Media Clips

COVERED CALIFORNIA BOARD CLIPS
Mar. 18, 2019 – May 15, 2019

Since the Mar. 14 board meeting, high-visibility media issues included: President Trump deciding he wants a GOP plan to replace the Affordable Care Act, before quickly being convinced to shelve the idea until after the 2020 elections. The administration's Department of Justice declared its opposition to the ACA, filing in a federal appeals court that the legislation is unconstitutional and should be struck down. Meanwhile in California, Gov. Newsom unveiled his new budget that includes changes for Covered California, while Americans weighed in on the current health care climate.

COVERED CALIFORNIA PRESS RELEASES AND REPORTS

PRINT

Articles of Significance

News Release

FOR IMMEDIATE RELEASE
May 7, 2019

New Analysis Finds Record Number of Renewals for Leading State-Based Marketplaces, but Lack of Penalty Is Putting Consumers at Risk

- *The analysis finds that even in states where there is no penalty, more consumers than ever before are keeping their coverage.*
- *The high rate of paid renewals is evidence that once insured, consumers keep their coverage even without the "nudge" of the penalty.*
- *However, the lack of an individual mandate penalty continues to put consumers at risk by lowering levels of new enrollment, which is leading to higher premiums that could force some people — particularly those who are unsubsidized — to lose their coverage.*

SACRAMENTO, CALIF — A new analysis reveals that more renewing consumers than ever before are keeping their health insurance in three of the leading state-based exchanges. The analysis provides the first complete picture of the impact of the removal of the federal penalty on the individual insurance market. Earlier data detailed the large drop in new enrollment in many marketplaces that was likely caused by the removal of the penalty, but this analysis finds that consumers are very likely to keep their coverage once they are insured.

"For the first time, we are getting a look at the impact of changes at the federal level, and the early news shows that once people get coverage, they want to keep it," said Covered California Executive Director Peter V. Lee.

(more)

"However, we remain extremely concerned that the removal of the individual mandate penalty is leading some Californians to roll the dice and stay uninsured, leading to higher than necessary premiums that could ultimately price them out of coverage — particularly for middle-class customers who do not receive financial help."

Effectuation Rates of Renewing Consumers

The analysis, which was produced by Covered California, the Massachusetts Health Connector and the Washington Health Benefit Exchange, found that instead of seeing a decline in consumers keeping their coverage with the removal of the penalty, an increasing number of existing consumers are staying enrolled in their health plan. The effectuation rate for renewing members reached its highest level for each of the three states: Covered California, with 89 percent of actively enrolled consumers in December of 2018 renewing and paying for their coverage in January 2019 compared to 86.5 percent in 2018; in Massachusetts, the renewal rate for the same period went from 87 percent in 2018 to 91 percent in 2019; and it went from 79 to 88 percent in Washington (see Table 1: Effectuation Rates for Renewing Consumers).

Table 1: Effectuation Rates for Renewing Consumers*

State Exchange	2018			2019			Difference
	Covered in Dec. of prior year	Covered in Jan.	Effectuation Rate	Covered in Dec. of prior year	Covered in Jan.	Effectuation Rate	
California	1.24M	1.07M	86.5%	1.29M	1.15M	89.0%	**+ 2.5%**
Massachusetts	252,178	219,055	86.9%	261,495	237,955	90.9%	**+ 4.0%**
Washington	166,961	131,642	79.0%	178,314	156,596	88.0%	**+ 9.0%**

*Data refers to renewing consumers only. Total effectuation, including new enrollment, will be available in the summer.

"Having health insurance matters, and once people sign up and get protection, benefits and peace of mind, they tend to stay covered," said Louis Gutierrez, executive director of the Massachusetts Health Connector. He added, "This information reinforces the lesson from our state that building a culture of coverage means that all consumers are the winners, with lower premiums and our state is reaching close to universal coverage."

Covered California's data shows that the renewal effectuation rates are relatively stable and consistent across different groups and statuses, taking into account subsidy eligibility, age, metal tier, service channel used, race, ethnicity and language.

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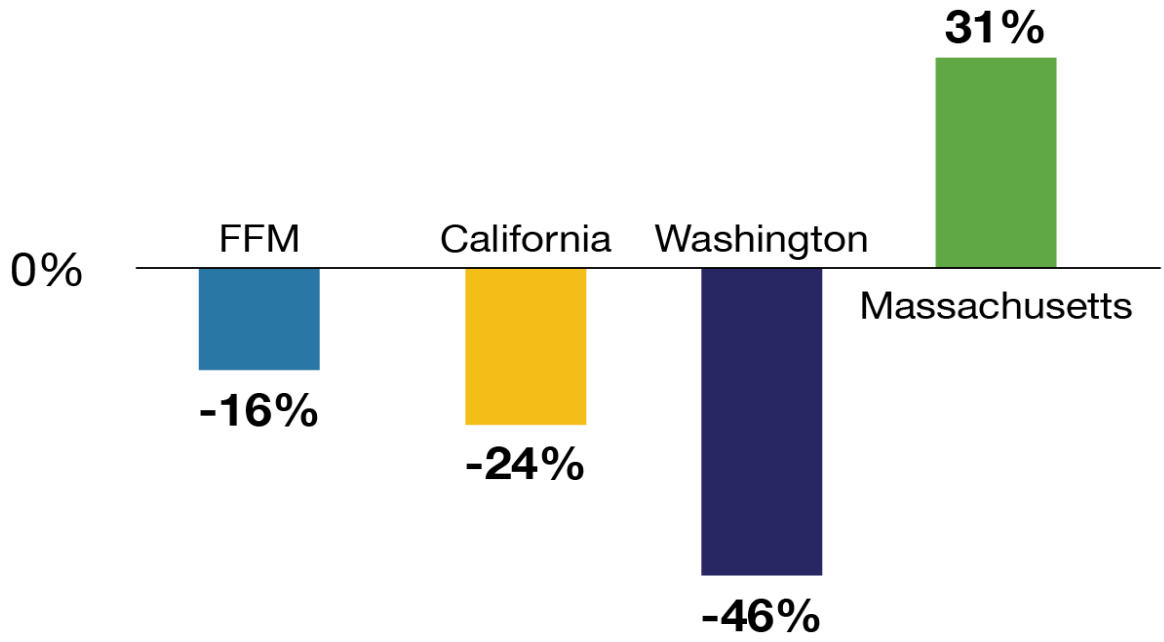
State exchange officials say there could be several reasons for the increase in renewal rates but note the issue needs to be studied more closely. These reasons include effective marketing, patient-centered plan designs that provide key benefits that are not subject to a deductible, and the year-over-year stability of the state marketplaces.

"What we do know is that this data is good news, because a higher renewal rate will help the risk mix in these states in the face of the penalty removal's effect on new enrollment," Lee said.

Lack of Penalty Hurts New Enrollment

While the states reported strong renewal totals, the federal decision to zero out the individual mandate penalty had a chilling effect on new consumers signing up for the 2019 coverage year. New enrollment in states operating in the federally facilitated marketplace (FFM) dropped 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 as well as other state policies, such as state-level affordability assistance — saw new enrollment increase by 31 percent (see Figure 1: New Enrollment Growth by Marketplace, Comparing 2018 to 2019).

Figure 1: New Enrollment Growth by Marketplace, Comparing 2018 to 2019



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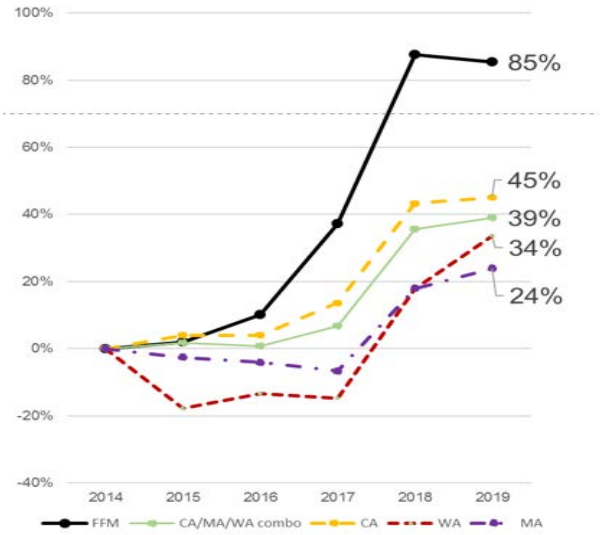
"The penalty matters: It is the nudge that gets new enrollees in the door," said Pam MacEwan, chief executive officer of the Washington Health Benefit Exchange. "Once people sign up for quality health coverage, they are more likely to stick with it, and that leads to better health outcomes and lower premiums."

Lack of Penalty Raises Premiums

While the exchanges remain stable, the lack of a penalty is continuing to cost consumers and put them at risk of losing their coverage. Lee noted that the federal decision to eliminate the penalty raised the premiums of health plans through Covered California between 2.5 and 6 percentage points in 2019.



"The fact is that consumers in much of the nation are paying higher premiums right now because of the decision to zero out the penalty," Lee said. "While the Affordable Care Act's financial help will offset those higher premiums for many, middle-class consumers who do not receive assistance will be more at risk of being priced out of coverage."

"Enrolling more people means a healthier risk pool, which lowers premiums and saves money for everyone in the individual market," MacEwan said. "In the absence of a penalty, we will need policy solutions to address the drop in new enrollment."

An earlier analysis 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 (see Figure 2: Average Benchmark Premium Growth by Percentage, Compared to 2014).

Figure 2: Average Benchmark Premium Growth by Percentage, Compared to 2014

In addition, the data found that 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 through lower subsidy payments between 2014 and 2018.

While the analysis 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.

(more)

Massachusetts officials credit the individual mandate, along with additional state subsidies, for helping the state achieve the lowest uninsured rate in the nation and for a record number of consumers signing up for coverage through their exchange. In addition, the state says the Health Connector had the lowest rates of any exchange in the country in 2018 and an average rate change of just 4.7 percent for the 2019 coverage year.

This analysis measures the effectuation rate of consumers who had coverage in the prior December and paid for their first month's premium in the new year. There is no comparative federal data that describes the actual number of those eligible to renew who paid their bill. Previously released data from the Centers for Medicaid and Medicare Services does not take into account which consumers either paid for their new year's premiums, or in some cases, had a change of coverage before the 2019 coverage year began.

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San Francisco Chronicle

Open Forum: Trump abolished the health care mandate. California needs to restore it.

Peter V. Lee

Once again, we are hearing the threat to “repeal and replace” the Affordable Care Act as distant thunder rumbling at the federal level. The story in California is much different, however, as Gov. Gavin Newsom and the Legislature are working to put our state on the path to universal coverage. One element includes bringing back the individual mandate penalty to individuals who can afford health insurance but do not to buy it.

The proposal is both bold and good policy, even though it may not be popular.

Throughout history, we have seen examples of public policies that are unpopular because they require consumer action, even many that establish federal standards in the name of safety, consumer protection and public benefit.

For example, the first mandatory seat belt law did not go into effect until 1985, when New York required drivers, front-seat passengers and all riders under the age of 10 to buckle up or face a fine. Up until then, there were no standards for seat belts, no national advertising campaigns to promote their use and drivers were more at-risk on the roads.

At the time, critics of the seat belt requirement called it an unwarranted intrusion or an attack on their personal choice, and 65% of those surveyed opposed the measure.

Today we know that seat belts reduce the risk of death for drivers and front-seat passengers by 45%, and they cut the risk of serious injury by 50%. The overwhelming majority of drivers buckle up because not only is it the law in nearly every state (New Hampshire, the “Live Free or Die” state, is the only holdout), we know that life can change in an instant.

The same is true for health care.

Just like the seat belt law, the Affordable Care Act initially required consumers to protect themselves or face the possibility of a fine. Unfortunately, the mechanism to enforce that requirement has been stripped away from all but Massachusetts, New Jersey, Vermont and the District of Columbia. These states have a mandate in place to “nudge” people to do the right thing and purchase the virtual seat belt of health care coverage.

California would be wise to join them and and federally it would be wise to return this to the rest of the nation.

Recent proposals to institute a state-level mandate in California will increase the number of people who get insured, and a larger consumer pool will in turn help lower the cost of premiums for everyone and protect more people from huge medical bills. Additionally, the Legislature and the Governor are working to help consumers pay for their health insurance coverage, including, for the first time, many middle-class Californians who are currently ineligible for assistance. Gov. Newsom's proposal would use the penalty revenue to make this a reality.

The evidence is clear: Not only are those who use seat belts more likely to walk away from a crash, those with health insurance coverage are more likely to get the care they need and be protected from bankruptcy if the worst-case scenario happens.

However, neither policy works as well as it could without a "nudge" or financial consequence. As an example, right now the national average of drivers who buckle up is 90%. However, it's just 70% in New Hampshire.

In California we have made good policy decisions that have resulted in well-regulated markets that help consumers make good choices. Just as we should not put the brakes on progress and drive back to the age of no seat belts, now is the time to go forward with bold actions and smart policies that put consumers first.

THE SACRAMENTO BEE

Gavin Newsom's health care budget has more help for Covered California, less for undocumented
Sammy Caiola, The USC Center For Health Journalism Collaborative

The revised state budget Gov. Gavin Newsom released this week includes more subsidies for Covered California enrollees but doesn't expand Medi-Cal to all undocumented adults as some lawmakers have pressed him to do.

On the campaign trail, Newsom came out in support of a single-payer system in which everyone receives the same government insurance. He says that's still his goal, but he's focusing on smaller steps toward providing all Californians health insurance they can afford.

That plan remains in the Newsom's updated budget proposal.

It includes a fine for Californians who don't carry insurance to replace a similar federal policy that the Trump administration ended in 2017. Newsom says he'll use the revenue from the penalty to make insurance more affordable for people who struggle to pay for plans on Covered California, the state's insurance marketplace created under the Affordable Care Act.

The absence of an insurance mandate could lead 300,000 California consumers to flee the individual insurance market, including as many as 250,000 people insured through Covered California, according to estimates by the California Association of Health Plans. Experts say fewer people means a less diverse risk pool, which raises costs for everyone.

The policy change is already having an effect — Covered California showed a 24 percent drop in the number of new enrollees from 2018 to 2019.

“Without a mandate, you will see an increase in your premiums — every single person in this room and everybody watching,” Newsom said. “I’d like to avoid that.”

In the January budget, Newsom proposed using revenue from the mandate to create state subsidies for people making 250 percent to 400 percent of the poverty level, or between $30,000 and $49,000 a year. Now, he says people making as little as $24,000 will also receive a boost. The state credits would be in addition to federal subsidies.

His proposed expansion also extends assistance to people earning up to $73,000 a year, or 600 percent of the federal poverty level, who don’t currently get federal subsidies. California would be the first state to make this change, though Minnesota had a temporary program to help this group in 2017 according to Laurel Lucia, health care program director with the UC Berkeley Labor Center.

Christen Linke Young, a fellow with the USC-Brookings Schaeffer Initiative for Health Policy in Washington, D.C., called it “an incredibly exciting piece of policy” for improving affordability, though she noted it would be tough to execute.

“It’s hard to put together a tax credit that sits on top of the federal tax credit in this way,” she said. “The system requires a high degree of operational excellence from Covered California and the tax agency in California … it is operationally complicated, and it certainly is something policymakers should have front of mind.”

Anthony Wright, executive director of the consumer group Health Access, said in a statement that revenue from the mandate could help California’s low- and middle-income families who “are still living one emergency away from financial ruin,” but added that more is needed because of the state’s high cost of living.

The new subsidies would go into effect for calendar year 2020, the first year the state penalty would be imposed. But Keely Bosler, Newsom’s director of finance, says penalty revenues won’t come in until 2021, so general fund dollars will be used at first. The subsidies would expire in three years.

Wright’s “Care4All California” coalition is pushing a package of 22 bills this year, including two that would create the individual mandate and several others that would further subsidize insurance costs.

The group also wants to see Medi-Cal, the state version of the federal Medicaid program that provides free or low-cost health insurance to those with limited incomes, expanded to all undocumented adults in the state who qualify based on their incomes.

But on Thursday, Newsom reiterated that his plan would extend Medi-Cal eligibility only to undocumented people up to age 26. Undocumented children 18 and under are already eligible.

In the January budget proposal, Newsom estimated that covering the young adults would cost $260 million. This week's version allocates just $98 million for this purpose.

The governor says he originally estimated that 138,000 people would benefit from the expansion, but his latest estimate puts it closer to 106,000 people. The revised budget states that the expansion will provide full-scope coverage to approximately 90,000 undocumented young adults in the first year, and that nearly 75 percent of these individuals are currently in the Medi-Cal system.

"It's fully funded from our perspective, and we are fully committed to implementing it," Newsom said. "Those numbers reflect a different reality. Rather than having a surplus, I'd rather be more honest going into the budget."

Some Republican lawmakers say Newsom is overspending in his May revision.

"In the last decade, California's state budget has more than doubled," said Republican Assemblyman Vince Fong of Bakersfield. "Even with a budget surplus, the governor has the audacity to propose even more taxes instead of returning it to hard-working Californians [who] earned it. Californians are rightfully fed up with the insane cost of living and working in this state."

Newsom insists that the individual mandate is not a tax.

He says he's not proposing a Medicaid expansion to all undocumented Californians due to the cost, which he estimates at $3.4 billion.

"If you're curious why I can't include it in the May revise, there's 3.4 billion reasons why it's a challenge," he said.

But he noted that the Legislature "may have new strategies, new approaches," and that he's willing to listen.

This proposal is the latest in a yearslong fight by universal health care advocates in California. Democratic lawmakers requested $1 billion last year to make these and other changes, but then-governor Jerry Brown did not set aside money in the budget.

Twelve State-based Marketplace Leaders Express Serious Concerns about Federal Health Reimbursement Arrangement Rule Changes
Staff
April 29, 2019

In an April 29, 2019 letter to the secretaries of the departments of Treasury, Labor, and Health and Human Services, 12 state-based marketplace leaders expressed serious concerns about delays in proposed federal rules that would significantly change states' insurance markets and marketplaces in 2020.

The proposed rules would impact health reimbursement arrangements (HRAs) — allowing employers to deposit pre-tax funds into accounts for employees to use to purchase insurance coverage. Previously, HRAs could only be tapped to purchase certain medical services and equipment. The government originally proposed the rule changes last October, but it has not released a final version of these rules yet, despite the fact the proposed changes are proposed to go into effect in 2020.

As proposed, implementation of the rule would require marketplaces to make significant policy and operational changes. With 2020 rate-filing deadlines starting next month and open enrollment beginning in six months, there is little time for marketplaces to implement changes.

In their letter, marketplace leaders emphasize that last-minute changes imposed by the final rule will lead to significant costs and a hasty implementation that would "detract from attention and service to marketplace enrollees and locally determined priorities for marketplace functionality." They also point out that little time remains to adjust insurance product offerings to account for the hundreds of thousands of individuals expected to switch from the group health market into individual market coverage.

- View the letter marketplace leaders sent to the secretaries of the departments of Treasury, Labor, and Health and Human Services here.
- For a full summary of changes proposed under the rule read: New Federal Health Reimbursement Proposal Adds New Variables to State Health Insurance Markets

UC BERKELEY
LABOR
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3.6 Million Californians Would Benefit if California Takes Bold Action to Expand Coverage and Improve Affordability Staff
April 25, 2019

California made historic gains in health insurance coverage under the Affordable Care Act (ACA), but several million Californians remain uninsured and many struggle to afford individual market insurance. If the state takes no action, the number of Californians uninsured is projected to increase to 4.4 million in 2023 due to the elimination of the individual mandate penalty as well as other trends such as premium growth, population growth, and changes in eligibility due to minimum wage increases.[1] Similarly, if the state takes no action the individual market is projected to be smaller and have a less healthy risk mix, resulting in higher premiums that would further reduce affordability.

Many California policymakers have expressed a desire and commitment to resist federal sabotage of the ACA, control health care costs, and achieve universal health care coverage. As the state explores ways to fundamentally redesign our health care delivery system—including by adopting a single payer or other unified public financing approach—state policymakers are also considering near-term policies that do not require federal approval but address the immediate challenges of improving affordability and expanding coverage. Options currently being considered include:

Expanding Medi-Cal to all low-income California adults regardless of immigration status;[2]
Providing robust help with individual market premium and out-of-pocket costs for those already eligible for ACA subsidies and eliminating the ACA eligibility cliff at four times the federal poverty level (FPL), as depicted in Exhibits 1 and 2 and outlined in the recent Covered California report to the legislature; [3] and
Implementing a state individual mandate penalty that mirrors the federal ACA penalty that was eliminated starting in 2019.
While the effects of these policy elements have been analyzed separately,[4] this brief is the first to look at the combined effects on affordability and coverage.

If these affordability improvements, along with Medi-Cal expansion and an individual mandate, were fully implemented by 2023, 3.6 million Californians would benefit, relative to projections if no action is taken. This includes 1.7 million Californians who would be enrolled in coverage instead of being uninsured in 2023, and 2.3 million people enrolled in the individual market who would either receive state assistance with health care costs or experience lower premiums. Approximately 400,000 Californians are counted in both totals—they would enroll in the individual market instead of being

uninsured and would also benefit from lower costs, resulting in there being 3.6 million people who are better off relative to the status quo. These projections are based on version 2.4 of the UCLA-UC Berkeley California Simulation of Insurance Markets (CalSIM) model.[5]

State action would result in 1.7 million more Californians with insurance
If the state took no action, we project the number of uninsured will rise to 4.4 million by 2023. If these policies were enacted, the number of uninsured Californians would fall by 1.7 million for a total of 2.7 million uninsured in 2023.

The largest group gaining coverage would be low-income undocumented adults who would become eligible for full-scope Medi-Cal coverage. In addition, more people would enroll in individual market coverage due to improved affordability and the stabilizing effect of the individual mandate penalty. Reinstating a penalty is also expected to stabilize Medi-Cal enrollment, which is otherwise expected to decline.[6]
These 1.7 million Californians would be disproportionately low-income (77% estimated to have income at or below 200% FPL) and Latino (67%). Continuing to close the coverage gaps for these groups would build on the ACA's success in reducing coverage disparities in the state.[7]
Health insurance matters: research has shown the value of health insurance for health, access to care, and financial security.[8]

2.3 million individual market enrollees would spend an average of 35% less on premiums

Premium contributions for the 2.3 million Californians projected to enroll in the individual market by 2023 under these policies would be, on average, 35% lower than individual market premium contributions for this group if no action were taken. Many would also have lower out-of-pocket costs for care. These 2.3 million include:

1.45 million individual market enrollees who are eligible for federal subsidies (earning up to 400% FPL) but who still struggle with costs would get additional relief.
This group would pay no more than 0% to 8% of family income on premiums for a benchmark plan, compared to no more than 2.08% to 9.86% of income under current policy. Premium contributions would decline an average of 48%, a decrease averaging approximately $70 per person per month for this group.[9]
Out-of-pocket costs would go down as everyone in this group would pay no more than the Gold-level out-of-pocket costs, approaching the norms for those with employer-sponsored insurance.[10]
This group would pay an average of 5% of family income in premium and out-of-pocket costs in the individual market, compared with an average of 9% of family income in the absence of these policies.
A single full-time minimum wage worker in Los Angeles earning $33,250 annually would go from paying approximately $220 per month (8% of income) for a plan with a $2,200 deductible to paying $90 per month (3% of income) for a plan with no deductible.

