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

DECLARATION OF PRITIKA DUTT IN SUPPORT OF PLAINTIFFS' MOTION FOR SUMMARY JUDGMENT

I, Pritika Dutt, hereby declare:

1. I am the Deputy Director for the Office of Financial Review (OFR) at the Department of Managed Health Care (DMHC). I have served in this position for one year, and prior to that, I

managed health care marketplace are actuarially sound and not unreasonable. This is accomplished through the annual rate review process, where health care service plans submit documentation required by law to support their proposed changes in premium rates. As a state regulatory body that reviews rates, the DMHC has deep knowledge about the market forces that influence the premium rates California consumers pay for their health coverage.

3. OFR is responsible for, among other things, reviewing proposed rate increases by health care service plans, and, in certain situations, making findings that certain premium rate increases are unreasonable or unjustified. As Deputy Director, I am responsible for supervising OFR's work and acting as liaison on health plan financial matters to the executive leadership and the administration.

4. On June 21, 2018, U.S. Department of Labor issued the final rule, "Definition of 'Employer' Under Section 3(5) of ERISA—Association Health Plans," (DOL final rule), to permit employers to form Association Health Plans (AHPs) and thereby allow those employers to more easily qualify for large group coverage. Specifically, the DOL final rule newly permits sole proprietors and small employers to obtain large group coverage through an AHP, with a looser requirement that AHP members have a commonality of interest than existed under prior law.

5. Expanding access to AHPs will expose more California consumers to unpaid claims when AHPs commit fraud or collapse because of a lack of financial solvency standards. Additionally, the DOL final rule will cause higher premiums and reduce availability of health

Arrangement (MEWA). MEWAs have a troubled history, marked with insolvencies and fraud. Insolvent or malfeasant MEWAs have harmed consumers and providers when claims go unpaid and consumers lose coverage and access to needed health services.

7. Fraudulent MEWAs have harmed California residents. In one significant 2001 case, the operators of Employers Mutual LLC formed 16 different employer associations that claimed to be fully funded. Employers Mutual managed the plans offered through these 16 associations and contracted with legitimate firms to market the plans and process the claims. Licensed agents marketed the 16 plans nationwide. The scheme was in operation for only 10 months, but in that amount of time, Employers Mutual collected $16 million in premiums and defaulted on $24 million of claims. The operators of Employers Mutual were eventually ordered to pay $7.3 million for their breach of fiduciary duty. The operators were criminally prosecuted and convicted in 2007, and one operator was ordered to pay more than $20 million in restitution. Other cases include Rubell-Helm Insurance Services of Irvine, a MEWA that operated in the late 1980s. Rubell-Helm claimed to be self-insured, but instead was found to be operating illegally, and was shut down in California and two other states. Its collapse left $10 million in unpaid medical claims. Further, a 1992 U.S. General Accounting Office report stated that between 1988 and 1990, California estimated that fraudulent or insolvent MEWAs had accumulated $45 million in unpaid claims, affecting 200,000 participants and beneficiaries.

8. Moreover, collapses of financially insolvent MEWAs have left California consumers and health care providers with substantial unpaid claims. For example, in 1989, Building

Market Instability and Segmentation

9. In order to maintain stable premium rates, the small group and individual health care markets require sufficient numbers of healthy consumers to offset the costs incurred by less-healthy consumers. Stable health care markets also require plans that compete for the same consumers to follow the same rules.

10. Allowing AHPs to avoid following Affordable Care Act (ACA) small group and individual market rules by making the large group market available to them would undermine the individual and small group market in two ways. First, it would siphon healthier individuals away from the ACA-compliant market. Second, it would give AHPs a competitive advantage over ACA-compliant individual and small group products by exempting them from important consumer protections.

11. The DMHC expects that as a result of the DOL final rule there will be an increase in the marketing of and enrollment in AHPs to healthier individuals. Expanding access to AHPs in this way will harm the state by segmenting the market and increasing premiums for the state's most vulnerable consumers.

12. AHPs are likely to attract healthier consumers who otherwise would have enrolled in ACA-compliant individual or small group products. Under the DOL final rule, AHPs would be able to lower costs by discouraging less-healthy individuals from enrolling. The DOL final rule would permit an AHP to keep out less healthy consumers by using benefit designs, membership requirements, geography, and other factors that can be proxies for health status. While the DOL

related discrimination. For example, an AHP might choose to operate only in the higher-income part of a metropolitan area, using income as a proxy for health. Such an AHP could pay lower premiums because it would expect fewer claims on account of membership rules designed to attract healthier consumers.

13. The DOL final rule also would give a competitive advantage to AHPs over ACA-compliant individual and small group products. Coverage through AHPs would be able to charge lower premiums because it could omit vital consumer protections and covered benefits, making this coverage even more attractive for the healthier consumers who are able to qualify for it. Consumers who have higher medical expenses—those who need the ACA's protections the most—would be left paying higher premiums because the ACA-compliant market would experience higher average claims. Ultimately, some of these less healthy consumers will lose their health coverage if they are ineligible for premium assistance and cannot afford the higher premiums caused by the segmented risk pool.

14. One recent study[1] estimated that, under the DOL final rule, up to 4.3 million consumers nationwide would shift from ACA-compliant individual and small group products to AHPs, causing an additional premium hike of up to 4% in the small group market and 2% in the individual market. The study noted that the DOL final rule could cause up to 140,000 individuals who would have had health coverage but for the DOL final rule to become uninsured. Because nearly one third of individual market enrollees are self-employed, the DMHC expects the impact of making large group coverage available to self-employed persons through AHPs

15. At some point, everyone receives health care services. When the uninsured rate rises, more people seek these services at safety-net providers and in emergency rooms, leading to higher rates of uncompensated care. In turn, this causes providers to charge higher rates when consumers do have coverage, leading to higher premiums for the whole market. It also directly harms the state, which provides a substantial portion of safety net provider funding through Medi-Cal, California's Medicaid program.

16. Californians who enroll in AHP coverage also are likely to suffer harm. Some will be left with unpaid medical claims when their AHP engages in fraud or becomes insolvent. Because large group coverage obtained through an AHP is not required to cover the state's Essential Health Benefits package, others will enroll in AHP coverage that lacks critical consumer protections and benefits. Some consumers who enroll in AHP coverage will face unexpected medical expenses if they need uncovered treatment as a result of illness, injury, or pregnancy.

Timing and Implementation Concerns

17. The timing of the proposed DOL rule is problematic. In order to meet state and federal deadlines, California health plans are required to submit rates in the individual markets for the 2019 plan year in July 2018, which they have already done. The DMHC will be reviewing updated rates into September, and is required, by law, to determine the reasonableness of rate increases by September 30, 2018. Further, by law, enrollees must receive written notice of any rate increase in October 2018. The DOL final rule was published in late June 2018, at the

they cover potential losses resulting from the market segmentation the DOL final rule promotes.

I declare under penalty of perjury under the laws of the United States that the foregoing is true and correct, and that this declaration was executed electronically, at my request, on August 16, 2018, in Sacramento, California.

Dated: August 16, 2018

[Pritika Dutt]