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, Governor Phil Bryant of the State of MISSISSIPPI, MISSOURI, NEBRASKA, NORTH DAKOTA, SOUTH CAROLINA, SOUTH DAKOTA, TENNESSEE, UTAH, WEST VIRGINIA, NEILL HURLEY, and JOHN NANTZ, 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 by and through its Department of Commerce, NEW JERSEY, NEW YORK, NORTH CAROLINA, OREGON, RHODE ISLAND, VERMONT, VIRGINIA, and WASHINGTON, Intervenor-Defendants.	

APPENDIX IN SUPPORT OF INTERVENOR-DEFENDANTS' BRIEF IN OPPOSITION TO PLAINTIFFS' APPLICATION FOR A PRELIMINARY INJUNCTION

The Defendant States submit the following appendix in support of their Opposition to Plaintiffs' Application for a Preliminary Injunction.

APPENDIX OF SUPPORTING EVIDENCE

Dated: June 7, 2018

Respectfully submitted,

Xavier Becerra
Attorney General of California
Julie Weng-Gutierrez
Senior Assistant Attorney General
Kathleen Boergers
Supervising Deputy Attorney General

/s/ Neli N. Palma
/s/ Nimrod P. Elias

Neli N. Palma
Nimrod P. Elias
Deputy Attorneys General
California State Bar No. 203374
California State Bar No. 251634
P.O. Box 944255
Sacramento, CA 94244-2550
Telephone: (916) 210-7522
Fax: (916) 322-8288
E-mail: Neli.Palma@doj.ca.gov
Attorneys for Intervenors-Defendants

GEORGE JEPSEN
Attorney General of Connecticut
JOSEPH RUBIN
Associate Attorney General
Attorneys for Intervenor-Defendant the State of Connecticut

MATTHEW P. DENN
Attorney General of Delaware
ILONA KIRSHON
Deputy State Solicitor
DAVID J. LYONS
Deputy Attorney General
Attorneys for Intervenor-Defendant the State of Delaware

RUSSELL A. SUZUKI
Attorney General of Hawaii
HEIDI M. RIAN
Deputy Attorney General
ROBERT T. NAKATSUJI
Deputy Solicitor General
Attorneys for Intervenor-Defendant the State of Hawaii

LISA MADIGAN
Attorney General of Illinois
David F. Buysse
Deputy Chief, Public Interest Division
Anna P. Crane
Public Interest Counsel
Matthew V. Chimienti
Assistant Attorney General, Special Litigation Bureau
Attorneys for Intervenor-Defendant the State of Illinois

ANDY BESHEAR
Attorney General of Kentucky
LA TASHA BUCKNER
Executive Director, Office of Civil and Environmental Law
S. TRAVIS MAYO
TAYLOR PAYNE
Assistant Attorneys General
Attorneys for Intervenor-Defendant the Commonwealth of Kentucky

MAURA HEALEY
Attorney General of Massachusetts
STEPHEN P. VOGEL
Assistant Attorney General
Attorneys for Intervenor-Defendant the Commonwealth of Massachusetts

OFFICE OF THE ATTORNEY GENERAL
State of Minnesota
SCOTT IKEDA
Assistant Attorney General
Attorneys for Intervenor-Defendant the State of Minnesota by and through its Department of Commerce

GURBIR S. GREWAL
Attorney General of New Jersey
JEREMY M. FEIGENBAUM
Assistant Attorney General
ANGELA JUNEAU BEZER
Deputy Attorney General
Attorneys for Intervenor-Defendant the State of New Jersey

BARBARA D. UNDERWOOD
Acting Attorney General of New York
STEVEN C. WU
Deputy Solicitor General
LISA LANDAU
Bureau Chief, Health Care Bureau
ELIZABETH CHESLER
Assistant Attorney General, Health Care Bureau
Attorneys for Intervenor-Defendant the State of New York

JOSHUA H. STEIN
Attorney General of North Carolina
SRIPRIYA NARASIMHAN
Deputy General Counsel
Attorneys for Intervenor-Defendant the State of North Carolina

ELLEN F. ROSENBLUM
Attorney General of Oregon
HENRY KANTOR
Special Counsel to the Attorney General
SCOTT KAPLAN
Assistant Attorney General
Attorneys for Intervenor-Defendant the State of Oregon

PETER KILMARTIN
Attorney General of Rhode Island
MICHAEL W. FIELD
Assistant Attorney General
MARIA R. LENZ
Special Assistant Attorney General
Attorneys for Intervenor-Defendant the State of Rhode Island

THOMAS J. DONOVAN, JR.
Attorney General of Vermont
BENJAMIN D. BATTLES
Solicitor General
Attorneys for Intervenor-Defendant the State of Vermont

MARK R. HERRING
Attorney General of Virginia
TOBY J. HEYTENS
Solicitor General
MATTHEW R. MCGUIRE
Deputy Solicitor General
Attorneys for Intervenor-Defendant the Commonwealth of Virginia

ROBERT W. FERGUSON
Attorney General of Washington
JEFFREY G. RUPERT
Chief, Complex Litigation Division
JEFFREY T. SPRUNG
Assistant Attorney General
Attorneys for Intervenor-Defendant the State of Washington

KARL A. RACINE
Attorney General for the District of Columbia
ROBYN R. BENDER
Deputy Attorney General
VALERIE M. NANNERY
Assistant Attorney General
Attorneys for Intervenor-Defendant the District of Columbia

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, Governor Phil Bryant of the State of MISSISSIPPI, MISSOURI, NEBRASKA, NORTH DAKOTA, SOUTH CAROLINA, SOUTH DAKOTA, TENNESSEE, UTAH, WEST VIRGINIA, NEILL HURLEY and JOHN NANTZ, 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 by and through its Department of Commerce, NEW JERSEY, NEW YORK, NORTH CAROLINA, OREGON, RHODE ISLAND, VERMONT, VIRGINIA and WASHINGTON, Intervenors-Defendants.	

DECLARATION OF HENRY J. AARON, PhD., IN SUPPORT OF INTERVENORS-DEFENDANTS' OPPOSITION TO APPLICATION FOR PRELIMINARY INJUNCTION

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]

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

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

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

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

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 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

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[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

[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

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 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

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[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

[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

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 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

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[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

[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.

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 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

[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

[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

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.

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]

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

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

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

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 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]

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[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

[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

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 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

[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
[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.

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 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

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[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

[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

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 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

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[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

[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

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 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.

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[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

[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/

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 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

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[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.

[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

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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]

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

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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.

[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.

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 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]

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[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/

[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/.

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 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 –

[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,*

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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 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

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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.

[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/.

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 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

[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
[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

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.

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]

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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

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 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

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[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.

[85] Centers for Medicare & Medicaid Services, Medicare Diabetes Prevention Program (MDPP) Expanded Model, no date, https://innovation.cms.gov/initiatives/medicare-diabetes-prevention-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 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

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[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.

[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.

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 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;

[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
[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/.

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, 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

[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/

[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

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 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)

[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

[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.

(continued…)

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.

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,

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(…continued)
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.

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.

Minnesota

103. Between 2010 and 2015, an estimated 250,000 people in Minnesota gained coverage. This number includes a large fraction of the people covered in the Minnesota Health Insurance Marketplace (called MNsure), an estimated 38,000 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. Without the ACA up to 2,318,738 people in Minnesota have a pre-existing condition and would be at risk for being charged unaffordable premiums or denied coverage altogether. Before the ACA, 2,043,000 people in Minnesota with employer or individual market coverage had lifetime limits on their insurance policies: if the ACA were enjoined, annual and lifetime limits would surely return. An estimated 2,761,583 people in Minnesota, including 1,075,362 women ages 15–64, would lose the federal guarantee of preventive services — such as 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 who have benefitted from these provisions would pay more out of pocket for health coverage or go without it altogether. Many of the 90,146 people in Minnesota covered in the Health Insurance Marketplace would lose coverage without the ACA. In 2017, 70 percent of Marketplace enrollees in Minnesota received premium tax credits that averaged $5,220 per person. That financial assistance would no longer be available under an injunction.

106. **Impact on Medicaid:** Without the ACA, an estimated 36,000 fewer people in Minnesota 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, 5,100 fewer struggling to pay medical bills, 3,000 fewer experiencing symptoms of depression, and 40 avoided deaths each year in Minnesota. 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 944,222 people with Medicare in Minnesota would also lose benefits and pay more under an injunction than they now do. Prescription drug discounts, that saved 66,930 Minnesotans an average of $1,077 per beneficiary in 2016 would end. It would roll back the coverage of proven preventive services with no cost sharing which 604,022 people with Medicare in Minnesota used in 2016. It would suspend payment policies that have lowered premiums, cost sharing, and taxpayer costs in Minnesota. 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 1,435 fewer unnecessary returns to the hospital in Minnesota in 2015. The 8 Accountable Care Organizations (ACOs) in Minnesota 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 Minnesota would also be reduced under an injunction. Minnesota received $83,959,272 from the law's Prevention and Public Health Fund between fiscal years 2012 and 2016. This sum includes $18,224,535 for immunizations and $3,177,506 for tobacco cessation efforts.

109. **Impact on Finances:** The financial impact on Minnesota would be significant. From 2019 to 2028, Minnesota would lose $1.9 billion in federal Marketplace spending and $14.6 billion in federal Medicaid spending. The combined loss of federal spending over this period would be $16.4 billion. Such a reduction in spending would have a major impact on health care providers. From 2019 to 2028, Minnesota hospitals could lose $7.3 billion and physicians could lose $2.7 billion. Uncompensated care costs in Minnesota would increase by $24.5 billion over this period.

New Jersey

110. 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.

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 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.

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 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.

113. **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.

114. **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.

115. **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.

116. **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

117. 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.

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 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.

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 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.

120. **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.

121. **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.

122. **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.

123. **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

124. 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.

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 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.

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 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.

127. **Impact on Medicaid:** If North Carolina expanded Medicaid under the ACA, an estimated 313,000 people would gain Medicaid coverage. This coverage would improve access to care, financial security, and health. For example, it would result 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 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.

128. **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.

129. **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.

130. **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

131. 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.

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 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.

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 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.

134. **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.

135. **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.

136. **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.

137. **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

138. 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.

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 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.

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 29,065 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.

141. **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.

142. **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.

143. **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.

144. **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

145. 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.

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

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.

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 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.

148. **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.

149. **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.

150. **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.

151. **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

152. 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.

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 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.

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 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.

155. **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.

156. **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.

157. **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.

158. **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

159. 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.

160. **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.

161. **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.

162. **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.

163. **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.

164. **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.

165. **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.

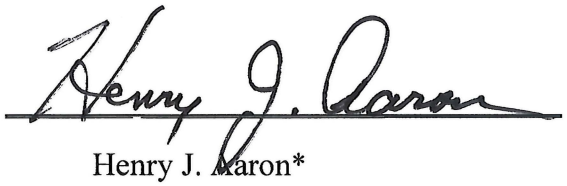
Conclusion

166. Based on my knowledge and experience, I believe that invalidating the Affordable Care Act would cause significant harm to the nation, across all States, to the economy and to the health insurance market. It would immediately end federal support for Medicaid coverage for nearly 12 million individuals in 32 states and the District of Columbia; it would deprive residents of the remaining states of the option to expand Medicaid coverage, an option that is under active debate in Virginia, Maine, and others, of broadening coverage in the future; it would reduce access to coverage for low and middle income Americans; it would increase drug costs. Further, the disruption caused by such an occurrence would cause immediate financial harm to medical providers and insurance companies, and significantly disrupt their ability to conduct business

across all healthcare markets, including individual, Medicaid and Medicare, and small group markets.

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

Executed on May 29, 2018, in Washington, D.C.



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, Governor Phil Bryant of the State of MISSISSIPPI, MISSOURI, NEBRASKA, NORTH DAKOTA, SOUTH CAROLINA, SOUTH DAKOTA, TENNESSEE, UTAH, WEST VIRGINIA, NEILL HURLEY and JOHN NANTZ, 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 by and through its Department of Commerce, NEW JERSEY, NEW YORK, NORTH CAROLINA, OREGON, RHODE ISLAND, VERMONT, VIRGINIA and WASHINGTON, Intervenors-Defendants.	

DECLARATION OF BENJAMIN BARNES IN SUPPORT OF INTERVENORS-DEFENDANTS' OPPOSITION TO APPLICATION FOR PRELIMINARY INJUNCTION

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.

This declaration is submitted in support of the Intervenors-Defendants' Opposition to Application for Preliminary Injunction. Based on my knowledge and experience, dismantling the Affordable Care Act would cause severe harm to the State of Connecticut, to its residents and to its economy. In addition to loss of benefits and services and federal investments to support Connecticut's healthcare system, dismantling or suspending implementation of the Affordable Care Act would cause harm and increased costs from the dismantling of the state's administrative structure and apparatus, created in compliance with, and to work in conjunction with, the Affordable Care Act " Connecticut projects costs of at least $3.2 million to change eligibility and issue notices, including the cost of system changes. While the cost of mailings to notify impacted individuals is projected to cost approximately $600,000, the cost to design, develop and implement the necessary system changes is projected to cost a minimum of $2.6 million. These figures do not

include state staff costs nor the potential cost of evaluating impacted individuals to determine eligibility for alternative coverage prior to termination.

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; $77.5 million through the Balancing Incentive Program; $11.3 million in enhanced reimbursement related to the behavioral health, health homes; and $21.8 million in enhanced reimbursement for the Children's Health Insurance Program (CHIP).
- 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 / CHIP) 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 State Plan option that enabled states to

provide payment for self-directed personal care attendants and other services without needing to apply for a waiver and which provided additional programmatic flexibility beyond that authorized under waivers; under the ACA, CFC also provides 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;

- 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; and
- The ACA expanded the permissible eligibility limits and scope of services under the section 1915(i) Home and Community-Based Services State Plan Option (which was an optional State Plan service initially established by the Deficit Reduction Act of 2005).

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 section 1945 of the Social Security Act whereby providers integrate and coordinate all primary, acute, behavioral health, and long-term services and supports to treat the

whole person. In addition to the increased programmatic options provided to health homes under the ACA, Connecticut also received federal reimbursement of 90% on behavioral health, health home expenditures during the first eight calendar quarters after the health home was established.

  - 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)

- Fully funded primary care provider rate increases in calendar years 2013 and 2014. These increases, 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.
- Broadened the scope of the preventive services benefit category in section 1905(a)(13)(C) of the Social Security Act to include services recommended by a physician or other licensed practitioner of the healing arts (previously, this benefit category was limited only to services actually provided by physicians and other licensed practitioners). The increased scope of this benefit category is crucial to enable appropriate coverage of services that are most effectively provided by a variety of practitioners and in a variety of settings (especially in home and community-based settings), particularly relevant for services that address behavioral health, substance use disorder, and/or developmental conditions.
  - This increased programmatic flexibility under this broadened Medicaid State Plan benefit category has enabled Connecticut to add coverage for Autism Spectrum Disorder services and is a key component of Connecticut's updated coverage of Early Intervention Services pursuant to Early and Periodic

Screening, Diagnostic and Treatment (EPSDT) services. Both of these services are primarily provided in the home and other community-based settings and permit broader access to early intervention services which are critical for school and social success and, to the degree feasible, ultimately independent living and integration within the community as adults.

- Established various optional State Plan services, demonstrations, and other flexibility that Connecticut is reviewing for potential future adoption. For example, Connecticut may elect to establish one or more additional health homes in the future and/or may establish coverage for one or more additional types of services under the ACA-broadened preventive services Medicaid State Plan benefit category.

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.

All of the foregoing benefits of the Affordable Care Act would be removed if the Plaintiffs' motion for preliminary injunction were granted. It would then be a policy decision for the next administration and/or legislature as to whether some of these programs are retained at state expense.

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

Executed on June 5, 2018, in Hartford, Connecticut.

Benjamin Barnes
Secretary
Connecticut Office of Policy and Management

Subscribed and sworn to before me
this 5th day of June, 2018

Signature of Notary Public
Date Commission Expires
Eleanor M. Michael
Printed Name of Notary Public

ELEANOR M. MICHAEL
NOTARY PUBLIC
MY COMMISSION EXPIRES JUNE 30, 2018

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, Governor Phil Bryant of the State of MISSISSIPPI, MISSOURI, NEBRASKA, NORTH DAKOTA, SOUTH CAROLINA, SOUTH DAKOTA, TENNESSEE, UTAH, WEST VIRGINIA, NEILL HURLEY and JOHN NANTZ, 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 by and through its Department of Commerce, NEW JERSEY, NEW YORK, NORTH CAROLINA, OREGON, RHODE ISLAND, VERMONT, VIRGINIA and WASHINGTON, Intervenors-Defendants.	

DECLARATION OF PETER BERNS IN SUPPORT OF INTERVENORS-DEFENDANTS' OPPOSITION TO APPLICATION FOR PRELIMINARY INJUNCTION

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.

4. 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 through 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.

5. 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.

6. 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.

7. 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 May 29, 2018, in Washington, DC.

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, Governor Phil Bryant of the State of MISSISSIPPI, MISSOURI, NEBRASKA, NORTH DAKOTA, SOUTH CAROLINA, SOUTH DAKOTA, TENNESSEE, UTAH, WEST VIRGINIA, NEILL HURLEY and JOHN NANTZ, 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
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DECLARATION OF SHARON C. BOYLE IN SUPPORT OF INTERVENORS-DEFENDANTS' OPPOSITION TO APPLICATION FOR PRELIMINARY INJUNCTION

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

1. I am the General Counsel for the Massachusetts Executive Office of Health and Human Services (EOHHS). Prior to April 15, 2018, I was the First Deputy General Counsel at the EOHHS 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. As General Counsel, I remain responsible to provide legal counsel to the MassHealth program. 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 or General 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.

7. If the Plaintiffs' motion for preliminary injunction is granted, the foregoing benefits of the ACA would be lost.

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

EXECUTED ON June 6, 2018.

Sharon C. Boyle
General Counsel
Executive Office of Health and Human Services
Commonwealth ofMassachusetts

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, Governor Phil Bryant of the State of MISSISSIPPI, MISSOURI, NEBRASKA, NORTH DAKOTA, SOUTH CAROLINA, SOUTH DAKOTA, TENNESSEE, UTAH, WEST VIRGINIA, NEILL HURLEY and JOHN NANTZ, 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
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DECLARATION OF SABRINA CORLETTE IN SUPPORT OF INTERVENORS-DEFENDANTS' OPPOSITION TO APPLICATION FOR PRELIMINARY INJUNCTION

I, Sabrina Corlette, declare:

1. I am a Research Professor at the Center on Health Insurance Reforms (CHIR) at Georgetown University's Health Policy Institute. At CHIR, I direct research on health insurance

reform issues. My areas of focus include state and federal regulation of private health insurance plans and markets and evolving insurance market rules. I have published numerous papers relating to the regulation of private health insurance and health insurance marketplaces. I also serve on the Standards Committee for the National Committee for Quality Assurance. Prior to joining the Georgetown faculty, I was Director of Health Policy Programs at the National Partnership for Women & Families, where I provided policy expertise and strategic direction for the organization's advocacy on health care reform, with a particular focus on insurance market reform, benefit design, and the quality and affordability of health care. I also served as an attorney at Hogan Lovells, during which time I advised clients on health insurance, health finance, and food and drug regulatory matters.

2. Since 2010, I have authored over 25 research papers about the Affordable Care Act and its implementation. I have been invited to testify as an Affordable Care Act expert before seven congressional committees (U.S. House of Representatives and U.S. Senate) in the last five years. The California General Assembly invited me in January 2018 to testify about the status of the individual health insurance market. I regularly provide technical assistance to state departments of insurance, state policymakers, and other health care organizations regarding Affordable Care Act regulations and guidance and their impact on consumers and other health care stakeholders. I am frequently consulted by journalists seeking Affordable Care Act expertise, and have been quoted numerous times on health insurance and Affordable Care Act issues in national and local print, radio, web-based, and television media. A full list of my publications and media is available on our website at https://chir.georgetown.edu.

3. I understand that this lawsuit involves a challenge to the Affordable Care Act and seeks to enjoin it. In my expert opinion, enjoining the Affordable Care Act would cause significant disruption to the U.S. health care market, resulting in harm to patients, providers, insurance carriers, and federal and state governments.

4. The Affordable Care Act was enacted in part to correct serious deficiencies in the individual health insurance market that left millions uninsured and millions more with

inadequate coverage that failed to protect them from serious financial harm if and when they got sick. In order to assess the effect the Affordable Care Act has had on the individual insurance market today, it is important to understand the market that Congress was seeking to change when it enacted the Affordable Care Act in 2010.

5. Prior to implementation of the Affordable Care Act's market reforms, approximately 48 million Americans lacked health insurance.[1] Those without health insurance have a lower life expectancy than those with coverage. Before the Affordable Care Act was enacted, an estimated 22,000 people per year died prematurely because they lacked insurance.[2] This is likely because the uninsured are more than six times as likely as the privately insured to delay or forego needed care due to costs. For example, uninsured cancer patients are more than five times more likely than their insured counterparts to forego cancer treatment due to cost.[3]

6. Being uninsured also results in financial insecurity. In 2010, when the Affordable Care Act was enacted, sixty percent of the uninsured reported having problems with medical bills or medical debt.[4]

7. Additionally, prior to the Affordable Care Act, the high and rising uninsured rate led to high and rising uncompensated care costs for providers, in 2009 estimated at $1000 worth of

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[1] DeNavas-Walt C, Proctor BD, Smith J. *Income, Poverty, and Health Insurance Coverage in the United States: 2012*, U.S. Census Bureau, Sept. 2013. Available at https://www.census.gov/prod/2013pubs/p60-245.pdf.

[2] Dorn S. *Uninsured and Dying Because of It,* The Urban Institute, Jan. 2008. Available at https://www.urban.org/sites/default/files/publication/31386/411588-Uninsured-and-Dying-Because-of-It.PDF.

[3] *Lives on the Line: The Deadly Consequences of Delaying Health Reform,* Families USA, Feb. 2010. Available at http://familiesusa.org/sites/default/files/product_documents/delaying-reform.pdf.

[4] Cunningham, P. and Sommers, A. *Medical Bill Problems Steady for U.S. Families 2007-2010,* Center for Studying Health System Change, Dec. 2011. Available at http://www.hschange.org/CONTENT/1268/?words=tracking%20report%2028.

services per uninsured person.[5] Providers ultimately passed those costs onto insured consumers and taxpayers.

8. Before the Affordable Care Act, approximately 19 million Americans purchased coverage in the individual insurance market because they lacked access to employer-based insurance or were not eligible for public programs such as Medicare or Medicaid.[6] The individual insurance market was an inhospitable place, particularly for anyone in less than perfect health. An estimated 133 million Americans have at least one pre-existing condition that could threaten their access to health care and health insurance.[7]

9. Prior to the Affordable Care Act, in most states, applicants for health insurance could be denied a policy because of their health status, or charged more in premiums based on their health and gender, along with a number of other factors. Insurers could also issue policies that didn't cover critical medical services like pharmacy benefits, mental health or substance use treatment, maternity, or any of the care required to treat a person's pre-existing condition. In addition, insurers often rescinded an individual's coverage if they got sick after enrolling in the plan, and many plans imposed annual or lifetime dollar limits on covered benefits.[8]

10. Prior to the Affordable Care Act, coverage was often simply not available to many individuals applying for coverage. One of the many ways insurers maximized revenue was through aggressive underwriting practices resulting in a denial of coverage to individuals posing

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[5] Hu, L. et al. *The Effect of the Patient Protection and Affordable Care Act Medicaid Expansions on Financial Wellbeing,* National Bureau of Economic Research, Feb. 2018. Available at http://www.nber.org/papers/w22170.

[6] DeNavas-Walt C, et al. *Income, Poverty, and Health Insurance Coverage in the United States: 2012.*

[7] 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, Jan. 2017. Available at https://aspe.hhs.gov/system/files/pdf/255396/Pre-ExistingConditions.pdf.

[8] Corlette S, Volk J, Lucia K. *Real Stories, Real Reforms*. Robert Wood Johnson Foundation, Sept. 2013. Available at https://georgetown.app.box.com/file/124506387872.

a potential health risk.[9] In most states, when an individual wanted to buy health insurance, they had to fill out and submit a voluminous application that included detailed information about their health history and status. Insurers would then review the individual's application and assess the likelihood he or she would incur future health costs. A Georgetown University study found that even people with minor health care conditions, such as hay fever, could be turned down for coverage.[10] Health insurers maintained underwriting guidelines that listed as many as 400 separate medical conditions that could trigger a denial of coverage.[11]

11. A U.S. Government Accountability (GAO) study in 2011 found that average insurer denial rates were 19 percent, but they varied dramatically market-to-market and insurer-to-insurer. For example, across six insurers in one state, denial rates ranged from 6 percent to 40 percent.[12] In practice, access to coverage for people with pre-existing conditions was probably less available than this study suggests, because of a common industry practice known as "street underwriting," in which an insurance agent or broker would ask a potential applicant questions about their health status, and discourage them from applying if they posed a health risk. These underwriting practices were banned by the Affordable Care Act in 2014.

12. Prior to the Affordable Care Act, it was not uncommon for insurers to rescind coverage after they had accepted an applicant. If an enrollee had any health care claims within their first

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[9] U.S. Government Printing Office, Senate Hearing 113-663. *A New, Open Marketplace: The Effect of Guaranteed Issue and New Rating Rules*, U.S. Senate Health, Education, Labor & Pension Committee, Apr. 11, 2013. Available at https://www.gpo.gov/fdsys/pkg/CHRG-113shrg95186/html/CHRG-113shrg95186.htm.

[10] Pollitz K, Sorian R. *How Accessible is Individual Health Insurance for Consumers in Less-than-perfect Health?* Georgetown University and Kaiser Family Foundation, Jun. 2001. Available at https://kaiserfamilyfoundation.files.wordpress.com/2013/01/how-accessible-is-individual-health-insurance-for-consumers-in-less-than-perfect-health-executive-summary-june-2001.pdf.

[11] U.S. Government Printing Office, Senate Hearing 113-663.

[12] U.S. Government Accountability Office. *Private Health Insurance: Data on Application and Coverage Denials*, Mar. 2011. Available at https://www.gao.gov/assets/320/316699.pdf.

year of coverage, the insurer would investigate that person's health history. If they found evidence that their condition was a pre-existing one and not fully disclosed during the initial underwriting process, the company would deny the relevant claims and rescind or cancel the coverage.[13] The Affordable Care Act prohibited this practice except in clear cases of fraud by the policyholder.

13. Prior to the Affordable Care Act, individual insurance was often unaffordable. Unlike those with employer sponsored coverage or in public programs like Medicare or Medicaid, people with individual insurance must pay the full cost of their premium. According to one national survey prior to the Affordable Care Act, 31 percent of individual market respondents spent 10 percent or more of their income on premium costs.[14]

14. Prior to the Affordable Care Act the cost of premiums caused many individuals to forego coverage completely. A national survey found that nearly three-quarters (73 percent) of people seeking coverage in the individual market did not end up buying a plan, most often because the premium was too high. The coverage was least affordable for those individuals who needed it the most – people with pre-existing conditions. The same national survey found that 70 percent of people with health problems reported it "very difficult" or "impossible" to find an affordable plan, compared to 45 percent of people in better health.[15]

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[13] Girion L. *Health Insurer Tied Bonuses to Dropping Sick Policyholders*, Los Angeles Times, Nov. 9, 2007. Available at http://articles.latimes.com/2007/nov/09/business/fi-insure9.

[14] Collins SR, Robertson R, Garber T, Doty MM. *Insuring the Future: Current Trends in Health Coverage and the Effects of Implementing the Affordable Care Act*, The Commonwealth Fund, Apr. 2013. Available at http://www.commonwealthfund.org/~/media/Files/Publications/Fund%20Report/2013/Apr/1681_Collins_insuring_future_biennial_survey_2012_FINAL.pdf.

[15] Doty MM, Collins SR, Nicholson JL, Rustgi SG. *Failure to Protect: Why the Individual Insurance Market Is Not a Viable Option for Most U.S. Families*, The Commonwealth Fund, Jul. 2009. Available at http://www.commonwealthfund.org/~/media/Files/Publications/Issue%20Brief/2009/Jul/Failure%20to%20Protect/1300_Doty_failure_to_protect_individual_ins_market_ib_v2.pdf.

15. Prior to the Affordable Care Act, older and less healthy individuals had to pay more for coverage because health insurers would segment their enrollees into different groups and charge them different prices based on their health or other risk factors. In practice, this meant that people would be charged more because of a pre-existing condition (even if they had been symptom-free for years), because of their age, gender (insurers assume women use more health care services than men), family size, geographic location, the work they do, and even their lifestyle.[16] A Georgetown University study of insurers' rating practices before the Affordable Care Act found rate variation of more than nine-fold for the same policy based on age and health status. In many states, people in their early sixties would be charged as much as six times the premium of someone in their early twenties, based on age alone. Even young people, when rated based on health status, could be subjected to significant premium costs.[17]

16. Under the Affordable Care Act, using health status and gender to set premium rates is prohibited. In addition, the Affordable Care Act provides low- and moderate-income people between 100 and 400 percent of the federal poverty line with subsidies to help defray their premium costs. In 2018, the average monthly premium tax credit is $550, resulting in an average monthly premium for consumers receiving a premium tax credit of $89.[18]

17. Prior to the Affordable Care Act, coverage in the individual market was often inadequate to meet people's health care needs. In addition to paying more in premiums, people in the

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[16] Buntin MB, Marquis MS, Yegian JM. *The Role Of The Individual Health Insurance Market And Prospects For Change*, Health Affairs, Nov./Dec. 2004. Available at https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.23.6.79.

[17] Pollitz K, Sorian R. *How Accessible is Individual Health Insurance for Consumers in Less-than-perfect Health?*

[18] Kaiser Family Foundation. *Marketplace Average Premiums and Average Advanced Premium Tax Credit (APTC)*, Open Enrollment 2018. Available at https://www.kff.org/health-reform/state-indicator/marketplace-average-premiums-and-average-advanced-premium-tax-credit-aptc/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.

individual market also spent a larger share of their income on cost-sharing than those with employer-sponsored coverage. Prior to the Affordable Care Act, people in the individual market were more than twice as likely to be considered "underinsured" than those in an employer plan.[19] Someone is considered "underinsured" when they have insurance but because of high deductibles, high cost-sharing, or non-covered benefits, the insurance offers inadequate financial protection for the health care services people need.

18. Prior to the Affordable Care Act, a primary reason people buying individual insurance coverage had high out-of-pocket costs was that many individual plans – over half according to one study – did not meet minimum standards for coverage.[20] Coverage in the individual market was inadequate for a number of reasons, including:

19. Pre-existing condition exclusions: in many states, insurers were permitted to permanently or for a period of time exclude from covered benefits treatments for any health problem that a consumer disclosed on their application. This practice was banned under the Affordable Care Act.

20. Benefit exclusions: Insurers in the individual market often sold policies that did not cover basic benefits such as maternity care, prescription drugs, mental health, and substance use treatment services. For example, 20 percent of adults with individual insurance lacked coverage for prescription medicines before the Affordable Care Act.[21] The Affordable Care Act requires individual market insurers to cover a minimum set of essential health benefits that includes maternity services, prescription drugs, and mental health and substance use treatment.

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[19] Collins SR, Robertson R, Garber T, Doty MM. *Insuring the Future: Current Trends in Health Coverage and the Effects of Implementing the Affordable Care Act.*

[20] Gabel JR et al. *More Than Half Of Individual Health Plans Offer Coverage That Falls Short Of What Can Be Sold Through Exchanges As Of 2014*, Health Affairs, Jun. 2012. Available at https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2011.1082.

[21] Doty MM, Collins SR, Nicholson JL, Rustgi SG. *Failure to Protect: Why the Individual Insurance Market Is Not a Viable Option for Most U.S. Families*

21. High out-of-pocket costs: Prior to the Affordable Care Act, individual insurance policies often came with high deductibles – $10,000 or more was not uncommon – and high cost-sharing. In fact, deductibles were often three times what they were in employer-sponsored plans.[22] As a result, many individual insurance plans were extremely low-value. One study found that individual policies paid for just 55 percent of the expenses for covered services, compared to 83 percent for small employer group plans.[23] The Affordable Care Act requires insurers to meet a minimum adequacy of coverage standard of 60 percent (meaning that on average, the plan must cover 60 percent of an average enrollee's covered health care costs). The law also helps protect consumers from catastrophic medical costs by capping their annual out-of-pocket spending (for 2018, the annual cap is $7350 per individual).

22. Lifetime or annual dollar limits on coverage: Prior to enactment of the Affordable Care Act, an estimated 102 million people were in plans with a lifetime limit on benefits and about 20,000 people hit those limits every year. An estimated 18 million people were in plans with annual dollar limits on their benefits. For people with serious high cost medical conditions, such as hemophilia, serious cancers, or end-stage renal disease, this can literally be a life or death issue. The Affordable Care Act ushered in bans on lifetime and annual dollar limits.

23. Among Congress' goals for the Affordable Care Act were to extend affordable, adequate health insurance coverage to more people and to correct many of the dysfunctions of the individual market, described above. Congress tried to achieve these goals through a three-pronged strategy:

24. (1) Insurance reforms to help people locked out of the system due to pre-existing conditions;

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[22] McDevitt R et al. *Group Insurance: A Better Deal For Most People Than Individual Plans*, Health Affairs, Jan. 2010. Available at https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2009.0060.

[23] Gabel J et al. *Trends In The Golden State: Small-Group Premiums Rise Sharply While Actuarial Values For Individual Coverage Plummet*, Health Affairs, Jul./Aug. 2007. Available at https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.26.4.w488.

25. (2) An individual mandate to encourage healthy people to enroll in the insurance pool and keep premiums stable; and

26. (3) Subsidies to help people afford the insurance coverage (with Medicaid expansion available for people under 138 percent of the federal poverty line). The Affordable Care Act also created state-based insurance marketplaces where people can apply for the subsidies and shop for plans.

27. To a significant degree, the Affordable Care Act has achieved its goals. It has expanded access to insurance coverage, improved health outcomes, and improved families' financial security.

28. Under the Affordable Care Act, the percentage of people uninsured declined from 14.5 percent in 2013 to 9.1 percent in 2017. An estimated 20 million people gained insurance coverage because of the Affordable Care Act.[24]

29. The goal of expanding coverage is ultimately to improve people's health outcomes and their financial security in the event of an unexpected illness or injury. The Affordable Care Act's reforms were fully implemented in 2014, so it is still relatively early to try to assess the law's impact on access to care, health outcomes, and financial security. However, data are emerging to suggest the law is having a significant positive impact.

