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

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

I, Alfred J. Gobeille, declare:

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

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

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

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

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

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

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

5. The ACA has positive economic benefits on states.

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

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

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

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

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

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

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

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

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

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

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

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

Alfred J. Gobeille
Secretary, Vermont Agency of Human Services

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

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

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

I, Frederick Isasi, declare:

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

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

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

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

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

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

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

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

a) California

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

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

b) Illinois

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

c) Illinois

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

d) Oregon

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

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

e) Pennsylvania

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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[7] Cited in ASPE, op cit.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Frederick Isasi
Executive Director
Families USA Foundation

IN THE UNITED STATES DISTRICT COURT

FOR THE NORTHERN DISTRICT OF TEXAS

WICHITA FALLS DIVISION

TEXAS, WISCONSIN, ALABAMA, ARKANSAS, ARIZONA, FLORIDA, GEORGIA, INDIANA, KANSAS, LOUISIANA, PAUL LePAGE, Governor of Maine, MISSISSIPPI, by and through Governor Phil Bryant, MISSOURI, NEBRASKA, NORTH DAKOTA, SOUTH CAROLINA, SOUTH DAKOTA, TENNESSEE, UTAH, and WEST VIRGINIA,

Plaintiffs,

v.

UNITED STATES OF AMERICA, UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, ALEX AZAR, in his Official Capacity as SECRETARY OF HEALTH AND HUMAN SERVICES, UNITED STATES INTERNAL REVENUE SERVICE, and DAVID J. KAUTTER, in his Official Capacity as Acting COMMISSIONER OF INTERNAL REVENUE,

Defendants,

and,

CALIFORNIA, CONNECTICUT, et al.,

Proposed Intervenors.

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

DECLARATION OF JENNIFER KENT IN SUPPORT OF STATES' MOTION TO INTERVENE

I, Jennifer Kent, declare:

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

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

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

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

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

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

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

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

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

Jennifer Kent
Director
Department of Health Care Servcies

IN THE UNITED STATES DISTRICT COURT

FOR THE NORTHERN DISTRICT OF TEXAS

WICHITA FALLS DIVISION

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

I, Mila Kofman, declare:

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

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

2. The DC Health Benefit Exchange Authority (HBX) was established as a requirement of Section 3 of the Health Benefit Exchange Authority Establishment Act of 2011, effective March 3, 2012 (D.C. Law 19-0094). The mission of the DC Health Benefit Exchange Authority is to implement an online health insurance marketplace in the District of Columbia in accordance with the Patient Protection and Affordable Care Act (PPACA), thereby ensuring access to quality and affordable health care to all DC residents.

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

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

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

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

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

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

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

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

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

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

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

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

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

Mila Kofman
Executive Director
District of Columbia Health Benefit Exchange Authority

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

FORT WORTH DIVISION

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

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

I, Dr. Jennifer Lee, declare:

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

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

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

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

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

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

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

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

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

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

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

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

I, Kimberley Lufkin, declare:

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

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

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

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

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

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

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

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

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

Kimberley Lufkin

SA2018100536

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

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

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

I, Chris Maley, declare:

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

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

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

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

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

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

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

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

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

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

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

IN THE UNITED STATES DISTRICT COURT

FOR THE NORTHERN DISTRICT OF TEXAS

FORT WORTH DIVISION

TEXAS, WISCONSIN, ALABAMA, ARKANSAS, ARIZONA, FLORIDA, GEORGIA, INDIANA, KANSAS, LOUISIANA, PAUL LePAGE, Governor of Maine, MISSISSIPPI, by and through Governor Phil Bryant, MISSOURI, NEBRASKA, NORTH DAKOTA, SOUTH CAROLINA, SOUTH DAKOTA, TENNESSEE, UTAH, and WEST VIRGINIA,

Plaintiffs,

v.

