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 PAM MACEWAN IN SUPPORT OF PLAINTIFFS' MOTION FOR SUMMARY JUDGMENT**

I, Pam MacEwan, declare as follows:

1. I am over the age of 18 years, have personal knowledge of all facts and matters herein, and am competent to testify to the matters below.

2. I am the chief executive officer of the Washington Health Benefit Exchange (WAHBE or the Exchange). I have held this position since 2015. I previously served as chief of staff from 2012 to 2015. I have 24 years of experience in healthcare management.

3. WAHBE is Washington State's health insurance exchange, or insurance marketplace. WAHBE was established in 2011 under the Patient Protection and Affordable Care

Act (ACA) and state legislation, Wash. Rev. Code 43.71. WAHBE is a self-sustaining, public-private partnership governed by an 11-member bipartisan board. WAHBE serves more than 1.7 million Medicaid and commercial insurance customers through its website, www.wahealthplanfinder.org. More than 200,000 Washington residents are covered by individual market health insurance through the Exchange, receiving high-quality coverage through Qualified Health Plans (QHPs) certified by the Exchange. Since implementation of the ACA and formation of the Exchange, the uninsured rate in Washington State has declined from 13.9% in 2012, to 5.8% in 2017.

4. I am submitting this declaration in support of the Plaintiff States' Motion for Summary Judgment following the Department of Labor's final rule re-interpreting the definition of employer under ERISA (Final Rule). 83 Fed. Reg. 28,912 (June 21, 2018).

5. The Final Rule is likely to segment risk and further destabilize the individual and small group insurance markets by undermining the stability that pooling of risk offers to any regulated market. The Final Rule will also harm Washington State consumers by eroding health coverage standards and protections that apply in the individual market under the ACA. Finally, the Final Rule will harm the Exchange by reducing premium assessments and fees on sales of QHPs that the Exchange requires to be a self-sustaining health insurance marketplace.

6. In regard to the market segmentation impacts of the Final Rule, Association Health Plans (AHPs) will be permitted to offer cheaper premiums and cover fewer benefits. This will encourage healthy people to leave regulated individual market and small group coverage, and risk segmentation will follow. In addition, as AHP enrollees develop health conditions and need services not covered by their AHP, they will reenter the regulated markets to obtain those services, further perpetuating segmentation of the risk pool and driving up the cost of coverage in the

regulated market. This phenomenon, also known as "adverse selection", means that remaining or re-entering Exchange enrollees will have more complex medical conditions, and pose greater risk to carriers. Those carriers will likely raise premiums on QHPs to compensate for increased risk. Increased premiums raise the possibility of a "death spiral" in the Exchange market, where more and more enrollees leave the marketplace due to higher costs and fewer carriers participate due to greater risk.

7. The Final Rule allows AHPs to vary rates based on age, gender, geography, and other differences between employer groups. This structure encourages rating based on characteristics that are proxies for health status, allowing "cherry picking" of health risk and further segmenting and destabilizing the individual and small group markets.

8. The Final Rule encourages segmentation of risk within a single employer group into more and less healthy employee sub-groups. The Final Rule incentivizes small employers to offer coverage that is lower than "minimum value" (56% AV), and therefore less expensive for the employer. Healthy employees will have an incentive to take the AHP coverage, as it will be cheaper and provide narrower benefits than individual market coverage. Sicker employees may decline the AHP coverage, apply for individual coverage through an ACA exchange, and be eligible for federal tax credits and cost-sharing reductions. These small groups are able to direct sicker workers and their families to the publicly-subsidized individual market, free from the countervailing influence of the employer shared responsibility payment, which deters larger employers from this practice in the large group market. This practice will further endanger individual market stability as that risk pool becomes less healthy, and negatively impact both individual market and AHP consumers.

9. Finally, the Final Rule encourages market segmentation by expanding the commonality of interest test to include merely having a principle place of business in the same state or, if in different states, in the same metropolitan area. There is not necessarily any employment-related nexus between employers in a given area and an employer-sponsored plan, as exists currently for associations consisting of employers in the same trade, industry, or line of business. Employers in the same trade, industry, or line of business may have similar workforces and employees that have similar health insurance needs; this is not true for all the small employers in a state. The formation of AHPs based on geographic lines is likely to exacerbate risk segmentation issues and encourage the proliferation of AHPs designed to seek only good risk, contributing to the destabilization of non-AHP markets.

10. In regard to harm to consumers, the Final Rule erodes coverage protections, may raise premiums for those left in the individual market, and opens the door to fraud and abuse.

11. By excluding Association Health Plans from the ACA's market rules applicable to the individual and small group insurance markets, including essential health benefits, rating, guaranteed issue, and single risk pool requirements, the Final Rule allows AHPs to tailor their products to attract healthier enrollees and discourage enrollees needing more comprehensive coverage. Consumers may not compare AHPs to QHP products available on the Exchange, and may not be aware that their QHP premiums can be offset by advance premium tax credits and cost sharing reduction benefits. Those consumers choosing AHPs with limited benefits who later develop health issues outside the annual open enrollment period are likely to be harmed when they find themselves with inadequate coverage and facing unanticipated medical bills. Benefits associated with more expensive health conditions, such as cancer care and maternity services, are not required to be covered under AHPs – nor are certain prescription drugs required to be covered

– allowing AHPs to "cherry pick" healthy individuals. This undermines the rules that prohibit discrimination on the basis of health status or condition.