30. Since enactment of the Affordable Care Act, the percentage of Americans reporting that they didn't see a doctor or fill a prescription because they couldn't afford it has declined by more

[24] Cohen RA, Zammitti EP, Martinez ME. *Health Insurance Coverage: Early Release of Estimates From the National Health Interview Survey, 2017*, Centers for Disease Control and Prevention, National Center for Health Statistics, May 2018. Available at https://www.cdc.gov/nchs/data/nhis/earlyrelease/insur201805.pdf.

than one-third.[25] Further, more people are reporting that they have a primary care doctor or have had a check-up in the last 12 months.[26]

31. Research to date also strongly suggests that expanding access to coverage leads to better health outcomes. For example, studies of the health reforms in Massachusetts, upon which the Affordable Care Act was modeled, have found that coverage expansion in that state led to reported improvements in physical and mental health, as well as reductions in mortality.[27] A Harvard study found that expanded coverage under the Affordable Care Act was linked to major improvements in the diagnosis and treatment of chronic diseases such as hypertension, diabetes, and high cholesterol.[28]

32. In addition to improving access to care, health insurance also provides financial security, particularly in the event of a large, unanticipated medical expense. Unfortunately, in this country, health care is extremely expensive. For example, the average cost of a single MRI is $1,119. An uncomplicated hospital labor and delivery costs an average of $10,808, while a C-section will average over $16,000. One course of treatment for colon cancer will cost between $21,000 and

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[25] McCarthy, J. *U.S. Women More Likely Than Men to Put Off Medical Treatment,* Gallup, Dec. 2017. Available at http://news.gallup.com/poll/223277/women-likely-men-put-off-medical-treatment.aspx.

[26] Karpman, M. et al. *Time for a Checkup: Changes in Health Insurance Coverage, Health Care Access and Affordability, and Plan Satisfaction among Parents and Children between 2013 and 2015,* Urban Institute, Jan. 2016. Available at http://hrms.urban.org/briefs/changes_coverage_access_affordability_parents_children.pdf .

[27] Van Der Wees, PJ, et al. *Improvements In Health Status After Massachusetts Health Care Reform,* National Center for Biotechnology Information, Dec. 2013. Available at https://www.ncbi.nlm.nih.gov/pubmed/24320165.

[28] Hogan DR et al. *Estimating The Potential Impact Of Insurance Expansion On Undiagnosed And Uncontrolled Chronic Conditions*, Health Affairs, Sept. 2015. Available at https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2014.1435.

$52,000. Yet over half of American families report that they would not be able to afford to pay just $500 in cash for an unexpected expense.[29]

33. Research suggests that the Affordable Care Act is helping to improve the financial security of the newly insured. Survey data show that the number of families who say they are having problems paying medical bills has fallen dramatically since 2013, particularly among low- and moderate-income families.[30] Other studies have shown that the Affordable Care Act's Medicaid expansion has led to reductions in the amount of debt sent to collection agencies and improvements in families' credit scores.[31]

34. The Affordable Care Act has also helped reduce uncompensated care costs borne by providers. For example, hospital-based uncompensated care fell by over 25 percent between 2013 and 2015, and in Medicaid expansion states it has fallen by closer to 50 percent.[32]

35. Unfortunately, much of the progress under the Affordable Care Act is at risk due to recent federal policy decisions designed to roll back key provisions of the law and bypass consumer protections. Ultimately, some of these decisions are likely to result in many consumers facing higher premiums and fewer plan choices in the individual insurance market.

36. A stable health insurance market depends on a large risk pool that is reasonably balanced between healthy individuals and sicker ones. The Affordable Care Act had a "three-prong"

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[29] Picchi A, A $500 Surprise Expense Would Put Most Americans into Debt, CBS MoneyWatch, Jan. 2017. Available at https://www.cbsnews.com/news/most-americans-cant-afford-a-500-emergency-expense/.

[30] Karpman, M and Long, S. *9.4 Million Fewer Families Are Having Problems Paying Medical Bills,* Urban Institute, May 2015. Available at http://hrms.urban.org/briefs/9-4-Million-Fewer-Families-Are-Having-Problems-Paying-Medical-Bills.pdf.

[31] Hu, L. et al. *The Effect of the Patient Protection and Affordable Care Act Medicaid Expansions on Financial Wellbeing,* National Bureau of Economic Research, Feb. 2018. Available at http://www.nber.org/papers/w22170.

[32] Schubel, J and Broaddus, M. *Medicaid Waivers That Create Barriers to Coverage Jeopardize Gains*, May 2018. Available at https://www.cbpp.org/research/health/uncompensated-care-costs-fell-in-nearly-every-state-as-acas-major-coverage.

strategy designed to facilitate such a stable insurance market by requiring all participating insurers to play by the same rules and, through subsidies and the individual mandate, encourage healthy people to become insured before they get sick.

37. The Affordable Care Act marketplaces had a rocky early start, but that was not unexpected given that insurers had little knowledge of the new population of people they were covering, leading many to make significant adjustments to their business strategy as they gained more experience and data about their enrollees. In addition, unanticipated Congressional actions, such as the dramatic reduction in funding for a key premium stabilization program (the "risk corridor" program) resulted in significant financial losses for many insurers.

38. Specifically, the Affordable Care Act included three programs intended to ensure that premiums remain stable, both during the initial years of the law's implementation and over the long term. These are the risk corridors, reinsurance, and risk adjustment programs – often called the "3Rs." The risk corridor program in particular was a temporary program designed to provide a buffer for insurers that did not adequately price their plans due to a lack of data about the health risk of the newly insured population in the Affordable Care Act marketplaces.

39. The risk corridor program works by requiring the federal government (through the U.S. Department of Health & Human Services or HHS) to partially reimburse insurers whose premium revenue was insufficient to pay claims. Insurers whose premium revenue exceeded their claims were required to pay HHS a fraction of the excess premium.[33]

40. In the first two years of the Affordable Care Act marketplaces, many insurers set relatively low premiums in order to capture more market share. In late 2014, long after insurers' pricing decisions were made, a Congressional appropriations bill dramatically limited the funds available to HHS to compensate insurers for significant losses.[34]

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[33] 42 U.S.C. §18062.

[34] Pub. L. No. 113-235.

41. Because more insurers experienced losses than gains in the first two years of the marketplaces, HHS was able to pay insurers only 12.6 percent of the risk corridor payments they were owed.[35] This decision had a serious financial impact on insurers, resulting in an estimated $12.3 billion in losses,[36] and likely accelerated the demise of several small, non-profit CO-OP health plans.[37]

42. The loss of risk corridor funds contributed to the significant premium increases many insurers implemented for plan year 2016. However, it is noteworthy that premiums in the individual market were still often below or close to those in the employer-sponsored insurance market in 2016.[38] Given that Affordable Care Act individual market benefit plans are designed to be similar to a typical employer plan, this suggests that during the first two years of the Affordable Care Act marketplaces (2014 and 2015), many insurers had underpriced their products in an effort to gain market share. Many of these same insurers subsequently left the

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[35] Department of Health and Human Services, Risk Corridors Payment Proration Rate for 2014, Oct. 1, 2015, https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/RiskCorridorsPaymentProrationRatefor2014.pdf.

[36] Small L. *Government's unpaid risk corridor tab swells to $12.3B*, FierceHealthcare, Nov. 2017. Available at https://www.fiercehealthcare.com/aca/government-s-unpaid-risk-corridor-tab-swells-to-12-3b.

[37] Corlette S, Miskell S, Lerche J, Lucia K. *Why are Many CO-OPs Failing? How New Non-profit Health Plans Have Responded to Market Competition*, The Commonwealth Fund, Dec. 2015. Available at http://www.commonwealthfund.org/~/media/files/publications/fund-report/2015/dec/1847_corlette_why_are_many_coops_failing.pdf.

[38] Holahan J, Blumberg LJ, Clemans-Cope L, McMorrow S, and Wengle E. *The Evidence on Recent Health Care Spending Growth and the Impact of the Affordable Care Act*, The Urban Institute and Robert Wood Johnson Foundation, May 2017. Available at https://www.urban.org/sites/default/files/publication/90471/2001288-the_evidence_on_recent_health_care_spending_growth_and_the_impact_of_the_affordable_care_act.pdf.

Affordable Care Act market because they were unable to compete with insurers that had been more successful in projecting a premium rate that would allow them to cover their costs.[39]

43. Going into plan year 2017, financial data from insurers demonstrate that the markets were beginning to stabilize and insurers were gaining their footing.[40] Indeed, in 2017 the Congressional Budget Office concluded that the Affordable Care Act's insurance markets would likely be stable in most places if left unchanged.[41] Consistent with this projection, 2017 appears to have been a profitable year for most individual market insurers.[42]

44. Unfortunately, my own review of insurers premium rate justifications (referred to as actuarial memoranda) for plan years 2018 and 2019 found that recent policy changes are putting the stability of the individual market at risk.[43] Specifically:

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[39] *See e.g.*, Sprung A, *Why Insurers Thrive (Or Dive) in ACA Marketplaces*, healthinsurance.org, Apr. 2016. Available at https://www.healthinsurance.org/blog/2016/04/28/why-insurers-thrive-or-dive-in-aca-marketplaces/.

[40] Banerjee D. *The ACA Individual Market: 2016 Will Be Better Than 2015, But Achieving Target Profitability Will Take Longer*, S&P Global Ratings, Dec. 2016. *See also* Herman B. *How some Blues made the ACA work while others failed*. Modern Healthcare. October 15, 2016. Available at www.modernhealthcare.com/article/20161015/MAGAZINE/310159989.

[41] *H.R. 1628 American Health Care Act of 2017,* Congressional Budget Office, May 2017. Available at https://www.cbo.gov/system/files/115th-congress-2017-2018/costestimate/hr1628aspassed.pdf.

[42] Cox C, Semanskee A, Levitt L. Individual Insurance Market Performance in 2017, Kaiser Family Foundation, May 2018. Available at http://files.kff.org/attachment/Issue-Brief-Individual-Insurance-Market-Performance-in-2017.

[43] *See* Corlette S. *The Effects of Federal Policy: What Early Premium Rate Filings Can Tell Us About the Future of the Affordable Care Act*, CHIRblog, May 2018. Available at http://chirblog.org/what-early-rate-filings-tell-us-about-future-of-aca/; Corlette S. *We Read Actuarial Memoranda so You Don't Have to: Trends from Early Health Plan Rate Filings*, CHIRblog, Jun. 2017. Available at http://chirblog.org/we-read-actuarial-memoranda-so-you-dont-have-to/; Corlette S. Proposed Premium Rates for 2018: What do Early Insurance Company Filings Tell Us? CHIRblog, May 2017. Available at http://chirblog.org/proposed-premium-rates-for-2018-what-do-early-filings-tell-us/.

45. The Trump administration's decision in October of 2017 to cut off reimbursement to insurers for low cost-sharing plans (called cost-sharing reduction or CSR plans) resulted in significant premium increases in 2018. Additionally, the uncertainty about that decision, which the President had been threatening for months, was a contributing factor for some insurers to either exit the marketplaces or reduce their service areas.

46. For example, in its 2018 rate filing in Virginia, Anthem informed the state: "A lack of CSR funding introduces a level of volatility which compromises the ability to set rates responsibly. It has been estimated that lack of CSR funding could increase premium rates for Silver plans an additional 20 percent…" Anthem went on to say that if CSR reimbursements were not guaranteed for 2018, it would consider exiting the marketplaces, reducing service areas, or requesting additional rate increases.

47. Additionally, although Congress did not zero out the individual mandate penalty until 2019, many insurers increased premiums for 2018 coverage on the expectation that the Trump administration would not enforce the individual mandate. For example, in its Maryland filing for 2018, CareFirst Blue Cross BlueShield stated: "we have assumed that the coverage mandate introduced by the ACA will not be enforced in 2018 and that this will have the same impact as repeal. Based on industry and government estimates as well as actuarial judgment, we have projected that this will cause morbidity to increase by an additional 20%."

48. Other insurers are projecting the effect of the individual mandate repeal to be felt in 2019. For example, Kaiser Foundation Health Plan projects that premiums will need to increase 32.1 percent in Virginia. "The primary cause," the company reports, is "related to nonenforcement of the Individual Mandate."

49. Similarly, insurers increased premiums due to the Trump administration's decision to decrease spending on marketplace advertising and consumer assistance, which are critical for educating and enrolling the healthy uninsured. For example, a Cigna filing for 2018 noted that they expected a smaller and sicker population in their risk pool due to the lower "overall awareness of individual health insurance products."

50. Going into 2019, insurers are also predicting that their risk pools will be smaller and sicker due to "potential movement into other markets." These markets include association health plans and short-term, limited duration insurance, both of which are exempt from many of the Affordable Care Act's consumer protections and are being promoted by the Trump administration as cheaper alternative coverage. For example, insurers such as Optima and CareFirst in Virginia note that the "availability of association health plans and expanded availability of short-term medical plans" was affecting their rate projections, with CareFirst adding 10 percent to its premium increase as a result.

51. Individuals who are eligible for the Affordable Care Act's premium tax credits are largely insulated from these premium increases because the tax credit rises, dollar for dollar, with the increase in premium for silver level health plans. The people who suffer the most from these premium increases are the working middle class: entrepreneurs who run their own businesses, freelancers and consultants, independent contractors, farmers and ranchers, and early retirees who earn too much to qualify for the Affordable Care Act's premium subsidies.

52. Granting the plaintiffs' request to enjoin the Affordable Care Act amounts to an effort to repeal the law without any clear public policy to replace it. Congress explicitly rejected repealing the Affordable Care Act without a replacement last year. This is because uprooting a complex law that has been in place for over eight years, touches almost every facet of our health care system, and includes many provisions with widespread bipartisan support (such as allowing young adults to stay on their parents' plans until age 26, closing the Medicare drug benefit "donut hole," and expanding Medicaid) will inevitably result in dramatic negative consequences, some of which are predictable, and outlined below.

53. First, millions of individuals will lose their insurance coverage. In 2017, the Congressional Budget Office and Joint Committee on Taxation estimated that repealing the

Affordable Care Act without implementing a replacement would result in 32 million people losing coverage by 2026, with 17 million people losing coverage in the first year after repeal.[44]

54. Second, those remaining in the individual market would see their premiums roughly double. The Congressional Budget Office estimated that individual market premiums would increase by 25 percent in the first year after repeal, by 50 percent by 2020, and almost double by 2026.[45] These premium increases are largely the result in the elimination of the individual mandate and the Affordable Care Act premium subsidies, resulting in fewer healthy individuals enrolling in individual market coverage and a costlier risk pool for insurers.

55. Third, even a partial repeal of the provisions of the Affordable Care Act would primarily harm working middle class Americans. The majority of people losing coverage – as many as 82 percent – would be in working families. Over half would be non-Hispanic whites, and up to 80 percent would not have college degrees. Thirty-eight percent would be young adults between ages 18 and 34.[46]

56. Fourth, repealing the Affordable Care Act will have significant negative consequences for public health and safety. For example, the Pennsylvania Budget and Policy Center found that repealing the Medicaid expansion and Affordable Care Act tax credit subsidies would result in 3,425 premature deaths each year in that state alone.[47] Researchers from Harvard and New York University found that repealing the Affordable Care Act would result in 1.25 million Americans

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[44] Congressional Budget Office. *Cost Estimate: H.R. 1628, Obamacare Repeal Reconciliation Act of 2017*, Jul. 2017. Available at https://www.cbo.gov/system/files/115th-congress-2017-2018/costestimate/52939-hr1628amendment.pdf.

[45] *Id*.

[46] Blumberg L, Buettgens M, Holahan J. *Implications of Partial Repeal of the ACA Through Reconciliation*, Urban Institute, Dec. 2016. Available at https://www.urban.org/sites/default/files/publication/86236/2001013-the-implications-of-partial-repeal-of-the-aca-through-reconciliation_1.pdf.

[47] Stier M. *Devastation, Death, and Deficits: The Impact of ACA Repeal on Pennsylvania*, Pennsylvania Budget and Policy Center, Jan. 2017. Available at https://pennbpc.org/sites/pennbpc.org/files/Impact_of_ACA_Repeal_Final.pdf.

with serious mental conditions losing coverage. They further estimate that 2.8 million Americans with a substance use disorder, including roughly 222,000 with an opioid-related disorder, would lose coverage.[48]

57. Fifth, repealing the Affordable Care Act will drive insurance companies out of the individual market. The Congressional Budget Office estimated that legislation repealing the Affordable Care Act would leave an estimated three-fourths the nation's population in areas where no insurers are willing to offer nongroup coverage by 2026.[49] These estimates align with my own research at Georgetown, in which colleagues and I conducted interviews with 13 health insurance company executives participating in the individual markets in 28 states. In those interviews, executives told us they would "seriously consider" a market withdrawal; they further told us that a bill repealing the Affordable Care Act without an immediate replacement would destabilize the market and create "significant" downside financial risk for those companies remaining.[50]

58. Sixth, an increase in the uninsured will impose significant financial harm on hospitals and other health care providers. For example, repealing the Affordable Care Act without a replacement was estimated to cost the nation's public hospitals $54.2 billion in uncompensated care charges between 2018 and 2026.[51] The Iowa Fiscal Partnership estimated that Affordable

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[48] Frank RG, Glied SA. *Keep Obamacare to Keep Progress on Treating Opioid Disorders and Mental Illnesses*, The Hill, Jan. 2017. Available at http://thehill.com/blogs/pundits-blog/healthcare/313672-keep-obamacare-to-keep-progress-on-treating-opioid-disorders.

[49] Congressional Budget Office. *Cost Estimate: H.R. 1628, Obamacare Repeal Reconciliation Act of 2017*, Jul. 2017.

[50] Corlette S, Lucia K, Giovannelli J, Palanker D. Uncertain Future for Affordable Care Act Leads Insurers to Rethink Participation, Prices, Georgetown University and Robert Wood Johnson Foundation, Jan. 2017. Available at https://georgetown.app.box.com/file/127781433019.

[51] America's Essential Hospitals. *ACA Replacement Must Protect Vulnerable People, Communities*, Feb. 2017. Available at https://essentialhospitals.org/wp-content/uploads/2017/02/UCC-policy-brief-February-2017-FINAL.pdf.

Care Act repeal would result in a $10 billion increase in the cost of uncompensated care in that state alone, with most of the burden borne by rural hospitals.[52]

59. Seventh, repeal of the Affordable Care Act would lead to significant negative economic consequences. For example, repealing just the Medicaid expansion and Affordable Care Act tax credits would result in an estimated loss of 2.6 million jobs across the country.[53] State-specific analyses align with these findings. For example, the University of California at Berkley's Center for Labor Research and Education found that just a partial repeal of the Affordable Care Act would cause California to suffer 209,000 lost jobs, $20.3 billion in lost gross domestic product, and $1.5 billion lost in state and local tax revenue.[54] Arizona State University's Seidman Research Institute similarly found that if Arizona lost federal Affordable Care Act funding, it would leave a $5 billion dent in the state's economy, cost over 62,000 jobs state wide, and lower personal income by almost $3.5 billion.[55]

60. Eighth, and finally, a full repeal of the Affordable Care Act would not only harm the individual insurance market. Other programs would be harmed as well. For example, repealing

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[52] Fisher P. *Repealing ACA: Pushing thousands of Iowans to the brink, Iowa Fiscal Partnership*, Jan. 2017. Available at http://www.iowafiscal.org/wp/wp-content/uploads/2017/01/170119-IFP-ACA.pdf.

[53] Ku L, Steinmetz E, Brantley E, Bruen B. *Repealing Federal Health Reform: Economic and Employment Consequences for States*, The Commonwealth Fund, Jan. 2017. Available at http://www.commonwealthfund.org/~/media/files/publications/issue-brief/2017/jan/ku-aca-repeal-job-loss/1924_ku_repealing_federal_hlt_reform_ib.pdf.

[54] Lucia L and Jacobs K. *California's Projected Economic Losses under ACA Repeal*, UC Berkeley Center for Labor Research and Education, Dec. 2016.

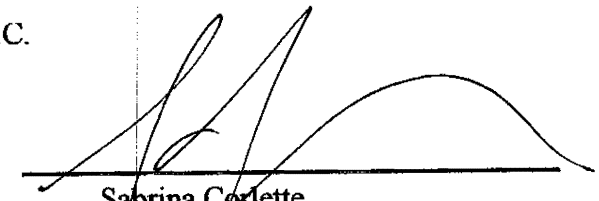
[55] Seidman Research Institute, W.P. Carey School of Business. *Economic Impact on Arizona Of Repeal of Funding Provisions Of the Affordable Care Act*, Arizona State University, Jan. 2017. Available at http://azchildren.org/wp-content/uploads/2017/05/ACA-Impact-Feb-6-.pdf.

the law is estimated to accelerate the insolvency of the Medicare Hospital Insurance Trust Fund (Part A) by five years, from 2026 to 2021.[56]

61. The plaintiff's suggestion that the Affordable Care Act be enjoined ignores the serious negative consequences of an action that would be tantamount to repealing the law without any clear federal policy to replace it. When such a strategy was proposed last year to Congress, it was rejected because of the serious economic and public health harms that would result, including: millions of Americans losing coverage, premiums doubling, insurers exiting the market, and the costs of uncompensated care putting providers at serious financial risk. Repeal-without-replace would also result in heavy job and productivity losses. These are serious adverse repercussions that should not be taken lightly.

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

Executed on June 5, 2018 in Washington, D.C.



Sabrina Corlette
Research Professor
Center on Health Insurance Reforms

[56] Committee for a Responsible Federal Budget. *Full Repeal of Obamacare Would Hasten Medicare's Insolvency*, Apr. 2017. Available at http://www.crfb.org/blogs/full-repeal-obamacare-would-hasten-medicares-insolvency.

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, Governor Phil Bryant of the State of MISSISSIPPI, MISSOURI, NEBRASKA, NORTH DAKOTA, SOUTH CAROLINA, SOUTH DAKOTA, TENNESSEE, UTAH, WEST VIRGINIA, NEILL HURLEY and JOHN NANTZ, 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 by and through its Department of Commerce, NEW JERSEY, NEW YORK, NORTH CAROLINA, OREGON, RHODE ISLAND, VERMONT, VIRGINIA and WASHINGTON, Intervenors-Defendants.	

DECLARATION OF JAMES DEBENEDETTI IN SUPPORT OF INTERVENORS-DEFENDANTS' OPPOSITION TO APPLICATION FOR PRELIMINARY INJUNCTION

I, James DeBenedetti declare:

1. I am the Director of the Plan Management Division for Covered California. I have worked for Covered California for three years. The fact stated herein are of my own personal knowledge, and I could and would competently testify to them.

2. Covered California is the state agency created to implement the Patient Protection and Affordable Care Act (ACA)and establish a Health Benefit Exchange in California.

3. The ACA increased access to affordable coverage in the State of California.

- The ACA expanded coverage through federal health subsidies to purchase coverage in new health insurance Exchanges for those individuals with low to moderate incomes. California built its own state-based Exchange, Covered California, for the individual and small group markets with federal grants in the amount of 1,065,213,056.
- Since its creation, 3,570,000 individuals have gained access to coverage using Covered California.
- The Exchanges are an important reform made by the ACA. As of March 2018, 1,417,248 individuals were enrolled through Covered California. 1,231,166 of those individuals received federal subsidies, worth an estimated $6.5 billion dollars for the 2018 plan year alone, to make that coverage more affordable. This equates to approximately 87% of enrollees receiving a federal subsidy through Covered California.
- Covered California receives funding from a percent of premium assessment on health plans participating in Covered California. In 2018, for the individual market, that fee was 4% percent of premium. In 2019, that fee will be 3.75% percent of the monthly premium. This assessment helps pay for Covered California's operations, including marketing and outreach to consumers. This assessment also funds the Navigator program to assist individuals with enrolling in coverage through Covered California.

4. The loss of federal subsidies available through the ACA would cause consumers to lose access to affordable health coverage through Covered California.

- Enjoining the ACA would harm Covered California and the consumers that have gained access to coverage as a result of the ACA. Based on my knowledge and experience, dismantling the Affordable Care Act (ACA) would cause a loss of benefits, services and initial grant funds invested to support Covered California, and would cause severe harm to the State of California, to its residents and to its economy. Without federal subsidies to lower the cost of health care coverage, the

1,231,166 consumers who are receiving these subsidies will face significant premium increases and many will lose access to much needed health care coverage as a result.

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

Executed on June 6, 2018, in Sacramento, California.

James DeBenedetti
Director, Plan Management Division
Covered California

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, Governor Phil Bryant of the State of MISSISSIPPI, MISSOURI, NEBRASKA, NORTH DAKOTA, SOUTH CAROLINA, SOUTH DAKOTA, TENNESSEE, UTAH, WEST VIRGINIA, NEILL HURLEY and JOHN NANTZ, 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 by and through its Department of Commerce, NEW JERSEY, NEW YORK, NORTH CAROLINA, OREGON, RHODE ISLAND, VERMONT, VIRGINIA and WASHINGTON, Intervenors-Defendants.	

DECLARATION OF ALFRED J. GOBEILLE IN SUPPORT OF INTERVENORS-DEFENDANTS' OPPOSITION TO APPLICATION FOR PRELIMINARY INJUNCTION

I, Alfred J. Gobeille, declare:

1. I am the Secretary of the Vermont Agency of Human Services (AHS). I have served in this position since January 2017. I have either personal knowledge of the matters set forth

below or, with respect to those matters for which I do not have personal knowledge, I have reviewed information gathered from AHS records and other publicly available information. This declaration is submitted in support of the Intervenor-States' Opposition to the Motion for Preliminary Injunction. Based on my knowledge and experience, dismantling the Affordable Care Act (ACA) would cause severe harm to the State of Vermont, to its residents, and to its economy. In addition to loss of benefits and services and federal investments to support Vermont's healthcare system, dismantling or suspending implementation of the ACA would cause Vermont to experience harm and increased costs from the dismantling of the State's own administrative structure and apparatus, created in compliance with, and to work in conjunction with, the Affordable Care Act.

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

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

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

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

- Overall the number of individuals with insurance has increased. In Vermont, the number of covered individuals increased from 583,674 in 2012 to 603,400 in 2014, according to the Vermont Household Health Insurance Survey (VHHIS). Over the same period, the number of uninsured Vermonters was nearly cut in half, dropping from 42,760 in 2012 to 23,231 in 2014. This correlates to an uninsured rate of 6.8% in 2012 and 3.7% in 2014. While the next VHHIS won't be completed until the second half of 2018, the U.S. Census has estimated that the number of uninsured Vermonters remained down in the 23,000 range in 2015 and 2016.
- The ACA expanded coverage through two key mechanism: Medicaid expansion for those individuals with the lowest incomes, and federal health subsidies to purchase coverage in new health insurance Exchanges, like Vermont Health Connect, for those individuals with moderate incomes.
- Medicaid is an important source of healthcare insurance coverage and has resulted in significant coverage gains and reduction in the uninsured rate, both among the low-income population and within other vulnerable populations. Vermont can be described as a "pre-expansion" state in the sense that it offered state health programs—the Vermont Health Access Plan and Catamount Health—to Vermonters with incomes up to 300% FPL years before Medicaid expansion. The change in Medicaid eligibility under the ACA from considering assets to only focusing on income also benefitted farmers and other land rich, cash poor Vermonters who previously could not afford health insurance and did not qualify for benefits but now qualify either for Medicaid or for health insurance subsidies. The uninsured rate for Vermonters with income up to 138% FPL (the expanded Medicaid threshold) dropped from 9.6% in 2012 to 5.0% in 2014, and the state's overall uninsured rate dropped from 6.8% in 2012 and 3.7% in 2014.
- Creation of health insurance exchanges is an important reform made by the ACA. In Vermont, 23,554 people have received federally subsidized coverage in 2018 as a result of the ACA.

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

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

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

- In 2011, Vermont was awarded a five-year $17.9 million Money Follows the Person (MFP) grant from CMS to help people living in nursing facilities overcome the barriers that have prevented them from moving to their preferred community-based setting. The grant works within the Choices for Care program and provides participants the assistance of a Transition Coordinator and up to $2,500 to address barriers to transition.
- Effective April 1, 2016, Vermont received a continued $8 million award for services through September 30, 2019.

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

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

1115 waiver (January 1, 2017-December31, 2021), which specifically allows Vermont Medicaid to enter into ACO arrangements that align in design with that of other healthcare payers in support of the Vermont All-payer ACO Model. The pilot now includes over 5,000 providers.

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

- The ACA created robust consumer protections to help ensure individuals can access the healthcare system.
    - Largely due to the ACA's provision that adult children can be covered by their parents' health plan until age 26, the number of uninsured young adults in Vermont between the ages of 18 and 24 was slashed from 10,839 in 2009 to 2,920 in 2014;
    - More than 79,000 Vermonters enrolled in qualified health plans as of February 2018 are benefitting from the ACA's mandated preventive services including access to birth control, cancer screenings, and immunizations for children;
    - More than 79,000 Vermonters enrolled in qualified health plans as of February 2018 are benefitting from access to essential health benefits such as substance use disorder treatment and cancer screenings.
- The ACA has led to improved access to care (39% drop in the number of individuals who needed medical care from a doctor but did not receive it because they could not afford it, 45% drop in individuals who skipped medications because they could not afford it).
- The ACA has led to improved financial security for Vermont families. The number of Vermonters who had trouble paying medical bills fell more than 30,000 from 2009 to 2014, a 20% drop. In addition, the number of Vermonters who were contacted by a collection agency about owing money for unpaid medical bills fell by 16% over the same period.

- In addition, the ACA created additional consumer protections and rights such as:
  - Under the ACA, no individual can be rejected by an insurance plan or denied coverage of essential health benefits for any health condition present prior to the start of coverage. Once enrolled, plans cannot deny coverage or raise rates based only on the enrollee's health.

9. The foregoing benefits of the ACA could be removed if Plaintiffs' motion for a preliminary injunction were granted.

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

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

Alfred J. Gobeille
Secretary, Vermont Agency of Human Services

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

TEXAS, WISCONSIN, ALABAMA, ARKANSAS, ARIZONA, FLORIDA, GEORGIA, INDIANA, KANSAS, LOUISIANA, PAUL LePAGE, Governor of Maine, Governor Phil Bryant of the State of MISSISSIPPI, MISSOURI, NEBRASKA, NORTH DAKOTA, SOUTH CAROLINA, SOUTH DAKOTA, TENNESSEE, UTAH, WEST VIRGINIA, NEILL HURLEY and JOHN NANTZ, **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 by and through its Department of Commerce, NEW JERSEY, NEW YORK, NORTH CAROLINA, OREGON, RHODE ISLAND, VERMONT, VIRGINIA and WASHINGTON, **Intervenors-Defendants.**	

DECLARATION OF CAROLE JOHNSON IN SUPPORT OF INTERVENORS-DEFENDANTS' OPPOSITION TO APPLICATION FOR PRELIMINARY INJUNCTION

I, Carole Johnson, declare:

1. I am the Commissioner of the New Jersey Department of Human Services. I previously served in the White House as senior health policy advisor and member of the Domestic Policy Council health team where I worked to increase health insurance coverage for millions of Americans, improve services and choices for individuals with disabilities, expand supports for older Americans, increase coverage of mental health and substance use disorder treatment, and improve health and economic security for all Americans. I also served on Capitol Hill working for the U.S. Senate Special Committee on Aging and for members of the U.S. Senate Finance Committee and U.S. House of Representatives Ways and Means Committee. In addition, I managed health care workforce policy issues for the U.S. Department of Health and Human Services' Health Resources and Services Administration.

2. The Department of Human Services is New Jersey's largest state agency, and it has overseen the distribution of New Jersey's Medicaid funds since January 1, 1970. The Department's Division of Medical Assistance and Health Services ("DMAHS") administers Medicaid and the Children's Health Insurance Program, which cover approximately 20% of the state's population.

3. The statements made in this declaration are based upon information made available to me in my official capacity and upon conclusions and determinations reached and made in accordance therewith.

4. This declaration is submitted in support of the Intervenor-States' Opposition to the Application for Preliminary Injunction. Based on my knowledge and experience, dismantling the Affordable Care Act would cause severe harm to the state of New Jersey, its residents, and its economy. First, the loss of health care benefits and services would bring harm to the residents who gained coverage through the Affordable Care Act. Second, New Jersey would experience harm and increased costs from the loss of billions of dollars in federal resources the state receives through the Affordable Care Act to support health care services. Third, our state would

experience harm from the dismantling of the state's administrative and policy structure created to comply with the Affordable Care Act.

The ACA's Benefits for New Jersey

5. The ACA increased access to affordable health care coverage in New Jersey. According to the U.S. Census Bureau, the rate of uninsured in the State is 8% as of 2016, down from 13.2% in 2013. See Health Insurance Coverage in the United States: 2016, Table 6, United States Census Bureau, https://www.census.gov/content/dam/Census/library/publications/2017/demo/p60-260.pdf

6. More than 555,000 New Jerseyans are enrolled in Medicaid expansion in New Jersey. See Medicaid Enrollment Data Collected through Medicaid Budget and Expenditure System, October-December 2016 Medicaid MBES Enrollment Report Posted December 2017, U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, https://www.medicaid.gov/medicaid/program-information/medicaid-and-chip-enrollment-data/enrollment-mbes/index.html.

7. According to the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, more than 274,000 New Jerseyans selected an Affordable Care Act Marketplace plan for 2018, with more than 211,000 receiving an advance premium tax credit and more than 130,000 receiving cost-sharing reductions. See 2018 Marketplace Open Enrollment Period Public Use Files, 2018 OEP State-level Public Use File, U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Marketplace-Products/2018_Open_Enrollment.html.

8. The ACA has directed billions of dollars to the State of New Jersey, including approximately $10.35 billion due to Medicaid expansion and $100.6 million through the Balancing Incentive Program.

9. In addition to increased coverage, New Jersey's expansion of Medicaid under the ACA has resulted in improved access to care, affordability, and health outcomes.

10. In addition, the ACA has had other positive economic benefits for New Jersey, including:

- The decline in the amount of uncompensated care as a result of the ACA has led to a 50% decrease in state spending on charity care since 2010; and
- Due to additional matching federal funds for previously covered populations and the effect that expanded eligibility has had on reducing charity care payments, New Jersey has saved an estimated $1.4 billion as a result of Medicaid expansion.

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

Executed on June 7, 2018, in Trenton, NJ.

Carole Johnson
Commissioner
New Jersey Department of Human Services

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF TEXAS
WICHITA FALLS DIVISION

TEXAS, WISCONSIN, ALABAMA, ARKANSAS, ARIZONA, FLORIDA, GEORGIA, INDIANA, KANSAS, LOUISIANA, PAUL LePAGE, Governor of Maine, Governor Phil Bryant of the State of MISSISSIPPI, MISSOURI, NEBRASKA, NORTH DAKOTA, SOUTH CAROLINA, SOUTH DAKOTA, TENNESSEE, UTAH, WEST VIRGINIA, NEILL HURLEY and JOHN NANTZ,

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.

CALIFORNIA, CONNECTICUT, DISTRICT OF COLUMBIA, DELAWARE, HAWAII, ILLINOIS, KENTUCKY, MASSACHUSETTS, MINNESOTA by and through its Department of Commerce, NEW JERSEY, NEW YORK, NORTH CAROLINA, OREGON, RHODE ISLAND, VERMONT, VIRGINIA and WASHINGTON,

Intervenors-Defendants.

