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 DR. ALLISON ARWADY

I, Dr. Allison Arwady, 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 started at the Chicago Department of Public Health (CDPH) in 2015 and served as Chief Medical Officer before being confirmed by the City Council as Commissioner in January, 2020. As Chief Medical Officer, I oversaw the disease control, environmental health, emergency preparedness, and behavioral health divisions. I have worked on disease outbreaks, immunization promotion, tuberculosis response, lead poisoning prevention, substance misuse, and more. Prior to CDPH, I worked for the U.S. Centers for Disease Control and Prevention as an Epidemic Intelligence Service officer. In that role, I focused on outbreak response, including international work on Ebola and Middle East Respiratory Syndrome. While based at the Illinois

Department of Public Health, I responded to disease outbreaks across the state. I have a bachelor's degree from Harvard University, a master's degree in public health from Columbia University, and I completed medical school and clinical training at Yale University. I am a board-certified internal medicine physician and pediatrician and continue to see primary care patients weekly.

The City of Chicago

3. Chicago, located in Cook County, is the largest city in Illinois and the third largest city in the United States.

4. The United States Census Bureau's statistics are the best available means for determining the population of Chicago and its demographic characteristics. Those statistics are available at https://www.census.gov/quickfacts/chicagocityillinois.

5. According to 2019 Census estimates, Chicago has nearly 2.7 million residents. Of those residents, 88%, or 2.38 million people, are under the age of 65. 6.9% of Chicago's population, or around 186,000 people, have a disability.

6. 2019 Census estimates for the proportion of Chicago's population without health insurance are unavailable. According to 2018 Census estimates, 11.9% of Chicago's population under the age of 65, or around 283,000 people, lack health insurance. Those same estimates show that 19.5% of Chicago's population, or around 526,500 people, live in poverty.

7. The Bureau of Labor Statistics reports that, in February 2020, the Chicago-Joliet-Naperville, Illinois metropolitan statistical area had 123,900 unemployed individuals.[1]

[1] *Economy at a Glance, Chicago-Joliet-Naperville, IL*, U.S. Bureau of Labor Statistics, https://www.bls.gov/eag/eag.il_chicago_md.htm (last visited June 14, 2020).

8. As a major American city, Chicago provides a wide range of services on behalf of its residents, including, as relevant here, health services, public assistance through human and social services, and emergency medical care.

The City's Health Infrastructure

9. Chicago has a Department of Public Health that generally seeks to promote and improve the health of city residents. The Department has an annual budget of around $221 million and is staffed by over 600 full-time employees.[2]

10. The Chicago Department of Public Health operates free clinics. Specifically, the Department operates five clinics that provide free vaccinations;[3] five clinics that provide mental-health services at no cost for uninsured and underinsured Chicago residents;[4] and three clinics that provide free testing and treatment for sexually transmitted infections.[5] The City also provides certain at-home or in-field health programs, such as nursing home support for pregnant women and newborn babies and directly observed therapy for tuberculosis. Collectively, these clinics and services serve thousands of uninsured and underinsured city residents and, in particular, provide services that may not be covered by non-ACA-compliant health coverage.

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[2] *2020 Budget Overview*, City of Chicago 126, https://www.chicago.gov/content/dam/city/depts/obm/supp_info/2020Budget/2020BudgetOverview.pdf.

[3] *Walk-In Immunization Clinics*, City of Chicago, https://www.chicago.gov/city/en/depts/cdph/supp_info/health-protection/immunizations_walk-inclinics.html.

[4] *Mental Health Centers*, City of Chicago, https://www.cityofchicago.org/city/en/depts/cdph/supp_info/behavioral-health/mental_health_centers.html.

[5] *STI/HIV Testing and STI Treatment*, City of Chicago, https://www.cityofchicago.org/city/en/depts/cdph/provdrs/health_services/svcs/get_yourself_evaluatedforstihivaids.html.

11. Each of these clinics faces greater demand when there is an increase in either the health needs of Chicago residents or in the number of uninsured or underinsured individuals who cannot obtain those services or other forms of health care elsewhere.

12. The Chicago Department of Public Health also partners with, and provides funding to, community-based health centers to offer a wide array of medical services, including for uninsured and underinsured patients.[6]

13. The higher the uninsured and underinsured rate, the more that the clinics operated by the Chicago Department of Public Health and its community-based partners will necessarily have to provide forms of free or reduced-cost care to patients.[7] In that event, Chicago either must provide the Department and its partners with more funding, or the Department and its partners must decrease the services that they provide.