UNITED STATES OF AMERICA, UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, ALEX AZAR, in his Official Capacity as SECRETARY OF HEALTH AND HUMAN SERVICES, UNITED STATES INTERNAL REVENUE SERVICE, and DAVID J. KAUTTER, in his Official Capacity as Acting COMMISSIONER OF INTERNAL REVENUE,

Defendants,

and,

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

DECLARATION OF JUDY MOHR PETERSON IN SUPPORT OF STATES' MOTION TO INTERVENE

CALIFORNIA, et al.,

Proposed Intervenors

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I, Judy Mohr Peterson, declare:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

I, Thea Mounts, declare:

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

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

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

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

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

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

B. The Affordable Care Act Increased Access to Affordable Coverage

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Thea N. Mounts

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

IN THE UNITED STATES DISTRICT COURT

FOR THE NORTHERN DISTRICT OF TEXAS

FORT WORTH DIVISION

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

I, Claudia Schlosberg, declare:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

[6] Bivens, *supra* note 3.

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

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

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

  - **Health Homes**

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

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

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

- **Payment Reform Initiatives**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

SA2018100536

IN THE UNITED STATES DISTRICT COURT

FOR THE NORTHERN DISTRICT OF TEXAS

FORT WORTH DIVISION

TEXAS, WISCONSIN, ALABAMA, ARKANSAS, ARIZONA, FLORIDA, GEORGIA, INDIANA, KANSAS, LOUISIANA, PAUL LePAGE, Governor of Maine, MISSISSIPPI, by and through Governor Phil Bryant, MISSOURI, NEBRASKA, NORTH DAKOTA, SOUTH CAROLINA, SOUTH DAKOTA, TENNESSEE, UTAH, and WEST VIRGINIA,

Plaintiffs,

v.

UNITED STATES OF AMERICA, UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, ALEX AZAR, in his Official Capacity as SECRETARY OF HEALTH AND HUMAN SERVICES, UNITED STATES INTERNAL REVENUE SERVICE, and DAVID J. KAUTTER, in his Official Capacity as Acting COMMISSIONER OF INTERNAL REVENUE,

Defendants,

and,

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

DECLARATION OF ZACHARY W. SHERMAN IN SUPPORT OF STATES' MOTION TO INTERVENE

CALIFORNIA, RHODE ISLAND, et al.

Proposed Intervenors.

I, Zachary W. Sherman, declare:

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

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

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

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

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

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

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

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

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

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

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

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

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

Zachary W. Sherman
Director
HealthSource RI

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

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

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

I, Ryan Smith, declare:

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

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

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

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

5. Even though I am no longer covered through a plan purchased through the marketplace, I continue to utilize mental health services, and the protections offered under the Affordable Care Act remain critical. I know that whatever plan I enroll in

will include mental health services as an essential health benefit, that mental health treatments will be in parity with other kinds of health services, and I will never be discriminated against for a pre-existing condition.

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

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

Executed on April 3, 2018, in Chicago, Illinois.

Ryan Smith

IN THE UNITED STATES DISTRICT COURT

FOR THE NORTHERN DISTRICT OF TEXAS

FORT WORTH DIVISION

TEXAS, WISCONSIN, ALABAMA, ARKANSAS, ARIZONA, FLORIDA, GEORGIA, INDIANA, KANSAS, LOUISIANA, PAUL LePAGE, Governor of Maine, MISSISSIPPI, by and through Governor Phil Bryant, MISSOURI, NEBRASKA, NORTH DAKOTA, SOUTH CAROLINA, SOUTH DAKOTA, TENNESSEE, UTAH, and WEST VIRGINIA,

Plaintiffs,

v.

UNITED STATES OF AMERICA, UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, ALEX AZAR, in his Official Capacity as SECRETARY OF HEALTH AND HUMAN SERVICES, UNITED STATES INTERNAL REVENUE SERVICE, and DAVID J. KAUTTER, in his Official Capacity as Acting COMMISSIONER OF INTERNAL REVENUE,

Defendants,

and,

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

DECLARATION OF DR. KARA ODOM WALKER IN SUPPORT OF STATES' MOTION TO INTERVENE

CALIFORNIA, et al.,

Proposed Interveners.

