IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

CITY OF CHICAGO,

Plaintiff,

vs.

ALEX M. AZAR, II, in his official capacity as Secretary of the United States Department of Health and Human Services, et al.,

Defendants.

Case No. 1:20-cv-1566

DECLARATION OF CHRISTEN LINKE YOUNG

I, Christen Linke Young, declare under penalty of perjury as prescribed in 28 U.S.C. § 1746:

1. The facts contained in this declaration are known personally to me and, if called as a witness, I could and would testify competently thereto under oath. I submit this sworn declaration in support of the City of Chicago's motion for a preliminary injunction or, in the alternative, expedited summary judgment.

2. I am a fellow with the USC-Brookings Schaeffer Initiative for Health Policy, a research center within the Economic Studies division of the Brookings Institution. My research concerns how Americans get health care coverage, how that coverage is financed, and how the health care system can be improved to make coverage affordable and accessible to more people. I have published many pieces of scholarly analysis on these topics. I have testified before Congress and before state legislatures, and my work is frequently cited in national media. My full curriculum vitae, including a list of publications, appears as an Appendix to this declaration.

I. Summary of observations and opinions.

3. Those without comprehensive health insurance coverage experience cost-related barriers to health care at higher rates than insured patients. These barriers may affect how they seek care and what services they receive, including for care related to COVID-19.

4. Current policy provides some protection for uninsured individuals who need COVID-19 care, but it is not comprehensive insurance coverage. Specifically, the two free-standing "funds" that reimburse providers for COVID-19 costs for uninsured patients do not provide the assurance of actual health coverage, and short-term insurance products may expose consumers to significant costs if they become seriously ill.

II. Uninsurance is associated with cost barriers to care.

5. A very large body of evidence, from both before and after implementation of the Patient Protection and Affordable Care Act (ACA),[1] demonstrates that health insurance coverage is associated with a greater likelihood that individuals will seek and receive needed care. As described below, research indicates that uninsured individuals are more likely to delay or forgo care because of costs and less likely to have reliable access to the health care system, as compared to those with comprehensive forms of health insurance coverage.

A. Uninsured individuals are more likely to go without care because of costs.

6. Evidence consistently reflects that uninsured individuals are more likely to go without needed health care services because of costs. Analysis of results from the National Health Interview Survey[2] administered by the Centers for Disease Control and Prevention (CDC)

---

[1] Pub. L. No. 111-148, 124 Stat. 119 (2010), *as amended*, Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029 (2010).

[2] *National Health Interview Survey*, CDC, https://www.cdc.gov/nchs/nhis/index.htm (last viewed May 27, 2020).

demonstrates that in 2017, uninsured adults were five times more likely to report that they had gone without health care "because of costs" in the previous twelve months (20% versus 4%).[3] When including individuals who delayed care, and not just those who avoided it altogether, that figure rises to 28% of the uninsured (compared to only 7% of the insured).[4] That is, in the relatively recent past more than a quarter of uninsured adults reported that costs had affected their ability to seek care in a twelve month period.

7. Indeed, CDC data reflect that in every year since 1998, uninsured individuals have been far more likely than the insured to report that they delayed or went without care due to cost. Implementation of the ACA was associated with a decrease in the rate at which uninsured individuals reported cost barriers to care, but the disparity between insured and uninsured individuals remain large.[5] Because uninsured individuals differ from the insured in many ways, including the fact that they are disproportionately low-income, these data cannot be used to infer that uninsurance is the only factor behind these disparities in cost-related barriers to care, but the data are consistent with insurance status playing an important role.

8. Researchers using a variety of data sources covering varying time periods have reached the same conclusion. To consider just a few examples: Gallup's Health and Healthcare poll reveals that the uninsured are more likely than the insured to delay care because of costs over the entire time horizon of the survey; nearly two thirds (across all insurance statuses) of

---

[3] Gary Claxton et al., *How Does Cost Affect Access to Care?*, Kaiser Family Found. (Jan. 22, 2019), https://www.healthsystemtracker.org/chart-collection/cost-affect-access-care. For survey question wording, see *NHIS Data, Questionnaires and Related Documentation*, CDC, https://www.cdc.gov/nchs/nhis/data-questionnaires-documentation.htm (last visited May 27, 2020).

