



# Media Clips

## COVERED CALIFORNIA BOARD CLIPS

Feb. 14, 2019 - Mar. 14, 2019

Since the Feb. 14 board meeting, high-visibility media issues include: Gov. Gavin Newsom further introducing and pushing his administration’s health care ideas in California and a new Democratic-controlled United States Congress doing the same in Washington D.C. and new data is revealing more about the Affordable Care Act marketplaces and more is revealed about the plans of financial heavyweights jumping into health care.

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# News Release

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March 6, 2019

## **New Analysis Finds Leading State-Based Marketplaces Have Performed Well, and Highlights the Impact of the Federal Mandate Penalty Removal**

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- *The report examines the impact that federal and state actions have had on state-based marketplaces and the federally facilitated marketplace (FFM).*
  - *Cumulative premium increases in California, Massachusetts and Washington are less than half of the increases seen in FFM states, but 2019 premium increases spiked in California and Washington compared to Massachusetts, which continued its state-based penalty.*
- 

WASHINGTON D.C. — A new report highlights the benefits of state-based exchanges, particularly in the areas of controlling premium costs and attracting new enrollment. The report, which was produced by Covered California, the Massachusetts Health Connector and the Washington Health Benefit Exchange, found that premiums in these states were less than half of what consumers saw in the 39 states that relied on the federally facilitated marketplace (FFM) between 2014 and 2019.

“The lesson is striking: Consumers are the big winners when marketplaces use all the tools of the Affordable Care Act,” said Covered California Executive Director Peter V. Lee. “The policies underway in these three states are easily transferable, and if applied to the federal marketplace, taxpayers would save billions of dollars in subsidies, and middle-class Americans would benefit from much lower premiums.”

[The joint report](#) examined how state and federal actions affected premiums and new enrollment.

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## State-Based Marketplaces Controlled Premium Growth

The report examined the cost of coverage by comparing the average benchmark premium in three states and the FFM between 2014 and 2019. The weighted average increase in California, Massachusetts and Washington was 39 percent, compared to the 85 percent increase in FFM states.

In addition, the report also found if the FFM states had experienced the same lower premium growth seen in the three states, the federal government could have saved roughly \$35 billion in lower subsidy payments between 2014 and 2018.

While the report did not quantify the increased costs paid by unsubsidized consumers in FFM states, they would have saved substantially and been less likely to have been priced out of coverage.

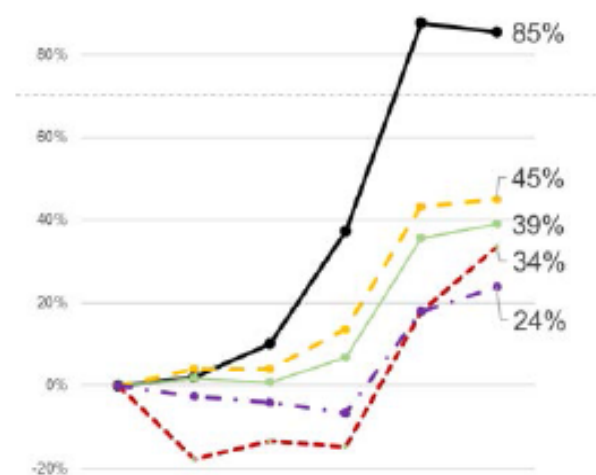
## State-Based Marketplaces Performed Better at Enrolling New Consumers

The report also examined the impact on new enrollment of recent federal decisions on marketing and outreach and the elimination of the individual mandate penalty.

During the final days of open enrollment for the 2017 plan year, the federal administration began a series of cuts to marketing and outreach on behalf of FFM states. These cuts have been deepened and maintained, resulting in a significant reduction in new enrollment in states served by the federal marketplace. The decrease in new enrollment likely means a less-healthy consumer pool, which would lead to the larger premium increases seen above.

From 2016 to 2018, the 39 FFM states saw the number of new enrollees drop from 4 million to 2.5 million, a decrease of 40 percent. By contrast, new enrollment in California, Massachusetts and Washington — states that control their own marketing and outreach — remained relatively stable (see Figure 2: New Enrollment Growth by Marketplace, Comparing 2016 to 2018).

**Figure 1: Average Benchmark Premium Growth by Percentage, Compared to 2014**

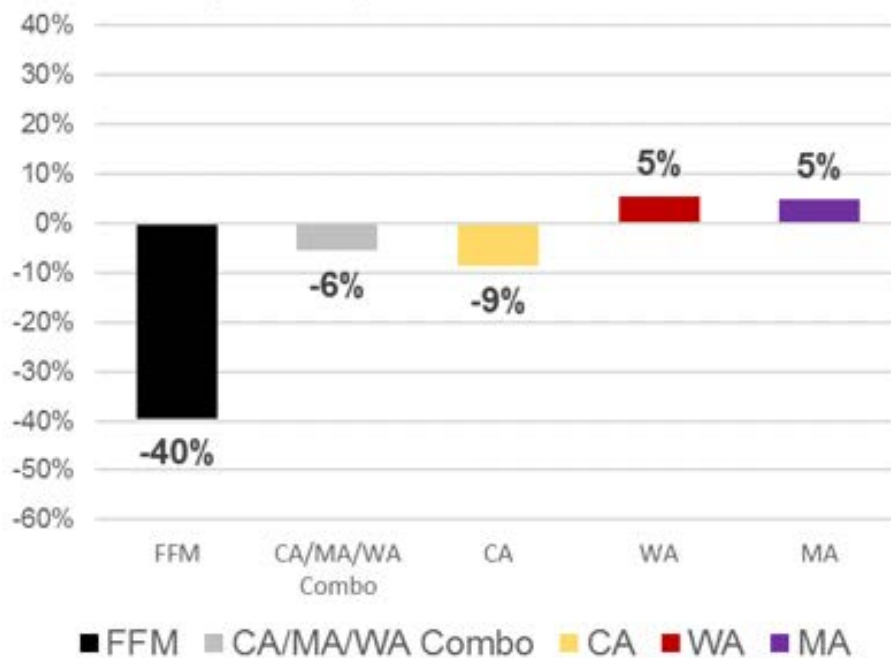


Source: Kaiser Family Foundation.  
<https://www.kff.org/health-reform/state-indicator/marketplace-average-benchmark-premiums/>  
Estimates of cost savings use benchmark premium data. FFM includes SBM-FP states.

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“State-based marketplaces know that health insurance is a product that needs to be actively sold to consumers, and getting the word out is a proven way to promote enrollment,” said Pam MacEwan, chief executive officer of the Washington Health Benefit Exchange. “Enrolling more people means a healthier risk pool, which lowers premiums and saves money for everyone in the individual market.”

**Figure 2: New Enrollment Growth by Marketplace, Comparing 2016 to 2018**

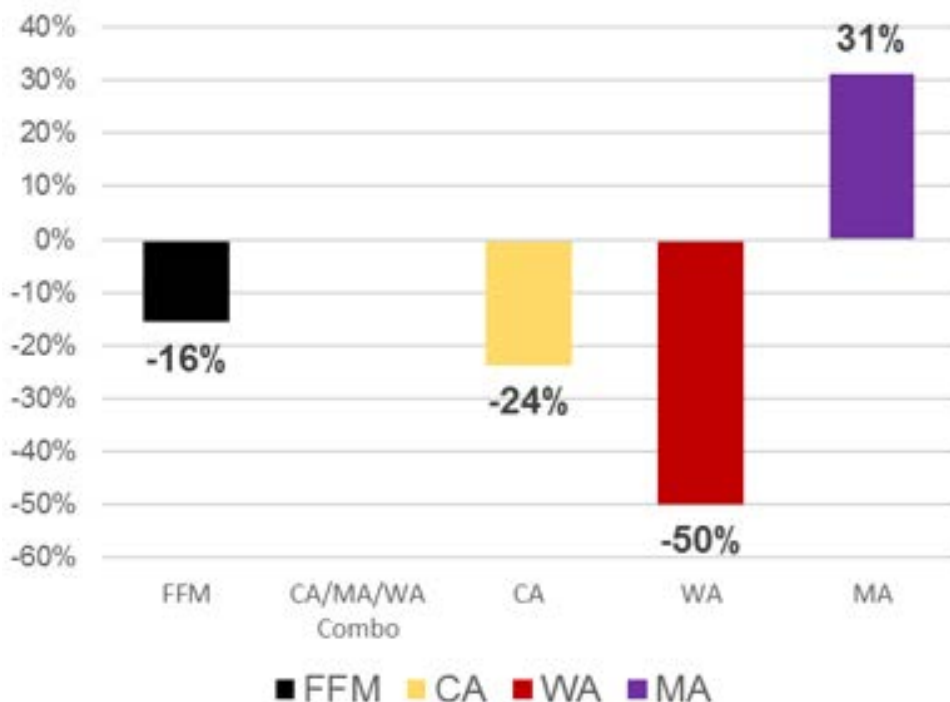


***Clear Indication of the Critical Role of the Individual Mandate Penalty in Promoting Enrollment***

The open-enrollment period that just concluded for the 2019 coverage year marked the first time the marketplaces would operate without a federal individual mandate penalty, which was zeroed out through the Tax Cuts and Jobs Act of 2017 and signed into law by the president. During the most recent open-enrollment period, new enrollment in FFM states dropped an additional 16 percent — on top of the already large drop of 40 percent in the prior two years. California and Washington also experienced steep declines in the number of new enrollees signing up for coverage. However, Massachusetts — which kept a state-level mandate penalty — saw new enrollment increase by 31 percent (see Figure 3: New Enrollment Growth by Marketplace, Comparing 2018 to 2019).

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**Figure 3: New Enrollment Growth by Marketplace, Comparing 2018 to 2019**



“The individual mandate in Massachusetts has proven to be an effective part of our effort to provide access to affordable coverage to everyone,” said Louis Gutierrez, executive director of the Massachusetts Health Connector. “Our experience shows that a mandate that provides incentive to participate, while also delivering important protections and benefits to consumers, plays a vital role not only in people getting covered, but also staying covered.”

Other marketplaces have also instituted a penalty, such as New Jersey and the District of Columbia. While critics may point to lower new enrollment in New Jersey as proof that a penalty is not effective, Lee says that is not the case. “The penalty works, and to solely highlight New Jersey — which had a penalty in place, but also had its marketing and outreach efforts undercut — is not a reasonable comparison.”

“While Washington kept premium increases in the early years of the Affordable Care Act to low single digits, the past three years have seen big increases due to federal policy changes that continue to bring uncertainty to the market, including the zeroing of the individual mandate penalty,” said MacEwan. “In particular, 2019 saw an almost 14 percent premium increase. These premium increases are having a large negative impact on the many Washington consumers who do not benefit from a subsidy.”

