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8
9 IN THE UNITED STATES DISTRICT COURT
10 FOR THE NORTHERN DISTRICT OF CALIFORNIA

11 **THE STATE OF CALIFORNIA; THE**
12 **STATE OF CONNECTICUT; THE STATE**
13 **OF DELAWARE; THE DISTRICT OF**
14 **COLUMBIA; THE STATE OF ILLINOIS;**
15 **THE STATE OF IOWA; THE**
16 **COMMONWEALTH OF KENTUCKY;**
17 **THE STATE OF MARYLAND; THE**
18 **COMMONWEALTH OF**
19 **MASSACHUSETTS; THE STATE OF**
20 **MINNESOTA; THE STATE OF NEW**
21 **MEXICO; THE STATE OF NEW YORK;**
22 **THE STATE OF NORTH CAROLINA; THE**
23 **STATE OF OREGON; THE**
24 **COMMONWEALTH OF PENNSYLVANIA;**
25 **THE STATE OF RHODE ISLAND; THE**
26 **STATE OF VERMONT; THE**
27 **COMMONWEALTH OF VIRGINIA; and**
28 **THE STATE OF WASHINGTON,**

Plaintiffs,

v.

22 **DONALD J. TRUMP, President of the United**
23 **States; ERIC D. HARGAN, Acting Secretary**
24 **of the United States Department of Health**
25 **and Human Services; UNITED STATES**
26 **DEPARTMENT OF HEALTH AND**
27 **HUMAN SERVICES; STEVEN T.**
28 **MNUCHIN, Secretary of the United States**
Department of the Treasury; UNITED
STATES DEPARTMENT OF THE
TREASURY; and DOES 1-20,

Defendants.

Case No. 4:17-cv-05895-KAW

DECLARATION OF AUDREY MORSE
GASTEIER, CHIEF OF POLICY AND
STRATEGY, MASSACHUSETTS
HEALTH INSURANCE CONNECTOR
AUTHORITY ISO PLAINTIFFS'
APPLICATION FOR A TEMPORARY
RESTRAINING ORDER AND ORDER
TO SHOW CAUSE WHY A
PRELIMINARY INJUNCTION SHOULD
NOT ISSUE

1 I, Audrey Morse Gasteier, hereby state the following:

2 1. I am the Chief of Policy and Strategy at the Massachusetts Health Insurance
3 Connector Authority (the “Health Connector”).

4 2. I am over 18 years of age and am not a party to this action. The facts set forth in
5 this declaration are based on my personal knowledge and my review of documents kept in the
6 ordinary course of business by the Health Connector.

7 3. I have been Chief of Policy and Strategy at the Health Connector since 2016 and
8 have worked at the Health Connector since 2012. I have worked in Massachusetts state
9 government on health reform policy since 2008, having worked at the Massachusetts Division of
10 Health Care Finance and Policy on implementation of Chapter 58 of the Acts of 2006
11 (Massachusetts’s state health reform law) from 2008 to 2012.

12 4. In my role as Chief of Policy and Strategy of the Massachusetts Health Connector,
13 I oversee program management, policy analysis and government affairs, and communications and
14 outreach.

15 5. Created in 2006 by state law, the purpose of the Health Connector is to facilitate
16 the availability, choice, and adoption of private health insurance plans to eligible individuals and
17 small groups as described in Mass. Gen. Laws c. 176Q.

18 6. The Health Connector has been designated by the state Legislature as the
19 Commonwealth’s American Health Benefit Exchange for purposes of the federal Affordable Care
20 Act.

21 7. The Health Connector offers health insurance plans to individuals and small
22 businesses.

23 8. In 2017, the Health Connector offered health coverage underwritten by ten
24 insurance carriers, offering a total of 62 unique product plan offerings for consumers. As of
25 October 2, 2017, 257,327 Massachusetts residents were insured under health coverage offered
26 through the Health Connector. This included 197,429 individuals enrolled in ConnectorCare, a
27 Health Connector program which assists eligible individuals in affording coverage who fall below
28 300 percent of the Federal Poverty Level.

1 9. Of those Massachusetts residents, those with incomes under 250 percent of the
2 Federal Poverty Level – approximately 161,000 – receive federal cost-sharing reductions
3 (“CSRs”) via ConnectorCare. These federal CSRs are applied to cost-sharing that members
4 would generally pay out-of-pocket for health care services, such as deductibles and co-payments,
5 thereby ensuring fuller access to health insurance coverage for individuals under 250 percent of
6 the Federal Poverty Level as well as certain American Indians/Alaska Natives.

7 10. Beginning in 2014 and until this month, the federal government has made
8 payments to insurers to reimburse them for federal CSRs (“CSR Payments”).

9 11. The general process leading into Open Enrollment entails year-long activity by the
10 Health Connector. In the first quarter of any given year, the Health Connector invites insurance
11 carriers to submit plans to be considered for inclusion on the Health Connector. Plans for calendar
12 year 2018 were all submitted in 2017 and were formulated based on an assumption that federal
13 CSR Payments would be continued. The third quarter includes a preliminary approval of qualified
14 plans, with a final approval occurring after a rate review by the Massachusetts Division of
15 Insurance. Finally, those selected plans are then offered to Massachusetts residents during Open
16 Enrollment in the fourth quarter of the year.