300,000 individual market enrollees with income above the ACA eligibility cliff (400% FPL) would receive financial help from the state so that they pay no more than 8% to 15% of family income on premiums for a benchmark plan.
Premiums for this group would decline by an average of 59%, creating savings of approximately $440 per person per month.
Improved premium affordability is expected to increase enrollment in plans that require less out of pocket spending.[11]
This group would pay an average of 9% of family income in premium and out-of-pocket costs in the individual market, compared with 19% in the absence of these policies.
A 60-year old married couple from San Mateo County earning $84,000 (approximately 450% FPL in 2023) would go from having to pay $3,350 in total premiums per month (close to 50% of income) to paying $630 per month (9% of income) toward premiums for the benchmark plan.

560,000 individual market enrollees would benefit from lower premiums due to a healthier risk mix in the individual market, even though they would not be eligible for federal or state subsidies in 2023.[12]
Premiums are projected to be 10% lower than they would be without the individual mandate penalty and without the extra affordability help as both policies would entice more healthy individuals to enroll.
Given lower premiums, some enrollees are expected to opt for more generous, higher value plans with lower out-of-pocket costs. As a result, we project that premiums for this group would on average be $35 lower per month.
A single 40-year old in Sacramento earning $83,000 (approximately 600% FPL in 2023) would go from paying $680 in premiums per month to $610 in premiums per month for a benchmark plan, a savings of over $800 per year.

California has the opportunity to build on its successes implementing the ACA by continuing to cover more Californians and providing greater relief from the high costs that some still experience with individual market coverage. If the state takes no action, we project that the number of uninsured will increase to 4.4 million by 2023 and the lack of an individual mandate penalty will increase premiums by an additional 8%.[13] If, however, the set of policies being proposed were fully implemented by 2023, the state would be able not only to maintain the progress realized under the ACA, but also to make substantial improvements in both coverage and affordability, providing relief to 3.6 million Californians. Furthermore, these policies would reduce coverage disparities that exist for undocumented immigrants, Latinos, and the lowest income Californians.

While other states have implemented some elements of this set of policies,[14] California could be the first to expand full-scope Medicaid coverage to undocumented adults and the first to cap premium contributions based on income for all individual market enrollees. Even as California explores options for more extensive health system reforms, including how to attain federal approval, the Golden State can be a model for other states by helping more Californians gain more affordable coverage now.

Technical Appendix: Modeling assumptions and details

We assume that the effect of a state mandate penalty on enrollment is the same as if the federal penalty had been in place. While the effect may phase in over time, we assume that by 2023 the full effect on enrollment would be evident. We model the effect of the mandate on enrollment as mostly psychological and only partially related to the actual dollar value of the penalty that a person would owe, or even whether that person would technically owe a penalty at all.

Our model suggests that eliminating the individual mandate penalty results in approximately 8% higher premiums in the individual market than if the penalty had not been eliminated—the 3.5% average increase in premiums due to penalty elimination that is already reflected in 2019 rates,[15] plus an additional 4.5% in future years. With a reinstated individual mandate penalty, the policies to provide state premium and cost sharing support that we model in this report result in an additional reduction in premiums in the individual market of approximately 2%.

Calculations of individual market savings compare what individual market enrollees are projected to pay in 2023 under the policy to what they are projected to have paid had they been enrolled in the individual market under the status quo scenario.

CalSIM does not project macroeconomic changes like recessions, but we do model scheduled increases in state and local minimum wages. We do not model the chilling effect on Medi-Cal enrollment from the proposed federal public charge rule, though this effect could substantially decrease enrollment.[16]

Our model focuses on the non-elderly population (under age 65). However, there are very few elderly uninsured; the California Health Interview Survey (CHIS) suggests 1% or less of the elderly population in California is uninsured—fewer than 50,000 people. Therefore, our total projections for the number of non-elderly uninsured are roughly equivalent to projections for the total number of uninsured.

CalSIM numbers of uninsured are different from survey-based estimates of the uninsured.

Undocumented California adults with restricted-scope Medi-Cal may report being uninsured or having Medi-Cal to CHIS and other surveys. Undocumented adults who report having Medi-Cal are presumed to have restricted-scope Medi-Cal because they are generally not eligible for full-scope Medi-Cal under current policy. For this reason, CalSIM considers all undocumented adults who currently report having Medi-Cal on surveys as uninsured. For more details, see Appendix C of Dietz et al., November 2018.

Survey totals for Medicaid are always lower than administrative totals, in large part because many people who are recorded as having Medicaid in administrative data fail to report it to surveys.

Who are the 1.7 million more Californians who would gain insurance coverage? How does this compare with earlier analyses of each policy separately?

There would be 700,000 fewer uninsured because of reinstating the individual mandate penalty. This consists of 250,000 in the individual market, 380,000 in Medi-Cal, and 70,000 in employer coverage. These numbers are slightly updated from those reported in our November 2018 report (which used an older version of CalSIM).

800,000 otherwise uninsured undocumented adults would gain coverage through Medi-Cal. Another 150,000 undocumented who would otherwise be enrolled in employer or individual market coverage are projected to enroll in Medi-Cal, for a total of 900,000 enrolled undocumented adults. This projection of enrollment is lower than other estimates that rely heavily on administrative data,[17] in part because survey totals for

Medicaid are almost always lower than administrative totals. We assume no reduction in enrollment due to the proposed public charge rule.
200,000 would take up coverage in the individual market as a result of state premium and cost sharing support, assuming the individual mandate penalty is in place. Our estimate for the effect of this extra affordability assistance in the absence of an individual mandate penalty is 240,000—close to the estimates from Covered California under a similar scenario (290,000 increase in the individual market under option 1)..

POLITICOPRO

California individual mandate would generate $350M a year, analysis says
Angela Hart
May 8, 2019

Under an individual mandate proposal, California would generate up to $350 million per year in penalties from those forgoing health coverage — less than Gov. Gavin Newsom first anticipated — according to a new Assembly Appropriations Committee analysis.

It's the first detailed estimate of revenues associated with a state individual mandate, part of an analysis of CA AB414 (19R) by Assemblyman Rob Bonta (D-Alameda). It's lower than the $500 million projected by Newsom during his January budget release, though Department of Finance spokesperson H.D. Palmer said the governor will provide his own updated estimate tomorrow in the May budget revision.

California Democrats are seeking to require residents to have health coverage or face financial penalties though several legislative proposals. In addition to A.B. 414, Sen. Richard Pan (D-Sacramento) is carrying an individual mandate bill, CA AB175 (19R), and Newsom has proposed a mandate as part of his budget.

The proposals come after a Republican-led Congress and President Donald Trump in 2017 zeroed out the tax penalty that had been a central component of the Affordable Care Act. Health policy researchers have said that a California mandate would help prevent a dramatic rise in uninsured residents.

Newsom and lawmakers want to use mandate-related revenue to reduce costs for consumers purchasing health coverage through Covered California. Some Democrats, however, have voiced concern that the mandate would not generate enough money to provide low- and middle-income people with adequate financial assistance, setting up a potential budget standoff with the governor over the appropriate subsidy level.

A.B. 414 was placed on the Assembly Appropriations Committee suspense file today.

POLITICOPRO

2M-plus California children lack adequate health care access, audit finds
Angela Hart
Mar. 18, 2019

SACRAMENTO — More than two million low-income children in California lack adequate access to basic health care, State Auditor Elaine Howle finds in a new audit.

California lawmakers should direct the state Department of Health Care Services to establish a new payment model for Medi-Cal providers that boosts reimbursement rates for physicians, hospitals and others who meet higher quality targets and achieve better health outcomes, Howle recommends.

The program should ensure that "plans are more consistently providing preventive services to children in Medi-Cal," she said. The Legislature should also increase funding to pay for that shift if DHCS determines additional money is required.

DHCS oversees California's Medi-Cal program, which provides free or low-cost health care to 13.2 million Californians — a third of the state's residents. Forty percent of the beneficiaries are children, according to the California Health Care Foundation.

The shift, also known as "value-based purchasing" or "pay-for-performance," is required in part because California lacks enough health providers and pays low reimbursement rates, the audit found.

On average, 2.4 million children enrolled in Medi-Cal over the past five years did not have adequate access to preventive care, and many babies didn't have access to pediatric preventive care. The findings show California ranks below the national average in the provision of basic health care for low-income children who depend on Medicaid.

Gov. Gavin Newsom has proposed a value-based payment program to increase provider rates using Proposition 56 tobacco tax revenue. Part of the $3.2 billion proposal includes incentive payments for Medi-Cal managed care plans that improve care for high-cost and high-need populations, according to DHCS.

If approved, the funding is expected to help low-income beneficiaries across the spectrum, but is not directed specifically at preventive health care services for children.

We read Democrats' 9 plans for expanding health care. Here's how they work.
Sarah Kliff and Dylan Scott
Mar. 20, 2019

Democrats are lining up behind Medicare-for-all. But what exactly do they mean?

Last year, dozens of Democratic candidates ran — and won — on a promise to fight to give all Americans access to government-run health care. A new Medicare-for-all bill in the House already has more than 100 co-sponsors. Many of the 2020 Democratic presidential candidates have endorsed the idea.

"Medicare-for-all" has become a rallying cry on the left, but the term doesn't capture the full scope of options Democrats are considering to insure all (or at least a lot more) Americans. Case in point: There are currently more than half a dozen proposals in Congress, which all envision very different health care systems.

"Democrats ran on health care," Hawaii Sen. Brian Schatz told Vox last year. "We now control one chamber of Congress. We have an opportunity and an obligation to demonstrate what we'd do if we were in charge of both chambers. We have an obligation to hear from experts and figure out the best path forward."

We spent a month reading through the congressional plans to expand Medicare (and a few to expand Medicaid, too) as well as proposals at major think tanks that are influential in liberal policymaking. We talked to the legislators and congressional staff who wrote those plans, as well as the policy experts who have analyzed them.

These plans are the universe of ideas that Democrats will draw from as they flesh out their vision for the future of American health care. While the party doesn't agree on one plan now, they do have plenty of options to choose from — and many decisions to make.

The nine plans fall into two categories. There are some that would replace private insurance and cover all Americans through the government. Then there are the others that would allow all Americans to buy into government insurance (like Medicare or Medicaid) if they wanted to, or they could continue to buy private insurance.

We learned these plans are similar in that they envision more Americans enrolling in public health plans. They would all give the government a greater role in everything from setting health prices to deciding what benefits get included in an insurance plan. Experts say all these bills would almost certainly create an insurance system that does better to serve Americans with high health care costs.

“If you’re really sick and have high drug costs, it would be hard not to benefit from these bills,” says Karen Pollitz, a senior fellow at the Kaiser Family Foundation who recently co-authored a report comparing the different Democratic plans to expand public coverage.

But the Democrats’ plans differ significantly in how they handle important decisions, like which public health program to expand and how aggressively to extend the reach of government. Some would completely eliminate private health insurance, moving all Americans to government-run coverage, whereas others still see a role for companies providing coverage to workers.

Some bills require significant tax increases to pay for the expansion of benefits — while others ask those signing up for government insurance to pay the costs.

And while Democrats aren’t under any illusion that they’ll pass Medicare-for-all this Congress, they see the next two years as key to figuring out where consensus in the party lies. House Democratic leaders have already promised the first-ever hearings on Medicare-for-all and requested a long list of information from the Congressional Budget Office.

“We want to have public hearings on this, we want to see movement on the issue,” says one Democratic House aide working on this legislation. “The Senate is still Republican but right now, Democrats have the opportunity to build support, have public hearings, and help move this idea along and educate members.”

Here are the key questions those hearings and that education will grapple with.

How many people get covered?
Bottom line: Some plans from the Democrats would cover all Americans — while others would provide insurance to more but leave some number of people uninsured.

In a way, this is the fundamental question. Even under the Affordable Care Act, 30 million Americans don’t have health insurance. The left believes health care is a human right, and mainstream Democrats aren’t far behind them. The whole reason Democrats are ready to take up health care reform again so soon after the ACA is to fix this problem.

Medicare-for-all (Senate and House): Every single American would be covered by a government insurance plan, after a short phase-in period.

Medicare for America (DeLauro and Schakowsky): This health care plan, informed by the work of the Center for American Progress and Yale professor Jacob Hacker, would achieve universal coverage for all legal residents, through a combination of private and public insurance — at least for the next few decades. It eventually foresees getting to a very similar level of coverage as the Medicare-for-all proposals in Congress, by

enrolling all newborns into a government health plan and taking steps that would diminish the role of employer-sponsored coverage.

Medicare and Medicaid buy-ins (congressional plans): Millions more Americans would likely be covered, but experts don't expect the various buy-in plans to achieve universal coverage. They would still, after all, be optional programs.

Healthy America (Urban Institute's Linda Blumberg, John Holahan, and Stephen Zuckerman): This center-left plan from three Urban Institute fellows is explicitly not a plan for universal coverage, by attempting to work within certain political constraints. But it would, according to Urban's estimates, cut the number of uninsured by 16 million in its first year.

A big part of the remaining uninsured would be undocumented immigrants. The plan's authors said the program could be adjusted to cover that population but didn't think there'd be political will to do so.

What happens to employer-sponsored insurance?
Bottom line: Democrats are split over whether expanded Medicare should make space for employer-sponsored plans — or get rid of them completely.

Nearly half of all Americans get their insurance at work — and Democrats' various health care plans make different decisions about whether that would continue.

Currently, the American health care system provides employers with a big incentive to provide coverage: Those benefits are completely tax-free. This means companies' dollars stretch further when they buy workers' health benefits than when they pay workers' wages.

This, however, creates an uneven playing field. Fortune 500 companies get, in effect, a huge federal subsidy to insure their workers, while an individual who doesn't get coverage through their job and makes too much money to receive subsidies under the Affordable Care Act doesn't get any advantageous treatment under the tax code.

Medicare-for-all (Senate and House): Both the Medicare-for-all plans would make the biggest change and eliminate employer-sponsored coverage completely. Under these options, all Americans who currently get insurance at work would transition to one big government health care plan.

Medicare for America: This plan does let employers continue to offer coverage to their workers so long as it meets certain federal standards. At the same time, it would give employers an alluring, simpler option: stop offering coverage and instead pay a payroll tax roughly equivalent to what they currently spend on health coverage.

As to how alluring that plan would be, that depends a lot on how generous Americans consider this new Medicare program to be. Premiums would be capped at about 10 percent of a household's income, while lower-income families would pay less. Out-of-

pocket costs would be capped at $3,500 for an individual, $5,000 for a family, with less affluent families again receiving a break. The great unknown is how quickly those benefits pull people away from their work-based coverage into the new Medicare program.

Medicare for America makes another policy decision that would erode employer-sponsored coverage: It automatically enrolls all newborns into the public program. That means a new generation of Americans likely won't get coverage through their parents' workplaces — and would assure the Medicare plan a constantly growing subscriber base.

Medicare/Medicaid buy-ins
The question of work-based insurance is prickliest for the Medicare buy-in plans. Broadly speaking, under those bills, more Americans would be allowed to purchase a public insurance plan under the Medicare umbrella. Everybody who currently buys insurance on the individual market would be allowed to buy a Medicare plan, under each of the buy-in bills.

But they differ in important ways in how much they would let people leave their current job-based insurance for the new government plan.

The "Choose Medicare" Act (Merkley and Murphy): Merkley described his bill with Murphy as, potentially, a glide path to true single-payer Medicare-for-all. Under their Medicare buy-in framework, workers could leave their company's insurance for the new public plan — but only if their employer decides to allow it. Otherwise, they'd be shut out.

(The bill does include a provision, however, allowing workers to keep the government plan once they sign up, even after they leave their current job.)

We asked Merkley why they left the decision up to the employers, not the employees. He pointed to a workers' compensation program that had been successful in Oregon that was modeled the same way. He's also worried about adverse selection (employers sending sick employees to the public plan while healthier workplaces stay in the private market).

Lastly, he emphasized the workers who transition to new jobs or go for a period without coverage would have a chance to sign up for Medicare and then keep that plan even after they get a new job.

"Workers can go to their employer and say, 'I really would prefer to be in the public option,'" Merkley says. "We wanted to avoid the situation of employers pushing people out."

The CHOICE Act (Schakowsky and Whitehouse): Small employers who are currently eligible to buy insurance through the ACA's marketplaces would be allowed to

participate in the Medicare buy-in. Workers at larger firms would be frozen out, however.

Medicare X (Bennet, Kaine and Higgins): Likewise, small employers eligible for ACA coverage could buy into Medicare under this legislation, but large employers could not. Medicare X would actually be limited to customers in Obamacare markets that had only one insurer or particularly high costs, for the program's first few years, before expanding to the rest of the individual market nationwide.

Medicare-at-50 (Stabenow): Any American 50 years old or older would be permitted to buy into Medicare, including those who currently receive health insurance through their job.

Think tank plans

Healthy America (Urban Institute): The Urban Institute explicitly designed its Healthy America plan with the goal of disrupting the large employer market as little as possible. They expect only lower-wage workers whose current insurance isn't very good anyway to move over into the brand new insurance marketplaces that would be set up under their plan.

Those markets would combine the Medicaid population with the people currently covered by Obamacare but more or less leave people who get insurance through their jobs alone.

"That's a real barrier to doing anything big," John Holahan at Urban said. "Most people with employer plans are reasonably happy with them."

What public program will expand?
Bottom line: The vast majority of proposals expand Medicare, the plan that covers Americans over 65. But there is one option that would expand Medicaid, the plan that covers low-income Americans — and another option that creates a new government program entirely.

The American government already finances two major health coverage plans: Medicare and Medicaid. Taken together, these two programs cover one-third of all Americans: 19 percent of Americans get their coverage from Medicare, and 14 percent from Medicaid.

What's more, both of these programs are popular. One recent poll found that 77 percent of Americans think Medicare is a "very important" program. Voters have recently given a boost to Medicaid, too: Voters in Idaho, Nebraska, and Utah all passed ballot initiatives that will expand the program in their states to thousands of low-income Americans.

Given the popularity and size of Medicare and Medicaid, nearly all the Democrats' proposals use these programs as a base for universal coverage, changing the rules to make more people eligible. But there are differences in which programs they pick, and one plan that starts a new government program entirely.

Medicare-for-all, Medicare buy-in, Medicare for America: As their names imply, all these plans use Medicare as the base program for expanding health insurance coverage. Medicare is, after all, the only major health program run exclusively by the federal government (Medicaid is run jointly with the states), which can make it an appealing choice for a national coverage expansion.

Traditionally, Democrats have focused on Medicare as a base for expanding coverage. And five of the six legislative proposals we looked at use the program that covers the elderly as the one that would absorb additional enrollees.

Medicaid buy-in (Senate and House bills): Recently, Democrats have begun to eye Medicaid as another option, suggesting that we should focus on expanding the health plan that covers the poor to Americans with higher incomes.

Sen. Brian Schatz (D-HI), for example, has offered a bill that would allow every state to let residents buy into Medicaid. A companion bill is offered by Rep. Ben Ray Lujan (D-NM) in the House.

This plan wouldn't mean moving all Americans into Medicaid — instead, it would give people the option to sign up for the public program, which would presumably offer lower premiums because it would pay doctors and hospitals lower reimbursement rates than private plans typically do.

In an interview with Vox, Schatz said he likes the idea of this Medicaid buy-in because the program has proved popular across the political spectrum. In the 2018 midterms, for example, three red states (Idaho, Nebraska, and Utah) voted to participate in Obamacare's Medicaid expansion. "Medicaid is popular in blue, red, and purple states," he says. "It's not politically fraught anymore. So it's a good place to land for progressives who want to make progress for everyone."

Healthy America (Urban Institute): Rather than rely on any existing program, Healthy America would create a new one. Obamacare and Medicaid would effectively be combined into a brand new insurance market covering upward of 100 million people, and there would be a public insurance plan under the Healthy America brand.

What benefits get covered?
Bottom line: Democrats generally agree that health insurance should cover a wide array of benefits, although there is some variation around how different plans cover long-term care, dental, vision, and abortion.

Every country with a national health care system has to decide what type of medical services it will pay for. Hospital trips and doctor visits are almost certainly included. But there is wide variation on how health care systems cover things like vision, dental, and mental health.

Covering more services mean citizens have more robust access to health care. But that also costs money — and a more generous health care plan is going to require more tax revenue to pay for all that health care.

Even Medicare, as it currently stands, has a relatively limited benefit package. It does not cover prescription drugs, for example, nor does it pay for eyeglasses or long-term care.

Instead, many seniors often take out supplemental policies to pay for those services — or end up selling off their assets to pay for care in a nursing home.

Medicare-for-all (Senate and House)
Both single-payer options envision Medicare covering more benefits than it currently does. The Sanders bill, for example, would change Medicare to cover vision, dental, and prescription drugs, as well as long-term care services as nursing homes. It would also cover a wide breadth of women's reproductive health services including abortion, a feature that would likely draw controversy.

The House bill covers a slightly different set of benefits but, according to one Democratic House aide, is undergoing revisions to look more similar to the Sanders package. "We want to make sure we're able to align the coverage services [of our bill] with the Sanders plan," said the aide, who asked to speak anonymously to discuss the ongoing negotiations.

Medicare for America (DeLauro and Schakowsky): The Medicare for America plan mandates that all health insurance cover a robust set of benefits including prescription drugs, hospital visits, doctor trips, maternity services, dental, vision, and hearing services.

Medicare/Medicaid buy-ins
All three notable Medicare buy-in plans would cover the 10 essential health benefits mandated by Obamacare: outpatient care, emergency services, hospitalization, maternity and newborn care, mental health and substance abuse services, and prescription drugs. None of them include vision or dental care.

The "Choose Medicare" Act (Merkley and Murphy): This bill covers essential health benefits, as well as the benefits included in Medicare's current inpatient, outpatient, and prescription drug plans. Abortion and other reproductive services would also be covered.

The CHOICE Act (Schakowsky and Whitehouse): The ACA's essential health benefits would be covered.

Medicare X (Bennet, Kaine and Higgins): Same. The new public plan would cover the essential health benefits dictated by the 2010 health care reform law.

“The policy would have all the ACA benefits. We’d give HHS the time and seed money to figure this out and price it,” Sen. Tim Kaine (D-VA) told Vox previously. “There are studies, back from 2010, that suggest a public option would not only save money but it would make the markets more competitive.”

Medicare-at-50 (Stabenow): This buy-in is distinct from the others in that it preserves the existing Medicare benefits: part A (hospital care), part B (physician care) and part D (prescription drugs) — a reflection of it being targeted to an older population that is already near the Medicare age.

