IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MARYLAND

CITY OF COLUMBUS, et al., *Plaintiffs*, v. DONALD J. TRUMP, in his official capacity as President of the United States of America, et al., *Defendants.*	No. 18-cv-2364-DKC

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 Plaintiffs' motion for 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. Millions of consumers are eligible for health insurance coverage but have not enrolled. A large and varying literature offers a number of explanations of why consumers fail to enroll, even when eligible for very generous financial support. Particularly important factors include the cost (or perceived cost) of obtaining a health plan and administrative barriers to enrollment. Policy actions that increase costs or administrative barriers will decrease enrollment and increase the uninsured and underinsured rates.

4. The challenged policies of the federal government's 2019 Notice of Benefit and Payment Parameters are expected to increase costs, increase perceptions of costs, and increase administrative burdens associated with enrollment. Therefore, these policies would be expected to depress enrollment and increase the number of people without comprehensive coverage.

5. Reducing coverage in this manner is likely to increase the uncompensated care burden borne by a variety of health care providers and affect the way patients seek care.

II. High costs and administrative barriers reduce enrollment.

6. Prior to the onset of COVID-19, an estimated 30 million Americans were uninsured.[1] Researchers estimate that two thirds of them—*i.e.*, 19.7 million people—are eligible to enroll in Medicaid or in coverage offered by the Affordable Care Act's Marketplaces (also referred to as Exchanges), including those who have incomes below 400% of the federal poverty line (FPL), and are therefore eligible for Medicaid or for advance premium tax credits, and those with incomes above 400% FPL.[2]

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[1] *See, e.g.*, Linda J. Blumberg, et al., *Characteristics of the Remaining Uninsured: An Update*, Urban Inst. 2 (July 2018), https://www.urban.org/sites/default/files/publication/98764/2001914-characteristics-of-the-remaining-uninsured-an-update_2.pdf.

[2] *See id.* at 9.

7. Multiple studies suggest that the cost of coverage—or the perceived cost of coverage—is a significant reason that eligible individuals may not enroll. For example, a 2019 survey of the uninsured revealed that 58% did not expect affordable coverage to be available.[3] Another survey found that, among uninsured individuals who had not visited an enrollment website, the perceived affordability of coverage was the most commonly reported reason for not seeking coverage.[4] Small scale surveys at particular points of care reveal a similar pattern: at one free clinic, roughly half of the uninsured reported that the primary reason they were not insured was because health insurance was "too expensive."[5] A study of consumer purchasing behavior in one state suggests that a $40 increase in monthly premiums can reduce enrollment by 25%.[6]

8. A number of factors affect the costs faced by different groups of consumers. Some potential enrollees—those with incomes too high to qualify for financial assistance—pay the gross or "sticker" premium charged by insurance companies. Therefore, steps that increase gross premiums will directly increase the cost of coverage for this group. Other consumers qualify to receive financial assistance; the structure of this assistance means they are generally

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[3] *New Polling Among ACA Marketplace Insured and Eligible Uninsured*, Hart Res. Assocs. 2 (Oct. 23, 2019), https://drive.google.com/file/d/0BwWzJPQpHwx9VXdlX2hSUlR0VW1UZjBmMklqSlZtZ0Ffd2d3/view.

[4] Munira Z. Gunja & Sara R. Collins, *Who Are the Remaining Uninsured, and Why Do They Lack Coverage?*, The Commonwealth Fund (Aug. 28, 2019), https://www.commonwealthfund.org/publications/issue-briefs/2019/aug/who-are-remaining-uninsured-and-why-do-they-lack-coverage.

[5] Drumil Bhatt & Ken Schellhase, *Barriers to Enrollment for the Uninsured: A Single-Site Survey at an Urban Free Clinic in Milwaukee*, 118 Wisc. Med. J. 44 (Apr. 2019), https://pubmed.ncbi.nlm.nih.gov/31083835/; Akiko Kamimura et al., *Why Uninsured Free Clinic Patients Don't Apply for Affordable Care Act Health Insurance in a Non-Expanding Medicaid State*, 41 J. Cmty. Health 119 (Feb. 2016), https://pubmed.ncbi.nlm.nih.gov/26275880/.

[6] Amy Finkelstein et al., *Subsidizing Health Insurance for Low-Income Adults: Evidence from Massachusetts*, 109 Am. Econ. Rev. 1530 (2019), https://pubs.aeaweb.org/doi/pdfplus/10.1257/aer.20171455.

shielded from certain types of increases in gross premiums. For this group, costs can be affected by policies that change the terms on which they receive financial assistance, and they will also experience some fluctuation in cost based on actual premiums. Therefore, policies that affect gross premiums or that affect financial assistance will raise (or lower) costs of coverage for different groups of consumers, which will in turn influence the likelihood that they enroll.

9. Consumers are also heavily influenced by the *perceived* cost of coverage, even if the actual costs they face may be something they would consider affordable. For example, many consumers who likely have free Medicaid coverage available to them report high costs as a barrier to seeking coverage,[7] and surveys report that most Marketplace-eligible uninsured consumers do not expect to find a plan for less than $100 per month,[8] even though many likely can.[9] Nor is it straightforward for consumers to learn about the affordability of coverage: a recent survey found that 57% of people who sought coverage but remained uninsured reported they found it difficult to understand their eligibility for assistance programs.[10]

10. Another important barrier to enrollment is the administrative burden associated with applying for and obtaining coverage. Across a variety of health care and other social service programs, including the ACA's Marketplaces, even small enrollment obstacles can meaningfully

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7 Bhatt & Schellhase, *Barriers to Enrollment*, *supra* note 5.

8 *New Polling*, Hart Res. Associates, *supra* note 3.

9 *See, e.g.*, *Health Insurance Exchanges 2020 Open Enrollment Report*, CMS (Apr. 1, 2020), https://www.cms.gov/files/document/4120-health-insurance-exchanges-2020-open-enrollment-report-final.pdf.; Rachel Fehr et al., *How Many of the Uninsured Can Purchase a Marketplace Plan for Free in 2020?*, Kaiser Family Found. (Dec. 10, 2019), https://www.kff.org/private-insurance/issue-brief/how-many-of-the-uninsured-can-purchase-a-marketplace-plan-for-free-in-2020/.

