

**IN THE UNITED STATES COURT OF APPEALS
FOR THE DISTRICT OF COLUMBIA CIRCUIT**

UNITED STATES HOUSE OF REPRESENTATIVES,
Plaintiff-Appellee,

v.

THOMAS E. PRICE, M.D., in his official capacity as Secretary of Health and Human Services; U.S. Department of Health and Human Services; STEVEN T. MNUCHIN, in his official capacity as Secretary of the Treasury; U.S. Department of the Treasury,
Defendants-Appellants.

On Appeal from the United States District Court
for the District of Columbia, No. 1:14-cv-01967
Honorable Rosemary M. Collyer

**DECLARATION OF MYRON BRADFORD “MIKE” KREIDLER,
INSURANCE COMMISSIONER FOR THE STATE OF WASHINGTON
IN SUPPORT OF THE STATES’ MOTION TO INTERVENE**

I, Myron Bradford “Mike” Kreidler, am over the age of eighteen years old. I make the following declaration based on first hand personal knowledge and am competent to testify to the facts set forth herein.

1. I am the elected Insurance Commissioner for the State of Washington. I was first elected to this position in 2000. I was reelected to my fifth four year term in 2016.

2. As Insurance Commissioner, I am charged with the regulation of the insurance market in Washington State through the enforcement of the Insurance Code, Title 48, Revised Code of Washington, and enforcement of applicable federal statutes that affect insurance. Wash. Rev. Code 48.02.060. I also sit as an ex officio member of the Washington Health Benefit Exchange (the Exchange) Board.

3. Since 1947, following the passage of the McCarran–Ferguson Act, 15 U.S.C. §§ 1011-1015, primary authority to regulate the business of insurance has belonged to the states. 15 U.S.C. § 1012. Only federal statutes that expressly regulate the business of insurance are considered to preempt Washington State laws, regulations, and authority concerning insurance.

4. The Patient Protection and Affordable Care Act (“Affordable Care Act”) is one example of federal law that expressly addresses insurance. More specifically, it addresses how health plans must be regulated. However, it does not strip the states of their authority or responsibility to regulate health insurance carriers, health plans, or their markets. Instead, the Act, and rules implementing the Act, heavily rely on states, particularly state insurance regulators, to enforce its various provisions. 42 U.S.C.A. § 300gg-22; 45 C.F.R. § 150.201.

5. Because of my role in regulating insurance carriers and the plans they offer, my office has been at the center of implementation of the Affordable Care Act for the State of Washington since its passage in 2010. As a result, I and my office are in a unique position to

understand the harmful impact caused by the threat that the United States Department of Health and Human Services (HHS) intends to unilaterally change its position regarding its obligation and ability to continue payments to carriers for reimbursement of cost sharing reductions (CSR) required by section 1402 of the Affordable Care Act, 42.U.S.C. §18071.

6. I and my office understand that the new administration at HHS needed time to grapple with these important issues, and come to their own conclusion. However, my office can no longer wait for HHS to decide and announce its official position. As described below, carriers need guidance on how to file plans for 2018 now. Given HHS's failure to announce an official position, or provide any meaningful guidance for carriers or regulators on this issue, I am forced to assume that HHS will no longer adequately represent the interests of Washington State, or other insurance regulators in this lawsuit.

7. At its core, the business of insurance is all about accurately predicting risk. In order to set plan rates, and compete in the market, a carrier must be able to accurately estimate 1) its costs to provide promised services to all of its enrollees, and 2) the number and nature of the enrollees a carrier believes it will have for the plan year. Both pieces involve complex analysis based on numerous factors including things like provider agreements, geographic locations, enrollee demographics, regulatory limits, past experience, and how other carriers are participating in the market. Further, those calculations are performed for each service where a carrier is considering doing business. Adding uncertainty to these calculations increases the risk that carriers are taking on, and in turn, the premiums they will charge.