Think tank plans
Healthy America (Urban Institute): The benefits package is again based on Obamacare’s essential health benefits.

How much does it cost enrollees?
Bottom line: Democrats do not agree on whether patients should pay premiums or fees when they go to the doctor. Some plans get rid of all cost sharing, while others (largely those that allow employer-sponsored coverage to continue) keep those features of the current system intact.

Medicare is currently similar to private health insurance in that it expects enrollees to pay a significant share of their medical costs.

The public program, for example, currently charges seniors a $134 monthly premium (and a higher premium for wealthier enrollees). Traditional Medicare also has deductibles and co-insurance. An estimated 80 percent of Medicare enrollees have additional coverage to help cover those costs.

The plans offered by Democrats have really different visions for whether enrollees in a newly expanded Medicare would end up paying these kinds of costs — or if premiums, deductibles, and copayments would become a thing of the past.

Medicare-for-all (Senate and House)
Both Medicare-for-all bills would eliminate cost sharing completely. This means no monthly premiums, no copayments for going to the doctor, and no deductible to meet before coverage kicks in.

The only place where enrollees might pay out of pocket is under the Sanders plan, which does give the government discretion to allow some charges for prescription drugs — but even that would be capped at $200 per year.

This is very similar to how the Canadian health care system works but is actually quite different from European countries. Most countries across the Atlantic actually do require patients to pay something for going to the doctor. In France, for example, patients are expected to pay 30 percent of the cost of their doctor visit — and in the Netherlands, copayments range from $10 to $30.

In a previous interview with Vox, Sanders said he considered copayments for his proposal but “the logic comes down on the way of what the Canadians are doing.”

The senator who rails regularly against “millionaires and billionaires” doesn’t see value in asking those people to pay when they show up at the doctor. They’ll pay more in taxes to finance a system without copayments, but when they go to the doctor, he argues, they ought to be treated the same as the poor.

Medicare for America (DeLauro and Schakowsky): This legislation, unlike the single-payer Medicare-for-all options, continues having some Americans pay premiums tethered to their incomes. This reduces the tax revenue necessary to finance an expanded Medicare program — but also requires a slightly more complex system that can calculate each family’s premium and collect that payment.

Low-income Americans would be enrolled in Medicare without any premiums and receive relief from their out-of-pocket obligations. Higher-income Americans would be expected to pay a monthly premium (at most, 10 percent of their income) and pay deductibles and copayments (deductibles are capped at $350 for an individual, $500 for a family; out-of-pocket costs are capped at $3,500 for one person and $5,000).

Medicare/Medicaid buy-ins
There is one important common thread through these bills: Premiums would be set to cover 100 percent of the actual medical costs that the government plan expects to cover, as well as any administrative expenses — but nothing more. There would not be any profits or robust executive compensation, as there still is in the private market. Premiums could be adjusted by a limited number of factors: a patient’s age, where they live, the size of their family, and whether they smoke tobacco.

The most notable difference in the buy-in proposal is in how much patients would be expected to pay out of pocket.

The “Choose Medicare” Act (Merkley and Murphy): This is the most generous Medicare buy-in plan. The new government plan would cover 80 percent of health care costs, matching the “gold” plans on the ACA marketplaces. The bill would also add new out-of-pocket caps for the traditional Medicare population, people 65 and older.

The CHOICE Act (Schakowsky and Whitehouse): This bill would offer several versions of the public plan, with varying out-of-pocket costs: They would cover between 60 and 80 percent of expected medical expenses.

Medicare X (Bennet, Kaine and Higgins): By default, the government plan would be offered at two tiers: one that covers 70 percent of medical costs and another that covers 80 percent. The health secretary could also decide to offer health plans covering 60 percent of costs or 90 percent, but it is not required.

Medicare-at-50 (Stabenow): The health department would be charged with determining the cost of covering the buy-in population and setting premiums accordingly to cover

that cost. Enrollees would be allowed to use the financial assistance available under Obamacare to help pay for their Medicare coverage.

Medicaid buy-in (Sen. Schatz and Rep. Lujan): The Schatz proposal would give the states leeway to decide how they want to set premiums, copayments, and deductibles. They would cap premiums at 9.5 percent of a family's income (a provision that already exists for those covered under Affordable Care Act plans) or the per-enrollee cost of Medicaid buy-in, whichever is less.

Think tank plans
Healthy America (Urban Institute): Premiums would range from 0 percent of a household's income, for people who make less money, up to 8.5 percent. Nobody would be asked to pay more than that.

The standard health insurance plan under Healthy America would cover 80 percent of medical costs. People with lower incomes would receive additional subsidies to reduce their out-of-pocket obligations, while consumers would also have the option to buy a plan with higher out-of-pocket costs but lower monthly premiums.

How is it paid for?
Bottom line: Most Democrats have focused their energy on figuring out what exactly an expanded Medicare program looks like. Legislators have given significantly less attention to how to pay for these expansions.

Bringing government health care to more Americans usually means finding more government revenue to pay for that expanded coverage. The Affordable Care Act, for example, expanded coverage to millions of people through a wide range of taxes that hit health insurers, medical device manufacturers, hospitals, wealthy Americans, and even tanning salons.

Right now, many of the details around financing remain murky. One reason for that is we don't actually know how much these different plans would cost; the Congressional Budget Office hasn't scored any of these plans yet (although there are a few independent estimates of how much the Sanders plan would cost).

Medicare-for-all
Senate: Sanders's office has released a list of financing options that generally impose higher taxes on the wealthiest Americans, such as increased income and estate taxes, establishing a new wealth tax on the top 0.1 percent, and imposing new fees on large banks.

House: Over on the House side, aides say that while they are currently working on revisions to HR 676, that focuses mostly on updating the benefits package — and less on deciding how to pay for the package. They do not currently expect to release a financing plan in early 2019.

“Let’s get our policy straight first and then look for suggestions on financing,” says one Democratic House aide involved in the process. “It’s possible we might offer some ideas on financing, but that’s still under debate.”

Medicare for America (DeLauro and Schakowsky): There is a more detailed financing plan laid out in the Medicare for America legislation. The Republican tax cuts would be rolled back. An additional 5 percent tax on income over $500,000 would be applied. Payroll taxes for Medicare would also be hiked, as would the net investment income tax rate. New excise taxes on tobacco, alcohol and sugary drinks would be introduced. The bill also requires states to continue making payments to the federal government equivalent to what they pay right now for Medicaid’s costs.

Medicare/Medicaid buy-ins
Depending on how you look at it, financing is either one big advantage of the buy-in approach or it reveals the flaw in their design. These plans still charge people premiums, which would be calculated to cover the costs of covering people who buy the new public option plan as well as any administrative costs.

So there isn’t necessarily a need for a big new revenue source; the premiums are the revenue source. None of the Medicare buy-in plans included major new taxes or anything like you would see to pay for the Medicare-for-all single-payer plans. All three of them do set aside some money for startup costs, but it’s a marginal amount in the context of the federal budget. And the Medicaid buy-in plan does bump up certain doctor payment rates, which the legislators say would come from general revenue.

The differences are so minor, they aren’t worth going through in detail. But it’s important to remember the trade-off: Medicare and Medicaid buy-ins don’t require a lot of new money because people will be asked to pay premiums — but that also means people will be asked to pay premiums, something the more ambitious versions of Medicare-for-all try to eliminate.

Think tank plans
Healthy America (Urban Institute): Because Healthy America combines Obamacare and most of Medicaid, the proposal is largely funded by repurposing the federal dollars that currently go to those programs. That would cover the bulk of the costs, but Urban does anticipate the need for new federal funding.

Like many of its peers, Urban isn’t yet set on a specific revenue stream, but it has floated a 1 percent increase on the Medicare payroll tax, split evenly between employers and employees. That would bring in about $820 billion over 10 years, which Urban thinks would be enough to cover most of the new costs needed to fund Healthy America.

HealthLeaders

ACA Marketplaces More Competitive In 2019

John Commins

Mar. 22, 2019

The Affordable Care Act's Marketplace plans got more competitive in 2019, but there are still more regions with only one or two plans to pick from, a new study suggests.The number of people living in areas with five or more marketplace insurers increased by 8% in 2019, from 18.6% to 20.1%, according to the analysis by the Urban Institute and the Robert Wood Johnson Foundation.At the same time, the analysis showed that the number of people living in areas with only one or two plans in 2019 dropped by 17%, from 45.1% to 37.5%, which the report said signals an increase in marketplace competition between 2018 and 2019.

However, the study found wide swings in plan availability depending upon geography.More than 20% of Americans live in an area with five or more marketplace insurers, the 322 least competitive rating regions are disproportionately concentrated in less populated areas of the country, especially the South."It's encouraging to see signs of stabilization in the individual market," said Anne F. Weiss, managing director at the Robert Wood Johnson Foundation, in comments accompanying the study."However, geographic location still plays too great a role in consumers' coverage options and how much they cost. Everyone should have affordable health insurance options, regardless of where they live, given the impact of coverage on health," Weiss said.Among the findings:

The Northeast leads the nation in marketplace insurer competition, with a little more than 40% of its population living in areas with five or more marketplace insurers.

In the South, only 4% of residents live in areas with five or more marketplace insurers, while a majority (just under 53%) live in areas with only one or two marketplace insurers.

Approximately 26% of the population in both the West and the Midwest live in areas with five or more insurers, with 19% and 40% living in areas with only one or two insurers, respectively.Consumers in areas with fewer marketplace insurers typically pay higher premiums. In 2019, the median benchmark silver plan premium for a 40-year-old non-smoker in regions with one insurer cost $592 per month compared to $376 per month in regions with five or more insurers, a difference of more than 36%.

A separate study issued this month by the Government Accountability Office found that enrollment in private health insurance plans continued to be concentrated among a small number of health insurers in 2015 and 2016.In the large group market, small group market, and individual market, the three largest commercial health insurance plans held 80% of the market or more in at least 37 of 51 states. The findings are similar to what GAO reported for 2011 through 2014.GAO also found that within the overall individual and small group markets in each state, the health insurance exchanges established by the ACA were also concentrated from 2015 to 2017.

- For the individual market exchanges, in each year, three or fewer issuers held 80% or more of the market, on average, in at least 46 of the 49 state exchanges.
- The largest insurers increased their market share in about two-thirds of exchanges.
- For the small group market exchanges, in each year, three or fewer issuers held 80% or more of the market in at least 42 of 46 state exchanges.

THE AMERICAN PROSPECT

How Trump's 'Invisible Wall' Frightens Legal Immigrants Out of Medical Care
Eric Pape
Mar. 22, 2019

President Donald Trump's anti-immigrant tweets and provocative border talk, along with his drive to toughen immigration enforcement around the nation, is scaring many immigrants away from medical care, claim a growing number of medical executives and health care professionals.

"Every other day he reminds us [with] all this talk about the Wall, the Wall, the Wall," says Castulo de la Rocha, the head of AltaMed Health Services, whose medical networks serve large numbers of undocumented people in Southern California. "People see images of children caged by this government. It all spreads like wildfire in immigrant communities. Think about what it means for people who hear that they will be picked up by an ICE [Immigration and Customs Enforcement] agent. The rage that they have to deal with day in and day out accumulates very quickly."

The end result is that more immigrants of all stripes seem to be holding off on medical visits they need.

Medical experts highlight some of the reasons that California's clinics offer free health care to people who cannot otherwise afford it in the first place. Namely, public safety.

"Diseases don't respect borders," explains de la Rocha. Nor do tuberculosis, AIDS, Zika, and countless other infectious diseases care about passports, citizenship, or residency.

"The health-care system is a backstop for society, to make sure that everyone receives at least a minimum level of attention so that they don't undermine the health of others."

Medical executives at several prominent Los Angeles-based organizations that provide free medical care to immigrants in need suggest that the Trump presidency's most detrimental impact on immigrant health may lie in what is sometimes described as the "invisible wall."

They point to the administration's longstanding efforts to officially change the immigration-adjudication process so that large numbers of legal immigrants can be prevented from securing long-term or permanent status in the U.S.

On October 10, 2018, the administration formally proposed new rules expanding the definition for immigrants of a "public charge"—i.e., someone deemed to be dependent on the government.

Whatever its final policy might look like, the White House clearly aims to make it easier to reject legal immigrants' efforts to extend visas, obtain green cards or secure citizenship, based partly on their health care. Factors that may be given new weight in making immigration decisions include whether someone accessed children's health insurance, used food stamps, or benefited from Obamacare.

While the new policy hasn't yet become official, it has jolted many immigrants who are awaiting decisions on their legal status, inspiring shock waves that continue to destabilize immigrant medical care.

Medical executives don't keep track of exact numbers, but say that many immigrants suddenly began calling early in the Trump presidency to see if they could have their names scrubbed from health clinic and Medi-Cal rosters. They were afraid that cross-referencing might put an end to their time in the country.

Other reactions have been more palpable, whether for undocumented immigrants fearful of ICE raids or for documented immigrants unable to convince immigration judges to let them remain in America.

"Parents are coming in and asking for extra bottles of diabetes medication and extra copies of their children's medical records in case they are deported," explains Joe Mangia, the president and CEO of St. John's Well Child and Family Center in Los Angeles.

He speaks of the stress that many patients are under, citing an anecdote about a person hurrying into one center's waiting room and announcing that they thought they saw ICE agents outside, sparking panic.

Immigration agents are allowed to visit the lobby of federally qualified health centers, but they are not supposed to violate the medical "safe haven" beyond without a warrant or some other form of special permission. Those rules, put in place during President Barack Obama's first term, have already been stretched under Trump.

To soothe patients' nerves at St. John's network of centers, staff members have been trained to respond to possible immigration enforcement actions by forming a human chain around their clinic to protect patients from ICE, Mangia says.

After Trump hyped up new immigration-related measures at the start of 2018, Mangia says St. John's centers endured a decline of 5,000 patients over the first six months of the year compared to previous years.
The tug of war often revolves around the president's tough-sounding pronouncements.
After Trump hyped up new immigration-related measures at the start of 2018, Mangia says St. John's centers endured a decline of 5,000 patients over the first six months of the year compared to previous years. That marked a 10 percent drop.

"The drop was really all about fear," says Mangia. "We started calling all of our patients and saying [these primary care clinics] are safe spaces and we did the human chain training."

Thanks to such outreach, he says, the center was quickly able to convince its patients to return, but that hasn't necessarily been the case for other clinics. "The fear is still palpable and the tragedy—the heartbreak—is the people who do not come in."

Odilia Romero, an indigenous-language translator and interpreter who frequently works in the medical sphere, says that many of the people she translates for are shaken and confused. "With all the news about the undocumented, people think they are not allowed to get services," Romero says. "At the end of the day, people are always afraid things will affect their immigration status."

The Trump administration is working to limit legal immigration on a plethora of fronts. The National Foundation for American Policy recently found that the State Department rejected 39 percent more visa applications—along with another five percent drop for non-immigrants who sought temporary visas—during the second fiscal year of Trump's presidency. The justifications for many of those decisions remain unclear.

But there is little doubt that pitting immigration against public health affects U.S. citizens in ways that go far beyond the threats from infectious diseases. People who end up in emergency rooms because they didn't get basic primary care tend to cost the health system far more money.

And many immigrants in California, whether legal or undocumented residents, have children who are citizens. Health-care officials note that "invisible wall" policies help create difficult situations where parents must balance the risks to their time in this country and the health of their children.

"Instead of creating walls," says de la Rocha, "we should be talking about bridges, particularly in medicine and health care."

The New York Times

Medicare for All Would Abolish Private Insurance. ‘There’s No Precedent in American History.’

Reed Abelson and Margot Sanger-Katz
Mar. 23, 2019

At the heart of the “Medicare for all” proposals championed by Senator Bernie Sanders and many Democrats is a revolutionary idea: Abolish private health insurance.

Proponents want to sweep away our complex, confusing, profit-driven mess of a health care system and start fresh with a single government-run insurer that would cover everyone.

But doing away with an entire industry would also be profoundly disruptive. The private health insurance business employs at least a half a million people, covers about 250 million Americans, and generates roughly a trillion dollars in revenues. Its companies’ stocks are a staple of the mutual funds that make up millions of Americans’ retirement savings.

Such a change would shake the entire health care system, which makes up a fifth of the United States economy, as hospitals, doctors, nursing homes and pharmaceutical companies would have to adapt to a new set of rules. Most Americans would have a new insurer — the federal government — and many would find the health insurance stocks in their retirement portfolios much less valuable.

“We’re talking about changing flows of money on just a huge scale,” said Paul Starr, a sociology professor at Princeton University and author of “The Social Transformation of American Medicine: The Rise of a Sovereign Profession and the Making of a Vast Industry.”

“There’s no precedent in American history that compares to this,” he said.

Economists have begun wrestling with basic questions about what this sort of change would mean and disagreeing over whether it would cost more or less than the country’s current health care system.

No one has examined the full economic impact of such plans on jobs, wages, investors, doctors and hospitals — or the health insurance companies themselves. Such an undertaking would be difficult, given the vagueness of key parts of the proposals being discussed and the wide-ranging possible effects.

There are few international analogues to the Medicare for all proposals, but Canada, which provides similar doctor and hospital benefits for its residents, probably comes

closest. Even there, people buy private insurance for benefits that are not covered by the government program, like prescription drugs and dental care.

Most other countries with single-payer systems allow a more expansive, competing role for private coverage. In Britain, for example, everyone is covered by a public system, but people can pay extra for insurance that gives them access to private doctors. Most countries in Europe don't have single-payer systems, but instead allow private insurance companies to compete under extremely tight regulations.

Legislators writing the bills acknowledge that people in the health insurance industry would lose their jobs. Proposals in the House and Senate would set aside large funds to help cushion the blow to displaced workers, offering them training, benefits, and income supports.

The health insurance industry is now composed of a mix of for-profit and nonprofit companies of various sizes. About 155 million Americans get private health coverage through an employer, but the reach of the industry extends into publicly funded insurance programs.

A third of Americans enrolled in Medicare, which insures older and disabled people, and four-fifths of those in Medicaid, which covers the poor and disabled, now get their benefits from a private insurer.

Simply talk of Medicare for all makes investors jittery. Shares of the large publicly held insurance companies, including Cigna, Humana and UnitedHealth, fell when Representative Pramila Jayapal, Democrat of Washington, introduced her bill in late February, but have largely rebounded.

The effective takeover of the health insurance industry in the United States would mean a huge hit to the companies' stocks, although the companies, which have additional lines of business, would most likely survive.

While the bills would give relief to insurance industry workers, they would provide no such compensation for investors. Not surprisingly, the insurance industry and many other health care industries vociferously oppose these plans and plan to spend heavily in fighting them.

Many supporters of this approach see elimination of private insurance as a key feature, not a bug, meant to improve the program's efficiency and equity by streamlining the health care system and weakening profit motives. With a single insurer covering every

patient, hospitals and doctors could spend less time and money complying with differing policies, negotiating contracts, and filing forms to get paid.

“It’s worth it,” said Adam Gaffney, the president of Physicians for a National Health Program, which supports single-payer health care and helped design Ms. Jayapal’s bill. “Because we are not going to get to true universal health care without the greater efficiency of a single-payer system.”

This idea — once at the edge of Democratic politics — has moved to the mainstream of the debate among the party’s numerous presidential contenders. Mr. Sanders, independent of Vermont, ran on the idea in his 2016 campaign, and now five 2020 Democratic aspirants have co-sponsored one of the two Medicare-for-all bills.

Senators Cory Booker of New Jersey, Kirsten Gillibrand of New York, Kamala Harris of California, and Elizabeth Warren of Massachusetts co-sponsored Mr. Sanders’s bill in the last Congress. Representative Tulsi Gabbard of Hawaii is a co-sponsor on this year’s House Medicare for All Act.

The concept, in broad strokes, appeals to many Democratic voters. But overall support diminishes by a third or more when people are told that the plan would involve eliminating private insurance, raising taxes, or requiring waits to obtain medical care, according to surveys from the Kaiser Family Foundation.

And the approach is a big departure from the Democrats’ strategy in 2010, when Congress passed the Affordable Care Act. That law expanded coverage, but did so largely using private insurance carriers. It set up marketplaces for Americans who didn’t have coverage through work to buy insurance, usually with federal subsidies, and broadened access to the Medicaid program for the poor.

Obamacare was designed to build on the current system, patching its holes while minimizing disruption and avoiding the fierce opposition from industry that helped sink earlier attempts to change the health care system.

But 107 Democratic House members are now co-sponsoring a Medicare for all bill written by Ms. Jayapal. Mr. Sanders, whose update of his bill is expected in the next few weeks, argues that only a single-payer approach would resolve problems he sees as inherent in private insurance. Both proposals are clear that a single, government-run insurer would replace the private sector, but they are less detailed about exactly how the government program would pay for medical care.

Their plans would include nearly every doctor and hospital in the United States and provide generous benefits, including dental care and hearing aids, and would not require patients to pay any out-of-pocket cost to see a doctor. The federal government, of course, would have to cover those benefits, and would need to raise taxes to pay for them.

Gerald Friedman, a labor economist at the University of Massachusetts Amherst, who was close to Mr. Sanders's 2016 campaign, estimated then that it could reduce the nation's health care spending by $6 trillion over a decade, while the left-leaning Urban Institute said it might increase the overall bill by nearly $7 trillion.

Both Mr. Sanders and Ms. Jayapal said the switch to a government insurer would mean no loss in access to health care that private insurance provides.

"There is a reason why the United States is the only major country on earth that allows private insurance companies to profit off of health care," Mr. Sanders said in an interview. "The function of private health insurance is not to provide quality care to all, it is to make as much money as possible for the private insurance companies, working with the drug companies."

There are sharp disagreements among Democrats in Congress over whether Medicare for all or a more incremental approach is best — and presidential candidates co-sponsoring Mr. Sanders's bill also support other, less sweeping measures.

Ms. Harris, asked directly about getting rid of private health insurance during a CNN forum in January, answered, "Let's eliminate all that. Let's move on." But after her comments were characterized as extreme, her campaign quickly clarified that, while she continued to endorse the Sanders plan, she would also support more incremental expansions of health coverage.

During her CNN forum last week, Ms. Warren said she was open to various ways to get to universal coverage. "When we talk about Medicare for all, there are a lot of different pathways," she said. "What we're all looking for is the lowest cost way to make sure that everybody gets covered."

Dr. David Blumenthal, a former Obama administration official who is now chief executive of the Commonwealth Fund, a nonprofit that funds health care research, voiced concern about the prospects for the most transformative approach. "I do think it's an uphill battle to take things away from people in the name of giving them something better," he said.

Believers in markets argue that consumer choice and competition among private health plans improve the quality of care. Others laud private industry's relative nimbleness compared with Medicare, which can be bureaucratic and prone to political influence. "Private plans have been able to evolve and test new models more quickly," said Caroline Pearson, a senior vice president at NORC, a research organization at the University of Chicago. "The political process slows things down."

