discriminatory manner. *See* Md. Code Ann., Health-Gen. § 15-151 (2023 Repl. Vol.). Maryland law also prohibits Maryland-regulated private health insurance carriers from discriminating against individuals by refusing enrollment, unenrolling, or withholding coverage from an individual on the basis of their gender identity, sexual orientation, or sex. *See* Md. Code Ann., Ins. § 15-1A-22 (2017 Repl. Vol.).

38. In 2024 all Marketplace plans offered in Maryland included coverage for services categorized as gender-affirming care.

39. The employer plans offered in Maryland often cover gender-affirming care. Similarly, Marketplace plans offered in Maryland also cover gender-affirming care.

40. Even in states like Maryland, where gender-affirming care is not listed as its own category of EHB in the state's benchmark plan, many services that fall within "gender-affirming care", such as surgeries, prescription medications, and mental health treatment, are treated as EHBs by state marketplaces. Furthermore, the Final Rule promulgates a definition of "sex trait modification procedure" which contains provisions that would be widely open to interpretation and therefore difficult to comply with as well as to enforce. For example, the Final Rule will force the Maryland Insurance Administration (MIA) to utilize time and resources in deciphering whether an individual undergoing certain medical procedures has "asserted" an identity that differs from the individual's physical appearance and whether the purpose of such procedure is to interfere with the "normal" physical development of the individual's gender. As an individual's assertion of gender, the interpretation of one's physical appearance, and the definition of "normal" are all subjective, it is unclear how it is to be determined whether medical procedures fall within this definition and ensure that they are not being included as EHBs in violation of the Final Rule.

41. Even in states like Maryland that do not have a mandate for insurers to cover gender-affirming care, the Rule will reduce the amount of premium eligible for Advance Premium Tax Credits, which will increase premiums for consumers.

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 July, 2025 in Baltimore, MD.

Michele Eberle

Michele Eberle
Executive Director
Maryland Health Benefit Exchange

EXHIBIT 13

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MASSACHUSETTS

STATE OF CALIFORNIA, et al.

Plaintiffs,

v.

ROBERT F. KENNEDY, JR., et al.,

Defendants.

Civil Action No.: 25-12019

DECLARATION OF JOSEPH A. GARCIA

I, Joseph A. Garcia, declare under the penalty of perjury pursuant to 28 U.S.C. § 1746 that the foregoing is true and correct:

1. I am a Senior Deputy Director and General Counsel at the Department of Insurance and Financial Services (DIFS) in Michigan. I have been employed as Senior Deputy Director for DIFS since February of 2025, as General Counsel at DIFS since December of 2022, and in total with DIFS for 17 years. The majority of my employment with DIFS has been within the Office of General Counsel, primarily as a Deputy General Counsel.

2. DIFS regulates Michigan's insurance and financial services industries. DIFS' mission is to ensure access to safe and secure insurance and financial services fundamental for the opportunity, security, and success of Michigan residents, while fostering economic growth and sustainability in both industries.

3. Michigan does not operate its own health insurance exchange. Rather, consumers in Michigan may enroll in health coverage using healthcare.gov, which is operated and maintained by the U.S. Department of Health and Human Services

4. I am familiar with the information in the statements set forth below through personal knowledge and from documents and information that have been provided to and reviewed by me.

5. I submit this Declaration in support of the States' Motion for a Preliminary Injunction.

Federally Facilitated Exchange States: Risk pool impacts

6. The Final Rule threatens to increase costs to Michigan by removing a pool of relatively young and healthy individuals from the pool of insureds participating in health coverage in our State.

7. The Final Rule makes several changes that adversely impact Michigan's risk pool, including, but not limited to, the following.

8. The Final Rule requires the Federal marketplace to conduct pre-enrollment eligibility verification for at least 75% of new enrollments through the SEPs, including the SEPs that can be triggered by a qualifying life event, such as a move to a new geographical area. These additional verification requirements may discourage younger, healthier individuals—who are less likely to navigate complex paperwork requirements successfully during life changes—from enrolling, undermining the stability of the risk pool and driving up costs for everyone.

9. The Final Rule requires the Federal marketplace to impose a $5 monthly charge on a subset of automatically reenrolled consumers who have $0 premiums because of the APTC for which they qualified. That charge would be levied until the consumer actively re-enrolls in coverage. This provision will pose an unjustified and duplicative reporting burden on consumers in our state who do not have changes to their accounts. Federal Plan Year 2025 data indicates that 51% of automatically reenrolled Michiganders had sufficient APTC to reduce their premiums to $10 or below, and many of these could have had sufficient APTC to reduce their premiums to $0. Under the Final Rule, automatic re-enrollees with such fully subsidized premiums would be charged $5 until they undertake an affirmative action to confirm their re-enrollment.

10. The imposition of this unexpected premium, when the consumer is accustomed to paying $0 out-of-pocket premiums, is likely to cause attrition and lead to lower enrollment in Michigan and thus causing consumers to lose coverage.

11. Prior to the Final Rule, exchange plans accepted the self-attestation of an enrollee who claimed eligibility by projecting annual household income at or above 100% of the FPL. This self-attestation policy was designed to ensure that the lowest-income enrollees are not discouraged from entering the risk pool due to paperwork burdens. The prior policy also recognized the challenges that low-income individuals face in accurately estimating their annual income and may experience significant fluctuations in their earnings over the course of the year. The Final Rule's elimination of this practice creates an administrative barrier to enrollment that could worsen the risk pool and increase premiums for both subsidized and unsubsidized consumers.

Increased healthcare costs to states + uncompensated care

12. The Final Rule acknowledges that the changes it makes will result in a decrease in enrollment in the ACA marketplace exchanges of up to 1.8 million people nationwide.

13. A decrease in enrollment under the Final Rule will result in a higher uninsured rate in Michigan and thus is likely to cause a corresponding increase in costs incurred by Michigan both in funding programs that pay for certain types of care offered to uninsured residents and costs for providing care that is uncompensated by such programs.

Public Health Impacts

14. The Final Rule is detrimental to Michigan's public health. With increased access to affordable health insurance via the Marketplace, individuals are more likely to seek preventive care and avoid costly emergency room visits. Individuals who do not have access to affordable health insurance are less likely to seek preventive care and thus incur costly expenses from emergency room visits and have the increased potential to have poor health outcomes.

Gender-Affirming Care EHBs

15. The ACA mandates that certain individual and small group health plans cover a set of Essential Health Benefits (EHBs) which must be equal to the scope of benefits provided under a

"typical employer plan" and may not have any annual or lifetime dollar limits, among other protections.

16. Per HHS, the items and services covered as EHBs must come from the following ten benefit categories: (1) ambulatory patient services; (2) emergency services; (3) hospitalization; (4) maternity and newborn care; (5) mental health and substance use disorder services including behavioral health treatment; (6) prescription drugs; (7) rehabilitative and habilitative services and devices; (8) laboratory services; (9) preventive and wellness services and chronic disease management; and (10) pediatric services, including oral and vision care.

17. The ACA and its effectuating regulations permit latitude to the states in determining how EHBs are defined. Accordingly, states submit their "benchmark" plans to HHS for approval. EHBs are a minimum standard, and plans can offer additional health benefits.

18. Each state maintains a benchmark plan on file with HHS, against which certain individual and small group health plans must compare to ensure compliance with the standards set forth therein. Further, if a state has not updated its benchmark plan to meet federal requirements, those insurers must also review plans for compliance with federal EHB mandates.

19. Michigan's EHB benchmark plan can be found here: https://www.michigan.gov/difs/industry/insurance/affordable-care-act/ehb-information

20. Michigan law prohibits discrimination in healthcare coverage. *See, e.g.,* MCL 37.2102; MCL 500.2027. In Michigan, this includes prohibiting differential treatment for care based on gender or gender identity or expression.

21. Requiring states to exclude these otherwise-covered services from EHB definitions would raise the defrayal cost borne by Michigan. This is because premium amounts that would otherwise be attributed to EHB services and covered by carriers in response to the state coverage mandate would be put back on states.

Signature Page

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

Executed this 16th day of July, 2025, in Lansing, Michigan.

Joseph A. Garcia
Senior Deputy Director and General Counsel
Department of Insurance and Financial Services

EXHIBIT 14

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MASSACHUSETTS

STATE OF CALIFORNIA, et al., *Plaintiffs*, v. ROBERT F. KENNEDY, JR., et al., *Defendants*.	Civil Action No. 25-12019 Judge

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 Plaintiffs' challenge to the Final Rule issued by the U.S. Department of Health and Human Services and Center for Medicaid Services entitled "Patient Protection and Affordable Care Act; Marketplace Integrity and Affordability."
3. 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 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

4. DHS is New Jersey's largest agency, serving approximately 2.1 million New Jersey residents. DHS administers social services for 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.

NJ FamilyCare and Related Healthcare Programs

NJ FamilyCare

5. NJ FamilyCare is a publicly-funded health insurance. 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"). NJ FamilyCare provides comprehensive healthcare coverage for a wide range of services, including primary care, hospitalization, laboratory tests, x-rays, prescriptions, mental health care, dental and vision care, preventive screenings, mental health services, and substance use services.

6. Eligibility for NJ FamilyCare health insurance programs, including eligibility for Federal-State Medicaid and CHIP, depends in part on age, immigration status, and household income.
7. Income eligibility for NJ FamilyCare generally depends upon income and family size. In general, adults who are over the age of 18 and under the age of 65 meet the income eligibility requirement for Federal-State Medicaid if their household's modified adjusted gross income is less than 138% of the federal poverty level.
8. New Jersey also operates programs specifically directed at individuals who cannot access federally funded health insurance through NJ FamilyCare, including the Supplemental Prenatal and Contraceptive Program and the Medical Emergency Payment Program, among others.

New Jersey Supplemental Prenatal and Contraceptive Program

9. 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 meet income-eligibility guidelines but do not qualify for NJ FamilyCare due to their immigration status, and do not have any other health insurance coverage. However, NJSPCP does not provide complete healthcare coverage, such as for hospital visits or labor and delivery services.
10. Emergency medical services for pregnant women who do not qualify for NJ FamilyCare insurance programs due to immigration status are covered through the Medical Emergency Payment Program, which is discussed below.
11. 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.
12. 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.

13. 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.

14. 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 and is reimbursed by the State.

15. NJSPCP is funded exclusively by the State of New Jersey.

16. In Federal Fiscal Year 2024, the period from October 2023 through September 2024, New Jersey spent $36 million on the NJSPCP program.

17. If a New Jersey pregnant woman, who for example lacked lawful immigration status, was previously on the exchange, is no longer able to obtain prenatal and family-planning services covered through their Marketplace insurance, and her current financial circumstances are such that she qualifies for NJSPCP, then she would need to rely on NJSPCP for their care, causing New Jersey to incur additional costs.

Medical Emergency Payment Program

18. New Jersey's Medical Emergency Payment Program pays for emergency services, including labor and delivery, for New Jersey residents age 19 and older who meet income-eligibility guidelines but do not qualify for Medicaid through NJ FamilyCare solely 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. Emergency medical conditions are covered only if the patient is experiencing severe symptoms 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.

19. The Medical Emergency Payment Program is 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). Under 42 C.F.R. 435.406, New Jersey residents who meet the income-eligibility criteria and whose immigration status prevents them from accessing coverage through other programs are eligible for the Medical Emergency Payment Program. 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.

20. Certain New Jersey residents, due to their immigration status, who lack private health insurance may be eligible for the Medical Emergency Payment Program.

21. Certain New Jersey pregnant women who lack private health insurance and are income-eligible would likely need to access the Medical Emergency Payment Program to obtain coverage for labor and delivery services.

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

Impacts of Health Insurance on Public Health

23. Increased access to health insurance provides significant benefits to public health. Enrollment in NJ FamilyCare has a positive impact on public health since individuals enrolled are more likely to receive preventative care services, reducing the need for more intensive health care treatments, including emergency care. This coverage means individuals are more likely to receive treatment, limiting the spread of infectious diseases across the state.

24. Access to healthcare, particularly to primary care, makes New Jersey residents healthier and communities stronger, and is a fiscally responsible investment in the future of New Jersey children.

25. Higher enrollments in NJ FamilyCare also reduces the financial burden on health care providers from providing care to uninsured individuals and ensures that households are not left with medical bills they are unable to pay. Having insurance coverage also makes it so that New Jersey has a reduced strain on uncompensated care burden on hospitals.

26. Without access to insurance coverage, New Jersey can anticipate a lower engagement with the health care system which can impact public health by leading to a decrease use of vaccines and other preventative medicine, causing increased risk for certain immunocompromised residents and increased expenses for the state in outreach, as well as emergency care for uninsured residents.

The Final Rule Will Irreparably Harm New Jersey

27. The Final Rule would harm New Jersey as it would likely render affordable health insurance coverage unavailable to certain New Jersey residents, thereby contributing to negative health

outcomes. Without access to affordable health insurance via the state insurance marketplace, New Jersey residents are less likely to seek preventive care, resulting in more costly emergency room visits.

28. If New Jersey residents are no longer eligible to obtain health insurance through the State's exchange, then New Jersey will likely incur increased costs resulting from paying for certain health care services provided to eligible individuals through other New Jersey programs.

29. If New Jerseyans are no longer able or eligible to obtain health insurance through the State's exchange, then New Jersey will likely incur increased costs resulting from paying for certain health care services provided to eligible New Jerseyans under the Medical Emergency Payment Program. See "Patient Protection and Affordable Care Act; Marketplace Integrity and Affordability," 90 Fed. Reg. at 13,010 (observing that the "majority" of individuals who lose exchange or basic health plan coverage would become uninsured, which would " result in costs … to States to provide limited Medicaid coverage for the treatment of an emergency medical condition to individuals who have a qualifying medical emergency and who become uninsured as a result of this rule").

30. Should the Final Rule go into effect, even a temporary disruption in health insurance coverage would likely cause significant harm to New Jersey's state agencies, healthcare providers, and residents seeking healthcare services.

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

Executed this 16th day of July, 2025, in Trenton, New Jersey.

Sarah Adelman
Commissioner
New Jersey Department of Human Services

EXHIBIT 15

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MASSACHUSETTS

STATE OF CALIFORNIA, et al., *Plaintiffs*, v. ROBERT F. KENNEDY, JR., et al., *Defendants*.	Civil Action No. Judge

DECLARATION OF JEFFREY A. BROWN

I, Jeffrey A. Brown, declare under the penalty of perjury pursuant to 28 U.S.C. § 1746, that the foregoing is true and correct:

1. I am the Acting Commissioner of the New Jersey Department of Health ("NJDOH"). The information in the statements set forth below were compiled through personal knowledge, through NJDOH personnel who have assisted in gathering this information, or from documents that have been provided to and reviewed by me. I have also familiarized myself with the Final Rule in order to understand its immediate impact on NJDOH and New Jersey.
2. I submit this Declaration in support of Plaintiffs' challenge to the Final Rule issued by the U.S. Department of Health and Human Services and Center for Medicaid Services entitled, "Patient Protection and Affordable Care Act; Marketplace Integrity and Affordability."

Professional Background

3. I have been serving as the NJDOH Acting Commissioner since April of 2025. Prior to becoming NJDOH's Acting Commissioner, I served as the NJDOH Deputy Commissioner of

Health Systems, overseeing inspections, licensing, and the enforcement of regulations for licensed New Jersey health care facilities, mental health and addiction services and programs, the Office of Health Care Affordability and Transparency, and major hospital funding programs, including Charity Care. Prior to serving as the NJDOH Deputy Commissioner, I served as the first Executive Director of the New Jersey Cannabis Regulatory Commission (CRC), where I led and managed a newly-created state commission. Prior to my position with the CRC, I served as Assistant Commissioner for Medical Marijuana within the NJDOH and worked within healthcare policy and healthcare quality improvement for the State of New Jersey. I graduated from Rutgers University and have devoted my career to serving the public.

The New Jersey Department of Health

4. NJDOH's mission 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.

5. 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.

6. 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.

7. 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 deidentified information on the health status of New Jerseyans.

8. 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.

9. Health Care Quality Assessment, an office of the NJDOH, collects data on the quality of health care services in New Jersey to produce reports which can help consumers, health care providers, policy makers, and regulators to make informed decisions.

Charity Care

10. 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.

11. The State offsets some of the costs that eligible hospitals incur 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). 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 costs of services through Charity Care (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 regardless of Charity Care status	246,826	247,171	231,164
Cost of Services for Uninsured Patients via Charity Care	$63,226,640.86	$72,764,116.66	$92,063,158.04

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 provides funding so Federally Qualified Health Centers are 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 required to serve all individuals, regardless of the individual's ability to pay. Federally Qualified Health Centers all provide primary care services and some are "one-stop" health centers with co-located services (medical, dental, and behavioral health) that make 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.			

Impacts of Health Insurance on Public Health

26. Increased access to health insurance improves public health. With increased access to affordable health insurance via the State's exchange, individuals are more likely to seek preventative care and avoid costly emergency room visits. However, without individuals having access to affordable health insurance, they are more likely to not seek preventative care, incur costly emergency room visits, and require New Jersey to cover costs for uninsured individuals.

27. Though the Uncompensated Care Fund covers primary care, dental care, and behavioral health services, it provides reimbursement only for limited specialty services and does not cover the cost of prescription medications. Thus, uninsured individuals who lack access to affordable, adequate health insurance, would be unable to properly cover all their medical needs.

28. 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. The Final Rule's change to marketplace eligibility criteria, which would create barriers to enrollment

resulting in New Jersey residents losing marketplace coverage would leave various individuals uninsured. So, an uninsured individual who does not qualify for Medicaid, like an individual who slightly falls above the Medicaid qualifying threshold, 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.

29. While the New Jersey Department of Health can reimburse Federally Qualified Health Centers for some limited specialty services provided to uninsured individuals, the reimbursement rate is substantially lower than that of Medicaid. Given that Federally Qualified Health Centers operate on narrow financial margins, they depend heavily on higher Medicaid reimbursements to maintain operations. A large-scale shift from Medicaid to the Uncompensated Care Fund would result in significant funding shortfall, ultimately forcing potential closures and reductions in services provided. In turn, this would reduce access to care for New Jersey's most vulnerable populations, leading to worsening existing health issues.

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, in New Jersey to access some degree of State-funded health care, there remain gaps in access.

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

33. If, for example, an uninsured or underinsured New Jerseyan needs to see a specialist for a cancer screening, or if they need prescription medication to treat high blood pressure, neither would be covered by the Uncompensated Care Fund. Thus, the Final Rule now creates a circumstance where, if the uninsured or underinsured New Jerseyan cannot pay out of pocket for those services, they cannot receive that care.

34. An uninsured individual failing to access such preventative care increases the risk that they 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.

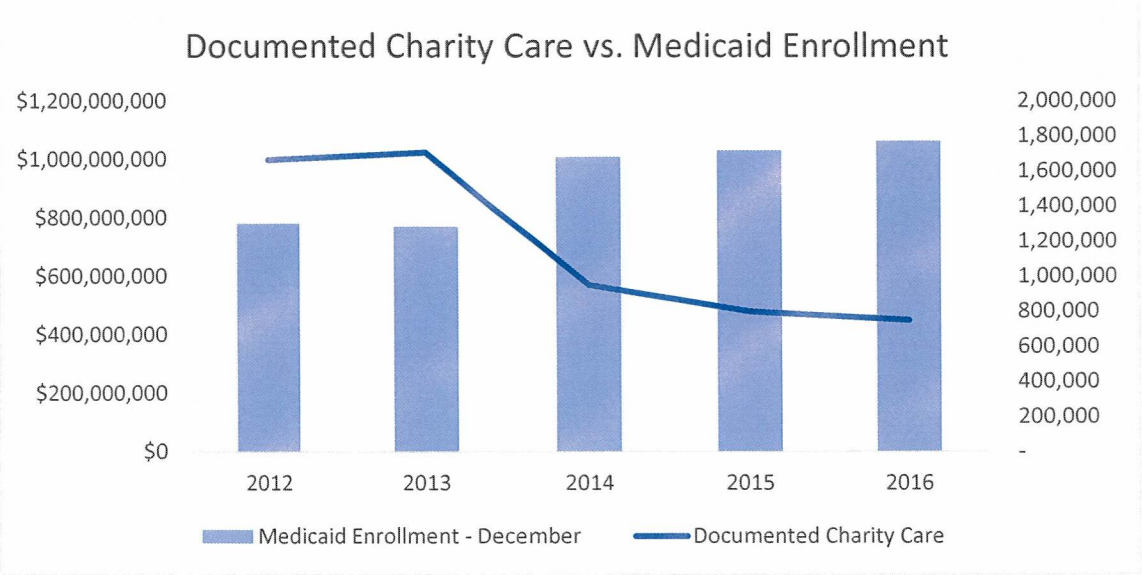
36. New Jersey's experience with Medicaid Expansion is an example of how increased access to health insurance can reduce the costs of uncompensated care.

