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African Americans, Asians and Pacific Islanders living in California are just as likely to have health insurance as whites, marking a significant turnaround from five years ago, new data shows.
The report, based on survey data from the UCLA Center for Health Policy Research, shows the uninsured rate for all racial and ethnic groups other than Latinos hovering between 4 and 7 percent in 2017, a statistically insignificant difference. That compares to 2013, when African Americans, Asians and Pacific Islanders were almost a third more likely than whites to be uninsured.
Analysts attributed the change to California's implementation of the Affordable Care Act in 2014, which has expanded health care coverage to more people, largely by widening eligibility for Medi-Cal and providing insurance subsidies for people with low to moderate incomes.

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Articles of Significance

Obamacare premiums are looking good. They'd be even better if they hadn't been sabotaged by the GOP

It's time for consumers who buy their own health insurance to start shopping for policies for next year. Open enrollment for Affordable Care Act coverage starts Thursday across most of the country.

But the shopping and buying experience will vary widely, depending on where people live.

In California, for example, where political leaders have always been supportive of the Affordable Care Act, legislators have allocated $100 million for outreach.

"We're going to be hitting the airwaves with TV, radio, interrupting people's Pandora," says Peter Lee, executive director of Covered California. "That means that in California the average Californian will hear us, see us, be interrupted by us over 50 times this open enrollment season."

That sort of hard-sell is crucial if you want to create lower premiums for everyone, Lee says.

"Look, no one thinks they're going to get sick unless they're already sick," he says. "No one wants to spend dollars today for something they think they're never going to use. You've got to *sell* insurance" to convince healthy people to sign up.

Article continues after sponsorship

Meanwhile, in states that rely on the federal government's insurance exchange — mostly conservative states whose leaders opposed the ACA — there won't be nearly as much outreach to potential customers.

The federal Centers for Medicare and Medicaid Services says it plans to spend about $10 million on marketing nationwide. The effort will include email and text messages to consumers and YouTube videos, according to the CMS website. The agency declined to talk to NPR about open enrollment.

Lee worries that consumers will be confused. With all the political fighting around the ACA, he says, many people believe insurance is now too expensive for them, or don't realize they likely can get government help to pay their premiums.

"Every place in America — no matter where you live — the subsidies are there today and people should check and find out if they're eligible for them," Lee says.

In February 2018, nearly 90 percent of people who had insurance through an exchange qualified for subsidies.

The average premium for a benchmark policy for a 27-year-old is about $405 per month, according to the Department of Health and Human Services. But because of subsidies, the average price a 27-year-old will actually pay is $140 per month.

The Trump Administration has made changes to the ACA's rules, including gutting the tax penalty for those who don't buy coverage, and making it easier for some people to buy a short-term policy that doesn't carry all the consumer protections of an ACA policy. Those changes have added to the cost of some ACA plans, according to Cynthia Cox of the Kaiser Family Foundation.

"Insurance companies, when they set their premiums for the coming year, have to show their math," Cox says. "They have to justify each element of what is driving up premiums each year — or driving them down."

The Kaiser Family Foundation analyzed hundreds of filings. And Cox says insurers pointed to the lack of a mandate and the availability of cheaper, short-term insurance to justify their prices. Some companies even mentioned the reduced marketing as as a factor that's driving up premiums.

Those changes, along with regulatory changes made by the Trump Administration last year, have resulted in premiums being about 16 percent higher than they would have been otherwise, Cox says.

In response, some states have made their own changes. In May, New Jersey adopted it's own individual mandate. And California banned the sale of short-term health policies that don't meet ACA standards. Maryland and Alaska have added other programs to stabilize the insurance marketplace. So premiums are stable or even going down in those places, Cox says.

In New Jersey, for example, the monthly premium for a benchmark policy is $289 for 2019 — a decline of 15 percent from 2018's premiums.

But in Wyoming, it's a different story. That state has the highest average benchmark premium — $709 a month — according to HHS.

"Rural areas have been particularly hard-hit by high premiums," Cox says. "There's not a lot of insurance market competition [there]."

Katie Nicol, senior manager of public benefits and insurance navigation at Whitman-Walker Health in Washington, D.C., helps people choose insurance plans.

"Our biggest role as navigators is to really ensure that people understand that the ACA is still the law of the land, and that the marketplace will be up and running [as of]Nov. 1," Nicol says.

The deadline to sign up for new insurance on Healthcare.gov is December 15. But some states, including California, have enrollment periods that extend into January.

Los Angeles Times

California spent $4 billion on Medi-Cal for people who may not have been eligible, audit finds
By Soumya Karlamangla

California spent $4 billion on Medi-Cal coverage between 2014 and 2017 for people who may not have been eligible for the government-funded health plan, according to a state audit released Tuesday.

Medi-Cal provides health coverage to 13.1 million Californians, approximately one-third of the state's population. To qualify, a single adult must make less than $16,754 annually.

County workers typically determine whether someone is eligible for health coverage under Medi-Cal, then send that information to the state. But the records don't always match up.

The audit found 453,000 beneficiaries who were marked as eligible in the state's system, but not in the counties' — indicating that they may not have actually been eligible for Medi-Cal. These beneficiaries may have died, moved or begun making more money and no longer qualified for Medi-Cal.

Yet the state's Department of Health Care Services paid $4 billion to health plans and doctors for those patients' medical care over four years. The audit found that 57% of the discrepancies lasted for more than two years.

In one instance, a Los Angeles County resident died in December 2013, yet the state continued to make monthly payments to the beneficiary's Medi-Cal health plan until August of this year. The state ultimately paid the plan $383,000 for a person who the state "should have known was no longer in need of services," according to the audit.

"Although Health Care Services has established a process for notifying counties of beneficiary records that require follow-up, gaps in this process allowed the problems we identified to persist," State Auditor Elaine Howle wrote in a letter to the Legislature accompanying the audit.

The audit also found 54,000 people who were marked eligible in the county system but not the state, which may have delayed or made it difficult for them to access services for which they did qualify.

"These individuals may have experienced hardships in accessing health care services, as they would have been denied benefits until the system discrepancies were resolved," the audit says.

The audit recommended that the department implement a better system by the end of the year and recover erroneous payments by June. The department said it agreed with the recommendations but could not comply with them within that timeline.

With One Hand, Administration Boosts ACA Marketplaces, Weakens Them With Another

By Julie Appleby

In the span of less than 12 hours last week, the Trump administration took two seemingly contradictory actions that could have profound effects on the insurance marketplaces set up by the Affordable Care Act.

First, officials issued guidance Monday morning that could weaken the exchanges set up for people who buy their own insurance. The new approach makes it easier for states to get around some ACA requirements, including allowing the use of federal subsidies for skimpier plans that can reject people with preexisting conditions.

Yet, the other move — a proposed rule unveiled Monday evening — could bolster ACA marketplaces by sending millions of people with job-based coverage there, armed with tax-free money from their employers to buy individual plans.

Both efforts play into the parallel narratives dominating the bitter political debate over the ACA.

The administration, frustrated that Congress did not repeal the law, say some critics and policy experts, is working to undermine it by weakening the marketplaces and the law's consumer protections. Those efforts make it easier for insurers to offer skimpier policies that bypass the law's rules, such as its ban on annual or lifetime limits or its protections for people with preexisting conditions. Congress also zeroed out the tax penalty for not having coverage, effective next year. Combined, the moves could reduce enrollment in ACA plans, potentially driving up premiums for those who remain.

The administration and Republicans in Congress say they are looking to assist those left behind by the ACA — people who don't get subsidies to help them buy coverage and are desperate for less expensive options — even if that means purchasing less robust coverage.

"These are people who were buying insurance before [the law] and then the rules changed and they could not buy it because they could not afford it," said Joe Antos, a resident scholar at the conservative American Enterprise Institute. "They have been slowly dropping out of insurance coverage altogether."

The efforts are dramatically reshaping the ACA and the individual insurance market to one that looks more as it did before the 2010 law, when regulation, coverage and consumer protections varied widely across the country.

"Some states will do everything they can to keep individual markets strong and stable. Others won't," said Sabrina Corlette, research professor at the Center on Health Insurance Reforms at Georgetown University.

So what expectations should consumers have? Here are three key takeaways:

Protections for preexisting health problems are uncertain.

Polls show that keeping the ACA's guarantees on coverage for people with medical problems is a top concern for Americans, and Democrats have made their defense of the health law a key part of their midterm election campaigns.

Republicans have gotten that message and even those who voted to repeal the ACA or joined a lawsuit by 20 red states to overturn it now say they want to protect people with preexisting conditions. Still, GOP lawmakers have not introduced any plan that would be as protective as the current law.

In August, the administration released a rule allowing expanded use of short-term plans, which are less expensive than ACA policies. To get those lower prices, most of these plans do not cover prescription drugs, maternity care, mental health or substance abuse treatments.

