



Media Clips

COVERED CALIFORNIA BOARD CLIPS

May 15, 2019 – June 24, 2019

Since the May 15 board meeting, Gov. Newsom and California passed a new budget that includes a health coverage mandate and increased state subsidies for consumers, while the federal administrations continued to pass executive actions affecting the Affordable Care Act and the state of Washington has pioneered the nation's first public option. In a landmark legislation, California also approved Medi-Cal expansion for undocumented seniors, young adults.

COVERED CALIFORNIA PRESS RELEASES AND REPORTS

[Covered California Announces Grants to Community-Based Organizations Across California in Preparation for 2020 and Beyond](#), May 24, 2019..... 4

PRINT

Articles of Significance

[California goes even bigger on Obamacare](#), Politico, June 16, 2019..... 7

[California Is Shoring Up Obamacare, Even As Trump Is Sabotaging It](#), Huff Post, June 11, 2019..... 9

[Covered Cal Determined to Reach Everyone](#), California Broker, May 27, 2019 13

[Spending proposed as part of the \\$214.8B California budget](#), Associated Press, June 13, 2019..... 16

[Budget Deal's Big Health Care Changes: Middle Class Subsidies On Covered California, And A State Individual Mandate](#), Capital Public Radio, June 12, 2019 18

[New College Grads May Qualify For Covered Cal Health Plans](#), Precinct Reporter Group, May 23, 2019..... 20

[The Trump Admin is Scrubbing Obamacare from Government Sites](#), Wired, May 15, 2019 21

[Nurse practitioners can improve Californians' access to healthcare](#), Los Angeles Times, May 16, 2019 24

<u>House Passes Legislation Aiming to Shore Up Health Law and Lower Drug Costs,</u> New York Times, May 16, 2019	25
<u>Washington pioneers public health care option, but controlling costs remains tricky,</u> CNN, May 18, 2019.....	27
<u>Obamacare Regains Strength Despite Trump's Legal Assault,</u> Forbes, May 19, 2019.....	30
<u>Surprise Medical Bills Give Both Parties an Unexpected Opportunity to Agree,</u> New York Times, May 24, 2019	31
<u>Administration moves to revoke transgender health protection,</u> Associated Press, May 24, 2019	34
<u>Think California's too big and influential? Wait until the presidential race heats up,</u> Los Angeles Times, May 27, 2019	37
<u>Senate approves Medi-Cal expansion for undocumented seniors, young adults,</u> Politico Pro, May 29, 2019.....	40
<u>Healthcare Costs Top Financial Problem for U.S. Families,</u> Gallup, May 30, 2019	42
<u>Trump takes aim at insurers and hospitals over health care costs,</u> CNN, May 30, 2019.....	44
<u>American Voters Have a Simple Health-Care Message for 2020: Just Fix It!</u> Wall St. Journal, June 2, 2019.....	47
<u>Obamacare rate hikes appear modest for 2020,</u> Politico, June 3, 2019	50
<u>'Swinging at Every Pitch': California's Governor Has Big Plans. Critics See Big Risks.</u> New York Times, June 5, 2019	53
<u>The Health 202: Health-care worker shortages would be even worse without immigrants,</u> Washington Post, June 5, 2019	56
<u>Low-income Californians and Health Care,</u> Kaiser Family Foundation, June 7 2019	58
<u>As Sharing Health-Care Costs Takes Off, States Warn: It Isn't Insurance</u> Wall St. Journal, June 10, 2019.....	59

<u>Data Note: Americans' Challenges with Health Care Costs,</u> Kaiser Family Foundation, June 11, 2019	62
<u>2 health organizations sue to stop new federal health rules,</u> Associated Press, June 11, 2019	64
<u>Romney says he has new plan to replace ObamaCare,</u> The Hill, June 12, 2019	65
<u>California to become first state to extend healthcare benefits to some undocumented immigrants,</u> Asian Journal, June 12, 2019	67
<u>Top Trump health official warned against controversial ObamaCare changes in private memo,</u> The Hill, June 14, 2019	68
<u>The Health 202: Trump administration rule opens door to more people buying Obamacare plans,</u> Washington Post, June 14, 2019	70
<u>California relies on federal funds to expand undocumented health coverage</u> Politico Pro, June 15, 2019	73
<u>Trump's assault on Obamacare was much more damaging than previously thought,</u> Los Angeles Times, June 18, 2019	76
<u>Taxpayer advocates say California's health coverage mandate is a tax, but experts say not so fast,</u> Politico Pro, June 19, 2019	78
<u>For Many Low-Income Californians, Health Care is Still Too Expensive,</u> California Health Report, June 19, 2019	81
<u>New Trump insurance rule could help Obamacare — or hurt it,</u> Politico Pro, June 19, 2019	83
<u>Trump Mounts New Push on Health Care Ahead of 2020 Election,</u> Wall St. Journal, June 21, 2019	85
<u>The Health 202: White House is reviewing a new index to cut Medicare drug spending,</u> Washington Post, June 21, 2019	88
<u>Supreme Court agrees to hear Obamacare cases with billions of dollars at stake,</u> Politico, June 24, 2019	90
<u>Trump order seeks disclosure of hospital prices,</u> Associated Press, June 24, 2019	92



News Release

May 24, 2019

Covered California Announces Grants to Community-Based Organizations Across California in Preparation for 2020 and Beyond

- *Community-based organizations and clinics will receive a total of \$6.3 million in grant funding to help people enroll in quality health care coverage.*
 - *The 105 organizations reflect California's diversity and will target populations that are hard to reach, uninsured and eligible for financial help through Covered California.*
 - *Approximately 89 percent of Californians live within a 15-minute drive of these community-based organizations.*
-

SACRAMENTO, Calif. — Covered California announced Friday that it intends to partner with 105 community-based organizations to educate consumers about their health care options, offer in-person enrollment and renewal assistance and provide ongoing support on how to get the best value from their health plan. The Navigator grants announced are part of Covered California's ongoing commitment to support robust marketing and outreach, including working with trusted organizations throughout the state to help hard-to-reach people understand this new era of health care.

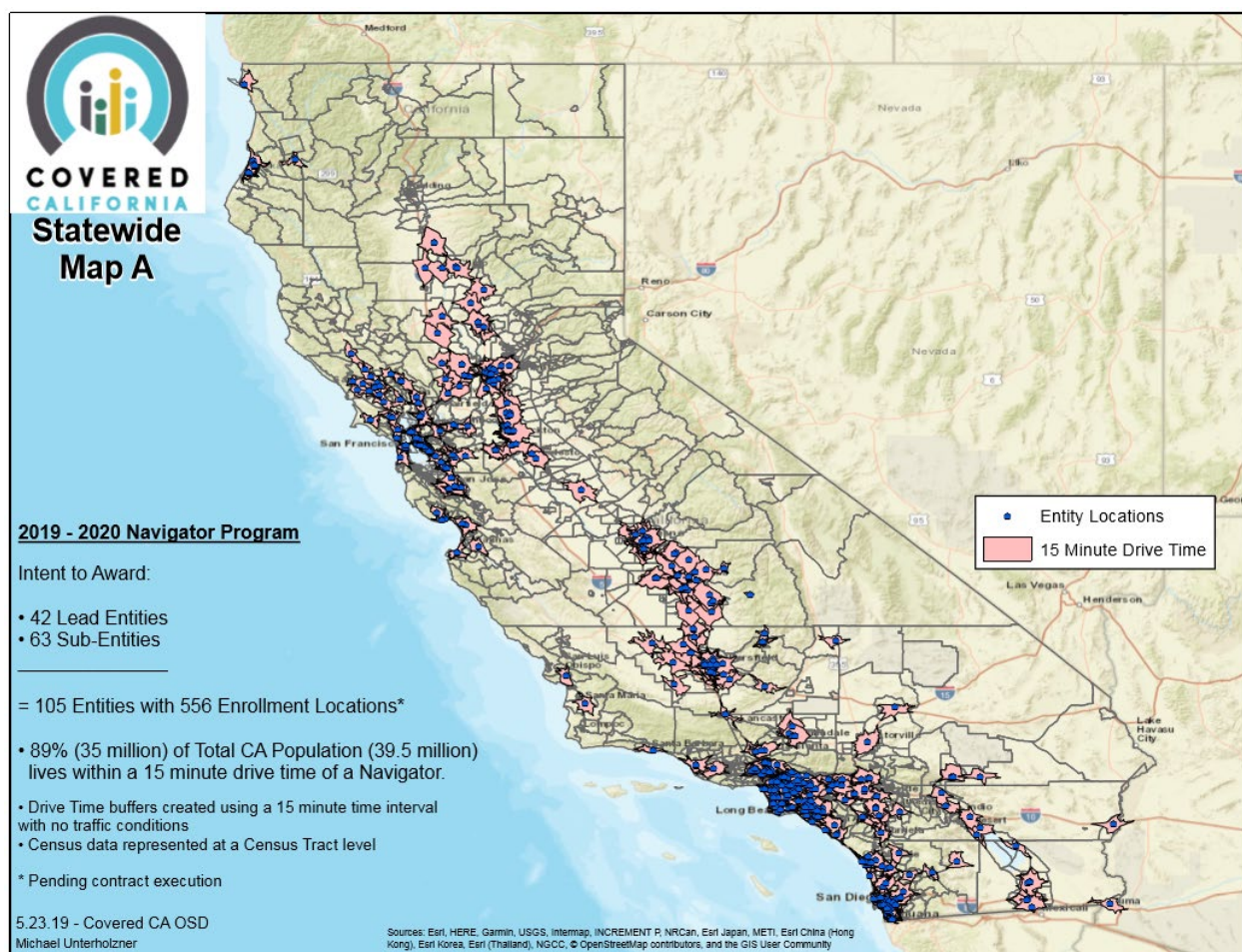
"We are partnering with experienced and trusted agencies, which represent the diversity of our state, to make sure every person knows about the financial help and quality coverage that is available through Covered California," said Executive Director Peter V. Lee. "Our plans for marketing and our continued commitment to supporting these local organizations, as well as the over 10,000 local insurance agents, are particularly important as we look ahead to the enrollment year for 2020 and beyond when California will likely be charting a new path to expand coverage for many Californians."

(more)

The organizations will receive annual grants through Covered California's Navigator program. The investment is part of Covered California's proposed \$111 million marketing, outreach and sales budget for next year. Covered California's aggressive outreach campaign helped it achieve one of the best take-up rates in the country, which in turn meant that enrollees in California were about 20 percent healthier on average than the enrollment of the 38 states that rely on the federal government to promote enrollment. The healthier population enrolling means that premiums in California are 20 percent lower than they would have been if the states enrollment looked more like much of the rest of the nation.

"Health coverage is something that needs to be sold, particularly to young and healthy individuals who are not familiar with insurance," Lee said. "Getting confidential and local one-on-one help from trusted sources is particularly important for the communities we target with these Navigator grants: Latino, African-American, Asian and Pacific-Islander and LGBTQ."

The 105 organizations will have a total of 556 enrollment locations across California, meaning that 89 percent of people in the state will live within a 15-minute drive of a Navigator.



(more)

In addition to Covered California's Navigator program, the agency also works with more than 15,000 Certified Insurance Agents and other representatives throughout the state. Enrolling in person is important to many people, as seen during the last open-enrollment period when nearly 70 percent of people signed up for coverage with the assistance of a Certified Insurance Agent, Certified Enrollment Counselors, Plan-Based Enroller, county eligibility worker or Covered California service center representative.

"Working with these organizations is a tremendous opportunity to expand Covered California's reach throughout the state," said Terri Convey, director of Covered California's Individual and Small Business Outreach and Sales Division. "For many people, there is nothing better than being able to sit down with someone in your community who can explain your options and help you make the best choice."

A list of Navigator organizations and the amounts Covered California intends to award is available online at [https://hbex.coveredca.com/navigator-program/PDFs/2019-20-Funding-Allocations-\(May-2019\).pdf](https://hbex.coveredca.com/navigator-program/PDFs/2019-20-Funding-Allocations-(May-2019).pdf).

The Navigator program and Covered California's marketing efforts are funded by revenue generated by Covered California. Navigators receive no state or federal support. Organizations were selected through a competitive grant application process.

###

California goes even bigger on Obamacare

Victoria Colliver

California is beefing up Obamacare, restoring an individual mandate, expanding health insurance subsidies well into the middle class and covering some undocumented adults through Medicaid. It's an incremental step toward universal coverage that can animate the Democrats' party-defining debate over how best to cover everyone — through a mixed public-private system or through "Medicare for All."

The Democratic-controlled state legislature on Thursday approved a budget, clearing the path for a statewide penalty for failing to purchase health insurance, which will help subsidize coverage for middle-income people earning too much to receive federal financial help from Obamacare. California will also become the first state to extend Medicaid coverage to low-income undocumented adults up to age 26, defying the Trump administration's efforts to shrink government benefits to immigrants.

The moves fall well short of a sweeping Medicare for All-style system vigorously supported by the party's progressive wing here in California and across the country — and viewed much more cautiously by much of the Democratic establishment.

The idea of expanding Obamacare subsidies could gain traction among more moderate Democrats in Washington who would rather build on the Affordable Care Act than engage in another protracted health reform battle should the party take back control in Washington. And they can sell it as a practical move toward expanding coverage immediately while the party weighs more progressive health plans.

"I view California as a model state that's likely to be used as a best practices example for how Congress can move ahead in a new Democratic administration without in any way creating barriers to do more aggressive policies in the future," said Chris Jennings, who was a health policy adviser in the Clinton and Obama administrations.

Case in point: California's new progressive governor, Gavin Newsom, said he remains committed to setting up a single-payer system in the state, but he made the Obamacare expansion and coverage for undocumented immigrants a priority his first year.

Peter Lee, executive director of Covered California, the state's Obamacare marketplace, said the legislature's coverage expansion was an indication "we can't stand still" while others debate more sweeping overhauls of the health care system.

California's plan isn't a done deal. Having cleared the \$215 billion budget, state lawmakers in the coming days must pass a series of bills approving the health measures through an expedited process.

House Democratic leaders in Washington, wary of pursuing a fully government-run single-payer system, have embraced a key element of the California plan. They unveiled a package this spring that would vastly expand eligibility for health insurance subsidies, though it didn't include reviving Obamacare's requirement to purchase coverage.

The proposed California mandate largely mirrors the federal penalty that was eliminated by Congress in late 2017. But California's mandate would be pegged to the state's income tax filing threshold, which is higher than the federal level, meaning more people would be exempt from the penalty.

The mandate penalty, along with \$450 million from the state's general fund over the next three years, helps pay for the expanded subsidies. The penalty is expected to generate an estimated \$295 million this coming fiscal year, and as much as \$380 million in 2022.

Under Obamacare, health insurance subsidies are cut off for people earning above four times the federal poverty level, or about \$50,000 for an individual. California is extending subsidies to those earning six times the poverty level, or about \$75,000 for an individual. About 190,000 Californians would be eligible for those expanded subsidies.

Even if the individual mandate is eventually approved as expected, some observers say it could face challenges in the courts — and possibly come at a political price. Opponents of the idea have criticized California for restoring the unpopular individual mandate while also extending Medicaid coverage to about 90,000 undocumented immigrants.

“How, for Pete’s sake, do you impose an individual mandate on contributing taxpayers who are citizens of California and subsidize undocumented immigrants by giving them free health care?” said Jon Coupal, president of the Howard Jarvis Taxpayers Association in California. “There’s an equity issue here that’s going to be part of the political miss.”

Coupal said the way the Legislature is advancing the mandate makes it ripe for a legal challenge. He said it amounts to a new tax, meaning it should go through regular legislative order instead of the fast-track budget process.

David McCuan, a California political analyst, said the state's health proposals “mark California as a barometer of where health care can go,” but he also expects to see “numerous” legal challenges, particularly over the mandate.