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.

The Final Rule Will Irreparably Harm New Jersey

45. The Final Rule would harm New Jersey as it would likely render affordable health insurance coverage unavailable to various New Jersey residents, thereby contributing to negative health outcomes. Without access to affordable health insurance via the state insurance marketplace, these uninsured or underinsured New Jersey residents are less likely to seek preventive care and avoid costly emergency room visits.

46. Additionally, a decrease of enrollment under the Final Rule, due to its increased barriers to enrollment in states' exchanges, would create a higher rate of uninsured in New Jersey, resulting in a higher amount of costs incurred by New Jersey in funding programs that pay for uninsured residents' care.

47. The Final Rule will further affect New Jersey providers such as Federally Qualified Health Centers who would become further overburdened. These centers are already grappling with significant workforce shortages that hinder their ability to expand services. The shortages would be further exacerbated in response to the rising demand that would be caused by having less individuals insured.

48. Should the Final Rule go into effect, the substantial increase in the uninsured population would place further strain on New Jersey's safety nets for individuals without insurance. The strains on these already overburdened providers will result in delays in accessing essential services for uninsured individuals. The delays could impact preventative care, immunizations, medical management, and timely referrals to specialist. These delays would potentially result in worsening health outcomes, avoidable hospitalizations, or even death.

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 July, 2025, in Trenton, New Jersey.

Jeffrey A. Brown
Acting Commissioner
New Jersey Department of Health

EXHIBIT 16

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MASSACHUSETTS

STATE OF CALIFORNIA, et al.

Plaintiffs,

v.

ROBERT F. KENNEDY, JR., et al.,

Defendants.

Civil Action No.: 25-12019

DECLARATION OF ELIZABETH CAULUM

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

1. I am the Chief Executive Officer at 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 been employed as CEO 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 offers low-cost and free health insurance options provided through government-sponsored programs, Medical Assistance and MinnesotaCare, which are managed through the Minnesota Department of Human Services, to individuals who qualify.

3. I am familiar with the information in the statements set forth below through personal knowledge and from documents and information that have been provided to and reviewed by me.

4. I submit this Declaration in support of the States' Motion for a Preliminary Injunction.

MNsure: Introduction

5. When MNsure was established in 2013, Minnesota's uninsured rate was approximately 8.6%. As of the most recent data available, Minnesota's uninsured rate has dropped in 2023 to 3.8%.

6. MNsure has established a competitive marketplace, a robust risk pool, and currently includes five health insurance plan issuers and three dental plan issuers.

7. MNsure is funded through 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.

8. The flexibility that the U.S. Department of Health and Human Services (HHS) and the Centers from Medicare and Medicaid Services (CMS) have afforded state-based exchanges (SBEs) in operating our unique marketplaces has allowed us to implement innovative policies which facilitate access to high-quality health and dental insurance plans at an affordable cost.

9. MNsure has typically maintained Open Enrollment Periods (OEP) to maximize consumer access, running from November 1 through approximately January 15, which is longer than the Federally-Facilitated Exchange (FFE). In years when the Federally Facilitated Exchange (FFE) has shortened its OEP, MNsure maintained a longer opportunity for individuals and families to enroll in coverage recognizing Minnesota's unique marketplace, consumer behavior, and needs.

10. Our special enrollment period (SEP) policies have also been uniquely designed to meet Minnesota's needs, ensuring continuous coverage and minimizing enrollment barriers.

Lack of MNsure enrollment fraud

11. MNsure has had very few instances of fraudulent enrollment. A review of consumer complaints and enrollment partner activity in recent years revealed that improper enrollments through MNsure are exceedingly rare, thanks to the tailored oversight measures we have implemented, such as automated verifications with federal HUB service, and reviews of enrollment activity by health insurance carriers.

12. For the few instances reported, MNsure has taken swift and decisive corrective actions, including conducting investigations and, when necessary, terminating enrollments.

13. We believe instances of fraud are low because of MNsure's tailored program integrity measures, including oversight of enrollment partners and enforcement mechanisms.

MNsure lost enrollment revenue

14. We estimate that the Final Rule will cause total enrollment in MNsure to decrease and will cause the risk pool to significantly worsen, thereby causing premiums to increase, especially for middle income enrollees who receive small or no premium subsidies.

15. One direct consequence of this anticipated decrease in enrollment is a loss of revenue. To fund operations, MNsure collects a user fee of 3.5% percent of the total monthly premiums collected by an issuer for each plan purchased through our individual exchange, pursuant to Minnesota Statutes, section 62V.05, subdivision 2.

16. If our estimates are accurate, MNsure anticipates our enrollments and revenue could decrease significantly at the same time we would be required to spend significant resources on implementing provisions within the rule. The loss in revenue and increased expenses would result in our inability to maintain adequate customer service levels.

MNsure compliance costs

17. We estimate that the numerous changes in the Final Rule will require us to spend significant financial resources and staff time updating our information technology (IT) systems. Additionally, the rule will require a substantial amount of staff time to implement its requirements, impose significant operational challenges on our SBE, and require significant new investment in

outreach and communication campaigns to inform consumers about changes imposed by the final rule.

18. Some of the technical changes to our IT systems cannot be completed in time for the 2026 plan year. Specifically, the new income verification requirements—such as requiring documentation when tax data shows income under 100 percent of the FPL and requiring documentation when no tax data is available through the federal data services hub—are impossible to implement within our existing system infrastructure.

19. Implementing these rules would necessitate new system programming and additional manual processes, which compromises the efficiency of our automated systems. This, in turn, would lead to higher operational costs, greater challenges for consumers, and added strain on critical resources. Specifically, it could impact the accuracy and timeliness of consumer notices, increase the volume and complexity of mailings, require expanded enrollee outreach efforts to address potential confusion, and place additional demands on service center operations, including longer wait times and increased staffing needs to handle inquiries and support requests.

20. Moreover, MNsure experiences a high amount of traffic during the OEP. As a result, MNsure requires internal teams and external partners to minimize technical changes during this period of time to prevent any unintended disruptions to consumers' ability to enroll by the deadline.

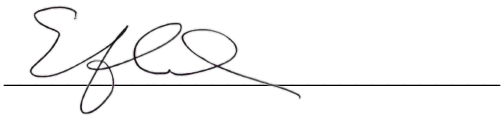
Risk pool impacts to MNsure

21. MNsure has consistently cultivated a stable and healthier risk pool compared to the FFE, as reflected by CMS's annual risk adjustment data, even when accounting for market-specific differences.

22. Historically, MNsure sees a greater number of younger (18–44-year-olds) enrollees sign up for coverage after December 15 (i.e., 54%). Therefore, the Final Rule could increase costs to Minnesota by removing a pool of relatively young and healthy individuals from the pool of insureds participating in state-based exchanges.

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 July 2025, in Saint Paul, Minnesota.



Elizabeth Caulum
Chief Executive Officer
MNsure

EXHIBIT 17

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MASSACHUSETTS

STATE OF CALIFORNIA, et al., *Plaintiffs*, v. ROBERT F. KENNEDY, JR., et al., *Defendants*.	Civil Action No. 25-12019 Judge

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 Plaintiffs' challenge of the Final Rule issued by the U.S. Department of Health and Human Services and Center for Medicaid Services entitled "Patient Protection and Affordable Care Act; Marketplace Integrity and Affordability."
3. 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 is detrimental to the State and New Jersey residents.

4. 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.

5. 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.

6. 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.

7. 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.

8. 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.

9. 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.

10. 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.
11. University Hospital provides care to patients without regard to immigration status.
12. 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.
13. The Final Rule would harm New Jersey as it would likely render affordable health insurance coverage unavailable to various New Jersey residents, thereby contributing to negative health outcomes. Without access to affordable health insurance via the state insurance marketplace, uninsured or underinsured New Jersey residents are less likely to seek preventive care and avoid costly emergency room visits.
14. Should the Final Rule go into effect, even a temporary disruption in health insurance coverage would likely cause significant harm to New Jersey's state hospitals, healthcare providers, and residents seeking healthcare services.

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 July, 2025, in Newark, New Jersey.

John Gary Huck, Chief Financial Officer
University Hospital

EXHIBIT 18

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MASSACHUSETTS

STATE OF CALIFORNIA, et al.

Plaintiffs,

v.

ROBERT F. KENNEDY, et al.,

Defendants.

Civil Action No.: 25-12019

DECLARATION OF JUSTIN ZIMMERMAN

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

1. I am Commissioner of the New Jersey Department of Banking and Insurance ("the Department"). I was appointed to lead the New Jersey Department of Banking and Insurance by Governor Phil Murphy in June 2023, and was subsequently unanimously confirmed by the State Senate. I lead Get Covered New Jersey, the state's official health insurance marketplace, and serve as the chief regulator of New Jersey's insurance industry, one of the largest in the nation, all state-chartered banks and credit unions, consumer finance licensees and the real estate industry.
2. The Department was the first state insurance department in which a state-based exchange is housed.
3. I have nearly 20 years of public service in New Jersey and joined the Department in January 2018, serving as the Department's Chief of Staff, where I oversaw the executive management team and managed all aspects of the department's policy implementation, under the direction

of the prior Commissioner. During my tenure as Chief of Staff, the department developed and implemented numerous consumer protections and programs impacting countless New Jerseyans, including New Jersey's out of network law, student loan protections, mortgage servicers licensing, expanding access to reproductive health care and Get Covered New Jersey. Since its inception in 2020, Get Covered New Jersey transformed New Jersey's health insurance landscape for consumers in the individual market, ensuring that more New Jerseyans have greater access to quality, affordable health insurance. New Jersey was the first in the nation to open its marketplace with state subsidies that lower premiums for most enrollees.

4. Since launching Get Covered New Jersey ("GetCoveredNJ") in 2020, I have overseen the leadership team of the Exchange, which has successfully implemented policies to expand access to and increase affordability of health insurance. 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).
5. I am familiar with the information in the statements set forth below through personal knowledge and from documents and information that have been provided to and reviewed by me.
6. I submit this Declaration in support of the States' Motion for a Preliminary Injunction.

Get Covered New Jersey

7. Among other functions, the Department operates 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 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.

8. 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 2025 Open Enrollment Period, plan selections increased over 108% since the Murphy Administration took over the marketplace's operations from the federal government in 2020.

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. In addition to federal subsidies, 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.

11. 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.

12. A total of 513,217 New Jersey residents signed up for health insurance under Get Covered New Jersey during the Open Enrollment Period for plan year 2025. This includes 197,876 new

or existing consumers who actively selected a plan and 315,341 who were automatically renewed. This year's record-breaking sign-ups represent nearly a 30% increase compared to last year's Open Enrollment Period (for plan year 2024) when 397,942 residents signed up for 2024 health coverage.

13. Since its launch, GetCoveredNJ has established a competitive market, a robust risk pool, and currently includes six health insurance plan issuers. Not only did GetCoveredNJ more than double the number of enrollees since its launch, GetCoveredNJ also doubled the number of carriers selling plans on the marketplace since its inception. Nine in ten individuals enrolling in GetCoveredNJ qualify for financial help that reduces 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.

14. The flexibility that the U.S. Department of Health and Human Services (HHS) and the Centers from Medicare and Medicaid Services (CMS) have afforded SBEs in operating our unique marketplaces influenced New Jersey's decision to operate our own state-based exchange and has allowed New Jersey to implement innovative policies which make it easier for our consumers to enroll in more generous plans at low or no cost. New Jersey law, N.J.S.A.17B:27A-6.1, requires GetCoveredNJ to maintain at least a 90-day open enrollment period. Therefore, GetCoveredNJ has maintained a consistent OEP since our launch over five years ago, running from November 1 through January 31, which strengthens our risk pool by enrolling healthier and younger individuals who are more likely to sign up later in the period.

Additionally, GetCoveredNJ's approach to special enrollment periods (SEP) has been to provide appropriate SEPs to meet New Jersey's needs, ensuring continuous coverage and minimizing enrollment barriers while maintaining a healthy risk pool. Moreover, our approach has successfully deterred fraud while also ensuring that consumer enrollments are conducted appropriately and effectively. GetCoveredNJ has experienced a negligible number of cases of fraud. These flexibilities allow New Jersey and other states the ability to tailor policies to local conditions while upholding program integrity and consumer protections.

Lack of enrollment fraud

15. GetCoveredNJ has had very few instances of fraudulent enrollment. A review of consumer complaints and enrollment partner activity in recent years revealed that improper enrollments are exceedingly rare and immediately addressed when found.
16. New Jersey's integrated eligibility and enrollment system verifies applicants for both Medicaid and marketplace coverage, limiting the potential for fraudulent enrollment.
17. We have no evidence of any significant amount of fraud stemming from any SEP. Because of GetCoveredNJ's tailored program integrity measures, reports of any improper enrollments within GetCoveredNJ remain very low. GetCoveredNJ did not experience the volume or type of fraudulent enrollments that healthcare.gov experienced.

Lost Enrollment Revenue

18. 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.
19. 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.

20. 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.

21. The changes made by the Final Rule are expected to cause decreased enrollment in the exchange. One direct consequence of this anticipated decrease in enrollment is a loss of State revenues due to reduced user fee revenue from premiums.

22. The Final Rule estimates that its changes will cause enrollment to be reduced nationwide by approximately by up to 1.8 million, which would be about over seven percent of the total 24.3 million enrollees in ACA exchanges in 2025. If New Jersey experienced a drop of seven percent from its 2025 enrollment of 513,217, it would mean 35,925 fewer enrollees. Using the average 2025 projected premium in the individual market, the projected loss of exchange user fees if these enrollees were excluded from the market is estimated to be $10,759,307.58 in 2025.

Compliance Costs

23. If the comment period for Proposed Rule had been longer than 23 days, GetCoveredNJ could have provided CMS with a robust analysis of the fiscal and administrative impact of the Final Rule's changes before they were finalized.

24. Implementing these rules would necessitate new system programming and additional manual processes. This, in turn, would lead to higher operational costs and greater challenges for consumers. Specifically, it would impact consumer notices, increase the volume and complexity of mailings, require expanded enrollee outreach efforts to address potential confusion, and place additional demands on service center operations, including longer wait times and increased staffing needs to handle inquiries and support requests.

25. Moreover, GetCoveredNJ on average experiences a high amount of traffic during the OEP. As a result, the State requires GetCoveredNJ's internal teams and external partners to minimize technical changes during this period of time to prevent any unintended disruptions to consumers' ability to enroll by the deadline.

26. With respect to providing essential health benefits for gender-affirming care, the Final Rule will force GetCoveredNJ to examine carrier submissions to ensure the appropriate amounts have been excluded from federal cost-sharing. GetCoveredNJ will need to implement technical assistance on the back end to ensure this is done consistently across the market in New Jersey. This will take up valuable time and resources. In addition, insurance carriers in New Jersey do not all maintain their data in the same way. This means that conducting targeted assessments will be necessary to ensure that gender-affirming care services, which can take many different forms, have been excluded from coverage as EHBs. These targeted assessments would require additional time on part of marketplaces.

27. We estimate that the numerous changes in the Final Rule will require us to spend approximately $2 million updating our information technology (IT) systems.

28. The Final Rule will also carry administrative burdens relating to "data matching issues" (DMI) generated as part of the new enrollee verification requirement when a consumer has income below 100% of the Federal Poverty Line (FPL).

Risk Pool Impacts

29. The Final Rule makes several changes that adversely impact GetCoveredNJ's risk pool, including, but not limited to, the following.

30. The Final Rule denies consumers APTC eligibility and imposes a tax liability after one year where an individual fails to file taxes and reconcile the projected household income that qualified them for APTC, rather than after two consecutive years, which was the previous policy. This added barrier to marketplace enrollment will discourage healthier individuals from enrolling, deteriorate the risk pool, and lead to higher premiums for those who remain insured.

31. Since the Market Integrity rule was announced, one carrier that sold plans on GetCoveredNJ announced that it was leaving the individual market nationally. That carrier currently represents approximately 25% of the plans sold on GetCoveredNJ. Additionally, another carrier that expressed interest in joining the individual market in New Jersey to sell products on GetCoveredNJ informed the Department that they were no longer going to pursue entering the individual market in New Jersey with one reason being the uncertainty from the federal administration. Less competition in the market will negatively impact the risk pool and over the long run possibly lead to higher premiums for consumers.
32. Prior to the Final Rule, exchange plans accepted the self-attestation of an enrollee who claimed eligibility by projecting annual household income at or above 100% of the FPL. This self-attestation policy was designed to ensure that the lowest-income enrollees, who are often younger and healthier, are not discouraged from entering the risk pool due to paperwork burdens. The prior policy also recognized the challenges that low-income individuals face in accurately estimating their annual income. Many low-income individuals experience significant fluctuations in their earnings over the course of the year. The Final Rule's elimination of this practice is an administrative barrier to enrollment that will likely cause younger and healthier consumers to drop out of the marketplace. That, in turn, will worsen the risk pool and increase premiums for both subsidized and unsubsidized consumers.

Gender-Affirming Care EHBs

33. The ACA mandates that certain individual and small group health plans cover a set of Essential Health Benefits (EHBs) which must be equal to the scope of benefits provided under a typical employer plan and may not have any annual or lifetime dollar limit under state plans.
34. Per HHS, the items and services covered must come from the following ten benefit categories: (1) ambulatory patient services; (2) emergency services; (3) hospitalization; (4) maternity and newborn care; (5) mental health and substance use disorder services including behavioral

health treatment; (6) prescription drugs; (7) rehabilitative and habilitative services and devices; (8) laboratory services; (9) preventive and wellness services and chronic disease management; and (10) pediatric services, including oral and vision care.

35. Under New Jersey law, P.L.2017, c.176, carriers are prohibited from discriminating on the basis of a covered person's or prospective covered person's gender identity or expression or on the basis that the covered person or prospective covered person is a transgender person. This prohibited discrimination includes, among other things, issuing or renewing health benefits plans containing provisions that discriminate, or act to discriminate, on the basis of a covered person's or prospective covered person's gender identity or gender expression or on the basis that the covered person or prospective covered person is a transgender person.

36. The Department has issued Bulletin 23-05 to direct carriers on following applicable state and federal laws, including P.L.2019, c.58 (Requires coverage and parity for Mental Health Conditions), The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act, 29 U.S.C. 1185a (MHPAEA), and the Patient Protection and Affordable Care Act, section 1557a (42 U.S.C. 18116). Under these laws, a carrier may not deny coverage for medically necessary, transition-related care on the basis of the covered person's gender identity or gender expression or on the basis that the covered person is a transgender person if the covered person's health benefits plan provides coverage for the same services related to the treatment of other conditions or illnesses. Additionally, among other things, Bulletin 23-05 reminds carriers that they may not apply a different medical necessity review process, or impose extra documentation requirements, for transgender individuals relative to other individuals seeking the same or similar services.

The Final Rule Will Irreparably Harm New Jersey

37. The Final Rule results in fewer New Jersey residents accessing the state exchange, increasing the number of uninsured individuals in the State.

