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 MILA KOFMAN IN SUPPORT OF PLAINTIFFS' MOTION FOR SUMMARY JUDGMENT

Pursuant to 28 U.S.C. § 1746, I, Mila Kofman, declare and state as follows:

1. I am over the age of eighteen (18) years, competent to testify to the matters contained herein, and testify based on my personal knowledge and information.

2. I am the Executive Director of the District of Columbia's Health Benefit Exchange Authority (DCHBX). I hold a J.D. from Georgetown University Law Center, and a B.A. in Government and Politics from the University of Maryland. The following is based on my experience as a regulator at the U.S. Department of Labor working on Employee Retirement Income Security Act (ERISA) and association health plan issues, a research faculty member at Georgetown University studying association health plans, Superintendent of Insurance in Maine regulating the insurance industry, and currently as the Executive Director of DCHBX.

3. From 1997 to 2001 I worked at the U.S. Department of Labor in the Pension and Welfare Benefits Administration (PWBA and now called the Employee Benefits Security Administration (EBSA)). I focused on development and implementation of ERISA regulations under the jurisdiction of EBSA. This included implementation of the Health Insurance Portability and Accountability Act (HIPAA) amendments to ERISA and related laws amending ERISA. In addition to other responsibilities, I worked with state insurance regulators on Multiple Employer Welfare Arrangements (MEWA) related issues.

4. From 2001 to 2008 and from 2011 to 2013, I was Project Director and a research faculty member at the Georgetown University Health Policy Institute. From 2001 to 2008, I focused my research on market failures and was the first in the nation to document the third cycle of health insurance scams related to association health plans (AHPs). From 2011 to 2013, I was also a Research Professor. The research informed a Congressional hearing on health insurance scams and a subsequent report from the Government Accountability Office (GAO). The research included a comprehensive study on how all 50 states and the District of Columbia regulate health insurance coverage sold through different types of associations including in-state and out-of-state AHPs/MEWAs, how states regulated self-insured MEWAs (including insolvencies), how EBSA regulated MEWAs, and how states and the federal government were responding to health insurance scams promoted through phony and real associations. The research also included ERISA preemption issues and ERISA-related challenges states faced when trying to shut down scams. In addition to authoring or co-authoring more than 30 publications, I have testified before Congress and numerous state legislatures, including before the U.S. Senate Finance Committee at a hearing on health insurance scams. I also served as an expert witness in MEWA insolvency cases and MEWA scam cases for states and private litigants. Publications related to AHPs/MEWAs include:

- Mila Kofman, Kevin Lucia, Eliza Bangit, and Karen Pollitz, *Association Health Plans: What's All the Fuss About*, Volume 25, Number 6, Health Affairs 1591 (November/December 2006).
- Mila Kofman and Karen Pollitz, *Health Insurance Regulation by the States and the Federal Government: A Review of Current Approaches and Proposals for Change*, Vol. 24, Issue 4 Journal of Insurance Regulation 77 (Summer 2006).
- Mila Kofman, Kevin Lucia, Eliza Bangit, and Karen Pollitz, *Association Health Insurance: Is It Time to Regulate This Product?* Vol. 24, Issue 1 Journal of Insurance Regulation 31 (Fall 2005).
- Mila Kofman, *Association Health Plans: Loss of State Oversight Means Regulatory Vacuum and More Fraud*, Georgetown University Health Policy Institute (July 2005).
- Mila Kofman and Jennifer Libster, *Turbulent Past, Uncertain Future: Is it Time to Reevaluate Regulation of Self-insured Multiple Employer Arrangements?* Vol. 23, Issue 3 Journal of Insurance Regulation 17 (Spring 2005).
- Mila Kofman, Eliza Bangit, and Kevin Lucia, *Multiple Employer Arrangements: Another Piece of a Puzzle, Analysis of Form M-1 Filings,* Vol. 23, Issue 1 Journal of Insurance Regulation 63 (Fall 2004).