1. **I, Dr. Kara Odom Walker, declare:**

- I am the Secretary of the Delaware Department of Health and Social Services (DHSS). I have served as the Secretary of the DHSS since February 6, 2017. Prior to my present post, I served as the Deputy Chief Science Officer at the Patient-Centered Outcomes Research Institute (PCORI) in Washington D.C. from August 2012 to January 2017. Furthermore, as a family physician with health services and community-based participatory research training, I previously was an assistant clinical professor in family and community medicine at the University of California, San Francisco, where I developed measurement instruments to better understand integrated care in health systems for diverse populations from July 2010 to July 2012.
- I graduated with honors from the University of Delaware with a BS in chemical engineering. Thereafter I received my MD from Jefferson Medical College and MPH from Johns Hopkins University. I completed postgraduate training at University of California, San Francisco, and served as a Robert Wood Johnson Clinical Scholar at the University of California, Los Angeles, where I conducted research on the impact of hospital closure on underserved, minority populations.
- As an advocate for health equity and minority and underserved populations, I was recognized for leadership by the Harvard Business School's program for leadership development, the American Medical Association, and the National Medical Association. I served as past national president of the Student National Medical Association and past postgraduate physician trustee of the National Medical Association.

2. As one of the largest agencies in state government, DHSS has 11 divisions, employs more than 4,000 people and in one way or another affects almost every citizen in our great state. Our divisions provide services in the areas of public health, social services, substance abuse and mental health, child support, developmental disabilities, long-term care, visual impairment, aging and adults with physical disabilities, state service centers, management services, financial coaching, and Medicaid and medical assistance. The Department includes three long-term care facilities and the state's only public psychiatric hospital, the Delaware Psychiatric Center.

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

- Delaware has received $800 million via Medicaid expansion alone.

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

Overall the number of individuals with insurance has increased. In Delaware, the percentage of population which was uninsured fell from 9.1% in 2013 to 5.7% in 2016. This translates into the number of people without coverage falling from 83,000 in 2013 to 53,000 in 2016.

- The ACA expanded coverage through two key mechanisms: Medicaid expansion for those individuals with the lowest incomes, and federal health subsidies to purchase coverage in new health insurance Exchanges for those individuals with moderate incomes.
- Medicaid is an important source of healthcare insurance coverage and has resulted in significant coverage gains and reduction in the uninsured rate, both among the low-income population and within other vulnerable populations. As a result of Medicaid expansion Delaware has been able to provide coverage to 11,000 new enrollees and maintain coverage for 50,000 adults from an earlier expansion with enhanced federal financial support, and the state has experienced a large reduction in the uninsured rate.

5. **The ACA has positive economic benefits on states.**
   - Studies have shown that states expanding Medicaid under the ACA have realized budget savings, revenue gains, and overall economic growth.
   - In Delaware, $500 million has been saved as a result of Medicaid expansion.
6. **The ACA has allowed States to test and implement reforms to healthcare delivery systems that support State policy priorities of increasing efficiency and quality of care.**
   - Delaware received Center for Medicare and Medicaid Innovation (CMMI) grants totaling $35 million over four years (2015-2018).

I declare that the foregoing is true and correct based on information and belief.

Executed on March 28, 2018, in New Castle, Delaware.

Dr. Kara Odom Walker
Cabinet Secretary
Delaware Department of Health
and Social Services

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

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

DECLARATION OF SHERRY WHITE IN SUPPORT OF MOTION TO INTERVENE BY CALIFORNIA, ET AL.

I, Sherry White, declare:

1. I am 46 years old and a resident of Corning, New York.

2. My husband and I are self-employed small business owners, and we have had to purchase our own insurance for the last 15 years.