The move is unlikely to benefit people with health problems, as short-term plans can reject people with preexisting conditions or decline to cover care for those medical problems.

Under the rule, insurers can sell them starting in 2019 for up to a year's duration, with an option to renew for up to three years, reversing an Obama-era directive that limited them to 90 days.

Administration officials estimate such plans could draw 600,000 new enrollees next year, and others have estimated the numbers could be far higher. The concern is if many healthy people in 2019 switch out of the ACA market and choose short-term plans, premiums will rise for those who remain, including those with preexisting conditions or make the ACA market less attractive for insurers.

Where you live matters more.

One of the biggest changes ushered in with the ACA was a standard set of rules across all states.

Before the law took effect, consumers buying their own coverage saw tremendous variation in what was offered and what protections they had, depending on the state where they lived.

Most states, for example, allowed insurers to reject people with medical conditions. A few states required insurers to charge similar premiums across the board, but most allowed wide variations based on age, gender or health. Some skimpy plans didn't cover prescription drugs, chemotherapy or other medical services.

By standardizing the rules and benefits, the ACA barred insurers from rejecting applicants with medical conditions or charging them more. Women and men get the same premium rates and insurers could charge older people no more than three times what they charged younger ones.

Under the new guidance issued this week giving states more flexibility on what is offered, consumers could again see a wide variation on coverage, premium rules and even subsidy eligibility.

“It shifts pressure to state politicians,” said Caroline Pearson, a senior fellow at NORC, a nonpartisan research institution at the University of Chicago. That could play into the calculus of whether a state will seek to make broad changes to help people who cannot afford ACA plans, even if the trade-off affect*s* people with medical conditions.

“You risk making some worse off by threatening those markets,” said Pearson. “That is always going to be hard.”

Millions more will join the “buy-your-own” ranks.

The proposed rule released Tuesday allows employers to fund tax-free accounts — called health reimbursement arrangements (HRAs) — that workers can use to buy their own coverage on the ACA marketplaces.

The administration estimates about 10 million people would do so by 2028 — a substantial boost for those exchanges, which policymakers say never hit the enrollment numbers needed to attract enough insurers and hold prices down.

John Barkett, senior director of policy affairs at Willis Towers Watson, a benefits consulting firm, said he expects employers to “seriously consider” the new market. The infusion of workers will improve options by attracting more insurers, he added.

“These people coming in will be employer-sponsored, they’ll have steady jobs,” Barkett noted, and will likely stick with coverage longer than those typically in the individual market.

Currently more than 14 million people buy their own insurance, with about 10 million of those using federal or state ACA marketplaces. The others buy private plans through brokers.

The proposed rule won’t be finalized for months, but it could result in new options by 2020.

If these workers seeking coverage are generally healthy, the infusion could slow premium increases in the overall ACA marketplace because it would improve the risk pool for insurers.

But, if employers with mainly higher-cost or older workers opt to move to the marketplaces, it could help drive up premiums.

In an odd twist, the administration notes in the proposed rule that the ACA has provisions that could protect the marketplace from that type of adverse selection, which can drive up prices. But most of the protective factors cited by the rule have been weakened, removed or expired, such as the tax penalty for being uninsured and the

federal subsidies for insurers to cover lower deductibles for certain low-income consumers.

Benefits consultants and policy experts are skeptical about how many companies will move to the HRA plan, given the tight labor market. Continued uncertainty about the fate of the ACA marketplace may keep them reluctant to send workers out on their own, they say.

Health benefits are a big factor in attracting and retaining workers, said Chris Condeluci, a Washington attorney who previously worked for Sen. Chuck Grassley (R-Iowa) and served as counsel to the Senate Finance Committee during the drafting of the ACA.

“Most employers believe their group health plan will provide better health coverage than an individual market plan,” he said.

Factors Likely To Drive Enrollment On Healthcare.gov In 2019

By David Anderson

Open enrollment for the Affordable Care Act (ACA) individual marketplaces is coming up soon. What should we expect? What policy choices will increase on-exchange enrollment, and what choices will decrease enrollment?

This will be the sixth open enrollment period and the second complete open enrollment run by the Trump Administration. We are now in a far more stable rule regime, in contrast to the year-long uncertainty that shaped the fifth open enrollment season. In 2017, insurers had spent the entire rate development decision cycle uncertain whether the ACA would be repealed or replaced, uncertain about the existence and enforcement of the individual mandate, and uncertain if insurers would be reimbursed for the cost-sharing reductions (CSRs) they are obligated to provide to qualifying low-income enrollees. They responded by raising rates and leaving markets.

This year has seen significant policy changes, including the impending elimination of a monetary penalty attached to the individual mandate, increased access to non-ACA-compliant plans, and the approval of several states’ reinsurance waivers. All of these changes either happened before the rate setting cycle started or were telegraphed.

The 2018 fifth open enrollment period saw 11.75 million people initially enroll. The silver-loading of CSR costs—which increased premium tax credits, since they are calculated based on the second-lowest-cost silver plan—led to a significant shift in enrollment composition as compared to the slightly higher enrollment during the fourth open enrollment.

Policy Actions Likely To Increase On-Exchange Enrollment

More states are silver-loading. Colorado and Delaware shifted from a broad-load of CSRs, meaning that CSR costs were incorporated into the premiums for all plans, to a silver load of CSR costs. North Dakota and Vermont are incorporating CSR costs into premiums for the first time. These steps will increase the value proposition for subsidized buyers.

Other states have taken action to lower unsubsidized premiums, notably through section 1332 reinsurance waivers. Lower non-subsidized premiums will make plans more attractive to healthier, relatively higher-income buyers who do not qualify for subsidies. Wisconsin, Maine, Maryland, and New Jersey will all begin reinsurance programs in 2019. Medicaid expansion in Virginia will likely lead to lower premiums than we otherwise would have seen as the Medicaid expansion population is more morbid than the general individual market population. HHS has estimated that Medicaid expansion reduces premiums by 7 percent, while other researchers studying two post-January 2014 Medicaid expansions estimated greater premium reductions.

Additionally, catastrophic plans are easier to qualify for via expanded mandate exemptions. Mandate exemptions will still be provided to allow individuals to qualify for catastrophic coverage even as there will be no financial penalty for an individual not being covered by a qualified health plan. Catastrophic plans have significant pricing advantages over "metal" plans because they are risk adjusted separately while covering a far healthier and younger population.

Finally, more insurers are entering and re-entering markets. Broker support tools are improving, and some insurers are paying individual market commissions to brokers.

All of these changes are likely to lower the effective prices that certain buyers will be paying for their policies. All else being equal, lower effective premiums will lead to more people buying policies Healthier buyers are more likely to be price sensitive, so lower premiums will be attractive to individuals who can bring down average morbidity in the risk pools.

Policy Actions Likely To Decrease On-Exchange Enrollment

The biggest threat to 2019 open enrollment is likely to be the increased availability of non-ACA-compliant, underwritten plan options. Short-term, limited-duration plans are being aggressively expanded. People have always been able to stay in transitional plans and grandfathered plans, and they could attempt to buy into health care sharing ministries. Very short-term plans (90 days) were also an option for individuals who wanted some protection but would not or could not buy an ACA policy. Now, however

the recently authorized short-term, limited-duration plans with 364-day terms—and renewability up to three years—will be attractively priced to individuals who do not qualify for subsidies and who can pass medical underwriting.

Association health plans have been opened up to more individuals. Farm Bureau plans are also expanding, explicitly not as insurance. The Iowa Farm Bureau is currently selling health benefit plans that are designated as not insurance and therefore free from insurance regulations. Tennessee's Farm Bureau has done the same thing for years, resulting in a sicker risk pool in the ACA-compliant market, since healthy people can opt for Farm Bureau plans instead.

As discussed, the financial penalty attached to the individual mandate will be eliminated after the end of this year. The impact this will have on enrollment will depend on whether consumers have developed a "taste for compliance" – and will thus feel compelled to obey even a mandate without penalty -- or instead view the decision whether to enroll as a purely financial matter.

Another threat to enrolment is the compression of the so-called silver spread. Premiums for the second-lowest-cost silver plans have been decreasing relative to other silver plans: Benchmark Healthcare.gov silver premiums are decreasing by an average 1.5 percent, while nationally premiums are increasing by 3.1 percent. Since premium tax credit amounts are set with reference to these plans, this means that the tax credit amounts will be smaller relative to premiums for the increasingly number of plans that are more expensive than the benchmark plans. Effective prices paid for most non-benchmark plans will increase for people who receive premium subsidies.

In addition, by shifting individuals out of the exchanges, continuing Medicaid expansion under the ACA may reduce 2019 enrollment. Virginia's expansion, for example, starts on January 19 of next year, and Maine's expansion will also likely start next year, when a new governor takes office. Virginia currently has 120,898 individuals in high CSR plans for 2018. Most of these individuals will be eligible for Medicaid. New Hampshire is moving premium assistance program Medicaid expansion beneficiaries to Medicaid managed care and out of the exchanges, which has improved the ACA risk pool and lowered rates compared to what they otherwise would have been.