Several health experts pointed out that a handful of states have passed individual mandates since Congress gutted Obamacare's — including New Jersey, Vermont and Washington, D.C — and none have been challenged in court. Rhode Island lawmakers are also considering mandate legislation this year. Massachusetts was the first state to

pass an individual mandate in 2006, and it became the model for the Affordable Care Act.



California Is Shoring Up Obamacare, Even As Trump Is Sabotaging It

Jonathan Cohn

Hundreds of thousands and maybe more than a million people in California will have an easier time getting health insurance next year, thanks to a package of reforms that could be a model for other states and eventually the federal government as well.

Under a new budget agreement that Democratic Gov. Gavin Newsom and his allies in the state legislature reached over the weekend, California in 2020 will begin offering state-funded health insurance to undocumented young adults, reintroduce the “individual mandate” penalty for people who don’t have insurance, and offer more financial assistance to people buying coverage on their own.

The new health care reforms aren’t supposed to be a substitute for “Medicare for All” or some of the other ambitious health plans that have captivated and energized progressives around the country. Newsom has previously endorsed the creation of such a single, government-run insurance program and the new budget agreement establishes a commission to figure out how such a proposal would work in California.

But that is looking more and more a long-term project, especially given that California has been talking about single-payer for years (decades, actually) and the necessary political support for it remains elusive. In the meantime, the new budget agreement will help significant numbers of Californians who are either struggling with high premiums or who have no insurance at all, helping California to realize the full potential of the Affordable Care Act while moving the state closer to universal coverage.

Gov. Gavin Newsom has said he wants California to pass progressive legislation that the rest of the nation can copy.

“California is showing the way to do both,” Anthony Wright, executive director of the California consumer advocacy group Health Access, told HuffPost. “You can have a vision for how you plan and think deliberately about getting to universal coverage, but that doesn’t have to get in the way of taking concrete, significant steps to provide health care now.”

Newsom, who became governor this year, has said he wants California to be a progressive trailblazer. This budget, which also includes bursts of new spending on early childhood programs and new tax breaks for the working poor, represents just the

kind of action that Democrats in other states or in Washington, D.C., could take quickly, if and when they get control of government.

Of course, California has a large budget surplus, thanks to a booming economy and years of thrifty fiscal management. It also has large Democratic majorities in each house of the legislature. In other parts of the country and in Washington, it would be harder to find the money and political will to shore up Obamacare, to say nothing of spending taxpayer dollars on undocumented immigrants.

Filling One Of Obamacare's Biggest Holes

California has a long record of using government to help people get health care.

State officials have implemented the Affordable Care Act enthusiastically, using the program's funds to expand Medicaid. They have also set up a dedicated state marketplace, where people buying coverage on their own can shop for policies and get federal financial assistance. The managers of the marketplace, known as Covered California, have special regulatory authority to negotiate aggressively with insurers over prices and benefit structure.

Thanks in no small part to those decisions, the number of people without insurance dropped dramatically after the law took full effect and the marketplace has remained relatively stable, with nearly a dozen insurers offering coverage and premiums rising moderately from year to year.

But even with California officials trying so hard to make the Affordable Care Act work, lots of people have struggled with the cost of insurance. Among them are residents who make just a little too much income to qualify for the law's financial assistance — that is, anybody making more than four times the poverty line, which today works out to about \$50,000 a year for an individual and \$103,000 for a family of four.

Covered California has been one of the most successful of the Affordable Care Act's exchanges. But lots of Californians still struggle with premiums and out-of-pocket costs. Because these people get no assistance, they pay full premiums. That has been particularly tough on some older Californians, because by law insurers can still charge them up to three times as much as they charge younger people, leaving them with a choice of scraping up money for insurance they can't really afford or taking their chances with no coverage at all.

California's new budget agreement addresses this "affordability" problem primarily in two ways. First, it offers additional state assistance to some of the people who are already eligible for federal subsidies. Second, the agreement pushes the income threshold for assistance all the way up to six times the poverty line. That works out to about \$75,000 for an individual and \$155,000 for a family of four.

Under an earlier version of the proposal, the average monthly savings would have been around \$10 at lower incomes and \$100 at higher incomes, according to official

estimates. For the small group of consumers facing the biggest sticker shock today, the savings would have been much bigger, literally hundreds of dollars a month.

The final budget agreement has more money going toward financial assistance, thanks in part to lobbying from groups like Health Access. That means the savings should be bigger too, although official estimates aren't available yet.

Peter Lee, executive director of Covered California, described the package as a “way to show you can build on the Affordable Care Act and not just stand still in the face of gridlock and intransigence. ... These are changes that are immediate and will be felt.”

Funding for the initiative, which the budget authorizes for three years at a cost of about \$1.5 billion, will come primarily from penalties that people without insurance will pay. This is basically a return of the individual mandate that President Donald Trump and congressional Republicans zeroed out as part of the 2017 tax cut legislation.

To Republicans in California, the new mandate and the effort to prop up the Affordable Care Act more generally make no sense. “We’re putting gum and MacGyvering Band-Aids on this system,” Andreas Borgeas, a Republican state senator, said in March. “It needs to be redone and reviewed top to bottom.”

But although the restoration of the mandate might not be popular, and although its actual impact on policy isn't entirely clear, the combination of more assistance and a restored penalty will likely lead more healthy people to buy insurance — which, in turn, should allow insurers to hold down premiums.

Based on previous projections, the number of newly insured Californians plus those getting new state assistance could easily exceed 1 million, according to several analysts that HuffPost contacted.

Extending Coverage To Undocumented Young Adults

The other big health care initiative in the budget is the one that's already generating headlines: It's the extension of coverage to some undocumented residents.

The change is not as dramatic as it sounds. California opened up its version of Medicaid, known as Medi-Cal, to younger low-income undocumented residents back in 2016. The new agreement merely raises the cutoff age from 18 to 26. Estimates suggest about 90,000 people will sign up for the program as a result.

Some California Democrats wanted to go farther and open up Medi-Cal to undocumented residents of all ages. They cited, among other things, evidence that undocumented workers, who make up about 10 percent of the workforce, were less likely to get regular care — and that, especially in the case of families, the inability of parents to get insurance meant that kids were going without coverage as well.

The legislature balked at that but advocates for immigrants and more health care access have said they will keep pushing, just as they intend to keep pushing for other reforms — including, for example, regulating the prices of hospitals.

“For California’s immigrant communities, today’s budget deal is bittersweet,” Cynthia Buiza, executive director of the California Immigrant Policy Center, said in a statement. Although she praised the new coverage for young adults, Buiza added that “The exclusion of undocumented elders from the same health care their U.S. citizen neighbors are eligible for means beloved community members will suffer and die from treatable conditions.”

Asked about coverage of undocumented residents, Kamala Harris, the senator from California and 2020 Democratic hopeful, said she would oppose any effort to “deny in our country any human being from access to ... public health, period.” Outside of California, the politics of covering undocumented residents looks a little different, even though the human impact of uninsurance on these communities doesn’t depend on geography.

The last time subsidizing health care for undocumented residents got attention in national politics was in 2009, during the debate over what became the Affordable Care Act, when some Republicans insisted, wrongly, the bill would pay to cover undocumented residents. A Republican U.S. House member famously shouted “You lie!” in the middle of a joint address to Congress that then-President Barack Obama was delivering.

Now the issue is getting some attention again, because the Medicare for All proposal from Sen. Bernie Sanders (I-Vt.), which multiple Democratic candidates have endorsed, allows for coverage of all residents (although the bill isn’t as specific as a previous version and appears to leave the federal government discretion over how to define “resident.”)

Earlier this year, one of those co-sponsors and presidential candidates, Sen. Kamala Harris (D-Cal.), answered a question about coverage of undocumented residents by saying she would oppose any effort to “deny in our country any human being from access to public safety, public education, or public health, period.”

The statement drew widespread criticism from conservatives like Fox News host Tucker Carlson, who blasted Democrats for “paying the health care bills of foreign nationals who have no right to be here in the first place.”

The topic is likely to come up again and, when it does, Republicans are sure to cite California’s decision as indicative of what Democrats want to do in the rest of the country.

A Blue-Red Divide On Health Care

For now, though, the main political divide on health care is between those who want government to do more to help people get health care and those who want government to do less.

The latter includes Trump and officials in his administration, who have undermined the Affordable Care Act by cutting outreach funds and weakening its insurance rules. It also includes Republican officials in states like Kansas, Kentucky, and Tennessee, who have tried, with various degrees of success, to shrink Medicaid and to undermine the Affordable Care Act's protections for people with pre-existing conditions.

Larry Levitt

@larry_levitt

Replying to @larry_levitt

Blue and red states continue to move in opposite directions on health care.

Blue states are expanding the reach of Medicaid and building on the ACA, while red states are restricting and capping Medicaid and exploring ways to scale back insurance regulation.

All of this is taking place against the backdrop of a presidential campaign in which the top Democratic candidates support more ambitious schemes, including Medicare for All, that would get the U.S. to universal coverage or at least awfully close while addressing other problems, like the difficulty of dealing with private insurers, that narrower reforms cannot.

Enacting these would be difficult, as even the fiercest proponents of these schemes understand. One potential benefit of the incremental reforms Newsom and his allies are about to pass in California is that they could build credibility with the voters, making those bigger changes more achievable in the future. Another advantage is that they could provide assistance to people who need it — and can't afford to wait.



Covered Cal Determined to Reach Everyone

Victoria Alexander

Covered California has earned their rep for innovative strategies to get the word out about health insurance options in the state. Remember last year's effort to have commencement speakers mention the importance of health insurance for new graduates? Now the organization has announced that it's partnering with 105 community organizations through its Navigator Grants program. The aim is to educate Californians about their health care options, offer in-person enrollment and renewal

assistance and provide info on how to get the best value from a health plan. Covered Cal says the partnerships are part of an ongoing commitment to aggressive marketing and outreach. Check out a full list of Navigator programs and the amounts awarded [here](#)

Blue Shield Of California and Landmark Partnership Helps Folks with Chronic Conditions

Blue Shield of California announced that this past year it enrolled approximately 3,500 physically vulnerable people in a program with Landmark Health to provide comprehensive, coordinated in-home care. Through the program, health care providers made 15,000 home visits. According to the companies, the program isn't a substitute for primary care physicians. It simply allows people with complex needs to get some health care assistance at home, hopefully leading to fewer expensive and unnecessary hospital visits. Blue Shield hasn't supplied data on patient outcomes or the financial impact of the effort yet. [Read more here.](#)

Alexander, Murray Include Agent and Broker Comp Disclosure in Proposed Act

Senators Lamar Alexander and Patty Murray have included a 15-page health insurance agent and broker compensation disclosure provision in their new Lower Health Care Costs Act of 2019 bill draft. Allison Bell at ThinkAdvisor reports:

The producer comp disclosure provision, described in Section 308 in the bill draft, would require "disclosure of direct and indirect compensation for brokers and consultants to employer-sponsored health plans and enrollees in plans on the individual market."

[Read a draft of the entire Act here.](#)

DENTAL

Delta Survey Finds Room For Dental IQ Improvement

What? You're not versed in bruxism, prophylaxis and caries? Well, join the club. A new survey by Delta Dental found a resounding majority of adults don't know their dental terms. Unfortunately, ignorance isn't bliss. In fact, the less you know the more unease you may have in the dental chair. So, err, brush up. On your terminology, of course.

PRESCRIPTION DRUGS

Drug Channels: Look For Change In How PBMs Profit

Adam Fein over at Drug Channels says it's a tough time to be a PBM. Fein says we can look for these four ways that PBM profits will change:

- 1) Bundled pricing of pharmacy and medical benefits will pressure margins.

- 2) PBMs will continue to reduce their reliance on profits from rebates.
- 3) PBMs will depend more on profits from dispensing specialty drugs.
- 4) Payer and government pressure will shrink PBMs' ability to capture network spreads.

Read the whole post. He discusses CVS and Cigna's upcoming annual investor days and much more.

WEBINARS

Beyond Zip Codes: Social Determinants of Health That Matter

Tuesday, June 4, 10-11a.m. PT

America's Health Insurance Plans and Welltok bring together three experts for a discussion on social determinants of health. They will share real-world examples of how leveraging consumer data, along with clinical and claims data, leads to a deeper understanding of consumer needs. [Register here.](#)

Mental & Behavioral Health Virtual Summit

Tuesday, June 4, 11 a.m. PT

Global Health Resources says mental and behavioral health issues have been stigmatized, especially in the workplace. In an effort to respect employee privacy, employers have avoided involvement. Not any longer. This virtual summit will address the importance of promoting mental health as a critical component to overall health and wellbeing, prevention, early identification and intervention for every employer's healthcare culture. According to the World Health Organization and the National Business Group on Health, mental and behavioral health conditions generate as much as \$100 billion in direct costs for employers. [Register here.](#)

Reduce Waste and Improve Outcomes

Wednesday, June 5, 10-11a.m. PT

The Institute of Medicine estimates that 30% of health care spending is attributed to waste. Waste in health care not only has a financial impact, but also has repercussions on patients' time, safety and well-being. In this AHIP webinar, 3M discusses how to use data analytics to measure and monitor where waste is coming from; how to build a value-based program, and how to sustain improvements. [Register here.](#)

PEOPLE

Mark Cover to lead growth of MassMutual Funds DCIO channel

MassMutual welcomes Mark Cover as head of defined contribution investment only (DCIO) field sales. Cover reports to Aruna Hobbs, Head of Institutional Investments for MassMutual's Institutional Solutions business.

EVENTS

IICF Women in Insurance Global Conference

June 12-14, 2019, New York City

Alliance of Comprehensive Planners 2019 Annual Conference

Nov. 12-15, Hyatt Regency Mission Bay, San Diego

The Alliance of Comprehensive Planners (ACP) is a community of tax-focused financial planners who provide planning strategies for clients on a fee-only retainer basis. Conference early bird registration rates (which expire Oct. 11, 2019) are in effect now. Participation is open to all interested financial professionals. Companies interested in sponsoring the ACP Annual Conference should contact Jill Colsch at jill@acplanners.org. The agenda is available here: <https://2019.acplanners.org/home>.



Spending proposed as part of the \$214.8B California budget

Adam Beam

SACRAMENTO, Calif. (AP) — Here's a look at some spending proposals in the \$214.8 billion budget the California Legislature sent Thursday to Gov. Gavin Newsom.

HEALTH CARE

Low-income adults 19 to 25 living in the country illegally would get government-funded health insurance. It would cost an estimated \$98 million to cover about 90,000 people.

Families of four earning as much as \$150,500 a year would get help paying their monthly health insurance premiums.

People who refuse to buy health insurance would have to pay a tax.

The budget would spend \$17.1 million to help people on Medi-Cal access vision, hearing, incontinence creams and washes, podiatry and speech therapy.

WILDFIRES

The budget proposal includes funding for 13 new fire engines, seven used C-130 air tankers and money to hire workers to operate heavy equipment during wildfires.

EDUCATION

California would spend \$12,018 for every student in K-12 public schools — an increase of \$444 over last year.

The budget would use \$80 million in marijuana taxes to pay for child care for low-income parents, and \$300 million from other sources to help build facilities for full-day kindergarten.

WATER

The budget takes \$100 million from a fund to reduce greenhouse gas emissions to help clean up contaminated drinking water.

PENSIONS

The budget spends \$356 million to temporarily reduce contributions by struggling school districts to the state's teacher requirement system.

PAID FAMILY LEAVE

The budget would expand California's paid family leave program from six to eight weeks. To pay for it, workers would see an additional 0.1% tax on wages.

HOMELESS AND HOUSING

The state would give \$650 million to local governments to tackle homelessness and pump \$500 million into a tax credit program to spur construction of residential rental units.