The release of the report comes on the same day that leaders of the California and Massachusetts marketplaces appeared before the Health Subcommittee of the U.S.

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House Committee on Energy and Commerce. [View the hearing on “Strengthening Our Health Care System: Legislation to Lower Consumer Costs and Expand Access.”](#)

Read the testimonies of representatives from [California](#) and [Massachusetts](#) at the committee hearing.

### **About Covered California**

Covered California is the state’s health insurance marketplace, where Californians can find affordable, high-quality insurance from top insurance companies. Covered California is the only place where individuals who qualify can get financial assistance on a sliding scale to reduce premium costs. Consumers can then compare health insurance plans and choose the plan that works best for their health needs and budget. Depending on their income, some consumers may qualify for the low-cost or no-cost Medi-Cal program.

Covered California is an independent part of the state government whose job is to make the health insurance marketplace work for California’s consumers. It is overseen by a five-member board appointed by the governor and the Legislature. For more information about Covered California, please visit [www.CoveredCA.com](http://www.CoveredCA.com).

Covered California can be contacted at [media@covered.ca.gov](mailto:media@covered.ca.gov) or (916) 206-7777.

### **About the Massachusetts Health Connector**

The Massachusetts Health Connector is the Commonwealth’s health insurance exchange, and currently provides health or dental insurance to more than 300,000 people. Individuals and small businesses can search for and purchase high-quality, commercial coverage, while reaping the health and financial benefits of being covered. Individuals and small businesses can find health insurance options at [www.MAhealthconnector.com](http://www.MAhealthconnector.com).

For information on the Massachusetts Health Connector, contact Jason Lefferts, director of Communications and Media Relations, at (617) 933-3141.

### **About the *Washington Health Benefit Exchange***

*The Washington Health Benefit Exchange, or Washington Healthplanfinder*, is an online marketplace for individuals and families in Washington to compare and enroll in health insurance coverage and gain access to tax credits, reduced cost-sharing and public programs such as Medicaid. The next open-enrollment period in *Washington* begins on Nov. 1.

The Washington Health Benefit Exchange can be reached at [ben.spradling@wahbexchange.org](mailto:ben.spradling@wahbexchange.org).

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# News Release

March 14, 2019

## Covered California Details Efforts to Lower Costs While Improving the Quality of Care

- *A new report provides a first glimpse at the results of Covered California's commitment to quality care, accountability and delivery reform.*
- *A national quality-rating system shows Covered California consumers are getting the right medical care at the right time and that care is getting better.*
- *Covered California plans are also improving in how effectively they treat chronic conditions like diabetes and high blood pressure, in addition to reducing hospital-acquired infections and unnecessary cesarean sections.*

SACRAMENTO, Calif. — Covered California released an extensive report, "[Covered California's Efforts to Lower Costs While Ensuring Consumers Get the Right Care at the Right Time](#)," to provide a first look at the results of its efforts to assure those enrolled get quality care and that contracted plans work to lower costs throughout the delivery system. The initial analysis shows that Covered California's health plans are making steady progress in improving quality and safety, which in turn helps keep health care costs down. The report also detailed the progress contracted plans have made in increasing their efforts to "pay for value."

"Covered California is committed to going beyond just getting people health care coverage — we want to make sure consumers are getting the quality care they need," said Covered California Executive Director Peter V. Lee. "This report shows that Covered California is working to fulfill its mission of not only providing better care, but also changing the delivery system so that it consistently delivers healthier outcomes at lower costs for all Californians."

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Covered California’s efforts are part of its contracts with health plans that set standards and requirements for quality improvement and delivery system reform. The contracts have been in place since Covered California first opened its doors in 2014 and are currently being revised for the 2021 plan year.

“By implementing standards and requirements, Covered California is working to address the underlying costs of health care,” Lee said.

### **Ensuring Patients Receive Quality Care at the Right Time**

Among the findings in the report is that Covered California plans continue to improve in providing quality care. A global quality-rating system (QRS) score summarizes 42 different measures and shows how our plans compare on helping members get the right medical care and on member-reported experiences of care and service.

In 2016, six of the products from Covered California’s plans earned a rating of one or two stars, while only two products received four or five stars. By 2018, all 14 of the individual products from Covered California’s 11 health plan issuers earned a rank of three stars or better, with five products earning four or five stars (see Table 1: Global Quality Rating by Reportable Products for the California Individual Market.)

<b>Table 1. Global Quality Rating by Reportable Products for the California Individual Market</b>						
<b>QRS Year</b>	<b>★</b>	<b>★★</b>	<b>★★★</b>	<b>★★★★</b>	<b>★★★★★</b>	<b>No. of Products with No Global Rating*</b>
2018	0	0	6	3	2	3
2017	0	2	6	1	1	4
2016	0	6	2	1	1	4

\* There is no global rating if a newer product that is ineligible for reporting, or has insufficient sample sizes to report results, for at least two of the three summary indicator categories.

In addition, the report details how Covered California’s plans have shown steady improvement in controlling chronic conditions such as diabetes and high blood pressure.

### **Improving Hospital Patient Safety**

Covered California is also working to align its efforts with other initiatives to increase the number of hospitals that take advantage of collaborative programs to improve quality and safety at their facilities. Infections acquired during a hospital stay are a leading cause of injury and death in hospitals and can be extremely costly because they create complications that extend the length of the hospitalization.

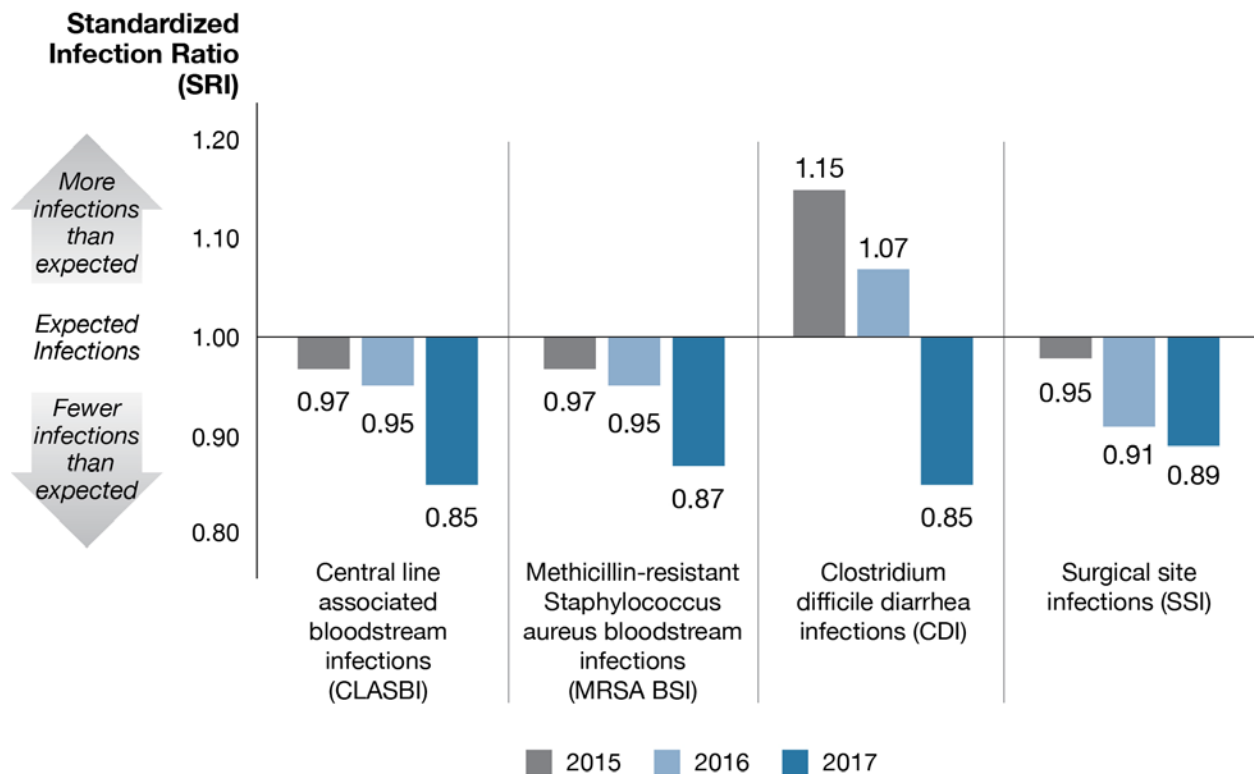
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Health care-acquired infections are reported as a Standardized Infection Ratio (SIR), a risk-adjusted measure managed nationally that compares observed versus expected number of events per year. A score of 1.0 means a hospital has an expected rate of infections. Below 1.0 is better and above is worse.

The following table shows five hospital-acquired infections (catheter-associated urinary tract infection, or CAUTI; central line-associated blood stream infections, or CLABSI; methicillin resistant staph, or MRSA; clostridium difficile bacterial infection, or C. diff; and surgical site infection of the colon surgery, or SSI Colon) that are linked to avoidable harm and hospital deaths.

As of 2018, virtually every hospital in California has joined collaborative efforts to improve safety performance, and the California Department of Public Health reports significant reduction in complication rates (see Figure 1: Health Care-Associated Infection Incidence in California Hospitals, 2015-2017).

**Figure 1: Health Care-Associated Infection Incidence in California Hospitals, 2015-2017**



### Matching Consumers With a Primary Care Clinician

Ensuring that people get the right care at the right time is enabled by giving consumers access to a provider who can guide them through a health care system that can be fragmented and complicated.

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In January 2017, Covered California became the first purchaser to require that all of its consumers, in both PPOs and HMOs, be matched to a primary care physician or other primary care clinician. The purpose of the requirement was to bring the physician match to the PPO environment and give consumers a single point of contact who would help them navigate their health care system.

Within a year, virtually all of Covered California's enrollees, 99 percent, had either selected or been matched with a primary care physician, which was nearly a 30 percentage point increase from the 2016 baseline rate of 70 percent. Covered California believes this primary care physician match will ultimately help people get better access to care in a timelier manner.

"While Covered California's initial efforts show steady improvement, the positive start only represents the beginning of the journey," Lee said. "Covered California's process is anchored in analyzing the best evidence available nationally and understanding how we can align our efforts with other purchasers to provide better quality, safer care and lower costs."

In addition to these improvements, Covered California's report also detailed improvements in promoting enrollment in Accountable Care Organizations and patient-centered medical homes, as well as achieving value in drug spending and increasing access to telehealth services and consumer support tools.

[Read the full report here.](#)

### **About Covered California**

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# POLITICOPRO

## **Newsom keeps Brown appointees on Covered California board**

Angela Hart

Feb. 28, 2019

Gov. Gavin Newsom announced Thursday he has reappointed Sandra Hernández and Jerry Fleming to the board of directors for Covered California, the state health insurance exchange.