Finally, reduced navigator funding may create a headwind for 2019 enrollment. Funding has been cut 72 percent from 2018 open enrollment levels. Multiple Healthcare.gov states, and large metropolitan regions, will have no navigators assisting enrollment.

Background Policy Factors Likely To Have Little Incremental Impact

Several factors regarding the coming open enrollment period mark significant changes from the first four open enrollment periods, but because these factors are little changed from the 2018 open enrollment, they are unlikely to change enrollment much compared to last year, For instance, open enrollment will only last six weeks in Healthcare.gov states, the same as last year's duration but down markedly from earlier open enrollment periods.

Federal messaging on the ACA is negative, but constant from last year. Partisan feedback loops will validate or ignore elite messaging in a consistent manner. State level messaging has been slightly more supportive during the last weeks of the midterm election: significant support for protection from pre-existing condition exclusions has come from both parties, although crucial details greatly vary.

Finally, federally funded advertising is significantly below the level for the fourth open enrollment period but it is, again, a constant relative to 2018. The ACA may have lost some earned media from the constant repeal and replace news reports, while it is gaining significant earned media from the Congressional mid-term campaigns.

Overall, relatively low premiums for exchange plans on the one hand, and additional non-ACA-compliant underwritten options for relatively healthy individuals on the other, are the most likely levers that will lead to changes in enrollment in ACA individual market plans sold on an exchange for the 2019 plan year. The positive pricing trends on the exchanges are likely to be attractive to individuals who earn between 200 and 400 percent of the federal poverty level. However, this cohort, as well as the non-subsidized population, will be the primary market for lower-cost underwritten plans as well.

Dialysis companies spend $111 million to kill ballot measure

By Sophia Bollag

Dialysis companies have contributed an extraordinary $111 million and counting to defeat a California ballot initiative that would cap their profits, the most any one side has spent on a U.S. ballot issue since at least 2002.

A $5 million donation from this week from dialysis provider Fresenius Medical Care pushed the anti-Proposition 8 campaign's total past the $109 million pharmaceutical companies spent two years ago to defeat a measure limiting prescription drug costs. More than $70 million has been spent on television and radio ads as well as consulting services in the last two months.

When corporate profits are at stake, campaign spending often balloons, said Kati Phillips of California Common Cause, which advocates campaign finance reform.

“Health care measures are expensive,” she said. “There’s a lot of money to be made off of sick people.”

Dialysis companies make roughly $3 billion in annual profits from their California operations, according to nonpartisan Legislative Analyst’s Office.

For weeks, anti-Proposition 8 ads have blanketed the California airwaves and feature dialysis patients saying passage could lead to clinic closures that endanger their lives. Dialysis providers say the measure is actually a tactic to pressure the companies to let workers unionize.

“We will spend what is necessary to protect patients from this dangerous and irresponsible ballot measure,” said Kathy Fairbanks, spokeswoman for the anti-Proposition 8 campaign.

The campaign supporting the measure, led by the Service Employees International Union-United Healthcare Workers West, has raised $18 million. Supporters say passage will ensure dialysis companies put patients before profits.

“These are huge corporations that have not been accountable to consumers — the patients,” campaign spokesman Sean Wherley said.

An Associated Press analysis found the campaign to defeat Proposition 8 is the most expensive effort on one side of a ballot measure anywhere in the country since the 2002 election, the earliest cycle for which data is available online. The AP reviewed California campaign finance records filed with the secretary of state and data compiled by the nonprofits MapLight and National Institute on Money in Politics, the leading authorities on ballot measure spending.

Data from the National Institute on Money in Politics shows the most costly ballot measures in the country are in California, the nation’s most populous state where reaching voters through political ads is very expensive.

The state keeps paper records prior to the 2002 election cycle in its archives. The secretary of state’s office doesn’t have reports on which campaigns were most expensive prior to that cycle, spokesman Sam Mahood said. Because of inflation, it’s unlikely any surpassed $111 million.

The largest for-profit dialysis providers in California — Fresenius, headquartered in Germany, and Denver-based DaVita Inc. — joined forces to fund the bulk of the No on 8 campaign. Many ads feature dialysis patients saying the measure endangers them.

“If clinics have to close, people like me would die,” a woman identified as California dialysis patient Sasona Goodblatt says in one ad. “Prop 8 literally threatens my life.”

Dialysis machines filter patients’ blood for toxins, essentially performing kidney functions outside the body. Patients typically undergo hours-long treatments three times a week.

Proposition 8 restricts dialysis clinics from charging patients more than 115 percent of what providers spend on patient care and quality improvement. If clinics exceed that limit, they'll have to provide rebates or pay penalties.

The law doesn't spell out exactly which expenses will count toward the limit. Dialysis clinics say critical management expenses will be counted as profits, which would bankrupt clinics.

SEIU-United Healthcare Workers West also is using dialysis patients to push their effort, including an ad where patient Robert Costa complains about conditions at a clinic where he says there's urine on the floor and cockroaches.

"They just care about the money. They don't care about the patients," he said.

Novel Measures Test Cities' Power — And Will — To Tame Health Care Costs

By Rob Waters

At a time of mounting national anger about rising health care prices, the country's largest union of health workers has sponsored ballot measures in two San Francisco Bay Area cities that would limit how much hospitals and doctors can charge for patient care.

The twin measures in Palo Alto and Livermore, sponsored by the Service Employees International Union-United Healthcare Workers West, take aim primarily at Stanford Health Care, which operates Stanford Hospital and Clinics, the facility with the third-highest profits in the country from patient care services, according to a 2016 study. The union also is sponsoring Proposition 8, a statewide measure that would impose a cap on profits for dialysis clinics. Together, the state and local measures seek to draw on public outrage over sky-high medical prices. And, for municipalities, they amount to a novel and untested effort to rein in those prices through the ballot box.

"I've been in this field almost 50 years, and I've never seen a local government regulating hospital prices," said Paul Ginsburg, director of public policy at the Schaeffer Center for Health Policy & Economics at the University of Southern California. A number of states set hospital rates in the 1970s, and two states, Maryland and West Virginia, do so today, he said.

Opponents question the legal authority of cities to regulate health care pricing, and they predict a flood of litigation against the measures if they pass. The city councils of both cities oppose the proposals, arguing that local officials with no expertise in health care costs would be required to create a new bureaucracy to regulate them.

Stanford Health Care officials say the measures could undermine quality. “It would threaten [the system’s] ability to provide top-quality health care to patients from Palo Alto and across the region,” according to a September statement from the system. Ginsburg expressed skepticism. “Of course, you could cut rates too much and harm hospitals financially,” he said. “But if done with intelligence, you could accomplish some price reduction without harming quality.”

For the union, the ballot measures could help it gain leverage in future bargaining or organizing efforts with Stanford and other hospitals. Stanford Health Care operates the largest hospital system in both cities where the price cap proposal is on the ballot. Stanford has opened, has acquired or is building health care centers with clinics and specialty services in Emeryville, Pleasanton and Redwood City — Bay Area cities where the SEIU-UHW tried but failed to place similar price-control measures on local ballots.

But union officials say their motive is simply to rein in prices. “Stanford Health is nonprofit. They don’t pay property taxes or incomes taxes,” said Sean Wherley, an SEIU-UHW spokesman. “Taxpayers are subsidizing their operations and getting wrung out by over-the-top prices.”

Stanford and other health systems have been on a buying spree in recent years acquiring hospitals and physician practices, and this concentration of ownership has stifled market competition and further boosted prices for insurers and patients.

The Palo Alto and Livermore initiatives, which also affect other medical systems in the cities, would cap prices charged by hospitals and other health care providers at 115 percent of “the reasonable cost of direct patient care.”
And there, some experts say, lies the rub.
“What is a seemingly simple idea — limiting prices to 115 percent of ‘costs’ — is neither simple in execution, nor concept,” said Benedic Ippolito, a research fellow at the American Enterprise Institute who studies health care financing. “What costs are acceptable? How will we stop providers from increasing costs as much as possible” to compensate for the cap?

Under the initiatives, hospitals and other medical providers would be obliged to pay back any charges above the cap each year to private commercial — but not government — insurers, and to patients who pay for their own care. They would also owe the cities a fine equal to 5 percent of the excess charges. Fines collected by the cities could be used to pay for enforcing the laws.

Stanford estimates that Proposition F, the Palo Alto measure, would reduce the health system's budget by 25 percent, forcing it to make cutbacks and possibly end essential services, said David Entwistle, the health system's president and chief executive officer. Livermore would need to spend $1.9 million a year on the staff required to implement Measure U — its version of the proposal — and would likely incur another $750,000 to $1 million in legal and startup costs, according to an analysis conducted for the city by Henry Zaretsky, a health economist who has worked for the state and the California Hospital Association.