In a Medicare-for-all world, private insurers might evolve into contractors for the big government system. They already perform various functions for Medicare, including helping the program manage paying its bills. The industry could retain that role, or take on new responsibilities.

“The government would have to build out infrastructure if they were to shut down all the private insurance companies,” said Mark Bertolini, the former chief executive of Aetna, now part of CVS Health. “It’s not that simple pulling all that apart.”

Donald Trump is very committed to taking away your health insurance
Sarah Kliff
Mar. 27, 2019

Candidate Donald Trump wanted to make sure you have health insurance. President Donald Trump is committed to taking it away.

During his presidential campaign, Trump told 60 Minutes, “I am going to take care of everybody.” On the campaign trail in 2018, he sounded similar. “We will always protect Americans with preexisting conditions,” he said at an event in Philadelphia just before the midterm elections.

Donald J. Trump ✓ @realDonaldTrump
Republicans will totally protect people with Pre-Existing Conditions, Democrats will not! Vote Republican.

But in office, Trump has attempted to implement an agenda that does the opposite. He’s backed legislation, regulations, and lawsuits that would make it harder for sick people to get health insurance, allow insurance companies to discriminate against patients with preexisting conditions, and kick millions of Americans off the Medicaid program.

This week, his Justice Department filed a legal brief arguing that a judge should find Obamacare unconstitutional — a decision that would turn the insurance markets back into the Wild West and eliminate Medicaid coverage for millions of Americans. By at least one estimate, a full repeal could cost 20 million Americans their health care coverage.

The morning after the filing, Trump went back to campaign mode, attempting to sound like his administration has a different agenda.

Donald J. Trump ✓ @realDonaldTrump
The Republican Party will become “The Party of Healthcare!”

Candidate Donald Trump and President Donald Trump have really different views about how the American health care system ought to work — and for patients who rely on the Affordable Care Act, the difference between which of those platforms gets implemented could be a matter of life or death.

Trump's position on health care, explained
President Trump has a lengthy history of promising voters a health care system that provides for all Americans — a position he hasn't ever tried to achieve since taking office.

Shortly before his inauguration, Trump gave an astonishing interview to the Washington Post. The president-elect told the newspaper that he was nearing completion of a plan that would provide "insurance for everyone."

"It's very much formulated down to the final strokes. We haven't put it in quite yet but we're going to be doing it soon," Trump continued.

Sitting in the press gallery of the Capitol building, surrounded by other health policy reporters reading the same article, the buzz began: What would this plan look like? When would we see it?

We still lived in a world where, when a president promised a policy plan, you generally expected to see one.

With the benefit of hindsight, the real answer to all our questions now seems obvious: There was no plan. There would never be a White House plan.

It's understandable why the health care policy press thought there just might be. He gave an interview to 60 Minutes's Scott Pelley promising to repeal the Affordable Care Act and replace it with something much better. Here's the key part:

DONALD TRUMP: Everybody's got to be covered. This is an un-Republican thing for me to say because a lot of times they say, "No, no, the lower 25 percent that can't afford private." But —

SCOTT PELLEY: Universal health care?

DONALD TRUMP: I am going to take care of everybody. I don't care if it costs me votes or not. Everybody is going to be taken care of much better than they're taking care of now.

SCOTT PELLEY: The uninsured person is going to be taken care of how?

DONALD TRUMP: They're going to be taken care of. I would make a deal with exiting hospitals to take care of people. And, you know, if this is probably—

SCOTT PELLEY: Make a deal? Who pays for it?

DONALD TRUMP: The government's gonna pay for it.

Instead, Trump fell back on the old repeal-and-replace proposals that had circulated around Congress for years. Instead of providing universal health care, these proposals would result in millions of Americans losing coverage and premiums spiking by as much as 850 percent for low-income, elderly Americans.

In Trump's first year in office, congressional Republicans spent a year attempting to repeal the Affordable Care Act and replace it. They rolled out a number of replacement plans. The bill that got furthest, the American Health Care Act, would have reopened the door for insurers to charge sick people higher premiums — and to stop covering the health law's essential health benefits, a requirement in Obamacare that made sure more insurance plans covered more of the basics. Ultimately, Republicans in Congress failed. Obamacare survived.

The Trump administration didn't stop there. It rolled out new regulations that were expected to drive up premiums for sicker Americans. He has widened the availability of skimpy "short-term" plans that are allowed to not cover prescription drugs, maternity benefits, or people with preexisting conditions. And he has let state Medicaid programs require beneficiaries to work, a move that has led to thousands of low-income Arkansans losing coverage.

But perhaps Trump's most revealing move is supporting a lawsuit that would eliminate Obamacare completely.

Trump is asking the federal courts to end Obamacare and leave millions uninsured. In early 2018, a coalition of conservative attorneys general filed a lawsuit arguing that Congress's new tax package — and its elimination of the fine for not carrying health insurance — makes the entirety of Obamacare unconstitutional (you can read more details about the legal argument here).

Usually, a presidential administration defends current law, but the Trump administration took a different approach in this case. Last June, it agreed with the conservative states that the mandate and, with it, the law's rules that prohibit insurers from denying people health insurance or charging them higher rates, should be found unconstitutional.

At the time, the Trump administration wasn't fully endorsing the challengers' view. It didn't agree, for example, that the Medicaid expansion — which covers millions of low-income Americans — would need to fall if the mandate fell. Instead, the Trump administration argued that the parts of Obamacare with the strongest policy connections to the mandate (the ban on preexisting conditions, the requirement to offer coverage to all shoppers) would need to be struck down as well.

What the Trump administration did yesterday goes much further. Now, the government is arguing that the court should find the entirety of Obamacare unconstitutional. This would mean repealing everything from the Medicaid expansion to the provision that allows young adults to stay on their parents' insurance until they turn 26.

If the courts does what the Trump administration wants, an estimated 19.9 million Americans would lose their health insurance coverage. The number of people who lack health insurance in Kentucky would rise by 151 percent, according to data from the nonprofit Urban Institute. In Montana, the number of uninsured would rise by 176 percent.

In fitting fashion, Donald Trump followed up the news with a tweet touting his party's position on the issue:

Donald J. Trump ✓ @realDonaldTrump
The Republican Party will become "The Party of Healthcare!"

Trump's position on health care matters to voters. But he isn't telling the truth about it. President Trump isn't telling the truth about his position on health care because his actual position, it turns out, isn't very popular. Americans like the idea of making sure sick people have access to health insurance.

The Kaiser Family Foundation has found that it was the most important health care issue going into the election. For 14 percent of Americans, it was the "single most important" factor heading into the voting booth.

I saw this firsthand two years ago, when I went to Kentucky to write a story about Obamacare enrollees who voted for Trump. I asked a lot of voters: Why did you support the candidate who campaigned on getting rid of your health insurance?

I heard the same answer again and again: He promised that something better would come along. The voters I met during that reporting trip had paid attention to the election. They knew that Trump wanted to repeal Obamacare. But they also listened to the promises that came after that: His repeated claims that he would come up with something better to replace it.

Americans are listening to the claims Trump makes about health care. They are hearing him say he wants "insurance for everyone." They listen when he says he has a plan.

But everything I've seen covering the Obamacare repeal debate — from the bills on Capitol Hill to this lawsuit filing— tells me that Trump is not interested in protecting preexisting conditions. There isn't a plan to create coverage for everybody, and there never will be.

PPIC | PUBLIC POLICY INSTITUTE OF CALIFORNIA

PPIC Statewide Survey: Californians and Their Government
Mark Baldassare, Dean Bonner, Alyssa Dykman, Rachel Ward
Mar. 28, 2019

Summary

Key findings from the current survey:

- Two-thirds of Californians—a record high—say housing affordability is a big problem in their region; seven in ten support Governor Newsom's spending plan to boost housing production.
- Majorities favor Newsom's budget proposals to combat wildfires (81%) and expand the state earned income tax credit (73%).
- Most Californians disapprove of the federal tax overhaul that took effect in 2018 and say they pay more in state and local taxes than they should.

The PPIC Statewide Survey delivers objective, advocacy-free information on the perceptions, opinions, and public policy preferences of California residents. PPIC invites input, comments, and suggestions from policy and public opinion experts and from its own advisory committee, but survey methods, questions, and content are determined solely by the PPIC survey team. The PPIC Statewide Survey relies on a rigorous survey methodology and is a charter member of the American Association for Public Opinion Research Transparency Initiative. The survey is conducted regularly throughout the year in the key areas of government, the environment, K–12 education, and higher education.

The New York Times

Trump Retreats on Health Care After McConnell Warns It Won't Happen
Robert Pear and Maggie Haberman
April 2, 2019

WASHINGTON — President Trump backed off plans to introduce a Republican replacement for the Affordable Care Act after Senator Mitch McConnell privately warned him that the Senate would not revisit health care in a comprehensive way before the November 2020 elections.

Reversing himself in the face of Republican consternation, Mr. Trump said his party would not produce a health care plan of its own, as he had promised, until after the elections, meaning he will only try to fulfill his first-term promise to repeal and replace his predecessor's signature program if he wins a second term.

The president's abrupt about-face, announced on Twitter on Monday night after talking with Mr. McConnell, all but ensured that health care will take a central place in next year's campaign, elevating an issue Democrats consider one of their strengths. But it may take the legislative heat off Republicans exasperated by Mr. Trump's unexpected push to devise a wholesale replacement for President Barack Obama's health law in the coming months.

"I made it clear to him that we were not going to be doing that in the Senate," Mr. McConnell, the majority leader from Kentucky, said on Tuesday. "He did say, as he later tweeted, that he accepted that and that he would be developing a plan that he would take to the American people during the 2020 campaign."

The president's last attempt to replace Mr. Obama's health care program blew up in 2017 when his party controlled both houses of Congress. Democrats seized the House in last year's midterm elections in part on a promise to defend the most popular parts of the Affordable Care Act, so when Mr. Trump revived the issue last week, it distressed Republicans who consider it a political liability.

Mr. Trump had surprised allies by ordering his administration to ask a federal court to invalidate the entire Affordable Care Act and then promised a Republican replacement. Democrats, consumer groups, doctors, hospitals and insurance companies have said that 20 million people could lose health coverage if courts accept the administration's argument.

Mr. McConnell said he spoke with Mr. Trump on Monday afternoon to explain that the Senate would not return to the issue in a broad way before the next election. "I pointed out to him the Senate Republicans' view on dealing with comprehensive health care reform with a Democratic House of Representatives," Mr. McConnell said.

But if that warning was meant to quiet the president, it did not work. Hours later, Mr. Trump wrote on Twitter, "The Republicans are developing a really great HealthCare Plan with far lower premiums (cost) & deductibles than ObamaCare."

"In other words it will be far less expensive & much more usable than ObamaCare," he said in a string of three tweets posted Monday night. "Vote will be taken right after the Election when Republicans hold the Senate & win back the House."

Democrats jumped at the opening.

"Last night the president tweeted that they will come up with their plan in 2021," Senator Chuck Schumer of New York, the Democratic leader, said at a rally in front of the Supreme Court. "Translation: they have no health care plan. It's the same old song they've been singing. They're for repeal. They have no replace."

Mr. Trump appeared to be gambling that he could turn the tables on an issue that has long favored Democrats by portraying them as increasingly extreme. Even as party

liberals, including some presidential candidates, embrace the idea of “Medicare for all,” Republicans have used it to accuse Democrats of favoring a socialist, government-run health care system that would close down all private insurers.

“I see what the Democrats are doing; it’s a disaster what they’re planning and everyone knows it,” Mr. Trump told reporters on Tuesday at the White House. “You’re going to lose 180 million people under their private insurance.”

Wary of such attacks, the Democratic congressional leadership has played down a single-payer system run by the government and advanced incremental measures to shore up the health care law and lower prescription drug prices.

Many Republicans in Congress were happy to assail Medicare for all but not enthusiastic about ditching Mr. Obama’s program without a ready replacement. No plan of their own could pass the House, but it would invariably require policy choices that Democrats could attack.

Even some of the president’s own advisers were confounded by his move. Soon after the president decided last week to intervene in a Texas court case on the side of invalidating the entire Affordable Care Act without a Plan B, Mr. Trump and Vice President Mike Pence held a conference call with Ronna McDaniel, the chairwoman of the Republican National Committee, and Brad Parscale, Mr. Trump’s campaign manager.

Both Mr. Parscale and Ms. McDaniel tried to tell the president that they could not understand what he was doing, according to a person familiar with the call.

Mr. Trump replied that if they did nothing, Democrats would continue to own the issue and the other option was being known as the party that could not figure out how to properly draft a health care legislative package, the person said.

In several private conversations since last week, Mr. McConnell told the president that he believed Democrats owned the dysfunction associated with the Affordable Care Act and that Mr. Trump was essentially letting them off the hook by inserting himself into the debate again, according to another person briefed on those discussions.

Mr. Trump denied on Tuesday that Mr. McConnell asked him to back off, saying, “I wanted to delay it myself” because Republicans do not control the House. “So if we get back the House and on the assumption we keep the Senate and we keep the presidency — which I hope are two good assumptions — we’re going to have a phenomenal health care,” he said.

Seeking to capitalize on the issue, the House will vote this week on a resolution urging the Justice Department to reverse its position and defend the 2010 health care law in court, forcing lawmakers to take a side on the case.

“The American people deserve to know exactly where their representatives stand on the Trump administration’s vicious campaign to take away their health care,” said Speaker Nancy Pelosi.

The resolution, offered by a freshman Democrat, Representative Colin Allred of Texas, says that the Justice Department should “cease any and all efforts to destroy Americans’ access to affordable health care, and reverse its position” in the court case, Texas v. United States.

Some of the president’s senior advisers pushed him to join the lawsuit challenging the constitutionality of the entire current health care law, a more expansive position than the administration had taken previously, when it argued that protections for people with pre-existing conditions should be struck down.

But others raised concerns, including the White House counsel, Pat Cipollone. Mr. Cipollone said that Attorney General William P. Barr had issues with joining the suit, too. But once the president made clear his mind was made up, the Justice Department went along without complaint, people familiar with the events said.

Among those objecting was Senator Susan Collins, a moderate Republican from Maine who sent a letter to Mr. Barr expressing her “profound disagreement” with the move.

“Rather than seeking to have the courts invalidate the A.C.A.,” she wrote, referring to the Affordable Care Act, “the proper route for the administration to pursue would be to propose changes to the A.C.A. or to once again seek its repeal. The administration should not attempt to use the courts to bypass Congress.”

Mr. McConnell sought to calm Republican nerves, saying “there’s no point in pushing the panic button” because the court system would take a long time to resolve the dispute.

“I don’t think any of these policies are in any immediate danger,” he said.

Mr. Trump has basically commissioned four Republican senators to devise a replacement for the Affordable Care Act. The group consists of two doctors, John Barrasso of Wyoming and Bill Cassidy of Louisiana, as well as Senator Lindsey Graham of South Carolina, a close ally of the president, and Senator Rick Scott of Florida, who was the chief executive of a large for-profit hospital firm before he entered politics.

Mr. Scott said on Tuesday that he was focused on bringing down health costs, especially prescription drug prices. “Obamacare has made health care way more expensive,” he said. “Co-payments are up. Deductibles are up. Premiums have skyrocketed.”

When asked about developing a wholesale replacement for the Affordable Care Act, Mr. Scott responded, “I’m a business guy,” adding, “I didn’t try to do grand bargains.”

The San Diego Union-Tribune

Survey finds a political divide on health care quality, despite similar problems paying for care

Paul Sisson
April 2, 2019

Though the ruinous consequences of high health care costs don't follow party lines, Republicans tend to believe they're getting more for their money than Democrats and independents do, according to the results of a new nationwide survey released today by San Diego's West Health.

The nonpartisan and nonprofit organization created by philanthropists Gary and Mary West worked with market research firm Gallup to poll 3,537 randomly-selected Americans across all 50 states and the District of Columbia, asking questions designed to gauge the impacts of and attitudes surrounding health costs.

West, also known for its work building health care clinics and other resources for seniors, has made health care costs its main policy focus convening its sixth-annual Health Care Innovations Summit in Washington this week.

The survey results come at a particularly polarized moment as the Trump Administration reportedly works behind the scenes with a handful of conservative think tanks to build an Affordable Care Act replacement as it simultaneously pushes forward with plans to have the legislation eliminated. Meanwhile, Democrats are coming forward with their own health reform ideas amid cries of Medicare for all.

While much of the national health care debate tends to revolve around specific proposals that increase health insurance coverage for one group or another, Tim Lash, president of the West Health Policy Center, said the organization thought it was important for policy makers to get a fresh take on how regular Americans are impacted by health care costs, which continue to rise despite already being the highest among industrialized nations.

Pollsters found that 26 percent of the people they surveyed said they did not seek treatment due to the cost of care. That ratio was similar regardless of political party, and that fraction, Lash noted, translates to about 65 million Americans who are actively avoiding needed treatments and medications with price tags they find affordable.

“Republicans, Democrats, independents, the rich, the poor, the middle class, they’re all skipping treatments, they’re all not filling prescriptions, they’re all borrowing money to afford care,” Lash said.

And yet, despite suffering these indignities across the board, survey results showed a significant disparity in terms of the perception of American health care quality. According to survey results, 67 percent of Republicans thought their nation’s health care system was “among the best in the world” compared with just 38 percent of Democrats and 46 percent of independents.

Academia has long found that America, despite spending the most, does not rank near the top in most broadly based measures of health care outcomes.

“When you look at just about every measure of performance — we’re 28th in life expectancy, 31st in infant mortality, 16th in heart attack mortality — we’re only No. 1 as it relates to cost,” Lash said.

These disparities have been studied in depth over the last 20 years by the Commonwealth Fund, a nonpartisan health care think tank which examines 1,200 different health measures across 30 industrialized nations to paint a picture of differences and similarities from country to country.

Dr. David Blumenthal, the fund’s president, said Monday that, through those 20 years of research, it’s clear that America does not get the kind of health care results that other nations do per dollar spent.

But that disparity, though it has been reported to the public for many years, has not universally affected the average American’s perception of health care quality. That probably, experts say, because not everyone sees outcomes like average infant mortality or average life expectancy to be the main measure of quality. Some, Blumenthal notes, are more open to these kinds of stats than others.

“It’s very hard to present these kinds of data to people in the United States in ways they find convincing if they’re not already critical of the health care system,” Blumenthal said. “That may be why Democrats are more prone to accept that information. Their leaders are more prone to talk about it, and, therefore their followers are more likely to be aware of it.”

But there is an alternative narrative that explains the political disparity on health care quality.

Lanhee Chen, director of domestic policy studies at Stanford University’s Hoover Institution, one of three think tanks rumored to be working with the Trump administration on an ACA replacement, said many Americans think of factors like the ability to choose

which provider they want to see and access to cutting-edge treatments when they're asked by a pollster to opine on American health care quality.

"Most progressives, I think, would argue that equity is a paramount value in health care, whereas conservatives might say the important factors are choice, optionality and access to innovative cures," Chen said.

But, regardless of political affiliation, a vast majority of Americans — 76 percent — believe that the cost of health care is too high relative to quality delivered.

And here, Lash said, is where West believes the public should focus. He noted that survey results found that only about one in 10 Americans had recently contacted their elected representatives about bringing health care costs down. And that's a shame, he added, because there are several first steps that could be taken to shrink the health care price tag, such as giving Medicare power to negotiate drug prices, mandating that doctors move away from quantity-based payment and requiring health care price transparency.

Lash said the consequences of public disengagement on the issue are stark. He cited a recent study in the Annals of Emergency Medicine, which estimated that 125,000 Americans die every year because they haven't taken prescribed medications, and of those, about two-thirds of those people aren't filling their prescriptions because they're unaffordable.

"That data suggests that roughly 85,000 people die every single year just as a result of not being able to afford their medications. To put that in context, during the entire Vietnam War roughly 59,000 soldiers were killed in action," Lash said. "Where are the protests in the streets over this?"

To start a more regular dialogue on the issue among those outside the world of health care economics, West is planning to launch a new website, healthcostcrisis.org, this week.

POLITICOPRO

House committee advances 6 bills to strengthen ACA
Sarah Owermohle
April 4, 2019

The House Energy and Commerce Committee advanced to the floor six meaures to bolster Obamacare late Wednesday night, hours after House Democrats voted nearly unanimously to condemn a Trump administration move to repeal the entire health law.

All six bills passed the committee in votes along party lines, including recorded votes for H.R. 1385 (116), which would provide $200 million annually for state-based Affordable Care Act marketplaces; H.R. 1386 (116), to provide $100 million to the federal navigator program; and H.R. 1425 (116), a reinsurance bill intended to lower ACA premiums, which was the last bill to pass, shortly after midnight.

The three other bills aim to peel back Trump administration policies that Democratic sponsors said weaken the ACA: H.R. 1010 (116) would reverse the administration's expansion of short-term health plans, while H.R. 986 (116), the only bill passed by voice vote, would require the administration to rescind guidance that made it easier for plans in general to soften protections for pre-existing conditions. The MORE Health Education Act, H.R. 987 (116), would restore ACA outreach and enrollment funding that had been slashed by the White House, while restricting the funds from going to any marketing for short-term plans.

In debate over H.R. 987 and its provision that would boost outreach funds to $100 million annually, sponsor Lisa Blunt Rochester (D-Del.) cited a POLITICO report last week that CMS spent millions on consultants to bolster Administrator Seema Verma's public image, while simultaneously cutting its ACA enrollment marketing and outreach budget by 90 percent. (HHS is suspending contracts with several GOP-connected communications firms, four people with knowledge of the situation told POLITICO Wednesday night.)

The spending "raises serious questions about the administration health care leadership" and its ability to oversee the Affordable Care Act, Blunt Rochester said.

The New York Times

Trump Is Being Vague About What He Wants to Replace Obamacare. But There Are Clues.
Margot Sanger-Katz
April 5, 2019

We don't know what will emerge as President Trump's plan to replace Obamacare, which he has promised to unveil immediately after the 2020 elections. But he has recently endorsed several proposals, and they could provide clues.

Over the last two weeks, he has sought to re-emphasize health care as an issue, after a set of bruising legislative defeats in 2017. He directed the Justice Department not to defend the Affordable Care Act against a legal challenge. And he issued statements and

tweets calling for Republicans to become “the party of health care,” at a moment when many of his party’s leaders had hoped to focus on different issues.

He also began reprising various promises about what a future plan to repeal and replace parts of the Affordable Care Act might achieve. The plan, short on specifics, will come with “far lower premiums (costs) & deductibles,” he said this week in a series of tweets. He promised that any Republican health plan would protect Americans with pre-existing health conditions, a major concern of voters that Democrats effectively exploited in the 2018 midterm elections.

After his election, President Trump made similar promises, saying that the Republican proposal would be “far less expensive and far better” than Obamacare. The legislation that came later, and earned his endorsement, would have made insurance less expensive, but only for certain groups of young, high-income, healthy Americans. The bills would have also eliminated coverage for millions of people by scaling back Medicaid, and would have made it harder for those with pre-existing illnesses — and those who are older with low incomes — to find meaningful affordable options if they didn’t get insurance from work.

