IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF TEXAS
FORT WORTH DIVISION

TEXAS, WISCONSIN, ALABAMA, ARKANSAS, ARIZONA, FLORIDA, GEORGIA, INDIANA, KANSAS, LOUISIANA, PAUL LePAGE, Governor of Maine, MISSISSIPPI, by and through Governor Phil Bryant, MISSOURI, NEBRASKA, NORTH DAKOTA, SOUTH CAROLINA, SOUTH DAKOTA, TENNESSEE, UTAH, and WEST VIRGINIA, Plaintiffs, v. UNITED STATES OF AMERICA, UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, ALEX AZAR, in his Official Capacity as SECRETARY OF HEALTH AND HUMAN SERVICES, UNITED STATES INTERNAL REVENUE SERVICE, and DAVID J. KAUTTER, in his Official Capacity as Acting COMMISSIONER OF INTERNAL REVENUE, Defendants.	Civil Action No. 4:18-cv-00167-O
CALIFORNIA, CONNECTICUT, DISTRICT OF COLUMBIA, DELAWARE, HAWAII, ILLINOIS, KENTUCKY, MASSACHUSETTS, MINNESOTA, NEW JERSEY, NEW YORK, NORTH CAROLINA, OREGON, RHODE ISLAND, VERMONT, VIRGINIA, and WASHINGTON, [Proposed] Intervenors-Defendants.	

MOTION TO INTERVENE AND MEMORANDUM IN SUPPORT THEREOF

The Intervenor States respectfully move pursuant to Federal Rule of Civil Procedure 24 to intervene as defendants in this action. Intervention as of right is warranted because the States' interests in preserving the Patient Protection and Affordable Care Act diverge from and will not be adequately represented by the federal defendants, and those interests will be gravely impaired if these States are not permitted to intervene. Fed. R. Civ.

P. 24(a)(2). Alternatively, the Intervenor States move for permissive intervention on similar grounds. Fed. R. Civ. P. 24(b).

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INTRODUCTION

The plaintiff States seek to eliminate the Patient Protection and Affordable Care Act (ACA), a remedy that would dismantle the nation's healthcare system, harm millions of people, and deprive the Intervenor States of hundreds of billions of dollars that they use to provide healthcare and coverage to their residents.[1] As recipients of this federal funding, and as the governmental entities responsible for administering health insurance programs dependent on ACA funding, the Intervenor States each have their own interests in protecting their states' unique healthcare infrastructures. Each Intervenor State has committed significant state funds and resources to implement the ACA. And each Intervenor State has an interest in the health and well-being of its citizens, who would be gravely harmed by the loss of the ACA. Therefore, the Intervenor States ask this Court to grant their motion to intervene as of right, or alternatively for permissive intervention, and allow them to participate as defendants to protect their own distinct fiscal, economic, sovereign, and quasi-sovereign interests in this litigation.

BACKGROUND

A. The ACA Is Central to America's Healthcare System

In 2010, Congress enacted the ACA to "increase the number of Americans covered by health insurance and decrease the cost of healthcare." *Nat'l Fed'n of Indep. Bus. v. Sebelius*, 567 U.S. 519, 538 (2012) (*NFIB*). The ACA has delivered on these promises by strengthening consumer protections in private insurance; making the individual insurance market accessible and affordable; expanding and improving the Medicaid program; modifying Medicare's payment systems while filling in benefit gaps; increasing funding and prioritization of prevention and public health; and supporting infrastructure such as community health centers, the National Health Service Corps, and the Indian Health Service. *See generally* Declaration of Henry J.

[1] The District of Columbia, which is a municipal corporation empowered to sue and be sued, and is the local government for the territory constituting the permanent seat of the federal government of the United States, shall be included herein as a "State" for ease of reference.

Aaron (Aaron Dec.) ¶¶ 4-41, Appx. 002-058; *see also* Declaration of Frederick Isasi (Isasi Dec.) ¶ 16, ID Appx. 107-108. As a result of these and other reforms adopted by the ACA, an additional 20 million people across the United States now have access to health coverage, representing a 43 percent drop in the uninsured rate. Aaron Dec. ¶ 5, Appx. 003; *see also* Declaration of Benjamin Barnes (Barnes Dec.) ¶ 4, Appx. 062-063; Declaration of Alfred J. Gobeille (Gobeille Dec.) ¶ 4, Appx. 095-096; Declaration of Jennifer Kent (Kent Dec.) ¶ 2, Appx. 112-113; Declaration of Dr. Jennifer Lee (Lee Dec.) ¶ 4, Appx. 120-121; Declaration of Judy Mohr Peterson (Peterson Dec.) ¶ 4, Appx. 132-133; Declaration of Thea Mounts (Mounts Dec.) ¶¶ 6, 8, Appx. 136-137; Declaration of Claudia Schlosberg (Scholsberg Dec.) ¶ 4, Appx. 143-144; Declaration of Zachary Sherman (Sherman Dec.) ¶ 3, Appx. 155-156; Declaration of Kara Odom Walker (Walker Dec.) ¶ 4, Appx. 163; Declaration of Dr. Howard Zucker (Zucker Dec. ¶ 5), Appx. 170-172. The ACA has lowered hospitals' uncompensated care by $10.4 billion in 2015 alone; and in States that expanded Medicaid, uncompensated care costs dropped by around half. Aaron Dec. ¶ 10, Appx. 006; Declaration of Matthew David Eyles (Eyles Dec.) ¶ 9, Appx. 090-091. Consequently, States have realized substantial budget savings. Aaron Dec. ¶¶ 11, 25, Appx. 006-007, 015-016; Isasi Dec. ¶ 14, Appx. 106-107; Mounts Dec. ¶¶ 13-16, Appx. 137-138; Barnes Dec. ¶ 5, Appx. 063-064; Gobeille Dec. ¶ 5, Appx. 096; Walker Dec. ¶ 5, Appx. 164; Declaration of Dr. John Jay Shannon (Shannon Dec.) ¶ 7, Appx. 151-152; Schlosberg Dec. ¶ 5, Appx. 144-145.

In addition to increasing access to healthcare, many of the ACA's reforms also address quality of care. ACA policies have improved care coordination, payment system efficiency, overall medical care quality, and consumer protections, leading to better overall health. Aaron Dec. ¶ 12, Appx. 007; Isasi Dec. ¶¶ 4, 17, Appx. 100-101, 108-109; Mounts Dec. ¶¶ 17-29, Appx. 138-140; Eyles Dec. ¶ 8, Appx. 89. The ACA's "guaranteed-issue" and "community-rating" provisions give peace of mind to the 133 million Americans with a pre-existing health condition, including the parents of 17 million children with such conditions, and has increased and improved healthcare access for women, young adults, veterans, and persons with disabilities.

Aaron Dec. ¶¶ 13-16, 26, Appx. 008-010, 016; Isasi Dec. ¶¶ 4-5, 12, 15, Appx. 100-103, 105, 107; Declaration of Peter Berns (Berns Dec.) ¶¶ 3-6, Appx. 072-075.[2]

The States are directly involved in implementing many of the ACA's reforms—particularly its expansion of affordable health coverage to lower-income residents. Aaron Dec. ¶¶ 21-26, Appx. 013-016; Declaration of Sharon Boyle (Boyle Dec.) ¶¶ 4, 6, Appx. 077. The ACA expanded Medicaid, which the States administer, making additional segments of the population eligible to receive benefits. *See* 42 U.S.C. §§ 1396a(a)(10)(A)(i)(VIII), 1396a(e)(14)(I)(i) (childless adults with incomes of up to 138% of the federal poverty level may receive Medicaid). And it obligates the federal government to pay the States for at least 90% of the cost of this expansion. *See* 42 U.S.C. § 1396d(y)(1). To date, thirty-three states have chosen to expand Medicaid coverage under the ACA. Isasi Dec. ¶ 7, Appx. 103-104; Aaron Dec. ¶¶ 21-22, Appx. 013-014.[3] Nationwide, over 11.8 million newly qualified low-income individuals were receiving health coverage through Medicaid at the end of 2016 in these expansion States, and the proportion of adults without insurance in those States dropped by 9.2 percentage points between 2014 and 2016. Isasi Dec. ¶¶ 7-8, Appx. 103-104. Medicaid expansion enrollment is 3,700,000 in California, 240,000 in Connecticut, 11,000 in Delaware, 16,000 in the District of Columbia, 33,000 in Hawaii, 340,000 in Illinois, 151,000 in Kentucky, 350,000 in

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[2] "Guaranteed-issue" and "community-rating" are provisions of the ACA that work together to bar insurers from denying coverage because of a person's medical history and from charging individuals with medical conditions higher premiums than healthy individuals. *See NFIB*, 567 U.S. at 547-548.

[3] Of the 33 jurisdictions that expanded Medicaid through the ACA, 7 are plaintiffs in this litigation and represent 1,282,554 expansion enrollees, including: Arizona (109,723 expansion enrollees); Arkansas (316,483); Indiana (278,610); Louisiana (376,668); North Dakota (19,965); and West Virginia (181,105). Maine, the seventh plaintiff state, adopted Medicaid expansion through a ballot initiative in November 2017 but has not yet implemented it. The remaining 26 expansion states are: Alaska, California, Colorado, Connecticut, Delaware, Hawaii, Illinois, Iowa, Kentucky, Maryland, Massachusetts, Michigan, Minnesota, Montana, Nevada, New Hampshire, New Jersey, New Mexico, New York, Ohio, Oregon, Pennsylvania, Rhode Island, Vermont, Washington, and the District of Columbia. Eyles Dec. ¶ 6.

Massachusetts, 194,000 in New Jersey, 301,721 in New York, 313,000 in North Carolina, 159,000 in Oregon, 77,846 in Rhode Island, 3,000 in Vermont, 55,000 in Washington, and is projected to be 179,000 in Virginia if the state enacts an expansion. Aaron Dec. ¶¶ 71, 85, 92, 106, 121, 127, 141, 148, 155, Appx. 033, 037, 039, 043, 047, 049, 053, 055, 057; Kent Dec. ¶ 2, Appx. 112-113; Barnes Dec. ¶ 4, Appx. 062-063; Walker Dec. ¶ 4, Appx. 163; Peterson Dec. ¶ 4, Appx. 132-133; Boyle Dec. ¶ 6, Appx. 077; Zucker Dec. ¶ 5, Appx. 170-172; Sherman Dec. ¶ 3, Appx. 155-156.

Both the federal and State governments have invested substantial monetary resources into Medicaid expansion.[4] The Medicaid expansion has led to documented savings for people, States, and the overall healthcare system. Aaron Dec. ¶ 25, Appx. 015-016; Isasi Dec. ¶ 14, Appx. 106-107.

The ACA also provides opportunities for States to participate in new and expanded programs that increase access to better-coordinated and high-quality care for low-income seniors and people with disabilities, reduce healthcare spending, and improve community health. *See* Aaron Dec. ¶¶ 26, 27, 39, Appx. 016-017, 021-022; Isasi Dec. ¶ 15, Appx. 107; Berns Dec. ¶¶ 5-6, Appx. 074-075; Sherman Dec. ¶ 4, Appx. 156; Schlosberg Dec. ¶¶ 3, 6-7, Appx. 142, 145-147; Peterson Dec. ¶¶ 5-6, Appx. 133-134; Lee Dec. ¶ 5, Appx. 121; Gobeille Dec. ¶ 6, Appx. 096-097; Barnes Dec. ¶¶ 6-7, Appx. 064-067; Zucker Dec. ¶ 4, 169-170; Walker Dec ¶ 6, Appx. 164; Mounts Dec. ¶ 5, Appx. 136.[5]

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[4] For example, in fiscal year 2015, the federal government spent $68.8 billion and States spent $4.28 billion to provide Medicaid coverage to the expansion population. Kaiser Family Foundation, "Medicaid Expansion Spending," FY 2015, https://www.kff.org/medicaid/state-indicator/medicaid-expansion-spending. Spending in FY 2015 does not take into full account those states that expanded Medicaid after October 1, 2014, including Pennsylvania (expanded January 1, 2015), Indiana (expanded February 1, 2015), Alaska (expanded September 1, 2015), Montana (expanded January 1, 2016), and Louisiana (expanded July 1, 2016). Over the same timeframe, based on the federal government's promise to pay the bulk of the costs at a 90/10 match rate, States invested over $4.2 billion to expand their Medicaid programs. *Id.*

[5] *See also* https://www.aarp.org/politics-society/advocacy/aarp-fights-for-your-health/.

The ACA also authorized creation of government-sponsored health insurance marketplaces (also known as exchanges) that allow consumers "to compare and purchase insurance plans." *King v. Burwell*, 576 U.S. __, 135 S.Ct. 2480, 2485 (2015); *see also* Aaron Dec. ¶¶ 17-20, Appx. 010-013. The ACA provides subsidies to individuals between 100 and 400 percent of the federal poverty line to purchase healthcare, but those subsidies can only be used in the marketplaces. *King*, 135 S. Ct. at 2487. The ACA affords each State the choice to establish its own exchange, while providing that the federal government will establish one if the State opts out. *Id*. at 2485. The States play a critical role in delivering plans offered through the exchanges. As of 2018, twelve States (including Intervenor States California, Connecticut, District of Columbia, Massachusetts, New York, Rhode Island, Vermont, and Washington) had established and are currently running their own exchanges (state-based exchanges), twenty-eight States used the federal government's website, HealthCare.Gov (federally-facilitated exchanges), and eleven States run exchanges in partnership with the Department of Health and Human Services (partnership exchanges). Aaron Dec. ¶ 17. Among other responsibilities, the States approve premium rates and review the plans offered on their exchanges to ensure that the cost and quality of the plans' health benefits are reasonable and compliant with the minimum requirements of both state and federal law. *See* 42 U.S.C. §§ 300gg-94(a)(1), 18031(b)-(e); 45 C.F.R. §§ 154.200-154.230, 154.301, 155.1000-155.1010, 156.20, 156.200. Nationally, 10.3 million people obtained health coverage through these exchanges in 2017, and 84 percent of this group—over 8 million people—receive ACA-funded subsidies (also known as premium tax credits) to help them pay for insurance premiums. Aaron Dec. ¶ 18, Isasi Dec. ¶ 6. Marketplace enrollment is 1,389,886 in California, 98,260 in Connecticut, 24,171 in Delaware, 17,808 in the District of Columbia, 16,711 in Hawaii, 673,000 in Illinois, 71,585 in Kentucky, 242,221 in Massachusetts, 243,743 in New Jersey, 207,083 in New York, 450,822 in North Carolina, 137,305 in Oregon, 29,065 in Rhode Island, 29,088 in Vermont, 410,726 in Virginia, and 184,070 in Washington. Aaron Dec. ¶¶ 49, 56, 63, 91, 98, 105, 112, 119, 126, 133, 140, 154;

Declaration of Mila Kofman (Kofman Dec.) ¶ 3; Peterson Dec. ¶ 4; Declaration of Chris Maley (Maley Dec.) ¶ 7; Lee Dec. ¶ 4.

B. Preservation of the ACA is Necessary to Prevent Grievous Harm to the States and Their Residents

Eliminating the ACA would cause immediate and long-term harm to the Intervenor States and to their residents' health and financial security, to state healthcare systems, and to state budgets. Aaron Dec. ¶¶ 42-46; Isasi Dec. ¶ 18; Eyles Dec. ¶ 12. The law is so interwoven into the U.S. health system that its elimination would even damage Medicare and other programs that pre-date the ACA. Aaron Dec. ¶¶ 42-43. Millions of Americans would lose their insurance coverage. *Id*. ¶ 44. That loss in turn would lead to downstream costs to state-funded hospitals, which must provide emergency care regardless of a patient's insurance status or ability to pay. 42 U.S.C. § 1395dd. Thus, the impact on the Intervenor States would be profound and widespread. Aaron Dec. ¶¶ 47-172. Most directly, the States themselves would lose over half a trillion dollars of anticipated federal funds used to provide health care to their residents, including:

- California $160.2 billion (Aaron Dec. ¶ 53),
- Connecticut $14.8 billion (*Id*. ¶ 60),
- Delaware $3.6 billion (*Id*. ¶ 67),
- District of Columbia $1.7 billion (*Id*. ¶ 74),
- Hawaii $4.3 billion (*Id*. ¶ 81),
- Illinois $49.9 billion (*Id*. ¶ 88),
- Kentucky $ 49.7 billion (*Id*. ¶ 95),
- Massachusetts $22.5 billion (*Id*. ¶ 102),
- New Jersey $59.7 billion (*Id*. ¶ 109),
- New York $57.2 billion (*Id*. ¶ 116),
- North Carolina $59.0 billion (*Id*. ¶ 123),

- Oregon $38.4 billion (*Id*. ¶ 130),
- Rhode Island $7.4 billion (*Id*. ¶ 137),
- Vermont $2.9 billion (*Id*. ¶ 144),
- Virginia $18 billion (*Id*. ¶ 151), and
- Washington $42.8 billion (*Id*. ¶ 158).

Moreover, without the ACA, individuals will face devastating losses in healthcare, security, and financial stability. Isasi Dec. ¶ 5; Eyles Dec. ¶ 8; *see also e.g.* Mounts Dec. ¶ 27; Sherman Dec. ¶ 5 (2016 Rhode Island Health Insurance Survey showed a decrease from 2012 in respondents reporting difficulties in paying medical bills.); Schlosberg Dec. ¶ 5 Zucker Dec. ¶ 6. For example, an individual in Illinois predicted she and her spouse would have to forgo medically necessary—but very expensive—medicine without the coverage provided by the ACA. Isasi Dec. ¶ 5(b). And millions of people with pre-existing conditions may not be able to continue receiving insurance coverage. *Id*. at ¶ 5(c), (d), (e); *see also* Berns Dec. ¶ 4. Essential health benefits of ACA-compliant insurance guarantee coverage for mental health care. Declaration of Ryan Smith ¶ 2; Berns Dec. ¶ 4; Aaron Dec. ¶ 12. Additionally, children born with conditions such as heart defects and diabetes would lose guaranteed access to coverage and care. Declaration of Angela Eilers ¶¶ 3-4; Declaration of Kim Lufkin ¶¶ 4-5. People with intellectual and developmental disabilities would lose crucial protections from lifetime and annual limits, which are especially important to a population that often experiences complicated and lifelong medical needs. Berns Dec. ¶ 4. The ACA has allowed individuals to continue to run small businesses without worrying about insurance costs. Declaration of Sherry White ¶ 7. Finally, the Medicaid expansion has allowed parents to care for seriously ill children without the threat of losing coverage in the case of a lost job. Declaration of Margaret Chism ¶¶ 5-8.

C. The Courts Have Repeatedly Rejected Attempts to Strike Down the ACA

Since its adoption, the ACA has been the subject of intense litigation, including review by the United States Supreme Court twice. *NFIB*, 567 U.S. at 540-43; *King*, 135 S.Ct. 2480 (upholding ACA authorization of tax credits for purchases on federal health exchange). But courts have routinely rejected claims that would have gutted its key reforms. In the landmark *NFIB* decision, the Supreme Court upheld the constitutionality of the individual mandate—a requirement that certain people pay a penalty for not obtaining health insurance. *Id*. at 574-75. The Court concluded that Congress had the power to impose a tax on those without health insurance, and had exercised that power in enacting the ACA. *Id*. Since *NFIB*, numerous litigants have attempted to undermine the ACA's core provisions, but time and again, courts have rebuffed those efforts, avoiding a "calamitous result." *King*, 135 S. Ct. at 2496 (rejecting interpretation of ACA that would have "destroy[ed]" the health insurance markets created by the ACA); *see also e.g. Sissel v. U.S. Dep't of Health & Human Servs.*, 760 F.3d 1, 3 (D.C. Cir. 2014), *cert. denied* 136 S. Ct. 925 (2016) (rejecting claim that ACA violated the Constitution's Origination Clause); *Coons v. Lew*, 762 F.3d 891, 902 (9th Cir. 2014), as amended, (Sept. 2, 2014), *cert. denied*, __ U.S. ___, 135 S. Ct. 1699 (2015) (ACA preempted Arizona law that allowed citizens to avoid minimum health insurance and abstain from paying mandate penalties); *Oklahoma ex rel. Pruitt v. Sebelius*, 2013 U.S. Dist. LEXIS 113232, 2013 WL 4052610, **27-30 (State lacked standing to seek a declaratory judgment that a state constitutional provision declaring an individual right for state residents not to be compelled to participate in certain conduct remained valid as a protection against mandated purchases of health insurance).

D. Congress Chose Not to Repeal the ACA and Instead Maintained It as Federal Law

The ACA has also been the subject of passionate political debate. Since its passage in 2010, Congress has attempted to repeal the law in its entirety an estimated 70 times, yet all such efforts have failed. *See, e.g*., H.R. 3762, 114th Cong. (2015), H.R. 45, 113th Cong. (2013), H.R.

6079, 112th Cong. (2012).[6] Indeed, in the past year alone, Congress attempted to "repeal and replace" the ACA at least three separate times, including rejecting a so-called "skinny repeal" that would have repealed substantial portions of the ACA. H.R. 1628, 115th Cong. (2017).

In December 2017, as part of an overall revision to federal income tax laws, Congress amended the tax code by reducing the tax penalty for individuals failing to demonstrate health insurance coverage, which is based on a percentage of the taxpayer's household income, from "2.5%" to "zero percent," and the applicable dollar penalty from "$695" to "$0." *See* PL 115-97, 2017 HR 1, at *2092 (Dec. 22, 2017) ("Tax Cuts and Jobs Act"). This change, effective in 2019, did not repeal any statutory provision of the ACA. *Id*. Yet, plaintiffs rely on this change to ask this Court to strike down the entire ACA.

E. The Plaintiff States File This Action, and Ask this Court to Strike Down the ACA "In Whole"

Approximately two months after the President signed the Tax Cuts and Jobs Act, the plaintiff States filed this action. ECF No. 1. They claim that because that law made the tax penalty for failing to purchase health insurance $0, the ACA's individual mandate is no longer constitutional under *NFIB*. They further assert that the individual mandate is not severable from the rest of the ACA, and ask this Court to invalidate the Act "in whole." Comp. ¶ 49. In the alternative, they ask this Court to strike down the ACA's "guaranteed issue" and "community-rating" provisions. Comp. ¶ 50.

ARGUMENT

I. THE INTERVENOR STATES ARE ENTITLED TO INTERVENE AS A MATTER OF RIGHT UNDER RULE 24(A)(2)

A party is entitled to intervene as a matter of right if: (1) its motion is timely; (2) it has an interest "relating to the property or transaction which is the subject of the action;" (3) the outcome of the action may, "as a practical matter, impair or impede his ability to protect that

[6] For a list of efforts, see Congressional Research Service, "Legislative Actions in the 112th, 113th, and 114th Congresses to Repeal, Defund, or Delay the Affordable Care Act," February 7, 2017, https://fas.org/sgp/crs/misc/R43289.pdf.

interest;" and (4) the existing parties cannot adequately represent that interest. *Wal-Mart Stores, Inc. v. Texas Alcoholic Beverage Commission*, 834 F.3d 562, 565 (5th Cir. 2016). This test applies whether a party seeks to intervene as a plaintiff or a defendant. *See Texas v. United States*, 805 F.3d 653, 657 (5th Cir. 2015).

Rule 24 is "liberally construed" in favor of intervention. *Brumfield v. Dodd*, 749 F.3d 339, 341 (5th Cir. 2014). "[D]oubts [are] resolved in favor of the proposed intervenor." *In re Lease Oil Antitrust Litig.*, 570 F.3d 244, 248 (5th Cir. 2009). Intervention as a matter of right "must be measured by a practical rather than a technical yardstick," and the inquiry is a "flexible one" focused on the "particular facts and circumstances" of each case. *Edwards v. City of Houston*, 78 F.3d 983, 999 (5th Cir. 1996) (en banc). "Federal courts should allow intervention where no one would be hurt and the greater justice could be obtained." *Texas*, 805 F.3d at 657; *Sierra Club v. Espy*, 18 F.3d 1202, 1206 (5th Cir. 1994) (same).

The Intervenor States satisfy all four requirements.

A. The Intervenor States' Motion Is Timely Because It Was Filed Six Weeks After this Action Was Initiated, Long Before Any Prejudice or Unusual Circumstances Could Arise

A court considers four factors when evaluating whether a motion to intervene is timely: (1) the length of time the applicants knew or should have known of their interest in the case; (2) prejudice to existing parties caused by the applicant's delay; (3) prejudice to the applicant if the motion is denied; and (4) any unusual circumstances. *Stallworth v. Monsanto Co.*, 558 F.2d 257, 264-66 (5th Cir. 1977). Each of these factors demonstrates that the Intervenor States' motion is timely under the circumstances of this case.

The first inquiry is contextual, as "absolute measures of timeliness should be ignored." *Espy*, 18 F.3d at 1205. The clock begins to run when the applicants knew or reasonably should have known of their interests, or from the time they became aware that their interests would no longer be protected by the existing parties to the lawsuit. *Edwards*, 78 F.3d at 1000; *Espy*, 18 F.3d at 1206. This motion was filed just six weeks after the plaintiff States filed their Complaint.

The Fifth Circuit has found motions to intervene to be timely even when filed at substantially later points in litigation. *Wal-Mart*, 834 F.3d at 565-566 (intervention motion timely after denial of motion to dismiss, three months after answer was filed, and "before discovery progressed"); *John Doe No. 1 v. Glickman*, 256 F.3d 371, 377 (5th Cir. 2001) (application timely when filed one month after the applicant's stake materialized—when the applicant learned the central issue would not be decided in a stayed action, but in a related action filed eight months earlier); *Association of Professional Flight Attendants v. Gibbs*, 804 F.2d 318, 320-21 (5th Cir. 1986) (finding a five-month delay reasonable when all *Stallworth* factors considered).

Nor do any of the other *Stallworth* factors weigh against the Intervenor States. Prejudice to the existing parties is measured by any delay in seeking intervention (of which there is none), not based on the inconvenience of permitting the intervenor to participate in the litigation. *Espy*, 18 F.3d at 1206. This action has not advanced to a stage where any existing party would be prejudiced. Also, no unusual circumstances weigh against a finding of timeliness.

On the other hand, for the reasons described below, the Intervenor States would be gravely prejudiced if not permitted to intervene to advocate in favor of the constitutionality of the ACA and its vital impact on the public fisc of their respective states. Courts should permit intervention "where no one would be hurt and the greater justice could be attained." *Espy*, 18 F.3d at 1205. The motion clearly satisfies Rule 24(a)(2)'s timeliness requirement.

B. The Intervenor States Have Direct, Substantial, and Legally Protectable Interests That May Be Impaired by this Litigation

The Intervenor States also satisfy Rule 24's requirement that intervenors must have a "'direct, substantial, legally protectable interest in the proceedings.'" *Texas*, 805 F.3d at 657 (quoting *Edward*, 78 F3d. at 1004). This requires a movant to show that it has a "stake in the matter" beyond a "generalized preference that the case come out a certain way." *Id.* Property or pecuniary interests are the "most elementary type[s] of right[s]" protected by Rule 24(a) and "are almost always adequate." *Id.* at 658. Rule 24(a) also safeguards less tangible interests, however, such as a right to vote. *See League of United Latin American Citizens, District 19 v. City of*

Boerne, 659 F.3d 421, 434 (5th Cir. 2011); *see also City of Houston v. American Traffic Solutions, Inc.*, 668 F.3d 291, 294 (5th Cir. 2012) (finding sufficient the interests that the sponsors of a city charter amendment have in "cementing their electoral victory and defending the charter amendment itself.").

The Intervenor States meet this test. The plaintiff States ask this Court to invalidate the ACA "in whole." Compl. ¶ 49. The Intervenor States have a direct, pecuniary interest in ensuring that that does not happen, and the combined loss of more than $650 billion is a sufficiently adequate injury to establish that they have an interest in this litigation. *See, e.g.*, *Wal-Mart*, 834 F.3d at 568 ("[W]e have continued to hold that economic interests can justify intervention when they are directly related to the litigation."). The possibility that the numerous ACA funding streams could be lost demonstrates that the Intervenor States have a "concrete, personalized, and legally protectable interest" in this litigation. *Texas*, 805 F.3d at 658. Moreover, the Intervenor States have invested substantial time and energy towards altering their public health infrastructure to align with the ACA's requirements, and the loss of the ACA would destroy the foundation on which this new infrastructure was built, impede state-level legislative and administrative decision-making, and cause enormous disruption to health care insurers, providers, and consumers throughout the States.

1. A decision striking down the ACA would deprive the States of hundreds of billions of dollars

A ruling declaring the ACA unconstitutional would immediately stop the flow of federal funding to the States, much to their detriment. Aaron Dec. ¶ 25, Appx. 015-016; Isasi Dec. ¶¶ 14, 18, Appx. 106-107, 109. The ACA directs hundreds of billions of dollars to the Intervenor States for a wide range of important programs, including:

- $592.1 billion to operate Marketplaces and expand their Medicaid programs. Aaron Dec. ¶¶ 25, 53, 60, 67, 74, 81, 88, 95, 102, 109, 116, 123, 130, 137, 144, 151, 158, Appx. 015-016, 027-028, 030, 031-032, 034, 036, 037-038, 039-040, 041-042, 043-044, 046, 048, 050, 052, 054, 056, 058; *see also* Boyle Dec. ¶ 6,

Appx. 077; Barnes Dec. ¶ 3, Appx. 060-062; Gobeille Dec. ¶ 3, Appx. 095; Kent Dec. ¶ 3, Appx. 113; Peterson Dec. ¶ 3, Appx. 132; Schlosberg Dec. ¶ 3, Appx. 142.

- $3.9 billion since 2010 to spend on programs funded by the Prevention and Public Health Fund ($650 million for fiscal year 2017). Aaron Dec. ¶ 34, Appx. 020; *see also* Peterson Dec. ¶ 3, Appx. 132; Lee Dec. ¶ 3, Appx. 120; Gobeille Dec. ¶ 3, Appx. 095; Barnes Dec. ¶ 3, Appx. 060-062; Schlosberg Dec. ¶ 3, Appx. 142; Zucker Dec. ¶ 4, Appx. 169-170.[7] Through the Prevention Fund, the Centers for Disease Control and Prevention (CDC) provided over $620 million in grants to States in fiscal year 2016 for preventive health goals including immunization, prevention of lead poisoning, and preventing infectious diseases. Aaron Dec. ¶¶ 35-37, Appx. 020-021; Zucker Dec. ¶ 9, Appx. 177-178 (New York has also used the Fund for prevention of tobacco use, to enhance water quality, and for rape crisis and sexual violence prevention).[8] The Fund has been critical in expanding and sustaining the capacity of state and local health departments to meet the needs of their communities, in particular through annual funding of the Preventive Health and Health Services Block Grant ($160 million a year) and Epidemiology and Laboratory Grants ($40 million a year). Aaron Dec. ¶ 37, Appx. 021. The two grants combined have put over $1.1 billion into communities in fiscal years 2010 through 2017. *Id*. In addition, the Fund helps provide funding for the Elder Justice Act—ACA provision that authorized efforts aimed at preventing, detecting, and treating elder abuse. 42 U.S.C. § 1397j-1.

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[7] Created by the ACA, this Fund allocates $2 billion each year to "provide for expanded and sustained national investment in prevention and public health programs" that improve health and restrain healthcare costs. 42 U.S.C. § 300u-11(a), (b)(6).

[8] Department of Health & Human Services, Office of the Actuary, Centers for Medicare & Medicaid Services, "2016 Actuarial Report on the Financial Outlook for Medicaid," p. 65, https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/ActuarialStudies/Downloads/MedicaidReport2016.pdf.

- Substantial funding for other optional Medicaid improvements, such as the Community First Choice Option, a program created by the ACA that has allowed some of the Intervenor States to provide better home and community-based attendant services for persons with disabilities. 42 U.S.C. §1396n(k); Aaron Dec. ¶ 26, Appx. 016; Zucker Dec. ¶ 4, Appx. 169-170. In fiscal year 2015 alone, the federal government paid $617 million for care through the on-going Community First Choice program, and States paid $436 million.[9]
- $1.5 billion invested in the Maternal, Infant, and Early Childhood Home Visiting Grants to support state-level expansion of the Nurse-Family Partnership. Aaron Dec. ¶ 38, Appx. 021; Lee Dec. ¶ 3, Appx. 120. This program has had a dramatic impact on medical care, child welfare, special education, and criminal justice system involvement by the families served by the program, with a savings to government programs of 1.9 times the cost. *Id*.
- $3.5 billion (New York) to the two States that chose to establish Basic Health Programs (BHPs)—New York and Minnesota. Zucker Dec. ¶ 5, Appx. 170-172. Under the ACA, States can choose to operate these programs, which provide alternative health coverage options to certain low-income individuals. *See* 42 U.S.C. § 18051.[10]
- The ACA expanded the Money Follows the Person program, 42 U.S.C. § 1396a, giving adults with disabilities more of their personal care. Isasi Dec. ¶ 15, Appx. 107. Through this program, States receive federal financial assistance to move elderly nursing home residents out of nursing homes and back into their own homes or into the homes of their loved ones. *See* Sherman Dec. ¶ 4, Appx. 156;

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[9] Centers for Disease Control and Prevention, "Accomplishing CDC's Mission with Investments from the Prevention & Public Health Fund, FY 2010-FY 2016," https://www.cdc.gov/funding/documents/CDC-PPHF-Funding-Impact.pdf.

[10] *See also* Medicaid.gov, *Basic Health Program*, https://www.medicaid.gov/basic-health-program/index.html (last visited May 17, 2017).

Gobeille Dec. ¶ 6, Appx. 096-097; Barnes Dec. ¶ 3, Appx. 060-062; Lee Dec. ¶ 5, Appx. 121; Peterson Dec. ¶ 5, Appx. 133; Schlosberg Dec. ¶ 6, Appx. 145-146; Zucker Dec. ¶ 4, Appx. 169-170. This grant allowed Rhode Island, for example, to expand its program to assist individuals in managing their care outside of a nursing home, thus decreasing institutional care costs. Sherman Dec. ¶ 4, Appx. 156.

2. A decision striking down the ACA would likely require increased State spending on healthcare for the uninsured

The Intervenor States also have a concrete and particularized interest in ensuring that their residents are not stripped of the high-quality, affordable health insurance guaranteed by the ACA. The ability of individuals to obtain quality, affordable health insurance through the ACA has conferred meaningful and tangible benefits on the Intervenor States, over and above the benefits to their residents. Both state and federal law require state-funded hospitals to provide emergency care, regardless of a patient's insurance status or ability to pay. 42 U.S.C. § 1395dd; *see also*, *e.g.*, Cal. Welf. & Inst. Code §§ 17000, 17600; N.Y. Public Health Law § 2807-k. When the uninsured rate goes down, so too does state spending on healthcare—as demonstrated by the Intervenor States' experiences under the ACA. Aaron Dec. ¶ 44, Appx. 024. Eighty-four percent of individuals enrolled in the marketplaces receive subsidies that make purchase of health insurance affordable for them. Isasi Dec. ¶ 6, Appx. 103. If these individuals were to lose their subsidies because of the elimination of the ACA, many, if not most, would no longer be able to afford to purchase insurance on the individual market, and would subsequently again seek uncompensated care, driving up the States' costs. Aaron Dec. ¶¶ 49, 53 (California), 56, 60 (Connecticut), 63, 67 (Delaware), 70, 74 (District of Columbia), 77, 81 (Hawaii), 84, 88 (Illinois), 91, 95 (Kentucky), 98, 102 (Massachusetts), 105, 109 (New Jersey), 112, 116 (New

York), 119, 123 (North Carolina), 126, 130 (Oregon), 133, 137 (Rhode Island), 140, 144 (Vermont), 147, 151 (Virginia), 154, 158 (Washington), Appx. 026-058.[11]

3. These interests are legally protectable under Rule 24

Thus, striking the ACA down would cause the Intervenor States to lose direct funding of billions of dollars, reduce the ability of more than 80 percent of consumers to purchase insurance in their marketplaces, undermine the public-health infrastructure that the States have established in reliance on the ACA's continuing operation, and saddle the States with increased uncompensated care costs. The Intervenor States thus have strong, legally protectable interests in this litigation; indeed, they have an actual legal entitlement to funds under the ACA. 42 U.S.C. § 1396d(y)(1) (federal share for Medicaid expansion); 42 U.S.C § 18051(d) (transfer of federal funds to States establishing Basic Health Programs); 42 U.S.C § 18051(d) (Prevention and Public Health Fund); 42 U.S.C. § 18204 (Pregnancy Assistance Fund). These interests are sufficient to meet Rule 24's requirements. *See Wal-Mart*, 834 F.3d at 568; *Espy,* 18 F.3d at 1207 (timber purchasers had a protectable property interest in existing timber contracts thus entitling them to intervene in a lawsuit by the Sierra Club against the U.S. Forest Service to curtail logging practices); *Cascade Natural Gas Corp. v. El Paso Natural Gas Co. et al*., 386 U.S. 129, 132-136 (1967) (error to deny California intervention to contest merger that would stifle competition for natural gas available to Californians); *United States House of Representatives v. Price*, 2017 U.S. App. LEXIS 14178, 2017 WL 3271445 at *7-8 (D.C. Cir. Aug, 1, 2017) (States had legally protectable interest in guaranteeing that residents have healthcare because it would decrease the "number of uninsured individuals form whom the States will have to provide healthcare"). And even without a legal entitlement, the Intervenor States should still be granted

[11] Loss of the ACA also threatens the financial security of the States' residents. Aaron Dec. ¶ 9. One study found consumer concerns "about the cost of health care dropped at a greater rate in two States that expanded Medicaid relative to one that did not." *Id*. Research shows that after the enactment of the ACA, the number of people having trouble paying medical bills dropped by 9.4 million people, while another study found that the amount of debt sent to collection was reduced by over $1,000 per person in areas where Medicaid was expanded compared to States that did not expand. *Id*.

intervention. *See Texas*, 805 F.3d at 661 (allowing intervention where the parties lacked a legal entitlement to agency action, but had an interest in the "opportunity" for such action). Here, like the intervenors in *Texas*, the Intervenor States, and their residents, are among the "intended beneficiaries of the [law] being challenged." *Texas*, 805 F.3d at 660-61. Finally, the Supreme Court has recognized that States have a quasi-sovereign interest in the physical and economic well-being of their residents. *See e.g.*, *Alfred L. Snapp & Son v. Puerto Rico*, 458 U.S. 592, 607-08 (1982), *Massachusetts v. E.P.A*, 549 U.S. 497, 519-20 (2007). The Intervenor States have amply demonstrated the extensive harm to themselves and their residents that would flow from plaintiff States' successful prosecution of this lawsuit.

C. This Suit Will Impair the Intervenor States' Ability to Protect Their Interests in the Proper Functioning of the ACA

It is also beyond dispute that, if plaintiffs were to prevail, the outcome of this suit will "impair or impede" the Intervenor States' ability to protect the interests detailed above. *Wal-Mart*, 834 F.3d at 565. A decision eliminating the ACA "in whole" would abruptly cut off hundreds of billions in federal funds to the Intervenor States.[12] It would devastate their insurance marketplaces and harm millions of their residents. It would increase the number of people without insurance, which would force the States to expend funds when the uninsured seek care at state-run facilities.

The Intervenor States should not be forced to "wait on the sidelines" while a court decides issues "contrary to their interests." *Brumfield*, 749 F.3d at 344-45. Rather, the "very purpose of intervention is to allow interested parties to air their views so that a court may consider them *before* making potentially adverse decisions." *Id*. at 345 (emphasis added). Indeed, the mere "'*stare decisis* effects of the district court's judgment'" sufficiently impairs the Intervenor States' interests to allow them to intervene now. *Espy*, 18 F.3d at 1207; *see also Fund*

[12] For example, under Illinois law, if the federal Medicaid matching rate falls below 90%, coverage for persons eligible through the Medicaid expansion will cease within three months. Shannon Dec. ¶ 8; Declaration of Chris Maley (Maley Dec.) ¶ 5.

for Animals, Inc. v. Norton, 322 F.3d 728, 735 (D.C. Cir. 2003) (even if intervenors "could reverse an unfavorable ruling by bringing a separate lawsuit, there is no question that the task of reestablishing the status quo if [the plaintiffs] succeed … will be difficult and burdensome").

D. Neither the Plaintiff States nor the Federal Defendants Adequately Represent the Intervenor States' Interests

Finally, no current party adequately represents the Intervenor States' interests. This requirement is "minimal," and is satisfied upon a showing that representation of the intervenors' interests "may be inadequate." *Edwards*, 78 F.3d at 1005 (quoting *Trbovich v. United Mine Workers of Am.*, 404 U.S. 528, 538 n.10 (1972) (quotation marks omitted)). In assessing this factor, the Fifth Circuit has "created two presumptions of adequate representation." *Id.* One presumption arises when an existing party is a "governmental body or officer charged by law" with representing the intervenors' interests. *Id.* The second arises when the "would-be intervenor has the same ultimate objective" as a party to the lawsuit. *Id*.

Neither presumption precludes the Intervenor States from participating in this lawsuit. First, the federal defendants are not "charged by law" with representing the interests of the States. *See Entergy Gulf States La., LLC v. EPA*, 817 F.3d 198, 203 (5th Cir. 2016) (holding that the EPA is not "a representative of the Sierra Club by law . . ."). Second, even assuming that the Intervenor States share the federal defendants' "ultimate objective," this presumption is overcome when a proposed intervenor demonstrates an "adversity of interest, collusion, or nonfeasance on the part of the existing party." *Id.*[13] "In order to show adversity of interest, an intervenor must demonstrate that its interests diverge from the putative representative's interests in a manner germane to the case." *Texas*, 805 F.3d at 662. This is not a high bar: intervenors need only show that "their interests may not align precisely" with one of the existing parties. *Brumfield*, 749 F.3d at 345. The Fifth Circuit has repeatedly held that "the lack of unity in *all* objectives, combined with real and legitimate additional or contrary arguments, is sufficient to

[13] The Fifth Circuit has left open the possibility that these are not the "only three circumstances that would make representation inadequate...". *Texas*, 805 F.3d at 662 n.5.

demonstrate that the representation *may* be inadequate." *Id*. at 346 (emphasis added); *see also Texas*, 805 F.3d at 663.