10 Karen Pollitz et al., *Consumer Assistance in Health Insurance: Evidence of Impact and Unmet Need*, Kaiser Family Found. (Aug. 7, 2020), https://www.kff.org/report-section/consumer-assistance-in-health-insurance-evidence-of-impact-and-unmet-need-issue-brief/.

deter enrollment. A literature that long predates the Affordable Care Act highlights the importance of administrative barriers. For example, one survey of potential recipients of the supplemental nutrition assistance program (SNAP) who were not enrolled found that 77% reported either "paperwork" or insufficient time to complete the application as the primary reason they did not apply; 25% of those who dropped out of the application process reported administrative burden as the cause.[11] Conversely, states that reduce administrative obstacles in their SNAP programs see increased enrollment.[12] Similarly, an empirical evaluation of different states' experience with implementing the Children's Health Insurance Program concluded that several specific interventions that eliminate application barriers and reduce paperwork result in statistically significant increases in program enrollment.[13] Increased administrative burdens in Medicaid are similarly thought to be associated with recent decreases in Medicaid enrollment (prior to the onset of COVID-19).[14] These findings are consistent with a growing literature reflecting that those facing a scarcity of resources (*e.g.*, money or time) have reduced mental bandwidth for complex administrative tasks.[15] As a result, policies that increase the

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[11] Pamela Herd, *How Administrative Burdens Are Preventing Access to Critical Income Supports for Older Adults: The Case of the Supplemental Nutrition Assistance Program*, 25 Pub. Pol'y & Aging Rep. 52 (2015), https://academic.oup.com/ppar/article/25/2/52/1501759.

[12] *Id.*

[13] *See* Sheila Hoag et al., *CHIPRA Mandated Evaluation of Express Lane Eligibility: Final Findings*, HHS (Dec. 2013), https://www.mathematica.org/our-publications-and-findings/publications/chipra-mandated-evaluation-of-express-lane-eligibility-final-findings; Jennifer Maier Snow, *Overcoming Barriers to Enrollment: A 50-State Assessment of Outreach and Enrollment Simplification Strategies for the State Children's Health Insurance Program (SCHIP)*, https://mpa.unc.edu/sites/default/files/MPA%20Capstone%20Paper%20Snow_0.pdf (last visited Aug. 4, 2020).

[14] Samantha Artiga & Olivia Pham, *Recent Medicaid/CHIP Enrollment Declines and Barriers to Maintaining Coverage*, Kaiser Family Found. (Sept. 24, 2019), https://www.kff.org/medicaid/issue-brief/recent-medicaid-chip-enrollment-declines-and-barriers-to-maintaining-coverage/.

[15] *See generally* Eldar Shafir & Sendhil Mullainathan, Scarcity (2013).

administrative burden associated with applying for Marketplace coverage would be expected to decrease enrollment, just as we see in other programs.

11. The Marketplace eligibility process is complex, and features a number of steps that can create such administrative barriers, particularly when seeking financial assistance. Indeed, in 2020, 24% of Marketplace enrollees reported that they found it difficult to provide the required documentation to the Marketplace.[16]

12. In particular, Marketplace financial assistance is largely paid as an "advance" payment of a refundable tax credit, so consumers must project the income that will be reflected on their tax return for the calendar year as part of the application process. This can be a complex process, especially for households experiencing changes (like a job loss). As described further below, policy changes affect the magnitude of the administrative burden.

13. Administrative barriers can also cause people to lose coverage after they have obtained it. While much of the existing literature focuses on barriers associated with initial enrollment, the Marketplace process contains a number of opportunities for people to lose coverage (or lose financial support, which is tantamount to losing coverage for most consumers) if they fail to complete administrative tasks. For example, the Marketplace may ask consumers for additional information about their citizenship or immigration status or tax-filing status, and consumers may be required to respond to those inquiries by mailing or uploading specific documents. Consumers may have difficulty understanding what is required, obtaining the required document, or simply being able to prioritize the task amid competing demands on their time and attention. These impacts can be large: data-matching issues, one type of mid-year

[16] Pollitz et al., *Consumer Assistance in Health Insurance*, *supra* note 10.

administrative barrier, caused 1.5 million people to lose coverage or financial assistance in 2015.[17]

14. Moreover, administrative barriers to getting and keeping coverage can also cause adverse selection that increases the cost of coverage, creating a feedback loop that further reduces enrollment. Marketplace premiums reflect the average costs of the entire risk pool served, meaning that a larger number of young and/or healthy people enrolling will result in lower gross premiums. However, healthy people who face administrative barriers to coverage would be expected to be less responsive to the steps needed to overcome those barriers—*i.e.*, because they have less need to enroll—while those with significant health care needs are likely to attend more closely to the steps they must take to obtain or maintain coverage.[18]

15. Therefore, administrative barriers would be expected to disproportionately drive away healthy consumers and worsen the risk pool. And, indeed, the Marketplaces have seen substantial evidence of this effect: the Department of Health and Human Services (HHS) has reported that across two different administrative processes associated with Marketplace coverage, young adults are about 25% less likely than older adults to successfully respond to requests for additional documentation.[19]

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[17] Judith Solomon, *Limiting Data-Matching Issues Could Help Stabilize Federal Marketplace Coverage*, Ctr. on Budget & Pol'y Priorities (Feb. 16, 2016), https://www.cbpp.org/health/limiting-data-matching-issues-could-help-stabilize-federal-marketplace-coverage.

[18] *See, e.g.*, Stan Dorn, *Helping Special Enrollment Periods Work Under the Affordable Care Act*, Urban Inst. 5-7 (June 2016), https://www.urban.org/sites/default/files/publication/81806/2000834-Helping-Special-Enrollment-Periods-Work-Under-the-Affordable-Care-Act.pdf.

[19] *Strengthening the Marketplace – Actions to Improve the Risk Pool*, CMS (June 8, 2016), https://www.cms.gov/newsroom/fact-sheets/strengthening-marketplace-actions-improve-risk-pool.

16. Taken together, this evidence suggests that policies that increase the costs or perceived costs of obtaining coverage under the Affordable Care Act and/or increase the administrative burden associated with obtaining or keeping coverage would be expected to increase the uninsured and underinsured (the latter of which refers to individuals who have coverage that exposes them to high costs). Actions taken since 2017 that decrease the value of the ACA's premium tax credit, increase premiums for unsubsidized consumers in the Marketplace, promote perceptions of the high cost of coverage, and magnify administrative burdens for Marketplace coverage have likely contributed to the fact that the number of uninsured has increased by 1.2 million since 2016.[20]

III. The challenged provisions of the 2019 Rule are associated with high costs and increased burden.

17. HHS has taken several policy actions, including the challenged provisions of the Notice of Benefit and Payment Parameters for 2019, 83 Fed. Reg. 16,930 (Apr. 17, 2018), that are expected to increase the costs, perceived costs, and administrative burden of obtaining coverage under the Affordable Care Act. These changes, for the reasons explained above, are expected to contribute to increased rates of uninsurance and underinsurance. Specifically, and as described further below:

- Allowing Marketplaces to take away financial assistance without communicating clearly about the cause creates very large administrative burdens for consumers. *See* 83 Fed. Reg. at 16,982-84.
- Reducing compliance reviews may lead to lower value coverage and will likely increase premiums for a plan of comparable quality. *See id.* at 17,024-26.

