IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

ASSOCIATION FOR COMMUNITY AFFILIATED PLANS, et al., *Plaintiffs*, v. UNITED STATES DEPARTMENT OF TREASURY, et al., *Defendants*.	Civil Action No. 18-cv-2133

DECLARATION OF GEORGE KOLODNER, MD

I, George Kolodner, MD, declare and state as follows:

1. I am board certified in psychiatry and in addiction psychiatry. I received my medical degree from the University of Rochester in 1967. I currently practice at Kolmac Outpatient Recovery Centers in Maryland and the District of Columbia.

2. I am a Distinguished Life Fellow and member of the American Psychiatric Association (APA) and have been a member for 45 years. I served on the APA Council on Addiction Psychiatry from 1996 to 1999 and the Committee on Treatment of Addicted Patients from to 1999-2008 acting as its Vice-Chair from 2005 to 2008.

3. In my practice, my patients all have substance use disorders and often have co-occurring medical and mental health conditions.

4. Psychiatry differs from some other medical subspecialties in that establishing a relationship of trust with the patient over time is essential to developing an accurate diagnosis. Additionally, psychiatric medications are titrated over time with patients and are frequently

adjusted depending upon the patient's response and tolerance. It is important to the patient's welfare to carefully follow the patient over time to ensure that the treatment plan is working and can be adjusted as necessary. As such, regular appointments are critical to my ability to successfully treat my patients.

5. In addition, the ethical rules to which psychiatrists are bound require that the psychiatrist not terminate a relationship with a patient unless and until the patient is safely working with another provider. During that transition, the psychiatrist must provide bridge care to ensure the stability of the patient.

6. Almost all my patients pay for my services with the assistance of insurance. I participate in insurance plans sold in the Affordable Care Act marketplace. Many of my patients have individual insurance policies and have been able to acquire them because of the Affordable Care Act's prohibition of discrimination against persons with preexisting conditions and requirement that mental health be covered and covered in parity with all other medical care.

7. My services are priced at approximately the same level as other psychiatrists in my area.

8. Prior to the ACA, some of these patients could not afford individual coverage because their pre-existing mental health or substance use disorder disqualified them from insurance coverage or because the cost of coverage was out of reach because it was based upon their health status. Without coverage, they did not seek treatment; if they did seek treatment it was not at a level that would allow them to establish a stable recovery from their substance use disorders. Further, necessary medications were often not included in the list of medicines that they could afford, making it difficult if not impossible for my patients to access the medications

they needed to manage their illnesses. The ACA has allowed them access to care which in many instances is life-saving, and in most cases at least life-improving.

9. According to the National Institutes of Mental Health, a component of the United States Department of Health and Human Services, 18.3% of adults live with a mental illness, with the highest rate of prevalence of mental illness being among young adults aged 18-25.[1] 4.2% of adults have a serious mental illness, with the highest rate of prevalence of serious mental illness again being among young adults aged 18-25.[2] 49.5% of adolescents have a mental disorder and 22% of those individuals are severely impaired by it.[3]

10. Data produced by SAMSHA indicates that of those with a mental illness, only 42.9% receive treatment.[4]

11. Because many patients rely on ACA marketplace plans to pay for their mental health/substance use disorder treatment, the number of persons receiving quality treatment for mental health and/or substance use disorders will decline if ACA marketplace plans are no longer available at a reasonable cost.

12. Some of my patients who are driven out of the ACA marketplace may be able to obtain cheaper, less comprehensive insurance which will not cover the cost of my services. As these are driven out of the ACA market, I will have to transfer their care to another psychiatrist in their new insurance plan. Moreover, if these patients purchase a short-term, limited-duration insurance plan that excludes patients with preexisting conditions and/or can charge higher rates for patients with preexisting conditions, they will not be able to find another psychiatrist to

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[1] https://www.nimh.nih.gov/health/statistics/mental-illness.shtml#part_154910
[2] *Id.*
[3] *Id.*
[4] https://www.samhsa.gov/data/sites/default/files/DistrictOfColumbia_BHBarometer_Volume_4.pdf

whom to transition. In that case, I and other APA members will be obligated by our professional ethical code of conduct to continue to provide essential treatment even though the patient cannot pay for their care.

13. As more and more patients are priced out of the ACA market, my ability to practice medicine and to treat people regardless of their personal income level will decline. My patient base will dwindle.

14. As a doctor who contracts with insurance plans, I am aware of the steps that plans take to decrease costs. As healthy individuals leave the ACA market, it will be more expensive for the plans to cover care for the high-cost users left in the marketplace. This increases insurance rates for consumers but also causes plans to change utilization management practices to reduce costs. In my experience, these practices include adopting administrative hurdles such as requiring prior authorizations for basic medications and procedures, more frequently auditing medical records and bills, and making more stringent medical necessity standards, all of which will require physicians to donate significantly more uncompensated time to ensuring that their patients get the treatment they require. When these measures were instituted in the past, many psychiatrists elected not to participate in insurance plans and to operate on a cash only basis. Similar (and more extensive) cost reduction methods are likely to result from diversion of the healthiest patients away from ACA plans, leaving me and other APA members with the choice of significant reductions in income or leaving the plan altogether in favor of cash-only practices. Many APA members may not be able to afford the reduction in income, and will thus opt out of insurance plans. When they do so they will need to transition their patients who cannot pay in full for treatment to other psychiatrists, but the number of psychiatrists willing to take on these

patients (and accept payment from insurers) will have decreased. The net result will be fewer psychiatrists available for middle and lower income people in need of psychiatric care.

15. Young, apparently healthy people are likely to opt into short term limited duration plans believing that they are and will continue to be healthy. However, the highest rate of prevalence of severe mental illness is among young adults and symptoms often do not show until late teens and early twenties.

16. Thus, a significant portion of those who purchase STLDI plans may find themselves lacking the ability to afford mental health treatment that they need. For example, some of these young people may attempt suicide as a result of a mental health crisis, causing themselves immense suffering and burdening overcrowded emergency rooms with trying to save their lives.

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

Executed on September 27, 2018, at Washington, D.C.

George Kolodner, MD