Lawmakers would spend \$5 million on grants to homeless shelters so they can accommodate pets.

MISCELLANEOUS

The budget would allocate \$5 million for suicide prevention measures on the Coronado Bridge in San Diego County.

It also seeks to end sales taxes on diapers and menstrual products with an exemption that would expire after two years.



Budget Deal's Big Health Care Changes: Middle Class Subsidies On Covered California, And A State Individual Mandate

Ben Adler

California lawmakers are expected to approve a state budget Thursday that would make the state the first in the nation to help middle-class consumers purchase health insurance on Covered California, the state's health insurance exchange created under the Affordable Care Act.

Gov. Gavin Newsom's Department of Finance and Covered California both say the \$429 million in subsidies are still being designed and calculated. But, depending on factors that include location and cost of health insurance coverage, the average subsidy will be more than \$100 a month.

But to help pay for the new subsidies, the budget crafted by Newsom and Democratic legislative leaders would create a state health insurance mandate, replacing the federal fine for not carrying insurance that was terminated two years ago.

That means starting next year, if you can afford health insurance but choose not to get it, you'll be charged a \$695 penalty or 2% of your household income — whichever is larger — when you pay your taxes. The fine is half as big for minors without insurance.

The subsidies, which will become available in January, are targeted at Californians who earn between 400 and 600% of the federal poverty level. That's between roughly \$50,000 and \$75,000 for individuals and between \$103,000 and \$155,000 for families of four.

Under the Affordable Care Act, consumers who earn more than 400% of the federal poverty level don't get any help purchasing health insurance on the individual market.

Some middle class Covered California consumers, could save up to hundreds of dollars a month, said Executive Director Peter Lee

"People that under the Affordable Care Act got no help — middle-class Californians paying a huge share of their income towards premiums — are going to get big assistance to make health care truly affordable for them," Lee said.

There's also money in the state budget deal for lower-income Covered California consumers, though not as much.

“California is saying, let’s take the Affordable Care Act and build on it, and make health care more affordable for middle-class Californians, and even more affordable for people already getting subsidies — because health care is too expensive,” Lee said.

But Republican Assemblyman Jay Obernolte questions whether the proposal will actually work and says the state should “be very cautious.”

“I understand and agree with the premise, which is to make sure that more Californians are covered by health insurance,” Obernolte said. “Unfortunately, it’s not clear to me that there’s any statistical evidence that extending these subsidies to the income ranges the governor’s proposing would have that effect.”

Under the Covered California subsidies and individual mandate provisions of the budget deal — some of which have yet to emerge publicly — the state is projected to bring in more than \$1 billion over a three-year period.

That revenue, along with additional permanent spending from California’s general fund, will fund new state aid for consumers at three different income levels starting in January.

Here’s how the \$429 million in state spending on the new Covered California subsidies will be broken down in 2020:

- \$10 million in subsidies for a relatively small group of Californians who earn between 0 and 138 percent of the federal poverty level — up to about \$17,000 a year for individuals — yet must obtain insurance via Covered California because they’re not eligible for MediCal. Their subsidies will bring their monthly premiums down to \$0.
- \$74 million in additional state aid for Californians who earn between 200 and 400 percent of the federal poverty level — between roughly \$25,000 and \$50,000 a year for individuals — on top of their existing federal subsidies. That’s projected to reduce an average consumer’s premium by a further \$10 a month.
- \$345 million in subsidies for middle-class consumers who earn between 400 and 600 percent of the federal poverty level — between about \$50,000 and \$75,000 a year. Those Californians, who are not eligible for any subsidies under the Affordable Care Act, are projected to save an average of at least \$100 a month on their premiums.

Lee says health care costs for all Californians are projected to drop between 3 and 5 percent because the individual mandate will broaden the insurance pool.

New College Grads May Qualify For Covered Cal Health Plans

Staff

Congratulations — the moment you have worked so hard for is finally here! You are ready to walk across that stage, grab that diploma and begin the rest of your life.

But life can be complicated, and it's imperative to have the important things — like your health — covered. Graduation can mean coming off a school-sponsored health plan, or turning 26, the limit for when you can remain on your parents' health plan.

As an older college student, Saul Guevara had to think about some of those things even before he graduated from the University of Southern California earlier this month in Los Angeles with a Master's Degree in Communication Management. Now 28, Guevara has been a Covered California consumer for the past two years while finishing work toward his degree.

"I chose to become a Covered California consumer because I learned that I qualified for federal subsidies to pay for my monthly health care payment," Guevara said. "I'm paying \$109 a month now instead of \$316. Covered California has allowed me to get my medical needs met with the same primary care physician at a fraction of the cost."

Guevara will begin working for the federal government this summer and plans to keep his Covered California coverage until he gets a health plan through his employer. Working part-time is a reality for many college graduates, as is getting married and starting your own business.

"Congratulations to all of this year's college graduates for all you have accomplished," said Covered California Executive Director Peter V. Lee. "But amidst all the changes in your life, make sure you always know what you will be doing for health care. If you are leaving your coverage behind when you graduate, then you may be eligible to enroll during Covered California's ongoing special-enrollment period. Taking care of your health gives you the freedom to pursue your dreams."

There are currently more than 336,000 Californians between the ages of 18 and 34 enrolled in a plan through Covered California, and they are receiving quality, name-brand insurance coverage.

The following circumstances are among the more common reasons people become eligible for Covered California special enrollment:

- Losing health coverage because you have lost or changed jobs.

- Turning 26-years-old.
- Getting married or entering a domestic partnership.
- Having a baby or adopting a child.
- Moving and gaining access to new Covered California health insurance plans that were not available where you previously lived.
- Becoming a citizen, a U.S. national or a lawfully present individual.

If you qualify under any of these conditions, you are eligible to get health insurance coverage and join your fellow Californians in having one less thing to worry about. Make sure you take advantage of the financial help available to you and your family. For more information on special-enrollment rules, visit <http://www.CoveredCA.com/individuals-and-families/getting-covered/special-enrollment>. Those who qualify for Medi-Cal may enroll through Covered California year-round.

Eligible consumers who are interested in signing up should go to www.CoveredCA.com where they can get help to enroll. They can explore their options and find out if they qualify for financial help by using the Shop and Compare Tool. They can also get free and confidential enrollment assistance by visiting www.coveredca.com/find-help/ and searching among 800 storefronts statewide, or more than 17,000 certified enrollers who can assist consumers in understanding their choices and enrolling, including individuals who can assist in other languages. In addition, consumers can reach the Covered California service center by calling (800) 300-1506.



The Trump Admin is Scrubbing Obamacare from Government Sites

Issie Lapowsky

PRESIDENT TRUMP HAS never been coy about his desire to repeal and replace the Affordable Care Act. While that pledge has faced setbacks in Congress, his administration has managed to gut Obamacare by other means, like cutting financial support. The executive branch can also undermine the law in subtler ways. According to a new report, the Trump administration has been systematically wiping crucial information about the ACA from government websites over the past two years. Unlike changes to funding, these modifications often happen with little fanfare or government oversight, but they can still have a dramatic impact on Americans' access to health care resources.

The report was published Wednesday by the Sunlight Foundation, an open government group whose Web Integrity Project monitors some 30,000 government pages for updates and alterations. Looking at sites administered by the Department for Health and Human Services, it documents 26 instances in which information related to the Affordable Care Act was substantially altered or removed. Some of the changes were subtle. Others, including the disappearance of an 85-page website devoted to the ACA,

were sweeping. Taken together, the researchers argue, the modifications are tantamount to government censorship and point to an increasing need for oversight of government websites.

"People rely on government information, and there's a presumption of objectivity that comes from the [government] address," says Sarah John, director of research for the Web Integrity Project and one of the paper's coauthors. "If a website says one thing one day and a different thing the next day, what is a citizen to make of that?" HHS did not respond to a request for comment.

That the Trump administration would whittle away at these online resources may not come as a surprise; it has already effectively gutted the financial resources that the Obama administration dedicated to promoting the law. Shortly after President Trump took office, the Center for Medicare and Medicaid Services announced it would cut funding for Affordable Care Act–related outreach and advertising by 90 percent, from \$100 million to \$10 million. The following year, the center slashed funding even further for so-called navigators, who help people sign up for insurance.

The website changes appear to be an extension of this strategy to make it harder for the average American, and particularly the most vulnerable Americans, to find information about coverage. Among the biggest changes was the removal of an entire 85-page website listing "facts and features" about the ACA. It had included 29 fact sheets about the law, as well as a breakdown of the impact of the law in each state.

Other changes appeared to take direct aim at communities that have been disproportionately uninsured or who would be entitled to special benefits under the ACA. Some time in the weeks after President Trump's inauguration, for example, the Affordable Care Act page on the website for the Office of Minority Health was removed. Later, a page offering guidance for American Indians and Alaska Natives was also removed. The Department of Health and Human Services removed multiple pieces of content noting that women could no longer be charged more or denied coverage under the ACA, and the Office of Women's Health removed a page informing women about breast cancer screening options. Still another page on MentalHealth.gov was altered to remove text explaining that most health plans cover preventative services like depression screening and behavioral assessments for children.

In most cases, the government made these changes without any official announcement. "What's interesting and potentially dangerous about website changes is they can be done without due process," says Rachel Bergman, director of the Web Integrity Project and another coauthor on the report. "Ultimately it can have the same consequences as a formal policy change."

Many of the modifications and removals do mirror formal policies the administration is pursuing. In August of 2018, several agencies finalized a rule to expand what are known as short-term, limited-duration insurance plans, which aren't bound by the ACA. That means that under those plans, women can be charged more for insurance, and people can be turned down for preexisting conditions. That could explain why some

changes to government websites appear to downplay the rights afforded to people under the ACA. Similarly, the researchers found that some training materials for navigators had been removed, echoing the administration's broader reduction of the navigator program.

Some changes the researchers discovered may appear tiny but could have a big impact. On one Frequently Asked Questions page maintained by the Department of Health and Human Services, a page called "Affordable Care Act" was replaced with a page called "Health Insurance Reform." It's a slight difference, but according to Josh Peck, former chief marketing officer for Healthcare.gov, it matters.

During the Obama administration, Peck says, search engine advertising was a key driver of new signups. Now that the advertising budget has been drastically reduced, organic searches for information related to the ACA are even more critical. And yet, he says, "Something as simple as changing 'Affordable Care Act' to 'health care law' can have a big impact on search engine optimization." Tinkering with the language in this way could force government websites farther down the page of Google results for certain queries, boosting websites and paid ads placed by companies that aren't always reputable.

"There's some unscrupulous actors out there who are happy to pose as government entities to mislead consumers," Peck says.

Peck says it's important to remember that these changes don't happen by accident. "It is a choice," he says. "Someone has to proactively go through the bureaucracy to take it all down."

The problem is, once government officials decide to take this information down, they rarely tell the public or leave any trace, beyond what exists in internet archives like the Wayback Machine. For a long time, this wasn't a huge issue. The George W. Bush administration disseminated far fewer policies and resources via government websites than the Obama administration did. But in the digital age, it stands to reason that each incoming occupant of the Oval Office will want to overhaul government websites to reflect their own priorities. Some past administration's pages do get archived, but these archives don't always cover incremental changes over time.

The Sunlight Foundation researchers believe the US needs a system that tracks all of those changes. Specifically, they propose that government agencies write formal memos to propose website changes, maintain archives of content that's been removed, and issue press releases on those removals. This, they say, would at least create a digital trail and lend some transparency to the process.

It's difficult to measure the exact impact website changes have had on people seeking coverage under the ACA. Under the Trump administration, enrollment in the ACA has declined substantially, but that decline undoubtedly has a lot to do with the reduction in outreach and the elimination of the so-called individual mandate, which penalized people for forgoing insurance. The report's authors are careful not to draw a straight line

between this drop and the website changes. But it's hard not to see how they're part of a larger pattern. As Bergman put it, "A public that is less aware and knowledgeable about the law is less likely to access important health care services the ACA affords."

Los Angeles Times

Nurse practitioners can improve Californians' access to healthcare

Editorial Board

Thanks to the state's embrace of Obamacare, California has expanded health insurance to millions of uninsured residents over the last five years. But as the number of people covered has grown, so has the strain on the doctors, clinics and hospitals that must respond to the increasing demand for care.

The problem is especially acute when it comes to primary care doctors and other front-line care providers, such as physician assistants and nurse practitioners. A study by UC San Francisco estimated that the state will have a shortfall of 4,700 of these clinicians by 2025. And the California Future Health Workforce Commission warned earlier this year: "Seven million Californians, the vast majority of them Latino, black and Native American, live in Health Professional Shortage Areas — a federal designation for counties experiencing shortfalls of primary care, dental care or mental health care providers."

Given the circumstances, the state needs to make the fullest possible use of the healthcare professionals who are already trained and ready to help patients. That's why the state Legislature should approve a long-sought bill (Assembly Bill 890 by Jim Wood, a Democrat from Healdsburg) to let nurse practitioners — registered nurses with extra years of training — offer the services they are certified to provide without requiring a doctor on hand to monitor them.

This seems like a no-brainer. Nurse practitioners in hospitals, clinics and medical groups would be free to provide the same care they do today, just without the requirement that a doctor be in the room or on call at the time the patient is treated. (That requirement currently applies to the 22,000 nurse practitioners in the state who are licensed to prescribe drugs.) Among other things, they could order tests, make diagnoses and prescribe certain drugs and medical devices, consistent with their training.

AB 890 would also create a state board to oversee the training and licensing requirements for nurse practitioners to operate their own offices, with no doctors on

staff. Before hanging out a shingle, a nurse practitioner would have to gain an additional three years or 4,600 hours of clinical experience under a doctor's supervision.

Sadly, the California Medical Assn. and a brace of other physicians' groups are opposing AB 890, just as they opposed its precursors in 2013 and 2015. They complain that the bill's provisions for assuring that nurse practitioners are competent to practice independently are too vague; they also say the state should build up the supply of doctors instead.

There's no reason not to let nurse practitioners do more while also trying to increase the supply of primary care doctors — both are necessary. Nevertheless, supporters fear the opposition from physician groups will prevent the bill from escaping from the Assembly Appropriations Committee, where it faces a key test Thursday (the bill has already won the unanimous support of the relevant policy panel, the Assembly Business and Professions Committee).

Lawmakers shouldn't let physicians' jealousy over turf trump the needs of their constituents for care. That's especially true for this Legislature, which is poised to extend insurance coverage to tens of thousands of additional Californians by making Medi-Cal available to all impoverished residents under age 26, regardless of immigration status. Coverage is meaningless if there's no one available to provide the care you need.

The New York Times

House Passes Legislation Aiming to Shore Up Health Law and Lower Drug Costs Abby Goodnough

WASHINGTON — The House on Thursday passed a suite of health care bills that tied shoring up the Affordable Care Act to lowering drug prices, as Democrats tried to hold Republicans to their campaign promises to secure coverage for pre-existing medical conditions and rein in the cost of prescription medicine.

But Democratic leaders appeared to be focused less on the substance of the measures than on their likely demise in the Republican-controlled Senate.

"There's been a relentless campaign of sabotage by the Trump administration to deny people health care, and thankfully, the new Democratic majority in the House has taken action," Speaker Nancy Pelosi said at a Wednesday news conference to push the legislation. "But the Republican-led Senate? No movement. Nothing."

By combining the bills to shore up the Affordable Care Act with several bipartisan measures to address high drug prices, Democrats had hoped to lure in some Republican support. But the minority party did not bite, calling the package “a bailout” for the health law and instead introducing a Republican bill that included only the drug-pricing measures, plus an extension of funding for community health centers and the National Health Service Corps.