[20] *See* Jennifer Tolbert et al., *Key Facts about the Uninsured Population*, Kaiser Family Found. (Dec. 13, 2019), https://www.kff.org/uninsured/issue-brief/key-facts-about-the-uninsured-population/.

- Relaxing oversight of direct enrollment insurance brokers can increase administrative burden for applicants who enroll through this channel, and will likely create perceptions of higher costs. *See id.* at 16,981-82.

- Eliminating standardized plan options increases the administrative burden associated with plan selection and enrollment. *See id.* at 16,974-75.

- Undermining the Navigator program makes it more difficult for consumers to get assistance that can help them overcome administrative barriers to enrollment, increasing the impact of those barriers. *See id.* at 16,979-81.

- Eliminating online enrollment options increases administrative barriers for small business seeking coverage and for their employees. *See id.* at 16,996-706.

- Imposing unnecessary new verification requirements for low-income enrollees also increases the administrative burden associated with enrollment among the group least able to bear the additional burden. *See id.* at 16,985-87

- Reducing review of premium increases may put upward pressure on costs. *See id.* at 16,972-73.

- Relaxing standards for insurer rebates would also tend to be associated with higher premiums. *See id.* at 17,032-36.

A. Eliminating direct notification requirements

18. As noted above, financial assistance in the Marketplaces is provided in large part through a refundable, advanceable tax credit. Individuals who receive the tax credit must "reconcile" the credit by filing federal income taxes and repaying any excess tax credit beyond what they actually qualified for that year. Existing regulations provide that, if a consumer has not reconciled the credit for a previous year, Marketplaces should not make advance payments of financial assistance (a restriction that does not appear in the statute).[21]

19. Because whether or not an individual has reconciled their tax credit is considered Federal Tax Information (FTI), that information must be protected from disclosure and handled consistently with federal privacy laws. Specifically, rules around the handling of FTI generally

[21] 45 C.F.R. § 155.305(f)(4).

prohibit the Marketplace from making the reason for the denial visible to Marketplace customer assistance representatives, or even from exposing it to the consumer in the consumer's online "account" with the Marketplace. As a result, consumers may find themselves in the Kafka-esque situation where the Marketplace is denying them financial assistance but does not say why, and when the consumer contacts the Marketplace, no one is able to provide an explanation, either. This means the consumer cannot evaluate if the denial was improper, nor can they learn what they must do to correct the issue.

20. Recognizing the absurdity of this outcome, Marketplace regulations prior to the 2019 Rule specified that Marketplaces could not deny assistance under this rule unless they had configured their operations in a way that provided at least some "direct notification" to the consumer of the reason for the denial.[22] This would ensure any consumer affected by a denial had at least some recourse to learn the reason, so they could determine whether to appeal or learn the steps they should take to regain financial assistance.

21. The 2019 Rule removes this requirement. As a result, Marketplaces, including the federal Marketplace, are free under the regulations to deny assistance without ever communicating with the consumer about the reason. A consumer seeking assistance but affected by such a denial faces a significant administrative barrier to obtaining financial assistance, because they must contend with a government bureaucracy that quite literally cannot explain to them the actions being taken.

22. Some consumers may be able to piece together the steps they must take to redress the denial from indirect communications that discuss these issues more generally, but others are

[22] *Notice of Benefit and Payment Parameters for 2018*, 81 Fed. Reg. 94,058, 94,124 (Dec. 22, 2016).

likely to be deterred from enrolling. Further, healthy consumers affected by the absence of clear information are the least likely to be motivated to successfully navigate this complex enrollment environment, so this policy will be expected to worsen the risk pool and increase gross premiums.

B. Eliminating federal review of network adequacy

23. Marketplace coverage must meet a series of standards specified in the ACA and its implementing regulations. Because health insurance is a complex product, health plans are generally subject to thorough review by regulators to ensure they meet applicable standards.[23] However, in the 2019 Rule, HHS announced it would no longer conduct some of those reviews and would instead rely on states' analyses in place of its own.

24. Of particular importance is the network adequacy review process, under which regulators review a plan to determine if its network contains a sufficient number of health care providers in each of a number of specialties to serve enrollees. When HHS conducted these reviews, it established specific numeric standards for several types of providers and geographic areas. These standards specified, for example, that in urban areas most enrollees should be within 10 minutes travel time or 5 miles of a primary care physician, and that in rural areas most enrollees should be within 75 minutes or 60 miles of a mental health provider.[24] These standards ensure that all Marketplace consumers have assurance that their plan will contain at least a minimum number of providers within a relatively convenient geographic range. By establishing

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[23] *See generally Review Standards Checklist Best Practices*, Nat'l Ass'n of Ins. Comm'rs, https://www.naic.org/documents/industry_rates_ursc_bestpractices.pdf?40 (last visited Aug. 4, 2020).

[24] *See, e.g.*, *2017 Letter to Issuers in the Federally-Facilitated Marketplaces*, CMS (Feb. 29, 2016), https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Final-2017-Letter-to-Issuers-2-29-16.pdf.

a clear minimum standard, they also help avoid a race-to-the-bottom with insurance companies competing to cut prices through offering ever-narrower provider networks.

25. Notably, HHS's standards for the federal Marketplace were modeled on the process used in some states. Some states have even more rigorous network adequacy review, but HHS's standards were generally more robust than the network adequacy review processes in place in a number of other states.

26. Under the 2019 rule, HHS will now rely entirely on state review and not conduct its own analyses. In some states this will not have a major impact on health plan networks, because the state conducts a robust review on its own. But in other states, HHS's new policy will lead to issuers offering narrower networks because state review will not require them to maintain an equally adequate network. If states decrease their standards in the future, that will similarly lead to issuers offering narrower networks as well.

27. While narrower networks may decrease gross premiums for some consumers, they would be expected to *increase* costs for consumers receiving financial assistance who want to maintain the same size network. This is because Marketplace financial assistance is based on the price of the second-lowest cost silver plan available to the consumer. If lower-quality options are newly permitted to be sold, it will drive down financial assistance and increase costs for the higher-quality plans. This cost increase for subsidized consumers to maintain comparable coverage may deter some from seeking coverage. Moreover, inadequate networks may make it more difficult for enrollees to obtain care, including specialty care that may only be available from a limited number of providers.