8. One of the most significant areas of uncertainty Washington carriers are facing now is whether the cost sharing reductions (CSR) carriers are required to provide will be reimbursed for the remainder of the 2017 plan year, and for the 2018 and future plan years. To date, there has

been no official communication from HHS to the carriers or insurance regulators as to how much longer CSR payments will be made. Carriers are required to offer the CSRs to their enrollees, whether they are reimbursed or not. Unlike other states that may allow carriers to stop selling plans in through the Exchange if CSR payments stop, Washington carriers cannot unilaterally leave the Exchange, or otherwise stop offering approved health plans mid year. Washington carriers cannot change their rates mid year. Any unreimbursed payments for 2017 will be an unanticipated loss for carriers in 2017:

9. Any failure to make payments in the 2017 plan year will cause a direct harm to the financial condition of carriers in Washington State. Because my office is also tasked with monitoring and correcting threats to carrier solvency, threats to the financial condition of Washington authorized carriers increase the workload imposed on my office. Because of the uncertainty surrounding CSR reimbursements, my office has already been forced to review which carriers may have significant solvency issues if payments are not received. That review has already taken approximately 2 days of financial examiner time. Carrier financial statements, which are filed with and monitored by my office, presently assume those payments will be made through the end of the plan year. If CSR reimbursement payments are not made through the end of 2017, my office will be obligated to closely review the financial impact any unreimbursed payments have on carriers operating in Washington State, to ensure it does not negatively impact the measures my office uses to determine the financial health of our carriers. If CSR payments are halted mid year, my office will need to conduct a careful review of all health carriers participating in the Exchange, who will be affected by this financial blow. That review is likely to take my financial examiners an additional 2 days of review.

10. The failure of HHS to provide clarity or guidance to carriers regarding CSR

payments is increasing administrative burden on my office. In the absence of HHS guidance, Washington carriers are turning to my office for guidance and instruction that should be offered by the federal government.

11. The failure of HHS to offer clarity and assistance to my office as a regulator is compounding this administrative burden. In the past, when carriers had questions about implementation of federal requirements, my office was often able to seek guidance and input from HHS staff about implementation. No such assistance is being offered by HHS concerning the critical issue of CSR payments. Between fielding questions from carriers, attempting to get some guidance from HHS, and reviewing possible options for addressing this uncertainty, my staff has spent at least 100 hours dealing with the uncertainty surrounding CSR payments.

12. The failure of HHS to provide clarity for the 2018 plan year will impose an additional burden to my office as we begin to conduct rate reviews. My office must review and approve any health plan (as that term is defined in Wash. Rev. Code 48.43.005(27)) that is submitted by a health carrier (as that term is defined in Wash. Rev. Code 48.43.005(26)) before that plan may be sold in Washington State. Wash. Rev. Code 48.18.110, 48.44.020, and RCW 48.46.060. The health plan filing deadline for plans that will be sold in 2018 is June 7, 2017.

13. The review performed by my office ensures that the forms being used by carriers (the contract between the carrier and its enrollee), and the rates they are charging consumers (also called premiums), are fully compliant with state and federal requirements. Wash. Rev. Code 48.18.110, 48.44.020, and RCW 48.46.060; Wash. Admin. Code 284-43-0140.

14. In order for my office to review rates proposed in a health plan, the carrier must file detailed data and actuarial analysis that justifies the basis for their rates with my office. Because of the complexity of this analysis, carriers need a substantial amount of time to perform it. Once

it is filed with my office, my staff need a significant amount of time to review it. Carriers are already working on the analysis that is required for the 2018 plan year.

15. After approval by my office, a plan that will be sold through the exchange must be independently certified by the Exchange as a Qualified Health Plan. The Exchange needs time to review and certify these health plans, and time to upload those plans into their system so that they are available to consumers when open enrollment begins on November 1, 2017 for the 2018 plan year. For the 2018 plan year, the Exchange has informed carriers that it intends to certify the plans my office has approved at its September 14, 2017 board meeting.

16. We have already adjusted the filing process as a result of the failure of HHS to provide clarity and guidance. My office originally informed carriers that their plan filings, which must include a detailed actuarial analysis justifying their rates, would be due May 5, 2017. However, due to the uncertainty of what actions the federal government might take affecting the Affordable Care Act, including uncertainty regarding the future of CSR payments, carriers indicated they needed more time to prepare their health plan filings. My office agreed to extend health plan filing deadline to June 7, 2017. This gives carriers more time to conduct the review and analysis they must provide with their filings. However, by pushing the filing deadline back to June 7, my office is already being negatively impacted, because this will compress the time available to review health plan filings.