That is the case here. The Intervenor States seek to protect hundreds of billions of dollars to which they are entitled under the ACA, and to make sure that their residents have access to high-quality healthcare. Beyond that, the States have a strong interest in protecting their existing healthcare infrastructure and the orderly operation of their healthcare systems, which would be thrown into disarray if the ACA were ruled unconstitutional. Aaron Dec. ¶¶ 42-45, Appx. 023-025. The federal defendants, on the other hand, represent the "broad public interest," *Espy*, 18 F.3d at 1208, not the Intervenor States' state treasuries or budgets. Nor do the defendants have an interest in the States' particularized decisions about how to operate their individual healthcare systems. Indeed, as the source of the funding flowing to the Intervenor States, the federal defendants cannot represent the States' interest in receiving those funds. And as the Fifth Circuit has already noted, the federal defendants' concerns include "'maintaining [their] working relationship with the [Plaintiffs] States, who often assist [them]'" in implementing various health care programs. *Texas*, 805 F.3d at 663. Even if the federal government's "more extensive interests will [not] *in fact* result in inadequate representation," they "surely … might, which is all that the rule requires." *Brumfield*, 749 F.3d at 346 (emphasis in original); *see also Fund for Animals, Inc.*, 322 F.3d at 736 (allowing intervention due to distinct sovereign interests). This "minimal" criterion is met.

Moreover, the Intervenor States' legal positions are "significantly different" from the federal defendants. *Brumfield*, 749 F.3d at 346; *see also Texas*, 805 F.3d at 663 (adversity of interest shown when intervenor identifies ways in which its interests will "impact[] the litigation"). First, the federal government has an "institutional interest in shielding its actions from state intervention through the courts," while the Intervenor States do not. *Texas*, 805 F.3d at 663. Second, the plaintiff States argue that the individual mandate is not severable from the entire ACA, and ask this Court to strike the Act down "in whole." Compl. ¶ 49. In the alternative, they argue that the "guaranteed-issue and community-rating provisions are non-

severable from the mandate" and must therefore be invalidated. Compl. ¶ 50. As the Complaint alleges, the federal government has already stated that it *agrees* with the latter point. *Id.* In *NFIB*, the federal government conceded that if the individual mandate is found unconstitutional, then the community-rating and guaranteed-issue provisions of the ACA could not stand, and it has not subsequently repudiated this position. *NFIB*, 567 U.S. at 558-59; *see also* Brief for Respondents (Severability), Supreme Court docket no. 11-393 and 11-400, at 26 (filed January 27, 2012). The Intervenor States, on other hand, disagree with that position and have a strong interest in ensuring that these provisions are upheld because they enable the States' residents to maintain insurance regardless of health status.

Because the Intervenor States have specified the "particular ways in which their interests diverge" from the federal government's, they are entitled to intervene here. *Texas*, 805 F.3d at 663. Indeed, over the past four years, the Fifth Circuit has repeatedly held that parties were entitled to intervene as a matter of right under materially indistinguishable circumstances. For example, in *Brumfield*, the Fifth Circuit held that parents whose children received school vouchers under a Louisiana law were entitled to intervene as defendants in a lawsuit brought by the federal government to stop the voucher program. 749 F.3d at 346. Although the State of Louisiana and the parents both "vigorously oppose[d] dismantling the voucher program," the court concluded that the parents had overcome the "ultimate objective" presumption because the State had more extensive interests to take into consideration, and because it had already made legal concessions that the parents contested. *Id.* In *Texas*, the Fifth Circuit held that individuals who would have been eligible for benefits under the challenged federal program were entitled to intervene. 805 F.3d at 663. The Court recognized that the federal government's interests were broader than those of the individuals, including the government's "interests in securing an expansive interpretation of executive authority, efficiently enforcing immigration law, and maintaining its working relationship with the States, who often assist it in detaining immigrants" like the intervenors. *Id*. In addition, the federal government took a legal position on the ability of States to issue drivers' licenses to benefit recipients adverse to the intervenors. *Id*. Similarly,

in *Entergy Gulf States*, the Sierra Club demonstrated adversity of interest with the EPA by showing that it held different positions on case management, including whether to stay or bifurcate the case, and how to best protect confidential information and cooperate with the opposing party to identify such information. 817 F.3d at 204-205. Finally, in *Wal-Mart*, a trade group representing liquor retailers demonstrated adversity of interest with the defendant regulatory commission because the intervenors intended to seek a declaratory judgment that the regulatory scheme was constitutional, while the commission merely sought to defend the action and would have "accept[ed] a procedural victory." 834 F.3d at 569.

These cases make clear that intervention is appropriate here. In each case, the Fifth Circuit held intervention was required where (1) the defendant was a governmental entity; (2) the putative intervenor(s) sought to intervene as a defendant(s); and (3) the putative intervenor(s) rebutted the presumption of adequate representation and met the adversity of interest standard by showing divergent interests and legal arguments from the governmental entity defendants.

In sum, the different interests and positions of the Intervenor States and the federal defendants demonstrate the need for the Intervenor States' participation in this litigation. These States have concrete economic, sovereign, and quasi-sovereign interests at stake that cannot be represented by the federal government and which are material to this litigation. In addition, should plaintiff States prevail, the Intervenor States and their residents will suffer grave and direct economic consequences. Finally, the goals and interests of the Intervenor States and the federal defendants do not match, even if they both seek to uphold the ACA—an assumption that is in no way certain.[14] For these reasons, the Intervenor States seek to participate in the case as defendants, and respectfully request that the Court grant them intervention as a matter of right.

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[14] Indeed, it is unclear whether the federal government shares the Intervenor States' objective of preserving the ACA. The President, for example, has stated that he wants to dismantle the ACA "[p]iece by piece by piece." *See* Rachel Wolfe, Read the Full Text of Trump's CPAC Speech, Vox (Feb. 23, 2018, 2:30 p.m.), https://www.vox.com/policy-and-politics/2018/2/23/17044760/transcript-trump-cpac-speech-snake-mccain. That comment underscores the far-reaching actions that this administration has taken to undermine the ACA.

II. THE STATES SHOULD BE GRANTED PERMISSIVE INTERVENTION

Alternatively, the Intervenor States are entitled to permissive intervention under Federal Rule of Civil Procedure 24(b)(1)(B). This rule authorizes permissive intervention on a timely motion, where the applicant "has a claim or defense that shares with the main action a common question of law or fact." *Id*. The proposed intervenor must demonstrate that: (1) the motion to intervene is timely; (2) an applicant's claim or defense has a question of law or fact in common with the existing action; and (3) intervention will not delay or prejudice adjudication of the existing parties' rights. *Id*.; *see United States v. League of United Latin American Citizens*, 793 F.2d 636, 644 (5th Cir. 1986) ("Although the court erred in granting intervention as of right, it might have granted permissive intervention under Rule 24(b) because the intervenors raise common questions of law and fact.").

The Intervenor States easily satisfy these conditions. The motion is timely, having been filed six weeks after the plaintiff States filed their Complaint. The Intervenor States' defenses that the ACA remains constitutional and the plaintiff States fail to state a claim in their Complaint share multiple common questions of law with the "main action." Finally, the States' intervention will assure that there is a robust defense of plaintiffs' claims, as already demonstrated by the declarations submitted by the Intervenor States in support of their motion to intervene. At the same time, there will be no delay or prejudice to the adjudication of the existing parties' rights. This action has not advanced to a stage where any existing party would be prejudiced by permitting the requested intervention due to delay or for any other reason. Where, as here, there is no prejudice at this early juncture of the litigation, intervention should be

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President Trump has already signed two Executive Orders designed to weaken the ACA. Exec. Order No. 13765, Minimizing the Economic Burden of the Patient Protection and Affordable Care Act Pending Repeal, 82 Fed. Reg. 8351 (Jan. 20, 2017); Exec. Order No. 13813, 82 C.F.R. 48385 (October 17, 2017). The federal government has also previously refused to defend key components of the law in court. *See* October 11, 2017, Office of the Attorney General Letter to the U.S. Department of Treasury and U.S. Department of Health & Human Services regarding *House v. Burwell*, 185 F.Supp.3d 165 (D.D.C 2016) (deciding that it would no longer defend the Executive Branch's authority to make "cost-sharing reduction" payments without further congressional appropriations) at https://www.hhs.gov/sites/default/files/csr-payment-memo.pdf.

permitted so that greater justice could be attained. *Espy*, 18 F.3d at 1205. By allowing Intervenor States to raise additional legal defenses in support of the ACA in order to protect their public fisc, as well as the physical and economic well-being of their citizens, the States will greatly contribute to the just resolution of the issues presented in this action.

CONCLUSION

For the foregoing reasons, the Intervenor States respectfully urge this Court to grant their motion to intervene as of right, or alternatively for permissive intervention, allowing them to intervene in this lawsuit as defendants.

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CERTIFICATE OF CONFERENCE

I hereby certify that on April 6, 2018, my Supervising Deputy Attorney General, Kathleen Boergers, conferred with Darren McCarty, counsel for the Plaintiff States, concerning the Intervenor States' (1) Motion to Intervene, and (2) Motion for Leave to Appear without Local Counsel. During that conference, Mr. McCarty indicated that while he had no opposition to the Motion for Leave to Appear without Local Counsel, he would oppose the Motion to Intervene. No conference was held with counsel for the Defendants to determine their position as to the motions since they have not yet appeared.

Dated: April 9, 2018

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Certificate of Service

On April 9, 2018, I electronically submitted the foregoing document with the clerk of court for the U.S. District Court, Northern District of Texas, using the electronic case filing system of the court. I hereby certify that I have served all counsel and/or *pro se* parties of record electronically or by another manner authorized by Federal Rule of Civil Procedure 5 (b)(2).

s/Michelle Schoenhardt
Michelle Schoenhardt

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF TEXAS
FORT WORTH DIVISION

TEXAS, WISCONSIN, ALABAMA, ARKANSAS, ARIZONA, FLORIDA, GEORGIA, INDIANA, KANSAS, LOUISIANA, PAUL LePAGE, Governor of Maine, MISSISSIPPI, by and through Governor Phil Bryant, MISSOURI, NEBRASKA, NORTH DAKOTA, SOUTH CAROLINA, SOUTH DAKOTA, TENNESSEE, UTAH, and WEST VIRGINIA, Plaintiffs, v. UNITED STATES OF AMERICA, UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, ALEX AZAR, in his Official Capacity as SECRETARY OF HEALTH AND HUMAN SERVICES, UNITED STATES INTERNAL REVENUE SERVICE, and DAVID J. KAUTTER, in his Official Capacity as Acting COMMISSIONER OF INTERNAL REVENUE, Defendants.	Civil Action No. 4:18-cv-00167-O
CALIFORNIA, CONNECTICUT, DISTRICT OF COLUMBIA, DELAWARE, HAWAII, ILLINOIS, KENTUCKY, MASSACHUSETTS, MINNESOTA, NEW JERSEY, NEW YORK, NORTH CAROLINA, OREGON, RHODE ISLAND, VERMONT, VIRGINIA, and WASHINGTON, [Proposed] Intervenors-Defendants.	

APPENDIX OF IN SUPPORT OF [PROPOSED] INTERVENOR-DEFENDANTS' MOTION TO INTERVENE

The Intervenor States submit the following appendix in support of their Motion to Intervene.

APPENDIX OF SUPPORTING EVIDENCE

Exhibit No.	Document	Pages
1	Declaration of Henry J. Aaron (Brookings Institute)	001–058
2	Declaration of Benjamin Barnes (CT)	059-070
3	Declaration of Peter Berns (The ARC)	071-075
4	Declaration of Sharon C. Boyle (MA)	076-078
5	Declaration of Margaret Chism (KY Resident)	079-081
6	Declaration of Angela Eilers (CA Resident)	082-085
7	Declaration of Matthew David Eyles (America's Health Insurance Plans, Inc.)	086-093
8	Declaration of Alfred J. Gobeille (VT)	094-098
9	Declaration of Frederick Isasi (Families USA Foundation)	099-110
10	Declaration of Jennifer Kent (CA)	111-113
11	Declaration of Mila Kofman (DC)	114-118
12	Declaration of Jennifer Lee (VA)	119-122
13	Declaration of Kimberly Lufkin (VA Resident)	123-126
14	Declaration of Chris Maley (IL)	127-129
15	Declaration of Judy Mohr Peterson (HI)	130-134
16	Declaration of Thea Mounts (WA)	135-140
17	Declaration of Claudia Schlosberg (DC)	141-148
18	Declaration of John Jay Shannon (IL)	149-153
19	Declaration of Zachary W. Sherman (RI)	154-157
20	Declaration of Ryan Smith (IL Resident)	158-160
21	Declaration of Kara Odom Walker (DE)	161-164
22	Declaration of Sherry White (NY Resident)	165-167
23	Declaration of Howard A. Zucker (NY)	168-180

Dated: April 9, 2018

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IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF TEXAS
FORT WORTH DIVISION

TEXAS, WISCONSIN, ALABAMA, ARKANSAS, ARIZONA, FLORIDA, GEORGIA, INDIANA, KANSAS, LOUISIANA, PAUL LePAGE, Governor of Maine, MISSISSIPPI, by and through Governor Phil Bryant, MISSOURI, NEBRASKA, NORTH DAKOTA, SOUTH CAROLINA, SOUTH DAKOTA, TENNESSEE, UTAH, and WEST VIRGINIA, Plaintiffs, v. UNITED STATES OF AMERICA, UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, ALEX AZAR, in his Official Capacity as SECRETARY OF HEALTH AND HUMAN SERVICES, UNITED STATES INTERNAL REVENUE SERVICE, and DAVID J. KAUTTER, in his Official Capacity as Acting COMMISSIONER OF INTERNAL REVENUE, Defendants.	Civil Action No. 4:18-cv-00167-O
CALIFORNIA, ET AL., Proposed Intervenor-Defendants.	

DECLARATION OF HENRY J. AARON, Ph.D., IN SUPPORT OF MOTION TO INTERVENE OF CALIFORNIA, ET AL.

I, Henry J. Aaron, declare as follows:

1. I am currently the Bruce and Virginia MacLaury Senior Fellow in the Economic Studies Program at the Brookings Institution. From 1990 through 1996, I was the Director of the Economic Studies Program. I am a member of the District of Columbia Health Benefits Exchange Executive Board and a member and former chair of the Social Security Advisory

Board. I am a graduate of UCLA and hold a Ph.D. in economics from Harvard University. I taught at the University of Maryland from 1967 through 1989, except for 1977 and 1978 when I served as Assistant Secretary for Planning and Evaluation at the Department of Health, Education, and Welfare. I chaired the 1979 Advisory Council on Social Security. During the academic year 1996-97, I was a Guggenheim Fellow at the Center for Advanced Studies in the Behavioral Sciences at Stanford University. I have been a member of the visiting committees for the Department of Economics and the Medical and Dental Schools at Harvard University. I am the author of many books and articles on health insurance and health care policy, including two studies of the impact on health care of limited resources in Great Britain (with William Schwartz), a study of health policy in the United States, and recommendations for modifications in Medicare (a book with Jeanne Lambrew and an article with Robert Reischauer).

2. In creating this declaration, I consulted with fellow national health experts Sara Rosenbaum, the Harold and Jane Hirsh Professor of Health Law and Policy and founding chair, Department of Health Policy, Milken Institute School of Public Health, George Washington University and Jeffrey Levi, Professor of Health Policy and Management at the Milken Institute School of Public Health, George Washington University. While I consulted with these individuals for their expert advice, I can attest to the information in this declaration based on my independent experience and background.

3. I understand that this lawsuit involves a challenge to the Affordable Care Act and seeks to enjoin it. As noted above, I am the author of numerous books and articles on health insurance and health care policy. In my expert opinion, enjoining the Affordable Care Act would completely disrupt the U.S. health care market for patients, providers, insurance carriers, and federal and state governments.

The Affordable Care Act Has Contributed to Improvements in Health Coverage, Access, Financial Security, and Affordability

4. The Affordable Care Act (ACA) is a comprehensive law that has improved the quality and affordability of health care and health insurance. It has done so by: strengthening consumer

protections in private insurance; making the individual insurance market accessible and affordable; expanding and improving the Medicaid program; modifying Medicare's payment systems while filling in benefit gaps; increasing funding and prioritization of prevention and public health; supporting infrastructure such as community health centers, the National Health Service Corps, and the Indian Health Service, among other policies. There is widespread agreement that the ACA is the most significant health legislation enacted since the Social Security Act amendments that created Medicare and Medicaid in 1965.

5. The ACA helped lower the number of people without health insurance by an estimated 20.0 million people from October 2013 to early 2016, a drop of 43 percent in the uninsured rate. This increase in coverage included 3 million African-Americans, 4 million people of Hispanic origin, and 8.9 million white non-elderly adults. An estimated 6.1 million young adults and 1.2 million children gained coverage between 2010 and early 2016.[1,2] The reduction in the uninsured rate occurred across the income spectrum: the 2013 to 2015 rate reduction was 36 percent, 33 percent, and 31 percent for non-elderly people with income below 138 percent of poverty, between 138 and 400 percent of poverty, and above 400 percent of poverty respectively.[3] The drop in the uninsured rate was larger in states that expanded Medicaid than in states that did not do so.[4]

6. Many studies have found that access to health care has improved since the ACA was enacted, especially among low-income people.[5] For example, from the fall of 2013 to the spring of 2017, the share of non-elderly adults without a regular source of care fell from 30 percent to

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[1] Uberoi N, Finegold K and Gee E, Health Insurance Coverage and the Affordable Care Act, 2010 – 2016, *Office of the Assistant Secretary for Planning and Evaluation Issue Brief,* 2016, https://aspe.hhs.gov/system/files/pdf/187551/ACA2010-2016.pdf

[2] Executive Office of the President Council of Economic Advisors, *2017 Economic Report of the President*, Chapter 4 Reforming the Health Care System, U.S. Government Publishing Office, 2017, https://obamawhitehouse.archives.gov/sites/default/files/docs/chapter_4-reforming_health_care_system_2017.pdf

[3] Executive Office of the President Council of Economic Advisors, *2017 Economic Report of the President*, Chapter 4 Reforming the Health Care System, U.S. Government Publishing Office, 2017, https://obamawhitehouse.archives.gov/sites/default/files/docs/chapter_4-reforming_health_care_system_2017.pdf

[4] Broaddus, M, *Census Data: States Not Expanding Medicaid Lag Further on Health Coverage,* Center on Budget and Policy Priorities, 2017, https://www.cbpp.org/blog/census-data-states-not-expanding-medicaid-lag-further-on-health-coverage

[5] Kominski GF, Nonzee NJ and Sorensen A, The Affordable Care Act's Impacts on Access to Insurance and Health Care for Low-Income Populations, *Annual Review of Public Health,* 2017, 38:489-505, https://www.annualreviews.org/doi/10.1146/annurev-publhealth-031816-044555

24.7 percent; the share that did not receive a routine checkup in the last 12 months fell from nearly 40 percent to 34 percent.[6] The Council of Economic Advisers (CEA) estimated a one-third drop in the share of people who reported that they were unable to obtain needed medical care because of cost, with the 2015 level falling below its pre-recession level. The CEA also found a correlation between increased coverage and an increased share of people having a personal doctor and receiving a checkup in the past 12 months.[7] A review of the literature in 2017 found evidence that significant improvements in access to and use of care were associated with gaining coverage. These gains included increased use of outpatient care; greater rates of having a usual source of care or personal physician; increased use of preventive services; increased prescription drug use and adherence; and improved access to surgical care.[8] Racial and ethnic disparities in access to care fell following the expansion of coverage.[9]

7. The expansion of coverage and other provisions of the ACA will contribute to longer, healthier lives. Research on previous coverage expansions has found that having health insurance coverage improves children's learning ability, adults' productivity, and seniors' qualify of life.[10] A recent review found that coverage improves rates of diagnosing chronic conditions, treatment of such conditions, outcomes for people with depression, and self-reported health.[11] The CEA estimated that, if the ACA experience matches that in Massachusetts, 24,000 deaths are being

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[6] Long SK, Bart L, Karmpan M, Shartzer A and Zuckerman S, Sustained Gains in Coverage, Access, and Affordability Under the ACA: A 2017 Update. *Health Affairs,* 36(9), 2017, https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2017.0798

[7] Executive Office of the President Council of Economic Advisors, *2017 Economic Report of the President*, Chapter 4 Reforming the Health Care System, U.S. Government Publishing Office, 2017, https://obamawhitehouse.archives.gov/sites/default/files/docs/chapter_4-reforming_health_care_system_2017.pdf

[8] Sommers BD, Gawande AA and Baicker K, Health Insurance Coverage and Health – What the Recent Evidence Tells Us, *The New England Journal of Medicine,* 2017, 377:586-593, http://www.nejm.org/doi/full/10.1056/NEJMsb1706645

[9] Chen J, Vargas-Bustamante A, Mortensen K and Ortega AN. Racial and Ethnic Disparities in Health Care Access and Utilization under the Affordable Care Act. *Med. Care,* 2016, 54:140–146, https://www.ncbi.nlm.nih.gov/pubmed/26595227; Sommers BD, Gunja MZ, Finegold K and Musco T. Changes in Self-Reported Insurance Coverage, Access to Care, and Health Under the Affordable Care Act. *JAMA,* 2015, 314:366–374, https://jamanetwork.com/journals/jama/fullarticle/2411283

[10] Institute of Medicine, Board on Health Care Services, *Coverage Matters: Insurance and Health Care,* National Academies Press, 2001, http://www.nationalacademies.org/hmd/Reports/2001/Coverage-Matters-Insurance-and-Health-Care.aspx

[11] Sommers BD, Gawande AA and Baicker K, Health Insurance Coverage and Health – What the Recent Evidence Tells Us, *The New England Journal of Medicine,* 2017, 377:586-593, http://www.nejm.org/doi/full/10.1056/NEJMsb1706645

avoided annually.[12] The Institute of Medicine also found that coverage improves community health by limiting the spread of communicable diseases and reducing the diversion of public health resources for medical care for the uninsured.[13]

8. The law's contribution to health extends beyond its coverage provisions. In part thanks to the ACA's payment incentives and its *Partnership for Patients* initiative, an estimated 125,000 fewer patients died in the hospital as a result of hospital-acquired conditions in 2015 compared to 2010, saving approximately $28 billion in health care costs over this period.[14] And its *Tips from Former Smokers* initiative resulted in an estimated 500,000 people quitting smoking permanently in the first five years of the campaign.[15]

9. The ACA strengthened financial security as well as physical and mental health. A study found that self-reported concerns about the cost of health care dropped at a greater rate for low-income people in two states that expanded Medicaid relative to one that did not.[16] Between September 2013 and March 2015, the number of people having problems paying medical bills dropped by an estimated 9.4 million, a reduction from 22.0 to 17.3 percent of non-elderly adults.[17] One study found that the amount of debt sent to collection was reduced by over $1,000 per person residing in ZIP Codes with the highest share of low-income, uninsured individuals in states that expanded Medicaid compared to those that did not expand the program.[18] The law also

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[12] Executive Office of the President Council of Economic Advisors, *2017 Economic Report of the President*, Chapter 4 Reforming the Health Care System, U.S. Government Publishing Office, 2017. https://obamawhitehouse.archives.gov/sites/default/files/docs/chapter_4-reforming_health_care_system_2017.pdf

[13] Institute of Medicine, Board on Health Care Services, *A Shared Destiny: Community Effects of Uninsurance*, The National Acadamies Press, 2003, https://www.nap.edu/catalog/10602/a-shared-destiny-community-effects-of-uninsurance.

[14] Agency for Healthcare Research and Quality, *National Scorecard on Rates of Hospital-Acquired Conditions 2010 to 2015: Interim Data from National Efforts to Make Health Care Safer*, December 2016, https://www.ahrq.gov/professionals/quality-patient-safety/pfp/2015-interim.html

[15] Centers for Disease Control and Prevention, Tips Impact and Results, no date, https://www.cdc.gov/tobacco/campaign/tips/about/impact/campaign-impact-results.html?s_cid=OSH_tips_D9391

[16] Sommers BD, Blendon RJ, Orav EJ and Epstein AM, Changes in Utilization and Health Among Low-Income Adults after Medicaid Expansion or Expanded Private Insurance, *JAMA Internal Medicine*, 2016, 176:1501–1509, https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2542420

[17] Kapman M and Long SK, *9.4 Million Fewer Families Are Having Problems Paying Medical Bills*, Urban Institute Health Policy Center, Health Reform Monitoring Survey, 2015, http://hrms.urban.org/briefs/9-4-Million-Fewer-Families-Are-Having-Problems-Paying-Medical-Bills.html

[18] Hu L, Kaestner R, Mazumder B, Miller S and Wong A, The Effect Of The Patient Protection And Affordable Care Act Medicaid Expansions On Financial Well-Being, *National Bureau of Economic Research*, 2016, No. 22170, http://www.nber.org/papers/w22170.pdf

has reduced income inequality: projected incomes in the bottom tenth of the distribution will increase by 7.2 percent while those in the top tenth will be reduced by 0.3 percent.[19]

10. Most experts agree that the ACA contributed to slower health care cost growth since its enactment, although there is disagreement about the size of the effect. The prices of health care goods and services grew more slowly in the period from 2010 to 2016 than in any comparable period since these data began to be collected in 1959. Adding to this, health care service use growth per enrollee slowed since 2010. National health expenditures and projections for 2010 to 2019, as of 2016, were over $2.6 trillion lower than the national health expenditure projections for the same period made in 2010. Additionally, employer-based health plan premiums and out-of-pocket costs grew more slowly from 2010 to 2016 than they did from 2000 to 2010. As a result, total spending associated with a family policy was $4,400 less in 2016 than it would have been had costs risen as fast as they did during the previous decade. The coverage expansion under the law also lowered hospitals' cost of providing uncompensated care by $10.4 billion in 2015; in states that expanded Medicaid, the share of hospital operating costs devoted to uncompensated care dropped by around half during this period.[20]

11. The ACA's contribution to lower health care cost growth has broader economic effects. It helped stabilize the share of gross domestic product spent on health. When the ACA was under consideration, the Congressional Budget Office (CBO) estimated that the ACA would reduce the federal budget deficit by an estimated $115 billion from 2010 to 2019 by cutting federal health spending and raising revenue.[21] States have realized budget savings as well because of increased federal Medicaid support and reduced uncompensated care costs. Because the ACA has lowered the cost to employers of health insurance for their employees, workers have received higher

[19] Aaron H and Burtless A, Potential Effects of the Affordable Care Act on Income Inequality, *Brookings Report*, 2014, https://www.brookings.edu/research/potential-effects-of-the-affordable-care-act-on-income-inequality/

[20] Executive Office of the President Council of Economic Advisors, 2017 *Economic Report of the President*, Chapter 4 Reforming the Health Care System, U.S. Government Publishing Office, 2017. https://obamawhitehouse.archives.gov/sites/default/files/docs/chapter_4-reforming_health_care_system_2017.pdf.

[21] Elmendorf DW, Letter to Honorable Nancy Pelosi, Speaker, U.S. House of Representatives, Congressional Budget Office, March 20, 2010, https://www.cbo.gov/sites/default/files/111th-congress-2009-2010/costestimate/amendreconprop.pdf

wages and other fringe benefits. The ACA also has reduced "job lock," by freeing workers to change jobs without fear of losing health insurance coverage. An estimated 1.5 million people became self-employed because of the ACA's individual market reforms and financial assistance.[22] Contrary to some critics' claims, there is no evidence that the law's benefits have come at the expense of employment, hours of work, or compensation.[23] ACA coverage also improves the U.S. system of automatic stabilizers by protecting families' health coverage during economic downturns. Improvement is greatest in states that expanded Medicaid.

The ACA Expanded Consumer Protections in All Types of Private Insurance

12. The ACA improved the quality, accessibility, and affordability of health insurance coverage both for people who were already insured and for the previously uninsured. Insurers may no longer set higher premiums for people with pre-existing conditions, charge women more than men, and carve out benefits for people who need them. They can no longer set annual or lifetime limits on total benefits or rescind coverage except in cases of fraud. Insurers must cover dependents up to age 26 under their parents' plans, include annual out-of-pocket limits, and provide rebates to the insured if total benefits do not exceed statutory shares of premiums received. All non-grandfathered private plans must cover such evidence-based preventive services as immunizations and cancer screenings, and they must do so with no cost sharing. Individual and small group plans now must include essential health benefits: ten categories of health services with a scope that is the same as a typical employer plan. The ACA also filled in the gaps in the Mental Health Parity and Addiction Equity Act, which requires group health plans and insurers that offer mental health and substance use disorder benefits to provide coverage that is comparable to coverage for general medical and surgical care.

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[22] Blumberg LJ, Corlette S and Lucia K, The Affordable Care Act: Improving Incentives for Entrepreneurship and Self Employment, *Timely Analysis of Immediate Health Policy Issues*, Urban Institute, May 2013, https://www.urban.org/sites/default/files/publication/23661/412830-The-Affordable-Care-Act-Improving-Incentives-for-Entrepreneurship-and-Self-Employment.PDF

[23] Abraham J and Royalty AB, How Has the Affordable Care Act Affected Work and Wages, Leonard Davis Institute of Health Economics, University of Pennsylvania, *Issue Brief,* January 2017, https://ldi.upenn.edu/brief/how-has-affordable-care-act-affected-work-and-wages

13. The ACA's guarantee of access to health insurance offers peace of mind to the up to 133 million Americans who have a pre-existing health condition, including parents of 17 million children with such conditions.[24] Before the ACA, those with pre-existing conditions had to worry about finding affordable coverage if they lost a job that provided health insurance or they stopped being eligible for programs such as Medicaid or the Children's Health Insurance Program (CHIP). Even if they could find insurance, they faced the risk that needed services might be "carved-out" for them or excluded for all enrollees: before 2014, 62 percent of individual market enrollees lacked maternity coverage, 34 percent lacked coverage for substance use disorders, 18 percent lacked coverage for mental health care, and 9 percent lacked prescription drug coverage.[25] Before enactment of the ACA, parents of children with autism typically lacked private health insurance coverage for habilitative services. The ACA bars benefit carve-outs and requires all individual and small group market plans to cover essential health benefits. The ACA's focus on comprehensive benefits has been particularly important in combatting the opioid epidemic: it requires coverage of screening and treatment for substance use disorders, has expanded parity to all plans, and supports integrating prevention and treatment with mental health, primary care, and other related services.[26]

14. The ACA has improved women's coverage as well. From 2010 to early 2016, 9.5 million women gained coverage.[27] Starting in 2014, the ACA banned the common practice of varying insurance rates by sex – a practice that had added an estimated $1 billion a year to women's health insurance premiums.[28] Health plans may no longer carve-out maternity care from plans

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[24] Office of the Assistant Secretary for Planning and Evaluation, Health Insurance Coverage for Americans with Pre-Existing Conditions: The Impact of the Affordable Care Act, *Issue Brief,* January 2017, https://aspe.hhs.gov/system/files/pdf/255396/Pre-ExistingConditions.pdf

[25] Office of the Assistant Secretary for Planning and Evaluation, Essential Health Benefits: Individual Market Coverage, *Issue Brief*, December 2011, https://aspe.hhs.gov/basic-report/essential-health-benefits-individual-market-coverage

[26] Abraham AJ, Andrews CM, Grogan CM, D'Aunno T, Humphreys KN, Pollack HA and Friedmann PD, The Affordable Care Act Transformation of Substance Use Disorder Treatment, *American Journal of Public Health,* 2017, 107(1):31-32, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5308192/

[27] Uberoi N, Finegold K and Gee E, Health Insurance Coverage and the Affordable Care Act, 2010 – 2016, *Office of the Assistant Secretary for Planning and Evaluation Issue Brief,* 2016. https://aspe.hhs.gov/system/files/pdf/187551/ACA2010-2016.pdf

[28] Garrett D, Greenberger M, Waxman J, Benyo A, Dickerson K, Gallagher-Robbins K, Moore R and Trumble S, Turning To Fairness: Insurance Discrimination Against Women Today and the Affordable Care Act, National Women's Law Center, *Report,* March 2012, https://www.nwlc.org/sites/default/files/pdfs/nwlc_2012_turningtofairness_report.pdf

and must allow women to see their obstetrician or gynecologist without a referral. All non-grandfathered plans must cover women's preventive services, which includes contraceptive services, screening for interpersonal and domestic violence, and breast-feeding services and supplies. The ACA's reduction in cost-sharing for contraceptive services increased women's use of these services, including long-term contraception methods.[29] The ACA's bar on sex discrimination makes it an important civil rights, as well as health reform, law.

15. The ACA has improved coverage for young adults. The ACA requires health insurers to extend dependent coverage to children up to age 26. An estimated 2.3 million young adults (ages 19 to 25) gained health insurance between 2010 and the end of 2013. Starting in 2014, millions more gained coverage through the Health Insurance Marketplaces and other reforms.[30] According to one review, "a wealth of evidence finds that the ACA dependent coverage expansions increased access to care, use of a wide variety of services, and reduced out-of-pocket spending."[31] For example, mental health visits increased by 9.0 percent and inpatient visits by 3.5 percent for young adults gaining coverage on their parents' plans.[32]

16. The ACA newly required all private health plans to end the use of annual and lifetime limits and to include an annual out-of-pocket limit on cost sharing. An estimated 22 million people enrolled in employer coverage are now protected against catastrophic costs.[33] While data collected on personal bankruptcy does not include causes, filings dropped by about 50 percent

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[29] Carlin CS, Fertig AR and Dowd BE, Affordable Care Act's Mandate Eliminating Contraceptive Cost Sharing Influenced Choices of Women With Employer Coverage, *Health Affairs* 35(9), 2016, https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2015.1457

[30] Uberoi N, Finegold K and Gee E, Health Insurance Coverage and the Affordable Care Act, 2010 – 2016, *Office of the Assistant Secretary for Planning and Evaluation Issue Brief,* 2016. https://aspe.hhs.gov/system/files/pdf/187551/ACA2010-2016.pdf

[31] Abraham J and Royalty AB, How Has the Affordable Care Act Affected Work and Wages, Leonard Davis Institute of Health Economics, University of Pennsylvania, *Issue Brief*, January 2017, https://ldi.upenn.edu/brief/how-has-affordable-care-act-affected-work-and-wages

[32] Akosa Antwi Y, Moriya AS and Simon KI, Access to Health Insurance and the Use of Inpatient Medical Care: Evidence from the Affordable Care Act Young Adult Mandate, *J Health Econ* 39:171-187, 2015, https://www.ncbi.nlm.nih.gov/pubmed/25544401

[33] Executive Office of the President Council of Economic Advisors, *2017 Economic Report of the President*, Chapter 4 Reforming the Health Care System, U.S. Government Publishing Office, 2017. https://obamawhitehouse.archives.gov/sites/default/files/docs/chapter_4-reforming_health_care_system_2017.pdf

between 2010 and 2016; experts attribute some of this change to the new financial protections offered by the ACA starting in 2010.[34]

The ACA's Health Insurance Marketplaces Have Given Millions Access to Quality Private Insurance, Often with Financial Assistance

17. The ACA created Health Insurance Marketplaces (Marketplaces), a new way for people not eligible for Medicare or Medicaid to get affordable, accessible private insurance independent of their jobs. These Marketplaces offer websites at which people can compare plans that have four different levels of cost sharing (bronze, silver, gold, and platinum).[35] Financial assistance comes through income-related, premium-based tax credits for qualified individuals with income between 100 and 400 percent of the federal poverty level and cost-sharing assistance or "reductions" for qualified individuals with income between 100 and 250 percent of the federal poverty level enrolled in silver plans. The Marketplaces also provide people with support in navigating the system through in-person help and call centers. In 2018, 12 states operate their State-based Marketplaces (SBMs) (operating their own websites rather than using the federally-run HealthCare.gov), 28 states rely entirely on the federal government to run their Marketplaces (use HealthCare.gov), and 11 states have hybrid Marketplaces (assuming some but not all functions).[36] The Marketplaces also offer small businesses a way to find qualified health plans (called SHOP).

18. Several aspects of the ACA contributed to the 57 percent increase between 2013 and 2016 in the number of people covered in the individual market (on and off Marketplaces).[37] An

[34] St. John A, How the Affordable Care Act Drove Down Personal Bankruptcy, *Consumer Reports*, May 2017, https://www.consumerreports.org/personal-bankruptcy/how-the-aca-drove-down-personal-bankruptcy/
[35] People under age 30 also have access to a plan that only covers catastrophic costs.
[36] Kaiser Family Foundation, State Health Insurance Marketplace Types, 2018, https://www.kff.org/health-reform/state-indicator/state-health-insurance-marketplace-types/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D
[37] Kaiser Family Foundation, Health Insurance Coverage of Nonelderly 0-64, 2013 and 2016, https://www.kff.org/other/state-indicator/nonelderly-0-64/?dataView=1&currentTimeframe=3&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

estimated 40 to 50 percent of the coverage gain explained by the ACA resulted from the Health Insurance Marketplaces' policies.[38] One key reason for this expansion is financial assistance, primarily in the form of premium tax credits. In 2017, 84 percent of the 10.3 million people enrolled in Marketplaces received premium tax credits, whose average annualized amount was $4,458 per enrollee.[39] The premium tax credit is set to limit the percent of income an enrollee pays for the second-lowest silver plan in an area. This method of setting assistance means that aid varies regionally with health insurance costs. Second, individual market insurance reforms contributed to increased individual market enrollment. The number of people with pre-existing conditions covered in the individual market rose by 64 percent between 2010 and 2014.[40] Coverage also increased because of the individual mandate, the requirement that people who can afford coverage have it. How much of this increase in coverage can be traced to financial incentives, changes in insurance requirements, or the coverage mandate remains a matter of academic dispute.

19. The ACA set up the Marketplaces to encourage competition among insurers, both the keep premiums low and improve customer service. To that end, it standardized benefits to facilitate shopping on price, required that the Marketplaces create tools to allow consumer to compare plans, and established a permanent risk-adjustment program to prevent insurers from profiting by disproportionately enrolling people with lower-than-average health care costs. The unsubsidized cost of coverage in the Marketplaces, before the start of the Trump Administration, was 10 percent lower than the average employer-sponsored insurance premium.[41] In the early years after the Marketplaces opened, some insurers set prices so low that they lost money in

[38] Frean M, Gruber J and Sommers BD, Premium Subsidies, the Mandate, and Medicaid Expansion: Coverage Effects of the Affordable Care Act, *National Bureau of Economic Research,* 53:72-86, 2016, http://www.nber.org/papers/w22213

[39] Centers for Medicare & Medicaid Services, 2017 Effectuated Enrollment Snapshot, June 2017, https://downloads.cms.gov/files/effectuated-enrollment-snapshot-report-06-12-17.pdf

[40] Office of the Assistant Secretary for Planning and Evaluation, Health Insurance Coverage for Americans with Pre-Existing Conditions: The Impact of the Affordable Care Act, *Issue Brief,* January 2017, https://aspe.hhs.gov/system/files/pdf/255396/Pre-ExistingConditions.pdf

[41] Blumberg LJ, Holahan J and Wengle E, Are Nongroup Marketplace Premiums Really High? Not in Comparison with Employer Insurance, Urban Institute, *Brief*, September 2016, https://www.urban.org/research/publication/are-nongroup-marketplace-premiums-really-high-not-comparison-employer-insurance

order to gain market share; others did not fully understand the risks of their new customers. In 2017, they raised premiums to correct those mistakes. After the 2017 price corrections, analysis indicated that premiums would have grown in single digits for 2018 but for the policy changes under the Trump Administration.[42] Premiums have been lower in SBMs than in HealthCare.gov states, because SBMs manage their plans more actively than the administration.[43] In 2017, 71 percent of enrollees could buy a health plan with a cost (net of tax-credit assistance) of less than $75 per month.[44] In 2016, most (70 percent) of Marketplace enrollees reported no difficulty paying out-of-pocket costs in the previous year, slightly lower than enrollees in employer plans (75 percent).[45] States benefited fiscally in two ways: Marketplace financial assistance is fully federally financed and expanded insurance reduces state outlays to offset the cost to providers of uncompensated care.

20. Access and satisfaction as well as affordability of individual market coverage have improved. According to one survey, in 2010, 60 percent of people seeking individual market coverage found it very difficult or impossible to find affordable care; by 2016, that proportion fell to 34 percent.[46] A study of people newly enrolled in one plan in California and Colorado found that the proportion of enrollees with a personal health care provider rose from 59 to 73 percent, and the proportion receiving a flu shot in the previous year rose from 41 to 52 percent.[47] Satisfaction was roughly the same among enrollees in Marketplace plans and employer plans in

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[42] Fiedler M, Taking Stock of Insurer Financial Performance in the Individual Health Insurance Market Through 2017, USC-Brookings Schaeffer Initiative for Health Policy, *Report,* October 2017, https://www.brookings.edu/wp-content/uploads/2017/10/individualmarketprofitability.pdf

[43] Hall MA and McCue MJ, Health Insurance Markets Perform Better in States That Run Their Own Marketplaces, *To the Point,* The Commonwealth Fund, March 2018, http://www.commonwealthfund.org/publications/blog/2018/mar/health-insurance-markets-states

[44] Office of the Assistant Secretary for Planning and Evaluation, Health Plan Choice and Premiums in the 2018 Federal Health Insurance Exchange, *Research Brief*, October 2017, https://aspe.hhs.gov/system/files/pdf/258456/Landscape_Master2018_1.pdf

[45] Presentation: 2016 Survey of US Health Care Consumers: A Look at Exchange Consumers, Deloitte Development LLC, 2016, https://www2.deloitte.com/content/dam/Deloitte/us/Documents/life-sciences-health-care/us-dchs-consumer-survey-hix.pdf

[46] Collins SR, Gunja MZ, Doty MM and Beutel S, How the Affordable Care Act Has Improved Americans; Ability to Buy Health Insurance on Their Own, The Commonwealth Fund, *Issue Brief,* 2016, http://www.commonwealthfund.org/publications/issue-briefs/2017/feb/how-the-aca-has-improved-ability-to-buy-insurance

[47] Schmittdiel JA, Barrow JC, Wiley D, Ma L, Sam D, Chau CV and Shetterly SM, Improvements in Access and Care Through the Affordable Care Act, *American Journal of Managed Care,* 23(3):e95-97, 2017, http://www.ajmc.com/journals/issue/2017/2017-vol23-n3/improvements-in-access-and-care-through-the-affordable-care-act

2016.[48] Satisfaction among adults with Marketplace or Medicaid coverage rose between 2014 (78 percent) and 2017 (89 percent).[49]

The ACA's Medicaid Provisions Expanded Eligibility, Improved Accessibility and Quality of Care, and Increased Savings

21. The ACA included a number of changes to Medicaid. It expanded Medicaid coverage to adults with income under 138 percent of the federal policy level (which the Supreme Court ruled was unenforceable as a mandate in 2012, but which 32 states have now adopted). It expanded minimum coverage standards for children ages 6 to 18, simplified program eligibility rules as well as the enrollment and renewal process, increased spending on long-term services and supports, added incentives to encourage quality measurement, and promoted care coordination for dual Medicare-Medicaid eligible beneficiaries. It made family planning coverage a state option, extended coverage for young adults aging out of foster care, increased Medicaid drug rebates, and increased efforts to combat fraud. Through the Center for Medicare and Medicaid Innovation (CMMI), the ACA also supported testing and evaluation of payment reforms to improve quality and decrease costs. The ACA also extended funding for CHIP and made policy changes that Congress recently largely incorporated in a ten-year reauthorization of the program.