Civ. Action No. 18-cv-00167-O

DECLARATION OF JENNIFER KENT IN SUPPORT OF INTERVENORS-DEFENDANTS' OPPOSITION TO APPLICATION FOR PRELIMINARY INJUNCTION

I, Jennifer Kent, declare:

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

2. Based on my knowledge and experience, dismantling the Affordable Care Act (ACA) would cause a loss of benefits, services and federal investments to support Medi-Cal, and would cause severe harm to the State of California, to its residents and to its economy. California would experience harm and increased costs from the dismantling of the state's administrative structure and apparatus, created in compliance with, and to work in conjunction with, the ACA. For example, there would be significant harm and administrative burden associated with: the cost of terminating coverage for millions of Californians and providing alternative options for individuals losing Medicaid coverage; eliminating subsidies and other ACA-authorized services; the cost of delivering health care through more traditional and expensive safety-net health systems; providing appropriate notice and instructions to individuals losing such support; regulatory costs; and the cost of reconstructing the state health exchange in the absence of the ACA.

3. The ACA increased access to affordable coverage.

- The ACA expanded coverage through two key mechanisms: Medicaid expansion for those individuals with the lowest incomes, and federal health subsidies to purchase coverage in new health insurance exchanges for those individuals with moderate incomes.
- Due to implementation of the ACA in California, the State has experienced a considerable decrease in the number of uninsured residents. This is predominantly attributable to the expansion of eligibility in the Medi-Cal program, and the

newfound availability of health coverage through the State's exchange marketplace known as Covered California.

- California's implementation of the Medicaid expansion has enabled more than 3.7 million Californians to obtain coverage, and we dramatically reduced the uninsured rate in the State from 17 percent in 2013 to 6.8 percent in 2017.
- As a result, the State collectively, including its political subdivisions, its safety net health care providers, and its residents, has begun to realize significant gains from both a public health, and an economic and fiscal standpoint. One of the principal financial benefits has been a meaningful reduction in the level of uncompensated care costs borne within the State's various health care systems and programs. For example, according to data collected and published by the Office of Statewide Health Planning and Development (OHSPD), California hospitals incurred uncompensated care costs totaling approximately $5.2 billion dollars in 2013, before full implementation of the ACA. In 2015, after implementation of the ACA, OSHPD data reflects that California hospitals experienced approximately $1.9 billion dollars in uncompensated care costs, which amounts to nearly a 64 percent decrease in hospital uncompensated care costs over this short period of time.

4. The invalidation of the ACA would cost California billions annually.

- All of the foregoing benefits of the ACA would be removed if the Plaintiffs' motion for preliminary injunction were granted.
- DHCS projects that the elimination of the Medicaid expansion in California would result in an annual loss of $22.2 billion starting in fiscal year 2020, and increasing to a loss of $32.6 billion in 2027. In addition, the elimination of the Community First Choice Option is projected to increase State costs by approximately $400 million in 2020, growing annually.
- In addition, if the number of uninsured in California were to increase, the State would incur a significant negative economic impact due to the accompanying increase in uncompensated care costs that would follow. Without any other options for care,

those residents finding themselves without coverage would turn to traditional and more costly safety-net sources of care, such as use of hospital emergency rooms, or forego care entirely. This would reintroduce the same type of financial strain on State, local and private health systems and programs that the ACA was intended to relieve.

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

Executed on June 6, 2018, in Sacramento, California.

Jennifer Kent
Director
Department of Health Care Servcies

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, Governor Phil Bryant of the State of MISSISSIPPI, MISSOURI, NEBRASKA, NORTH DAKOTA, SOUTH CAROLINA, SOUTH DAKOTA, TENNESSEE, UTAH, WEST VIRGINIA, NEILL HURLEY and JOHN NANTZ, 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 by and through its Department of Commerce, NEW JERSEY, NEW YORK, NORTH CAROLINA, OREGON, RHODE ISLAND, VERMONT, VIRGINIA and WASHINGTON, Intervenors-Defendants.	

DECLARATION OF MILA KOFMAN IN SUPPORT OF INTERVENORS-DEFENDANTS' OPPOSITION TO APPLICATION FOR PRELIMINARY INJUNCTION

I, Mila Kofman, declare:

1. This declaration is submitted in support of the Intervenors-Defendants' Opposition to the Motion to for Preliminary Injunction. This is based on my knowledge and experience on

private health insurance and federal and state reforms as Executive Director of the DC Health Benefit Exchange Authority, former Superintendent of Insurance (Maine), and former research faculty member at Georgetown University. Dismantling the Affordable Care Act would cause severe harm to the District of Columbia, to its small businesses, to its residents and to its economy. In addition to federal investments to support the District of Columbia's individual and small group marketplaces (exchange), dismantling or suspending implementation of the Affordable Care Act would cause severe harm to the District of Columbia. District of Columbia residents received approximately $2.57 million in advanced premium tax credits (APTC) in 2017. The loss of those dollars will likely cause those people to drop coverage as they will not have the affordability assistance provided under the ACA. That loss of coverage will harm the risk pool, causing the experience to degrade and premiums to increase for those who remain. The loss of ACA consumer protections will harm people who need comprehensive and secure health insurance. Also without Medicaid expansion, the private risk pool would be more expensive because "Expansion population" (childless adults) are sicker with numerous co-morbidity factors. The damage to District residents and small businesses would be irreparable, as the lack of coverage would lead to a lack of care, with fatal or irreversible permanent health conditions that currently are being prevented and treated because people have health insurance.

2. I am the Executive Director of the District of Columbia Health Benefit Exchange Authority. Prior to my appointment, I was on the faculty at Georgetown University Health Policy Institute as a Research Professor and Project Director. Before that I served as Superintendent of Insurance in Maine for over three years, and as a federal regulator at the Department of Labor.

3. The DC Health Benefit Exchange Authority (HBX) was established as a requirement of Section 3 of the Health Benefit Exchange Authority Establishment Act of 2011, effective March 3, 2012 (D.C. Law 19-0094). The mission of the DC Health Benefit Exchange Authority

is to implement an online health insurance marketplace in the District of Columbia in accordance with the Patient Protection and Affordable Care Act (PPACA), thereby ensuring access to quality and affordable health care to all DC residents.

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

- Overall the number of individuals with insurance has increased. The ACA has enabled the District to expand health coverage so that more than 96% of our residents are now covered (less than 4% uninsured in 2016 compared to 7.2% in 2009). We have the lowest uninsured rate we've ever had and rank between first and third (depending on the study) among all states in the nation for having the lowest uninsured rate. As of March 12, 2018, there are 17,808 District residents enrolled in individual health insurance and more than 76,000 people enrolled in small group coverage through our marketplace, DC Health Link. A 2016 survey of our enrolled customers revealed that more than 25,500 people, who were not previously covered in 2015, gained access to health coverage in 2016 through the marketplace. 25% of the people who enrolled in individual private health insurance coverage were previously uninsured. 53% of the people who were determined eligible for Medicaid were uninsured before applying. 40% of the small businesses enrolled in DC Health Link did not offer health insurance to their employees prior to enrollment through DC Health Link.
- The Marketplace is an important reform made by the ACA, for a number of reasons. The on-line health insurance marketplace has provided access to quality affordable health insurance, and has created transparency, encouraged market competition, simplified the purchase of insurance. Many residents have benefitted from reduced premiums for health insurance. There are approximately 4,187 District residents who have received APTC; this does not include residents who received premium tax credits when they filed their taxes. Tens of thousands of residents have

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

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

- the ACA have had a significant positive effect on states. States realized budget savings, revenue gains, and overall economic growth. A Commonwealth study modeled the effects of ACA repeal, and shows the deleterious economic impact such an action would have. *See* The Commonwealth Fund, *Repealing Federal Health Reform: Economic and Employment Consequences for States*, (Jan. 2017),

http://www.commonwealthfund.org/publications/issue-briefs/2017/jan/repealing-federal-health-reform.

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

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

- The ACA created robust consumer protections to help ensure individuals can access the healthcare system by permitting covered dependents to access coverage on their parents' plans until age 26, mandating preventive services including access to birth control, cancer screenings, and immunizations for children, and providing essential health benefits, such as substance use disorder treatment and cancer screenings. The ACA's consumer protections prohibiting medical underwriting, preexisting conditions exclusions, rating based on gender, health factors, industry and employer size have helped District residents and small businesses have private health insurance that was not available before. Also, ACA restrictions on annual and lifetime limits and required essential health benefits have resulted in many District residents and small businesses having financial security and access to medical care that was not available before the ACA.
- The District has built on the consumer protections under the ACA. The District prohibits premiums based on tobacco use. The District also prohibits benefit substitutions in the essential health benefits categories, protecting residents' access to all essential health benefits. HBX requires carrier to offer standard benefit plans, in addition to carrier designed plans. The standard plan designs have the same benefits and out-of-pocket features, *e.g.*, co-pays, deductibles, co-insurance, within a metal level. Networks, premiums, and quality are the major differences. This

makes shopping even easier. Importantly, enrollees can receive many medical services such as specialist visits, urgent care visits, primary care visits, mental health services, and prescription medication before meeting deductibles, even with bronze plan coverage. In addition, HBX has invested in strong consumer shopping tools so that people can make informed choices. The DC Health Link Plan Match tool enables customers to compare plans based on expected annual out-of-pocket costs; search a doctor directory which enables consumers to see which plans their doctors participate in; and a prescription drug formulary tool that enables customers to compare their medication costs across plans.

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

7. All of the foregoing benefits of the Affordable Care Act would be removed if the Plaintiffs' preliminary injunction were granted.

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

Executed on June 6, 2018 in Washington, District of Columbia.

Mila Kofman
Executive Director
District of Columbia Health Benefit
Exchange Authority

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

TEXAS, WISCONSIN, ALABAMA, ARKANSAS, ARIZONA, FLORIDA, GEORGIA, INDIANA, KANSAS, LOUISIANA, PAUL LePAGE, Governor of Maine, Governor Phil Bryant of the State of MISSISSIPPI, MISSOURI, NEBRASKA, NORTH DAKOTA, SOUTH CAROLINA, SOUTH DAKOTA, TENNESSEE, UTAH, WEST VIRGINIA, NEILL HURLEY and JOHN NANTZ, 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 by and through its Department of Commerce, NEW JERSEY, NEW YORK, NORTH CAROLINA, OREGON, RHODE ISLAND, VERMONT, VIRGINIA and WASHINGTON, Intervenors-Defendants.	

DECLARATION OF DR. JENNIFER LEE IN SUPPORT OF INTERVENORS-DEFENDANTS' OPPOSITION TO APPLICATION FOR PRELIMINARY INJUNCTION

I, Dr. Jennifer Lee, declare:

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

2. This declaration is submitted in support of the Intervenor-States' Opposition to the Motion for a Preliminary Injunction. Based on my knowledge and experience, dismantling or suspending the Affordable Care Act (ACA) would cause severe harm to the Commonwealth of Virginia, to its residents, and to its economy. Virginia would experience harm and increased costs from the dismantling of the state's administrative structure and apparatus, created in compliance with, and to work in conjunction with, the ACA. In particular, the Commonwealth would experience significant costs associated with unwinding changes that were made to Medicaid eligibility determination by the ACA.

3. With a budget of $10 billion, DMAS's mission is to provide a system of high quality and cost effective health care services to qualifying Virginians and their families. Today, DMAS

provides health care coverage to more than 1 million Virginians through the Medicaid program and CHIP.

4. Virginians receive billions of dollars directly as a result of the ACA. For example, in 2017, Virginians received an estimated $1,148,490,000 in total annual premium tax credits. Moreover, Virginia has received more than $25,320,000 through the Public Health and Prevention Fund. The Public Health and Prevention Fund has funded grants for programs that include, in part, "Making a Healthier Virginia the Priority" (more than $2,600,000), "Affordable Care Act – Maternal, Infant and Early Childhood Home Visiting Program – Expansion" (more than $7,600,000) "Preventive Health Services" (more than $3,170,000), "Immunization and Vaccines for Children" (more than $2,130,000), and "Immunization PPHF Supplemental" (more than $4,900,000).

5. In addition to direct funds, the ACA has increased Virginians access to affordable health care coverage. Since the ACA was enacted, the overall number of individuals with insurance in Virginia has increased. In 2009, prior to the implementation of the ACA, Virginia's uninsured rate for non-elderly adults (ages 19-64) was 16.4%, representing 779,000 non-elderly adults in Virginia who lacked health insurance. By 2016, after the ACA was in effect, Virginia's uninsured rate for non-elderly adults dropped to 12.4%, representing 621,000 non-elderly adults in Virginia who lacked health insurance. Moreover, the ACA expanded coverage in Virginia through the federal health subsidies that enabled individuals with moderate incomes to purchase health insurance in the Exchanges. In 2017, 410,726 Virginians purchased health insurance on the Federally Facilitated Marketplace (FFM). Of those individuals purchasing coverage on the FFM in 2017, 334,942 individuals received a federal premium subsidy. Finally, Medicaid is an important source of healthcare insurance coverage.

Although Virginia has not yet expanded Medicaid coverage under the ACA, the Virginia General Assembly adopted a budget on May 30, 2018 that expands Medicaid in the new state fiscal year that begins July 1, 2018. Many Virginians see this as a strategic opportunity to expand access to care, improve Virginians overall health, and bolster the economy. DMAS is currently in the planning and implementation phase of expanding the Virginia Medicaid program, and expects that expanded coverage will be available in early 2019. Eliminating the ACA would result in the elimination of the opportunity to provide health care coverage to up to 400,000 Virginians beginning in 2019. In addition to the harm caused to individuals losing the promise of health care coverage, the Commonwealth estimates that it would lose $458 million in federal funds in FY 2019 and $1.9 billion in federal funds in FY 2020.

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

7. All of the foregoing benefits of the ACA would be removed if the Plaintiffs' motion for preliminary injunction were granted.

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

Executed on June 6, 2018, in Richmond, Virginia.

Dr. Jennifer Lee
Director
Virginia Department of Medical
Assistance Services

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

TEXAS, WISCONSIN, ALABAMA, ARKANSAS, ARIZONA, FLORIDA, GEORGIA, INDIANA, KANSAS, LOUISIANA, PAUL LePAGE, Governor of Maine, Governor Phil Bryant of the State of MISSISSIPPI, MISSOURI, NEBRASKA, NORTH DAKOTA, SOUTH CAROLINA, SOUTH DAKOTA, TENNESSEE, UTAH, WEST VIRGINIA, NEILL HURLEY and JOHN NANTZ, 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 by and through its Department of Commerce, NEW JERSEY, NEW YORK, NORTH CAROLINA, OREGON, RHODE ISLAND, VERMONT, VIRGINIA and WASHINGTON, Intervenors-Defendants.	

DECLARATION OF KIMBERLEY LUFKIN IN SUPPORT OF INTERVENORS-DEFENDANTS' OPPOSITION TO APPLICATION FOR PRELIMINARY INJUNCTION

I, Kimberley Lufkin, declare:

1. I am 37 years old and a resident of Fairfax, Virginia. I work with international health nonprofits that focus on issues ranging from reproductive health to HIV/AIDS.
2. I was diagnosed with type-1 diabetes at five years old. For my most of my life, I have been in a constant battle with insurance companies that repeatedly denied me coverage and care for a pre-existing medical condition. Even though I have maintained continuous employer-sponsored coverage, I often experienced discrimination or difficulties receiving care because of my diagnosis.
3. The Affordable Care Act eliminated any discrimination based on my diabetes. I no longer needed to fill out paperwork or prove continuous coverage before insurance companies would cover my care every time I started a new job or had a change in employer-sponsored coverage. When the law went into effect, I felt like a huge and constant worry in my life had been lifted.
4. This was made all the more pressing for me and my family in 2016, when my 18-month-old son was diagnosed with type-1 diabetes. My husband and I were shocked, worried, and scared for three days after his diagnosis in the ICU, and we knew that our son's childhood would be forever be impacted. With all the fears we had as parents of a young child with a chronic condition, I was at least relived that because of the protections under the ACA, my son wouldn't face the same struggles I did with insurance coverage.
5. I'm terrified that that efforts to overturn the ACA will cause people like me and my son to lose the protections we have. My family will now have to constantly worry about our ability to access lifesaving health care. We shouldn't have to worry if we can afford insulin for my three-year-old son, or if he'll miss out of medical innovations because of our inability to pay. We shouldn't have to fight with insurance companies to cover care for a medical condition he developed at just 18 months old.

6. I support the Intervenor-Defendants' defense of the ACA. 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 June 1, 2018, in Fairfax, VA.

Kimberley Lufkin

SA2018100536

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

TEXAS, WISCONSIN, ALABAMA, ARKANSAS, ARIZONA, FLORIDA, GEORGIA, INDIANA, KANSAS, LOUISIANA, PAUL LePAGE, Governor of Maine, Governor Phil Bryant of the State of MISSISSIPPI, MISSOURI, NEBRASKA, NORTH DAKOTA, SOUTH CAROLINA, SOUTH DAKOTA, TENNESSEE, UTAH, WEST VIRGINIA, NEIL HURLEY and JOHN NANTZ, 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 by and through its Department of Commerce, NEW JERSEY, NEW YORK, NORTH CAROLINA, OREGON, RHODE ISLAND, VERMONT, VIRGINIA and WASHINGTON, Intervenors-Defendants.	

DECLARATION OF CHRIS MALEY IN SUPPORT OF INTERVENORS-DEFENDANTS' OPPOSITION TO APPLICATION FOR PRELIMINARY INJUNCTION

I, Chris Maley, declare:

1. This declaration is submitted in support of the Intervenors-Defendants' Opposition to the Application for Preliminary Injunction.

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

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

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

5. The Illinois Department of Healthcare and Family Services (HFS) is responsible for administering the Medical Assistance Programs under the Illinois Public Aid Code, the Children's Health Insurance Program Act, the Covering All Kids Health Insurance Act, the Veterans Health Insurance Program Act, other provisions of state law, and Title XIX and XXI of

the federal Social Security Act. Specifically, HFS is the Illinois state agency responsible for providing healthcare coverage for adults and children who qualify for Medicaid, including those who qualify for Medicaid through the Medicaid expansion. As part of its review of state agency programs, the Illinois Comptroller's Office receives and reviews information from HFS about the resources allocated to the medical assistance program (Medicaid).

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

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

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

9. Any of the foregoing financial contributions received under the Affordable Care Act would be terminated if the Plaintiffs' motion for preliminary injunction were granted.

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

Executed on June 5, 2018, in Springfield, Illinois.

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

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

TEXAS, WISCONSIN, ALABAMA, ARKANSAS, ARIZONA, FLORIDA, GEORGIA, INDIANA, KANSAS, LOUISIANA, PAUL LePAGE, Governor of Maine, Governor Phil Bryant of the State of MISSISSIPPI, MISSOURI, NEBRASKA, NORTH DAKOTA, SOUTH CAROLINA, SOUTH DAKOTA, TENNESSEE, UTAH, WEST VIRGINIA, NEILL HURLEY and JOHN NANTZ, 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 by and through its Department of Commerce, NEW JERSEY, NEW YORK, NORTH CAROLINA, OREGON, RHODE ISLAND, VERMONT, VIRGINIA and WASHINGTON, Intervenor-Defendants.	

DECLARATION OF THEA MOUNTS IN SUPPORT OF IN SUPPORT OF INTERVENORS-DEFENDANTS' OPPOSITION TO APPLICATION FOR PRELIMINARY INJUNCTION

I, Thea Mounts, declare:

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

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

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

4. This declaration is submitted in support of the Intervenor-States' Opposition to the Motion for Preliminary Injunction. Based on my knowledge and experience, dismantling the Affordable Care Act would cause severe harm to the state of Washington, to its residents and to its economy. In addition to loss of benefits and services and federal investments to support Washington's health care system as stated below, Washington would experience harm and increased costs from the dismantling of the state's administrative structure and apparatus created in compliance with, and to work in conjunction with, the Affordable Care Act. For example:

   a. The state would have to rebuild the eligibility and enrollment system for Medicaid, which would have a significant cost associated with it.
   b. The state would have to take on the costs of the call center for Medicaid.
   c. The state would have to pick up outreach, marketing, and other functions for Medicaid currently performed by the Exchange.

d. The state would have to revert to the law related to individual market coverage in place prior to the ACA's enactment. Under those provisions, all applicants for individual health insurance would be required to complete a standard health questionnaire, which would be used to determine whether an individual meets a health cost/risk threshold sufficient to allow the carrier to deny coverage and trigger the individual's eligibility for the Washington State Health Insurance Pool (WSHIP), the state's high risk pool program. The substantial cost impacts of reversion to this system would include:

   i. WSHIP is funded by a combination of enrollee premiums and assessments on health carriers and stop loss insurers doing business in Washington State. WSHIP coverage would be more costly for consumers, especially those who would be eligible for an APTC payment under current law, directly harming those consumers.

   ii. Carriers and stop loss insurers in Washington state would be required to fund the difference between WSHIP enrollee claims costs and premiums paid by enrollees, through as assessment formula. After implementation of the ACA, WSHIP enrollment was closed because consumers have guaranteed access to coverage. Carriers would be confronted with the additional costs of the assessment.

   iii. The Office of the Insurance Commissioner would face substantial administrative costs associated with major regulatory changes, modifications to individual and small group health plan filing requirements and other administrative changes required to return to the rules and policies that were in place prior to ACA implementation.

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

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

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

B. The Affordable Care Act Increased Access to Affordable Coverage

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

8. The Affordable Care Act (ACA) expanded coverage through two key mechanisms: Medicaid expansion for those individuals with the lowest incomes, and federal health subsidies to purchase coverage in new health insurance Exchanges for those individuals with moderate incomes.

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

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

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

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

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

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

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

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

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

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

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

18. Washington State continues to benefit from the infusion of resources for health reform and innovation that has catalyzed higher quality, safer and better

coordinated care delivery, smarter spending and the realization of savings to public programs, more engaged providers, and healthier populations.

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

a. Developed, implemented, and managed the Washington State Common Measure Set, which sends aligned signals to providers.

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

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

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

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

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

21. Amidst the success of the Medicaid expansion, leaders in Washington state and nationwide recognize access to coverage is just the beginning, and barriers remain to improved health and wellbeing of individuals and families. The innovation opportunities offered through ACA-facilitated models like SIM, Partnership for Patients, Transforming Clinical Practice Initiative and more help ensure we are not expanding access to a system

that is unsafe, fragmented and wasteful. One success story from these opportunities is that the Washington State Hospital Association's leadership in the state for the Partnership for Patients program led to a reduction in hospital-acquired conditions and avoidable readmissions. Through the first round of this program, 23,000 patients were saved from harm and saw a reduction of $336 million in health care spending.

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

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

23. The ACA created robust consumer protections to help ensure individuals can access the health care system.

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

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

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

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

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

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

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

31. All of the foregoing benefits of the Affordable Care Act would be removed if the Plaintiffs' motion for preliminary injunction were granted.

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

Executed on this 5 day of June, 2018, at Olympia, Washington.

Thea N. Mounts

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

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

TEXAS, WISCONSIN, ALABAMA, ARKANSAS, ARIZONA, FLORIDA, GEORGIA, INDIANA, KANSAS, LOUISIANA, PAUL LePAGE, Governor of Maine, Governor Phil Bryant of the State of MISSISSIPPI, MISSOURI, NEBRASKA, NORTH DAKOTA, SOUTH CAROLINA, SOUTH DAKOTA, TENNESSEE, UTAH, WEST VIRGINIA, NEILL HURLEY and JOHN NANTZ, 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 by and through its Department of Commerce, NEW JERSEY, NEW YORK, NORTH CAROLINA, OREGON, RHODE ISLAND, VERMONT, VIRGINIA and WASHINGTON, Intervenor-Defendants.	

DECLARATION OF NELI PALMA IN SUPPORT OF OPPOSITION TO

APPLICATION FOR PRELIMINARY INJUNCTION

I, Neli N. Palma, declare:

1. I am an attorney at law licensed to practice in all Courts of the State of California. I have been appointed and currently serve as a Deputy Attorney General in the California Office of the Attorney General. In this capacity, I have been assigned to appear on behalf of the Intervenor-Defendants in this matter.

2. I have reviewed the exhibits listed and attached hereto, and if called upon could testify that each document is a true and correct copy downloaded from the referenced web address on June 6, 2018:

Exhibit A – Glied, Sherry A., et al., "Access to Coverage and Care for People with Preexisting Conditions: How it Has Changed Under the ACA?," The Commonwealth Fund, June 22, 2017. http://www.commonwealthfund.org/publications/issue-briefs/2017/jun/coverage-care-preexisting-conditions-aca.

Exhibit B – Maine Equal Justice Partners Consumers for Affordable Health Care, et al. v. Ricker Hamilton, Commissioner Maine Department of Health and Human Services, Order on M.R. Civ. P. 80C Appeal of Agency Action, Business and Consumer Court Civil Action, Doc. No. BCD-AP-18-02, June 4, 2018. http://www.courts.maine.gov/news_reference/high_profile/equal-justice-partners/order-on-mrcivp80c-appeal-of-agency-action.pdf.

Exhibit C – Kaiser Family Foundation, "Medicaid Expansion Spending," FY 2015. https://www.kff.org/medicaid/state-indicator/medicaid-expansion-spending.

Exhibit D – Kaiser Family Foundation, "High-Risk Pools for Uninsurable Individuals," February 22, 2017. https://www.kff.org/health-reform/issue-brief/high-risk-pools-for-uninsurable-individuals/.

Exhibit E – Congressional Research Service "Legislative Actions in the 112th, 113th, and 114th Congresses to Repeal, Defund, or Delay the Affordable Care Act," February 7, 2017. https://fas.org/sgp/crs/misc/R43289.pdf.

Exhibit F – Internal Revenue Serv., Affordable Care Act Provision 9010 - Health Insurance Providers Fee (Rev. Mar. 2018). https://www.irs.gov/businesses/corporations/affordable-care-act-provision-9010.

Exhibit G – Internal Revenue Serv., U.S. Department of the Treasury, Pub. No. 1304, Individual Income Tax Returns 2015 26 (Rev. Sept. 2017) [portion].

Exhibit H – Congressional Budget Office, "Repealing the Individual Health Insurance Mandate: An Updated Estimate," November 2017. https://www.cbo.gov/system/files/115th-congress-2017-2018/reports/53300-individualmandate.pdf.

Exhibit I – Internal Revenue Service, "Federal Tax Compliance Research: Tax Gap Estimates for Tax Years 2008–2010," Publication 1415, May 2016. https://www.irs.gov/pub/irs-soi/p1415.pdf.

Exhibit J – Congressional Budget Office, "Federal Subsidies for Health Insurance Coverage for People Under Age 65: 2018 to 2028," May 2018. https://www.cbo.gov/system/files/115th-congress-2017-2018/reports/53826-healthinsurancecoverage.pdf.

Exhibit K – Congressional Budget Office, "The Effects of Terminating Payments for Cost-Sharing Reductions," August 2017. https://www.cbo.gov/ system/files/115th-congress-2017-2018/reports/53009-costsharingreductions.pdf.

Exhibit L – Centers for Medicare & Medicaid Services "Health Insurance Exchanges 2018 Open Enrollment Period Final Report," April 3, 2018. https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2018-Fact-sheets-items/2018-04-03.html.

Exhibit M – Miller, Thomas P., "Examining the Effectiveness of the Individual Mandate under the Affordable Care Act: Statement before the House Committee on Ways and Means Subcommittee on Oversight," January 24, 2017. https://waysandmeans.house.gov/wp-content/uploads/2017/01/20170124-OS-Testimony-Miller.pdf.

Exhibit N – Tricia Brooks et al., *Medicaid and CHIP Eligibility, March 2018 Enrollment, Renewal, and Cost Sharing Policies as of January 2018: Findings from a 50-State Survey*, Kaiser Family Foundation, March 2018. https://www.kff.org/medicaid/report/medicaid-and-chip-eligibility-enrollment-renewal-and-cost-sharing-policies-as-of-january-2018-findings-from-a-50-state-survey/.

Exhibit O – Texas Health and Human Services, *Community First Choice*. https://hhs.texas.gov/services/health/medicaid-chip/programs/community-first-choice.

Exhibit P – Texas Health and Human Services Commission, "Report on the Cost-Effectiveness of Community First Choice in Star+Plus," February 2017. https://hhs.texas.gov/services/health/medicaid-chip/programs/community-first-choice.

I declare under penalty of perjury under the laws of the United States that the foregoing is true and correct and that this declaration was signed on this date in Sacramento, California. Executed on this 7th day of June, 2018, at Sacramento, California.

NELI PALMA

Texas, et al. v.

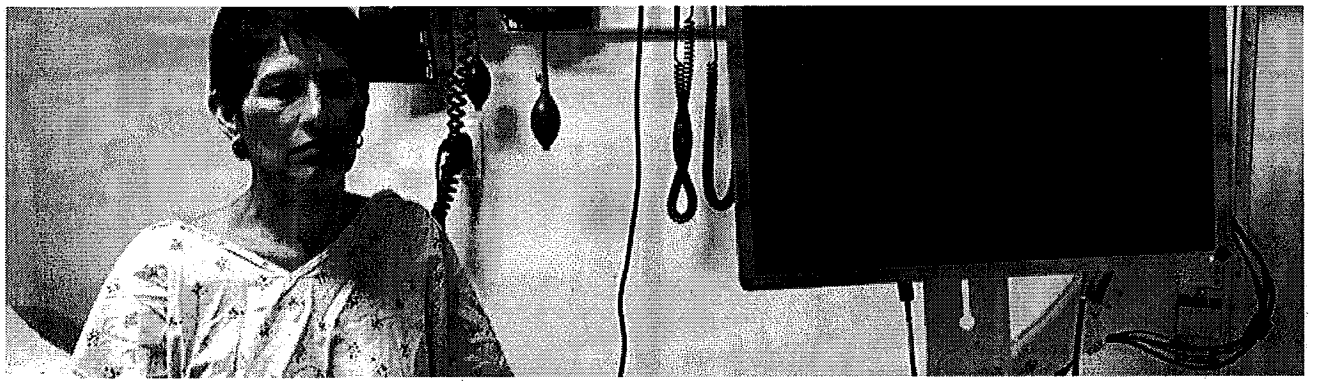
United States of America, et al.

USDC Northern District of Texas

Case No. 4:18-cv-00167-O

Exhibit A

A Century of Advancing Health Care for All



Access to Coverage and Care for People with Preexisting Conditions: How Has It Changed Under the ACA?

June 22, 2017

Authors

Sherry A. Glied, Adlan Jackson

Citation

S. A. Glied and A. Jackson, *Access to Coverage and Care for People with Preexisting Conditions: How Has It Changed Under the ACA?* The Commonwealth Fund, June 2017.

Abstract

Issue: Prior to the Affordable Care Act (ACA), people with preexisting health conditions could be denied insurance coverage or charged higher rates. If the law is repealed, these protections could be diluted or lost altogether.
Goals: Assess the ACA's impact on coverage and access for people with preexisting conditions and compare their coverage gains with state high-risk-pool enrollment pre-ACA.
Methods: Analysis of Behavioral Risk Factor Surveillance System data for the period 2011–13 to 2015.
Key Findings and Conclusions: Between 2013 and 2015, 16.5 million nonelderly adults gained coverage following full ACA implementation. Of those, 2.6 million had preexisting conditions that could have otherwise precluded them from coverage because of discriminatory denials and pricing; 9.4 million had conditions that could have otherwise affected insurance cost. We found strong correlations between these coverage gains and access to care. Coverage and access gains for people with preexisting conditions were unrelated to the size or existence of the state high-risk pools that 35 states funded for such individuals pre-ACA. Our findings suggest that proposals to replace current protections for people with preexisting conditions with high-risk pools are unlikely to be sufficient to maintain the ACA's gains.

Background

Americans with chronic health conditions are at the center of the debate over access to health care coverage. The U.S. Department of Health and Human Services' Office of the Assistant Secretary for Planning and Evaluation (ASPE) estimates the number of Americans with such "preexisting conditions" ranges from 19 percent to 50 percent of all nonelderly Americans.[1,2 (#/#1)] This range represents the difference between conditions that fit into a "narrow" definition of preexisting conditions (19%), and a "broad" definition (50%). The narrow definition includes very costly health conditions that would cause insurers to refuse coverage absent the Affordable Care Act's (ACA) provisions; the broad definition includes slightly less expensive chronic health conditions that could nevertheless make the cost of insurance in the individual market without the ACA largely unaffordable for most patients.

In 2016, the Henry J. Kaiser Family Foundation, in its review of pre-ACA medical underwriting practices, estimated that 27 percent of nonelderly American adults had health conditions that "would likely leave them uninsurable if they applied for individual market coverage."[3 (#/#3)] Similarly, a Commonwealth Fund study found that, in 2010, 36 percent of adults ages 19 to 64 who had tried to buy a plan in the individual market over the prior three years were turned down, charged a higher price, or had a condition excluded from their coverage because of a health problem.[4 (#/#4)]

The presence of preexisting conditions is particularly important for the millions of Americans who have gained coverage under the ACA, which Congress and the Trump administration are seeking to repeal.[5 (#/#5)] The Commonwealth Fund study found significant improvements in the ability of people with health problems to purchase plans on their own in 2016 relative to 2010.[6 (#/#6)]

In this issue brief, we observe whether the coverage gains for people with preexisting conditions also have resulted in better access to care. Better access is defined as a greater likelihood of having a regular health care provider (whether one or more than one clinician) and having less trouble seeing a provider because of the cost.