- Mila Kofman and Karl Polzer, *Federal Association Health Plans – Will This Proposal Remedy the Health Insurance Crisis?* 5 Policy, Politics & Nursing Practice 167 (Aug. 2004).
- Mila Kofman, Eliza Bangit, and Kevin Lucia, *MEWAs: The Threat of Plan Insolvency and Other Challenges* (Commonwealth Fund March 2004).
- Mila Kofman and Karl Polzer, Opinions Commentary, *Disassociate from this plan*, Modern Healthcare, Feb. 2004 (invited guest column).
- Mila Kofman and Karl Polzer, *What Would Association Health Plans Mean for California?: Full Report* (California HealthCare Foundation Jan. 2004).
- Mila Kofman and Karl Polzer, *Insurance Markets: What Would Association Health Plans Mean for California* (California HealthCare Foundation Jan. 2004).
- Mila Kofman, Kevin Lucia, and Eliza Bangit, *Issue Brief: Health Insurance Scams: How Government Is Responding and What Further Steps Are Necessary* (Commonwealth Fund Aug. 2003).
- Mila Kofman, Kevin Lucia, and Eliza Bangit, *Proliferation of Phony Health Insurance: States and the Federal Government Respond* (BNA Plus Fall 2003).
- Mila Kofman, Eliza Bangit, and Kevin Lucia, *Insurance Markets: Group Purchasing Arrangements: Implications of MEWAs* (California HealthCare Foundation July 2003).
- Mila Kofman, *Issue Brief: Group Purchasing Arrangements: Issues for States* (State Coverage Initiatives, Vol. IV, No. 3 April 2003).
- Mila Kofman, *Health Insurance Scams Promoted Through Associations: A Primer* (The Insurance Receiver, Vol. 11, No. 3 Sept. 2002).

Congressional Testimony (excludes testimony while Superintendent of Insurance (Maine) and Executive Director DCHBX):

- Invited Testimony before the U.S. Senate Finance Committee, Hearing on Health Insurance Scams, March 2004. *See* U.S. Senate Committee on Finance, "Health Insurance Challenges: Buyer Beware," Mar. 3, 2004, at https://www.finance.senate.gov/imo/media/doc/030304mk.pdf.
- Invited Testimony before the U.S. House of Representatives Committee on Education and the Workforce Subcommittee on Employer-Employee Relations, Hearing: Examining the Impact of State Mandates on Employer-Provided Health Insurance ("The Interplay Between ERISA and State Health Policy Reform Efforts," May 2006).
- Invited Testimony before the U.S. House of Representatives Committee on Education and Labor, Subcommittee on Health, Employment, Labor and Pensions, Hearing: Health Care Reform: Recommendations to Improve Coordination of Federal and State Initiatives, May 22, 2007.

5. From 2008 to 2011, I was the Superintendent of Insurance in Maine. I also served on the National Association of Insurance Commissioners' (NAIC) Executive Committee, having been elected Secretary/Treasurer of the Northeast Zone in June 2010. I chaired the Health Insurance Regulatory Framework Task Force (responsible for Affordable Care Act (ACA)

changes to NAIC models), co-chaired the Consumer Information Working Group (statutory working group under ACA), and was a member of the Health Insurance and Managed Care (B) Committee, the Exchanges Working group, the Executive Committee's Professional Health Insurance Advisors Task Force, Anti-Fraud Task Force, and many other task forces and working groups. As Superintendent of Insurance, I was also the hearing officer. I presided over a case involving an AHP health insurance scam and another case that involved AHPs selling limited-benefit plans as comprehensive coverage.

6. Since 2013 I have served as the Executive Director of the DC Health Benefit Exchange Authority, which is responsible for DC Health Link—the online health insurance marketplace for District residents and small businesses.

7. The DC Health Benefit Exchange Authority was established as a requirement of Section 3 of the Health Benefit Exchange Authority Establishment Act of 2011, effective March 3, 2012 (D.C. Law 19-0094). The mission of the DC Health Benefit Exchange Authority is to implement an online health insurance marketplace in the District of Columbia in accordance with the Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010.

8. In the District of Columbia, individual and small group health insurance is sold only through DC Health Link. D.C. Official Code § 31-3171.09a. This policy has helped create market competition, had created lower prices for small businesses, has created transparency, and has ensured strong consumer protections.

9. As of July 15, 2018, DC Health Link covers approximately 66,700 people (excluding Congress) through the small group marketplace and approximately 16,900 residents through the individual marketplace. Including members of Congress and their staff, the small group market covers over 77,000 people, and is growing. Since January 1, 2014, all health insurance sold to District residents and small businesses must cover essential health benefits including primary and specialty care, hospital stays, lab work, prescription drugs, preventive care (with no cost sharing), maternity care, mental health and substance abuse treatment. Annual and lifetime limits on coverage are prohibited. People cannot be denied coverage or charged more because they had a medical condition in the past or currently. Pre-existing medical conditions cannot be excluded from coverage. Rating based on industry or occupation as well as employer size is now prohibited. And, women cannot be charged higher rates than men. There are limits on how much more an insurer can charge someone based on age. The District went beyond minimum federal standards to prohibit insurers from tobacco rating – charging people more because they smoke. The District has the second lowest average individual market premiums in the country (CMS 2018 Marketplace Open Enrollment Period Public Use Files).