C. Reducing oversight of direct enrollment

28. Consumers enroll in ACA-compliant coverage through a variety of enrollment channels, including, most obviously, the ACA's Marketplaces. A closely related path is direct enrollment, where a consumer uses a third-party website rather than a government website to obtain Marketplace coverage. While direct enrollment can be an effective complement to other enrollment options, direct enrollment entities may receive a commission for enrolling consumers and/or may be operated by a single insurance company—giving them significant financial incentives that may sometimes be in conflict with the best interests of a consumer. Therefore, this enrollment channel requires close oversight to ensure that the consumer is presented with accurate and complete information and receives the support they need to get and stay enrolled.

29. For example, consumers who receive inaccurate eligibility information may be asked to pay more for coverage than is necessary, which may deter them from enrolling, cause them to drop coverage, or cause them to enroll in coverage which is inappropriate for them. This is especially true for consumers who should enroll in Medicaid but are instead steered toward private coverage. Moreover, because Medicaid does not pay commissions, direct enrollment entities generally do not benefit financially when customers enroll in Medicaid, and so do not have a financial incentive to ensure accuracy with respect to Medicaid information. For example, a 2019 report revealed that, in exchange for commissions, some direct enrollment entities were deliberately steering consumers away from Medicaid and instead promoting plans which cost hundreds of dollars more per month than Medicaid in exchange. That same report showed that many were not presenting information about the Medicaid enrollment process.[25] Consumers

[25] Tara Straw, *"Direct Enrollment" in Marketplace Coverage Lacks Protections for Consumers, Exposes Them to Harm*, Ctr. on Budget & Pol'y Priorities (Mar. 15, 2019),

offered these choices were being asked to pay far more for their own or their child's coverage than if they enrolled in Medicaid, creating the impression that coverage was much costlier than it actually is and reinforcing the perception that coverage is unaffordable.

30. Consumers visiting direct enrollment websites may also be presented with information about various forms of coverage that do not comply with ACA standards, especially because non-compliant plans generally pay higher commissions than ACA-compliant coverage.[26] This poses risks for consumers enrolling in these plans, because non-compliant products generally do not cover pre-existing conditions and exclude various benefits from their coverage, and also drives up costs for consumers in regulated plans by "cherry-picking" healthy enrollees out of the regulated market's risk pool.[27]

31. Ultimately, relaxing oversight standards increases the likelihood that direct enrollment entities will not comply with federal standards related to Medicaid, display of non-compliant plans, or other issues. The more that those entities do not comply with federal standards, the more likely that consumers will forgo enrollment entirely, especially if they believe coverage to be costlier than it truly is. It also makes it more likely that some consumers who might have purchased ACA-compliant coverage will instead purchase coverage that is not in the ACA's single risk pool. Together, these factors will increase the uninsured and underinsured rates and drive up gross premiums in the individual market.

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https://www.cbpp.org/research/health/direct-enrollment-in-marketplace-coverage-lacks-protections-for-consumers-exposes.

[26] *See id.*; *see also Shortchanged: How the Trump Administration's Expansion of Junk Short-Term Health Insurance Plans is Putting Americans at Risk*, U.S. House of Reps. Comm. on Energy & Commerce (June 2020), https://degette.house.gov/sites/degette.house.gov/files/STLDI%20Report%2006%2025%2020%20FINAL_.pdf.

[27] *See* Christen Linke Young, *Taking a Broader View of "Junk Insurance,"* Brookings (July 6, 2020), https://www.brookings.edu/research/taking-a-broader-view-of-junk-insurance/.

D. Eliminating standardized options

32. Health insurance is a complex product. A major challenge for health insurance Marketplaces is presenting information about available plans in ways that do not overwhelm consumers. In making choices about the display of plan information, Marketplaces can have a significant impact on the likelihood that consumers purchase coverage and the quality of their choices.[28]

33. Outside of health care, a robust behavioral economics literature has demonstrated that—across many domains—consumers presented with more choices are less likely to purchase a product.[29] This phenomenon, known as "choice overload," is a consistent finding of experiments conducted in both laboratory and real-world settings, and is thought to arise because additional choices both increase the costs of evaluating products and generate fear of making the wrong decision.[30] Consumers facing choice overload may simply give up and refrain from purchasing a product, or they may make worse decisions about the product and make a choice that does not maximize their utility.

34. Researchers have demonstrated that potential health care consumers experience choice overload when considering insurance products in many contexts, including Marketplace, Medicare Part D, Medicare Advantage, and employer coverage. Consumers presented with more plan options have been shown to make worse decisions in selecting coverage appropriate for

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[28] *See, e.g.*, Erin Audrey Taylor et al., *Consumer Decisionmaking in the Health Care Marketplace*, Rand (2016), https://www.rand.org/content/dam/rand/pubs/research_reports/RR1500/RR1567/RAND_RR1567.pdf.

[29] For a thorough review of this literature, see Barry Schwartz, The Paradox of Choice (2004).

[30] *Id.*

them and their needs, and more options have also been associated with a reduced likelihood of enrolling in coverage at all.[31]

35. Experts,[32] state Marketplaces,[33] and the federal government[34] have relied on this wide-ranging evidence to conclude that offering standardized plan options—meaning plans that share certain essential cost-sharing features—can structure the choice environment and mitigate against choice overload. Consumers offered standardized plans have a simpler rubric to compare plan choices, and are presented with some scaffolding to shape their decision-making across many complex and overlapping dimensions. This can increase the likelihood that consumers successfully select a plan because they are less likely to be so overwhelmed that they exit the shopping experience. Equally important, it promotes choices that better maximize enrollees'

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[31] *See, e.g.*, J. Michael McWilliams et al., *Complex Medicare Advantage Choices May Overwhelm Seniors—Especially Those With Impaired Decision Making*, 30 Health Aff. 1786 (2011), https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2011.0132; Keith M. Marzilli Ericson & Amanda Starc, *How Product Standardization Affects Choice: Evidence from the Massachusetts Health Insurance Exchange*, 50 J. Health Econ. 71 (2016), https://www.sciencedirect.com/science/article/abs/pii/S0167629616302156?via%3Dihub; *see also* Saurabh Bhargava et al., *Do Individuals Make Sensible Health Insurance Decisions? Evidence from a Menu with Dominated Options* (NBER Working Paper No. 21160, 2015), https://www.nber.org/papers/w21160; M. Kate Bundorf et al., *Are Prescription Drug Insurance Choices Consistent with Expected Utility Theory?*, 32 Health Psych. 986 (Sept. 2013), https://pubmed.ncbi.nlm.nih.gov/24001249/; M. Kate Bundorf & Helena Szrek, *Choice Set Size and Decision Making: The Case of Medicare Part D Prescription Drug Plans*, 30 Med. Decision Making 582 (Mar. 2010), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3774274/; Yaniv Hanoch et al., *How Much Choice Is Too Much? The Case of the Medicare Prescription Drug Benefit*, 44 Health Servs. Res. 1157 (Aug. 2009), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2739022/; Yaniv Hanoch et al., *Choosing the Right Medicare Prescription Drug Plan: The Effect of Age, Strategy Selection and Choice Set Size*, 30 Health Psych. 719 (Nov. 2011), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5595365/.