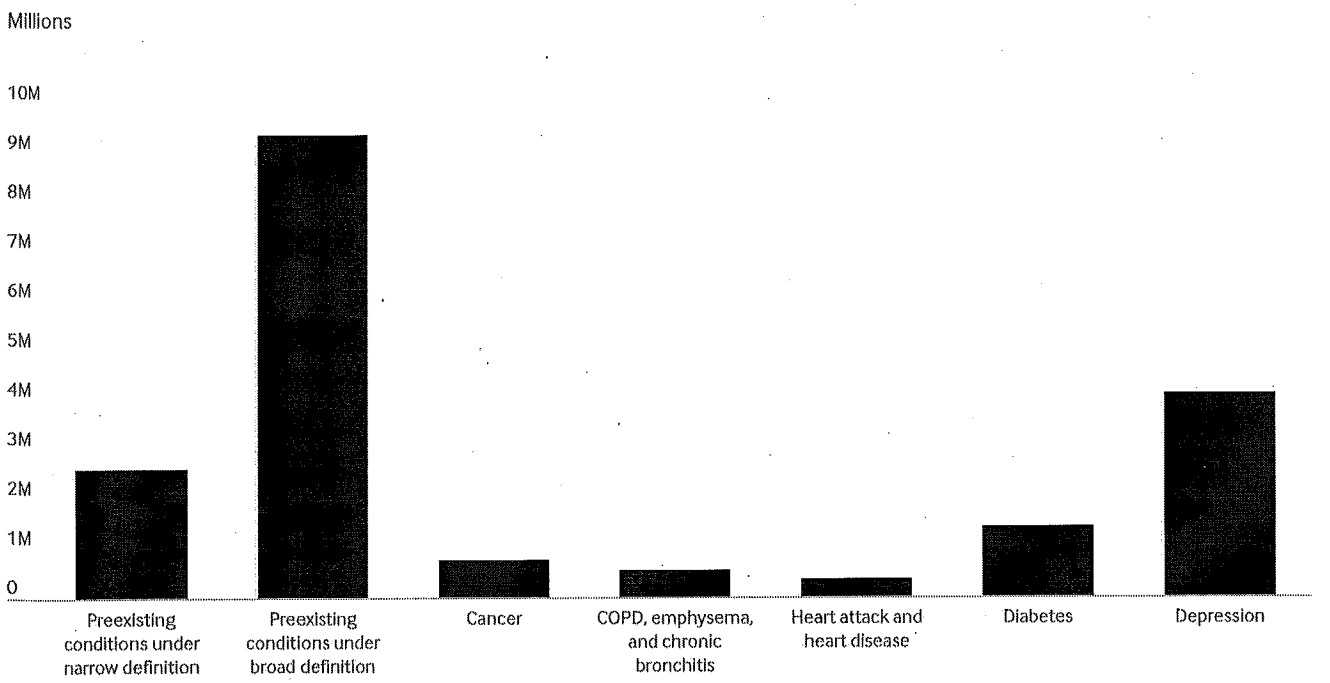
Prior to passage of the ACA, many states had high-risk pools that sought to provide coverage to individuals locked out of the individual insurance market because of expensive preexisting conditions. Between 2010 and 2013, the ACA funded the Pre-Existing Condition Insurance Program, a set of federally funded high-risk pools to provide interim coverage for those with such conditions. If these pools had been successful in addressing coverage for those with preexisting conditions, we would expect to see a smaller gain in access to care for this population in those states that had previously enrolled substantial shares of the nongroup market in the pools.

Under the ACA, Americans with Preexisting Conditions Gained Coverage and Better Access to Care

For this brief, we considered both the narrow and broad definitions of preexisting conditions. Among the general population surveyed between 2011 and 2015, data from the Behavioral Risk Factor Surveillance System (BRFSS) indicate that 20 percent of Americans have preexisting conditions under the narrow definition and 61 percent of Americans have these conditions under the broader definition. Using the BRFSS data, we estimate that 16.5 million more people were insured in 2015 than in the 2011–2013 period.[7 (#/#7)] Among this newly insured group, 2.6 million had one or more preexisting conditions under the narrow definition and 9.4 million had one or more under the broader definition (Exhibit 1).

Exhibit 1

Newly Insured Nonelderly Adults with Preexisting Conditions



Data: Authors' analysis of Behavioral Risk Factor Surveillance System data for 2011-13 to 2015.

Share

Under the narrow and broad definitions, those with preexisting conditions accounted for 16 percent and 57 percent, respectively, of the newly insured population. These findings suggest that the newly insured population is neither substantially healthier nor sicker than the general population.

Among the 2.6 million newly insured people under the narrow definition of preexisting conditions were an estimated 364,000 people ever diagnosed with heart attack or heart disease; 536,000 people ever diagnosed with chronic obstructive pulmonary disease (COPD), emphysema, or chronic bronchitis; 770,000 people ever diagnosed with cancer; and 1.4 million people ever diagnosed with diabetes. Among the 9.4 million newly insured under the broad definition were 1.5 million people ever diagnosed with asthma, 3.3 million people ever diagnosed with high blood pressure, and 4.1 million ever diagnosed with depression.

The prevalence of preexisting conditions rises with age. Among adults ages 55 to 64 who gained coverage (in both expansion and nonexpansion states) between 2011 and 2015, nearly 40 percent had a preexisting condition under the narrow definition, and nearly 80 percent had a preexisting condition under the broad definition. The share of those gaining coverage who had a preexisting condition was somewhat higher among white non-Hispanics (65%) than among black non-Hispanics (59%) or Hispanics (54%).

We also found that, among populations with preexisting conditions, these increases in insurance coverage were associated with increased access to care. The share of people reporting cost-related access problems in the past 12 months fell in all the preexisting-condition groups (Exhibit 2). Likewise, the share reporting they had a usual source of care (one or more clinicians they consider to be their personal doctor or health care professional) increased (Exhibit 3).

Improvements in access to care over time might have been a result of other changes happening contemporaneously. To determine that these improvements in access were a consequence of the ACA's coverage expansions, we compared gains in access among those with preexisting conditions to gains in coverage across states. In Exhibits 4 and 5 respectively, we plot affordability and access to a usual source of care against the share of people with preexisting conditions among the newly insured. Improvements in access among those with preexisting conditions were greatest in states where coverage gains were greatest.

High-Risk Pools

In Republican proposals to replace the ACA's insurance regulations, high-risk pools are suggested as the mechanism to ensure coverage for those with preexisiting conditions who would otherwise be locked out of the individual insurance market. High-risk pools had existed in 35 states before passage of the ACA, and the ACA included $5 billion in funding for the high-risk pools that operated between 2010 and 2013.[8 (#/#8)]

In this study, we hypothesized that if high-risk pools had been effective in covering people with serious preexisting conditions and improving their access to care, we would expect to find that the populations with preexisting conditions in those states would have already been insured and had access to care prior to the ACA's full rollout in 2014. To test this proposition, we examined the relationship between the increase in insurance coverage and access to care among those with serious preexisting conditions and prior enrollment in the PCIP and high-risk-pool programs.

We found no relationship between either enrollment in the PCIP or the share of the nongroup market enrolled in high-risk pools and gains in coverage or access post-2014. If anything, people with preexisting conditions living in states with a higher enrollment in the PCIP (or in high-risk pools) saw slightly greater gains in access to care under the full rollout of the ACA (Appendix (~/media/0556148f906548268d7528a6262613ae.ashx)). That is an indication that these individuals may not have been covered when the PCIP was in operation.

Conclusion

A significant portion of Americans—up to 61 percent—could have preexisting health conditions that affect the price of their health insurance or their ability to get any coverage at all. Should the Affordable Care Act be repealed and its protections for coverage of preexisting conditions removed, millions of Americans could find it difficult to obtain affordable health care. Gains in coverage under the ACA have led to corresponding gains in access to care, as measured both by the reduction in cost-related problems getting care and by the increased proportion of people who report having a usual source of care. By contrast, the high-risk pools in place prior to the ACA's implementation did not have comparable effects on coverage or access to care. Our results suggest that proposals to use states' high-risk pools in place of ACA protections will be insufficient to maintain the health care access gains made since 2010.

The group of people with preexisting conditions changes over time as its members' health changes. The group seeking coverage in the individual insurance market also changes: people gain and lose employment and access to employer-sponsored insurance, experience fluctuations in income and eligibility for Medicaid, age in or out of public coverage, and undergo other life changes. Alternatives to the ACA's prohibitions on underwriting will need to address the needs of these ever-changing populations.

How This Study Was Conducted

The analyses in our study are based on the Behavioral Risk Factor Surveillance System (BRFSS). This survey asks participants simple, point-in-time questions about their health. The questions used for this brief ask participants whether they have "ever [been] told" that they have the chronic health conditions we include in our estimates.

We use BRFSS data from 2011, 2013, and 2015 because the BRFSS has included only the questions on the chronic health conditions we consider in those years. These data include those who were "ever diagnosed" with diabetes, stroke, cancer, COPD, emphysema, chronic bronchitis, angina, kidney disease, heart attack, or heart disease. This lower bound comes to 20 percent of Americans ages 19 to 64. The BRFSS does not include questions for as broad a range of chronic conditions as other data sets, including some conditions that companies have listed as preexisting conditions, so these estimates may be lower than the actual population with preexisting conditions that can lead to discriminatory pricing.

The set of preexisting conditions our study defines as narrow coincides with the conditions cited in a study by the U.S. Department of Health and Human Services' Office of the Assistant Secretary for Planning and Evaluation (ASPE) as conditions that would categorically lead to a denial by a private insurer. It also accords with conditions included in states' high-risk pools.

The set of preexisting conditions that our study defines as broad includes conditions that could cause an individual to be charged more for health coverage. In the BRFSS, these conditions were arthritis, asthma, high blood pressure, high cholesterol, obesity, and depression. We also included those who described their general health as "poor." Under this definition, 61 percent of the population could have a preexisting condition.

Our enrollment rate for the Pre-Existing Condition Insurance Plan was calculated by using enrollment numbers reported by the Center for Consumer Information and Insurance Oversight as of March 31, 2013. We divided those state enrollment numbers by the total state nonelderly adult population in 2013. The 2011 nongroup market enrollment rate in state-run high-risk pool programs used in Appendix Exhibit C (/~/media/files/publications/issue-brief/2017/jun/glied_access_to_coverage_care_preexisting_conditions_aca_appendix.pdf?la=en) is from the Henry J. Kaiser Family Foundation.[2 (#f#2)]

Notes

1 Office of the Assistant Secretary for Planning and Evaluation, *At Risk: Pre-Existing Conditions Could Affect 1 in 2 Americans: 129 Million People Could Be Denied Affordable Coverage Without Health Reform (https://aspe.hhs.gov/basic-report/risk-pre-existing-conditions-could-affect-1-2-americans)* (U.S. Department of Health and Human Services, Nov. 2011).

2 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 (https://aspe.hhs.gov/pdf-report/health-insurance-coverage-americans-pre-existing-conditions-impact-affordable-care-act)* (U.S. Department of Health and Human Services, Jan. 2017).

3 G. Claxton, C. Cox, A. Damico et al., *Pre-existing Conditions and Medical Underwriting in the Individual Insurance Market Prior to the ACA (http://www.kff.org/health-reform/issue-brief/pre-existing-conditions-and-medical-underwriting-in-the-individual-insurance-market-prior-to-the-aca/)* (Henry J. Kaiser Family Foundation, Dec. 2016).

4 S. R. Collins, M. Z. Gunja, M. M. Doty, and S. Beutel, *How the Affordable Care Act Has Improved Americans' Ability to Buy Health Insurance on Their Own (/publications/issue-briefs/2017/feb/how-the-aca-has-improved-ability-to-buy-insurance)* (The Commonwealth Fund, Feb. 2017).

5 R. Abelson, "Donald Trump Says He May Keep Parts of Obama Health Care Act (https://www.nytimes.com/2016/11/12/business/insurers-unprepared-for-obamacare-repeal.html)," *New York Times*, Nov. 11, 2016.

6 S. R. Collins, M. Z. Gunja, M. M. Doty, and S. Beutel, *How the Affordable Care Act Has Improved Americans' Ability to Buy Health Insurance on Their Own (/publications/issue-briefs/2017/feb/how-the-aca-has-improved-ability-to-buy-insurance)* (The Commonwealth Fund, Feb. 2017).

7 Based on our tabulations of data from the Centers for Disease Control and Prevention's Behavioral Risk Factor Surveillance System (BRFSS).

[1] Center for Consumer Information and Insurance Oversight data as of March 31, 2013.

[2] K. Pollitz, *High-Risk Pools for Uninsurable Individuals (http://www.kff.org/health-reform/issue-brief/high-risk-pools-for-uninsurable-individuals/)* (Henry J. Kaiser Family Foundation, Aug. 2016, updated Feb. 2017).

Texas, et al. v.

United States of America, et al.

USDC Northern District of Texas

Case No. 4:18-cv-00167-O

Exhibit B

STATE OF MAINE
CUMBERLAND, ss

BUSINESS AND CONSUMER COURT
CIVIL ACTION
Doc. No. BCD-AP-18-02

MAINE EQUAL JUSTICE PARTNERS, CONSUMERS FOR AFFORDABLE HEALTH CARE, et al.

Petitioners

v.

RICKER HAMILTON, COMMISSIONER MAINE DEPARTMENT OF HEALTH AND HUMAN SERVICES

Respondent

ORDER ON M.R. CIV. P. 80C APPEAL OF AGENCY ACTION

I. Background

On November 7, 2017, the people of Maine enacted "An Act to Enhance Access to Affordable Health" ("2017 I.B. 2") by citizens' initiative. It was codified at 22 M.R.S. § 3174-G(1)(H). 2017 I.B. 2 adds the following language to Section 3174-G:

> **1. Delivery of services.** The department shall provide for the delivery of federally approved Medicaid services to the following persons:
> ...
> G. No later than 180 days after the effective date of this paragraph, a person under 65 years of age who is not otherwise eligible for assistance under this chapter and who qualifies for medical assistance pursuant to 42 United States Code, Section 1396a(a)(10)(A)(i)(VIII) when the person's income is at or below 133% plus 5% of the nonfarm income official poverty line for the applicable family size. The department shall provide such a person, at a minimum, the same scope of medical assistance as is provided to a person described in paragraph E.
>
> Cost sharing, including copayments, for coverage established under this paragraph may not exceed the maximum allowable amounts authorized under section 3173-C, subsection 7. No later than 90 days after the effective date of this paragraph, the department shall submit a state plan amendment to the United

> States Department of Health and Human Services, Centers for Medicare and Medicaid Services ensuring MaineCare eligibility for people under 65 years of age who qualify for medical assistance pursuant to 42 United States Code, Section 1396a(a)(10)(A)(i)(VIII).
>
> The department shall adopt rules, including emergency rules pursuant to Title 5, section 8054 if necessary, to implement this paragraph in a timely manner to ensure that the persons described in this paragraph are enrolled for and eligible to receive services no later than 180 days after the effective date of this paragraph. Rules adopted pursuant to this paragraph are routine technical rules as defined by Title 5, chapter 375, subchapter 2-A.

22 M.R.S. § 3174-G(1)(H), 2017 I.B. 2. By voting in favor of 2017 I.B. 2, the people of Maine voted to expand MaineCare coverage to low-income individuals under the age of 65 who qualify for assistance according to federal guidelines set out in 42 United States Code, Section 1396a(a)(10)(A)(i)(VIII). Expansion pursuant to 2017 I.B. 2 allows the State of Maine to take advantage of a provision of the Patient Protection and Affordable Care Act ("ACA") that extends Medicaid coverage to this group and offered complete federal cost coverage between 2013 and 2016, after which that federal contribution gradually decreases to a permanent 90% coverage in and after 2020.

2017 I.B. 2 requires the Commissioner to submit a state plan amendment ("SPA") to the United States Department of Health and Human Services, Centers for Medicare and Medicaid Services within 90 days of the effective date of 2017 I.B. 2; promulgate rules within 180 days of the effective date; and provide coverage to the above described group within 180 days of the effective date. Ninety days have passed since 2017 I.B. 2 was enacted and the Commissioner has not filed a SPA. Petitioners seek an order of the Court requiring the Commissioner to file a SPA immediately and adopt rules and provide coverage within the statutory deadline of 180 days from the effective date of 2017 I.B. 2.

II. Standard of Review

When reviewing the determination of a government agency, the Court looks to issues of statutory construction de novo. *Munjoy Sporting & Ath. Club v. Dow*, 2000 ME 141, ¶ 7, 755 A.2d 531. If the agency's decision was committed to the reasonable discretion of the agency, the party appealing has the burden of demonstrating that the agency abused its discretion in reaching the decision. *See Sager v. Town of Bowdoinham*, 2004 ME 40, ¶ 11, 845 A.2d 567. "An abuse of discretion may be found where an appellant demonstrates that the decision maker exceeded the bounds of the reasonable choices available to it, considering the facts and circumstances of the particular case and the governing law." *Id.* Ultimately, the petitioner must prove that "no competent evidence" supports the agency's decision. *Seider v. Bd. of Examiners of Psychologists,* 2000 ME 206, ¶ 9, 762 A.2d 551 (citing *Bischoff v. Bd. of Trustees*, 661 A.2d 167, 170 (Me. 1995)). The mere fact that there is "[i]nconsistent evidence will not render an agency decision unsupported." *Id.*

Review of an agency's interpretation of statute is performed in the following manner:

> First, the court decides de novo whether the statute is ambiguous or unambiguous.
>
> Second, if the statute is unambiguous, the statute is construed directly, without deference to the agency's interpretation on the question of law. An agency cannot, by regulation, create an ambiguity in interpretation of a statute that does not otherwise exist.
>
> Third, if the statute is viewed as ambiguous, the agency's interpretation, although not conclusive, is reviewed with great deference and will be upheld unless contrary to the plain meaning of the statute.

Alexander, *Maine Appellate Practice* § 8(b)(3) (4th ed. 2013); citations omitted, *citing City of Bangor v. Penobscot County*, 2005 ME 35, ¶ 9, 868 A.2d 177; *Whitney v. Wal-Mart Stores, Inc.*, 2006 ME 37, ¶¶ 22-23, 895 A.2d 309; *Dep't of Corrections v. Pub. Utils. Comm'n*, 2009 ME 40,

¶ 8, 968 A.2d 1047; *S.D. Warren Co. v. Bd. Of Environmental Prot.*, 2005 ME 27, ¶¶ 4-5, 868 A.2d 210, *aff'd*, 547 U.S. 370; *Kane v. Comm'r of Dep't of Health and Human Servs.*, 2008 ME 185, ¶ 12, 960 A.2d 1196. "Only if the statute is ambiguous will we look to extrinsic indicia of legislative intent such as relevant legislative history." *Sabina v. JPMorgan Chase Bank, N.A.*, 2016 ME 141, ¶ 6; *quoting Strout v. Cent. Me. Med. Ctr.*, 2014 ME 77, ¶ 10, 94 A.3d 786.

III. Discussion

A. Record

Petitioners attached an affidavit of State Representative Andrew Gattine to their reply brief and used language suggesting a motion for the Court to take additional evidence. The Commissioner objects to the taking of additional evidence and to consideration of the Rep. Gattine affidavit "to the extent that Rep. Gattine's affidavit is offered in some capacity as a purported expert on the appropriations process or DHHS funding." The Commissioner does not object to Court consideration of the exhibits attached to the affidavit, but does not concede that the documents are relevant or accurate. At hearing, the Court offered the Commissioner the opportunity to submit additional documents to the record but the Commissioner declined the invitation.

In analyzing legislative intent, the Court will not consider Rep. Gattine's affidavit submitted by the Petitioners or any other material submitted by the parties created after the passage of 2017 I.B. 2. "[P]ost-enactment comments are not legally cognizable legislative history." *Seven Islands Land Co. v. Maine Land Use Regulation Com.*, 450 A.2d 475, 481 n. 9 (Me. 1982). Additionally, the Court denies any motion Petitioners may have made for the taking of additional evidence in their Reply Brief because any evidence presented would likely be post-

enactment comments. In terms of deciphering the Commissioner's reasons for not taking action on 2017 I.B. 2, the Court will consider all documentation presented without objection.

B. Ripeness

i. Questions before the Court

The Commissioner argues that because 180 days have not passed since the effective date of 2017 I.B. 2, the question of whether or not the Commissioner is required to promulgate rules or provide coverage is not yet ripe. 2017 I.B. 2 will have been effective for 180 days on July 2, 2018.[1] "[A] case is ripe when there exists a genuine controversy between the parties that presents a concrete, certain, and immediate legal problem." *Johnson v. City of Augusta*, 2006 ME 92, ¶ 7, 902 A.2d 855. The Commissioner argues that because it has not yet failed to comply with 2017 I.B. 2's language concerning what must occur 180 days after its effective date, there is no genuine controversy and the issue is not ripe for appeal. The Court finds that only the questions concerning the filing of the SPA are ripe, not those pertaining to rulemaking or coverage because the deadlines for those actions are still on the horizon.

ii. Effective Date

The Commissioner disputes the effective date of 2017 I.B. 2, arguing that the effective date is in fact February 17, 2018, not January 3, 2018 as stated by the Petitioners. According to the Maine Constitution:

> Any measure referred to the people and approved by a majority of the votes given thereon shall, unless a later date is specified in said measure, take effect and become a law in 30 days after the Governor has made public proclamation of the result of the vote on said measure, which the Governor shall do within 10 days after the vote thereon has been canvassed and determined; provided, however, that any such measure which entails expenditure in an amount in excess of available and unappropriated state funds shall remain inoperative until 45 days

[1] According to the Commissioner's argument, 2017 I.B. 2 will not have been effective for 180 days until August 16, 2018. See discussion below.

> after the next convening of the Legislature in regular session, unless the measure provides for raising new revenues adequate for its operation.

Maine Const. Art. IV, pt. 3, § 19.

The Petitioners calculated the effective date as "30 days after the Governor has made public proclamation of the result of the vote", finding it to be January 3, 2018. The Commissioner argues that, because the 2017 I.B. 2 requires expenditures for which there have not yet been appropriations, and because the legislation itself did not provide for raising new revenues adequate for its operation, 2017 I.B. 2 "remain[ed] inoperative until 45 days after the next convening of the Legislature in regular session," bringing the effective date to February 17, 2018.

As Petitioner points out in its Reply, the operative date of legislation is delayed where the law "entails expenditure in an amount in excess of available and unappropriated state funds." The constitutional language does not concern itself with whether the funds have been appropriated for the purpose found in the new law, but instead whether there are "available and unappropriated funds." *See Maine Senate v. Sec. of State et al.*, 2018, ME 52, ¶ 30, __ A.3d __ (distinction between unappropriated and unavailable, appropriated funds). Petitioners further argue in their Reply Brief that there is reason to believe that there are available funds to cover the expenditures required by 2017 I.B. 2.[2]

Additionally, Petitioners argue that even were the Court to find that there were not unallocated, available funds to cover the expenditures required by 2017 I.B. 2, the effective date would still be January 3, 2018. What would have been delayed were there not unallocated,

[2] The Office of Fiscal and Program Review's estimate of available funds attached to Petitioners' Reply Brief exceed the alleged estimated expenditures. The Commissioner argues that the numbers in the OFPR estimate are current, but that the Court should instead be looking at figures as of the effective date of the statute. The Court declines both parties' requests to consider funding in order to calculate the effective date of 2017 I.B. 2.

available funds would be the date the law became operative, not the effective date. *See Opinion of the Justices*, 460 A.2d 1341, 1349-50 (Me. 1982). Finally, again as noted by Petitioners in their Reply Brief, until the Commissioner's Opposition Brief, the Commissioner appeared to concede the effective date of January 3, 2018 as is evidenced by the written effective date on 2017 I.B. 2.

The Court agrees with the Petitioners' argument that the cited constitutional provision may cause a statute to remain "inoperative" when there are insufficient available and unappropriated funds, but the effective date would be unchanged.[3] The Court finds that regardless of the "operative" date of 2017 I.B. 2, the effective date of 2017 I.B. 2 was January 3, 2018. Additionally, more than 90 days have elapsed since *both* the effective date proposed by the Petitioners and that proposed by the Commissioner. Therefore, the Court need not delve into the exact figures of when and whether there were and are sufficient unallocated, available funds to cover the expenditures required by 2017 I.B. 2.

C. Separation of Powers

The Commissioner argues that the Court does not have jurisdiction over the current controversy because compliance with 2017 I.B. 2 is a question of funding which may only be determined by the Legislature. The Commissioner contends that were the Court to weigh in, the Court would violate the separation of powers established in the Maine State Constitution.[4]

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[3] What the Court finds most notable about the constitutional language providing for a later operative date for a measure referred to the people "which entails expenditure in an amount in excess of available and unappropriated state funds," is that the framers anticipated that there would be unfunded referenda and initiatives, and that not only would they not be funded, but that some of these unfunded referenda would require funding in excess of available state funds. In anticipation of such a situation, the framers expressed that they did not intend for the unfunded law to become unenforceable, but instead provided for the operation of the law to be delayed in order that the legislature have the time to carry out the will of the people.

[4] The Commissioner also objects to the Court's jurisdiction over the matter arguing that the current issue is a political question and therefore not appropriate for judicial review. As the Law Court has consistently held, "it is not our duty to judge the wisdom of legislative enactments." *Davies v. Bath*, 364 A.2d 1269, 1271 (Me. 1976). The Court is not entering the debate concerning whether or not MaineCare expansion is good policy. Following years of

According to the Maine Constitution, "[n]o person or persons, belonging to one [of the three branches of government], shall exercise any of the powers properly belonging to either of the others, except in the cases herein expressly directed or permitted." Me. Const. art. III, §§ 1-2. "Each of the three departments being independent, as a consequence, are severally supreme within their legitimate and appropriate sphere of action." *Ex parte Davis*, 41 Me. 38, 53 (Me. 1856.

As explained in Marshall Tinkle's *The Maine State Constitution*,

> Section 1 [of the Maine State Constitution] broadly distributes all governmental power into the legislative, executive, and judicial departments. These are distinct, co-equal branches of state government. In general, the first branch enacts laws, the second approves and executes them, and the third expounds and enforces them....
>
> The doctrine of separation of powers presupposes that a member of one branch of government may not undertake the duties properly belonging to another branch. Thus, this section prevents the judiciary from restricting or enlarging interpretation to laws in conflict with properly rendered judicial opinion, and the legislature from attempting to enact laws that the court declares unconstitutional."

Tinkle, *The Maine State Constitution* 70-71 (2d ed. 2013). As recently explained by the U.S. Supreme Court of the U.S. Constitution, "[t]o the Framers, the separation of powers and checks and balances were more than just theories. They were practical and real protections for individual liberty in the new Constitution." *Perez v. Mortg. Bankers Ass'n,* 575 U.S. __, 135 S. Ct. 1199, 1216 (2015). "The Framers were well aware of the natural desire of office holders as well as others to seek to expand the scope and authority of their particular office at the expense of others. They sought to provide against success in such efforts by erecting adequate checks and balances in the form of grants of authority to each branch of the government in order to counteract and prevent usurpation on the part of the others." *Furman v. Ga.*, 408 U.S.

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debate between the legislative and executive branches, any question concerning the wisdom of the current policy has been resolved, at least for the time being, by the people's initiative enacting 2017 I.B. 2.

238, 469-470 (1972). As in the U.S. Constitution, the checks and balances of the Maine Constitution maintain the separation of powers among the branches of government and the independent liberties of the governed.

To that end, the Court recognizes it does not have the authority to require the Legislature to appropriate funds, especially in a case such as this one where the act in question, namely the submission of the SPA, may be performed without appropriation. *Maine Senate,* 2018 ME 52, ¶ 30, __ A.3d __. However, it is the Court's role to interpret the law in the context of a controversy, such as is currently before it. As the Law Court recently wrote in *Maine Senate*, "our constitutional structure does not require that the Judicial Branch shrink from a confrontation with the other two coequal branches." *Id.* ¶ 29; citing *Raines v. Byrd*, 521 U.S. 811, 833 (1997) (Souter, J., concurring). In fact the vehicles by which the Petitioners have brought this action, Maine Rule of Civil Procedure 80C and the Maine Administrative Procedures Act, were created in anticipation of cases such as this one, in which a party seeks to challenge the actions of an administrative body for decisions "(1) In violation of constitutional or statutory provisions; (2) In excess of the statutory authority of the agency; (3) Made upon unlawful procedure; (4) Affected by bias or error of law; (5) Unsupported by substantial evidence on the whole record; or (6) Arbitrary or capricious or characterized by abuse of discretion." 5 M.R.S. § 11007.

The Law Court did just that in *Manirakiza v. Dep't of Health and Human Services*. In *Manirakiza*, following a legislative amendment expanding food stamp benefits, the Department of Health and Human Services argued that the Court could not require its compliance with the amended statute because doing so would require appropriations, thereby violating the separation of powers. *Manirakiza v. HHS*, 2018 ME 10, 177 A.3d 1264. The Law Court found that engaging in statutory analysis could not violate the separation of powers and held that DHHS

was required to provide food stamp benefits to those newly eligible because of the amendment "in the same way that it must provide food assistance to those persons eligible under" the earlier enacted provisions. *Id.* ¶ 15. In this case, as in *Manirakiza*, it is the duty of the Court to interpret the legislative intent of L.D. 1039 and review the Commissioner's decisions, regardless of the status of appropriations.

D. Statutory Interpretation

Law created through the initiative process "is evaluated under the ordinary rules of statutory construction." *League of Women Voters v. Sec. of State*, 683 A.2d 769, 771 (Me. 1996). The general rules of statutory interpretation require the Court to interpret statutes by their plain language where the language is unambiguous. *Arsenault v. Sec. of State*, 2006 ME 111, ¶ 11, 905 A.2d 285; *Opinion of the Justices*, 460 A.2d 1341, 1345 (Me. 1982) ("Where the meaning of terms used in a statute is plain, we need look no further to conclude that the law means exactly what it says.") In this case, when read as a whole, the statute is clear and unambiguous. Coverage shall be extended "no later than 180 days after the effective date" of 2017 I.B. 2, the state plan amendment shall be submitted "no later than 90 days after the effective date," and the department shall adopt rules to implement the expansion within 180 days of the effective date. If there were any question as to the meaning of the word "shall," 1 M.R.S. § 71 defines shall, must, and may as indicating "a mandatory duty, action or requirement." 1 M.R.S. § 71.

Nevertheless, the Commissioner argues that the language setting out the timeline for the tasks to be accomplished – namely the SPA, rulemaking, and expansion of coverage – is directory rather than mandatory. The Commissioner cites to *Anderson v. Comm'r of Dep't of Human Services* in support of his argument. In *Anderson*, the Petitioner appealed the recovery of overpayment of Aid to Families with Dependent Children benefits, conceding the overpayment,

arguing that the Department violated federal and state regulations requiring that the agency take action to recover overpayment by the end of the quarter following the quarter in which the overpayment is first identified, and therefore the agency should be estopped from recovery. *Anderson v. Comm'r of Dep't of Human Services*, 489 A.2d 1094, 1096-97 (Me. 1985). Despite clear regulatory language concerning the time in which the agency was to take action to recover overpayment, the Law Court considered the Department's argument that the language of the regulations proscribing the time in which the Department had to act in order to recover overpayment of benefits was directory language, not mandatory. The Court cited to 1A Sutherland, *Statutes and Statutory Construction* § 25.03 at 298-99 (4th ed. C. Sands ed. 1972):

> Generally those directions which are not of the essence of the thing to be done, but which are given with a view merely to the proper, orderly and prompt conduct of the business, and by the failure to obey no prejudice will occur to those whose rights are protected by the statute, are not commonly considered mandatory. Likewise, if the act is performed but not in the time or in the precise manner directed by the statute, the provision will not be considered mandatory if the purpose of the statute has been substantially complied with and no substantial rights have been jeopardized.

Anderson, 489 A.2d at 1098 (Me. 1985). In its analysis, the Law Court found that the general purpose of the regulations concerning the time in which the agency seeks to recover overpayment was to reduce federal spending. *Id.* at 1098. Additionally, the Law Court found that there was no negative effect on the plaintiff because the overpayment had ceased to accrue before the Department identified the error. *Id.* Because the Law Court found that the recovery timeline set out in the regulation spoke to the "orderly and prompt conduct of business" rather than "the essence of the thing to be done;" and "by the failure to obey no prejudice will occur to those whose rights are protected by statute," the Law Court found that the regulation timelines were directory rather than mandatory, requiring substantial compliance rather than strict compliance. *Id.* at 1099.

The Commissioner argues that the facts of the current matter track those of *Anderson*, and the Court should find that the language of 2017 I.B. 2 is directory instead of mandatory. Petitioners argue that *Anderson* predated 1 M.R.S. § 71, and was thus replaced by 1 M.R.S. § 71, which statutorily clarified that the word "shall" indicates that the thing to be done is mandatory.

The Court need not make a determination as to whether the language of 2017 I.B. 2 is mandatory or directory, because even if the language is directory as the Commissioner suggests, the Commissioner has not substantially complied with 2017 I.B. 2. A finding that statutory language is directory rather than mandatory does not permit non-compliance. Even where statutory language is directory, the agency must substantially comply. *Id.* at 1098. In this case, the Commissioner has taken no action at all to submit the SPA according to 2017 I.B. 2. He argues that his obligations do not begin until the appropriations are made. The Court disagrees. The Court is not persuaded that the executive branch is excused from clear statutory obligations by the legislature's failure to follow through with legislative obligations - as defined by the executive branch. The Commissioner has not cited to any authority suggesting that an agency can be considered to have substantially complied with a directory statute by taking no action at all. The Court concludes that the Commissioner's complete failure to act cannot be considered substantial compliance with 2017 I.B. 2.[5]

[5] The Commissioner cites to three sections of Title 5 of the Maine Revised Statutes in support of its argument that "specifically restrict—under penalty of criminal prosecution—the authority of the Commissioner (and other state officials) to exceed the limits of appropriated funds." The Court finds that the cited statutes do not apply to the current controversy. Section 1543 states: "Money may not be drawn from the State Treasury except in accordance with appropriations duly authorized by law. Every disbursement from the State Treasury must be upon the authorization of the State Controller and the Treasurer of State..." 5 M.R.S. § 1543. Section 1543 does not apply because no money need be drawn from the State Treasury in order for the Commissioner to submit the SPA. Section 1582(1) states: "A state department may not establish a new program or expand an existing program beyond the scope of the program already established, recognized and approved by the Legislature until the program and the method of financing are submitted to the Department of Administrative and Financial Services, Bureau of the Budget for evaluation and recommendation to the Legislature and until the funds are made available for the program by the Legislature." 5 M.R.S. § 1582(1). This section is not applicable because 2017 I.B. 2 expands the MaineCare program through legislation, no expansion has been accomplished by a state department. Finally, 5 M.R.S. § 1583 states: "No agent or officer of the State or any department or agency thereof, whose duty it is to expend money

IV. Conclusion

The Court Orders the Commissioner to submit a state plan amendment to the United States Department of Health and Human Services, Centers for Medicare and Medicaid Services ensuring MaineCare eligibility for people under 65 years of age who qualify for medical assistance pursuant to 42 United States Code, Section 1396a(a)(10)(A)(i)(VIII) by June 11, 2018.

The Clerk is directed to incorporate this Order into the docket by reference pursuant to M.R. Civ. P. 79(a).

DATE: June 4, 2018

/ S
Michaela Murphy
Justice, Superior Court

under an appropriation by the Legislature, shall contract any obligation on behalf of the State in excess of the appropriation. Whoever exceeds in his expenditure said appropriation shall not have any claim for reimbursement. Any person who knowingly violates this section shall be guilty of a Class E crime." 5 M.R.S. § 1583. Because this case addresses only the SPA, and because no money need be expended to submit the SPA, the Court finds that this section also does not apply. The Commissioner further argues that the SPA would act as a binding contract requiring the Commissioner to expend money that has not been appropriated, and thereby causing the Commissioner to act in violation of Section 1583. The Court is not persuaded by the Commissioner's argument as it seems clear from the record that federal law permits States to withdraw from Medicaid expansion, and the Legislature is always free to amend or repeal the statute before the Court.