22. The number of non-elderly people with Medicaid coverage increased by 13 percent between 2013 and 2016,[50] largely because 32 states (including the District of Columbia) expanded eligibility to low-income adults under the new category created by the ACA.[51] Eligibility rule streamlining and other simplifications, increased outreach efforts, a "spillover" effect from the opening of the Marketplaces, and the individual mandate appear to have had a coverage effect as well. A recent literature review listed numerous studies documenting

[48] Presentation: 2016 Survey of US Health Care Consumers: A look at Exchange Consumers, Deloitte Development LLC, 2016, https://www2.deloitte.com/content/dam/Deloitte/us/Documents/life-sciences-health-care/us-dchs-consumer-survey-hix.pdf

[49] The Commonwealth Fund, A Majority of Marketplace and Medicaid Enrollees Are Getting Health Care They Could Not Have Afforded Prior to Having Coverage, *Affordable Care Act Tracking Survey*, no date, http://acatracking.commonwealthfund.org/

[50] Kaiser Family Foundation, Health Insurance Coverage of Nonelderly 0-64, 2013 and 2016, https://www.kff.org/other/state-indicator/nonelderly-0-64/?dataView=1&currentTimeframe=3&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

[51] Maine has also scheduled an expansion to begin on July 1, 2018.

reductions in all states of the proportion of people without insurance. Reductions have been larger in states that expanded Medicaid than in those that did not. It also found that the Medicaid expansion improved coverage among young adults, people with HIV, veterans, rural residents, and racial and ethnic minorities.[52] The law's Medicaid expansion's impact on coverage may have exceeded that of other ACA policies.[53]

23. At least 40 studies have found improved access to and use of health care associated with the Medicaid expansion. For example, one study found that, from November 2013 to December 2015, low-income adults in two expansion states reported a greater increase (12.1 percentage points) in having a personal physician and a greater reduction (18.2 percentage points) in cost-related barriers to access to care compared to low-income adults in a non-expansion state.[54] Medicaid coverage also has increased access to treatment for substance use disorder, including opioid addiction.[55] Some critics of the ACA have alleged that Medicaid expansion caused addiction. What researchers have found is that states that expanded eligibility tended to have higher rates of addiction *before* enactment of the ACA but that drug related mortality *fell* compared to states that did not expand Medicaid after enactment.[56] Evidence is also building that Medicaid coverage for low-income adults has helped provide continuity of care for people going in and out of prisons and may reduce recidivism.[57]

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[52] Antonisse L, Garfield R, Rudowitz R and Artiga S, The Effects of Medicaid Expansion Under the ACA: Updated Findings From a Literature Review, Henry J Kaiser Family Foundation, *Issue Brief,* September 2017, https://www.kff.org/medicaid/issue-brief/the-effects-of-medicaid-expansion-under-the-aca-updated-findings-from-a-literature-review-september-2017/

[53] Frean M, Gruber J and Sommers BD, Premium Subsidies, the Mandate, and Medicaid Expansion: Coverage Effects of the Affordable Care Act, *National Bureau of Economic Research,* 53:72-86, 2016, http://www.nber.org/papers/w22213

[54] Sommers BD, Blendon RJ, Orav EJ and Epstein AM, Changes in Utilization and Health Among Low-Income Adults After Medicaid Expansion or Expanded Private Insurance, *JAMA Intern Med.,* 176(1):1501-1509, 2016, https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2542420

[55] Clemens-Cope L, Epstein M and Kenney G, Rapid Growth in Medicaid Spending on Medications to Treat Opioid Use Disorder and Overdose, The Urban Institute, *Report,* 2017, http://www.urban.org/sites/default/files/publication/91521/2001386-rapid-growth-in-medicaid-spending-on-medications-to-treat-opioid-use-disorder-and-overdose_3.pdf
Wen H, Hockenberry J, Borders T and Druss B, Impact of Medicaid Expansion on Medicaid-Covered Utilization of Buprenorphine for Opioid Use Disorder Treatment, *Medical Care,* 55(4):336-341, 2017, http://journals.lww.com/lww-medicalcare/Fulltext/2017/04000/Impact_of_Medicaid_Expansion_on_Medicaid_covered.5.aspx

[56] Goodman-Bacon A and Sandoe E, Did Medicaid Expansion Cause The Opioid Epidemic? There's Little Evidence That It Did., *Health Affairs Blog,* August 2017, https://www.healthaffairs.org/do/10.1377/hblog20170823.061640/full/.

[57] Regenstein M and Rosenbaum S, What The Affordable Care Act Means For People With Jail Stays, *Health Affairs,* 33(3), 2014, https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2013.1119.

24. Much of the evidence on improvements to health stemming from the ACA comes from its Medicaid expansion. One analysis found a 6.1 percent relative reduction in adjusted all-cause mortality in states that had expanded Medicaid before the ACA.[58] In addition, studies have documented improved outcomes for such services as cardiac surgery associated with the ACA's Medicaid policies.[59]

25. The ACA's Medicaid expansion has also led to documented savings to people, states, and the health system. For example, self-reported medical debt in Ohio fell by nearly 50 percent after it broadened Medicaid eligibility.[60] An analysis of prescription drug transaction data found that uninsured people gaining Medicaid coverage due to the expansion experienced a 79 percent reduction in out-of-pocket spending per prescription.[61] State budgets may have also benefited from receiving federal matching payments for state-funded programs and reductions in payments for uncompensated care; Louisiana, for example, estimated such savings at $199 million in 2017.[62] A recent national study found no significant increase in state Medicaid spending, nor a decrease in education, transportation, or other state spending, as a result of the expansion.[63] States also have not shown regret about their decisions to expand Medicaid, as indicated by reauthorizations of and public statements supporting the Medicaid expansion, even in Republican-led states.[64] The health system, in particular the hospital sector, has also gained financially from the Medicaid expansion. As previously mentioned, not only has uncompensated

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[58] Sommers BD, Baicker K and Epstein AM, Mortality and Access to Care among Adults after State Medicaid Expansions, *The New England Journal of Medicine,* 367:(1025-1034), 2012, http://www.nejm.org/doi/full/10.1056/nejmsa1202099.

[59] Charles E, Johnston LE, Herbert MA, Mehaffey JH, Yount KW, Likosky DS, Theurer PF, Fonner CE, Rich JB, Speir AL, Ailawadi G, Prager RL and Kron IL, Impact of Medicaid Expansion on Cardiac Surgery Volume and Outcomes, *The Annals of Thoracic Surgery,* 104:1251-1258, June 2017, http://www.annalsthoracicsurgery.org/article/S0003-4975(17)30552-0/pdf.

[60] The Ohio Department of Medicaid, Ohio Medicaid Group VIII Assessment: A Report to the Ohio General Assembly, January 2017, http://medicaid.ohio.gov/Portals/0/Resources/Reports/Annual/Group-VIII-Assessment.pdf.

[61] Mulcahy AW, Eibner C and Finegold K, Gaining Coverage through Medicaid Or Private Insurance Increased Prescription Use And Lowered Out-Of-Pocket Spending, *Health Affairs,* 35(9), 2016, https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2016.0091.

[62] Louisiana Department of Health, Medicaid Expansion 2016/17, June 2017, http://dhh.louisiana.gov/assets/HealthyLa/Resources/MdcdExpnAnnlRprt_2017_WEB.pdf.

[63] Sommers B and Gruber J, Federal Funding Insulated State Budgets From Increased Spending Related To Medicaid Expansion, *Health Affairs,* 65(5):938-944, 2017, https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.2016.1666.

[64] Hall M, Do States Regret Expanding Medicaid? *USC-Brookings Schaeffer On Health Policy,* March, 2018, https://www.brookings.edu/blog/usc-brookings-schaeffer-on-health-policy/2018/03/26/do-states-regret-expanding-medicaid/

care decreased to a greater degree in states that expanded Medicaid as compared to those that did not; the hospitals that gained the most tended to be small, rural, for-profit, and non-federal governmental hospitals.[65]

26. The ACA's Medicaid provisions indirectly and directly improved coverage for people with disabilities. Its expansion directly helped those who did not qualify under pre-ACA rules, including those awaiting a disability determination. It also authorized a new eligibility pathway for full Medicaid benefits for people who were previously only eligible for partial Medicaid benefits under home- and community-based care waivers. The law created new programs such as the Community First Choice Options as well as demonstration programs to integrate care for people eligible for both Medicaid and Medicare. Medicaid covers about 6 million low-income seniors and 10 million non-elderly people with disabilities, with these two groups accounting for nearly two-thirds of overall Medicaid spending. As of 2016, 17 states had adopted the ACA's option for home- and community-based services and 8 were participating in Community First Choice.[66]

The ACA's Medicare Provisions Improved Benefits, Reduced Overpayments, Supported Value-Based Purchasing, and Tackled Fraud and Abuse

27. The ACA modified Medicare to improve its benefits; promote quality, value-based purchasing, and alternative payment models; and lower overpayments and fraud in its traditional program and Medicare Advantage. It created CMMI to develop and test new payment models which, if determined to reduce spending without harming quality of care (or to improve quality without increasing spending), could be adopted by Medicare nationwide. It also included specific payment models as alternatives to paying for volume, such as Accountable Care Organizations (ACOs) and bundled payments that pay per person or episode, respectively. New quality "star

[65] Blavin F, How Has the ACA Changed Finances for Different Types of Hospitals? Updated Insights from 2015 Cost Report Data, *The Urban Institute*, April 2017, https://www.rwjf.org/content/dam/farm/reports/issue_briefs/2017/rwjf436310.
[66] Musumeci M and Young K, State Variation in Medicaid Per Enrollee Spending for Seniors and People with Disabilities, Henry J Kaiser Family Foundation, *Issue Brief*, May 2017, https://www.kff.org/medicaid/issue-brief/state-variation-in-medicaid-per-enrollee-spending-for-seniors-and-people-with-disabilities/.

rating" programs were expanded to inform choices. The law also raised the Medicare payroll tax for high-income people to support Medicare's Hospital Insurance Trust Fund.

28. The ACA included a major focus on preventive services (described below as well). It created an annual wellness visit in Medicare and eliminated cost sharing for certain evidence-based preventive services. In 2016, more than 10.3 million Medicare beneficiaries had an annual wellness visit and 40.1 million used at least one preventive service with no copay (provisions included in the ACA). It also included a provision that would gradually close the coverage gap or "donut hole" in Medicare's Part D drug benefit. Before the ACA, Medicare beneficiaries had no drug coverage after the standard benefit that ends with $2,830 in total spending and its catastrophic benefit that begins with $4,550 in out-of-pocket spending (2010 values). Because of changes contained in the ACA, nearly 12 million Medicare beneficiaries received cumulative prescription drug savings from 2010 to 2016 that averaged $2,272 per person ($1,149 per beneficiary in 2016 alone).[67] Research suggests the policy both reduced out-of-pocket costs and contributed to greater use of generic drugs.[68] Drug savings for Medicare – and other payers – will also flow from ACA's new pathway for approval of lower-cost "biosimilar" drugs. A RAND analysis estimated that this provision could reduce U.S. health spending by $54 billion from 2017 to 2026.[69]

29. Most of the ACA's savings come from reducing Medicare overpayments. The ACA, for the first time, built permanent productivity adjustments into Medicare payment formulas. The ACA also phased in new benchmark payment rates and reduced upcoding for risk in Medicare Advantage (MA). Despite concerns about an estimated 12 percentage point reduction in MA

[67] Centers for Medicare & Medicaid Services, Nearly 12 Million People with Medicare Have Saved over $26 Billion on Prescription Drugs since 2010, Press Release, January 2017, https://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2017-Press-releases-items/2017-01-13.html.

[68] Bonakdar Tehrani A and Cunningham PJ, Closing the Medicare Doughnut Hole: Changes in Prescription Drug Utilization and Out-of-Pocket Spending Among Medicare Beneficiaries With Part D Coverage After the Affordable Care Act, *Medical Care,* 55(1):43-49, 2017, https://journals.lww.com/lww-medicalcare/Abstract/2017/01000/Closing_the_Medicare_Doughnut_Hole__Changes_in.7.aspx.

[69] Mulcahy AW, Hlavka JP and Case SR, Biosimilar Cost Savings in in the United States, RAND Corporation, *Perspectives,* 2017, https://www.rand.org/pubs/perspectives/PE264.html.

rates, MA program enrollment has grown by over 70 percent and premiums have dropped since 2010.[70] The ACA also included new tools and resources to combat health care fraud; in 2015, the government recovered $2.4 billion, returning $6.10 for each dollar invested, and conducted its largest ever nationwide health care fraud takedown, charging 243 people with false billing.[71]

30. The ACA prioritized delivery system reform to promote more efficient, high-quality care, led by Medicare. As of 2016, nearly 30 percent of payments in Medicare and major private plans were made through new payment models, virtually none of which existed in 2010.[72] In 2017, 21 percent of Medicare beneficiaries received care from an ACO or medical home, with another 33 percent in Medicare Advantage.[73] Because these innovations are new, few evaluations have been done. Some demonstrations seem to have been successful. For example, the pioneer ACOs saved Medicare $24 million in 2016, reduced spending by 1 to 2 percent relative to a comparison group in 2013, and had overall quality composite scores that increased over time.[74] And, research has found that the bundled payments for lower extremity joint replacement reduced readmissions while cutting average Medicare per-episode spending by 21 percent if there were no complications and 14 percent if there were complications.[75]

31. Medicare is on stronger financial footing because of the ACA. In 2010, CBO estimated that the ACA would reduce Medicare spending by over $400 billion from 2010 to 2019.[76] A

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[70] Jacobson G, Damico A, Neuman T and Gold M, Medicare Advantage 2017 Spotlight: Enrollment Market Update, Henry J Kaiser Family Foundation, *Issue Brief,* June 2017, https://www.kff.org/medicare/issue-brief/medicare-advantage-2017-spotlight-enrollment-market-update/.

[71] Department of Justice, Fact Sheet; The Health Care Fraud and Abuse Control Program Protects Consumers and Taxpayers by Combating Health Care Fraud, Press Release, February 2016, https://www.justice.gov/opa/pr/fact-sheet-health-care-fraud-and-abuse-control-program-protects-conusmers-and-taxpayers.

[72] Health Care Payment Learning & Action Network, Measuring Progress: Adoption of Alternative Payment Models in Commercial, Medicaid, Medicare Advantage, and Fee-for-Service Medicare Programs, *Report,* October 2017, https://hcp-lan.org/groups/apm-fpt-work-products/apm-report/.

[73] Henry J Kaiser Family Foundation, Medicare Delivery System Reform: The Evidence Link, no date, https://www.kff.org/medicare-delivery-system-reform-the-evidence-link/.

[74] Henry J Kaiser Family Foundation, Medicare Delivery System Reform: The Evidence Link, Side-by-Side Comparison: Medicare Accountable Care Organization (ACO) Model, no date, https://www.kff.org/interactive/side-by-side-comparison-medicare-accountable-care-organization-aco-models/.

[75] Navathe AS, Troxl AB, Liao JM, Nan N, Zhu J, Zhon W, and Emanuel EJ, Cost of Joint Replacement Using Bundled Payment Models, *JAMA Intern Med.,* 177(2):214-222, 2017, https://jamanetwork.com/journals/jamainternalmedicine/article-abstract/2594805.

[76] Elmendorf DW, Letter to Honorable Nancy Pelosi, Speaker, U.S. House of Representatives, Congressional Budget Office, March 20, 2010, https://www.cbo.gov/sites/default/files/111th-congress-2009-2010/costestimate/amendreconprop.pdf

study by the U.S. Department of Health and Human Services found Medicare spent $473.1 billion less from 2009 to 2014 than it would have had the 2000 to 2008 average growth rate continued.[77] Reduced Medicare spending, combined with increased revenue, contributed to extending the life of Medicare's Hospital Insurance Trust Fund by 12 years (to 2029) as compared to its projected insolvency when the ACA was enacted (2017).[78] The benefits of slower Medicare cost growth accrue to beneficiaries and states as well. In 2016, Medicare premiums and cost sharing for traditional Medicare were $700 lower per beneficiary compared to what such spending would have been under 2009 projections.[79] States similarly have saved since they pay Medicare premiums and cost sharing for certain low-income beneficiaries.

The ACA Strengthened the Public Health System and Made Other Capacity Improvements

32. Key coverage and funding provisions of the ACA have protected millions of Americans from infectious and chronic diseases through clinical preventive services, funding for state and local public health services, and investments in healthier communities. It supports improving health system infrastructure through policies such as a new Community Health Center Fund to expand services, a program to build school-based health clinics, a permanent authorization of the Indian Health Care Improvement Act, and a set of workforce policies to promote primary care and increase the number of people trained through the National Health Service Corps. It also encourages integration of behavioral and primary care services through training programs as well its insurance and payment policies.

[77] Chappel A, Sheingold S and Nguyen N, Health Care Spending Growth And Federal Policy, Office of the Assistant Secretary for Planning and Evaluation, *Issue Brief,* March 2016, https://aspe.hhs.gov/system/files/pdf/190471/SpendingGrowth.pdf.
[78] *Medicare Trustees Report*. Note that 2029 was also the projection in the 2010 report in which the Trustees attributed much of the improvement to the ACA. For Trustees report, see: https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/index.html.
[79] Executive Office of the President Council of Economic Advisors, *2017 Economic Report of the President*, Chapter 4 Reforming the Health Care System, U.S. Government Publishing Office, 2017. https://obamawhitehouse.archives.gov/sites/default/files/docs/chapter_4-reforming_health_care_system_2017.pdf

33. The required coverage of clinical preventive services has resulted in increased use of key preventive services such as blood pressure and cholesterol screenings and flu vaccinations.[80] Insurance coverage of vaccinations and ACA investments in the Section 317 Immunization Program, totaling almost $768 million for fiscal years 2010 to 2017, have increased protection against vaccine-preventable diseases among Americans. For example, women were 3.3 times as likely to have had the HPV vaccine after implementation of the ACA.[81] Increased coverage of smoking cessation services under Medicaid, newly mandated under the ACA, has also been demonstrated both to reduce state health care costs and to improve health outcomes. One analysis in Massachusetts found savings of $3.12 in medical costs for every $1 spent on smoking cessation services.[82]

34. The Prevention and Public Health Fund (PPHF), a new funding stream created by the ACA, has sent over $3.9 billion to states since 2010 ($650 million for fiscal year 2017).[83] This fund has supported key programs, three of which are described below in paragraphs 35-37.

35. The PPHF funded *Tips from Former Smokers*, an advertising campaign to encourage quit attempts. The Centers for Disease Control and Prevention estimated that it led 500,000 people to quit smoking for good in the first five years of the campaign, with an estimated cost of $2,000 for every life saved from a smoking death.[84] In addition, states have received PPHF grants for their smoking cessation programs, totaling over $133 million since 2010.

36. The PPHF investment, including nearly $17 million in fiscal year 2017, permitted expansion of the Diabetes Prevention Program (DPP), a community-based lifestyle change

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[80] Han X, Yabroff KR, Guy GP, Zheng Z and Jemal A, Has Recommended Preventive Service Use Increased after Elimination of Cost-Sharing as Part of the Affordable Care Act in the United States? *Preventive Medicine,* 78:85–91, 2015, http://doi.org/10.1016/j.ypmed.2015.07.012.

[81] Corriero R, Gay JL, Robb SW and Stowe EW, Human Papillomavirus Vaccination Uptake Before and After the Affordable Care Act: Variation According to Insurance Status, Race, and Education (NHANES 2006-2014), *Journal of Pediatric and Adolescent Gynecology,* 31(1):23-27, 2017, https://doi.org/10.1016/j.jpag.2017.07.002.

[82] Richard P, West K and Ku L, The Return on Investment of a Medicaid Tobacco Cessation Program in Massachusetts, *PLoS ONE,* 7(1): e29665, 2012. https://doi.org/10.1371/journal.pone.0029665.https://doi.org/10.1371/journal.pone.0029665

[83] Trust for America's Health, Updated Prevention and Public Health Fund (PPHF) State Funding Data (FY10-FY17), March 2018, http://healthyamericans.org/health-issues/news/updated-prevention-and-public-health-fund-pphf-state-funding-data-fy10-fy17/

[84] Centers for Disease Control and Prevention, Tips Impact and Results, no date, https://www.cdc.gov/tobacco/campaign/tips/about/impact/campaign-impact-results.html?s_cid=OSH_tips_D9391.

program. This program has been shown to prevent progression to diabetes among many of those with prediabetes, resulting in savings and improved health outcomes. In testing by CMMI, DPP saved Medicare an estimated $2,650 for each person enrolled in DPP over a 15-month period.[85] The Medicare Diabetes Prevention Program (MDPP) is now available to all eligible beneficiaries.

37. PPHF has been critical in expanding and sustaining the capacity of state and local health departments to meet the needs of their communities, in particular through annual funding of the Preventive Health and Health Services Block Grant ($160 million a year) and Epidemiology and Laboratory Grants ($40 million a year). The two grants combined have put over $1.1 billion into communities in fiscal years 2010 through 2017.

38. The ACA invested $1.5 billion in the Maternal, Infant, and Early Childhood Home Visiting Grants to support state-level expansion of the Nurse-Family Partnership. This program has had a dramatic impact on medical care, child welfare, special education, and criminal justice system involvement by the families served by the program, with a savings to government programs of 1.9 times the cost.[86]

39. There is growing evidence that pediatric asthma, diabetes, heart disease and other chronic conditions are linked with social and economic factors or conditions where people live, grow, and work.[87] Through both the PPHF and CMMI, the ACA has supported investments in the multi-sector partnerships that can address the health-related social needs of people served by our health system. CMMI is supporting a $157 million initiative, Accountable Health Communities (AHC), in 23 states across the country as well as accountable communities for health models

[85] Centers for Medicare & Medicaid Services, Medicare Diabetes Prevention Program (MDPP) Expanded Model, no date, https://innovation.cms.gov/initiatives/medicare-diabetes-prevention-program/.
[86] Miller, TR, Projected Outcomes of Nurse-Family Partnership Home Visitation during 1996-2013, USA., *Prevention Science*, 16(6):765-777, 2015, https://www.ncbi.nlm.nih.gov/pubmed/26076883.
[87] Magnan, S, Social Determinants of Health 101 for Health Care: Five Plus Five. NAM Perspectives. *National Academy of Medicine*, 2017, https://nam.edu/social-determinants-of-health-101-for-health-care-five-plus-five.

through the State Innovation Models grants in 10 states.[88] Through various community prevention programs supported by the PPHF's over $1 billion investment from 2010 to 2017, every state has received support to build stronger partnerships across sectors that will improve the health of communities.

40. ACA investments have also expanded the health care workforce in every state. More primary care providers are now working in teams to address complex care needs of populations. The increases are due in large part to the expansion of primary care training programs for physicians, physician assistants, and nurse practitioners funded through the PPHF, which added approximately 4,500 providers.[89] There was also the expansion of residency training programs under the ACA, such as the Teaching Health Centers program, that added approximately 1,555 primary care physicians working in shortage areas. Through a $1.5 billion investment in the National Health Service Corps, the number of people served by Corps clinicians rose from 9 million in 2010 to 15.9 million in 2016. The ACA investment increased its number of health care providers from 7,358 to 15,159, including physicians, nurses, dentists, and behavior health providers serving in over 14,000 shortage area sites. Corps clinicians had an 80 percent retention rate after one year of completed service requirements.

41. The ACA invested in health care facilities as well as workers. Its Community Health Center Fund has been used, among other activities, for facility improvement, expanded access points, and expanded service capacity.[90] This Fund, plus the expansion of Medicaid, contributed to growth in the number of patients served from 19.5 million in 2010 to 25.9 million in 2016.[91] It supported construction and renovation of school-based health clinics, providing about 520

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[88] Centers for Medicare & Medicaid Services, CMS' Accountable Health Communities Model Selects 32 Participants to Serve as Local 'Hubs' Linking Clinical and Community Services, Press Release, April 2017, https://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2017-Press-releases-items/2017-04-06.html.

[89] Health Resources and Services Administration, *FY 2016 Annual Performance Report*, 2016, https://www.hrsa.gov/sites/default/files/about/budget/peformancereport2016.pdf.

[90] Congressional Research Service Reports, *The Community Health Center Fund: In Brief*, 2017, https://www.everycrsreport.com/reports/R43911.html.

[91] Rosenbaum S, Tolbert J, Sharac J, Shin P, Gunsalus R and Zur J, Community Health Centers: Growing Importance in a Changing Health System, Henry J Kaiser Family Foundation, *Issue Brief,* March 2018, http://files.kff.org/attachment/Issue-Brief-Community-Health-Centers-Growing-Importance-in-a-Changing-Health-Care-System

awards.[92] The ACA also authorized new programs within the Indian Health Service, including behavior health programs, and expanded subsidies in Medicaid and the Marketplaces for American Indians and Native Americans.[93]

Enjoining the ACA Would Cause Widespread Harm in All States for the Vast Majority of Americans

42. As this review of the impact of the ACA illustrates, enjoining the ACA would cause grievous immediate and long-term harm to Americans' health and financial security, to the health system, and to federal and state budgets. The law's provisions are so interwoven in the health system that the harms from an injunction would go far beyond negating the benefits directly traceable to the ACA. Some ACA policies could not simply fall back to what they were almost a decade ago. For example, Medicare probably could not make payments to Medicare Advantage plans pursuant to an injunction since the ACA replaced the previous payment system; 19 million beneficiaries could lose their plans and publicly traded insurers' stocks could plummet. Some programs that pre-dated the ACA would cease to function under an injunction. For example, the ACA's PPHF is now the only source of support for the long-standing Preventive and Public Health Services Block Grant. This grant supports critical services, including lab capacity to test for outbreaks of flu or virus-borne diseases such as Zika, responses to emerging public health threats such as the opioid epidemic, and chronic health threats such as damage to children through exposure to lead.[94] Beyond the heightened threat to public health,

[92] Pilkey D, Skopec L, Gee E, Finegold K, Amaya K and Robinson W, The Affordable Care Act and Adolescents, Office of the Assistant Secretary for Planning and Evaluation, *Research Brief,* August 2013, https://aspe.hhs.gov/system/files/pdf/180281/rb_adolescent.pdf.

[93] Ross RW, Garfield LD, Brown DS and Raghavan R, The Affordable Care Act and Implications for Health Care Services for American Indian and Alaska Native Individuals, *J Health Care Poor Underserved,* 26(4):1081-1088, 2015, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4824684/.

[94] Clary A, Rosenthal J, Riley T, The Prevention and Public Health Fund – Lessons from States; Questions for Policymakers, National Academy for State Health Policy, *State Health Policy Blog,* March 2017, https://nashp.org/the-prevention-and-public-health-fund-lessons-from-states-questions-for-policymakers/

states' credit ratings could fall due to their increased financial exposure from such funding cuts along with the loss of federal Medicaid funding.[95]

43. CBO acknowledged these and other challenges when it estimated the implications of the full repeal of the ACA in 2015. It projected that repealing the ACA would increase the federal budget deficit by $353 billion over ten years, not taking into account macroeconomic feedback. Medicare spending would increase by $802 billion over this period, raising seniors' premiums and hastening Medicare Trust Fund insolvency. CBO projected that 24 million people would become uninsured.[96]

44. CBO prepared similar estimates in 2016 and early 2017 when legislation to repeal parts of the ACA (without a replacement) was under consideration. The Urban Institute found that partial repeal would increase in the number of uninsured by 29.8 million, of whom 82 percent would be in working families and 38 percent would be young adults. This dramatic increase in the number of uninsured would increase the cost of uncompensated care by an estimated $1.1 trillion over a decade, which would put significant budget stress on state and local governments as well as the health system.[97] An analysis funded by the American Hospital Association estimated that income of hospitals would be reduced by $165.8 billion from 2018 to 2026.[98]

45. No analysis has systematically examined the immediate implications of an injunction of the entire law. It is not clear how Medicare would continue to make payments if the basis for those payment rates is nullified, whether states would get federal funding in the next quarter for service and eligibility categories authorized by the ACA, and if insurers no longer receiving premium tax credits could immediately revert to medical underwriting. Workers in programs

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[95] Schneider A, Fitch Report: Proposed Medicaid Cuts Could Impact States' Credit Ratings, Georgetown University Health Policy Institute, Center for Children and Families, *Say Ahhh! Blog,* June 2017, https://ccf.georgetown.edu/2017/06/28/fitch-report-medicaid-cuts-will-impact-states-schools-and-more/

[96] Congressional Budget Office, Budgetary and Economic Effects of Repealing the Affordable Care Act, June 2015, https://www.cbo.gov/sites/default/files/114th-congress-2015-2016/reports/50252-effectsofacarepeal.pdf

[97] Blumberg LK, Buettgens M and Holahan J, Implications of Partial Repeal of the ACA through Reconciliation, Urban Institute, *Report,* December 2016, https://www.urban.org/sites/default/files/publication/86236/2001013-the-implications-of-partial-repeal-of-the-aca-through-reconciliation_1.pdf

[98] Dobson DaVanzo & Associates, LLC, Estimating the Impact of Repealing the Affordable Care Act on Hospitals, 2016, American Hospital Association, *Report,* 2016, https://www.aha.org/system/files/2018-02/impact-repeal-aca-report_0.pdf

funded by the ACA, such as CMMI programs, may become immediately unemployed. Drug discounts provided to seniors with Medicare coverage could immediate cease. People with disabilities whose care is funded by Community First Choice could immediately lose access to care without state intervention. These few examples illustrate that enjoining the entire ACA would create both chaos and inflict harm.

State-Specific Impacts

46. Enjoining the ACA would harm the health system, public health, and budgets of states across the country. If people cannot access health coverage, more people will become uninsured, uncompensated care costs for states will increase, and states will be pressured to fill the void left from the ACA. The estimates described below come from four sources: (1) state fact sheets from the Department of Health and Human Services;[99] (2) Urban Institute estimates of the impact of a repeal of the ACA's funding-related provisions;[100] (3) the Trust for America's Health;[101] and (4) the Centers for Medicare and Medicaid Services.[102] While some of these numbers come from older or national versus state-specific studies, they are consistent in magnitude and direction with the likely impact of an injunction.

[99] Office of the Assistant Secretary of Planning and Evaluation, Compilation of State Data on the Affordable Care Act, December 2016, https://aspe.hhs.gov/compilation-state-data-affordable-care-act. Note that some estimates are not available for all states due to small sample size.

[100] Blumberg LK, Buettgens M and Holahan J, Implications of Partial Repeal of the ACA through Reconciliation, Urban Institute, *Report,* December 2016, https://www.urban.org/sites/default/files/publication/86236/2001013-the-implications-of-partial-repeal-of-the-aca-through-reconciliation_1.pdf.
Buettgens M, Blumberg LJ, Holahan J, The Impact on Health Care Providers of Partial ACA Repeal Through Reconciliation, Urban Institute, *Report,* January 2017, https://www.urban.org/sites/default/files/publication/86916/2001046-the-impact-on-health-care-providers-of-partial-aca-repeal-through-reconciliation_1.pdf.

[101] Trust for America's Health, Updated Prevention and Public Health Fund (PPHF) State Funding Data (FY10-FY17), March 2018, http://healthyamericans.org/health-issues/news/updated-prevention-and-public-health-fund-pphf-state-funding-data-fy10-fy17/

[102] Centers for Medicare & Medicaid Services, 2017 Effectuated Enrollment Snapshot, June 2017, https://downloads.cms.gov/files/effectuated-enrollment-snapshot-report-06-12-17.pdf; Centers for Medicare & Medicaid Services, Nearly 12 Million People with Medicare Have Saved over $26 Billion on Prescription Drugs since 2010, Press Release, January 2017, https://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2017-Press-releases-items/2017-01-13.html.

California

47. Between 2010 and 2015, an estimated 3,826,000 people in California gained coverage. This includes a large fraction of the people covered in the California Health Insurance Marketplace (called Covered California), an estimated 294,000 young adults who gained coverage by staying on their parents' health insurance, and those gaining coverage from the law's Medicaid (called Medi-Cal) expansion and employer shared responsibility policy. This coverage would be at risk if the ACA were enjoined.

48. **Impact on Consumer Protections**: Numerous consumer protections in private insurance would also be lost if the ACA were enjoined or if there were an injunction ending the law. Up to 16,133,192 people in California have a pre-existing condition and would be at risk for being charged unaffordable premiums or denied coverage altogether without the ACA. Before the ACA, 12,092,000 people in California with employer or individual market coverage had a lifetime limit on their insurance policy: annual and lifetime limits would return under an injunction to the ACA. An estimated 15,867,909 people in California, including 6,324,503 women ages 15–64, would lose federally guaranteed of preventive services — like flu shots, cancer screenings, and contraception – which are now provided at no extra cost to consumers. These are just a few of the ACA's consumer protections that could be lost if this court allows the ACA to be enjoined.

49. **Impact on Marketplace Coverage**: The ACA provides financial support for private coverage through premium tax credits and cost-sharing reductions. If the ACA were enjoined, individuals and families that have benefitted from these provisions would pay more for health coverage or go without it altogether. Many of the 1,389,886 people in California covered in the Health Insurance Marketplace would lose coverage without the ACA. In 2017, 85 percent of Marketplace enrollees in California received a premium tax credit that averaged $4,150 per person. That financial assistance would no longer be available under an injunction.

50. Impact on Medicaid: Without the ACA, an estimated 1,188,000 fewer people in California would have Medicaid coverage. The law's Medicaid expansion improved access to

care, financial security, and health. For example, it resulted in an estimated 136,000 more getting all needed care, 169,000 fewer struggling to pay medical bills, 109,000 fewer experiencing symptoms of depression, and 1,430 avoided deaths each year in California. Enjoining the law would put these benefits at risk, along with improvements to long-term services and supports, eligibility simplifications, and policies to lower drug costs and improve the quality of care in Medicaid. This could, for example, mean that people with disabilities in California's Community First Choice program could lose access to services.

51. **Impact on Medicare**: The 5,829,777 people with Medicare in California would also lose benefits and pay more under an injunction. Prescription drug discounts, which provided 403,631 people in California with $1,169 in average annual savings per beneficiary in 2016, would end. It would roll back the coverage of proven preventive services with no cost sharing which 3,879,678 people with Medicare in California used in 2016. It would suspend payment policies which would increase premiums, cost sharing, and well as taxpayer costs in California. It would also disrupt programs to reduce preventable patient harms and avoidable readmissions. Hospital readmissions for Medicare beneficiaries dropped between 2010 and 2015, which translates into 5,580 fewer unnecessary returns to the hospital in California in 2015. The 29 Accountable Care Organizations (ACOs) in California that offer Medicare beneficiaries the opportunity to receive higher quality, more coordinated care would no longer operate under an injunction.

52. **Impact on Public Health**: Support for public health in California would also be reduced under an injunction. California received $317,998,658 from the law's Prevention and Public Health Fund between fiscal years 2012 and 2016. This includes $61,653,559 for immunizations and $15,110,953 for tobacco cessation efforts.

53. **Impact on Finances**: The financial impact on California would be significant. From 2019 to 2028, it would lose $61.1 billion in federal Marketplace spending and $99.1 billion in federal Medicaid spending. The combined loss of federal spending over this period would be $160.2 billion. This would have a major impact on health care providers. From 2019 to 2028,

California hospitals could lose $64.1 billion and physicians could lose $24.7 billion. Uncompensated care costs in California would increase by $140.1 billion over this period.

Connecticut

54. Between 2010 and 2015, an estimated 110,000 people in Connecticut gained coverage. This includes a large fraction of the people covered in the Connecticut Health Insurance Marketplace (called AccessHealthCT), an estimated 25,000 young adults who gained coverage by staying on their parents' health insurance, and those gaining coverage from the law's Medicaid expansion and employer shared responsibility policy. This coverage would be at risk if the ACA were enjoined.

55. **Impact on Consumer Protections**: Numerous consumer protections in private insurance would also be lost if the ACA were enjoined or if there were an injunction ending the law. Up to 1,554,628 people in Connecticut have a pre-existing condition and would be at risk for being charged unaffordable premiums or denied coverage altogether without the ACA. Before the ACA, 1,386,000 people in Connecticut with employer or individual market coverage had a lifetime limit on their insurance policy: annual and lifetime limits would return under an injunction to the ACA. An estimated 1,819,938 people in Connecticut, including 746,444 women ages 15–64, would lose federally guaranteed of preventive services — like flu shots, cancer screenings, and contraception – which are now provided at no extra cost to consumers. These are just a few of the ACA's consumer protections that could be lost if this court allows the ACA to be enjoined.

56. **Impact on Marketplace Coverage:** The ACA provides financial support for private coverage through premium tax credits and cost-sharing reductions. If the ACA were enjoined, individuals and families that have benefitted from these provisions would pay more for health coverage or go without it altogether. Many of the 98,260 people in Connecticut covered in the Health Insurance Marketplace would lose coverage without the ACA. In 2017, 77 percent of

Marketplace enrollees in Connecticut received a premium tax credit that averaged $5,312 per person. That financial assistance would no longer be available under an injunction.

57. **Impact on Medicaid:** Without the ACA, an estimated 72,000 fewer people in Connecticut would have Medicaid coverage. The law's Medicaid expansion improved access to care, financial security, and health. For example, it resulted in an estimated 8,000 more getting all needed care, 10,200 fewer struggling to pay medical bills, 7,000 fewer experiencing symptoms of depression, and 90 avoided deaths each year in Connecticut. Enjoining the law would put these benefits at risk, along with improvements to long-term services and supports, eligibility simplifications, and policies to lower drug costs and improve the quality of care in Medicaid. This could, for example, mean that people with disabilities in Connecticut's Community First Choice program could lose access to services.

58. **Impact on Medicare:** The 644,136 people with Medicare in Connecticut would also lose benefits and pay more under an injunction. Prescription drug discounts, which provided 65,248 people in Connecticut with $1,268 in average annual savings per beneficiary in 2016, would end. It would roll back the coverage of proven preventive services with no cost sharing which 473,312 people with Medicare in Connecticut used in 2016. It would suspend payment policies which would increase premiums, cost sharing, and well as taxpayer costs in Connecticut. It would also disrupt programs to reduce preventable patient harms and avoidable readmissions. Hospital readmissions for Medicare beneficiaries dropped between 2010 and 2015, which translates into 1,306 fewer unnecessary returns to the hospital in Connecticut in 2015. The 12 Accountable Care Organizations (ACOs) in Connecticut that offer Medicare beneficiaries the opportunity to receive higher quality, more coordinated care would no longer operate under an injunction.

59. **Impact on Public Health**: Support for public health in Connecticut would also be reduced under an injunction. Connecticut received $86,545,015 from the law's Prevention and Public Health Fund between fiscal years 2012 and 2016. This includes $10,382,997 for immunizations and $971,964 for tobacco cessation efforts.

60. **Impact on Finances:** The financial impact on Connecticut would be significant. From 2019 to 2028, it would lose $4.3 billion in federal Marketplace spending and $10.5 billion in federal Medicaid spending. The combined loss of federal spending over this period would be $14.8 billion. This would have a major impact on health care providers. From 2019 to 2028, Connecticut hospitals could lose $6.0 billion and physicians could lose $2.4 billion. Uncompensated care costs in Connecticut would increase by $14.9 billion over this period.

Delaware

61. Between 2010 and 2015, an estimated 35,000 people in Delaware gained coverage. This includes a large fraction of the people covered in the Delaware Health Insurance Marketplace, an estimated 7,000 young adults who gained coverage by staying on their parents' health insurance, and those gaining coverage from the law's Medicaid expansion and employer shared responsibility policy. This coverage would be at risk if the ACA were enjoined.

62. **Impact on Consumer Protections:** Numerous consumer protections in private insurance would also be lost if the ACA were enjoined or if there were an injunction ending the law. Up to 383,607 people in Delaware have a pre-existing condition and would be at risk for being charged unaffordable premiums or denied coverage altogether without the ACA. Before the ACA, 320,000 people in Delaware with employer or individual market coverage had a lifetime limit on their insurance policy: annual and lifetime limits would return under an injunction to the ACA. An estimated 417,265 people in Delaware, including 171,575 women ages 15–64, would lose federally guaranteed of preventive services — like flu shots, cancer screenings, and contraception – which are now provided at no extra cost to consumers. These are just a few of the ACA's consumer protections that could be lost if this court allows the ACA to be enjoined.

63. **Impact on Marketplace Coverage:** The ACA provides financial support for private coverage through premium tax credits and cost-sharing reductions. If the ACA were enjoined, individuals and families that have benefitted from these provisions would pay more for health coverage or go without it altogether. Many of the 24,171 people in Delaware covered in the

Health Insurance Marketplace would lose coverage without the ACA. In 2017, 83 percent of Marketplace enrollees in Delaware received a premium tax credit that averaged $5,010 per person. That financial assistance would no longer be available under an injunction.