The three senators he has chosen to lead the effort — Bill Cassidy of Louisiana, John Barrasso of Wyoming and Rick Scott of Florida — have so far also declined to point to many specifics. When asked about an Obamacare replacement this week, they mentioned their more modest bills to reduce health care costs in the emergency room and at the drugstore. (A fourth senator the president has mentioned, the majority leader, Mitch McConnell of Kentucky, has been even more clear that he has little interest in pursuing comprehensive health care legislation.)

One clue to Mr. Trump’s thinking is the choice of Mr. Cassidy. Along with Senator Lindsey Graham of South Carolina, he was the author of a legislative plan that received some scrutiny in 2017 but never came up for a vote. Another hint can be found in the president’s own budget, released just before his reinvigorated health care push. A third is a draft proposal developed by a group of conservative Washington policy groups.

The Graham-Cassidy bill

The president has spoken fondly several times about this proposal, which did not have enough support in Congress to advance to a vote. It would eliminate current programs funding Obamacare’s Medicaid expansion, which covers the working poor, and insurance subsidies helping low- and middle-income Americans buy their insurance. Instead, that money would be grouped together, then parceled out to states to use in the service of health care programs they favor.

The legislation attaches some rules to how the money can be used — it must go toward health care, for example — but its main goal is to provide states with maximum flexibility

to develop local and innovative solutions. (Some experts worry that states could struggle to develop such plans on the bill's abbreviated timetable.)

That flexibility would allow states, if they so chose, to waive Obamacare's rules that plans must cover a standard set of medical benefits, and that insurers must charge the same prices to customers with different health histories. It would be easy for states to circumvent current protections for Americans with pre-existing conditions. That ability would be at odds with the president's recent promises to protect such rules.

The bill would also restructure the Medicaid program, even for populations that were enrolled in the program before Obamacare.

The bill's formula for allocating money among the states would also lead to big redistributions, generally taking money away from states that have expanded Medicaid, toward those that have not. It would also restrict the growth of the block grants over time. Those funding formulas, while technical, make a big difference in the impact of the program. It would result in substantial funding shortfalls for several large states nearly immediately, and leave nearly every state in a funding crunch over the long term.

Because the 2020 White House budget was developed and published by the White House itself, it is perhaps the most useful clue about how the president imagines a world without Obamacare.

Like the Graham-Cassidy proposal, it includes block grants to the states to replace the Obamacare coverage expansion, and it replaces the remainder of Medicaid with a set of fixed payments to states.

But the rate at which the different grants would grow over time would be even smaller than under the legislation, "to make the system more efficient."

The budget is vague about what sorts of insurance regulations would be allowed, but it does note that a tenth of funds would need to be set aside for people with pre-existing conditions, a sign that states would be allowed to exclude such people from the mainstream insurance markets.

The conservative coalition proposal

A group of conservative health policy experts, including the Heritage Foundation, has developed a health care proposal that shares a basic structure with the two systems described above: It would hand states blocks of money and a few rules, and encourage them to develop their own health care systems.

The rules in the conservative plan differ a bit from those in Graham-Cassidy. The plan would require that government-subsidized systems offer every American a choice of a

private health plan, a requirement that would probably foreclose a liberal state from enacting a single-payer program and that might require restructuring of some state-run Medicaid programs.

The plan shies away from specifying funding formulas. It doesn't say how the block of money should be divvied up among the states, though it says that states with more low-income residents should get a bigger share. It also doesn't specify precisely how quickly the pot of money should grow over time.

Like the budget proposal, it nods to concerns about Americans with pre-existing conditions by encouraging states to develop special programs, like high-risk pools, to insure people with expensive health needs. But it also encourages insurance strategies, like discounts for young customers, or stripped-down benefit plans, that would tend to make mainstream insurance less useful for people with serious health needs.

The proposal also leaves the legacy Medicaid program as is. That choice neutralizes one possible political line of attack. But it also substantially diminishes the program's possible cost savings.

The court case over the Affordable Care Act will be decided on the judiciary's timetable, so it's not clear how long the White House may have to develop a replacement plan. But, since it certainly has at least months, there is time to develop some new proposal more aligned with the president's recent promises.

Doing so will not be easy, however. Health care in the United States is expensive, which means that health plans that cover everyone with low deductibles are likely to be costly. The block grant plans the president has admired reduce rather than increase current federal spending on health care. Looser rules on health insurance are likely to increase costs on customers unfortunate enough to need care. That makes the block-grant approach a troublesome fit with the president's stated desire for a system that Americans find "far less expensive & much more usable than Obamacare."

Center for American Progress

Trump Is Being Vague About What He Wants to Replace Obamacare. But There Are Clues.
Emily Gee and Topher Spiro
April 5, 2019

Anyone interacting with the U.S. health care system is bound to encounter examples of unnecessary administrative complexity—from filling out duplicative intake forms to

transferring medical records between providers to sorting out insurance bills. This administrative complexity, with its associated high costs, is often cited as one reason the United States spends double the amount per capita on health care compared with other high-income countries even though utilization rates are similar.1

Each year, health care payers and providers in the United States spend about $496 billion on billing and insurance-related (BIR) costs, according to Center for American Progress estimates presented in this issue brief. As health care costs continue to rise, a logical starting point for potential savings is addressing waste. A 2010 report by the National Academy of Medicine (NAM) estimated that the United States spends about twice as much as necessary on BIR costs.2 That administrative excess currently amounts to $248 billion annually, according to CAP's calculations.

This issue brief provides an overview of administrative expenditures in the U.S. health care system. It first explains the components of administrative costs and then presents estimates of the administrative costs borne by payers and providers. Finally, the issue brief describes how the United States can lower administrative costs through comprehensive reforms and incremental changes to its health care system. Many of the universal health care plans being discussed to expand coverage and lower costs would lower administrative costs through rate regulation, global budgeting, or simplifying the number of payers.3 Each of these financing changes deserves consideration—even in the absence of major systemwide reform.

Components of administrative costs

The main components of administrative costs in the U.S. health care system include BIR costs and hospital or physician practice administration.4 The first category, BIR costs, is part of the administrative overhead that is baked into consumers' insurance premiums and providers' reimbursements. It includes the overhead costs for the health insurance industry and providers' costs for claims submission, claims reconciliation, and payment processing. The health care system also requires administration beyond BIR activities, including medical record-keeping; hospital management; initiatives that monitor and improve care quality; and programs to combat fraud and abuse.

To date, few studies have estimated the systemwide cost of health care administration extending beyond BIR activities. In a 2003 article in The New England Journal of Medicine, researchers Steffie Woolhandler, Terry Campbell, and David Himmelstein concluded that overall administrative costs in 1999 amounted to 31 percent of total health care expenditures or $294 billion5—roughly $569 billion today when adjusted for medical care inflation.6 A more recent paper by Woolhandler and Himmelstein, which looked at 2017 spending levels, placed the total cost of administration at $1.1 trillion.7

Billing and insurance-related costs

Many studies of administrative costs limit their scope to BIR costs. The BIR component of administration is most relevant to systemwide reforms that seek to reduce the expenses related to claims processing, billing rates, or health insurance. The largest share of BIR costs is attributable to insurance companies' profits and overhead and to providers8 where BIR costs include tasks such as record-keeping for claims submission and billing.

The costs associated with BIR administration can extend beyond the chief parties involved in receiving and submitting claims. The process of claims denials has become an industry unto itself, with private firms squeezing dollars out of Medicaid programs.9 One study estimated that the aggregate value of challenged claims ranges from $11 billion to $54 billion annually.10 Claims can also be manipulated to boost providers' or insurers' profits by recording services rendered in maximum detail and exaggerating the severity of patients' conditions—a practice known as upcoding.11 Upcoding costs Medicare Advantage billions of dollars in excess expenditures,12 and in many cases the practice constitutes fraud.13

The NAM published one of the most thorough reports on U.S. administrative costs related to billing and insurance in 2010. In a synthesis of the literature on administrative costs, the NAM report concluded that BIR costs totaled $361 billion in 2009—about $466 billion in current dollars—among private insurers, public programs, and providers, amounting to 14.4 percent of U.S. health care spending at the time. The NAM estimated that BIR costs account for 13 percent of physician care spending; 8.5 percent of hospital care spending; 10 percent of spending on other providers; 12.3 percent of spending on private insurance; and 3.5 percent of public program spending, including Medicare and Medicaid.14

Applying the NAM's percentages of BIR costs to recent projections of national health expenditures from the Centers for Medicare and Medicaid Services (CMS), CAP estimates that BIR costs will amount to $496 billion for 2019.15 (see Table 1) According to CAP's calculations, this includes $158 billion in overhead for private insurance; $56 billion for administration of public insurance programs; and $282 billion for the BIR costs of hospitals, physicians, and other care providers. CAP's estimate does not include the administrative costs associated with retail sales of medical products, including prescription drugs and durable medical equipment.

Even the most inclusive studies of administrative costs have not included at least one key piece of the U.S. health care system, namely, patients.[16] The administrative complexity of the U.S. system also burdens patients, whether they are deciphering bewildering bills or shuttling records between providers. Three-quarters of consumers report being confused by medical bills and explanations of benefits.[17] A Kaiser Family Foundation survey of people newly enrolled in the health insurance marketplace found that many were not confident in their understanding of the definitions of basic terms and

concepts such as “premium,” “deductible,” or “provider network.”[18] Insurers and employers spend an estimated $4.8 billion annually to assist consumers with low health insurance literacy, according to the consulting firm Accenture.[19]

Excess administrative costs

While U.S. administrative care spending is indisputably higher than that of other comparable countries, it’s unclear how much of the difference is excess and how much of that excess could be trimmed. The NAM report estimated that excess BIR costs amount to $190 billion—$245 billion in current dollars—or roughly half of total BIR expenditures in a year.[20] The NAM report estimated that 66 percent of BIR costs for private insurers and 50 percent of BIR costs among providers are excess.[21] Based on these percentages, $248 billion of the total $496 billion BIR costs in CAP’s updated estimate are excess administrative costs.

Most studies that have attempted to identify excess costs in the American health care system rely on comparisons between the United States and Canada.[22] In their 2010 review of the literature on the difference between the two countries’ health expenditures, economists Alexis Pozen and David M. Cutler looked at the sources of the gap between U.S. and Canadian health spending. They found that 62 percent of the difference between the two countries was attributable to prices and intensity of care, and 38 percent was linked to administrative costs.[23] Compared with Canada, the United States has 44 percent more administrative staff, and U.S. physicians dedicate about 50 percent more time on administrative tasks.[24] Inflated to current dollars and today’s population, Pozen and Cutler’s estimate of per capita administrative excess in the United States, when compared with Canada, translates into a gap of $340 billion.[25]

Woolhandler and Himmelstein estimate that the United States currently spends $1.1 trillion on health care administration, and of that amount, $504 billion is excess.[26]Woolhandler and Himmelstein rely on surveys of physicians’ time use and utilized physician income data to translate the share of time physicians spend on administrative tasks into monetary value; their estimate of excess costs is the difference between U.S. and Canadian administrative spending[27] Woolhandler and Himmelstein’s original 2003 article estimated that Canada spent $307 per capita on health system administration, compared with $1,059 per capita in the United States. Assuming this difference is excess requires an assumption that a Canadian-style health care system would achieve an identical level of administrative costs in the United States.

A separate criticism of the original 2003 Woolhandler and Himmelstein estimates, as articulated by Henry J. Aaron, an economist at the Brookings Institution, is that their methodology failed to account for differences in prices.[28] Woolhandler and Himmelstein arrive at their national total administrative costs by tallying up costs in each country for items such as rent and salaries. As a consequence, the U.S.-Canada comparison

captures not just the differences in the quantity of resources devoted to administration—such as physician time or office space—but also the differences in office rates, wages, and salaries. Taking Woolhandler and Himmelstein's estimate of total administrative costs as a given and then making standard adjustments for price differences, Aaron argues that the two researchers exaggerated U.S. administrative spending in their 2003 report and that the true portion of excess would be about one-quarter less than what they estimated.

All estimates of administrative costs are inherently sensitive to what portion of health care spending one considers administrative.[29] For example, time spent recording diagnosis or prescription information used in billing may also be vital for patient care, allowing medical teams to share up-to-date information or avoid harmful drug interactions. A recent study of an electronic health records (EHR) system estimated that on average, half of a primary care physician's day is spent on EHR interaction, including billing, coding, ordering, and communication.[30] Such tasks, however, can fall into a gray area between administrative and clinical. In a separate study, economist Julie Sakowski and her fellow researchers reported finding varying attitudes among physicians about whether interaction with electronic medical records—a subset of EHR—represented administrative or clinical time. As Sakowski and co-authors wrote, "Some felt they spent extra effort adding documentation that was needed only for billing. Others seemed to feel that nearly all of that information was needed for accurate clinical records."[31]

Administrative costs for payers

Within the U.S. system, the share of expenditures that are attributable to administrative costs varies greatly by payer. The BIR costs for traditional Medicare and Medicaid hover around 2 percent to 5 percent, while those for private insurance is about 17 percent.[32]Some public finance experts, including Robert Book, have argued that the low levels of Medicare overhead are deceptive. Because seniors have relatively high health expenditures, the argument goes, administrative costs make up a relatively small share of their total health care spending. However, Medicare's per capita administrative expenditures are higher than those in other forms of insurance.[33] Even if one compares higher-end estimates of Medicare administrative costs to low-end estimates of costs for private insurance, the gulf between administrative costs for Medicare and private coverage is large.[34] Organisation for Economic Co-operation and Development (OECD) data also show that other nations are able to achieve low levels of administrative costs while maintaining universal coverage across all ages of the population.[35]

International health system data demonstrate that the United States is a clear outlier on administrative spending. And while the OECD's definition includes administrative costs to government, public insurance funds, and private insurance, but not those borne by hospitals, physicians, and other providers, the stark difference is still informative. In 2016, administration accounted for 8.3 percent of total health care expenditures in the

United States—the largest share among comparable nations. (see Figure 1) Countries with single-payer systems are among those with the lowest administrative costs. For example, administrative spending accounts for just 2.7 percent of total health care expenditures in Canada.[36] OECD data also show that within a country, administrative costs are higher in private insurance than in government-run programs.[37]

Countries that have multipayer systems with stricter rate regulation also achieve much lower administrative costs than the United States. Administrative expenditures account for 4.8 percent of total health care expenditures in Germany, 3.9 percent in the Netherlands, 3.8 percent in Switzerland, and 1.6 percent in Japan, according to the OECD. If the United States could reduce administrative costs down to Canadian levels, it would save 68 percent of current administrative expenditures; reducing to German-level administrative costs would save 42 percent of current administrative expenditures. However, to assume that by simply adapting another country's health care system—whether it is Canada's single-payer Medicare, Germany's sickness funds, or Switzerland's heavily regulated private plans—the United States would automatically achieve the same level of administrative costs may ignore other fundamental differences between countries, including the market power of health care providers, political systems, and attitudes toward health care. Nevertheless, the experience of other multipayer systems such as those in Germany and Switzerland suggests that the United States could substantially reduce both administrative expenditures and overall health care spending by bringing down reimbursement rates and regulating insurance—even while continuing to allow multiple payers and private health care providers.

The lowest possible level of administrative spending for the U.S. health care system is not necessarily the optimal level of spending. As researchers Robert A. Berenson and Bryan E. Dowd have noted, administrative spending in Medicare may in fact be too low; the program would be more efficient with greater investment in initiatives to lower costs and improve quality.[38] Many reforms that could generate overall savings require administrative resources to design and implement. Innovations such as bundled payments—the practice of paying providers a lump sum for an episode of care such as a knee replacement or childbirth rather than reimbursing each individual component—involve upfront investment in development. Increasing resources to combat fraud and abuse would also lower overall spending. While the U.S. Department of Health and Human Services (HHS) boasts that it sees a $5 return on every $1 it puts toward fraud and abuse investigations, that number indicates that the government may be underinvesting in those efforts.[39]

Administrative costs for health care providers

A number of studies have focused on the administrative costs borne by providers. Beyond BIR expenses, hospitals, physician practices, and other health care institutions house departments that are complementary to clinical services such as medical

libraries, public relations, and accounting.[40] A study of administrative costs in California found that administrative costs represented about one-quarter of physician revenue and one-fifth of hospital revenue, and BIR costs accounted for roughly half of administrative expenditures for physician and hospital services covered by private insurance.[41] (see Figure 2) In a separate study, Himmelstein and others reported that one-quarter of U.S. hospital spending went toward administration; they found little difference between nonprofit hospitals and for-profit institutions, where administrative spending was 25 percent and 27.2 percent of total spending, respectively.[42]

On a per-encounter basis, BIR costs vary as a proportion of overall cost depending on the type of visit. In a 2018 study of an academic health care system, Phillip Tseng and others found that professional billing costs amounted to $20.49 for a primary care visit, $61.54 for an emergency department visit, and $124.26 for a general inpatient stay.[43] Relative to the professional revenue associated with each encounter studied, the emergency department visit ranked the highest, with billing costs equal to 25.2 percent of revenue. Inpatient visits were the lowest, at 8 percent of a general inpatient stay and 3.1 percent for inpatient surgery.[44] Encounters involving hospital care incurred additional facility-level billing costs. (see Figure 3)

In addition to the dollar cost of BIR activity, the study also reported the time spent on administration for typical encounters. The average processing time was 13 minutes for a primary care visit, 32 minutes for an emergency department visit, and 73 minutes for a general inpatient stay.45

Among other research on provider BIR costs, a 2009 study by Larry Casalino and others estimated that the cost of the time physicians spend on interactions with health plans is about $23 billion to $31 billion per year.46 A 2011 study by Dante Morra of the University of Toronto and others estimated that interaction with payers costs the equivalent of $22,205 per physician annually in Canada and $82,975 per physician annually in the United States, suggesting that the United States would save $27.6 billion annually if U.S. administrative costs could be brought down to Canadian levels.47

As with BIR costs, provider administrative costs in the United States are higher than those in other comparable countries. Hospital administrative costs in the United States far exceed those of other nations. In their comparison of hospital administrative costs among eight Western nations, Himmelstein and co-authors found that the United States had the highest levels, at 25.3 percent of total hospital expenditures.48 They conclude that in nations where hospital administrators have minimal responsibilities for procuring financing and where the hospital reimbursement system is least complex, administrative costs can be reduced to 12 percent of expenditures.49 These findings suggest that reforms that introduce global budgeting or limit the need to bargain with multiple payers could potentially bring down excess hospital administrative costs in the United States.

Lower administrative costs in single-payer and multipayer systems

Although administrative costs contribute to the high expenditures in the United States, they are not the primary reason for the health care spending gap. As economist Uwe Reinhardt and others candidly put it, “It’s the prices, stupid.”50 The United States pays more for care than other countries do—both for administrative services and for other components of health care.

Policies that target administrative costs alone would not necessarily bring overall U.S. health care expenditures in line with other countries. As economists Sherry Glied and Adam Sacarny observed, “there are very substantial variations in administrative costs among countries with universal health insurance, which do not translate directly into variations in overall costs.”51 Comparative evidence from U.S. states also suggests that America’s multipayer system explains some, but by no means all, of the discrepancy between the United States and other developed nations. Harvard University researchers Joseph P. Newhouse and Anna Sinaiko observe that “there is considerable variation across the states in spending levels, with the lowest quintile of states spending approximately the same percentage as the higher spending OECD countries other than the U.S. This implies that the [United States’] pluralistic financing system may not be an important cause of the large percentage of GDP that the U.S. devotes to health care.”52

Systemwide reforms to lower administrative costs

Health care financing experts believe that changes to how Americans pay for coverage could dramatically reduce administrative costs. Researchers simulating the effects of single-payer programs have assumed that administrative costs would be brought down substantially. The Urban Institute set administrative costs at a “plausible” 6 percent of health care claims for their simulation of the single-payer plan proposed by Sen. Bernie Sanders (I-VT), noting that they “do not believe that administrative costs can fall far below this level; far too many administrative functions must be conducted.”53 In its analysis of a single-payer system for New York state, the RAND Corporation assumed administrative costs at 6 percent of total health expenditures in its base case, representing a reduction from 18 percent among commercial insurers and 7 percent in New York’s Medicaid program. RAND specified administrative costs at 13 percent and 3 percent in its alternative scenarios. 54 In a separate column, however, RAND researcher Jodi Liu cautioned that achieving the administrative expenditure levels of other countries “may be aspirational and is not guaranteed” under a single-payer system.

Exactly how such lower costs could be achieved is another question. Reducing BIR costs requires simplifying the billing and payment process, which could be accomplished in a number of ways. Two avenues for reducing administrative costs as well as overall health costs are global budgeting and uniform rate-setting.56 These two

concepts are central to health systems around the world and are also responsible for keeping administrative costs lower, whether a country has a multipayer or single-payer system. Another paperwork-reducing option would be a centralized claims clearinghouse to allow providers to submit all claims to a single entity, as they do in Germany and Japan. 57

All-payer rates and global budgeting

Setting all-payer reimbursement rates would eliminate the need for providers to negotiate rates with individual private insurers, while also giving policymakers better leverage for controlling overall health care cost growth. In the current U.S. system, providers charge different rates to different payers, and the billing process is complicated and opaque. The list prices that hospitals are now required to publish bear little connection to what individual patients—or those patients' insurers—actually pay.58 Setting all-payer rates would simplify billing and improve transparency by establishing a single set of rates for each provider, while also giving regulators a tool to protect consumers from exorbitant rates.59

Global budgeting—the practice of paying providers revenue based on their expected costs—also holds promise for both lowering administrative spending and overall costs. As opposed to traditional fee-for-service payments, which reward providers for doing more, global budgeting incentivizes providers to deliver care more efficiently.60 Global budgeting is a feature of many countries with much lower health care administrative costs, including Scotland, Wales, and Germany.61 As Woolhandler, Campbell, and Himmelstein point out in their 2003 article, "The existence of global budgets in Canada has eliminated most billing and minimized internal cost accounting, since charges do not need to be attributed to individual patients and insurers."62 As Germany shows, both single-payer and multipayer systems can use global budgets.

A system combining all-payer rates and global budgeting is already partially in place in the state of Maryland, where each hospital has a single set of rates it bills to Medicare, Medicaid, commercial insurers, and other payers. Maryland's system is keeping overall cost growth lower than the national trend.63 According to RAND analysis of hospital costs, Maryland hospitals have administrative costs that are 9 percent lower than the national average and not far off from the 13 percent savings RAND assumed providers would achieve under a single-payer system. 64

Centralized claims processing

Germany and Japan both have multiple payers but centralized claims processing.65 Despite having more than 3,000 health plans,66 Japan's administrative expenditures were a stunningly low 1.6 percent of overall health care costs in 2015, one of the lowest among OECD member nations.67

In their analysis of three universal health care options for Vermont, including single payer, researchers William C. Hsiao, Steven Kappel, and Jonathan Gruber estimated substantial savings from administrative simplicity from each option. The two single-payer options they examined would result in even greater administrative savings of between 7.3 percent and 7.8 percent, depending on the rate-setting mechanism.68 The group estimated that a third scenario, which would establish a centralized claims clearinghouse while allowing multiple payers, could generate savings equal to 3.6 percent of total expenditures.69 This suggests that about half of the total administrative savings from a single-payer system could be obtained within a regulated multipayer system.