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Exhibit C

Medicaid Expansion Spending | The Henry J. Kaiser Family Founc

Timeframe: FY2015

Location	Total Medicaid Spending	Traditional Medicaid - Federal Spending	Traditional Medicaid - State Spending	Expansion Group - Federal Spending	Expansion Group - State Spending
United States	**$523,017,640,000**	**$259,913,762,800**	**$190,034,108,800**	**$68,782,512,900**	**$4,287,255,500**
Alabama	$5,359,732,800	$3,727,766,000	$1,631,966,800	N/A	N/A
Alaska [1]	$1,561,793,700	$916,877,400	$644,824,400	$91,900	$0
Arizona	$10,493,071,500	$5,771,357,000	$2,445,719,000	$2,032,795,200	$243,200,300
Arkansas	$5,537,216,200	$2,974,318,700	$1,187,284,500	$1,375,613,100	$0
California	$79,235,061,900	$30,187,018,400	$29,427,523,400	$19,620,520,100	$0
Colorado	$7,321,807,100	$3,052,671,000	$2,914,907,800	$1,350,776,600	$3,451,700
Connecticut	$7,686,415,900	$3,209,975,900	$3,117,001,800	$1,309,458,500	$49,979,700
Delaware	$1,845,979,100	$771,851,900	$668,007,500	$335,896,200	$70,223,500
District of Columbia	$2,492,791,300	$1,504,228,400	$646,015,900	$340,595,200	$1,951,900
Florida	$20,775,031,700	$12,543,630,800	$8,231,400,900	N/A	N/A
Georgia	$9,688,582,900	$6,551,323,800	$3,137,259,100	N/A	N/A
Hawaii	$2,005,789,100	$780,388,300	$704,571,300	$490,247,000	$30,582,500
Idaho	$1,805,626,800	$1,298,620,800	$507,006,100	N/A	N/A
Illinois	$17,257,281,200	$7,196,342,900	$6,779,091,500	$3,208,343,300	$73,503,500
Indiana [1]	$9,289,821,200	$5,451,840,900	$2,710,394,500	$912,288,400	$215,297,500
Iowa	$4,536,093,800	$2,142,345,900	$1,644,687,400	$730,414,600	$18,645,900
Kansas	$3,054,480,500	$1,740,969,600	$1,313,510,900	N/A	N/A
Kentucky	$9,445,054,700	$4,554,147,000	$1,915,011,100	$2,975,896,600	$0
Louisiana [2]	$7,577,572,200	$4,728,883,500	$2,848,688,800	N/A	N/A
Maine	$2,598,315,200	$1,624,850,200	$973,465,000	N/A	N/A
Maryland	$9,521,364,000	$3,931,039,300	$3,832,108,600	$1,758,507,800	-$291,700
Massachusetts	$16,085,870,300	$7,226,545,700	$6,996,287,900	$1,471,090,700	$391,946,000
Michigan	$16,047,915,500	$8,437,966,300	$4,353,616,500	$3,211,493,500	$44,839,300
Minnesota	$10,968,220,600	$4,647,584,700	$4,574,549,500	$1,745,618,200	$468,100
Mississippi	$5,204,753,500	$3,860,362,100	$1,344,391,400	N/A	N/A
Missouri	$9,653,587,200	$6,183,598,400	$3,469,988,800	N/A	N/A
Montana [2]	$1,156,544,800	$782,360,200	$374,184,600	N/A	N/A
Nebraska	$1,875,764,100	$1,007,517,200	$868,247,000	N/A	N/A
Nevada	$3,063,109,400	$1,396,275,100	$748,629,900	$918,204,400	$0
New Hampshire	$1,724,417,700	$728,415,100	$711,708,600	$283,061,100	$1,232,900
New Jersey	$14,399,836,100	$5,890,857,400	$5,567,031,800	$2,941,947,000	$0
New Mexico	$4,897,689,600	$2,494,317,400	$1,028,889,200	$1,374,483,000	$0
New York	$59,204,446,800	$24,953,872,700	$23,627,742,200	$7,719,925,800	$2,902,906,100
North Carolina	$12,734,419,800	$8,432,788,300	$4,301,631,600	N/A	N/A
North Dakota	$1,098,597,600	$436,471,400	$422,415,000	$236,736,900	$2,974,300
Ohio	$20,727,785,000	$10,918,448,200	$6,284,095,000	$3,453,889,800	$71,352,000
Oklahoma	$4,992,200,800	$3,170,115,100	$1,822,085,800	N/A	N/A
Oregon	$8,169,086,300	$3,641,333,000	$1,862,726,500	$2,664,050,600	$976,200
Pennsylvania [1]	$23,389,577,800	$11,226,998,100	$10,229,293,600	$1,853,506,400	$79,779,600
Rhode Island	$2,603,843,400	$1,078,441,600	$1,065,245,100	$460,156,700	$0
South Carolina	$5,983,144,000	$4,233,188,500	$1,749,955,400	N/A	N/A

South Dakota	$835,071,400	$468,266,700	$366,804,700	N/A	N/A
Tennessee	$9,072,234,900	$5,925,396,600	$3,146,838,300	N/A	N/A
Texas	$34,885,244,100	$20,511,500,500	$14,373,743,600	N/A	N/A
Utah	$2,274,274,100	$1,612,573,600	$661,700,400	N/A	N/A
Vermont	$1,632,322,400	$774,757,600	$599,613,500	$210,423,400	$47,528,000
Virginia	$8,023,384,800	$4,061,853,100	$3,961,531,700	N/A	N/A
Washington	$10,810,661,100	$3,924,855,400	$3,759,189,600	$3,089,908,000	$36,708,100
West Virginia	$3,677,053,400	$2,122,670,400	$847,809,900	$706,573,200	$0
Wisconsin	$8,190,622,000	$4,824,538,000	$3,366,083,900	N/A	N/A
Wyoming	$547,078,400	$279,446,800	$267,631,600	N/A	N/A

NOTES

Notes

Medicaid is financed by both the federal government and the states using a formula that is based on a state's per capita income. The federal share (FMAP) va from a floor of 50% to a high of 74% with exceptions for certain services or populations. The Affordable Care Act (ACA) expanded Medicaid eligibility for adult 65 and provided the states that chose to expand with an Enhanced FMAP of 100% federal funding through 2016 for the newly eligible adults. The federal sha expansion population phases down to 95% in 2017 and to 90% by 2020 and beyond.

Spending is rounded to the nearest 100. States totals may not sum to national total due to rounding.

Sources

Kaiser Family Foundation analysis of Medicaid spending data from the Centers for Medicare and Medicaid Services (CMS) Medicaid Budget and Expenditure S (MBES).

Definitions

Traditional Medicaid Spending: Medicaid spending that does not include spending on adults enrolled in the ACA expansion group.

Expansion Group Spending: Spending for adults who have enrolled in Medicaid through the ACA's expansion of the program.

N/A: Not applicable. State did not expand Medicaid.

FOOTNOTES

1. Three states expanded Medicaid mid-way through FY 2015: Pennsylvania on 1/1/15, Indiana on 2/1/15, and Alaska on 9/1/15.
2. Montana expanded Medicaid on 1/1/16 and Louisiana expanded Medicaid on 7/1/16; therefore, neither state reported spending on the expansion group i

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Exhibit D

High-Risk Pools For Uninsurable Individuals

Karen Pollitz (https://www.kff.org/person/karen-pollitz/)

Published: Feb 22, 2017

ISSUE BRIEF

Updated on February 22, 2017. Originally posted August 1, 2016.

In the debate over the future of the Affordable Care Act (ACA), proposals have emerged that would repeal or weaken rules prohibiting health insurance discrimination based on health status, instead offering high-risk pools as a source of coverage for people who would be uninsurable due to pre-existing conditions.

Last year, HR 2653 (https://www.congress.gov/bill/114th-congress/house-bill/2653/text?q=%7B%22search%22%3A%5B%22%5C%22hr2653%5C%22%22%5D%7D&resultIndex=1#toc-HBE4E8AAE94E54C8E92D7F70A2C2983A8) was introduced by members of the House Republican Study Committee to repeal the ACA and replace it with other changes, including state high-risk pools. This bill would authorize $50 million for seed grants to help states establish high-risk pools, and $2.5 billion annually for 10 years to help states fund high-risk pools. More recent ACA replacement proposals (http://kff.org/interactive/proposals-to-replace-the-affordable-care-act/) would modify ACA market rules to guarantee access to non-group coverage for individuals who maintain continuous coverage, but not necessarily for other individuals; several proposals also would provide grants to states to help fund high-risk pools.

For more than 35 years, many states operated high-risk pool programs to offer non-group health coverage to uninsurable residents. The federal government also operated a temporary high-risk pool program established under the ACA to provide coverage to people with pre-existing conditions in advance of when broader insurance market changes took effect in 2014. This issue brief reviews the history of these programs to provide context for some of the potential benefits and challenges of a high-risk pool.

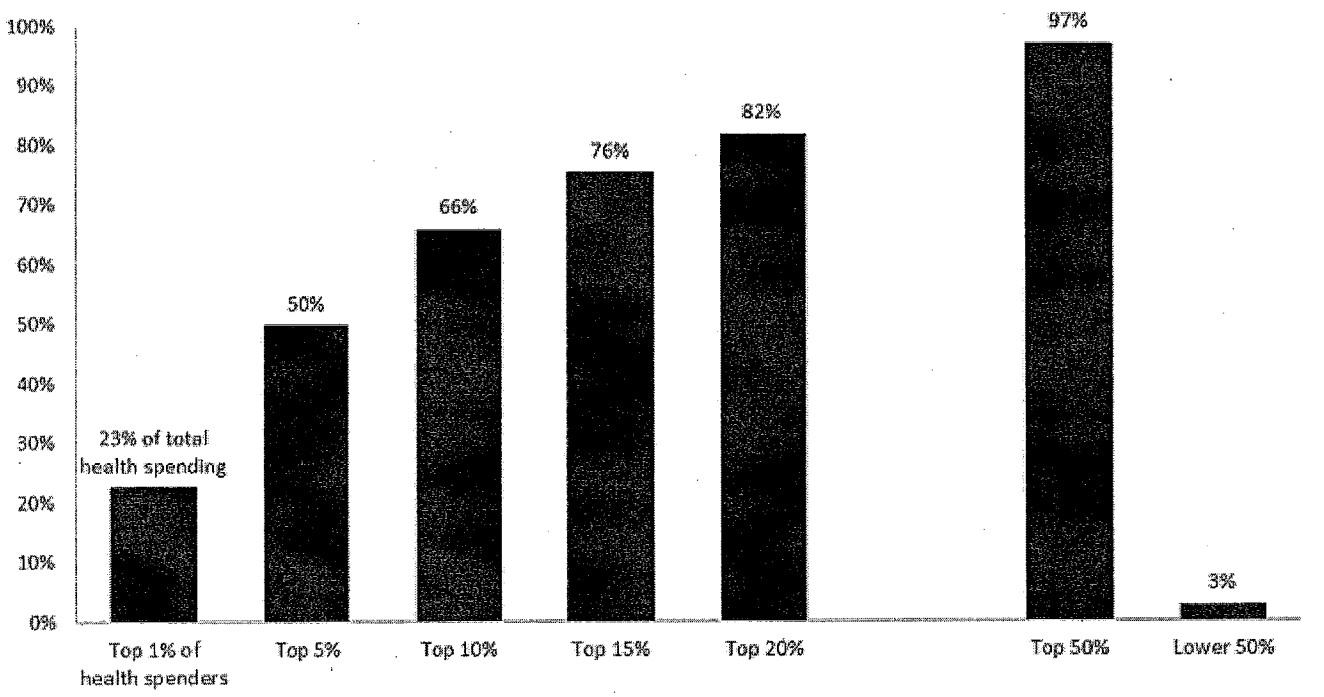
Distribution and Persistence of Population Health Spending

In the U.S. and other developed nations, population health care spending is highly concentrated: in any given year, the healthiest 50% of the population accounts for less than 3% of total health care expenditures, while the sickest 10% account for nearly two-thirds of population health spending (Figure 1). Private health insurance pools risks so that premiums paid by most enrollees, who have low claims costs, help pay claims for the small share of enrollees with high costs.

Who is included in the high-cost and low-cost groups changes from year to year. Most people are healthy most of the time, but illness and injury can and do onset unexpectedly for millions of people. Some high-cost conditions, such as hemophilia or HIV, persist and require treatment for extended periods, even a lifetime. Other high-cost conditions may improve or resolve, allowing patients to return to low annual health care spending. In any given year, among the 50% least expensive people in a year, 73% will remain in that group for a second year; similarly, of people who are among the most expensive 10% of the population in one year, only 45% would still be in that group the following year.[1] (https://www.kff.org/health-reform/issue-brief/high-risk-pools-for-uninsurable-individuals/view/footnotes/#footnote-194232-1)

Figure 1

Concentration of Health Care Spending in U.S. Population



Source: Kaiser Family Foundation analysis of Medical Expenditure Panel Survey, Agency for Healthcare Research and Quality, U.S. Department of Health and Human Services

Figure 1: Concentration of Health Care Spending in U.S. Population

Prior to implementation of the ACA, insurers selling individual insurance commonly practiced medical underwriting (https://kaiserfamilyfoundation.files.wordpress.com/2013/01/how-accessible-is-individual-health-insurance-for-consumer-in-less-than-perfect-health-report.pdf), excluding people with pre-existing conditions or charging them higher premiums. Medical underwriting effectively excludes a large proportion of total health care spending from th insurance pool. This can permit less expensive policies for healthier individuals, but requires some other mechanism, such as high-risk pools, to help finance costs attributable to the sickest individuals if they are to be covered. Enrollee premiums can finance a portion of the cost of such programs, but by definition, significant additional funding will also be required because the cost of each person covered will be substantial. For example, based on the distribution illustrated in Figure 1, per person costs in the top 10th percentile are more than 100 times, on average, that of people in the bottom 50th percentile.

State High-Risk Pools

Prior to implementation of the ACA, 35 states offered high-risk pools as a source of non-group health insurance for eligible residents (Figure 2). The first pools were implemented by Minnesota and Connecticut in 1976; North Carolina implemented a high-risk pool in 2009. Pools offered eligibility to people in one or more of the following categories:

Medically eligible – Originally, high-risk pools were created to offer coverage to state residents with pre-existing conditions that made them uninsurable in the medically underwritten non-group health insurance market. Alabama was the only state high-risk pool that did not provide coverage to medically eligible individuals. (The Florida pool, which did provide such coverage, closed to new enrollment in 1991.)[2] (https://www.kff.org/health-reform/issue-brief/high-risk-pools-for-uninsurable-individuals/view/footnotes/#footnote-194232-2) Medically eligible individuals had to demonstrate their application for individual health insurance had been denied or restricted, or – in about two-thirds of state pools with presumptively eligible medical conditions lists – that they had been diagnosed with an eligible condition.[3] (https://www.kff.org/health-reform/issue-brief/high-risk-pools-for-uninsurable-individuals/view/footnotes/#footnote-194232-3)

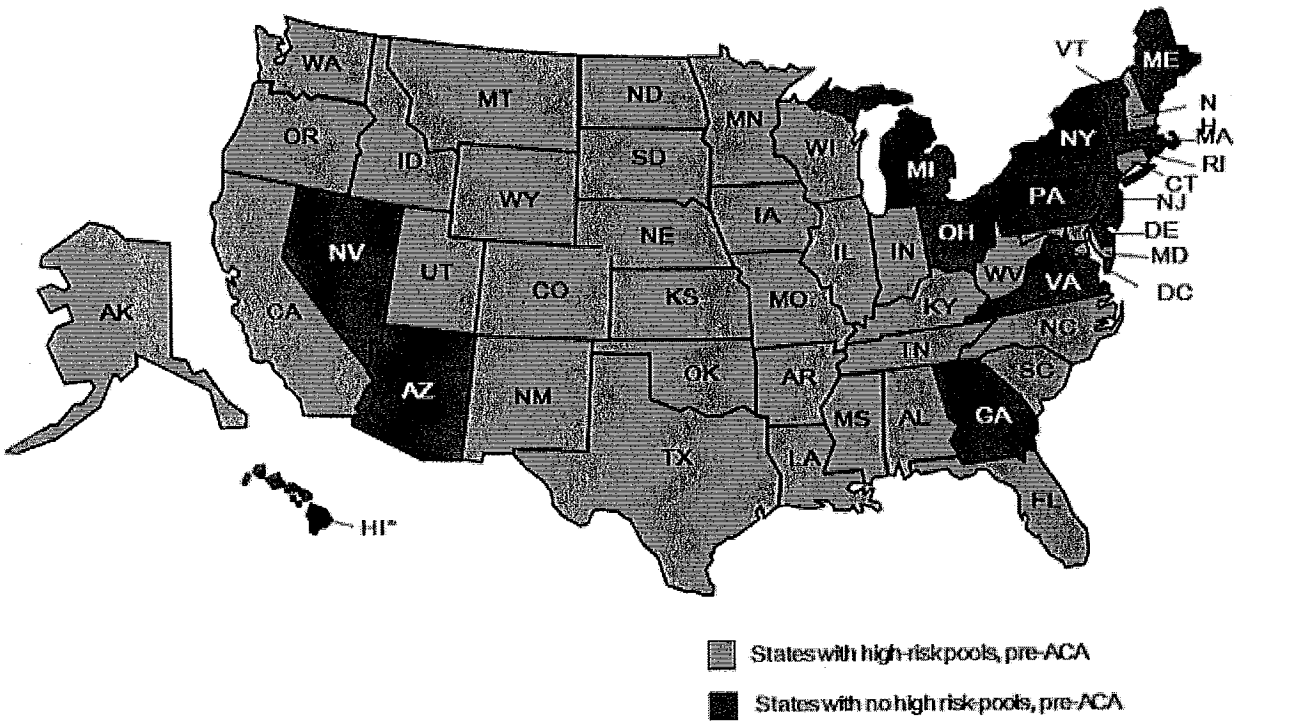
HIPAA eligible – Following enactment of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) – a federal law requiring non-group coverage to be available on a guaranteed issue basis with no pre-existing condition exclusions to certain individuals who had lost group health plan coverage – most state high-risk pools extende eligibility to HIPAA-eligible individuals. One state, Alabama, opened its pool only to HIPAA eligible individuals.[4] (https://www.kff.org/health-reform/issue-brief/high-risk-pools-for-uninsurable-individuals/view/footnotes/#footnote-194232-4)

HCTC eligible – The Trade Act of 2002 established a federal health coverage tax credit (HCTC) to subsidize HIPAA-like coverage for certain eligible individuals with trade-related job loss. Roughly two-thirds (http://naschip.org/2012/Quick%20Checks/tab15.pdf) of state pools extended eligibility to HCTC-eligible individuals.

Medicare eligible – Finally, nearly two-thirds (http://naschip.org/2012/Quick%20Checks/tab15.pdf of state high-risk pools offered coverage to Medicare-eligible residents who needed supplemental coverage.

Figure 2

Traditional State High-Risk Pools, Pre-ACA



SOURCE: Congressional Research Service, "Health Insurance: State High Risk Pools," January 26, 2011.

Figure 2: Traditional State High-Risk Pools, Pre-ACA

State High-Risk Pool Enrollment, Program Features, and Costs

Before HIPAA was enacted in 1996, there were 25 state high-risk pools with combined enrollment of 91,054.[5] (https://www.kff.org/health-reform/issue-brief/high-risk-pools-for-uninsurable-individuals/view/footnotes/#footnote-194232-5) By the end of 2011, combined enrollment in 35 state high-risk pools reached 226,615 (http://naschip.org/2012/Quick%20Checks/Pool%20Membership%202011.pdf). In four states (Maryland, Minnesota, Texas and Wisconsin) enrollment exceeded 20,000 individuals; in eleven states fewer than 2,000 individuals were enrolled. On average, state high-risk pool membership constituted about 2 percent of the number of non-group health insurance market participants that year.[6] (https://www.kff.org/health-reform/issue-brief/high-risk-pools-for-uninsurable-individuals/view/footnotes/#footnote-194232-6) (Table 1)

Table 1. State High-Risk Pool Enrollment as Percent of Non-Group Market Enrollment, 2011

Alabama	0.1%	Kentucky	2.8%	Oklahoma	1.6%
Alaska	2.5%	Louisiana	1%	Oregon	5%
Arkansas	2.4%	Maryland	7.6%	South Carolina	1%
California	0.2%	Minnesota	10.2%	South Dakota	1%
Colorado	3.5%	Mississippi	2.4%	Tennessee	1%
Connecticut	1%	Missouri	1.2%	Texas	2.6%
Florida	0.02%	Montana	3.5%	Utah	2.5%
Idaho	1.3%	Nebraska	2.9%	Washington	1.1%
Illinois	3.4%	New Hampshire	3.8%	West Virginia	4.4%
Indiana	3.9%	New Mexico	9.9%	Wisconsin	6.8%
Iowa	1.8%	North Carolina	2%	Wyoming	3.4%
Kansas	1%	North Dakota	2.3%	**Total**	**2.2%**

SOURCE: KFF calculations based on NASCHIP enrollment data (http://naschip.org/2012/Quick%20Checks/Pool%20Membership%202011.pdf) for 2011 and U.S. Census Bureau data, 2011 Current Population Survey

The potentially medically eligible population in high-risk pool states was likely much larger. A Kaiser Family Foundation study (http://kff.org/health-reform/issue-brief/pre-existing-conditions-and-medical-underwriting-in-the-individual-insurance-market-prior-to-the-aca/) found that 27% of adults under the age of 65 have health conditions that, prior to the ACA, would have rendered them uninsurable if they had sought coverage in the non-group market.

Although no two traditional state-high risk pools were identical, nearly all adopted certain common features that tended to limit enrollment of eligible individuals.[7] (https://www.kff.org/health-reform/issue-brief/high-risk-pools-for-uninsurable-individuals/view/footnotes/#footnote-194232-7) These included:

- *Premiums above standard non-group market rates* – All state high-risk pools set premiums at a multiple of standard (i.e., typical or average) rates for medically underwritten coverage in the non-group market; in most states (http://naschip.org/2011/Quick%20Checks/25/Premium%20Rate%20Setting%20Methodology%2010.pdf the pool premium was capped at 150%-200% of market rates. Nineteen pools (http://naschip.org/2012/Quick%20Checks/Lifetime%20Maximums.pdf) provided low-income premium subsidies that varied in comprehensiveness. The Oregon pool, for example, discounted premiums 95% for enrollees with income up to 185% of the poverty level, while the New Hampshire pool provided a 20% premium discount for enrollees with income below 200% FPL.[8] (https://www.kff.org/health-reform/issue-brief/high-risk-pools-for-uninsurable-individuals/view/footnotes/#footnote-194232-8) Other pools required people to pay the full premium, regardless of income.

- *Pre-existing condition exclusions* – Nearly all state high-risk pools excluded coverage of pre-existing conditions for medically eligible enrollees, usually for 6-12 months. This made coverage less attractive for people who needed coverage specifically for their pre-existing conditions. In nine states, (CT, ID, MS, MO, MT, NC, OK, TX, and WY) the exclusion period was 12 months; in Colorado and Indiana it was 3 months. The Alabama pool, which was only open for HIPAA-eligible individuals, did not impose pre-existing condition exclusion periods.[9] (https://www.kff.org/health-reform/issue-brief/high-risk-pools-for-uninsurable-individuals/view/footnotes/#footnote-194232-9)
- *Lifetime and annual limits* – Thirty-three pools imposed lifetime dollar limits (http://naschip.org/2012/Quick%20Checks/Lifetime%20Maximums.pdf) on covered services, most ranging from $1 million to $2 million. In addition, six pools imposed annual dollar limit: on all covered services while 13 others imposed annual dollar limits on specific benefit such as prescription drugs, mental health treatment, or rehabilitation.[10] (https://www.kff.org/health-reform/issue-brief/high-risk-pools-for-uninsurable-individuals/view/footnotes/#footnote-194232-10)
- *High deductibles* – Most pools offered a choice of plan options with different deductibles; in 29 programs (http://naschip.org/2012/Quick%20Checks/Lifetime%20Maximums.pdf), the plan option with the highest enrollment had a deductible of $1,00(or higher; in ten states it was $5,000 or higher.

A small number of states capped or closed enrollment to limit program costs, though enrollment caps were not allowed for HIPAA-eligible individuals. Limiting enrollment, directly or indirectly, was a key strategy to limit the cost of high-risk pools to states. By design, all state high-risk pools experienced net losses – that is, expenses (http://naschip.org/2012/Quick%20Checks/Total%20Expenses.pdf) greater than premium revenue (http://naschip.org/2012/Quick%20Checks/Total%20Revenue.pdf). In 2011, net losses for 35 state high-risk pools combined were over $1.2 billion, or $5,510 per enrollee, on average.[11] (https://www.kff.org/health-reform/issue-brief/high-risk-pools-for-uninsurable-individuals/view/footnotes/#footnote-194232-11) Most states financed net losses through an assessment on private non-group health insurance premiums; however, nearly all state high-risk pool assessments were offset by tax credits so that, in effect, general state revenue funding applied. A few states used other revenue sources – tobacco taxes and hospital assessments – to fund high-risk pool losses. In addition, in 2003-2010 federal grants were available intermittently, subject to appropriations, to help fund qualified state-high risk pools that met certain criteria. For the first two fiscal years (2003-2004) $8 million per year was appropriated; $75 million in grants was next awarded in 2006, followed by $49 million in 2008, $73.5 million in 2009, and $55 million in each of 2010 anc 2011. In some years, a portion of federal grant funds was reserved for states that adopted supplemental consumer benefits such as low-income premium subsidies. Federal grants comprised between 2% and 12% of program expenses in states that received them.[12] (https://www.kff.org/health-reform/issue-brief/high-risk-pools-for-uninsurable-individuals/view/footnotes/#footnote-194232-12)

Federal Pre-existing Condition Insurance Program (PCIP)

The ACA established a temporary, national high-risk pool program, implemented in 2010, to offer coverage for uninsured individuals with pre-existing conditions until 2014, when private non-group policies would be available under new market rules prohibiting insurance discrimination based on health status. The law required PCIP enrollees to pay premiums and appropriated $5 billion to fund expected net losses during the program's duration. Twenty-seven states opted to administer PCIP for their residents; the federal government operated PCIP for 23 states and D.C.

PCIP Enrollment, Program Features, and Costs

Program features under PCIP varied from state high-risk pools in several significant respects. Under the law, PCIP premiums were set at 100% of the standard risk rate for non-group health insurance in each state, meaning rates varied by age but were otherwise equivalent to what a typical person without a pre-existing condition would pay. Low income premium subsidies were not offered. PCIP did not impose annual or lifetime dollar limits on covered benefits. Annual out-of-pocket-cost sharing was capped at the level set for tax-favored high-deductible health plans ($6,050 in 2012) and a minimum actuarial value of 65% was established for program coverage (meaning patients were expected to pay, on average, 35% of their health expenses). In 42 states, the lowest deductible option offered in 2012 was at least $1,000.[13] (https://www.kff.org/health-reform/issue brief/high-risk-pools-for-uninsurable-individuals/view/footnotes/#footnote-194232-13)

PCIP did not impose pre-existing condition exclusions. However, to prevent "crowd out" from existing state pools and other private insurance, PCIP eligibility was limited to individuals who had been uninsured for at least 6 months immediately prior to enrolling.

PCIP was operational in all 50 states by the fall of 2010. By late 2012, just over 100,000 individuals were enrolled and program expenses had consumed nearly half of the $5 billion appropriation. For the final 12-month period for which PCIP expense data were reported, net losses for the program were over $2 billion. (Table 2)

Table 2. PCIP Enrollment and Net Expenses, 2011-2013

Date	Enrollment as of date	Cumulative expenditures net of premiums	Quarterly increase in net expenditures
May 31, 2011	24,712	$0.180 billion	—
Sep. 30, 2011	37,624	$0.386 billion	$207 million
Dec.31, 2011	48,879	$0.618 billion	$232 million
Mar. 31, 2012	61,619	$0.963 billion	$334 million
June 30, 2012	77,877	$1.401 billion	$439 million
Sep. 30, 2012	90,347	$1.861 billion	$460 million
Dec. 31, 2012	103,160	$2.406 billion	$545 million
Mar. 31,2013	114,959	$2.978 billion	$571 million
June 30, 2013	104,966	$3.602 billion	$625 million
Sep. 30, 2013	89,438	$3.956 billion	$354 million

SOURCE: PCIP quarterly data reports (https://www.cms.gov/cciio/Resources/Forms-Reports-and-Other-Resources/index.html#Pre-Existing Condition Insurance Plan (PCIP)), 2011-2013.

In 2012, average per enrollee claims costs for PCIP were $32,108, or more than 2.5 times higher than average per enrollee claims costs ($12,471) under traditional state high-risk pools, all of which continued to operate that year.[14] (https://www.kff.org/health-reform/issue-brief/high-risk-pools-for-uninsurable-individuals/view/footnotes/#footnote-194232-14) Compared to traditional state high-risk pool enrollees, PCIP enrollees tended to have more immediate and intensive health care needs, including higher hospital admissions, likely due to the six-month prior uninsurance requirement and lack of pre-existing condition exclusions.[15] (https://www.kff.org/health-reform/issue-brief/high-risk-pools-for-uninsurable-individuals/view/footnotes/#footnote-194232-15) By contrast, many traditional state pool enrollees were HIPAA-eligible, meaning they had to have been continuously covered and were less likely to have put off needed treatment prior to joining the pool. Pre-existing condition exclusions would have limited traditional pool coverage of initial treatment costs of (or enrollment by) other non-HIPAA eligible individuals.[16] (https://www.kff.org/health-reform/issue-brief/high-risk-pools-for-uninsurable-individuals/view/footnotes/#footnote-194232-16)

In addition, PCIP premiums were based on standard rates for underwritten non-group coverage, while under traditional state pools, premiums were usually set at 150%-200% o standard market rates. As a result, enrollees under traditional state pools paid a greater share of their claims costs compared to PCIP enrollees. This meant that the loss ratio – th ratio of claims costs to premiums – would naturally be higher in PCIP compared to the traditional state pools. In 2011, claims under traditional state high-risk pools averaged

181% of pool premiums; that year, PCIP claims averaged 417% of premiums. By late 201: the PCIP loss ratio had reached 600%.[17] (https://www.kff.org/health-reform/issue-brief/high-risk-pools-for-uninsurable-individuals/view/footnotes/#footnote-194232-17)

In the face of growing expenses, PCIP adopted a series of changes to limit program costs. In 2012 federally-administered programs switched to a less expensive provider network and negotiated additional discounts with targeted hospitals that treated large numbers o PCIP enrollees. State-run programs were required to achieve similar cost savings or transition to federal administration; 17 state programs transitioned in mid-2013. The federal PCIP program also consolidated plan options for 2013, eliminating those offering the lowest patient cost sharing. Even with these changes, program expenses were still projected to exceed appropriated funds before the end of 2013. In March 2013, new PCIF enrollment was suspended to ensure sufficient funds to pay claims for people already enrolled.[18] (https://www.kff.org/health-reform/issue-brief/high-risk-pools-for-uninsurable-individuals/view/footnotes/#footnote-194232-18) PCIP enrollment peaked at nearly 115,000 in March 2013, then declined below 90,000 six months later.

Discussion

Nearly four decades of experience with high-risk pools suggests they have the potential t provide health coverage to a substantial number of people with pre-existing conditions. State high-risk pools that existed prior to passage of the ACA covered over 200,000 peopl at their peak, and the temporary PCIP pool created as part of the ACA covered over 100,000 individuals.

These high-risk pools likely covered just a fraction of the number of people with pre-existing conditions who lacked insurance, due in part to design features that limited enrollment. State pools typically excluded coverage of services associated with pre-existing conditions for a period of time and charged premiums substantially in excess of what a typical person would pay in the non-group market. PCIP had fewer barriers to enrollment – charging standard premiums with no pre-existing condition exclusions – but it did restrict signups to people who had been uninsured for a least six months.

Even with these limitations, the government subsidies required to cover losses in these high-risk pools were substantial – over $1 billion per year in the state pools and about $2 billion in the final year of PCIP. A high-risk pool with minimal barriers to enrollment coulc cost substantially more.

The Henry J. Kaiser Family Foundation Headquarters: 2400 Sand Hill Road, Menlo Park, CA 94025 | Phone 650-854-9400

Washington Offices and Barbara Jordan Conference Center: 1330 G Street, NW, Washington, DC 20005 | Phone 202-347-5270

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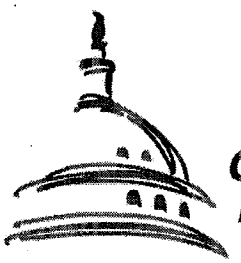
Texas, et al. v.

United States of America, et al.

USDC Northern District of Texas

Case No. 4:18-cv-00167-O

Exhibit E



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Legislative Actions in the 112th, 113th, and 114th Congresses to Repeal, Defund, or Delay the Affordable Care Act

C. Stephen Redhead
Specialist in Health Policy

Janet Kinzer
Senior Research Librarian

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CRS REPORT
Prepared for Members and
Committees of Congress

Summary

Congress is deeply divided over implementation of the Affordable Care Act (ACA), the health reform law enacted in March 2010 during the 111th Congress. Since the ACA's enactment, lawmakers opposed to specific provisions in the ACA or the entire law have repeatedly debated its implementation and considered bills to repeal, defund, delay, or otherwise amend the law.

During the 112th, 113th, and 114th Congresses, the Republican-led House passed numerous ACA-related bills, including legislation that would repeal the entire law. There was much less debate in the Senate, which remained under Democratic control during the 112th and 113th Congresses. Most of the House-passed ACA legislation was not considered in the Senate during that period. With Republicans in control of both chambers in the 114th Congress, opponents of the ACA sought new opportunities to pass legislation that would change the law.

The House-passed legislation included stand-alone bills as well as provisions in broader, often unrelated measures that would have (1) repealed the ACA in its entirety and, in some cases, replaced it with new law; (2) repealed, or by amendment restricted or otherwise limited, specific provisions in the ACA; (3) eliminated appropriations provided by the ACA and rescinded all unobligated funds; (4) replaced the ACA's mandatory appropriations with authorizations of (discretionary) appropriations, and rescinded all unobligated funds; or (5) blocked or otherwise delayed implementation of specific ACA provisions.

Republican leaders used a special legislative process known as budget reconciliation in an effort to repeal parts of the ACA. On October 23, 2015, the House passed a reconciliation bill that would have repealed several provisions of the ACA. The House-passed bill (H.R. 3762) was taken up by the Senate, which substituted its own more extensive set of ACA repeal provisions. The Senate approved H.R. 3762, as amended, on December 3, 2015. The House subsequently approved the Senate-passed bill. President Obama vetoed H.R. 3762 on January 8, 2016. The House failed to override the veto.