17. In addition, because the threatened, but not official, change in CSR payments creates enormous uncertainty for insurance markets, it creates significant challenges to my office's ability to review the underlying assumptions developed by carriers in setting their rates. It will take more time for my actuarial staff to review assumptions related to the payment or nonpayment of CSR reimbursements. It will be more difficult for my staff to determine if these assumptions

are in fact reasonable and sound. Assumptions that appear to be extreme will be more difficult for my staff to challenge, because the uncertainty of CSR reimbursements is so significant.

18. Some carriers have indicated that they are considering filing two versions of each health plan they intend to offer for the 2018 plan year: one that assumes the CSR reimbursement, and one that assumes no CSR reimbursement. This kind of dual filing will double the work my office has to do in reviewing and approving the assumptions related to CSR payments, and any exhibits or supporting materials impacted by these assumptions. In my judgment, that review will increase the workload for my actuarial staff by at least an additional 30%.

19. The burden imposed by our compressed review schedule and additional rate review work will ripple through my office. Because the actuarial review done by my office is highly specialized, I cannot easily hire additional staff or outside consultants to perform this work. In order to accommodate the additional work in less time, trained staff must be pulled from other projects. Pulling staff from review of other types of insurance products means review of those products will be delayed, thus delaying when carriers can begin selling them. Even for health plans, staff will not have as much time to work with carriers to correct filings with significant errors or problems. This could mean that more plans do not make it through the review process in time to be certified by the Exchange. That could mean fewer options in the individual market.

20. In addition to the administrative burdens this uncertainty is imposing on my office, the possibility that HHS will determine that CSR reimbursements will not be funded presents a real threat to the existence of a stable, fair, robust, and competitive insurance market in Washington State, and all the benefits that come with it.

21. For the last 17 years, I have worked with carriers, constituents, and lawmakers to rebuild the individual insurance market in Washington State. We have fully implemented the

requirements of the Affordable Care Act with great success. Our uninsured rate has dropped from 13.9% in 2012 to 5.8% in 2017. The average rate increases that have been approved each year have dropped from 13.1%, prior to passage of the Affordable Care Act, to 3.9 % in 2016. And the percentage of uncompensated care our state hospitals and health care providers have had to shoulder has dropped from \$2.35 billion in 2013 to \$1.20 billion in 2014, when the Exchange became operational and premium subsidies and CSRs became effective.

22. The uncertainty surrounding CSR payments threatens to unravel these benefits. First, we anticipate that failure to fund CSRs will result in a dramatic premium increase for Washington consumers. If carriers only raise premiums sufficiently to offset the loss of CSR reimbursements, we calculate that would necessitate an increase of 6-20%, depending on the carrier, and the area where that carrier is offering plans.

23. As a result, all Washington consumers (even those who do not qualify for CSRs individually) will be harmed by the increasing premiums that provide no additional benefit to them. Some may choose to purchase off the Exchange from a carrier whose plans are not directly affected by the CSR uncertainty. However, those individuals whose incomes fall between 250 – 400% of the federal poverty level, who are eligible for premium subsidies, can only receive subsidies through plans sold through the Exchange.

24. Because the premium subsidies are established based on the second lowest cost silver plan available, individuals receiving premium subsidies who purchase anything other than the second lowest silver plan, are likely to be paying more out of pocket in premiums.

25. Although a premium increase will impact all consumers in the individual market, for individuals who are not eligible for tax credits or CSRs, the impact is even more profound. Because carriers have to use the same risk pool as the basis for all of their health plans, both inside

and outside of the Exchange, it is not only silver level plans, and not only Exchange plans whose rates are likely to increase. As a result, consumers who will not receive CSRs, or increased premium subsidies, will receive no benefit from a premium increase designed to capture CSR payments.

26. Our own state's history and experience demonstrates that, as premiums increase, fewer people purchase insurance. This is even more likely in light of the federal government's decision to relax (or eliminate) enforcement of the individual mandate in the Affordable Care Act.

27. Further, the Affordable Care Act exempts individuals from the obligation to purchase coverage if the least expensive plan available in their area is more than 8.13% of their income. As premiums rise, more people qualify for this exemption, which leads to a further reduction of enrollment in the risk pool.

28. Our state has seen that when premiums increase, the people who continue to purchase coverage are generally those with significant health risks and health costs, who can't afford to go without it. With a smaller and sicker risk pool, premiums will likely continue to rise, creating smaller and sicker risk pools, and even higher premiums.