Patients in the wealthy region expect high-quality services but also can be savvy consumers and passionate voters. It is an open question whether the measures would pass.

Industry consolidation is far more pronounced in Northern California than in Southern California, according to a recent study from the University of California-Berkeley. As a result, inpatient hospital prices in the north were 70 percent higher and outpatient costs as much as 55 percent higher than in the south. The price disparities, even within the Northern California region, can be dramatic.

For instance, independent doctors in the Bay Area are reimbursed, on average, a median $2,408.45 for a routine vaginal delivery, which includes prenatal and postnatal visits, according to a 2017 Kaiser Health News analysis of claims data from Amino, a health cost transparency company. That compares with $5,238.13 for the same bundle of services for Stanford physicians (and $8,049.84 for doctors employed by the University of California-San Francisco).

The higher cost of medical care also pushes up insurance premiums for patients. Health plans purchased on the state insurance exchange were 35 percent higher in Northern California than in Southern California, the 2018 UC Berkeley study showed.

Earlier this year, California Attorney General Xavier Becerra took aim at medical industry consolidation and the high prices associated with it. He sued Sutter Health, one of the nation's largest health systems, saying it was systematically overcharging patients and illegally driving out competition in Northern California.
To C. Duane Dauner, a former president and CEO of the California Hospital Association, the ballot proposals are "a power play by SEIU-UHW to put pressure on Stanford Health Care." The union wants Stanford "to be neutral when they try to organize employees in Redwood City, Emeryville, Pleasanton and Livermore," said Dauner, who heads the campaign committee opposing both measures.

Larry Tramutola, a veteran campaign consultant who is not involved on either side, agrees.

"I don't think it has anything to do with controlling health care prices," said Tramutola, who recently managed successful local initiatives to tax sodas and ban menthol

cigarettes. “It’s about bargaining. Win or lose on this, other hospitals in other places will take notice and realize that SEIU is a formidable foe.”

Protect Our Local Hospitals and Health Care, the campaign committee opposing the measures, has raised $4.2 million so far this year. The union’s political action committee has spent $1.5 million in support of the initiatives.

California Healthline senior correspondent Barbara Feder Ostrov contributed to this report.

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California nurses move their ‘Medicare-for-all’ fight to the national stage

By Angela Hart

The union representing 100,000 nurses across California has shifted its “Medicare-for-all” campaign from California to the national stage, perhaps relieving political pressure on Democratic gubernatorial candidate Gavin Newsom to fulfill what the union sees as his top campaign promise: Delivering a single-payer health care system in the nation’s largest state.

The California Nurses Association, which led the coalition behind the high-profile 2017 push for a single-payer system, has re-branded its campaign with the slogan “Fight to Win Medicare-for-All!” Its social media feeds reflect the new national scope of their efforts.

Until this month, the coalition, previously called “Campaign for a Healthy California,” was focused solely on passing a single-payer health care bill in California. Their campaign reached a fervor in late 2017 and early 2018, when nurses and single-payer activists stormed the California Democratic Party convention and later, the state Capitol, calling on Democratic lawmakers to approve their single-payer bill.

Representatives for the union, joined by its parent organization, National Nurses United, are now expanding their efforts to Congress and other states, such as Florida, Maine, Minnesota and Texas. They say they’re not letting up in California.

“We’re not conceding or taking a loss here. There will be a single-payer bill next year,” said Stephanie Roberson, a spokeswoman for the California nurses union. “Our aim is to put strategic pressure on states where we see opportunities to provide health care for all, so we can make that national shift.”

“California is a starting point,” Roberson said.

Still, individual states face steep challenges in creating, within their borders, a new health care system that operates under a different set of rules and laws than the nation as a whole, said Gerald Kominski, a professor of health policy at the UCLA Center for Health Policy Research.

He said the nurses’ new efforts to apply pressure on Congress, and national candidates, could also be an acknowledgment that California can’t do it alone.

To create and pay for a single-payer system, under which the government would be the sole “payer” of health care services, California would need multiple approvals from the federal government to both collect federal health care dollars for the state-run system and to bypass regulations on employer-based private health plans. It would also have to amend the state Constitution.

“I think it’s the realization that developing a single-payer system at the state level faces significant legal barriers that maybe they’ve acknowledged…are more substantial than they were willing to admit publicly a year ago,” Kominski said. “It also might be a recognition that you’re pushing the next governor out too far on a limb, where you’re likely to be left hanging.”

Newsom has shifted his tone on single-payer, a system under which government, generally, becomes the primary payer of all health care services. Before the primary he said of single-payer: “It’s about time, Democrats.” He now says universal health care is the ultimate goal.

Nurses say they plan to hold Newsom accountable on his earlier comments and expect him sign a single-payer health care bill into law should he become governor. But their shift to a national focus could also be an opening to letting Newsom off the hook, Kominski said.

“Part of what this shows is the fight really does need to take place in Washington,” he said.

Holly Miller, a spokeswoman for the national nurses union, said the expansion into other states also aligns the push for a nationwide single-payer system, championed by Sens. Bernie Sanders and Kamala Harris.

“We did the re-branding of the social media feeds so we could show the much broader focus of the ‘Medicare-for-all’ campaign,” Miller said. “We’re using the movements in

California and Florida to talk about the national fight. We're for single-payer health care, whether we get it at the state level, or nationally."

How Repeal of the Individual Mandate and Expansion of Loosely Regulated Plans are Affecting 2019 Premiums
By Rabah Kamal, Cynthia Cox, Rachel Fehr, Marco Ramirez, Katherine Horstman, and Larry Levitt

In health insurance systems designed to protect people with pre-existing conditions and guarantee availability of coverage regardless of health status, countervailing measures are also needed to ensure people do not wait until they are sick to sign up for coverage (as doing so would drive up average costs for other enrollees). The Affordable Care Act (ACA) included a variety of "carrots" (e.g., premium tax credits and cost-sharing reductions) and "sticks" (e.g., the individual mandate penalty and limited enrollment opportunities) to encourage healthy as well as sick people to enroll in health insurance coverage.

Despite the enduring popularity of the ACA's protections for people with pre-existing conditions, the individual mandate – which requires most people to maintain health insurance coverage or else pay a penalty – has consistently been viewed negatively by a substantial share of the public. After broader attempts to repeal and replace the ACA stalled out in the summer of 2017, Congress reduced the individual mandate penalty to $0 effective in 2019 as part of tax reform legislation passed last December.

Soon thereafter, the Trump administration also announced new rules that will allow more loosely regulated plans – short-term limited duration (STLD) plans and association health plans (AHPs) – to proliferate on the individual market in competition with ACA-compliant coverage. These more loosely regulated plans will serve as a more affordable option for some people who are not eligible for the ACA's premium tax credits.

However, particularly in the case of short-term plans, this lower-cost coverage is generally unavailable to people with pre-existing conditions and the plans often exclude coverage for certain services. STLD plans do not meet the ACA's requirement to maintain coverage, but, because the penalty for going without coverage will soon be $0, the attractiveness of STLD coverage will grow for healthy people. These plans will attract disproportionately healthy individuals away from ACA-compliant coverage, thus having an upward effect on premiums in the ACA-compliant individual market.

With the effective repeal of the individual mandate penalty and the expansion of short term and association health plans, we set out to quantify how much of an upward effect these policy and legislative changes are having on 2019 premiums. Among insurers that publicly specify the effect of these legislative and policy changes in their filings to state insurance commissioners, we found that 2019 premiums will be an average of 6% higher, as a direct result of individual mandate repeal and expansion of more loosely regulated plans, than would otherwise be the case.

Adding the impact from the loss of cost-sharing reduction payments – which drove up silver premiums by an average of 10% according to the Congressional Budget Office – to the impact from individual mandate penalty repeal and expansion of more loosely regulated plans, this analysis suggests on-exchange benchmark silver premiums will be about 16% higher in 2019 than would otherwise be the case.

Analyzing Insurer Rate Filings

Each year, insurers submit rate filings to state regulators justifying their premium changes for the upcoming year. These filings include varying amounts of detail, depending on the state and insurer, and sections of the publicly available filings are often redacted. Insurers sometimes do not include much detail in the public filings, and do not always explicitly mention the effect policy changes will have on rates.

We reviewed all publicly available filings insurers across the United States submitted to state regulators detailing their justifications for rate changes in the ACA-compliant individual market, both on- and off-exchange. While many insurers identify the repeal of the individual mandate penalty and/or the expansion of STLD/AHP plans as factors that will have an upward effect on 2019 premiums, not all companies quantify the amount by which rates will increase specifically due to these changes, and others redact this information from their publicly available filings. Additionally, some companies group together the upward effect of the individual mandate penalty repeal with the expansion of short-term and association plans, while other companies report these effects separately or only publicly quantify the effects of one of these changes.

