UNITED STATES DISTRICT COURT
FOR THE
DISTRICT OF COLUMBIA

STATE OF NEW YORK, COMMONWEALTH OF MASSACHUSETTS, DISTRICT OF COLUMBIA, STATE OF CALIFORNIA, STATE OF DELAWARE, COMMONWEALTH OF KENTUCKY, STATE OF MARYLAND, STATE OF NEW JERSEY, STATE OF OREGON, COMMONWEALTH OF PENNSYLVANIA, COMMONWEALTH OF VIRGINIA, and STATE OF WASHINGTON, Plaintiffs, v. U.S. DEPARTMENT OF LABOR; R. ALEXANDER ACOSTA, in his official capacity as Secretary of the U.S. Department of Labor, and UNITED STATES OF AMERICA, Defendants.	Civ. Action No. 18-1747-JDB

DECLARATION OF KEVIN LUCIA IN SUPPORT OF PLAINTIFFS' MOTION FOR SUMMARY JUDGMENT

I, Kevin Lucia, declare:

1. I am a Research Professor at the Center on Health Insurance Reforms ("CHIR"), a research center which is part of the Health Policy Institute ("HPI") within the McCourt School of Public Policy at Georgetown University. As part of a specialized research team, I study and analyze how states and the federal government regulate private health insurance with a focus on access, affordability, and adequacy of coverage. My research includes analysis of state and federal laws, pending legislation and regulations, and current market practices related to private

health insurance. For many years, one focus of my research and that of HPI has been the regulation of health insurance sold through association health plans ("AHPs"), a type of multiple employer welfare arrangement ("MEWA").

2. Before co-founding CHIR in 2011, I directed the State Compliance Division within the Office of Oversight, Center for Consumer Information and Insurance Oversight, Centers for Medicare and Medicaid Services. From 2012-2016, I served as an Executive Board Member and Chair of the Insurance Market Committee of the Health Benefit Exchange Authority for the District of Columbia.

3. I have authored or co-authored many papers concerning AHPs and other MEWAs: *President Trump's Executive Order: Can Association Health Plans Accomplish What Congress Could Not?* Kevin Lucia and Sabrina Corlette, To the Point, The Commonwealth Fund, Oct. 10, 2017.; *Association Health Plans: Maintaining State Authority Is Critical to Avoid Fraud, Insolvency, and Market Instability,* Kevin Lucia and Sabrina Corlette, To the Point, The Commonwealth Fund, Jan. 24, 2018; *Federal and State Policy Towards Association Health Plans in Oregon,* Kevin Lucia, Sandy Ahn and Sabrina Corlette, Urban Institute and Robert Wood Johnson Foundation, October 2014; *Association Health Plans: What's All the Fuss About*, Mila Kofman, Kevin Lucia, Eliza Bangit and Karen Pollitz, Health Affairs, November/December 2006; *Association Health Insurance: Is It Time to Regulate This Product?* Mila Kofman, Kevin Lucia, Eliza Bangit and Karen Pollitz, Journal of Insurance Regulation, Fall 2005; *MEWAs: The Threat of Plan Insolvency and Other Challenges*, Mila Kofman, Eliza Bangit and Kevin Lucia, The Commonwealth Fund, March 2004; *Health Insurance Scams: How Government Is Responding and What Further Steps Are Necessary,* Mila Kofman, Kevin Lucia and Eliza Bangit, The Commonwealth Fund, August 2003; *Proliferation of Phony Health Insurance:*

States and the Federal Government Respond, Mila Kofman, Kevin Lucia and Eliza Bangit, Bureau of National Affairs, August 2003; *Insurance Markets: Group Purchasing Arrangements: Implications of MEWAs,* Mila Kofman, Eliza Bangit and Kevin Lucia, California Health Care Foundation, July 2003.

4. As part of my academic research, I have closely read and analyzed the Department of Labor's ("DOL") recent rulemaking effort pursuant to which DOL has sought to redefine the term "employer" under Section 3(5) of ERISA for the purpose of encouraging the formation and enrollment in AHPs and which resulted in the release of a final rule on June 21, 2018. 83 Fed. Reg. 28912 (June 21, 2018) (the "Final Rule").