Both were first appointed last year by former Gov. Jerry Brown.

Hernandez, 61, of San Francisco, is also president and CEO of the California Health Care Foundation. Fleming, 67, of Walnut Creek, previously served in key leadership positions at the Kaiser Foundation Health Plan, including as senior vice president for health reform implementation and policy.

Both are Democrats. Their appointments require Senate confirmation.

# POLITICOPRO

## **Californians who lose Medi-Cal would be auto-enrolled in Covered California under new bill**

Angela Hart

Feb. 14, 2019

Californians who lose Medi-Cal coverage would be automatically enrolled in Covered California under a new bill by state Sen. Melissa Hurtado (D-Sanger).

CA SB260 (19R), introduced Tuesday, is aimed at preventing gaps in care by encouraging people who lose coverage to sign up for a plan in the individual market.

It's not uncommon for Medi-Cal enrollees to churn in and out of the low-income health program as they gain or lose employment. Under S.B. 260, patients who lose Medi-Cal would be automatically enrolled in Covered California's silver-tier health plan, which has a \$2,500 annual deductible for individuals and \$5,000 for families, and out-of-pocket maximums of \$7,550 and \$15,100, respectively.

The coverage would pick up once enrolled. Consumers could choose to opt out, but if they want to keep coverage, they'd have more time to pay their first premium. Currently, patients have 10 days to enroll in alternative coverage if they're dropped from Medi-Cal. Hurtado's bill would prohibit the first bill from being due before the 30th day of the first

month of enrollment. If people get injured before they pay, their coverage would be retroactive.

"When someone loses Medi-Cal, they don't have enough time to enroll in a Covered California plan that will start when their Medi-Cal ends," said Jen Flory, a lobbyist for the Western Center on Law and Poverty, in a statement. "This legislation will help ensure consumers don't face gaps in coverage just because they start earning a little more money."

Under another provision in S.B. 260, health plans and insurers would have to notify Covered California when consumers lose coverage. The health exchange would then inform them of "potential financial assistance," according to the nonprofit advocacy group Health Access California, a co-sponsor of the bill along with the Western Center on Law and Poverty.

## The New York Times

### **How Much Will Americans Sacrifice for Good Health Care?**

Editorial Board

Feb. 16, 2019

It's been nearly 10 years since the passage of the Affordable Care Act — one of the most sweeping health care overhauls in the nation's history. The law has brought the number of uninsured people in America to an all-time low, secured protections for people with pre-existing conditions and advanced the notion that health care is a human right.

But the system was never perfect, and its fractures and stress points have become too great to ignore. The number of people who are uninsured or underinsured is rising again, after two years of sabotage to the current law by the Trump administration. A Republican-led lawsuit that once seemed like a lark is threatening Obamacare's protections for pre-existing conditions. And high out-of-pocket costs, absurd hospital billing practices and ever-rising prescription drug prices have forced too many people to skip crucial treatments, avoid emergency rooms and ration life-sustaining medications.

America may be a country rich in medical innovation — a place where robots perform surgery — but it's also one where tens of thousands of people die every year because they can't afford basic care.

Both parties seem certain to make health care a significant election issue over the next two years. There are no fewer than six Democratic bills floating through Congress that would address these problems. And "Medicare for all" — a concept that describes only some of those proposals — has become both a rallying cry and a test of progressive credentials.

Voters, however, appear more ambivalent. Though health care has long topped the electorate's list of concerns, including in the 2018 midterms, surveys suggest that most Democrats want their party to focus on fixing the Affordable Care Act rather than on starting a long-shot bid for a single-payer health care system. In a recent Kaiser Family Foundation poll, some 56 percent of Americans, including nearly a quarter of Republicans, supported the idea of a new federal program; but when trade-offs like higher taxes or the loss of private insurance options were factored in, that support evaporated.

As the 2020 race heats up, here's a primer to help citizens sort out where they stand.

What are the options?

The plans currently in play differ in their particulars: Senator Bernie Sanders's Medicare for All Act would scrap private insurance and create a new federal system to cover everyone; a plan from the Center for American Progress, a think tank, would create an optional public program that anyone could buy into; and a plan from Senator Debbie Stabenow would give all Americans the option to buy into Medicare when they turn 50. But these plans would extend coverage to more people and would increase the federal government's role in providing and policing health insurance.

The proposals fall into two broad categories: universal and incremental. On the universal side, Medicare for all would largely eliminate the need for private insurance and for other public programs like Medicaid and the Children's Health Insurance Program. Its coverage would also be more expansive than current Medicare: It would include eye and dental care as well as prescription drugs, and it would eliminate premiums, deductibles, copays and surprise medical bills.

A single federal payer — as such proposals envision — may well eliminate the waste, inefficiency and corruption that make the current system so expensive and inaccessible; the experience of countries like Canada and Britain that rely heavily on one government payer suggests as much. But such a system would require dramatic changes from the status quo and would be a tough political sell. What's more, single-payer is not the only way to achieve universal coverage.

On the incremental side, several different proposals would allow certain people to buy into existing public plans. Some would enable older Americans who are not yet eligible for Medicare to buy into that program — at age 50 or 55 or 60. One would let people who don't have other insurance coverage buy into Medicaid (as long as their state opted into the program).

Because these programs don't rely on a single payer, they would not do as much to clean up the existing system. But they have a better chance of being adopted by Congress, and some could bring the country very close to achieving universal coverage.

What would happen to private insurance?

A recent Kaiser poll found that the potential loss of private insurance was what turned most people off the concept of Medicare for all. That's not surprising. About half of all Americans — some 156 million people — get their health insurance through employer-based plans, and another 30 million rely on other forms of private coverage, including the A.C.A. marketplace and Medicare Advantage plans. The vast majority of those people say that they like their coverage. And so far, the majority of Americans seem loath to give up what they have, no matter how good the alternative is made to sound.

That's too bad. The idea of forcing more than half the country off existing programs might sound scary, but the majority of those people are at constant risk of losing their health coverage — for instance, if they lose or leave their jobs, if their employers change plans or if their insurers change their terms in ways that increase out-of-pocket costs.

Still, the choice between universal health care and private insurance will very likely prove to be a false one. Most of the six plans leave ample room for private options to play a role, and the ones that don't — the true Medicare for all proposals — will almost certainly change as they are negotiated. As Vox points out, no other country has managed to achieve universal health care without including some form of private insurance.

Who pays?

Proponents of Medicare for all say that total health care spending would remain roughly the same, but that more of that spending would be shouldered by the federal government and less of it would be wasted.

A single-payer system would mean fewer administrative costs. Eliminating other government programs would free up billions of dollars for the new plan. And eliminating private insurers would bring billions more dollars worth of profits and employer taxes back into the health care system. (Businesses currently enjoy a tax break on the money they spend covering their employees.)

But there would also be new taxes. Proponents say that, to the extent those taxes fell on consumers, they would be offset by the elimination of premiums, deductibles and copays. But that may not be enough to assuage voters. In Vermont and Colorado, legislators dropped bids for a state-run single-payer system when it became clear that people would not support the tax increases needed to sustain such a program.

Taxes are not the only trade-off. Increased efficiency and less profiteering should mean that more people would be covered and could afford the care they needed. But a single-payer system could also mean the elimination of many thousands of health care jobs and lower pay for providers, both of which could impede access to, and the quality of, care. Those impediments could be small — slightly longer wait times, for example. Or they could be substantial — much longer wait times and far fewer doctors.

What would be covered?

There are two basic ways for insurance programs to curb costs. One is to cover fewer things; the other is to negotiate on prices.

Medicare for all would forgo the first option, meaning that it would cover everything. But it would use the massive bargaining power of so many users — the entire United States population — to negotiate far better deals on prescription drugs, hospital stays and more. The different incremental programs would use both levers: Most would not cover vision or dental, for example. But all of them would also direct the secretary of health and human services to negotiate costs with providers.

Most other countries use negotiating power to control health care costs; that's why prescription drugs cost so much less elsewhere than they do in the United States. But those countries accept a trade-off, inherent in this approach that the United States has so far resisted: They forgo access to certain innovations, like pricey new drugs and medical devices whose benefits are found to be minimal.

A plan that results in higher taxes but skimps on cutting-edge medicine may seem unfair — and may well be unpopular. But many Americans are already being denied essential services every day. It may make sense to forgo innovations that a growing number of people can't benefit from anyway in exchange for a program that sets fair prices at the outset and doesn't leave people rationing low-tech essentials or begging for donations to cover basic costs.

The fight to once again remake American health care will almost certainly be brutal. Before voters can decide if they want to have that fight, candidates will need to clarify what they are selling. Only then can the nation have an honest dialogue about the risks, benefits and trade-offs ahead.

The logo for the Los Angeles Times, featuring the words "Los Angeles Times" in a white, serif font on a dark rectangular background.

## **Courts hammer Trump for sabotaging Obamacare, in rulings that could cost the Treasury billions**

Michael Hiltzik

Feb. 19, 2019

Legal experts thought that one of President Trump's cruder attacks on the Affordable Care Act would come back to bite him once the courts took a crack at it.

Court rulings have flooded in over the last few weeks, and the experts are right. The cost to the government could be \$12 billion a year, payable to health insurers who were cheated by Trump's action. That's not chump change. As Nicholas Bagley of the University of Michigan wrote this week, "Insurers could buy us a damn border wall every year with that money."



The most recent beneficiary of a court judgment is the Los Angeles insurer L.A.Care Health Plan, which was awarded nearly \$6 million on Feb. 14 by Judge Thomas C. Wheeler of the Court of Federal Claims. Observing that the money was promised by the ACA and that Trump had no right to stiff the insurers, Wheeler wrote that “L.A. Care should not be left ‘holding the bag’ for taking our Government at its word.”

The money is the so-called cost-sharing reduction written into the ACA. It was designed to cover a subsidy made available to buyers of ACA exchange plans with household income below 250% of the federal poverty limit, or \$63,125 this year for a family of four. Those buyers receive not only a subsidy to reduce their insurance premiums, but also an additional subsidy to reduce their deductibles and co-pays.

There are a couple of differences. One is that the premium subsidies are paid to the customer, but the CSR is paid to the insurer, which is required by law to give its enrollees the cost-sharing reduction regardless of whether it’s repaid by the government.

Another is that although Congress specifically appropriated funds for the premium subsidies in the ACA, it didn’t do so for the cost-sharing break. Conservatives in Congress argued that this meant the insurers were out of luck if the government decided to stiff them. And that’s exactly what Trump did when he canceled the CSR in 2017.

Many experts predicted that this wouldn’t work, since creditors armed with a government promise to pay could go to the Court of Federal Claims, which has the power to order the government to pay up even when Congress hasn’t appropriated the necessary funds. (The payments come from a separate Judgment Fund, a permanent, uncapped fund established for claims such as these.)