3. Prior to the Affordable Care Act, our family of four purchased a plan through the private market at $800 per month. While our family is fortunate to be relatively healthy, we found ourselves needing our insurance for several small things over the years and each time, we found that our plan did not provide the coverage we needed. For example, I required physical therapy after I tore a tendon in my wrist and my husband needed a CPAP machine to treat sleep apnea. I learned that our plan did not cover both my physical therapy and his CPAP machine and we were forced to pay out of pocket if we wanted care.

4. We found ourselves paying for a plan that did not cover what we needed and cost more than our mortgage. And at one point, we were forced to choose between paying for the premiums and putting groceries on the table. We chose to drop our coverage.

5. Because of the Affordable Care Act, we were able to purchase a plan through the NY State of Health state marketplace that is more robust than our previous coverage and after the tax credit subsidy is taken into account, half of the price. Because of the provision allowing children to stay on their parents' plan, we have been able to cover our young adult daughters until they are able to secure coverage of their own.

6. It is impossible to overstate the importance of the essential health benefits for our family. Between us, we have been able to receive coverage for preventive services, prescription drugs, medical equipment, and a hospitalization. Thankfully, we no longer have to worry about our plan turning down care the way our last one did.

7. Having stable, comprehensive coverage has helped us avoid a catastrophe that would have required us to close our business. While on this plan, I experienced a kidney stone and was forced to go to the hospital; the lithotripsy and overnight hospital stay cost us over $10,000. If our insurance did not have meaningful coverage for hospitalizations and limits to our out of pocket costs, it would have been catastrophic. There is no way we could have afforded to pay that out of pocket. As

small business owners, when we are injured or sick, we close the doors and lose all sources of income.

8. The Affordable Care Act has given our family the coverage and security of knowing that if we get sick, we will not go bankrupt as a result.

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

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

Executed on March 23, 2018 in Corning, New York.

Sherry White

SA2018100536

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

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

DECLARATION OF DR. HOWARD A. ZUCKER IN SUPPORT OF THE STATES' MOTION TO INTERVENE

I, Howard A. Zucker, declare:

1. I am the Commissioner of the New York State Department of Health (DOH). I make this declaration in my capacity as the Commissioner after consultation with DOH program staff directing the initiatives detailed below and in support of New York State's Motion to Intervene in the above-captioned action.

2. DOH's mission is to protect, improve and promote the health, productivity and wellbeing of all New Yorkers. DOH administers several programs that receive funding through the Affordable Care Act (ACA) in order to achieve this mission.

3. As described below, the ACA has significantly increased New York State's ability to provide access to affordable comprehensive health insurance coverage and health care services to state residents. Rolling back the ACA's provisions puts the health of millions of New Yorkers at risk.

4. **The Affordable Care Act provides billions of dollars directly to New York to improve the health of its residents.**

- Funding available through the ACA has allowed New York to improve the health of its residents. New York has received more than $17 billion in federal revenue to expand affordable health coverage in the appropriate setting for New Yorkers, including: $12.9 billion in federal revenue as a result of state adoption of the Medicaid expansion provisions of the ACA; $3.5 billion in federal funding to support the Basic Health Program option of the ACA making health care coverage

more affordable for lower income New Yorkers; $26.9 million in funding through the Public Health and Prevention Fund; $618 million in funding to support the Balancing Incentive Program; $100 million in continuing grants from the Center for Medicare and Medicaid Innovation for transforming primary care practices to advanced patient centered care; and nearly $185 million in funding to support the Money Follows the Person (MFP) program.