38. The Final Rule would harm New Jersey as it would likely render quality affordable health insurance coverage more difficult to access for certain New Jerseyans, thereby contributing to negative health outcomes. Without access to quality affordable health insurance via the state's official health insurance marketplace, some New Jersey residents may be less likely to seek preventative care and avoid costly emergency room visits. This may also make these New Jerseyans more likely to incur costly medical bills leading to an increased financial strain on these individuals.

39. Should the Final Rule go into effect, even a temporary disruption in health insurance coverage due to barriers to access would likely cause significant harm to impacted New Jersey residents seeking healthcare services.

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

Executed this 16th day of July, 2025, in Mercer County, New Jersey.

Justin Zimmerman
Commissioner
New Jersey Department of Banking and Insurance

EXHIBIT 19

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MASSACHUSETTS

STATE OF CALIFORNIA, et al.

Plaintiffs,

v.

ROBERT F. KENNEDY, JR., et al.,

Defendants.

Civil Action No.: 25-12019

DECLARATION OF COLIN BAILLIO

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

1. I am the Health Care Coverage Innovations Director at the New Mexico Health Care Authority. I received my BA from the University of New Mexico in 2013 and have five years of experience in state government and over ten years of experience in health insurance policy. I have been employed as the Health Care Coverage Innovations Director since September of 2024. Prior to my current position, I served as the Deputy Superintendent of Insurance and the Coverage Affordability and Expansion Director at the New Mexico Office of Superintendent of Insurance (OSI). I also serve on the Board of Directors for BeWell, New Mexico's Health Insurance Marketplace, and have served on the Board in various capacities in the past, including as a representative for OSI and as a consumer representative.

2. The New Mexico Health Care Authority operates several state-funded affordability programs to ensure New Mexicans have access to quality, affordable health coverage. The Authority is also the state agency that administers the state's Medicaid program, Turquoise Care. Since the State's affordability programs have gone into effect, enrollment in Qualified Health

Plans has nearly doubled. Affordable coverage helps previously uninsured New Mexicans get the care they need and have better financial security.

3. I am familiar with the information in the statements set forth below through personal knowledge and from documents and information that have been provided to and reviewed by me.

4. I submit this Declaration in support of the States' Motion for a Preliminary Injunction.

Introduction

1. New Mexico's Health Insurance Marketplace was established by the state legislature in 2013. Until 2022, New Mexico used a hybrid model, leveraging the federal platform for individual market enrollment while conducting outreach, enrollment assistance, and other operations at the state level. The State Based Exchange (SBE) launched in 2022. Then, in 2023, state-funded subsidies began providing even more affordable coverage for members. Today, more than 73,000 New Mexicans rely on BeWell for their coverage, the highest level of enrollment ever recorded.

2. When BeWell, New Mexico's Health Insurance Marketplace, was established in 2013, our state's uninsured rate was approximately 22.6%. As of 2022, our state's uninsured rate has dropped to 10.6%, according to the United States Census.

3. Our SBE has established a competitive market, a robust risk pool, and currently includes four health insurance plan issuers and two dental plan issuers.

4. The flexibility that the U.S. Department of Health and Human Services (HHS) and the Centers from Medicare and Medicaid Services (CMS) have afforded SBEs in operating our unique marketplaces has allowed us to implement innovative policies which make it easier for consumers to enroll in more generous plans at low or no cost. For example, New Mexico offers enhanced premium and out-of-pocket assistance to members, provides innovative renewal policies to maximize savings for members, and maximizes enrollment opportunities for low-income state residents.

Enrollment Period Changes

5. As an SBE, BeWell has maintained a longer Open Enrollment Period (OEP) than the Federally-Facilitated Exchange (FFE), running from November 1 through January 15. According to joint comments submitted by the Health Care Authority, Office of Superintendent of Insurance, and BeWell,

> In BeWell's most recent enrollment cycle, a substantial portion of consumers enrolled during the final weeks of the OEP: in Open Enrollment 2024, 56% of new BeWell consumers enrolled between December 16, 2024, and January 15, 2025—an increase from 43% during that same timeframe in the previous year. Additionally, greater proportions of younger consumers enroll in their coverage in the second half of OEP; in OEP 2024, nearly two-thirds (65%) of all children under 18 with BeWell coverage, along with 56% of all enrollees aged 18 to 34, were enrolled after December 15. In contrast, more than half (52%) of all enrollees aged 55 to 64 enrolled before December 15. Allowing states to retain the flexibility to set the terms for their OEP is essential for effectively serving states' consumers… This change could also impact BeWell's broader partner network, including certified agents, brokers, and assisters. In previous OEPs, they have observed increased activity during the final weeks as consumers seek assistance. A compressed timeline may exacerbate this issue, leading to errors, consumer confusion, abrupt designation and de-designation of agents of record, and enrollment disruptions. Moreover, the increased enrollment volume in a shorter timeframe could elevate the risk and impact of system or human errors, undetected fraud, and technical issues. A longer OEP allows for smoother daily enrollment traffic and greater opportunity for real-time quality assurance and oversight. Should a system outage occur near the end of a shortened OEP, there would be limited recourse to address disruptions. While BeWell has historically experienced few system outages, a federally-mandated, firm deadline would eliminate New Mexico's ability to extend enrollment or mitigate harm to affected consumers in the event of system issues.

6. New Mexico's special enrollment period (SEP) strategies have also been uniquely designed to meet New Mexico's needs, ensuring continuous coverage and minimizing enrollment barriers. According to the joint comments referenced above, the income-based SEP

> "is one of the most frequently used on BeWell's platform, accounting for 1,254 enrollments in Plan Year 2024, and its removal would require system changes as well as extensive review of outreach and communications materials. However, while this SEP has a relatively high utilization compared to other [types of SEPs], enrollments under this SEP represent only a small percentage of BeWell's enrollment: approximately 2% of all enrollments in PY 2024. Fifty-nine percent of those who used the low-income SEP in 2024 live in a rural or frontier county… With the existing program integrity measures in place, there is no documented evidence of fraud or misuse of this SEP in New Mexico. BeWell's proactive outreach and consumer education efforts year-round are effectively encouraging early, preventive enrollment—before medical need becomes urgent. In 2024, 85% of those who used the low-income SEP remained enrolled through the rest of the plan year, indicating most enrollees did not sign up for short-term medical needs but instead needed coverage to maintain their health and financial security. This also supports health care providers, especially in rural and frontier communities, so their patients can access care and pay for services through their health plan, thus reducing uncompensated care for providers."

7. Although CMS suggested this low-income SEP contributed to fraudulent and improper enrollments, BeWell data demonstrates this not an issue in New Mexico. BeWell conducts rigorous verification of applicants' income and household data as part of the standard enrollment process, as it is required to do under federal law. Additionally, New Mexico supplements federal subsidies with its own New Mexico Premium Assistance, which provides additional financial help to consumers earning between 138% and 400% FPL. On average, the population with incomes of 138-200% of FPL receives the highest amount of state-funded support, approximately $53 per member per month. This gives our state a direct fiscal stake in ensuring eligibility determinations are accurate and that subsidies are not improperly paid.

8. According to information provided by BeWell, the Marketplace received fewer than 15 consumer complaints regarding certified brokers' and assisters' activity on the marketplace – none of which reported fraudulent enrollment. BeWell provides rigorous training to enrollment assisters, which must be completed before being certified; tightly controlled access to the marketplace, which is contingent upon certification and can be revoked timely in the event of suspected fraud;

procedures where customers must initially designate their broker or assister; and system features that require consumer confirmation of changes. Because of BeWell's tailored program integrity measures, including oversight of enrollment partners and enforcement mechanisms, reports of improper enrollments through BeWell remain very low, as demonstrated through federal enforcement mechanisms. BeWell has met all SMART requirements and remains in good standing with CMS oversight, with no material deficiencies or major compliance issues identified in SMART or IPPTA assessments.

BeWell Compliance Costs

9. According to BeWell, prior to the finalization of the rule, exchange plans accepted the self-attestation of an enrollee who claimed eligibility by projecting annual household income at or above 100% of the FPL. The Finalized Marketplace Integrity and Affordability Rule changes this policy in two ways. First, anytime IRS data shows a consumer has income below 100% of the FPL, a "data matching issue" (DMI) will be generated. Second, in the absence of IRS data, a DMI will be generated. Whenever a DMI is generated, consumers will be required to track down and submit the necessary paperwork in order to purchase health insurance. DMIs also create administrative burdens on SBEs, which are required to receive, process, and determine whether the newly submitted paperwork adequately addresses the issue. These changes impose a heavy burden on SBEs, including BeWell, necessitating an immediate and complex system development to implement a new DMI with intricate logic requirements. Development of the DMI would potentially divert resources from other efforts, such as our current platform transition designed to serve New Mexicans better through an improved BeWell system.

Impact on Uninsured Rate, State Costs, and Uncompensated Care

10. The Final Rule acknowledges that the changes it makes will result in a decrease in enrollment in the ACA marketplace exchanges of up to 2 million people. This represents an enrollment reduction of approximately 8.3% from the 24.2 million who enrolled in Marketplace

coverage, during 2025 open enrollment period, based on figures from CMS' Marketplace Open Enrollment Public Use Files. If New Mexico experienced a proportional enrollment decline as a percentage of total enrollment, about 6,008 individuals who have coverage today through BeWell would lose their health insurance.

11. A direct consequence of this decreased enrollment under the Final Rule is a higher rate of uninsured individuals in New Mexico, and correspondingly higher costs incurred by the State, both in funding programs that pay for certain types of care offered to uninsured residents and in costs for providing care that is uncompensated by such programs. Mitigating these coverage losses could mean pulling back on investments for other urgent priorities.

12. Decreased enrollment under the Final Rule would cause a rise in the state's uninsured rate, which drives up uncompensated care for health care providers. New Mexico is facing a significant provider shortage and has made concerted efforts to decrease its uninsured rate to ensure health care providers are fairly compensated for their services. A loss of marketplace coverage does not automatically open the door to Medicaid, because Medicaid eligibility is tied to strict income limits that many marketplace enrollees exceed. New Mexico has programs to address gaps in the coverage system. However, if these coverage losses were to be directly mitigated by the state, it would be very costly. The Advance Premium Tax Credit (APTC) is the federal income-based premium subsidy created under the Affordable Care Act that makes coverage affordable for qualifying Marketplace enrollees. The average monthly Advance Premium Tax Credit (APTC) in New Mexico is $583, according to information posted on bewellnm.com. If the state were to absorb those costs for 6,008 individuals for one year, it would cost the state additional $42 million. Without state action, it is likely that many of these individuals would become uninsured. There would also be substantial work and costs to implement the changes necessary to mitigate the coverage losses and to conduct outreach to those individuals who will lose coverage.

13. All hospitals are required to treat patients presenting in their emergency departments, regardless of the patient's ability to pay. An increase in the uninsured rate could put greater

pressure on hospitals, especially rural clinics that are struggling. *See* the federal Emergency Medical Treatment and Labor Act (EMTALA).

14. The Safety Net Care Pool (SNCP) Fund (27-5-6.1 NMSA 1978) also provides funding to hospitals for its uncompensated care costs and is administered by the HCA. Counties levy a gross receipts tax, which are then transferred to the Fund and matched with federal Medicaid dollars that are used to reimburse hospitals for uncompensated care costs. The increased number of uninsured individuals could place an increased burden on this Fund.

15. If the state is unable to directly maintain coverage for these individuals, there is an option in New Mexico that can help individuals maintain coverage. The New Mexico Medical Insurance Pool (NMMIP) was established by the 1987 New Mexico State Legislature (59A-54-4) to provide access to health insurance coverage to residents of New Mexico who are denied health insurance and considered uninsurable. As a state-run, high-risk insurance pool, NMMIP is a non-profit organization that provides a health care coverage option to the uninsured so that they can obtain insurance. Adding more members to the Pool could increase individual and small group rates, as the NMMIP is funded by assessments on insurance carriers.

Public Health Impacts

16. The Final Rule is detrimental to New Mexico's public health. With record enrollment there is increased access to affordable health insurance via BeWell, individuals are more likely to seek preventive care and avoid costly emergency room visits. Without individuals having access to affordable health insurance, they are more likely to not seek preventative care, incur costly emergency room visits, and require New Mexico to cover costs for uninsured individuals.

17. Increased access to health insurance also improves public health. Uninsured individuals who lack access to affordable, adequate health insurance are less likely to seek preventive care or attend routine health screenings, and may delay necessary medical care due to prohibitive costs.

18. According to the Health Care Cost Institute, preventive care represents 3.5% of total health care spending, approximately $205 per person per year. However, the cost of these services for an

uninsured individual would be cost prohibitive. For example, the average price of a colonoscopy is $1,444, a mammogram is $255, and the insertion of an IUD is $213. These types of preventive services have proven positive public health effects. However, these high prices would make these services prohibitively expensive for many New Mexicans who lose coverage under the new rule.

19. With the exception of NMMIP, existing New Mexico uncompensated care programs provide only financial reimbursement for hospital services. (NMMIP is an insurer of last resort, providing coverage to individuals who are ineligible and/or denied coverage for employer-sponsored, Medicaid, Marketplace and other forms of public insurance). Additionally, health care access via these programs can be limited, thus an uninsured individual who does not qualify for Medicaid and cannot pay out of pocket for services would be unable to access coverage.

20. Lack of insurance and resulting negative health outcomes also result in downstream consequences, including, absenteeism in the workplace and increased reliance on unemployment insurance, which relies on State funding.

21. Decreased access to adequate and affordable health care could mean infectious diseases spread more widely and rapidly with those affected not seeking care due to being uninsured or underinsured.

22. 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 July, 2025, in Santa Fe, New Mexico.

Signed by:
Colin Baillio
681D4C45F19A485...

Colin Baillio
Health Care Coverage Innovations Director
New Mexico Health Care Authority

EXHIBIT 20

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MASSACHUSETTS

STATE OF CALIFORNIA, et al.,

Plaintiffs,

v.

ROBERT F. KENNEDY, JR., in his official capacity as Secretary of Health and Human Services, et al.,

Defendants.

Civil Action No.: 25-12019

DECLARATION OF DANIELLE HOLAHAN

I, Danielle Holahan, declare under the penalty of perjury pursuant to 28 U.S.C. § 1746 that the following is true and correct:

1. I am the Executive Director at NY State of Health, New York State's Official Health Plan Marketplace. I hold a Bachelor of Arts from Franklin & Marshall College and a Master of Public Health (MPH) from Columbia University's Joseph L. Mailman School of Public Health. I have been employed as Executive Director of NY State of Health since September 2021 after serving as Deputy Director since April 2011. I worked at the United Hospital Fund of New York from 1999 to 2011, where I was Co-Director of the Health Insurance Project, and from 1994 to 1997 at AARP's Public Policy Institute in Washington, D.C.

2. I am familiar with the information in the statements set forth below either through personal knowledge, consultation with NY State of Health staff, or from my review of relevant documents and information.

3. I submit this Declaration in support of the States' Motion for a Preliminary Injunction.

4. New York's state-based health benefit exchange ("SBE"), known as "NY State of Health, the official health plan Marketplace" or "Marketplace," is authorized by the Federal Patient Protection and Affordable Care Act of 2010 ("ACA") and NY Public Health Law. The Marketplace is a division of the New York State Department of Health, an executive agency of the State of New York, which was established in April 2012 by Executive Order 42 for coverage starting January 1, 2014. It was codified in Article 2, Title VII of the NY Public Health Law in 2019.

5. The Marketplace certifies health plans and determines if an individual is eligible for insurance affordability programs including Medicaid, Child Health Plus, Essential Plan, premium tax credits ("PTCs") and cost-sharing reductions ("CSR"), as well as Qualified Health Plan ("QHP") coverage. It also provides an organized marketplace where New Yorkers shop for, and enroll in, public and private health insurance. Individuals, families, and small businesses use the Marketplace to compare insurance options, calculate costs, and select and enroll in health plans.

6. In 2015, with approval from the Centers for Medicare and Medicaid Services ("CMS"), the Marketplace established a Basic Health Program ("BHP"), branded the "Essential Plan." Pursuant to Section 1331(a) of the ACA, States may establish a BHP to offer health coverage for individuals with family incomes between 133 and 200% of the federal-poverty level (FPL) and for individuals from 0 to 200% FPL who are lawfully present in the United States but do not qualify for Medicaid due to their immigration status. Essential Plan coverage is in lieu of QHP coverage through the Marketplace for qualified individuals.

7. In 2023, to continue to address the affordability of health insurance for New Yorkers, the Marketplace sought approval from CMS of a Section 1332 State Innovation Waiver to operate

the Essential Plan pursuant to Section 1332 of the ACA (State Innovation Waivers), rather than under Section 1331 of the ACA (Basic Health Program). In addition, New York requested a suspension of its BHP through December 31, 2028, with an option to extend for an additional 5 years.

8. On March 1, 2024, CMS approved the Marketplace's 1332 State Innovation Waiver, which allowed an expansion of New York's successful Essential Plan. Under the 1332 Waiver, New Yorkers with incomes up to 250% of the FPL, who would otherwise be eligible for subsidized coverage on the Marketplace through enrollment in a QHP with premium tax credits, are eligible for the Essential Plan. New York has used waiver funds not expended to support the EP expansion to create additional care innovations like more generous cost-sharing reductions and benefits to support social determinates of health.

9. Consumers enrolled in plans that have been certified by the Marketplace and cover all essential health benefits required by the ACA, called QHPs, may also apply through the Marketplace for PTCs and CSRs to lower the cost of premiums and out of pocket costs for QHPs. PTCs, which are available based on a consumer's household income and the cost of QHPs in the consumer's area, may be applied directly by the insurer to lower monthly premium payments. Consumers with a household income of up to 250% of the FPL may also be eligible for financial assistance through CSRs, which reduce the cost of using their health insurance coverage. In New York, pursuant to our 1332 Waiver, consumers earning up to 400% of the FPL may also qualify for additional cost-sharing assistance. The Marketplace assists individuals in determining whether such financial assistance is available. New Yorkers must enroll in a QHP directly through the Marketplace during the annual Open Enrollment Period to qualify for and use PTCs and CSRs (unless they qualify for a Special Enrollment Period). Any New Yorker who needs health coverage can apply.

10. When NY State of Health was established in 2012, approximately 11% of New York residents were uninsured. As of 2023, the rate has dropped to 4.8%.

11. There are over 6.7 million New York residents enrolled through NY State of Health, including 4.2 million enrolled in Medicaid, over 580,000 enrolled in Child Health Plus, over 220,000 enrolled in commercial QHPs (nearly 90% of the commercial individual market), and over 1.6 million in the Essential Plan. Nearly 65% of QHP enrollees have been determined eligible to receive PTC.

12. NY State of Health has established a competitive market with 12 health-insurance-plan issuers and five dental-plan issuers.

13. NY State of Health's QHP related costs are funded through a special revenue fund derived from a surcharge on health care services. In State Fiscal Year 2025, New York paid an estimated $154 million of NY State of Health operating costs. Other operating costs, totaling $357.1 million in State Fiscal year 2025, were supported by federal funds supporting Medicaid, Child Health Plus and Essential Plan administrative costs.

14. The flexibility that the U.S. Department of Health and Human Services ("HHS") and CMS have afforded SBEs in operating our unique marketplaces has allowed us to implement innovative policies that make it easier for consumers to enroll in more generous plans at low or no cost. New York's Marketplace provides a centralized platform through which all eligible individuals can access public and private coverage and one in three residents enroll in health coverage here. The system allows individual enrollees to seamlessly transition between programs in response to changes in individual circumstances. Additionally, under the approved Section 1332 Waiver, known as the Essential Plan, New York has expanded access to $0 premium coverage to 1.6 million low- and moderate-income individuals and extended cost sharing reductions to 45,000 moderate-income consumers in the QHP market—all of which has been achieved without increasing the federal deficit. In addition, commercial individual market coverage is significantly more affordable through NY State of Health today than it was prior to the implementation of the ACA in New York. In 2012, the average monthly premium for individual market coverage was unaffordable to most New Yorkers at $1,250, with significant cost-sharing, and only 18,000 individuals purchased this coverage. In 2025, over 240,000 are

enrolled in the individual market, most of whom purchase through the Marketplace. More than 140,000 enrollees through NY State of Health are eligible for federal PTCs and the average monthly premium is $300.