[32] *See, e.g.*, Taylor et al., *Consumer Decisionmaking in the Health Care Marketplace*, *supra* note 28.

[33] *See, e.g.*, Shelby Livingston, *How California Made Obamacare Work*, Modern Healthcare (June 13, 2017), http://www.modernhealthcare.com/article/20170613/NEWS/170619961.

[34] *See, e.g.*, *Proposed Notice of Benefit and Payment Parameters for 2017*, 80 Fed. Reg. 75,488, 75,542 (Dec. 2, 2015).

utility, decreasing the number of people who enroll in plans that are poorly suited to them. This is likely to improve enrollees' satisfaction with the coverage selected, thus making it more likely that they stay enrolled and reducing the uninsured rate over time.

36. Eliminating standardized plan options can have the opposite effect. It makes it more difficult for consumers to compare the choices available to them, increasing the cognitive costs of decision-making. It may be especially likely to increase fear of making a wrong decision, since there is no designated "standard" choice in which an uncertain consumer can be confident. Some marginal consumers may choose not to enroll because of the increased choice overload. Further, many consumers who do enroll will likely make worse decisions, exposing them to higher costs than they might have elected in a more streamlined choice environment. For example, they may inadvertently enroll in a "dominated" plan choice (which is worse along all dimension than other choices available to the consumer[35]), may enroll in a plan that has a combination of premiums and cost-sharing that is higher than other choices given the consumer's specific circumstances, or may choose a plan where their providers or prescription drugs are out-of-network or off-formulary, resulting in higher costs. These high costs may cause consumers to drop coverage, which they would have maintained if they had made a more accurate plan selection.

37. Moreover, moving away from standardized plan options and the structured competition it facilitates may also increase premiums. When plans differ along a wide variety of dimensions, it becomes harder for consumers to directly compare prices, which reduces direct

[35] *See* Taylor et al., *Consumer Decisionmaking in the Health Care Marketplace*, *supra* note 28.

price competition between plans. California reports that it believes the structured competition that standardized plan options allow has contributed to lower premiums.[36]

E. Undermining the Navigator program

38. Navigators provide assistance to consumers to help them enroll in coverage in Medicaid and the Marketplace. Survey data suggests that, in 2016, 5,000 assister programs (including Navigators and other non-profits) helped more than 5 million people to enroll in coverage.[37] Another study estimated that, in the three states examined, 49% of Latino enrollees, 41% of Black enrollees, and 36% of White enrollees received application assistance from a Navigator or similar organization.[38] Similarly, a survey of consumers who shopped for coverage in 2017 found that 66% of those who received assistance, but only 48% of those who did not, successfully enrolled in a plan.[39] These data all reflect that assistance can be an important component of the Marketplace shopping experience.

39. Assister programs report that consumers seek out their services because they "lack confidence" in their ability to navigate the enrollment process, they need help with "plan choices," and/or they need support in specific components of the Marketplace application, among other factors.[40] That is, Navigator and other assister programs help to ameliorate the

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[36] Livingston, *How California Made Obamacare Work*, *supra* note 33.

[37] Karen Pollitz et al., *2016 Survey of Health Insurance Marketplace Assister Programs and Brokers*, Kaiser Family Found. (June 8, 2016), https://www.kff.org/health-reform/report/2016-survey-of-health-insurance-marketplace-assister-programs-and-brokers/.

[38] Adrian Garcia Mosqueira et al., *Racial Differences in Awareness of the Affordable Care Act and Application Assistance Among Low-Income Adults in Three Southern States*, 52 Inquiry (2015), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5813629/.

[39] Sara R. Collins et al., *Following the ACA Repeal-and-Replace Effort, Where Does the U.S. Stand on Insurance Coverage?*, The Commonwealth Fund (Sept. 7, 2017), https://www.commonwealthfund.org/publications/issue-briefs/2017/sep/following-aca-repeal-and-replace-effort-where-does-us-stand.

[40] Pollitz et al., *2016 Survey*, *supra* note 37.

administrative burdens associated with applying for health coverage. Many programs also report that they serve people who do not have internet at home, and/or that they serve a population that needs support with translation services,[41] thereby offering services tailored to the particular needs of target populations. Forty percent of enrollees who used the services of an assister program report that they are unlikely to have enrolled in the same coverage they have now without the assistance they received.[42]

40. The trio of changes to the Navigator program in the 2019 Rule all make it less likely that Navigators will be able to support consumers in this way. Allowing HHS to award only one Navigator grantee in each state (instead of two), and to make that award to an organization that is not a community-based non-profit and does not have a physical presence in the service area it intends to serve, reduces the footprint of the program and directs funding to organizations that are less able to serve the population as a whole. Put simply, fewer Navigator grantees will mean fewer sources of consumer assistance, making it harder for consumers to obtain reliable information about insurance.

41. Awarding grants to entities that do not have a physical presence in the service area means that affected consumers will no longer be able to receive in-person assistance. This can be expected to decrease the effectiveness of the assistance, especially for consumers who need language translation services or who need assistance understanding complicated health insurance concepts (though the absence of in-person assistance may have a somewhat attenuated impact during the COVID-19 pandemic when in-person services in general are less common). And preventing consumers from receiving assistance from a community-based non-profit will

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41 *Id.*

42 Pollitz et al., *Consumer Assistance in Health Insurance*, *supra* note 10.

mean that affected consumers cannot get assistance from a trusted local partner and will instead have to rely on an organization that may not have the same claim to offering unbiased or neutral assistance—making it less likely that some consumers will be aware of or seek out their support.

42. Together, these changes to the Navigator program increase the impact of administrative barriers to coverage by making it harder for individuals to find trusted assistance suitable to their unique needs. Thus, available evidence suggests that, as outlined above, these changes will decrease enrollment in coverage and increase the uninsured rate.