64. **Impact on Medicaid:** Without the ACA, an estimated 6,000 fewer people in Delaware would have Medicaid coverage. The law's Medicaid expansion improved access to care, financial security, and health. For example, it resulted in an estimated 1,000 more getting all needed care, 900 fewer struggling to pay medical bills, 1,000 fewer experiencing symptoms of depression, and 10 avoided deaths each year in Delaware. Enjoining the law would put these benefits at risk, along with improvements to long-term services and supports, eligibility simplifications, and policies to lower drug costs and improve the quality of care in Medicaid.

65. **Impact on Medicare:** The 186,835 people with Medicare in Delaware would also lose benefits and pay more under an injunction. Prescription drug discounts, which provided 23,485 people in Delaware with $1,292 in average annual savings per beneficiary in 2016, would end. It would roll back the coverage of proven preventive services with no cost sharing which 149,051 people with Medicare in Delaware used in 2016. It would suspend payment policies which would increase premiums, cost sharing, and well as taxpayer costs in Delaware. It would also disrupt programs to reduce preventable patient harms and avoidable readmissions. Hospital readmissions for Medicare beneficiaries dropped between 2010 and 2015, which translates into 575 fewer unnecessary returns to the hospital in Delaware in 2015. The 7 Accountable Care Organizations (ACOs) in Delaware that offer Medicare beneficiaries the opportunity to receive higher quality, more coordinated care would no longer operate under an injunction.

66. **Impact on Public Health:** Support for public health in Delaware would also be reduced under an injunction. Delaware received $34,384,937 from the law's Prevention and Public Health Fund between fiscal years 2012 and 2016. This includes $5,146,859 for immunizations and $314,964 for tobacco cessation efforts.

67. **Impact on Finances:** The financial impact on Delaware would be significant. From 2019 to 2028, it would lose $900 million in federal Marketplace spending and $2.7 billion in federal

Medicaid spending. The combined loss of federal spending over this period would be $3.6 billion. This would have a major impact on health care providers. From 2019 to 2028, Delaware hospitals could lose $1.5 billion and physicians could lose $500 million. Uncompensated care costs in Delaware would increase by $2.8 billion over this period.

District of Columbia

68. Between 2010 and 2015, an estimated 25,000 people in the District of Columbia gained coverage. This includes a large fraction of the people covered in the District of Columbia Health Insurance Marketplace (called DC Health Link), an estimated 6,000 young adults who gained coverage by staying on their parents' health insurance, and those gaining coverage from the law's Medicaid expansion and employer shared responsibility policy. This coverage would be at risk if the ACA were enjoined.

69. **Impact on Consumer Protections:** Numerous consumer protections in private insurance would also be lost if the ACA were enjoined or if there were an injunction ending the law. Up to 268,134 people in the District of Columbia have a pre-existing condition and would be at risk for being charged unaffordable premiums or denied coverage altogether without the ACA. Before the ACA, 208,000 people in the District of Columbia with employer or individual market coverage had a lifetime limit on their insurance policy: annual and lifetime limits would return under an injunction to the ACA. An estimated 281,235 people in the District of Columbia, including 127,531 women ages 15–64, would lose federally guaranteed of preventive services — like flu shots, cancer screenings, and contraception – which are now provided at no extra cost to consumers. These are just a few of the ACA's consumer protections that could be lost if this court allows the ACA to be enjoined.

70. **Impact on Marketplace Coverage:** The ACA provides financial support for private coverage through premium tax credits and cost-sharing reductions. If the ACA were enjoined, individuals and families that have benefitted from these provisions would pay more for health coverage or go without it altogether. Many of the 18,038 people in the District of Columbia

covered in the Health Insurance Marketplace would lose coverage without the ACA. In 2017, 4 percent of Marketplace enrollees in the District of Columbia received a premium tax credit that averaged $2,967 per person. That financial assistance would no longer be available under an injunction.

71. **Impact on Medicaid:** Without the ACA, an estimated 16,000 fewer people in the District of Columbia would have Medicaid coverage. The law's Medicaid expansion improved access to care, financial security, and health. For example, it resulted in an estimated 2,000 more getting all needed care, 2,300 fewer struggling to pay medical bills, 1,000 fewer experiencing symptoms of depression, and 20 avoided deaths each year in the District of Columbia. Enjoining the law would put these benefits at risk, along with improvements to long-term services and supports, eligibility simplifications, and policies to lower drug costs and improve the quality of care in Medicaid.

72. **Impact on Medicare:** The 90,492 people with Medicare in the District of Columbia would also lose benefits and pay more under an injunction. Prescription drug discounts, which provided 3,360 people in the District of Columbia with $1,181 in average annual savings per beneficiary in 2016, would end. It would roll back the coverage of proven preventive services with no cost sharing which 54,535 people with Medicare in the District of Columbia used in 2016. It would suspend payment policies which would increase premiums, cost sharing, and well as taxpayer costs in the District of Columbia. It would also disrupt programs to reduce preventable patient harms and avoidable readmissions. Hospital readmissions for Medicare beneficiaries dropped between 2010 and 2015, which translates into 346 fewer unnecessary returns to the hospital in the District of Columbia in 2015. The 8 Accountable Care Organizations (ACOs) in the District of Columbia that offer Medicare beneficiaries the opportunity to receive higher quality, more coordinated care would no longer operate under an injunction.

73. **Impact on Public Health:** Support for public health in the District of Columbia would also be reduced under an injunction. The District of Columbia received $79,091,220 from the

law's Prevention and Public Health Fund between fiscal years 2012 and 2016. This includes $9,212,443 for immunizations and $2,144,515 for tobacco cessation efforts.

74. **Impact on Finances:** The financial impact on the District of Columbia would be significant. From 2019 to 2028, it would lose about $100 million in federal Marketplace spending and $1.7 billion in federal Medicaid spending. The combined loss of federal spending over this period would be about $1.7 billion. This would have a major impact on health care providers. From 2019 to 2028, District of Columbia hospitals could lose $700 million and physicians could lose $200 million. Uncompensated care costs in the District of Columbia would increase by $1.7 billion over this period.

Hawaii

75. Between 2010 and 2015, an estimated 54,000 people in Hawaii gained coverage. This includes a large fraction of the people covered in the Hawaii Health Insurance Marketplace, an estimated 9,000 young adults who gained coverage by staying on their parents' health insurance, and those gaining coverage from the law's Medicaid expansion and employer shared responsibility policy. This coverage would be at risk if the ACA were enjoined.

76. **Impact on Consumer Protections:** Numerous consumer protections in private insurance would also be lost if the ACA were enjoined or if there were an injunction ending the law. Up to 560,494 people in Hawaii have a pre-existing condition and would be at risk for being charged unaffordable premiums or denied coverage altogether without the ACA. Before the ACA, 462,000 people in Hawaii with employer or individual market coverage had a lifetime limit on their insurance policy: annual and lifetime limits would return under an injunction to the ACA. An estimated 631,152 people in Hawaii, including 256,448 women ages 15–64, would lose federally guaranteed of preventive services — like flu shots, cancer screenings, and contraception – which are now provided at no extra cost to consumers. These are just a few of the ACA's consumer protections that could be lost if this court allows the ACA to be enjoined.

77. **Impact on Marketplace Coverage:** The ACA provides financial support for private coverage through premium tax credits and cost-sharing reductions. If the ACA were enjoined, individuals and families that have benefitted from these provisions would pay more for health coverage or go without it altogether. Many of the 16,711 people in Hawaii covered in the Health Insurance Marketplace would lose coverage without the ACA. In 2017, 82 percent of Marketplace enrollees in Hawaii received a premium tax credit that averaged $4,238 per person. That financial assistance would no longer be available under an injunction.

78. **Impact on Medicaid:** Without the ACA, an estimated 33,000 fewer people in Hawaii would have Medicaid coverage. The law's Medicaid expansion improved access to care, financial security, and health. For example, it resulted in an estimated 4,000 more getting all needed care, 4,700 fewer struggling to pay medical bills, 3,000 fewer experiencing symptoms of depression, and 40 avoided deaths each year in Hawaii. Enjoining the law would put these benefits at risk, along with improvements to long-term services and supports, eligibility simplifications, and policies to lower drug costs and improve the quality of care in Medicaid.

79. **Impact on Medicare:** The 252,514 people with Medicare in Hawaii would also lose benefits and pay more under an injunction. Prescription drug discounts, which provided 22,212 people in Hawaii with $1,361 in average annual savings per beneficiary in 2016, would end. It would roll back the coverage of proven preventive services with no cost sharing which 158,239 people with Medicare in Hawaii used in 2016. It would suspend payment policies which would increase premiums, cost sharing, and well as taxpayer costs in Hawaii. It would also disrupt programs to reduce preventable patient harms and avoidable readmissions. Hospital readmissions for Medicare beneficiaries dropped between 2010 and 2015, which translates into 315 fewer unnecessary returns to the hospital in Hawaii in 2015.

80. **Impact on Public Health:** Support for public health in Hawaii would also be reduced under an injunction. Hawaii received $30,145,284 from the law's Prevention and Public Health Fund between fiscal years 2012 and 2016. This includes $3,914,688 for immunizations and $227,370 for tobacco cessation efforts.

81. **Impact on Finances:** The financial impact on Hawaii would be significant. From 2019 to 2028, it would lose $500 million in federal Marketplace spending and $3.7 billion in federal Medicaid spending. The combined loss of federal spending over this period would be $4.3 billion. This would have a major impact on health care providers. From 2019 to 2028, Hawaii hospitals could lose $2.6 billion and physicians could lose $800 million. Uncompensated care costs in Hawaii would increase by $2.8 billion over this period.

Illinois

82. Between 2010 and 2015, an estimated 850,000 people in Illinois gained coverage. This includes a large fraction of the people covered in the Illinois Health Insurance Marketplace, an estimated 91,000 young adults who gained coverage by staying on their parents' health insurance, and those gaining coverage from the law's Medicaid expansion and employer shared responsibility policy. This coverage would be at risk if the ACA were enjoined.

83. **Impact on Consumer Protections:** Numerous consumer protections in private insurance would also be lost if the ACA were enjoined or if there were an injunction ending the law. Up to 5,635,622 people in Illinois have a pre-existing condition and would be at risk for being charged unaffordable premiums or denied coverage altogether without the ACA. Before the ACA, 4,670,000 people in Illinois with employer or individual market coverage had a lifetime limit on their insurance policy: annual and lifetime limits would return under an injunction to the ACA. An estimated 5,883,105 people in Illinois, including 2,380,326 women ages 15–64, would lose federally guaranteed of preventive services — like flu shots, cancer screenings, and contraception – which are now provided at no extra cost to consumers. These are just a few of the ACA's consumer protections that could be lost if this court allows the ACA to be enjoined.

84. **Impact on Marketplace Coverage:** The ACA provides financial support for private coverage through premium tax credits and cost-sharing reductions. If the ACA were enjoined, individuals and families that have benefitted from these provisions would pay more for health coverage or go without it altogether. Many of the 314,038 people in Illinois covered in the

Health Insurance Marketplace would lose coverage without the ACA. In 2017, 81 percent of Marketplace enrollees in Illinois received a premium tax credit that averaged $4,372 per person. That financial assistance would no longer be available under an injunction.

85. **Impact on Medicaid:** Without the ACA, an estimated 340,000 fewer people in Illinois would have Medicaid coverage. The law's Medicaid expansion improved access to care, financial security, and health. For example, it resulted in an estimated 39,000 more getting all needed care, 48,400 fewer struggling to pay medical bills, 31,000 fewer experiencing symptoms of depression, and 410 avoided deaths each year in Illinois. Enjoining the law would put these benefits at risk, along with improvements to long-term services and supports, eligibility simplifications, and policies to lower drug costs and improve the quality of care in Medicaid.

86. **Impact on Medicare:** The 2,118,300 people with Medicare in Illinois would also lose benefits and pay more under an injunction. Prescription drug discounts, which provided 187,357 people in Illinois with $1,133 in average annual savings per beneficiary in 2016, would end. It would roll back the coverage of proven preventive services with no cost sharing which 1,546,769 people with Medicare in Illinois used in 2016. It would suspend payment policies which would increase premiums, cost sharing, and well as taxpayer costs in Illinois. It would also disrupt programs to reduce preventable patient harms and avoidable readmissions. Hospital readmissions for Medicare beneficiaries dropped between 2010 and 2015, which translates into 8,108 fewer unnecessary returns to the hospital in Illinois in 2015. The 29 Accountable Care Organizations (ACOs) in Illinois that offer Medicare beneficiaries the opportunity to receive higher quality, more coordinated care would no longer operate under an injunction.

87. **Impact on Public Health:** Support for public health in Illinois would also be reduced under an injunction. Illinois received $115,192,088 from the law's Prevention and Public Health Fund between fiscal years 2012 and 2016. This includes $28,383,246 for immunizations and $5,106,535 for tobacco cessation efforts.

88. **Impact on Finances:** The financial impact on Illinois would be significant. From 2019 to 2028, it would lose $12.5 billion in federal Marketplace spending and $37.4 billion in federal

Medicaid spending. The combined loss of federal spending over this period would be $49.9 billion. This would have a major impact on health care providers. From 2019 to 2028, Illinois hospitals could lose $24.6 billion and physicians could lose $8.0 billion. Uncompensated care costs in Illinois would increase by $54.5 billion over this period.

Kentucky

89. Between 2010 and 2015, an estimated 404,000 people in Kentucky gained coverage. This includes a large fraction of the people covered in the Kentucky Health Insurance Marketplace, an estimated 31,000 young adults who gained coverage by staying on their parents' health insurance, and those gaining coverage from the law's Medicaid expansion and employer shared responsibility policy. This coverage would be at risk if the ACA were enjoined.

90. **Impact on Consumer Protections:** Numerous consumer protections in private insurance would also be lost if the ACA were enjoined or if there were an injunction ending the law. Up to 1,894,874 people in Kentucky have a pre-existing condition and would be at risk for being charged unaffordable premiums or denied coverage altogether without the ACA. Before the ACA, 1,414,000 people in Kentucky with employer or individual market coverage had a lifetime limit on their insurance policy: annual and lifetime limits would return under an injunction to the ACA. An estimated 1,884,719 people in Kentucky, including 762,897 women ages 15–64, would lose federally guaranteed of preventive services — like flu shots, cancer screenings, and contraception – which are now provided at no extra cost to consumers. These are just a few of the ACA's consumer protections that could be lost if this court allows the ACA to be enjoined.

91. **Impact on Marketplace Coverage:** The ACA provides financial support for private coverage through premium tax credits and cost-sharing reductions. If the ACA were enjoined, individuals and families that have benefitted from these provisions would pay more for health coverage or go without it altogether. Many of the 71,585 people in Kentucky covered in the Health Insurance Marketplace would lose coverage without the ACA. In 2017, 78 percent of

Marketplace enrollees in Kentucky received a premium tax credit that averaged $3,519 per person. That financial assistance would no longer be available under an injunction.

92. **Impact on Medicaid:** Without the ACA, an estimated 151,000 fewer people in Kentucky would have Medicaid coverage. The law's Medicaid expansion improved access to care, financial security, and health. For example, it resulted in an estimated 17,000 more getting all needed care, 21,500 fewer struggling to pay medical bills, 14,000 fewer experiencing symptoms of depression, and 180 avoided deaths each year in Kentucky. Enjoining the law would put these benefits at risk, along with improvements to long-term services and supports, eligibility simplifications, and policies to lower drug costs and improve the quality of care in Medicaid.

93. **Impact on Medicare:** The 881,938 people with Medicare in Kentucky would also lose benefits and pay more under an injunction. Prescription drug discounts, which provided 83,989 people in Kentucky with $1,194 in average annual savings per beneficiary in 2016, would end. It would roll back the coverage of proven preventive services with no cost sharing which 634,656 people with Medicare in Kentucky used in 2016. It would suspend payment policies which would increase premiums, cost sharing, and well as taxpayer costs in Kentucky. It would also disrupt programs to reduce preventable patient harms and avoidable readmissions. Hospital readmissions for Medicare beneficiaries dropped between 2010 and 2015, which translates into 2,384 fewer unnecessary returns to the hospital in Kentucky in 2015. The 22 Accountable Care Organizations (ACOs) in Kentucky that offer Medicare beneficiaries the opportunity to receive higher quality, more coordinated care would no longer operate under an injunction.

94. **Impact on Public Health:** Support for public health in Kentucky would also be reduced under an injunction. Kentucky received $36,712,458 from the law's Prevention and Public Health Fund between fiscal years 2012 and 2016. This includes $11,025,151 for immunizations and $2,112,229 for tobacco cessation efforts.

95. **Impact on Finances:** The financial impact on Kentucky would be significant. From 2019 to 2028, it would lose $2.9 billion in federal Marketplace spending and $46.8 billion in federal Medicaid spending. The combined loss of federal spending over this period would be $49.7

billion. This would have a major impact on health care providers. From 2019 to 2028, Kentucky hospitals could lose $23.1 billion and physicians could lose $6.9 billion. Uncompensated care costs in Kentucky would increase by $15.6 billion over this period.

Massachusetts

96. Between 2010 and 2015, an estimated 107,000 people in Massachusetts gained coverage. This includes a large fraction of the people covered in the Massachusetts Health Insurance Marketplace (called the Massachusetts Health Connector), an estimated 52,000 young adults who gained coverage by staying on their parents' health insurance, and those gaining coverage from the law's Medicaid expansion and employer shared responsibility policy. This coverage would be at risk if the ACA were enjoined.

97. **Impact on Consumer Protections:** Numerous consumer protections in private insurance would also be lost if the ACA were enjoined or if there were an injunction ending the law. Up to 2,931,068 people in Massachusetts have a pre-existing condition and would be at risk for being charged unaffordable premiums without the ACA. Before the ACA, 2,520,000 people in Massachusetts with employer or individual market coverage had a lifetime limit on their insurance policy: annual and lifetime limits would return under an injunction to the ACA. An estimated 3,399,092 people in Massachusetts, including 1,412,394 women ages 15–64, would lose federally guaranteed of preventive services — like flu shots, cancer screenings, and contraception – which are now provided at no extra cost to consumers. These are just a few of the ACA's consumer protections that could be lost if this court allows the ACA to be enjoined.

98. **Impact on Marketplace Coverage:** The ACA provides financial support for private coverage through premium tax credits and cost-sharing reductions. If the ACA were enjoined, individuals and families that have benefitted from these provisions would pay more for health coverage or go without it altogether. Many of the 242,221 people in Massachusetts covered in the Health Insurance Marketplace would lose coverage without the ACA. In 2017, 74 percent of

Marketplace enrollees in Massachusetts received a premium tax credit that averaged $2,135 per person. That financial assistance would no longer be available under an injunction.

99. **Impact on Medicaid:** Without the ACA, an estimated 2,000 fewer people in Massachusetts would have Medicaid coverage. The law's Medicaid expansion improved access to care, financial security, and health. Enjoining the law would put these benefits at risk, along with improvements to long-term services and supports, eligibility simplifications, and policies to lower drug costs and improve the quality of care in Medicaid.

100. **Impact on Medicare:** The 1,252,277 people with Medicare in Massachusetts would also lose benefits and pay more under an injunction. Prescription drug discounts, which provided 90,664 people in Massachusetts with $1,194 in average annual savings per beneficiary in 2016, would end. It would roll back the coverage of proven preventive services with no cost sharing which 938,405 people with Medicare in Massachusetts used in 2016. It would suspend payment policies which would increase premiums, cost sharing, and well as taxpayer costs in Massachusetts. It would also disrupt programs to reduce preventable patient harms and avoidable readmissions. Hospital readmissions for Medicare beneficiaries dropped between 2010 and 2015, which translates into 2,213 fewer unnecessary returns to the hospital in Massachusetts in 2015. The 14 Accountable Care Organizations (ACOs) in Massachusetts that offer Medicare beneficiaries the opportunity to receive higher quality, more coordinated care would no longer operate under an injunction.

101. **Impact on Public Health:** Support for public health in Massachusetts would also be reduced under an injunction. Massachusetts received $108,021,166 from the law's Prevention and Public Health Fund between fiscal years 2012 and 2016. This includes $12,404,884 for immunizations and $2,147,272 for tobacco cessation efforts.

102. **Impact on Finances:** The financial impact on Massachusetts would be significant. From 2019 to 2028, it would lose $5.4 billion in federal Marketplace spending and $17.2 billion in federal Medicaid spending. The combined loss of federal spending over this period would be $22.5 billion. This would have a major impact on health care providers. From 2019 to 2028,

Massachusetts hospitals could lose $6.1 billion and physicians could lose $2.6 billion. Uncompensated care costs in Massachusetts would increase by $17.1 billion over this period.

New Jersey

103. Between 2010 and 2015, an estimated 398,000 people in New Jersey gained coverage. This includes a large fraction of the people covered in the New Jersey Health Insurance Marketplace, an estimated 59,000 young adults who gained coverage by staying on their parents' health insurance, and those gaining coverage from the law's Medicaid expansion and employer shared responsibility policy. This coverage would be at risk if the ACA were enjoined.

104. **Impact on Consumer Protections:** Numerous consumer protections in private insurance would also be lost if the ACA were enjoined or if there were an injunction ending the law. Up to 3,847,727 people in New Jersey have a pre-existing condition and would be at risk for being charged unaffordable premiums or denied coverage altogether without the ACA. Before the ACA, 3,274,000 people in New Jersey with employer or individual market coverage had a lifetime limit on their insurance policy: annual and lifetime limits would return under an injunction to the ACA. An estimated 4,210,183 people in New Jersey, including 1,701,115 women ages 15–64, would lose federally guaranteed of preventive services — like flu shots, cancer screenings, and contraception – which are now provided at no extra cost to consumers. These are just a few of the ACA's consumer protections that could be lost if this court allows the ACA to be enjoined.

105. **Impact on Marketplace Coverage:** The ACA provides financial support for private coverage through premium tax credits and cost-sharing reductions. If the ACA were enjoined, individuals and families that have benefitted from these provisions would pay more for health coverage or go without it altogether. Many of the 243,743 people in New Jersey covered in the Health Insurance Marketplace would lose coverage without the ACA. In 2017, 79 percent of Marketplace enrollees in New Jersey received a premium tax credit that averaged $4,205 per person. That financial assistance would no longer be available under an injunction.

106. **Impact on Medicaid:** Without the ACA, an estimated 194,000 fewer people in New Jersey would have Medicaid coverage. The law's Medicaid expansion improved access to care, financial security, and health. For example, it resulted in an estimated 22,000 more getting all needed care, 27,600 fewer struggling to pay medical bills, 18,000 fewer experiencing symptoms of depression, and 230 avoided deaths each year in New Jersey. Enjoining the law would put these benefits at risk, along with improvements to long-term services and supports, eligibility simplifications, and policies to lower drug costs and improve the quality of care in Medicaid.

107. **Impact on Medicare:** The 1,528,961 people with Medicare in New Jersey would also lose benefits and pay more under an injunction. Prescription drug discounts, which provided 202,098 people in New Jersey with $1,344 in average annual savings per beneficiary in 2016, would end. It would roll back the coverage of proven preventive services with no cost sharing which 1,131,754 people with Medicare in New Jersey used in 2016. It would suspend payment policies which would increase premiums, cost sharing, and well as taxpayer costs in New Jersey. It would also disrupt programs to reduce preventable patient harms and avoidable readmissions. Hospital readmissions for Medicare beneficiaries dropped between 2010 and 2015, which translates into 6,774 fewer unnecessary returns to the hospital in New Jersey in 2015. The 29 Accountable Care Organizations (ACOs) in New Jersey that offer Medicare beneficiaries the opportunity to receive higher quality, more coordinated care would no longer operate under an injunction.

108. **Impact on Public Health:** Support for public health in New Jersey would also be reduced under an injunction. New Jersey received $54,491,391 from the law's Prevention and Public Health Fund between fiscal years 2012 and 2016. This includes $14,039,534 for immunizations and $2,578,857 for tobacco cessation efforts.

109. **Impact on Finances:** The financial impact on New Jersey would be significant. From 2019 to 2028, it would lose $6.7 billion in federal Marketplace spending and $53 billion in federal Medicaid spending. The combined loss of federal spending over this period would be $59.7 billion. This would have a major impact on health care providers. From 2019 to 2028, New

Jersey hospitals could lose $30.2 billion and physicians could lose $10.4 billion. Uncompensated care costs in New Jersey would increase by $29.0 billion over this period.

New York

110. Between 2010 and 2015, an estimated 939,000 people in New York gained coverage. This includes a large fraction of the people covered in the New York Health Insurance Marketplace (called New York State of Health), an estimated 147,000 young adults who gained coverage by staying on their parents' health insurance, and those gaining coverage from the law's Medicaid expansion and employer shared responsibility policy. This coverage would be at risk if the ACA were enjoined.

111. **Impact on Consumer Protections:** Numerous consumer protections in private insurance would also be lost if the ACA were enjoined or if there were an injunction ending the law. Up to 8,616,234 people in New York have a pre-existing condition and would be at risk for being charged unaffordable premiums or denied coverage altogether without the ACA. Before the ACA, 6,432,000 people in New York with employer or individual market coverage had a lifetime limit on their insurance policy: annual and lifetime limits would return under an injunction to the ACA. An estimated 8,619,856 people in New York, including 3,582,133 women ages 15–64, would lose federally guaranteed of preventive services — like flu shots, cancer screenings, and contraception – which are now provided at no extra cost to consumers. These are just a few of the ACA's consumer protections that could be lost if this court allows the ACA to be enjoined.

112. **Impact on Marketplace Coverage:** The ACA provides financial support for private coverage through premium tax credits and cost-sharing reductions. If the ACA were enjoined, individuals and families that have benefitted from these provisions would pay more for health coverage or go without it altogether. Many of the 207,083 people in New York covered in the Health Insurance Marketplace would lose coverage without the ACA. In 2017, 55 percent of

Marketplace enrollees in New York received a premium tax credit that averaged $2,763 per person. That financial assistance would no longer be available under an injunction.

113. **Impact on Medicaid:** Without the ACA, an estimated 143,000 fewer people in New York would have Medicaid coverage. The law's Medicaid expansion improved access to care, financial security, and health. For example, it resulted in an estimated 16,000 more getting all needed care, 20,300 fewer struggling to pay medical bills, 13,000 fewer experiencing symptoms of depression, and 170 avoided deaths each year in New York. Enjoining the law would put these benefits at risk, along with improvements to long-term services and supports, eligibility simplifications, and policies to lower drug costs and improve the quality of care in Medicaid. This could, for example, mean that people with disabilities in New York's Community First Choice program could lose access to services.

114. **Impact on Medicare:** The 3,424,666 people with Medicare in New York would also lose benefits and pay more under an injunction. Prescription drug discounts, which provided 348,566 people in New York with $1,320 in average annual savings per beneficiary in 2016, would end. It would roll back the coverage of proven preventive services with no cost sharing which 2,440,280 people with Medicare in New York used in 2016. It would suspend payment policies which would increase premiums, cost sharing, and well as taxpayer costs in New York. It would also disrupt programs to reduce preventable patient harms and avoidable readmissions. Hospital readmissions for Medicare beneficiaries dropped between 2010 and 2015, which translates into 8,407 fewer unnecessary returns to the hospital in New York in 2015. The 38 Accountable Care Organizations (ACOs) in New York that offer Medicare beneficiaries the opportunity to receive higher quality, more coordinated care would no longer operate under an injunction.

115. **Impact on Public Health:** Support for public health in New York would also be reduced under an injunction. New York received $211,920,470 from the law's Prevention and Public Health Fund between fiscal years 2012 and 2016. This includes $49,114,866 for immunizations and $6,245,494 for tobacco cessation efforts.

116. **Impact on Finances:** The financial impact on New York would be significant. From 2019 to 2028, it would lose $9.9 billion in federal Marketplace spending and $47.3 billion in federal Medicaid spending. The combined loss of federal spending over this period would be $57.2 billion. This would have a major impact on health care providers. From 2019 to 2028, New York hospitals could lose $23.2 billion and physicians could lose $9.0 billion. Uncompensated care costs in New York would increase by $47.4 billion over this period.

North Carolina

117. Between 2010 and 2015, an estimated 552,000 people in North Carolina gained coverage. This includes a large fraction of the people covered in the North Carolina Health Insurance Marketplace, an estimated 70,000 young adults who gained coverage by staying on their parents' health insurance, and those gaining coverage from the law's Medicaid expansion and employer shared responsibility policy. This coverage would be at risk if the ACA were enjoined.

118. **Impact on Consumer Protections:** Numerous consumer protections in private insurance would also be lost if the ACA were enjoined or if there were an injunction ending the law. Up to 4,099,922 people in North Carolina have a pre-existing condition and would be at risk for being charged unaffordable premiums or denied coverage altogether without the ACA. Before the ACA, 3,091,000 people in North Carolina with employer or individual market coverage had a lifetime limit on their insurance policy: annual and lifetime limits would return under an injunction to the ACA. An estimated 3,966,308 people in North Carolina, including 1,631,312 women ages 15–64, would lose federally guaranteed of preventive services — like flu shots, cancer screenings, and contraception – which are now provided at no extra cost to consumers. These are just a few of the ACA's consumer protections that could be lost if this court allows the ACA to be enjoined.

119. **Impact on Marketplace Coverage:** The ACA provides financial support for private coverage through premium tax credits and cost-sharing reductions. If the ACA were enjoined, individuals and families that have benefitted from these provisions would pay more for health

coverage or go without it altogether. Many of the 450,822 people in North Carolina covered in the Health Insurance Marketplace would lose coverage without the ACA. In 2017, 93 percent of Marketplace enrollees in North Carolina received a premium tax credit that averaged $7,100 per person. That financial assistance would no longer be available under an injunction.

120. **Impact on Medicaid:** Without the ACA, an estimated 313,000 fewer people in North Carolina would have Medicaid coverage. The law's Medicaid expansion improved access to care, financial security, and health. For example, it resulted in an estimated 36,000 more getting all needed care, 44,500 fewer struggling to pay medical bills, 29,000 fewer experiencing symptoms of depression, and 380 avoided deaths each year in North Carolina. Enjoining the law would put these benefits at risk, along with improvements to long-term services and supports, eligibility simplifications, and policies to lower drug costs and improve the quality of care in Medicaid.

121. **Impact on Medicare:** The 1,823,454 people with Medicare in North Carolina would also lose benefits and pay more under an injunction. Prescription drug discounts, which provided 165,931 people in North Carolina with $1,117 in average annual savings per beneficiary in 2016, would end. It would roll back the coverage of proven preventive services with no cost sharing which 1,377,219 people with Medicare in North Carolina used in 2016. It would suspend payment policies which would increase premiums, cost sharing, and well as taxpayer costs in North Carolina. It would also disrupt programs to reduce preventable patient harms and avoidable readmissions. Hospital readmissions for Medicare beneficiaries dropped between 2010 and 2015, which translates into 2,472 fewer unnecessary returns to the hospital in North Carolina in 2015. The 20 Accountable Care Organizations (ACOs) in North Carolina that offer Medicare beneficiaries the opportunity to receive higher quality, more coordinated care would no longer operate under an injunction.

122. **Impact on Public Health:** Support for public health in North Carolina would also be reduced under an injunction. North Carolina received $109,531,769 from the law's Prevention

and Public Health Fund between fiscal years 2012 and 2016. This includes $12,919,323 for immunizations and $3,778,227 for tobacco cessation efforts.

123. **Impact on Finances:** The financial impact on North Carolina would be significant. From 2019 to 2028, it would lose $38.2 billion in federal Marketplace spending and $20.7 billion in federal Medicaid spending. The combined loss of federal spending over this period would be $59.0 billion. This would have a major impact on health care providers. From 2019 to 2028, North Carolina hospitals could lose $22.7 billion and physicians could lose $8.7 billion. Uncompensated care costs in North Carolina would increase by $35.0 billion over this period.

Oregon

124. Between 2010 and 2015, an estimated 403,000 people in Oregon gained coverage. This includes a large fraction of the people covered in the Oregon Health Insurance Marketplace called OregonHealthCare.gov, an estimated 28,000 young adults who gained coverage by staying on their parents' health insurance, and those gaining coverage from the law's Medicaid expansion and employer shared responsibility policy. This coverage would be at risk if the ACA were enjoined.

125. **Impact on Consumer Protections:** Numerous consumer protections in private insurance would also be lost if the ACA were enjoined or if there were an injunction ending the law. Up to 1,692,205 people in Oregon have a pre-existing condition and would be at risk for being charged unaffordable premiums or denied coverage altogether without the ACA. Before the ACA, 1,356,000 people in Oregon with employer or individual market coverage had a lifetime limit on their insurance policy: annual and lifetime limits would return under an injunction to the ACA. An estimated 1,737,240 people in Oregon, including 721,318 women ages 15–64, would lose federally guaranteed of preventive services — like flu shots, cancer screenings, and contraception – which are now provided at no extra cost to consumers. These are just a few of the ACA's consumer protections that could be lost if this court allows the ACA to be enjoined.

126. **Impact on Marketplace Coverage:** The ACA provides financial support for private coverage through premium tax credits and cost-sharing reductions. If the ACA were enjoined, individuals and families that have benefitted from these provisions would pay more for health coverage or go without it altogether. Many of the 137,305 people in Oregon covered in the Health Insurance Marketplace would lose coverage without the ACA. In 2017, 75 percent of Marketplace enrollees in Oregon received a premium tax credit that averaged $4,144 per person. That financial assistance would no longer be available under an injunction.

127. **Impact on Medicaid:** Without the ACA, an estimated 159,000 fewer people in Oregon would have Medicaid coverage. The law's Medicaid expansion improved access to care, financial security, and health. For example, it resulted in an estimated 18,000 more getting all needed care, 22,600 fewer struggling to pay medical bills, 15,000 fewer experiencing symptoms of depression, and 190 avoided deaths each year in Oregon. Enjoining the law would put these benefits at risk, along with improvements to long-term services and supports, eligibility simplifications, and policies to lower drug costs and improve the quality of care in Medicaid. This could, for example, mean that people with disabilities in Oregon's Community First Choice program could lose access to services.

128. **Impact on Medicare:** The 784,032 people with Medicare in Oregon would also lose benefits and pay more under an injunction. Prescription drug discounts, which provided 50,777 people in Oregon with $1,035 in average annual savings per beneficiary in 2016, would end. It would roll back the coverage of proven preventive services with no cost sharing which 496,232 people with Medicare in Oregon used in 2016. It would suspend payment policies which would increase premiums, cost sharing, and well as taxpayer costs in Oregon. It would also disrupt programs to reduce preventable patient harms and avoidable readmissions. Hospital readmissions for Medicare beneficiaries dropped between 2010 and 2015, which translates into 75 fewer unnecessary returns to the hospital in Oregon in 2015. The 4 Accountable Care Organizations (ACOs) in Oregon that offer Medicare beneficiaries the opportunity to receive higher quality, more coordinated care would no longer operate under an injunction.

129. **Impact on Public Health:** Support for public health in Oregon would also be reduced under an injunction. Oregon received $52,128,626 from the law's Prevention and Public Health Fund between fiscal years 2012 and 2016. This includes $15,494,592 for immunizations and $1,864,629 for tobacco cessation efforts.

130. **Impact on Finances:** The financial impact on Oregon would be significant. From 2019 to 2028, it would lose $3.3 billion in federal Marketplace spending and $35.1 billion in federal Medicaid spending. The combined loss of federal spending over this period would be $38.4 billion. This would have a major impact on health care providers. From 2019 to 2028, Oregon hospitals could lose $17.5 billion and physicians could lose $5.7 billion. Uncompensated care costs in Oregon would increase by $15.2 billion over this period.

Rhode Island

131. Between 2010 and 2015, an estimated 68,000 people in Rhode Island gained coverage. This includes a large fraction of the people covered in the Rhode Island Health Insurance Marketplace (called HealthSource RI), an estimated 8,000 young adults who gained coverage by staying on their parents' health insurance, and those gaining coverage from the law's Medicaid expansion and employer shared responsibility policy. This coverage would be at risk if the ACA were enjoined.

132. **Impact on Consumer Protections:** Numerous consumer protections in private insurance would also be lost if the ACA were enjoined or if there were an injunction ending the law. Up to 462,538 people in Rhode Island have a pre-existing condition and would be at risk for being charged unaffordable premiums or denied coverage altogether without the ACA. Before the ACA, 374,000 people in Rhode Island with employer or individual market coverage had a lifetime limit on their insurance policy: annual and lifetime limits would return under an injunction to the ACA. An estimated 484,193 people in Rhode Island, including 201,595 women ages 15–64, would lose federally guaranteed of preventive services — like flu shots, cancer screenings, and contraception – which are now provided at no extra cost to consumers. These are

just a few of the ACA's consumer protections that could be lost if this court allows the ACA to be enjoined.

133. **Impact on Marketplace Coverage:** The ACA provides financial support for private coverage through premium tax credits and cost-sharing reductions. If the ACA were enjoined, individuals and families that have benefitted from these provisions would pay more for health coverage or go without it altogether. Many of the 29,065 people in Rhode Island covered in the Health Insurance Marketplace would lose coverage without the ACA. In 2017, 78 percent of Marketplace enrollees in Rhode Island received a premium tax credit that averaged $2,974 per person. That financial assistance would no longer be available under an injunction.

134. **Impact on Medicaid:** Without the ACA, an estimated 22,000 fewer people in Rhode Island would have Medicaid coverage. The law's Medicaid expansion improved access to care, financial security, and health. For example, it resulted in an estimated 3,000 more getting all needed care, 3,200 fewer struggling to pay medical bills, 2,000 fewer experiencing symptoms of depression, and 30 avoided deaths each year in Rhode Island. Enjoining the law would put these benefits at risk, along with improvements to long-term services and supports, eligibility simplifications, and policies to lower drug costs and improve the quality of care in Medicaid.

135. **Impact on Medicare:** The 208,324 people with Medicare in Rhode Island would also lose benefits and pay more under an injunction. Prescription drug discounts, which provided 14,990 people in Rhode Island with $1,004 in average annual savings per beneficiary in 2016, would end. It would roll back the coverage of proven preventive services with no cost sharing which 148,724 people with Medicare in Rhode Island used in 2016. It would suspend payment policies which would increase premiums, cost sharing, and well as taxpayer costs in Rhode Island. It would also disrupt programs to reduce preventable patient harms and avoidable readmissions. Hospital readmissions for Medicare beneficiaries dropped between 2010 and 2015, which translates into 487 fewer unnecessary returns to the hospital in Rhode Island in 2015. The 5 Accountable Care Organizations (ACOs) in Rhode Island that offer Medicare beneficiaries the

opportunity to receive higher quality, more coordinated care would no longer operate under an injunction.

136. **Impact on Public Health:** Support for public health in Rhode Island would also be reduced under an injunction. Rhode Island received $34,890,537 from the law's Prevention and Public Health Fund between fiscal years 2012 and 2016. This includes $5,997,036 for immunizations and $326,347 for tobacco cessation efforts.

137. **Impact on Finances:** The financial impact on Rhode Island would be significant. From 2019 to 2028, it would lose $700 million in federal Marketplace spending and $6.7 billion in federal Medicaid spending. The combined loss of federal spending over this period would be $7.4 billion. This would have a major impact on health care providers. From 2019 to 2028, Rhode Island hospitals could lose $3.8 billion and physicians could lose $1.4 billion. Uncompensated care costs in Rhode Island would increase by $2.8 billion over this period.

Vermont

138. Between 2010 and 2015, an estimated 26,000 people in Vermont gained coverage. This includes a large fraction of the people covered in the Vermont Health Insurance Marketplace (called Vermont Health Connect), an estimated 5,000 young adults who gained coverage by staying on their parents' health insurance, and those gaining coverage from the law's Medicaid expansion and employer shared responsibility policy. This coverage would be at risk if the ACA were enjoined.

139. **Impact on Consumer Protections:** Numerous consumer protections in private insurance would also be lost if the ACA were enjoined or if there were an injunction ending the law. Up to 280,727 people in Vermont have a pre-existing condition and would be at risk for being charged unaffordable premiums or denied coverage altogether without the ACA. Before the ACA, 215,000 people in Vermont with employer or individual market coverage had a lifetime limit on their insurance policy: annual and lifetime limits would return under an injunction to the ACA. An estimated 285,858 people in Vermont, including 122,892 women ages 15–64, would lose

federally guaranteed of preventive services — like flu shots, cancer screenings, and contraception – which are now provided at no extra cost to consumers. These are just a few of the ACA's consumer protections that could be lost if this court allows the ACA to be enjoined.

140. **Impact on Marketplace Coverage:** The ACA provides financial support for private coverage through premium tax credits and cost-sharing reductions. If the ACA were enjoined, individuals and families that have benefitted from these provisions would pay more for health coverage or go without it altogether. Many of the 29,088 people in Vermont covered in the Health Insurance Marketplace would lose coverage without the ACA. In 2017, 76 percent of Marketplace enrollees in Vermont received a premium tax credit that averaged $3,898 per person. That financial assistance would no longer be available under an injunction.

141. **Impact on Medicaid:** Without the ACA, an estimated 3,000 fewer people in Vermont would have Medicaid coverage. The law's Medicaid expansion improved access to care, financial security, and health. Enjoining the law would put these benefits at risk, along with improvements to long-term services and supports, eligibility simplifications, and policies to lower drug costs and improve the quality of care in Medicaid.

142. **Impact on Medicare:** The 136,021 people with Medicare in Vermont would also lose benefits and pay more under an injunction. Prescription drug discounts, which provided 10,466 people in Vermont with $1,206 in average annual savings per beneficiary in 2016, would end. It would roll back the coverage of proven preventive services with no cost sharing which 94,170 people with Medicare in Vermont used in 2016. It would suspend payment policies which would increase premiums, cost sharing, and well as taxpayer costs in Vermont. It would also disrupt programs to reduce preventable patient harms and avoidable readmissions. Hospital readmissions for Medicare beneficiaries dropped between 2010 and 2015. The 3 Accountable Care Organizations (ACOs) in Vermont that offer Medicare beneficiaries the opportunity to receive higher quality, more coordinated care would no longer operate under an injunction.