15. Our current special enrollment period (SEP) policies strike a balance between ensuring timely access to health coverage when individuals need it and minimizing the risk of adverse selection to help to maintain a stable risk pool.

16. NY State of Health already prevents and responds to its limited cases of fraudulent enrollment. A review of consumer complaints and enrollment partner activity in recent years revealed that improper enrollments are rare thanks to our tailored oversight measures such as regular training of certified enrollment assistors and monitoring of enrollment activities.

17. For the limited cases of identified inappropriate enrollment activity, NY State of Health has responded with swift and decisive corrective actions. This includes the immediate suspension of the implicated Marketplace account credentials pending investigation of the enroller. If unauthorized enrollment activity is confirmed, the Marketplace permanently terminates the relevant credentials and refers the matter to the appropriate authorities, which may include law enforcement, the New York State Office of the Medicaid Inspector General, and the New York Department of Financial Services.

18. The Final Rule will not only decrease total enrollment in NY State of Health by an estimated 12,000 individuals, but also drive-up premiums as it will worsen the risk pool.

19. One direct consequence of this anticipated decrease in enrollment is a loss of State revenues. To fund operations, NY State of Health leverages a special revenue fund derived from a surcharge on health care services. Revenue raised through this fund is directly correlated to the number of insured individuals using health care services.

20. The increased demands in the Final Rule will likely require New York to spend over $10 million on staff time, alone, to update our information technology (IT) systems. Additionally, the Final Rule will require redirecting a substantial amount of staff time away from other care-focused initiatives and impose significant operational challenges on our SBE.

21. If the comment period for the Proposed Rule had been longer than 23 days, NY State of Health could have provided CMS with a robust analysis of the fiscal and administrative impact of the Final Rule's changes before they were finalized.

22. Some of the technical changes to our IT systems cannot be completed in time for the 2026 plan year. Specifically, the new income verification requirements—which require collection and review of documents when tax data shows income under 100% of the FPL and when no tax data is available through the federal data services hub or other approved data sources—are impossible to implement within the implementation timeline and our existing system infrastructure.

23. Implementing these rules would necessitate new system programming and additional manual processes which would compromise the efficiency of our current, automated systems. This, in turn, would lead to higher operational costs, greater challenges for consumers, and added strain on critical resources. Specifically, it would impact the accuracy and timeliness of consumer notices, increase the volume and complexity of mailings, require expanded enrollee outreach efforts to address potential confusion, and place additional demands on service center operations, including longer wait times and increased staffing needs to handle inquiries and support requests.

24. Moreover, NY State of Health, which enrolls consumers across four programs with a total of 6.7 million enrollees, experiences an above-average amount of traffic during the Annual Open Enrollment Period ("OEP"). As a result, the State requires NY State of Health's internal teams and external partners to minimize technical changes during this period to prevent any unintended disruptions to consumers' ability to enroll by the deadline.

25. The Final Rule would increase costs to New York by removing a group of relatively young and healthy individuals from the pool of insureds participating in state-based exchanges. New York estimates that such changes to the risk pool for NY State of Health will result in a loss of up to 12,000 individuals from the risk pool when fully implemented.

26. Further, prior to the Final Rule, exchange plans accepted the self-attestation of an applicant who projected an annual household income at or above 100% of the FPL. This self-attestation policy was designed to ensure that the lowest-income enrollees, often younger and healthier than

the average enrollee, are not discouraged from entering the risk pool due to paperwork burdens. The prior policy also recognized the challenges that low-income individuals face in accurately estimating their annual income. Many low-income individuals experience significant fluctuations in their earnings over the course of the year. The Final Rule's temporary elimination of this practice is an administrative barrier to enrollment that will likely cause younger and healthier consumers to drop out of the Marketplace. That, in turn, will worsen the risk pool and increase premiums for both subsidized and unsubsidized consumers.

27. The Final Rule's requirement to implement certain provisions on a temporary, one-year basis imposes significant yet transitory burdens on New York. This approach necessitates duplicative expenditures on IT system modifications, Customer Service Center operations, and training for staff and enrollment assistors—first for the initial implementation, and again when states must transition to the subsequent policy framework.

28. The Final Rule acknowledges that the changes it makes will result in a decrease in enrollment in the ACA marketplace exchanges of up to 2 million people nationwide.

29. A direct consequence of this decreased enrollment under the Final Rule is a higher rate of uninsured in New York, and a corresponding higher amount of costs incurred by New York both in funding programs that pay for certain types of care offered to uninsured residents and costs for providing care that is uncompensated by such programs.

30. In addition, in New York, emergency departments are required to screen all patients who appear, stabilize them, and provide treatment for an emergency medical condition or a pregnant person in labor, or transfer the patient to a hospital that can provide treatment. *See,* 42 U.S.C. § 1395dd; N.Y. Pub. Health Law § 2805-b (Consol. 2025). Hospitals must afford to each patient the right to treatment without discrimination as to source of payment. N.Y. Comp. Codes R. & Regs. tit. 10, § 405.7 (2019). New York offsets some of the costs that eligible hospitals sustain because of this requirement. Federally Qualified Health Centers are also required to treat patients, regardless of coverage status.

31. In Fiscal Year 2024, New York State provided $3.2 billion through the Safety Net Hospital State Directed Payment. *See* 42 C.F.R. § 438.6(c) and the Hospital Vital Access Provider Assurance Program (Hospital VAPAP). These programs administered by the New York State Department of Health provide additional subsidies to providers that serve a majority of Medicaid and uninsured members.

32. The Final Rule is detrimental to New York's public health. With increased access to affordable health insurance via NY State of Health, individuals are more likely to seek preventive care and avoid costly emergency room visits. Without access to affordable health insurance, the same individuals are less likely to seek preventive care and more likely to incur costly emergency room visits. Under the Final Rule, New York will have to cover the costs of those emergency room visits for uninsured individuals.

33. Increased access to health insurance also improves public health. Uninsured individuals who lack access to affordable, adequate health insurance are less likely to seek preventive care or complete routine health screenings, and may delay necessary medical care due to prohibitive costs.

34. Lack of insurance and resulting negative health outcomes also result in downstream consequences, including, absenteeism in the workplace and increased reliance on unemployment insurance, which relies on State funding.

35. Decreased access to adequate and affordable health care could mean infectious diseases spread more widely and rapidly with those affected not seeking care due to being uninsured or underinsured.

36. The ACA mandates that certain individual and small-group health plans cover a set of EHBs which must be equal to the scope of benefits provided under a typical employer plan and may not have any annual or lifetime dollar limit under state plans.

37. Per HHS, the items and services covered must come from the following ten benefit categories: (1) ambulatory patient services; (2) emergency services; (3) hospitalization; (4) maternity and newborn care; (5) mental health and substance use disorder services including behavioral health treatment; (6) prescription drugs; (7) rehabilitative and habilitative services and

devices; (8) laboratory services; (9) preventive and wellness services and chronic disease management; and (10) pediatric services, including oral and vision care.

38. The ACA and its effectuating regulations permit latitude to the states in determining how EHBs are defined. Accordingly, states submit their "benchmark" plans, selecting from one of ten benchmark plan options and supplementing, as needed to meet the EHB minimum standards, to HHS for approval. States can also choose to offer additional health benefits, like vision, dental, and medical management programs (e.g., weight loss).

39. Each state maintains a benchmark plan on file with HHS, against which private insurers must compare plans to ensure compliance with the standards set forth therein. Further, if a state has not updated its benchmark plan to match federal requirements, private insurers must also review plans for compliance with federal EHB mandates.

40. The New York State benchmark plan includes broad coverage for mental health and substance use disorder treatment, ambulatory patient services, laboratory services, hospitalization, and prescription drugs due to state law requirements that were in effect well before the enactment of the Affordable Care Act and consistent with typical employer plans.

41. New York Insurance Law §§ 3216(i)(35)(A), 3221(l)(5)(A), and 4303(g) require health insurance policies to provide coverage for the diagnosis and treatment of mental health conditions. Insurance Law §§ 3216(i)(35)(E)(iv), 3221(l)(5)(E)(iv), and 4303(g)(6)(D), define "mental health condition" as any mental health disorder as defined in the most recent edition of the diagnostic and statistical manual of mental disorders ("DSM") or the most recent edition of another generally recognized independent standard of current medical practice, such as the international classification of diseases ("ICD"). The most recent DSM edition (5-TR edition) includes "gender dysphoria" as a mental health condition that afflicts people whose gender at birth is contrary to the one with which they identify. As such, New York Insurance Law requires health insurance policies to provide coverage for the treatment of gender dysphoria.

42. New York Insurance Law §§ 3216(i)(35)(C), 3221(l)(5)(C), and 4303(g)(4) and the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008

("MHPAEA"), 29 U.S.C. § 1185a, prohibit an insurer from applying financial requirements or treatment limitations to mental health benefits that are more restrictive than the predominant financial requirements and treatment limitations applied to substantially all medical and surgical benefits covered by the policy or contract. Imposing a treatment limitation on gender dysphoria that is not imposed on other benefits is inconsistent with both state law and MHPAEA.

43. New York State laws and regulations also prohibit discrimination in healthcare coverage. Specifically, Insurance Law §§ 3243 and 4330 prohibit discrimination in comprehensive health insurance policies because of sexual orientation, gender identity or expression, and transgender status. N.Y. Comp. Codes R. & Regs. tit. 11, § 52.16(c) prohibits an insurer from limiting coverage by type of illness, treatment, or medical condition. Separately, Section 52.75(a)(2) prohibits an insurer from denying, limiting, or otherwise excluding medically necessary services or treatment otherwise covered by a policy or contract on the basis that the treatment is for gender dysphoria. N.Y. Comp. Codes R. & Regs. tit. 11, § § 52.75(a)(2). In addition, § 52.75(a)(1) prohibits a policy or contract clause that purports to deny, limit, or exclude coverage based on an insured's sexual orientation, gender identity or expression, or transgender status. Under these laws and regulations, if a health insurance policy provides coverage for benefits like ambulatory surgical services, hospitalizations, and prescription drugs, that policy cannot limit the benefit to only cover certain conditions like a traumatic injury or cancer, but not other conditions like gender dysphoria.

44. State laws in New York prohibit discrimination in healthcare coverage. In New York, this includes:

a. N.Y. Const. art. I, § 11 ("No person shall, because of . . . sex, including sexual orientation, gender identity, gender expression, . . . be subjected to any discrimination in their civil rights by any other person or by any firm, corporation, or institution, or by the state or any agency or subdivision of the state, pursuant to law.");

b. N.Y. Civ. Rights Law § 40-c (prohibiting private and public entities from discriminating);

c. N.Y. Exec. Law § 300 (Human Rights Law is liberally construed independent of less protective federal laws);

d. N.Y. Comp. Codes R. & Regs. tit. 9, § 466.13 (discrimination on the basis of gender identity or expression is also sex discrimination and gender dysphoria counts as a disability which may grant reasonable accommodations) (state);

e. N.Y. Comp. Codes R. & Regs. tit. 10, § 405.7(c) ("The hospital shall afford to each patient the right to: . . . treatment without discrimination as to race, color, religion, sex, gender identity, national origin, disability, sexual orientation, age, or source of payment.");

f. N.Y. Civ. Rts. Law §§ 64(3) (saying name changes must be honored), 67, 67-A, 67-B (respecting name changes and sex designation changes, sealing records for privacy of transgender status);

g. N.Y. Vehicle and Traffic Law §§ 490, 502 (recognizing gender x on state IDs and self-attestation of gender);

h. N.Y. Public Health Law §§ 4132, 4138(f) (allowing inclusive of trans identities on birth certificates);

i. NYC Admin. Code § 8-107 et seq. (city law prohibiting discrimination);

j. 47 NYCRR §§ 2-01 (city) (definition of gender and gender identity inclusive of transgender and nonbinary individuals), 2-06 (prohibition on discrimination based on gender identity), § 2-10 (city) (prohibition on discrimination based on sexual or reproductive health decisions).

45. Even in states like New York, where gender-affirming care is not listed as its own category of EHB in the state's benchmark plan, many services that fall within "gender-affirming care," including mental health and substance use disorder, ambulatory patient services, laboratory services, hospitalization, and prescription drugs are covered services in state marketplaces.

46. The New York State statutory and regulatory coverage requirements and prohibitions on discrimination apply to all fully insured individual, small-group, and large-group health insurance

policies delivered or issued for delivery in New York. As a result, all these health insurance policies cover treatment for gender dysphoria. There are 3,715,726 people covered under these policies as of April 30, 2025, in the commercial market (with 934,653 people covered under individual and small-group policies and 2,781,073 people covered under large-group policies). In addition, the New York State Health Insurance Program (NYSHIP), a comprehensive self-funded health insurance program for New York State public employees, also covers treatment for gender dysphoria. NYSHIP is one of the largest employer-sponsored group health insurance programs in the United States, covering nearly 1.2 million people. Clearly, a significant number of people in New York with fully insured and self-funded coverage have coverage for gender dysphoria under their health insurance policies.

47. Requiring states to exclude these otherwise-covered services from EHB definitions would raise the defrayal cost borne by New York. This is because premium amounts that would otherwise be attributed to EHB services and covered by carriers in response to the state coverage mandate would be put back on states. In 2023, insurers in New York paid $17 million in claims for medical and surgical services and prescription drugs for gender affirming care under individual and small group health insurance policies. This number is expected to increase in 2026 to an estimated $21 to $27 million.

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

Executed this 16th day of July, 2025, in Westchester, NY

Danielle Holahan
Executive Director
NY State of Health

EXHIBIT 21

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MASSACHUSETTS

STATE OF CALIFORNIA, et al.,

Plaintiffs,

v.

ROBERT F. KENNEDY, JR., in his official capacity as Secretary of Health and Human Services, et al.,

Defendants.

Civil Action No.: 25-12019

DECLARATION OF MICHAEL HUMPHREYS

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

1. I am familiar with the information in the statements set forth below through personal knowledge and from documents and information that have been provided to and reviewed by me.

2. I submit this Declaration in support of the States' Motion for a Preliminary Injunction.

3. I am the Commissioner of the Pennsylvania Insurance Department (PID) located in Harrisburg, Pennsylvania. As Commissioner, I have the responsibility of regulating the Commonwealth's insurance marketplace, overseeing licensed agents and insurance professionals, monitoring the financial landscape of companies doing business in Pennsylvania, educating consumers, and ensuring residents are treated fairly. As Commissioner, I also serve as Chair of the Board of Directors of the Pennsylvania Health Insurance Exchange Authority d/b/a Pennie®

(Pennie®), Pennsylvania's state-based health insurance exchange. I joined PID in 2019 as Chief of Staff, and was appointed as Commissioner in 2022 (unanimously confirmed in early 2023). I previously served as Assistant Commissioner for Insurance at the Tennessee Department of Commerce and Insurance (TDCI). I have a Master's in Public Administration from Bowling Green State University and a Bachelor of Arts in Political Science from the University at Buffalo.

I. The Pennsylvania Insurance Department & Pennie®

4. PID protects and assists consumers, licenses insurance professionals and companies, and regulates the insurance marketplace. Relating to health insurance and the Affordable Care Act (ACA), PID is the primary regulator of the insurance industry to protect Pennsylvania's health insurance consumers.

5. PID requires insurance carriers intending to sell accident and health insurance policies in Pennsylvania to submit a Compliance Checklist and Certification with each policy form or rate that it files. With this certification, an insurer certifies that its product filing complies with all applicable ACA laws and regulations. All insurers make this certification as to the market-wide requirements of the ACA; insurers intending to sell a product on Pennie® additionally certify compliance with the Qualified Health Plan (QHP) requirements of the ACA.

6. Once a product is in the market, PID uses its enforcement authority to assure compliance with all of the ACA provisions as to which the company has certified compliance, as well as all applicable state law provisions. Through its market conduct division, PID is able to monitor the activities of insurers in the Pennsylvania market to assure that compliance is occurring, and take actions that will assure direct PID oversight of future violations. Further, PID regulates its producers (agents and brokers) as well as its navigators and exchange assisters.

7. CMS has recognized Pennsylvania as an effective rate review state since 2012, and as having an effective external review process since 2024.

8. Pennie® was made possible when Act 42 was signed into law in 2019 as a bipartisan effort to improve the accessibility and affordability of individual market health coverage for

Pennsylvanians. Pennie®, as a state-based health insurance marketplace, provides the flexibility to react to changes and serve Pennsylvania residents in a way that's best for them; to lower health insurance premiums; and to work more closely with insurers to foster a competitive marketplace.

9. In 2025, enrollment increased by over 14% from the previous year to a record 496,661 Pennsylvanians. This open enrollment period saw the highest number of new enrollees which was coupled with a smooth auto-renewal process. Enrollment has increased 50% - 164,836 - since Pennsylvania assumed responsibility for operating the marketplace, compared with the last year of enrollment under federal operations. When Pennie® began operations in 2020 for the 2021 coverage year, Pennsylvania's uninsured rate was approximately 5.6%. As of earlier this year, Pennsylvania's uninsured rate had dropped to 5.3%.

10. Pennsylvania has a competitive market, a robust risk pool, and the individual market currently includes eight health insurance plan issuers and nine dental plan issuers.

11. Pennie® is funded through fees collected from on-exchange insurers on the basis of 3% of gross premium. A portion of the user fee provides the state portion of Pennsylvania's Section 1332 Waiver Reinsurance program[1], which helps stabilize rates and premiums for health insurance policies in the individual market and provides greater financial certainty to consumers of health insurance in Pennsylvania. *See* 40 Pa.C.S. § 9305(b)(4); 40 Pa.C.S. § 9502(b). In 2024, Pennie® transmitted $44,400,000 to PID to maintain the reinsurance program.

12. The flexibility that the U.S. Department of Health and Human Services (HHS) and the Centers from Medicare and Medicaid Services (CMS) have afforded SBEs in operating our unique marketplaces has allowed Pennie® to implement innovative policies which make it easier for consumers to enroll in more generous plans at low or no cost.

13. Pennie® has adopted an Open Enrollment Period ("OEP") that allows Pennsylvania residents to enroll in health or dental plans through Pennie® from Nov. 1 through Jan. 15 every

[1] The reinsurance program also receives pass-through funds from the Center for Medicare and Medicaid Services and Center for Consumer information and Insurance Oversight (CMS/CCIIO).

year to ensure enough resources to assist with enrollments and sufficient time for individuals to compare plans. As needed, Pennie® has used flexibilities to adjust enrollment periods to meet unique situations or needs. For example, Pennie® has extended the OEP when the last day falls on a holiday. Pennsylvania also used flexibility afforded to SBEs to create policies unique to the unwinding of the COVID-19 Public Health Emergency, such as the extension of loss of Minimum Essential Coverage Special Enrollment Period ("SEP") to 120 days, and allowing for retroactive coverage for enrollments within the first 60 days of the SEP. These policies supported coverage transitions for tens of thousands of individuals transitioning from Medicaid. These SEP strategies have also been uniquely designed to meet Pennsylvania's needs, ensuring continuous coverage and minimizing enrollment barriers.

II. Enrollment fraud in Pennsylvania is exceedingly rare.

14. Pennie® has had very few instances of fraudulent enrollment. A review of consumer complaints and enrollment partner activity in recent years revealed that improper enrollments are exceedingly rare, thanks to the tailored oversight measures the marketplace has implemented to ensure brokers can only enroll individuals with their knowledge and consent. This includes relying mainly on consumer-initiated requests for broker help and best practice multi-factor authentication and identity proofing standards.

15. In the instances where fraudulent broker activity is reported, such cases are sent to PID for investigation, and are investigated.

16. Pennie® works closely with the Pennsylvania Department of Human Services (DHS), the agency that operates the Medical Assistance program within Pennsylvania. Through this partnership, Pennie® and DHS transfer applications only if income falls within the appropriate range, further limiting any potential for fraudulent enrollment.