Policy proposals directed at administrative costs

While major changes to the U.S. health care system have the greatest potential to bring down costs, more incremental changes could reduce administrative waste. A recent bill proposed by Sens. Bill Cassidy (R-LA) and Tina Smith (D-MN) would direct the HHS secretary to set goals to cut “unnecessary costs and administrative burdens” throughout the health care system by 50 percent over the next 10 years. It would also provide grant money for state-based efforts to bring down administrative costs.70 Some possible avenues for achieving those kinds of reductions include changes to payment rules, improvements to facilitate electronic record-keeping and information exchange, and simplification of public insurance programs.

In their 2009 article in The New England Journal of Medicine, David Cutler, Elizabeth Wikler, and Peter Basch proposed one such package of reforms. The authors estimated that providers could save $17.9 billion to $23 billion annually with several, more incremental changes to the system, including greater adoption of EHR systems; integrated administrative and clinical systems; national and standardized reporting requirements and credentialing of providers; streamlined enrollment in public insurance programs; and greater automation.71 In a separate report, the same authors proposed additional reforms that they estimated could reduce excess administrative costs by $40 billion, or 25 percent of total health care expenditures.72

In a 2010 study published in Health Affairs, Bonnie B. Blanchfield and other Massachusetts researchers concluded that the administrative burden on physician organizations could be reduced by a “single transparent set of payment rules for a system with multiple payers.” The authors recommended that the United States adopt “a standard set of payment requirements, increased payment-rule transparency, standardized forms, and a standard set of data exchange requirements.” Doing so could save $7 billion in billing costs for physician and other clinical services, according to the authors’ estimates.73

Conclusion

Although estimates vary, a large body of evidence shows that the United States is spending about twice as much as needed on the administration of health care. Other nations enjoy world-class health care systems while spending a fraction of what the United States does on governance, billing, and insurance.

A structural overhaul of how health care is financed and priced that includes key features of other countries' systems—whether one payer or many—would go a long way toward eliminating excess administrative costs. Simplifying the payment system should be an essential part of future health reform and would make the U.S. system work better for taxpayers and patients alike.

THE WALL STREET JOURNAL.
WSJ

Opinion: Republicans Managed to Make ObamaCare Popular
Jason L. Riley
April 9, 2019

A Kaiser Family Foundation poll released in December 2016, just before President Obama left office, showed that the Affordable Care Act had a favorability rating of 43%, while 46% viewed it unfavorably. Last month, the same poll showed the nine-year-old health-insurance law well above water, with 50% viewing it positively to 39% negatively.

Those numbers help explain why most Republicans in Congress aren't eager to campaign on repealing ObamaCare in 2020. Republican candidates ran hard on "repeal and replace" in 2016, and voters rewarded them with the presidency and GOP majorities in both chambers of Congress. The party's infighting and epic failure to deliver on that campaign promise is one reason Nancy Pelosi is once again speaker of the House.

Some aspects of ObamaCare—protection for people with pre-existing medical conditions, coverage for young adults through their parents' insurance plans—enjoy bipartisan support among voters, and many Republican lawmakers are content to focus for the time being on tweaking the law rather than repealing it. Alas, President Trump has other ideas. Republicans today are no closer to agreeing on an ObamaCare alternative than they were when Mr. Trump was elected, yet he wants to dust off the "repeal and replace" slogan for 2020.

Last month the Justice Department reversed itself and opted to support a federal District Court ruling that the Affordable Care Act is unconstitutional. In December, Judge Reed O'Connor ruled that since ObamaCare's individual mandate violates the Constitution, so does the rest of the law. Previously, Justice argued that only certain provisions of the law should be invalidated. Now it agrees with Judge O'Connor that the whole thing

should go. The case is currently before the Fifth Circuit Court of Appeals, but chances of success are slim. Chief Justice John Roberts, who provided the fifth vote in the Supreme Court decision upholding the individual mandate in 2012, is not likely to change his mind. But even if he did, the Supreme Court has a long history of voiding certain provisions of a law without declaring the entire statute unconstitutional.

Even if Republicans prevailed in court, the victory would almost certainly be pyrrhic. After House Republicans voted in 2017 to grant states conditional waivers to avoid certain ObamaCare mandates, Democrats accused them of opposing insurance coverage for people with pre-existing conditions. It wasn't true but it was easy to demagogue, which is exactly what Democrats did. In the midterm elections the following year, Republicans got pummeled by swing voters who didn't trust them on health care. Imagine the backlash that would follow a Republican-backed court decision that stripped people of their health coverage and forced states to roll back Medicaid expansion with no viable alternative in place—all right before a presidential election.

Repealing ObamaCare is impossible so long as Democrats control the House and it's impractical so long as Republicans can't get their act together on a replacement. Democrats would like nothing better than to run next year as guardians of health insurance while painting Republicans as keen to take it away. The mystery is why Mr. Trump sounds so eager to oblige his political opponents in a manner that complicates not only his own re-election but that of other Republicans on the ballot.

If the president wants Republicans to run on health care next year, why not put forward some pragmatic ways to lower premiums and deductibles for low-income patients? Why not talk up the merits of more health savings plans, or of expanding the use of health reimbursement accounts to cover out-of-pocket medical expenses? Just 5% of patients account for around half of the nation's health-care spending, and the president might explain how a federal reinsurance fund could help states finance their care. None of this will stop Democrats from lying to voters about Republicans and health insurance, but it will enable GOP candidates to go on offense when the topic turns to ObamaCare.

Mr. Trump could also put his Twitter account to use explaining the pitfalls of Medicare for All proposals that Kamala Harris, Bernie Sanders, Elizabeth Warren and other leading Democratic presidential candidates have been hyping. When voters learn that these schemes involve tax increases and the elimination of private health insurance, support tanks. The White House should make sure more people know the details.

As things stand now, Republicans will have plenty to brag about when making their case to voters next year: Strong economic growth and job creation, less regulation, conservative judges and vindication in the Robert Mueller investigation. If Mr. Trump wants to add health care to the mix, fine, so long as he's mindful that Republicans have made a mess of the issue thus far and that voters don't have an infinite amount of patience.

Supreme Court may get to decide fate of Obamacare before 2020 election
Devan Cole, Tami Luhby and Ariane de Vogue
April 10, 2019

Washington (CNN) A federal appeals court on Wednesday granted a Trump administration request to expedite oral arguments in a case challenging the legality of the Affordable Care Act.

The new time frame -- with arguments in early July -- means that the fate of Obamacare could come before the Supreme Court next term, with an opinion rendered by June of 2020 in the heart of the presidential campaign.

As in 2016 and the 2018 midterms, health care has already emerged as a core issue, though there are fissures in both parties. Congressional Democrats have rallied around Obamacare, while some of the party's presidential nominees are supporting "Medicare for All" plans that would offer universal, government-backed health coverage.

President Donald Trump, who campaigned in 2016 on repealing the law, has promised that Republicans will pass a "really great" health care plan after the 2020 election, although none has been proposed.

The administration last month sided with Republican-led states that are pushing for the law to be invalidated by the courts.

Attorney General William Barr said Wednesday he believes the Justice Department's decision not to argue in favor of upholding the Affordable Care Act is a "defensible legal position to take."

Initially, the Trump administration argued that two key provisions of the law that protect people with pre-existing conditions could no longer be defended, but the rest of the law could stand. But after a district court ruled in December 2018 that the entire law should be invalidated, the Justice Department changed its position and argues the district court ruling should be upheld in full.

As the administration debated its litigation strategy, Barr at first opposed to fully striking down the law. On Wednesday, he suggested that he is ready to back the administration's position.

When California Democratic Sen. Dianne Feinstein pressed on why Barr, as attorney general, didn't think it was his "duty to defend" the current law, Barr doubled down.

"Well, the law was originally upheld because the (individual) mandate was upheld as a tax," Barr said of the 2012 Supreme Court decision that upheld the law.

The inside story of how John Roberts negotiated to save Obamacare

The inside story of how John Roberts negotiated to save Obamacare

"Once the penalty was removed, the financial penalty was removed, that provision could no longer be justified as a tax which means that it would have to fall. So the mandate fell," he added, referring to Congress' decision in 2017 to effectively remove the penalty for not having insurance. "Then the question becomes if the mandate falls, even though there was no penalty attached to it, what's its impact on the rest of the statute? Four of the justices in the (2012 case) felt that the whole statute had to fall. So, as I said before you arrived, senator, you know at the end of the day, I felt that this was defensible legal position to take."

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Feinstein also pressed Barr on who in the administration changed its stance.

"Is this determined by the White House?" she asked.

Barr said that it was "determined by the process within the executive branch" and a "number of different players."

"Well, I assume you wouldn't take this position unless this is what the President wanted," Feinstein added.

"Well -- that would be a safe assumption," Barr said.

The administration's latest court filing came after months of heated internal debate that pitted Barr along with Health and Human Services Secretary Alex Azar against acting White House chief of staff Mick Mulvaney and officials aligned with him, a source close to the White House told CNN at the time.

Overturning the law would have far-reaching consequences -- way beyond disrupting coverage for the millions of people who get their health insurance on the exchanges or through Medicaid expansion.

Obamacare saves senior citizens money on their Medicare coverage and prescription drugs. It lets many Americans obtain free birth control, mammograms and cholesterol

tests. And it allows children to stay on their parents' health insurance plans until they turn 26.

Because the Trump administration is no longer defending the law in court, a coalition of 21 Democratic states led by California has stepped in to do so.

"Before the ACA, 133 million Americans faced barriers to coverage because of a pre-existing condition like diabetes or pregnancy -- yes, pregnancy," California's Attorney General Becerra said in a statement on Wednesday.

"We will be in court defending Americans' healthcare that President Trump seeks to strip from them, " he added.

Barr's comments on Wednesday came after he faced a similar grilling from members of the House Appropriations Committee Tuesday on the new decision. At one point during the hearing, he told Rep. Matt Cartwright, a Pennsylvania Democrat, that concerned lawmakers should "let the courts do their job."

Mulvaney said over the weekend that the White House could introduce a proposal "fairly shortly."

Why States Want Certain Americans to Work for Medicaid
Lola Fadulu
April 10, 2019

The letters went out to governors on March 14, 2017. Seema Verma had recently been appointed by President Donald Trump as the administrator of the Centers for Medicare and Medicaid Services, the agency within the Department of Health and Human Services that oversees health-care programs for more than 130 million Americans. Verma and then–HHS Secretary Tom Price, also a Trump appointee, wanted to alert state leaders across the nation that a new era was dawning: Some people would be required to work in exchange for Medicaid benefits.

Ushering in this new regime was, in some ways, what Verma had spent her entire career seeking to accomplish. In 2001, five years after earning a master’s degree in public health at Johns Hopkins University, Verma founded a consulting company called SVC. The company, which exists now as HMA Medicaid Market Solutions, helps states adjust how Medicaid programs are operated and delivered. (Verma sold the company shortly after becoming CMS administrator.)

In 2010, SVC took center stage in state-level Medicaid reform when the Patient Protection and Affordable Care Act—Obamacare—gave states the option of expanding Medicaid, with a hefty federal subsidy, to people making up to 138 percent of the poverty line. (The current poverty line is $12,490 per year for individuals and $25,750 per year for a family of four.) In Indiana, Verma partnered with Mike Pence, who at the time was the state's governor, to implement an expansion program called the Healthy Indiana Plan 2.0. Among other things, the program instituted a system of premiums, ranging from $1 to $27 per month, for the new Medicaid-expansion population.

Policy makers on the right applauded the move. But there was a consequence. Medicaid expansion in Indiana did give approximately 240,000 new people coverage, but in the years since it was implemented, portions of those eligible for benefits have been unable to pay their premiums. From 2015 to 2017, about 25,000 people in Indiana lost access to Medicaid.

In 2017, in her new position as CMS administrator, Verma gained the power to influence how every state administered its Medicaid programs.

In January 2018, for the first time since Medicaid's creation, in 1965, Verma's CMS gave permission to a state government to require certain citizens to work in order to keep benefits. The state was Kentucky, which planned to launch a work-requirement program this year. Details about who exactly would be subject to the requirement are still being ironed out. But according to Kentucky state officials' estimates, at least 95,000 people would lose Medicaid coverage over a five-year period.

Then, in March, Arkansas received permission to introduce a work requirement—and Arkansas was faster out of the starting gate, inaugurating its effort in phases. Beginning last June, people on Medicaid in Arkansas ages 30 to 49 who earned at or below the poverty line had to find work or participate in activities such as volunteering or job training to continue receiving Medicaid benefits. Certain people were exempt, such as those who were medically frail or who had a dependent child. From June to December, more than 18,000 people lost coverage in Arkansas as a result of the new policy, according to the Arkansas Department of Human Services.

Medicaid advocates have not been quiet. Both HHS and CMS, along with Verma and Alex Azar II—who took over as HHS secretary after Price resigned following a scandal involving his use of chartered jets and military aircraft—were immediately the target of lawsuits seeking to overturn the work requirements. They were filed in the U.S. District Court for the District of Columbia on behalf of people in Arkansas and Kentucky, as well as those in New Hampshire, whose work-requirement mandate has just gone into effect.

The plaintiffs allege that work requirements contradict one of the two chief stated objectives of Medicaid, as laid out in the 1965 Social Security Act Amendments: to "furnish medical assistance on behalf of families with dependent children and of aged,

blind, or disabled individuals, whose income and resources are insufficient to meet the costs of necessary medical services."

For its part, the Trump administration argues that work requirements further the second objective of Medicaid: to provide "rehabilitation and other services to help such families and individuals attain or retain capability for independence or self-care." Verma and others maintain, in effect, that employment should be considered a form of rehabilitation that leads to financial independence.

A judge examining this rehabilitation interpretation has found that it stretches the statutory language considerably: In the first round of rulings on the lawsuits, earlier this year, Kentucky and Arkansas were told to go back to the drawing board. Still, other states have followed their lead undeterred. In January 2019, Indiana began implementation of its work-requirement program. Programs in Arizona, Michigan, Wisconsin, Ohio, and Utah have been approved by HHS but have not yet started. Alabama, Mississippi, Oklahoma, South Dakota, Tennessee, and Virginia have submitted plans and are awaiting the green light.

This push for work requirements isn't new. Politicians and policy experts on the right have been promoting them for decades, and have successfully implemented them in other programs, such as Temporary Assistance for Needy Families (TANF) and the Supplemental Nutrition Assistance Program (SNAP). The stated rationale is that work requirements will discourage dependence on welfare. In 1984, Charles Murray—who later wrote the controversial work The Bell Curve—published a book called Losing Ground, in which he claimed that welfare programs deter poor people from working, because welfare recipients know they can rely on government help instead. The book was the subject of heated criticism and debate.

As an era of work requirements potentially looms for Medicaid, it's possible to look beyond conjecture at the likely impact. By now a significant number of studies have considered what work requirements for social programs do and don't accomplish. Are the new policies a good-faith effort to help people help themselves? Are they simply a way of using supposedly good intentions to clamp down on entitlements? Are they a tool for whittling away the ACA? Are they all those things? This battle is going to be fought for years to come.

Medicaid covers more than 65 million people (not including those covered under the Children's Health Insurance Program, or CHIP), at an annual cost of about $560 billion, which is borne by both the federal government and the states. All told, 36 states and the District of Columbia have opted to expand Medicaid under the ACA.

The way Verma has characterized it, the ACA moved millions of working-age, nondisabled adults onto Medicaid. She contends that CMS must give people more than a health service: "We owe our fellow citizens more than just giving them a Medicaid

card. We owe a card with care, and more importantly a card with hope," she said in a November 2017 speech to the National Association of Medicaid Directors. "Hope that they can break the chains of generational poverty and no longer need public assistance." In this view, Medicaid—or, more precisely, the threat of losing it—is a tool to encourage people to provide for themselves.

This is where work requirements come in. Section 1115 of the Social Security Act lets states propose experimental projects that promote the twin objectives of Medicaid: providing medical care as well as services designed to guide people toward independence. Verma maintained in the 2017 speech that the Barack Obama administration's refusal to approve work requirements for Medicaid on the grounds that they don't satisfy the program's objectives is an example of "the soft bigotry of low expectations," a phrase coined by Michael Gerson, a speechwriter for President George W. Bush. (The phrase appears in Bush's defense of the 2001 No Child Left Behind Act, which attempted to make additional federal aid contingent on better test-score results.) In other words, those who do not believe that low-income people can hold down a job and engage with their communities are making assumptions that have a way of proving self-fulfilling.

The argument over the statutory objectives of Medicaid is central when it comes to the actual conduct of government. Dustin Pugel, a policy analyst at the Kentucky Center for Economic Policy, believes that Verma's case for the meaning of Medicaid's second objective is inadequate. "The context of that part is really specific to physical rehabilitation," he says. "It talks about folks who have some sort of ailment that is preventing them from a full, independent life, and Medicaid is meant to fill in the gaps so that people can get back on their feet." In this light, the second objective is simply about achieving physical independence through medical care. It is not about withdrawing benefits to influence people's behavior.

In January 2018, CMS announced in a letter to state Medicaid directors, written by Brian Neale, then the director of the Center for Medicaid and CHIP Services, that it would begin approving proposals that promote participation in community-engagement activities—working, volunteering, going to school, receiving job training—in return for Medicaid benefits. Neale cited research showing that higher earnings are positively correlated with a longer life span, that unemployment is generally harmful to people's health, and that activities such as volunteering are associated with improved health and can lead to paid employment.

In Arkansas, the first state to implement work requirements, nearly 280,000 people are on Medicaid. About 69,000 are subject to the new requirements. Unless exempted, a person must log 80 hours of work or community activities a month and report those hours online or by phone. If, over a period of three successive months, a person fails to show that he or she has met the monthly threshold, Medicaid benefits will cease until the next calendar year.

The 18,000 Arkansas residents who lost their coverage last year failed to meet these work requirements for many reasons. Some people lost coverage for reasons beyond their control. Many simply didn't know about the change or were confused by it. Others couldn't navigate the website. A significant number didn't have computers or reliable cellphone or internet access. As of February, just 11 percent of the 18,000 had reapplied for and regained coverage.

Last month, Secretary Azar testified during a Senate Finance Committee hearing that this small proportion of reapplications "seems a fairly strong indication that the individuals who left the program were doing so because they got a job [in] this booming economy." But the Center on Budget and Policy Priorities, a liberal think tank, analyzed new Arkansas state data and found that, of the 18,000 beneficiaries who lost coverage, only 1,981 "had matches in the state's New Hire Database, indicating they found work." The analysis uncovered no evidence that the remaining 16,019 have found new jobs. (An HHS spokeswoman told Politico that Azar's comments were not intended to be definitive.)

Arkansas' second phase of work-requirement implementation began in January of this year and targeted two groups: 30-to-49-year-olds who earn from 101 to 138 percent above the poverty line, and 19-to-29-year-olds who make up to 138 percent above the poverty line. By March, "7,066 enrollees had one month of non-compliance with the requirements, and 6,472 enrollees had two months of non-compliance in the new calendar year," according to a March 2019 report from the Kaiser Family Foundation.

If it weren't for the recent string of lawsuits, Kentucky would have rolled out its own work-requirements plan by now. Kentucky's January 2018 case involved 15 residents—represented by the National Health Law Program, the Southern Poverty Law Center, and the Kentucky Equal Justice Center—who sued HHS and CMS, naming Verma, Azar, and two other top officials. The group argued that the Kentucky plan does not fulfill the objectives of Medicaid and would put them and others "in danger of losing" their health insurance altogether.

Reihan Salam: 'Medicare for all' is a fantasy

In June 2018, the 15 residents won their case. Judge James Boasberg ruled that Kentucky had ignored Medicaid's first objective—providing medical assistance, pure and simple—by disregarding the state's own estimates that work requirements would kick at least 95,000 people off the Medicaid rolls. Kentucky had focused primarily on its broad interpretation of Medicaid's second objective—furnishing rehabilitation and other services that lead to independence or self-care. Judge Boasberg vacated the approval of Kentucky's plan and "remanded the matter to HHS for further review."

In November, HHS approved Kentucky's revised program. The state had made some changes, but what it resubmitted was largely identical to the first application. The

consequences would be exactly the same: At least 95,000 people would still lose Medicaid coverage. The same plaintiffs, plus one new resident, sued Kentucky again. And in March of this year, they won for a second time. Kentucky's governor, Matthew Bevin, had already warned of what could happen next. In January 2018, he had directed officials within the Cabinet for Health and Family Services to essentially un-expand Medicaid as soon as legally possible if any part of Kentucky's Section 1115 waiver, which asked for work requirements, was prevented from being implemented.

Also in March of this year, and in the same court, the state of Arkansas lost a similar lawsuit brought against its existing work-requirement effort. On April 10, Justice Department attorneys appealed the decisions dealing with Arkansas and Kentucky on behalf of Verma and Azar—and HHS continues to push ahead. The New Hampshire case is still in its initial phase.

When asked to respond to the court rulings, CMS offered a statement that Seema Verma had made in March: "We will continue to defend our efforts to give states greater flexibility to help low income Americans rise out of poverty. We believe, as have numerous past Administrations, that states are the laboratories of democracy and we will vigorously support their innovative, state-driven efforts to develop and test reforms that will advance the objectives of the Medicaid program."

As politicians and policy analysts on the right have claimed for decades, work requirements are intended to address work disincentives. If people know they can receive food, health care, and housing from the government, more or less for free, then why would they work? Recent data, however, suggest that only a small proportion of people who receive Medicaid benefits might avoid work simply because they don't want to and don't have to.

In January 2018, the Kaiser Family Foundation published its analysis of 2016 data on the 25 million Medicaid recipients aged 19 to 64, as reported in the March 2017 Current Population Survey, which interviews people in person and via phone to gather results. It found that 42 percent of those people worked full-time, and that 18 percent worked part-time. Of the 10 million remaining people who reported not working, 36 percent said it was because they were disabled, 30 percent said it was because they were taking care of their home or family, and 15 percent said it was because they were going to school. Six percent said they couldn't find work, and 9 percent said they were retired; 3 percent reported "other" reasons. Based on these data, only about 2 million to 5 million people of the 25 million nonelderly people on Medicaid could even work in the first place, depending on families' abilities to find other caretakers, come out of retirement, and so forth.

Over a two-year period, researchers at the Brookings Institution's Hamilton Project collected data on the work status of people on Medicaid. They found that the way data had been gathered for a 2018 report by the White House's Council of Economic

Advisers—taking a nationwide snapshot in a single month—masked the fact that low-income Americans were continually entering and leaving the labor force, and doing so for many reasons, often temporary. A person might work nine months out of the year, but if he or she doesn't work for three consecutive months, this person would still lose health care in Arkansas.