143. **Impact on Public Health:** Support for public health in Vermont would also be reduced under an injunction. Vermont received $16,564,102 from the law's Prevention and Public Health

Fund between fiscal years 2012 and 2016. This includes $2,706,809 for immunizations and $299,828 for tobacco cessation efforts.

144. **Impact on Finances:** The financial impact on Vermont would be significant. From 2019 to 2028, it would lose $1.0 billion in federal Marketplace spending and $1.9 billion in federal Medicaid spending. The combined loss of federal spending over this period would be $2.9 billion. This would have a major impact on health care providers. From 2019 to 2028, Vermont hospitals could lose $500 million and physicians could lose $300 million. Uncompensated care costs in Vermont would increase by $2.4 billion over this period.

Virginia

145. Between 2010 and 2015, an estimated 327,000 people in Virginia gained coverage. This includes a large fraction of the people covered in the Virginia Health Insurance Marketplace, an estimated 59,000 young adults who gained coverage by staying on their parents' health insurance, and those who gained coverage due to the employer shared responsibility policy. This coverage would be at risk if the ACA were enjoined.

146. **Impact on Consumer Protections:** Numerous consumer protections in private insurance would also be lost if the ACA were enjoined or if there were an injunction ending the law. Up to 3,491,076 people in Virginia have a pre-existing condition and would be at risk for being charged unaffordable premiums or denied coverage altogether without the ACA. Before the ACA, 2,974,000 people in Virginia with employer or individual market coverage had a lifetime limit on their insurance policy: annual and lifetime limits would return under an injunction to the ACA. An estimated 3,902,716 people in Virginia, including 1,587,663 women ages 15–64, would lose federally guaranteed of preventive services — like flu shots, cancer screenings, and contraception – which are now provided at no extra cost to consumers. These are just a few of the ACA's consumer protections that could be lost if this court allows the ACA to be enjoined.

147. **Impact on Marketplace Coverage:** The ACA provides financial support for private coverage through premium tax credits and cost-sharing reductions. If the ACA were enjoined,

individuals and families that have benefitted from these provisions would pay more for health coverage or go without it altogether. Many of the 364,614 people in Virginia covered in the Health Insurance Marketplace would lose coverage without the ACA. In 2017, 83 percent of Marketplace enrollees in Virginia received a premium tax credit that averaged $3,807 per person. That financial assistance would no longer be available under an injunction.

148. **Impact on Medicaid:** Virginia is debating expanding Medicaid under the ACA, which could lead to an estimated 179,000 people in Virginia gaining coverage. This would improve access to care, financial security, and health. For example, it could result in an estimated 20,000 more getting all needed care, 25,500 fewer struggling to pay medical bills, 16,000 fewer experiencing symptoms of depression, and 220 avoided deaths each year in Virginia. Enjoining the law would put these potential benefits at risk, along with improvements to long-term services and supports, eligibility simplifications, and policies to lower drug costs and improve the quality of care in Medicaid.

149. **Impact on Medicare:** The 1,392,261 people with Medicare in Virginia would also lose benefits and pay more under an injunction. Prescription drug discounts, which provided 109,517 people in Virginia with $1,104 in average annual savings per beneficiary in 2016, would end. It would roll back the coverage of proven preventive services with no cost sharing which 1,026,111 people with Medicare in Virginia used in 2016. It would suspend payment policies which would increase premiums, cost sharing, and well as taxpayer costs in Virginia. It would also disrupt programs to reduce preventable patient harms and avoidable readmissions. Hospital readmissions for Medicare beneficiaries dropped between 2010 and 2015, which translates into 2,302 fewer unnecessary returns to the hospital in Virginia in 2015. The 25 Accountable Care Organizations (ACOs) in Virginia that offer Medicare beneficiaries the opportunity to receive higher quality, more coordinated care would no longer operate under an injunction.

150. **Impact on Public Health:** Support for public health in Virginia would also be reduced under an injunction. Virginia received $79,675,902 from the law's Prevention and Public Health

Fund between fiscal years 2012 and 2016. This includes $15,357,774 for immunizations and $3,545,823 for tobacco cessation efforts.

151. **Impact on Finances:** The financial impact on Virginia would be significant. From 2019 to 2028, it would lose $15.4 billion in federal Marketplace spending and $2.6 billion in federal Medicaid spending. The combined loss of federal spending over this period would be $18.0 billion. This would have a major impact on health care providers. From 2019 to 2028, Virginia hospitals could lose $7.8 billion and physicians could lose $3.7 billion. Uncompensated care costs in Virginia would increase by $28.7 billion over this period.

Washington

152. Between 2010 and 2015, an estimated 537,000 people in Washington gained coverage. This includes a large fraction of the people covered in the Washington Health Insurance Marketplace (called Washington Healthplanfinder), an estimated 50,000 young adults who gained coverage by staying on their parents' health insurance, and those gaining coverage from the law's Medicaid expansion and employer shared responsibility policy. This coverage would be at risk if the ACA were enjoined.

153. **Impact on Consumer Protections:** Numerous consumer protections in private insurance would also be lost if the ACA were enjoined or if there were an injunction ending the law. Up to 2,969,739 people in Washington have a pre-existing condition and would be at risk for being charged unaffordable premiums or denied coverage altogether without the ACA. Before the ACA, 2,427,000 people in Washington with employer or individual market coverage had a lifetime limit on their insurance policy: annual and lifetime limits would return under an injunction to the ACA. An estimated 3,079,369 people in Washington, including 1,258,201 women ages 15–64, would lose federally guaranteed of preventive services — like flu shots, cancer screenings, and contraception – which are now provided at no extra cost to consumers. These are just a few of the ACA's consumer protections that could be lost if this court allows the ACA to be enjoined.

154. **Impact on Marketplace Coverage:** The ACA provides financial support for private coverage through premium tax credits and cost-sharing reductions. If the ACA were enjoined, individuals and families that have benefitted from these provisions would pay more for health coverage or go without it altogether. Many of the 184,070 people in Washington covered in the Health Insurance Marketplace would lose coverage without the ACA. In 2017, 63 percent of Marketplace enrollees in Washington received a premium tax credit that averaged $3,040 per person. That financial assistance would no longer be available under an injunction.

155. **Impact on Medicaid:** Without the ACA, an estimated 55,000 fewer people in Washington would have Medicaid coverage. The law's Medicaid expansion improved access to care, financial security, and health. For example, it resulted in an estimated 6,000 more getting all needed care, 7,800 fewer struggling to pay medical bills, 5,000 fewer experiencing symptoms of depression, and 70 avoided deaths each year in Washington. Enjoining the law would put these benefits at risk, along with improvements to long-term services and supports, eligibility simplifications, and policies to lower drug costs and improve the quality of care in Medicaid. This could, for example, mean that people with disabilities in Washington's Community First Choice program could lose access to services.

156. **Impact on Medicare:** The 1,238,649 people with Medicare in Washington would also lose benefits and pay more under an injunction. Prescription drug discounts, which provided 71,499 people in Washington with $1,065 in average annual savings per beneficiary in 2016, would end. It would roll back the coverage of proven preventive services with no cost sharing which 805,142 people with Medicare in Washington used in 2016. It would suspend payment policies which would increase premiums, cost sharing, and well as taxpayer costs in Washington. It would also disrupt programs to reduce preventable patient harms and avoidable readmissions. Hospital readmissions for Medicare beneficiaries dropped between 2010 and 2015, which translates into 1,388 fewer unnecessary returns to the hospital in Washington in 2015. The 6 Accountable Care Organizations (ACOs) in Washington that offer Medicare beneficiaries the

opportunity to receive higher quality, more coordinated care would no longer operate under an injunction.

157. **Impact on Public Health:** Support for public health in Washington would also be reduced under an injunction. Washington received $84,038,862 from the law's Prevention and Public Health Fund between fiscal years 2012 and 2016. This includes $21,648,368 for immunizations and $4,207,707 for tobacco cessation efforts.

158. **Impact on Finances:** The financial impact on Washington would be significant. From 2019 to 2028, it would lose $4.7 billion in federal Marketplace spending and $38.1 billion in federal Medicaid spending. The combined loss of federal spending over this period would be $42.8 billion. This would have a major impact on health care providers. From 2019 to 2028, Washington hospitals could lose $23.3 billion and physicians could lose $7.7 billion. Uncompensated care costs in Washington would increase by $33.9 billion over this period.

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

Executed on 9 April 2018, in Washington, DC.

Henry J. Aaron*

Bruce and Virginia MacLaury Senior Fellow

The Brookings Institution

**The views expressed here are my own and do not necessarily represent those of the trustees, officers or other staff of the Brookings Institution. Affiliation listed for identification only.*

IN THE UNITED STATES DISTRICT COURT

FOR THE NORTHERN DISTRICT OF TEXAS

FORT WORTH DIVISION

TEXAS, WISCONSIN, ALABAMA, ARKANSAS, ARIZONA, FLORIDA, GEORGIA, INDIANA, KANSAS, LOUISIANA, PAUL LePAGE, Governor of Maine, MISSISSIPPI, by and through Governor Phil Bryant, MISSOURI, NEBRASKA, NORTH DAKOTA, SOUTH CAROLINA, SOUTH DAKOTA, TENNESSEE, UTAH, and WEST VIRGINIA, Plaintiffs, **v.** **UNITED STATES OF AMERICA, UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, ALEX AZAR, in his Official Capacity as SECRETARY OF HEALTH AND HUMAN SERVICES, UNITED STATES INTERNAL REVENUE SERVICE, and DAVID J. KAUTTER, in his Official Capacity as Acting COMMISSIONER OF INTERNAL REVENUE,** Defendants, and,	Civ. Action No. 18-cv-00167-O **DECLARATION OF BENJAMIN BARNES IN SUPPORT OF STATES' MOTION TO INTERVENE**

CALIFORNIA, CONNECTICUT, et al.,

Proposed Intervenors.

I, Benjamin Barnes declare:

1. I am the Secretary of the Connecticut Office of Policy and Management. In that role, I report directly to the Governor and oversee budget and policy development and implementation for the State of Connecticut, including health policy issues. The facts stated herein are of my own personal knowledge and knowledge I have gained from information provided by the Departments of Public Health and Social Services, the Office of Health Strategy and Access Health CT.

2. The Connecticut Office of Policy and Management (OPM) functions as the Governor's staff agency and plays a central role in state government, providing the information and analysis used to formulate public policy for the state and assisting state agencies and municipalities in implementing policy decisions on the Governor's behalf. OPM prepares the Governor's budget proposal and implements and monitors the execution of the budget as adopted by the General Assembly. Through intra-agency and inter-agency efforts, OPM strengthens and improves the delivery of services to the citizens of Connecticut, and increases the efficiency and effectiveness of state government through integrated processes and system improvements.

3. The Affordable Care Act directs billions of dollars directly to Connecticut.

- Connecticut sought and received extensive new federal resources under the Affordable Care Act (ACA). Specifically, Connecticut has received $5.9 billion via Medicaid expansion ($1.2 billion as an early adopter beginning April 2010 and $4.7 billion from January 2014 through December 2017); $73.1 million through the Community First Choice Option; $51.5 million in enhanced reimbursement related to the Money Follows the Person Demonstration (from October 2011, when the demonstration was extended (and expanded) under the ACA, through December

2017); $29.0 million through the Prevention and Public Health Fund and $19.8 million through other public health grants-in-aid that were awarded to Connecticut state agencies; and $77.5 million through the Balancing Incentive Program.

- The ACA also enabled Connecticut's Medicaid agency, the Department of Social Services, to partner with the state-based health insurance exchange, Access Health CT, to launch a shared / integrated eligibility system that encompasses HUSKY Health (Medicaid / Children's Health Insurance Program) and private qualified health plans offered through the Exchange. This has created a common entry point for all individuals seeking health insurance, has automated many aspects of eligibility verification and has improved the integrity and timeliness of the eligibility process. Efficient and comprehensive documentation of eligibility is an essential feature of ensuring appropriate access to the range of available insurance coverage options.
- In addition to the $48.8 million provided through the Prevention and Public Health Fund (PPHF) and other public health grants-in-aid awarded to state agencies, other Connecticut organizations were direct beneficiaries of ACA-funded initiatives to help address the health care needs of vulnerable populations, such as federally qualified health centers, school based health centers, hospitals, and universities. Furthermore, since 100% of funding for the Preventive Health and Health Services Block Grant (PHHSBG) comes from the Prevention and Public Health Fund, if the ACA is repealed and funding for the block grant is eliminated, the following programs would be greatly impacted: asthma management education, cancer prevention, cardiovascular disease prevention, childhood lead poisoning surveillance, diabetes education and self-management classes, smoking cessation, injury prevention, suicide prevention, and rape crisis programs. PHHSBG funds also support the state's emergency medical services, public health surveillance and

evaluation efforts, and national and local public health accreditation initiatives. Since 2014, Connecticut has received a total of $9.0 million in PHHSBG funding.

4. The Affordable Care Act increased access to affordable coverage.

- Overall, the number of individuals with insurance has significantly increased. Based on data from the U.S. Census Bureau, the percentage of people in Connecticut without health insurance decreased from 9.4% in 2013 to 4.9% in 2016. The percentage of uninsured adults between 18 and 64 years of age decreased from 14.8% in 2011 to 8.2% in 2016. Connecticut has historically had a high percentage of children with health coverage and saw similar improvements in the rate of insured children, although exact numbers are not readily available.
- The ACA expanded coverage through two key mechanisms: Medicaid expansion for those individuals with the lowest incomes, and federal health subsidies which allowed individuals with moderate incomes to purchase coverage in new health insurance exchanges.
- Medicaid is an important source of healthcare coverage and has resulted in significant coverage gains, as well as reductions in the uninsured rate, both among the low-income population and within other vulnerable populations. As a result of Medicaid expansion, approximately 240,000 people have coverage which enabled them to access a Medicaid benefit – HUSKY D, our Medicaid expansion group, which increased from 44,753 in April 2010, when Connecticut became an early adopter, to 99,103 in December 2013. With the increase in income eligibility to 138% of the federal poverty level, enrollment has grown to approximately 240,000.
    - Research shows that coverage: gives people more financial security from the catastrophic costs of a serious health condition; tends to improve mental health; and enables earlier diagnosis and more effective self-management of conditions such as diabetes.

- Pursuant to the ACA, the Exchange serves the residents of the State of Connecticut by offering enrollees in qualified health plans financial assistance through advance payments of the premium tax credit (APTCs) to help pay health insurance premiums, and cost-sharing reductions (CSRs) that reduce the amount of out-of-pocket costs that eligible consumers are required to pay for health care expenses during the year.
- The Exchange is one of the important reforms created by the ACA, allowing individuals and small employers to access health insurance plans in a setting where they can compare various options, and also apply for and receive financial assistance to help pay for their coverage. In Connecticut, an average of 85,000 individuals per year receive federally subsidized coverage because of the ACA.
- The ACA created robust consumer protections to help ensure individuals can access the healthcare system. Through Connecticut's Exchange, over 14,000 individuals under age 26 receive health insurance coverage on their parent's plan – a benefit offered under the ACA. Connecticut does not have statewide estimates for how many individuals under age 26 receive coverage under parent-held policies, but given the rate of coverage under parental plans for the 85,000 Access Health CT recipients (slightly over 16%), one could assume tens of thousands more each year receive coverage under parent-held policies.

5. The ACA has had positive economic benefits on states.

- Studies have shown that states expanding Medicaid under the ACA have realized budget savings, revenue gains, and overall economic growth.
- Based on an analysis prepared by the Milken Institute School of Public Health at the George Washington University, repealing two key elements of the ACA (federal premium tax credits and federal payments to states for expansion of Medicaid eligibility for low-income adults) would result in the loss in 2019 of approximately

35,900 jobs across many industries in Connecticut and would result in the loss of the following over a five-year period (from 2019 through 2023):

- $12.5 billion in federal funds;
- $39.1 billion in business output;
- $23.3 billion in gross state product; and
- $748 million in state and local taxes.

6. The ACA expanded programs in Medicaid to provide States with increased opportunities to increase access to home and community-based services.

- The ACA authorized the extension of and additional federal funding for the highly successful Money Follows the Person (MFP) demonstration grant; MFP has supported nearly 5,000 individuals with disabilities and older adults in moving from nursing facilities to their setting of choice, at lower cost and with greater opportunity for community engagement;
- The ACA established the Community First Choice (CFC) State Plan Option, encouraging states to provide home and community-based attendant services and supports to individuals who would otherwise require institutional level of care under the Medicaid State Plan, by providing a 6 percentage point increase in federal matching payments for these services; CFC has enabled thousands of people at risk of nursing home placement to hire personal care attendants, providing flexible, personalized in-home supports; and
- The ACA appropriated funding for the Balancing Incentive Program (BIP), which provided an enhanced match rate of 2% for non-institutional long-term services and supports to states that commit to increasing access to community-based long-term services and supports; in total, Connecticut received over $77 million in BIP funding, which was reinvested in home and community-based long-term services and supports.

These programs have all helped Connecticut in its efforts to continue to shift the balance of long-term services and supports spending for Medicaid members from institutional settings to home and community-based care.

7. The ACA has allowed States to test and implement reforms to healthcare delivery systems that support State policy priorities of increasing efficiency and quality of care.

- Since 2013, Connecticut has received $2.8 million for a planning grant and a commitment of $45 million through 2020 for the State Innovation Model (SIM) Test grant from the Center for Medicare and Medicaid Innovation (CMMI) to develop and implement a model for healthcare delivery supported by value-based payment methodologies tied to the totality of care delivered to at least 80% of our population within five years, supporting the triple aim of better health while eliminating health disparities, improving healthcare quality and experience, and reducing growth in healthcare costs. This initiative has brought private and public payers, including Medicaid, together to implement a value-based care delivery and payment approach that has focused upon alignment with the Medicare Accountable Care Organization (ACO) strategy, development of common quality measures, and use of shared savings and other payment mechanisms. In addition, Connecticut Medicaid has implemented a pay-for-performance primary care medical home initiative that serves almost half of all members, and has built on this by layering on additional features of care coordination and a shared savings feature.
    - Implementing value-based care delivery reforms and payment strategies has enabled new person-centered strategies that have better coordinated services and supports for high need, high cost individuals and allowed Medicaid to tie outcomes and care experience to payment.

Under Connecticut's Medicaid program, the ACA has:

- Permitted coverage of new services that are of great benefit to Medicaid beneficiaries – just one example is coverage of tobacco cessation services (counseling, treatment and medications)
    - This is a well-targeted service because many sources estimate that far more Medicaid beneficiaries smoke than is typical of the general population, and smoking-related conditions are ubiquitous and expensive to manage
- Provided new family planning services for eligible individuals
    - Family planning services support good reproductive health and help reduce unintended pregnancies, which in turn promotes better long-term health, completion of education and improved outcomes of subsequent pregnancies
- Enabled Connecticut to implement a behavioral health, health home effort under which providers integrate and coordinate all primary, acute, behavioral health, and long term services and supports to treat the whole person
    - Health homes are enabling local mental health authorities and their affiliates to integrate behavioral health, primary care and community-based supports for people with Serious and Persistent Mental Illness (SPMI)
- Funded primary care provider rate increases which, though continued on a somewhat more limited basis in Connecticut, have dramatically increased participation of primary care practitioners in Medicaid from 1,622 in January 2012 to 3,598 in December 2017
    - Access to primary care is a key aspect of Medicaid reform and an essential means of reducing use of the emergency department, as well as effective management of chronic conditions.

In addition, the ACA strengthened overall public health with many initiatives, including:

- Establishing a nationwide program for national and state background checks on direct patient access employees of long-term care facilities – 42,658 background checks completed since October 1, 2015, helping to ensure a safe workforce.

- Requiring nursing facilities to: (1) report information regarding members of the governing body of the facility, promoting transparency of governance to Connecticut's nursing facility residents, their families and/or other responsible parties; (2) implement and strictly enforce a compliance and ethics program, thereby fostering compliance with regulations and a culture of program integrity; (3) establish standards for Quality Assurance and Performance Improvement programs and codify best practices, improving quality of care and service delivery; (4) electronically submit staffing information to help ensure adequate staffing is in place to deliver quality care and services; and (5) provide written notification at least 60 days in advance of a closure to allow residents adequate time to successfully relocate to another facility or a home or community-based setting.
- Developing consumer-oriented websites, providing useful information to consumers when accessing care, posting deficiency statements, violation letters, and facility plans of corrections, and standardizing a complaint process for consumers to report quality of care or other issues.
- Requiring that nurse aide training programs include dementia management training and patient abuse prevention training, thus enhancing the skill set of the workforce.

8. The ACA resulted in better quality and more accessible, affordable healthcare for consumers.

- The ACA not only improves access to healthcare for the uninsured, it ensures better healthcare coverage for immunizations for those with existing insurance coverage by requiring that insurance plans cover all recommended vaccines outside of the patient's insurance deductible.
- The ACA helped meet the increasing needs of Connecticut's most vulnerable populations by increasing National Health Service Corps funding for scholarships and loan repayment, more than doubling the primary, dental, and mental health clinicians working in Connecticut's Health Professional Shortage Areas.

- The PPHF allowed 16 health systems, between 2014 and 2018, to improve their capacity to identify patients with poorly controlled diabetes and hypertension, resulting in improved care for up to 164,118 individuals in Connecticut (and also improved their awareness of prediabetes, identifying 33, 081 patients with prediabetes)
- ACA funding supported an expansion in the capacity of the CT Quitline. Between July 1, 2013 and June 30, 2017, an additional 500 Quitline callers stopped their tobacco use, resulting in an estimated $4 million in averted future medical and non-medical costs related to tobacco use.
- Between 2011 and 2018, over 6,830 youth ages 13-19 have participated in the ACA-funded Personal Responsibility Education Program (PREP) program, which provides education on abstinence and contraception in order to prevent pregnancy and sexually transmitted infections. The delivery of evidence-based, comprehensive PREP prevention education to at-risk youth has contributed to a significant decline in the birth rates for teens ages 15-19. The Connecticut teen birth rate dropped from 18.8 per 1,000 births in 2012 to 14.9 per 1,000 births in 2014.
- ACA PHHSBG funding allowed community-based public health providers to address existing service gaps in their communities. These providers reported measurable improvements in health outcomes, access to services, and reductions in health risk behaviors as a result of their programmatic interventions, such as:
    - Reduction in children under 6 years of age with confirmed blood lead levels at or above the CDC reference value of (5μg/dL) from 3.1% in 2012 to 2.7% in 2016
    - Reduction in the percent of youth (high school) who currently smoke cigarettes from 14% in 2011 to 5.6% in 2015
    - Increases in estimated influenza vaccination coverage levels for adults (18-64 years of age) from 34.4% in 2012 to 43.6% in 2016

- Increases in estimated HPV vaccination coverage for female adolescents 13-17 years of age meeting the CDC guidelines from 43.6% in 2012 to 56.9% in 2016
- Increases in estimated HPV vaccination coverage for male adolescents 13-17 years of age meeting the CDC guidelines from 8.5% in 2012 to 41.5% in 2016
- Reduction in number of newly diagnosed cases of HIV from 351 in 2011 to 269 in 2016
- Reduction in rate of chlamydia incidence among youth 15-19 years of age from 1,973 per 100,000 in 2011 to 1,289 per 100,000 in 2016
- Increases in estimated vaccine coverage levels for Advisory Committee on Immunization Practices recommended vaccines among children 19-35 months of age from 57.9% in 2010 to 75.7% in 2016.

- Prevention and Public Health Fund dollars have been utilized to maintain high childhood immunization coverage levels, track vaccination coverage and contain disease outbreaks. If this funding were eliminated, it could adversely affect Connecticut's vaccination rates, resulting in disease outbreaks of vaccine preventable diseases. Of note, newborn babies would be at increased risk, particularly from hepatitis B, influenza and pertussis. Additionally, the state would experience a loss of funding for critical technology to sustain the state's immunization information system.
- In addition, ACA funding has strengthened the state's capacity to address infectious disease outbreaks through the use of molecular fingerprinting tools, resulting in more timely identification and treatment of impacted individuals. These funds have also supported the state's capacity to address hospital-acquired infections and drug-resistant infections.

I declare under penalty of perjury that the foregoing is true and correct to the best of my knowledge and belief.

Executed on March 28, 2018, in Hartford, Connecticut.

Benjamin Barnes
Secretary
Connecticut Office of Policy and Management

Subscribed and sworn to before me
this 28 day of March, 2018

Signature of Notary Public

Date Commission Expires February 21, 2018

KATHLEEN TAYLOR
Printed Name of Notary Public

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF TEXAS
FORT WORTH DIVISION

TEXAS, WISCONSIN, ALABAMA, ARKANSAS, ARIZONA, FLORIDA, GEORGIA, INDIANA, KANSAS, LOUISIANA, PAUL LePAGE, Governor of Maine, MISSISSIPPI, by and through Governor Phil Bryant, MISSOURI, NEBRASKA, NORTH DAKOTA, SOUTH CAROLINA, SOUTH DAKOTA, TENNESSEE, UTAH, and WEST VIRGINIA, Plaintiffs, v. UNITED STATES OF AMERICA, UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, ALEX AZAR, in his Official Capacity as SECRETARY OF HEALTH AND HUMAN SERVICES, UNITED STATES INTERNAL REVENUE SERVICE, and DAVID J. KAUTTER, in his Official Capacity as Acting COMMISSIONER OF INTERNAL REVENUE, Defendants.	Civil Action No. 4:18-cv-00167-O
CALIFORNIA, ET AL., Proposed Intervenor-Defendants.	

DECLARATION OF PETER BERNS IN SUPPORT OF MOTION TO INTERVENE BY CALIFORNIA, ET AL.

I, Peter Berns, declare:

1. Since July 2008, I have served as Chief Executive Officer of The Arc. Prior to taking on this position, I served as the Executive Director of the Maryland Association of Nonprofit Organizations for sixteen years as well as Deputy Chief of Consumer Protection in the Maryland Attorney General's Office. In my current role, I oversee the wide variety of work performed by our national office staff-in conjunction with our nationwide chapter

network—in support of the right of people with intellectual and developmental disabilities and their families to live, work, learn, and socialize in the community, free from discrimination. Preserving and protecting the Affordable Care Act has been and continues to be a top priority for The Arc.

2. The Arc is the largest national community-based organization advocating for and serving people with intellectual and developmental disabilities (I/DD) and their families, with more than 650 state and local chapters nationwide. The Arc promotes and protects the human rights of people with intellectual and developmental disabilities and actively supports their full inclusion and participation in the community throughout their lifetimes.

3. The Arc views the Affordable Care Act (ACA) as critical for people with I/DD and their families in providing benefits, supports, and civil rights protections that help make community living possible. Through its public policy and legal advocacy work, The Arc has and continues to work vigorously to ensure the ACA is protected and preserved.

3. The ACA increased access to affordable coverage for individuals with I/DD and their families. People, including those with I/DD, who have access to comprehensive and affordable health insurance are more likely to receive the prescription drugs, therapies, and medical treatment they need to be healthy and maintain the ability to function in the community. The ACA has helped this population gain insurance through a variety of mechanisms:

- The ACA ended exclusions for pre-existing conditions, prohibiting medical underwriting, and ending retroactive denials of coverage. Children and adults can access health insurance now that was previously denied because of a pre-existing condition. A pre-existing condition is one that existed before health coverage began and can include conditions that many people with I/DD have including seizures, diabetes, asthma and other conditions.

- The ACA allowed coverage of dependents until age 26. This benefits many people with I/DD, who may have a longer transition period from youth to employment-based health coverage.
- The ACA gave states the opportunity to expand Medicaid eligibility to childless adults with incomes up to 133% of the federal poverty level.
- The ACA created private insurance exchanges for individuals as well as subsidies to assist low-income individuals in purchasing coverage.

4. The ACA has also improved the quality of insurance and health care that people with I/DD receive. People with I/DD often have multiple health conditions and are at risk of developing secondary disabilities without quality health care. Studies have documented a higher prevalence of adverse conditions, inadequate attention to health care needs, inadequate focus on health promotion, and inadequate access to quality health care services. The ACA improved health care quality in many ways, including the following:
   - The ACA eliminated co-pays for critical prevention services
   - The ACA included mental health services, rehabilitative and habilitative services and devices, and other critical disability services in the health plans sold in the exchanges
   - The ACA included coverage of dental and vision care for children in health insurance plans sold on the exchanges
   - The ACA eliminated lifetime limits on health insurance coverage and phasing out annual limits. These benefits can be crucial to many families with a member with I/DD who experiences complex and lifelong medical needs such as compromised breathing or swallowing or difficulty walking.
   - The ACA allows a free annual Medicare well visit with assessments and an individualized prevention plan.

- The ACA eliminated Medicare Part D (drug coverage) co-pays for persons who are dual-eligible for Medicaid and Medicare, and who are receiving Medicaid waiver services.
- The ACA expanded Medicare Part D coverage of anti-seizure, anti-anxiety, and anti-spasm medications.

5. The ACA prioritized home care rather than institutionalization as a cost-effective and community-based method of care for people with I/DD. Expanding home- and community-based long term services and supports will reduce the need for nursing home and other institutional settings. In the long run, these investments in health care and home- and community-based services will improve health and reduce dependence on costly institutions.

- The ACA created an option to provide health homes for Medicaid enrollees with chronic conditions. Health homes are intended to be person-centered systems of care that integrate primary, acute, behavioral health, and long term services.
- The ACA established the Community First Choice Option for states to cover comprehensive community attendant services under the state's Medicaid optional service plan and avoid costlier nursing home and other institutional care.
- The ACA improved the existing Medicaid Section 1915(i) option for home and community based services by making it easier for individuals to qualify for services, allow states to target specific populations, and avoid costlier nursing home and other institutional care.
- The ACA reduced Medicaid's institutional bias by creating new financial incentives for states to rebalance their services from costlier institutional settings toward home and community based services.
- The ACA extended the Money Follows the Person Demonstration program that provides additional federal payments to help people transition from costlier institutions to home- and community-based services.

6. The ACA expands the information that researchers, policy makers and advocates have about the health care status of people with disabilities and supports future developments in health care for people with I/DD through a variety of programs that nurture innovation and improvement:

- The ACA allows states in partnership with the federal government to try new models of care to provide better health care at lower costs to people with complex health care needs who are eligible for both Medicare and Medicaid.
- The ACA created the Prevention and Public Health Fund to greatly expand wellness, disease prevention, and other public health priorities.
- The ACA has improved data collection on health care access for people with disabilities.

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

Executed on April 2, 2018, in Baltimore.

Peter Berns
Chief Executive Officer
The Arc

SA2018100536

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF TEXAS
FORT WORTH DIVISION

TEXAS, WISCONSIN, ALABAMA, ARKANSAS, ARIZONA, FLORIDA, GEORGIA, INDIANA, KANSAS, LOUISIANA, PAUL LePAGE, Governor of Maine, MISSISSIPPI, by and through Governor Phil Bryant, MISSOURI, NEBRASKA, NORTH DAKOTA, SOUTH CAROLINA, SOUTH DAKOTA, TENNESSEE, UTAH, and WEST VIRGINIA, Plaintiffs, v. UNITED STATES OF AMERICA, UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, ALEX AZAR, in his Official Capacity as SECRETARY OF HEALTH AND HUMAN SERVICES, UNITED STATES INTERNAL REVENUE SERVICE, and DAVID J. KAUTTER, in his Official Capacity as Acting COMMISSIONER OF INTERNAL REVENUE, Defendants.	Civil Action No. 4:18-cv-00167-O
MASSACHUSETTS, et al. Proposed Intervenor-Defendants.	

DECLARATION OF SHARON C. BOYLE

I, Sharon C. Boyle, do hereby depose and state the following:

1. I am the First Deputy General Counsel at the Massachusetts Executive Office of Health and Human Services and Chief MassHealth Counsel. MassHealth is the Medicaid and Children's Health Insurance Program for the Commonwealth of Massachusetts.

2. I began working as an Assistant General Counsel at the Division of Medical Assistance, the agency then responsible for administration of the MassHealth program in or about 1995. The Executive Office of Health and Human Services has administered the MassHealth program since in or around 2003. I moved into my role as Chief MassHealth Counsel in or about 2011. I have personal knowledge of the rules, regulations, and processes governing MassHealth, including those related to the Affordable Care Act (ACA).

3. I have either personal knowledge of the matters set forth below or, with respect to those matters for which I do not have personal knowledge; I have reviewed information gathered for me in my capacity as Chief MassHealth Counsel.

4. The ACA established a new Medicaid eligibility group for childless adults below 133% of the federal poverty limit (as determined using a Medicaid formula known as Medicaid Adjusted Gross Income or MAGI). This eligibility group is commonly referred to as the "Medicaid Expansion Population" or the "New Adult Group".

5. Under the ACA, states that opt to provide Medicaid coverage to the Medicaid Expansion population receive federal matching funds on their medical assistance expenditures at the rate of 89.6% in calendar year 2018.

6. Currently, the Commonwealth's Medicaid program, includes approximately 350,000 Massachusetts residents who are enrolled Members, under the Medicaid Expansion. In the most recently completed state fiscal year 2017, MassHealth claimed $1.775 billion in federal financial participation for these members.

PURSUANT TO 28 U.S.C. § 1746, I DECLARE UNDER PENALTY OF PERJURY THAT THE FOREGOING IS TRUE AND CORRECT.

EXECUTED ON April 6, 2018.

Sharon C. Boyle
First Deputy General Counsel and Chief
MassHealth Counsel
Executive Office of Health and Human Services
Commonwealth of Massachusetts

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF TEXAS
FORT WORTH DIVISION

TEXAS, WISCONSIN, ALABAMA, ARKANSAS, ARIZONA, FLORIDA, GEORGIA, INDIANA, KANSAS, LOUISIANA, PAUL LePAGE, Governor of Maine, MISSISSIPPI, by and through Governor Phil Bryant, MISSOURI, NEBRASKA, NORTH DAKOTA, SOUTH CAROLINA, SOUTH DAKOTA, TENNESSEE, UTAH, and WEST VIRGINIA, Plaintiffs, v. UNITED STATES OF AMERICA, UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, ALEX AZAR, in his Official Capacity as SECRETARY OF HEALTH AND HUMAN SERVICES, UNITED STATES INTERNAL REVENUE SERVICE, and DAVID J. KAUTTER, in his Official Capacity as Acting COMMISSIONER OF INTERNAL REVENUE, Defendants.	Civil Action No. 4:18-cv-00167-O
CALIFORNIA, ET AL., Proposed Intervenor-Defendants.	

DECLARATION OF MARGARET CHISM IN SUPPORT OF MOTION TO INTERVENE BY CALIFORNIA, ET AL.

I, Margaret Chism, declare:

1. I am 33 years old and a resident of Richmond, Kentucky.

2. In 2016, I learned that my daughter would be born with a hypoplastic left heart syndrome, a condition that leaves the left side of the heart, including the aorta, aortic

valves, mitral valves, and left ventricle severely underdeveloped. It is always fatal if not treated. My doctors provided me two options: to terminate the pregnancy, or to continue with the pregnancy. I opted to continue the pregnancy.

3. I welcomed Evelyn in September 2016, and her birth kicked off an extremely challenging year.

4. Evelyn's treatment started with a staged heart reconstruction. At six days old, Evelyn had her first open heart surgery. Several months later, she had a second. For most of the first year of her life, I watched my baby hooked up to monitors, breathing and gastric feeding tubes. We lived in the CICU for months at a time, and when we weren't in the CICU, we were in specialists' offices for testing. The bills for Evelyn's care well surpassed a million dollars, just within the first few months of her life.

5. When we started this journey, I was working full time and the two of us were covered through my employer-sponsored plan. Because of the Affordable Care Act, I knew that my maternity and pregnancy care would be included, and after Evelyn's birth, I never had to worry about her care being denied because of a pre-existing condition or her reaching a lifetime cap.

6. Our circumstances have changed over the last year, as we've had to accommodate Evelyn's needs. We've learned that she has several developmental delays and that she will require round-the-clock care. She needs regular monitoring and will likely require another open heart surgery at some point in the next few years. In order to be there for her, I needed to leave my job. This meant losing access to our employer-based health insurance.

7. With the help of a social worker, we were able to enroll Evelyn in Medicaid and a home and community based services waiver program, allowing us access to home visits and nursing care we would not have otherwise have been able to afford. And because Kentucky use the Affordable Care Act to expand access to Medicaid, I was able to enroll in coverage for myself. Because of Medicaid expansion, I don't have to worry about going without coverage while taking care of my daughter. This has been invaluable.

8. While watching the various efforts to repeal, roll back, and cut parts of the Affordable Care Act and Medicaid, my family has endured constant stress. As Evelyn was recovering from heart surgery, as she was hanging on to life by a thread, I watched efforts unfold that would make it harder for her to access care. If I were to lose coverage, it would put my health and our financial stability at risk.

9. I support Plaintiffs' motion to intervene. Elimination of the ACA would hurt me and my family.

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

Executed on March 24, 2018, in Richmond, KY.

Margaret Chism

Margaret Chism

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF TEXAS
FORT WORTH DIVISION

TEXAS, WISCONSIN, ALABAMA, ARKANSAS, ARIZONA, FLORIDA, GEORGIA, INDIANA, KANSAS, LOUISIANA, PAUL LePAGE, Governor of Maine, MISSISSIPPI, by and through Governor Phil Bryant, MISSOURI, NEBRASKA, NORTH DAKOTA, SOUTH CAROLINA, SOUTH DAKOTA, TENNESSEE, UTAH, and WEST VIRGINIA, Plaintiffs, v. UNITED STATES OF AMERICA, UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, ALEX AZAR, in his Official Capacity as SECRETARY OF HEALTH AND HUMAN SERVICES, UNITED STATES INTERNAL REVENUE SERVICE, and DAVID J. KAUTTER, in his Official Capacity as Acting COMMISSIONER OF INTERNAL REVENUE, Defendants.	Civil Action No. 4:18-cv-00167-O
CALIFORNIA, ET AL., Proposed Intervenor-Defendants.	

DECLARATION OF ANGELA EILERS IN SUPPORT OF MOTION TO INTERVENE BY CALIFORNIA, ET AL.

I, Angela Eilers, declare:

1. I am 43 years old and a resident of Yorba Linda, California.
2. I am the mother of three young children, who all benefit from protections for individuals with pre-existing conditions.

3. My 8-year-old daughter was born with pulmonary stenosis, an undiagnosed heart defect and because of that, she will forever have a pre-existing condition. After she was born, she spent 2 ½ weeks in the neo-natal intensive care unit (NICU) and during her first year of life, she endured two open heart surgeries, at four and eleven months old. Because of her condition, my daughter will need a heart valve replacement at some point in her life. We hope that her current heart valve will last until she is a teenager, otherwise, she will need a second she has finished growing. Her ongoing care requires regular monitoring by a cardiologist and a team of medical professionals. To date, my daughter's medical care has cost over $500,000.
4. Before the Affordable Care Act, my daughter would have faced serious difficulties getting health care coverage. She might have been issued an insurance policy, but turned down for care related to her heart. Or, she could have been denied an insurance policy altogether. Either option would have been catastrophic, because our family cannot afford to pay out-of-pocket for the expert care she needs.
5. Additionally, my twin boys were born at 34 ½ weeks and were in the NICU for an extended period of time. Although they are otherwise healthy, they, too, could have been turned down for insurance simply because being born premature was enough to justify the label of having a pre-existing condition.

My husband is an Air Force veteran and today, he is the owner of a small, very successful company. While he can receive care through the VA, that doesn't provide coverage for the rest of our family; and we are ineligible for TRICARE. We currently receive our coverage through a small group plan that covers us and our employees. If the ACA is repealed, we fear that the cost of insurance will go up for everyone, or that our plan might be cancelled outright. If it is cancelled and there are no longer protections for individuals with pre-existing conditions, there's no guarantee that we will even be able to find a plan that would cover our children. The uncertainty around whether our children will continue to have coverage is an

enormous stress on our family. I go to bed and get up every day worrying about the future of their care. Just because my children got a rough start in life doesn't mean that they should be penalized. They should have the same rights as their normal, healthy classmates. I support Plaintiffs' motion to intervene. Elimination of the ACA would hurt me and my family.

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

Executed on March 23, 2018 in Yorba Linda, California.

Angela Eilers

SA2018100536

My husband is an Air Force veteran and today, he is the owner of a small, very successful company. While he can receive care through the VA, that doesn't provide coverage for the rest of our family; and we are ineligible for TRICARE. We currently receive our coverage through a small group plan that covers us and our employees. If the ACA is repealed, we fear that the cost of insurance will go up for everyone, or that our plan might be cancelled outright. If it is cancelled and there are no longer protections for individuals with pre-existing conditions, there's no guarantee that we will even be able to find a plan that would cover our children. The uncertainty around whether our children will continue to have coverage is an enormous stress on our family. I go to bed and get up every day worrying about the future of their care. Just because my children got a rough start in life doesn't mean that they should be penalized. They should have the same rights as their normal, healthy classmates. I support Plaintiffs' motion to intervene. Elimination of the ACA would hurt me and my family.

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

Executed on March 23, 2018 in Yorba Linda, California.

Angela Eilers

SA2018100536

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IN THE UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF TEXAS
FORT WORTH DIVISION

TEXAS, et al.,	)	
	)	
Plaintiffs,	)	
	)	
v.	)	Civil Action No. 4:18-cv-00167-O
	)	
UNITED STATES OF AMERICA, et al.,	)	
	)	
Defendants.	)	
	)	

DECLARATION OF MATTHEW DAVID EYLES, SENIOR EXECUTIVE VICE PRESIDENT AND CHIEF OPERATING OFFICER OF AMERICA'S HEALTH INSURANCE PLANS, INC. IN SUPPORT OF CERTAIN STATES' MOTION TO INTERVENE

I, Matthew David Eyles, declare:

1. I am Senior Executive Vice President and Chief Operating Officer of America's Health Insurance Plans, Inc. (AHIP). I have served as AHIP's Senior Executive Vice President and Chief Operating Officer since September 2017. From January 2015 to September 2017, I was AHIP's Executive Vice President of Policy and Regulatory Affairs, and I continue to lead the Policy and Regulatory Affairs department at AHIP. I will assume the role of AHIP's President and CEO beginning June 1, 2018. In both my roles as Senior Executive Vice President of AHIP and Executive Vice President of Policy and Regulatory Affairs, I have led the development and implementation of AHIP's health policy initiatives and advocacy efforts at both the federal and state levels. I have nearly two decades of experience working within the healthcare industry and over twenty (20) years of health policy experience. This includes experience working within the health

insurance, pharmaceutical and healthcare consulting industries. The facts below are based on my personal knowledge and expertise and I could and would competently testify to them.