14. The Department of Public Health also conducts citywide surveillance and response efforts for communicable and vaccine-preventable diseases, including 31 employees and around $3.5 million for communicable disease, 32 employees and around $11.5 million for vaccine-preventable disease, 44 employees and around $28.5 million for emergency preparedness, and 25 employees and around $5 million for epidemiology and IT/informatics.[8]

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[6] *Health Services*, City of Chicago, https://www.cityofchicago.org/city/en/depts/cdph/provdrs/health_services.html.

[7] *See, e.g.*, John Holahan & Bowen Garnett, *The Cost of Uncompensated Care With and Without Health Reform*, Urban Inst. 4 (Mar. 2010), https://www.urban.org/sites/default/files/publication/28431/412045-The-Cost-of-Uncompensated-Care-with-and-without-Health-Reform.PDF (A higher "number of uninsured and … amount of uncompensated care …. will translate into increased pressure on state and local government to finance the growing cost of the uninsured."); Erin F. Taylor et al., *Community Approaches to Providing Care for the Uninsured*, 25 Health Aff. 173, 173 (2006), https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.25.w173 ("Increases in the number of uninsured people often strain local safety nets and health systems.").

[8] *2020 Chicago Budget Overview* at 126-28.

15. The Department of Public Health also partners with all hospitals and healthcare organizations in the City of Chicago through the Healthcare System Preparedness Program, which supports the Chicago Health System Coalition for Preparedness and Response.[9] This program includes coordination of all thirty five acute care and specialty hospitals, 110 long term care facilities, 50 dialysis centers, all Federally Qualified Healthcare Centers, and other organizations that provide health care services within the City.

16. This program includes safety net hospitals which, as part of their participation, demonstrate their ability to react to patient surges and complete accreditation requirements. Safety net hospitals provide healthcare for individuals regardless of their insurance status or ability to pay, and typically serve a higher proportion of uninsured, low-income, and other vulnerable individuals than do other hospitals.

17. Chicago's partnership with these hospitals includes financial support such as situational awareness communication, support for data collection and reporting, disaster exercises, clinical trainings, and providing supplies, such as personal protective equipment, mechanical ventilators, and radios. In particular, this program benefits patients during surge events, like the novel coronavirus pandemic.

18. The Chicago Fire Department provides ambulance transportation services to its residents, including its uninsured and underinsured residents. The Department receives around $94 million in annual funding for emergency medical services, employing more than 800 people to provide those services.[10]

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[9] *Healthcare System Preparedness Program*, City of Chicago, https://www.chicago.gov/city/en/depts/cdph/supp_info/health-protection/healthcare-system-preparedness-program.html (last visited June 14, 2020).

[10] *2020 Chicago Budget Overview* at 120.

19. Based on my review of the Department's records, the Department's paramedics provide ambulance-transportation services approximately 250,000 times per year, with over 260,000 in 2019.

20. The Chicago Fire Department provides ambulance services regardless of the patient's income or insurance status. Chicago generally seeks reimbursement for ambulance services from the patient or, if applicable, the patient's insurer.[11]

21. However, Chicago usually does not receive full reimbursement for ambulance services from its uninsured and underinsured residents. Based on my review of the Department's records, in 2018, for example, the Chicago Fire Department provided ambulance services to 60,007 patients for whom no insurance was identified. Chicago charged these patients $63,717,638 for ambulance services but collected just $1,028,713—a loss of $62,688,925. These numbers increased in 2019, during which the Chicago Fire Department provided ambulance services to 61,377 patients for whom no insurance was identified. Chicago charged these patients $65,970,368 for ambulance services but collected just $1,564,799—a loss of $64,958,819.[12]

22. In Chicago's experience, the uninsured and underinsured disproportionately rely on ambulance service for transport to the emergency department.[13] A higher number of

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[11] *Ambulance Bills*, City of Chicago, https://www.cityofchicago.org/city/en/depts/fin/supp_info/revenue/ambulance_bills.html (last visited June 14, 2020).

[12] Because efforts to collect for 2019 are ongoing, these figures may change with time.

[13] *See, e.g.*, Benjamin T. Squire et al., *At-Risk Populations and the Critically Ill Rely Disproportionately on Ambulance Transport to Emergency Departments*, 56(4) Annals of Emergency Med. 341, 347 (2010), https://www.ncbi.nlm.nih.gov/pubmed/20554351; *see also* Zachary F. Meisel et al., *Variations in Ambulance Use in the United States: The Role of Health Insurance*, 18(10) Acad. Emergency Med. 1036, 1041 (2011), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3196627/pdf/nihms314403.pdf ("EMS use is higher among those who historically have had difficulty accessing routine medical care, specifically poor and uninsured patients.").

uninsured and underinsured individuals or an increase in acute health needs will therefore result in more ambulance transports for which Chicago does not receive reimbursement and thus must make up for the shortfall in its budget.