Although work requirements have been built into two major programs, TANF and SNAP, studies show that those requirements have not been wildly successful. When Bill Clinton ran for president in 1992, he promised to "end welfare as we have come to know it." Four years later, he signed the Personal Responsibility and Work Opportunity Reconciliation Act—generally referred to simply as "Clinton's welfare reform"—which ended a program known as Aid to Families With Dependent Children and replaced it with TANF. The new program introduced a limit on how long families could receive benefits as well as a requirement to work, and states could determine which adults would be subject to it.

In its 2017 study of TANF, the Kaiser Family Foundation looked at two groups of aid recipients: those who were and were not required to work. It found that people who had not been required to work were just as likely to be working five years later as those who had been subject to a work requirement—and sometimes were even more likely to be working. Later that same year, the Urban Institute released a report that looked at the first decade of TANF. It found that employment gains had been modest and had declined over time. Moreover, the requirements did not increase stable employment.

Intriguingly, there is evidence that what the Trump administration aims to accomplish by instituting work requirements is already happening without them. Medicaid expansion has had "positive or neutral effects on employment and the labor market," according to another 2018 Kaiser Family Foundation report. It has not led to droves of people halting job searches in order to live off the government's largesse. Instead, more people find work. Or volunteer. Or go back to school.

More than 80 percent of people on Medicaid in Ohio, for example, say that "coverage made it easier to work," and 60 percent say that "coverage made their job search easier," according to state data. The reason, the Kaiser Family Foundation report found, is that many adults on Medicaid who are not working are not working because of an illness or a disability that prevents them from doing the physically demanding tasks that most entry-level or low-income jobs require. Health care helps many of them manage those health issues well enough to participate in the labor force.

In the agency's statement to The Atlantic, CMS did not address requests for comment on these studies.

Medicaid work requirements might not encourage more people to seek employment, but they do remove large numbers of people from health-care coverage. The result is

especially severe for African Americans. The pattern is familiar: The Urban Institute found in its 2017 report that work requirements for TANF had a disparate impact on African Americans. States with higher concentrations of African Americans tended to have more severe sanctions for initial incidents of noncompliance, and African Americans were more likely to be sanctioned than their white counterparts, even when the form of noncompliance was the same.

Last May, Nicholas Bagley and Eli Savit, who teach law at the University of Michigan, argued in The New York Times that Michigan's proposed work requirements for Medicaid discriminated against African Americans by exempting people living in high-unemployment rural counties, which are predominantly white. Michigan's minority population tends to live in cities, such as Flint and Detroit, which have high unemployment but are embedded in low-unemployment counties.

In terms of access to health care, the ACA, including Medicaid expansion, has had the effect of narrowing disparities in coverage between people of color and other Americans for the first time in years. If work requirements for Medicaid accomplish nothing else, they will widen these disparities once again.

The Washington Post
Democracy Dies in Darkness

Obamacare marketplaces fare better in states that embrace them
Paige Winfield Cunningham
April 16, 2019

Obamacare's health insurance marketplaces haven't failed, as some Republicans still insist. Yet the Obama appointee who set them up gives them only a passing grade. Kathleen Sebelius – the former Health and Human Services secretary who played a crucial roll in implementing the Affordable Care Act – said she'd give the marketplaces "maybe a 'B' or 'C-plus.'" "It isn't that the marketplaces are failing in their own," Sebelius said in a recent interview with Health 202. "The framework in which they operate is – I would say – more constrained than could be helpful." As I wrote in this weekend piece, the Affordable Care Act is more enmeshed than ever before in the country's health-care system, even as President Trump recently renewed calls for Congress to repeal and replace it. Thirty-six states and the District of Columbia have expanded Medicaid — including more than a dozen run by Republicans — and 25 million more Americans are insured, with millions more enjoying coverage that is more comprehensive because of the law. In a broad sense, the ACA accomplished what lawmakers set out to do: Dramatically reduce the U.S. uninsured rate and make comprehensive coverage available to people no matter what their health condition. Yet its marketplaces, a central component of the law, are seeing enrollments gradually diminish and its plans remains

unaffordable for many consumers who don't get federal subsidies. Few have more experience with marketplace challenges than Sebelius, who presided over the initially disastrous launch of Healthcare.gov in 2013 and resigned from her position shortly thereafter. To her, the possibilities for improvements in the marketplaces are most evident in comparing states that have embraced the ACA and those that haven't. "You have a mix and match in these marketplaces," she told me. "The states that are engaged and all in…and the states where they've sat back."

At this point, only 11 states and the District run their own marketplaces rather than relying on the federal Healthcare.gov website. But these states appear to have achieved more stable enrollments and insurer participation, partly because their leaders have played a more active role in promoting the marketplaces and tailoring their own enrollment portals. For example, nine of the dozen states chose to lengthen their signup periods beyond the federal deadline. And leaders in these states tend to take a more proactive role in trying to improve the marketplaces. California Gov. Gavin Newsom (D) has suggested expanding subsidies to people earning more than 400 percent of the federal poverty level and reinstating a mandate to buy coverage after Congress repealed the national penalty for lacking coverage. Minnesota Gov. Tim Walz (D) has proposed funding additional premium subsidies by reallocating some of the state's reinsurance dollars. The efforts appear to have paid off. Enrollment in the state-run marketplaces held steady – at around 3 million people – while enrollments in the federal-run marketplaces declined from 8.7 million last year to 8.4 million this year, according to the latest enrollment figures from the Centers for Medicare and Medicaid Services. Of course, there's plenty Congress and the administration could do to improve the marketplaces, but Republican uniformly opposed a recent slate of such measures from House Energy and Commerce Democrats. Sebelius said enhancing subsidies for monthly premiums and funding targeted outreach could go a long way – even as she acknowledged the chance for bipartisan agreement on the matter is slim. "There has never been a piece of legislation that is as massive and complicated as the Affordable Care Act where there was an absolute refusal of the U.S. Congress to ever try and make it work – to even provide technical assistance to clarify issues that might not be clear," Sebelius said. Yet individual Republicans appear increasingly willing to acknowledge the successes of the ACA, even as they remain unwilling to try to improve it. Ten years ago, Sen. Chuck Grassley (R-Iowa) was at the forefront of GOP opposition to the law, ominously pushing the debunked claim that it would allow the government to "pull the plug on grandma" by creating "death panels." Today, Grassley is chairman of the Senate Finance Committee, the panel that would be responsible for drafting a new health-care law, and he has shown little enthusiasm for Trump's call for congressional Republicans to produce a replacement for the ACA. Republicans from states that embraced the law's Medicaid expansion also concede that it has benefited large portions of the low-income population, many of whom were previously uninsured. "For the people who are in that tranche of expanded Medicaid, I think it has been very helpful," said Sen. Shelley Moore Capito (R-W.Va.). Nearly one-third of West Virginians

are on Medicaid, and the percentage of uninsured has dropped by about 56 percent since 2013.

POLITICOPRO

Trump administration finalizes plan to trim Obamacare subsidies
Paul Demko
April 18, 2019

CMS is finalizing a technical change to how Obamacare subsidies are calculated, raising insurance costs for some customers and likely shrinking enrollment in the law's marketplaces.

The Trump administration expects the changes in the final 2020 payment and benefit rules will result in $980 million less in federal financial assistance in 2020 and 70,000 fewer Obamacare customers.

The administration is also finalizing its proposal to reduce the exchange fee that insurers pay by half a percentage point. That should reduce premiums slightly since insurers typically add that fee into their rates.

CMS said its decision to adjust the subsidy formula was justified in part by the removal of cost-sharing-reduction payments, which President Donald Trump eliminated in 2017. Insurers hiked premiums in response to that decision, resulting in significantly higher subsidies for Obamacare customers.

In past years, CMS only used premiums for employer-based plans in the formula to calculate subsidies, in part because of big fluctuations in individual market premiums during Obamacare’s early years. But now it will use a blend of premiums for individual market and employer-sponsored plans to calculate financial assistance, resulting in less aid.

The cuts in assistance will be smaller for lower-income customers and bigger for those with higher incomes.

Under the administration's original proposal, which was tweaked in the final version released today, an exchange customer who earns 300 percent of the federal poverty threshold would have seen see their annual subsidies decrease by $92 in 2020, according to calculations by the Brookings Institution’s Matt Fiedler. A family of four at the same income level would have lost $189 in annual aid.

CBO: over 1 million Americans have become uninsured since 2016
Sarah Kliff
April 19, 2019

More than 1 million Americans have lost health coverage since 2016, a new report from the Congressional Budget Office finds.

The report — which came out within hours of the Mueller report on Thursday and so didn't get much attention — follows other studies, all suggesting that America's uninsured rate is rising under President Trump, whose administration has passed new rules that make it more difficult to enroll in coverage.

The CBO estimates that the number of Americans without insurance has risen from 27.5 million in 2016 to 28.9 million in 2018, an increase of 1.4 million Americans going uninsured.

Much of that increase is concentrated in the Medicaid program, where the Trump administration has approved new rules like work requirements that can make it more difficult for low-income Americans to enroll in the program.

The other area where health coverage has declined is among Americans who purchase their own health insurance outside the Affordable Care Act's marketplaces.

The CBO report does note that measuring the uninsured rate is a challenging task. It largely relies on survey data that Americans submit, rather than measuring enrollment in government programs, for example, where the agency can turn to administrative data sources.

Still, this report isn't the first to sound alarm bells about a rising uninsured rate.

Gallup, for example, found in January that the country's uninsured rate was at a four-year high — and that most of the increase had happened under the Trump administration.

It's notable that these declines in coverage are happening even though Republicans were unable to repeal the Affordable Care Act — and all before the repeal of the requirement to carry health insurance took effect (that provision only kicked in at the start of 2019). The rising uninsured rate is happening at a moment when, on paper, Obamacare looks a lot like it did under President Obama.

There is some evidence that all the discussion of Obamacare repeal may be depressing insurance enrollment. A YouGov poll at the end of 2017 found that 31 percent of Americans believed Republicans had successfully repealed the Affordable Care Act. More recent polling from the Kaiser Family Foundation finds that 17 percent of Americans believe the law has been repealed and 14 percent aren't sure if it's still standing. With that many Americans believing Obamacare doesn't exist, it makes sense that you're seeing lower sign-up rates in both the individual markets and Medicaid.

We also have more concrete evidence that new rules requiring Medicaid enrollees to work have led to lower enrollment in that public program, which is meant to serve low-income Americans. More than 18,000 people there have lost coverage since the Trump administration approved that new rule, which requires Medicaid recipients to work at least 80 hours per month (or participate in other qualifying activities) in order to receive their benefits.

Even without repealing Obamacare, it appears that the Trump administration is still having a tangible impact on insurance sign-ups — and fewer Americans are getting the coverage they used to.

Americans are more focused on health costs than Medicare-for-all, poll shows
Amy Goldstein
April 24, 2019

Most Americans want Congress to take action to lower their family's health care expenses, rather than make sweeping changes such as adopting Medicare-for-all, or repealing and replacing the Affordable Care Act, according to a new survey.

At a time when Democratic presidential candidates are emphasizing universal health coverage — with those on the left advocating Medicare-for- all — not quite half of the respondents who identify as Democrats regard that as a priority for Congress in the latest poll by the Kaiser Family Foundation. That compares with 14 percent of Republicans.

Majorities of both parties, on the other hand, believe Congress should find ways to lower the expense of prescription drugs, according to the poll results released on Wednesday. Drug costs are the top priority for respondents of both parties in Kaiser's poll, as they have been for some time.

Preserving consumer protections so that insurance is affordable for people with preexisting medical conditions also ranks high as something people want Congress to

do, with nearly two-thirds of Americans supporting the idea, the poll shows. So does legislation intended to cushion patients from surprise medical bills, supported by 50 percent of the public, including nearly half of Republicans.

Kaiser's long-running tracking poll also shows that the Trump administration is out of sync with public attitudes in its renewed determination, in both the president's recent remarks and its legal position in a federal lawsuit, to eliminate the Affordable Care Act.

Just slightly more than one-fourth of the public overall say that Congress should repeal the ACA, the sprawling 2010 health-care law that was a signature domestic accomplishment of President Barack Obama. But the partisan divide is sharp, with 16 percent of Democrats and 52 percent of Republicans saying the repeal should be a priority.

And asked about the most popular aspects of the law, majorities say they fear the effects if ACA were to go away.

Nearly two-thirds say they are concerned that they or someone in their family would be unable to afford coverage if the Supreme Court overturned either the entire law or its protections for people with pre-exising conditions. And more than half say they fear they or someone in their family would lose coverage as a result.

As people were asked those questions, the law has been ruled unconstitutional by a federal judge in Texas and is now before an appellate court.

Meanwhile, large majorities of those polled say that the government should protect patients if they end up with large surprise bills because part of their care was delivered by a provider outside of their insurers' networks. More than three-quarters of those polled said the government should protect people taken to an emergency room by an out-of-network ambulance or taken to an out-of-network emergency room.

Three-quarters also believe patients should be protected financially if they are at a hospital in their insurers' network but treated by a doctor who is outside it.

After Vox reporting, California moves forward on plan to end surprise ER bills
Sarah Kliff
April 24, 2019

California is moving forward on a new law to end surprise emergency room bills like those that left one patient with a $20,000 treatment bill after a minor bike crash — legislation that was inspired by Vox's reporting on the issue.

The new bill, introduced by state Assembly member David Chiu and state Sen. Scott Wiener, would bar California hospitals from pursuing charges beyond a patient's regular copayment or deductible. The ban would apply even if a hospital was out of network with a patient's health insurance.

The bill passed out of the California Assembly Committee on Health on Tuesday and now heads to the appropriations committee. No members of the health committee voted against the proposal.

In January, a series of stories published by Vox drew nationwide attention to the aggressive billing tactics used by Zuckerberg San Francisco General Hospital, which have left insured emergency room patients with overwhelming medical debt.

The problem is especially acute for patients like Nina Dang and Jason Zanders, both of whom were brought to the hospital by ambulance — Dang after a bike accident, and Zanders after being hit in the face with a pole hanging off a city bus.

Both Dang and Zanders have health insurance but didn't realize that Zuckerberg Hospital was out of network for all private coverage — something that academic experts and patient advocates describe as an extremely unusual billing practice.

Dang ended up with a bill of $20,243, which the hospital reduced to $200, the copay listed on her insurance card, after our story about her experience. Zanders received a bill of $27,660 that he spent two years fighting in court.

Zuckerberg San Francisco General Hospital has, in light of reporting from both Vox and the San Francisco Chronicle, revised its billing policies to end surprise bills and cap what it charges privately insured patients, based on their income.

But Chiu, who represents San Francisco, thinks even more action is needed: a statewide law that would outlaw this kind of behavior.

“This all came to my attention through your article,” he said. “When your story broke, I started digging into how state law impacted the situation and saw that there were some clear holes in California policy that we needed to address.”

How California legislators want to end surprise emergency room bills
California actually has some of the country’s strongest protections against surprise medical bills, but the state’s laws never anticipated a hospital with billing practices like Zuckerberg San Francisco General.

In 2016, California passed a law that protected patients from surprise bills from out-of-network doctors they didn’t choose.

This might happen if, for example, a patient went to an in-network hospital and then received a bill from an out-of-network anesthesiologist or radiologist they never even met.

That law covered patients receiving scheduled care like surgery or delivering a baby. Separately, a decade-old California Supreme Court ruling provided similar protections for emergency room patients.

Neither the court ruling nor the 2016 law anticipated a situation like the one at Zuckerberg, where the entire hospital is “out of network” with all private health insurance.

Most big hospital ERs negotiate prices for care with major health insurance providers and are considered “in network.” But Zuckerberg San Francisco General had not done that bargaining. Prior to Vox’s reporting, it had a longstanding policy of remaining out of network with all private health insurance plans.

A hospital spokesperson initially told Vox that the hospital’s focus is on serving those with public health coverage, even if that means offsetting those costs with high bills for the privately insured.

“It’s a pretty common thing,” Brent Andrew, the hospital spokesperson, told Vox in January. “We’re the trauma center for the whole city. Our mission is to serve people who are underserved because of their financial needs. We have to be attuned to that population.”

But most data finds that this isn’t a common practice: Academic researchers estimate that just 1 percent of emergency room visits happen at out-of-network facilities. Similarly, I’ve seen this in my own reporting. I’ve read more than 1,000 emergency room bills, and in nearly all of them, the facility is “in network” with the patient’s insurance.

This new legislation would tackle that rarer situation where a hospital is not in network and then sends the patient a bill for whatever balance their insurer won’t pay.

There are two key parts to the proposal. First, the bill would prohibit hospitals from pursuing any balance that the patient owed beyond their regular copayment or contributions to the health plan's deductible.

Second, the bill would regulate the prices the hospital could charge for its care, limiting the fees to 150 percent of the Medicare price or the average contracted rate in the area, whichever is greater.

"Patients would no longer receive exorbitant, surprise bills," Chiu said. "The discussion between insurers and hospitals would become far more predictable."

Chiu said the hospital and insurance industries are aware of the effort but haven't yet seen the full text of the legislation, which will be introduced on Monday.

Vox's emergency room billing investigation has inspired multiple pieces of legislation — and reversed half a dozen bills
The bills included in Vox's reporting on Zuckerberg San Francisco General Hospital were all submitted by patients to our emergency room billing database, which has served as the basis for a year-long investigation into ER billing practices. Vox has collected more than 1,900 bills from all 50 states and the District of Columbia.

Vox's reporting on emergency room billing has resulted in more than $92,000 in emergency room bills being reversed, including three from Zuckerberg Hospital. It has also inspired new legislation in the Senate to prevent these bills from happening nationwide.

You can read the rest of our series here — and if you're a local reporter interested in writing about bills in our database, you can fill out this form and we'll try to help connect you with a patient.

The New York Times

Trump Administration Files Formal Request to Strike Down All of Obamacare
Jan Hoffman and Abby Goodnough
May 1, 2019

The Trump administration formally declared its opposition to the entire Affordable Care Act on Wednesday, arguing in a federal appeals court filing that the signature Obama-era legislation was unconstitutional and should be struck down.

Such a decision could end health insurance for some 21 million Americans and affect many millions more who benefit from the law's protections for people with pre-existing

medical conditions and required coverage for pregnancy, prescription drugs and mental health.

In filing the brief, the administration abandoned an earlier position — that some portions of the law, including the provision allowing states to expand their Medicaid programs, should stand. The switch, which the administration disclosed in late March, has confounded many people in Washington, even within the Republican Party, who came to realize that health insurance and a commitment to protecting the A.C.A. were among the main issues that propelled Democrats to a majority in the House of Representatives last fall.

The filing was made in a case challenging the law brought by Ken Paxton, the attorney general of Texas, and 17 other Republican-led states. In December, a federal judge from the Northern District of Texas, Reed O'Connor, ruled that the law was unconstitutional.

A group of 21 Democratic-led states, headed by California, immediately appealed, and the case is now before the Fifth Circuit Court of Appeals in New Orleans. The House of Representatives has joined the case as well to defend the law.

Democrats wasted no time responding to the filing Wednesday. Xavier Becerra, the attorney general of California, a Democrat, said: "The Trump administration chose to abandon ship in defending our national health care law and the hundreds of millions of Americans who depend on it for their medical care. Our legal coalition will vigorously defend the law and the Americans President Trump has abandoned."

The government's brief did not shed light on why it had altered its earlier position, referring only to "further consideration and review of the district court's opinion."

Oral arguments in the appeals court are expected in July, with a possible decision by the end of the year, as the 2020 presidential campaign gets going in earnest. Whichever side loses is expected to appeal to the Supreme Court.

The Justice Department's request to expedite oral arguments, granted last month, suggests that the administration is eager for a final ruling. In its application, it said that "prompt resolution of this case will help reduce uncertainty in the health care sector, and other areas affected by the Affordable Care Act."

Democrats, seizing on the health law's popularity and its decisive role in their winning the House last fall, are already using the case as a cudgel against President Trump as his re-election campaign gets started. The law's guarantee of coverage for people with pre-existing medical conditions, in particular, remains very popular with voters in both parties as well as independents.

But Mr. Trump has appeared undaunted, tweeting in April that "Republicans will always support Pre-Existing Conditions" and that a replacement plan "will be on full display during the Election as a much better & less expensive alternative to Obamacare."

Instead of providing specifics, though, Mr. Trump, members of his administration and other Republicans have focused on attacking the Medicare for All plans that some Democratic presidential candidates have sponsored or endorsed as a dangerous far-left idea that would, as Mr. Trump tweeted, cause millions of Americans “to lose their beloved private health insurance.”

As the administration and Texas noted in their briefs, Judge O’Connor’s ruling turned on the law’s requirement that most people have health coverage or be subject to a tax penalty.

But in the 2017 tax legislation, Congress reduced that penalty to zero, effectively eliminating it. Judge O’Connor, the plaintiff states, and now the Trump administration reasoned that, like a house of cards, when the tax penalty fell, the so-called individual mandate became unconstitutional and unenforceable. Therefore, the entire law had to fall as well.

Mr. Paxton, the Texas attorney general, whose office also filed a brief on Wednesday, said: “Congress meant for the individual mandate to be the centerpiece of Obamacare. Without the constitutional justification for the centerpiece, the law must go down.”

Whether that position will survive judicial scrutiny is another question. Nicholas Bagley, who teaches health law at the University of Michigan Law School, noted that only two lawyers signed the brief. That is highly unusual in a case with such a high profile, he said.

“This is a testament to the outrageousness of the Justice Department position, that no reasonable argument could be made in the statute’s defense,” Mr. Bagley said. “It is a truly indefensible position. This is just partisan hardball.”

Many legal scholars have also said that even before appellate judges wade into the more obscure pools of legal reasoning, they could reach a decision by addressing the question of congressional intent. If Congress had meant the erasure of the tax penalty to wipe out the entire act, such an argument goes, it would have said so.

If the Fifth Circuit overturns the O’Connor decision, there is no guarantee that the Supreme Court would take an appeal. The court has ruled on two earlier A.C.A. challenges, finding in favor of the act, although narrowing it.

Of course, the composition of the Supreme Court has since changed.

Los Angeles Times

Health insurance deductibles soar, leaving Americans with unaffordable bills
Noam N. Levey
May 2, 2019

Soaring deductibles and medical bills are pushing millions of American families to the breaking point, fueling an affordability crisis that is pulling in middle-class households with health insurance as well as the poor and uninsured.

In the last 12 years, annual deductibles in job-based health plans have nearly quadrupled and now average more than $1,300.

Yet Americans' savings are not keeping pace, data show. And more than four in 10 workers enrolled in a high-deductible plan report they don't have enough savings to cover the deductible.