So far, more than 90 insurers, including scores brought into court as part of a class-action lawsuit, have won their cases before the Court of Claims. The rulings are coming from Wheeler and his bench colleagues Margaret M. Sweeney, who decided the class-action case on Feb. 15, and Elaine D. Kaplan, who ruled in a Montana case in September. As Bagley observed, “None of these judges bought the Justice Department’s rationale for refusing to pay. And good reason: it’s garbage.”

What’s most interesting about these rulings, the experts say, is that they apply to expenses that the insurers essentially worked their way around in 2018, through a maneuver known as “silver loading.”

Essentially, the insurers calculated their potential losses from the CSR suspension, then raised their premiums for benchmark silver ACA plans to cover the losses. This was done with the agreement of state regulators, including Covered California, which oversees ACA plans in that state.

Because the benchmark plan also sets the level of premium subsidies for all ACA plans, this turned out to be a boon to millions of ACA buyers — the subsidies increased to the point that they made higher-benefit gold and platinum plans cheaper and, in many cases, made lower-benefit bronze plans free for buyers. The U.S. Treasury ended up eating the higher cost.

Indeed, as David Anderson of Duke University points out, Trump’s attempt to damage the ACA “strengthened the market instead as subsidized buyers earning between 200-400 percent of the Federal Poverty Level are seeing tremendous discounts, the best discounts.”

It was as if a slingshot ball Trump aimed at Obamacare ricocheted back and hit him between the eyes.

Silver loading made Trump’s suspension of the CSR a non-issue for ACA insurers in 2018 and later, since the cost of the subsidy was henceforth covered by the higher premiums.

But that brings us to another wrinkle in the latest court rulings. For the most part, the judges say that it doesn’t matter that the insurers worked around the lost cost-sharing reimbursements — the federal government owes them that money anyway, year after year. That’s the source of the \$12-billion annual estimate.

“Nowhere in the legislative history, statutory text or implementing regulations,” Wheeler wrote in the L.A. Care case, “are CSR payments subject to alteration based on the availability of offsetting funds derived from premium increases permitted by state regulators.”

Sweeney evidently agreed, for in the class-action case she ruled that the plaintiffs could recover their CSR payments for 2018 even though the government pleaded that allowing the insurers to recover costs that they had mitigated through higher premiums would give them “an unwarranted windfall.” Sweeney says she was “not convinced” by the argument.

As it happens, it may not be the insurers that reap the benefit, but their customers. That’s because the ACA sets limits of up to 20% on the gross profits that insurers can earn from the ACA plans and requires them to rebate the excess to the customers. As ACA expert Charles Gaba observed, this rule has been “extremely successful” — by 2016 it had resulted in nearly \$4 billion in rebates, and could result in \$10 billion to \$12 billion in annual CSR payments flowing directly to the consumers.

That may be too much to hope for. The government is likely to appeal the Court of Claims rulings, and the idea that the insurers should keep getting paid even though they’ve stopped incurring CSR costs is likely to be a main point of attack.

But it still shows that there was a silver lining, so to speak, in the Trump administration’s assault on the Affordable Care Act — although some of its sabotage was effective,

some of its moves were so incompetent that they ended up helping the very consumers Trump was trying to harm. If he and his minions weren't such boobs, things might have been much, much worse.



### **Government headed for close to half of nation's health tab**

Ricardo Alonso-Zaldivar

Feb. 20, 2019

WASHINGTON (AP) — Even without a history-making health care remake to deliver “Medicare-for-all,” government at all levels will be paying nearly half the nation’s health care tab in less than 10 years, according to a federal report released Wednesday.

The government growth is driven by traditional Medicare, which is experiencing a surge in enrollment as aging baby boomers shift out of private coverage, according to the analysis from the Centers for Medicare and Medicaid Services, part of the U.S. Department of Health and Human Services.

Federal, state and local governments will be paying 47 percent of the nation’s health care costs in 2027, up from 45 percent currently, the report said.

The report did not consider the potential impact of “Medicare-for-all” national health insurance plans from Democratic presidential candidate Bernie Sanders and other liberals. Nor did it delve into a financial rescue of traditional Medicare that could become a pressing political priority for all sides in just a few years. Medicare’s trustees have said the program will be insolvent in seven years, when its giant trust fund for inpatient care won’t be able to fully cover expected medical bills.

Spelling out the economic consequences of current laws and policies, the report serves as a reality check on the political debate over health care. That debate ranges from President Donald Trump’s warnings about lurking “socialism” to the suggestion from Sen. Kamala Harris, D-Calif., a 2020 contender, that the U.S. can simply “move on” to a new taxpayer-financed system that would cover all Americans.

“To the extent that a Martian landed and saw how much of the American health care system is funded by the government, it’s been about 50 percent for some time,” said economist Paul Hughes-Cromwick of Altarum, a nonprofit research organization.

The report projected that U.S. health care spending will surpass \$5.9 trillion in 2027, growing to represent more than 19 percent of the economy. Health care spending is expected to increase somewhat more rapidly than overall economic growth from 2018 to 2027, underscoring an ingrained affordability problem for government, employers and U.S. households.

Rising prices for health care goods and services are expected to account for nearly half the spending growth, said the report, with the rest driven by a mix of factors, including an aging population and more intensive use of services. “The baby boom generation is expected to shift from private health insurance coverage to Medicare coverage during the projection period,” said Andrea Sisko, an author of the report.

Some experts have called attention to higher U.S. prices as a chief reason for the disparity in medical costs with other economically advanced countries.

Spending on prescription drugs is expected to pick up again after a recent slowdown, averaging about 6 percent a year from 2020 to 2027, the report found.

The nation’s uninsured rate was expected to remain relatively stable, hovering around 10 percent.

For politicians, the numbers are a double-edged reality check.

Trump’s warnings about “socialism” are undercut by the fact that much of the health care system is already paid for by the government. For Democrats contemplating a system fully funded by government, the trillions of dollars in new government spending that would entail are detailed in the report’s tables.

The report was published online by the journal Health Affairs.



## **New Details of Amazon, Berkshire Hathaway, JPMorgan Health Venture Emerge in Court Testimony**

Jon Kamp and Anna Wilde Mathews

Feb. 20, 2019

BOSTON—A health-care joint venture launched by Amazon.com Inc., AMZN -0.14% Berkshire Hathaway Inc. and JPMorgan Chase is looking at how to redesign health insurance, among other efforts, according to newly unsealed court testimony from an executive at the health startup.

The three companies announced the venture last year with stated goals of trying to improve health care and rein in costs for their employees. The still-unnamed venture has released few specifics, however, about its long-term aims.

Chief Operating Officer Jack Stoddard shed some light while testifying in federal court in Boston late last month. He was there for a hearing in a lawsuit filed by UnitedHealth Group Inc.'s Optum health-services unit, which aims to stop a former employee from working for the new venture.

In testimony unsealed Wednesday, Mr. Stoddard said the venture is focusing on the complexity of health insurance and asking if it can "reinvent what insurance looks like in terms of benefit design?" He said workers are often confused about what their plans cover. Employers could try different approaches and see what works, he suggested.

A spokeswoman for the venture declined to comment.

The newly unsealed testimony added some details to remarks Mr. Stoddard had made in open court while describing the venture, which he said is focused on helping its three founding companies' more than 1.2 million workers.

Mr. Stoddard had testified that the venture will be deploying smaller-scale tests of ideas like making primary-care access easier, or maintenance drugs cheaper. If these ideas work, they could be scaled up among the venture's owners.

One goal is to bolster the importance of primary care, he said in the newly public testimony.

The venture wants to "make it easier for doctors to do good care and to spend more time, not less time" providing care, he said.

Optum, which owns medical groups around the country, could be a good partner, Mr. Stoddard testified.

The new health venture had sought to keep part of Mr. Stoddard's testimony private. U.S. District Court Judge Mark Wolf ruled on Wednesday that a full transcript should be released, siding with a motion brought by Dow Jones & Co. Inc., publisher of The Wall Street Journal, and Boston Globe Media Partners LLC.

Mr. Stoddard said the startup is initially focused on analyzing data to "understand where there's variation in care, quality, where prices don't match value, where doctors are performing."

The venture also is looking at pharmacy costs, Mr. Stoddard testified, but has no plans to compete with existing pharmacy-benefit managers. Optum owns one of the largest PBMs.

“But we will look and say, could we contract with one of them to get more transparency?” Mr. Stoddard said.

Optum argues the three-company venture, known as ABC in court documents, is a rival and that former employee David W. Smith is bound by a noncompete agreement. Mr. Smith and ABC say they aren’t aiming to directly compete with Optum, which sells a variety of health-related services to employers and others.

Mr. Stoddard also has said the venture doesn’t have any products and is working on partnering with companies that can offer them. But the venture could consider building them if it doesn’t find what it needs in the market, he has said.

Judge Wolf hasn’t yet ruled on an Optum request for a temporary restraining order aimed at barring Mr. Smith from working for his new employer or sharing trade secrets. In a recent two-day court hearing, the judge sought testimony to help understand the venture’s scope and goals.



## **California’s Individual Mandate: A Fix For A Broken System? Or A Penalty On The Poor?**

Sophia Bollag, Michael Finch II and Sammy Caiola

Feb. 21, 2019

When Kate Green, calculated her health care costs last year, it just didn’t add up for her to stay insured.

The 30-year-old worker in a real estate referral company had signed up for the lowest-cost plan possible, but it came with high out-of-pocket costs. Premiums ate up money Green had planned on spending to pay off car and college loans. The final straw: a \$1,200 doctor bill for a minor knee injury. Green dropped her coverage in late 2018, and the tax penalty for not having insurance disappeared this year for the first time since the launch of the Affordable Care Act. So far, she hasn’t regretted the gamble.

“If I have a life-threatening injury and I get taken to the hospital in an ambulance, yes, right now I’d have hundreds of thousands [in] bills,” the Sacramento resident said. “And if I was insured it might be like tens of thousands. It’s bankrupting me effectively either way.”

When the federal Affordable Care Act first took effect in 2014, Americans had to pay a penalty known as the individual mandate if they didn't have insurance. Congress has since rolled back the penalty, meaning Green won't be fined for not having coverage.

But that could change if California Gov. Gavin Newsom recreates the individual mandate at the state level as part of his plan to prop up the state's health insurance exchange and get more people insured.

Newsom and his legislative allies say they want the state-level mandate to work the same way as the federal one. The goal is to encourage enough healthy people to buy coverage to offset costs from those who need expensive care.

Newsom characterized the mandate as necessary to stabilize the health care system under the Affordable Care Act in the face of the federal government's "vandalism" of the law.