F. Weakening small business exchanges

43. Small businesses may face the same sort of enrollment barriers that individual consumers do. Many lack sophisticated human resources staff, and small business leaders must generally investigate and chose among health coverage opportunities on their own. This may contribute to the fact that only 56% of small businesses, compared to 99% of large businesses, offer coverage.[43]

44. The Small Business Health Options Program (SHOP) was intended to ameliorate some of these administrative obstacles by creating an online Marketplace where small businesses could shop for, compare, and enroll in coverage and support enrollees through the enrollment process. The SHOP was also designed to enable employees to choose among different plans—a feature common among large employer health plan options but much harder for smaller firms to achieve. The creation of the SHOP complemented other reforms, like the guaranteed issue and community rating requirements of the Affordable Care Act, which prevent discrimination based on pre-existing conditions in the market for small group health insurance. Specifically,

[43] *Employer Health Benefits, 2019 Annual Survey*, Kaiser Family Found. (2019), http://files.kff.org/attachment/Report-Employer-Health-Benefits-Annual-Survey-2019.

guaranteed issue and community rating make it possible for employers to select among a variety of insurance options without being required to provide detailed claims history for their employees, and the SHOP is a tool that actually brings that choice and competition to fruition.

45. Changes in the 2019 Rule eliminate the option for small businesses and their consumers to enroll through a SHOP website. Instead, small business must shop for coverage independently, working directly with an insurance company or a broker to obtain coverage. Similarly, employees must enroll using a process prescribed by their individual health plan, with little regulatory oversight to ensure consumers can smoothly and successfully enroll in the coverage offered by their employer.

46. This step increases administrative barriers to enrollment for both small businesses and their individual enrollees. The small business decisionmaker may find it harder to compare plans and choose among options, increasing "choice overload" as described above. This could deter some businesses from enrolling at all, especially very small firms. It also is likely to decrease the quality of the decisions made, leading to plans that impose higher costs for individual enrollees. Further, unnecessarily high costs and more complex enrollment processes will likely deter some individual enrollees from enrolling in coverage, or will result in those who do enroll being less satisfied with their coverage and less likely to stay enrolled over time. Together, this increase in administrative burden and potential increase in costs could put upward pressure on the uninsured rate.

G. Imposing burdensome and unnecessary income verification requirements

47. One of the most significant sources of administrative burden in the Marketplace enrollment process is the creation of data-matching issues (DMIs). A DMI arises when the Marketplace determines it has insufficient data to electronically verify the information reported

by a consumer on their application, and therefore the Marketplace requires the consumer to provide additional documentation in order to continue to receive financial assistance and/or stay enrolled. This documentation must either be mailed to the Marketplace or uploaded electronically into the online application.[44]

48. This is exactly the kind of administrative barrier that substantially reduces enrollment. In 2015, 1.5 million people enrolled at HealthCare.gov lost coverage or financial assistance because of a data matching issue, a very substantial coverage loss.[45]

49. For the first several years of Marketplace operations, HHS endeavored to reduce the impact of DMIs, by, for example, implementing application improvements that made it less likely a consumer would generate a DMI, conducting extensive outreach to consumers affected by DMIs to encourage them to submit required documents, and making policy changes that limited the circumstances that generated DMIs.[46] HHS reported that these efforts were expected to decrease the number of people who lost coverage because of the administrative burden associated with a DMI.[47] Further, HHS expected that reducing the impact of DMIs would improve the Marketplace risk pool because attrition associated with DMIs was likely to disproportionately pull healthy people out of the risk pool. Indeed, as noted above, in 2016 HHS noted that younger consumers were about 25% less likely than older consumers to resolve a DMI.[48]

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[44] *Helping Consumers Resolve Data Matching Issues*, CMS (Oct. 2017), https://marketplace.cms.gov/technical-assistance-resources/helping-consumers-resolve-dmi-.pdf.

[45] Solomon, *Limiting Data-Matching Issues*, *supra* note 17.

[46] *Keeping Consumers Covered*, CMS (Apr. 27, 2018), https://marketplace.cms.gov/technical-assistance-resources/keeping-consumers-covered.pdf; *Strengthening the Marketplace*, *supra* note 19.

[47] *Id.*

[48] *Id.*

50. In the 2019 Rule, HHS has taken the opposite approach, expanding the circumstances that generate DMIs in ways that burden the very lowest income Marketplace consumers. In general, Marketplace rules specify that consumers will generate a DMI if they report on their application a *lower* income than available electronic records reflect, but not if they report a *higher* income. The 2019 Rule departs from this process by establishing a special rule for low-income consumers near the poverty line: if a consumer reports an income above the poverty line, but electronic records indicate that their income is below the poverty line, a DMI will be generated. Consumers near the poverty line must now submit additional documentation via the mail or by an internet upload if they want to maintain access to thousands of dollars in financial assistance.

51. These low-income consumers are likely to experience the greatest difficulty in obtaining income documentation, successfully mailing or uploading their documents, and in maintaining the mental bandwidth to complete these tasks on time.[49] Moreover, low-income enrollees are more likely to have fluctuating income, part-year or part-time employment, and multiple employers, and to have difficulty accessing and supplying necessary documentation. One analysis estimates that 50 percent of adults with income below 200 percent of the poverty level experience income changes that make them move between eligibility for Medicaid and the exchanges.[50] As such, this policy change is likely to increase the uninsured rate as consumers lose their financial assistance (and therefore their coverage) due to a DMI.

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[49] *See generally* Scarcity, *supra* note 15.

[50] Benjamin D. Sommers & Sara Rosenbaum, *Issues in Health Reform: How Changes in Eligibility May Move Millions Back and Forth Between Medicaid and Insurance Exchanges*, Health Aff. (Feb. 2011), https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2010.1000.

H. Curtailing insurance rate review

52. Rate review is a longstanding feature of health insurance regulation, under which insurance companies submit rate filing justifications that outline the assumptions that went into their rate setting process, and regulators then review those assumptions. In some states, regulators can disapprove rate filings, while in others they can express that rate filings are or are not justified, though insurers remain free to implement "unjustified" rate increases. Moreover, the rate review process forces insurers to defend their rate increases and justifications publicly, improving public accountability.

53. The ACA implemented a series of reforms intended to strengthen the rate review process and ensure that all health insurance consumers in all states were protected by some form of rate review. This includes setting a threshold above which all rate increases must be reviewed and evaluated by states or the federal government to determine if they are justified.[51]

54. While some economists are skeptical of the rate review process, some available evidence suggests rate review lowers health insurance premiums. For example, a 2015 review of the implementation of the ACA's rate review provisions found that stronger state rate review processes were statistically significantly associated with lower premiums.[52] Similarly, the federal government estimated that, in 2015, rate review reduced premiums by $1.5 billion.[53]

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[51] *See Review of Insurance Rates*, CMS, https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Market-Reforms/Review-of-Insurance-Rates (last visited Aug. 10, 2020).

[52] Pinar Karaca-Mandic et al., *States with Stronger Health Insurance Rate Review Authority Experienced Lower Premiums in the Individual Market in 2010-13*, 34 Health Aff. (Aug. 2015), https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2014.1463.

[53] *Rate Review Annual Report*, HHS (Dec. 2015), https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/Rate-Review-Annual-Report_508.pdf.