We exclude from this analysis states that have implemented their own individual mandates (Massachusetts, New Jersey, and Washington, DC) or, in the case of New York, prohibited insurers from loading an individual mandate surcharge into 2019 premiums.

Among insurers that publicly quantify a rate impact from legislative and regulatory changes – effective repeal of the individual mandate penalty and/or expansion of more loosely regulated plans – the upward effect on 2019 premiums ranges from 0% to 16%. Among these insurers, the average rate increase in 2019 due to the individual mandate

penalty repeal and expansion of more loosely regulated plans is 6%. Most 2019 rate impacts due to these legislative and policy changes fall between 4% and 8% (the 25th and 75th percentiles).

Table 3 in the Appendix shows rate increases by state and insurer among companies that publicly quantified the amount by which premiums will increase due to these legislative and policy changes in either 2018 or 2019.

In many cases, these rate increases come on the heels of similar assumptions made going into 2018 that the individual mandate would be repealed or weakly enforced (as insurers had to finalize 2018 rates before a decision had been made in Congress to effectively repeal the individual mandate). In setting rates for 2018, some insurers assumed either repeal, reduced enforcement, or public perception of reduced enforcement of the individual mandate would lead to a sicker risk pool in 2018 and priced accordingly. In 2018, among insurers that publicly quantified an impact of uncertainty about the individual mandate, companies incorporated a premium increase of 0% to 25%. Among these insurers, the average rate increase due to individual mandate uncertainty in 2018 was 5% and most fell between 2% and 6% (the 25th and 75th percentiles).

A number of insurers factored in rate impacts due to individual mandate uncertainty in 2018 and individual mandate penalty repeal in 2019. In many of these cases, though, the 2019 load appears to supersede the 2018 load and the two are not cumulative. There may be some cases when the 2019 individual mandate load is in addition to the 2018 load, but we assume the values in 2019 and 2018 are never cumulative, which is the more conservative approach.

Table 1: Range of Premium Impacts from Individual Mandate Uncertainty/Repeal in 2018 and 2019

Year of filings	Min	25th Percentile	Average	75th Percentile	Max
2019	0%	4%	6%	8%	16%
2018	0%	2%	5%	6%	25%

NOTE: In some cases, the effect due to the individual mandate also includes the expansion STLD/AHPs, reduced outreach, or other legislative uncertainty.
SOURCE: Kaiser Family Foundation analysis of insurer rate filings to state regulators, state insurance regulators, and ratereview.healthcare.gov.

The upward effect on 2019 premiums due to the effective repeal of the individual mandate and expansion of more loosely regulated plans is in addition to other significant rate increases due to the Trump administration's decision to halt cost-sharing reduction subsidy payments. This decision, the Congressional Budget Office estimates, is responsible for a 10% increase in 2018 on-exchange silver premiums.[1] Altogether, on-exchange silver premiums in 2019 are therefore approximately 16% higher than would otherwise be the case if federal CSR payments had continued (the loss of which contributed approximately 10% to silver exchange premiums), the individual mandate

penalty were still enforced, and more loosely-regulated plans were not expanding (the latter changes contributed an additional 6% to 2019 rates).[2]

Many states allowed insurers to load the loss of CSR payments onto silver premiums and many insurers only added that cost to plans offered on the marketplace in 2018. Therefore, in most states, the effect of the loss of CSR payments was considerably smaller for bronze and gold plans offered off-exchange than for silver plans offered on-exchange. Because premium tax credits on the exchanges are tied to the cost of silver premiums, the effect of the loss of CSR payments was cushioned for many enrollees on-exchange. The impact of the individual mandate penalty repeal and expansion of more loosely regulated plans, however, is concentrated primarily off-exchange, where enrollees do not receive a subsidy to offset increases.

Table 2: Premium Impacts from Legislative and Policy Changes to the ACA

Legislative or Policy Change	Average percent by which 2019 unsubsidized premiums are higher than would be the case without change
• Individual mandate penalty repeal • Expansion of AHP / STLD plans	6% (all premiums on/off exchange)
• Loss of CSR payments	10% (silver exchange premiums)*
	16% (silver exchange premiums)*
Combined Impact: • Individual mandate penalty repeal • Loss of CSR payments • Expansion of AHP / STLD plans	

SOURCE: Kaiser Family Foundation analysis of insurer rate filings to state regulators, state insurance regulators, and ratereview.healthcare.gov. Premium impact due to CSR loss is from Congressional Budget Office (CBO) estimate.

NOTES: Premium changes represent the change in premiums before accounting for the premium tax credit. How each premium impact relates to other impacts depends on how each insurer calculates rate impacts. We conservatively assume the rates are additive (6% + 10% = 16%), as opposed to multiplicative (1.06 x 1.1 = 1.166, or 16.6%). *The CBO estimate of the loss of CSR payments' effect was specifically for silver exchange premiums. However, some insurers also applied a CSR load onto other metal levels and/or off-exchange premiums.

Going into 2018, insurers on average likely increased rates more than was necessary. As of mid-2018, insurers in the individual market are doing quite well financially on

average, so many are unable to justify another year of premium increases going into 2019. Therefore, despite repeal of the individual mandate penalty and expansion of more loosely regulated plans in 2019, premiums in much of the country are holding flat or decreasing relative to 2018. In states that use healthcare.gov, unsubsidized benchmark premiums are dropping an average of 1.5% next year, from $502 per month for a 40-year-old in 2018, to $495 in 2019.

Our analysis therefore suggests the average healthcare.gov benchmark silver premium for a 40-year-old would be approximately $427 per month (instead of $495) in 2019, if it were not for the repeal of the individual mandate penalty, expansion of short-term plans, and loss of cost-sharing subsidy payments.[3]

Discussion

Exchange premiums will be moderating in 2019, as many insurers are currently profitable after overshooting with 2018 rates. Benchmark silver premiums in states that use Healthcare.gov will be an average of 1.5% lower in 2019 than they were in 2018, which will likely come as welcomed news to people who are ineligible for subsidies and paying full-price for coverage in the individual market in states where there is a decrease. However, a number of middle and upper-middle income individuals and families have already been priced out of the market and a small decrease in premiums may not be enough to bring them back.

Among insurers that publicly specify the effect of these legislative and policy changes, we found that 2019 premiums will be an average of 6% higher, as a direct result of individual mandate penalty repeal and expansion of more loosely regulated plans, than would otherwise be the case. Combined with estimates from the Congressional Budget Office, our analysis suggests the elimination of the cost-sharing subsidy and individual mandate penalty, as well as expansion of more loosely regulated plans, has caused on-exchange silver premiums to be 16% higher than would otherwise be the case. Instead of 2019 benchmark silver premiums on healthcare.gov averaging $495 per month for a 40-year-old, as was recently reported by HHS, we estimate the premium would be approximately $427 in the absence of individual mandate penalty repeal, expansion of more loosely regulated plans, and the loss of cost-sharing subsidy payments.

From a consumer perspective, the rate impact from these policy and legislative changes has played out differently for subsidized on-exchange consumers than for unsubsidized off-exchange consumers. Heading into 2018, off-exchange consumers generally experienced the 5% rate impact from uncertainty around the individual mandate enforcement, but many were able to avoid the steeper premium increases due to the loss of cost-sharing subsidy payments as insurers in many states were able to load this cost onto only silver plans, and/or only exchange plans. In some cases, on-exchange consumers in 2018 may have ended up paying less because of the loss of CSR payments, because of larger subsidies due to silver loading.

Looking ahead to 2019, premiums in much of the country are holding flat or decreasing a bit, but unsubsidized off-exchange consumers on average will nonetheless pay an

average of 6% more than they otherwise would have, if it were not for repeal of the individual mandate and expansion of more loosely regulated plans. On the exchange, meanwhile, subsidized customers will continue to pay sliding-scale premiums based largely on their incomes, and so the amount of premium they pay is mostly unaffected by the repeal of the individual mandate and expansion of short-term plans.

The Washington Post

Trump says he's taking 'revolutionary' action to lower drug prices

By Paige Winfield Cunningham and Felicia Sonmez

President Trump took his most significant action yet to lower drug prices, saying his administration is moving to stop "global freeloading" by foreign nations when it comes to the price that Americans pay for prescription drugs. The announcement is a sign that the president and his aides are shifting their focus to health care two weeks before the midterm elections.

In a speech Thursday afternoon at the Department of Health and Human Services, Trump said his administration would be taking the "revolutionary" step of allowing Medicare to directly negotiate prices with drug companies that he says have "rigged" the system, leading to U.S. patients paying more for their medicines.

"Americans pay more so other countries can pay less," Trump said. "It's wrong. It's unfair."