10. Currently, small businesses in the District have more than 150 plans from three United Health companies, two Aetna companies, Kaiser, and CareFirst Blue Cross Blue Shield. Like a large company, a small business can pick a level of coverage (called "metal" level, like platinum, gold, silver, and bronze) and their employees can enroll in any of the many insurance companies at that level. The employer pays only one monthly bill no matter how many different insurance companies provide coverage. Small businesses can also choose one insurer and

employees have the option of any coverage level and any plan offered. Or an employer can choose one plan from one insurer. Price points are competitive, with some premiums decreasing the past few years because of this competition. People buying coverage in the individual market have a choice of 26 health plans (including catastrophic) from Kaiser and CareFirst.

11. Because of the ACA and DCHealthLink, the District has cut its uninsured rate (*i.e.*, the number of people without health coverage) in half. Now more than 96% of our population has coverage. Specifically, the District's uninsured rate dropped from 7.6% in 2010 to 3.9% in 2016, with the most dramatic decrease occurring since DC Health Link opened in 2013 — 6.7% to 3.9%. (Source: American Community Survey, United States Census Bureau).

12. I have reviewed both the proposed and final regulations issued by the U.S. Department of Labor (DOL) titled "Definition of 'Employer' Under Section 3(5) of ERISA-Association Health Plans" (AHP regulation), challenged in this lawsuit (the Final Rule).

13. As Executive Director of the DCHBX, I submitted comments to the U.S. Department of Labor on the proposed regulation "Definition of 'Employer' under Section (3) of ERISA- Association Health Plans- RIN 1201-AB85," published January 5, 2018.

14. The Mayor and the Chairman of the Council of the District of Columbia also submitted comments.

15. By exempting AHPs from key requirements under the ACA, the rule will destabilize the private health insurance market for small businesses and individuals in the District. The private ACA health insurance market will shrink and may collapse. Premiums will increase for small businesses and individual market enrollees. Some people will become uninsured. Insurers are likely to leave the market.

16. The key provisions in the final regulation, published on June 21, 2018, that will destabilize the market include the provisions that exempt AHPs selling coverage to self-employed people and/or small businesses from ACA consumer protections that apply in the individual and small group markets, such as rating restrictions, essential benefit requirements, guaranteed issue requirements, single risk pool requirements and risk adjustment requirements.

17. DCHBX commissioned an analysis by Oliver Wyman, a consulting company that provides independent actuarial services to DCHBX, to estimate the potential impact of DOL's proposed rule on the District's small group and individual health insurance markets (Exhibit 1).

18. After the Final Rule was issued, DCHBX commissioned Oliver Wyman to update its analysis to estimate the impact of the Final Rule on the District's small group and individual health insurance markets (Exhibit 2). In part, the update looked at potential impact if DC had a local individual responsibility requirement, and impact assuming there is no individual responsibility requirement.

19. Both the February and July 2018 Oliver Wyman analyses are based on the characteristics of the District's small group and individual health insurance markets. Oliver Wyman estimates that under the Final Rule:

- The District's small group market would shrink by as much as 90% and the individual market would shrink by as much as 25%. See Exhibit 1
- The number of people in the District without health insurance would also increase because of the Final Rule. See Exhibit 1.
- Assuming the worst case—high penetration of AHP coverage—people who stay in ACA plans will see their premiums increase: small group premiums would increase by as much as 23.3% and individual market premiums would increase by as much as 23.0%. These estimates exclude other factors that impact premiums, such as medical trend. See Exhibit 2.
- On an annual basis, a small business would be paying $1,640 per employee (on average) *more* for ACA-compliant health coverage because of the Final Rule. See Exhibit 2.
- A person with individual coverage would be paying $1,307 *more* per year because of the Final Rule. See Exhibit 2.

20. In addition, the uncertainty about the legality of the Final Rule will increase costs to people who enroll in AHPs and/or to people who stay in ACA-compliant policies. Specifically, if a person enrolls in an AHP with a deductible and has medical claims that count toward that deductible, but the Final Rule is later vacated, those enrollees will then lose their coverage and when they enroll in an ACA-compliant plan, they will have a new deductible. Enrollees will not be able to recover the monies they paid toward the AHP deductible, and will be in a worse position than they would have been had they enrolled in an ACA-compliant plan. If, however, the Court allows non-ACA compliant AHP coverage to remain until renewal, that will hurt people in ACA-compliant policies due to cherry picking and market segmentation.