A few bills to amend specific elements of the ACA that attracted sufficiently broad and bipartisan support were approved by both the House and the Senate and signed into law. During the 111th Congress, a number of clarifications and technical adjustments to the ACA were enacted. During the 112th, 113th, and 114th Congresses, several more substantive ACA amendments became law. For example, Congress repealed Title VIII of the ACA—the Community Living Assistance Services and Supports (CLASS) Act—which would have established a voluntary, long-term care insurance program to pay for community-based services and supports for individuals with functional limitations. Lawmakers also repealed a tax-filing provision (IRS Form 1099) that had been included in the ACA, and, in two separate legislative actions, reduced the annual appropriations to the ACA's Prevention and Public Health Fund over the period FY2013-FY2024 by a total of $9.75 billion.

In addition to considering ACA repeal or amendment in authorizing legislation, lawmakers used the annual appropriations process in an effort to eliminate funding for the ACA's implementation and address other concerns they have with the law. A companion report, CRS Report R44100, *Use of the Annual Appropriations Process to Block Implementation of the Affordable Care Act (FY2011-FY2017)*, summarizes the ACA-related language added to annual appropriations legislation by congressional appropriators since the ACA was signed into law.

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Introduction

Congress is deeply divided over implementation of the Affordable Care Act (ACA), the health reform law enacted in March 2010 during the 111th Congress.[1] Since the ACA's enactment, lawmakers opposed to specific provisions in the ACA or the entire law have repeatedly debated its implementation and considered bills to repeal, defund, delay, or otherwise amend the law.

This report summarizes legislative actions taken during the 112th, 113th, and 114th Congresses to repeal, defund, delay, or otherwise amend the ACA. Much of this legislative activity took place in the House, which reverted to Republican control at the beginning of the 112th Congress (2011-2012). The Republican-led House passed numerous ACA-related bills, including legislation that would have repealed the entire law.

There was less debate in the Senate, which remained under Democratic control during the 112th and 113th Congresses. Most of the House-passed ACA legislation was not considered in the Senate during that period. A few bills to amend specific elements of the ACA that attracted sufficiently broad and bipartisan support were approved by both the House and the Senate and signed into law.

With Republicans in control of both chambers in the 114th Congress, opponents of the ACA sought new opportunities to pass and send to the President legislation that would change the law.

Republican leaders used a special legislative process known as budget reconciliation in an effort to repeal parts of the ACA. Pursuant to the Congressional Budget Act (Budget Act), budget reconciliation allows Congress to use expedited procedures when considering legislation that would bring existing spending, revenue, and debt limit laws into compliance with the fiscal priorities set out in the annual budget resolution. Using the reconciliation process to try and dismantle the ACA appeals to opponents of the law because reconciliation bills are not subject to filibuster and can be passed with a simple majority vote in the Senate.

On October 23, 2015, the House passed a reconciliation bill (H.R. 3762) containing provisions submitted by three committees—Ways and Means, Energy and Commerce, and Education and Workforce—pursuant to reconciliation instructions included in the FY2016 budget resolution. This bill would have repealed several provisions of the ACA, among other things.[2]

The House-passed bill was taken up by the Senate, which substituted its own more extensive set of ACA repeal provisions. These provisions were submitted by the Finance Committee and the Health, Education, Labor, and Pensions (HELP) Committee in accordance with the instructions in the budget resolution. The Senate approved H.R. 3762, as amended, on December 3, 2015.[3] The House approved the Senate-passed bill on January 6, 2016, and the measure was sent to President Obama. On January 8, 2016, the President vetoed H.R. 3762. The House was unable to override the veto in a vote taken on February 2, 2016.

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[1] The ACA was signed into law on March 23, 2010 (P.L. 111-148, 124 Stat. 119). A week later, on March 30, 2010, the President signed the Health Care and Education Reconciliation Act (HCERA; P.L. 111-152, 124 Stat. 1029). HCERA included several new health reform provisions and amended numerous provisions in the ACA. Several subsequently enacted bills made additional changes to selected ACA provisions. All references to the ACA in this report refer collectively to the law and to the changes made by HCERA and subsequent legislation.

[2] For more information, see CRS Report R44238, *Potential Policy Implications of the House Reconciliation Bill (H.R. 3762)*, coordinated by Annie L. Mach.

[3] For more information, see CRS Report R44300, *Provisions of the Senate Amendment to H.R. 3762*, coordinated by Annie L. Mach.

The information in this report is presented in three tables. **Table 1** summarizes the ACA changes that were signed into law during the 112th, 113th, and 114th Congresses. **Table 2** lists all the other ACA bills passed by the House during that period. **Table 3** summarizes the ACA provisions in the reconciliation bill that President Obama vetoed. While a detailed examination of the ACA itself is beyond the scope of this report, a brief overview of the ACA's core provisions and its impact on federal spending is provided as context for the material presented in the tables.[4]

In addition to considering ACA repeal or amendment in authorizing legislation, lawmakers have used the annual appropriations process in an effort to eliminate funding for ACA implementation and address other concerns they have with the law. A companion report, CRS Report R44100, *Use of the Annual Appropriations Process to Block Implementation of the Affordable Care Act (FY2011-FY2017)*, summarizes the ACA-related language added to annual appropriations legislation by congressional appropriators since the ACA was signed into law.

A Brief Overview of the ACA

The ACA made significant changes to the way U.S. health care is financed, organized, and delivered. Its primary goal is to increase access to affordable health care for the medically uninsured and underinsured. To that end, the law included a complex set of interconnected provisions that address the private health insurance market.

First, the ACA requires health insurers to comply with a set of federal standards ("market reforms") to ensure that individuals may purchase, keep, and renew coverage that provides a minimum level of benefits and consumer protections, with some limits on costs. Second, the law establishes competitive private health insurance exchanges (also known as marketplaces) through which individuals and small employers are able to compare and enroll in qualified health plans.

Exchanges operate in every state and the District of Columbia. They are administered by states or by the federal government, or through a partnership between the state and federal governments. Qualified individuals who enroll in exchange plans may receive financial assistance if they meet income and certain other requirements. Refundable tax credits are available to individuals and families with incomes between 100% and 400% of the federal poverty level (FPL) to help pay the insurance premium. The premium tax credits are available upon enrollment so that eligible individuals and families can choose to receive the subsidy immediately rather than wait until they file taxes the following year. In addition, certain individuals and families receiving the tax credit may be eligible for cost-sharing subsidies to reduce their out-of-pocket costs (e.g., deductibles, co-payments) when receiving health services. Small employers with no more than 25 full-time equivalent employees (FTEs) may also use the exchanges to purchase insurance coverage for their employees and may qualify for a tax credit to help cover the cost of providing that coverage.

In June 2015, the U.S. Supreme Court in *King v. Burwell* ruled that the premium tax credits are available to all qualified individuals who enroll in exchange plans and meet the necessary income and other requirements, regardless of whether the exchange is administered by the state or the federal government.[5]

Third, the ACA's "individual mandate" requires most U.S. citizens and legal residents to obtain coverage. Those who remain uninsured may have to pay a penalty unless they qualify for an

[4] Numerous CRS products that provide more in-depth information on the many new programs and activities authorized and funded by the ACA are available at http://www.crs.gov/iap/health-care.

[5] *King v. Burwell*, No. 14-114 slip op. (June 25, 2015), http://www.supremecourt.gov/opinions/14pdf/14-114_qol1.pdf.

exemption. The individual mandate is intended to encourage healthy individuals to participate in the insurance market and not wait until they get sick to buy coverage. Finally, the law's "employer mandate" requires employers with 50 or more FTEs to offer health coverage that meets affordability and adequacy standards for their full-time employees and those workers' dependents. Employers who do not comply with these requirements may be subject to a tax if one or more of their employees purchase coverage through an exchange and receive a subsidy. The purpose of the ACA's employer requirements is to encourage larger firms to maintain affordable and adequate coverage for their employees.

The ACA coupled its private insurance provisions with the requirement that states expand their Medicaid programs to cover all nonelderly individuals with incomes up to 138% FPL. Those with higher incomes, up to 400% FPL, may be eligible to get subsidized coverage through an exchange. In June 2012, the U.S. Supreme Court in *NFIB v. Sebelius* found the Medicaid expansion to be unconstitutionally coercive and prohibited the federal government from enforcing it.[6] The Court's decision made Medicaid expansion optional for states.

In addition to expanding access to insurance coverage, the ACA contains hundreds of other provisions that address health care access, costs, and quality. They include new programs to test alternative ways of delivering and paying for health care. The law also includes new taxes and fees as well as adjustments to Medicare payments to hospitals and other health care providers. These provisions are designed to offset the federal spending on exchange subsidies and Medicaid expansion.

ACA's Impact on Federal Spending

Implementation of the ACA is affecting both mandatory and discretionary spending. *Mandatory spending*—also referred to as direct spending—is controlled through authorizing laws.[7] It includes spending on entitlement programs such as Medicare and Social Security. Authorizing laws may provide permanent or temporary appropriations or other forms of budget authority for such spending. When the authorizing law contains no appropriations, mandatory programs may be funded through the annual appropriations process. This is sometimes referred to as "appropriated mandatory" or "appropriated entitlement" spending.[8] *Discretionary spending* is both controlled and funded through the annual appropriations process. It typically covers the routine costs of running federal agencies and offices, including wages and salaries.[9]

Federal spending on ACA implementation can be grouped into three categories: (1) mandatory spending on expanding insurance coverage, (2) mandatory spending on other programs, and (3) discretionary spending. Each of these categories is briefly discussed below.

[6] *NFIB v. Sebelius*, No. 11-393, slip op. (June 28, 2012), http://www.supremecourt.gov/opinions/11pdf/11-393c3a2.pdf. For more information, see CRS Report R42367, *Medicaid and Federal Grant Conditions After NFIB v. Sebelius: Constitutional Issues and Analysis*, by Kenneth R. Thomas.

[7] Authorizing legislation generally refers to substantive legislation, reported by a committee (or committees) of jurisdiction other than the House or Senate Appropriations Committees, that establishes or continues the operation of a federal program or agency either indefinitely or for a specific period.

[8] For further information on direct spending, see CRS Report RS20129, *Entitlements and Appropriated Entitlements in the Federal Budget Process*, by Bill Heniff Jr.

[9] For further information on discretionary spending, see CRS Report R42388, *The Congressional Appropriations Process: An Introduction*, by Jessica Tollestrup.

Mandatory Spending on Expanding Insurance Coverage

This category accounts for most of the federal spending under the ACA. It includes the exchange subsidies (i.e., premium tax credits and cost-sharing subsidies), the federal government's share of the costs of Medicaid expansion, and tax credits for small employers. The Congressional Budget Office (CBO) and the Joint Committee on Taxation (JCT) projected that this and other ACA mandatory spending (discussed in the second category, below) would be more than offset by (1) revenues from the ACA's new taxes and fees, and (2) savings from the law's adjustments to Medicare provider payments that are projected to slow the rate of growth of Medicare spending.[10]

Mandatory Spending on Other Programs

The ACA authorized new Medicare and Medicaid spending. For example, it phased out the Medicare prescription drug benefit "donut hole" through a combination of subsidies and manufacturer discounts, and it increased Medicare payments for primary care services and medical education. The ACA also included numerous appropriations that are providing billions of dollars of mandatory funding to support grant programs and other activities authorized by the law.[11] For example, the law funded temporary insurance programs for targeted groups prior to the exchanges becoming operational, and it provided funding for grants to states to plan and establish health insurance exchanges. The ACA included a permanent appropriation, available for 10-year periods, for the Center for Medicare & Medicaid Innovation (CMMI), within the Centers for Medicare & Medicaid Services (CMS), to test and implement innovative health care payment and service delivery models.

In addition, the ACA created four special funds and appropriated amounts to each one. First, the Community Health Center Fund (CHCF) has provided almost $11 billion over five years (FY2011-FY2015) for the federal health centers program and the National Health Service Corps.[12] Second, the Patient-Centered Outcomes Research Trust Fund (PCORTF) is supporting patient-centered comparative clinical effectiveness research through FY2019 with a mix of appropriations, fees on health plans, and transfers from the Medicare trust funds. Third, the Prevention and Public Health Fund (PPHF), for which the ACA provided a permanent annual appropriation, is supporting prevention, wellness, and other public health-related programs and activities. Finally, the Health Insurance Reform Implementation Fund (HIRIF), for which the ACA appropriated $1 billion, helped pay for the initial administrative costs of implementing the law.

Discretionary Spending

The ACA is affecting discretionary spending in two ways. First, the law created numerous new discretionary grant programs and provided each of them with an authorization of appropriations.

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[10] U.S. Congressional Budget Office, letter to the Honorable Nancy Pelosi, Speaker, U.S. House of Representatives, providing an estimate of the direct spending and revenue effects of ACA, as amended by HCERA (March 20, 2010), http://www.cbo.gov/sites/default/files/cbofiles/ftpdocs/113xx/doc11379/amendreconprop.pdf.

[11] For a summary of all the ACA's mandatory appropriations, and the status of obligation of those funds, see CRS Report R41301, *Appropriations and Fund Transfers in the Affordable Care Act (ACA)*, by C. Stephen Redhead.

[12] The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA; P.L. 114-10, 129 Stat. 87) extended CHCF funding for the health centers program and the NHSC for two years by appropriating a total of $3.910 billion to the fund for each of FY2016 and FY2017. Of that amount, $3.6 billion is for the health centers program and the remaining $310 million is for the NHSC.

To date, however, few of these programs have received discretionary funding through annual appropriations acts, though several of them have been supported with mandatory funds from the PPHF.[13] Second, the two agencies primarily responsible for implementing the ACA's provisions to expand insurance coverage—CMS's Center for Consumer Information and Insurance Oversight (CCIIO) and the Internal Revenue Service (IRS)—are incurring significant costs in connection with administering and enforcing the law. Both agencies requested increases in funding in each of their past four budget submissions (i.e., FY2013-FY2016) to help pay for ACA implementation. But congressional appropriators have not provided either agency with any additional discretionary funds. CMS instead has relied on discretionary fund transfers from other accounts, amounts from the Nonrecurring Expenses Fund (NEF),[14] and ACA mandatory funds (i.e., HIRIF, PPHF) to support its ACA implementation activities. CMS also has transferred HIRIF funds to the IRS.

ACA Provisions in Authorization Legislation

Enacted Laws

Table 1 summarizes the authorizing legislation to amend the ACA that has been enacted since the ACA became law in March 2010. Each table entry includes the public law number and date of enactment, the original bill number and sponsor, and a brief description and explanation of the change(s) made to the ACA. The laws are listed in reverse chronological order, beginning with the most recently enacted legislation and extending back to the first measure signed into law following enactment of the ACA and the accompanying package of amendments in the Health Care and Education Reconciliation Act (HCERA).[15]

During the 111th Congress, when the House was still under Democratic control, a number of clarifications and technical adjustments to the law were enacted. In the 112th, 113th, and 114th Congresses, several more substantive ACA amendments that garnered bipartisan support were signed into law. For example, Congress repealed Title VIII of the ACA—the Community Living Assistance Services and Supports (CLASS) Act—which would have established a voluntary, long-term care insurance program to pay for community-based services and supports for individuals with functional limitations. Lawmakers also repealed a tax-filing provision (IRS Form 1099) that had been included in the ACA, and, in two separate legislative actions, they reduced the PPHF annual appropriations over the period FY2013-FY2024 by a total of $9.75 billion.

[13] The ACA also reauthorized funding for many *existing* discretionary grant programs authorized under the Public Health Service Act; notably, the federal health workforce programs administered by the Health Resources and Services Administration (HRSA). The authorizations of appropriations for many of these programs expired prior to the ACA's enactment, though most of them were still receiving annual appropriations. The ACA also permanently reauthorized appropriations for the federal health centers program and for programs and services provided by the Indian Health Service (IHS). Congressional appropriators have in general continued to provide discretionary funding for these long-standing programs, though typically at funding levels below the amounts authorized by the ACA. For more details on all the authorizations (and reauthorizations) of discretionary funding in ACA, including the FY2011-FY2015 funding levels for programs that received an appropriation, see CRS Report R41390, *Discretionary Spending Under the Affordable Care Act (ACA)*, coordinated by C. Stephen Redhead.

[14] The Nonrecurring Expenses Fund is an account within the Department of the Treasury. The HHS Secretary is authorized to transfer to the NEF unobligated balances of expired discretionary funds. NEF funds are available until expended for use by the HHS Secretary for capital acquisitions including facility and information technology infrastructure.

[15] See footnote 1.

In compiling **Table 1**, CRS made decisions about which laws—or specific provisions in a particular law—to include, and which ones to leave out. CRS elected to include only those provisions that made changes (including funding extensions or rescissions) to *new* programs and activities first authorized and funded by the ACA. CRS excluded provisions addressing *established* programs and activities that predate the ACA and were amended or extended by it. For example, the ACA extended multiple existing Medicare and Medicaid program payments and activities that have since been further extended and/or modified by provisions in more recently enacted laws. The ACA also extended funding for a number of existing grant programs whose funding has been further extended by provisions in newer laws. None of these types of provisions are included in **Table 1**.

House-Passed Bills

Table 2 summarizes the ACA provisions in authorizing legislation that passed the House in the 112th, 113th, and 114th Congresses (2011-2016) but saw little if any further legislative action. As noted in the table, some of these House-passed ACA bills were used by the Senate as vehicles for considering other, unrelated legislation.

The House-passed legislation included stand-alone bills as well as provisions in broader, often unrelated measures that would have (1) repealed the ACA in its entirety and, in some cases, replaced it with new law; (2) repealed, or by amendment restricted or otherwise limited, specific provisions in the ACA; (3) eliminated appropriations provided by the ACA and rescinded all unobligated funds;[16] (4) replaced the mandatory appropriations for one or more ACA programs with authorizations of (discretionary) appropriations, and rescinded all unobligated funds; and (5) blocked or otherwise delayed implementation of specific ACA provisions.

Generally, **Table 2** lists only legislation that, if enacted, would have had a direct impact on the ACA and its implementation; measures that would not have had such an effect are not included. Thus, budget resolutions, which are only binding on certain matters before Congress, are not included.[17]

[16] Appropriations bills provide agencies with budget authority, which is the legal authority to incur financial obligations (e.g., hire employees, purchase services, award grants, or sign contracts) that result in immediate or future government expenditures (or outlays). Budget authority is generally made available for obligation during a specified time period, typically the upcoming fiscal year. Once budget authority reaches the end of that time period, it "expires," meaning that it is no longer available for obligation. A rescission is a provision of law that cancels budget authority prior to when it would otherwise expire, making it unavailable for future obligation. For further explanations of these terms, see GAO, *A Glossary of Terms Used in the Federal Budget Process*, GAO-05-734SP, September 2005, pp. 85-86, available at http://www.gao.gov.

[17] The House has taken multiple votes on amendments to, and passage of, budget resolutions that expressed support for a full repeal of the ACA, or the repeal or amendment of specific provisions in the law. However, budget resolutions are concurrent resolutions that apply only to Congress. They are not presented to the President for his signature and do not have the force of law. The House approved budget resolutions for FY2012 and FY2013 (H.Con.Res. 34 and H.Con.Res. 112, respectively) during the 112th Congress (2011-2012) and passed budget resolutions for FY2014 and FY2015 (H.Con.Res. 25 and H.Con.Res. 96, respectively) during the 113th Congress (2013-2014). All four House budget resolutions included language addressing full repeal of the ACA. In 2015, the House and the Senate each passed a budget resolution for FY2016 (H.Con.Res. 27 and S.Con.Res. 11, respectively). Both measures—as well as the subsequent conference agreement (S.Con.Res. 11) approved by the two chambers—included language calling for full repeal of the ACA. Neither the House nor the Senate passed a FY2017 budget resolution in 2016.

ACA Reconciliation Legislation

In addition to their efforts to repeal or otherwise amend the ACA through regular legislative procedures, Republican leaders used the reconciliation process to pass legislation that would eliminate several core provisions of the ACA. **Table 3** summarizes the ACA provisions in H.R. 3762, the Restoring Americans' Healthcare Freedom Reconciliation Act of 2015, which President Obama vetoed on January 8, 2016.

H.R. 3762 was reported by the House Budget Committee on October 16, 2015, and passed by the full House on October 23, 2015. The measure contained provisions submitted by three committees—Ways and Means, Energy and Commerce, and Education and Workforce—pursuant to reconciliation instructions included in the FY2016 budget resolution (S.Con.Res. 11).[18]

As passed by the House, H.R. 3762 would have repealed the individual and employer mandates, eliminated the medical device tax and the tax on high-value employer-sponsored health plans (i.e., "Cadillac tax"), and defunded the PPHF, among other things. CBO and JCT estimated that the bill would reduce the budget deficit over the period FY2016-FY2025 by about $129 billion. That amount reflects not just the bill's direct impact on federal spending and revenues but also its broader impact on the U.S. economy, the so-called macroeconomic feedback effects.[19]

The Senate took up consideration of H.R. 3762 and substituted its own significantly broader set of ACA provisions. Those provisions were submitted by the Finance and HELP Committees, in accordance with the reconciliation instructions in S.Con.Res. 11. As amended, H.R. 3762 passed the Senate on December 3, 2015.[20]

The House approved the Senate-passed bill on January 6, 2016. The enrolled bill was sent to the President, who vetoed it on January 8, 2016. The House voted to override the veto on February 2, 2016, but did not muster the two-thirds vote required.

As summarized in **Table 3**, the vetoed bill would have repealed the premium tax credits and cost-sharing subsidies, eliminated the penalties associated with the individual and employer mandates, terminated the requirements and enhanced federal funding for the Medicaid expansion, and repealed most of the ACA's taxes and fees, among other things.

CBO and JCT estimated that the loss of tax and other revenue under the bill would be more than offset by eliminating spending on subsidies and Medicaid expansion. They projected that the bill would reduce the budget deficit over the period FY2016-FY2025 by about $474 billion, including macroeconomic feedback effects.[21]

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[18] For more information, see CRS Report R44238, *Potential Policy Implications of the House Reconciliation Bill (H.R. 3762)*, coordinated by Annie L. Mach.

[19] U.S. Congressional Budget Office, "Estimate of Direct Spending and Revenue Effects of H.R. 3762, The Restoring Americans' Healthcare Freedom Reconciliation Act, as Passed by the House and Following Enactment of the Bipartisan Budget Act of 2015," November 4, 2015, https://www.cbo.gov/sites/default/files/114th-congress-2015-2016/costestimate/hr3762aspassed.pdf. Excluding macroeconomic feedback effects, CBO and JCT estimated that H.R. 3762 would reduce the deficit by about $78 billion over the FY2016–FY2025 period. They estimated that macroeconomic feedback effects would reduce deficits by an additional $51 billion over that period. The largest effect would be an increase in revenues arising from the increased supply of labor, which in turn would boost employment and taxable income.

[20] For more information, see CRS Report R44300, *Provisions of the Senate Amendment to H.R. 3762*, coordinated by Annie L. Mach.

[21] U.S. Congressional Budget Office, "Re: Budgetary Effects of H.R. 3762, the Restoring Americans' Healthcare Freedom Reconciliation Act, as Passed by the Senate on December 3, 2015," December 11, 2015,
(continued...)

The Senate's Byrd Rule

Reconciliation bills are considered by the full House and Senate under expedited procedures. In the Senate, a reconciliation bill can pass with only a simple majority—rather than the 60 votes that are often needed for controversial legislation—because reconciliation bills are not subject to filibuster. The Budget Act limits Senate debate on a reconciliation bill to 20 hours and requires any amendments offered to be germane to the bill.

However, the Budget Act includes language known as the Byrd rule, after the late Senator Robert Byrd, that allows Senators to block provisions of (or amendments to) a reconciliation bill that are determined to be "extraneous" to the bill's basic purpose of implementing budget changes.[22] The Byrd rule includes several criteria for determining whether a provision is extraneous. For example, a provision is extraneous if

- it does not produce a change in outlays or revenues, unless the provision establishes the terms and conditions of another provision that has a budgetary impact;
- it produces a change in outlays or revenues that is "merely incidental" to the provision's non-budgetary effects; or
- it increases the deficits in any year after the time period covered by the reconciliation instructions, unless other provisions recommended by the same committee fully offset those "out-year" costs.[23]

Senators may raise a parliamentary objection (i.e., a point of order) against any provision that they believe to be extraneous. If the point of order is sustained by the parliamentarian, the extraneous material is deleted. Importantly, the Budget Act requires 60 votes to waive the Byrd rule or override the parliamentarian's ruling on a point of order under the Byrd rule.[24]

After the House first approved H.R. 3762 and referred the measure to the Senate, the Senate parliamentarian ruled that the bill's provisions to repeal the individual and employer mandates were extraneous. Specifically, the parliamentarian determined that the budgetary impact of repealing the mandates, though significant, was "merely incidental" to the broader non-budgetary (i.e., policy) impact of making those changes in law.

The ruling meant that Senate Republicans would need 60 votes to protect the language if Democrats raised Byrd Rule points of order. Lacking such a supermajority in the Senate, the Republicans chose instead to modify the provisions so that they would not violate the Byrd Rule. The Senate version kept the mandates but eliminated the penalties for noncompliance.

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https://www.cbo.gov/sites/default/files/114th-congress-2015-2016/costestimate/hr3762senatepassed.pdf. Excluding macroeconomic feedback effects, CBO and JCT estimated that H.R. 3762, as amended and passed by the Senate, would reduce the deficit by about $282 billion over the FY2016–FY2025 period. They estimated that macroeconomic feedback effects would reduce deficits by an additional $193 billion over that period. The largest effect would be an increase in revenues arising from the increased supply of labor, which in turn would boost employment and taxable income.

[22] 2 U.S.C. §644.

[23] 2 U.S.C. §644(b)(1).

[24] For more information, see CRS Report RL30862, *The Budget Reconciliation Process: The Senate's "Byrd Rule"*, by Bill Heniff Jr.

H.R. 3762 also would have repealed most of the ACA's taxes and fees. Each provision that permanently repeals an ACA tax or fee is potentially vulnerable to a challenge under the Byrd rule because it reduces revenues (and, thus, increases the deficit) in the out years. However, as noted above, such provisions are not considered extraneous if the loss of revenue is offset by other provisions.

While CBO and JCT projected that the loss of revenue under H.R. 3762 would be more than offset by the spending reductions during the first 10 years (i.e., FY2016-FY2025), they concluded that the bill could start adding to the deficit over the longer term because the revenue losses would grow more rapidly beyond 2025 than the spending reductions, primarily as a result of repealing the Cadillac tax.[25] According to CBO and JCT, the loss of revenue from repealing this tax on high-premium health insurance plans would grow at a significantly higher rate than other components of their estimate, as more and more plans became subject to the tax over time.

U.S. House of Representatives v. Burwell

On July 30, 2014, the House approved a simple resolution (H.Res. 676) on a party-line vote that authorized Speaker John Boehner to sue the President or other executive branch officials for actions taken to implement the ACA that are inconsistent with their duties under the Constitution and laws of the United States.

On November 21, 2014, the House filed a lawsuit in the U.S. District Court for the District of Columbia, which contained two counts against the Administration.[26] First, the lawsuit claimed that the President had exceeded his constitutional duty to faithfully execute federal laws by delaying implementation of the ACA's employer mandate. Second, the lawsuit asserted that the cost-sharing subsidies were in violation of the Constitution because Congress had not appropriated any funds for them.[27]

The Administration challenged the lawsuit claiming that the House had no legal standing to sue, and asked for the lawsuit to be dismissed. On September 9, 2015, the judge agreed that the House did not have standing to pursue its claim regarding delay of the employer mandate. But the judge ruled that the House did have standing to pursue the second claim that the Administration was violating the Constitution by paying cost-sharing subsidies without an appropriation to cover those outlays.[28] On May 12, 2016, the judge issued a merits decision, holding that Congress had not appropriated funds for the payment of cost-sharing subsidies.[29]

That ruling has been stayed while the case is on appeal to the U.S. Court of Appeals for the D.C. Circuit.

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[25] See footnote 21.

[26] *United States House of Representatives v. Burwell*, 1:14-cv-01967 (D.D.C. 2014), http://www.speaker.gov/sites/speaker.house.gov/files/HouseLitigation.pdf.

[27] Article I of the U.S. Constitution states that "No money shall be drawn from the Treasury, but in consequence of appropriations made by law."

[28] The cost-sharing subsidies are paid directly to insurers to compensate them for providing certain beneficiaries with reduced deductibles, co-payments, and other out-of-pocket costs. Through the end of FY2016, a total of $13.145 billion in cost-sharing subsidies was paid to insurers according to the IRS budget office.

[29] *United States House of Representatives v. Burwell*, 2016 U.S. Dist. LEXIS 62646 (May 12, 2016).

Table 1. Enacted Legislation That Modified, or Extended or Rescinded Funding for, Programs Established by the ACA

Public Law and Date of Enactment	Bill (Sponsor)	Summary of ACA Provisions
		114th Congress
P.L. 114-301 Dec. 16, 2016	H.R. 5687	**GAO Mandates Revision Act of 2016.** Among its provisions, P.L. 114-301: • Amended Section 399V–4 of the Public Health Service Act ("State Demonstration Programs to Evaluate Alternatives to Current Medical Tort Litigation"), as added by ACA Section 10607, regarding the composition and duties of the expert panel established to review demonstration grant applications.
P.L. 114-255 Dec. 13, 2016	H.R. 34	**21st Century Cures Act.** Among its provisions, P.L. 114-255: • Amended provisions in Title XIX of the Social Security Act (SSA) to improve the ability of states to identify health care providers who have been terminated from participating in Medicare or in another state's Medicaid or CHIP program, by (1) requiring providers participating in Medicaid and CHIP managed care to enroll with the state, and (2) increasing state oversight and reporting requirements. [The ACA required CMS to establish a system for notifying each state Medicaid/CHIP program of health care providers who have been terminated from participating in Medicare or in another state's Medicaid/CHIP program.] • Amended ACA Section 4002 to reduce the PPHF annual appropriations over the period FY2017-FY2024 by a total of $3.5 billion. [This is the second time that the PPHF annual appropriations have been reduced; see entry for P.L. 112-96, below.] • Instructed the Secretary to collect certain specified information from each state that has participated in the Medicaid Emergency Psychiatric Demonstration program, established by ACA Section 2707, and, within two years, submit to Congress a report that summarizes and analyses that information. • Amended provisions in the Internal Revenue Code (IRC) to allow certain small employers to use health reimbursement arrangements (HRAs) without incurring penalties under the ACA, provided the reimbursement payments do not exceed specified amounts. [An HRA is an arrangement that is funded solely by an employer and that reimburses an employee for medical care expenses incurred by the employee (or his/her spouse and dependents) up to a maximum dollar amount. The IRS had concluded that HRAs are group health plans that fail to comply with the ACA market reforms and are therefore subject to tax penalties under the law. However, the IRS provided transition relief from the penalty.]
P.L. 114-113 Dec. 18, 2015	H.R. 2029 (Dent)	**Consolidated Appropriations Act, 2016.** P.L. 114-113 incorporated a number of ACA tax provisions, including a two-year delay of the Cadillac tax, a one-year moratorium on the ACA's annual fee on certain health insurance providers, and a two-year moratorium on the ACA's medical device excise tax. [For more information on all the ACA-related provisions in P.L. 114-113, see CRS Report R44100, *Use of the Annual Appropriations Process to Block Implementation of the Affordable Care Act (FY2011-FY2017)*, by C. Stephen Redhead and Ada S. Cornell.]
P.L. 114-97 Dec. 11, 2015	S. 599 (Cardin)	**Improving Access to Emergency Psychiatric Care Act.** Extended the Medicaid Emergency Psychiatric Demonstration program, established by ACA Section 2707, through September 30, 2016, provided it meets budget neutrality requirements. Gives the HHS Secretary the authority to further extend and expand the demonstration program through December 31, 2019, subject to the budget neutrality requirements. Requires the Secretary, by April 1, 2019, to submit recommendations to Congress on whether to make the program permanent.

Public Law and Date of Enactment	Bill (Sponsor)	Summary of ACA Provisions
P.L. 114-74 Nov. 2, 2015	H.R. 1314 (Meehan)	**Bipartisan Budget Act of 2015.** Among its provisions, P.L. 114-74: • Repealed the ACA requirement that employers with more than 200 employees automatically enroll new full-time employees in health insurance and continue coverage for current employees.
P.L. 114-60 Oct. 7, 2015	H.R. 1624 (Guthrie)	**Protecting Affordable Coverage for Employees (PACE) Act.** Amended the ACA's definition of small employer to mean employers with up to 50 employees, while giving states the option to expand the definition to include employers with up to 100 employees. [Under the ACA as originally enacted, all employers with 100 or fewer employees would have been regarded as small employers as of January 1, 2016. The PACE Act limits small employers to those with up to 50 employees, which typically is how small employers are defined under state law. Employers with 51 to 100 employees are now defined under the ACA as large employers. This change is significant because certain ACA reforms apply only to individual and small group (i.e., small employer) plans. For example, these plans must cover ten essential health benefits and meet the actuarial value levels (platinum, gold, silver, bronze) defined by the ACA. Moreover, insurers may only consider age, geographic location, family composition, and tobacco use in setting premium rates for small groups. Large group plans are not bound by these requirements.]
P.L. 114-41 July 31, 2015	H.R. 3236 (Shuster)	**Surface Transportation and Veterans Health Care Choice Improvement Act of 2015.** Among its provisions, P.L. 114-41: • Incorporated the Hire More Heroes Act, which excludes employees who receive health care through the Department of Veterans Affairs or TRICARE from an employer's FTE count for the purpose of meeting the ACA's employer responsibilities.
P.L. 114-10 Apr. 16, 2015	H.R. 2 (Burgess)	**Medicare Access and CHIP Reauthorization Act of 2015.** Among its provisions, P.L. 114-10: • Amended Section 1848(p) of the SSA, as added by ACA Section 3007, to terminate application of the physician value-based payment modifier (VBM) at the end of 2018. [Beginning in 2019, the VBM will be used as one of the components of the composite score under the new Merit-Based Incentive Payment System (MIPS).] • Appropriated a total of $3.910 billion to the CHCF for each of FY2016 and FY2017; $3.600 billion for the health centers program, and $310 million for the NHSC. • Appropriated $60 million for each of FY2016 and FY2017 for graduate medical education (GME) payments to teaching health centers, authorized by ACA Section 5508(c). • Appropriated $400 million for each of FY2015 through FY2017 for the Maternal, Infant, and Early Childhood Home Visiting program, established by ACA Section 2951. • Appropriated $75 million for each of FY2016 and FY2017 for the Personal Responsibility Education Program (PREP), established by ACA Section 2953. • Appropriated $85 million for each of FY2016 and FY2017 for the Health Profession Opportunity Grant (HPOG) program, established by ACA Section 5507(a). • Appropriated $20 million for the two-year period FY2016 through FY2017 to develop Medicaid adult quality measures, pursuant to ACA Section 2701.