12. The Final Rule also erodes consumer protections by overturning the well-established interpretation of ERISA to require a working owner to have at least one employee to sponsor and participate in an ERISA employee benefit plan. To the extent that AHPs will attract healthier risk through narrower benefits and lower premiums, extending AHPs to working owners with no employees will increase premiums for those who remain in the individual market. Moreover, the reasoning that justifies looser rating and market rules in the large group market does not exist with respect to working owners with no employees. These individuals would receive none of the protections with respect to essential health benefits, rating, and guaranteed issue that apply in the individual market, and would not be able to benefit from the buffering impacts of population variation provided in a large group plan.

13. The Final Rule provides that individuals seeking participation in an AHP shall attest to meeting the "working owner" standard to be eligible. The Rule provides an earned income minimum threshold of the cost of the AHP monthly premium, which could be as low as or lower than $100. This low earned income requirement is likely to result in fraudulent attestation of employer status. The Final Rule's re-interpretation of the long-standing ERISA definition of "working owner" opens the door to fraud and abuse, exacerbated by a federal governance structure that would provide very little oversight.

14. AHPs are exempt from ACA essential health benefits, rating, guaranteed issue, single risk pool, and nondiscrimination rules, and therefore are able to structure association eligibility, plan benefits, and rates in such a way that could result in de facto discrimination based on health status factors. For example, the Final Rule permits AHPs to be available only in

geographic areas that have a history of a low incidence of cancer, or to be unavailable to employers in specific industries that have histories of higher medical claims. AHPs are permitted to offer coverage without maternity care, mental health benefits, or coverage of certain prescriptions. The Rule permits rating to be applied with discriminatory impact, charging women higher rates than men, older individuals higher rates without limit, or individuals in certain industries higher rates than others. Demographic and other factors can be used as proxies to achieve de facto discrimination based on health factors, even if health status is not used explicitly in eligibility or rating decisions.

15. The implications noted above have been discussed nationally in recent publications.[1] [2]

16. Finally, the potential loss of Exchange enrollment due to AHPs threatens the Exchange's sustainability. Any loss of enrollees will lower WAHBE's revenues because WAHBE's operations are mostly financed through fees paid by carriers. Federal and state law authorize user fees on carriers that offer plans on the Exchange. 45 C.F.R. §§ 155.160, 156.50; Wash. Rev. Code 43.71.080, 48.14.020(2)(b), 48.14.0201(5)(b). Carriers are taxed two percent on the value of premiums paid, and also charged a flat per-member per-month assessment for enrollees on the Exchange. These premium taxes and assessments are deposited in the state treasurer's health benefit exchange account. Wash. Rev. Code § 43.71.060(2).

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[1] Corlette, Sabrina, *What's in the Association Health Plan Final Rule? Implications for States*, Georgetown Center on Health Insurance Reforms, https://www.shvs.org/whats-in-the-association-health-plan-final-rule-implications-for-states/, June 22, 2018.

[2] Cousart, Christina, *The New Association Health Plan Rule: What Are the Issues and Options for States*, National Academy for State Health Policy, https://nashp.org/the-new-association-health-plan-rule-what-are-the-issues-and-options-for-states/, June 26, 2018.

17. For state fiscal year 2018 (July 2017 to June 2018), Exchange revenues related to QHP premiums and assessments were $36.7 million, and projected revenues for state fiscal year 2019 (July 2018 to June 2019) are $ 39.1 million. A 20 percent reduction in QHP enrollment could decrease state fiscal year 2019 revenues by approximately $10 million using 2018 premium tax rates. The exact amount of enrollment loss cannot be precisely calculated, but a*ny* decline in enrollment will reduce the Exchange revenue. Further, if premium tax funds are not available as state Medicaid match, additional state general fund dollars would be needed to replace those premium tax funds to support the Exchange's costs for enrolling Medicaid applicants through the shared on-line portal "Washington Healthplanfinder."

18. In sum, the Final Rule is likely to have a negative impact on the individual and small group markets in Washington State, including WAHBE and the population it serves. AHPs that cover fewer benefits than ACA-compliant plans will encourage healthy people to leave regulated individual market and small group coverage, and risk segmentation will follow. As healthier consumers gravitate toward skimpier AHPs and consumers needing more comprehensive coverage remain in or return to the individual and small group markets, premiums in those markets will rise. Enrollees in individual and small group plans will be harmed as they face higher premiums, and AHP enrollees may face confusion and unanticipated medical costs when they find themselves underinsured and needing benefits that are not covered by their plan. AHPs will have a destabilizing impact on insurance markets and are likely to cause harm to individual and small group consumers in Washington State. Any loss in QHP enrollment due to the AHP rule will also subject the Exchange to lower revenues through reduced revenue generated from carrier premium assessments and fees.

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

Executed on August 10, 2018, in Olympia, Washington.

Pam MacEwan
Chief Executive Officer
Washington Health Benefit Exchange