21. The AHP Final Rule will destabilize the District's small group market. If as many as 90% of people now covered through the District's small businesses leave their small group coverage, there would be only about 6,700 people left in the District's small group market covered through small businesses. Currently, members of Congress and their designated staff also receive coverage through DC Health Link, adding approximately 11,000 individuals to the small group risk pool. But even with staff and members of Congress in the small group risk pool, it is unlikely that commercial insurers, as a matter of economic viability, will choose to stay in a market with only 17,700 covered lives compared to approximately 77,000 (and growing) in the current market. The Final Rule will make the insurance market for small businesses in the District extremely unstable, and will likely lead insurance companies to leave the District's small group market. No insurer wants to insure small businesses with only sicker and older employees, and the remaining pool would simply be too small for any insurer to want to make an investment to compete. The individual market would also be destabilized as healthier people move to AHP coverage. There is also substantial risk that a carrier in the individual market could leave.

22. Beginning on September 1, 2018, AHPs will sell cheaper coverage to residents and small businesses. Coverage will be less expensive for two main reasons: 1. It will not be comprehensive coverage; and 2. Even if it is comprehensive coverage, it will be limited to healthy residents and small businesses with healthy and young employees. As AHPs pull

healthy lives out of the insurance markets, the risk pools will be left with sicker and older people and eventually markets will collapse. This means insurers will leave and people will no longer have access to comprehensive private health insurance.

23. Under the Final Rule, an AHP is exempt from providing essential health benefits (EHBs). Consequently, AHPs could offer limited benefits at prices lower than what comprehensive coverage costs. Additionally, using benefit design, an AHP can attract healthier groups and individuals. For example, an AHP could offer coverage without maternity, mental health benefits, and expensive prescriptions. People who need such coverage would not enroll in AHP coverage.

24. Even if an AHP offers comprehensive coverage, it can "cherry pick" the healthiest people and coverage would be less expensive because healthy people don't cost as much as people with medical needs. AHPs can cherry pick because the Final Rule exempts them from rate reforms, guaranteed issue, single-risk-pool, and risk adjustment requirements. Consequently, an AHP can simply avoid covering people and businesses with medical needs. Also, an AHP could discriminate in rates, charging women higher rates than men, charging smaller businesses higher rates than larger businesses, charging businesses in certain industries higher rates, and charging older people higher rates without limit. Exemptions from guaranteed issue and single risk pool requirements and rating practices would result in healthier groups and individuals being covered through an AHP. Furthermore, an AHP could engage in marketing practices targeted at attracting healthier people. An AHP could avoid a geographic area where there is a high incidence of cancer, heart disease, and diabetes and thereby avoid covering sicker populations. Inevitably, this will lead to a substantial increase in premiums for those who remain in the traditional insurance markets, putting the cost of comprehensive health insurance out of reach for many people. As a result, the District's uninsured rate will go up.

25. The cost of uncompensated care will also increase as a result of people becoming uninsured and from being underinsured. The Final Rule could result in as much as $26,598,000 (24.6% increase) in additional uncompensated care in the District. (Source: Internal Analysis for DCHBX by Ellen O'Brien, PhD, Department of Health Care Finance)

26. History shows us that wider use of AHPs caused substantial harm to regulated health insurance markets. For example, Kentucky's health insurance market collapsed in the 1990s. Kentucky implemented market reforms, but exempted AHPs from these reforms, including rating reforms. The exemption resulted in healthy people in Kentucky seeking coverage through AHPs, which were not community rated, leaving unhealthy people to seek coverage in the regulated insurance markets. More than 20 insurance carriers left the market, leaving two carriers, one of which experienced millions in losses.

27. Although under the Final Rule self-insured AHPs formed pursuant to the Final Rule will not be eligible to enter the market until 2019, the damage that fully-insured AHPs can do to our insurance markets between September 1, 2018 and January 1, 2019 is substantial. For example, in Kentucky in the 1990s, once AHPs were exempted from insurance market reforms, it took only 90 days for enrollment in AHPs to increase from approximately 91,000 covered lives to over 151,000. ("Health Insurance Reform in the 1990s: A Kentucky Historical Perspective,"

Kentucky Department of Insurance; "Market Report on Health Insurance," Kentucky Department of Insurance, April 1997.)