"You need that stability of the mandate because that increases the purchasing pool, which lowers your cost," Newsom said last month when outlining his budget proposal. "Every single person in California should be celebrating that."

Assemblyman Rob Bonta, D-Alameda, is carrying a bill that would implement the governor's vision. "We want as many people participating in the health care market as possible," Bonta said.

The Newsom administration estimates the penalty would generate about \$500 million each year. Newsom wants to earmark that revenue to fund insurance subsidies for what he calls "middle-income" families — individuals earning between \$48,560 and \$72,840 or a family of four with a household income of less than \$150,000.

In a report last week, the nonpartisan Legislative Analyst's Office said the mandate could be "one of the state's most effective policy options" to increase the number of insured Californians and lower coverage costs by using the threat of a penalty to increase the pool of healthy people paying into the system.

But the LAO also cautioned that the individual mandate's goal of getting more people to buy insurance is "at odds with the goal of raising revenue for insurance subsidies." That's because as more Californians sign up for insurance, fewer people will pay the penalty, generating less money.

People who fall below a certain income threshold wouldn't have to pay a penalty under Newsom's plan. But the mandate would still disproportionately affect people in lower- and middle-income tax brackets, according to an analysis by the USC Center for Health Journalism Collaborative.

Almost 600,000 Californians paid a penalty in 2016, the most recent year for which data is available. Nearly three in four of those Californians earned less than \$50,000 in gross income, IRS data shows.

In 2016, the penalty was \$695 per adult or 2.5 percent of yearly household income, whichever was higher.

Congressional Republicans and President Donald Trump argued it was unfair to penalize people for choosing not to have insurance when they rolled back the individual mandate in 2017.

The mandate isn't popular among California Republicans either. State Sen. Andreas Borgeas said it would prop up the existing patchwork system.

"We're putting gum and MacGyvering Band-Aids on this system," the Fresno Republican said during an event at the Sacramento Press Club last week. "It needs to be redone and reviewed top to bottom."

Even for Democrats, who have supermajorities in each chamber of the Legislature, voting for the individual mandate could be a heavy lift. Lawmakers in vulnerable districts are often targeted if they vote for taxes. Last year, Democratic state Sen. Josh Newman of Fullerton was recalled after he voted to increase California gas taxes.

Taxes also typically require a higher threshold for passage in the California Legislature: a two-thirds supermajority instead of the simple majority required for most bills. The Newsom administration says it believes its individual mandate proposal will require only a majority because it would simply reimpose the federal penalty at the state level. Bonta said that when it comes to his bill, that will be up to the Legislature's lawyers to decide.

If the state doesn't take action, as many as 450,000 more Californians will be uninsured in 2020 than if the federal government had left the individual mandate in place, according to a recent analysis by researchers at UC Berkeley and UCLA.

While some celebrate plans to shore up the finances of California's individual health care market with a state penalty for going uninsured, Green, the woman who dropped her insurance, isn't among them. Even with additional subsidies, the mandate would still hurt people who have trouble affording insurance, she said.

"I think the idea of penalizing people for not being able to afford health insurance is kind of counterintuitive," Green said. "You already can't afford it, and here, let's charge you more money."





## **Trump's under-the-radar \$1 abortion bill idea: Will it undermine Obamacare in California?**

Elizabeth Aquilera

Feb. 24, 2019

A little-noticed Trump administration proposal aims to force California's health exchange insurers to send all their customers a second premium bill every month, for \$1 —the amount the state requires to cover unrestricted abortion benefits.

The Resistance State, unsurprisingly, is pushing back. State officials fear that many Californians insured through the Covered California exchange will be confused about receiving a second monthly bill, and may even neglect to pay it, putting their coverage at risk. And the insurers warn that the cost and labor involved in sending multiple bills for 1.5 million people could drive up the cost of their premiums.

"We believe these rules are unnecessary," Peter Lee, director of Covered California, said during a board meeting last month, explaining why the agency sent a letter challenging the proposed federal rule change. "Our plans are segregating funds. There's not one penny of federal dollars being spent on abortion related services in California."

The reason for such segregation: Federal programs, including Affordable Care Act (Obamacare) insurance plans receiving federal subsidies, only allow abortion coverage in cases of rape, incest or if the mother's life is in danger, as outlined in the Hyde amendment. Conversely, California law requires insurers to include abortion services in all health care plans—an extra cost which Covered California insurers now collect by factoring an extra dollar in to the total of a customer's existing monthly bill.

That's not enough, the Trump administration contends.

"The administration is committed to making sure taxpayer dollars are spent appropriately," said Seema Verma, administrator for the Centers for Medicare and Medicaid Services, which is overseeing this proposed change. Her statement added that the goal is simply to enforce existing laws that require "separate" billing for abortion services.

Critics see the \$1 abortion bill idea as another Trump attempt to undermine Obamacare and abortion services.

“This policy can only be understood as an attempt to impose an arbitrary political penalty on states offering non-Hyde abortion services,” Blue Shield of California wrote in its opposition letter to the federal government.

Last year the Trump Administration eliminated the financial penalty Obamacare levied on Americans who disregarded the federal mandate requiring people have health insurance—prompting California Gov. Gavin Newsom to recently propose a state mandate and state penalty. And in recent days, the Trump administration published its final draft of a rule that will prohibit any organization that provides or refers patients for abortions from receiving any funding from Title X, the federal program that provides birth control and other health services.

In November, the U.S. Department of Health and Human Services published the proposed change in the Federal Register. It would require that consumers not only receive two separate bills via paper mail or email every month, but that customers make two separate payment transactions every month.

The agency said it needed to ensure that no premium payments or federal credits are being used for prohibited abortion services, and to ensure the funds are being kept separately.

In Covered California’s letter, Lee asked the department to reconsider—warning that the change would trigger consumer confusion, decrease enrollment and impose a burden on insurers.

“People are not going to understand why that’s happening,” added Gary Cohen, vice president for government affairs at Blue Shield of California, among the insurers that would be affected by the proposed change. “It’s singling out this one procedure, abortion services, for reasons that have nothing to do with health care for women.”

Blue Shield estimates that customers’ delinquency rates could shoot up 40 to 60 percent, which would in turn delay payments to medical providers.

The nonprofit insurer argued in a letter to the federal government that it already has a system in place that segregates abortion fees from federal program dollars, and predicted that the substantial costs involved in sending out double bills and replying to bewildered customers could lead to increased premiums. Blue Shield has 435,000 members in Obamacare plans.

For Blue Shield, the cost could be \$4 to \$6 million to implement and about \$900,000 monthly, Cohen said.

Opponents of the federal idea also fear that some Californians in the insurance exchange who are against abortion may disregard the separate \$1 monthly bill—which could lead to them losing their health coverage.

“If the opposition is all about choice, then the insured individuals should be made aware of their premium— even a small amount of it being utilized for abortions,” said Wynette Sills, director of Sacramento-based Californians for Life, which opposes abortion. “Over time, the discussion could be raised about people’s choice in the matter.”

Sills said the new bill should indicate what the payment is for. Currently, Blue Shield’s monthly bills note: “A portion of this invoice includes the amount necessary to cover services required to be segregated under Section 1303 of the federal Affordable Care Act.”

The federal government is reviewing public comment and expected to make its decision in the next few months. If it does change adopt the rule, Covered California has asked that the start date be pushed to after the 2020 enrollment period to give insurers time to put the system in place.

Open enrollment for Covered California ended in January. Total enrollment was about the same as last year, staying steady at about 1.5 million, but the number of new enrollees was down nearly 24 percent, mostly because of the elimination of the federal mandate penalty.

## POLITICO PRO

### **E.R. bills would be capped at in-network rates under new legislation**

Angela Hart

Feb. 24, 2019

A pair of San Francisco lawmakers is expected Monday to introduce a bill aimed at preventing surprise emergency room bills, POLITICO has learned.

Assembly Bill 1611 by Assemblyman David Chiu (D-San Francisco) and Sen. Scott Wiener (D-San Francisco) would prohibit insurers or providers from charging patients anything more than their in-network cost-sharing payments for emergency room trips. It would also prevent insurers, health plans or hospitals from taking patients to collections for additional out-of-network costs even if it services are not covered under a patient's health plan.

The practice is known as "balance billing" and can take patients by surprise when they are billed for an emergency room visit in a hospital that is not in their insurer's network of preferred providers.

The proposal would prevent insurers, health plans and hospitals from billing patients for outstanding balances for visits to out-of-network providers. The authors hope to prevent hospitals from covering high patient costs by billing extra charges to insurers.

It would limit insurer payments to hospitals to 150 percent of Medicare or the average contracted rate for in-network plans.

"In order to avoid an untenable negotiation between hospitals and health plans, the bill caps what can be charged, otherwise there would be uncertainty about what the rules are in out-of-network situations," Wiener told POLITICO in an interview.

The bill was sparked by reports of sky-high emergency room bills, even when patients are insured, authors said. Zuckerberg San Francisco General Hospital and Trauma Center is under the spotlight for such high E.R. bills, largely because it has no contracts with private health insurance companies and is the only trauma center in San Francisco, which means patients needing emergency care in the city inevitably end up there.

"The only thing anyone should be thinking about when you or a loved one is lying on a gurney in an emergency room is how to get better, not the bill for that care," Chiu said in an interview. "Thousands of patients have received outrageous bills...and hospitals are billing these exorbitant bills — that drives up health care costs for everyone."

California in 2016 banned balance billing under CA AB72 (15R), but the law applies only to non-emergency health care services. In addition, the California Supreme Court in 2009 found the practice of balance billing against the law, but that decision only applies to health plans regulated by the state Department of Managed Health Care, leaving some consumers at risk.

Patients covered under federally regulated and self-insured plans — policies usually held by large employers and union trust funds — are regulated by the California Department of Insurance, which are not covered by the court ruling.

Though most Californians are enrolled in plans regulated by the Department of Managed Health Care and thus shielded from the practice of balance billing, roughly 7 million Californians enrolled in self-insured or federally regulated plans could face unexpected, high emergency room bills.

"For most patients, there's a good chance you're OK, but you never know," Wiener said. "And of course if you're in an emergency situation, you have no input on where the ambulance takes you."

The bill is sponsored by the nonprofit advocacy group Health Access California and the California Labor Federation, which also sponsored the 2016 balance billing legislation. Chiu and Wiener said they expect opposition, particularly from hospital groups.

Jan Emerson Shea, spokeswoman for the California Hospital Association, said the group has not reviewed the proposal and was not able to comment specifically. But in general, she said hospitals want "fairness" in what they can charge insurers and health plans.

“Fundamentally, our belief is patients should not be in the middle of this – that is clear,” Emerson Shea told POLITICO. “At the same time, there has to be an incentive for health plans to fairly compensate hospitals... We have to create a level playing field.”