5. **The Affordable Care Act increased residents' access to affordable coverage.**

- The ACA expanded health coverage for New Yorkers through three key mechanisms: (1) the Medicaid expansion for those individuals with the lowest incomes; (2) the Basic Health Program (BHP), known as the "Essential Plan" in New York, for individuals with income slightly higher than Medicaid levels and lawfully present immigrants ineligible for Medicaid; and (3) federal subsidies to lower the cost of coverage for individuals with moderate incomes.
- Since implementing the ACA, New York has seen significant coverage gains. Since 2013, nearly 1 million people have gained coverage, and the rate of uninsured in New York has declined from 10 to below 5 percent, its lowest level ever. Coverage gains were seen among:
    - Young adults ages 19 to 25, whose uninsured rate fell from 17 percent to 8 percent;
    - African American/Black New Yorkers, whose uninsured rate fell from 12 percent to 7 percent;
    - Asian New Yorkers, whose uninsured rate fell from 14 percent to 8 percent;

- Hispanic/Latino New Yorkers, whose uninsured rate fell from 20 percent to 12 percent;
- New Yorkers who are full-time employees, whose uninsured rate fell from 12 percent to 7 percent; and
- New Yorkers with household incomes under 200 percent of FPL, whose uninsured rate fell from 16 percent to 10 percent.

- Medicaid is an important source of healthcare insurance coverage for low income residents and the most vulnerable citizens. Prior to the ACA, New York had been a leader in making access to health care accessible to low-income residents through Medicaid expansion permitted under Section 1115 federal waivers. Nonetheless, an estimated one million people who were eligible for Medicaid remained uninsured, placing financial burden on the health care system when these individuals presented for services sicker and had no health plan to pay providers, often hospitals.
- As a result of implementing the ACA's Medicaid expansion, 301,721 New Yorkers became newly eligible for health care coverage. An additional 1,148,587 New Yorkers are covered by Medicaid with the state receiving an enhanced federal Medical Assistance Percentage (FMAP) under the provisions of the ACA.
- New York has also provided its residents with coverage under the Basic Health Program, a program created by the ACA, and available to states to opt into through submission of a "blueprint" to HHS. As of January 31, 2018, BHP provides 738,851 lower income New Yorkers with health coverage at a lower monthly premium cost, no annual deductible and lower copayments for services

as compared to a silver tier Qualified Health Plan (QHP) with cost sharing reductions. In late 2015, modeling by The Urban Institute found that Essential Plan, as compared to a QHP, reduces both premium and out-of-pocket costs for these individuals by over $1,100 a year.

- Prior to implementing the ACA, New York's individual insurance market was often described as being in a "death spiral." With individual monthly premiums of well over $1,000 a month, only the wealthiest individuals and/or people with high medical service utilization were likely to purchase coverage. Enrollment in the state's individual insurance markets had dropped to about 17,000.
- Since the 2014 implementation of the ACA, New York's individual insurance market has grown by 2000 percent to over 365,000. With this extraordinary increase in membership, individual market premiums have fallen by over 50 percent as compared to premiums in 2013, making coverage more accessible for New Yorkers.
- In addition to this dramatic reduction in premiums, the ACA allows nearly 150,000 New Yorkers to receive federal tax credits to further reduce the cost of coverage and cost sharing reductions to help reduce out of pocket costs such as deductibles, coinsurance and copayments. In 2018, New Yorkers are expected to receive over $531 million in tax credits, bringing the cumulative benefit of the ACA tax credits received by New Yorkers to over $2.7 billion since 2014.
- In 2016, 348,566 Medicare beneficiaries in New York received discounts on the Medicare Part D prescription drug coverage gap, known as the "donut hole," totaling more than $2.1 billion. On average, the beneficiary discount was $1,320.

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

- Given that health care comprises 18 percent of the national gross domestic product, the federal assistance states receive through the Affordable Care Act has a significant effect on the economy. A Commonwealth Fund analysis estimated that the repeal of the Medicaid expansion and premium tax credits could lead to the loss of 2.6 million jobs nationwide and $1.5 trillion gross state products over five years. According to the report, in New York the repeal of the Medicaid expansion and tax credits would result in 131,000 jobs lost, $154 billion in lost business output, and $90 in lost gross state product.
- Since implementation of the ACA, the number of uninsured has been reduced significantly, and New York hospitals have reported a dramatic decrease in self-pay hospital utilization as patients have gained a usual source of payment. New York State Institutional Cost Reports show a 23 percent reduction in self-pay hospital emergency room visits, a 40 percent reduction in self-pay inpatient services and a 17 percent reduction in self-pay outpatient visits. Having a usual source of payment for patients reduces the risk of uncompensated care costs.