5. My curriculum vitae is attached to this Declaration as Exhibit A.

Background – History and Regulation of AHPs

6. The Employee Retirement Income Security Act of 1974 ("ERISA") was enacted to reform employee pensions and other employee benefit programs, including employee welfare benefit plans. ERISA federalized regulation and oversight of employee benefit plans. Title I of ERISA, which governs employee benefit plans including group health plans, was adopted by Congress in 1974, among other reasons, to remedy the abuses that existed in the handling and management of welfare and pension plan assets. ERISA also preempted many state laws that related to employee benefit plans.

7. Since ERISA's enactment, there has been an extensive history of scams connected to the federal framework under which MEWAs are regulated. Promoters of phony or deceptively-marketed multiple employer benefit plans have used the federal law in an attempt to avoid scrutiny by state regulators and law enforcement. When states sought to enforce their own insurance laws to regulate MEWAs prior to a 1983 amendment to ERISA, the entities sponsoring

and promoting these plans argued that ERISA preempted state law, in many cases hindering efforts to stop fraudulent and illegal activity. At the same time, DOL claimed to lack authority over these insurance arrangements because the vast majority were not, in fact, ERISA plans. To help address these concerns, a 1983 amendment to ERISA explicitly allowed for state insurance regulation of self-insured and fully-insured AHPs. Also, because fully-insured AHPs obtain insurance from state-licensed carriers, states have always retained authority to regulate products these AHPs offer. This means that states may apply and enforce their insurance laws with respect to self-insured and fully-insured AHPs.

8. Both before and after the 1983 amendment to ERISA, AHPs and other types of MEWAs have been rife with fraud, insolvency, gross mismanagement, and deceptive conduct. For example, in the late 1980s, one MEWA, purporting to be a union plan, reportedly left 3,600 people in 32 states with some $25 million in unpaid claims, according to a DOL report. A 1992 Government Accounting Office ("GAO") report found that from 1988 to 1991, failed MEWAs, such as AHPs, phony unions, and employee leasing firms, left thousands of people in dozens of states without health insurance and nearly 400,000 patients with medical bills exceeding $123 million.

9. Similarly, a 2004 GAO report again found that employers and individuals were vulnerable to unlicensed or "bogus" entities selling fraudulent health insurance coverage through, among other things, "associations they created or through established associations of employers or individuals." In total, GAO identified 144 unauthorized entities that covered at least 15,000 employers and more than 200,000 policyholders from 2000 through 2002. These entities failed to pay at least $252 million in medical claims and, at the time of the report, federal regulators were able to recover less than a quarter of this amount.

10. Employers Mutual LLC is an example of a scam perpetrated through AHPs. This entity – using a name similar to a legitimate Iowa-based insurance company – sold unauthorized health insurance across the United States through existing associations such as the National Writers Union – a professional association for journalists – and sixteen associations that Employers Mutual established. By the time regulators intervened in 2001, over 30,000 people nationwide were left without coverage and these individuals had at least $27 million in unpaid claims. Employers Mutual's operators were eventually indicted, but not until thousands of individuals were severely harmed by their fraud.

11. Similarly, in 2002, American Benefit Plans ("ABP"), a nationwide scam, left over 40,000 people without health insurance and with over $28 million in unpaid medical bills when it failed due to widespread fraud. ABP sold coverage through four associations it created, such as the National Association for Working Americans and the United Employer Voluntary Employee Beneficiary Association.

12. Prior to the enactment of the Patient Protection and Affordable Care Act ("ACA"), millions of individuals and small employers bought health insurance through associations. Business and trade associations often offered coverage as part of their broader mission to serve the professional needs of their members. Some associations catered primarily to individuals, including the self-employed, while others catered to employer groups. Some associations focused on a population within a specific state, such as those operated by a state medical association or a local chamber of commerce. Others were domiciled in one state but marketed AHP coverage in multiple states.

13. The regulation of AHPs has been a combined federal and state endeavor. In general, states are the primary regulators of health insurance and health insurance issuers. Prior

to the ACA, states sometimes exempted AHPs from state rules and standards that applied to commercial insurers, such as filing requirements, underwriting restrictions, benefit mandates, and solvency standards. Additionally, AHPs would sometimes set up headquarters in one state with limited regulatory oversight and then market policies to businesses and consumers in other states with more robust regulation of rating and plan benefits.