[4] *How Does Cost Affect Access to Care*.

[5] *See id.*

those delaying care report that care is associated with a "serious condition."[6] Another news organization survey in 2005 found that 51% of the uninsured (compared to 25% of the insured) reported that a member of their household "skipped medical treatment, cut pills or did not fill a prescription in the past year because of the cost."[7] Analyzing 1997 and 1998 data from a different CDC survey, the Behavioral Health Risk Factor Surveillance Survey,[8] researchers found that 39% of adults who had been uninsured for one year and only 7% of insured adults reported that they could not see a physician due to costs in the prior year.[9]

9. Analysis of the impact of the ACA's Medicaid expansion reveals the same pattern. A review by the Kaiser Family Foundation identifies 91 different studies that find Medicaid expansion and the associated increase in insurance coverage is associated with better utilization of care and 55 studies showing improved access to care.[10] For example, Medicaid

---

6 Lydia Saad, *Delaying Care a Healthcare Strategy for Three in 10 Americans*, Gallup (Dec. 17, 2018), https://news.gallup.com/poll/245486/delaying-care-healthcare-strategy-three-americans.aspx.

7 *Health Care Costs Survey*, USA Today, Kaiser Family Found. & Harv. Sch. of Pub. Health (Aug. 2005), https://www.kff.org/wp-content/uploads/2013/01/7371.pdf.

8 *See Behavioral Risk Factor Surveillance System*, CDC, https://www.cdc.gov/brfss/index.html (last updated Nov. 5, 2019).

9 *See* John Z. Ayanian et al., *Unmet Health Needs of Uninsured Adults in the United States*, 284(16) J. Am. Med. Ass'n 2061 (2000), https://jamanetwork.com/journals/jama/fullarticle/193207.

10 *See* Madeline Guth et al., *The Effects of Medicaid Expansion under the ACA: Updated Findings from a Literature Review*, Kaiser Family Found. 8 fig. 4 (Mar. 17, 2020), https://www.kff.org/report-section/the-effects-of-medicaid-expansion-under-the-aca-updated-findings-from-a-literature-review-report/. The review identifies a small number of studies that are inconclusive on each of these metrics, which the authors conclude is generally because "early studies using 2014 data" are limited by the fact that "changes in utilization may take more than one year to materialize." *Id.*

expansion is associated with statistically significant decreases in the rate at which individuals report being unable to afford care, including follow-up and specialist care.[11]

10. Some research indicates that cost-related barriers deter uninsured individuals from receiving care specifically for acute conditions. One study of "health shocks"—injuries or newly emerging chronic conditions—found that uninsured individuals were less likely to receive any care at all (79% versus 89%). Moreover, they were about twice as likely to go without needed follow-up care because of costs (19% versus 9% for injuries, or 9% versus 4% for a new chronic condition), and were in worse health several months after the shock had occurred.[12]

B. Uninsured individuals are less likely to have a usual source of care.

11. Uninsured individuals are also far less likely to report having a usual source of care compared to insured people, meaning that treatable conditions may be detected later and when treatment is more expensive. National Health Interview Survey data reflect that in 2017, half (50%) of uninsured people reported that they did not have a place that they would "usually go to if [they were] sick and need health care," compared to just 11% of the privately insured.[13]

---

[11] *See, e.g.*, Sarah Miller & Laura R. Wherry, *Four Years Later: Insurance Coverage and Access to Care Continue to Diverge Between ACA Medicaid Expansion and Non-Expansion States*, 109 Am. Econ. Ass'n Papers & Proceedings 327, 327 (2019), https://pubs.aeaweb.org/doi/pdfplus/10.1257/pandp.20191046.

[12] *See* Jack Hadley, *Insurance Coverage, Medical Care Use, and Short-Term Health Changes Following an Unintentional Injury or the Onset of a Chronic Condition*, 297(16) J. Am. Med. Ass'n 1073 (2007), https://pubmed.ncbi.nlm.nih.gov/17356028/.