The vote was 234 to 183, with five Republicans siding with the majority. One bill would restore \$100 million in funding the Trump administration had cut for “navigator” groups that help people sign up for insurance through the Affordable Care Act’s online exchanges. Another would reverse a Trump administration rule that expanded the sale of short-term health insurance plans that often cost less than Obamacare plans but do not have to meet the same requirements, including covering pre-existing conditions and “essential health benefits” such as maternity care and prescription drugs.

The bills would also provide money for states to create their own online marketplaces where people can buy health coverage under the law. Currently, all but 11 states and the District of Columbia rely on the federal marketplace, HealthCare.gov. But state-based marketplaces have generally offered a greater choice of insurers and lower premiums.

The bills came a week after the House passed another measure pushing back on President Trump’s efforts to weaken the Affordable Care Act; in all, Democrats are planning to pass a dozen bills meant to strengthen the law this month as part of a campaign to keep Republicans on the defensive on health care before the 2020 election.

Democrats from both chambers went so far as to wield a sledgehammer — representing the Republican approach to health care protections, they said — at a news conference on Wednesday.

The drug-pricing bills passed Thursday would take aim at the tactics that drug makers use to protect their monopolies and market share, which help keep drug prices high. One would seek to ban “pay-for-delay” deals, in which brand-name manufacturers pay makers of generic pharmaceuticals to delay bringing a lower-priced drug to market. Another would loosen the rules on the exclusive six-month sales period that a generic drug maker gets when it is the first to market after a brand-name drug loses its patent protection.

The measures are considered low-hanging fruit that would not substantially lower what Americans and their insurers pay for drugs.

Still, Democrats and their allies framed the bills as a test for Senate Republicans to make good on their pledge to lower drug prices.

“President Trump and his allies in Congress claim to care about Americans’ health care and making prescription drugs more affordable — now we’ll find out if that’s true,” Margarida Jorge, the executive director of Health Care for America Now, a coalition of labor unions and other groups that promote the Affordable Care Act, said in a statement before the vote.

The Senate is working on its own package of health-related bills, based partly on recommendations on cost controls that Senator Lamar Alexander, Republican of Tennessee, solicited from doctors, patients and others. The Senate health committee plans to mark up the legislation this summer, focusing less on expansion of coverage and more on the cost of care.

The Trump administration has stepped up its own efforts to prove Republicans are the “Party of Great HealthCare,” as the president tweeted in March, even as it seeks to have the entire Affordable Care Act struck down in court. Last week, the administration announced it would start requiring pharmaceutical companies to include the price of prescription drugs in television advertisements if the cost exceeds \$35 per month.

The next day, Mr. Trump called on Congress to help Americans who get unexpected bills from out-of-network doctors and hospitals after both emergency and scheduled medical visits. The so-called surprise billing issue is a popular one; in the week since Mr. Trump’s appeal, both the House and Senate have presented bipartisan proposals to address it.



Washington pioneers public health care option, but controlling costs remains tricky

Tami Luhby

(CNN) Washington, DC, may be gridlocked over what to do about health care, but Washington state is blazing a trail for progressives looking to lower costs and expand coverage.

The Evergreen State is the first to authorize the creation of a state-run public health insurance option on its Affordable Care Act exchange. Gov. Jay Inslee, a 2020

Democratic presidential candidate, signed legislation on Monday that will make the option available in 2021.

The move comes as Democrats on the campaign trail and in Congress debate how best to expand health care in the US -- ranging from a complete overhaul through "Medicare for All" or more gradual shifts through ideas such as the public option.

Your cheat sheet to all the 2020 Democrats' 'Medicare for All' plans

Your cheat sheet to all the 2020 Democrats' 'Medicare for All' plans

Passing a public option wasn't that easy on the state level, either. A delicate balance had to be struck between trying to control spending and making sure hospitals and doctors were willing to participate. The Washington plan, dubbed "Cascade Care," is only expected to reduce premiums by 5% to 10% after lawmakers boosted payment rates to providers.

In addition, the state's efforts lay bare the challenges of getting the government more involved in health care.

The Affordable Care Act bill originally contained a public option, but the contentious provision was ultimately struck before it became law amid opposition from the industry and some members of Congress. Some argued that a public option wasn't needed to boost coverage, said Chiquita Brooks-LaSure, managing director at Manatt Health, who worked on the law's passage and implementation for the Obama administration.

"Ten years later, we may feel differently about what's necessary," she said.

With little movement on health care coverage issues on the federal level, states are well positioned to take action, said Heather Howard, director of State Health & Value Strategies at Princeton University. Several blue and red states, including Colorado, New Mexico and Maryland, are looking to test innovative methods of broadening access to health insurance.

But so far, Washington is the only one to make a big move.

The state's primary goals are to rein in soaring costs for consumers, but also make sure that everyone has at least one set of plans to choose from on the exchange. Premiums in the state's individual market soared about 50%, on average, over the past two years, said Jason McGill, Inslee's senior health policy adviser.

House passes bills to lower drug prices but leaves Republicans fuming over Obamacare provisions

House passes bills to lower drug prices but leaves Republicans fuming over Obamacare provisions

Also, about one-third of the state's counties have only one insurer participating in Obamacare, and some residents faced the threat of having no options for 2018 -- though at least one carrier stepped in before open enrollment began. Roughly 201,500 people enrolled in exchange plans this year, down 4% from a year ago. Total enrollment in the individual market comes to just under 300,000 when those in off-exchange policies are included, McGill said.

Here's how the public option will work: The state will contract with insurers to provide a standardized set of policies -- which state and exchange officials have yet to develop --

on the Obamacare exchanges to compete with the plans already offered by private carriers. Premiums for the public option policies will vary by area, but deductibles and co-pays are expected to be the same in each plan tier across the state.

The state's insurers have mixed feelings about the public option, and the national industry group called for Inslee to veto the bill, saying it will "limit access, stifle innovation and reduce choices" for residents. But the state is wielding a big stick: Carriers that cover state workers and public school employees in a county must participate if they want to keep the business.

Most Americans want lower health care costs, not 'Medicare for All' or Obamacare repeal

Most Americans want lower health care costs, not 'Medicare for All' or Obamacare repeal

An even larger sticking point is how Washington plans to reduce costs -- by capping payment rates to doctors and hospitals at an average of 160% of the federal Medicare rate, with some exceptions for the state's roughly 50 rural hospitals, which are generally more financially stressed. It is one of the main reasons why the state's hospital and medical associations oppose the idea, warning that it could reduce the number of providers willing to join.

"The imposition of a rate cap would jeopardize physician participation, leading to health plans with limited access to care for patients," said Sean Graham, director of legislative and political affairs for the Washington State Medical Association.

Also, providers are upset that no restraints were put on insurers or drug makers and that the law doesn't address other problems that affect spending, such as residents' health status. Also, it doesn't enhance the federal subsidies that have made Obamacare more attractive for those who qualify, though the state plans to try to bolster that assistance.

"We are concerned that one of the precedents that this bill sets is that health care costs may only be controlled or reduced by capping reimbursement rates to providers and hospitals, instead of looking at all of the cost drivers in health care," said Chelene Whiteaker, senior vice president of government affairs for the Washington State Hospital Association.

The rate cap is actually much higher than originally planned. Initially, lawmakers were looking to pay providers the same as Medicare, which would have reduced costs somewhere in the 40% range, McGill said, adding the state can't do much about drug prices though it will try in the future.

However, the legislature then boosted the cap to an average of 160% of Medicare rates to bring in more providers -- but that reduced the savings projection to only 5% to 10%. "We all wish we could do more for consumers," McGill said. "It's balancing that cost savings with ensuring that there is a provider network. It's a first step. So we'll see how this works."



Obamacare Regains Strength Despite Trump's Legal Assault

Bruce Japsen

Even with a potentially devastating court case hanging over the Affordable Care Act, health insurers say they are expanding coverage options to new markets thanks to an improving financial performance.

Oscar Health, which made its name as a startup focused on providing Obamacare coverage, last week was the latest health insurer to announce improving profits and future expansion of health benefits under the ACA in 2020 and beyond.

"Oscar is committed to expanding our footprint so we can offer our tech-driven, consumer-facing health insurance to more people across the country," Oscar said after the insurer reported its enrollment grew to 255,000 while its underwriting profit increased nearly 5% to \$81.7 million in the first quarter of this year.

Oscar's expansion strategy and similar moves by other insurers comes despite the Donald Trump White House's efforts through the U.S. Justice Department to invalidate the entire ACA. Earlier this month, the Justice Department filed a formal request to strike down the law, which expanded health insurance coverage to more than 20 million Americans.

But health insurer business strategies are becoming more aggressive as the market stabilizes in part because of price increases and Democratic control of the U.S. House Representatives, which has vowed to fight Trump's and Republican efforts to strip away the ACA's patient protections, particular those with pre-existing medical conditions. Oscar has expanded its individual and small business coverage over the years into 14 markets in 9 states and has another market in its sights for 2020, according to reports.

"There are regulatory requirements with which we need to comply and licenses we need to obtain in order to operate in new markets," Oscar said in a statement. "These new entities are merely preparatory and, pending approval, we will announce our 2020 footprint and the products we will offer in each market later this year."

Oscar is the latest insurer to talk about expanding into new individual markets under the ACA. Centene, the biggest provider of Obamacare, operates in 20 states and regularly talks about future expansion. Centene's proposed acquisition of WellCare Health Plans could also be a beachhead for expansion into new markets.

Other insurers are also looking at returning to markets they left. Molina Healthcare last month said it plans to expand its business under the ACA next year.

“Our marketplace business continues to perform well,” Molina CEO Joseph Zubretsky told analysts on the company’s first quarter earnings call. “Recall that for the 2019 underwriting year, we took a conservative rating posture to maintain our attractive margin position. We now have a scaled and profitable business that we plan to grow in 2020 and beyond.”

The New York Times

Surprise Medical Bills Give Both Parties an Unexpected Opportunity to Agree Margot Sanger-Katz

President Trump and House Democrats are fighting over the Affordable Care Act as hard as ever, with Mr. Trump still vowing to repeal it and House Democrats passing bills to bolster it. And yet both parties have found a health issue they can agree to fight together: surprise medical bills.

The question is how.

Washington finds itself having a genuine policy debate that isn’t driven by party line. The president gave a speech this month about the need for action, standing in front of patients who’d received huge surprise bills. Various lawmakers from the House and the Senate have introduced bills with solutions — all bipartisan. Some of them include elements that might seem unusual for Republican proposals: price setting, if only in limited circumstances.

After a midterm election heavy with talk of health care, everyone wants to be seen as doing something to tackle parts of the system that seem costly and unfair.

Mr. Trump plans to issue an executive order next week, according to The Wall Street Journal, that would bring more transparency to patients about the costs of their care. One of the recent bills, from Lamar Alexander of Tennessee and Patty Murray of Washington, the leaders of the Senate Committee on Health, Education, Labor and Pensions, also includes some provisions that would enhance price transparency in other aspects of patient care.

Industry officials are likely to fight those broader efforts, which they argue undermine their negotiations. But all the major players — hospitals, doctors, and insurance

companies — have come on board for a solution to surprise bills, which occur when a hospitalized patient is treated by a doctor who is not in the same insurance network as the hospital, and is billed for the difference.

Loren Adler, an associate director at U.S.C.-Brookings Schaeffer Initiative for Health Policy, said that lawmakers he talks to immediately understand. “It’s facially absurd” that certain doctors can spring large, surprise bills onto patients who carefully choose their hospital. Compared with most issues he discusses with legislators, he said, “it’s just a lot more intuitive of a problem.”

But just because everyone agrees that the problem should be solved doesn’t mean there’s broad agreement about the right solution.

Currently, there are four public pieces of legislation on the issue. And legislators expect more hearings, debate and revision. The bill’s authors have been holding sessions with professors and policy experts — and with lobbyists for insurers, hospitals and doctors, all of whom would be affected by such a law and have strong preferences about how it should be written.

“The real fight is between industries, not Republicans and Democrats,” said Shawn Gremminger, the senior director of federal relations at the consumer advocacy group Families USA.

Several studies have found that about 20 percent of patients seen in an emergency room or admitted to a hospital are treated by an out-of-network doctor. Although the practice is fairly common, research has also shown that it’s not random: A small number of hospitals use doctors who routinely go out of network. Surprise billing has emerged as a major voter concern, and is showing up in public opinion surveys.

What should happen when an insurer and a doctor can’t agree on a price? For most health care services, there is pressure to make a deal because both sides benefit. But because people generally don’t pick their own emergency room doctor or anesthesiologist, these types of doctors can walk away from the bargaining table without losing any patients.

All of the recent pieces of legislation share one crucial feature. In each, the patient must be taken out of the middle; doctors would be barred from billing them for fees that insurance won’t cover. In cases when patients can decide about their care in advance, a hospital must notify them about any out-of-network doctors related to their care and obtain consent.

But there are various ways to resolve disagreements between a doctor and an insurance company over the right payment.

One solution is to pay out-of-network doctors a set price, based on amounts that other doctors have negotiated with insurance companies. That's the approach embraced in recent draft legislation written by the bipartisan leadership from the House Energy and Commerce Committee. Under that bill, if doctors and insurers can't agree on a price, the doctor will get the median price paid to in-network doctors in that area.

Two bills, one from a bipartisan group of senators including the Republican Bill Cassidy of Louisiana and the Democrat Maggie Hassan of New Hampshire, and another from a bipartisan group of House legislators, would let doctors and insurers who disagree bring their dispute to a professional arbiter. Each would offer the arbitrator a price, and the arbitrator would pick one.

A last option, which the White House appears to favor, would require doctors who work in hospitals to sign contracts with the same set of health insurers.

In general, the insurance companies like the price-setting approach, and the medical providers like arbitration. The constituency for the contract approach is mostly professors.

The most recent bill, from Mr. Alexander and Ms. Murray, has yet to commit to a solution. Their draft bill asks for comments on all three options.

Which will Congress pick? The answer probably depends a bit on how comfortable legislators are with the idea of price setting. If Congress dictates how much out-of-network doctors should be paid, it will affect negotiations between doctors and insurance companies. Currently, a doctor who doesn't like an insurance company's offer can walk away from the negotiating table and just charge higher prices to patients directly.

Those dynamics tend to drive up the negotiated prices for their work, said Ben Ippolito, an economist at the American Enterprise Institute, who has spoken with legislators about the issue. Over time, he said, it is likely that more doctors would come to be paid something similar to the benchmark, as insurers know that they won't have to pay more if they fail to make a deal.

But experts note that arbitration could lead to a similar clustering of prices. In choosing between bids, arbiters will need to decide their own benchmarks for what a reasonable price looks like, and they will tend to pick prices close to that number.

In New York, which set up an arbitration system five years ago, very few claims make it to arbitration. The theory goes that, as players come to understand the preferences of the arbitrators, they will settle the bill themselves at a similar rate. Those who like the approach say it is less heavy-handed than setting a standard price. Critics say that arbitration is simply a more complicated way to set prices.

The third approach, requiring doctors who work in a hospital to accept all the same insurance as the hospital itself, would eliminate the possibility of a surprise bill, rather than establishing a process for resolving the dispute later. Advocates of this approach say, in practice, that it will probably mean hospitals will do much of the negotiating on behalf of doctors who work with them.

Though there's a lot to be figured out before Congress's flurry of bill releases leads to a law, the breadth of the consensus has made optimism high among all the major players.

"I can't think of another single issue that has been getting this level of attention, that has this level of bipartisan support, and where across the health care spectrum you do, at the very least, have consensus we need to address this," said Adam Beck, vice president for employer health policy and initiatives at the health insurance trade group America's Health Insurance Plans.