14. The federal government, through DOL, is responsible for the enforcement of federal law with respect to employee benefit plans subject to ERISA. Thus, to the extent an AHP constitutes an ERISA employee welfare benefit plan, states and DOL have concurrent oversight responsibility. Until issuance of the Final Rule, however, DOL has not considered an AHP offered by an association to member employers to be an employer benefit plan subject to ERISA (called a "bona fide" employer group or association) except under rare conditions, discussed in more detail below.

15. For decades, DOL has interpreted ERISA to provide that a MEWA consisting of self-employed members is not a bona fide employer group or association because self-employed persons are not employers of common-law employees.

16. Historically, the lower premiums frequently associated with AHPs derive from their ability to attract healthier enrollees and deter those with higher health care costs. One method AHPs used to attract healthier enrollees is to exclude benefits that appealed to employers and individuals with higher health risks. As a result, absent the ACA's protections, AHPs would siphon healthy small groups and individuals away from ACA-compliant plans, leaving a smaller and sicker risk pool for the traditional insurance market and fewer plan options and higher prices for the small businesses and individuals that remain in that market.

17. The ACA was enacted to expand access to health insurance and make insurance more affordable. The ACA included reforms designed to help curb past abuses and solvency concerns raised by AHPs. These included greater enforcement authority for DOL, criminal penalties for false statements to state or federal officials, federal registration, and additional reporting requirements.

18. More broadly, the ACA ushered in a suite of market reforms and consumer protections that apply to commercial insurance. Different protections apply to the individual, small employer, and large employer markets. Among the reforms that apply to the small group market (defined as fewer than 50 full-time equivalent employees) but not to the large group market (defined as 50 or more full-time equivalent employees), are the following: (a) required coverage of "Essential Health Benefits;" (b) the application of adjusted community rating rules; (c) the creation of a single risk pool for all of an insurer's market participants; and (d) participation in the risk adjustment program.

19. For example, plans offered in the individual and small employer market must cover the ACA's ten Essential Health Benefits, which include, among other services, mental health and substance use disorders, prescription drugs, and rehabilitative and habilitative services and devices. Plans offered in the large employer market are not required to cover these benefits.

20. The Essential Health Benefits also requires maternity and newborn care to be included in all plans offered in the individual and small employer market. While the Pregnancy Discrimination Act ("PDA") requires employers with 15 or more employees to provide maternity care benefits on the same basis as other health benefits to employees and their spouses, plans in the large employer market sometimes exclude maternity care for other dependents. In addition, the PDA is an employer requirement and not a requirement on the plan, so employers with less

than 15 employees that are able to offer a plan that does not need to comply with the Essential Health Benefits could exclude maternity if not otherwise required by state law.

21. Similarly, the individual and small employer markets have premium rating rules that prohibit insurers from adjusting premiums based on an individual's occupation, health status, and gender, among other factors. Under the ACA, insurers may only adjust premiums based on the number of family members enrolled in the plan; geography; tobacco use (insurers may charge those that use tobacco more than those that do not if the state allows; however, the variation in premiums is limited to 1.5 to 1); and age (insurers may charge older adults more than younger adults; however, the variation in premiums is limited to 3 to 1). These rules do not apply to the large employer market.

22. The creation of a single risk pool for each of the individual and small employer markets requires insurers offering products in those markets to set rates using a single risk pool that includes all enrollees across their individual plans and across their small group plans in the state. This requirement does not apply to the large employer market.

23. Finally, the ACA established a risk adjustment program. The risk adjustment program transfers funds from insurers in the individual and small employer markets with lower risk enrollees to plans in these markets with higher risk enrollees. This program does not apply to the large employer market.

24. Together, the ACA's reforms to the individual and small employer market were designed to ensure that health insurance is more readily available, affordable, and provides comprehensive coverage to small employers, their employees, and individuals – a demographic that historically faced significant challenges obtaining and/or affording quality health insurance.