2. The Patient Protection and Affordable Care Act (ACA) was adopted to expand access to affordable, quality health care coverage. To achieve this goal, the ACA adopted several reforms, including: (1) expanding Medicaid to cover low-income adults ages 19-64 up to 138% of the federal poverty level (FPL); (2) enacting a number of reforms to Medicare, including the phasing out of the coverage gap or "donut hole" in Part D prescription drug coverage; and (3) restructuring the individual and small group markets, including financial assistance for individuals and families under 400% of FPL and providing tax credits to certain small employers who offer coverage.

3. AHIP is the national trade association representing health insurance providers and the tens of millions of Americans they serve every day. AHIP's members provide health and supplemental benefits through employer-sponsored coverage, the individual insurance market, and public programs such as Medicare (including prescription drug coverage under Part D) and Medicaid. This includes eighty-six (86) AHIP member health plans that offer Part D coverage and sixty-five (65) member health plans that offer coverage to Medicaid beneficiaries through Medicaid managed care organizations. In 2017, seventy (70) of AHIP's members offered qualified health plans through an Exchange. Together, these members provide health coverage across all fifty (50) states, the District of Columbia and Puerto Rico, and are composed of large national health plans; state-based plans; plans that predominately serve Medicaid, individual and small group markets; and regional health maintenance organizations.

4. Millions of individuals benefit from the coverage provided by these health plans. In 2017, there were 75,653,251 individuals enrolled in Medicaid,[1] of which 55,225,193 individuals were enrolled in Medicaid managed care plans.[2] Medicaid expansion, which in 2016 included 31 states and the District of Columbia, accounted for 15,343,481 enrollments; 11,996,598 of those expansion enrollees obtained coverage through the ACA expansion.[3] A 32nd state, Maine, voted to expand Medicaid in late 2017.

5. Similarly, millions of individuals have enrolled in fully-insured coverage in both the individual market (18.4 million based on the first quarter of 2017) and the small group market (13.6 million based on the first quarter of 2017).[4] AHIP's member health plans actively participate in both markets, including by offering qualified health plans through an Exchange. For example, based on the same health plan data available for the first quarter of 2017, 13.5 million consumers were insured with individual market coverage provided by AHIP member health plans, of which approximately 7 million were insured through an Exchange health plan.[5] Similarly, 8.7 million consumers were insured in small group coverage provided by an AHIP member health plan.[6]

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[1] *See* Centers for Medicare & Medicaid Services (CMS), Monthly Medicaid and CHIP Application, Eligibility Determination, and Enrollment Report, December 2017 (and including Puerto Rico managed care enrollment numbers (where managed care penetration is 100%) derived as specified in fn. 2 *infra*.).

[2] This number is based on an analysis conducted by Health Management Associates for AHIP of data from state agencies, National Association of Insurance Commissioners (NAIC) and S&P Global Market Intelligence (HMA AHIP Analysis).

[3] Reflects total 2016 expansion enrollment figures (2017 expansion enrollment data not yet available). Centers for Medicare & Medicaid Services, Medicaid Budget and Expenditure System (MBES) Enrollment Report, December 2016.

[4] This number is based on data available in the *AIS's Directory of Health Plans: 2017. Washington, DC. Available on CD. Atlantic Information Services, Incorporated* which includes data on 9.6 million individuals of the approximate 11 million individuals insured on Exchanges. This data set includes some portion of 230,000 lives covered on Small Business Health Options (SHOP) exchange coverage which accounts for less than 2% of the total lives represented in the AIS data. SHOP covered lives as of January 2017 are reported as a distinct number in CMS data resource found at https://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/SHOP-Marketplace-Enrollment-Data.pdf (last accessed Apr. 6, 2018).

[5] *Id.*

[6] *Id.*

6. Of the 33 jurisdictions that expanded Medicaid through the ACA, 7 are plaintiffs in this litigation and represent 1,282,554 expansion enrollees, including: Arizona with 109,723 expansion enrollees; Arkansas with 316,483; Indiana with 278,610; Louisiana with 376,668; North Dakota with 19,965; and West Virginia with 181,105.[7] Maine, the seventh plaintiff state in this case, adopted Medicaid expansion through a ballot initiative in November 2017 but has not yet implemented it. The remaining 26 expansion jurisdictions are: Alaska, California, Colorado, Connecticut, Delaware, Hawaii, Illinois, Iowa, Kentucky, Maryland, Massachusetts, Michigan, Minnesota, Montana, Nevada, New Hampshire, New Jersey, New Mexico, New York, Ohio, Oregon, Pennsylvania, Rhode Island, Vermont, Washington and the District of Columbia.[8]

7. Millions of hardworking Americans with low incomes (under 138% FPL, or $16,642 for a single individual or $33,948 for a family of four in 2017) depend on Medicaid and the health plans offered through Medicaid managed care organizations to get affordable access to medical care. Medicaid managed care organizations are at the forefront of implementing systems and programs that promote high-quality, coordinated health care for millions of low-income beneficiaries across the country. More than 70% of all Medicaid beneficiaries rely on health plans provided by Medicaid managed care organizations for their coverage.[9] These health plans coordinate care so that physician services, hospital care, prescription drugs, long-term services and supports, and other

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[7] *See supra* fn. 3.

[8] *See* Henry J. Kaiser Family Foundation, Status of State Action on the Medicaid Expansion Decision, *available at* https://www.kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D (last accessed Apr. 6, 2018).

[9] Based on 2017 data reflecting 75,653,251 individuals enrolled in Medicaid, of which 55,225,193 individuals were enrolled in Medicaid Managed Care plans. *See supra* fns. 1 and 2.

health care services are integrated and delivered through organized systems designed to improve and maintain health outcomes and quality of life. By emphasizing care and benefits coordination, Medicaid managed care organizations help states control escalating program costs and achieve greater value for their health care dollars.

8. Recent studies demonstrate the value of Medicaid managed care programs. For example, Medicaid beneficiaries access health care at rates comparable to the rates for privately insured people and at sharply higher rates than the uninsured.[10] Adults and children with a Medicaid health plan report better access to care and greater utilization of preventative services than uninsured individuals, and at levels similar to those who have commercial coverage.[11] This access to affordable health care and use of primary and preventative services results in increased economic and health security for low-income households by reducing financial strain and protecting against time lost from work, catastrophic medical cost burdens, and medical debt.[12]

9. Recent studies document that increased coverage through Medicaid expansion resulted in a $6.2 billion reduction in uncompensated health care costs for hospitals.[13] Improved financial stability of hospitals allows them to invest in strategies to improve care

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[10] *See, e.g.*, Henry J. Kaiser Family Foundation, Data Note: Three Findings about Access to Care and Health Outcomes in Medicaid, *available at* https://www.kff.org/medicaid/issue-brief/data-note-three-findings-about-access-to-care-and-health-outcomes-in-medicaid/ (last accessed Apr. 6, 2018).

[11] *See, e.g.*, Henry J. Kaiser Family Foundation, Data Note: Medicaid's Role in Providing Access to Preventative Care for Adults, *available at* https://www.kff.org/medicaid/issue-brief/data-note-medicaids-role-in-providing-access-to-preventive-care-for-adults/ (last accessed Apr. 6, 2018).

[12] *See, e.g.*, *supra* fn. 10.

[13] *See* The Commonwealth Fund, The Impact of the ACA's Medicaid Expansion on Hospitals' Uncompensated Care Burden and the Potential Effects of Repeal, *available at* http://www.commonwealthfund.org/publications/issue-briefs/2017/may/aca-medicaid-expansion-hospital-uncompensated-care (last accessed Apr. 6, 2018). The $6.2 billion figure is based on acute-care and critical-access hospitals filing a cost report and excludes Arizona, California, Massachusetts, and Minnesota. It extrapolates estimates to all hospitals that had expanded Medicaid as of March of 2017. This includes five states that did not expand in 2014 but have since expanded: Pennsylvania, Indiana, Alaska, Michigan, and Louisiana.

coordination, hire new staff, and develop better infrastructure to monitor costs and has an overall benefit to the communities these hospitals serve.[14] A sudden increase in uncompensated care would result in increased costs for other purchasers of health insurance such as private-sector employers.[15]

10. The ACA makes Medicare prescription drug coverage (Medicare Part D) more affordable by closing the "coverage gap" during which Medicare beneficiaries pay out of pocket the full cost of their prescriptions after they reach their initial coverage limits and prior to their reaching the catastrophic coverage phase for prescriptions. This coverage gap has been narrowing each year since the enactment of the ACA and was scheduled to close in 2020. With the passage of the Bipartisan Budget Act of 2018 (Public Law No. 115-123), the gap will now close one year earlier, in 2019 rather than 2020 for brand drugs and biological products approved by the U.S. Food and Drug Administration as "biosimilar" to branded reference products.[16] In addition, the ACA added preventive health services to be covered fully under the Medicare program, extending life-saving screenings to Medicare beneficiaries without any cost-sharing (*i.e.* copayments or deductibles).[17]

11. In addition, the funding of Advance Premium Tax Credits (APTCs) has been a significant driver of enrollment by millions of Americans through the Exchanges. The ACA

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[14] *See, e.g.,* The Commonwealth Fund, Comparing the Affordable Care Act's Financial Impact on Safety-Net Hospitals in States that Expanded Medicaid and Those That Did Not, *available at* http://www.commonwealthfund.org/~/media/files/publications/issue-brief/2017/nov/dobson_impact_medicaid_expanion_safety_net_hosps_ib.pdf (last accessed Apr. 6, 2018).
[15] *See* American Benefits Council, Letter to Congressional Leadership (Mar. 14, 2018), *available at* https://www.americanbenefitscouncil.org/pub/72dab87f-0553-0914-6199-b21a5606e424 (last accessed Apr. 6, 2018).
[16] *See, e.g.,* Henry J. Kaiser Family Foundation, Summary of Recent and Proposed Changes to Medicare Prescription Drug Coverage and Reimbursement (Feb. 15, 2018), *available at* https://www.kff.org/medicare/issue-brief/summary-of-recent-and-proposed-changes-to-medicare-prescription-drug-coverage-and-reimbursement/ (last accessed Apr. 6, 2018).
[17] ACA § 4104, codified at 42 U.S.C. § 1395x(ddd).

provides tax credits that reduce monthly insurance premiums for individuals who earn between 100% and 400% of the federal poverty level (FPL)—in 2017, between $24,600 and $98,400 for a family of four—and who satisfy additional criteria.[18] In 2017, of the approximately 10.3 million people enrolled through Exchanges, 8.7 million (approximately 85%) rely on premium tax credits to lower the costs of insurance.[19] The ACA also includes additional tax benefits for certain small employers, who may elect the ACA's small business health care tax credit for offering coverage to their employees, which enables them to provide health insurance benefits, some for the first time.[20] Currently, the maximum credit is 50% of premiums paid for small business employers and 35% percent of premiums paid for small tax-exempt employers.[21] The credit is refundable, can be carried back or forward to other tax years, is available to eligible employers for two consecutive taxable years and the amount is calculated on a sliding scale (*i.e.* the smaller the employer, the bigger the credit).[22]

12. Based on my knowledge and experience, I believe that invalidating the Affordable Care Act would cause significant business disruption, uncertainty, and confusion among health insurance providers across all relevant markets (*i.e.* the individual, small group, Medicaid and Medicare markets). Such disruption would result in immediate financial harm and adversely impact or otherwise materially disrupt health plans' ability to plan for and/or

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[18] *See* Internal Revenue Service, Questions and Answers about the Premium Tax Credit (Mar. 16, 2018), *available at* https://www.irs.gov/affordable-care-act/individuals-and-families/questions-and-answers-on-the-premium-tax-credit (last accessed Apr. 6, 2018).
[19] *See* CMS, 2017 Effectuated Enrollment Snapshot (Jun. 12, 2017), *available at* https://downloads.cms.gov/files/effectuated-enrollment-snapshot-report-06-12-17.pdf (last accessed Apr. 6, 2018).
[20] ACA § 1421, codified at 26 U.S.C. § 45R.
[21] *See* Internal Revenue Service, Small Business Health Care Tax Credit and the SHOP Marketplace, *available at* https://www.irs.gov/affordable-care-act/employers/small-business-health-care-tax-credit-and-the-shop-marketplace (last accessed Apr. 6, 2018).
[22] *Id.*

otherwise conduct business in those markets. Furthermore, abrogation of the Affordable Care Act will result in: reduced enrollment across Medicaid programs in 32 states and the District of Columbia by eliminating coverage for the nearly 12 million individuals enrolled as a result of the ACA's Medicaid expansion; reduced coverage for low and middle income Americans; increased drug costs and reduced access to wellness visits for the elderly and disabled covered under Medicare; increased costs to states; and significant destabilization of the individual and small group markets, particularly for individuals who rely on APTCs.

Pursuant to 28 U.S.C. § 1746, I declare under penalty of perjury that the foregoing is true and correct, and that this declaration was executed on April 6, 2018, in Washington, DC.

Dated: April 6, 2018

Matthew D. Eyles

Matthew David Eyles

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF TEXAS
FORT WORTH DIVISION

TEXAS et al., Plaintiffs, **v.** **UNITED STATES OF AMERICA et al.,** Defendants, and, **CALIFORNIA, VERMONT et al.,** Proposed Intervenors.	Civ. Action No. 18-cv-00167-O **DECLARATION OF ALFRED J. GOBEILLE IN SUPPORT OF STATES' MOTION TO INTERVENE**

I, Alfred J. Gobeille, declare:

1. I am the Secretary of the Vermont Agency of Human Services (AHS). I have served in this position since January 2017. I have either personal knowledge of the matters set forth below or, with respect to those matters for which I do not have personal knowledge, I have reviewed information gathered from AHS records and other publicly available information.

2. AHS was created by the Vermont Legislature in 1969 to serve as the umbrella organization for all human service activities within state government. AHS is led by the Secretary, who is appointed by the Governor. The Secretary's Office is responsible for leading the agency and its departments: the Department for Children and Families; the Department of Corrections, the Department of Disabilities, Aging and Independent Living; the Department of Mental Health; and the Department of Vermont Health Access (DVHA). DVHA is the state office responsible for the management of Medicaid, the State Children's Health Insurance Program, and other publicly funded health insurance programs in Vermont. As such, it is the largest insurer in Vermont in terms of dollars spent and the second largest insurer in terms of covered lives. DVHA is responsible for administering Vermont Health Connect, which is the State's health insurance marketplace.

3. **The Affordable Care (ACA) Act directs billions of dollars directly to Vermont.**

- Specifically, Vermont has received $772 million via Medicaid expansion; $8 million through the Prevention and Public Health Fund; and more than $85 million for federal premium subsidies.

4. **The ACA increased access to affordable coverage.**

- Overall the number of individuals with insurance has increased. In Vermont, the number of covered individuals increased from 583,674 in 2012 to 603,400 in 2014, according to the Vermont Household Health Insurance Survey (VHHIS). Over the same period, the number of uninsured Vermonters was nearly cut in half, dropping from 42,760 in 2012 to 23,231 in 2014. This correlates to an uninsured rate of 6.8% in 2012 and 3.7% in 2014. While the next VHHIS won't be completed until the second half of 2018, the U.S. Census has estimated that the number of uninsured Vermonters remained down in the 23,000 range in 2015 and 2016.
- The ACA expanded coverage through two key mechanism: Medicaid expansion for those individuals with the lowest incomes, and federal health subsidies to purchase coverage in new health insurance Exchanges, like Vermont Health Connect, for those individuals with moderate incomes.

- Medicaid is an important source of healthcare insurance coverage and has resulted in significant coverage gains and reduction in the uninsured rate, both among the low-income population and within other vulnerable populations. Vermont can be described as a "pre-expansion" state in the sense that it offered state health programs—the Vermont Health Access Plan and Catamount Health—to Vermonters with incomes up to 300% FPL years before Medicaid expansion. The change in Medicaid eligibility under the ACA from considering assets to only focusing on income also benefitted farmers and other land rich, cash poor Vermonters who previously could not afford health insurance and did not qualify for benefits but now qualify either for Medicaid or for health insurance subsidies. The uninsured rate for Vermonters with income up to 138% FPL (the expanded Medicaid threshold) dropped from 9.6% in 2012 to 5.0% in 2014, and the state's overall uninsured rate dropped from 6.8% in 2012 and 3.7% in 2014.
- Creation of health insurance exchanges is an important reform made by the ACA. In Vermont, 23,554 people have received federally subsidized coverage in 2018 as a result of the ACA.

5. The ACA has positive economic benefits on states.

- Studies have shown that states expanding Medicaid under the ACA have realized budget savings, revenue gains, and overall economic growth.
- In Vermont, $260 million has been saved as a result of Medicaid expansion.

6. The ACA expanded programs in Medicaid to provide States with increased opportunities to increase access to home and community-based services.

- In 2011, Vermont was awarded a five-year $17.9 million Money Follows the Person (MFP) grant from CMS to help people living in nursing facilities overcome the barriers that have prevented them from moving to their preferred community-based setting. The grant works within the Choices for Care program and provides participants the assistance of a Transition Coordinator and up to $2,500 to address barriers to transition.

- Effective April 1, 2016, Vermont received a continued $8 million award for services through September 30, 2019.

7. The ACA has allowed States to test and implement reforms to healthcare delivery systems that support State policy priorities of increasing efficiency and quality of care.

- The Vermont All-payer Accountable Care Organization (ACO) Model Agreement with CMS is a new test of an alternative payment model in which the most significant payers through Vermont—Medicare, Medicaid, and commercial healthcare payers—incentivize healthcare value and quality, with a focus on health outcomes, under the same payment structure for the majority of providers throughout the state's care delivery system. The model began on January 1, 2017 and will span six performance years, concluding on December 31, 2022. The Vermont Medicaid Shared Savings Program (VMSSP) was a three-year program (2014-2016) to test if the ACO models in Vermont could improve health quality while also reducing costs. Upon conclusion of the VMSSP, the Vermont Medicaid Next Generation ACO program began (January 1, 2017). On October 24, 2016, CMS approved a five-year extension of Vermont's Global Commitment to Health 1115 waiver (January 1, 2017-December31, 2021), which specifically allows Vermont Medicaid to enter into ACO arrangements that align in design with that of other healthcare payers in support of the Vermont All-payer ACO Model. The pilot now includes over 5,000 providers.

8. The ACA resulted in better quality and more accessible, affordable healthcare for consumers.

- The ACA created robust consumer protections to help ensure individuals can access the healthcare system.
    - Largely due to the ACA's provision that adult children can be covered by their parents' health plan until age 26, the number of uninsured young adults in Vermont between the ages of 18 and 24 was slashed from 10,839 in 2009 to 2,920 in 2014;

- More than 79,000 Vermonters enrolled in qualified health plans as of February 2018 are benefitting from the ACA's mandated preventive services including access to birth control, cancer screenings, and immunizations for children;
- More than 79,000 Vermonters enrolled in qualified health plans as of February 2018 are benefitting from access to essential health benefits such as substance use disorder treatment and cancer screenings.

- The ACA has led to improved access to care (39% drop in the number of individuals who needed medical care from a doctor but did not receive it because they could not afford it, 45% drop in individuals who skipped medications because they could not afford it).
- The ACA has led to improved financial security for Vermont families. The number of Vermonters who had trouble paying medical bills fell more than 30,000 from 2009 to 2014, a 20% drop. In addition, the number of Vermonters who were contacted by a collection agency about owing money for unpaid medical bills fell by 16% over the same period.
- In addition, the ACA created additional consumer protections and rights such as:
  - Under the ACA, no individual can be rejected by an insurance plan or denied coverage of essential health benefits for any health condition present prior to the start of coverage. Once enrolled, plans cannot deny coverage or raise rates based only on the enrollee's health.

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

Executed on April 6, 2018, in Waterbury, Vermont.

Alfred J. Gobeille
Secretary, Vermont Agency of Human Services

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF TEXAS
FORT WORTH DIVISION

TEXAS, WISCONSIN, ALABAMA, ARKANSAS, ARIZONA, FLORIDA, GEORGIA, INDIANA, KANSAS, LOUISIANA, PAUL LePAGE, Governor of Maine, MISSISSIPPI, by and through Governor Phil Bryant, MISSOURI, NEBRASKA, NORTH DAKOTA, SOUTH CAROLINA, SOUTH DAKOTA, TENNESSEE, UTAH, and WEST VIRGINIA, Plaintiffs, v. UNITED STATES OF AMERICA, UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, ALEX AZAR, in his Official Capacity as SECRETARY OF HEALTH AND HUMAN SERVICES, UNITED STATES INTERNAL REVENUE SERVICE, and DAVID J. KAUTTER, in his Official Capacity as Acting COMMISSIONER OF INTERNAL REVENUE, Defendants.	Civil Action No. 4:18-cv-00167-O
CALIFORNIA, ET AL., Proposed Intervenor-Defendants.	

DECLARATION OF FREDERICK ISASI IN SUPPORT OF MOTION TO INTERVENE OF CALIFORNIA, ET AL.

I, Frederick Isasi, declare:

1. I am the Executive Director of Families USA Foundation, a role that I assumed in April 2017. Prior to assuming this role, I served as the Health Division Director at the bipartisan National Governor's Association's Center for Best Practices, as Vice President for Health Policy at the Advisory Board Company, and I served as Senior Legislative

Counsel for Health Care on the U.S. Senate Finance Committee and on the Senate Committee on Health, Education, Labor and Pensions during the creation of the Affordable Care Act. I hold a JD from Duke University and an MPH from the University of North Carolina.

2. Founded in 1981, Families USA Foundation is a nonprofit, nonpartisan, 501(c)(3) organization that is dedicated to the achievement of high-quality, comprehensive, and affordable health care for all Americans. We advance our mission through public policy analysis, advocacy, and collaboration with partners to promote a patient- and community-centered health system. We work closely with more than 8,000 consumer leaders and more than 30,000 grassroots activists in all 50 states. We work closely with other national health care patient and consumer organizations on Medicaid and private insurance coverage, health care transformation, and health equity issues. As part of our work, we talk directly with thousands of individual consumers about their experiences with the health care system. We help connect these individuals with opportunities to share their experiences publicly and help to seek improvements in health care.

3. The Affordable Care Act ("ACA") has increased access to affordable health insurance and health care across the country. Through an expansion of Medicaid eligibility to low-income childless adults and the apportionment of subsidies to enable middle-income people to afford coverage from insurance exchanges, the ACA has helped millions more Americans to get insurance for themselves and their families. As a result of these policies, the number of uninsured nonelderly Americans was less than 28 million as of the end of 2016, down from 44 million in 2013.[1]

4. In addition to expanding coverage, the ACA provides robust consumer protections so that those in need of insurance are able to obtain high-quality coverage without discrimination

[1] "Key Facts about the Uninsured Population," Kaiser Family Foundation, November 2017, analyzing the 2016 National Health Interview Survey. Available at http://files.kff.org/attachment/Fact-Sheet-Key-Facts-about-the-Uninsured-Population.

and with federal subsidies to improve affordability. By guaranteeing that consumers are not denied coverage or rated based-on preexisting conditions, allowing children to remain on their parents' insurance through age 26, removing lifetime benefit caps, establishing minimum actuarial values, requiring insurance plans to cover specified preventive services and essential health benefits, and providing federal support for the cost of health care for lower-income families and individuals, the ACA has ensured that Americans' health insurance is accessible, fair, and comprehensive.

5. Through our website, emails, publications, and outreach to other patient and community-based organizations, Families USA invites consumers to "tell us your story" with respect to health care. Some consumers also contact us in response to information we have published about how health coverage laws work, or because news articles have quoted us. Among the many consumers who have contacted us are the following regarding the critical protections they receive under the ACA are the following:

a) California

A 50-year-old woman who is unemployed contacted us. In 2013, around the same time she lost her job, she was diagnosed with a hypoactive thyroid. At first, she was able to transition to COBRA, and in 2014, a plan purchased through Covered California. Since that time, she has been diagnosed with essential tremors and thyroid eye disease, her condition has deteriorated to the point where she has required several invasive eye surgeries and she is almost fully disabled. Since 2013, her income has steadily declined and she can no longer afford housing of her own—she now sleeps on a friend's couch. She says that she has diligently reported changes in her income to Covered California, and now she qualifies for Medi-Cal (California's Medicaid program). Based on her household circumstances, her only basis for Medi-Cal eligibility is the income-based coverage of adults established through the ACA. Without the ACA, she would no

longer qualify. She says she has no idea what she will do if cuts are made and she is no longer eligible for Medi-Cal.

b) Illinois

A couple purchased a plan with a subsidy through the Illinois exchange. While the plan is expensive, the subsidy, combined with guaranteed coverage for pre-existing conditions, means that they are better off financially than they would be otherwise. The wife told Families USA that without the subsidy, the couple would pay almost $2000 a month in premiums, and they would be forced to drop their coverage. Their prescriptions are thousands of dollars more and they would have no choice but to stop taking medically necessary treatments.

c) Illinois

We were contacted by a young woman who has struggled with chronic depression and suicidal urges since she was 12 years old. Her condition necessitated several stays in intensive care units and psychiatric hospitals over the years. While her parents' insurance always covered her treatments, she says that she was relieved when the ACA passed, because she was afraid her history of treatment would render her uninsurable. Now at 24, she takes two medications and sees a therapist weekly. She says that while she can never be cured, she knows how to manage her condition, and cites that it now has been years since she last felt the urge to take her own life. She remains on her parents' plan and says, "I am alive today because I have had access to medication, and above all, to great doctors. [Repealing the ACA means] that I will once again become a target because I have a pre-existing condition. It will be a threat to my life."

d) Oregon

A woman and her partner are organic farmers. Prior to the ACA, the partner had been uninsured for years and the woman had "the most minimal coverage possible" because it was all she could afford. Even though she was healthy, she

had been subject to coverage denials based on pre-existing conditions. She was able to appeal the denials only because she was able to prove continuous coverage. Following the passage of the ACA, the two were able to enroll in a plan purchased through the marketplace that she says, "Was health coverage that we could actually use and afford." Since then, she has given birth to a baby, who is now covered through the Children's Health Insurance Program ("CHIP"). She says that the uncertainty around the future of the ACA makes it seem like "everything is up in the air and unknown and far from secure or stable.....This is detrimental to our security, our sanity, and our health as a family. The sheer amount of anxiety and stress we are feeling around this matter and having no idea where it's all going to land, is exhausting and soul crushing. We need CHIP. We need a functioning ACA that isn't being undermined. Our lives depend on it."

e) Pennsylvania

We were contacted by a woman who had been diagnosed with sudden-onset aggressive breast cancer in 2005. While she was treated at the time, she is at a high risk of the cancer coming back. She says that if the ACA were to go away, she is afraid she will be charged more based on a pre-existing condition, "I see my oncologist every six months, but I need coverage for whatever lies ahead!"

6. In every single State, whether the state has a federally run or state-run exchange, millions of citizens depend on tax credits to afford health insurance. Nationally, 10.3 million individuals effectuated enrollment in 2017 in the marketplaces. Of these, 8.7 million, or 84 percent, received tax credits that lowered their costs.[2]

7. In 31 States and the District of Columbia, low-income citizens have access to health coverage through the expanded Medicaid program. Across the nation, over 11.8 million

[2] Centers for Medicare and Medicaid Services, "2017 Effectuated Enrollment Snapshot," June 12, 2017, available at https://downloads.cms.gov/files/effectuated-enrollment-snapshot-report-06-12-17.pdf.

people who were newly-eligible for Medicaid due to this expansion were enrolled as of the last quarter of 2016.[3] An additional state, Maine, passed a ballot initiative in November 2017 to expand Medicaid but has not yet implemented this expansion.

8. The U.S. Department of Health and Human Services Office of the Assistant Secretary for Planning and Evaluation found that Medicaid expansion states realized a 9.2 percentage point reduction in the number of uninsured adults from 2014 to 2016, a 49.5 percent decline in the uninsured rate. Non-expansion states realized a 7.9 percentage point reduction in the number of uninsured adults, a 33.8 percent decline in the uninsured rate.[4]

9. Medicaid expansion increased access to primary care, expanded use of prescription medications, and increased rates of diagnosis of chronic conditions, such as diabetes, for new enrollees.[5] National survey data show that the expansion significantly improved access to preventive care for low-income childless adults.[6]

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[3] Centers for Medicare and Medicaid Services, "October-December 2016 Medicaid MBES Enrollment Report," posted December 2017 and available at https://www.medicaid.gov/medicaid/program-information/downloads/cms-64-enrollment-report-oct-dec-2016.pdf.

[4] ASPE Office of Health Policy, "Medicaid Expansion Impacts on Insurance Coverage and Access to Care," January 18, 2017. Available on https://aspe.hhs.gov/system/files/pdf/255516/medicaidexpansion.pdf.

[5] Ibid; H. Kaufman, et al, "Surge in Newly Identified Diabetes Among Medicaid Patients in 2014 Within Medicaid Expansion States Under the Affordable Care Act," *Diabetes Care*, March 2015, available on http://care.diabetesjournals.org/content/early/2015/03/19/dc14-2334; L. Wherry and S. Miller, "Early Coverage, Access, Utilization, and Health Effects of the Affordable Care Act Medicaid Expansions: A Quasi-Experimental Study" *Annals of Internal Medicine*, June 21, 2016, available on http://annals.org/aim/article-abstract/2513980/early-coverage-access-utilization-health-effects-associated-affordable-care-act.

[6] Kosali Simon, et al, "The Impact of Health Insurance on Preventive Care and Health Behaviors: Evidence from the 2014 ACA Medicaid Expansions," National Bureau of Economic Research Working Paper No. 22265, issued in May 2016, revised in September 2016. Available at http://www.nber.org/papers/w22265.

10. Several consumer surveys have found decreases in problems paying medical bills, reductions in out-of-pocket spending, and reductions in self-reported unmet medical needs due to Medicaid expansion.[7]

11. Medicaid expansion has improved people's financial security. Researchers from the Federal Reserve Bank of Chicago, the University of Michigan, and the University of Illinois found that after Medicaid expansion the proportion of bills that were unpaid and sent to collection agencies declined.[8] Similarly, a study from researchers at the Federal Reserve Bank in New York found that consumers in states that expanded Medicaid carried an average $200 less in credit card debt than they had prior to the expansion and had lower rates of third-party collection. Consumers in non-expansion states did not experience this improved financial status.[9]

12. About 340,000 veterans receive coverage through the ACA's Medicaid expansion. This number includes many veterans who cannot use the Veteran's Health System because they do not meet its eligibility requirements or because they do not live near a Veterans Affairs provider. In total 913,000 veterans between the ages of 18 and 64 receive Medicaid.[10]

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[7] Cited in ASPE, op cit.

[8] Luojia Hu, et al, "The Effect of the Patient Protection and Affordable Care Act Medicaid Expansions on Financial Wellbeing," National Bureau of Economic Research Working Paper No. 22170, issued in April 2016 and revised in February 2018. Available at http://nber.org/papers/w22170.

[9] Nicole Dussault, et al, "Is Health Insurance Good for Your Financial Health," *Liberty Street Economics,* June 6, 2016. Available at http://libertystreeteconomics.newyorkfed.org/2016/06/is-health-insurance-good-for-your-financial-health.html#.V2fhz_krLct.

[10] Andrea Callow, "Cutting Medicaid Would Hurt Veterans," Families USA analysis of 2013 and 2015 American Community Survey data, May 2017. Available at http://familiesusa.org/product/cutting-medicaid-would-hurt-veterans.

13. The nation is struggling with an unprecedented crisis of opioid use disorder.[11] More than 116 people in our nation are dying daily during this crisis. In 2016 42,000 people died from opioid overdoses.[12] In the 12-month period ending in August 2017, drug-related deaths were 8,000 higher than during the 12-month period ending August 2016, and the Centers for Disease Control found that the increase was driven primarily by synthetic opioids.[13] The Medicaid expansion has played a critical role in providing access and financing for substance use disorder treatment. In states that expanded Medicaid, the share of patients in specialized Substance Use Disorder programs whose care was paid by the Medicaid program increased 12.9 percentage points, or 75 percent, from 2014 to 2016, while the share who were uninsured and whose care was paid by state and local resources declined. Medicaid also was a significant payer of outpatient, medication-assisted treatment.[14]

14. Medicaid also has been helpful to state economies. Data from eleven Medicaid expansion states (Arkansas, California, Colorado, Kentucky, Michigan, New Mexico, Oregon, Maryland, Pennsylvania, Washington, West Virginia) and the District of Columbia show that every state realized savings and new revenue as a result of expanding Medicaid.

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[11] D. Dowell, et al, "Contribution of Opioid-Involved Poisoning to the Change in Life Expectancy in the United States, 2000-2015," *JAMA*. 2017;318(11):1065-1067, available at https://jamanetwork.com/journals/jama/fullarticle/2654372.

[12] Statement of Kimberley Brandt, Principal Deputy Administrator for Operations, Centers for Medicare and Medicaid Services, on "The Opioid Crisis" before the U.S. House Committee on Ways and Means, Subcommittee on Oversight, January 2018, available at https://waysandmeans.house.gov/wp-content/uploads/2018/01/20180117OS-Testimony-Brandt-.pdf.

[13] Written testimony of Dr. Ann Schuchat, Acting Director, Centers for Disease Control and Prevention, for the Energy and Commerce Subcommittee on Health Hearing, March 21, 2018, available on http://docs.house.gov/meetings/IF/IF14/20180321/108049/HHRG-115-IF14-Wstate-SchuchatA-20180321.pdf.

[14] J. Maclean and B. Saloner, "The Effect of Public Insurance Expansions on Substance Use Disorder Treatment: Evidence from the Affordable Care Act," National Bureau of Economic Research Working Paper No. 23342, April 2017 revised in September 2017, available at http://www.nber.org/papers/w23342.

Expansion states are able to reduce spending on programs for the uninsured and bring in additional revenue from insurer or provider taxes.[15]

15. Medicaid is an important source of coverage for people with disabilities. About 10 million people qualify for Medicaid based on their disability, and of those, 6.2 million do not have Medicare benefits.[16] The ACA improved Medicaid coverage for people with disabilities in several ways. First, in states that expanded Medicaid, more people with disabilities could qualify for Medicaid coverage based on income alone, without having to go through the lengthy process of proving their disability. Second, the ACA extended home and community based care through the Medicaid program for many people with disabilities. Third, the ACA authorizes Medicaid to pay for case management for adults and children with chronic illnesses in states that have established health homes. Twenty-one states and the District of Columbia had established those health homes by December 2017.[17]

16. The ACA resulted in better quality, more accessible, more affordable health care for consumers. Studies have found that the proportion of Americans without a primary care doctor and the proportion who reported inability to afford care both decreased when marketplace subsidies began, and that access continued to improve the following year.[18] A survey by the Commonwealth Fund found that 72 percent of people enrolled in the

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[15] Deborah Bacharach, et al, "States Expanding Medicaid See Significant Budget Savings and Revenue Gains," State Health Reform Assistance Network, Robert Wood Johnson Foundation, March 2016, available at https://www.rwjf.org/content/dam/farm/reports/issue_briefs/2016/rwjf419097.

[16] MACPAC, "People With Disabilities," February 2017, available at https://www.macpac.gov/subtopic/people-with-disabilities/.

[17] CMS, "Approved Medicaid Health Home State Plan Amendments," https://www.medicaid.gov/state-resource-center/medicaid-state-technical-assistance/health-home-information-resource-center/downloads/hh-map.pdf.

[18] B. D. Sommers, M. Z. Gunja, K. Finegold et al., "Changes in Self-Reported Insurance Coverage, Access to Care, and Health Under the Affordable Care Act," *Journal of the American Medical Association*, July 28, 2015 314(4):366–74.

marketplace or newly enrolled in Medicaid used their insurance for health care, and more than half would not have been able to access or afford care before getting coverage through the ACA.[19] The National Health Interview Survey and the Behavioral Risk Factor Surveillance System both show dramatic improvements in access to care as people gained coverage through the ACA.[20]

17. The ACA included a number of initiatives to improve quality of care, including initiatives to hold hospitals accountable for quality and improve safety; opportunities for providers to receive Medicare payments based on quality and care coordination; funding for states to improve the quality of care to people with chronic illnesses and complex situations and to reduce health disparities; funding for states to redesign the health care system to improve efficiency and value through the State Innovation Models Initiative, and provision of a fuller scope of care needed to address health problems, including preventive care, mental health and substance use services, and pediatric oral health care. These initiatives are working. For instance, the rate of hospital-acquired infections declined dramatically after the ACA was implemented.[21] Oregon is one state that redesigned its Medicaid program to improve coordination of care and reduce health disparities. This redesign has already shown associated reductions in disparities in

[19] S. R. Collins, M. Z. Gunja, M. M. Doty, and S. Beutel, *Americans' Experiences with ACA Marketplace and Medicaid Coverage: Access to Care and Satisfaction* (The Commonwealth Fund, May 2016).

[20] S. Glied, et al, "Effect of the Affordable Care Access on Health Care Access" (Commonwealth Fund, May 2017). Available at http://www.commonwealthfund.org/~/media/files/publications/issue-brief/2017/may/glied_effect_of_aca_on_hlt_care_access_ib.pdf.

[21] Agency for Healthcare Research and Quality Saving lives and saving money: hospital-acquired conditions update. Updated December 2015. Available at http://www.ahrq.gov/professionals/quality-patient-safety/pfp/interimhacrate2014.html.

primary care visits as well as reductions in the disparities in access to care between white and black Medicaid enrollees.[22]

18. Prior to my work at Families USA, I directed the Center for Best Practices Health Division at the National Governor's Association where I helped states work on myriad issues related to improving the quality and value of health care to state residents, including: health insurance coverage and Medicaid, public health, health care data, behavioral health, and health care workforce. I know first-hand that the funding provided through the ACA for the aforementioned issues was welcomed and used by states. For example, we worked with Governors and their leaders to leverage new Medicaid authorities and other flexibilities included in the ACA to realign health care incentives, improve health care workforce, provide evidence-based comprehensive services such as Housing First interventions, and integrate behavioral and physical health services.[23]

19. Enjoining the ACA would derail these reforms, which are making health care more accessible, more affordable, and higher quality, and it would seriously damage the health of state residents, state budgets, and state economies.

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

Executed on March 28, 2018 in Washington, D.C..

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[22] K. John McConnell, et al, "Oregon's Emphasis On Equity Shows Signs Of Early Success For Black And American Indian Medicaid Enrollees," Health Affairs, March 2018, available at https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2017.1282.

[23] F. Arabo, S. Wilkniss, S. Malone and F. Isasi, *Housing as Health Care: A Road Map for States* (Washington, D.C.: National Governors Association Center for Best Practices, September, 2016), available at https://www.nga.org/cms/home/nga-center-for-best-practices/center-publications/page-health-publications/col2-content/main-content-list/housing-as-health-care-road-map.html and documents available on "Complex Care Populations" section of National Governors Association website, https://www.nga.org/cms/center/issues/health/complex-care-populations.

Executed on March 28, 2018 in Washington, D.C..

Frederick Isasi
Executive Director
Families USA Foundation

IN THE UNITED STATES DISTRICT COURT

FOR THE NORTHERN DISTRICT OF TEXAS

WICHITA FALLS DIVISION

TEXAS, WISCONSIN, ALABAMA, ARKANSAS, ARIZONA, FLORIDA, GEORGIA, INDIANA, KANSAS, LOUISIANA, PAUL LePAGE, Governor of Maine, MISSISSIPPI, by and through Governor Phil Bryant, MISSOURI, NEBRASKA, NORTH DAKOTA, SOUTH CAROLINA, SOUTH DAKOTA, TENNESSEE, UTAH, and WEST VIRGINIA, Plaintiffs, **v.** **UNITED STATES OF AMERICA, UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, ALEX AZAR, in his Official Capacity as SECRETARY OF HEALTH AND HUMAN SERVICES, UNITED STATES INTERNAL REVENUE SERVICE, and DAVID J. KAUTTER, in his Official Capacity as Acting COMMISSIONER OF INTERNAL REVENUE,** Defendants, and, **CALIFORNIA, CONNECTICUT, et al.,** Proposed Intervenors.	Civ. Action No. 18-cv-00167-O **DECLARATION OF JENNIFER KENT IN SUPPORT OF STATES' MOTION TO INTERVENE**

I, Jennifer Kent, declare:

1. I am the Director the California Department of Health Care Services (DHCS), which operates California's version of the federal-state Medicaid program under title XIX of the federal Social Security Act, known as Medi-Cal. In this capacity, I am responsible for overseeing the administration of the Medi-Cal program and the delivery and financing of care for over 13.5 million beneficiaries. The facts stated herein are of my own personal knowledge, and I could and would competently testify to them.

2. The Affordable Care Act (ACA) increased access to affordable coverage.

- The ACA expanded coverage through two key mechanisms: Medicaid expansion for those individuals with the lowest incomes, and federal health subsidies to purchase coverage in new health insurance exchanges for those individuals with moderate incomes.
- Due to implementation of the ACA in California, the State has experienced a considerable decrease in the number of uninsured residents. This is predominantly attributable to the expansion of eligibility in the Medi-Cal program, and the newfound availability of health coverage through the State's exchange marketplace known as Covered California.
- California's implementation of the Medicaid expansion has enabled more than 3.7 million Californians to obtain coverage, and we dramatically reduced the uninsured rate in the State from 17 percent in 2013 to 6.8 percent in 2017.
- As a result, the State collectively, including its political subdivisions, its safety net health care providers, and its residents, has begun to realize significant gains from both a public health, and an economic and fiscal standpoint. One of the principal financial benefits has been a meaningful reduction in the level of uncompensated care costs borne within the State's various health care systems and programs. For example, according to data collected and published by the Office of Statewide Health Planning and Development (OHSPD), California hospitals incurred uncompensated care costs totaling approximately $5.2 billion dollars in 2013, before full

implementation of the ACA. In 2015, after implementation of the ACA, OSHPD data reflects that California hospitals experienced approximately $1.9 billion dollars in uncompensated care costs, which amounts to nearly a 64 percent decrease in hospital uncompensated care costs over this short period of time.