Administration moves to revoke transgender health protection

Ricardo Alonso-Zaldivar

WASHINGTON (AP) — The Trump administration moved Friday to revoke newly won health care discrimination protections for transgender people, the latest in a series of actions that aim to reverse gains by LGBTQ Americans in areas ranging from the military to housing and education.

The Health and Human Services Department released a proposed regulation that in effect says "gender identity" is not protected under federal laws that prohibit sex discrimination in health care. It would reverse an Obama-era policy that the Trump administration already is not enforcing.

"The actions today are part and parcel of this administration's efforts to erase LGBTQ people from federal regulations and to undermine nondiscrimination protections across the board," said Omar Gonzalez-Pagan, a senior attorney on health care at Lambda Legal, a civil rights organization representing LGBT people.

House Speaker Nancy Pelosi, D-Calif, said the action shows “utter contempt for the health, safety and humanity of women and transgender Americans.”

The administration also has moved to restrict military service by transgender men and women, proposed allowing certain homeless shelters to take gender identity into account in offering someone a bed for the night and concluded in a 2017 Justice Department memo that federal civil rights law does not protect transgender people from discrimination at work. As one of her first policy moves, Education Secretary Betsy DeVos withdrew guidance that allowed students to use bathrooms matching their gender identity.

More than 1.5 million Americans identify as transgender, according to the Williams Institute, a think tank focusing on LGBT policy at the UCLA School of Law. A bigger number — 4.5% of the population — identify as lesbian, gay, bisexual or transgender (LGBT), according to Gallup.

Pushing back against critics, the HHS official overseeing the new regulation said transgender patients would continue to be protected by other federal laws that bar discrimination on the basis of race, color, national origin, sex, age and disability.

“Everyone deserves to be treated with dignity and respect,” said Roger Severino, who heads the HHS Office for Civil Rights. “We intend to fully enforce federal laws that prohibit discrimination.”

Asked about the charge that the administration has opened the door to discrimination against transgender people seeking needed medical care of any type, Severino responded, “I don’t want to see that happen.”

In some places LGBT people are protected by state laws, said Lambda Legal attorney Gonzalez-Pagan, “but what do you say to people living in a state that doesn’t have state-explicit protections? Do they move their home?”

Behind the dispute over legal rights is a medically recognized condition called “gender dysphoria” — discomfort or distress caused by a discrepancy between the gender that a person identifies as and the gender at birth. Consequences can include severe depression. Treatment can range from sex-reassignment surgery and hormones to people changing their outward appearance by adopting a different hairstyle or clothing.

Many social conservatives disagree with the concept.

“Sex is not subjective, it is an objective biological reality,” Tony Perkins, president of the Family Research Council, said in a statement supporting the Trump administration’s move. The proposed rule will ensure that federal law “isn’t used as a vehicle to advance transgender or abortion politics,” he said.

Under the Obama-era federal rule, a hospital could be required to perform gender-transition procedures such as hysterectomies if the facility provided that kind of treatment for other medical conditions. The rule was meant to carry out the anti-discrimination section of the Affordable Care Act, which bars sex discrimination in health care but does not use the term “gender identity.”

The proposed new rule would also affect the notices that millions of patients get in multiple languages about their rights to translation services. Such notices often come with insurer “explanation of benefits” forms. The Trump administration says the notice requirement has become a needless burden on health care providers, requiring billions of paper notices to be mailed annually at an estimated five-year cost of \$3.2 billion.

The American Civil Liberties Union served notice it expects to challenge the rule in court when it is final. Louise Melling, ACLU deputy legal director said the potential impact could go beyond LGBT people and also subject women to discrimination for having had an abortion.

That’s because the proposal would remove “termination of pregnancy” as grounds for making a legal claim of sex discrimination in health care, one of the protections created in the Obama years. Abortion opponents had argued that the Obama regulation could be construed to make a legal argument for federal funding of abortions.

UCLA legal scholar Jocelyn Samuels, who oversaw the drafting of the HHS transgender anti-discrimination rule under Obama, said that rule reflected established legal precedent that transgender people are protected by federal anti-discrimination laws.

“This administration has manifested its intent to roll back that well-considered understanding in every context,” she said.

Samuels questioned the timing of the Trump action, since the U.S. Supreme Court has agreed to hear three cases this year looking at whether federal civil rights law bans job discrimination on the basis of sexual orientation and gender identity.

The proposed rule change is unlikely to have immediate consequences beyond the realm of political and legal debate. It faces a 60-day comment period and another layer of review before it can be finalized.

HHS official Severino said the Trump administration is going back to the literal text of the ACA’s anti-discrimination law to correct an overly broad interpretation.

The Obama rule dates to a time when LGBT people were gaining political and social recognition. But a federal judge in Texas has said the rule went too far by concluding that discrimination on the basis of gender identity is a form of sex discrimination.

Severino said the proposed rule does not come with a new definition of a person’s sex. Earlier, a leaked internal document suggested the administration was debating whether to issue an immutable definition of sex, as based on a person’s genital organs at birth.

Think California's too big and influential? Wait until the presidential race heats up David Shirbman

One by one, the Democratic presidential candidates campaigning in Iowa show their fealty to ethanol, the corn-based fuel that supports about 42,000 jobs and buoys the state's crucial agriculture economy.

That is the raw power that Iowa, which holds the first test of the 2020 presidential election, possesses in American politics. At least for a while. By the morning after the Feb. 3 caucuses, the contenders may never mention the commodity again.

Many years ago, the late historian Kevin Starr said that modern California was "an ecumenical experiment conducted on an unprecedented level."

Now the product of that experiment — carried out over centuries by missionaries and miners, dreamers and the down-and-out, producers of airliners, iPhones and Hollywood films — has the real potential of dominating one of the most important elections of modern times.

For it is the trademark issues and values of California — immigration, healthcare, trade and the environment — that to a large extent will drive this presidential contest.

The notion of a national race being a referendum on one state's values — or, in another conception, a struggle between the worldview of California and the worldview of President Trump — could only emerge in a political environment where urgent economic and foreign policy issues won't dominate as they ordinarily do.

To the extent that economic issues are in play, they are poverty, globalization and income inequality, all central to the California zeitgeist.

"These are the topics where California conflicts the most with Trump," said Bill Carrick, a veteran Los Angeles-based Democratic strategist. "We are as far out of touch with this president as we have ever been with any president. It's striking and it's all over California and over all the issues."

An early March 3 primary and the presence of California candidates, including Sen. Kamala Harris and Bay Area Rep. Eric Swalwell, among the nearly two dozen Democratic contenders, only serves to heighten the California orientation of the 2020 election.

Or as Mark Baldassare, the president of the nonprofit Public Policy Institute of California, put it, "The issues that are front and center in California are the very ones the country will be forced to confront in the next four or five years."

::

For decades, California has been where the American future first came into focus, thanks to visionaries who peered beyond the present. The pioneers of the film, aerospace and high-tech industries, yes. But also political leaders like the liberals Hiram Johnson and Upton Sinclair, and the conservatives Arthur Laffer and Ronald Reagan.

Those ideological fault lines persist — dominant on the left but not dormant on the right — in a California that, more than ever, seems a world of its own.

The state boasts the world's fifth-largest economy. The population of 40 million exceeds that of Canada. California's 55 electoral votes alone are more than a fifth of the total required to win the White House, dwarfing the swing states of Michigan, Wisconsin and Pennsylvania as well as the perennial battlegrounds of Florida and Ohio.

Today, the state is big and powerful enough to pursue its own economic and foreign policies.

A key issue setting California apart, and setting a standard for the rest of the country, is climate change. The state has pledged to reduce greenhouse-gas emissions to 40% below 1990 levels in fewer than a dozen years while dramatically increasing renewable energy and reducing the reliance on fossil fuels.

"We are committed as first-movers," said Bruce Cain, a Stanford political scientist and longtime student of California. "We are willing here to be ahead and to staying ahead, and it is a reflection of our high-tech industries and of the reality that drought, fires and flooding have shown us the consequences of climate change."

The release of Los Angeles Mayor Eric Garcetti's Green New Deal, with its zero-emissions transportation network and the elimination of plastic straws and single-use take-out food receptacles, echoes previous pioneering initiatives. It signaled the primacy of environmental issues in a state that, in 1882, ended hydraulic mining operations after Central Valley farmers complained of the damaging debris — a decision regarded as a landmark in American environmental history.

"Very early on, Californians realized getting the environment right involved balancing the needs and interests of a lot of people," said David Festa, senior vice president for ecosystems for the California chapter of the Environmental Defense Fund.

That process — weighing the competing interests of economic growth and environmental protection — has always been a challenge, often taken up first in California and then the rest of the country. Few sectors are as sensitive to that tension as the state's farm economy, which accounts for more agricultural production — above \$50 billion — than any other American state.

More than a third of the nation's vegetables and two-thirds of the country's fruits and nuts are produced in this state, with exports drawing almost \$21 billion. This is an area where the Trump tariffs have hit particularly hard; almond exports to China, which primarily uses the nut for skin-beauty products, are down more than 30%.

"This is a big California issue," said Jamie Johansson, a Northern California olive farmer who heads the California Farm Bureau Federation. "These tariffs have had a terrible effect, particularly for citrus and cherries. For certain this will be an issue in the election."

So will immigration, which has dominated California politics off and on since well before the Gold Rush and the construction of the transcontinental railroad. Today, immigrants account for more than a third of the state's civilian, non-government workforce; more than two-thirds of its agricultural workers; four-fifths of its housekeepers and nine-tenths of its sewing-machine operators.

"It is not a theoretical issue in this state," said Victor Narro, a professor in the labor and workplace studies program at UCLA. "It is a real social and cultural issue that goes to the heart of what the state is — and what the country will be."

As Trump continues to advocate the repeal of the Affordable Care Act, healthcare remains an important political issue in California, which under Obamacare cut the rate of the uninsured more than half, from 17% to 7% — more than any other state.

"Whatever the label is, Obamacare is generally supported and affirmed here," said Peter Lee, executive director of Covered California, the health insurance marketplace for the state.

The majority of California voters are more likely to support an expansion of Obamacare than its replacement. "This is a very blue state filled with Democrats and minorities for whom health is a top issue," said Drew Altman, president of the San Francisco-based Kaiser Family Foundation, which studies healthcare-related issues.

The Trump tax bill also will get substantial attention, especially in California, where taxpayers this spring unhappily discovered one of the bill's major features, the \$10,000 federal cap imposed on the deduction of state and local taxes. The average state and local tax burden in California is \$18,438, according to a Pew Foundation study, making the impact particularly onerous.

"This seemed to us to be done out of sheer meanness," said Carrick, the Democratic consultant.

::

Another notable part of the 2020 political calculus is the increased role California could play in selecting Trump's opponent. This is a direct result of moving the California

primary from June, at the end of the primary season, to March 3, after the four lead states of Iowa, New Hampshire, Nevada and South Carolina vote.

Of course, not all hold California and its brand of left-coast liberalism in particularly high regard.

The influence of the state — by virtue of its size, its position on the primary calendar and perhaps if the eventual nominee or vice presidential candidate is a Californian — could prove worrisome for Democrats if it's seen as moving the party too far left.

"The Democrats are in the middle of an argument about who they are, and one of the options is to be a California party with California views," said Dennis Goldford, a political scientist at Drake University in Des Moines.

"All the themes that work for a large portion of Democrats are themes that really resonate in California," Goldford continued. "But they have to be careful, because in being a California party they risk alienating the Midwestern voters they didn't get last time."

Thad Kousser, who teaches political science at UC San Diego, agreed.

"If the Democrats view this election as a choice between California and Donald Trump, they risk winning only states like California," Kousser said, "and winning states like California isn't enough as long as we still have an electoral college."

POLITICOPRO

Senate approves Medi-Cal expansion for undocumented seniors, young adults Angela Hart

SACRAMENTO — The state Senate Wednesday approved a bill that would expand Medi-Cal eligibility to undocumented young adults and seniors despite opposition from Republicans — one of whom said American citizens "deserve" to reap the benefits of California health care investments, not those living here illegally.

The bill would expand Medi-Cal beyond Gov. Gavin Newsom's proposal, but stops short of providing coverage to all undocumented adults, as some Democratic senators originally wanted. The Senate's 24-11 vote came after some of the most heated rhetoric so far this year in the upper house.

"We need to take care of Californians that are here legally first," said Sen. Jeff Stone (R-Temecula), who argued California's safety-net system has been over-burdened by an "invasion of people migrating into the country."

His opposition drew immediate blowback from Democrats, particularly from Sen. Holly Mitchell (D-Los Angeles), the Senate Budget Committee chairwoman.

"I never cease to be amazed ... I had to come to the California Legislature to hear some of the most racist, classist banter in my entire life," Mitchell said on the Senate floor. "An invasion? It's intriguing to me that aggressive words like invasion are only used in reference to immigrants coming into the country today ... that's how our country was built — through the invasion of people from other countries."

Sen. Maria Elena Durazo (D-Los Angeles), author of CA SB29 (19R), argued that immigrants — here legally or illegally — are not only worthy of taxpayer-funded health care, but deserve it just like anybody else.

"They work hard to make our wine industry successful, they take care of our children ... and they build our homes and skyscrapers," Durazo said. "California would not be the fifth largest economy in the world without their hard work and contributions."

She referenced UC Berkeley research showing undocumented immigrants contribute more than \$3 billion in state and local taxes, saying it's wrong that they're "excluded from the lifesaving safety net program that they help pay for."

Democrat after Democrat rose on the Senate floor to voice support, with some saying they found Stone's argument to be "nationalistic," "xenophobic," and "personally offensive." Others, meanwhile, focused on economic arguments, saying undocumented immigrants should benefit from a system they pay into, and the expansion could help drive down costly emergency room treatment that leads to higher health care costs for everyone.

"They are subsidizing us," said Sen. Jim Beall (D-San Jose).

All 10 Senate Republicans voted against the bill, as did Sen. Steve Glazer (D-Orinda). Three Democrats declined to vote, including Sen. Bill Dodd (D-Napa), Sen. Henry Stern (D-Canoga Park) and Sen. Tom Umberg (D-Santa Ana).

SB 29 is more robust than Newsom's proposal, which would expand eligibility to young adults ages 19 to 25 beginning in 2020, but not seniors. Democrats are expected to push for the broader Medi-Cal plan in the upcoming budget.

In addition to including undocumented elders ages 65 and older, it would increase eligibility to undocumented immigrants through age 26 in January 2021, with subsequent one-year increases every calendar year thereafter. It is projected to cost \$373 million per year, though that annual price tag would rise when accounting for in-home supportive services and the additional one-year expansion year in subsequent years.

The Newsom administration projects that Medi-Cal expansion for ages 19 to 25 would cost \$98 million in the upcoming budget year and \$315 million per year at full implementation in 2021.

The Assembly this week approved a more robust bill by Assemblyman Joaquin Arambula (D-Fresno), which seeks to expand Medi-Cal to all undocumented adults.

But the likelihood of it being adopted in its current form is dim. Newsom doesn't support it, and the Assembly didn't include full expansion in his budget. Still, the Assembly's support for a larger expansion suggests both houses will push Newsom to go beyond covering undocumented young adults in the upcoming budget process.

SB 29 excludes an immediate expansion to the largest segment of undocumented immigrants in California — adults ages 26 to 64, a population that would also be the most expensive to cover at a projected \$2 billion per year.

Durazo said the state must go further in future years, but called SB 29 "a building block to achieve universal health care in California."



Healthcare Costs Top Financial Problem for U.S. Families

Jeffrey M. Jones

WASHINGTON, D.C. -- Americans are more likely to name healthcare costs than any other issue when asked to say what is the most important financial problem facing their family. Seventeen percent name healthcare, followed by lack of money or low wages, named by 11%. A year ago, those two issues and personal debt essentially tied for first; healthcare was also the clear leader in 2017.