25. The ACA enacted more limited reforms to the large group market through new requirements on large employers, who historically have provided their employees with far more comprehensive coverage than was available in the small group market. For example, the ACA requires large employers to offer health coverage to their full-time employees or face the possibility of paying a tax penalty. If a large employer offers coverage but that coverage is not considered "minimum essential coverage" that is "affordable" and meets "minimum value" standards pursuant to the ACA's provisions, then the employer may be assessed a tax penalty. The tax penalty discourages, but does not prohibit, large group plans that do not meet these standards or that do not otherwise offer "minimum essential coverage." In addition, Congress extended certain reforms that apply in the small group and individual markets to the large group market: small and large group plans cannot deny coverage to eligible enrollees based on pre-existing conditions; must cover certain benefits such as preventive care and screenings for women, without cost-sharing; and, for those health plans that offer dependent coverage, must cover dependents up to their twenty-sixth birthday.

26. Certain states have in the past structured their health insurance markets so that different rules apply to the small group and/or individual markets, on the one hand, and to AHPs, on the other. The results of such experiments have resulted in significant market dysfunction and, in some cases, market failure.

27. For example, in the mid-1990s, Kentucky enacted health insurance reforms for the individual and small group markets that were, in many ways, similar to the ACA in that they required insurers to accept all applicants regardless of health status and adjusted community rating in setting premiums and prohibited excluding applicants with pre-existing conditions. A few years later, Kentucky exempted associations of employers or individuals from various

requirements of the law, allowing them to sell insurance with less stringent requirements than applied to the small group and individual markets. For the reasons discussed above (*see* ¶ 16), healthy Kentucky residents enrolled in AHPs, resulting in increasing premiums for the sicker enrollees in the traditional markets. Post-reform, nearly all insurers stopped selling policies in the traditional individual market or declined to sell new policies leading to a collapse of the individual insurance market. The AHP exemption likely contributed, at least in part, to what the Kentucky Department of Insurance referred to as the start of a death spiral in the insured market. Ultimately, the Kentucky legislature repealed most of the market reforms and created a high-risk pool for those that were denied coverage based on their health status.

28. Similarly, Tennessee currently has a fragile individual insurance market in large part due to a large AHP – the Tennessee Farm Bureau – that is open to all Tennessee residents who pay a fee and can pass the AHP's medical underwriting standards. In particular, the Farm Bureau screens members for high-cost medical conditions. The Farm Bureau is not considered a health insurer subject to the Tennessee insurance code, but nevertheless provides health coverage that is not ACA complaint to as many as 73,000 people. As a result, the Society of Actuaries found in 2015 that the population enrolled in individual ACA-compliant plans in Tennessee had the worst overall health risk score in the country. If the healthy people insured by the Farm Bureau were included in the individual market, it would very likely improve the overall balance of healthy and sick in the Tennessee individual marketplace.

DOL Guidance Regarding AHPs and ERISA Before the Final Rule

29. Prior to its 2018 rulemaking, when DOL assessed whether an association or group of employers could be considered a bona fide single employer group under ERISA, it generally focused on three issues: (a) whether the association is a bona fide organization with a purpose

and function other than the provision of benefits; (b) whether the employers in the association share some commonality unrelated to the provision of benefits; and (c) whether the employers that participate in the benefit program exercise control over the program.

30. DOL considers the following factors as part of an evaluation of all facts and circumstances in determining whether a bona fide group or association of employers exists for purposes of ERISA: how members are solicited; who is entitled to participate and who actually participates in the association; the process by which the association was formed; the purposes for which it was formed and what, if any, were the pre-existing relationships of its members; the powers, rights, and privileges of employer-members; and who actually controls and directs the activities and operations of the benefit program. In addition, employer-members of the group or association that participate in the AHP must, either directly or indirectly, exercise control over that program, both in form and substance, to act as a bona fide employer group or association with respect to the benefit program. To be recognized as an employer by ERISA, the association must be acting in the interest of its employer-members to provide benefits to their employees and there must be a genuine organizational relationship among the employers. Finally, where membership in an association is open to anyone engaged in a particular trade or profession regardless of their status as employers or where control of the association is not vested solely in employer members, the association is not a bona fide employer group or association under ERISA.

31. DOL has issued guidance, including multiple advisory opinions and the 2013 publication "Multiple Employer Welfare Arrangements under the Employee Retirement Income Security Act (ERISA): A Guide to Federal and State Regulation," stating that associations with self-employed members are not eligible for bona fide employer group or association of

employers status within the meaning of ERISA § 3(5) because they are not treated as employers for this purpose, since self-employed members may not have common-law employees. Pursuant to DOL regulations dating to the implementation of ERISA, individual working owners without separate employees are not considered "employers" under ERISA and any AHP that offers coverage only to such individuals is not a group health plan under ERISA.