The Novel Coronavirus Pandemic in Chicago

23. As of June 14, 2020, over 49,000 people have been confirmed to have been diagnosed with the novel coronavirus in the City of Chicago, and over 2,300 people have been confirmed to have died from it.[14]

24. Chicago has been subject to the State of Illinois's stay at home orders and has issued its own coronavirus-related guidance, which generally provides that City residents "should practice physical distancing, wear a face covering and wash their hands often."[15] The Department of Public Health has issued several COVID 19-related Executives Orders and guidance available on the City's website,[16] as well as disseminated guidance to health care providers through the Department of Public Health's Health Alert Network.

25. As a result of the economic crisis caused by the novel coronavirus, the Chicago-Joliet-Naperville area's unemployment rate spiked to 640,300 in April 2020, an increase of 516,400, or roughly ~416%.[17] More recent statistics are unavailable, but given national trends, that rate has likely remained high.

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[14] *Coronavirus Response Center*, City of Chicago, https://www.chicago.gov/city/en/sites/covid-19/home.html (last updated June 14, 2020).

[15] *Latest Guidance*, City of Chicago, https://www.chicago.gov/city/en/sites/covid-19/home/latest-guidance.html (last visited June 14, 2020). As of June 14, 2020, Chicago was in Phase 3, which permits certain additional industries to reopen cautiously, following specific safety guidelines. *Phase III Cautiously Reopen: Industry Guidelines for Reopening*, City of Chicago, https://www.chicago.gov/city/en/sites/covid-19/home/reopening-business-portal.html (last visited June 14, 2020).

[16] *Id.*

[17] *Economy at a Glance.*

26. Similarly, while more recent uninsured rate statistics are unavailable, the uninsured rate described above is now likely much higher, given that many individuals who have lost their employment have also lost their employer-provided health insurance as a result.[18]

27. At the same time, the pandemic has necessarily created a new and widespread need for health care services.

The City's Response to the Pandemic

28. In response to the novel coronavirus, Chicago has mounted a comprehensive effort to connect city residents to necessary health, food, housing, financial, and other resources.[19]

29. Specifically, Chicago has directed its uninsured and underinsured residents to its clinics and other community health centers to receive necessary health services during the pandemic.[20] Where in-person services are not possible or are unnecessary, Chicago is committed to using telemedicine and technology to continue the health services it provides directly to Chicago residents (*e.g.*, mental health services, nursing home services, and WIC support).

30. Chicago also supports seven coronavirus testing sites within the City, operated by the nonprofit CORE Foundation, and which are available to symptomatic residents, asymptomatic residents with known exposure to the novel coronavirus, and asymptomatic frontline workers.[21] The City provides the funding for all testing kits and lab work for these sites.

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[18] Selena Simmons-Duffin, *Millions Of Americans Have Lost Health Insurance As Unemployment Soars*, NPR (May 24, 2020), https://www.npr.org/2020/05/13/855096156/millions-of-americans-have-lost-health-insurance-as-unemployment-soars.

[19] *See Coronavirus Response Center*.

[20] *Managing Your Health*, City of Chicago, https://www.chicago.gov/city/en/sites/covid-19/home/managing-your-health.html?#tab-shouldtest.

[21] *Managing Your Health.*

31. The Department of Public Health operates a mobile app, Chi COVID Coach, which "allows people who have coronavirus questions—or symptoms—to connect with trained public health employees who can answer questions about symptoms, quarantine, testing locations and more."[22] It has also established a call center and email address to take questions from the public.[23]

32. Although Chicago advises that individuals isolate themselves at home and receive telephonic medical care, individuals who believe they have contracted the novel coronavirus and/or are in medical distress sometimes use ambulance services to receive necessary care.[24] If those individuals are uninsured or underinsured, the City will provide transport but, for the reasons explained above, is unlikely to receive reimbursement for the expense.

33. Even though Chicago provides certain forms of care to its uninsured and underinsured residents, Chicago is concerned that those residents may be less likely to obtain necessary testing and treatment for the novel coronavirus. In the City's experience, uninsured and underinsured individuals are more likely to skip or postpone needed care due to cost.[25]

34. As of May 8, 2020, Chicago has distributed over 7 million pieces of personal protective equipment, including over 4 million gloves and over 3 million masks.[26]

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[22] Kelly Bauer, *City's New Chi COVID Coach App Lets You Sign Up For Vaccine Alerts, Testing Information And More*, Block Club Chi. (Apr. 27, 2020), https://blockclubchicago.org/2020/04/27/citys-new-chi-covid-coach-app-lets-you-sign-up-for-vaccine-alerts-testing-information-and-more/.