After healthcare costs and low wages, college expenses, housing costs and taxes are the problems mentioned next-most commonly in this year's survey, with 8% of Americans citing each.

The April 17-30 survey comes at a time of high economic confidence, when relatively few Americans name economic matters as the most important problem facing the country. Additionally, several different measures of Americans' personal financial situations are among the most positive Gallup has measured in years.

Consistent with their sunny financial outlook, 20% of Americans respond that they do not have a "most important financial problem." That is one of the highest percentages responding "none" in Gallup's 14-year trend on the question, surpassed only by the 21% who said so in a February 2005 poll. Still, even in these generally good economic

times, the vast majority of Americans do mention some financial matter that is a major concern for their family.

Healthcare Costs Usually Near Top of the List

Gallup has asked the "most important family financial problem" question on 48 separate occasions since 2005. During that time, only three issues -- healthcare costs, energy costs/oil and gas prices and lack of money/low wages -- have topped the list in any single poll.

Healthcare costs typically vied with energy costs as the top problem before the Great Recession, largely dependent on the price of gasoline. This included a record-high 29% mentioning gas prices in July 2008, when gasoline prices averaged over \$4 per gallon nationwide. But in the ensuing periods of high unemployment and a sluggish economic recovery between 2009 and 2014, lack of money or low wages was most often the No. 1 personal financial problem. Healthcare costs have ranked first in two of the past three surveys, and have been at least tied for first in each poll since 2014.

Mentions of energy costs have dwindled in recent years as gas prices have been lower, and in the current survey, no respondent cited energy costs as the most important financial problem. Since 2005, an average of 8% of U.S. adults have named energy costs. Healthcare costs (14%) and lack of money (13%) have been most frequently mentioned. Those are the highest averages for any issues and the only two above 10%.

Older Americans Especially Likely to Name Healthcare Costs as Top Problem

Healthcare is the most commonly mentioned financial challenge for key subgroups and is especially likely to be named by older Americans. Twenty-five percent of adults between the ages of 50 and 64, and 23% of those aged 65 and older, say healthcare costs are the biggest problem for their family's finances.

Healthcare ties for first among adults younger than 50, who are about as likely to name lack of money, college expenses and housing costs as their greatest financial challenges. The youngest adults -- those under age 30 -- also commonly mention debt and the high cost of living.

Retirement savings are a greater concern for those in the pre-retirement years (aged 50 to 64), but something few young adults or senior citizens view as a problem.

Americans at different income levels are about equally likely to name healthcare as the most important financial problem, with between 17% and 19% in each income group doing so. Lack of money is, not surprisingly, a much greater concern for lower-income Americans. Upper- and middle-income Americans are more inclined to cite college expenses, taxes and retirement savings as their chief financial challenges.

Implications

Even in generally good economic times, Americans still face significant personal financial challenges. Foremost among these are healthcare costs, which have been a

consistent concern over time but currently stand above all other concerns. As such, healthcare will likely continue to be a major focus in national elections, including the 2020 presidential election. Older Americans, who are more likely to need healthcare and who are more likely to vote than younger Americans, may pay special attention to what the candidates' plans are for addressing healthcare costs.



Trump takes aim at insurers and hospitals over health care costs

Tami Luhby

(CNN) President Donald Trump has repeatedly taken aim at drug makers for contributing to the nation's runaway health care spending.

Now he's setting his sights on insurers, hospitals and other providers as a way to achieve one of his top promises -- lowering costs for consumers.

The administration is considering requiring these players to disclose the rates they privately negotiate, an idea that has sparked a backlash from the influential industry. The Department of Health & Human Services touched on the concept in a proposed rule released in March, noting that making such information public could drive health care prices down.

Now, the administration is preparing an executive order that could require greater disclosure of negotiated health prices, a move first reported by the Wall Street Journal. Trump teased the effort earlier this month, saying that his administration plans to announce a new transparency effort in coming weeks.

"I think, in a way, it's going to be as important as a healthcare bill," he said in a press conference on surprise medical bills. "But this could be something that will have a tremendous impact ... the numbers you're talking about through transparency are tremendous."

While the President and administration officials often say they want to reduce government regulation on businesses to unleash more economic power, they acknowledge it doesn't mean hands off completely.

"We don't have a competitive market because we are not requiring price transparency," Seema Verma, administrator of the Centers for Medicare & Medicaid Services, told CNN. "That's where the government has a role to play -- in ensuring that we have a competitive free market and to make sure there's a level playing field so providers can compete for patients on the basis of price and quality. That's what we are trying to drive towards."

Just how transparent health care prices should be, however, remains a point of contention. The executive order has been delayed by internal disputes over how aggressively to mandate disclosure, according to the Journal.

Asked what type of disclosure she is focused on, Verma said: "Those are some of the things we are grappling with internally. At the end of the day, we want patients to understand what they are going to pay in advance."

Officials have already taken some initial steps to require drug makers and medical providers to release more cost information, though it has generally focused on the industry's list prices rather than the negotiated rates or what consumers are actually billed. Some experts question how much this will actually achieve, especially, they say, since most Americans don't shop when it comes to health care.

Earlier this month, Health Secretary Alex Azar announced that drug makers will have to start including the list price of any medication costing more than \$35 for a month's supply or usual course of treatment in their television ads. The effort is the first rule implemented from the administration's blueprint to lower drug costs, which was released a year ago.

Senators look for bipartisan path on health care amid House squabbles

"Requiring the inclusion of drugs' list prices in TV ads is the single most significant step any administration has taken toward a simple commitment: American patients deserve to know the prices of the healthcare they receive," Azar said.

And starting this year, the Centers for Medicare & Medicaid Services is requiring hospitals to post their standard charges for their services on their websites in a format that can be imported into a computer system. It plans to do more in this arena to allow patients to more easily compare prices, as well as quality, said Verma, who believes consumers are interested in prices -- especially when they are still subject to deductibles -- and do have to power to influence what providers charge.

Lawmakers on both sides of the aisle in Congress are also working together in hopes of increasing awareness of pricing and of the behind the scenes tactics that keep costs high.

So far, however, the administration's efforts will likely do little to help consumers or to rein in health care spending, some experts said. Most people don't pay the list price for drugs or the full cost for hospital services so this information will not tell them much about what they are on the hook for and could even dissuade them from pursuing care. The majority of Americans have health insurance, so what they pay is typically based on the deals the carriers work out with the health care providers and on their particular policies. What consumers are more interested in is their out-of-pocket costs for a medication or medical service.

That's why policy experts were more encouraged by a new rule that would require insurers in the Medicare Part D drug program to provide doctors with real-time information on patients' prescription benefits, including what a particular medication would cost them.

Still, even when consumers have tools to give them pricing information, they don't really shop around for health care, said Lynn Quincy, director of Altarum Healthcare Value Hub, a non-profit research firm. And they don't have the muscle to get doctors and hospitals to lower their charges.

"The people with the power to put pressure on providers is not the patient -- that's just really a ridiculous notion," Quincy said. "But the health plan who is at the point of contracting with providers for the next year, they're the ones who can say whether or not a given rate is out of line with the market."

Trump administration to require drug prices in TV ads

Releasing details about the negotiated rates between specific insurers and hospitals, however, could reveal which providers are charging high prices. That could prompt insurers -- and large employers -- to try to get a better deal.

For instance, California Public Employees' Retirement System, which manages health benefits for more than 1.5 million members and their families, saw its spending drop after it set a maximum reimbursement level of \$30,000 for hip and knee replacements in 2011, Quincy said. Patients, who had to foot the bill for any amount above this reference price, flocked to lower-priced hospitals, prompting some costlier institutions to lower their charges.

But some worry that more information could actually lead to higher prices. If the secret negotiations in the drug supply chain became public, for example, it might prompt those who charge less to demand more, said Ian Spatz, a senior adviser at Manatt Health, a consulting firm.

"It's great politics, but bad public health policy and bad economics," Spatz said. Health care industry associations are already lining up to quash the idea of disclosing contracted rates, which they argue could cause more harm than good. The insurers' trade group pointed to a 2015 Federal Trade Commission blog post that said too much transparency can interfere with competition in the medical market.

"If every contract and every negotiated rate were public, no doctor or hospital would want to be paid the lowest rate -- they would all be motivated to demand higher payments," said Matt Eyles, CEO of America's Health Insurance Plans.

The main hospital lobbying organization also opposes this type of disclosure, saying that patients are more interested in their out-of-pocket costs.

"Disclosing negotiated rates between insurers and hospitals could undermine the choices available in the private market," Tom Nickels, executive vice president at the American Hospital Association said in March when the Centers for Medicare & Medicaid Services first broached the idea. "While we support transparency, this approach misses the mark."



American Voters Have a Simple Health-Care Message for 2020: Just Fix It!

Stephanie Armour

Nine years after Democrats passed the Affordable Care Act and more than a year after Republicans failed in their effort to repeal it, health care promises once again to be a major issue in the 2020 elections.

Drug costs are rising, as are insurance premiums. Rural hospitals are closing. Even as an estimated 20 million people have gained coverage under the ACA, widely known as Obamacare, nearly 30 million people remain uninsured. Surveys consistently find that Americans see the health-care system as broken.

Americans cited health care as the top issue for the federal government to address, ahead of the economy, immigration, national security and other issues, Wall Street Journal/NBC News polling found this month.

The financial burden of health care was of particular concern for American families, according to a new Gallup poll released last week, trumping worries linked to wages, college expenses, housing and taxes.

As such, health care presents an opportunity for both major parties heading into the 2020 presidential election. The state of health coverage is the one issue for which a big chunk of the polarized electorate could become amenable to whomever they see as offering the best prospect of a permanent solution, irrespective of political party.

Half of Americans say they would support paying more in taxes to assure that all Americans have health care, according to a WSJ/NBC News poll. "The American people are saying we still need this fixed," said Lara Brown, director of George Washington University's graduate school of political management.

“Both parties tried different approaches with I think genuine sincerity,” said Rep. Greg Walden (R., Ore.). “No one’s found the magic fairy dust yet.”

Democrats leveraged the issue to great effect during last year’s midterm election. They reclaimed the House and flipped seven governorships. Constituents in Republican strongholds such as Utah, Nebraska and Idaho voted to expand Medicaid under the ACA after GOP leaders refused.

Across 75 competitive Republican-held seats—the ones Democrats needed to win the House of Representatives—health care was a defining issue for 63% of voters, according to a 2018 election exit poll by Public Policy Polling. Nationally, polls gave Democrats an 8-point advantage on the issue.

Now, fearful of pushing too hard, some Democratic presidential candidates—including Sens. Elizabeth Warren of Massachusetts and Cory Booker of New Jersey—are distancing themselves from some ideas welcomed by their base, including a plan to provide government care to everyone, known as Medicare for All. That plan and others are seen as extreme by many Republicans and less-liberal Democrats.

While the idea of government-provided insurance is broadly popular with voters, support plummets when voters are asked if they would be willing to give up company-sponsored health care. Former Vice President Joe Biden, whom polls list as Democratic front-runner for the 2020 presidential nomination, hasn’t endorsed Medicare for All.

Republicans are quick to paint Democratic health-care solutions as extreme as the GOP seeks to appeal to voters who don’t want a system upending private and employer-sponsored insurance. Republicans—and some centrist Democrats—are focused on what polls show are more incremental ideas, including price transparency and the introduction of more low-cost alternatives to health insurance.

The Trump administration is considering developing new regulations that could force doctors and hospitals to disclose publicly their secret, negotiated rates with insurers. The hope is that more transparency will allow patients to shop for better prices, which would drive down costs.

“Right now everyone is feeling frustrated because the cost is more out of your pocket than at any time in history for most,” said Mr. Walden. “They see list prices and news stories, and it scares them.”

Democrats are saying Republicans are the ones being extreme, noting the party’s repeated efforts to kill the ACA, which could mean millions would lose coverage and others with pre-existing medical conditions would lose certain protections. Many

congressional Republicans have sought to distance themselves from a recent Trump administration decision to support a federal judge's ruling that would kill the ACA entirely.

Support for the law reached a peak of 55% when Republicans sought to dismantle it last year, and support is particularly broad for aspects of the law, such as the guarantee of coverage for people with pre-existing conditions. Support for the law currently stands at 50%, according to an April 2019 Gallup poll.

Arizona last year elected its first Democrat to the Senate since 1988 over promises to bolster Obamacare, and Democrats who pledged to protect health-care coverage won House seats in the deep red states of Georgia and Oklahoma.

Everyone agrees costs for consumers have soared. Drug prices are climbing faster than inflation, a big reason workers' out-of-pocket expenses for health care leapt 53.5% between 2006 and 2016, according to the Economic Policy Institute. Today, as costs continue to rise, spending on health care makes up nearly 18% of U.S. gross domestic product, more than double health care's share in 1980.

All told, 69% of Americans said reducing health-care costs should be a top priority for the president and Congress, according to a 2019 Pew survey. The number has risen steadily from 59% in 2014.

Those without coverage are struggling amid those soaring costs. Those who have coverage are scared of losing it. Fewer than one-third of Americans are confident lawmakers can work together to come up with a bipartisan solution, according to the Kaiser Family Foundation.

Obamacare lowered the number of those without insurance, with red states seeing some of the biggest benefits. But costs continue to rise, even as some people still struggle to get access to care, creating the perpetual sense of crisis.

As a result, Republican-leaning states such as Utah are moving to vigorously roll back the law, welcoming plans that have skimpier benefits but cost less, for example. States such as Arkansas, Kentucky, New Hampshire and Indiana have gotten federal approval to require people who get Medicaid benefits to work, although courts have blocked some of these measures.

Blue states, meanwhile, are swinging the other way and looking to protect and expand the ACA.

In California, newly elected Democratic Gov. Gavin Newsom asked the Trump administration to support a statewide government health plan. He is proposing letting unauthorized immigrants under age 26 enroll in the state's Medicaid program.

New Jersey last year adopted an insurance requirement after Republicans in Congress eliminated the ACA's penalty for not having coverage. Washington is set to let residents buy individual plans on the ACA exchange from insurers under contract with the state, making it the first so-called public option.

"After nearly a decade, we find ourselves debating the same issue: how to make health care more affordable to more Americans," said Rep. Tom Cole (R., Okla.) in a recent hearing on Capitol Hill.

And yet, health care also poses risks for elected officials. For all those who worry about the state of health care in the U.S., an even bigger percentage of Americans—4 out of 5, according to Gallup—rate the quality of their health-care coverage as either "excellent" or "good."

Because so many people are content with their own coverage, any politician pushing policies deemed too disruptive can easily lose the argument.



Obamacare rate hikes appear modest for 2020

Paul Demko

The era of annual eye-popping Obamacare rate hikes appears to be over.

Premium increases in the law's marketplaces are on track to be relatively modest for the second straight year, according to the first batch of 2020 rates proposed by insurers. The rate filings are an early indication that this year's small rate hikes weren't a fluke and that other Trump administration policies — including support for a lawsuit that could torch the Affordable Care Act — have proven less disruptive than some experts feared.

"It seems like things have stabilized," said James Whisler, a principal with Deloitte Consulting who works with insurers on rate setting.

Fewer than a dozen states have so far released initial proposed rate hikes for the enrollment season starting in November. They range from an average increase of 13 percent in Vermont to average reductions of 2.9 percent in Maryland. Insurers in New

York are seeking rate hikes of 8.4 percent; Washington's health plans want to boost premiums by less than 1 percent.

The proposed rates are likely to get pushback from insurance regulators in many states, meaning that actual 2020 premium increases could be lower when they're finalized shortly before open enrollment begins.

This past year, for the first time since the marketplaces were established in 2014, premiums for the popular benchmark plans — which are used to establish subsidies — dipped by 1.5 percent in the 39 states relying on HealthCare.gov. In addition, enrollment largely held steady, dropping 2.6 percent nationwide, despite widespread concerns about the Trump administration's cuts to outreach and marketing efforts.