## **Providing health insurance can be a challenge for San Joaquin County’s small businesses**

Joe Goldeen

Feb. 25, 2019

STOCKTON — Providing employer-sponsored health insurance presents a conundrum for many small businesses. The expense has little to do with contributing directly to the bottom line, but it’s proven to be good for attracting and retaining skilled workers.

A recent survey of employers who use the Covered California for Small Business exchange indicated that prospective employees expect to be offered health insurance. After salary, health insurance is the next consideration employees use to base their decisions on whether they work for one employer over another, the survey showed.

However, for employers offering at or near minimum wage to their workers and struggling with all the hurdles of just keeping the doors open and the lights on, health insurance is barely on the table.

“If you are a small business, you have no buying power whatsoever. We are at the mercy of the insurance companies,” said Mike Letizia, president and CEO of Stockton-based Letizia HR Solutions Inc., who described his two-person shop as a full-scope human resources service provider. Letizia himself has more than 30 years’ experience in human resources, much of that time spent with a local bank.

Small employers with less than 50 full-time-equivalent workers are exempt from the federal mandate that they must provide coverage to their workers. But there is still an incentive for some if they do provide employer-sponsored coverage.

The Small Business Health Care Tax Credit is equal to 50 percent of the premiums paid by an eligible business with less than 25 employees. So if the business shells out \$15,000 in premium costs, it could be entitled to a \$7,500 tax credit from the Internal Revenue Service.

Businesses do have the option of enrolling with Covered California for Small Business, or CCSB, part of California’s State Health Benefit Exchange where employers with 100 or fewer workers can access health plans that are relatively affordable.

CCSB currently offers five plans, including two preferred provider organization (PPO) plans from Blue Shield of California and Health Net, and two health maintenance organization (HMO) plans that are provider- and hospital-based from Kaiser Permanente and Blue Shield.

For employers concerned about premiums, Covered California spokesman James Scullary said “there is no business too small for our plans, and CCSB is seeing a substantial increase in the lower end of small businesses — in the two- to 10-employee range — now offering health insurance. Interested employers can visit [CoveredCA.com](http://CoveredCA.com) or call us at (844) 332-8384 for more information.”

Letizia won't be one of those calling, however.

“I would really love to offer my employee health benefits,” he said. “But Covered California does not measure up. That's not health coverage, at least certainly not what I am used to,” Letizia said, referring to what he described as low-premium “catastrophic policies” with “unrealistic” four-figure deductibles.

“The quality of health care I received 15 to 20 years ago simply does not exist today,” he said.

While CCSB may be attracting more small business operations, a recent random survey of independent businesses in one Stockton shopping center did not find a single employer offering coverage through the state exchange. In fact, the results were startlingly consistent. Not a single employer in the center offers health insurance benefits, period.

One simply said, “No insurance,” waving off further questions. Another noted his status as a military veteran eligible for VA health care.

Several employees shared that they were receiving government-funded Medi-Cal (California's version of federal Medicaid benefits) through Health Plan of San Joaquin. Even though they were all working, they met the income eligibility requirements because of their low wages.

Muhammad Sultan, 55, who holds a master's degree in geography and worked as a high school principal in his native Pakistan before moving to San Joaquin County in 2010, now works in a friend's smoke shop. He has Medi-Cal for his entire family of five, including his oldest child who also works.

“I like it. It works for me,” Sultan said. “We are happy with Health Plan of San Joaquin and have no problems. I can pick any doctor with no problem.”

# The Mercury News

## **Editorial: Trump gag rule devastates women's access to health care**

Editorial Board

Feb. 26, 2019

The notion of President Donald Trump offering medical advice on any topic should send shudders down the spines of Americans.

Imagine him being in the doctor's office when a woman is discussing family planning issues with her physician. It's wrong on so many levels, starting with the idea that men know what's best for women and their health.

But the president, in effect, did just that Friday. Trump announced that his administration will bar organizations that provide abortion referrals from participating in the \$286 million Title X federal family-planning program that serves more than 4 million patients, mostly low-income women.

Congress can't make it right. Not with Trump poised to veto corrective legislation. The only hope rests with states already working to challenge the gag rule. Doctors at medical clinics should have the ability to have candid discussions with their patients about all legal care options, including abortion.

Trump is targeting Planned Parenthood, which gets \$60 million from the program and serves about 40 percent of Title X patients. The president wants to put Planned Parenthood out of business because a tiny portion of its services — 3 percent — go to provide abortions. Never mind that the organization doesn't use federal money to fund abortions. Indeed, federal law already prohibits using Title X funds for abortions.

Planned Parenthood Mar Monte CEO Stacy Cross says there is no question that federal funding cuts are going to leave people without health care in California. A significant number of the 250,000 women her affiliate cares for in 35 clinics, stretching across Northern and Central California and Northern Nevada, could lose services.

But the most devastating impact would be in rural regions throughout the country that lack the alternative resources found in the Bay Area, which has 19 Planned Parenthood clinics in Alameda, Contra Costa, Santa Clara, San Francisco and San Mateo counties.

Planned Parenthood uses Title X funding to offer contraception, HIV testing, treatment of sexually transmitted diseases, screening for breast and cervical cancer, pregnancy tests and counseling, and educational programs.

Title X programs have proven results. A Guttmacher Institute study reveals that the affordable birth control that Title X provides prevents 1 million unintended pregnancies each year, resulting in tens of thousands fewer abortions. The institute also estimates that every dollar invested through Title X saves \$7.09 in Medicaid-related costs.

The Title X national family planning program had broad, bipartisan support when it was created in 1970. It was championed by a Republican, then-Rep. George H.W. Bush, and signed into law by another Republican, President Richard Nixon.

"We need to make population and family planning household words." Bush said in 1969 when Congress took up the issue.

Title X programs have enabled Planned Parenthood to improve the lives of women across the United States and helped reduce the teenage pregnancy rate for three consecutive decades. The president should stop trying to undermine that success to appease his right-wing base.

## POLITICOPRO

### **California takes aim at hospital consolidation in effort to control health costs**

Angela Hart

Feb. 26, 2019

SACRAMENTO — Gov. Gavin Newsom and lawmakers are taking aim at consolidation across the health care industry as large hospital groups snap up small rural hospitals and physician practices, which state leaders fear has resulted in artificially high prices as competition dwindles.

The Democratic governor specifically identified market consolidation as a problem in his State of the State address this month, and now Assemblyman Jim Wood has introduced legislation that could pressure hospitals by identifying where they are consolidating in the state.

Wood (D-Santa Rosa) said in a statement that he wants "to make sure that if hospitals consolidate, they are doing so most importantly to improve patient care and reduce health care costs, not increase hospital profits."

A growing body of research suggests market consolidation has driven up prices of health care goods and services, as well as consumer premiums.

Across California, integration in "highly concentrated hospital markets" was associated with a 12 percent increase in patient premiums between 2013 and 2016, for example, as well as a 9 percent increase in specialist prices and a 5 percent in primary care prices, according to a September 2018 study published in the journal Health Affairs.



Wood's CA AB910 (19R) calls for the California Department of Public Health, which oversees hospital licensing, to identify consolidation of particular facilities in a report to the Legislature.

It calls for the state Department of Public Health to identify every general acute care hospital operating multiple plants more than 15 miles apart — a situation that generally involves rural facilities or outpatient physician practices. The department would have to begin annual reports of that information by 2022.

The bill, however, is expected to change. Wood eventually plans to propose more specific language addressing hospital consolidations, his office told POLITICO.

More detailed information on market consolidation and integration can help the state attorney general's office, health care regulators and the Legislature understand how such trends factor into health care costs, said the authors of the 2018 Health Affairs study.

"California's health care markets are at a pivotal point," the authors said. "Rapid integration and consolidation may have significant benefits. Care coordination and quality improvement are possible, but so are significant increases in the cost of care."

Wood's bill comes as Newsom tries to rein in drug prices and dominant industry players blame each other for rising costs on the commercial side.

A new, industry-backed research report out Tuesday, for example, found that private physician practices are joining larger health care groups due to increasing regulatory requirements, insurance mandates, lower reimbursements and "the industry's accelerating consolidation."

"Although driven into large provider-controlled practices, most physicians do not feel this is a positive trend," said the report from the research firm Colliers International, titled "Health Care Consolidation: The disappearing independent doctor and health care's growth in Sacramento."

A separate January report by the Physicians Advocacy Institute found that from 2012 to 2018, the percentage of hospital-owned physician practices more than doubled.

Carmela Coyle, president and CEO of the California Hospital Association, urged the Newsom administration and California lawmakers to pause before targeting hospitals.

She pointed to research that indicates insurance markets in California are also "highly concentrated." In 2016, for example, the California Department of Insurance sent a letter to the U.S. Department of Justice opposing the proposed merger of insurance giants Anthem and Cigna. It said the four largest insurers controlled 82 percent of the state's large group market, 88 percent of the small group market and 93 percent of the individual market.

"It is short-sighted to single out hospitals in the health care market dynamics," Coyle said in an interview. "There is, right now, a lot of focus on hospitals, but that ignores integration in the rest of the health care sector, whether that is large and growing insurance companies or whether that is large and growing physician practices ... I think it can be easy to say there's market integration going on and that's yielding higher prices and for me, that's too simplistic."

Coyle argued that consolidation among large and small hospitals, and across the industry, isn't a bad thing. She said such consolidation could benefit patients, though she acknowledged that it can also drive up prices.

"We are seeing an integration of hospitals, whether that's hospitals coming together or whether it's building a more complete continuum of care for patients ... that holds the potential for better and more efficient care that is a benefit and that is sometimes overlooked," she said.

Newsom has been tight-lipped about how, specifically, he plans to address soaring health care costs, across the system and for consumers. But he pledged again this month to address the problem and for the first time in office called out health care consolidation.

"We must address rising costs throughout the system, like the consolidation of hospitals and other health providers, which limits patient choice and makes care more expensive," he said during his State of the State address.

That has encouraged labor groups, which have unsuccessfully pursued bills to control costs on the commercial side.

"We're very hopeful he's going to tackle this issue and help figure out a way to maintain integration and coordination but stop consolidation that results in higher prices," said Sara Flocks, a lobbyist with the California Labor Federation. "You don't need consolidation and monopoly power to have well-coordinated care."



## **More than 100 House Democrats to unveil 'battle-ready' Medicare-for-all plan as 2020 election looms**

Jeff Stein

Feb. 26, 2019

More than 100 House Democrats plan to unveil a new "Medicare-for-all" plan Wednesday to provide government health insurance to every American, according to a

copy of the bill provided to The Washington Post, as a number of Democratic-leading presidential candidates for 2020 feud over the party's health-care platform.

