IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MARYLAND

CITY OF COLUMBUS, *et al.*, *Plaintiffs*, v. DONALD J. TRUMP, *et al.*, *Defendants.*	Civil Action No. 1:18-cv-02364-DKC

SECOND DECLARATION OF JEFF WU IN SUPPORT OF DEFENDANTS' MOTION TO DISMISS THE AMENDED COMPLAINT

Pursuant to 28 U.S.C. § 1146, I, Jeff Wu, make the following declaration based on personal knowledge, on information I have reviewed in the records of the U.S. Department of Health and Human Services ("HHS") and its subsidiary agencies, or on information provided to me by HHS employees and contractors:

1. I am the Deputy Director for Policy for the Center for Consumer Information and Insurance Oversight ("CCIIO"), one of the centers in the Centers for Medicare & Medicaid Services ("CMS"), a component agency within HHS. CCIIO is charged with administering many of the responsibilities assigned to the Secretary of Health and Human Services with respect to the private insurance market requirements established under the Patient Protection and Affordable Care Act ("ACA").

2. I graduated from Harvard College in 1992 with a bachelor's degree in economics, and from Stanford Business School and Stanford Law School in 2001 with a master's degree in business administration and a juris doctor degree, respectively. In 2011, I joined CCIIO as a health insurance specialist, and I have served in various policy roles at CCIIO since then. I am currently the senior member of the career staff responsible for overseeing CCIIO's policy and regulatory

activities, including policymaking with respect to the ACA's market reforms. My staff and I also perform research, outreach, and policymaking with respect to the interaction between ACA-compliant and ACA-exempt insurance.

The ACA Health Insurance Market & Advanced Premium Tax Credit

3. The vast majority of Americans across the country have private health care coverage provided by large group market plans, self-insured health plans, and government sponsored plans, such as Medicare and Medicaid, which make up the largest portion of the health coverage markets. In 2017, the most recent year for which data is available, approximately 92% of the American population received their health insurance from large group market plans, self-insured health plans, and government sponsored plans, such as Medicare and Medicaid, and only about 3 percent of the American population obtained individual insurance through an American Health Benefit Exchange ("Exchange") established under the Affordable Care Act ("ACA").

4. Through the Exchange, qualified individuals and qualified employers can purchase ACA-compliant "qualified health plans." *See* 42 U.S.C. §§ 18031, 18021, 18032. Qualified health plans are generally the only type of health plan that may be sold through an Exchange. 42 U.S.C. § 18031(d)(2)(B)(i). To help low-income individuals obtain individual market qualified health plan coverage, the law provides subsidies in the form of premium tax credits. Section 1401 of the ACA amended the Internal Revenue Code by adding 26 U.S.C. § 36B, which provides a tax credit for applicable taxpayers with household incomes between 100% and 400% of the federal poverty level ("FPL") for individual health insurance coverage purchased through an Exchange. Because the section 36B tax credit is refundable, it can subsidize individual market insurance purchased by individuals who have no income tax liability. The vast majority of individuals who buy individual health insurance coverage on an Exchange elect to receive an advance payment of this tax credit ("APTC"), which may be applied to reduce the individual's monthly premium. In 2018, 87% of all

Exchange individual market enrollees received APTC. *See* CMS, Early 2018 Effectuated Enrollment Snapshot (July 2, 2018), p. 2, *available at*: https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces/Downloads/2018-07-02-Trends-Report-1.pdf (last visited: March 7, 2019).