[13] Rachel Garfield et al., *The Uninsured and the ACA: A Primer*, Kaiser Family Found. (Jan. 25, 2019), https://www.kff.org/report-section/the-uninsured-and-the-aca-a-primer-key-facts-about-health-insurance-and-the-uninsured-amidst-changes-to-the-affordable-care-act-how-does-lack-of-insurance-affect-access-to-care/; *NHIS Data, Questionnaires and Related Documentation*; *see also, e.g.*, *How Does Cost Affect Access to Care*; Catherine Hoffman & Julia Paradise, *Health Insurance and Access to Health Care in the United States*, 1136 Annals of the N.Y. Acad. of Scis. 149 (2008), https://nyaspubs.onlinelibrary.wiley.com/doi/full/10.1196/annals.1425.007; *Summary Health Statistics for U.S. Adults: National Health Interview Survey, 2006*, CDC 12-13 (Dec. 2007), https://www.cdc.gov/nchs/data/series/sr_10/sr10_235.pdf.

12. Other research demonstrates that those who gained coverage in the first several months of the ACA's implementation were far less likely to be without a usual source of care than those who remain uninsured. Researchers found that 39% of the newly insured in the fall of 2014, compared to 57% of those who remained uninsured, did not have a regular source of health care services.[14]

C. These cost barriers may affect COVID-19 care.

13. Together, these data suggest that cost-related barriers to care for the uninsured can impact COVID-19 treatment. Delays in seeking care and foregone care because of costs are common for the uninsured in general, and these obstacles are likely to continue to apply in the COVID-19 context.

14. Indeed, an April 2020 Gallup poll found that 14% of Americans (insured and uninsured alike) would "avoid seeking treatment due to concerns about the cost of care" if they experienced COVID-19 symptoms. Further, 9% indicated they would avoid care because of costs even if they suspected COVID-19 infection.[15] Given the wide disparities between the rate at which insured and uninsured individuals report delaying or foregoing care because of costs, it is probable that uninsured individuals would be more likely to avoid COVID-19 care.

15. This avoidance or delay in seeking care could mean individuals delay seeking a COVID-19 test, resulting in a longer period of time during which a person is capable of infecting others, but not aware of their infection. It could result in individuals avoiding a test entirely. It

---

[14] Rachel Garfield et al., *Access to Care for the Insured and Remaining Uninsured: A Look at California During Year One of ACA Implementation*, Kaiser Family Found. fig. 1 (May 28, 2015), https://www.kff.org/report-section/access-to-care-for-the-insured-and-remaining-uninsured-issue-brief/.

[15] *See* Dan Witters, *In U.S., 14% With Likely COVID-19 to Avoid Care Due to Cost*, Gallup (Apr. 28, 2020), https://news.gallup.com/poll/309224/avoid-care-likely-covid-due-cost.aspx.

could also mean that individuals who become very ill may ultimately enter care at a later point in the trajectory of the disease.

16. Insurance status may also affect how individuals seek care if they ultimately decide to do so. Because the uninsured disproportionately lack a usual source of care, many will not have any connection to primary care. And because they lack insurance coverage, they also face difficulty obtaining care in advance of a serious illness or before an existing illness becomes more severe. As a result, they may be more likely to seek care in high acuity settings like an emergency room or other emergency services.

17. Insurance status may also affect the nature and extent of care. For example, coverage for prescription drugs and physician visits makes it more likely that people experiencing illness will be able to stay home, seek diagnosis, and obtain treatment without coming to the hospital. That reduces the demands placed on a hospital system that may face resource constraints during the current pandemic. Patients who have comprehensive insurance also retain coverage across treatment settings, enabling ongoing care.

III. Current policy does not provide the protection of insurance coverage.

18. Some new programs have been established to address COVID-19-related care for uninsured patients, but they differ from actual health insurance in important ways and are unlikely to provide the same access to the health care system that comprehensive coverage would provide. Specifically, two government-administered funds are available to cover some costs related to COVID-19 *testing* and COVID-19 *treatment*, respectively, but there are major gaps in these programs compared to comprehensive coverage. Short-term health insurance plans also leave consumers exposed to potentially large bills. A national special enrollment period allowing uninsured Americans to enroll in marketplace coverage would create a comprehensive alternative.