Trump's remarks were the first as president at HHS and come at a time when health care is playing a defining role in midterm campaigns, with Democrats slamming Republicans over whether they support protecting access to health care for people with preexisting conditions. Trump argued that other countries were being "very disrespectful" by selling their prescription drugs to Americans for higher prices than their citizens are paying for them.

Under the new approach, the Centers for Medicare and Medicaid Services (CMS) plans to experiment with a new way of setting prices for most drugs administered through Medicare's Part B program, which covers all doctor's visits for seniors and the drugs prescribed to them during their visits.

HHS estimates the new pricing index — which the agency says would apply to 50 percent of the country — would save Medicare $17.2 billion over five years. Medicare now pays the average sales price of a medicine in the United States, plus a

fee based on a percentage of that price. Under the new model, Medicare would pay fees to doctors that are more closely aligned with what other countries pay.

Trump's has said lowering drug prices is a key goal of his administration. Thursday's announcement suggests a more prominent role for the government in setting drug prices than many Republicans may be comfortable with and is likely to face significant pushback from the pharmaceutical industry.

It also highlights an increasing push by the president personally and by his administration more generally to emphasize health care in the run-up to the elections, an issue polls show is at the top of voters' minds. On Wednesday afternoon the president signed sweeping legislation to tackle the opioid drug epidemic, and he has tweeted that "all Republicans" will protect people with preexisting health conditions in response to Democratic charges otherwise.

"It's hard to take the Trump administration and Republicans seriously about reducing health care costs for seniors two weeks before the election when they have repeatedly advocated for and implemented policies that strip away protections for people with pre-existing conditions," Senate Minority Leader Charles E. Schumer (D-N.Y.) said in a statement.

On the campaign trail, Democrats have been hammering away at Republicans for their failed attempt last summer to repeal and replace the Affordable Care Act, which enabled people with prior illnesses to receive affordable health care. Trump's administration has worked to chip away at several ACA requirements, including supporting GOP repeal of the individual mandate in the party's tax overhaul and supporting waivers for Medicaid work requirements.

[Trump's false claim ignores long GOP effort to repeal Obamacare]

Trump's announcement on drug prices came hours after HHS released a report highlighting the steep spending by the U.S. government on prescription drugs.

The report compares the price paid by Medicare for 27 prescription drugs with the average price paid for the same drugs by countries with similar economic conditions. It concludes the higher U.S. prices means Medicare pays nearly twice as much as the program would pay for the same or similar drugs in other countries. During his speech, Trump cited an example of a "common" cancer drug that he said is seven times as expensive for Americans as for people living outside the United States, though he did not name the drug specifically.

"Medicare could achieve significant savings if prices in the U.S. were similar to those of other large market based economies," the report concludes.

Trump's announcement represents the next leg in the administration's quest to appear tough on the pharmaceutical industry. Medicare, which covers 55 million elderly and disabled Americans, is responsible for 29 percent of the nation's prescription drug spending.

HHS Secretary Alex Azar criticized a system in which other countries pay significantly less for drugs than the U.S. government. The United States is the biggest funder of research and development in the pharmaceutical sector yet lacks the bargaining power to bring prices down — unlike in countries with public health-care programs.

“For some drugs we are paying upwards of 300 or 400 percent, and in some instances we pay 700 percent more than other countries do,” Azar told reporters after Trump’s address. “President Trump asked us to fix this problem and here’s how we plan to do it.”

The new payment model will affect only drugs purchased and dispensed by doctors themselves under Medicare’s Part B program — not medicines purchased at pharmacies. In the five-year experiment, carried out through CMS’s innovation center, prices will be gradually and increasingly pegged to the new international index instead of average U.S. sales price.

The proposed rule also sets up a first-time system inside Medicare in which drugs would be sold to vendors instead of directly to doctors and hospitals. It would remove incentives for doctors to prescribe more-expensive drugs by paying them a flat fee for storing the medications instead of a fee based on a percentage of the drug’s price.

Officials said the aim is to introduce more competition into Part B, which has doubled its spending on drugs since 2006. In contrast, Part D spending on drugs dispensed by pharmacies has risen much more slowly. The report notes Part B is not subject to restrictions on the drugs that are covered, meaning there is little incentive to tamp down costs.

The 19-page HHS report, which looks specifically at drugs purchased and dispensed by doctors under Part B, “provides troubling insight into how the current international drug pricing system has put America in last place,” Azar tweeted.
Protecting people with preexisting conditions and bringing down prescription drug prices rank high among voters’ concerns headed into the elections. In a March Kaiser Family Foundation poll, 8 in 10 respondents said drug costs are unreasonable and 92 percent said passing legislation to bring down the cost of prescription drugs should be a top or important priority.
Trump kicked off his drug-costs initiative in May in the White House Rose Garden, where he announced a 44-page blueprint containing ideas that could threaten industries along the drug supply chain.

The president in May also claimed drug companies would be announcing “massive” voluntary price cuts. When Pfizer and Novartis announced over the summer they were pulling back on some planned price increases, Trump touted it as proof his pressure tactics were working.

The administration has moved twice this month to lower drug prices in other ways. Trump signed a bill banning “gag clauses” that prohibited pharmacists from telling patients when they could save money by paying cash or trying a cheaper alternative

medicine. Last week, Azar proposed a rule requiring companies to list in television ads the price for a 30-day supply or course of treatment for drugs they are trying to sell.

The San Diego Union-Tribune

Looking for an ACA alternative? Harder to do in California

By Paul Sisson

Since it started, some people have been quite unhappy with the sweeping changes that the Affordable Care Act made to the individual health insurance market.

The health-care law requires that all plans cover a wide range of benefits, that insurers cannot deny anyone with a pre-existing condition, and it removes a cap on the maximum amount of claims that a policy will pay. So yes, the ACA raised the bar for health plans purchased by those who don't get coverage from an employer or a government program such as Medicare.

But requiring such a robust range of benefits also eliminated lower-end options which covered less but also charged lower monthly premiums.

After the ACA's health insurance mandate took effect in 2014, some turned to short-term health insurance plans as a cheaper option. These plans cost less because, unlike ACA plans, short-term coverage is not required to cover those with pre-existing conditions, is allowed to cap maximum payments and is not required to cover the ACA's full list of services. They deliver less coverage at a cheaper price.

The federal government cracked down in 2016, limiting the duration of short-term policies to no more than three months.

Newly-released draft guidelines from the Trump administration restore the old rules, allowing anyone to buy a short-term plan that lasts nearly 12 months. Association plans, which previously allowed groups of employees at different companies to band together when negotiating for health insurance, will now be extended to sole business owners.

Like short-term plans, association plans have more leeway in terms of the services covered. While they're not allowed to bar anyone with a pre-existing condition, association plans don't have to offer the full range of benefits that ACA plans do — they can skip prescription drug or maternity coverage for example — and they are allowed to have a wider disparity in the premiums they charge to their youngest and oldest policyholders.

While Covered California plans have been a boon to those at the lower end of the economic scale, those in higher income brackets who don't qualify for cost-sharing subsidies or discounted copays and deductibles have been paying premiums and facing deductibles that may be more expensive than they were before the ACA.

Generally, short-term plans are most popular with healthy people who feel they don't need to pay for comprehensive coverage that they seldom use. But health care economists worry that short-term and association plans will siphon those customers way from comprehensive ACA markets, and leave behind people who are, on average, sicker and older, causing premiums to rapidly increase.

The California Legislature had those exact concerns. Over the summer, it passed two bills that effectively blocked what many Democrat legislators branded "junk insurance" and eliminated Californians' ability to enroll in the new types of short-term and association plans that will be allowed by the Trump administration's recent changes. Gov. Jerry Brown signed the bills in September.

While healthy consumers looking to trade benefits for lower premiums will surely be unhappy about having fewer options for 2019, many who study health care and health insurance say that the way to lower costs is not through benefit levels.

Kristof Stremikis is director of market analysis with the nonprofit California Health Care Foundation. He said most people who study the issue deeply believe the true target for premiums should be reducing the cost of health care. Current initiatives to pay for services based on the value they deliver to patients move toward that goal.

"I would say the problem is not that we're covering too many things. The real driver of the affordability problem is the underlying price of health care. Until that gets solved, we're just going to see these premium increases year after year after year," Stremikis said.

The San Diego Union-Tribune

Rate increases on the horizon in Covered CA as mandate disappears

By Paul Sisson

If you are one of the nearly 1.4 million Californians currently on a Covered California plan, or if you're newly self employed and faced with choosing coverage on the individual market for the first time, it is time to take a look at your options for 2019.

As always seems to be the case, rates are going up next year. The state's health insurance exchange announced this summer that the average premium increase for its customers in 2019 will be 8.7 percent.
But that's just an average.

The actual change ranges from a decrease of 8 percent to an increase of 32 percent, depending on the specific plan and rates involved.

For Adam McLane of Rolando, the increase is near the middle of the range.