- If the number of uninsured in California were to increase, the State would incur a significant negative economic impact due to the accompanying increase in uncompensated care costs that would follow. Without any other options for care, those residents finding themselves without coverage would turn to traditional and more costly safety-net sources of care, such as use of hospital emergency rooms, or forgo care entirely. This would reintroduce the same type of financial strain on State, local and private health systems and programs that the ACA was intended to relieve.

3. The invalidation of the ACA would result in billions of lost Medicaid dollars to California annually.

- DHCS projects that the elimination of the Medicaid expansion in California would result in an annual loss of $22.2 billion starting in fiscal year 2020, and increasing to a loss of $32.6 billion in 2027. In addition, the elimination of the Community First Choice Option is projected to increase State costs by approximately $400 million in 2020, growing annually.

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

Executed on April 9, 2018, in Sacramento, California.

Jennifer Kent
Director
Department of Health Care Servcies

IN THE UNITED STATES DISTRICT COURT

FOR THE NORTHERN DISTRICT OF TEXAS

WICHITA FALLS DIVISION

TEXAS, WISCONSIN, ALABAMA, ARKANSAS, ARIZONA, FLORIDA, GEORGIA, INDIANA, KANSAS, LOUISIANA, PAUL LePAGE, Governor of Maine, MISSISSIPPI, by and through Governor Phil Bryant, MISSOURI, NEBRASKA, NORTH DAKOTA, SOUTH CAROLINA, SOUTH DAKOTA, TENNESSEE, UTAH, and WEST VIRGINIA, Plaintiffs, v. **UNITED STATES OF AMERICA, UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, ALEX AZAR, in his Official Capacity as SECRETARY OF HEALTH AND HUMAN SERVICES, UNITED STATES INTERNAL REVENUE SERVICE, and DAVID J. KAUTTER, in his Official Capacity as Acting COMMISSIONER OF INTERNAL REVENUE,** Defendants, and, **CALIFORNIA, et al.,** Proposed Intervenors.	Civ. Action No. 18-cv-00167-O **DECLARATION OF MILA KOFMAN IN SUPPORT OF STATES' MOTION TO INTERVENE**

I, Mila Kofman, declare:

1. I am the Executive Director of the District of Columbia Health Benefit Exchange Authority. Prior to my appointment, I was on the faculty at Georgetown University Health Policy

Institute as a Research Professor and Project Director. Before that I served as Superintendent of Insurance in Maine for over three years.

2. The DC Health Benefit Exchange Authority (HBX) 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 (PPACA), thereby ensuring access to quality and affordable health care to all DC residents.

3. **The Affordable Care Act (ACA) increased access to affordable coverage in the District of Columbia.**

- Overall the number of individuals with insurance has increased. The ACA has enabled the District to expand health coverage so that more than 96% of our residents are now covered (less than 4% uninsured in 2016 compared to 7.2% in 2009). We have the lowest uninsured rate we've ever had and rank between first and third (depending on the study) among all states in the nation for having the lowest uninsured rate. As of March 12, 2018, there are 17,808 District residents enrolled in individual health insurance and more than 76,000 people enrolled in small group coverage through our marketplace, DC Health Link. A 2016 survey of our enrolled customers revealed that more than 25,500 people, who were not previously covered in 2015, gained access to health coverage in 2016 through the marketplace; 25% of the people who enrolled in individual private health insurance coverage were previously uninsured; 53% of the people who were determined eligible for Medicaid were uninsured before applying; and 40% of the small businesses enrolled in DC Health Link did not offer health insurance to their employees prior to enrollment through DC Health Link.
- The Marketplace is an important reform made by the ACA, for a number of reasons. The on-line health insurance marketplace has provided access to quality affordable health insurance, and has created transparency, encouraged market competition, and

simplified the purchase of insurance. Many residents have benefitted from reduced premiums for health insurance. There are approximately 4,187 District residents who have received APTC; this does not include residents who received premium tax credits when they filed their taxes. Tens of thousands of residents have benefited from having access to comprehensive health insurance that includes prescription drug coverage, hospitalization, specialists, and mental health coverage. Because of the requirements for essential health benefits, prohibitions on benefit limits, medical underwriting, and gender and health-based discrimination, thousands of District residents and small businesses have benefitted. Furthermore, easy apples-to-apples comparison of plans have enabled thousands of residents to make more informed decision about which health plan is best for them. Robust on-line consumer decision support tools have made the purchase of health insurance easier for thousands of residents. Small businesses have the type of market power only large employers had in the past and are able to offer their employees not just one insurance plan but plans from all carriers. Residents and small businesses – and their employees – can see in one place all of the different products, compare benefit packages side-by-side, and compare prices for all products. With the purchasing power of thousands, DC's small businesses now have insurers competing for their business. HBX advocates for the lowest possible rates. HBX hires independent actuaries to review proposed rates and challenge the assumptions made by carriers. HBX provides actuarial analysis to insurance regulators advocating for lower rates. DC Health Link also has on-line portals for brokers and General Agencies/TPAs. There are more than 800 brokers supporting more than 65,000 people covered through District small businesses through DCHealthLink.com.

4. The ACA has positive economic benefits on the District of Columbia.

- Studies have shown that states expanding Medicaid under the ACA have realized budget savings, revenue gains, and overall economic growth. A Commonwealth study modeled the effects of ACA repeal, and shows the deleterious economic

impact such an action would have. *See* The Commonwealth Fund, *Repealing Federal Health Reform: Economic and Employment Consequences for States*, (Jan. 2017), http://www.commonwealthfund.org/publications/issue-briefs/2017/jan/repealing-federal-health-reform.

- Further, the decline in uncompensated care in hospitals by 60% from 2010 to 2015 has led to decreased spending as a result of the ACA. *See* https://hbx.dc.gov/sites/default/files/dc/sites/hbx/event_content/attachments/Uncompensated_care_updated_10_11_15.pdf.

5. The ACA resulted in better quality and more accessible, affordable healthcare for consumers.

- The ACA created robust consumer protections to help ensure individuals can access the healthcare system by permitting covered dependents to access coverage on their parents' plans until age 26, mandating coverage for preventive services including birth control, cancer screenings, and immunizations for children, and providing essential health benefits, such as substance use disorder treatment.
- The District has built on the consumer protections under the ACA. The District prohibits premiums based on tobacco use. The District also prohibits benefit substitutions in the essential health benefits categories, protecting residents' access to all essential health benefits. HBX requires carriers to offer standard benefit plans, in addition to carrier designed plans. The standard plan designs have the same benefits and out-of-pocket features, *e.g.*, co-pays, deductibles, co-insurance, within a metal level. Carriers compete based on networks, premiums, and quality. This makes shopping even easier. Importantly, enrollees can receive many medical services such as specialist visits, urgent care visits, primary care visits, mental health services, and prescription medication before meeting deductibles, even with bronze plan coverage. In addition, HBX has invested in strong consumer shopping tools so that people can make informed choices. The DC Health Link Plan Match tool enables customers to compare plans based on expected annual out-of-pocket

costs; search a doctor directory which enables consumers to see which plans their doctors participate in; and a prescription drug formulary tool that enables customers to see which plans cover their prescriptions and how they are covered.

- In addition, the District requires all small group and individual health insurance to be sold only through the DC Health Link. This has created significant competition among health insurers. For example, in 2013, one carrier refiled their proposed rates twice, lowering the proposed rates to be more competitive. Another carrier refiled their rates proposing lower premiums and filed additional products for sale. Another carrier refiled their rates proposing lower premiums. This product and price competition continues, and each year carriers offer new products and offer products with reduced premiums or no or almost no increase in premiums compared to the prior year. Small businesses in the District have 151 different health plans offered by 3 United Health Care companies, 2 Aetna companies, Kaiser Permanente, and Care First Blue Cross Blue Shield.

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

Executed on April 9, 2018 in Washington, District of Columbia.

Mila Kofman
Executive Director
District of Columbia Health Benefit
Exchange Authority

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF TEXAS

FORT WORTH DIVISION

TEXAS, WISCONSIN, ALABAMA, ARKANSAS, ARIZONA, FLORIDA, GEORGIA, INDIANA, KANSAS, LOUISIANA, PAUL LePAGE, Governor of Maine, MISSISSIPPI, by and through Governor Phil Bryant, MISSOURI, NEBRASKA, NORTH DAKOTA, SOUTH CAROLINA, SOUTH DAKOTA, TENNESSEE, UTAH, and WEST VIRGINIA, Plaintiffs, UNITED STATES OF AMERICA, UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, ALEX AZAR, in his Official Capacity as SECRETARY OF HEALTH AND HUMAN SERVICES, UNITED STATES INTERNAL REVENUE SERVICE, and DAVID J. KAUTTER, in his Official Capacity as Acting COMMISSIONER OF INTERNAL REVENUE, Defendants.	Civil Action No. 4:18-cv-00167-O
CALIFORNIA, ET AL., Proposed Intervenor-Defendants.	

DECLARATION OF DR. JENNIFER LEE IN SUPPORT OF MOTION TO INTERVENE BY CALIFORNIA, ET AL.

I, Dr. Jennifer Lee, declare:

1. I am the Director of the Department of Medical Assistance Services (DMAS), which is the agency responsible for administering Medicaid and the State Children's Health Insurance Program (CHIP) in Virginia. Before becoming the Director of DMAS, I served as Deputy Secretary of Health and Human resources for Governor Terence McAuliffe from 2014 until 2016. I have also previously served on the Virginia Board of Medicine from 2008 until 2011, and I served as the Deputy Under Secretary for Health for Policy and Services, and Senior Advisor to the Secretary at the U.S. Department of Veterans Affairs. I have a bachelor's degree in biophysics and biochemistry from Yale University, a medical degree from Washington University School of Medicine, and completed my residency at Johns Hopkins. I am a board-certified, practicing emergency physician and a fellow of the American College of Emergency Physicians.

2. With a budget of $10 billion, DMAS's mission is to provide a system of high quality and cost effective health care services to qualifying Virginians and their families. Today, DMAS provides health care coverage to more than 1 million Virginians through the Medicaid program and CHIP.

3. Virginians receive billions of dollars directly as a result of the Affordable Care Act (ACA). For example, in 2017, Virginians received an estimated $1,148,490,000 in total annual premium tax credits. Moreover, Virginia has received more than $17,670,000 through the Public Health and Prevention Fund. The Public Health and Prevention Fund has funded grants for programs that include, in part, "Making a Healthier Virginia the Priority" (more than $2,600,000), "Preventive Health Services" (more than $3,170,000), "Immunization and Vaccines for Children" (more than $2,130,000), and "Immunization PPHF Supplemental" (more than $4,900,000). Additionally, Virginia received more than $7,500.000 through the Maternal, Infant, and Early Childhood Home Visiting Program.

4. In addition to direct funds, the ACA has increased Virginians access to affordable health care coverage. Since the ACA was enacted, the overall number of individuals with insurance in Virginia has increased. In 2009, prior to the implementation of the ACA, Virginia's uninsured rate for non-elderly adults (ages 19-64) was 16.4%, representing 779,000 non-elderly

adults in Virginia who lacked health insurance. By 2016, after the ACA was in effect, Virginia's uninsured rate for non-elderly adults dropped to 12.4%, representing 621,000 non-elderly adults in Virginia who lacked health insurance. Moreover, the ACA expanded coverage in Virginia through the federal health subsidies that enabled individuals with moderate incomes to purchase health insurance in the Exchanges. In 2017, 410,726 Virginians purchased health insurance on the Federally Facilitated Marketplace (FFM). Of those individuals purchasing coverage on the FFM in 2017, 334,942 individuals received a federal premium subsidy. Finally, Medicaid is an important source of healthcare insurance coverage. Although Virginia has not yet expanded Medicaid coverage under the ACA, many Virginians see Medicaid expansion as a strategic opportunity to expand access to care, improve Virginians overall health, and bolster the economy. Medicaid expansion is an ongoing discussion in the Virginia General Assembly.

5. The ACA also expanded various Medicaid programs to provide States with increased opportunities to increase access to home and community based services. For example, in 2008, Virginia launched its Money Follows the Person (MFP) program. MFP provides extra support and services to Virginians choosing to transition from long-term care institutions to the community. MFP has helped Virginia move closer to a rebalanced long-term support system that promotes choice, quality, and flexibility. Under the ACA, funding for MFP was extended from 2012 through 2016. Over 1,000 Virginians have been discharged from a facility to the community since 2012 with assistance from MFP.

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

Executed on April 5, 2018, in Richmond, Virginia.

Jennifer S. Lee, MD
Director
Virginia Department of Medical Assistance Services

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF TEXAS
FORT WORTH DIVISION

TEXAS, WISCONSIN, ALABAMA, ARKANSAS, ARIZONA, FLORIDA, GEORGIA, INDIANA, KANSAS, LOUISIANA, PAUL LePAGE, Governor of Maine, MISSISSIPPI, by and through Governor Phil Bryant, MISSOURI, NEBRASKA, NORTH DAKOTA, SOUTH CAROLINA, SOUTH DAKOTA, TENNESSEE, UTAH, and WEST VIRGINIA, Plaintiffs, v. UNITED STATES OF AMERICA, UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, ALEX AZAR, in his Official Capacity as SECRETARY OF HEALTH AND HUMAN SERVICES, UNITED STATES INTERNAL REVENUE SERVICE, and DAVID J. KAUTTER, in his Official Capacity as Acting COMMISSIONER OF INTERNAL REVENUE, Defendants.	Civil Action No. 4:18-cv-00167-O
CALIFORNIA, ET AL., Proposed Intervenor-Defendants.	

DECLARATION OF KIM LUFKIN IN SUPPORT OF MOTION TO INTERVENE BY CALIFORNIA, ET AL.

I, Kimberley Lufkin, declare:

1. I am 37 years old and a resident of Fairfax, Virginia. I work with international health nonprofits that focus on issues ranging from reproductive health to HIV/AIDS.

2. I was diagnosed with type-1 diabetes at five years old. For my most of my life, I have been in a constant battle with insurance companies that repeatedly denied me

coverage and care for a pre-existing medical condition. Even though I have maintained continuous employer-sponsored coverage, I often experienced discrimination or difficulties receiving care because of my diagnosis.

3. The Affordable Care Act eliminated any discrimination based on my diabetes. I no longer needed to fill out paperwork or prove continuous coverage before insurance companies would cover my care every time I started a new job or had a change in employer-sponsored coverage. When the law went into effect, I felt like a huge and constant worry in my life had been lifted.

4. This was made all the more pressing for me and my family in 2016, when my 18-month-old son was diagnosed with type-1 diabetes. My husband and I were shocked, worried, and scared for three days after his diagnosis in the ICU, and we knew that our son's childhood would be forever be impacted. With all the fears we had as parents of a young child with a chronic condition, I was at least relived that because of the protections under the ACA, my son wouldn't face the same struggles I did with insurance coverage.

5. I'm terrified that that efforts to overturn the ACA will cause people like me and my son to lose the protections we have. My family will now have to constantly worry about our ability to access lifesaving health care. We shouldn't have to worry if we can afford insulin for my three-year-old son, or if he'll miss out of medical innovations because of our inability to pay. We shouldn't have to fight with insurance companies to cover care for a medical condition he developed at just 18 months old.

6. I support Plaintiffs' motion to intervene. Elimination of the ACA would hurt me and my family.

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

Executed on March 23, 2018, in Fairfax, Virginia.

Kimberley Lufkin

SA2018100536

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF TEXAS
FORT WORTH DIVISION

TEXAS, WISCONSIN, ALABAMA, ARKANSAS, ARIZONA, FLORIDA, GEORGIA, INDIANA, KANSAS, LOUISIANA, PAUL LePAGE, Governor of Maine, MISSISSIPPI, by and through Governor Phil Bryant, MISSOURI, NEBRASKA, NORTH DAKOTA, SOUTH CAROLINA, SOUTH DAKOTA, TENNESSEE, UTAH, and WEST VIRGINIA, Plaintiffs, v. UNITED STATES OF AMERICA, UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, ALEX AZAR, in his Official Capacity as SECRETARY OF HEALTH AND HUMAN SERVICES, UNITED STATES INTERNAL REVENUE SERVICE, and DAVID J. KAUTTER, in his Official Capacity as Acting COMMISSIONER OF INTERNAL REVENUE, Defendants.	Civil Action No. 4:18-cv-00167-O
CALIFORNIA, *et. al.*, Proposed Intervenor-Defendants.	

DECLARATION OF CHRIS MALEY IN SUPPORT OF MOTION TO INTERVENE BY CALIFORNIA, ET. AL.

I, Chris Maley, declare:

1. My name is Chris Maley. I am employed by the Office of the Illinois State Comptroller as the Director of Research and Fiscal Reporting.

2. Susana A. Mendoza is the Illinois State Comptroller. The Comptroller is the chief fiscal control officer for Illinois government, charged by the Constitution with maintain the

state's central fiscal accounts and ordering payments into and out of the appropriate funds. The Illinois Constitution empowers the Comptroller to record transactions, pre-audit expenditures and contracts, issue financial reports and provider leadership on the fiscal affairs of the state. The office processes more than 16 million transactions annually and serves as a "fiscal watchdog" to ensure all state payments meet the requirements of the law. The office provides current and accurate fiscal information to the Governor, the General Assembly, local governments and the public. Financial Impact analyses and other studies are published to assist the Governor and lawmakers in making informed budget decisions. As part of its responsibility to ensure the operations of state government are transparent, the Illinois Comptroller's Office collects information from participating state agencies about the programs they administer and reviews financial resources allocated to those programs.

3. As Director of Research and Fiscal Reporting, one of my responsibilities is to oversee the assembly of several reports produced by the Office of the Illinois Comptroller that provide facts, figures and analysis of various aspects of the State of Illinois' fiscal condition and economic outlook. As part of my duties, I am responsible for the preparation of the Public Accountability Report, a compilation of data reported by State government agencies addressing agency initiatives, effectiveness, program administration, goals and objectives.

4. The Illinois Department of Healthcare and Family Services (HFS) is responsible for administering the Medical Assistance Programs under the Illinois Public Aid Code, the Children's Health Insurance Program Act, the Covering All Kids Health Insurance Act, the Veterans Health Insurance Program Act, other provisions of state law, and Title XIX and XXI of the federal Social Security Act. Specifically, HFS is the Illinois state agency responsible for providing healthcare coverage for adults and children who qualify for Medicaid, including those who qualify for Medicaid through the Medicaid expansion. As part of its review of state agency programs, the Illinois Comptroller's Office receives and reviews information from HFS about the resources allocated to the medical assistance program (Medicaid).

5. In 2013, Illinois adopted what is commonly known as the Medicaid expansion pursuant to the Patient Protection and Affordable Care Act. 42 U.S.C. § 1396a(a)(10(A)(i)(VIII). Beginning January 1, 2014, Illinois law required that individuals aged 19 or older, but younger than 65, with incomes at or below 133% of the federal poverty level, be eligible for coverage under Illinois' Medicaid program. 305 ILCS 5/5-2(18). Illinois law also provides that if Illinois' federal medical assistance percentage is reduced below 90% for persons eligible for medical assistance through the Medicaid expansion, coverage for such persons shall terminate no later than the end of the third month following the month in which the reduction takes effect. *Id.*

6. I have reviewed data regarding HFS' financial operations provided by HFS to the Comptroller's Office for publication in the fiscal year 2017 Public Accountability Report. According to that data, Illinois received approximately $9,553,600,000 from the federal Department of Health and Human Services for Illinois' Medicaid expansion population for the years FY 2014 through FY 2017. Illinois is projected to receive $3,740,400,000 in FY 2018 for the Medicaid expansion population.

7. Additional data provided by HFS indicates that more than 673,000 individuals in Illinois are projected to be enrolled in an Affordable Care Act health insurance exchange plan in FY 2018. Enrollment by individuals in an Affordable Care Act health insurance exchange plan in Illinois has continued to increase since enrollment began in 2014: 457,000 enrollees in FY 2014; 642,000 enrollees in FY 2015; 651,747 enrollees in FY 2016; and 639,418 enrollees in FY 2017. In total, that amounts to 2,390,165 unique enrollments from FY 2014 through FY 2017.

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

Executed on April 4, 2018, in Springfield, Illinois.

Chris Maley
Director of Research and Fiscal Reporting
Office of Illinois State Comptroller

IN THE UNITED STATES DISTRICT COURT

FOR THE NORTHERN DISTRICT OF TEXAS

FORT WORTH DIVISION

TEXAS, WISCONSIN, ALABAMA, ARKANSAS, ARIZONA, FLORIDA, GEORGIA, INDIANA, KANSAS, LOUISIANA, PAUL LePAGE, Governor of Maine, MISSISSIPPI, by and through Governor Phil Bryant, MISSOURI, NEBRASKA, NORTH DAKOTA, SOUTH CAROLINA, SOUTH DAKOTA, TENNESSEE, UTAH, and WEST VIRGINIA, Plaintiffs, **v.** **UNITED STATES OF AMERICA, UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, ALEX AZAR, in his Official Capacity as SECRETARY OF HEALTH AND HUMAN SERVICES, UNITED STATES INTERNAL REVENUE SERVICE, and DAVID J. KAUTTER, in his Official Capacity as Acting COMMISSIONER OF INTERNAL REVENUE,** Defendants, and,	Civ. Action No. 18-cv-00167-O **DECLARATION OF JUDY MOHR PETERSON IN SUPPORT OF STATES' MOTION TO INTERVENE**

CALIFORNIA, et al.,

Proposed Intervenors

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I, Judy Mohr Peterson, declare:

1. I serve as the Medicaid Director for the State of Hawaii. I have been in this role since July 2015. Prior to that, I served as the Medicaid Director for the State of Oregon in the Oregon Health Authority (2009-June 2015).

2. Med-QUEST, Department of Human Services, is the single state Medicaid Agency for the State of Hawaii and implements Hawaii's Medicaid program. I am the administrator of the Med-QUEST Division.

3. **The Affordable Care Act directs billions of dollars directly to Hawaii.**

- Specifically, Hawaii has received $2.1 billion via the Medicaid expansion.
- The Public Health and Prevention Fund provides approximately $8 million annually to Hawaii, which the state uses to manage and administer data systems like the Behavioral Risk Factor Surveillance System and Hawaii's Surveillance and Disease Outbreak Management System. The funding is also used to recognize disease trends, incidence, and impact, and to develop preventive and response measures as needed. Health care services to those with HIV or Zika are also affected.

4. **The Affordable Care Act (ACA) increased access to affordable coverage.**

- Overall the number of individuals with insurance has increased. In Hawaii, the rate of uninsured was 5% in 2016, the most recent figure available. The ACA expanded coverage through two key mechanisms: Medicaid expansion for those individuals with the lowest incomes, and federal health subsidies to purchase coverage in new health insurance Exchanges for those individuals with moderate incomes.
- Medicaid is an important source of healthcare insurance coverage and has resulted in coverage gains and reduction in the uninsured rate, both among the low-income population and within other vulnerable populations. As a result of Medicaid

expansion in Hawaii, 117,000 people have coverage -- approximately one-third of our total of 360,000 on Medicaid -- and the state has experienced a reduction in the uninsured rate. This 117,000 figure includes individuals who became eligible for Medicaid under Hawaii's early (pre-2013) expansion as well as the 33,000 who became eligible under the further expansion implemented in October 2013. Without the ACA, all of these people would lose coverage. About 30% of the expansion group suffers from mental illness, 4% of them with severe mental illness; 1 in 4 have diabetes; 30% have asthma while 1 in 8 has chronic obstructive disease; and over one third struggle with some sort of substance use issue. Lack of health insurance would likely lead to an exacerbation of the health conditions, negatively impacting their health. On average, Hawaii spends about $510 monthly for each Medicaid expansion person or about $6,120 annually. We receive enhanced federal match for this population.

- The Exchange is an important reform made by the ACA. In Hawaii in 2017, 16,711 people were covered on the Marketplace, with 13,728 eligible for APTC subsidies.

5. The ACA expanded programs in Medicaid to provide States with increased opportunities to increase access to home and community based services.

- Medicaid Money Follows the Person Demonstration: in 2015 Hawaii received over $2 million under this program. It has helped move 584 people living in institutions into home or community based settings.

6. The ACA has allowed States to test and implement reforms to healthcare delivery systems that support State policy priorities of increasing efficiency and quality of care.

- The State Innovation Model planning grant allowed Hawaii to design a framework for health care delivery system transformation focusing on the integration of medical and behavioral health care.

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

Executed on April 5, 2018, in Honolulu, Hawaii.

Judy Mohr Peterson
Administrator, Med-QUEST Division
Department of Human Services
State of Hawaii

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF TEXAS
FORT WORTH DIVISION

TEXAS, WISCONSIN, ALABAMA, ARKANSAS, ARIZONA, FLORIDA, GEORGIA, INDIANA, KANSAS, LOUISIANA, PAUL LePAGE, Governor of Maine, MISSISSIPPI, by and through Governor Phil Bryant, MISSOURI, NEBRASKA, NORTH DAKOTA, SOUTH CAROLINA, SOUTH DAKOTA, TENNESSEE, UTAH, and WEST VIRGINIA, Plaintiffs, v. UNITED STATES OF AMERICA, UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, ALEX AZAR, in his Official Capacity as SECRETARY OF HEALTH AND HUMAN SERVICES, UNITED STATES INTERNAL REVENUE SERVICE, and DAVID J. KAUTTER, in his Official Capacity as Acting COMMISSIONER OF INTERNAL REVENUE, Defendants.	Civil Action No. 4:18-cv-00167-O
CALIFORNIA, WASHINGTON, et al., Proposed Intervenor-Defendants.	

DECLARATION OF THEA MOUNTS IN SUPPORT OF MOTION TO INTERVENE BY CALIFORNIA, ET AL.

I, Thea Mounts, declare:

1. I am over the age of 18 years and make this declaration based on my personal knowledge of the matters stated below.

2. I am a Senior Forecasting and Research Manager/WA-APCD Program Director at the Washington State Office of Financial Management. My responsibilities include supervising a team that provides analytic and research support for budget and policy development of the state's health and human service programs. We analyze and monitor data related to trends in the state's health care coverage, service utilization, quality, costs and workforce capacity, in addition to producing the state's Medicaid per-capita forecast.

3. The Washington State Office of Financial Management is the Governor's office for vital information, fiscal services and policy support that the Governor, Legislature and state agencies need to serve the people of Washington.

A. The Affordable Care Act Directs Billions of Dollars Directly to Washington State

4. Washington received $10.1 billion in additional funds from the federal government to support its Medicaid expansion between January 2014 and June 2017.

5. Washington has spent $48.7 million in Center for Medicare and Medicaid Innovation grant dollars between February 2015 and February 2018.

B. The Affordable Care Act Increased Access to Affordable Coverage

6. Overall, the number of individuals with health insurance has increased. In Washington State in 2016, 6.9 million people had coverage. The State's total uninsured rate declined by 61% between 2013 and 2016, falling from 14.0% to 5.4%.

7. The Affordable Care Act (ACA) expanded coverage through two key mechanisms: Medicaid expansion for those individuals with the lowest incomes, and

federal health subsidies to purchase coverage in new health insurance Exchanges for those individuals with moderate incomes.

8. Adults ages 18-64 experienced the largest reduction in the number of uninsured and the uninsured rate, declining from 877,000 (19.8%) in 2013 to 352,000 (7.9%) in 2016.

9. Medicaid is an important source of health coverage and has resulted in significant coverage gains and reduction in the uninsured rate, both among the low-income population and within the vulnerable populations. In the first year of Medicaid expansion, the increase in Medicaid accounted for at least 93% of Washington State's total coverage gains. In turn, low-income non-elderly adults accounted for 92% of the net increase in the state's Medicaid enrollment in 2014.

10. The State's Exchange is an important reform made by the ACA that has had a major impact on access to affordable health insurance. In Washington State, over 132,500 residents currently receive federally subsidized coverage as a result of the law.

11. In 2017, an average of 156,000 people per month received tax credits totaling over $342 million dollars.

12. In 2017, an average 101,000 people per month received cost-sharing reductions totaling over $56 million dollars.

C. The Affordable Care Act Has Positive Economic Benefits on States

13. Our State's experience shows that expansion of Medicaid under the ACA has resulted in budget savings, revenue gains, and overall economic growth.

14. In 2015, an estimated 51,196 jobs were saved or created as a result of the ACA Medicaid expansion in Washington State.

15. The amount of uncompensated care in Washington State's community hospitals declined by $1.332 billion, or two-thirds (66.7%), in FY 2016, when compared to the level seen in FY2013.

16. The state budget benefited by nearly $1.14 billion through June 2017 thanks to refinancing health programs that were previously all or partially funded by the State-General Fund (Basic Health, Medical Care Services, Presumptive SSI, state only behavioral health programs, Medically Needy, etc.). These programs served vulnerable populations who were not previously eligible for federally funded Medicaid prior to the ACA.

D. The Affordable Care Act Has Allowed States to Test and Implement Reforms to Healthcare Delivery Systems That Support State Policy Priorities of Increasing Efficiency and Quality of Care

17. Washington State continues to benefit from the infusion of resources for health reform and innovation that has catalyzed higher quality, safer and better coordinated care delivery, smarter spending and the realization of savings to public programs, more engaged providers, and healthier populations.

18. Successes to date that have been achieved pursuant to ACA authority or funding include:

a. Development, implementation, and management of the Washington State Common Measure Set, which sends aligned signals to providers.

b. Launched fully-integrated Managed Care contracts aligning the financing for physical and behavioral health, resulting in better patient outcomes.

c. Created a value-based plan option called UMP Plus for state employees and their families, starting in 2016. Over 25,000 state employees and their families are enrolled in the plan. Year 1 (2016) results show state employee received high quality care for chronic and preventive services, and the State spent $2.7M less for UMP Plus members (compared to benchmark) or roughly 1% less than if non-UMP Plus providers had been caring for this same population.

d. Stood up nine Accountable Communities of Health to link clinical and community supports in service to the whole person.

e. Matured the State's analytic and data capabilities, to include data aggregation infrastructure and overall improvement of data and reporting quality and consistency.

19. Funding available under the ACA supported the design and development work that created the Health Home program, a care management strategy for high risk clients. This is the first program in the state to offer such services to Medicare-Medicaid dual eligible clients. Under an ACA supported demonstration agreement with CMS has brought tens of millions of dollars in savings to the state.

20. Amidst the success of the Medicaid expansion, leaders in Washington state and nationwide recognize access to coverage is just the beginning, and barriers remain to improved health and wellbeing of individuals and families. The innovation opportunities offered through ACA-facilitated models like SIM, Partnership for Patients, Transforming Clinical Practice Initiative and more help ensure we are not expanding access to a system that is unsafe, fragmented and wasteful. One success story from these opportunities is that the Washington State Hospital Association's leadership in the state for the Partnership for Patients program led to a reduction in hospital-acquired conditions and avoidable readmissions. Through the first round of this program, 23,000 patients were saved from harm and saw a reduction of $336 million in health care spending.

21. Also as a result of the innovation opportunities offered through ACA-facilitated models, five Transforming Clinical Practice Initiative sites statewide are set up to help clinicians achieve large-scale health transformation through comprehensive quality improvement strategies.

E. The ACA Resulted in Better Quality and More Accessible, Affordable Healthcare for Consumers

22. The ACA created robust consumer protections to help ensure individuals can access the healthcare system.

23. Between 2009 and 2016, nearly 100,000 young adults aged 18-26 in Washington State gained access to private coverage. Many of these young adults were able to stay on their parents' coverage policy as a result of the ACA.

24. Since January 2014, more than 27,000 adults in Washington State have been treated for cancer while enrolled under the ACA's Medicaid expansion.

25. Since January 2014, more than 90,000 new adult Medicaid enrollees received substance use disorder services as a result of the ACA.

26. The ACA has led to improved access to care in Washington State: between 2013 and 2016, the share of adults with a doctor increased 3.2 percentage points; and between 2013 and 2014, the percent of adults who skipped medications because of cost declined 1.5 percentage points.

27. The ACA led to improved financial security for over 90,000 adults in Washington State in 2014. The share of adults carrying medical debts declined from 19.5% in 2013 to 17.7% in 2014.

28. The ACA has resulted in improved health outcomes. The share of adults in Washington state reporting fair or poor health dropped by 1.4 percentage points between 2013 and 2016.

29. The number of adults in Washington state delaying care due to costs dropped from 15.5% in 2013 to 10.1% in 2016.

I declare under penalty of perjury under the laws of the United States of America and the State of Washington that the foregoing is true and correct.

Executed on this 9th day of April, 2018, at Olympia, Washington.

Thea N. Mounts

THEA MOUNTS
Senior Forecasting and Research Manager/WA-APCD Program Director
Washington State Office of Financial Management

IN THE UNITED STATES DISTRICT COURT

FOR THE NORTHERN DISTRICT OF TEXAS

FORT WORTH DIVISION

TEXAS, WISCONSIN, ALABAMA, ARKANSAS, ARIZONA, FLORIDA, GEORGIA, INDIANA, KANSAS, LOUISIANA, PAUL LePAGE, Governor of Maine, MISSISSIPPI, by and through Governor Phil Bryant, MISSOURI, NEBRASKA, NORTH DAKOTA, SOUTH CAROLINA, SOUTH DAKOTA, TENNESSEE, UTAH, and WEST VIRGINIA, Plaintiffs, **v.** **UNITED STATES OF AMERICA, UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, ALEX AZAR, in his Official Capacity as SECRETARY OF HEALTH AND HUMAN SERVICES, UNITED STATES INTERNAL REVENUE SERVICE, and DAVID J. KAUTTER, in his Official Capacity as Acting COMMISSIONER OF INTERNAL REVENUE,** Defendants, and, **CALIFORNIA, et al.,** Proposed Intervenors.	Civ. Action No. 18-cv-00167-O **DECLARATION OF CLAUDIA SCHLOSBERG IN SUPPORT OF STATES' MOTION TO INTERVENE**

I, Claudia Schlosberg, declare:

1. I am the Senior Deputy and State Medicaid Director for the Department of Health Care Finance (DHCF) for Washington, D.C. I am responsible for the effective management of

the Medicaid, CHIP and Alliance Health Insurance Programs. Together, these programs provide DHCF health insurance coverage to over 270,000 low income residents of the District of Columbia. I currently oversee policy development, eligibility, fee-for-service and managed care service delivery, program operations, program integrity, long-term care and implementation of health care reform and innovation. Previously, I served as DHCF's Director of the Health Care Policy and Research Administration. I have been employed at DHCF since August 2011 and have over 30 years of experience in health care policy, program administration and regulatory and legislative affairs pertaining to publicly-financed health care programs.

2. DHCF is the single state agency for the administration of Medicaid in the District of Columbia (the District). DHCF is accountable to the United States Centers for Medicare and Medicaid Services (CMS), the federal agency responsible for administration and oversight of the Medicaid program under Titles IXX and XXI of the Social Security Act, as amended by the Patient Protection and Affordable Care Act (the ACA) and accompanying regulations. Under the Affordable Care Act, the District has made significant gains with regard to healthcare funding, Medicaid coverage, access to care, and the quality of health care services delivered, as highlighted below:

3. **The Affordable Care Act directs significant funding to the District of Columbia:**

- Specifically, the District of Columbia has received $2.05 billion in federal reimbursement for Medicaid expansion; $53 million in grants provided under the Public Health and Prevention Fund from 2010 to 2016[1]; $4.2 million in grants and funding from the Center for Medicare and Medicaid Innovation; and $6.8 million in federal Medicaid reimbursement to provide Health Home services authorized under Section 2703 of the ACA.

[1] *Prevention and Public Health Fund Detailed Information - Trust for America's Health* (Trust for America's Health, August 2017) http://healthyamericans.org/report/134/.

4. **The Affordable Care Act increased access to affordable coverage.**

- The ACA expanded coverage through two key mechanism: Medicaid expansion for those individuals with the lowest incomes, and federal health subsidies to purchase coverage in new health insurance exchanges for those individuals with moderate incomes.
- From 2010 to 2016, the District's overall uninsured rate fell 44%, from 7.8% to 4%, and the uninsured rate for the lowest-income individuals (0-199 percent of the federal poverty level (FPL) covered under the District's Medicaid expansion program fell 42 percent, from 13.5 percent to 7.8 percent. This increase in coverage has directly resulted from the ACA's new affordable coverage options and the Medicaid expansion, combined with new support for outreach from assisters and one-stop streamlined enrollment through the Health Benefits Exchange portal, DC Healthlink, all funded and directed under the ACA.
- Medicaid is an important source of healthcare insurance coverage and has resulted in significant coverage gains and reduction in the uninsured rate, both among the low-income population and within other vulnerable populations. Nearly 60 percent of the 321,518 individuals served by the District Health Benefits Exchange from when the Exchange opened in October 2013 through April 2017 were Medicaid beneficiaries. In FY 2017, the District Medicaid program provided coverage to approximately 40 percent of all District residents. Total average monthly Medicaid enrollment has grown 54 percent since the District expanded Medicaid, from nearly 170,000 in 2010 to 262,250 in 2017 and most of these coverage gains have been from the Medicaid expansion eligibility group. The District's generous levels of coverage for children under Medicaid and a CHIP-funded Medicaid expansion have also contributed to strong coverage rates overall. The District's rate of insurance coverage for children (97%) and its participation rate in public coverage programs (98.6%) are among the highest in the nation. In FY 2017, 93,184 childless Medicaid expansion adults and 89,491 children were enrolled in the District's Medicaid program, with each group comprising one-third of total Medicaid enrollment.
- The ACA has led to increased access to affordable care in the District as well as improved financial security for individuals who previously experienced trouble paying medical bills.

According to the Commonwealth Fund, from 2013 to 2016, there was approximately a 20 percent decrease in the number adults in the District who went without care due to cost and a similar decrease in the number of individuals with high out-of-pocket medical spending.[2] From 2013 to 2016, there was a 40 percent decrease in the number of at risk adults who were without a routine doctor visit in the past two years.

5. **The ACA has had a positive economic benefit for the District.**

- The District has realized budget savings and revenue gains under the ACA.
- As an estimate of the substantial economic gains the District has experienced from coverage expansions and other provisions of the ACA, the Economic Policy Institute estimated that the District would lose between an estimated $100 and $146 million in federal health care spending per year in the event of ACA repeal.[3]
- The District also gained financially by having the federal government fund programs that were previously locally funded. Before the ACA was enacted, the District operated the DC Healthcare Alliance Program (Alliance), a 100 percent locally-funded program designed to provide medical assistance to low-income District residents ineligible for Medicaid or Medicare. With the Medicaid expansion to childless adults in 2010, the District was able to transition over 30,000 individuals who previously received coverage under the Alliance program to the new Medicaid expansion, thereby shifting the financial burden for coverage for these individuals from local to federal funds, which were covered at 100% federal medical assistance percentage in the first few years. In 2014 and 2015, the District saved approximately $82 million in averted local spending as a result of receiving federal matching funds for these individuals who previously were enrolled in the District's Alliance program.[4]

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[2] Susan Hayes, et al., *What's at Stake: States' Progress on Health Coverage and Access to Care, 2013–2016* (The Commonwealth Fund, Dec. 2017) http://www.commonwealthfund.org/publications/issue-briefs/2017/dec/states-progress-health-coverage-and-access.

[3] Josh Bivens, *Repealing the Affordable Care Act Would Cost Jobs in Every State* (Economic Policy Institute, (Jan. 31, 2017) https://www.epi.org/files/pdf/120447.pdf.

[4] Deborah Bachrach, et al., *States Expanding Medicaid See Significant Budget Savings and Revenue Gains,* (RWJF State Health Reform Assistance Network, March 2016), https://www.rwjf.org/content/dam/farm/reports/issue_briefs/2016/rwjf419097

- By covering previously uninsured and underinsured individuals, the District's Medicaid expansion also enabled the District to save in spending for locally-funded behavioral health service programs that previously provided services to most of the more than 93,000 individuals now covered under the childless adult expansion.
- District hospital uncompensated care costs declined by 60% from $250,000 in 2010 to $100,000 in 2015 as the District's Medicaid expansion and ACA coverage expansion was implemented.[5]
- Researchers have estimated that the District has also experienced strong job and economic growth as a result of the ACA and could risk losing an estimated 1,400 jobs in year one and over 6,000 jobs over the next eight years if the ACA or its Medicaid expansion is repealed.[6]

6. **The ACA expanded Medicaid programs to provide States with increased opportunities to increase access to home and community based services.**

- The ACA extended and expanded the Money Follows the Person (MFP) demonstration program. The District's MFP rebalancing demonstration project is a pathway to independent living for individuals who have physical disabilities, and with intellectual and developmental disabilities. MFP functions through the District's two home and community-based (HCBS) waiver programs operated by DHCF and the District's Department on Disability Services. The federal grant program provides support to the District in order to shift Medicaid spending on long-term care away from a facility based system to one that offers services and supports in HCBS by allowing individuals receiving to choose where to receive their services. The District has received a cumulative award of $18.5 million under the demonstration program attributable to the ACA, from 2012 until the first quarter of FY 2018.
- In addition to covering HCBS costs for these individuals at an enhanced federal match rate for up to 365 days after discharge, the MFP grant provided important support to build the

[5] *Uncompensated Care Summary*, 2010-2015, DC Department of Health, State Health Planning Development Administration, https://hbx.dc.gov/sites/default/files/dc/sites/hbx/event_content/attachments/Uncompensated_care_updated_10_11_15.pdf

[6] Bivens, *supra* note 3.

District's capacity to provide transition coordination, housing identification, and intensive case management services for people moving from facility-based care to the community. From its inception in 2008 to 2014, MFP has transitioned an average of 29 beneficiaries per year from facilities to HCBS. From 2015 to 2017, MFP transitioned approximately 38 beneficiaries per year. In 2017, MFP funding helped transition 38 beneficiaries to the community and another 40 beneficiaries received HCBS and support services funded through the demonstration.