A. Current testing funding is less protective than comprehensive coverage.

19. In the Families First Coronavirus Relief Act, Congress provided $1 billion to reimburse health care providers for the COVID-19 testing for the uninsured,[16] and Congress has since added an additional $1 billion to the fund.[17] This funding can be used to pay for specific health care services delivered to an uninsured patient. Specifically, the fund will reimburse providers for "in vitro diagnostic products" that test for COVID-19, and for the cost of health care services delivered during a visit to a health care provider (such as a doctor's office or emergency department), but only if the visit "result[s] in an order" for a COVID-19 test and if the services "relate to" the test.[18]

20. This is a limited benefit that will not pay for many services that may be delivered, even in the case of an uninsured individual presenting with the intention of getting a COVID-19 test. For example, if an uninsured person sees a health care provider seeking a COVID-19 test, but for whatever reason no test is ultimately ordered by the provider, the fund cannot be accessed for any of the services received and the patient may be responsible for payment.[19]

21. Even if a test is ordered, other services that may be obtained by the patient during the visit—like a flu test or imaging services for more serious cases—cannot be reimbursed from the fund and may be billed to the patient.[20]

---

[16] Pub. L. No. 116-127, 134 Stat. 178 (2020).

[17] Paycheck Protection Program and Health Care Enhancement Act, Pub. L. No. 116-139, 134 Stat. 620 (2020).

[18] Families First Coronavirus Relief Act, § 6001.

[19] *See, e.g.*, Kirk Siegler, *Many Who Need Testing For COVID-19 Fail To Get Access*, NPR (Apr. 3, 2020), https://www.npr.org/2020/04/03/826044608/many-who-need-testing-for-covid-19-fail-to-get-access (describing cases where patients did not have a COVID-19 test ordered, despite their concerns about COVID-19).

[20] *See* Sabrina Corlette, *Expanded Coverage for COVID-19 Testing is an Important Step, But Loopholes Expose All of Us to Greater Risk*, Ctr. on Health Insurance Reforms (Apr. 6, 2020), http://chirblog.org/expanded-coverage-for-covid-19-testing/.

22. In addition, if a COVID-19 test occurs during a hospital admission, then the provider may not be reimbursed for the visit from the testing fund.[21] If the patient ultimately tests positive for COVID-19, some costs can be reimbursed from the treatment fund, as described below, but if the test is negative those costs may be billed to the patient.

23. Further, individual uninsured patients do not have any direct access to fund dollars, even if the services they received qualify for reimbursement. Providers can submit claims to the Department of Health and Human Services (HHS).[22] However, there is nothing an individual can do to seek protection from the fund; it is entirely at the discretion of the provider whether to ask for reimbursement. If the provider does not do so—either because they are unaware of the option or they simply elect not to—then uninsured individuals can be, and have been, billed for the services, even if they would otherwise qualify for reimbursement.[23]

24. These gaps mean that an uninsured individual who may wish to obtain a COVID-19 test has no meaningful assurance that their health care costs will be covered by the fund—and

---

[21] *See Frequently Asked Questions for the COVID-19 Claims Reimbursement to Health Care Providers and Facilities for Testing and Treatment of the Uninsured*, Health Resources & Servs. Admin., https://www.hrsa.gov/coviduninsuredclaim/frequently-asked-questions (last visited May 27, 2020) ("The testing-related visit (the admission) would not be eligible for reimbursement because the care setting is not an office visit, telehealth visit, urgent care or emergency room and is not separately billable with applicable CPT/HCPCS codes on the inpatient claim. Unless COVID-19 is the primary diagnosis for the admission, no portion of this claim would be eligible for reimbursement under the program since the primary reason for treatment is not COVID-19.") ("*Frequently Asked Questions*").

[22] *See COVID-19 Claims Reimbursement to Health Care Providers and Facilities for Testing and Treatment of the Uninsured*, Health Resources & Servs. Admin., https://www.hrsa.gov/CovidUninsauredClaim (last updated May 2020).