17 12. In preparing for Open Enrollment for the 2018 plan year, which will occur in
18 November and December of 2017 and January of 2018, the Health Connector has spent
19 considerable efforts engaged in contingency planning, including a minimum of a thousand staff
20 hours across every level of the organization, in pursuit of a dual track approach to respond to the
21 possibility that federal CSR Payments would not continue.

22 13. In addition to the resources expended by the Health Connector, insurance carriers
23 have also been burdened with preparing for uncertainty, having to provide two sets of plans and
24 associated rates for approval for Open Enrollment: one set based on the continuation of federal
25 CSR Payments; and another set, increasing an additional roughly 18 percent over what their 2018
26 rates would have been in order to compensate for the loss of federal CSR Payments.

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1 14. On October 12, 2017, the Health Connector announced that it would proceed with
2 rates for health insurance in 2018 that reflected an assumption of continuation of federal CSR
3 Payments by the federal government.

4 15. The federal government announced hours later, without prior notice to the Health
5 Connector, that it will cease federal CSR Payments, less than a month prior to the commencement
6 of Open Enrollment in Massachusetts.

7 16. With the most recent announcement, the Health Connector is still deliberating on
8 how best to respond to the announced cessation of CSR Payments by the federal government –
9 not just with respect to which set of plans and rates to offer for 2018, but also with respect to how
10 to respond to the overall market need for stability and clarity, how to avoid confusion among
11 consumers, and how to protect the value and function of the state’s exchange over the medium
12 and long term.

13 17. The loss of federal CSR Payments to Massachusetts insurance carriers for the
14 remainder of 2017 are estimated to be \$27-28 million. To date, there is no identified mechanism
15 through which the carriers may recoup these losses.

16 18. The amount of federal CSR Payments that would be lost for 2018 for
17 Massachusetts insurance carriers is estimated to be \$146 million.

18 19. Raising premium rates to reflect a cessation of CSR Payments by the federal
19 government will impose a meaningful administrative burden on the Health Connector, including
20 undoing work that had been done to approve and sell plans with lower rates based on an
21 assumption of continued CSR Payments.

22 20. For plans that are impacted by the cessation of federal CSR Payments, premium
23 rates will need to be further increased, beyond ordinary market trends, by approximately 18% for
24 2018. Up to 80,000 Massachusetts residents – those with incomes above 400% of the Federal
25 Poverty Level or those who did not seek a subsidy – are expected to be enrolled in those plans at
26 the time of Open Enrollment and do not receive a premium tax credit that would offset the
27 expected rate increase. Those residents would thus face the full impact of those increases unless
28 they change plans for 2018.

1 21. There will be an increased burden on the Health Connector in informing and
2 educating those individuals impacted by a potential rate increase. Outreach to those consumers
3 will require providing highly individualized information, including information about coverage
4 options outside of the Health Connector's products that may be less expensive than the plan
5 available through the Health Connector, but which will require the consumer to take potentially
6 complex and burdensome actions in order to purchase and enroll.

7 22. The significant rate increases, which would only be avoidable for many by
8 switching plans, can be reasonably expected to result in consumer concern, confusion and some
9 loss of coverage altogether. Furthermore, even if consumers are able to find a new plan, either on
10 or off the Exchange, that is affordable to them or similarly priced to their 2017 plan, real hurdles
11 may still exist in terms of ensuring continuity of care with long-standing providers who may no
12 longer be in the provider network for the consumer's new, cost-appropriate plan.

13 23. The loss of unsubsidized non-group membership and general market disarray
14 likely to ensue as a result of the CSR non-payment causes immense and potentially irreparable
15 harm to the policy objective of a state health insurance Exchange like the Health Connector,
16 which was the first of its kind in the country. The Health Connector has worked diligently over
17 the last ten years to steadily grow membership in the individual market. That membership, both
18 for subsidized and unsubsidized enrollees, in turn allows the Health Connector to be a vehicle for
19 price competition among insurance carriers and thus more effectively deliver affordable coverage
20 to the residents of the Commonwealth. There is evidence that the Health Connector's scale and
21 the organization of its marketplace has effectively "bent the cost curve." (The Health Connector's
22 benchmark plan, which is used to determine the amount of federal premium tax credit subsidy
23 expended by the federal government, has declined every year for the last four years, while most
24 states and the US average have increased, and Massachusetts's 2017 benchmark plan was more
25 than 30% below the US average). Loss of the scale that the state has spent a decade growing in
26 the Exchange is likely to imperil that progress, resulting in higher health care costs, reduced
27 competition, and reduced efficacy of the Exchange's principle values to the market.

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24. The cutoff of the CSR subsidy has thus caused meaningful burden and harm to the Health Connector and will cause harm to Massachusetts residents unless enjoined.

I declare under penalty of perjury that the foregoing is true and correct. Executed on October 18, 2017.



Audrey Morse Gasteier
Chief of Policy and Strategy
Massachusetts Health Insurance Connector Authority