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

Dated: April 9, 2018

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IN THE UNITED STATES DISTRICT COURT
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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

[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

[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.

[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

[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

[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

[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

[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

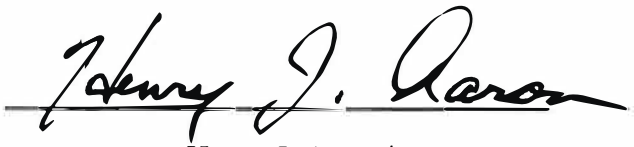
opportunity to receive higher quality, more coordinated care would no longer operate under an injunction.

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

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