Rep. Pramila Jayapal (D-Wash.), co-chair of the Congressional Progressive Caucus, is expected to release legislation Wednesday that incorporates key policy demands of single-payer activists, aiming to overhaul the U.S. health-care system even faster and more dramatically than legislation proposed in 2017 by Sen. Bernie Sanders (I-Vt.).

Jayapal's Medicare-for-all would move every American onto one government insurer in two years, while providing everyone with medical, vision, dental and long-term care at no cost. Similar proposals have been projected to increase federal expenditures by at least \$30 trillion but virtually eradicate individuals' health spending by eliminating payments such as premiums and deductibles. About 30 million Americans do not have insurance, while tens of millions more are "underinsured," meaning they cannot afford or do not seek care, according to the nonpartisan Kaiser Family Foundation.

The bill has 106 co-sponsors but essentially no chance of passing the House or Republican-controlled Senate this term. It comes amid a wider debate about the meaning of Medicare-for-all in Democratic policy circles, as some presidential candidates and center-left think tanks have said they support both Medicare-for-all while also aiming to preserve private insurance that currently enrolls about 150 million Americans. Jayapal's plan would leave only a minimal role for private insurance in the United States, similar to Sanders's bill in the Senate.

"We have a plan. We have a real plan," Jayapal told reporters, calling the state of U.S. health care "atrocious" and dominated by a handful of wealthy corporate interests. "Americans are literally dying because they cannot afford insulin and can't get the cancer treatments they need . . . I think this Medicare-for-all bill makes it clear what we mean by health care for all. We mean a complete transformation of our health-care system."

The plan is, in a number of ways, more aggressive than the Sanders plan co-sponsored by more than a dozen Democratic senators, including presidential candidates Sens. Cory Booker (D-N.J.), Kamala D. Harris (D-Calif.) and Elizabeth Warren (D-Mass.). It is also significantly more detailed than the previous single-payer bill in the House introduced by then-Rep. John Conyers Jr. (D-Mich.), which at about 30 pages outlined only a set of goals with few legislative specifics.

Tim Faust, a single-payer advocate, said it was the first "comprehensive, battle-ready" single-payer plan to be introduced in Congress.

"The idea of Medicare-for-all has become extremely popular, but it's at risk of being co-opted by those who want modest, incremental proposals that fall well short of true universal health care," said Adam Gaffney, president of Physicians for a National Health Program, a group of doctors supporting single-payer that provided input to the Jayapal plan. "What we're doing here is a big step forward to clarify exactly what Medicare-for-all means."

Critics say the plan would require impossibly large new taxes, given its estimated \$30 trillion price tag, and question the political wisdom of forcing nearly half the country to switch from the current private plan to a public insurer. Conservatives have also argued that a single-payer system could impede quality of care for those who have it, pointing to the potential for longer wait times.

Supporters point out that U.S. health-care spending per capita is more than two times as large as the average for developed nations, even as Americans have below-average life expectancy at birth and lag on a number of other key health outcomes. Single-payer advocates say one government insurer would have the bargaining power to drive down costs, while giving free health care to those who lack coverage.

Jayapal's plan, about 120 pages, would transition every American to Medicare-for-all over two years, cutting the four-year transition in Sanders's Senate bill in half. Sanders is currently working on an updated version of his legislation, according to Josh Miller-Lewis, a spokesman for the senator.

Some health policy experts fear that dramatically disrupting the health markets over four years could lead prices to explode in the private market, increasing the urgency of a quicker transition.

Jayapal's bill also includes two big new provisions left out of the Senate legislation: a crackdown on the pharmaceutical industry aimed at lowering drug prices, and new government-run long-term care to help people with disabilities. It does not specify how it would finance the new legislation.

The number of Americans who require long-term care is expected to explode over the next few decades as the baby-boom generation ages, with the number of Americans with a disability projected to more than double from 2015 to 2065. Jayapal's new Medicare-for-all bill, unlike the one Sanders introduced in the Senate in 2017, would guarantee free long-term care, including home health care, for Americans with disabilities as part of the single-payer system.

"This one part of it is, in some ways, as complicated and expansive as the Affordable Care Act itself," said Harold Pollack, a University of Chicago health expert. "It's an unbelievably complicated and fraught issue."

Jayapal's bill will include a proposal from Rep. Lloyd Doggett (D-Tex.) aimed at bringing down prescription drug prices by allowing Medicare to negotiate the price of drugs. The bill would give the government the ability to issue a generic license to produce the medication if negotiations fail, a provision known as "compulsory licensing."

The previous version of the Medicare-for-all bill called for the elimination of all for-profit hospitals, and it called on the government to give financial compensation to providers that would be forced to become nonprofits. That provision was removed from the new Jayapal bill, in part because House aides feared it would lead the government to

compensate hospital shareholders. In December 2018, Politico reported that hospitals, insurance companies and other health-care lobbies had launched a unified front to beat back the push for Medicare-for-all, raising the political stakes for Democrats who embrace the plan.

The new bill specifies that funds from the government's Medicare-for-all could not be used "for profit," union-busting, marketing or federal campaign contributions. Many hospitals with the biggest budget surpluses are also nonprofit, which seems to diminish the case for converting all hospitals to that model.

Jayapal also said between 1 million and 2 million people currently work in the private health insurance system, and that 1 percent of the new Medicare-for-all fund would go to a five-year transition program to pay for pension benefits, job training programs and other assistance for affected workers.

Congressional Democrats have proposed a number of incremental health reform provisions recently, including a plan by Sen. Debbie Stabenow (D-Mich.) and Tammy Baldwin (D-Wis.) that would create a public option for Americans from ages 50 to 64 to buy into Medicare. Sen. Brian Schatz (D-Hawaii) has proposed a Medicaid expansion via a state-based buy-in program. The recent push leftward on single-payer has made those plans, which would still use the federal government to expand health insurance to millions of people, seem more modest by comparison.

"Even though it's still extremely unlikely to pass, Medicare-for-all has moved the political landscape so suddenly, it's created a window for these other proposals to seem quite feasible," said Pollack, a single-payer skeptic.

Hearings on the legislation are expected to begin later this year.



### **Few Californians pay the health insurance penalty. Often, those that do are poor**

Michael Finch II

Feb. 28, 2019

Internal Revenue Service data paints an unsettling picture of the uninsured in California, revealing that three out of four people who paid the tax penalty earned less than \$50,000.

A Sacramento Bee analysis of tax data showed that in 2016 more than 598,000 people paid a penalty to the federal government. The implications could be significant because political leaders are eyeing a new state-level penalty to replace the federal health coverage mandate.

Some studies suggest that without a penalty to compel people to buy coverage, the state-run insurance market could begin to sputter and thousands of consumers could opt out.

The data suggest, however, that to help the poor and uninsured lawmakers will be penalizing low- and middle-income earners. For the analysis, The Bee focused on ZIP codes with 1,000 or more income tax filers who paid the so-called “health care responsibility payment” in 2016.

Many were concentrated in the metro areas of Southern California.

Policy experts and consumer advocates say the data in some ways overstate the number of people paying the penalty, since everyone eligible for Medicaid is exempt. In California for the year 2015, that would include individuals making \$16,243 or less or a family of four living on less than \$33,465 a year.

“Low-income people are exempt from an individual mandate but we do know from this data that substantial numbers of people paid it anyway. The basic reason is the IRS instructions were not clear,” said Jason Levitis, who authored a report on state-created tax penalties for the USC-Brookings Schaeffer Initiative for Health Policy.

By counting those with incomes below \$50,000, the results also include people who are eligible for subsidies but are not purchasing insurance. Experts say affordability may still be an issue in the state where three out of 10 residents surveyed in 2017 cited cost as the reason for not purchasing health insurance, according to the California Health Interview Survey.

That does not mean the state should not levy its own tax penalty, said Anthony Wright, executive director of insurance advocacy group Health Access California.

“Our issue is if there are people paying the penalty, especially at these income levels, the problem isn’t the penalty,” Wright said. “The problem is that we are not making coverage affordable enough where we need to have additional subsidies especially in our high-cost-of-living state.”



## **Medicare Trims Payments To 800 Hospitals, Citing Patient Safety Incidents**

Jordan Rau

Feb. 28, 2019

Eight hundred hospitals will be paid less by Medicare this year because of high rates of infections and patient injuries, federal records show.

The number is the highest since the federal government five years ago launched the Hospital Acquired Conditions (HAC) Reduction Program, created by the Affordable Care Act. Under the program, 1,756 hospitals have been penalized at least once, a Kaiser Health News analysis found.

This year, 110 hospitals are being punished for the fifth straight time.

In California, 99 hospitals out of 339 face penalties. Over five years, 187 California hospitals have been punished at least once, and 16 have been punished every year.

The penalties pit hospitals against one another in a race to prevent the most infections, blood clots, cases of sepsis, bedsores, hip fractures and other complications. Each year, the quarter of general hospitals with the highest rates are punished, even if their records have improved from the previous year.

Under the latest round of sanctions, each hospital will lose 1 percent of its Medicare payments for patients discharged between last October and this September. That comes on top of other penalties created by the health care law, such as annual payment reductions for hospitals with too many patients being readmitted.

The hospital industry has protested the HAC penalties, saying the program's design creates an arbitrary cutoff for which institutions get punished and which don't. The American Hospital Association calculated that only about 41 percent of the 768 hospitals penalized in 2017 had HAC scores that were statistically significantly higher than hospitals not being penalized.

"There are not statistical differences that would warrant a quarter of the hospitals in America getting a penalty," said Nancy Foster, the association's vice president for quality and patient safety.

Hospitals also complain that the ones that do the best job testing for infections and other threats to patients appear to be among the worst based on statistics, while their more lackadaisical peers look better than they might be.

Supporters of the punishments argue that the penalties are warranted in prodding hospitals to improve quality. The threat of losing money elevates the issue in many hospitals to the attention of directors and owners, said Missy Danforth, the vice president of health care ratings at the Leapfrog Group, a nonprofit devoted to patient safety.

"The fact that everyone's talking about it, from front-line nurses to boards of directors, is positioning patient safety where it should be, which is at the forefront of everyone's minds," Danforth said.

Danforth dismissed hospital complaints that the penalties are not always fairly applied. “There’s a lot of really strong, good best practices to getting to zero on these infections,” she said.

Hospital patients suffered an avoidable injury in 9 of every 100 patient stays in 2016, about 2.7 million times, according to a June report from the federal Agency for Healthcare Research and Quality. Those included a bad reaction to medication, an injury from a procedure, a fall or an infection.

The frequency of complications has been dropping in hospitals. The report found an overall 8 percent decrease from 2014 to 2016. However, the report also found a jump in the numbers of bedsores and urinary tract infections in patients with catheters during that time.