III. The Final Rule will harm the Commonwealth.

A. The Final Rule will decrease enrollment and negatively impact the risk pool.

17. Pennie® estimates that the Final Rule will cause up to an estimated 45,000 fewer enrollments in health insurance through Pennie®, which is likely to cause the risk pool to significantly worsen, thereby causing premiums to rise.

18. Pennsylvania anticipates that tens of thousands of younger and healthier individuals – who help the risk pool – will enroll in significantly lower numbers due to the enrollment burdens set forth in the Final Rule, thereby increasing costs to Pennsylvanians.

19. Prior to the Final Rule, exchange plans accepted the self-attestation of an enrollee who claimed eligibility by projecting annual household income at or above 100% of the FPL. This self-attestation policy was designed to ensure that the lowest-income enrollees, who are often younger and healthier, are not discouraged from entering the risk pool due to paperwork burdens. The prior policy also recognized the challenges that low-income individuals face in accurately estimating their annual income. Many low-income individuals experience significant fluctuations in their earnings over the course of the year.

20. The Final Rule changes this policy in two ways. First, any time Internal Revenue Service (IRS) data shows that a consumer has income below 100% of the FPL, a "data matching issue" (DMI) will be generated. Second, in the absence of IRS data, a DMI will be generated. Whenever a DMI is generated, consumers will be required to track down and submit the necessary paperwork in order to purchase health insurance. DMIs also create administrative burdens on SBEs, which are required to receive, process, and determine whether the newly submitted paperwork adequately addresses the issue. These changes impose a heavy burden on SBEs, contributing to the increased operating costs already outlined. These costs include conducting outreach and determining DMI outcomes for applicants whose tax return data is unavailable, and providing higher levels of customer support.

21. The Final Rule's elimination of self-attestation is an administrative barrier to enrollment that will likely cause younger and healthier consumers to drop out of the marketplace. That, in

turn, will worsen the risk pool and increase premiums for both subsidized and unsubsidized consumers.

22. PID and Pennie® have consistently cultivated a stable and healthier risk pool compared to the FFE, as reflected by CMS's annual risk adjustment data, even when accounting for market-specific differences. Due to holistic market oversight by PID, and with Pennie®'s funding of the reinsurance program, Pennsylvania has a strong and highly competitive individual market, and with rate increases consistently at or below the national average.

23. The Final Rule acknowledges that the changes it makes will result in a decrease in enrollment in the ACA marketplace exchanges of up to 1.8 million people nationwide.

B. The Final Rule will decrease revenue and require significant compliance costs.

24. One direct consequence of this anticipated decrease in enrollment is a loss of user fees. To fund operations, Pennsylvania collects a user fee of 3 percent of the total monthly premiums collected by an issuer for each plan purchased through our individual exchange pursuant to 40 Pa.C.S. § 9305(b)(4). Because a portion of the user fee provides the state portion of Pennsylvania's Section 1332 Waiver Reinsurance program funding, a decrease in enrollment and a decrease in the user fee collected will also result in a decrease in the impact of the Reinsurance program.

25. If Pennie®'s estimates are accurate, then decreased enrollment due to the Final Rule will result in approximately $12.53 million dollars in revenue lost from fees no longer being collected on premiums no longer being paid by individuals who are no longer enrolled in plans via Pennie®.

26. Implementing the Final Rule will also necessitate new system programming and additional manual processes, which would compromise the efficiency of Pennie®'s automated systems. This, in turn, would lead to higher operational costs, greater challenges for consumers, and added strain on critical resources. Specifically, it would impact the accuracy and timeliness of consumer notices, increase the volume and complexity of mailings, require expanded enrollee outreach efforts to address potential confusion, and place additional demands on service center operations, including longer wait times and increased staffing needs to handle inquiries and support requests.

27. Moreover, Pennie® on average experiences a high amount of traffic during the OEP. SBEs, including Pennie®, minimize or decrease technical changes during this period of time to prevent any unintended disruptions to consumers' ability to enroll by the deadline.

28. It is estimated that the numerous changes in the Final Rule will require Pennie® to spend up to an estimated $5.5 million dollars in annual operating costs—an 8.4% increase for costs such as information technology (IT) system updates and operational costs.

29. If the comment period for the Proposed Rule had been longer than 23 days, SBEs, including Pennie®, could have provided CMS with a robust analysis of the fiscal and administrative impact of the Final Rule's changes before they were finalized.

C. The Final Rule will harm public health in the Commonwealth.

30. A direct consequence of this decreased enrollment under the Final Rule is a higher rate of uninsured in Pennsylvania.

31. The Final Rule is detrimental to Pennsylvania's public health. With increased access to affordable health insurance via Pennie®, individuals are more likely to seek preventive care and avoid costly emergency room visits. Without individuals having access to affordable health insurance, they are more likely to not seek preventive care, incur costly emergency room visits, and require Pennsylvania to cover costs for uninsured individuals.

32. Increased access to health insurance also improves public health. Uninsured individuals who lack access to affordable, adequate health insurance are less likely to seek preventive care or attend routine health screenings, and may delay necessary medical care due to prohibitive costs.

33. The ACA mandates that certain individual and small group health plans cover a set of EHBs which must be equal to the scope of benefits provided under a typical employer plan and may not have any annual or lifetime dollar limit in individual and small group health plans sold in the state.

34. In addition, the Final Rule limits what states can include as essential health benefits (EHBs), which guarantee the minimum items and services that all insurance plans must cover. Per

HHS, the items and services covered must come from the following ten benefit categories: (1) ambulatory patient services; (2) emergency services; (3) hospitalization; (4) maternity and newborn care; (5) mental health and substance use disorder services including behavioral health treatment; (6) prescription drugs; (7) rehabilitative and habilitative services and devices; (8) laboratory services; (9) preventive and wellness services and chronic disease management; and (10) pediatric services, including oral and vision care.

35. The ACA and its effectuating regulations permit latitude to the states in determining how EHBs are defined. Accordingly, states submit their "benchmark" plans to HHS for approval. EHBs are a minimum standard, and benchmark plans can choose to offer additional health benefits, like vision, dental, and medical management programs (e.g., weight loss).

36. As explained in Pennsylvania's "Notice Regarding Nondiscrimination: Notice 2016-05" (46 Pa. B. 2251, Apr. 30, 2016), both State and Federal law prohibit discrimination against individuals in the terms, conditions and benefits covered by a policy. *See generally* § 1557 of the Affordable Care Act (42 U.S.C. § 18116). In Pennsylvania law, section 626 of The Insurance Company Law of 1921 (40 P.S. § 761) and section 5(a)(7)(i) of the Unfair Insurance Practices Act (40 P.S. § 1171.5(a)(7)(ii)) prohibit discrimination generally among individuals "of the same class." To that end, Notice 2016-05 announced PID's expectation "that a policy will not exclude services based on gender identity and will not contain a categorical exclusion of coverage for all health services related to gender transition, as described in [the HHS Office of Civil Rights then-proposed rule at 80 FR 54172 (September 8, 2015)], and also will affirmatively provide that medically necessary covered services will be available to a policyholder regardless of their gender identity."

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 July, 2025, in Harrisburg, Pennsylvania.

Michael Humphreys
Commissioner
Pennsylvania Insurance Department

EXHIBIT 22

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MASSACHUSETTS

STATE OF CALIFORNIA, et al.

Plaintiffs,

v.

ROBERT F. KENNEDY, JR., et al.,

Defendants.

Civil Action No.: 25-12019

DECLARATION OF LINDSAY M. LANG

I, Lindsay M. Lang, declare under the penalty of perjury pursuant to 28 U.S.C. § 1746 that the foregoing is true and correct:

1. I am the Director of HealthSource RI ("HSRI") located in Rhode Island. I have served as Director since 2019. Prior to that, I served as HSRI's General Counsel and Chief of Staff.

2. HSRI is Rhode Island's State-Based Health Exchange ("SBE") established under the Patient Protection and Affordable Care Act and R.I. Gen. Laws § 42-157-1 et seq.

3. I am familiar with the information in the statements set forth below through personal knowledge and from documents and information that have been provided to and reviewed by me.

4. I submit this Declaration in support of the States' Motion for a Preliminary Injunction.

5. When HSRI was established in 2013, our State's uninsured rate was approximately 12%. As of 2024, our state's uninsured rate has dropped to approximately 2%.

6. Our SBE has established a competitive market, a robust risk pool, and currently includes two health insurance plan issuers and two dental plan issuers.

7. HSRI is funded through a combination of general revenue and carrier assessments pursuant to R.I. Gen. Laws § 42-157-4. In Fiscal Year 2025, Rhode Island spent approximately $2,031,602.00 in general revenue to operate HSRI.

8. The flexibility that the U.S. Department of Health and Human Services (HHS) and the Centers from Medicare and Medicaid Services (CMS) have afforded SBEs in operating our unique marketplaces has allowed us to implement innovative policies which make it easier for consumers to enroll in more generous plans at low or no cost.

9. Our special enrollment period (SEP) strategies have also been uniquely designed to meet Rhode Island's needs, encourage a healthy risk pool and ensure continuous coverage and minimizing enrollment barriers.

10. HSRI has had very few instances of fraudulent enrollment. A review of consumer complaints and enrollment partner activity in recent years revealed that improper enrollments are exceedingly rare, thanks to the tailored oversight measures we have implemented, such as requiring Certified Application Assisters and Navigators to verify consumer consent.

11. Rhode Island's integrated eligibility and enrollment system verifies applicants for both Medicaid and marketplace coverage, further limiting any potential for fraudulent enrollment through this SEP.

12. Our data has not identified even a single instance of fraud stemming from this low-income SEP. Notably, Rhode Island does not have individual market brokers, agents or web-brokers operating in our individual market. HSRI instead relies upon its Navigator network and Certified Application Counselors to support customers in need of assistance enrolling in health coverage. The services of Navigators and CACs are provided at no cost to the consumer and these assisters are not individually compensated based on the help they provide to consumers. Because of this, as well as HSRI's tailored program integrity measures, including oversight of enrollment enforcement mechanisms, reports of any improper enrollments within HSRI remain very low.

13. We estimate that the Final Rule will cause total enrollment through HSRI to decrease by 3 percent and will also cause the risk pool to worsen, which will likely lead to increases in premiums.

14. One direct consequence of this anticipated decrease in enrollment is a loss of State revenues. To fund operations, HSRI collects an assessment of 3.5 percent of the total monthly

premiums collected by an issuer for each plan purchased through our individual exchange, pursuant to R.I. Gen. Laws § 42-157-4.

15. If our estimates are accurate, then decreased enrollment due to the Final Rule will result in approximately $273,000.00 in revenue lost from fees no longer being collected on premiums no longer being paid by individuals who are no longer enrolled in plans through HSRI.

16. The numerous changes in the Final Rule will require us to spend a significant number of hours of staff time updating our information technology (IT) systems. Additionally, the rule will require a substantial amount of staff time to implement its requirements and impose significant operational challenges on our SBE.

17. If the comment period for the Proposed Rule had been longer than 23 days, HSRI could have provided CMS with a robust analysis of the fiscal and administrative impact of the Final Rule's changes before they were finalized.

18. Implementing these rules would necessitate new system programming and additional manual processes, which would compromise the efficiency of our automated systems. This, in turn, would lead to higher operational costs, greater challenges for consumers, and added strain on critical resources. Specifically, it would impact the accuracy and timeliness of consumer notices, increase the volume and complexity of mailings, require expanded enrollee outreach efforts to address potential confusion, and place additional demands on service center operations, including longer wait times and increased staffing needs to handle inquiries and support requests.

19. Moreover, HSRI on average experiences a high amount of traffic during the OEP. As a result, the State requires HSRI's internal teams and external partners to minimize technical changes during this period of time to prevent any unintended disruptions to consumers' ability to enroll by the deadline.

20. Prior to the Final Rule, exchange plans accepted the self-attestation of an enrollee who claimed eligibility by projecting annual household income at or above 100% of the FPL. The Final Rule changes this policy in two ways. First, any time IRS data shows that a consumer has income below 100% of the FPL, a "data matching issue" (DMI) will be generated. Second, in the absence

of IRS data, a DMI will be generated. Whenever a DMI is generated, consumers will be required to track down and submit the necessary paperwork to verify their attested annual household income in order to purchase health insurance. DMIs also create administrative burdens on SBEs, which are required to receive, process, and determine whether the newly submitted paperwork adequately addresses the issue. These changes impose a heavy burden on SBEs. I estimate that HSRI will need to spend a significant number of hours to receive, process, and review documents generated by these new DMIs. Updating our eligibility systems and performing technical updates relating to this change will cost approximately $117,645.00.

21. With respect to providing essential health benefits for gender-affirming care, the Final Rule will force HSRI to examine carrier submissions to ensure the appropriate amounts have been excluded from federal cost-sharing. HSRI will need to implement technical assistance on the back end to ensure this is done consistently across the market in Rhode Island. This will take up valuable time and resources. In addition, insurance carriers in Rhode Island do not all maintain their data in the same way. This means that conducting targeted assessments will be necessary to ensure that gender-affirming care services, which can take many different forms, have been excluded from coverage as EHBs. These targeted assessments would require additional time on part of marketplaces.

22. HSRI has consistently cultivated a stable and healthy risk pool. The Final Rule would increase costs to Rhode Island by removing a pool of relatively young and healthy individuals from the pool of insureds participating in state-based exchanges.

23. Prior to the Final Rule, exchange plans accepted the self-attestation of an enrollee who claimed eligibility by projecting annual household income at or above 100% of the FPL. This self-attestation policy was designed to ensure that the lowest-income enrollees, who are often younger and healthier, are not discouraged from entering the risk pool due to paperwork burdens. The prior policy also recognized the challenges that low-income individuals face in accurately estimating their annual income. Many low-income individuals experience significant fluctuations in their earnings over the course of the year. The Final Rule's elimination of this practice is an

administrative barrier to enrollment that will likely cause younger and healthier consumers to drop out of the marketplace. That, in turn, will worsen the risk pool and increase premiums for both subsidized and unsubsidized consumers.

24. The Final Rule acknowledges that the changes it makes will result in a decrease in enrollment in the ACA marketplace exchanges of up to 1.8 million people nationwide. An anticipated and direct consequence of this decreased enrollment under the Final Rule is a higher rate of uninsured in Rhode Island.

25. The Final Rule is detrimental to Rhode Island's public health. With increased access to affordable health insurance through HSRI, individuals are more likely to seek preventive care and avoid costly emergency room visits. Without individuals having access to affordable health insurance, they are more likely to not seek preventative care, incur costly emergency room visits, and require Rhode Island and the Rhode Island health care system to cover costs for uninsured individuals.

26. Increased access to health insurance also improves public health. Uninsured individuals who lack access to affordable, adequate health insurance are less likely to seek preventive care or attend routine health screenings, and may delay necessary medical care due to prohibitive costs.

27. Lack of insurance and resulting negative health outcomes also result in downstream consequences, including, absenteeism in the workplace and increased reliance on unemployment insurance, which relies on State funding.

28. Decreased access to adequate and affordable health care could mean infection diseases spread more widely and rapidly with those affected not seeking care due to being uninsured or underinsured.

29. The ACA mandates that certain individual and small group health plans cover a set of Essential Health Benefits (EHBs) which must be equal to the scope of benefits provided under a typical employer plan and may not have any annual or lifetime dollar limit under state plans.

30. Per HHS, the items and services covered must come from the following ten benefit categories: (1) ambulatory patient services; (2) emergency services; (3) hospitalization;

(4) maternity and newborn care; (5) mental health and substance use disorder services including behavioral health treatment; (6) prescription drugs; (7) rehabilitative and habilitative services and devices; (8) laboratory services; (9) preventive and wellness services and chronic disease management; and (10) pediatric services, including oral and vision care.

31. The ACA and its effectuating regulations permit latitude to the states in determining how EHBs are defined. Accordingly, states submit their "benchmark" plans to HHS for approval. EHBs are a minimum standard, and benchmark plans can choose to offer additional health benefits, like vision, dental, and medical management programs (e.g., weight loss).

32. Each state maintains a benchmark plan on file with HHS, against which private insurers must compare plans to ensure compliance with the standards set forth therein. Further, if a state has not updated its benchmark plan to match federal requirements, private insurers must also review plans for compliance with federal EHB mandates.

33. State laws in Rhode Island prohibit discrimination by state agencies, including HSRI. *See* R.I. Gen. Laws § 28-5.1-7 (prohibiting state agencies from discriminating on the basis of "gender identity or expression"). Further, Rhode Island state law prohibits insurance carriers from engaging in "unfair discrimination between individuals of the same class and of essentially the same hazard" with respect to costs and plan terms and conditions, and also prohibits plans from "refusing to insure, refusing continue to insure, or limiting the amount of coverage available to an individual because of the sex or marital status of the individual." *See* R.I. Gen. Laws §§ 27-29-7(ii), (v). This includes prohibiting differential treatment for care for transgender enrollees. *See* Health Insurance Bulletin 2015-3, Guidance Regarding Prohibited Discrimination on the Basis of Gender Identity or Expression (November 23, 2015), https://ohic.ri.gov/sites/g/files/xkgbur736/files/bulletins/Bulletin-2015-3-Guidance-Regarding-Prohibited-Discrimination.pdf.

34. Even in states like Rhode Island, where gender-affirming care is not listed as its own category of EHB in the state's benchmark plan, many services that fall within "gender-affirming

care", such as surgeries, prescription medications, and mental health treatment, are treated as EHBs by state marketplaces.

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

Executed this 15 day of July, 2025 in Providence, RI

Lindsay M. Lang
Director
HealthSource RI

EXHIBIT 23

UNITED STATES DISTRICT COURT
DISTRICT OF MASSACHUSETTS

STATE OF CALIFORNIA, et al.,

Plaintiffs,

v.

ROBERT F. KENNEDY, JR., in his official capacity as Secretary of Health and Human Services, et al.,

Defendants.

DECLARATION OF JANE BEYER

Civil Action No.: 25-12019

ATTORNEY GENERAL OF WASHINGTON
1125 Washington Street SE
PO Box 40100
Olympia, WA 98504-0100
360-753-6200

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

1. I am the Senior Health Policy Advisor at the Washington State Office of the Insurance Commissioner (OIC) located in Washington State. I earned an undergraduate degree in Political Science and a Juris Doctor degree from the University of North Carolina at Chapel Hill. I am licensed to practice law in Washington State and Washington D.C. I have been employed as the Senior Health Policy Advisor since January 2017. I served as staff to the Washington State House of Representatives from 1988 to 1994, and again from 1999 to 2012. In that role, I staffed the health care and human services committees. I was Washington State's Medicaid Director from 1994 to 1997 and served as the Washington State Behavioral Health Commissioner from 2012 to 2015.

2. The OIC regulates fully insured health plans offered in the state of Washington. This includes individual and small group health plans sold both on and off our state Health Benefit Exchange, which was established under the Affordable Care Act (ACA). The Health Benefit Exchange has provided the means for individuals to access health insurance coverage, cost-sharing reductions, and advance premium tax credits since 2014. OIC reviews and must approve all individual and small group health plans prior to their being sold. To that end, each health insurer seeking to offer individual or small group health plan coverage must submit the details of their proposed health plan forms and networks, as well as proposed rates for review. For Plan Year (PY) 2026, those documents were filed with OIC on May 15, 2025. Washington State's ACA Essential Health Benefits benchmark plan, which sets minimum benefit standards for individual and small group health plans, includes coverage of gender-affirming care. State law requires that health insurers offer gender-affirming care in their fully-insured individual, small group, and large group health plans, as well as the state's public employee health plans. OIC is responsible for ensuring that health insurers comply with these laws in their fully-insured health plans.

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3. I am familiar with the information in the statements set forth below through personal knowledge and from documents and information that have been provided to and reviewed by me.