5. The premium tax credit is available only for individual market qualified health plans purchased through an Exchange. The amount of the premium tax credit generally is determined by the individual's annual household income and the cost of the applicable second-lowest cost silver plan on the relevant Exchange. The premium tax credit helps ensure that the amount the individual pays for health insurance relative to household income remains relatively consistent, even as premiums rise. For instance, for 2018, an applicable taxpayer with household income equal to 100% of the FPL ($12,140 in 2018) will pay no more than 2.01% of their monthly household income for their monthly premium ($20.33) after the premium tax credits are taken into account, if the individual were to purchase the applicable second-lowest cost silver individual market qualified health plan, regardless of the total cost of that plan. Because premium tax credits limit a recipient's health insurance premium costs for the second-lowest cost silver plan at a percentage of household income, these premium tax credits insulate those who receive them from the impact of rising premiums. This is generally true for all 87% of Exchange individual market enrollees who receive APTC nationwide. The impact of the increase is instead generally borne by the federal government.

Rate-Setting for the 2019 Benefit Year.

6. CCIIO is in frequent contact with state insurance regulators, issuers, and State-based Exchanges that utilize the federal eligibility and enrollment platform. In certain states, CCIIO also reviews issuer premium rate filings. Insurance companies that offer health plans in the individual or small group market generally are required to undergo a process by which proposed health insurance products for the upcoming plan year are submitted to state insurance regulators for a review of rates

and benefits. This process typically commences in the spring or summer of the calendar year prior to the benefit year when the new rates will take effect, and concludes by late summer of that same calendar year. During that time, insurance companies file actuarial memoranda supporting their rate proposals for the following year and the assumptions on which the proposals are based. Although states generally oversee this rate-setting process, CCIIO is often in touch with states to provide technical assistance on issues of federal law or practice. In addition, CCIIO conducted direct review of individual and small group market products and/or rates for the 2019 plan year in four states—Missouri, Oklahoma, Texas, and Wyoming. Accordingly, CCIIO has reviewed the rate filings of numerous issuers that offer plans in 2019.

7. In setting their rates, insurances companies may take into account a wide-range of factors, which can include federal and state laws and regulations, administrative costs, drug costs, the age and utilization of the insured population, changes in the benefits, demographics, and networks, among numerous other things.

8. Moreover, because states are the primary regulators of health insurance, they may enact laws or promulgate regulations that are more stringent than or in addition to federal requirements, potentially affecting the premiums set by issuers in their states. For example, the federal final rule on short-term, limited duration insurance ("STLDI"), 83 Fed. Reg. 38, 212 (Aug. 3, 2018) changed the permissible initial term of such coverage from less than three months (first instituted in a rulemaking finalized in 2016) to any period of less than one year, and additionally caps the total duration of coverage under an STLDI policy, including any renewals or extensions of the initial term, at 36 months. Beyond these requirements, states are free to limit STLDI to impose shorter duration requirements or otherwise regulate STLDI plans in a manner that is more restrictive than federal requirements. For example, a number of states, including Illinois and Virginia, restrict issuers from selling STLDI policies with terms exceeding 185 days. Other states, including Maryland, limit the

policy term to three months or less, while another group of states, including Ohio, permit STLDI policies with terms of less than twelve months but place restrictions on renewals. Still other states do not permit the sale of any STLDI plans.

Issuer Participation, Premium, and Enrollment Trends for the 2019 Benefit Year

A. An Increase in Issuers Participating for 2019 Benefit Year

9. In 2019, the 39 Exchanges that rely on the federal Exchange's eligibility and enrollment platform (the "federal platform") saw an increase in individual market issuers as compared to 2018. There are 23 more issuers in 2019 than were participating during open enrollment in 2018. Further, 29 current individual market issuers expanded their service area into new counties that they did not serve last year. Major issuers Anthem, Wellmark, Molina, and Cigna have returned to the individual market Exchanges that they left in 2016 or 2017.

10. The number of counties with a single individual market issuer offering coverage on Exchanges that rely on the federal platform decreased in 2019. In 2019, only 39% of counties in Exchanges that rely on the federal platform had a single individual market issuer compared to 56% in 2018. This means that only 20% of individual market consumers in Exchanges that relied on the federal platform had access to only one issuer, down from 29% in 2018. The majority of consumers in states with Exchanges that relied on the federal platform – 57% – had access to three or more individual market issuers through the Exchange.