[23] *Resources.*

[24] *See* Mark Guarino, *This Hospital Was Built for A Pandemic*, Wash. Post (Apr. 9, 2020), https://www.washingtonpost.com/health/2020/04/09/rush-hospital-coronavirus/.

[25] *See, e.g.*, *The Chicago Health Care Access Puzzle*, City of Chicago 8 (Nov. 2008), https://www.chicago.gov/dam/city/depts/cdph/policy_planning/PP_ChgoHealthCareAccessRpt-1-.pdf.

[26] *Health Care Workers*, City of Chicago, https://www.chicago.gov/city/en/sites/health-care-workers/home.html (last updated May 8, 2020).

Overall Impact on the City

35. Chicago has a strong interest in ensuring that its residents can obtain adequate medical care. The City would prefer that those residents obtain affordable, ACA-compliant coverage, so that they can seek comprehensive care for all of their medical needs. However, Chicago is committed to caring for its uninsured and underinsured residents.

36. In ordinary times, Chicago is harmed as a whole when its residents feel they cannot obtain necessary medical care. A population that cannot obtain medical care is necessarily sicker, less productive, and less able to participate in the community and civic life.

37. However, amidst the current pandemic, it is an absolute necessity that Chicago residents be able to obtain care, including testing and treatment for the novel coronavirus. The more uninsured and underinsured individuals that do not seek care, the more the novel coronavirus will spread, further harming the City, its budget, its economy, and its well-being.

38. Ultimately, the pandemic has had effects across all of Chicago's programs. Many City agencies and programs are closed or only offering telephonic services as a result of the pandemic, and have had to redirect their personnel and resources and adjust their operations in response. For example, Chicago's clinics that provide vaccinations and treat sexually-transmitted infections have been closed since mid-March, and the staff at those clinics diverted to Chicago's pandemic response. Some City employees have also contracted the novel coronavirus, making it harder for the City to operate effectively.

39. Chicago expects to face a budget shortfall of at least $700 million, in part as a result of the pandemic.[27] That "conservative" figure "depend[s] on how long it takes for

[27] Gregory Pratt & John Byrne, *Mayor Lori Lightfoot: Chicago's Coronavirus Budget Shortfall at Least $700 Million*, Chicago Trib. (June 9, 2020), https://www.chicagotribune.com/politics/ct-

consumers to regain confidence and whether coronavirus cases surge again."[28] Specifically, Chicago faces hundreds of millions of dollars in lost revenue.[29] At the same time, Chicago is facing extraordinary strain on its health, emergency response, and other services.[30]

40. It is not clear when Chicago, or other cities, will be able to fully reopen, or whether they will need to impose restrictions again in the face of another wave of the novel coronavirus.

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

Dated: June 15, 2020

Chicago, Illinois

Dr. Allison Arwady

coronavirus-chicago-budget-shortfall-lori-lightfoot-20200609-d6pb4n7drje6xfe4tzaioesrgu-story.html.

[28] Fran Spielman, *Estimated 2020 Budget Shortfall Is $700 Million, Says Mayor, Who Won't Rule Out Property Tax Increase*, Chicago Sun-Times (June 9, 2020), https://chicago.suntimes.com/city-hall/2020/6/9/21285650/chicago-city-budget-shortfall-700-million-coronavirus-federal-help-lightfoot.

[29] *Id.*

[30] Becky Vevea, *How COVID-19 Could Hit Chicago's Budget*, NPR (May 8, 2020), https://www.npr.org/local/309/2020/05/08/852760731/how-c-o-v-i-d-19-could-hit-chicago-s-budget.

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CITY OF CHICAGO,

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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)

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[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

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[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

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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]

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[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

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[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]

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[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

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[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.

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[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

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[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.

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[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]

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[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.

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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.

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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.

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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).

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 DR. EMILY GEE

I, Dr. Emily Gee, 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 the Health Economist for the Health Policy team at the Center for American Progress in Washington, DC. The Center for American Progress (CAP) is an independent nonpartisan and multi-issue policy institute dedicated to improving the lives of all Americans. CAP staff regularly advise federal, state, and local government policy makers, and CAP analyses and policy proposals are frequently cited by the news media. I have worked at CAP since February 2017. I have written dozens of publications on health policy topics for CAP, including on health care reform, hospital finance, the Affordable Care Act (ACA), and the COVID-19

pandemic.[1] My research and analysis has received attention in such media outlets as Politico, NPR, Vox, *The Washington Post,* CNBC, and *The Hill.* I have also been interviewed for television as an expert on health policy issues by C-SPAN, Univision, and local networks.