4. I submit this Declaration in support of the States' Motion for a Preliminary Injunction.

5. Each health insurer seeking to offer individual or small group health plan coverage in Washington must submit the details of their proposed health plan forms and networks, as well as proposed rates, for review to OIC annually. For Plan Year (PY) 2026, those documents were filed with OIC on or before May 15, 2025. A carrier cannot offer an individual or small group health plan until its form, rate and network filings have been approved by OIC (Wash. Rev. Code §§ 48.18.110, 48.43.733, 48.44.020, 48.46.060). The purpose of form and rate filing review is to ensure that all individual and small group health plans comply with applicable federal and state laws, including the requirement under 42 CFR 154.301 that states have effective rate review programs and Wash. Rev. Code § 48.18.110(2) that generally requires that rates must be reasonable. OIC staff engage in extensive review of health plan filings and rates. An analyst checklist[1] includes all federal and state health plan design requirements and is used by OIC staff to ensure that a plan filing complies with applicable law. OIC actuarial staff undertake extensive review of proposed individual and small group health plan rates to ensure that rates are actuarially sound and are not unreasonable in relation to the benefits provided by the health plan. This process often involves multiple interactions with carriers in which they must respond to questions and make needed revisions to their forms, networks and rates to comply with applicable law.

6. To ensure that the Washington Health Benefit Exchange can certify health plans to be offered as Qualified Health Plans on the Health Benefit Exchange and be ready for open

[1] OIC analyst tools, including the checklist, are publicly available at OIC's website: https://www.insurance.wa.gov/insurers-regulated-entities/rate-and-form-filing/rate-filing-speed-market-tools-health-life-and-disability.

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enrollment beginning November 1, 2025, the Health Benefit Exchange has set a date of September 4, 2025, for OIC to complete its review of individual market Exchange health plans.

7. Adoption of the Marketplace Integrity Rule three months following submission of proposed health plan forms and rates to OIC presents major challenges to OIC's timely review of health plan filings, to the carriers seeking to offer qualified health plans on the Exchange and to the Health Benefit Exchange. The amended rule at 45 CFR 156.115 prohibiting inclusion of gender-affirming care (called "sex trait modification" in the final rule) as an essential health benefit will very likely require carriers to submit revised health plan rates to OIC. Carriers will need at least ten days to two weeks to identify those claims that are considered "sex trait modification procedures" as defined in 45 CFR 156.400, so that they can revise their rates to reflect removal of those services from the essential benefits and prepare revised filing documentation. OIC will be confronted with reviewing and finalizing these now revised rates before the September 4, 2025, deadline established by the Washington Health Benefit Exchange. The OIC anticipates that it will need three to four weeks to complete this process, given that rates from twelve carriers must be reviewed and finalized.

8. At the same time, the exclusion of gender-affirming care from Washington's essential health benefit benchmark plan will force OIC to develop, in an extremely short period of time, a mechanism to defray the cost of providing gender-affirming care under 45 CFR 155.170. Washington state has never had to defray the cost of benefits outside of the essential health benefits benchmark plan. OIC will need to determine how carriers will calculate the cost of the services, likely by estimating future claims costs, how carriers will report that information to OIC, and how OIC will fund these costs and compensate the carriers for these claims costs.

9. The ACA mandates that certain individual and small group health plans cover a set of Essential Health Benefits (EHBs) that must be equal to the scope of benefits provided

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under a typical employer plan and may not have any annual or lifetime dollar limit under state plans.

10. Per the Health and Human Services Department (HHS), the items and services covered must come from the following ten benefit categories: (1) ambulatory patient services, (2) emergency services, (3) hospitalization, (4) maternity and newborn care, (5) mental health and substance use disorder services including behavioral health treatment, (6) prescription drugs, (7) rehabilitative and habilitative services and devices, (8) laboratory services, (9) preventive and wellness services and chronic disease management, and (10) pediatric services, including oral and vision care.

11. The ACA and its effectuating regulations permit latitude to the states in determining how EHBs are defined. Accordingly, states submit their "benchmark" plans to HHS for approval. EHBs are a minimum standard, and benchmark plans can choose to offer additional health benefits, like vision, dental, and medical management programs (e.g., weight loss).

12. Each state maintains a benchmark plan on file with HHS, against which private insurers must compare plans to ensure compliance with the standards set forth therein. Further, if a state has not updated its benchmark plan to match federal requirements, private insurers must also review plans for compliance with federal EHB mandates.

13. In November 2024, the Centers for Medicare and Medicaid Services (CMS) approved an updated Essential Health Benefits Benchmark Plan (EHB-BP) for Washington State. The new benchmark plan is effective January 1, 2026. Washington State's EHB-BP meets all ACA requirements for the EHBs. In reviewing Washington State's application for its EHB-BP update, CMS required the state to expand access to certain services that had previously been limited based on an individual's age or health condition. These changes were required in order to ensure that the state's EHB-BP was non-discriminatory, as required by 45 C.F.R. § 156.125 (2022).

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14. The updated approved EHB-BP explicitly includes coverage of gender-affirming care, as does Washington State's current EHB-BP. This requirement stems from both OIC's interpretation of Section 1557 of the ACA and Wash. Rev. Code § 48.43.0128, which explicitly prohibits discrimination in health plans based upon race, color, national origin, disability, age, sex, gender identity, or sexual orientation and prohibits a health carrier from denying or limiting coverage for medically necessary gender-affirming treatment.

15. As noted above, Wash. Rev. Code § 48.43.0128 prohibits fully insured health plans, including individual, small group, and large group health plans from denying or limiting coverage of gender-affirming care. Many of the state's largest employers, including Amazon, Microsoft, Starbucks, and T-Mobile USA,[2] offer transgender-inclusive health care benefits. Additionally, Washington's public employee benefit plans, the Public Employees Benefits Board and School Employees Benefits Board programs, which cover, in total, approximately 700,000 people in Washington State, cover gender-affirming care as required by state law. The appropriate analysis regarding the typical employer plan is not whether most other states include gender-affirming care in their benchmark plans or the number of enrollees utilizing this care nationwide, but instead how this care is being offered by plans within each state. Because gender-affirming care is a benefit offered by typical employer plans in Washington State, marketplace plans offered in Washington State also cover gender-affirming care.

16. Requiring states to exclude these otherwise covered services from EHB definitions would require Washington State, for the first time, to bear the cost of defrayal. This

[2] Premera Blue Cross, Gender Affirming Benefit Information (Jan. 1, 2024) available at: https://www.premera.com/documents/033046.pdf; Premera Blue Cross, Microsoft Gender Affirming Benefit Information (Feb. 2, 2022) available at: https://www.premera.com/documents/031800.pdf; Starbucks, Medical, Dental & Vision available at: https://www.starbucksbenefits.com/en-us/home/health-benefits/medical-dental-vision/; Premera Blue Cross, T-Mobile Gender-Affirming Benefit Information (July 9, 2024) available at: https://www.premera.com/documents/059461.pdf; *see also* Beth Umland & Eliza Hilfer, Health Benefits that Matter to the LGBTQ+ Community: By the Numbers, Mercer.com ("Half of all large employers covered gender affirmation surgery in 2022, as did nearly three-fourths of those with 20,000 or more employees.") available at: https://www.mercer.com/en-us/insights/us-health-news/health-benefits-that-matter-to-the-lgbtq-community/#:~:text=Gender%20affirmation%20benefits,reconstructive%20procedures%20(60%20percent).

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is because premium amounts that would otherwise be attributed to EHB services and covered by carriers in response to the state coverage mandates would be put back on states. Based upon the language in the notice of proposed rulemaking, OIC estimates a cost of at least $1 million annually to defray the cost of gender-affirming care.

17. The Washington State legislature has appropriated state-only funding for state fiscal year 2026 to supplement premium subsidies offered through ACA advance premium tax credits. The Rule will require Washington State to contribute additional funding to make up the difference for the lost federal subsidies for the portion of premiums attributable to non-EHB services.

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

SIGNED this 7th day of July, 2025, at Olympia, Washington.

JANE BEYER
Senior Health Policy Advisor
Washington State Office of the Insurance Commissioner

EXHIBIT 24

The Honorable _____

UNITED STATES DISTRICT COURT
DISTRICT OF MASSACHUSETTS

STATE OF CALIFORNIA, et al.

Plaintiffs,

v.

ROBERT F. KENNEDY, JR., et al.,

Defendants.

NO.

DECLARATION OF INGRID ULREY

Civil Action No.: 25-12019

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

1. I am the chief executive officer at the Washington Health Benefit Exchange (Exchange), located in Washington State. I hold a master's in public policy from Georgetown University. I have been employed as chief executive officer at the Exchange since March 2023. Before my current position, I served as the Regional Director, HHS Region 10, for the U.S. Department of Health and Human Services. I have more than 30 years of experience in health care policy, public health, and advocacy.

2. I am familiar with the information in the statements set forth below through personal knowledge and from documents and information that have been provided to and reviewed by me.

3. I submit this Declaration in support of the States' Motion for a Preliminary Injunction.

INTRODUCTION

4. The Exchange is Washington State's health insurance exchange, or insurance marketplace. The Exchange was established in 2011 under the Patient Protection and Affordable Care Act (ACA) and state legislation, Wash. Rev. Code 43.71. The Exchange is a self-sustaining, public-private partnership governed by an 11-member bipartisan board. The Exchange serves more than 1.8 million Medicaid and commercial insurance customers through its website, www.wahealthplanfinder.org.

5. When the Exchange was established in 2011, Washington's uninsured rate was approximately 14.2%. As of 2023 (the most recent year data are available), our state's uninsured rate has dropped to 4.8%.

6. Our state-based exchange (SBE) has established a competitive individual market for health and dental insurance, maintained a robust risk pool, and currently includes 11 health insurance plan issuers and 5 dental plan issuers.

7. The Exchange operates Washington Healthplanfinder, the state's integrated eligibility and enrollment platform that determines eligibility for multiple health and dental programs. These include Washington Apple Health (modified adjusted gross income or "MAGI"-based Medicaid and Children's Health Insurance Program (CHIP)) coverage, commercial health insurance in the individual market (qualified health plans or QHPs), federal advance premium tax credits (APTC) and cost-sharing reduction subsidies, state premium assistance for health coverage, and commercial dental insurance. Healthplanfinder's integrated eligibility functionality provides customers with a seamless experience to identify what they and their family members are eligible for. In order to provide real time eligibility results, Healthplanfinder connects with multiple state and federal systems to check for eligibility. These include systems maintained by Washington State Department of Social and Health Services (DSHS) for program eligibility information; Employment Security Department (ESD) for state wage data; and Health Care Authority (HCA) for Medicaid enrollment. Healthplanfinder also connects to the federal eligibility hub, through which Social Security data, IRS financial data, and other program eligibility information is validated.

8. Changes to Healthplanfinder system functionality are performed in sprints, which begin with design and refinement sprints and then move to coding and testing sprints, and finally deployment, which typically occur quarterly. System changes take a minimum of twelve weeks in this system development lifecycle. Large changes, such as those impacting eligibility, require multiple teams and multiple sprint cycles. Changes to Healthplanfinder system functionality that require corresponding changes to be made with the DSHS Eligibility Service or HCA Provider One system take a minimum of eight months to coordinate, develop and execute. System changes to support new Exchange policies or laws must be balanced with system changes necessary to maintain, operate, and secure Healthplanfinder and system changes required by other programs or systems that Healthplanfinder connects to. Sprints for Healthplanfinder's third quarter (July to September) are already in their design phase, a majority of which are for mandatory security

enhancements, version upgrades to platform software products (current version no longer supported), and routine changes required to prepare the system for Exchange open enrollment. Sprints for Healthplanfinder's fourth quarter (October to December) are primarily consumed by supporting open enrollment which requires mid cycle deployments and a focus on system performance and stability during these maximum use months.

9. The Exchange is primarily funded through a premium tax and carrier assessment on plans that are sold through the Exchange on Washington Healthplanfinder. The plan year 2026 carrier assessment for QHP is $5.11 per member per month (PMPM) and premium tax is 2%. The Exchange also receives some General Fund-State dollars and General Fund-Federal dollars. The Exchange's budget is appropriated by the state legislature, with federal funds being approved by the Centers for Medicare and Medicaid Services (CMS). In Fiscal Year 2024, the Exchange received a total operational appropriation of $83,669,000.

10. The state and federal partnership designed in the ACA results in consumers having uniform federal protections and state residents having marketplaces designed to meet unique needs of the state. This state flexibility has resulted in the Exchange implementing innovative policies that meet all federal minimum marketplace standards and are responsive to Washington's marketplace conditions that improve market competition and enrollment, making it easier for consumers to enroll in more generous plans at lower cost. For example, the Exchange features:

a. Standard plans (Cascade Care plans) designed by the Exchange in collaboration with the Office of the Insurance Commissioner, the Health Care Authority, and a group of stakeholders representing a broad spectrum of health care and insurance perspectives from across the state. These plan designs have lower deductibles and more services up-front before the deductible. They allow for easy apples-to-apples plan comparison, where benefits are the same and customers shop based on metal tier, premium, provider network and carrier quality.

b. A state premium assistance program (Cascade Care Savings) that allows for more affordable net premiums in selected standard plans. The Cascade Care Savings program provides premium assistance for lower-income Washingtonians who enroll in silver and gold metal level Cascade Care plans and has received funding from the state legislature at an amount of $55 million for Plan Year 2026. Due to the program's capped annual appropriation, as premiums increase, more state premium assistance dollars will be expended per enrollee and the number of enrollees that can receive Cascade Care Savings decreases.

c. Enrollment periods that are optimized to meet Washington's needs, ensuring continuous coverage and minimizing enrollment barriers. The Exchange has historically maintained an open enrollment period from November 1 through January 15. This is based on over a decade of experience that combines customer survey feedback, assister and carrier input, and deep data analysis to deliver optimized enrollment with healthy risk pools and high customer satisfaction in the most efficient time and operational cost. Washington specific special enrollment periods (SEPs) include one for individuals that are eligible for state premium assistance to enroll in a qualifying plan and take advantage of available premium subsidies.

d. Other affordability programs authorized by legislation. Public option plans (Cascade Select plans) utilize aggregate provider reimbursement caps to lower gross premiums, and therefore lower costs to the 25% of customers who pay full price and reduce expenditures on federal or state premium subsidies that reduce net premiums. A sponsorship program allows Tribes and community organizations to support enrollment for eligible individuals through the Exchange.

11. Health insurance shopping is complex and challenging for most people, including residents that need coverage on the individual market who don't have someone like their employer managing health benefits and steering them through the process. The Exchange's reputation among consumers, brokers and health insurance carriers as a trusted, simple and stable

marketplace has grown, evidenced by its year-over-year enrollment growth and the steady presence of 11 or more health insurance carriers on the Exchange for the past five years. Even as we approach a year in which enrollment loss is expected due to anticipated expiration of the enhanced federal tax credits originally authorized under the American Rescue Plan Act (ARPA) in 2021, a new health carrier is planning to enter the Exchange marketplace for 2026. The Exchange has also experienced strong growth in partnerships, with now more than 1000 enrollment assisters, 2000 brokers, and 150 Tribal and community-based organizations signing up to help customers enroll in coverage through Healthplanfinder. The Exchange's investment in developing Healthplanfinder as a customer-friendly website that is easy to use supports 150,000 QHP customers who prefer to self-serve in applying and choosing a plan that is right for them. The Exchange has further built confidence by providing high quality customer service during open enrollment, evidenced by 96.2% handled calls, average caller wait times of under 90 seconds, and an average phone call resolution time of 13 minutes, during the 2025 open enrollment period.

12. The Exchange has grown over time to be viewed as a reliable, efficient steward of state resources by the Washington State legislature. Early technical failures that occurred in the first few years of the Exchange's operations resulted in restricted funds and increased oversight and reporting. However, the legislature has exhibited increased trust in the Exchange and Healthplanfinder through less scrutiny and new responsibilities. For example, the Exchange secured Legislative support to expand dental plan coverage offerings in 2016, implement the Cascade Care program (including standard plans and the nation's first public option) in 2021, fund the Cascade Care Savings premium subsidy program in 2023, and launch an Immigrant Health Coverage program in 2024. Recently the Legislature exhibited continuing trust in the Exchange by funding coverage expansion projects utilizing Healthplanfinder technology (e.g., bringing non-MAGI Medicaid eligibility determinations onto the Healthplanfinder platform,

implementing facilitated enrollment functionality for individuals who lose Washinton Apple Health coverage).

13. The Exchange has built over a decade of expertise in analyzing its marketplace data and providing reports and analyses relied upon by its Board, the legislature, state and federal agencies, carriers, consumer advocates, and other stakeholders. Exchange employees and contractors regularly perform data analysis using Healthplanfinder enrollment, eligibility, and premium data and using Washington's All Payer Claims Database (APCD). Analysis includes historical, current and projected future enrollment, premiums, and health care utilization. It is used for audit and compliance purposes, providing public and legislative reports, setting premium assessments and state subsidy levels, and for analyzing impacts of policy changes, including state and federal laws. The Exchange estimates in this declaration are based on Washington Healthplanfinder and APCD data and prepared or reviewed by senior policy analysts, data scientists, associate director for strategic budget planning, analytics leader, policy director, and contracted certified actuaries who conduct analysis for the Exchange as part of their regular responsibilities. For example, the uncompensated care in hospital setting estimate is based on the latest complete year of Exchange enrollee hospital claims (Healthplanfinder enrollee data and APCD utilization data for inpatient and outpatient hospital expenditures) and applies enrollment loss projections.

A. Immediate and Irreparable Harm Caused by Enrollment Loss and Requirements to Comply with Final Rule for Plan Year 2026.

14. Generally, the Final Rule will have the impact of reducing enrollment through the Exchange. The Exchange estimates that the cumulative impact of enrollment loss directly resulting from the rule change could range from 6.1% to 16.6% of Exchange's current enrollment of about 280,000 Washington residents. This enrollment loss would be in addition to the loss of up to 80,000 enrollees that is projected from the expiration of ARPA enhanced premium tax

credits for 2026. A decreased enrollment of 16.6% results in loss of revenue to the Exchange of $10,299,000 annually. It is too late to change the plan year 2026 (PY2026) assessment set by the Exchange Board in March 2025 and already included in proposed 2026 carrier rates submitted to the Office of Insurance Commissioner in May 2025. Neither this assessment amount nor our legislatively appropriated budget account for increased operational costs or projected enrollment loss caused by this rule. If the Exchange is not able to cover operational costs with reduced assessment revenues, it will have to reduce costs through contract or staff reductions or cut other programs that support the success of open enrollment (e.g., pre-open enrollment system testing to ensure operational success, Customer Support Center funding, broker and navigator training, direct customer marketing and education), further reducing enrollment, damaging the individual market risk pool, and increasing uninsurance. Once lost, enrollment cannot easily be recaptured; once terminated, employees and programs cannot easily be reinstated.

15. Implementing this rule in Washington is not feasible for plan year 2026 because of the timing and magnitude of the required changes. CMS engages in annual marketplace rulemaking with the typical timing being a late fall proposed rule that is finalized by early spring for the following plan year because marketplaces and carriers need these "instructions" early in the year in order to incorporate changes that impact carrier premium rates filed in late spring and provide a minimal required amount of time for marketplace readiness. CMS already proposed in October 2024 and finalized in January 2025 the marketplace rule for plan year 2026. This unprecedented second rule for plan year 2026 would upend months of planning, updates and premium rate filings that followed the then current law.

16. Compliance with several provisions of the final rule would necessitate new system programming and additional manual processes and staff, which would compromise the efficiency of our operations. This, in turn, would lead to higher operational costs, greater challenges for consumers, and added strain on critical resources. The proposed rule estimated that several provisions, including verification changes, would cost Washington State up to $21.7

million per year to implement and all state marketplaces up to $596 million. Even with some provisions removed in the final rule, CMS estimated a total implementation cost for exchanges of up to $370 million in 2026. We expect that Washington State's portion of that total would likely remain in the $20-25 million range for 2026, or about 25% of our appropriated operating budget for 2024. The final rule would impact the accuracy and timeliness of consumer notices, increase the volume and complexity of mailings, require expanded enrollee outreach efforts to address potential confusion, and place additional demands on customer service center operations, including longer wait times and increased staffing needs to handle inquiries and support requests. All of these impacts would be felt during the critical open enrollment period at the end of 2025 for the 2026 plan year if the Exchange were to pursue compliance with even some of the rule's provisions taking effect in plan year 2026. Moreover, the Exchange on average experiences a high amount of traffic during the open enrollment period. As a result, it is necessary for the Washington Exchange and external partners to minimize technical changes during this period of time to prevent any unintended disruptions to consumers' ability to enroll by the deadline.