The Hospital Acquired Conditions Reduction Program assesses penalties based on a subsection of the injuries examined in the AHRQ report. For each hospital, Medicare judges infection rates related to colon surgeries, hysterectomies, urinary tract catheters and central lines inserted into veins. Medicare also counts the number of infections of methicillin-resistant *Staphylococcus aureus*, or MRSA, and *Clostridium difficile*, known as C. diff.

Finally, the government tracks the rate of blood clots, sepsis, post-surgical wounds, bedsores, hip fractures and five other types of in-hospital injuries. Because the penalties will be applied as hospitals submit claims for reimbursement, the total dollar amount of penalties for each hospital will not be known until the federal fiscal year ends in September.

Medicare excludes from consideration a number of specialized hospitals: those serving children, veterans and psychiatric patients. Maryland hospitals are also exempted because the federal government gives that state leeway in how it pays hospitals. And more than 1,000 “critical access” hospitals, which are the only institutions in their area, are also excluded.

For the remaining hospitals, penalties are assigned to the quarter of institutions with the highest HAC rates. That threshold varies slightly from year to year, and is a major reason that the number of hospitals being punished fluctuates annually. Before this, the largest number of hospitals punished was 769, two years ago.





## **How Affordable are 2019 ACA Premiums for Middle-Income People?**

Rachel Fehr, Cynthia Cox, Larry Levit and Gary Claxton

Mar. 5, 2019

The majority of enrollees who purchase health coverage through Affordable Care Act (ACA) exchanges receive premium tax credits to help them afford their monthly premiums. To a large extent, subsidized enrollees are shielded from premium increases because their subsidies rise along with premiums. On the other hand, middle-income people with incomes above 400% of the Federal Poverty Line (“FPL”, equal to \$48,560 for an individual and \$100,400 for a family of four in 2019) are not eligible for subsidies and may struggle to afford ACA-compliant plans.

Marketplace enrollment among subsidized enrollees rose from 8.7 million in 2015 to 9.2 million in 2018. However, premiums increased significantly, and the number of unsubsidized enrollees in ACA-compliant plans has fallen over this same period from 6.4 million to 3.9 million. Unlike subsidized enrollees, those with incomes over 400% of poverty have to bear the full cost of premium increases if they buy an ACA-compliant plan.<sup>1</sup>

While premiums for ACA Marketplace plans are holding steady or falling slightly on average in 2019, whether ACA plan premiums are actually affordable for an individual depends on where they live, how old they are, and how much money they make. We analyzed 2019 premiums data to show how affordable the lowest-cost ACA Marketplace plan is in each county, by age and income, with a focus on middle-class people whose incomes are too high to qualify for subsidies.

This brief finds that affordability challenges are particularly acute for older adults with incomes just above the premium subsidy cutoff (400% of poverty), particularly in rural areas where premiums are highest.

Most unsubsidized enrollees who enroll in ACA-compliant plans do so outside of the Marketplace. This brief only includes premiums for plans that are available on the Marketplace, but bronze premiums for people who are not eligible for subsidies are generally similar whether an enrollee buys through the Marketplace or not. (In all but 14 counties, the lowest-cost plan available is a bronze plan.)

The interactive map shows a substantial decline in affordability between a \$45,000 income (which would put an individual at 371% of the poverty level and make them eligible for subsidies) and \$50,000 (412% of poverty and therefore not eligible for

subsidies). This phenomenon is referred to as the “subsidy cliff” because subsidy eligibility ends sharply at 400% of poverty without a phase-out, even if premiums represent a substantial share of income for those above 400% of poverty.

In 21% of counties, a 40-year-old making \$50,000 would have to pay more than 10% of their income for the lowest-cost plan in the Marketplace. However, because premiums are lower in urban areas than in rural areas, just 8% of Marketplace enrollees are in a county where that would be the case. In 25% of non-metropolitan counties (weighted by enrollment), a 40-year-old making \$50,000 would spend more than 10% of their income on premiums for the cheapest plan available, compared with only 5% of people in metropolitan counties.<sup>2</sup>

Rhode Island has the lowest average premiums for middle-class people ineligible for subsidies in 2019: a 40-year-old making \$50,000 would pay about 5% of their income in premiums for the cheapest plan, on average. Wyoming has the highest average premiums for unsubsidized people: a 40-year-old making \$50,000 would pay about 14% of their income in premiums for the cheapest plan, on average, with Nebraska and West Virginia in a close second and third place.

Figure 2 presents an interactive chart showing how much the national average premiums for a low-cost plan vary as a share of income at different income levels for people at various ages. (Figure 3 presents similar results as a static chart.) On average across the U.S., a 40-year-old making \$45,000 would pay \$227 a month (6% of their income) for a subsidized bronze exchange plan, whereas the same person making \$50,000 would pay \$340 a month (8% of their income) for the same plan without a subsidy. Because the ACA allows premiums for older adults to be three times those for younger enrollees, middle-class older people with unsubsidized coverage are the most likely to face affordability challenges. For example, a 27-year-old making \$50,000 would pay 7% of their income in premiums for the average lowest-cost plan nationally, whereas a 60-year-old making the same income would pay 17% of their income in premiums. Even at an income of \$70,000 (577% of the poverty level), a 60-year-old would have to pay 12% of income for a low-cost plan on average.

For older people living in very high-premium counties, the affordability gap is much more stark; in the 28 Nebraska counties with the highest premiums, a 60-year-old making \$45,000 would pay nothing in monthly premiums and the same person making \$50,000 would pay \$1,314 (32% of income) for the lowest-cost plan.

The premiums in this analysis are for the lowest-cost plan available in each county, but these low-cost bronze plans come with higher deductibles, copayments, or coinsurance than plans at higher metal tiers with higher monthly premiums. The average deductible for bronze plans in 2019 is \$6,258, compared to \$4,375 for silver plans (for people who do not receive cost-sharing subsidies because their incomes are above 250% FPL). While some services, including preventative care and often a few physician visits, are covered before enrollees reach their deductible, sicker enrollees may be better off choosing a silver or gold plan even if that means they spend a larger proportion of their income on premiums.

## Discussion

After several years of rising ACA plan premiums, premiums are falling in many parts of the country for 2019. Despite this trend, premiums for even the cheapest exchange plans are still out of reach for many middle class people who are not eligible for ACA subsidies, particularly those who are older or live in high-premium areas. Several policy options have been proposed to address affordability for people buying their own coverage without a subsidy, such as expanding more loosely regulated short-term plans, creating state-based reinsurance programs, extending subsidies beyond 400% of poverty, and expanding eligibility for Medicaid or Medicare.

The Trump administration recently made changes to short-term, limited duration plans, with the goal of creating a more affordable option for people who are not eligible for subsidies. Short-term plans generally have significantly lower premiums than ACA-compliant coverage, in large part because these plans can exclude people with pre-existing conditions and may not cover certain services. Thus, while short-term plans come with lower premiums, these plans are generally not an option for people who have pre-existing conditions or expect to need high-cost services (e.g. for pregnancy, prescription drugs, or mental health care). Additionally, these plans will disproportionately attract healthy individuals away from ACA-compliant coverage, thus having an upward effect on premiums in the ACA-compliant individual market and possibly making unsubsidized coverage less affordable for people with pre-existing conditions.

The ACA established a temporary reinsurance program from 2014 to 2016 with the goal of making premiums more affordable during the early years of new market reforms. Reinsurance covers a portion of the health care expenses for high-cost patients, allowing insurers to reduce premiums.

Seven states (Alaska, Maine, Maryland, Minnesota, New Jersey, Oregon, and Wisconsin) have since created their own reinsurance programs, and initial evidence indicates that these programs have been successful in reducing individual market premiums, although the details of these plans vary widely between states. How much a reinsurance program can reduce premiums depends on the level of funding dedicated to it. Reinsurance reduces premiums somewhat for all enrollees ineligible for premium subsidies. However, this reduction in prices will not be enough to make plans affordable for all unsubsidized middle class people, particularly those facing the highest premiums as a share of income. For example, the cheapest plan in Natrona County, Wyoming costs \$1,237 a month for an unsubsidized 60-year-old (25% of income for someone making \$60,000). If the implementation of a reinsurance plan reduced all premiums by 10%, the cheapest plan would cost \$1,113 (22% of income), which is still too expensive for many people to afford.

Expanding premium tax credits to enrollees over 400% of poverty would provide more significant assistance to those newly eligible for subsidies. For example, California Governor Newsom recently proposed expanding premium tax credits to incomes between 400 and 600% of poverty (incomes up to \$72,840 for an individual).

Avoiding a subsidy cliff altogether would cost taxpayers more. One federal bill introduced in the House last year would extend premium subsidies to enrollees in all income brackets, and increase the amount of subsidies across the board. On average nationally, tax credits would need to extend to nearly 800% FPL to bring 2019 bronze premium payments down to 10% of income for a single 64-year-old, or just over 1,100% FPL to accomplish the same for silver premiums. In the 28 Nebraska counties with the most expensive 2019 premiums in the U.S., tax credits would need to extend beyond 1,400% FPL to bring bronze premium payments down to 10% of income for a single 64-year-old, or over 2,000% FPL to accomplish the same for silver premiums. In the case of an older couple living in a high-premium county, subsidies would need to extend beyond 3,000% FPL (a \$500,000 income), for 2019 silver premiums to cost less than 10% of their income.

In late 2018, the Trump administration released new guidance and the Centers for Medicare and Medicaid Services (CMS) issued a discussion paper on Section 1332 waivers established by the ACA. This new guidance may prompt states to apply subsidies to ACA non-compliant plans or experiment with different subsidy structures, such as tax credits based on age and not income. One of the CMS waiver concepts describes extending subsidies to higher-income residents to address the “subsidy cliff.” Under a budget neutral waiver, however, increasing subsidy resources for one population group would necessitate reducing subsidy dollars available to other groups. Currently, ACA subsidies are structured so that lower-income enrollees pay a smaller percentage of their income (2% premium cap for those 100-133% of poverty) than higher-income enrollees (10% for those 300-400% of poverty), and they receive the bulk of subsidies. Additionally, as noted above, subsidies would need to extend well beyond 400% FPL to do away with the subsidy cliff altogether.

A number of recent congressional proposals would provide lower premium options to middle-class people buying their own coverage by expanding access to public programs like Medicare and Medicaid. For example, one bill would allow people age 50 and over to buy into Medicare, potentially lowering premiums through reduced prices paid to health care providers and curtailing administrative costs and profits. Another bill would allow states to set up programs that allow people to buy into the Medicaid program, capping premiums at 9.5% of income.

So far, while there seems to be a consensus that individual market premiums are out of reach for some middle-class people ineligible for ACA subsidies, there is little consensus around what to do about it.