55. Of course, rate review will be impactful only to the extent regulators are, in fact, reviewing rates. However, the 2019 Rule raises the threshold for mandatory review to determine if rates are justified from a 10% increase to a 15% increase. This exempts many rates from the review process, and means that rate review will have less of an impact on insurer behavior. This change would be expected to increase gross premiums, especially in years where a substantial number of issuers seek increases of around 10% or slightly greater, and therefore decrease enrollment.

I. Reducing medical loss ratio rebates

56. Another provision in the ACA intended to put downward pressure on health insurance premiums is the law's medical loss ratio (MLR) requirement. Issuers are required to spend at least 80 (for small group and individual insurance plans) or 85 percent (for large group insurance plans) of their premium revenue on health care services or quality improvement activities, allowing only 15 or 20 percent of premium for administrative costs and profits. If they fail to do so, they must pay rebates to consumers.

57. This provision can reduce premiums in two ways. First, it prevents insurers from receiving an underwriting profit of more than a few percent of premium or allowing excessive spending on administrative costs, since excess profits or administrative costs result in insurers spending less than the prescribed percentage and owing rebates. This will tend to reduce premiums. Conversely, if insurers initially set premiums too high and fail to spend the required percentage on medical costs, then they will owe rebates to consumers, effectively reducing the premium consumers pay throughout the year. Thus, even if consumers pay "too much" for some period of time, they will subsequently receive a rebate that effectively compensates them for that higher premium. Including rebates expected to be paid in 2020, nearly $8 billion has been paid

out as rebates since this policy went into effect,[54] which does not count the amounts consumer saved because insurers prospectively reduced premiums to avoid triggering the rebate requirement.

58. A policy change in the 2019 Rule blunts the impact of this policy, reducing its ability to put downward pressure on premiums. Specifically, the 2019 Rule allows issuers to count a blanket 0.8 percent of premium as having been spent on "quality improvement activities" and thus counting towards the 80 or 85 percent requirement. This is true even if the issuer did not actually spend all—or any—of that amount of qualifying quality improvement activities. For insurers that spend less than 0.8 percent of premium on these activities, the policy change allows issuers to charge a higher premium without paying rebates. Indeed, an insurer can now avoid paying rebates when it maintains an MLR of only 79.2 percent, 0.8 percent lower than would otherwise be required.

59. While this is a relatively small change, its effect is to allow issuers to avoid rebating some amount of money that they would otherwise be required to pay. This means some consumers will receive smaller rebates than they otherwise would have and some issuers will charge slightly higher premiums because they have a larger cushion before they must begin rebating consumers. For both of these reasons, the change is expected to increase the premium paid by consumers, at least at the margins. Moreover, it allows issuers to claim credit for quality improvement activities without actually improving the quality of health care services, reducing the value that their coverage provides to consumers.

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[54] Rachel Fehr & Cynthia Cox, *Data Note: 2020 Medical Loss Ratio Rebates*, Kaiser Family Found. (Apr. 17, 2020), https://www.kff.org/private-insurance/issue-brief/data-note-2020-medical-loss-ratio-rebates/.

IV. Reduced enrollment can be expected to increase the amount of uncompensated care paid for by third parties.

60. By contributing to increases in the uninsured and underinsured rates, the provisions of the 2019 Rule can be expected to increase the amount of uncompensated care paid for by third parties, including free and reduced-cost clinics, safety net hospitals, emergency services, and other entities.

61. The term "uncompensated care" refers to health care services that are delivered by a health care provider for which it is not reimbursed. It includes cases where the provider agrees (either before or after providing the service) that it will not collect payment for the service, and cases where the provider bills someone—usually the patient—for all or part of the care but the bill is never paid.[55] Uncompensated care sometimes arises because a person is uninsured, but it can also arise when a patient has insurance and the insurance does not cover the relevant costs, *i.e.*, when the patient is underinsured. For example, insurers may completely exclude a particular service from a patient's benefit package or impose significant cost-sharing that requires the patient to pay a large fraction of the costs.

A. Research shows that increases in the uninsured and underinsured rates increase uncompensated care costs.

62. In general, decreases in the uninsured rate are expected to decrease uncompensated care costs, as demonstrated by the enactment of the Affordable Care Act. At the time the ACA was adopted, 46.5 million non-elderly Americans, 17.8% of the population, still lacked health coverage.[56] By 2016, the ACA had driven the number of uninsured and

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[55] *Uncompensated Hospital Care Cost Fact Sheet – January 2019*, Am. Hosp. Ass'n (2019), https://www.aha.org/factsheet/2019-01-02-uncompensated-hospital-care-cost-fact-sheet-january-2019.

[56] Tolbert et al., *Key Facts about the Uninsured Population*, *supra* note 20.

uninsurance rates down dramatically, to 26.7 million and 10%.[57] Gaps in coverage also became shorter and access to health care improved.[58] The available empirical evidence underscores that Medicaid expansion has played a particularly important role in reducing the uninsured rate.[59]

63. As coverage increased, provider uncompensated care decreased. Between 2013 and 2015, total hospital charity care and bad debt (the two components of uncompensated care) decreased by $8.6 billion nationwide.[60] In some states, uncompensated care dropped by as much as 63 or 64%.[61] The share of hospital operating expenses consumed by uncompensated care dropped 30% nationally, from 4.4% in 2013 to 3.1% in 2015.[62]

64. That drop in uncompensated care costs is likely associated with the ACA's expansion of subsidized coverage that is comprehensive in scope and covers people with preexisting conditions, which gave vastly more people an affordable and non-discriminatory path

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[57] *Id*.

[58] Herman K. Bhupal et al., *Health Insurance Coverage Eight Years After the ACA*: *Fewer Uninsured Americans and Shorter Coverage Gaps, But More Underinsured*, The Commonwealth Fund (Feb. 7, 2019), https://www.commonwealthfund.org/publications/issue-briefs/2019/feb/health-insurance-coverage-eight-years-after-aca; *see also* Anais Borja et al., *Effect of the Affordable Care Act on Health Care Access*, The Commonwealth Fund, (May 8, 2017), https://www.commonwealthfund.org/publications/issue-briefs/2017/may/effect-affordable-care-act-health-care-access.

[59] Madeline Guth et al., *The Effects of Medicaid Expansion under the ACA: Updated Findings from a Literature Review*, Kaiser Family Found. (Mar. 17, 2020), https://www.kff.org/medicaid/issue-brief/the-effects-of-medicaid-expansion-under-the-aca-updated-findings-from-a-literature-review-august-2019/.