3. Prior to my current job, I was a career employee for the federal government. I served as an Economist in the U.S. Department of Health and Human Services (HHS) in the Office of the Assistant Secretary for Planning and Evaluation. I led the office's team for Health Insurance Marketplace enrollment analytics, participated in interagency working groups on the implementation of the Affordable Care Act, and authored issue briefs on trends in health insurance coverage and eligibility for public insurance programs. I collaborated with colleagues across the Centers for Medicare and Medicaid Services (CMS) and other offices in HHS to support the department's outreach to uninsured individuals during the initial launch of the Exchanges and the first few ACA open enrollment periods. In fall 2016, I was detailed from HHS to the staff of the Council of Economic Advisers (CEA) at the White House. As an Economist at the CEA, my duties included tracking trends in health care coverage, access, and costs and reviewing regulations related to provider payments, prescription drugs, and private insurance.

4. I hold an A.B. in government from Harvard College. I earned an M.A. in Political Economy and a Ph.D. in Economics from Boston University, where I wrote my dissertation on consumer choice in health insurance markets. I also taught a course in health economics at Boston University, and I have given talks and guest lectures on health insurance coverage at

[1] *See Emily Gee*, Ctr. for Am. Progress, https://www.americanprogress.org/about/staff/gee-emily/bio/ (last visited May 28, 2020).

other academic institutions and conferences. My research on health insurance coverage has been published in peer-reviewed economics journals.

I. Summary of observations and opinions.

5. The COVID-19 pandemic is expected to cause tens of millions of Americans to lose their current health insurance coverage. This is a problem because, among other things, health care providers are often not reimbursed for care provided to uninsured individuals, and because uninsured individuals often delay seeking necessary care or forgo care altogether.

6. A national special enrollment period (SEP) would rapidly provide individuals who lacked coverage before the pandemic, as well as individuals who have lost coverage as a result, with the ability to obtain ACA-compliant coverage. Based on national enrollment figures and figures released by state Exchanges that have conducted their own special enrollment periods, I conservatively estimate that a national special enrollment period on the 38 federally-facilitated or hybrid Exchanges would have resulted in 422,000 to 667,000 Americans enrolling in such coverage from mid-March to mid-May 2020. A longer SEP would likely result in far more sign-ups.

II. Coverage losses during the pandemic and implications.

7. Prior to the COVID-19 pandemic, over half of all nonelderly Americans, or 153 million people, had health insurance coverage through an employer.[2] This includes both workers and their dependents.

8. Many Americans have lost insurance as a result of the pandemic. Specifically, over 38 million people filed unemployment claims from March through May 2020,[3] which also means that millions have lost their source of health insurance coverage.

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[2] *2019 Employer Health Benefits Survey: Summary of Findings*, Kaiser Fam. Found. (Sept. 25, 2019), https://www.kff.org/report-section/ehbs-2019-summary-of-findings/.

9. Two recent studies highlight the tremendous volume of potential coverage losses that the Exchanges may face this year. Based on unemployment claims filed as of early May, the Kaiser Family Foundation estimates 26.8 million people across the country would become uninsured due to loss of job-based health coverage if they don't sign up for other coverage. Of those, 12.7 million would be Medicaid eligible, 8.4 million would be eligible for tax credits through the Exchanges, and yet others would be eligible for unsubsidized Exchange coverage.[4]

10. The Urban Institute projects a shift in insurance coverage of a similar magnitude. It estimates that if the COVID-19 crisis generates a 20% increase in unemployment, 25 million people would lose their job-based coverage.[5] While 12 million could be expected to obtain coverage through Medicaid and 6 million through the Exchanges or other private coverage, about 7 million of those who lost employer-sponsored coverage would remain uninsured. The Urban report also notes that some people who lose job-based coverage may not realize they are eligible for Exchange coverage and that "creating a national special open enrollment period, regardless of whether a person had prior insurance coverage" could help minimize the number who end up uninsured.

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[3] *"Jaw-Dropping" Fraud Reported as Jobless Claims Reach 38.6 Million*, N.Y. Times, (May 21, 2020), https://www.nytimes.com/2020/05/21/us/coronavirus-news-tracker.html.

[4] Rachel Garfield et al., *Eligibility for ACA Health Coverage Following Job Loss*, Kaiser Fam. Found. (May 13, 2020), https://www.kff.org/coronavirus-covid-19/issue-brief/eligibility-for-aca-health-coverage-following-job-loss/.