7. **The ACA has allowed the District to test and implement reforms to healthcare delivery systems that support State policy priorities of increasing efficiency and quality of care.**

- Under CMMI State Innovation Model (SIM) Round Two, DHCF spent over $720,000 of a Design Award to develop a State Health Innovation Plan (SHIP). The SHIP set forth the District's plan to: reform care delivery by implementing an integrated system capable of delivery value-based care; reform reimbursement by designing a payment structure that aligns provider reimbursement with improvement in health outcomes; and improve population health through integration of community linkages and care redesign. As the District works toward realization of the goals set forth in the SHIP DHCF has implemented several programs and initiatives. A few of these initiatives are set forth below.

  - **Health Homes**

On January 1, 2016, DHCF, in coordination with the District Department of Behavioral Health, launched My DC Health Home, a new Health Home benefit (authorized under Section 2703 of the ACA) for Medicaid beneficiaries with serious and persistent mental health care needs. The health home provider coordinates a person's full array of health and social service needs—including primary and hospital health services; mental health care, substance abuse care and long-term care services and supports. My DC Health Home currently provides services to over 1,700 District Medicaid beneficiaries. The goal of the program is to serve unmet need in this vulnerable population an in the process reduce avoidable health care costs,

specifically preventable hospital admissions, readmissions, and avoidable emergency room visits for the individuals with serious and persistent mental illnesses enrolled My DC Health Home.

On July 1, 2017, DHCF launched My Health GPS, a second Health Home program for Medicaid beneficiaries with multiple chronic conditions. Under this initiative, interdisciplinary teams embedded in the primary care setting serve as the central point for integrating and coordinating the full array of eligible beneficiaries' primary, acute, behavioral health, and long-term services and supports to improve health outcomes and reduce avoidable and preventable hospital admissions and ER visits. My Health GPS currently serves over 3,500 District Medicaid beneficiaries.

- **Payment Reform Initiatives**

DHCF has also implemented a number of payment reforms for providers in an effort to move incrementally toward the goal of value-based purchasing. Payment reform initiatives include: a pay-for-performance program for Federally-Qualified Health Centers; a quality improvement incentive program for nursing facilities; and two quality improvement incentive programs for My Health GPS providers.

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

Executed on April 9, 2018, in Washington, District of Columbia.

Claudia Schlosberg
State Medicaid Director, Senior Deputy Director
Department of Health Care Finance

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF TEXAS
FORT WORTH DIVISION

TEXAS, WISCONSIN, ALABAMA, ARKANSAS, ARIZONA, FLORIDA, GEORGIA, INDIANA, KANSAS, LOUISIANA, PAUL LePAGE, Governor of Maine, MISSISSIPPI, by and through Governor Phil Bryant, MISSOURI, NEBRASKA, NORTH DAKOTA, SOUTH CAROLINA, SOUTH DAKOTA, TENNESSEE, UTAH, and WEST VIRGINIA, Plaintiffs, v. UNITED STATES OF AMERICA, UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, ALEX AZAR, in his Official Capacity as SECRETARY OF HEALTH AND HUMAN SERVICES, UNITED STATES INTERNAL REVENUE SERVICE, and DAVID J. KAUTTER, in his Official Capacity as Acting COMMISSIONER OF INTERNAL REVENUE, Defendants.	Civil Action No. 4:18-cv-00167-O
CALIFORNIA, *et al.*, Proposed Intervenor-Defendants.	

DECLARATION OF JOHN JAY SHANNON, M.D., CHIEF EXECUTIVE OFFICER OF THE COOK COUNTY HEALTH & HOSPITALS SYSTEM, IN SUPPORT OF MOTION TO INTERVENE BY CALIFORNIA, ET AL.

I, John Jay Shannon, M.D., declare:

1. I am a board certified physician and the Chief Executive Officer of the Cook County Health & Hospitals System (CCHHS).

2. CCHHS is one of the largest public health care systems in the United States, providing a range of health care services regardless of a patient's ability to pay. CCHHS serves approximately 300,000 unique patients annually through more than 1 million outpatient visits and more than 20,000 inpatient hospitals admissions.

3. CCHHS is comprised of two hospitals (John H. Stroger, Jr. Hospital and Provident Hospital), a robust network of more than a dozen community health centers, the Ruth M. Rothstein CORE Center, the Cook County Department of Public Health, Cermak Health Services, which provides health care to individuals at the Cook County Jail and the Juvenile Temporary Detention Center, and CountyCare, a Medicaid managed care health plan.

4. The enactment of the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, and the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, (collectively the "Affordable Care Act") has had a positive effect on CCHHS' ability to serve the residents of Cook County. In particular, the Affordable Care Act offered states the option to expand eligibility for their state Medicaid plan to individuals with incomes at or below 133% of the federal poverty level with heightened matching of federal funds. 42 U.S.C. § 1396a(a)(10)(A)(i)(VIII). Illinois enacted a law to expand the eligibility for its state Medicaid plan to individuals aged 19 or older but younger than 65 with incomes at or below 133% of the federal poverty level. 305 ILCS 5/5-2(18). These newly eligible individuals are often known as "ACA adults." The expansion of Medicaid to ACA adults in Illinois created access to coverage for many existing CCHHS patients who were previously uninsured.

5. The CountyCare Medicaid managed care health plan launched in 2012 as a demonstration project through a federal Centers for Medicare and Medicaid Services (CMS) 1115 Waiver granted to the state of Illinois to early-enroll eligible low-income Cook County ACA adults into a Medicaid managed care program. In 2014, CountyCare was awarded a contract with the Illinois Department of Healthcare and Family Services to operate as a Managed Care Community Network health plan to provide coverage for Cook County Medicaid eligible beneficiaries. CountyCare was also awarded a contract from the State of Illinois' Department of

Healthcare and Family Services to provide services under its Medicaid Managed Care Program beginning January 1, 2018. As part of that program, encouraged by the Affordable Care Act, CountyCare receives a capitated per-member per-month payment from the State of Illinois to pay for services rendered to Illinois Medicaid recipients in its network. CountyCare provides coverage to more than 320,000 members, of which 54,000 are ACA adults who are only eligible for Medicaid because Illinois expanded eligibility pursuant to the Affordable Care Act. In FY2015, CountyCare spent approximately $300 million on claims for ACA adults. Many of CountyCare's members are long-standing CCHHS patients who have previously received care regardless of their ability to pay. Without coverage through Illinois' Medicaid expansion, many of these individuals would be uninsured and may require crucial medical care from CCHHS without being able to provide insurance or other coverage. Unfortunately, many of these patients may decline to seek necessary medical care if they were to lose their Medicaid coverage.

6. The Medicaid expansion has reduced the number of CCHHS patients who receive services without insurance or other coverage. In FY 2012, 63% of CCHHS' patients were uninsured. By FY 2017, the percentage of patients without insurance or other coverage had dropped to 39%. This decrease is largely attributed to the number of ACA adults who were newly eligible for Medicaid because of Illinois' Medicaid expansion pursuant to the Affordable Care Act.

7. The decrease in the number of patients who are uninsured has had a noticeable effect on CCHHS' costs for uncompensated care. In FY 2013, CCHHS provided $585.8 million in uncompensated care. Newly eligible ACA adults were entitled to enroll in Medicaid beginning January 1, 2014. 305 ILCS 5/5-2(18). As a result, the amount of uncompensated care that CCHHS provided in FY 2014 dropped to $313.6 million. Although that number has increased in recent years, CCHHS' costs for uncompensated care have stayed below the costs prior to Illinois' Medicaid expansion. This drop in uncompensated care costs has enabled CCHHS to improve services and care for Illinois patients and engage in a multi-year strategy to address behavioral health services pursuant to a pending Medicaid Section 1115 Waiver Proposal

submitted by the State of Illinois. As a result of ACA funding, CCHHS has also reduced the amount of local tax dollars that are required to support its operations from $481 million in 2009 to $103.5 million in FY2018.

8. Pursuant to Illinois law, if federal matching funds to Illinois for the Medicaid expansion population falls below 90%, coverage for persons eligible for Medicaid through the Medicaid expansion shall cease no later than the end of the third month following the reduction of federal funding below 90%. 305 ILCS 5/5-2(18).

9. If persons enrolled in Medicaid through the Medicaid expansion lose coverage, Illinois hospitals, including CCHHS and other public hospitals in Illinois, will experience an increase in uncompensated care that they must provide to their communities. CCHHS estimates that it could lose $100-200 million in reimbursements from CountyCare and $100-250 million in reimbursements from other Medicaid managed care organizations for services provided if ACA adults lose their Medicaid coverage. CCHHS is also likely to experience a migration of patients from other systems without insurance or other coverage because of CCHHS' policy to provide care to all patients regardless of their ability to pay. CCHHS estimates that it could experience at least $100 million annually in increased uncompensated care costs, with a potential additional $500 million in additional expenses, if the Affordable Care Act and the Medicaid expansion were repealed.

10. Should the ACA be enjoined from operation, CCHHS and other public hospitals will face increased costs from uncompensated care and will suffer additional strains on their ability to deliver high-quality healthcare services to our patients.

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

Executed on March 28, 2018, in Chicago, Illinois.

John Jay Shannon
Chief Executive Officer
Cook County Health & Hospitals System

SA2018100536

IN THE UNITED STATES DISTRICT COURT

FOR THE NORTHERN DISTRICT OF TEXAS

FORT WORTH DIVISION

TEXAS, WISCONSIN, ALABAMA, ARKANSAS, ARIZONA, FLORIDA, GEORGIA, INDIANA, KANSAS, LOUISIANA, PAUL LePAGE, Governor of Maine, MISSISSIPPI, by and through Governor Phil Bryant, MISSOURI, NEBRASKA, NORTH DAKOTA, SOUTH CAROLINA, SOUTH DAKOTA, TENNESSEE, UTAH, and WEST VIRGINIA, Plaintiffs, **v.** **UNITED STATES OF AMERICA, UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, ALEX AZAR, in his Official Capacity as SECRETARY OF HEALTH AND HUMAN SERVICES, UNITED STATES INTERNAL REVENUE SERVICE, and DAVID J. KAUTTER, in his Official Capacity as Acting COMMISSIONER OF INTERNAL REVENUE,** Defendants, and,	Civ. Action No. 18-cv-00167-O **DECLARATION OF ZACHARY W. SHERMAN IN SUPPORT OF STATES' MOTION TO INTERVENE**

CALIFORNIA, RHODE ISLAND, et al.

Proposed Intervenors.

I, Zachary W. Sherman, declare:

1. I am the Director of HealthSource RI, Rhode Island's state-based health insurance exchange. I have been Director for over two years, and have served in multiple capacities at HealthSource RI since shortly after the Affordable Care Act passed in 2010.

2. HealthSource RI was created in 2011 and has been operational since 2013, connecting Rhode Islanders with affordable plans and participating in many aspects of federal health reform.

3. **The Affordable Care Act increased access to affordable coverage.**

- Overall, the number of individuals with insurance in Rhode Island has increased. According to the 2016 Rhode Island Health Insurance Survey (HIS), a comprehensive phone-based household survey, in Rhode Island, 999,145 people have coverage, bringing the rate of uninsured in this state down to just 4.2%. This marks a significant improvement from 2012, when the rate of uninsured was 11%, and is representative of 73,000 more Rhode Islanders obtaining coverage. One out of every ten Rhode Islanders have health insurance through the ACA.
- The ACA expanded coverage through two key mechanisms: Medicaid expansion for those individuals with the lowest incomes, and federal subsidies to purchase coverage in new health insurance Exchanges for those individuals with moderate incomes.
- Medicaid is an important source of healthcare insurance coverage and has resulted in significant coverage gains and a reduction in the uninsured rate, both among the low-income population and among other vulnerable populations. As a result of Medicaid expansion in Rhode Island, as of February 2018, 77,846 people have coverage.

- The Exchange is an important reform enacted by the ACA. In Rhode Island, 25,159 people enrolled in coverage with federal affordability subsidies during this most recent Open Enrollment Period. In other words, 82% of all enrollees in commercial plans through the Exchange are receiving federal assistance towards the purchase of their health coverage.

4. The ACA expanded programs in Medicaid to provide States with opportunities to increase access to home and community based services.

- Through the Medicaid Money Follows the Person Demonstration, Rhode Island receives federal financial assistance to move elderly nursing home residents out of nursing homes and back into their own homes or into the homes of their loved ones. This grant has allowed the state to expand the program to assist individuals in managing their care outside of a nursing home. Over the grant period, the state has seen a shift in Long Term Services and Supports spending for the state. The percent of the state Medicaid expenditures for home and community based services increased over the period of the grant, with a corresponding decline in the percent of expenditures for institutional care.

5. The ACA resulted in better quality and more accessible, affordable healthcare for consumers.

- The ACA created robust consumer protections to help ensure individuals can access the healthcare system.
    - As of April 2017, 88,827 Rhode Islanders were enrolled in ACA compliant Individual and Small Group market plans sold by a Rhode Island carrier. It is because of the ACA that these enrollees have access to coverage for dependents through a parents' plan until the dependent turns twenty-six, access to certain mandated preventive services including access to birth control, cancer screenings, and immunizations for children, and access to essential health benefits

such as substance use disorder treatment and maternity and newborn care.

- The ACA has led to improved access to care. For example, in 2016, 4.8% of those surveyed through the HIS in RI said they'd skipped or took less of a medication in order to make it last longer as compared to 6.1% in 2012. In that same time period, the percentage of respondents in the same survey who said that they did not get a prescription filled because they could not afford it dropped from 5.5% to 4.5%.
- The ACA has led to improved financial security. For example, in 2016, results from the HIS showed that 19.1% of respondents said they had experienced trouble paying medical bills at some time during the past year, down from 24.1% in 2012.
- The ACA also created important additional consumer protections and rights such as:
  - A prohibition on higher premiums for those with pre-existing conditions;
  - A prohibition on annual and lifetime limits for covered benefits and discrimination in benefit design;
  - Guaranteed issue and renewability of health coverage; and
  - Transparency of plan benefits, providers, and drug coverage.

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

Executed on March 30, 2018, in East Providence, RI.

Zachary W. Sherman
Director
HealthSource RI

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF TEXAS
FORT WORTH DIVISION

TEXAS, WISCONSIN, ALABAMA, ARKANSAS, ARIZONA, FLORIDA, GEORGIA, INDIANA, KANSAS, LOUISIANA, PAUL LePAGE, Governor of Maine, MISSISSIPPI, by and through Governor Phil Bryant, MISSOURI, NEBRASKA, NORTH DAKOTA, SOUTH CAROLINA, SOUTH DAKOTA, TENNESSEE, UTAH, and WEST VIRGINIA, Plaintiffs, v. UNITED STATES OF AMERICA, UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, ALEX AZAR, in his Official Capacity as SECRETARY OF HEALTH AND HUMAN SERVICES, UNITED STATES INTERNAL REVENUE SERVICE, and DAVID J. KAUTTER, in his Official Capacity as Acting COMMISSIONER OF INTERNAL REVENUE, Defendants.	Civil Action No. 4:18-cv-00167-O
CALIFORNIA, ET AL., Proposed Intervenor-Defendants.	

DECLARATION OF RYAN SMITH IN SUPPORT OF MOTION TO INTERVENE BY CALIFORNIA, ET AL.

I, Ryan Smith, declare:

1. I am 28 years old and a resident of Chicago, Illinois. I am currently employed as a legal assistant and will be attending law school in fall 2018.

2. In the summer of 2013, my physician diagnosed me with two separate mental illnesses: generalized anxiety disorder and panic disorder. I made the decision to go on a daily medication to manage my mental illness. At the time, my employer provided health insurance that made the cost of my medications affordable. Prior to medication, I was experiencing daily panic attacks. These attacks were debilitating; they lasted for hours, left me unable to sleep at night, and interfered with my normal work routine. The medication I was prescribed, Sertraline, helped prevent my panic attacks. I went from having one to two every day to none at all.

3. In the fall of 2014, I lost my job and with it, my health benefits. Fortunately, my then-home of Michigan had established a healthcare exchange, and I was able to purchase health insurance on the exchange that was affordable, thanks in part to subsidies provided by the ACA. This helped keep the cost of my medication and doctor's visits at an affordable level. Without insurance, my prescriptions would have cost hundreds of dollars a month, which I could not afford while I was unemployed.

4. If I had not been able to afford my medication, searching for a job would have been exceptionally difficult, and my unemployment would have been prolonged. With my medication, and the affordable insurance I had through the healthcare exchange, I was able to actively search for employment. Access to mental healthcare is as critical as access to physical healthcare, and without the Affordable Care Act, my experience with unemployment might have been substantially worse.

5. Even though I am no longer covered through a plan purchased through the marketplace, I continue to utilize mental health services, and the protections offered under the Affordable Care Act remain critical. I know that whatever plan I enroll in

will include mental health services as an essential health benefit, that mental health treatments will be in parity with other kinds of health services, and I will never be discriminated against for a pre-existing condition.

6. I support Plaintiffs' motion to intervene. Elimination of the ACA would hurt me and my family.

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

Executed on April 3, 2018, in Chicago, Illinois.

Ryan Smith

IN THE UNITED STATES DISTRICT COURT

FOR THE NORTHERN DISTRICT OF TEXAS

FORT WORTH DIVISION

TEXAS, WISCONSIN, ALABAMA, ARKANSAS, ARIZONA, FLORIDA, GEORGIA, INDIANA, KANSAS, LOUISIANA, PAUL LePAGE, Governor of Maine, MISSISSIPPI, by and through Governor Phil Bryant, MISSOURI, NEBRASKA, NORTH DAKOTA, SOUTH CAROLINA, SOUTH DAKOTA, TENNESSEE, UTAH, and WEST VIRGINIA, Plaintiffs, **v.** **UNITED STATES OF AMERICA, UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, ALEX AZAR, in his Official Capacity as SECRETARY OF HEALTH AND HUMAN SERVICES, UNITED STATES INTERNAL REVENUE SERVICE, and DAVID J. KAUTTER, in his Official Capacity as Acting COMMISSIONER OF INTERNAL REVENUE,** Defendants, and,	Civ. Action No. 18-cv-00167-O **DECLARATION OF DR. KARA ODOM WALKER IN SUPPORT OF STATES' MOTION TO INTERVENE**

CALIFORNIA, et al.,

Proposed Interveners.

1. **I, Dr. Kara Odom Walker, declare:**

- I am the Secretary of the Delaware Department of Health and Social Services (DHSS). I have served as the Secretary of the DHSS since February 6, 2017. Prior to my present post, I served as the Deputy Chief Science Officer at the Patient-Centered Outcomes Research Institute (PCORI) in Washington D.C. from August 2012 to January 2017. Furthermore, as a family physician with health services and community-based participatory research training, I previously was an assistant clinical professor in family and community medicine at the University of California, San Francisco, where I developed measurement instruments to better understand integrated care in health systems for diverse populations from July 2010 to July 2012.
- I graduated with honors from the University of Delaware with a BS in chemical engineering. Thereafter I received my MD from Jefferson Medical College and MPH from Johns Hopkins University. I completed postgraduate training at University of California, San Francisco, and served as a Robert Wood Johnson Clinical Scholar at the University of California, Los Angeles, where I conducted research on the impact of hospital closure on underserved, minority populations.
- As an advocate for health equity and minority and underserved populations, I was recognized for leadership by the Harvard Business School's program for leadership development, the American Medical Association, and the National Medical Association. I served as past national president of the Student National Medical Association and past postgraduate physician trustee of the National Medical Association.

2. As one of the largest agencies in state government, DHSS has 11 divisions, employs more than 4,000 people and in one way or another affects almost every citizen in our great state. Our divisions provide services in the areas of public health, social services, substance abuse and mental health, child support, developmental disabilities, long-term care, visual impairment, aging and adults with physical disabilities, state service centers, management services, financial coaching, and Medicaid and medical assistance. The Department includes three long-term care facilities and the state's only public psychiatric hospital, the Delaware Psychiatric Center.

3. **The Affordable Care Act directs billions of dollars directly to Delaware.**
   - Delaware has received $800 million via Medicaid expansion alone.

4. **The Affordable Care Act (ACA) increased access to affordable coverage.**

   Overall the number of individuals with insurance has increased. In Delaware, the percentage of population which was uninsured fell from 9.1% in 2013 to 5.7% in 2016. This translates into the number of people without coverage falling from 83,000 in 2013 to 53,000 in 2016.

   - The ACA expanded coverage through two key mechanisms: Medicaid expansion for those individuals with the lowest incomes, and federal health subsidies to purchase coverage in new health insurance Exchanges for those individuals with moderate incomes.
   - Medicaid is an important source of healthcare insurance coverage and has resulted in significant coverage gains and reduction in the uninsured rate, both among the low-income population and within other vulnerable populations. As a result of Medicaid expansion Delaware has been able to provide coverage to 11,000 new enrollees and maintain coverage for 50,000 adults from an earlier expansion with enhanced federal financial support, and the state has experienced a large reduction in the uninsured rate.

5. **The ACA has positive economic benefits on states.**
   - Studies have shown that states expanding Medicaid under the ACA have realized budget savings, revenue gains, and overall economic growth.
   - In Delaware, $500 million has been saved as a result of Medicaid expansion.
6. **The ACA has allowed States to test and implement reforms to healthcare delivery systems that support State policy priorities of increasing efficiency and quality of care.**
   - Delaware received Center for Medicare and Medicaid Innovation (CMMI) grants totaling $35 million over four years (2015-2018).

I declare that the foregoing is true and correct based on information and belief.

Executed on March 28, 2018, in New Castle, Delaware.

Dr. Kara Odom Walker
Cabinet Secretary
Delaware Department of Health
and Social Services

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF TEXAS
FORT WORTH DIVISION

TEXAS, WISCONSIN, ALABAMA, ARKANSAS, ARIZONA, FLORIDA, GEORGIA, INDIANA, KANSAS, LOUISIANA, PAUL LePAGE, Governor of Maine, MISSISSIPPI, by and through Governor Phil Bryant, MISSOURI, NEBRASKA, NORTH DAKOTA, SOUTH CAROLINA, SOUTH DAKOTA, TENNESSEE, UTAH, and WEST VIRGINIA, Plaintiffs, v. UNITED STATES OF AMERICA, UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, ALEX AZAR, in his Official Capacity as SECRETARY OF HEALTH AND HUMAN SERVICES, UNITED STATES INTERNAL REVENUE SERVICE, and DAVID J. KAUTTER, in his Official Capacity as Acting COMMISSIONER OF INTERNAL REVENUE, Defendants.	Civil Action No. 4:18-cv-00167-O
CALIFORNIA, ET AL., Proposed Intervenor-Defendants.	

DECLARATION OF SHERRY WHITE IN SUPPORT OF MOTION TO INTERVENE BY CALIFORNIA, ET AL.

I, Sherry White, declare:

1. I am 46 years old and a resident of Corning, New York.
2. My husband and I are self-employed small business owners, and we have had to purchase our own insurance for the last 15 years.

3. Prior to the Affordable Care Act, our family of four purchased a plan through the private market at $800 per month. While our family is fortunate to be relatively healthy, we found ourselves needing our insurance for several small things over the years and each time, we found that our plan did not provide the coverage we needed. For example, I required physical therapy after I tore a tendon in my wrist and my husband needed a CPAP machine to treat sleep apnea. I learned that our plan did not cover both my physical therapy and his CPAP machine and we were forced to pay out of pocket if we wanted care.
4. We found ourselves paying for a plan that did not cover what we needed and cost more than our mortgage. And at one point, we were forced to choose between paying for the premiums and putting groceries on the table. We chose to drop our coverage.
5. Because of the Affordable Care Act, we were able to purchase a plan through the NY State of Health state marketplace that is more robust than our previous coverage and after the tax credit subsidy is taken into account, half of the price. Because of the provision allowing children to stay on their parents' plan, we have been able to cover our young adult daughters until they are able to secure coverage of their own.
6. It is impossible to overstate the importance of the essential health benefits for our family. Between us, we have been able to receive coverage for preventive services, prescription drugs, medical equipment, and a hospitalization. Thankfully, we no longer have to worry about our plan turning down care the way our last one did.
7. Having stable, comprehensive coverage has helped us avoid a catastrophe that would have required us to close our business. While on this plan, I experienced a kidney stone and was forced to go to the hospital; the lithotripsy and overnight hospital stay cost us over $10,000. If our insurance did not have meaningful coverage for hospitalizations and limits to our out of pocket costs, it would have been catastrophic. There is no way we could have afforded to pay that out of pocket. As

small business owners, when we are injured or sick, we close the doors and lose all sources of income.

8. The Affordable Care Act has given our family the coverage and security of knowing that if we get sick, we will not go bankrupt as a result.

9. I support Plaintiffs' motion to intervene. Elimination of the ACA would hurt me and my family.

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

Executed on March 23, 2018 in Corning, New York.

Sherry White

Sherry White

SA2018100536

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF TEXAS
FORT WORTH DIVISION

TEXAS, WISCONSIN, ALABAMA, ARKANSAS, ARIZONA, FLORIDA, GEORGIA, INDIANA, KANSAS, LOUISIANA, PAUL LePAGE, Governor of Maine, MISSISSIPPI, by and through Governor Phil Bryant, MISSOURI, NEBRASKA, NORTH DAKOTA, SOUTH CAROLINA, SOUTH DAKOTA, TENNESSEE, UTAH, and WEST VIRGINIA, Plaintiffs, v. UNITED STATES OF AMERICA, UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, ALEX AZAR, in his Official Capacity as SECRETARY OF HEALTH AND HUMAN SERVICES, UNITED STATES INTERNAL REVENUE SERVICE, and DAVID J. KAUTTER, in his Official Capacity as Acting COMMISSIONER OF INTERNAL REVENUE, Defendants.	Civil Action No. 4:18-cv-00167-O
CALIFORNIA, ET AL., Proposed Intervenor-Defendants.	

DECLARATION OF DR. HOWARD A. ZUCKER IN SUPPORT OF THE STATES' MOTION TO INTERVENE

I, Howard A. Zucker, declare:

1. I am the Commissioner of the New York State Department of Health (DOH). I make this declaration in my capacity as the Commissioner after consultation with DOH program staff directing the initiatives detailed below and in support of New York State's Motion to Intervene in the above-captioned action.

2. DOH's mission is to protect, improve and promote the health, productivity and wellbeing of all New Yorkers. DOH administers several programs that receive funding through the Affordable Care Act (ACA) in order to achieve this mission.

3. As described below, the ACA has significantly increased New York State's ability to provide access to affordable comprehensive health insurance coverage and health care services to state residents. Rolling back the ACA's provisions puts the health of millions of New Yorkers at risk.

4. **The Affordable Care Act provides billions of dollars directly to New York to improve the health of its residents.**

- Funding available through the ACA has allowed New York to improve the health of its residents. New York has received more than $17 billion in federal revenue to expand affordable health coverage in the appropriate setting for New Yorkers, including: $12.9 billion in federal revenue as a result of state adoption of the Medicaid expansion provisions of the ACA; $3.5 billion in federal funding to support the Basic Health Program option of the ACA making health care coverage

more affordable for lower income New Yorkers; $26.9 million in funding through the Public Health and Prevention Fund; $618 million in funding to support the Balancing Incentive Program; $100 million in continuing grants from the Center for Medicare and Medicaid Innovation for transforming primary care practices to advanced patient centered care; and nearly $185 million in funding to support the Money Follows the Person (MFP) program.

5. **The Affordable Care Act increased residents' access to affordable coverage.**

- The ACA expanded health coverage for New Yorkers through three key mechanisms: (1) the Medicaid expansion for those individuals with the lowest incomes; (2) the Basic Health Program (BHP), known as the "Essential Plan" in New York, for individuals with income slightly higher than Medicaid levels and lawfully present immigrants ineligible for Medicaid; and (3) federal subsidies to lower the cost of coverage for individuals with moderate incomes.
- Since implementing the ACA, New York has seen significant coverage gains. Since 2013, nearly 1 million people have gained coverage, and the rate of uninsured in New York has declined from 10 to below 5 percent, its lowest level ever. Coverage gains were seen among:
    - Young adults ages 19 to 25, whose uninsured rate fell from 17 percent to 8 percent;
    - African American/Black New Yorkers, whose uninsured rate fell from 12 percent to 7 percent;
    - Asian New Yorkers, whose uninsured rate fell from 14 percent to 8 percent;

- Hispanic/Latino New Yorkers, whose uninsured rate fell from 20 percent to 12 percent;
- New Yorkers who are full-time employees, whose uninsured rate fell from 12 percent to 7 percent; and
- New Yorkers with household incomes under 200 percent of FPL, whose uninsured rate fell from 16 percent to 10 percent.

- Medicaid is an important source of healthcare insurance coverage for low income residents and the most vulnerable citizens. Prior to the ACA, New York had been a leader in making access to health care accessible to low-income residents through Medicaid expansion permitted under Section 1115 federal waivers. Nonetheless, an estimated one million people who were eligible for Medicaid remained uninsured, placing financial burden on the health care system when these individuals presented for services sicker and had no health plan to pay providers, often hospitals.
- As a result of implementing the ACA's Medicaid expansion, 301,721 New Yorkers became newly eligible for health care coverage. An additional 1,148,587 New Yorkers are covered by Medicaid with the state receiving an enhanced federal Medical Assistance Percentage (FMAP) under the provisions of the ACA.
- New York has also provided its residents with coverage under the Basic Health Program, a program created by the ACA, and available to states to opt into through submission of a "blueprint" to HHS. As of January 31, 2018, BHP provides 738,851 lower income New Yorkers with health coverage at a lower monthly premium cost, no annual deductible and lower copayments for services

as compared to a silver tier Qualified Health Plan (QHP) with cost sharing reductions. In late 2015, modeling by The Urban Institute found that Essential Plan, as compared to a QHP, reduces both premium and out-of-pocket costs for these individuals by over $1,100 a year.

- Prior to implementing the ACA, New York's individual insurance market was often described as being in a "death spiral." With individual monthly premiums of well over $1,000 a month, only the wealthiest individuals and/or people with high medical service utilization were likely to purchase coverage. Enrollment in the state's individual insurance markets had dropped to about 17,000.
- Since the 2014 implementation of the ACA, New York's individual insurance market has grown by 2000 percent to over 365,000. With this extraordinary increase in membership, individual market premiums have fallen by over 50 percent as compared to premiums in 2013, making coverage more accessible for New Yorkers.
- In addition to this dramatic reduction in premiums, the ACA allows nearly 150,000 New Yorkers to receive federal tax credits to further reduce the cost of coverage and cost sharing reductions to help reduce out of pocket costs such as deductibles, coinsurance and copayments. In 2018, New Yorkers are expected to receive over $531 million in tax credits, bringing the cumulative benefit of the ACA tax credits received by New Yorkers to over $2.7 billion since 2014.
- In 2016, 348,566 Medicare beneficiaries in New York received discounts on the Medicare Part D prescription drug coverage gap, known as the "donut hole," totaling more than $2.1 billion. On average, the beneficiary discount was $1,320.

6. **The ACA has positive economic benefits on states.**

- Given that health care comprises 18 percent of the national gross domestic product, the federal assistance states receive through the Affordable Care Act has a significant effect on the economy. A Commonwealth Fund analysis estimated that the repeal of the Medicaid expansion and premium tax credits could lead to the loss of 2.6 million jobs nationwide and $1.5 trillion gross state products over five years. According to the report, in New York the repeal of the Medicaid expansion and tax credits would result in 131,000 jobs lost, $154 billion in lost business output, and $90 in lost gross state product.
- Since implementation of the ACA, the number of uninsured has been reduced significantly, and New York hospitals have reported a dramatic decrease in self-pay hospital utilization as patients have gained a usual source of payment. New York State Institutional Cost Reports show a 23 percent reduction in self-pay hospital emergency room visits, a 40 percent reduction in self-pay inpatient services and a 17 percent reduction in self-pay outpatient visits. Having a usual source of payment for patients reduces the risk of uncompensated care costs.

7. **The ACA expanded programs in Medicaid to provide States with increased opportunities to increase access to home and community based services.**

- Funding available to states through the ACA has allowed New York to increase opportunities for residents to access home and community based services through several programs. In January 2007, the federal Centers of Medicare and Medicaid Services (CMS) approved New York's application to participate in the Money Follows the Person Rebalancing Demonstration Program (MFP). The MFP

Demonstration, authorized under the Deficit Reduction Act and extended by the Affordable Care Act, involves transitioning eligible individuals from long-term institutions like nursing facilities and intermediate care facilities into qualified community-based settings.

- The MFP has helped New York State to rebalance the Medicaid long-term care systems by assisting people who want to leave institutional settings to receive services in their communities of choice.
- Initiatives like MFP have contributed to the rebalancing of New York State's long-term health care system, increasing the amount of Medicaid spending on Home and Community Based Services in New York State by 56.68% from 2008 through calendar year 2016. MFP provides enhanced federal match of home and community based services provided to former residents of institutional settings who successfully transition to community living. These additional federal dollars support rebalancing efforts in long term care systems in New York. New York State MFP has utilized between $15-$20 million dollars for each of the last three years to provide assistance to individuals in nursing homes and intermediate care facilities to facilitate their transition to living.
- Community First Choice Option (CFCO) is an enhanced personal care benefit established under the Affordable Care Act. States were authorized to amend their state plan to cover enhanced personal attendant services and supports to address activities of daily living (ADL), instrumental activities of daily living (IADL) and health-related needs through hands-on assistance, supervision and/or cueing. Other services and supports required under CFCO include assistance with

skill acquisition, maintenance or enhancement to facilitate an individual meeting his or her own ADL, IADL or health-related needs. Also, voluntary training to provide individuals with the skills to hire, train and dismiss personal attendants is required. Optional CFCO services and supports include social transportation, home and vehicle modifications and assistance with moving expenses for those transitioning to community based care from institutional settings. CFCO services are intended to be primarily self-directed either by the person receiving the services and supports or through a designated representative. States who opt to implement a CFCO state plan benefit are eligible for an additional 6% FMAP.

- The Balancing Incentive Program (BIP) was authorized in the Affordable Care Act in 2010. It provides grants to states that agree to develop and implement three structural reforms believed to facilitate rebalancing of Medicaid expenditures toward community-based rather than institutional long-term services and supports (LTSS). Grants are earned through enhanced FMAP based on each state's spending on certain HCBS LTSS spending during the BIP period between the grant approval and September 30, 2015. While earnings ceased during the initial BIP period, states were granted additional time to meet the requirements and spend the funds generated during the BIP period. The final BIP period ended September 30, 2017.
- New York was one of 18 states that elected to participate in the BIP program. The program's overarching goal was to increase the percentage of state Medicaid expenditures on community-based long-term services and supports over 50% prior to the end of the BIP period. New York exceeded this goal early on and

now spends nearly 65% of its Medicaid LTSS expenditures in community-based settings. From 2014 through 2017, more than 57,000 individuals were served through BIP.

8. **The ACA has allowed States to test and implement reforms to healthcare delivery systems that support State policy priorities of increasing efficiency and quality of care.**

- The ACA created the Center for Medicare and Medicaid Innovation (CMMI) which established the State Innovation Models (SIM) initiative to encourage state payment and delivery reforms. New York is a SIM award state. With this $100 million award, DOH has implemented a primary care transformation initiative to meet the goals of having improved access to high quality, cost-effective health care for 80% of New York residents, improving the health of our population. With this initiative, over 2,500 practices will receive transformation assistance to increase practice capability for access to appointments, patient-centric coordinated care using health information to improve quality and outcomes.
- New York State has two facilities participating in Accountable Health Communities, a program that focuses on addressing the gap between clinical care and community services addressing health-related social needs or social determinants of health. Data from this program will inform models for addressing social determinants in communities, essential to increasing access to primary care and reducing unnecessary hospital utilization.

9. **The ACA created a dedicated funding stream to improve the nation's public health system.**

- The Prevention and Public Health Fund was established under Section 4002 of the ACA. Also known as the Prevention Fund or PPHF, it is the nation's first mandatory funding stream dedicated to improving our nation's public health system.
- PPHF funds that have been allocated to the Centers for Disease Control and Prevention (CDC) have enhanced state capacity to provide immunizations against infectious diseases; increase detection and prevention efforts related to infectious disease threats including pandemic influenza; have supported the Preventive Health & Health Services Block Grant that addresses unique public health issues on state levels including prevention of lead poisoning, fall prevention, rape crisis and sexual violence prevention, tobacco use prevention, hunger prevention, and enhanced water quality; and has supported state funding through the Epidemiology and Laboratory Capacity (ELC) and Emerging Infections Program (EIP) grants that have built capability critical during recent outbreaks including those related to multi-state foodborne illness, influenza, and fungal meningitis, and provides a foundation for the antibiotic resistance and healthcare associated infections programs that is estimated to avert billions of dollars in healthcare spending.
- New York State currently receives funding from the PPHF to conduct chronic disease prevention programs addressing diabetes, obesity, cardiovascular disease tobacco use, and arthritis. Chronic diseases are among the leading causes of death

and disability in New York State. They account for approximately 60% of all deaths in the state and affect the quality of life for millions of New Yorkers. However, chronic diseases are also among the most preventable, if there is adequate support for effective prevention programs and policies.

- In addition to addressing chronic diseases, without continued PPHF funding, grants that support communicable disease prevention, detection, and control would be severely impacted. Current grant funding through the CDC supports communicable disease surveillance and outbreak control in communities, healthcare settings (hospitals and nursing homes), tuberculosis prevention and control, and combating vaccine preventable diseases. CDC funds New York annually through the Emerging Infections Program grant, the Epidemiology and Laboratory Capacity grant, the Immunization and Vaccines for Children Cooperative Agreement funding, and Preventive Health & Health Services Block grant. A portion of the PPHF funding is directed to increase and improve the critical public health work conducted at the local level which extends the reach and impact of the state capacity.

10. **The ACA resulted in better quality and more accessible, affordable healthcare for consumers.**

- Compared to individuals in states that have chosen not to implement key coverage mechanisms in the ACA, individuals who live in states that are implementing the

law have improved access to care. According to a recent Commonwealth Fund Survey[1]:

- Nationally, in 2012 the share of individuals who reported they could not access needed care due to cost was 43 percent. This share dropped to 34 percent in 2016 nationally, and in New York the percentage dropped to 29 percent in 2016. In comparable large states like Florida and Texas, the share of individuals who reported they could not access needed care in 2016 was far higher: 41 percent and 45 percent, respectively.
- Nationally, in 2012 the share of individuals who reported having trouble paying their medical bills was 41 percent. This share dropped to 37 percent in 2016, and in New York, the number dropped to 28 percent. In comparison, the share of individuals reporting having trouble paying medical bills was 41 percent and 44 percent in Florida and Texas, respectively.

[1] The Commonwealth Fund, Issue Brief, March 2017, *Insurance Coverage, Access to Care, and Medical Debt Since the ACA: A Look at California, Florida, New York and Texas* http://www.commonwealthfund.org/~/media/files/publications/issue-brief/2017/mar/1935_gunja_coverage_access_four_largest_states_ib.pdf.

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

Executed on April 6, 2018 in New York, New York.

Howard A. Zucker, MD, JD

Howard A. Zucker, M.D., J.D.
Commissioner
Department of Health
New York State

Certificate of Service

On April 9, 2018, I electronically submitted the foregoing document with the clerk of court for the U.S. District Court, Northern District of Texas, using the electronic case filing system of the court. I hereby certify that I have served all counsel and/or *pro se* parties of record electronically or by another manner authorized by Federal Rule of Civil Procedure 5 (b)(2).

s/Michelle Schoenhardt
Michelle Schoenhardt

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF TEXAS
FORT WORTH DIVISION

TEXAS, WISCONSIN, ALABAMA, ARKANSAS, ARIZONA, FLORIDA, GEORGIA, INDIANA, KANSAS, LOUISIANA, PAUL LePAGE, Governor of Maine, MISSISSIPPI, by and through Governor Phil Bryant, MISSOURI, NEBRASKA, NORTH DAKOTA, SOUTH CAROLINA, SOUTH DAKOTA, TENNESSEE, UTAH, and WEST VIRGINIA, Plaintiffs, v. UNITED STATES OF AMERICA, UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, ALEX AZAR, in his Official Capacity as SECRETARY OF HEALTH AND HUMAN SERVICES, UNITED STATES INTERNAL REVENUE SERVICE, and DAVID J. KAUTTER, in his Official Capacity as Acting COMMISSIONER OF INTERNAL REVENUE, Defendants.	Civil Action No. 4:18-cv-00167-O
CALIFORNIA, CONNECTICUT, DISTRICT OF COLUMBIA, DELAWARE, HAWAII, ILLINOIS, KENTUCKY, MASSACHUSETTS, MINNESOTA, NEW JERSEY, NEW YORK, NORTH CAROLINA, OREGON, RHODE ISLAND, VERMONT, VIRGINIA, AND WASHINGTON, [Proposed] Intervenors-Defendants.	

[PROPOSED] ORDER GRANTING MOTION TO INTERVENE

Before the Court is the Motion to Intervene of the Intervenors-Defendants California, Connecticut, District of Columbia, Delaware, Hawaii, Illinois, Kentucky, Massachusetts,

Minnesota, New Jersey, New York, North Carolina, Oregon, Rhode Island, Vermont, Virginia, and Washington ("Movants"). The motion is meritorious and should be GRANTED.

It is therefore ORDERED that the Movants' Motion to Intervene as defendants is GRANTED.

It is further ORDERED that Movants shall be granted leave to intervene under Federal Rule of Civil Procedure 24.

It is further ORDERED that Movants shall be permitted to file, within _____ days of the date this Order, their answer in intervention.

SIGNED on this ____ day of _____, 2018.

_____
HONORABLE JUDGE REED O'CONNOR
UNITED STATES DISTRICT JUDGE

Certificate of Service

On April 9, 2018, I electronically submitted the foregoing document with the clerk of court for the U.S. District Court, Northern District of Texas, using the electronic case filing system of the court. I hereby certify that I have served all counsel and/or *pro se* parties of record electronically or by another manner authorized by Federal Rule of Civil Procedure 5 (b)(2).

s/Michelle Schoenhardt
Michelle Schoenhardt