"We just got a notice from Kaiser in the mail that says our rates are increasing 15 percent next year," McLane said.

The family enrolled in a Covered California plan over the summer after McLane's wife lost her job.

The increase, he said, has gotten him thinking more seriously about seeking care in Mexico. He said he's had good experiences in Mexican hospitals in the past, and next year there is no penalty for going without health-care coverage due to changes made in 2017 by the Trump administration.

"We're a creative family, so we're certainly not afraid to cross the border. It would be something we would definitely consider. At this point, we're not sure what we're going to do," McLane said.

While the rate increases are unwelcome, many, including the McLane family, receive help paying their premiums from the federal government.

The Trump administration's decision to do away with the Affordable Care Act's requirement to buy insurance or pay a penalty was predicted to cause a large spike in monthly rates, but that hasn't happened, according to the nonprofit Kaiser Family Foundation. While states such as Vermont and Georgia have seen double-digit percentage premium increases, most states have seen price hikes in the single digits and some have even seen decreases.

"The reason, perhaps, that you're not seeing an enormous increase is because the individual mandate was not that severe a penalty in the first place," said Kristof Stremikis, director of market analysis with the nonprofit California Health Care Foundation. "The premium subsidies seem like they have been the biggest key factor in getting people to enroll."

With a little shopping around, Covered California notes, it's possible to find a plan that comes close to holding prices steady.

To help you do that we've built a full-page list that shows how premiums have changed across the five different carriers that sell plans through Covered California in San Diego County. We chose three of the most-common scenarios — an individual in their 20s, a couple nearing Medicare eligibility age and a family with young kids — to help you see at a glance how your rates might change from plan to plan and at different income levels with subsidies applied.

However, for those solidly in the middle class, premiums can still add up to hundreds per month, and standard deductibles are still often several thousand dollars.

While much cheaper deductibles and copays are available to those with low enough incomes to qualify, people like McLane say they still feel they're buying coverage that they don't feel they can really afford to use.

"It just starts to feel like a racket you can't escape," McLane said. "You try not to be cynical, but that can be difficult."

Three important points

If you're in a Covered California plan or know you will be shopping for one this fall, there are a few important items it pays to understand:

•Your children can end up in Medi-Cal, the state's program for disadvantaged residents, even if your household makes more than $50,000 per year. Using a family of four as an example, Covered California offers plans for households with a combined annual income of $34,638 or more. Any less than that and the entire family will automatically be directed to enroll in Medi-Cal. But the state offers Medi-Cal enrollment for children age 18 and younger who live in households making up to 266 percent of the federal poverty level. That's equal to $66,766 in combined annual income for a family of four. So if you make less than that amount and try to enroll through Covered California's website, your

kids will most likely be automatically enrolled in Medi-Cal. That's exactly what happened to the McLane family when they enrolled in mid-2018.

"(Our children) were assigned a case worker and everything, and that's not what we wanted to happen. It actually took a lot of effort to get that changed," McLane said.

It is possible to enroll children in the same plans as their parents even if the family's income qualifies them for free Medi-Cal coverage. However, if you take that step, a Covered California representative confirmed, you will need to pay full price for the portion of your monthly premium that covers your kids. The government does not subsidize the premiums of anyone who qualifies for Medi-Cal. If you do want to enroll in a Covered California plan and you don't want your kids enrolled in Medi-Cal, it's best to call Covered California's enrollment hotline at (800) 300-1506. The enrollment workers who answer the line are well versed in handling this specific situation.

•If you are receiving a subsidy payment from Covered California that reduces the amount of your monthly premium payments, Covered California asks you what you think your income will be in the coming year, and also takes a look at your previous tax returns to determine if that amount is reasonable. It's completely up to you to monitor your income and let Covered California know if your best guess is turning out to be wrong. If you made more than expected in a year, then the IRS will find that you received more financial help than you should have and you will likely have to pay a portion of that back on your return. So, it's important to track your income as the year continues and report any changes to Covered California.

•Preventive services aren't subject to your deductible. This means you don't pay extra for screening services, vaccinations, and well-baby or well-child visits. Annual physical examinations for adults, however, are not covered. Health insurance companies and medical providers have, however, been known to get this wrong during the billing process. If you have received a service that you believe was preventive, rather than responding to a specific medical complaint, you can check out the official list maintained by the U.S. Centers for Medicare and Medicaid Services at bit.ly/ACAcovered.

CaliforniaHealth REPORT

Lesbians, Gay Men and Bisexuals are Delaying Health Care, Study Finds

By Claudia Boyd-Barrett

Lesbians, gay men and bisexual adults in California are more likely than straight people to delay seeking medical care, even though they have the same or even higher rates of health insurance coverage, according to a new study.

Researchers at UCLA examined survey data from about 83,000 California adults that included questions on a variety of health indicators, including access to health care and insurance, health problems, health behaviors and sexual orientation. They found that gay and bisexual men were more likely than straight men to have health insurance, while lesbian and bisexual women had similar rates of health insurance coverage compared to straight women.

But when it came to actually using their health insurance coverage, gay, lesbian and bisexual adults lagged significantly behind their straight peers. Twenty percent of gay men and 21 percent of bisexual men reported delaying seeking health care in the past year, compared to 13 percent of straight men.

Among gay and bisexual women the difference was even more pronounced. While just 18 percent of straight women reported delaying care, almost 30 percent of lesbians and bisexual women said they'd put off seeing a doctor.

"Unfortunately we don't have the data to answer (why) directly," said Susan Babey, one of the authors of the report. "But other research suggests that one possibility is that lesbian, gay and bisexual adults have experienced discrimination or not feeling welcome in health care settings in the past and so are avoiding repeating those kinds of experiences by delaying care even if they need to see a medical provider."

That conclusion sounded right to Amanda Wallner, director of the California LGBT Health and Human Services Network, a statewide coalition of non-profit providers, community centers, and researchers advocating for policies and resources to advance LGBT health.

"It's something that we've actually known about for a while. Other studies have shown similar findings and anecdotally we hear stories about this all the time," she said. "It's an

entirely rational reaction…[LGBT adults] are responding to either their own previous experiences of discrimination or to a perception that they may experience that."

Wallner said she's heard stories of doctors refusing to provide certain medical treatment to LGBT people, questioning their lifestyle behaviors and not respecting their relationships. Another problem is transportation, she said. Some people only want to go to clinics they know are friendly to the LGBT community. But getting to those clinics can be a challenge, she said, because there often aren't many of them and they may be far from where patients live.

When people don't seek medical care early it can be costly to both patients and society, said Babey. Those who delay seeing a doctor can end up with more serious and difficult-to-treat health conditions, and are more likely to need emergency care, she said. In fact, the UCLA study shows gay, lesbian and bisexual adults visited the emergency department more often than straight adults. The difference was especially pronounced for bisexuals.

The study didn't examine health access for transgender and questioning people. That was due to a lack of survey data on that population, Babey said. However, the researchers plan to look into the issue in a future study, she said.

Wallner said health providers can help address LGBT patients' distrust of the medical system by taking steps to be more affirming toward them. Practices should include using patients' preferred names and pronouns, asking LGBT people about their relationships but not focusing on sexual orientation to the exclusion of other aspects of their lives, conducting training on LGBTQ awareness and cultural competency, partnering with local LGBTQ organizations to do outreach, and showing posters in their health care practices that include LGBT people and families, she said.

"I look forward to the day when we start to chip away at those disparities and people do feel comfortable going into their doctor," Wallner said. "We need to break down the stigma because it's killing people."

The ACA has helped, not hurt, the health care industry

By Bob Herman

The earnings and stock prices of health care companies have increased a lot more than the broader market since former President Obama signed the Affordable Care Act into law in 2010.

Between the lines: The ACA was designed to expand coverage and nudge companies toward new behaviors. But despite critics' warnings about the end of private insurance or a government takeover of health care, the law has not upended the system's underlying structure or stifled the industry's ability to reap large profits.

By the numbers: The S&P 500 health care index, which tracks the stocks of 63 major companies, has soared by 186% since the ACA became law. By comparison, the S&P 500 and Dow Jones increased by 141% and 139%, respectively, according to FactSet.

Winners: Health insurers. The stock price of Centene, a major Medicaid and ACA marketplace insurer, has multiplied by 12 times or 1,100%. Shares of UnitedHealth Group have jumped by more than 700%.

•Insurers weathered cuts to Medicare Advantage and new requirements forcing them to cover sick people, but in return they got millions of taxpayer-subsidized customers through Medicaid expansion and the individual marketplaces.

•Wall Street analysts say investors and companies were afraid the ACA was going to hurt the profitability of employer plans and Medicare Advantage. That never happened.

•The individual marketplaces started out shaky but are now lucrative for the companies that remain. Medicare Advantage is expected to explode with growth over the next three years, and as more states expand Medicaid, more people get enrolled into private Medicaid plans.