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

- Funding available to states through the ACA has allowed New York to increase opportunities for residents to access home and community based services through several programs. In January 2007, the federal Centers of Medicare and Medicaid Services (CMS) approved New York's application to participate in the Money Follows the Person Rebalancing Demonstration Program (MFP). The MFP

Demonstration, authorized under the Deficit Reduction Act and extended by the Affordable Care Act, involves transitioning eligible individuals from long-term institutions like nursing facilities and intermediate care facilities into qualified community-based settings.

- The MFP has helped New York State to rebalance the Medicaid long-term care systems by assisting people who want to leave institutional settings to receive services in their communities of choice.
- Initiatives like MFP have contributed to the rebalancing of New York State's long-term health care system, increasing the amount of Medicaid spending on Home and Community Based Services in New York State by 56.68% from 2008 through calendar year 2016. MFP provides enhanced federal match of home and community based services provided to former residents of institutional settings who successfully transition to community living. These additional federal dollars support rebalancing efforts in long term care systems in New York. New York State MFP has utilized between $15-$20 million dollars for each of the last three years to provide assistance to individuals in nursing homes and intermediate care facilities to facilitate their transition to living.
- Community First Choice Option (CFCO) is an enhanced personal care benefit established under the Affordable Care Act. States were authorized to amend their state plan to cover enhanced personal attendant services and supports to address activities of daily living (ADL), instrumental activities of daily living (IADL) and health-related needs through hands-on assistance, supervision and/or cueing. Other services and supports required under CFCO include assistance with

skill acquisition, maintenance or enhancement to facilitate an individual meeting his or her own ADL, IADL or health-related needs. Also, voluntary training to provide individuals with the skills to hire, train and dismiss personal attendants is required. Optional CFCO services and supports include social transportation, home and vehicle modifications and assistance with moving expenses for those transitioning to community based care from institutional settings. CFCO services are intended to be primarily self-directed either by the person receiving the services and supports or through a designated representative. States who opt to implement a CFCO state plan benefit are eligible for an additional 6% FMAP.

- The Balancing Incentive Program (BIP) was authorized in the Affordable Care Act in 2010. It provides grants to states that agree to develop and implement three structural reforms believed to facilitate rebalancing of Medicaid expenditures toward community-based rather than institutional long-term services and supports (LTSS). Grants are earned through enhanced FMAP based on each state's spending on certain HCBS LTSS spending during the BIP period between the grant approval and September 30, 2015. While earnings ceased during the initial BIP period, states were granted additional time to meet the requirements and spend the funds generated during the BIP period. The final BIP period ended September 30, 2017.
- New York was one of 18 states that elected to participate in the BIP program. The program's overarching goal was to increase the percentage of state Medicaid expenditures on community-based long-term services and supports over 50% prior to the end of the BIP period. New York exceeded this goal early on and

now spends nearly 65% of its Medicaid LTSS expenditures in community-based settings. From 2014 through 2017, more than 57,000 individuals were served through BIP.

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

- The ACA created the Center for Medicare and Medicaid Innovation (CMMI) which established the State Innovation Models (SIM) initiative to encourage state payment and delivery reforms. New York is a SIM award state. With this $100 million award, DOH has implemented a primary care transformation initiative to meet the goals of having improved access to high quality, cost-effective health care for 80% of New York residents, improving the health of our population. With this initiative, over 2,500 practices will receive transformation assistance to increase practice capability for access to appointments, patient-centric coordinated care using health information to improve quality and outcomes.
- New York State has two facilities participating in Accountable Health Communities, a program that focuses on addressing the gap between clinical care and community services addressing health-related social needs or social determinants of health. Data from this program will inform models for addressing social determinants in communities, essential to increasing access to primary care and reducing unnecessary hospital utilization.