The Final Rule

32. On June 21, 2018, DOL released the Final Rule. As noted above, I have closely read and analyzed DOL's Final Rule related to AHPs. To analyze its impact on the private health insurance markets, I have completed a comprehensive review of research and analysis related to AHPs conducted by HPI faculty before and after the ACA, along with more recently published quantitative analysis. My analysis was informed by discussions with former DOL officials, current and former state regulators, and stakeholders such as AHPs, consumer groups, insurers, and brokers.

33. Under the Final Rule, existing AHPs can continue to operate under previous DOL regulations and guidance. However, DOL also authorized the sale of new AHPs that need only comply with the new standards under the Final Rule. As discussed below, these new standards mark a dramatic shift away from previous DOL regulations and guidance and are expected to result in the proliferation of AHPs in many states across the country.

34. Under the Final Rule, AHPs can qualify as a bona fide ERISA association even if they form an association primarily to provide insurance benefits, in addition to one other business purpose, and gain the regulatory advantages of being treated as a large group. Additionally, DOL expanded what it means for employers to "share some commonality." To be considered a single-employer AHP under the Final Rule, employer-members could either: (a) be

in the same trade, industry, line of business, or profession; or (b) have their principal place of business in the same geographic region, either within a state or metropolitan area that includes more than one state. If the former, the AHP could sell coverage nationwide, so long as its members are in the same trade, industry, line of business, or profession. If the latter, an AHP could enroll all businesses in a State, or all businesses in a metropolitan area that crosses state lines.

35. The Final Rule would allow self-employed individuals to be treated as "employers" to join an association and at the same time be treated as their own "employees" to be covered under the benefit plan. The Final Rule would require these "worker-owners" to earn a minimum income or work a minimum number of hours. However, the Rule's income standard is vague and low, providing minimal guidance to AHPs on how to enforce the requirement. The Final Rule permits the AHP to rely on "the accuracy of the information in written documentation or a sworn statement submitted by a working owner, without independent verification." The Final Rule would also allow AHPs to cover individuals by allowing them to maintain coverage for former employees and family members.

Impact of Final Rule on National Small Group and Individual Markets

36. Based on my extensive study of AHPs and my knowledge of state and national small group and individual health insurance markets, it is my expectation that the Final Rule will lead to a proliferation in the marketing and promotion of, and enrollment in, AHPs throughout the United States.

37. The Final Rule will cause a very significant increase in the number of AHPs recognized as employee welfare benefit plans under ERISA and, as a result of this recognition, these AHPs will not be required to abide by the ACA's rules governing the individual and small

group markets. Because the ACA's more robust protections will not apply to these AHPs, it is to be expected that the results of prior experiences with AHPs will repeat themselves. In particular, AHPs will likely attract younger and healthier individuals because they are not required to offer the same comprehensive set of benefits required of ACA-compliant plans and they are allowed to use additional rating factors based on age, gender, industry, and other non-health related factors. For example, an ACA-compliant plan in the individual market is limited to charging an older person no more than three times the premium charged to a younger person. Under the new Federal Rule, AHPs will not have to comply with this requirement, which would allow AHPs to increase premiums for older members, while offering lower premiums to younger individuals, who generally have lower health costs than older individuals. This premium differential is expected to encourage younger, healthier individuals to migrate from the individual insurance market to AHPs.

38. Healthy small groups and individuals can be expected to leave ACA-compliant plans for AHPs that provide skimpier benefits and fewer consumer protections because they are lower cost, leaving a smaller and sicker risk pool for the traditional insurance market. Over time, this loss of healthy risk will likely result in fewer plan options and higher prices for the most vulnerable small businesses and individuals that remain in the traditional markets because they need access to the comprehensive benefits and consumer protections in those markets.

39. In addition, in the past fraudsters and other bad actors often used periods of regulatory uncertainty – such as will result from the Final Rule – to market and promote fraudulent, abusive, and deceptive health coverage. There is a long history of this sort of conduct being committed through AHPs. Because the Final Rule will create confusion among market actors – especially as to the continued applicability of state insurance laws concerning

AHPs – we are very likely to see an increase in fraud and deception as has been the historical practice with MEWAs and AHPs. As a result, many small employers and individuals may find that they do not in fact have the insurance coverage that they had been led to believe and will find themselves unable to receive needed medical care or stuck with very large medical bills.