[23] *See, e.g.*, Kimberly Leonard, *Trump and Congress Tried to Make Coronavirus Testing and Treatment Free, but People Are Still Getting Big Bills When They Go to the Hospital*, Bus. Insider (May 21, 2020), https://www.businessinsider.com/coronavirus-patients-medical-bills-hospitals-doctors-insurance-2020-5 (describing cases where individual patients received bills despite the fact that the services provided qualified for reimbursement); *see also Expanded Coverage for COVID-19 Testing*.

no way to obtain that assurance. To be sure, the testing fund will relieve some financial burden that would otherwise fall upon uninsured consumers, and will compensate providers for some care that might otherwise have been uncompensated. But because a consumer cannot rely on the fund, it does not serve the same role as health insurance in promoting access to care.[24]

B. Treatment funding is also less protective than comprehensive coverage.

25. The fund described above is limited to costs associated with COVID-19 testing. However, testing is a fairly inexpensive service when compared to *treatment* for a serious COVID-19 illness.

26. For example, one analysis of potential COVID-19 spending assumes that a COVID-19 test for an uninsured patient costs an average of $100, and the visit at which that test might be delivered costs an average of $112 (for a doctor's office) or $582 (for the emergency room). However, if a person is hospitalized for COVID-19, which the authors assume will happen in 2% of COVID-19 cases, hospital costs will average $17,000 if the patient does not require a ventilator and $58,000 if he or she does.[25]

27. In contrast to testing, Congress has not appropriated any funding specifically to reimburse for the COVID-19 treatment costs of the uninsured.

---

[24] *See* Christen Linke Young et al., *Responding To COVID-19: Using The CARES Act's Hospital Fund To Help The Uninsured, Achieve Other Goals*, Health Affairs (Apr. 11, 2020), https://www.healthaffairs.org/do/10.1377/hblog20200409.207680/full/ (discussing the ways in which fund-based reimbursement differs from insurance).

[25] Matthew Fiedler & Zirui Song, *Estimating Potential Spending on COVID-19 Care*, Brookings Inst. (May 7, 2020), https://www.brookings.edu/research/estimating-potential-spending-on-covid-19-care/ (tbl. 2 discussing unit prices of COVID-19 services).

28. However, Congress has provided a large "Provider Relief Fund,"[26] a fund administered by HHS to support health care providers as they incur COVID-19-related costs at the same time they experience major revenue shortages because of physical distancing measures that required postponing or canceling most non-urgent care.

29. HHS has determined that it will use a portion of this Provider Relief Fund to reimburse providers for COVID-19 treatment costs of the uninsured. Providers can submit claims for reimbursement through an online portal.[27] This arrangement suffers from many of the same limitations as the testing coverage fund, as well as some additional gaps due to the high cost of treatment and the structure of the support.

30. Most importantly, providers can only access the treatment funding if COVID-19 is the primary diagnosis associated with the health care claim.[28] Services (other than testing) delivered to patients who seek care because they think they may have COVID-19, but are not diagnosed as such will not be eligible for reimbursement. This would include all treatment services delivered to someone who tests negative for COVID-19, as well as services delivered that are not associated with COVID-19 even if the patient tests positive.[29]

31. COVID-19 patients often experience other illness, and therefore are especially likely to need comprehensive coverage for services beyond just COVID-19, but the fund will not

---

[26] Coronavirus Aid, Relief, and Economic Security Act, Pub. L. No. 116-136, 134 Stat. 281 (2020); *see also* Paycheck Protection Program and Health Care Enhancement Act;*see also CARES Act Provider Relief Fund*, HHS, https://www.hhs.gov/coronavirus/cares-act-provider-relief-fund/index.html (last visited May 27, 2020).

[27] *See COVID-19 Claims Reimbursement*.

[28] *See id.* (describing payment for "services with a primary COVID-19 diagnosis"). A narrow exception is available in the case of pregnancy; COVID-19 may be listed secondary to pregnancy.

[29] *See, e.g.*, *Frequently Asked Questions* (providing an example of cancer treatment for a COVID-19 patient that cannot be reimbursed).

reimburse any of those costs. Cost-related fears could lead some who do not know that they have COVID-19 to delay care, further slowing detection and accelerating the pandemic's spread.

32. The fund cannot be used to reimburse for any outpatient prescription drugs or hospice services, even if an individual has a COVID-19 diagnosis.[30]

33. In this environment, individuals in need of health care services will have no ability to predict if the costs they incur will be eligible for reimbursement from the fund. They do not know if they will test positive for COVID-19, or if the care they receive will be the type of service for which COVID-19 will be considered the primary diagnosis. They do not know if they will face significant outpatient drug costs.