17. The enrollment loss expected to result from the Final Rule will harm the Exchange risk pool. System changes and other operational fallout from rushed compliance with the changes in a few months will result in a more administratively challenging and burdensome customer experience during open enrollment, which will disproportionately cause younger and healthier customers to drop coverage, further harming the risk pool. The harm to the risk pool will be compounding and cannot easily be reversed.

18. Individual market enrollment loss expected from the Final Rule will result in an increased uninsurance rate in Washington State and an increase in uncompensated care. Washington individual market customers use at least $425 million annually in hospital care, and a reduction of the Exchange market by up to one-third will lead to uninsured (and largely uncompensated) hospital care increasing by at least $100 million. Uncompensated care costs will result in additional costs borne by the state, providers, carriers, employers, and others, and will

cause irreparable harm to Washington's healthcare system. For example, PBGH, a non-profit coalition representing 40 private employers and public entities across the U.S. that collectively spend $350 billion annually purchasing health care services for more than 21 million Americans and their families estimates[1] that 20% of uncompensated care costs is passed onto employer sponsored insurance, which includes both private employers and state employee benefits.

19. Below we have described and provided data to quantify the harms to the Exchange and Washington State caused by specific provisions of the Final Rule.

B. Exchanges must determine a tax filer ineligible for advance premium tax credits (APTC) if the individual failed to file or reconcile a tax return in a prior year.

20. The Final Rule requires the Exchange to deny an individual APTC if the tax filer (or spouse) received APTC for a prior year but there is not a verification that Federal income tax return was filed with APTC reconciled. This is called failure to reconcile or FTR. This is a change from the current requirement for the Exchange to deny APTC if it is notified by HHS that the tax filer or spouse received APTC in the past two years but did not file taxes or reconcile the APTC received. The "past two years" rule that was in effect during the 2025 open enrollment period was the first year of that requirement being in place, after the IRS paused all FTR functionality during the pandemic and it remained paused for the past four years.

21. This provision applies to all exchanges, including SBEs, upon the effective date of the Final Rule, and sunsets at the end of 2026.

(i) Washington Data

a. Up to 16,768 enrollees have received two-year FTR codes since these codes were reinstated in 2024. These individuals were permitted to attest to having filed or reconciled

[1] Purchaser Business Group on Health, PBGH Encourages Congress to Prioritize Health Care Affordability and Access in Budget Reconciliation Process available at: https://www.pbgh.org/pbgh-encourages-congress-to-prioritize-health-care-affordability-and-access-in-budget-reconciliation-process/.

their taxes and their eligibility for tax credits was re-checked on June 12, 2025. If an FTR code was received, APTC has been terminated.

b. The Exchange estimates that this provision of the Final Rule could drive rate increases of up to 1.6% and could cause an enrollment loss of up to 8.4%.

c. Up to 16,966 fewer enrollees could receive Cascade Care Savings based on projected premium increases caused by this provision in the Final Rule.

(ii) Evidence of Harm

22. Exchange: Exchange analysis indicates that enrollment loss of up to 8.4% could occur, causing loss of revenue to the Exchange which is funded directly by a carrier assessment and premium tax on each enrollment. Lost revenue endangers the Exchange's operational functioning, resulting in the need to cut costs by terminating employees and/or reducing programs that support the success of open enrollment, which will cause further enrollment declines.

23. This rule will likely result in irreparable reputational harm to the Exchange due to the complex nature of the message and the timing. Messages about tax filing status are not welcomed or trusted by customers, especially when they are inconsistent (varying from year to year), inaccurate (IRS data incomplete or backlogged), or the customer has authorization (tax filing extension) but is now being denied a tax credit they are entitled to. They are also complex. Messaging about tax filing is required to be vague so as not to disclose any federal tax information to a household and it will be contradictory to the messaging that was required to be provided to customers about their tax filing requirements last year. This will result in lost trust, customer confusion, and frustration, and customers that leave the Exchange during this process are unlikely to return to seek coverage in the future, even after tax filing issues are resolved. In addition, the final rule mandates this change for a single year (plan year 2026), so the customer message would change again, shortly after adoption. This flip-flopping creates uncertainty. In a similar situation, customers were told they would be eligible for state subsidy, but due to the

popularity of the program, entry into the program was halted mid-way through open enrollment, resulting in 2,300 of individuals not enrolling in coverage who otherwise would have. The Exchange also heard from its assisters how difficult it was to maintain trust with customers who were told different things at different times.

24. Updates to the Washington Healthplanfinder system that are necessary to comply with this change are not possible to complete while also preparing for and running open enrollment. The Exchange's technical roadmap is already at 100% of capacity for the next six-month period and changes that can occur prior to open enrollment were required to be on the roadmap in May so that design and refinement as well as dependency mapping can occur. The roadmap is planned in advance to account for dependencies among programs, among different subsystems and across three agencies' technology roadmaps, as well as the federal hub, where applicable. Technical changes currently in flight are necessary to comply with law (such as security updates), Medicaid program changes, and open enrollment configuration and deployment. In addition to lack of capacity, timing is too late for 2026. Quarter three system changes (July through September) have already begun and are in or have completed their design and refinement. No system changes are deployed during October when plan renewals for next plan year must be processed. System changes in November through January 15 are minimized to stabilize the system and preserve open enrollment functioning. Specific to this rule provision, at least a three-month development period would be necessary for prioritization, design, building/testing, and release. The Exchange is incapable of coming into compliance with this provision of the Final Rule prior to its implementation date.

25. In addition to system impacts, training materials for the Customer Support Center and enrollment assisters will need to be revised. The Exchange Customer Support Center and in-house Eligibility and Enrollment teams expect increased ticket and call volume driven by increased volume of notifications and increased customer confusion. For example, when customer confusion driven by the COVID outbreak occurred in 2020, we saw negative impacts

to the level of customer service the Exchange was able to provide and evidence of decreased customer satisfaction, including a longer average wait time before customers could talk to a representative (2 minutes 47 seconds in 2020 versus 2 minutes 3 seconds in 2019) and a significantly higher percentage of customers abandoning calls (9.12% in 2020 compared to 2.37% in 2019). To support the increase in customer support needs, the Customer Support Center contract would have to be amended to fund additional call center staffing that is not currently legislatively appropriated. The Exchange's ability to effectively support enrollment of new customers, who numbered about 50,000 in the last open enrollment period, as well as renewing customers will be endangered when customer support resources that are already stretched thin are further taxed during open enrollment.

26. This provision in the Final Rule, effective only for plan year 2026, causes additional harm to the Exchange because under current law the Exchange will be required to reverse system and other operational changes made to comply with this change in advance of the 2027 plan year (when this provision will no longer apply).

27. Washington State: Increased premium rates result in enrollment loss, with younger and healthier consumers disproportionately leaving the market, which directly harms Washington's state premium subsidy program, Cascade Care Savings. As rates increase due to this provision of the Final Rule, the state's investment in coverage ($55M for plan year 2026) would be diluted and the state subsidy would be able to help up to 16,966 fewer customers afford coverage. The state's ability to achieve the intent of the state subsidy program, providing necessary premium support to help more Washingtonians get and stay covered, would be frustrated, irreparably harming the state.

C. Creating data matching inconsistencies (DMIs) and requiring further income verifications when federal tax data (1) indicates a customer's income is below 100% FPL or (2) is unavailable.

28. The Exchange requires that an enrollee attest to the accuracy of their income and verifies that claim using federal income data or other trusted electronic data sources (e.g., Employment Security Department in Washington State), and considers the data to match if the electronically verified income is not more than 25% higher than the customer's attested income. The Final Rule changes this policy in two ways. First, anytime a consumer has an attested income of 138% or higher (above the threshold for WA Apple Health eligibility) and IRS or other electronic data source returns income below 100% FPL, a DMI will be generated. Second, when IRS data is absent (an IRS error unrelated to a customer's tax filing activity), a DMI will be generated if other electronic income data is not available to validate the attested income. These changes apply to all exchanges, including SBEs, upon the effective date of the final rule, and sunset at the end of 2026.

(i) Washington Data

a. For plan year 2025 coverage, 39,739 customers have attested to income above 138% FPL and verified (federal or state) income was below 100%.

b. For plan year 2025 coverage, 65,476 Washington enrollees have received a "Null" income response from the federal hub.

c. The Exchange estimates that these provisions of the Final Rule could drive rate increases of up to 1.6% and could cause enrollment loss off up to 6.4%.

d. Up to 16,966 fewer enrollees could receive Cascade Care Savings based on projected premium increases.

(ii) Evidence of Harm

29. Exchange: These provisions could result in enrollment loss of up to 6.4%, causing loss of revenue to the Exchange which is funded directly by a carrier assessment and premium tax on each enrollment. Lost revenue will endanger the Exchange's operational functioning,

resulting in the need to cut costs by terminating employees and/or reducing programs that support the success of open enrollment, which would cause further enrollment declines.

30. When a DMI is generated, consumers are required to track down and submit the necessary paperwork in order to stay enrolled in their health insurance with premium subsidies applied to reduce their monthly costs. Customers will be notified that they are required to provide documentation of their income, which will drive customer confusion and increased volume of contacts to the Customer Support Center during open enrollment. The Exchange will likely be viewed as implementing barriers to affordable coverage, causing negative customer experiences and irreparable Exchange reputational damage. The Exchange Customer Support Center and in-house Eligibility and Enrollment teams expect increased ticket and call volume driven by increased volume of notifications and increased customer confusion. For example, when customer confusion driven by the COVID outbreak occurred in 2020, we saw negative impacts to the level of customer service the Exchange was able to provide and evidence of decreased customer satisfaction, including a longer average wait time before customers could talk to a representative (2 minutes 47 seconds in 2020 versus 2 minutes 3 seconds in 2019) and a significantly higher percentage of customers abandoning calls (9.12% in 2020 compared to 2.37% in 2019). To support the increase in customer support needs, the Customer Support Center contract would have to be amended to fund additional call center staffing that is not currently legislatively appropriated. Training materials for the Customer Support Center and enrollment assisters will need to be revised. The Exchange's ability to effectively support enrollment of new customers, who numbered about 50,000 in the last open enrollment period, as well as renewing customers will be endangered when customer support resources that are already stretched thin are further taxed during open enrollment.

31. DMIs also create administrative burdens on SBEs, which are required to receive, process, and determine whether the newly submitted paperwork adequately addresses the issue. These changes impose a heavy burden on SBEs. The additional volume of manual effort that would be created by up to 105,000 additional DMIs would require hiring six Eligibility

Specialists at the Grade 6 level and one supervisor at the Grade 9 level. The Exchange estimates that it would need these additional resources for a six-month period during and after open enrollment when most DMIs would be generated. The cost of these additional resources would be more than $345,000 for a six-month period.

32. Updates to the Washington Healthplanfinder system that are necessary to comply with this change are not possible to complete while also preparing for and running open enrollment. The Exchange's technical roadmap is already at 100% of capacity for the next six-month period and changes that can occur prior to open enrollment were required to be on the roadmap in May so that design and refinement as well as dependency mapping can occur. The roadmap is planned in advance to account for dependencies among programs, among different subsystems and across three agencies' technology roadmaps, as well as the federal hub, where applicable. Technical changes currently in flight are necessary to comply with law (such as security updates); Medicaid program changes; and open enrollment configuration and deployment. In addition to lack of capacity, timing is too late for 2026. Quarter three system changes (July through September) have already begun and are in or have completed their design and refinement. No system changes are deployed during October when plan renewals for next plan year must be processed. System changes in November through January 15 are minimized to stabilize the system and preserve open enrollment functioning.

33. Specific to this rule provision, at least a three-month development period would be necessary for prioritization, design, building/testing, and release of Healthplanfinder changes. This provision also requires an aligned system release with the Eligibility Service operated by DSHS, whose release roadmap is finalized at 100% capacity through January 2026. The next availability for an aligned release with DSHS for this provision in the Final Rule is April 2026. The three-month Healthplanfinder development period described above could begin after completion of the April 2026 DSHS release.

34. In addition to system impacts, training materials for the Customer Support Center and enrollment assisters will need to be revised. The Exchange Customer Support Center and in-house Eligibility and Enrollment teams expect increased ticket and call volume driven by increased volume of notifications and increased customer confusion. To support the increase in customer support needs, the Customer Support Center contract would have to be amended to fund additional call center staffing that is not currently legislatively appropriated. The Exchange's ability to effectively support enrollment of new customers, who numbered about 50,000 in the last open enrollment period, as well as renewing customers will be endangered when customer support resources that are already stretched thin are further taxed during open enrollment.

35. These provisions in the Final Rule, effective only for plan year 2026, cause additional harm to the Exchange because under current law the Exchange will be required to reverse system and other operational changes made to comply with these changes in advance of the 2027 plan year (when these provisions will no longer apply).

36. Washington State: This rule will harm the State's investment in Cascade Care Savings by resulting in premium increases which dilute Washington's investment in the program and allow fewer enrollees to receive Cascade Care Savings. In addition, when enrollees who qualify for state premium subsidies do not also receive federal premium subsidies, the state's expenditure per enrollee is much greater. Each Cascade Care Savings enrollee that receives the full amount of Cascade Care Savings ($250 per member per month (PMPM) in 2025) instead of receiving a lesser amount as a supplement to their federal APTC (average of $36 PMPM in 2025) has a significant impact on sustainability of a program with a total annual budget of $55 million. These factors will reduce the reach of the state's investment, resulting in up to 17,000 fewer customers being able to benefit from Cascade Care Savings. The state's ability to achieve the intent of the state subsidy program, providing necessary premium support to help as many

Washingtonians as possible get and stay covered, would be frustrated, irreparably harming the state.

D. Modifying the automatic re-enrollment hierarchy by removing the option for Exchanges to direct re-enrollment from a bronze QHP to a silver QHP, with same or lower premium, in the same product, with same provider network.

37. This change to 45 CFR § 155.335(j)(4) applies to all Exchanges, including SBEs, upon the effective date of the final rule. Because of reasoning included in the preamble to the Final Rule, there is concern that the Exchange would not be able to secure CMS approval of an alternate procedure under 45 CFR § 155.335(a)(2)(iii), as it has in the past, that would map certain enrollees to a higher value plan with the same or a lower premium, with the same carrier and network. If the Exchange does not have the ability to employ this mapping for 2026 as it would under alternate procedures approved by CMS in the past, the harms described below would occur.

(i) Washington Data

a. The Exchange estimates that approximately 54,000 current enrollees would qualify under previously-approved alternate procedures to be cross-mapped from a silver plan to a higher value, lower premium plan of a different metal level in the upcoming open enrollment.

b. Up to 60,000 fewer people will be able to benefit from Cascade Care Savings in 2026 if the Exchange is not able to employ its previously-approved cross-mapping approach, because program expenditures per enrollee will be significantly higher when individuals remain enrolled in plans with higher premiums.

(ii) Evidence of Harm

38. Exchange: Enrollment loss will occur when individuals experience large net premium increases in silver plans that they could otherwise be shielded from by planned Exchange cross-mapping to higher value, lower premium gold plans, causing loss of revenue to

the Exchange which is funded directly by a carrier assessment and premium tax on each enrollment. Lost revenue endangers the Exchange's operational functioning, resulting in the need to cut costs by terminating employees and/or reducing programs that support the success of open enrollment, which will cause further enrollment declines.

39. The Exchange will suffer significant reputational harm if customers, who could otherwise be shielded from premium increases by planned cross-mapping activity, experience significant and unnecessary premium increases as they are automatically renewed into 2026 coverage. Confusion and frustration will follow, damaging customer trust in the Exchange, followed by increased volume of Customer Support Center contacts and potentially appeals. As an example, the market experienced its highest single-year rate increase in 2018, when Exchange silver plan premiums increased by 35% on average. During the open enrollment period for 2018, the Exchange Customer Support Center experienced a significantly higher volume of calls compared to both 2017 (13.6% higher volume) and 2019 (14.9% higher volume). This volume resulted in negative impacts to the level of customer service the Exchange was able to provide and evidence of decreased customer satisfaction, including a significantly longer average wait time before customers could talk to a representative (4 minutes 51 seconds in 2018 versus 1 minute 48 seconds in 2019) and a higher percentage of customers abandoning calls (5.56% in 2018 compared to 3.38% in 2019). To support the increase in customer support needs, the Customer Support Center contract would have to be amended to fund additional call center staffing that is not currently legislatively appropriated. The Exchange's ability to effectively support enrollment of new customers, who numbered about 50,000 in the last open enrollment period, as well as renewing customers will be endangered when customer support resources that are already stretched thin are further taxed during open enrollment.

40. Washington State: This rule would harm the state's investment in Cascade Care Savings by resulting in more Cascade Care Savings being expended per eligible enrollee. When certain Cascade Care Savings eligible individuals remain in silver plans instead of moving to

lower premium, higher value gold plans under the Exchange's intended cross-mapping strategy, they will receive a larger Cascade Care Savings subsidy per person, although their silver plan will cover less out-of-pocket for them and also result in higher net premiums. This will reduce the reach of the state's investment and result in up to 60,000 fewer customers being able to benefit from Cascade Care Savings. The state's ability to achieve the intent of the state subsidy program, providing necessary premium support to help as many Washingtonians as possible get and stay covered, will be frustrated, irreparably harming the state.

E. Updating the premium adjustment percentage methodology to include premium changes in the private individual and group markets (excluding Medigap and property and casualty insurance).

41. This change to 45 CFR § 156.130(e) would apply beginning with PY 2026 cost-sharing limits and applies to all exchanges. It causes out-of-pocket limits for customers to increase faster and reduces premium tax credits for customers over time.

(i) Washington Data

a. This change will increase the 2026 maximum out-of-pocket amount (MOOP) by 15% over 2025 ($10,600 MOOP for individual coverage in 2026 compared to $9,200 in 2025).

b. When adopted by the Internal Revenue Service (IRS), this change would result in lower premium tax credit amounts resulting in 4.5% higher net premiums.

c. The Exchange estimates that this change could result in gross premium increases of up to 0.3% and enrollment losses of up to 1.8% for 2026.

d. Up to 3,863 fewer enrollees could receive Cascade Care Savings based on projected premium increases.

(ii) Evidence of Harm

42. Exchange: Enrollment loss of up to 1.8% will occur when premiums increase as a result of this provision in the Final Rule. Lost revenue endangers the Exchange's operational functioning, resulting in the need to cut costs by terminating employees and/or reducing programs that support the success of open enrollment, which will cause further enrollment declines.

43. The Exchange will suffer reputational harm when customers experience significant premium increases as they are automatically renewed into 2026 coverage. While numerous factors will be responsible for premium increases in 2026, an average additional net increase of 4.5% caused by this provision of the Final Rule on top of other expected drivers of premium increases, including expiration of enhanced premium tax credits for 2026, will result in loss of customer trust. Confusion and frustration will follow, damaging customer confidence in the Exchange, followed by increased volume of Customer Support Center contacts and potentially appeals. As an example, the market experienced its highest single-year rate increase in 2018, when Exchange silver plan premiums increased 35% on average. During the open enrollment period for 2018, the Exchange Customer Support Center experienced a significantly higher volume of calls compared to both 2017 (13.6% higher volume) and 2019 (14.9% higher volume). This volume resulted in negative impacts to the level of customer service the Exchange was able to provide and evidence of decreased customer satisfaction, including a significantly longer average wait time before customers could talk to a representative (4 minutes 51 seconds in 2018 versus 1 minute 48 seconds in 2019) and a higher percentage of customers abandoning calls (5.56% in 2018 compared to 3.38% in 2019). To support the increase in customer support needs, the Customer Support Center contract would have to be amended to fund additional call center staffing that is not currently legislatively appropriated. The Exchange's ability to effectively support enrollment of new customers, who numbered about 50,000 in the last open enrollment period, as well as renewing customers will be endangered when customer support resources that are already stretched thin are further taxed

during open enrollment. Customers who leave individual market coverage in such a year of premium increases and confusion may never return to the market.