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

Executed on August 17, 2018, in Washington, D.C.

Kevin Lucia
Research Professor and Project Director
Center on Health Insurance Reforms
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EXHIBIT A

KEVIN LUCIA, J.D., M.H.P.

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Health Policy Researcher

Kevin Lucia is a Research Professor and Project Director at the Center on Health Insurance Reforms (CHIR) at Georgetown University's McCourt School of Public Policy. Mr. Lucia currently directs policy research and analysis of federal and state law related to access, affordability and adequacy of private health insurance. He provides expertise, training and strategic advice and prepares resources to inform regulators, policymakers, stakeholders organizations and the media. He speaks regularly on status of federal health coverage reform. His research has been funded by government, private foundations and various stakeholder organizations.

Prior to CHIR, Mr. Lucia led the State Compliance Division within the Office of Oversight, Center for Consumer Information and Insurance Oversight (CCIIO), Centers for Medicare and Medicaid Services (CMS).

Mr. Lucia holds his J.D. from The George Washington University Law School and an M.H.P. from Northeastern University.

Education

The George Washington University Law School, George Washington University
Juris Doctor — Jan. 2005

Bouve College of Health Sciences, Northeastern University
Master of Health Professions — June 1995
Major: Health Policy

Bouve College of Health Sciences, Northeastern University
Bachelor of Science — June 1994
Major: Physical Therapy

Health Policy Experience

Center on Health Insurance Reforms, Health Policy Institute, Georgetown University, Washington DC
Co-founder; Research Professor; Project Director — June 2011 – Present

Office of Oversight, CCIIO, CMS, Washington DC
Director State Compliance Division — May 2010 – May 2011

Health Policy Institute, Georgetown University, Washington DC
Assistant Research Professor — June 2006 – Apr. 2010

Health Policy Institute, Georgetown University, Washington DC
Health Policy Researcher June 2001 – June 2006

United States Department of Defense, Army
Captain, Medical Specialty Corps Sept. 1995 – Sept. 1999
Multiple Duty Stations:
-West Point: United States Military Academy
-Pentagon: Department of Defense
-WRAMC: Walter Reed Army Medical Center

Teaching Experience

1. Adjunct Professor of Law, Georgetown University Law Center, Georgetown University, *The Affordable Care Act: Law and Policy Governing Private Health Insurance*, 3 Credit Course, Spring 2015.

2. Co-Director, *O'Neill Summer Program on Health Reform-The Affordable Care Act*, O'Neill Institute For National & Global Health Law, Georgetown University Law Center, Georgetown University, Summer 2014.

3. Assistant Professorial Lecturer, School of Public Health and Health Services, George Washington University, *Private Health Insurance: Building Blocks For Reform*, 2 Credit Course, Summer 2007-2009.

Appointments

1. Board Member, Health Benefit Exchange Authority, District of Columbia, Appointed by Mayor Vincent C. Grey, 3 year term, July 2012-2016.

2. Consumer Liaison Representative, National Association of Insurance Commissioners, 2008-2010.

Selective Publications*

1. State Regulation of Coverage Options Outside of the Affordable Care Act: Limiting the Risk to the Individual Market, The Commonwealth Fund, March 2018.

2. Stepping into the Breach: How States and Insurers Worked Together to Prevent Bare Counties for 2018, Kevin Lucia, Jack Hoadley, Sabrina Corlette, Dania Palanker, Olivia Hoppe, the Robert Wood Johnson Foundation, November 2017

3. Balance Billing by Health Care Providers: Assessing Consumer Protections Across States, Kevin Lucia, Jack Hoadley and Ashley Williams, The Commonwealth Fund, June 2017.

4. Post–Affordable Care Act Trends in Health Coverage for Small Businesses: Views From the Market, Kevin Lucia, Sabrina Corlette and Sandy Ahn, Urban Institute and Robert Wood Johnson Foundation, September 2015

*For a compreheisve list of publication, see https://chir.georgetown.edu/publications.html