28. Based on my experience, and knowledge of insurance markets and AHPs, I believe the Final Rule will cause premiums to increase for small businesses and individuals who need comprehensive coverage, including EHB under the ACA, and will cause some small businesses to lose coverage and some District residents to become uninsured. Some insurers will likely leave the District's small group market.

29. The Final Rule opens the door to fraud and insolvencies. The AHP market has a long history of attracting bad actors and being susceptible to fraud. The Final Rule creates opportunities for fly-by-night promoters to set up scams—taking premiums and never paying claims—and to use ERISA as a shield to avoid state enforcement actions.

30. There is a long history of health insurance scams promoted through AHPs. Since the 1970s when ERISA was enacted, promoters of AHPs used ERISA as a shield to evade state oversight and enforcement by arguing that ERISA preempted state regulation. In 1982 ERISA was amended to clarify that states and DOL have authority over AHPs. However, promoters of AHP scams continued to look for ways to evade state oversight, and continued to argue that state regulation was preempted by ERISA. Many associations funneled resources away from paying enrollees' claims and toward fighting oversight. ("Association Health Plans: Loss of State Oversight Means Regulatory Vacuum and More Fraud," Kofman (2005); "Proliferation of Phony Health Insurance: States and Federal Government Respond; Kofman, Lucia and Bangit (2003)).

31. According to the GAO, between 1988 and 1991, operators of multiple employer entities left 400,000 people with medical bills exceeding $123 million; and between 2000 and 2002, 144 entities left 200,000 policyholders with $252 million in unpaid medical bills. ("Private Health Insurance: Employers and Individuals are Vulnerable to Unauthorized or Bogus Entitles Selling Coverage," GAO-04-312, United State General Accounting Office, February 2004; "Employee Benefits: States Need Labor's Health Regulating Multiple Employer Welfare Arrangements," GAO/HRD-92-40, United States General Accounting Office, March 1992.)

32. Promoters of scams market AHPs to small businesses and self-employed individuals, offering health-insurance premiums at prices below what is generally available. Promoters of scams set up fake associations and also sell through well-established professional and trade associations.

33. The Final Rule adds new ambiguity to ERISA that will be used by promoters to evade state oversight, and overturns decades of ERISA guidance that will make it easier for promoters to set up scams. The Final Rule allows entities to form for the primary purpose of offering health coverage, and does not define the purported "substantial business purpose" that associations must have. This leaves open a gaping loophole that will allow AHPs to operate like commercial insurance companies, without the requirements the ACA applies to commercial insurance carriers. In the past, promoters of phony AHPs purported to have a business purpose other than health insurance even when they did not. Under the Final Rule, they can follow this same old pattern and make it harder for regulators to determine whether an AHP is a scam. Also,

there is no requirement that an entity be in existence for any period of time or have a proven track record. These entities can spring up with ease, and target unsuspecting small businesses and the self-employed.

34. Furthermore, unlike states that license and certify entities to help keep convicted felons and fly-by-night promoters out of the insurance business, DOL does not certify or license ERISA plans. And although AHPs must file a MEWA registration form called M-1 with DOL, there is no evidence that DOL conducts regular reviews or takes actions based on filings. DOL has itself admitted that there is a high M-1 noncompliance rate and estimated that in 2003 fewer than half of existing MEWAs registered with DOL. Furthermore, while there is a fine of $1,000 per day if AHPs do not file or file incomplete information, there is no evidence that DOL has ever used its authority to fine AHPs.

35. States have oversight and enforcement resources that DOL does not have. States have numerous tools that allow them to conduct regular oversight and intervene before consumers are harmed. These tools include background checks for operators of AHPs, financial and market conduct examinations, form reviews, and rate reviews. States also have and use enforcement tools, including cease and-desist authority and state receivership laws. DOL generally investigates plans only after they establish a pattern of failure to pay claims. Thus, by the time DOL acts, consumers have already been harmed. Also, states can act quickly to prevent harm; brokers serve as "eyes and ears" on the ground and help state regulators to identify bad actors who promote fake insurance.

36. While the Final Rule creates new opportunities for promoters of phony coverage to argue ERISA preemption to evade state oversight, it has no standards and no regulatory framework to keep bad actors out.

37. The Final Rule puts thousands of District residents and small businesses at risk of financial harm.

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

Executed on August 17, 2018 in Washington, DC.

Mila Kofman
Executive Director
DC Health Benefit Exchange Authority