29. Our market has already demonstrated that carriers will not simply continue to raise premiums indefinitely. Each carrier has a point at which the administrative costs of running a health plan, and the risk associated with a small and costly pool of enrollees is no longer a financially viable option for the carrier. If premiums have to be raised too much, carriers are likely to simply stop selling health plans in the Exchange where CSRs are required.

30. Even for carriers that continue to sell in the Exchange, they are likely to look at other options for reducing their costs, such as eliminating service areas. My office is particularly concerned that rural counties, where the cost of providing services is higher, are particularly

vulnerable if CSR reimbursements are not made. Some of our rural counties have some of the highest percentages of individuals enrolled in qualified health plans receiving CSRs.

31. My concern that non-payment of CSRs will erode the individual market is not merely a speculative parade of horrors. This has been the actual experience of the State of Washington. When I took office in 2000, our individual insurance market had been devastated. In the early 1990s, Washington state enacted health insurance reforms that provided meaningful but expensive benefits to enrollees, with market controls that provided stability needed by carriers (an individual mandate). In 1995, the stabilizing provisions were eliminated by lawmakers, but the rich benefits were not. Rates went up, pricing healthy people out of the market. The risk pool got smaller and sicker, and rates went up again. Over the course of a few years, this “death spiral” resulted in the complete collapse of our individual market. For two years, Washington consumers could not buy an individual or family health insurance policy in Washington State. Requiring carriers to continue to offer CSRs, without the reimbursements that stabilize this benefit, has the potential to similarly devastate the individual market in Washington State.

32. There is also a very real possibility that some carriers may choose to simply stop selling plans for the 2018 plan year in the Exchange all together. My office recently received a letter from Molina Health Plan of Washington indicating that their company, which has 50,000 enrollees through the Exchange, is seriously considering not participating in the Exchange market at all for the 2018 plan year, due to the uncertainty of whether they will receive CSR reimbursements. Attached as Exhibit A is a copy of the letter I received from Peter Adler, President, Molina Healthcare of Washington, on May 05, 2017.

33. The uncertainty facing carriers like Molina will not be eliminated simply by a statement that CSRs will be paid for this year and 2018. Assuming the Affordable Care Act

remains the law of the land, carriers will continue to have to file their plans in May or June in Washington State. Congress does not typically pass its operating budgets until September. Until this issue is clarified, this uncertainty will resurface every summer. Only a permanent answer to the payment of CSRs will eliminate the uncertainty and administrative burden faced by my office and insurance regulators across the country.

34. More importantly, only a decision aligned with the position taken by HHS in its opening brief will alleviate the potential harm to Washington State's insurance market. 42.U.S.C. §18071 plainly requires HHS to reimburse carriers for the CSRs they provide to enrollees. Only a decision finding that Congress has in fact made a permanent appropriation for CSR reimbursements, will prevent the spiraling premium increases that devastated our individual market in the 1990s. Without clear alignment on this issue, I do not believe that HHS can adequately represent Washington State's position.

35. Had HHS announced via a proposed rule or an official statement that it intends to impose a completely opposite interpretation of the funding provisions affecting CSR reimbursements, a broad interpretive and policy change affecting virtually every Washington carrier participating in the Exchange, regulators and carriers could have provided input and taken steps to address the impact this change in course would have. However, HHS has not taken steps to clearly communicate its change in position to regulators and carriers through official channels. Therefore, there has not been an opportunity to address this broad change in policy through an administrative action.

36. In fact, even in the course of this litigation, HHS has not officially clarified its position to date. However, should HHS change its position in this appeal, the underlying decision by the district court would likely be used by HHS as justification for refusing CSR reimbursements

in the near future. Because the harm that change in position would cause to our individual market would be substantial, I and the State of Washington cannot risk allowing that decision to be implemented without a meaningful and truly adversarial challenge.

I declare, under the penalty of perjury, the foregoing is true and correct.

DATED this 9th day of May 2017, at Olympia, Washington.