9. **The ACA created a dedicated funding stream to improve the nation's public health system.**

- The Prevention and Public Health Fund was established under Section 4002 of the ACA. Also known as the Prevention Fund or PPHF, it is the nation's first mandatory funding stream dedicated to improving our nation's public health system.
- PPHF funds that have been allocated to the Centers for Disease Control and Prevention (CDC) have enhanced state capacity to provide immunizations against infectious diseases; increase detection and prevention efforts related to infectious disease threats including pandemic influenza; have supported the Preventive Health & Health Services Block Grant that addresses unique public health issues on state levels including prevention of lead poisoning, fall prevention, rape crisis and sexual violence prevention, tobacco use prevention, hunger prevention, and enhanced water quality; and has supported state funding through the Epidemiology and Laboratory Capacity (ELC) and Emerging Infections Program (EIP) grants that have built capability critical during recent outbreaks including those related to multi-state foodborne illness, influenza, and fungal meningitis, and provides a foundation for the antibiotic resistance and healthcare associated infections programs that is estimated to avert billions of dollars in healthcare spending.
- New York State currently receives funding from the PPHF to conduct chronic disease prevention programs addressing diabetes, obesity, cardiovascular disease tobacco use, and arthritis. Chronic diseases are among the leading causes of death

and disability in New York State. They account for approximately 60% of all deaths in the state and affect the quality of life for millions of New Yorkers. However, chronic diseases are also among the most preventable, if there is adequate support for effective prevention programs and policies.

- In addition to addressing chronic diseases, without continued PPHF funding, grants that support communicable disease prevention, detection, and control would be severely impacted. Current grant funding through the CDC supports communicable disease surveillance and outbreak control in communities, healthcare settings (hospitals and nursing homes), tuberculosis prevention and control, and combating vaccine preventable diseases. CDC funds New York annually through the Emerging Infections Program grant, the Epidemiology and Laboratory Capacity grant, the Immunization and Vaccines for Children Cooperative Agreement funding, and Preventive Health & Health Services Block grant. A portion of the PPHF funding is directed to increase and improve the critical public health work conducted at the local level which extends the reach and impact of the state capacity.

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

- Compared to individuals in states that have chosen not to implement key coverage mechanisms in the ACA, individuals who live in states that are implementing the

law have improved access to care. According to a recent Commonwealth Fund Survey[1]:

- Nationally, in 2012 the share of individuals who reported they could not access needed care due to cost was 43 percent. This share dropped to 34 percent in 2016 nationally, and in New York the percentage dropped to 29 percent in 2016. In comparable large states like Florida and Texas, the share of individuals who reported they could not access needed care in 2016 was far higher: 41 percent and 45 percent, respectively.
- Nationally, in 2012 the share of individuals who reported having trouble paying their medical bills was 41 percent. This share dropped to 37 percent in 2016, and in New York, the number dropped to 28 percent. In comparison, the share of individuals reporting having trouble paying medical bills was 41 percent and 44 percent in Florida and Texas, respectively.

[1] The Commonwealth Fund, Issue Brief, March 2017, *Insurance Coverage, Access to Care, and Medical Debt Since the ACA: A Look at California, Florida, New York and Texas* http://www.commonwealthfund.org/~/media/files/publications/issue-brief/2017/mar/1935_gunja_coverage_access_four_largest_states_ib.pdf.

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

Executed on April 6, 2018 in New York, New York.

Howard A. Zucker, MD, JD

Howard A. Zucker, M.D., J.D.
Commissioner
Department of Health
New York State

Certificate of Service

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

s/Michelle Schoenhardt
Michelle Schoenhardt