[5] Bowen Garrett & Anuj Gangopadhyaya, *How the COVID-19 Recession Could Affect Health Insurance Coverage*, Urban Inst. 3 (May 2020), https://www.urban.org/sites/default/files/publication/102157/how-the-covid-19-recession-could-affect-health-insurance-coverage_0.pdf.

11. Surveys show that the uninsured are more than twice as likely to delay or forgo care due to cost compared to those with Medicaid.[6] Historically, people who are uninsured are less likely to have a usual source of care,[7] and are more likely to report that when they do seek out care, they rely on the emergency department.[8]

12. When uninsured and underinsured people seek care they cannot afford, hospitals and other providers, including clinics and emergency departments, sometimes provide uncompensated care. This can take the form of care provided free upfront as a form of charity or as written-off medical debt. In other cases, however, hospitals and other providers have historically resorted to aggressive measures to collect payment such as selling debt to collection, garnishing wages, or suing patients. Increasing comprehensive health insurance coverage, including through Exchange enrollment, would protect patients from medical debt and help ensure that health care providers are paid for services they provide. For example, studies show that uncompensated care declined as a share of hospitals' operating costs in the wake of the ACA's Medicaid expansion.[9]

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

[7] Rachel Garfield et al., *The Uninsured and the ACA: A Primer—Key Facts about Health Insurance and the Uninsured Amidst Changes to the Affordable Care Act*, Kaiser Fam. 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/.

[8] Rachel Garfield et al., *The Uninsured at the Starting Line: Findings from the 2013 Kaiser Survey of Low-Income Americans and the ACA*, Kaiser Fam. 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/.

[9] *See, e.g.*, David Dranove et al., *Uncompensated Care Decreased at Hospitals in Medicaid Expansion States but Not at Hospitals in Nonexpansion States*, 35 Health Affairs 1471 (Aug. 1, 2016), https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2015.1344.

13. Without insurance, people run the risk of large and unexpected medical costs. Although the legislative packages passed by Congress during the pandemic have helped to make COVID-19 testing free and COVID-related care affordable, people in the United States remain vulnerable to high medical bills for care related to the diagnosis of and treatment related to COVID-19 symptoms. This includes patients who ultimately do not receive a COVID-19 test or are tested and treated for conditions other than COVID-19.[10] To stop the spread of the novel coronavirus, it is crucial that people with COVID-like illness be willing to step forward for testing and treatment, regardless of whether their illness is confirmed to be COVID-19.

III. The need for a broad, nationwide SEP.

14. In general, people who have lost job-based coverage qualify for a special enrollment period for individual market plans through the Affordable Care Act's Health Insurance Exchanges, allowing them to enroll outside the annual open enrollment period. As it is, the Exchanges will likely attract an unusually high number of enrollment applications during the pandemic, in addition to the typical SEP activity among people who qualify based on job changes, moving, marriage, and other qualifying events.

15. Opening a nationwide special enrollment period, without eligibility restrictions, in response to the pandemic would immediately provide an opportunity for many of the uninsured

[10] *See* Kao-Ping Chua & Rena Conti, *Congress Must Do More to Lower Out-Of-Pocket Costs for Coronavirus Detection*, Detroit Free Press (Apr. 26, 2020), https://www.freep.com/story/opinion/contributors/2020/04/25/coronavirus-testing-isnt-always-free-congress-should-fix-that/3016162001/; Phil Galewitz, *COVID-Like Cough Sent Him To ER—Where He Got A $3,278 Bill*, Kaiser Health News (May 25, 2020), https://khn.org/news/covid-like-cough-covid19-symptoms-emergency-room-billing-code-surprise-medical-bill/.

to obtain coverage. A dozen state-based exchanges, in states that operate their own enrollment platforms, have already offered SEPs to the uninsured due to the pandemic.[11]

16. However, CMS has not declared a similar SEP for the 38 states using the federally-facilitated Exchange (FFE) platform, including the state-based Exchanges that use the federal HealthCare.gov website as an enrollment portal. These states account for the vast majority of Exchange enrollment: during the open enrollment period for 2020 coverage, 11.4 million people enrolled in Exchange coverage nationwide; of these, 8.3 million people were enrolled in FFE states.[12]

17. Without a nationwide SEP with broad eligibility, newly jobless Americans face hurdles to obtaining Exchange coverage. If a person qualifies for an SEP based on the loss of job-based coverage, they generally need to file documents proving their eligibility and receive verification prior to enrollment. This process may be overly burdensome at a time when millions of Americans who have lost their jobs are simultaneously experiencing other disruptions to their lives, such as complying with stay-at-home orders and being unable to access websites for filing for unemployment.