Public Law and Date of Enactment	Bill (Sponsor)	Summary of ACA Provisions
		113th Congress
P.L. 113-93 Apr. 1, 2014	H.R. 4302 (Pitts)	**Protecting Access to Medicare Act of 2014.** Among its provisions, P.L. 113-93: • Eliminated paragraph (2) of ACA Section 1302(c), which capped deductibles for small group health plans at $2,000 for singles and $4,000 for families (indexed after 2014 to average per capita premium costs). [Insurers were finding it difficult staying within the deductible cap while covering all essential health benefits and meeting the 60% actuarial level (AV) level for bronze plans. CMS had already agreed to waive the deductible cap if a plan could not "reasonably reach" the AV level without exceeding the cap.] • Appropriated $400 million for the first half of FY2015 for the Maternal, Infant, and Early Childhood Home Visiting program, established by ACA Section 2951. [Superseded by the appropriation in P.L. 114-10.] • Appropriated $85 million for FY2015 for HPOG program, established by ACA Section 5507(a). • Appropriated $75 million for FY2015 for the PREP, established by ACA Section 2953.
		112th Congress
P.L. 112-240 Jan. 2, 2013	H.R. 8 (Camp)	**American Taxpayer Relief Act of 2012.** Among its provisions, P.L. 112-240: • Transferred 10% of the remaining unobligated Consumer Operated and Oriented Plan (CO-OP) program funds to a new CO-OP contingency fund (to provide assistance and oversight to CO-OP loan recipients) and rescinded the other 90% of these funds.[a] • Repealed ACA Title VIII, the Community Living Assistance Services and Supports (CLASS) Act. • Repealed the ACA's appropriations for the National Clearinghouse for Long-Term Care Information and rescinded all unobligated funds.
P.L. 112-141 July 6, 2012	H.R. 4348 (Mica)	**Moving Ahead for Progress in the 21st Century Act, or "MAP-21."** Among its provisions, P.L. 112-141 further modified the Medicaid disaster-recovery Federal Medical Assistance Percentage (FMAP) adjustment (see entry for P.L. 112-96, below) by changing the adjustment factor and effective date.
P.L. 112-96 Feb. 22, 2012	H.R. 3630 (Camp)	**Middle Class Tax Relief and Job Creation Act of 2012.** Among its provisions, P.L. 112-96: • Amended ACA Section 4002 to reduce the PPHF annual appropriations over the period FY2013-FY2021 by a total of $6.25 billion to help offset the cost of extending the payroll tax cut and other programs in P.L. 112-96. • Amended SSA Section 1923(f) to extend by one year the disproportionate share hospital (DSH) allotment reduction imposed by ACA Section 3203. • Amended SSA Section 1905(aa), as added by ACA Section 2006, to make a technical correction to the formula to phase down the Medicaid disaster-recovery FMAP adjustment as originally intended. [The purpose of the adjustment was to help Louisiana avoid a significant reduction in its federal Medicaid match (i.e., FMAP) in the aftermath of Hurricane Katrina. As written in ACA Section 2006, the formula for the disaster-recovery FMAP adjustment unintentionally caused the FMAP adjustment to increase, rather than phase down, each year the state qualifies for the adjustment.]
P.L. 112-56 Nov. 21, 2011	H.R. 674 (Herger)	**3% Withholding Repeal and Job Creation Act.** Among its provisions, P.L. 112-56 amended IRC Section 36B, as added by ACA Section 1401(a) (as amended), by modifying the calculation of Modified Adjusted Gross Income (MAGI) to include Social Security benefits. MAGI will be used to determine eligibility for exchange subsidies and Medicaid, beginning in 2014.

Public Law and Date of Enactment	Bill (Sponsor)	Summary of ACA Provisions
P.L. 112-9 Apr. 14, 2011	H.R. 4 (Lungren)	**Comprehensive 1099 Taxpayer Protection and Repayment of Exchange Subsidy Overpayments Act of 2011.** Amended IRC Section 6041, as amended by ACA Section 9006, to repeal the requirement that businesses file an information report (IRS Form 1099) whenever they pay a vendor more than $600 for goods in a single year. To pay for the 1099 repeal, P.L. 112-9 amended Section 36B of the IRC, as added by ACA Section 1401(a), by further modifying the sliding scale that determines the amount of excess advance premium tax credits that individuals have to repay based on household income (see entry for P.L. 111-309, below).
		111th Congress
P.L. 111-383 Jan. 7, 2011	H.R. 6523 (Skelton)	**Ike Skelton National Defense Authorization Act for Fiscal Year 2011.** Extended TRICARE coverage to dependent adult children up to age 26, to conform to the private health insurance requirements under the ACA.
P.L. 111-312 Dec. 17, 2010	H.R. 4853 (Oberstar)	**Tax Relief, Unemployment Insurance Reauthorization, and Job Creation Act of 2010.** Amended ACA Section 10909 to extend the nonrefundable adoption tax credit through tax year 2012. The adoption tax credit helps offset the cost of qualified adoption expenses. [Subsequently, P.L. 112-240 made the nonrefundable adoption tax credit permanent.]
P.L. 111-309 Dec. 15, 2010	H.R. 4994 (Lewis)	**Medicare and Medicaid Extenders Act of 2010.** To help offset the costs of the Medicare and Medicaid program extensions and the postponement of cuts in Medicare physician payments, P.L. 111-309 amended IRC Section 36B, as added by ACA Section 1401(a), to increase the amount of excess advance premium tax credits that individuals would have to repay. [Under the ACA, the amount received in advance premium tax credits is based on estimated income for the upcoming year. Estimated income is later checked against actual income during tax filing season. This can result in an overpayment of tax credits if actual income ends up exceeding estimated income. The ACA placed limits on the amount of any advance premium tax credit overpayment that had to be repaid to the government by creating a sliding scale for such repayments based on household income. P.L. 111-309 modified the sliding scale.]
P.L. 111-226 Aug. 10, 2010	H.R. 1586 (Rangel)	**FAA Air Transportation Modernization and Safety Improvement Act.** Among its provisions, P.L. 111-226 amended SSA Section 1927(k)(1)(B)(i)(IV) (as added by ACA Section 2503(a)(2)(B), as amended by HCERA Section 1101(c)) by modifying the definition of average manufacturer price (AMP) to include inhalation, infusion, implanted, or injectable drugs that are not generally dispensed through a retail community pharmacy.
P.L. 111-173 May 27, 2010	H.R. 5014 (Filner)	**[No title.]** Amended IRC Section 5000A(f)(1)(A), as added by ACA Section 5101(b), to clarify that health care provided by the Department of Veterans Affairs constitutes minimal essential health care coverage as required by the ACA. [Beginning in 2014, the ACA requires most U.S. citizens and legal residents to have minimal essential health care coverage or pay a penalty.]
P.L. 111-159 Apr. 26, 2010	H.R. 4887 (Skelton)	**TRICARE Affirmation Act.** Amended IRC Section 5000A(f)(1)(A), as added by ACA Section 5101(b), to clarify that health care provided under TRICARE, TRICARE for Life, and the Nonappropriated Fund Health Benefits program constitutes minimal essential health care coverage as required by the ACA. [Beginning in 2014, the ACA requires most U.S. citizens and legal residents to have minimal essential health care coverage or pay a penalty.]

Source: Prepared by the Congressional Research Service based on the text of the public laws listed in the table.

a. The FY2011 and FY2012 Labor-HHS-ED appropriations acts (P.L. 112-10 and P.L. 112-74, respectively) rescinded a total of $2.6 billion of the ACA's original $6 billion appropriation for the CO-OP program. At the time P.L. 112-240 was enacted, according to HHS budget documents, the CO-OP program had an unobligated balance of $2.532 billion. P.L. 112-240 rescinded 90% of that amount (i.e., $2.279 billion), and transferred the remaining funds (i.e., $253 million) to the contingency fund. In all, Congress has rescinded $4.879 billion of the $6 billion CO-OP program appropriation.

Table 2. ACA Provisions in Bills Approved by the House in the 112th, 113th, and 114th Congresses

Bill (Sponsor)	Bill Title, House Vote, Summary of ACA Provisions
	114th Congress
H.R. 954 (Smith, Adrian)	**CO-OP Consumer Protection Act of 2016.** Passed the House by a vote of 258-165 on September 27, 2016. H.R. 954 would have exempted from the individual mandate and its penalties certain individuals who had obtained coverage through the CO-OP program that was later terminated. [Note: The ACA established and funded the Consumer Operated and Oriented Plan (CO-OP) program to provide low-interest loans to nonprofit member-run health insurance issuers that offer qualified health plans to individuals and small employers.]
H.R. 1270 (Jenkins, L.)	**Restoring Access to Medication and Improving Health Savings Act of 2016.** Passed the House by a vote of 243-164 on July 6, 2016. Title I of H.R. 1270—the Restoring Access to Medication Act of 2016—would have repealed the ACA's restrictions on using tax-preferred accounts to pay for over-the-counter drugs. The House passed the same language as part of the ACA reconciliation bill (H.R. 5447, see **Table 3**) and as part of H.R. 436 in the 112th Congress (see below). Title II of H.R. 1270—the Health Care Security Act of 2016 (H.R. 5445)—would have allowed both spouses to make catch-up contributions to the same health savings account (HSA). Under current law, each spouse must have their own HSA in order to make catch-up contributions. Title III of H.R. 1270—the Protecting Taxpayers by Recovering Improper Obamacare Subsidy Overpayment Act (H.R. 4723)—would again have modified the limits on the amount of excess advance premium tax credits that must be repaid based on household income. [Under the ACA, the amount received in advance premium tax credits is based on estimated income for the upcoming year. Estimated income is later checked against actual income during tax filing season. This can result in an overpayment of tax credits if actual income ends up exceeding estimated income. The ACA placed limits on the amount of any advance premium tax credit overpayment that had to be repaid to the government by creating a sliding scale for such repayments based on household income. Since the ACA's enactment the sliding scale has been modified on two separate occasions; see P.L. 111-309 and P.L. 112-9 in **Table 1**.]
H.R. 5447 (Boustany)	**Small Business Health Care Relief Act of 2016.** Passed the House by voice vote on June 21, 2016. H.R. 5447 would have allowed employers with fewer than 50 full-time employees to offer a qualified small employer health reimbursement arrangement (QSEHRA), under which the employer pays directly for or reimburses the medical expenses of employees (and their dependents) enrolled in an individual plan. [Note: In September 2013, the IRS issued a notice prohibiting HRAs and other employer payment plans under the ACA.]
H.R. 3762 (Price, T.)	**Restoring Americans' Healthcare Freedom Reconciliation Act of 2015.** Passed the House by vote of 240-189 on October 23, 2015. As originally passed by the House, the bill would have repealed the following ACA provisions: individual mandate; employer mandate; Cadillac tax; medical device tax; automatic enrollment requirement for large employers; and PPHF. It also would have appropriated an additional $235 million to the CHCF in each of FY2016 and FY2017 for health center operations. The Senate took up H.R. 3762 and substituted its own more extensive set of ACA repeal provisions. The amended bill passed the Senate by a vote of 52-47 on December 3, 2015, and passed the House by a vote of 240-181 on January 6, 2016. H.R. 3762 was sent to the President, who vetoed it on January 8, 2016. The House failed to override the veto in a vote taken on February 2, 2016. See **Table 3** for a summary of the provisions in H.R. 3762, as passed by both chambers.
H.R. 2061 (Davis, R.)	**Equitable Access to Care and Health (EACH) Act.** Passed the House by voice vote on September 28, 2015. H.R. 2061 would have expanded the religious exemption in the ACA by exempting from the law's insurance mandate any individual who is a member of a religious sect or division, who relies solely on a religious method of healing, and for whom accepting medical health services (not including certain preventive and other specified services) would be inconsistent with his or her religious beliefs. [Note: The ACA's religious exemption applies only to religious sects that are recognized by the Social Security Administration as being conscientiously opposed to accepting all insurance benefits, including Medicare and Social Security (e.g., Amish).] The House passed a related bill in March 2014 (see H.R. 1814 in the 113th Congress).

Bill (Sponsor)	Bill Title, House Vote, Summary of ACA Provisions
H.J.Res 61 (Davis, R.)	**Hire More Heroes Act of 2015.** Passed the House by voice vote on July 27, 2015. H.J.Res 61 would have excluded employees who receive health care through the Department of Veterans Affairs or TRICARE from an employer's FTE count. The House passed the same legislation in January 2015 (see H.R. 22 below) and in March 2014 (see H.R. 3474 in the 113th Congress). [Note: The Hire More Heroes Act was incorporated into P.L. 114-41; see **Table 1**.] H.J.Res 61 *was used unsuccessfully by the Senate as the legislative vehicle to provide continuing appropriations for FY2016.*
H.R. 1190 (Roe)	**Protecting Seniors' Access to Medicare Act of 2015.** Passed the House by a vote of 244-154 on June 23, 2015. H.R. 1190 would have repealed the authority and appropriations for the Independent Payment Advisory Board (IPAB). It also would have reduced the PPHF annual appropriations over the period FY2017-FY2025 by a total of $8.846 billion to offset the cost of repealing IPAB. [Note: This is the second time the House has passed a stand-alone bill to repeal IPAB.]
H.R. 160 (Paulsen)	**Protect Medical Innovation Act of 2015.** Passed the House by a vote of 280-140 on June 18, 2015. H.R. 160 would have repealed the ACA's 2.3% excise tax on medical devices. [Note: This is the second time the House has passed a stand-alone bill to repeal the medical device tax.]
H.R. 1191 (Barletta)	**Protecting Volunteer Firefighters and Emergency Responders Act.** Passed the House by a vote of 415-0 on March 17, 2015. H.R. 1191 would have excluded the hours worked by volunteer firefighters and emergency medical responders from being counted toward the ACA's 30-hour-a-week benchmark that determines whether an employee is classified as full-time. [Note: The ACA requires employers with at least 50 FTEs to offer affordable health coverage or risk paying a penalty if at least one full-time worker gets a premium tax credit for coverage purchased at an exchange. Last year the IRS ruled that it will not require volunteer emergency responders to count towards these ACA requirements. H.R. 1191 would codify that ruling.] The House passed the same legislation in January 2015 (see H.R. 33 below) and in March 2014 (see H.R. 3979 in the 113th Congress). *The Senate took up H.R. 1191 and used it as the legislative vehicle for the Iran Nuclear Agreement Review Act of 2015, which passed both chambers and was signed into law (P.L. 114-17).*
H.R. 596 (Byrne)	**A bill to repeal the Patient Protection and Affordable Care Act.** Passed the House by a vote of 239-186 on February 3, 2015. H.R. 596 would have repealed the ACA in its entirety and restore the provisions of law amended or repealed by the ACA as if it had not been enacted. It also instructed four House Committees (Education & Workforce, Energy & Commerce, Judiciary, and Ways & Means) each to report health reform legislation that addresses various issues specified in the bill. [Note: This was the fourth time the House passed a full-repeal bill.]
H.R. 7 (Smith, C.)	**No Taxpayer Funding for Abortion and Abortion Insurance Full Disclosure Act of 2015.** Passed the House by a vote of 242-179 on January 22, 2015. H.R. 7 would have prohibited exchange applicants from obtaining premium tax credits or cost-sharing subsidies to help purchase health plans that cover elective abortions, and would have prohibited tax credits for health plans offered by an employer that include elective abortion coverage. Individuals would still be able to purchase separate abortion coverage, but would not be able to receive a tax credit or cost-sharing subsidy. H.R. 7 also would have prohibited OPM-contracted multi-state plans from including elective abortion coverage. [Note: The ACA permits exchange applicants to obtain premium tax credits and cost-sharing subsidies to help purchase health plans that cover elective abortions; however, the law prohibits the use of those federal funds to pay for abortion services and requires plans to collect an abortion surcharge from enrollees to pay for such services. The ACA also specifies that at least one multi-state plan offered in an exchange must not include elective abortion coverage.] The House passed the same measure in January 2014 (see H.R. 7 in the 113th Congress).

Bill (Sponsor)	Bill Title, House Vote, Summary of ACA Provisions
H.R. 33 (Barletta)	**Protecting Volunteer Firefighters and Emergency Responders Act.** Passed the House by a vote of 401-0 on January 12, 2015. H.R. 33 would have excluded the hours worked by volunteer firefighters and emergency medical responders from being counted toward the ACA's 30-hour-a-week benchmark that determines whether an employee is classified as full-time. [Note: The ACA requires employers with at least 50 FTEs to offer affordable health coverage or risk paying a penalty if at least one full-time worker gets a premium tax credit for coverage purchased at an exchange. Last year the IRS has ruled that it will not require volunteer emergency responders to count towards these ACA requirements. H.R. 33 would codify that ruling.] The House passed the same measure in March 2014 (see H.R. 3979 in the 113th Congress). *The Senate took up H.R. 33 and substituted language to provide continuing FY2015 appropriations for the Department of Homeland Security. As amended by the Senate, H.R. 33 passed both chambers and was signed into law (P.L. 114-3).*
H.R. 30 (Young, T.)	**Save American Workers Act of 2015.** Passed the House by a vote of 252-172 on January 8, 2015. H.R. 30 would have amended the ACA's definition of full-time employees to those who work on average at least 40 hours a week. [Note: The ACA requires employers with at least 50 FTEs to offer affordable health coverage or risk paying a penalty if at least one full-time worker gets a premium tax credit for coverage purchased at an exchange. Full-time employees are defined as those who work on average at least 30 hours a week. The House passed the same measure in 2014; see H.R. 2575 below.]
H.R. 22 (Davis, R.)	**Hire More Heroes Act of 2015.** Passed the House by a vote of 412-0 on January 6, 2015. H.R. 22 would have excluded employees who receive health care through the Department of Veterans Affairs or TRICARE from an employer's FTE count. The House first passed the Hire More Heroes Act in 2014; see H.R. 3474 below. [Note: The Hire More Heroes Act was incorporated into P.L. 114-41; see **Table 1**.] *H.R. 22 was used as the legislative vehicle for the Fixing America's Surface Transportation (FAST) Act, which passed both chambers and was signed into law (P.L. 114-94).*
	113th Congress
H.R. 3522 (Cassidy)	**Employer Health Care Protection Act of 2014.** Passed the House by a vote of 247-167 on September 11, 2014. H.R. 3522 would have permitted health insurance companies to continue to offer group coverage that was in effect on any date during 2013, even if the coverage does not meet the ACA's essential health benefit standards and other market reforms that took effect at the beginning of 2014. Insurers could offer such coverage to existing or new enrollees through December 31, 2018, but could not offer the coverage through health insurance exchanges. [Note: The House passed a comparable measure in 2013; see H.R. 3350 below.]
H.R. 4414 (Carney)	**Expatriate Health Coverage Clarification Act of 2014.** Passed the House by a vote of 268-150 on April 29, 2014. H.R. 4414 would have exempted from certain ACA requirements expatriate health care plans offered to individuals working outside the United States. These plans are often used by corporate executives, nongovernmental organization employees, foreign aid workers, contractors, and others working abroad. U.S. insurance companies offering these plans are required to comply with the ACA whereas foreign insurance companies are not. [Note: A modified version of this legislation was enacted into law as Division M of the Consolidated and Further Continuing Appropriations Act, 2015 (P.L. 113-235).]
H.R. 4194 (Issa)	**Government Reports Elimination Act of 2014.** Passed the House by voice vote on April 28, 2014. Among its provisions, H.R. 4194 would have modified the ACA's requirement for periodic reviews and evaluations of all federal disease prevention and health promotion programs. Instead of joint reviews conducted by the HHS and GAO, the reviews would be conducted by HHS alone. *H.R. 4194 subsequently passed the Senate, amended, by unanimous consent on September 16, 2014.*
H.R. 2575 (Young, T.)	**Save American Workers Act of 2014.** Passed the House by a vote of 248-179 on April 3, 2014. H.R. 2575 would have amended the ACA's definition of full-time employees to those who work on average at least 40 hours a week. [Note: The ACA requires employers with at least 50 FTEs to offer affordable health coverage or risk paying a penalty if at least one full-time worker gets a premium tax credit for coverage purchased at an exchange. Full-time employees are defined as those who work on average at least 30 hours a week.]

Bill (Sponsor)	Bill Title, House Vote, Summary of ACA Provisions
H.R. 4015 (Burgess)	**SGR Repeal and Medicare Provider Payment Modernization Act of 2014.** Passed the House by a vote of 238-181 on March 14, 2014. H.R. 4015 would have replaced the Sustainable Growth Rate (SGR) formula, which determines the annual updates to Medicare's payment rates for physician services, with new systems for establishing those payment rates. To help pay for its cost, H.R. 4015 would have delayed enforcement of the ACA's individual mandate by five years by shifting the schedule of penalties for individuals who do not comply with the mandate (or obtain an exemption) to begin in 2019. CBO estimated that this would result in 13 million fewer Americans with health insurance coverage in 2018 relative to current-law projections.
H.R. 3979 (Barletta)	**Protecting Volunteer Firefighters and Emergency Responders Act of 2014.** Passed the House by a vote of 410-0 on March 11, 2014. H.R. 3979 would have excluded the hours worked by volunteer firefighters and emergency medical responders from being counted towards the ACA's 30-hour-a-week benchmark that determines whether an employee is classified as full-time. [Note: The ACA requires employers with at least 50 FTEs to offer affordable health coverage or risk paying a penalty if at least one full-time worker gets a premium tax credit for coverage purchased at an exchange. Prior to passage of H.R. 3979, the IRS ruled that it will not require volunteer emergency responders to count towards these ACA requirements. H.R. 3979 would have codified that ruling.] *The Senate passed H.R. 3979 by a vote of 59-38 on April 7, 2014, after adding a five-month extension of unemployment benefits to the bill, among other provisions, and renaming it the Emergency Unemployment Compensation Act of 2014. No further action was taken on that measure. H.R. 3979 subsequently was used as the legislative vehicle for the FY2015 National Defense Authorization Act (P.L. 113-291).*
H.R. 3474 (Davis, R.)	**Hire More Heroes Act of 2014.** Passed the House by a vote of 406-1 on March 11, 2014. H.R. 3474 would have permitted an employer to exclude employees who receive health care through the Department of Veterans Affairs or TRICARE from its FTE count.
H.R. 1814 (Schock)	**Equitable Access to Care and Health (EACH) Act.** Passed the House by voice vote on March 11, 2014. H.R. 1814 would have expanded the religious exemption in the ACA by exempting from the law's insurance mandate any individual who objects to purchasing health coverage because of sincerely held religious beliefs. [Note: The ACA's religious exemption applies only to religious sects that are recognized by the Social Security Administration as being conscientiously opposed to accepting all insurance benefits, including Medicare and Social Security (e.g., Amish).]
H.R. 4118 (Jenkins)	**Suspending the Individual Mandate Penalty Law Equals (SIMPLE) Fairness Act.** Passed the House by a vote of 250-160 on March 5, 2014. H.R. 4118 would have delayed enforcement of the ACA's individual mandate by one year by shifting the schedule of penalties for individuals who do not comply with the mandate (or obtain an exemption) to begin in 2015. [Note: The House passed similar legislation in 2013; see H.R. 2668 below.]
H.R. 7 (Smith, C.)	**No Taxpayer Funding for Abortion and Abortion Insurance Full Disclosure Act of 2014.** Passed the House by a vote of 227-188 on January 28, 2014. H.R. 7 would have prohibited exchange applicants from obtaining premium tax credits or cost-sharing subsidies to help purchase health plans that cover elective abortions, and would have prohibited tax credits for health plans offered by an employer that include elective abortion coverage. Individuals would still be able to purchase separate abortion coverage, but would not be able to receive a tax credit or cost-sharing subsidy. H.R. 7 also would have prohibited OPM-contracted multi-state plans from including elective abortion coverage. [Note: The ACA permits exchange applicants to obtain premium tax credits and cost-sharing subsidies to help purchase health plans that cover elective abortions; however, the law prohibits the use of those federal funds to pay for abortion services and requires plans to collect an abortion surcharge from enrollees to pay for such services. The ACA also specifies that at least one multi-state plan offered in an exchange must not include elective abortion coverage.]

Bill (Sponsor)	Bill Title, House Vote, Summary of ACA Provisions
H.R. 3362 (Lee)	**Exchange Information Disclosure Act.** Passed the House by a vote of 259-154 on January 16, 2014. H.R. 3362 would have required the HHS Secretary to submit to Congress and make public a detailed weekly report, through March 2015, on (1) consumer interactions with healthcare.gov (or subsequent sites) and efforts undertaken to remedy problems that impact consumers; and (2) calls to the federal consumer service call center, including the number of calls received by the call center, problems identified by users, and referrals of those calls. The Secretary also would have been required to make public a list (with contact information) of all navigators and certified application counselors trained and certified by exchanges, and a list of all agents and brokers trained and certified by the federally facilitated exchange. Both lists would have to be updated weekly through March 2015.
H.R. 3811 (Pitts)	**Health Exchange Security and Transparency Act of 2014.** Passed the House by a vote of 291-122 on January 10, 2014. H.R. 3811 would have required the HHS Secretary to notify affected individuals within two business days of a breach of their personally identifiable information maintained by an exchange.
H.R. 3350 (Upton)	**Keep Your Health Plan Act of 2013.** Passed the House by a vote of 261-157 on November 15, 2013. H.R. 3350 would have permitted health insurance companies to continue to offer individual coverage that was in effect as of January 1, 2013, even if the coverage did not meet the ACA's essential health benefit standards and other market reforms that took effect at the beginning of 2014. Insurers could offer such coverage to existing or new enrollees at any time during 2014, but could not offer the coverage through health insurance exchanges. [Note: This legislation was prompted by the decision of insurers to send cancellation notices to individuals and small businesses with health plans in the individual and small group markets. The Administration also has taken steps to address this issue. On November 14, 2013, it announced a transitional policy under which insurers may choose, subject to the approval of state insurance regulators, to renew noncompliant health plans that have been cancelled, or are slated for cancellation. Under the ACA, insurers are not permitted to sell noncompliant coverage to new enrollees. H.R. 3350 would allow insurers to sell such coverage in the individual market during 2014.]
H.R. 2775 (Black)	**No Subsidies Without Verification Act.** Passed the House by a vote of 235-191 on September 12, 2013. H.R. 2775 would have required the HHS Inspector General to certify to Congress that a program was in place to verify the household income of exchange applicants before making any premium tax credits or cost-sharing subsidies available. [Note: H.R. 2775 became the legislative vehicle for the FY2014 Continuing Appropriations Act, P.L. 113-46. That act incorporated a modified version of the language in H.R. 2775.]
H.R. 2009 (Price)	**Keep the IRS Off Your Health Care Act of 2013.** Passed the House by a vote of 232-185 on August 2, 2013. H.R. 2009 would have prohibited the Internal Revenue Service (IRS) from implementing or enforcing any provisions of the ACA.
H.R. 2668 (Young)	**Fairness for American Families Act.** Passed the House by a vote of 251-174 on July 17, 2013. H.R. 2668 would have delayed enforcement of the ACA's individual mandate by one year by shifting the schedule of penalties for individuals who do not comply with the mandate (or obtain an exemption) to begin in 2015. It also would have incorporated the provisions in H.R. 2667 (see below) to delay the employer mandate and related reporting requirements.
H.R. 2667 (Griffin)	**Authority for Mandate Delay Act.** Passed the House by a vote of 264-161 on July 17, 2013. H.R. 2667 would have delayed for one year certain ACA reporting requirements for insurers and employers as well as the penalties for employers who do not offer affordable coverage. [Note: H.R. 2667 would have essentially codified the Administration's announcement on July 2, 2013, that it was delaying the ACA employer mandate and related reporting requirements.]
H.R. 45 (Bachmann)	**A bill to repeal the Patient Protection and Affordable Care Act.** Passed the House by a vote of 229-195 on May 16, 2013. H.R. 45 would have repealed the ACA in its entirety and restored the provisions of law amended or repealed by the ACA as if it had not been enacted.

Bill (Sponsor)	Bill Title, House Vote, Summary of ACA Provisions
	112th Congress
H.R. 6684 (Cantor)	**Spending Reduction Act of 2012.** Passed the House by a vote of 215-209 on December 20, 2012. H.R. 6684 would have eliminated the FY2013 sequestration of direct defense spending (as required under the Budget Control Act of 2011), reduced the FY2013 overall discretionary cap by $19 billion, and implemented numerous other mandatory spending reductions. Among its provisions, H.R. 6684 would have (1) repealed the authority and appropriations for the exchange planning and establishment grants and rescinded all unobligated funds; (2) repealed the authority and permanent annual appropriation for the PPHF and rescinded all unobligated funds; (3) rescinded all remaining unobligated funds for the Consumer Operated and Oriented Plan (CO-OP) program; and (4) eliminated all limits on repayment of any premium credit overpayment, making individuals liable for the full amount.
H.R. 6079 (Cantor)	**Repeal of Obamacare Act.** Passed the House by a vote of 244-185 on July 11, 2012. H.R. 6079 would have repealed the ACA in its entirety and restored the provisions of law amended or repealed by the ACA as if it had not been enacted.
H.R. 436 (Paulsen)	**Health Care Cost Reduction Act of 2012.** Passed the House by a vote of 270-146 on June 7, 2012. H.R. 436 would have (1) repealed the ACA's 2.3% excise tax on medical devices; (2) repealed the law's restrictions on using tax-preferred accounts to pay for over-the-counter drugs; (3) allowed individuals to recoup up to $500 of unused funds remaining in their flexible spending account (FSA) after the end of the plan year; and (4) eliminated all limits on repayment of any premium credit overpayment, making individuals liable for the full amount.
H.R. 5652 (Ryan)	**Sequester Replacement Reconciliation Act of 2012.** Passed the House by a vote of 218-199 on May 10, 2012. H.R. 5652, which was introduced pursuant to the reconciliation instructions in the House FY2013 budget resolution (H.Con.Res. 112), would have eliminated the FY2013 sequestration of direct defense spending (as required under the Budget Control Act of 2011), reduced the FY2013 overall discretionary cap by $19 billion, and implemented a series of mandatory program savings recommended by six House committees. Among its many provisions, H.R. 5652 would have (1) eliminated all limits on repayment of any premium credit overpayment, making individuals liable for the full amount; (2) repealed the authority and appropriations for the exchange planning and establishment grants and rescinded all unobligated funds; (3) repealed the authority and permanent annual appropriation for the PPHF and rescinded all unobligated funds; (4) rescinded all remaining unobligated funds for the CO-OP program; (5) extended by one year the disproportionate share hospital (DSH) allotment reduction imposed by the ACA; and (6) repealed the ACA's Medicaid maintenance of effort requirements.
H.R. 4628 (Biggert)	**Interest Rate Reduction Act.** Passed the House by a vote of 215-195 on April 27, 2012. H.R. 4628 would have postponed by one year a scheduled increase in Stafford education loan rates and, to offset the costs of that adjustment, repealed the authority and appropriations for the PPHF and rescinded all unobligated funds. [Note: The one-year Stafford loan rate extension was incorporated as Division F, Title III of MAP-21, the surface transportation reauthorization bill (see entry for P.L. 112-141 in **Table 1**). The provision in H.R. 4628 to repeal the PPHF and rescind all unobligated funds was not included in MAP-21.]
H.R. 5 (Gingrey)	**Protecting Access to Healthcare Act.** Passed the House by a vote of 223-181 on March 22, 2012. Title II of H.R. 5 would have repealed the authority and appropriations for IPAB.
H.R. 1173 (Boustany)	**Fiscal Responsibility and Retirement Security Act of 2012.** Passed the House by a vote of 267-159 on February 1, 2012. H.R. 1173 would have repealed Title VIII of the ACA, the Community Living Assistance Services and Supports (CLASS) Act. [Note: P.L. 112-240, enacted January 2, 2013, included a repeal of the CLASS Act; see **Table 1**.]

Bill (Sponsor)	Bill Title, House Vote, Summary of ACA Provisions
H.R. 358 (Pitts)	**Protect Life Act.** Passed the House by a vote of 251-172 on October 13, 2011. H.R. 358 would have prohibited using any funds authorized or appropriated by the ACA to pay for an abortion or to pay for any part of the costs of a health plan that covers abortions, except if the pregnancy is the result of rape or incest, or the life of the pregnant female is at risk unless an abortion is performed. It would have required insurers that offer plans through the exchanges that cover abortion services to offer identical plans that do not cover abortion services. It also would have prohibited federal, state, or local government programs that receive ACA funding from discriminating against health care entities that refuse to provide abortion services or abortion training.
H.R. 1216 (Guthrie)	**A bill to convert funding for graduate medical education (GME) in qualified teaching health centers (THCs) to an authorization of appropriations.** Passed the House by a vote of 234-185 on May 25, 2011. H.R. 1216 would have replaced the appropriation for GME payments to THCs with an authorization of appropriations for each of FY2012 through FY2015, and rescinded all unobligated funds. It would have prohibited the GME funds from being used to provide abortions, except in cases of rape or incest or when the woman's life is in danger.
H.R. 1214 (Burgess)	**A bill to repeal ACA funding for school-based health center (SBHC) construction.** Passed the House by a vote of 235-191 on May 4, 2011. H.R. 1214 would have repealed the authority and appropriations for SBHC construction grants and rescinded all unobligated funds.
H.R. 1213 (Upton)	**A bill to repeal ACA funding for health insurance exchanges.** Passed the House by a vote of 238-183 on May 3, 2011. H.R. 1213 would have repealed the authority and appropriations for state exchange planning and establishment grants and rescinded all unobligated funds.
H.R. 1217 (Pitts)	**A bill to repeal the Prevention and Public Health Fund (PPHF).** Passed the House by a vote of 236-183 on April 13, 2011. H.R. 1217 would have repealed the authority and permanent annual appropriation for the PPHF and rescinded all unobligated funds.
H.R. 2 (Cantor)	**Repealing the Job-Killing Health Care Law Act.** Passed the House by a vote of 245-189 on January 19, 2011. It was offered as an amendment during Senate floor debate on an unrelated bill (S. 223) and rejected on a procedural motion by a vote of 47-51. H.R. 2 would have repealed the ACA in its entirety and restored the provisions of law amended or repealed by the ACA as if it had not been enacted.

Source: Prepared by the Congressional Research Service based on the text of the bills listed in the table.