34. Further, HHS has not specified the amount of funding that will be available to reimburse providers for COVID-19 treatment costs of the uninsured.[31] Given the high cost of COVID-19 treatment, the fund could be exhausted before a provider submits a request for reimbursement for the patient, leaving the patient responsible for the full bill. And because information about the size of the fund is unavailable, providers and uninsured individuals face significant uncertainty about whether a claim could ultimately be paid through the fund. This may be a particularly acute concern in cases where individuals are facing a long period of illness and hospitalization, because the provider will not be able to generate a claim for potential reimbursement until the individual is discharged from the hospital, several weeks in the future.

35. As above, even when services qualify and when funding is available, an individual patient has no direct recourse to the fund. It is at the discretion of the provider whether to seek fund reimbursement or bill the patient directly.

---

[30] *See COVID-19 Claims Reimbursement*.

[31] *See Frequently Asked Questions* (under "General Questions" header; then click "How much money is available in the fund?") (declining to specify the amount of available funding).

36. For all of these reasons, concern about high costs could be a real barrier to accessing care and the existence of the treatment fund will not ameliorate those concerns in the way comprehensive health insurance would. The fund may alleviate some meaningful amount of financial burden on uninsured individuals and providers, but does not provide the assurance that comprehensive coverage can offer.

C. Short term insurance products have major gaps.

37. Short-term limited duration health insurance plans also have major gaps for patients who may need COVID-19 care, including their exclusion of pre-existing conditions and limitations on coverage.

38. These products often do not cover pre-existing conditions.[32] If any signs of illness appeared in the period before enrollment, or, often, in the days immediately following enrollment, the plan will not cover any claims, and the person will face costs as if they had been without any form of coverage. Further, if an individual becomes sick with COVID-19, the insurance company may engage in a lengthy examination of medical records to determine if the individual displayed any signs of illness prior to obtaining her insurance product. Press reports reflect that this process, known as post-claims underwriting, has been applied to patients seeking care related to concerns about COVID-19.[33]

---

[32] *See* Christen Linke Young & Kathleen Hanick, *Misleading Marketing Of Short-Term Health Plans Amid COVID-19*, USC-Brookings Schaeffer Initiative for Health Pol'y (Mar. 24, 2020), https://www.brookings.edu/blog/usc-brookings-schaeffer-on-health-policy/2020/03/24/misleading-marketing-of-short-term-health-plans-amid-covid-19/.

[33] *See, e.g.*, Ben Conarck, *A Miami Man Who Flew to China Worried He Might Have Coronavirus. He May Owe Thousands*, Miami Herald (Feb. 24, 2020), https://www.miamiherald.com/news/health-care/article240476806.html; *see also Misleading Marketing Of Short-Term Health Plans Amid COVID-19*.

39. Aside from concerns about pre-existing condition exclusions, these plans have limited benefit designs that could leave consumers exposed to very large costs. A recent examination of 12 widely available short-term plans across three states (each of which uses the federal Exchange) finds that consumers needing hospital care for COVID-19 would be exposed to costs much higher than they would face if they had comprehensive health insurance. Patients requiring ventilation could face out-of-pocket costs greater than $30,000 in popular short-term plans, and even those with a lower cost hospitalization could be responsible for costs greater than $15,000.[34] In contrast, in a comprehensive ACA-regulated health insurance, out-of-pocket costs are capped at $8,150, and lower levels for lower-income households.[35]

40. As a result, short-term plans are likely far less effective in ameliorating cost-related barriers to care than comprehensive coverage. Consumers do not know if their illness will be considered a pre-existing condition and excluded from payment entirely, and even if not, they face significant costs if they are seriously ill.

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

Dated: June 14, 2020

Washington, DC

Christen Linke Young

[34] *See* Emily Curran et al., *In the Age of COVID-19, Short-Term Plans Fall Short for Consumers*, The Commonwealth Fund (May 12, 2020), https://www.commonwealthfund.org/blog/2020/age-covid-19-short-term-plans-fall-short-consumers.

[35] *Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2020*, 84 Fed. Reg. 17,454, 17,541 (Apr. 25, 2019).