18. Reportedly, CMS has waived the requirements to file documentation to qualify for an SEP for loss of job-related coverage during the pandemic, allowing an attestation instead.[13] Yet as of May 27, the federal HealthCare.gov enrollment portal still tells consumers

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[11] *State Data and Policy Actions to Address Coronavirus*, Kaiser Fam. Found. (June 11, 2020), https://www.kff.org/coronavirus-covid-19/issue-brief/state-data-and-policy-actions-to-address-coronavirus/.

[12] *Marketplace Enrollment, 2014–2020*, Kaiser Fam. Found. (2020), https://www.kff.org/health-reform/state-indicator/marketplace-enrollment/.

[13] Amy Lotven, *CMS Won't Do SEP Outreach, But Will Grant Flexibility*, InsideHealthPolicy, Apr. 20, 2020, https://insidehealthpolicy.com/daily-news/cms-wont-do-sep-outreach-will-grant-flexibility.

who say they have lost coverage that "you may be required to submit documents showing the coverage you lost and the date it ended" and that they can "select a plan now and submit the documents later," along with a link to "acceptable documents."[14] The appearance of these requirements may discourage some people from seeking coverage or completing applications.

19. In addition, no SEP is available for uninsured people who have lost their job or are working reduced hours but did not lose job-based coverage, or for people who were uninsured or underinsured to begin with. As of 2018, approximately 28 million Americans were uninsured, according to the U.S. Census Bureau.[15] A categorical special enrollment period without eligibility restrictions would allow these individuals to enroll as well.

IV. Estimates for how many would seek to enroll.

20. National enrollment figures and figures from the state exchanges that offered their own special enrollment period are the best measure for estimating how many Americans might seek to enroll through a national SEP. For example, Covered California, the Exchange for the state of California, was among those that opened enrollment to "any eligible uninsured individuals" due to the pandemic. It made enrollment eligibility criteria "similar to those in place during the annual open-enrollment period." Covered California reported that 123,810 people had signed up via an SEP between March 20 and May 16, "nearly 2.5 times higher than the level

[14] *It Looks Like You May Qualify for A 2020 Special Enrollment Period*, HealthCare.gov, https://www.healthcare.gov/screener/loss-of-coverage.html (last visited May 27, 2020).

[15] Edward R. Berchick et al., *Health Insurance Coverage in the United States: 2018*, No. P60-267 (RV), U.S. Census Bureau (Nov. 8, 2019), https://www.census.gov/library/publications/2019/demo/p60-267.html.

Covered California saw during the same time period in 2019."[16] Covered California's SEP is scheduled to close on June 30.[17]

21. Based on those figures, and as explained more fully below, I conservatively estimate that about 422,000 to 667,000 people would have enrolled in coverage if CMS had allowed a similar SEP during that roughly 60-day March–May period. More would enroll if the SEP were to last beyond that.

22. The 422,000 figure uses historical SEP enrollment as a starting point. CMS had reported that "[f]or states using the Federal platform for plan year 2017, 1.1 million individuals applied for coverage after OEP [the Open Enrollment Period] and made a plan selection through a SEP, while approximately 9.2 million individuals had an active plan selection at the close of the 2017 OEP."[18] In other words, SEP activity in a typical year is about 12% of total open enrollment plan selections. If 2020 SEP enrollment were similar to that in 2017, in the absence of the pandemic and its associated economic disruption, one would expect total SEP enrollment for 2020 to be 12% of total open enrollment, or 1.0 million enrollments. This would mean approximately 169,000 expected enrollments over a given 60-day period if SEP enrollment were spread out evenly over the 12 months of the year. If CMS had declared an SEP open to all eligible uninsured Americans and the FFE states had SEP enrollment also roughly 2.5 times the typical level (akin to Covered California), we would have expected 422,000 people to have

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[16] Press Release, *Covered California Sees More Than 123,000 Consumers Sign Up for Coverage During the COVID-19 Pandemic*, Covered Cal. (May 20, 2020), https://www.coveredca.com/uploads/05-20-20-coveredca-sep-data.pdf.

[17] Press Release, *California Responds to COVID-19 Emergency by Providing Path to Coverage for Millions of Californians*, Covered Cal. (Mar. 20, 2020), https://www.coveredca.com/newsroom/news-releases/2020/03/20/california-responds-to-covid-19-emergency-by-providing-path-to-coverage-for-millions-of-californians/.

[18] *The Exchanges Trend Report*, CMS (July 2, 2018), https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces/Downloads/2018-07-02-Trends-Report-3.pdf.

enrolled in Exchange coverage in the FFM states, which is 253,000 more people compared to expected normal levels.