The rest of the industry — which helped craft the law through intensive lobbying — has benefited, too.

•Hospitals have faced sizable Medicare payment cuts from the ACA, but those reductions were largely offset by the law's Medicaid expansion and other forms of new coverage.

•Rural hospitals, especially in states that have not expanded Medicaid, have struggled. Admissions also have stagnated. But the largest publicly traded hospitals (and big not-for-profit hospitals) have fared rather well.

•The ACA did not meaningfully touch the pharmaceutical industry's business or patent practices, and those companies have reaped record profits. Pharma stocks over the past 8 years have fluctuated based on sales and new drug approvals, not on anything related to the ACA.

•Medical device companies hate the ACA's device tax, but Congress has already deferred that fee a few times. The device tax hasn't hampered earnings and hasn't led to widespread job losses.

Go deeper: The ACA boom has helped pad the wallets of health care leaders.

McConnell: GOP may take another shot at repealing Obamacare after the midterms

By Felicia Sonmez

Senate Majority Leader Mitch McConnell (R-Ky.) said Wednesday that Republicans may try again to repeal the Affordable Care Act after the November midterm elections, reviving an issue that polls show has swung sharply in the Democrats' favor.

In an interview with Reuters, McConnell said that his party's failure last year to repeal the health-care law, also known as Obamacare, was "the one disappointment of this Congress from a Republican point of view."

"If we had the votes to completely start over, we'd do it. But that depends on what happens in a couple weeks. . . . We're not satisfied with the way Obamacare is working," McConnell said.

Republicans are optimistic about their chances of maintaining control of the Senate next month, while polls suggest that a Democratic takeover of the House is increasingly likely.

The House last May narrowly passed a bill to repeal and replace the Affordable Care Act, with 20 Republicans and every Democrat voting "no." Two months later, a "skinny repeal" effort in the Senate failed by one vote as Sens. John McCain (R-Ariz.), Susan

Collins (R-Maine) and Lisa Murkowski (R-Alaska) opposed the measure. McCain died of brain cancer in August.
Polls show that health care is a top issue for voters, and many GOP candidates have begun campaigning on a longtime Democratic theme — protecting people with preexisting medical conditions — despite the fact that congressional Republicans have voted time and again to repeal the Affordable Care Act, which provides those protections.

A Washington Post-ABC News poll released Sunday showed Democrats hold an 18-point advantage over Republicans on the question of which party voters trust to do a better job of handling health care. Eighty-two percent of respondents cited health care as either "one of the single most important issues" or "a very important issue" in their vote for Congress this year.

Repealing the Affordable Care Act remains popular with the Republican base, however, and McConnell's remarks could be aimed at turning out core voters ahead of next month's election.

Democrats immediately seized on McConnell's comments, with the Democratic National Committee, the Senate Democratic campaign arm, House Minority Leader Nancy Pelosi (D-Calif.) and Senate Minority Leader Charles E. Schumer (D-N.Y.) releasing statements casting them as indicative of Republicans' plans to do away with protections for preexisting conditions should they keep control of the Senate.

"Americans should make no mistake about it: If Republicans retain the Senate, they will do everything they can to take away families' health care and raise their costs, whether it be eliminating protections for pre-existing conditions, repealing the health care law, or cutting Medicare and Medicaid," Schumer said in a statement. "Americans should take Senator McConnell at his word."

Pelosi said Republicans "keep blurting out the truth," while Sen. Brian Schatz (D-Hawaii) said in a tweet that McConnell's statement underscores that Republicans "really are coming after your healthcare."

"I mean like they are no kidding coming after all of it — pre-existing conditions, essential health benefits — mental health, privatizing the VA — Medicare, Medicaid," Schatz said. "They believe that more healthcare equals less liberty or something. In any case we have to vote them out."

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2.7 million Californians don't have health insurance. Can that number go lower?

By Michael Finch II

After a streak of steady declines, California's uninsured rate bottomed out last year with some 2.7 million people still without health coverage.

The latest estimates from the U.S. Census offer a fragmented portrait of the remaining people who are uninsured while posing an even bigger question for the state: How much lower can the uninsured rate go?

According to the Census Bureau, 7.2 percent of Californians were without health insurance in 2017. That's lower than the national average of 8.7 percent.

As open enrollment begins this week, health care experts say it will be difficult for the state to move forward, largely because of California's population of immigrants who don't qualify for Affordable Care Act plans.

Shana Alex-Charles, a health policy professor at California State University, Fullerton, said about 60 percent of Califfornia's uninsured are hampered by their immigration status.

"The other half is people that still say they're caught in the middle, and you get this a lot in San Francisco and Los Angeles," Alex-Charles said.

Last year, the insurance rate fell a modest one-tenth of a point, from 7.3% in 2016. While it's still vastly better than the 16% uninsured rate in 2013 — the year before the Affordable Care Act provided insurance plans to all Americans — there are still millions without insurance.

The slowed progress and challenges from the federal government have led to conversations about universal health coverage.

California offers insurance to all children regardless of their immigration status, and Medicaid also covers adults. A sizable number of people still remain uninsured, including immigrants and many young working-age adults between the ages 26 and 44. More than 400,000 residents who were surveyed in 2016 said cost remains a challenge in spite of generous subsidies, and another 550,000 were not eligible for financial help at all.

“There are always some people on the margins who are harder sells for insurance but they aren’t the same ones each year,” said Peter Lee, executive director for Covered California. “It is absolutely the case that on the margins it is lower-income people and younger people who are less apt to sign up for coverage.”

Shannon McConville, a health care researcher at the Public Policy Institute of California, said even Massachusetts found the goal of providing every resident with health coverage elusive. In a law that went into effect in 2006, the state mandated that residents carry health insurance.

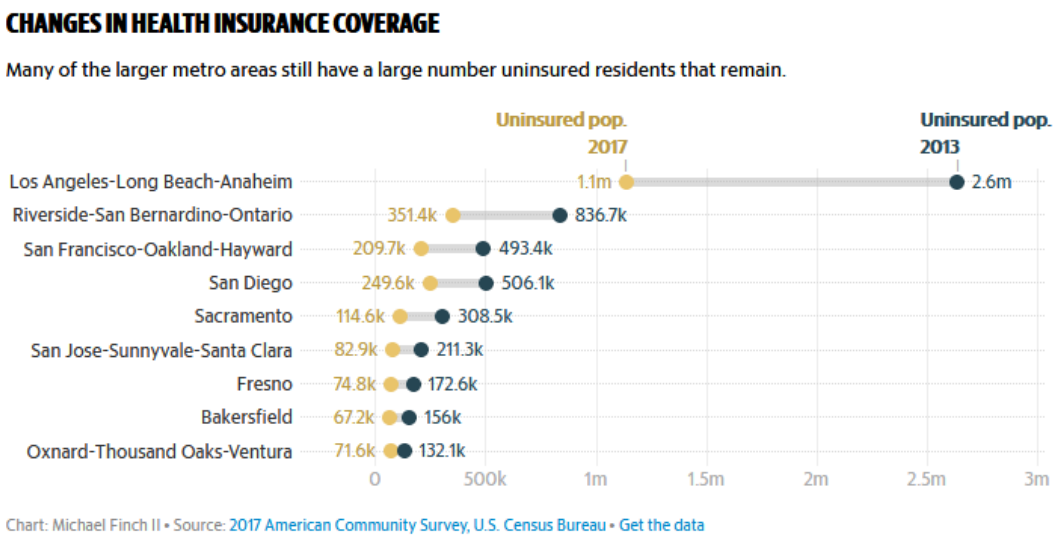
The Affordable Care Act was modeled after Massachusetts’ program, and as of 2017, there were still 190,000 people uninsured — almost 3 percent of the state’s population. “Massachusetts is a good example. They implemented a reform in 2006. They sit right now at the lowest uninsured rate across all the states,” McConville said. “But they still do have uninsured residents.

“To get to 100 percent insurance coverage under current policy seems unlikely, which is why I think at the state level the legislature is trying to explore different options to try and get to universal coverage, but that would require different policies than we currently have,” McConville said.

This question was actually contemplated and debated before the ACA was passed. “The Congressional Budget Office concluded that it will be great and saves the country $1 trillion in about 10 years but it will not cover everybody,” said Alex-Charles. “Even when the Affordable Care Act was as good as it could be, we would have 30 million uninsured.”

In California, there is bipartisan consensus on getting people into whatever coverage they’re eligible for, but many barriers to improvement remain, Alex-Charles said. Perhaps the biggest unforeseen challenge in recent years has come from the federal government, where a new presidential administration has shown little interest in maintaining the benefits of the health law.

Changes in Health Insurance Coverage



“The problem is now in 2017 there was a real shift with the new administration coming in, changing focus from how can we improve and enroll more people to how can we make it more business-friendly,” Alex-Charles said, “and if we lose people that’s fine.”