11. In 2018, of the states with an Exchange that relied on the federal platform, 10 states had only one individual market issuer offering coverage in each county. But in 2019, that number was cut in half, leaving only five states (Alaska, Delaware, Nebraska, Mississippi, and Wyoming) with one individual market issuer in each county.

12. In 2019, a new health insurance issuer, HealthKeepers, Inc. (affiliated with Anthem, Inc.) entered the individual market Exchange in Albemarle County, Virginia (the county surrounding

the City of Charlottesville where the Individual Plaintiffs reside). Consumers in that county therefore had the option to purchase qualified health plans from either of those insurers for the 2019 plan year.

B. A Decrease in Individual Market Plan Premiums

13. Individual market premiums stabilized for the first time for the 2019 plan year since the enactment of the ACA. In 2019, monthly premiums for individual market plans offered through the 39 Exchanges that rely on the federal platform decreased on average. For the second-lowest cost silver plan, monthly premiums dropped by an average of 1.5 percent across issuers. This information is publicly available via a CMS-administered website.

14. Similarly, in 2019, monthly individual market premiums for plans offered through Exchanges that rely on the federal platform declined for lowest cost plans (that is, the lowest cost bronze plans, or, in cases where no bronze plan was available, the lowest cost silver plan) by an average of 1 percent. This information is also publicly available via the same CMS-administered website.

15. Some states, of course, may experience more significant premium decreases. In the State of Maryland, for example, all insurers for the individual market reported significantly greater decreases in premiums than the national average.

16. In 2019, the average individual market monthly premiums charged in the City of Charlottesville and Albemarle County, where the Individual Plaintiffs reside, for both bronze and silver plans issued by the Optima Health Plan, decreased, as shown in the following charts:

Optima Bronze						
Year	**Age 21**	**Age 27**	**Age 30**	**Age 40**	**Age 50**	**Age 60**
2018	$634.85	$665.32	$720.55	$811.33	$1,133.83	$1,722.97
2019	$433.56	$454.37	$492.09	$554.09	$774.34	$1,176.68
Percent	-31.7%	-31.7%	-31.7%	-31.7%	-31.7%	-31.7%

Optima Silver						
Year	**Age 21**	**Age 27**	**Age 30**	**Age 40**	**Age 50**	**Age 60**
2018	$806.03	$844.72	$914.84	$1,030.10	$1,439.56	$2,187.55
2019	$595.27	$623.85	$675.64	$760.76	$1,063.16	$1,615.58
Percent	-26.1%	-26.1%	-26.1%	-26.1%	-26.1%	-26.1%

17. The information contained in the above charts can be calculated from data reported publicly as Health Insurance Exchange Public Use Files (Exchange PUFs) available on a government website administered by CMS and available here: https://www.cms.gov/CCIIO/Resources/Data-Resources/marketplace-puf.html (last accessed: March 7, 2019). The specific files located at the link above necessary for the calculations are the Rate PUF, the Service Area PUF, and the Plan Attributes PUF.

C. Enrollment in Individual Market Plans

18. In terms of enrollment, preliminary data indicates that plan selections in individual market plans offered through the 39 Exchanges that rely on the federal platform decreased modestly in 2019, by approximately 332,000 enrollees (or roughly 3.8 percent).[1] Because employment across the 39 states for which comprehensive data is available increased by two million in 2018, *see* CMS News, Enrollment Through Federal Exchange Remains Steady (Dec. 19, 2018), and given that 90

[1] During open enrollment, applicants select plans. Applicants are not technically enrolled into those plans until they pay for the first month of coverage and their coverage is "effectuated." Effectuation data is not yet available for 2019.

percent of workers are employed by firms that offer health benefits, it is possible that some of the enrollees that dropped Exchange coverage in 2019 may have obtained employer-sponsored coverage. *Id.*

Executed on March 8, 2019 at Bethesda, Maryland.

Jeff Wu