23. For the second, 667,000 estimate, note that Covered California's total SEP enrollment during the 60-day COVID SEP was equal to about 8% of that state's 1.5 million sign-ups during the open enrollment period for plan year 2020 coverage and the state says that SEP activity was 2.5 times higher than typical than last year over the same 60-day period. If CMS had designated a similar SEP and enrollment was equivalent to 8% of the 8.3 million open enrollment period sign-ups, then the 38 FFE states would have enrolled a total of 667,000 people via that SEP. If, like in California, that FFE SEP enrollment had been 2.5 times greater than typical, then that total FFE SEP sign-ups would have been 396,000 greater than would be expected in the absence of the pandemic over the period.

24. Again, I believe these estimates of SEP enrollment are conservative. If an SEP for the FFE commenced sometime after today, enrollment for a given 60-day period might be even greater. Given that the pandemic and the economic hardship it has caused are expected to last months, an SEP of a longer duration would likely result in even more enrollment in the Exchanges. Moreover, Covered California's SEP began relatively early in the pandemic, and the mounting job losses and the crisis's financial strain on families may have heightened the salience of health insurance coverage among potential enrollees.

25. In comparison, an analysis by health care analyst Charles Gaba estimates that, based on recent jobless claims numbers, as many as 1.8 million to 2.4 million people would enroll in Exchange coverage if there were an SEP for the pandemic in all states.[19] In addition, the

[19] Charles Gaba, *UPDATE: 1.8 - 2.4 Million more Americans would likely #GetCovered if HealthCare.Gov launched #COVID19 SEP*, ACASignups.net (Apr. 14, 2020),

projections by the Kaiser Family Foundation and the Urban Institute also suggest that the economic effects of the pandemic will make millions newly eligible for subsidized and unsubsidized coverage. The extent to which those people enroll in coverage—and avoid becoming uninsured—will depend on awareness of the Exchanges and the ease of enrollment.

26. A national SEP with broad eligibility could reduce uninsurance beyond the Exchanges. An SEP is likely to have spillover effects that boost enrollment in other public programs, including among those eligible for Medicaid and the Children's Health Insurance Program (CHIP). The "welcome mat" effect of the ACA's coverage expansion is well-documented: the expansion of Medicaid in some states and the opening of the Exchanges led to increases in the rate of insurance coverage among people who were already eligible for Medicaid/CHIP.[20] Amid the ongoing financial strain of the economic crisis on American families, Medicaid/CHIP coverage is also more important for protecting them from additional, unexpected costs from health care.

27. Some may argue that introducing an SEP during a pandemic increases the risk of adverse selection in the Exchanges, making it more likely that people who are or expect to be sicker than average enroll in coverage, which could raise insurers' costs and increase premiums in the future. Concern about adverse selection is why health insurance enrollment is typically only available during certain annual periods. In my opinion, the value of expanding coverage amid the novel threat posed by the pandemic outweighs the risk of some adverse selection in

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http://acasignups.net/20/04/16/update-18-24-million-more-americans-would-likely-getcovered-if-healthcaregov-launched.

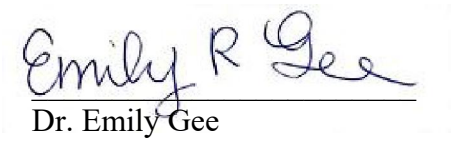
[20] Molly Frean et al., *Understanding ACA's Coverage Gains: Welcome Mat Effect & State Marketplaces Keys to Success*, Geo. Univ. Health Pol'y Inst.: Say Ahhh! Blog, (May 18, 2016), https://ccf.georgetown.edu/2016/05/18/understanding-acas-coverage-gains-welcome-mat-effect-state-marketplaces-keys-successful-expansion/.

enrollment under a broad SEP. In fact, enrollees at the margin may be younger and healthier than average. An SEP for the uninsured could attract enrollees among the so-called young invincibles who previously believed that their good health made insurance not worth the cost. Some of the states that have created a COVID-19 SEP for their own Exchanges have seen just such an increase in younger customers. Maryland and Rhode Island report that more than half of those enrolling through the COVID-19 SEP are below the age of 35.[21] By contrast, just 35% of enrollees in the FFE during open enrollment were under age 35.

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

Dated: June 12, 2020

Washington, DC



Dr. Emily Gee

[21] Rachel Schwab et al., *During the COVID-19 Crisis, State Health Insurance Marketplaces Are Working to Enroll the Uninsured*, The Commonwealth Fund: To The Point, (May 19, 2020), https://www.commonwealthfund.org/blog/2020/during-covid-19-crisis-state-health-insurance-marketplaces-are-working-enroll-uninsured.