One big reason why the Obamacare marketplaces have settled: Insurers are now making lots of money on their Obamacare customers — the vast majority of which are heavily subsidized — after jacking up rates to account for higher-than-expected medical costs in the early years.

In addition, the administration's looser rules for selling plans that don't meet ACA requirements don't appear to have had a major impact almost a year after they were finalized. The insurance industry's muted response to rules expanding short-term and association health plans shows that the Obamacare markets have matured, experts said.

"If it was four years ago and everything was on fire, [insurers] would ... definitely try to get every 0.5 to 1 percent increase they need," said Dave Dillon, a fellow with the Society of Actuaries who advises several states on rate review. "I don't really see explicit assumptions for those items."

Still, it's too soon to gauge the level of competition among insurers for 2020. Two years ago, there were dozens of counties across the country in danger of not having any Obamacare options, although insurers eventually stepped in to sell coverage. But competition ticked up in 2019, and most market watchers expect that to continue for next year.

"I would be surprised if we start hearing about bare counties," said Cynthia Cox, an insurance expert at the Kaiser Family Foundation. "It's probably more likely that we see insurers entering the market."

The main driver of rates in 2020 will be increased medical costs, which are expected to swell by 4 to 8 percent. There are a few minor changes in federal policies that will affect

rates around the margins. Most notably, the ACA's health insurance tax kicks back in after a one-year hiatus, which will boost premiums by around 2 percent.

The relative stability in the ACA markets means that insurers are focused more on tweaking plan design, including scrutinizing their networks to see if there are ways to reduce costs by trimming providers without risking backlash, said Deloitte's Whisler. In addition, they're focused on boosting their ability to document exactly how expensive their customers are so that they can get their fair share of risk adjustment payments. Under that program, insurers that attract the most expensive customers receive payments, while those that attract a healthier clientele have to cut checks.

"That is a zero-sum game," Whisler said. "There's really large checks being written or received."

Obamacare insurers are still anxious about steps the Trump administration could take to undermine the markets. HHS has sought input on whether it should prohibit "silver-loading," in which insurers pack the rate increases caused by the administration's 2017 decision to eliminate cost-sharing reduction payments onto the most popular ACA plans. That increased the size of premium subsidies, allowing more people to sign up for plans with low or no monthly costs.

The biggest potential land mine, however, remains the lawsuit filed by conservative states seeking to dismantle the entire ACA. In December, a federal judge ruled that the removal of the individual mandate in the 2017 GOP tax cut legislation rendered the entire federal health care law unconstitutional. Most legal observers expect that decision to be overturned on appeal, but the Trump administration raised the threat level in March by backing the lower court ruling. A federal appeals court in New Orleans will hear the case in July, and it could reach the Supreme Court next term.

The ramifications of that lawsuit succeeding would be so profound — the ACA marketplaces could be invalidated in an instant — that there's little insurers can do to account for that possibility in their 2020 filings, experts said.

"I would be hopeful that there would be some kind of transition period" if the ACA is ultimately overturned, Dillon said. "The markets would be in an uproar."

The New York Times

‘Swinging at Every Pitch’: California’s Governor Has Big Plans. Critics See Big Risks.

Tim Arango

Amid the swirl of big name presidential candidates who descended on San Francisco recently for the Democratic Party’s state convention, Gov. Gavin Newsom made sure there was a place in the spotlight for him.

When he wasn’t schmoozing in the hallways with delegates, or hosting a fund-raiser for his favored candidate, Senator Kamala Harris, at the home of billionaires Gordon and Ann Getty, he took to the podium and urged his fellow Democrats to “take a look around” at his defiantly progressive agenda as they prepare to take on President Trump.

“We are nothing less than a progressive answer to a transgressive president,” he said.

Touting the state’s diversity and liberal policies, he added, “others are talking about it, we’re doing it.”

Indeed, Mr. Newsom’s ambitions as governor read like a liberal’s holiday wish list. Bigger health care subsidies for the poor and medical coverage for more undocumented immigrants, steps toward his goal of universal health care. Then there’s free community college, longer parental leave, college savings accounts for kindergartners. All are part of a promise to nurture Californians from “cradle-to-career.”

Five months into his tenure, Mr. Newsom is hopscotching the state on a health care tour one day, announcing a task force on homelessness another — all while promoting California as an alternative to President Trump’s agenda and speaking out on a host of national issues, from immigration to abortion.

But his approach has drawn criticism for lacking focus and trying to appease too many groups at once. “Swinging at every pitch” is how some describe him. His big plans for spending risk squandering a large surplus if the economy tanks, and set him apart from his predecessor, Gov. Jerry Brown. Mr. Brown was famously disciplined, preferring to devote his full attention to just a small number of issues, like climate change and criminal justice. Mr. Newsom, by contrast, is making grand promises that critics say could be difficult to deliver on.

All of Mr. Newsom’s ambitions — he has also vowed to spend more on homelessness, tackle the housing crisis and eliminate taxes on tampons and diapers — will be challenged if the economy takes a tumble.

Rob Stutzman, a Republican strategist in Sacramento who was an aide to former Gov. Arnold Schwarzenegger, said, “This comes due for Newsom at some point. And that will be his true test. How does a progressive governor manage through a downturn of tens

of billions of dollars in tax revenue. There's been a lot of big, bold talk. And there's potential for some political falls down the road."

As the presidential race kicks into gear, California finds itself in the spotlight in a way that it hasn't in years, placing attention on Mr. Newsom as a sense of his governance starts to emerge. The shift forward by three months of California's presidential primary, to March, means candidates will spend more time campaigning here, mixing with ordinary voters as they fight for the state's delegates, rather than just flying in and out for fund-raisers in California's gilded enclaves.

California may be a symbol of liberal values, but it's also a symbol of the failures of liberal policy. It has the highest poverty rate in the country, housing costs are out of reach for many, and squalor and deprivation plague the streets of the biggest cities. And the criticism has not come only from the right, where California is a frequent target on Fox News and from Republicans in Washington. Recent opinion pieces in the Washington Post, The New York Times and The New Yorker have called out California for its failure to extend prosperity to more people.

For now, Mr. Newsom's broad, liberal agenda is made possible by two things: a buoyant economy that has produced a growing budget surplus — as much as \$21.5 billion, plus a separate \$16.5 billion "rainy day" fund — and a super majority of Democrats in both chambers of the Legislature.

"We have not had a governor this progressive arguably in the history of this state," said Bill Whalen, a fellow at the Hoover Institution who worked as an aide to former Gov. Pete Wilson, a Republican.

Mr. Newsom's path is being closely watched by the national Democratic Party as a measure of how far liberal governance can go in a time of prosperity. It comes just as many presidential candidates are proposing policy ideas that California is trying to implement. Already, Mr. Newsom's moratorium on the death penalty, announced in March, injected the issue into the presidential race.

"I can assure you I wasn't asked to do one or two things," Mr. Newsom said in an interview, referring to his campaign last fall. "I was asked to do 20 or 30 things. Everywhere I went. "

"I'm not naïve, I read history, I read the punditry, I listen to the columnists. People say, 'Just focus on one or two big things.'"

But, he continued, "we dove into all that because it needs to be addressed."

On a recent morning, Mr. Newsom's sleeves were rolled up, and he was digging into his budget, surrounded by an inner circle of advisers. California's economy is humming, pouring revenues into the state coffers. He said he wanted to give some of that money back to working families, in the form of a tax credit — an idea, aides noted approvingly,

that had once been championed by Republicans like Richard Nixon and Ronald Reagan.

Mr. Newsom was disappointed, though, with how his advisers proposed to brand his earned-income tax credit: “California EITC, a cost-of-living refund.” He said it sounded too wonky, just the sort of language, he said, that had alienated Democrats from ordinary Americans.

“Not a human being on planet Earth understands EITC,” he said. “Policy wonks are why Trump’s president.” (He lost the argument.)

It is proposals like the tax credit that Mr. Newsom and his aides point to as indications of how essential California is to the Democratic Party’s direction just as the presidential campaign gathers steam.

“Things are actually happening here,” said Ann O’Leary, Mr. Newsom’s chief of staff. “Kamala Harris is out there, she has a big EITC expansion,” she said, “well, we’re doing it right now. Cory Booker is out there with baby bonds. Well, we’re going to do that right now. Elizabeth Warren, her big proposal is on child care. And we’re really doing it comprehensively.”

“Eat your heart out, guys,” Mr. Newsom said of the candidates. “People say, ‘What does the Democratic Party stand for?’ I say, ‘Come out to California.’”

But California, given its size as the largest state, has long held outsized influence regardless of who the governor is. It is far from certain, too, whether Mr. Newsom will succeed in his goal of shaping the party’s agenda; while candidates are talking about similar policies, they are not holding up California as the example. And it is too early to say how far left the party will be pulled during the presidential campaign.

Neera Tanden, a former aide to Hillary Clinton and president of the Center for American Progress, a research and policy organization in Washington, D.C., placed Mr. Newsom’s administration in a national context. “The way I look at Gov. Newsom is he has the opportunity and responsibility to demonstrate how progressive governance can work,” she said.

“I think there will be a big question hanging over the national debate over the next two years about whether Democrats can deliver on prosperity,” she said. “There will be lots of attacks from conservatives. Being able to deliver a progressive agenda against a backdrop of a state that is growing, that is still having innovation, is really important.”

Ms. O’Leary is among a number of aides working for Mr. Newsom who previously worked for Ms. Clinton or President Barack Obama. She acknowledged the criticism that Mr. Newsom’s administration has taken a scattershot approach to governing, but said that many of the initiatives are about tackling the problem of how expensive life has become in California.

“We are at a moment in time where people will remember what he did or he will be part of the problem,” said Ms. O’Leary. “We now have over 60 percent of young people in California say they cannot afford to live in California. They can’t imagine how they are going to make it or stay in California.”

Daniel Zingale, who worked for three former governors — Mr. Brown during his first period in office in the 1970s, Gray Davis and Mr. Schwarzenegger — before becoming a communications aide to Mr. Newsom, said he had urged his new boss to focus his attention on a few key issues.

“I was just pointing out that there was a political advantage to having signature issues,” he said. “That’s just a political fact. But he made a more compelling argument that we live in these times of the fierce urgency of now, on a whole bunch of issues.”

Mr. Newsom makes no apologies for talking about many things, or for being a different style of leader than Mr. Brown. Mr. Newsom’s office is sparsely decorated: There is signed sports memorabilia; a photo of his late father, William, a judge, with Senator Robert Kennedy; and a decades-old snapshot of him and Ms. Harris at Tosca Café in San Francisco (“literally, we were kids,” he said).

Reflecting on how he sees his role as governor, he speaks in grand terms that inspire some, and grate on others.

“You can’t legislate spirit and pride,” he said. “I think about Reagan a lot, because this was his office. If there was one thing he captured, was a sense of pride. We talk about the California Dream. There’s the American Dream and the California Dream. That’s it. No other state is attached to a dream. We’ve lost a little of our self-confidence. And I want to restore that.”



The Health 202: Health-care worker shortages would be even worse without immigrants

Paige Winfield Cunningham

Health-care jobs are among the fastest-growing sectors in the historically low-unemployment economy President Trump loves to tout. It’s immigrants who fill a lot of them — something the president might consider as he seeks new limits on immigration.

Immigrants — both citizens and noncitizens — make up a disproportionate share of workers who care for the elderly and disabled and ensure their surroundings are safe, according to a study published this week in the health policy journal *Health Affairs*.

The study finds more than one-fourth of direct care workers and 30.3 percent of nursing home housekeeping and maintenance workers are immigrants, underscoring their key role as the U.S. population ages. They make up 18.2 percent of the total health-care workforce at more than 3 million people.

“This is a workforce responsible for everything from making sure the floors are clean and making sure our elderly and disabled don’t fall to washing linens and other things critical to wellness,” Leah Zallman, the study’s author and a physician at Cambridge Health Alliance, told me.

Health-care jobs — particularly those involving elder care — are expected to skyrocket in coming years as the baby boomers grow older. The Institute of Medicine has projected that 3.5 million more health-care workers will be needed by 2030. Immigrant health-care workers, who tend to be older and have more education than their nonimmigrant counterparts, are a key filler of these roles.

“Policies curtailing immigration will likely compromise the availability of care for elderly and disabled Americans,” Zallman wrote in her study.

It’s true that Trump isn’t exactly regarded as a pro-immigrant president. He’s currently seeking congressional support for cutting back on immigrant visas for relatives of U.S. citizens and replacing them with merit-based visas obtained through a points system. He has spent much of this year mired in battles with the Democrat-led House over funding for a border wall. House Democrats, however, passed a measure last night granting a pathway to citizenship for more than two million undocumented immigrants already in the country, including “dreamers,” though its chances in the Senate are poor.

Yet despite the president’s rhetoric, the number of people becoming U.S. citizens actually reached a five-year high last year, my Washington Post colleague Abigail Hauslohner reports.

Even as the administration pledged to tighten immigration protocols (Trump’s new ICE chief says he’ll increase family deportations), the government has maintained the same rate of approving citizenship applications. U.S. Citizenship and Immigration Services reported naturalizing 756,800 people in fiscal year 2018, a 16 percent increase from 2014. Approval rates for applications declined slightly, to just below 90 percent.

“In keeping with, and even exceeding, previous years’ totals for new citizens and green cards issued by USCIS, the report’s key statistics appear to suggest efforts to limit legal immigration have not taken root,” Abigail writes.

And a steady influx of immigrants bodes well for sectors such as the health-care industry, in which worker shortages could especially be felt as the country approaches what economists call full employment. Health care had the third-highest job gains in April, with 27,000 jobs added that month, after business services and construction, my Post colleague Heather Long reported.

“The U.S. economy added 263,000 jobs in April, notching a record 103 straight months of job gains and signaling the current economic expansion shows little sign of stalling,” Heather wrote.



Low-income Californians and Health Care

Liz Hamel, Lunna Lopes, Bryan Wu, Mollyann Brodie, Lisa Aliferis, Kristof Stremikis, and Eric Antebi

Introduction

Despite its large economy, California is also the state with the highest poverty rate (19 percent) according to the U.S. Census Bureau.¹ As Governor Gavin Newsom begins his tenure in office, Californians across income groups see health care as a key issue for the new governor and legislature to address. In late 2018, the Kaiser Family Foundation and the California Health Care Foundation conducted a representative survey of the state’s residents to gauge their views on health policy priorities and their experiences in California’s health care system. This summary examines key findings from the survey among “low-income” Californians, defined here as those whose self-reported incomes are below 200 percent of the federal poverty level (approximately \$49,000 for a family of four). Where relevant, they are compared to higher-income Californians — those with self-reported incomes at or above 200 percent of the federal poverty level.

Overall, the survey finds that while Californians at all income levels see health care as an important priority for the governor and legislative leaders to work on, health care affordability and access emerge as particularly prominent concerns among low-income residents of the state. Key findings include:

- Affordability of health care has affected treatment decisions for many low-income Californians, with over half saying that in the past year, they or someone in their family has delayed or forgone some type of medical or dental treatment due to costs.

- Californians with low incomes are almost twice as likely as higher-income residents to say they have had problems paying medical bills. As a result, many of those who experienced difficulty paying medical bills say they have had to cut back spending in other areas, use savings, or borrow money.
- Low-income Californians are also more likely than other residents to report nonfinancial barriers to accessing health care, such as long wait times to get an appointment. A majority of Californians with low incomes say their community does not have enough mental health providers, and about four in ten say their community lacks enough primary care doctors and specialists to meet the needs of residents.
- The distinctive health care experience of low-income Californians is also evident in their attitudes toward Medi-Cal. While overwhelming majorities of Californians across income levels say Medi-Cal is important to the state, low-income Californians are twice as likely as those with higher incomes to say the program is important to them and their families.