Table 3. ACA Provisions in the Restoring Americans' Healthcare Freedom Reconciliation Act (H.R. 3762)

Vetoed by President Obama on January 8, 2016

Topic	Summary of Provision (As Passed by the House and Senate)
Prevention and Public Health Fund (PPHF)	Repeals the authority and permanent annual appropriation for the PPHF. [The PPHF annual appropriation is currently $1 billion through FY2017. Thereafter, it will increase in increments to $2 billion for FY2022 and each subsequent fiscal year.]
Community Health Center Fund (CHCF)	Appropriates an additional $235 million to the CHCF for community health center operations for each of FY2016 and FY2017.
Funding for U.S. Territories	Prohibits the HHS Secretary from allocating ACA funds to Puerto Rico and the other U.S. territories, effective January 1, 2018. [The ACA appropriated $1 billion for U.S. territories that elect to establish an exchange. The funds are available through 2019.]
Risk Reinsurance	Prohibits the HHS Secretary from collecting risk reinsurance fees or making payments, effective January 1, 2016. [Under the ACA's transitional risk reinsurance program, most health insurance plans are assessed fees that are used to make payments to ACA-compliant plans in the individual market that enroll high-risk individuals. The program runs through 2016.]
Premium Tax Credits and Cost-Sharing Reductions	Repeals temporarily the limits on the amount of any premium tax credit overpayment that has to be repaid to the government. The repeal applies to taxable years ending after December 31, 2015, and before January 1, 2018. Repeals the premium tax credits; cost-sharing reductions; and the HHS Secretary's authority to determine individuals' eligibility to participate in an exchange and receive the tax credits and cost-sharing reductions. Repeals the IRS's authority to disclose taxpayer return information to HHS for eligibility determinations. All these provisions take effect after December 31, 2017.
Small Business Tax Credits	Repeals the tax credit for small employers with no more than 25 FTEs. The repeal applies to taxable years ending after December 31, 2017.
Individual Mandate	Eliminates the penalties for failing to comply with the individual mandate, effective January 1, 2015. [Under the ACA, most U.S. citizens and legal residents have to obtain health insurance coverage. Those who remain uninsured have to pay a penalty unless they qualify for an exemption.]
Employer Mandate	Eliminates the penalties associated with the employer mandate, effective January 1, 2015. [The ACA's employer shared responsibility provisions ("employer mandate") require larger employers to offer health coverage that meets affordability and adequacy standards. Employers who do not comply with the employer mandate may be subject to a tax penalty if one or more of their employees purchase subsidized coverage through an exchange. The mandate went into effect in 2015 for employers with at least 100 FTEs and is to be expanded to employers with at least 50 FTEs in 2016.]
Medicaid Expansion	Repeals the optional Medicaid expansion on December 31, 2017. This section also repeals several other ACA Medicaid provisions.
Medicaid DSH Payments	Repeals the ACA's reductions in Medicaid disproportionate share hospital (DSH) payments. [The ACA, as amended, directs the HHS Secretary to make aggregate reductions in Medicaid DSH allotments for FY2018 through FY2025.]
Cadillac Tax	Repeals the ACA's excise tax on high-premium employer-sponsored health coverage. [The "Cadillac Tax," which takes effect in 2018, is equal to 40% of the amount by which the total value of the coverage exceeds a specified dollar limit.]

Topic	Summary of Provision (As Passed by the House and Senate)
OTC Medications	Modifies the definition of qualified medical expenses for tax-advantaged health accounts so that it includes over-the-counter (OTC) medications. [Under the ACA, a medicine or drug must be a prescribed drug or insulin to be considered a qualified medical expense for the following tax-advantaged health accounts: health flexible spending accounts (health FSAs), health reimbursement accounts (HRAs), Archer medical savings accounts (Archer MSAs), and health savings accounts (HSAs).]
Health Savings Account Tax	Reduces the tax on withdrawals from HSAs and Archer MSAs that are not used to pay for qualified medical expenses from 20% to 10% and 15%, respectively.
Flexible Spending Accounts	Repeals the $2,500 contribution limit on health FSAs, effective for taxable years beginning after December 31, 2015.
Annual Fee on Prescription Drugs	Repeals the ACA's annual fee on manufacturers and importers of branded prescription drugs, effective January 1, 2016.
Medical Device Tax	Repeals the ACA's 2.3% tax on the sale of medical devices, beginning January 1, 2016. Medical devices that are regularly available at retail for individual use and not primarily intended for use by a medical professional are exempt from the tax.
Annual Fee on Health Insurance Providers	Repeals the ACA's annual fee on certain health insurance providers, effective January 1, 2016.
Deduction for Retiree Prescription Drug Costs	Reverses the ACA's amendment to the tax code so that employers do not have to reduce their business-expense deductions for retiree prescription drug costs by the amount of any federal subsidies. This change is effective for taxable years beginning after December 31, 2015. [Employers that provide Medicare-eligible retirees with prescription drug coverage are eligible for a tax-exempt federal subsidy to encourage them to maintain that coverage. Prior to the ACA, employers deducted retiree prescription drug costs from their income taxes without regard to the subsidies they received. The ACA amended the tax code requiring employers to reduce the allowable deduction for retiree prescription drug costs by the amount of any subsidy received.]
Tax Deduction for Medical Expenses	Reduces the income threshold for deducting medical expenses from 10% to 7.5%, effective for taxable years beginning after December 31, 2015. [Taxpayers who itemize their deductions may deduct qualifying medical expenses that exceed 10% of their adjusted gross income. The ACA had increased the threshold from 7.5% to 10%.]
Medicare Surtax on Higher-Income Individuals	Repeals the ACA's 0.9% Medicare surtax on higher-income individuals, effective for taxable years beginning after December 31, 2015.
Excise Tax on Tanning Services	Repeals the ACA's 10% excise tax on indoor tanning services, effective December 31, 2015.
Investment Tax on High-Income Individuals	Repeals the ACA's 3.8% tax on the net investment income of higher-income individuals, effective for taxable years beginning after December 31, 2015.
Remuneration Paid by Health Insurance Providers	Terminates the provision in the tax code, added by the ACA, which prohibits health insurance providers from deducting as business expenses any remuneration paid to an officer, director, or employee in excess of $500,000.

Source: Prepared by the Congressional Research Service based on the text of H.R. 3762, as amended and passed by the House and Senate.

Author Contact Information

C. Stephen Redhead
Specialist in Health Policy
credhead@crs.loc.gov, 7-2261

Janet Kinzer
Senior Research Librarian
jkinzer@crs.loc.gov, 7-7561

TRIP OVERVIEW

Trip Name: Demurrer Hrg Alvarez

Start Date: June 07, 2018

End Date: June 08, 2018

Created: June 04, 2018, Yun Hwa Harper *(Modified: June 04, 2018)*

Description: (No Description Available)

4 digit Unit-Cost Code: 2710

Docket-Matter number (20 digits): 48172270SA2018300365

Agency Record Locator: XKFHFC

Reservation for: Yun Hwa Harper

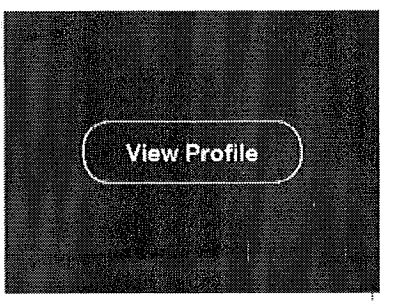
Total Estimated Cost: $90.00 USD

Agency Name: CalTravelStore (State of CA RX0F)

Address:
CalTravelStore
707 3rd street 3rd Floor
West Sacramento, CA 94608

Daytime Phone: 877-454-8785

You're almost done!
Now that you've booked, make sure your profile is up to date.



Homewood Suites by Hilton Fresno

6820 N Fresno St
Fresno, California, 93710
US
559-440-0801

Checking In: Thu Jun 7
Room 1, Days 1, Guests 1

Confirmation: 83774884
Status: **Confirmed**

Checking Out: Fri Jun 8

Additional Information
Daily Rate: $90.00 USD

Total Rate: $90.00 USD

Room Details
Room Description: RoomDescriptionCodeA05A6T
Special Instructions: Nonsmoking

Cancellation Policy

Must Cancel By 0 Am

TOTAL ESTIMATED COST

Hotel:	**$90.00** USD
Total Estimated Cost:	**$90.00** USD

REMARKS

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CALTRAVELSTORE PHONE NUMBER 877 454-8785

Texas, et al. v.

United States of America, et al.

USDC Northern District of Texas

Case No. 4:18-cv-00167-O

Exhibit F

IRS

Affordable Care Act Provision 9010 - Health Insurance Providers Fee

Section 9010 of the Patient Protection and Affordable Care Act (ACA) imposes a fee on each covered entity engaged in the business of providing health insurance for United States health risks. The first filings were due from covered entities by April 15, 2014 and the first fees were due September 30, 2014. There was a moratorium on the fee for 2017.

HealthCare.gov

Learn more about the Affordable Care Act.

Visit HealthCare.gov

Moratorium on the Providers Fee was for 2017 and 2019, Not for 2018

The due date for Form 8963, Report of Health Insurance Provider Information, for Fee Year 2018 is April 17, 2018.

The Consolidated Appropriations Act of 2016, Title II, § 201, Moratorium on Annual Fee on Health Insurance Providers, suspended collection of the health insurance provider fee for the 2017 calendar year only. Thus, health insurance issuers were not required to pay the fee for 2017. This moratorium did **not** affect the filing requirement and payment of the fee for 2016 or 2018. Enacted on January 22, 2018, along with continuing resolution legislation, H.R. 195, Division D – Suspension of Certain Health-Related Taxes, § 4003, suspends collection of the fee for the 2019 calendar year only. Again, this does not affect the filing requirement and payment of the fee for 2018. For additional information on the 2017 and 2019 moratoriums, see our questions and answers. The "applicable amount" for fee year 2018 remains at $14.3 billion (see Treas. Reg. § 57.4(a)(3)).

Related Items

- T.D. 9830 Health Insurance Providers Fee
- REG-134438-15 Health Insurance Providers Fee
- P5213 2018 IPF Newsletter

Covered Entity

A covered entity is generally any entity with net premiums written for health insurance for United States health risks during the fee year that is (1) a health insurance issuer within the meaning of section 9832(b)(2); (2) a health maintenance organization within the meaning of section 9832(b)(3); (3) an insurance company that is subject to tax under subchapter L, Part I or II, or that would be subject to tax under

subchapter L, Part I or II, but for the entity being exempt from tax under section 501(a); (4) an insurer that provides health insurance under Medicare Advantage, Medicare Part D, or Medicaid; or (5) a non-fully insured multiple employer welfare arrangement (MEWA).

For more information on what is a covered entity, please see the final regulations and final regulations/removal of temporary regulations.

Exclusions

The term covered entity generally does not include

- A self-insured employer
- A governmental entity
- Certain nonprofit corporations
- Certain voluntary employees' beneficiary associations (VEBAs)

For more information on what entities are excluded from the fee, please see the final regulations and final regulations/removal of temporary regulations.

United States Health Risk

A United States health risk is the health risk of any individual who is (1) a United States citizen, (2) a resident of the United States (within the meaning of section 7701(b)(1)(A)), or (3) located in the United States, with respect to the period such individual is so located.

On December 16, 2014, Congress enacted the Expatriate Health Coverage Clarification Act of 2014 (EHCCA). Section 3(a) of the EHCCA provides that the ACA generally does not apply to expatriate health plans. Section 3(c)(1) of the EHCCA specifically excludes expatriate health plans from the § 9010 fee by providing that, for calendar years after 2015, a qualified expatriate enrolled in an expatriate health plan is not considered a United States health risk. These rules are generally effective for expatriate health plans issued or renewed on or after July 1, 2015, unless otherwise specified. In the absence of final regulations under EHCCA, a fee payer may rely on the proposed regulations or use any other reasonable method to determine its expatriate plans. The IRS considers the approach taken in Notice 2016-14 for the 2016 fee year a reasonable method. That notice used the MLR final rule definition for expatriate policies in 45 CFR 158.120(d)(4) along with an accompanying certification attached to the Form 8963.

Health Insurance

Health insurance generally has the same meaning as the term "health insurance coverage" in section 9832(b)(1)(A), defined to mean benefits consisting of medical care (provided directly, through insurance or reimbursement, or otherwise) under any hospital or medical service policy or certificate, hospital or medical service plan contract, or health maintenance organization contract offered by a covered entity. The term health insurance includes limited scope (also called stand-alone) dental and vision benefits under section 9832(c)(2)(A) and retiree-only health insurance.

For more information on what is health insurance, please see the final regulations.

Reporting

Each covered entity, including each controlled group that is treated as a single covered entity, must report its net premiums written for health insurance of United States health risks during the previous year to the IRS by April 15th of the year in which the fee is due (the fee year) on Form 8963 (pdf, 64.65KB) "Report of Health Insurance Provider Information" in accordance with the instructions (pdf, 150.38KB) for the form.

Covered entities are encouraged to submit Form 8963 via e-file. E-file reduces the risk of transcription errors and reduces the report processing time. In addition, electronic filers receive immediate acknowledgement of receipt and are able to track submission status online.

Please see "e-file Affordable Care Act Information Reports" for additional information on e-filing Form 8963 or visit ACA Form Acceptance (AFA) for Form 8963.

Controlled Groups

Controlled groups must select a designated entity, which is responsible for filing the Form 8963 on behalf of the controlled group members and maintaining documentation of the members' consents to the selection of the designated entity. If a controlled group does not select a designated entity, the IRS will select the designated entity (members are deemed to have consented to the IRS's selection).

For more information on controlled groups, please see the final regulations and final regulations/removal of temporary regulations.

Calculating the Fee

The annual fee for each covered entity is equal to an amount that bears the same ratio to the applicable amount as the covered entity's net premiums written for health insurance of United States health risks during the data year taken into account bears to the aggregate net premiums written for health insurance of United States health risks of all covered entities during the data year taken into account.

For more information on calculation of the fee, please see the final regulations.

Applicable Amount

Applicable amount means the aggregate fee amount each year for all covered entities under section 9010. The applicable amounts for fee years are—

Fee Year	Applicable Amount
2014	$ 8,000,000,000
2015	$11,300,000,000
2016	$11,300,000,000
2017	$13,900,000,000
2018	$14,300,000,000
2019 and thereafter	The applicable amount in the preceding fee year increased by the rate of premium growth (within the meaning of section 36B(b)(3)(A)(ii).

Net Premiums Written Taken Into Account

The amount of net premiums written taken into account for each covered entity per calendar year is:

Covered entity's net premiums written during the data year that are:	Percentage of net premiums that are taken into account is:
Not more than $25,000,000	0

Covered entity's net premiums written during the data year that are:	Percentage of net premiums that are taken into account is:
More than $25,000,000 but not more than $50,000,000	50
More than $50,000,000	100

Partial Exclusion for Certain Exempt Activities

After application of the net premiums written taken into account, if the covered entity (or any member of the controlled group treated as a single covered entity) is exempt from tax by section 501(a) and is described in section 501(c)(3) (generally a charity), 501(c)(4) (generally a social welfare organization), 501(c)(26) (generally a high-risk health insurance pool), or 501(c)(29) (a consumer operated and oriented plan (CO-OP) health insurance issuer), only 50 percent of the remaining net premiums written that are attributable to its exempt activities will be taken into account.

Notice of Preliminary Fee Calculation

For each fee year, the IRS will make a preliminary calculation of the fee for each covered entity. The IRS will notify each covered entity of its preliminary fee calculation for that fee year using Letter 5066C, and it will include the following:

- The covered entity's allocated fee.
- The covered entity's net premiums written for health insurance of United States health risks.
- The aggregate net premiums written for health insurance of United States health risks taken into account for all covered entities.
- Instructions for how to submit a corrected Form 8963 to correct any errors through the error correction process.

For more information regarding the preliminary fee calculation, please see the final regulations and Notice 2013-76.

Correction Process

If a covered entity believes that the notice of preliminary fee calculation contains an error, a corrected report must be provided to the IRS by July 15th of the fee year. The covered entity will make an

error correction report by completing in full a new Form 8963 and checking the "Corrected Report" box on the form. The corrected Form 8963 will replace the original Form 8963. Therefore, the corrected report must contain all of the information required by the form's instructions. In the case of a controlled group, the corrected Form 8963 must include all of the information required by the instructions for the entire controlled group, including the information for members that do not have corrections.

For more information on the error correction process, please see the final regulations and Notice 2013-76.

Notice of Final Fee Calculation

The IRS will send each covered entity its final fee calculation for that year by August 31st using Letter 5067C.

For more information regarding the final fee calculation, please see the final regulations and Notice 2013-76.

Payment of the Fee

Each covered entity must pay its final fee by September 30th of the fee year.

Method of Paying the Fee

The fee is to be paid by electronic funds transfer (EFTPS). There are 3 Options for this payment. See EFTPS Payment Options (pdf, 18KB). If your financial institution has not added the tax type for the IPF payment to its software, you can still make an EFTPS same day wire payment. The financial institution can call the Federal Tax Collection Service (FTCS) at 1-800-382-0045 and a representative will be able to walk through the process. To assist your financial institution, you may download the attached Same Day Payment Worksheet (pdf, 60KB).

Joint and Several Liability

Each member of a controlled group is jointly and severally liable for the fee.

Tax Treatment of the Fee

The annual fee is treated as a nondeductible excise tax. For more information, please see the final regulations and Revenue Ruling 2013-27.

Penalties

There is a penalty for failure to report the required information by April 15th of the fee year, unless such failure is due to reasonable cause. The penalty for failure to report is $10,000 plus the lesser of $1,000 multiplied by the number of days during which the failure continues, or the amount of the fee. There is an accuracy related penalty for any understatement of a covered entity's net premiums written. The accuracy related penalty is equal to the excess of the amount of the fee for the fee year that should have been paid, over the amount of the fee determined based on the understatement.

Disclosure

The information submitted on both the original and corrected Forms 8963 is not confidential. All information on Form 8963 will be open for public inspection or available upon request. You may download a copy of available data here:

- 2016 Final Information (xlsx, 164KB)
- 2016 Preliminary Information (xlsx, 164KB)
- 2015 Final Information (xlsx, 171KB)
- 2014 Final Information (xlsx, 164KB)

IPF Contact Information: LB&I IPF

Page Last Reviewed or Updated: 23-Mar-2018

Texas, et al. v.

United States of America, et al.

USDC Northern District of Texas

Case No. 4:18-cv-00167-O

Exhibit G

Department of the Treasury
Internal Revenue Service

Individual Income Tax Returns 2015

Publication 1304 (Rev. 09-2017)

John A. Koskinen
Commissioner

Benjamin Herndon
Director,
Research, Applied Analytics,
and Statistics

Barry Johnson
Director,
Statistics of Income Division

David P. Paris
Chief, Individual and Tax-Exempt Branch

This report contains data on sources of income, adjusted gross income, exemptions, deductions, taxable income, income tax, modified income tax, tax credits, self-employment tax, and tax payments. Classifications by tax status, size of adjusted gross income, marital status, type of tax computation and age.

The Statistics of Income Division also makes this report and the results of its other studies available on the Internet. You can sample these products by visiting SOI's Internet site at http://www.irs.gov/taxstats. Most of the tables included in this publication are available there in Microsoft Excel format.

For questions about this publication or other SOI products and services, contact SOI's Statistical Information Services (SIS) staff who provide data, statistical analysis, and information in response to requests from customers. In addition, they provide data referral services, act as liaisons between requesters and IRS analysts on technical questions, and answer questions on the availability of SOI data. The SIS staff can be reached by e-mail at sis@irs.gov.

Suggested Citation

Statistics of Income—2015
Individual Income Tax Returns
Internal Revenue Service
Washington, D.C.

the premiums. A taxpayer's APTC eligibility was based on the Marketplace's estimate of the PTC that the taxpayer would be able to claim on his or her tax return. Differences between the APTC that was paid during the year and final value of the PTC are reconciled on Form 8962, Premium Tax Credit, filed with the taxpayer's return. If the APTC was more than the PTC, the taxpayer had to repay this excess, subject to a limit. If the PTC was more than the APTC, the excess was used to reduce the taxpayer's tax payment or increased the taxpayer's refund.

The total premium tax credit was taken on 5.0 million returns on the Form 8962 in 2015 (an increase of 61.1 percent from 2014), for a total of $18.1 billion (up 61.8 percent) (Figure G). Also in 2015, 5.7 million returns (up 70.1 percent) reported an APTC on Form 8962, totaling $20.2 billion (up 68.1 percent). When the PTC and APTC were reconciled, 2.3 million returns (a 56.3 percent increase) received a net PTC totaling $1.5 billion (up 52.8 percent), and 3.3 million returns (up 82.6 percent) had to repay excess APTCs of $2.7 billion (up 88.6 percent). These data do not reflect amended returns or errors that were corrected after initial processing.

The Affordable Care Act required that individuals have health care coverage for 2015, qualify for a health coverage exemption, or make a shared responsibility payment with a tax return. A health care individual responsibility payment was made on 6.7 million returns, down from the 8.1 million returns in 2014. The health care individual responsibility payment totaled $3.1 billion, an average of $465 per tax return paying this penalty. In 2014, the health care individual responsibility payment totaled $1.7 billion, for an average of $210 per tax return paying the penalty (see Changes in Law in Section 1). (Other ACA tax provisions, like the credit for small employer health insurance premiums and the additional Medicare tax, took effect in earlier years.)

For more 2014 changes in law and Internal Revenue Service administrative changes, see Section 1 of this publication. In Section 5 find definitions for all items appearing in tables. All the statistics are based on a sample of individual income tax returns (Forms 1040, 1040A, and 1040EZ, including electronically filed returns) filed during Calendar Year 2015. For more information on the data sources and limitations, see Section 6.

Figure G. Affordable Care Act Items, Tax Years 2014 and 2015

[Money amounts are in thousands of dollars]

Item	2014		2015		Percentage change	
	Number of returns	Amount	Number of returns	Amount	Number of returns	Amount
	(1)	(2)	(3)	(4)	(5)	(6)
Total premium tax credit	3,104,620	11,175,462	5,002,765	18,081,434	61.1	61.8
Advance payment of premium tax credit	3,362,356	11,993,488	5,718,907	20,155,707	70.1	68.1
Net premium tax credit	1,499,446	1,010,733	2,343,256	1,544,319	56.3	52.8
Excess advance premium tax credit repayment	1,803,176	1,431,168	3,292,753	2,699,501	82.6	88.6
Health care individual responsibility payment	8,061,604	1,694,088	6,691,982	3,109,377	-17.0	83.5

Data in the figure does not reflect amended returns or errors that were corrected after initial processing.
Source: IRS, Statistics of Income Division, Publication 1304, September 2017.

Texas, et al. v.

United States of America, et al.

USDC Northern District of Texas

Case No. 4:18-cv-00167-O

Exhibit H

Congressional Budget Office

NOVEMBER 2017

Repealing the Individual Health Insurance Mandate: An Updated Estimate

The Affordable Care Act (ACA) includes a provision, generally called the individual mandate, that requires most U.S. citizens and noncitizens who lawfully reside in the country to have health insurance meeting specified standards and that imposes penalties on those without an exemption who do not comply. In response to interest from Members of Congress, the Congressional Budget Office and the staff of the Joint Committee on Taxation (JCT) have updated their estimate of the effects of repealing that mandate. As part of repealing the mandate, the policy analyzed would eliminate the penalty that people who have no health insurance and who are not exempt from the mandate must pay under current law.

The analysis underlying this estimate incorporates revised projections—of enrollment in health insurance, premiums, and other factors—made as part of the usual process CBO follows to update its baseline projections. This report updates a budget option published in December 2016 and is not based on specific legislative language.[1]

The Results of CBO and JCT's Analysis

CBO and JCT estimate that repealing that mandate starting in 2019—and making no other changes to current law—would have the following effects:

- Federal budget deficits would be reduced by about $338 billion between 2018 and 2027 (see Table 1).
- The number of people with health insurance would decrease by 4 million in 2019 and 13 million in 2027 (see Table 2).
- Nongroup insurance markets would continue to be stable in almost all areas of the country throughout the coming decade.
- Average premiums in the nongroup market would increase by about 10 percent in most years of the decade (with no changes in the ages of people purchasing insurance accounted for) relative to CBO's baseline projections.

Those effects would occur mainly because healthier people would be less likely to obtain insurance and because, especially in the nongroup market, the resulting increases in premiums would cause more people to not purchase insurance.

If the individual mandate penalty was eliminated but the mandate itself was not repealed, the results would be very similar to those presented in this report. In CBO and JCT's estimation, with no penalty at all, only a small number of people who enroll in insurance because of the mandate under current law would continue to do so solely because of a willingness to comply with the law. If eliminating the mandate was accompanied by changes to tax rates or premium tax credits or by other significant changes, then the policy analyzed here would interact with those changes and have different effects.

For this analysis, CBO and JCT have measured the budgetary effects relative to CBO's summer 2017 baseline, which underlies the Concurrent Resolution on the Budget for Fiscal Year 2018.[2] In that baseline, the ACA's other provisions, including premium tax credits and

1. See Congressional Budget Office, *Options for Reducing the Deficit: 2017 to 2026* (December 2016), www.cbo.gov/publication/52142.

2. See Congressional Budget Office, *An Update to the Budget and Economic Outlook: 2017 to 2027* (June 2017), www.cbo.gov/publication/52801. For additional information about the baseline presented in that report, see *Federal Subsidies for Health Insurance Coverage for People Under Age 65: 2017 to 2027* (September 2017), www.cbo.gov/publication/53091.

Table 1.

Estimate of the Net Budgetary Effects of Repealing the Individual Mandate

Billions of Dollars, by Fiscal Year

	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027	Total, 2018–2027
Change in Subsidies for Coverage Through Marketplaces and Related Spending and Revenues[a,b]	0	-4	-9	-19	-23	-24	-25	-26	-27	-28	-185
Medicaid	0	-5	-9	-16	-20	-22	-24	-26	-28	-29	-179
Change in Small-Employer Tax Credits[b,c]	0	*	*	*	*	*	*	*	*	*	*
Change in Penalty Payments by Employers[c]	0	0	0	*	*	*	*	*	*	*	1
Change in Penalty Payments by Uninsured People	0	*	5	5	5	5	5	6	6	6	43
Medicare[d]	0	1	2	4	5	5	5	6	7	7	44
Other Effects on Revenues and Outlays[e]	0	*	-2	-6	-8	-8	-9	-9	-10	-10	-62
Total Effect on the Deficit	**0**	**-8**	**-13**	**-33**	**-40**	**-44**	**-47**	**-49**	**-51**	**-54**	**-338**
Memorandum:											
Total Change in Direct Spending	0	-7	-14	-30	-36	-40	-42	-44	-46	-49	-307
Total Change in Revenues[f]	0	1	-2	3	4	4	5	5	6	6	31

Sources: Congressional Budget Office; staff of the Joint Committee on Taxation.

Estimates are based on CBO's summer 2017 baseline.

Changes in budget authority would equal the changes in outlays shown.

Except as noted, positive numbers indicate an increase in the deficit, and negative numbers indicate a decrease in the deficit.

Numbers may not add up to totals because of rounding.

* = between -$500 million and $500 million.

a. "Related spending and revenues" includes spending for the Basic Health Program and net spending and revenues for risk adjustment.

b. Includes effects on both outlays and revenues.

c. Effects on the deficit include the associated effects that changes in taxable compensation would have on revenues.

d. Effects arise mostly from changes in payments to hospitals that treat a disproportionate share of uninsured or low-income patients.

e. Consists mainly of the effects that changes in taxable compensation would have on revenues.

f. Positive numbers indicate an increase in revenues; negative numbers indicate a decrease in revenues.

Table 2.

Effects of Repealing the Individual Mandate on Health Insurance Coverage for People Under Age 65

Millions of People, by Calendar Year

	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027
Change in Coverage Under the Policy										
Medicaid[a]	0	-1	-2	-4	-4	-4	-4	-5	-5	-5
Nongroup coverage, including marketplaces	0	-3	-4	-5	-5	-5	-5	-5	-5	-5
Employment-based coverage	0	*	-1	-2	-2	-3	-3	-3	-2	-2
Other coverage[b]	0	*	*	*	*	*	*	*	*	*
Uninsured	0	4	7	12	12	12	12	13	13	13

Sources: Congressional Budget Office; staff of the Joint Committee on Taxation.

Estimates are based on CBO's summer 2017 baseline. They reflect average enrollment over the course of a year among noninstitutionalized civilian residents of the 50 states and the District of Columbia who are under age 65, and they include spouses and dependents covered under family policies.

For these estimates, CBO and the staff of the Joint Committee on Taxation consider individuals to be uninsured if they would not be enrolled in a policy that provides financial protection from major medical risks.

Numbers may not add up to totals because of rounding.

* = between -500,000 and zero.

a. Includes noninstitutionalized enrollees with full Medicaid benefits.

b. Includes coverage under the Basic Health Program, which allows states to establish a coverage program primarily for people whose income is between 138 percent and 200 percent of the federal poverty level. To subsidize that coverage, the federal government provides states with funding that is equal to 95 percent of the subsidies for which those people would otherwise have been eligible.

cost-sharing reduction (CSR) subsidies in the marketplaces that the legislation established, are assumed to remain in place.[3]

In the budget option presented last year, CBO and JCT examined the same policy starting a year earlier and relative to CBO's March 2016 baseline: They estimated that the policy would reduce federal budget deficits by $416 billion between 2018 and 2026 and increase the number of uninsured people by 16 million in 2026.

The differences between the budgetary effects shown here and those estimated in December 2016 stem from several sources. The current estimate relies on updated baseline projections related to the federal costs of subsidizing health insurance. This estimate also incorporates CBO and JCT's expectation that individuals' and employers' full reaction to the elimination of the individual mandate would phase in more slowly than the agencies previously projected. (The agencies have incorporated that expectation in all estimates for legislative proposals related to the mandate that they have prepared after the 2017 budget reconciliation process ended in September.) And this estimate includes an interaction with Medicare, whose "disproportionate share hospital" payments to facilities that serve a higher percentage of uninsured patients would be affected.[4]

In addition to updates to the baseline, which occur on a regular cycle, CBO and JCT sometimes make major

3. After consultation with the Budget Committees, CBO has not changed its baseline to reflect the Administration's announcement on October 12, 2017, that it would stop making payments for CSRs. The Balanced Budget and Emergency Deficit Control Act of 1985, which specifies construction of the baseline, requires that CBO assume full funding of entitlement authority. CBO has long viewed the cost-sharing subsidies as a form of entitlement authority—that is, legal authority for federal agencies to incur obligations and to make payments out of the Treasury for specified purposes. On that basis, in the agencies' initial cost estimate for the ACA and in all subsequent baseline projections, they have recorded the CSR payments as direct spending (that is, spending that does not require appropriation action). For a related discussion, see Congressional Budget Office, *The Effects of Terminating Payments for Cost-Sharing Reductions* (August 2017), www.cbo.gov/publication/53009.

4. That interaction, which would add costs totaling $44 billion over the 2018–2027 period, was not included in the December 2016 estimate because, as is often the case with budget options, it followed a simplified method. However, during 2017, the interaction with Medicare has been included in estimates of the effects of major changes to policies affecting health insurance.

methodological changes to improve their estimates. Accordingly, the agencies have undertaken considerable work to revise their methods to estimate the effects of repealing the individual mandate. CBO's Panel of Health Advisers and experts at the American Enterprise Institute, the Office of the Actuary in the Centers for Medicare & Medicaid Services, the RAND Corporation, and the Urban Institute, along with other sources, have provided valuable information during that process.[5] However, the evidence available to inform CBO and JCT's work on that issue is limited. Because that work is not complete and significant changes to the individual mandate are being considered as part of the budget reconciliation process, the agencies are publishing this update now without incorporating major changes to their analytical methods.

However, the preliminary results of analysis using revised methods indicates that the estimated effects on the budget and health insurance coverage would probably be smaller than the numbers reported in this document. The agencies are continuing to work on those methods, and they expect to complete and publish an estimate including and explaining the revisions at some point after the current budget reconciliation process is complete or along with a future update to the baseline.

Uncertainty Surrounding the Estimates

CBO and JCT's estimates of this policy are inherently imprecise because the ways in which federal agencies, states, insurers, employers, individuals, doctors, hospitals, and other affected parties would respond to it are all difficult to predict. The responses by individuals in the short term to a policy that would repeal the mandate are uncertain, for example.

The policy's nonfinancial effects—changes in people's tendency to comply with laws and attitudes about health insurance and their greater responsiveness to penalties than to subsidies—amplify its financial effects in CBO and JCT's analysis. The amplification from those nonfinancial effects is harder to project. In large part because of the difficulty in projecting that amplification, different organizations' estimates of the effects of repealing the mandate have varied. The effects could be smaller than those presented here: Some organizations have recently published such smaller estimates that appear to ascribe lesser effects to nonfinancial factors.[6] Alternatively, the nonfinancial effects of the mandate might grow over time—as the effects of many provisions of the tax code appear to have done after their implementation and as could occur if awareness and enforcement of the mandate changed. Under that circumstance, the effects of repealing the mandate could be larger over time.

CBO and JCT's baseline projections are also uncertain, and revisions to them would alter interactions and change the estimates of the effects of eliminating the mandate. For example, if there are no payments for CSRs, premiums in the marketplaces would probably be higher than projected in the baseline. (The Administration has halted those payments, but the baseline projections used in this estimate incorporated the assumption that they would continue.) Premiums that are higher than those in the baseline projections would tend to boost the budgetary savings under this policy by increasing the estimated per-person savings from people no longer enrolling in nongroup coverage. As another example, subsidized enrollment in the marketplaces might be lower than projected in the baseline, which would tend to decrease the budgetary savings under this policy.

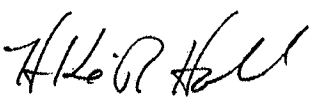
Despite the uncertainty, some effects of this policy are clear: For instance, the federal deficit would be many billions of dollars lower than under current law, and the number of uninsured people would be millions higher.

5. For additional information, see Alexandra Minicozzi, Unit Chief, Health Insurance Modeling Unit, Congressional Budget Office, *Modeling the Effect of the Individual Mandate on Health Insurance Coverage* (presentation to CBO's Panel of Health Advisers, Washington, D.C., September 15, 2017), www.cbo.gov/publication/53105; and Congressional Budget Office, "Panel of Health Advisers" (accessed November 7, 2017), www.cbo.gov/about/processes/panel-health-advisers.

6. Those estimates were for the early years of policies that would have initially repealed the individual mandate and later made many other changes. See Office of the Chief Actuary, Centers for Medicare & Medicaid Services, *Estimated Financial Effect of the "American Health Care Act of 2017"* (June 2017), https://go.usa.gov/xnTzU; and Linda Blumberg, Matthew Buettgens, and John Holahan, *Implications of Partial Repeal of the ACA Through Reconciliation* (Urban Institute, December 2016), http://tinyurl.com/y6vkugs4.

This report updates CBO and JCT's estimate of the effects of a budget option that CBO published in December 2016. Susan Yeh Beyer, Kate Fritzsche, Jeffrey Kling, Sarah Masi, Kevin McNellis, Eamon Molloy, Allison Percy, Lisa Ramirez-Branum, and Robert Stewart prepared the report with guidance from Jessica Banthin, Chad Chirico, Holly Harvey, and Alexandra Minicozzi and with contributions from Ezra Porter and the staff of the Joint Committee on Taxation. Theresa Gullo, Mark Hadley, Robert Sunshine, and David Weaver reviewed the document; John Skeen edited it; and Casey Labrack prepared it for publication.

An electronic version is available on CBO's website (www.cbo.gov/publication/53300).



Keith Hall
Director