Myron Bradford "Mike" Kreidler
Washington State Insurance Commissioner



Peter Adler
President
Molina Healthcare of Washington, Inc.
Direct: 425-398-2642
Peter.Adler@MolinaHealthcare.com

May 01, 2017

Mike Kreidler
Insurance Commissioner, State of Washington
Office of the Insurance Commissioner
Insurance Building
302 Sid Snyder Ave SW, Suite 200
PO Box 40258
Olympia, WA 98504

Dear Commissioner Kreidler,

For over 37 years, Molina Healthcare has fulfilled its mission by serving vulnerable populations, with a focus on low income individuals and families. Nationally, Molina serves over 3.6 million Medicaid and Medicare members. Our deep commitment to lower income Americans is further reflected in our 2014 decision to enter and make a major commitment to the ACA Marketplaces. Today, that decision has manifested in an additional one million Marketplace members across 9 states, bringing Molina's total national membership to over 4.6 million. In Washington State, in addition to being the largest Medicaid Managed Care Organization with over 730,000 Medicaid members, Molina is honored to also be the State's largest Marketplace carrier, with nearly 50,000 members.

Molina's strategic decision to actively participate on the Washington Health Benefit Exchange was based on our Mission and 22 year history in the state's Medicaid market, and was made knowing that there were higher actuarial risks and volatility in the anticipated Exchange population due to the uncertainty of their healthcare needs and trends of a previously uninsured population. Those risks and the volatility associated with the newly insured Marketplace population were openly acknowledged in the ACA and by the Washington Health Benefit Exchange. To attract carriers to take those risks, and to attract eligible, low income individuals to seek and retain coverage on the Exchange, certain explicit commitments were provided in the ACA to participating carriers to mitigate some of those risks. Specifically, Molina offered multiple insurance products on the Washington Health Benefit Exchange based on the explicit commitment provided in the ACA by the Federal Government to fund the ACA-defined Cost Savings Reduction (CSR) payments to health plans for eligible members. Without the CSR mechanism and payments, the ACA Marketplaces would have posed too much financial volatility and uncertainty, and Molina would not have entered or participated on any Exchange in any state, including Washington.

The CSR mechanism is the means by which eligible individuals receive reductions in their out-of-pocket costs (copays, deductibles, co-insurance, etc.) so as to make Exchange-based health plans more affordable. Greater affordability is required not only to make health insurance more accessible for eligible individuals, but also to reduce insurance volatility and to maintain actuarial stability in the Exchange insurance risk pools. Reduced volatility and greater predictability in the insurance world translates into lower premiums and increased ability for carriers to price products appropriately. Hence, the very stability of Marketplace offerings on the Exchange for both members and carriers depend on the existence and continuation of the CSRs.

As you know, Congress and the new Administration in Washington DC are threatening to cease and/or reduce CSR funding – a renegeing on a fundamental commitment upon which carriers and members entered the Exchanges. The uncertainty generated by these threats has already caused a number of carriers to withdraw from the Exchanges, including in Washington State. Molina does not want to withdraw from the Exchange in Washington State; however, if the Federal government’s full CSR funding commitments are in jeopardy, we believe that the viability of the Exchange market is in immediate jeopardy of failing. That risk, if not remedied by Congress or the Administration in advance of June 7 (the Washington State 2018 filing deadline), will present a major challenge for Molina to financially sustain the costs or risks associated with the ensuing instability of the Exchange Marketplaces. This uncertainty, coupled with any further undermining of the individual mandate, which ensures that insurance pools continue to include younger and healthier people along with those with high healthcare needs, places the Washington Exchange market in general - and Molina’s participation in specific - in serious jeopardy.

To date, Molina’s commitment to offering insurance coverage on the Washington Health Benefit Exchange has been unwavering. We expanded, not contracted, the number of counties we served in 2017, and offered some of the lowest average cost increases to consumers in comparison to other carriers in both 2016 and 2017. We wish to continue our commitment to Washingtonians who select the Exchange for their health coverage. However, to do so, we need the Federal Government to keep its commitment to continue and fully fund the promised CSR payments from May 1 through December 31, 2017, and we need an equally firm commitment that the CSRs will be fully funded throughout the entirety of calendar year 2018. Without those commitments, Molina will have to very seriously consider its ability to remain on the Exchange. We continue to intend to make good on our commitments as long as the Federal Government makes good on theirs. We appreciate your ongoing leadership and support in seeing that Washington State Health Benefit Exchange and the individual insurance market remain stable, viable and accessible to the hundreds of thousands of Washingtonians who now look to the Washington Health Benefit Exchange for their healthcare coverage.

Please do not hesitate to contact me if you desire additional information or wish to discuss further.

Sincerely,



Peter Adler
President, Molina Healthcare of Washington

CC: Joseph White, Interim CEO, Molina Healthcare, Inc.