44. Washington State: Due to resulting premium increases, this change in the Final Rule would increase premiums and reduce the reach of the state's investment in the Cascade Care Savings premium subsidy, resulting in up to 3,863 fewer customers being able to benefit from Cascade Care Savings. The state's ability to achieve the intent of the state subsidy program, providing necessary premium support to help as many Washingtonians as possible get and stay covered, would be frustrated, irreparably harming the state.

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

SIGNED this _14_ day of ___July___, 2025, at _____Olympia_____, Washington.

Ingrid Ulrey

INGRID ULREY
Chief Executive Officer
Washington Health Benefit Exchange

EXHIBIT 25

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MASSACHUSETTS

STATE OF CALIFORNIA, et al.

Plaintiffs,

v.

ROBERT F. KENNEDY, JR., et al.,

Defendants.

Civil Action No.: 25-12019

DECLARATION OF SARAH SMITH

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

1. I am the Director of Public Affairs at the State of Wisconsin's Office of the Commissioner of Insurance (OCI) located in Madison, Wisconsin. I have been employed as OCI Director of Public Affairs since November 2020.

2. Wisconsin law gives the Commissioner broad powers and duties to protect the public and to ensure that the insurance industry responsibly meets the insurance needs of Wisconsin citizens.

3. Wis. Stat. chs. 631 and 632 set out minimum standards for regulating the terms of all insurance contracts. These chapters grant OCI authority related to regulating the issuance of insurance coverage (i.e. ensuring insurable interest and consent), material misrepresentations, policy forms, mid-term alternations or nonrenewals, and more.

4. The federal McCarran-Ferguson Act of 1945 granted states the ability to regulate insurance, established insurance licensing requirements, and preserved state laws of insurance.

5. Wisconsin state law and regulation grants OCI regulatory authority over Disability (accident & health) insurance which is generally defined as any type of insurance that covers policy

claims involving: (1) medical and surgical expenses; (2) indemnities for loss of income due to accident or health; (3) accidental death and disability; (4) hospital care; and (5) long-term care.

6. The Affordable Care Act (ACA) of 2010 made a number of reforms including prohibiting lifetime dollar limits and annual dollar limits on essential health benefits (EHBs), required coverage of specific preventive services with no cost-sharing, guaranteed issue of health insurance policies, and prohibiting preexisting condition limitations.

7. Under the ACA, an insurance plan sold on the health insurance marketplace must be certified by the health insurance marketplace as a qualified health plan (QHP). The operations of QHPs are regulated by OCI for the purposes of form filings, rate filings, and general insurance regulation.

8. Pursuant to Wis. Stat. §§ 625.13 and 601.42, all health insurers authorized to write comprehensive health insurance, including QHPs, shall make initial and subsequent rate change filings with OCI. For PY (Plan Year) 2026, annual rate filings from QHPs were due on June 25, 2025, and filings for additional scenarios are due July 16, 2025. OCI will consider accepting rate filing revisions after July 16 when significant regulatory changes impacting the applicable plan year affect rates such as tax credit changes, cost-sharing reduction changes, and other provisions that will limit enrollment and destabilize the risk pool.

9. OCI is also responsible for licensing insurance agents, Certified Application Counselors (CACs), and Navigators who assist individuals with enrollment. CACs can assist with applications for public assistance programs and compare health insurance plans sold on the health insurance exchange/marketplace for consumers. Navigators help individuals determine their eligibility for public assistance programs using the health insurance exchange/marketplace website. Navigators cannot legally provide advice to consumers about which health insurance plan to choose and are not permitted to sell insurance.

Marketplace Integrity

10. Wisconsin does not operate its own state-based exchange. Wisconsin residents purchase health insurance through the federal exchange, healthcare.gov. OCI works collaboratively with agents, Navigators, CACs, and other enrollment assistance entities to promote health insurance coverage options on the federal exchange throughout the year but primarily during the annual Open Enrollment Period (OEP). As funding for the state's federal Navigator entity is dramatically reduced by the Centers for Medicare and Medicaid Services (CMS), enrollment suffers while consumers are unable to access their free, unbiased assistance that would otherwise help the consumer navigate unexpected changes to the OEP timeframe. During the 2025 PY OEP, 8,100 Wisconsinites enrolled in coverage on the marketplace between December 15 and January 15. Shortening this deadline in a landscape without sufficient Navigator capacity could impact those thousands of individuals who enroll during that timeframe, which would be after the close of open enrollment under the Final Rule.

11. The Final Rule requires the Federal platform to conduct pre-enrollment eligibility verification for at least 75% of new enrollments through SEPs that are accessible following a triggering event, such as a loss of minimum essential coverage or a move to a new area. Enrollees claiming eligibility for a SEP will not be able to access coverage until their eligibility is verified, an administrative barrier which may lead to diminished enrollment particularly among younger and healthier enrollees. Because such enrollees are especially important to the overall health of the risk pool in our state, any barrier to enrollment risks destabilizing the risk pool.

12. Other changes like increasing max out-of-pocket costs, reducing actuarial values, and adding a $5 monthly penalty for those that do not actively re-enroll could encourage consumers to leave the market. The impact of these changes could result in fewer individuals enrolled in coverage in 2026 than in 2025. Resulting coverage losses could compromise the integrity and health of the risk pool, discourage carrier participation, lead to higher premiums, and destabilize state insurance markets.

13. During PY 2025, 99,560 Wisconsinites were auto re-enrolled and 41,815 of these individuals qualified for a premium of $10 or less. Auto re-enrollment applies to anyone who already has Marketplace coverage and doesn't take proactive action to change or end their coverage. If the insurer isn't offering any similar plans for the next year, HealthCare.gov re-enrolls the individual in a comparable plan with a different insurance company. If the individual qualifies for cost savings and they're not enrolled in a Silver plan, they may be re-enrolled in one that lowers their out-of-pocket costs. CMS's Final Rule will implement two substantive changes to the auto-reenrollment process. It establishes a $5 monthly premium for consumers who are automatically re-enrolled and previously qualified for a monthly premium of $0 until the consumer actively confirms eligibility and enrollment. During the 2025 OEP, 39% of consumers nationwide selected plans with a $0 monthly premium. Adding an arbitrary $5 monthly charge to the thousands of Wisconsinites who qualify for a $0 premium when auto re-enrolled will contribute to lower effectuation of coverage rates as consumers experience confusion or distrust upon receiving a bill for coverage they anticipated would be without a premium and do not continue with their coverage.

14. We estimate that the Final Rule will cause total enrollment in Wisconsin's individual marketplace to decrease and will also destabilize the healthy mix needed in the risk pool to hold premiums down, ultimately making healthcare less accessible as premiums become less affordable.

15. Wisconsin has achieved two record-breaking years in a row with the highest enrollment ever on the individual market. With the changes from the Final Rule in place, those trends are likely to reverse and our uninsured rate will grow. In 2022, the number of uninsured Wisconsinites was estimated to be 312,000. As hospitals and other facilities like Federally-Qualified Health Centers are required to provide certain types of care to those without an ability to pay, their costs will rise along with the uninsured population increasing on account of the Final Rule.

Gender-Affirming Care EHBs.

16. The ACA mandates that certain individual and small group health plans cover a set of Essential Health Benefits (EHBs) which must be equal to the scope of benefits provided under a typical employer plan and may not have any annual or lifetime dollar limit under state plans.

17. Per HHS, the items and services covered must come from the following ten benefit categories: (1) ambulatory patient services; (2) emergency services; (3) hospitalization; (4) maternity and newborn care; (5) mental health and substance use disorder services including behavioral health treatment; (6) prescription drugs; (7) rehabilitative and habilitative services and devices; (8) laboratory services; (9) preventive and wellness services and chronic disease management; and (10) pediatric services, including oral and vision care.

18. The ACA and its effectuating regulations permit latitude to the states in determining how EHBs are defined. Accordingly, states submit their "benchmark" plans to HHS for approval. EHBs are a minimum standard, and benchmark plans can choose to offer additional health benefits, like vision, dental, and medical management programs (e.g., weight loss).

19. Each state maintains a benchmark plan on file with HHS, against which private insurers must compare plans to ensure compliance with the standards set forth therein. Further, if a state has not updated its benchmark plan to match federal requirements, private insurers must also review plans for compliance with federal EHB mandates.

20. The plan established by OCI is the Wisconsin EHB Benchmark Plan. The Wisconsin EHB Benchmark Plan includes not only the 10 categories of benefits outlined by the ACA, but also the mandated benefits defined in Wisconsin law that require coverage for specific treatments for medical conditions.

21. The mandated benefits required by Wisconsin state law include coverage for: (1) newborn infants (2) adopted children (3) children with disabilities (4) grandchildren born to dependent children under the age of 18 who are covered by the policy (5) dependents under age 26 (6) health care services provided by certain nonphysician health care providers (7) nervous and mental disorders, alcoholism, and other drug abuse (8) home health care (9) skilled nursing care

(10) kidney disease (11) mammography (12) diabetes (13) lead screening (14) temporomandibular joint treatment (15) breast reconstruction following a mastectomy (16) anesthesia for certain dental procedures (17) maternity coverage for all persons covered under the policy if it provides maternity coverage for anyone (18) immunizations for children under the age of 6 (19) coverage of certain health care costs in cancer clinical trials (20) coverage of a student on medical leave (21) treatment for autism spectrum disorders (22) hearing aids, cochlear implants, and related treatment for infants and children (23) contraceptives and services (24) colorectal cancer screening

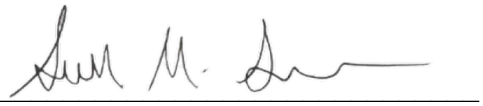
22. State selection of EHB since the ACA was established, and over time has given states greater flexibility in defining EHB that matches the variety of employer plans across the country and allows states to respond to the needs of their residents.

23. Even in states like Wisconsin, where gender-affirming care is not listed as its own category of EHB in the benchmark plan, many services that fall within the undefined category of "gender-affirming care," which may include prescription medications, surgical procedures, or mental health treatment, are covered by QHPs for cisgender policyholders and OCI would not permit QHPs to deny coverage of those same services to transgender policyholders.

24. Additionally, under Wisconsin law, "no insurer may unfairly discriminate among policyholders by … offering different terms of coverage except on the basis of classifications related to the nature and the degree of the risk." Wis. Stat. § 628.34(3). Further, it is unlawful to deny benefits or refuse coverage on the basis of sex. Wis. Admin. Code § Ins 6.55 (1976). An insured's gender identity is unrelated to the nature and degree of risk and denying benefits or coverage based on gender identity is unlawful discrimination based on the sex of the insured. Therefore, excluding coverage for health treatments that would otherwise be covered based on gender identity is unfairly discriminatory under Wisconsin law. The exclusion, limitation, or denial of covered benefits under individual or group health insurance based on an insured's gender identity is also a violation of Wis. Stat. §§ 632.746(10), and 632.748(2). Further, the exclusion, limitation, or denial of covered benefits based on an insured's gender identity by self-funded, non-federal governmental plans is a violation of Wis. Stat.§ 632.746 (10)(b)2.

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

Executed this 15 day of July, 2025, in Madison, Wisconsin.



Sarah Smith
Director of Public Affairs
Wisconsin Office of the Commissioner of Insurance

EXHIBIT 26

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MASSACHUSETTS

STATE OF CALIFORNIA, et al.

Plaintiffs,

v.

ROBERT F. KENNEDY, JR., et al.,

Defendants.

Civil Action No.: 25-12019

DECLARATION OF T.K. KEEN

I, T.K. Keen, declare under the penalty of perjury pursuant to 28 U.S.C. § 1746 that the foregoing is true and correct:

1. I am the Interim Oregon Insurance Commissioner and the Administrator for the Division of Financial Regulation of the Oregon Department of Consumer and Business Services (DCBS). I have been in this role since June of 2025. Prior to that, I served as Deputy Insurance Commissioner of DCBS from 2015 to 2025.

2. I am responsible for enforcement of the Oregon Insurance Code, including regulation of insurance carrier licensing, solvency, and product offerings; review and approval of rates and forms used by insurance carriers; and ensuring a fair insurance marketplace for Oregon consumers. These duties encompass the area of health insurance subject to regulation by the State of Oregon. They also include the enforcement of Oregon's prohibition against insurers' denial of medically-necessary gender-affirming treatment.

3. Oregon does not operate its own health insurance exchange. Rather, consumers in Oregon enroll in health coverage using healthcare.gov, which is operated and maintained by the U.S. Department of Health and Human Services.

4. I am familiar with the information in the statements set forth below through personal knowledge and from documents and information that have been provided to and reviewed by me.

5. I submit this Declaration in support of the States' Motion for a Preliminary Injunction.

The Final Rule Will Adversely Impact Oregon's Risk Pool

6. CMS's 2025 Marketplace Integrity and Affordability Final Rule (Final Rule) would increase costs to Oregon by removing a pool of relatively young and healthy individuals from the pool of insureds participating in health coverage in our State. While Oregon cannot yet estimate precisely how many of such individuals will be removed, as discussed below, the overall effect is likely to be significant.

7. The Final Rule makes several changes that adversely impact Oregon's risk pool, including, but not limited to, the following.

8. The Final Rule requires the Federal marketplace to conduct pre-enrollment eligibility verification for at least 75% of new enrollments through Special Enrolment Periods (SEP), including the SEPs that can be triggered by events such as a move to a new geographical area or the birth of a child. Compared to verification of SEPs triggered by the loss of minimum coverage, which was required by the prior policy, verification of other SEPs often cannot employ electronic data sources for auto-verification to the same extent, and therefore rely on consumers to submit supporting documentation. As a result, verification of all SEPs is likely to discourage younger, healthier individuals—who are less likely to navigate complex paperwork requirements successfully during life changes—from enrolling, undermining the stability of the risk pool and driving up costs for everyone.

9. Prior to the Final Rule, exchange plans accepted the self-attestation of an enrollee who claimed eligibility by projecting annual household income at or above 100% of the FPL. This self-attestation policy was designed to ensure that the lowest-income enrollees, who are often younger and healthier, are not discouraged from entering the risk pool due to paperwork burdens. The prior policy also recognized the challenges that low-income individuals face in accurately estimating their annual income. Many low-income individuals experience significant fluctuations in their

earnings over the course of the year. The Final Rule's elimination of this practice is an administrative barrier to enrollment that will likely cause younger and healthier consumers to drop out of the marketplace. That, in turn, will worsen the risk pool and increase premiums for both subsidized and unsubsidized consumers.

The Final Rule Will Increase Oregon's Healthcare Costs

10. The Final Rule acknowledges that the changes it makes will result in a decrease in enrollment in the ACA marketplace exchanges of up to 1.8 million people nationwide.

11. A direct consequence of this decreased enrollment under the Final Rule is a higher rate of uninsured individuals in Oregon and a corresponding higher amount of costs incurred by hospitals. Hospitals would be responsible for paying the uncompensated care costs that result when an uninsured or underinsured patient requires emergency or other hospital-based medical care. Due to Oregon's generous financial assistance laws (outlined, for example, at ORS 442.601-618), as well as the Emergency Medicaid Treatment and Labor Act, hospitals in Oregon will still be required to provide services to people who are no longer insured by a Marketplace plan. Other health care providers would either lose patients or incur uncompensated care costs.

12. Oregon does not have a program in which the state would subsidize hospital uncompensated care, so the bulk of the cost burden would be shifted directly to hospitals. This, in turn, will likely put upward pressure on the price of hospital services, thereby increasing healthcare costs for the state—which directly pays for hospital services through its state Medicaid program, among other sources— and it will also have an impact on spending for public employee benefits. This will also likely drive up healthcare costs for all Oregonians.

13. Oregon cannot estimate the full cost impact to hospitals at this time because the precise magnitude of coverage losses based on this Rule are difficult to predict. Even so, because it is likely that the number of uninsured individuals in Oregon will increase because of the Final Rule, it is also likely that hospitals costs will increase, thereby increasing healthcare costs overall.

The Final Rule Will Adversely Impact Public Health in Oregon

14. The Final Rule is detrimental to public health in Oregon. With increased access to affordable health insurance via healthcare.gov, individuals are more likely to seek preventive care and avoid costly emergency room visits. Without individuals having access to affordable health insurance, they are more likely to refrain from seeking preventative care and incur costly emergency room visits. Oregon cannot yet predict the precise magnitude of this harm because it will depend, among other things, on how many individuals lose insurance coverage. But the cost is likely to be significant.

15. Increased access to health insurance improves public health. Uninsured individuals who lack access to affordable, adequate health insurance are less likely to seek preventive care or attend routine health screenings and may delay necessary medical care due to prohibitive costs.

16. Lack of insurance and resulting negative health outcomes also result in downstream consequences, including absenteeism in the workplace and increased reliance on unemployment insurance, which relies on State funding.

17. Decreased access to adequate and affordable health care could mean infectious diseases spread more widely and rapidly with those affected not seeking care due to being uninsured or underinsured.

The Final Rule's Exclusion of Gender-Affirming Care as an EHB Harms Oregon

18. The ACA mandates that certain individual and small group health plans cover a set of Essential Health Benefits (EHBs) which must be equal to the scope of benefits provided under a typical employer plan and may not have any annual or lifetime dollar limit under state plans.

19. Per HHS, the items and services covered must come from the following ten benefit categories: (1) ambulatory patient services; (2) emergency services; (3) hospitalization; (4) maternity and newborn care; (5) mental health and substance use disorder services including behavioral health treatment; (6) prescription drugs; (7) rehabilitative and habilitative services and devices; (8) laboratory services; (9) preventive and wellness services and chronic disease management; and (10) pediatric services, including oral and vision care.

20. The ACA and its effectuating regulations permit latitude to the states in determining how EHBs are defined. Accordingly, states submit their "benchmark" plans to HHS for approval. EHBs are a minimum standard, and benchmark plans can choose to offer additional health benefits, like vision, dental, and medical management programs (e.g., weight loss).

21. Each state maintains a benchmark plan on file with HHS, against which private insurers must compare plans to ensure compliance with the standards set forth therein. Further, if a state has not updated its benchmark plan to match federal requirements, private insurers must also review plans for compliance with federal EHB mandates.

22. Even in states like Oregon, where gender-affirming care is not listed as its own category of EHB in the state's benchmark plan, many services that fall within "gender-affirming care", such as surgeries, prescription medications, and mental health treatment, are treated as EHBs by state marketplaces.

23. Coverage for gender-affirming care is protected by law in Oregon. In 2023, the Oregon Legislative Assembly enacted Oregon House Bill 2002, including Section 20, since codified as ORS 743A.325. The statute codified a pre-existing regulatory requirement prohibiting an insurance carrier offering a health benefit plan from denying or limiting coverage for gender-affirming treatment that is medically necessary as determined by the physical or behavioral health care provider who prescribes the treatment and is prescribed in accordance with accepted standards of care. The bill prohibits carriers from applying categorical cosmetic or blanket exclusions to medically necessary gender-affirming treatment, including but not limited to tracheal shave, hair electrolysis, facial feminization surgery or other facial gender-affirming treatment, revisions to prior forms of gender-affirming treatment, and any combination of gender-affirming treatment procedures. HB 2002 required DCBS to adopt rules to implement these provisions. Those rules were adopted and codified at OAR 836-053-0441, and they became effective January 1, 2025.

24. Given the above legal requirements, employer-based health insurance plans offered in Oregon always cover gender-affirming care. Because of that, marketplace plans offered in Oregon also cover gender-affirming care.

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

Executed this 16th day of July, 2025 in Salem, Oregon.

T.K. KEEN
Interim Oregon Insurance Commissioner and Administrator
Oregon Department of Consumer and Business Services