One in six Americans who get insurance through their jobs say they've had to make "difficult sacrifices" to pay for healthcare in the last year, including cutting back on food, moving in with friends or family, or taking extra jobs. And one in five say healthcare costs have eaten up all or most of their savings.

Those are among the key findings of a Los Angeles Times examination of job-based health insurance — the most common form of coverage for working-age Americans — which has undergone a rapid transformation, requiring patients to pay thousands of dollars out of their own pockets.

The conclusions are based in part on a nationwide poll The Times conducted in partnership with the nonprofit Kaiser Family Foundation, or KFF. Two Washington-based think tanks — the Health Care Cost Institute and the Employee Benefit Research Institute — provided supplemental analysis.

The Times also interviewed doctors, business leaders, researchers and dozens of Americans with high-deductible coverage and reviewed scores of studies and surveys of health insurance in the U.S.

At a time when healthcare is poised to be a central issue in the 2020 presidential election, these sources provide a comprehensive look at changes that have profoundly reshaped insurance.

The explosion in cost-sharing is endangering patients' health as millions, including those with serious illnesses, skip care, independent research and the Times/KFF poll show.

The shift in costs has also driven growing numbers of Americans with health coverage to charities and crowd-funding sites like GoFundMe in order to defray costs.

And it is feeding resentments and deepening inequalities, as healthier and wealthier Americans are able to save for unexpected medical bills while the less fortunate struggle to balance costly care with other necessities.

"It feels like the system isn't working," said Andrew Holko, a 45-year-old father of two who is facing $5,000 in outstanding medical bills because of diabetes medications, cortisone injections his wife needs for pelvic pain, a recent trip to the emergency room for his 9-year-old daughter and other services.

Holko's information technology job puts his household income above $80,000, close to the median for a family of four. But with a mortgage, student loans and two growing children, Holko says he has little extra to cover a $4,000 annual deductible.

"We shop at discount grocery stores. My wife is couponing. We are putting every single bill we can on the credit card," Holko said, noting that even a family meal at McDonald's seems like a luxury. "We're drowning."

In the poll of working-age adults with job-based insurance, a quarter said they had put off vacations or major purchases in order to pay for healthcare. A quarter have curtailed spending on clothing and other basic household goods.

Half said costs had forced them or a close family member to delay a doctor's appointment, not fill a prescription or postpone some other medical care in the previous year. That is higher than some other national surveys, but a study published Thursday by American Cancer Society researchers found that in the last year, 56% of all U.S. adults had problems paying medical bills, delayed care or worried about affording care.

Hardest hit in the cost shift are lower-income workers and those with serious medical conditions such as diabetes, heart disease and cancer — who are more than twice as likely as healthier workers, according to the Times/KFF poll, to report problems paying medical bills and to say they've cut back on spending for food, clothing and other household items.

"There has been a quiet revolution in what health insurance means in this country," said Drew Altman, the longtime head of the Kaiser Family Foundation. "This happened under the radar while everyone was focused on the Affordable Care Act."

The 2010 healthcare law — often called Obamacare — provided landmark protections to Americans once shut out of health coverage. But as Democrats and Republicans fought over the law, Altman said, neither focused on the rapid run-up in costs for people covered through work.

"We forgot that most people get their insurance through an employer, and for them, the issue is medical bills that they increasingly cannot afford," Altman said.

As recently as 2006, nearly half of workers had a health plan with no deductible at all: Their insurance began immediately covering medical costs, often requiring them to pay, at most, a small percentage of their bills.

The average deductible for a single worker with a job-based insurance plan in 2006 was just $379, adjusted for inflation, according to an annual employer survey that KFF has conducted for more than two decades. By 2018, that figure had more than tripled to $1,350. Four in 10 U.S. workers have at least a $1,500 deductible — the threshold the poll used for high-deductible coverage for individuals.

Over the same time, insurance premiums also increased, rising at more than double the rate of inflation and outpacing wage gains.

"People are trying hard to do the right thing, but care is being priced out of their reach," said Dr. Barbara McAneny, president of the American Medical Assn., the nation's largest physicians' organization.

Like many doctors, nurses and hospital leaders, McAneny, an oncologist in New Mexico, can tick off stories of patients who have health insurance yet delayed critical care, fearing the bills.

"The original idea of deductibles and co-pays theoretically might have made sense — if patients have more responsibility for how they spend medical dollars, they would be more careful," McAneny said. "But it is just shifting costs to the patients, and people are forgoing care they need."

Feeling the strain are people like Sandy Westbrook, a 55-year-old nurse's assistant at an Ohio nursing home.

Westbrook, who earns less than $12 an hour, says she cut back on trips to the grocery store as she scrimped to pay off nearly $1,000 in medical bills after she broke her wrist and had to see a cardiologist for stress. "I get fed at work, thank God," she said.

Shanona Nichols, a 26-year-old office assistant in Michigan, moved back in with her mother to save money to pay medical bills from treatment for endometriosis.

Tomas Krusliak, a 27-year-old chef in western Virginia, took on two extra jobs, working some days from 5 a.m. to 11 p.m., to pay medical bills after his wife had a miscarriage as the couple tried to have their first baby. They had a $5,000 deductible.

“I was used to having insurance where I could go to the doctor and get the treatment I needed,” said Krusliak, who is originally from Slovakia. “It was definitely a shock when I got to the U.S. and learned that even when you are working and getting insurance, you have to spend even more money to get treatment.”

Many other industrialized nations rely on private health insurance, but few of their citizens face the kind of medical bills Americans routinely do. Fewer than one in 10 patients in Germany and Holland, for example, reported problems getting medical care because of cost, the New York-based Commonwealth Fund found in a 2016 survey.

By contrast, four in 10 U.S. workers had difficulty paying a medical bill or insurance premium in the previous 12 months, according to the Times-KFF poll conducted last fall.

The challenges are most severe for people with the highest deductibles, according to the poll: Nearly half of those in a plan with at least a $3,000 individual deductible or a $5,000 family deductible reported problems affording healthcare.

Even Americans with chronic conditions such as diabetes use less medical care if they have a high-deductible plan, according to an analysis conducted for The Times by the Health Care Cost Institute, which examined three years of insurance data for 10 million workers.

Other academic studies show patients with cancer, epilepsy, arthritis, multiple sclerosis and other serious diseases also delay care or skimp on vital medications when they are required to pay more out of pocket. Doctors typically recommend patients with such conditions get regular care to control the disease and prevent complications.

This wasn’t how the high-deductible revolution was supposed to play out.

Twenty years ago, amid a backlash against HMO restrictions on people’s ability to choose their doctors, high-deductible plans were billed as a way to empower patients and free them from the unpopular constraints of managed care.

Even then there were red flags: As far back as the 1970s, a landmark study by the California-based Rand Corp. had found that requiring people to pay more out of pocket caused them to cut back on medical care they needed as well as on unnecessary services.

Backers of the high-deductible strategy nevertheless argued that patients, given “skin in the game,” would become active consumers who would force drugmakers, hospitals and other medical providers to rein in prices.

“The thing that caught people’s imagination was this idea of unleashing American patients as consumers,” said Dr. Arnie Milstein, medical director of the California-based Pacific Business Group on Health, an organization of large companies, including Boeing, Safeway, Walmart and Wells Fargo.

Employers, desperate for a way to control healthcare spending, saw an opportunity to hold down costs.

Many of the first companies to offer high-deductible plans gave employees seed money for medical savings accounts, with the idea that the cash would help workers pay their deductibles. Within a few years, the George W. Bush administration — backed later by Congress — carved out tax benefits for the accounts.

As high-deductible plans caught fire, however, many employers saw they could save even more by not contributing to their employees’ accounts.

“The idea was hijacked,” said Tony Miller, a Minnesota healthcare entrepreneur who developed some of the first high-deductible plans for large employers like medical device giant Medtronic, but who has since grown disenchanted with how companies shifted costs onto patients.

The change left workers responsible for saving for healthcare on their own.

Yet government data show that most workers haven’t had extra money to set aside.

In 2016, the most recent year with available data, just half of single households and six in 10 multi-person households had even $2,000 in available savings — including cash, non-retirement stocks, mutual funds and other liquid assets — according to a KFF analysis of government data conducted for The Times.

“In the real world, average people are living paycheck to paycheck,” said Helen Darling, the former head of the National Business Group on Health, a leading employer organization focused on health benefits. “Unfortunately, that never got through to the policy debate.”

Moreover, the vision of legions of patients becoming engaged shoppers pushing down prices has turned out to be a mirage.

Only 17% of workers say they have attempted to shop around to find the best price for a medical service in the previous year, according to the Times-Kaiser poll.

And doctors, hospitals and clinics continue to make costs nearly impossible for patients to determine, according to consumer advocates, independent research and the Times/KFF survey. Two-thirds of surveyed workers said finding out the cost of a medical treatment or procedure was somewhat or very difficult.

Today, most Americans with a job-based health plan still give their insurance good marks. Two-thirds call their coverage excellent or good, according to the Times/KFF poll, which found that workers are primarily grateful to have any coverage.

But those with the highest deductibles are substantially less satisfied, with fewer than half giving their plans high marks.

Americans with chronic illnesses are more likely than healthy workers to say their insurance has gotten worse in recent years and less likely to feel the system works well for people like them, the poll found.

Across the board, large numbers of U.S. workers are looking for relief.

In a major reversal from 15 years ago, six in 10 Americans with job-based coverage now call affordability the most important feature of a health plan, outranking previous top concerns such as a broad choice of doctors and hospitals and a wide range of benefits.

“The whole situation drives me nuts,” said Bryan Shirley, a lawyer in Minnesota who said in the past he would question whether he needed to take his children to the doctor because he worried about paying the deductible. “It’s the worst feeling as a parent.”

Shirley, 46, said he put off medical attention for his sports injuries and at one point put thousands of dollars of medical bills on credit cards.

“I know we are better off than most,” he said. “But I feel like there must be a better way.”

He’s not alone.

A growing number of healthcare officials, and even some corporate leaders, say it’s time to reassess the cost-sharing revolution.

“I would love to see us reevaluate the whole purpose of co-pays and deductibles,” said McAneny, the American Medical Assn. president. “It makes no sense to put a barrier in front of care patients need to get.”

Even former Utah Gov. Mike Leavitt, a Republican who supported the move to higher deductibles as Health and Human Services secretary in the George W. Bush administration, acknowledged that adjustments may be needed, even if returning to the days of no-deductible coverage is not the solution.

“There needs to be a way to relieve the pressure,” Leavitt said. “Otherwise, people will feel like they have no insurance at all.”

Individual Insurance Market Performance in 2018
Cynthia Cox, Rachel Fehr and Larry Levitt
May 2, 2019

The early years of the Affordable Care Act (ACA) exchanges and broader ACA-compliant individual market were marked by volatility. Markets in some parts of the country have remained fragile, with little competition, an insufficient number of healthy enrollees to balance those who are sick, and high premiums as a result. By 2017, however, the individual market generally had begun to stabilize. Absent any policy changes, it is likely insurers would have required only modest premium increases to regain or maintain profitability in 2018.

However, by mid-2017 when insurers were considering 2018 premiums and participation, it was unclear whether the individual mandate would be enforced, cost-sharing subsidies would be paid, or the ACA as a whole would remain law. In October 2017, the Trump Administration ceased payments for cost-sharing subsidies, which led some insurers to exit the market or request larger premium increases than they would have otherwise. The Administration also reduced funding for advertising and outreach. And, Congress ultimately repealed the individual mandate penalty, effective for 2019. Amid these policy changes and legislative uncertainty, insurers raised benchmark premiums by an average of 34% going into 2018.

In this analysis, we find individual market insurers saw better financial performance in 2018 than in all the earlier years of the ACA and returned to, or even exceeded, pre-ACA levels of profitability. Premiums fell slightly on average for 2019, as it became clear that some insurers had raised 2018 rates more than was necessary. It is likely premiums would have fallen even more if the individual mandate penalty were still in effect.

In this brief, we use financial data reported by insurance companies to the National Association of Insurance Commissioners and compiled by Mark Farrah Associates to look at the average premiums, claims, medical loss ratios, gross margins, and enrollee utilization from 2011 through 2018 in the individual insurance market, as well as the amount of medical loss ratio rebates insurers expect to issue to 2018 enrollees. These figures include coverage purchased through the ACA’s exchange marketplaces and ACA-compliant plans purchased directly from insurers outside the marketplaces (which

are part of the same risk pool), as well as individual plans originally purchased before the ACA went into effect.

Our analysis also finds that insurers are expecting to pay a record total of about $800 million in rebates to individual market consumers for not meeting the ACA medical loss ratio threshold, which requires them to spend at least 80% of premium revenues on health care claims or quality improvement activities. This comes from initial estimates reported by insurers; actual rebates could end up being either higher or lower. In total, across the individual, small group, and large group markets, insurers expect to issue about $1.4 billion in rebates this year based on their 2018 performance. If insurer expectations hold true, these will be the largest consumer rebates issued since the MLR program began.

These new data from 2018 offer further evidence that insurers in the individual market are regaining profitability, though more recent policy and legislative changes taking effect in 2019 – the repeal of the individual mandate penalty as part of tax reform legislation and the proliferation of loosely-regulated short-term insurance plans – continue to cloud expectations somewhat for the future.

Medical Loss Ratios

As we found in our previous analysis, insurer financial performance as measured by loss ratios (the share of health premiums paid out as claims) worsened in the earliest years of the ACA Marketplaces, but began to improve more recently. This is to be expected, as the market had just undergone significant regulatory changes in 2014 and insurers had very little information to work with in setting their premiums.

The chart below shows simple loss ratios, which differ from the formula used in the ACA's MLR provision.1 Loss ratios began to decline in 2016, suggesting improved financial performance. In 2017, following relatively large premium increases, individual market insurers saw significant improvement in loss ratios, a sign that individual market insurers on average were beginning to better match premium revenues to claims costs. Loss ratios have continued to decline, averaging 70% in 2018. This suggests insurers were able to build in the loss of cost-sharing subsidy payments when setting premiums and some insurers likely over-corrected.

Margins

Another way to look at individual market financial performance is to examine average gross margins per member per month, or the average amount by which premium income exceeds claims costs per enrollee in a given month. Gross margins are an indicator of performance, but positive margins do not necessarily translate into profitability since they do not account for administrative expenses.

Gross margins show a similar pattern to loss ratios. Insurer financial performance improved dramatically through 2018 (increasing to $167 per enrollee, from a recent annual low of -$9 in 2015). These data suggest that insurers in this market are now financially healthy, on average.

Underlying Trends

Driving recent improvements in individual market insurer financial performance are the premium increases in 2018 combined with more modest growth in claims for medical expenses. On average, premiums per enrollee grew 26% from 2017 to 2018, while per person claims grew only 7%. This growth in premiums is in part due to the loss of cost-sharing subsidy payments; insurers are required by law to provide cost-sharing subsidies to eligible enrollees, but are no longer being reimbursed by the federal government. Rate hikes to offset the termination of federal cost-sharing subsidy payments were a major factor in 2018 premium increases.

One concern about rising premiums in the individual market was whether healthy enrollees would drop out of the market in large numbers rather than pay higher rates. While the vast majority of exchange enrollees are subsidized and sheltered from paying premium increases, those enrolling off-exchange would have to pay the full increase. Despite this dynamic, the average number of days individual market enrollees spent in a hospital in 2018 was slightly lower than inpatient days in the previous three years.2

Taken together, these data on claims and utilization suggest that the individual market risk pool is relatively stable, though sicker on average than the pre-ACA market, which is to be expected since people with pre-existing conditions have guaranteed access to coverage under the ACA. Despite concerns that healthier enrollees may be dropping out of the market in recent years, somewhat lower average inpatient days indicate that the individual market did not get sicker, on average, during 2018.

Expected Rebates

The medical loss ratio (“MLR”) provision of the ACA requires most insurance companies that cover individuals to spend at least 80% of their premium income on health care claims and quality improvement, leaving the remaining 20% for administration, marketing, and profit. Beginning in 2012, insurers failing to meet the applicable MLR standard for the prior year (2011) were required to issue rebates to consumers and employers. Thus far, the 2011 rebates had remained the largest ever issued – totaling $399 million in the individual market alone (and $1.071 billion across the individual, small group, and large group markets).

Insurers’ preliminary estimates indicate they expect to issue about $800 million in rebates to 2018 individual market enrollees, which would be the highest total for the individual market by far since the program began. While this represents initial insurer

estimates, and the actual rebate amount issued could be lower or higher3, these high expected rebates provide further evidence that some insurers over-corrected in raising individual market premiums for 2018.

Insurers estimate more than 3 million 2018 individual market enrollees, or 26%, are eligible to receive rebates. Insurers owing rebates expect to issue about $260 per member, on average. All rebates must be issued by September 30 of the year following the applicable MLR reporting period (i.e., September 2019 for the 2018 reporting period).

Across all commercial markets – individual, small group, and large group – rebates are expected to total approximately $1.4 billion. If insurer estimates hold true, these will be the largest rebates issued since the MLR program began. These higher rebates are mostly driven by the individual market. Rebates in the small and large group markets are expected to be larger than average, but not significantly so.

Discussion

Annual results from 2018 suggest that despite significant challenges and recent enrollment declines, insurers in the individual insurance market are now generally profitable. Insurer financial results from 2018 – after the Administration's decision to cease cost-sharing subsidy payments, but before the repeal of the individual mandate penalty in the tax overhaul went into effect – reveal the most favorable year in the ACA-compliant market's history.

Premium and claims data support the notion that 2017 premium increases were necessary as a one-time market correction to adjust for a sicker-than-expected risk pool, and premium increases in 2018 were in large part compensating for policy uncertainty and the termination of cost-sharing subsidy payments, though some insurers appear to have over-compensated. Without these policy changes, it is likely that insurers would generally have required only modest premium increases in 2018. Low loss ratios and higher margins indicate that some insurers raised premiums more than was necessary to cover claims and administrative costs and earn a reasonable profit in 2018.

Across the individual market, insurers expect to pay record-high rebates to consumers for failing to meet the medical loss ratio requirement, providing further evidence that insurers over-corrected when setting 2018 premiums. Before the ACA's MLR provision went into effect, insurers in such a situation would have experienced windfall profits. The MLR rule requires insurers to repay consumers in the form of a cash rebate or premium credit when the prior year's premiums are determined to have been too high relative to claims costs.

While markets in some parts of the country remain more fragile, the individual market on average is becoming more profitable. Some insurers have exited the market in recent

years, but others have been successful and expanded their footprints, as would be expected in a competitive marketplace. Even though repeal of the individual mandate penalty and expansion of loosely-regulated insurance options had an upward effect on 2019 premiums, premiums actually decreased slightly because 2018 premiums were higher than necessary to cover claims costs. In 2019, new insurers have entered and some insurers are reentering markets they had previously exited. While signups through the marketplace during the 2019 open enrollment period declined somewhat compared to 2018, financial results suggest the market is still stable and sustainable.

Methods

We analyzed insurer-reported financial data from Health Coverage Portal TM, a market database maintained by Mark Farrah Associates, which includes information from the National Association of Insurance Commissioners. The dataset analyzed in this report does not include NAIC plans licensed as life insurance or California HMOs regulated by California's Department of Managed Health Care; in total, the plans in this dataset represent at least 80% of the individual market. All figures in this issue brief are for the individual health insurance market as a whole, which includes major medical insurance plans and mini-med plans sold both on and off exchange. We excluded some plans that filed negative enrollment, premiums, or claims and corrected for plans that did not file "member months" in the annual statement but did file current year membership.

To calculate the weighted average loss ratio across the individual market, we divided the market-wide sum of total incurred claims by the sum of all unadjusted health premiums earned. Medical loss ratios in this analysis are simple loss ratios and do not adjust for quality improvement expenses, taxes, or risk program payments. Gross margins were calculated by subtracting the sum of total incurred claims from the sum of unadjusted health premiums earned and dividing by the total number of member months (average monthly enrollment) in the individual insurance market. Using earned premiums adjusted for taxes and fees to calculate loss ratios and gross margins increases the MLR by 6 percentage points and decreases the gross margin per member by $42 in 2018. On average across all years, using earned premiums adjusted for taxes and fees increases the MLR by 3 percentage points and decreases the gross margin per member by $14.

Total rebates are based on preliminary estimates from insurers. Since 2014, the total rebate amount issued across the individual, small group and large group markets has varied by 3 to 5% from insurer estimates. At the market level, the difference between estimates and actual rebate totals have been more volatile. Since 2014, individual market estimates have varied by as much as $34 million, or over 20%, as compared to the final actual rebates reported in December of the year following the applicable MLR reporting period. In some years, final rebates are higher than expected and in other years, final rebates are lower.

Government reports Obamacare coverage gains are starting to retreat
Tami Luhby
April 10, 2019

(CNN)The coverage gains achieved by the Affordable Care Act are starting to erode.

The uninsured rate for those ages 45 to 64 jumped to 10.3% in 2018, up from 9.3% a year earlier, according to a report from the Centers for Disease Control and Prevention published Thursday.

It's the first time a government study has shown an increase in the rate, though polling and research groups had previously found that people had been losing their health insurance since President Donald Trump took office.

The increase comes two years into Trump's administration, which has sought to undermine and dismantle the Affordable Care Act as well as add restrictions to Medicaid. Enrollment in both programs has been slipping.

The landmark health care law is credited with extending coverage to millions of Americans, prompting the uninsured rate for non-elderly adults to plummet from 22.3% in 2010, the year Obamacare passed, to a low of 12.4% in 2016. Last year, it stood at 13.3%, though the agency noted the difference was not statistically significant.

The CDC report does not explain why the rate for those ages 45 to 64 has climbed while remaining stable for younger adults. These middle-age Americans have the lowest uninsured rate among non-elderly adults. The share of this cohort without insurance began creeping up in 2015, but the changes were not statistically significant until now.

The uninsured rate serves as a gauge for Trump's impact on coverage. Other nongovernmental research groups have previously reported evidence that it has been on the rise.

The Kaiser Family Foundation reported in December that the number of uninsured non-elderly Americans rose by nearly 700,000 in 2017 and the rate inched up to 10.2%, from 10%. It used federal American Community Survey data, which draws on a larger sample size than the survey the Census Bureau uses to determine the official uninsured rate, which showed no significant change between 2016 and 2017.

Driving the increase was an upswing in the uninsured rate in states that did not expand Medicaid, particularly among non-Hispanic blacks and those living above the poverty line within those states, Kaiser found.

While coverage rates rose and then stabilized in the first few years after the Affordable Care Act's implementation, "now we are starting to see signs that things are going in a different direction," said Rachel Garfield, associate director in Kaiser's Program on Medicaid and the Uninsured.

The most common reason why people remained uninsured is because the cost of coverage is too high, according to Kaiser. Some may not be aware that they are entitled to federal assistance.

Meanwhile, Gallup found that the uninsured rate for adults was 13.7% in the fourth quarter of 2018, the highest in more than four years and well above the low point of 10.9% in 2016. That represents an increase of about 7 million uninsured people, according to Gallup, which polls Americans on their health coverage status