[60] *Report to Congress on Medicaid and CHIP*, Medicaid & CHIP Payment & Access Comm'n (Mar. 2018), https://www.macpac.gov/wp-content/uploads/2018/03/Report-to-Congress-on-Medicaid-and-CHIP-March-2018.pdf.

[61] *Id*.

[62] *Id*.; Jessica Schubel & Matt Broaddus, *Uncompensated Care Costs Fell in Nearly Every State as ACA's Major Coverage Provisions Took Effect*, Ctr. on Budget & Pol'y Priorities (May 23, 2018), https://www.cbpp.org/research/health/uncompensated-care-costs-fell-in-nearly-every-state-as-acas-major-coverage.

to comprehensive coverage. Uncompensated care costs declined for several years as the ACA was implemented, but since 2016, uncompensated care costs have grown by over $5 billion.[63]

65. More recently, the Trump Administration has sought to promote the use of non-ACA-compliant insurance plans. These plans have discriminatory gaps[64] that can leave providers exposed to high uncompensated care costs, especially as compared to the affordable, comprehensive, and non-discriminatory coverage of the ACA. Non-compliant plans generally do not cover care needed to treat a preexisting condition.[65] Some individuals may therefore be turned down by insurers based on their prior health status.[66] Others will face benefit exclusions based on prior health care needs.[67] These plans are also generally subject to other conditions that limit their value, like large amounts of cost-sharing, annual or lifetime limits on coverage, limitations on services, or limitations on the amount paid per visit.[68] Thus, non-compliant forms of coverage would not be expected to reduce uncompensated care costs to the same degree as ACA-compliant coverage.

66. Uninsured and underinsured individuals are also more likely to report that they have limited options for receiving care.[69] As a result, uninsured and underinsured individuals are

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63 *Uncompensated Hospital Care Cost Fact Sheet*, *supra* note 55.

64 *See* Young, *Taking a Broader View of Junk Insurance*, *supra* note 27.

65 *See* Karen Pollitz et al., *Understanding Short-Term Limited Duration Health Insurance*, Kaiser Family Found. (Apr. 23, 2018), https://www.kff.org/health-reform/issue-brief/understanding-short-term-limited-duration-health-insurance/.

66 *Id.*

67 *Id.*

68 *See* Sarah Lueck, *Key Flaws of Short-Term Health Plans Pose Risks to Consumers*, Ctr. on Budget & Pol'y Priorities (Sept. 20, 2018), https://www.cbpp.org/research/health/key-flaws-of-short-term-health-plans-pose-risks-to-consumers.

69 Rachel Garfield et al., *The Uninsured at the Starting Line: Findings from the 2013 Kaiser Survey of Low-Income Americans and the ACA*, Kaiser Family Found. (Feb. 6, 2014), https://www.kff.org/report-section/the-uninsured-at-the-starting-line-findings-from-the-2013-kaiser-survey-of-low-income-americans-and-the-aca-iii-gaining-coverage-getting-care/.

more likely to use services like free clinics, community health centers,[70] and emergency medical services.[71] Local governments often bear a significant share of the costs for providing these services.[72]

B. Uninsured and underinsured individuals access care in ways that worsen health outcomes and increase costs further.

67. Insurance status is also associated with major differences in whether and how patients obtain medical care. Analysis of results from the National Health Interview Survey[73] administered by the Centers for Disease Control and Prevention (CDC) 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%).[74] When including

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[70] *See, e.g.*, Heather Angier et al., *An Early Look at Rates of Uninsured Safety Net Clinic Visits*, 13 Annals of Fam. Med. 10 (Jan. 2015), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4291259/; David O. Barbe, *Free Clinics and the Uninsured*, Am. Med. Ass'n (2009), https://www.ama-assn.org/sites/ama-assn.org/files/corp/media-browser/public/about-ama/councils/Council%20Reports/council-on-medical-service/a09-cms-free-clinics.pdf; Erin F. Taylor et al., *Community Approaches to Providing Care for the Uninsured*, 25 Health Aff. 173 (Apr. 2006), https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.25.w173.

[71] *See, e.g.*, Benjamin T. Squire et al., *At-Risk Populations and the Critically Ill Rely Disproportionately on Ambulance Transport to Emergency Departments*, 56 Annals of Emergency Med. 341 (Oct. 2010), https://www.ncbi.nlm.nih.gov/pubmed/20554351; Zachary F. Meisel et al., *Variations in Ambulance Use in the United States: The Role of Health Insurance*, 18 Acad. Emergency Med. 1036 (2011), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3196627/pdf/nihms314403.pdf.

[72] *See A Shared Destiny: Community Effects of Uninsurance*, Institute of Medicine 128 (2003), https://www.ncbi.nlm.nih.gov/books/NBK221329/.

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

[74] 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).

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).[75]

68. 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 those delaying care report that care is associated with a "serious condition."[76] 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."[77] Analyzing 1997 and 1998 data from a different CDC survey, the Behavioral Health Risk Factor Surveillance Survey,[78] 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.[79]

69. 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

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[75] Claxton et al., *How Does Cost Affect Access to Care*, *supra* note 74.

[76] 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.

[77] *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.

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

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

utilization of care and 55 studies showing improved access to care.[80] For example, Medicaid 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.[81]

70. 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.[82] 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,

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[80] *See* Guth et al., *The Effects of Medicaid Expansion under the ACA*, *supra* note 59. 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.*

[81] *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 & Proc. 327 (2019), https://pubs.aeaweb.org/doi/pdfplus/10.1257/pandp.20191046.

[82] 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*, *supra* note 74; see also, e.g., Claxton et al., *How Does Cost Affect Access to Care?*, *supra* note 74; 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 (Dec. 2007), https://www.cdc.gov/nchs/data/series/sr_10/sr10_235.pdf.

compared to 57% of those who remained uninsured, did not have a regular source of health care services.[83]

71. 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 facility.

72. 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 health system that may face resource constraints, including during the current pandemic. Patients who have comprehensive insurance also retain coverage across treatment settings, enabling ongoing care.

[83] 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/.

73. Ultimately, delaying care for treatable conditions tends to worsen health outcomes and may increase the overall cost of providing treatment.[84]

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

Dated: August 13, 2020

Washington, DC

Christen Linke Young

[84] *See, e.g.*, Aleli D. Kraft et al., *The Health and Cost Impact of Care Delay and the Experimental Impact of Insurance on Delays: Evidence from a Developing Country*, 155 J. Pediatrics 281 (Aug. 2009), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2742317/; Joel S. Weissman et al., *Delayed Access to Health Care: Risk Factors, Reasons, and Consequences*, 114 Annals of Internal Med. 325 (1991), http://citeseerx.ist.psu.edu/viewdoc/download?doi=10.1.1.947.5743&rep=rep1&type=pdf.

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
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