APPENDIX

CHRISTEN LINKE YOUNG

EXPERIENCE

Brookings Institution **Washington, DC**
Fellow, USC-Brookings Schaeffer Initiative for Health Policy 2018-Present
Conduct legal and policy research at preeminent public policy think-tank. Research portfolio focuses on implementation of the Affordable Care Act and forward-looking policies in health reform, including auto-enrollment, strategies for the regulation of non-compliant insurance products, and policies to improve subsidized coverage.

NC Department of Health and Human Services **Raleigh, NC**
Deputy Secretary 2017-2018
Served the State of North Carolina as the number two official in the Department of Health and Human Services, managing a $20 billion budget and 15,000 employees. Oversaw initial transformation of state Medicaid program from fee-for-service to managed care.

Center for Consumer Information and Insurance Oversight **Washington, DC**
Principal Deputy Director 2015-2017
Served as the second-highest ranking official in the federal agency responsible for implementing the insurance market reforms in the Affordable Care Act. Led the agency as the primary day-to-day decision-maker with responsibilities similar to a chief operating officer.

White House Domestic Policy Council **Washington, DC**
Senior Policy Advisor for Health Reform 2013-2015
Managed the policy portfolio related to the Affordable Care Act's insurance reforms, Medicaid expansion, and tax policy.

U.S. Department of Health and Human Services **Washington, DC**
Director of Coverage Policy, Office of Health Reform 2013
Supported the Secretary's Office in implementation of the Affordable Care Act's coverage expansion, including insurance reforms and Medicaid expansion.

U.S. Department of Health and Human Services **Washington, DC**
Policy Analyst & Presidential Management Fellow 2009-2011
Supported policy analysis in the Office of Health Reform and the Washington Office of the CDC.

EDUCATION

Yale Law School **New Haven, CT**
Juris Doctor 2009
Editor-in-Chief, *Yale Journal of Health Policy, Law, and Ethics*; Senior Editor & Admissions Committee, *Yale Law Journal*

Stanford University **Stanford, CA**
Bachelor of Science with Honors and with Distinction, Biological Sciences 2004

PUBLICATIONS

Christen Linke Young and Sobin Lee, "Making ACA Enrollment More Automatic for the Newly Unemployed," *Brookings Institution*, May 28, 2020.

Christen Linke Young and Sobin Lee, "How Well Could Tax-Based Auto-Enrollment Work," *Brookings Institution*, April 14, 2020.

Christen Linke Young, Stan Dorn, Loren Adler, Cheryl Fish-Parchman, and Tara Straw, "Responding to COVID-19: Using the CARES Act's Hospital Fund To Help the Uninsured, Achieve Other Goals" *Health Affairs Blog*, April 13, 2020.

Christen Linke Young and Kathleen Hannick, "Misleading Marketing of Short-Term Plans Amid COVID-19," *Brookings Institution*, March 24, 2020.

Christen Linke Young, "What Do I Do If I Lose My Job-Based Health Insurance?," *Brookings Institution*, March 17, 2020.

Matthew Fiedler, Christen Linke Young, and Loren Adler, "What Are the Health Coverage Provisions in the House Coronavirus Bill?," *Brookings Institution*, March 13, 2020.

Howard P. Forman, Elizabeth Fowler, Megan L. Ranney, Ruth J. Katz, Sara Rosenbaum, Kavita Patel, Timothy Jost, Abbe R. Gluck, Christen Linke Young, Erica Turret, Suhas Gondi, and Adam Beckman, "Health Care Priorities for a COVID-19 Stimulus Bill," *Health Affairs Blog*, March 13, 2020.

Christen Linke Young, "There Are Clear Race-Based Inequalities in Health Insurance and Health Outcomes," *Brookings Institution*, February 19, 2020.

Matthew Fiedler, Loren Adler, and Christen Linke Young, "Health Care in President Trump's Fiscal Year 2021 Budget," *JAMA Health Forum*, February 13, 2020.

Christen Linke Young and Jason Levitis, "Georgia's 1332 Waiver Violates the ACA and Cannot Lawfully Be Approved," *Brookings Institution,* January 23, 2020.

Christen Linke Young, "Remanding *Texas v. U.S.* to the Lower Court Prolongs Harms to Consumers and the Health Care Industry," *Brookings Institution*, January 3, 2020.

Christen Linke Young, "The Supreme Court Will Hear a Health Care Case in December, but its Decision on Risk Corridors Won't Affect the ACA," *Brookings Institution*, November 4, 2019.

Christen Linke Young and Abigail Durak, "How Do We Tackle the Opioid Crisis," *Brookings Institution*, October 18, 2019.

Christen Linke Young, Matthew Fiedler, Loren Adler, and Sobin Lee, "What Is Surprise Billing for Medical Care," *Brookings Institution*, October 15, 2019.

Christen Linke Young and Matthew Fiedler, "What Would the 2020 Candidates' Proposals Mean for Health Care Coverage?," *Brookings Institution*, October 15, 2019.

Matthew Fiedler and Christen Linke Young, "Current Debates in Health Care Policy: A Brief Overview," *Brookings Institution*, October 15, 2019.

Christen Linke Young, "Retroactive Enrollment: A Feasible Way To Bring Auto-Enrollment to the Individual Market," *Health Affairs Blog*, October 10, 2019.

Christen Linke Young, "The Trump DOJ Has Taken an Unexpected and Unworkable Position on the ACA," *Brookings Institution*, September 18, 2019.

Kathleen Hannick and Christen Linke Young, "Where Does Your State Stand in *Texas v. U.S.*," *Brookings Institution*, September 18, 2019.

Loren Adler, Steven M. Lieberman, Christen Linke Young, and Paul B. Ginsburg, "Considerations for Expanding International Reference Pricing beyond Medicare Part B," *Health Affairs Blog*, September 9, 2019.

Christen Linke Young, Matthew Fiedler, Loren Adler, and Sobin Lee, "What Is Surprise Billing," *Brookings Institution*, August 1, 2019.

Loren Adler, Erin Duffy, Paul B. Ginsburg, Mark Hall, Erin Trish, and Christen Linke Young, "Rep. Ruiz's Arbitration Proposal for Surprise Billing (H.R. 3502) Would Lead to Much Higher Costs and Deficits," *Brookings Institution*, July 16, 2019.

Christen Linke Young, "Federal Surprise Billing Legislation Does Not Violate the Constitution," *Brookings Institution*, July 1, 2019.

Sobin Lee and Christen Linke Young, "Insurance Status Churn and Auto-Enrollment," *Brookings Institution*, June 19, 2019.

Christen Linke Young, Matthew Fiedler, and Jason Levitis, "The Trump Administration's Final HRA Rule: Similar to the Proposed but Some Notable Choices," *Brookings Institution*, June 14, 2019.

Christen Linke Young, "Three Ways To Make Auto-Enrollment Work," *Brookings Institution*, June 13, 2019.

Christen Linke Young, Loren Adler, Paul B. Ginsburg, and Mark Hall, "The Relationship Between Network Adequacy and Surprise Billing," *Brookings Institution*, May 10, 2019.

Matthew Fiedler, Henry J. Aaron, Loren Adler, Paul B. Ginsburg, and Christen Linke Young, *Building on the ACA To Achieve Universal Coverage*, 380 N. ENGL. J. MED. 1685 (2019).

Loren Adler, Matthew Fiedler, Paul B. Ginsburg, Mark Hall, Erin Trish, Christen Linke Young, and Erin Duffy, "State Approaches to Mitigating Surprise Out-of-Network Billing," *Brookings Institution*, February 19, 2019.

Christen Linke Young, Jason A. Levitis, and Matthew Fiedler, "Evaluating the Administration's Health Reimbursement Arrangement Proposal," *Brookings Institution*, December 28, 2018.

Christen Linke Young, "The Trump Administration Side-Stepped Rulemaking Processes on the ACA's State Innovation Waivers," *Brookings Institution*, November 28, 2018.

Christen Linke Young, Note, *Pay or Play and ERISA Section 514*, 10 YALE J. HEALTH POL'Y, L. & ETHICS 197 (2009).

Christen Linke Young, Note, *Childbearing, Childrearing, and Title VII*, 118 YALE L.J. 1182 (2009).

Christen Linke Young, *FDA Preemption Inputs in* Riegel v. Medtronic, 118 YALE L.J. POCKET PART 22 (2008).