As Sharing Health-Care Costs Takes Off, States Warn: It Isn't Insurance

Stephanie Armour and Anna Wilde Mathews

Religious organizations where members help pay each other's medical bills have grown from niche insurance alternatives to operations bringing in hundreds of millions of dollars, an increase that is also driving more consumer complaints and state scrutiny.

More than a million people have joined the groups, known as health-care sharing ministries, up from an estimated 200,000 before the Affordable Care Act, which granted members an exemption from the law's penalty for not having health insurance. The organizations generally provide a health-care cost-sharing arrangement among people with similar religious beliefs, and their cost is often far lower than full health insurance.

Consumers typically pay a set monthly amount that goes into a general account or directly to others who have an eligible medical bill. They also submit their own eligible bills to be shared by other members.

As membership swells, more people have complained that their medical bills weren't paid or were paid months late. Some states said they have seen an increase in complaints filed with regulators. More negative reviews have also appeared online.

Because the ministries aren't regulated by state insurance commissioners, consumers have little recourse. Many legislatures have passed bills guarding the ministries from state regulation, on the grounds that the state shouldn't interfere in a religious organization.

Sharing ministries say the uptick in complaints is negligible when compared against the surge in membership. They also say they tell members they aren't buying insurance and that they have an appeals process for denied claims.

Unlike plans sold on the ACA exchanges, health-care sharing ministries have many limitations. Most don't cover pre-existing conditions or preventive services such as checkups and mammograms. They don't cover abortion and most birth control, and typically don't share bills for mental-health services or addiction treatment. They may have limits on the total amount that will be paid for any treatment.

Millions of dollars are at stake. Among some of the largest ministries, Christian Healthcare Ministries, based in Barberton, Ohio, reported \$340 million in revenue in its 2017 tax filing. Liberty HealthShare of Canton, Ohio, saw its total program revenue surge from \$6.5 million in 2015 to \$65 million in 2017. Samaritan Ministries International of Peoria, Ill., said its members shared \$1.2 billion in health-care bills from 2007 through 2017.

Insurance regulators in several states have taken action.

The Nebraska Department of Insurance in 2018 warned that health-care sharing ministries aren't insurance, aren't regulated and can't be forced to pay members' medical bills.

Last month, Washington's state insurance commissioner ordered two affiliated entities, Alera Healthcare Inc. and Trinity HealthShare, to stop sales in the state, saying Trinity wasn't a legitimate health-care sharing ministry and Alera's promotional efforts could mislead consumers into believing the products were insurance.

Mike Kreidler, the Washington insurance commissioner, said his agency is investigating other entities described as health-care sharing ministries.

"There are some other opportunists in the insurance business who are attempting to take advantage of what they perceive as a loophole," he said.

The insurance regulator in Texas has made similar allegations against Alera and Trinity, saying they weren't legitimate sharing ministries and were illegally operating as insurers, while spending a small fraction of customers' money on health care.

Aliera said it would “vigorously defend against the false claims.” Trinity said it is a bona fide health-care sharing ministry and is contesting the Texas inquiry. A Texas court recently temporarily blocked the state regulator from moving forward. A spokesman for the Texas regulator declined to comment on the court’s action.

The Ohio Attorney General’s office has received 18 complaints this year about Liberty HealthShare. The office declined to comment on whether it is investigating the organization.

“I got the sense they were growing so quickly and they couldn’t keep up,” said Rachel Payne, a 58-year-old fitness trainer and former member in Stone Mountain, Ga., who filed a complaint against Liberty HealthShare over a bill she said wasn’t paid at the time. “The concept is really a great idea, but you have to have a system that works.”

Health-care sharing ministries were relatively small in the 1980s, built on the notion that people should share each other’s burdens. Members pooled money and submitted their own bills for other members to pay. Checks would come in with notes of support and offers of prayer.

When the ACA was written, ministries won the exemption to health-insurance requirements—a carve-out for what at the time were relatively small groups that argued their nonparticipation in health-insurance markets was a matter of religious freedom. The entities also aren’t subject to ACA requirements that apply to insurers, such as covering pre-existing health conditions. That helps to lower their costs.

The exemption and the ministries’ lower costs have propelled growth. Official figures aren’t kept, but Samaritan Ministries says its membership swelled from 57,227 individuals in 2011 to 269,809 people today. Liberty HealthShare says it has 239,000 members.

Many ministries are nonprofits, or are part of religious organizations. They require members to practice a certain religious faith. But some have built membership by welcoming secular consumers. Top executives can command six-figure salaries.

A Bigger Niche

“Many have transformed to give the appearance of traditional insurance. As these entities grow, so too do the risks of consumer confusion,” according to a 2018 report by The Commonwealth Fund, which supports research on health-care issues.

Some ministries say they work to make the distinction clear. In marketing and communications, “we constantly try...to make clear that we are not insurance,” said Samaritan Ministries spokesman Anthony Hopp.

Jonathan Horgan of McLean, Va. said in an April 1 complaint with the Ohio Attorney General against Liberty HealthShare that he had paid in \$4,200 over six months and requested a reimbursement of \$153.60 for a valid service.

“They are over 90 days late,” he said in the complaint. “They do not respond to emails.”

Liberty HealthShare said Mr. Horgan’s submitted expense was renegotiated with his provider to lower the cost and paid by other members in 114 days.

Kristi Celico of Lafayette, Colo. said in an April complaint that she decided to leave Liberty HealthShare and obtain insurance because of problems getting responses from the organization.

“I couldn’t get anyone to answer the phone or respond to an email even about simple questions,” she said in an email.

Liberty HealthShare said Ms. Celico likely was trying to call during a period when its phone system vendor had technical problems. It said it was continually taking steps to improve technology and response time.

“We care deeply about our 239,000 members all across the country, and in 2018 we facilitated the sharing of over \$315 million in medical expenses,” said Terrie Ipson, a spokeswoman for Liberty HealthShare.



Data Note: Americans’ Challenges with Health Care Costs

Ashley Kirzinger, Cailey Muñana, Bryan Wu, and Mollyann Brodie

The cost of health care affects every aspect of the U.S. health care system. It dominates political discussions on health care, impacts decisions about insurance coverage, and ranks at the top of things Americans worry about. It also plays a significant role in the patient experience from decisions on whether or not to get care to the impact of medical bills after receiving care. This data note summarizes the most recent Kaiser Family Foundation polling on the public’s experiences with and worries about health care costs. Main takeaways include:

- Health care costs dominate public and personal discussions on health care. Americans consistently put health care costs at the top of their list when it comes to health care issues they want the government to address and for political candidates to talk about and recent KFF polling indicates health care costs now occupy a tier of their own on the public's list of pressing health care issues. Health care costs also top the list of household expenses the public worries about affording.
- Some insured adults report difficulty affording the routine costs of health insurance. While majorities of those with health insurance report that it is easy (either "very easy" or "somewhat easy" for them to afford to pay the routine costs of health insurance like premiums and deductibles, some insured adults (at least one-fourth) say it is difficult for them to afford these routine costs. In fact, one-third (34 percent) of insured adults say it is either "very difficult" or "somewhat difficult" for them to afford to pay their deductible.
- Costs can be prohibitive to Americans seeking or adhering to health or dental care. Half of U.S. adults in the past year say they or a family member delayed or skipped care — or relied on an alternative treatment — because of costs.
- Health care costs stop people from getting needed care or filling prescriptions. Half of U.S. adults say they or a family member put off or skipped some sort of health care or dental care or relied on an alternative treatment in the past year because of the cost, and about one in eight say their medical condition got worse as a result. Three in ten of all adults (29 percent) also report not taking their medicines as prescribed at some point in the past year because of the cost.
- Difficulty paying medical bills can have significant consequences for U.S. families. About one-fourth of U.S. adults (26 percent) say they or a household member have had problems paying medical bills in the past year, and about half of this group (12 percent of all Americans) say the bills had a major impact on their family. Medical bill problems also disproportionately affect sicker populations like individuals living in households with a serious medical condition.
- Individuals with employer-sponsored insurance coverage are not immune to problems with health care costs. Many problems associated with the cost of health care coverage and services in this country are frequently attributed to the share of the population who are uninsured or buy their own coverage. Yet, KFF polling finds that even individuals with employer-sponsored insurance, especially those in high deductible plans, have difficulty affording their health care or health insurance, or report problems paying medical bills.
- Some populations experience the most difficulty with affording the cost of their health care and health insurance. Individuals living in households where someone has a serious medical condition, the uninsured, and those with lower-incomes are more likely to struggle with medical bills and report putting off care because of cost.

Cost Issues Dominate Political and Public Discussions of Health Care

Americans have consistently put health care costs at the top of their list when it comes to health care issues they want the government to address and for political candidates to talk about. Prior to the passage of the 2010 Affordable Care Act, politicians spoke frequently about health care during elections with equal attention paid to “health care costs” as “access to coverage.” For example, leading up to the 2008 presidential election, a KFF Health Tracking Poll found that “reducing the cost of health care and insurance” (41 percent) was the top health care issue chosen by voters from a list of possible health care issues, but it was closely followed by “expanding health coverage for the uninsured” (31 percent). Since the implementation of the ACA, health care costs now occupy a tier of their own on the public’s list of pressing health care issues. For example, leading up to the 2018 general election, KFF found at least twice as many voters said they wanted hear candidates talk about health care costs (27 percent) as any other health care issue such as increasing access or decreasing the number of uninsured people (11 percent) or universal coverage (8 percent).



2 health organizations sue to stop new federal health rules

Larry Neumeister

NEW YORK (AP) — Two health organizations sued the federal government Tuesday to stop a new policy creating obstacles for women seeking abortions.

The National Family Planning & Reproductive Health Association and Public Health Solutions Inc. sued the U.S. Department of Health and Human Services in Manhattan federal court, joining other women’s groups, organizations and multiple states seeking to reverse the rule announced in February.

In the lawsuit, the groups labeled as “arbitrary, capricious and an abuse of discretion” the rule letting health care clinicians object to providing abortions and other services that conflict with their moral or religious beliefs. It was filed by lawyers for the American Civil Liberties Union and the New York Civil Liberties Union.

A similar lawsuit was filed last month in Manhattan by nearly two dozen states and municipalities.

In a release, the organizations said that the rule would let a hospital receptionist refuse to schedule an appointment for a transgender patient seeking gender-affirming care or

allow an orderly to refuse to move a patient to the operating room for an emergency abortion.

The Department of Justice, whose lawyers would represent the federal government, did not return a message seeking comment.

“Freedom of religion is a fundamental right, but it cannot be used to harm others — especially when that includes withholding emergency care or critical information about patients’ health,” said Alexa Kolbi-Molinas, an attorney with the ACLU’s Reproductive Freedom Project.

“The rule could eviscerate the delivery of high-quality family planning services in this country,” said Clare Coleman, head of the National Family Planning & Reproductive Health Association, which represents over 850 health care organizations nationwide that serve millions of people, including over 3.7 million low-income, uninsured and underinsured individuals.

“This discriminatory rule will undermine access to health care for populations nationwide and roll back the years of progress we’ve made on advancing the quality of family planning services,” said Lisa David, president of Public Health Solutions, which annually serves 105,000 primarily low-income individuals and families in New York.

Other organizations which have sued include the Planned Parenthood Federation of America, the National Women’s Law Center and Democracy Forward.



Romney says he has new plan to replace ObamaCare

Peter Sullivan

Sen. Mitt Romney (R-Utah) said Wednesday that he has a new plan to replace ObamaCare.

“It’s a replacement for ObamaCare,” Romney told The Hill. “We’re ready with that, but we’ll see what kind of support we get.”

Romney commands a certain stature in the Senate as the former GOP presidential nominee. But Senate Majority Leader Mitch McConnell (R-Ky.) has made clear that he does not want to dive back into the divisive ObamaCare debate.

In April, McConnell shut down a push by President Trump to work on a new ObamaCare repeal and replacement plan.

A spokesman for McConnell declined to comment when asked about Romney's effort on Wednesday.

Romney did not provide any details of what his replacement plan entails. His office also declined to elaborate.

Even if Senate GOP leaders were interested in Romney's plan, it has no chance of becoming law this year or next, given Democratic control of the House.

As governor of Massachusetts, Romney signed into law a plan that is widely seen as a precursor to ObamaCare. In later years and as a presidential candidate in 2012, Romney fiercely opposed the federal health law.

The existence of Romney's plan was first reported by Bloomberg on Wednesday.

Several GOP Senate offices said Wednesday that they had not heard anything about Romney's ObamaCare replacement plan or what is in it.

Democrats have been eagerly attacking Republicans over their efforts to undermine ObamaCare, including a GOP-backed lawsuit currently making its way through the courts that seeks to overturn the entire health law.

Democrats used GOP ObamaCare attacks as a key issue in their electoral victories last year, and many Republicans have been seeking to move past those attacks this year and instead focus on bipartisan health care efforts like reducing the cost of prescription drugs.

Asked when he will release his plan, Romney indicated he is seeking to gain support from his colleagues first.

"It depends on the support, or lack thereof," he said.



California to become first state to extend healthcare benefits to some undocumented immigrants

Klarize Medenilla

California is closer to becoming the first state to guarantee health coverage for eligible undocumented immigrants after state Democrats on Sunday, June 9 agreed to the plan first proposed by Gov. Gavin Newsom.

As previously reported in the Asian Journal, Newsom's May budget revision includes a statewide health care plan that would expand Medi-Cal (California's state Medicare program) to all working low-income residents under the age of 26, regardless of citizenship status.

The governor's budget proposal was approved by the California Legislature's Conference Committee on the Budget in the Democratic-led legislature. The Medi-Cal expansion would cost nearly \$100 million and would provide "full-scope coverage" for more than 130,000 undocumented people in the first year, according to the budget summary.

About 75% of all eligible immigrants already receive coverage through Medi-Cal or receive benefits through SB 75.

Newsom's plan satisfies two of his campaign promises: maintain California's status as a sanctuary state and move the state more toward a universal health care plan that believes "in covering everybody regardless of immigration status," Newsom said during a recent teleconference.

The Medi-Cal expansion is only a part of the wide-ranging changes Newsom plans to make within the state's public health care system. Newsom also plans to reinstate a version of the individual mandate imposed by the Affordable Care Act, which would penalize individuals who forego health insurance coverage. The GOP rolled back the individual mandate on a federal level in 2017.

California may also become the first state to extend eligibility for health insurance subsidies under Covered California to middle-class families that earn a maximum of 600% below the federal poverty level. A family of four may earn up to \$154,500 a year and still qualify for a discount.

Both the Medi-Cal expansion and the subsidies extension would partially be funded tax dollars generated from the individual mandate's tax penalty.

Newsom's budget plan are currently pending final approval from both the Senate and the Assembly, which are going to review the proposal later this week — the deadline for a new state budget is Saturday, June 15.



Top Trump health official warned against controversial ObamaCare changes in private memo

Peter Sullivan

A top Trump administration health official warned against controversial changes that could undermine ObamaCare in a private memo last year that was released by House Democrats on Friday.

One of the three changes was later finalized by the administration, despite the warning from Centers for Medicare and Medicaid Services Administrator Seema Verma in the memo. And the other two have not yet been proposed but remain under consideration.

House Democrats said Friday the fact that the administration approved an alteration that could undermine ObamaCare over the objections of one of its own top officials shows that the Trump administration is intent on “sabotage” of the Affordable Care Act. The August 2018 private memo to Secretary of Health and Human Services (HHS) Alex Azar shows Verma was concerned with keeping ObamaCare markets stable and preventing disruption, but on at least one front was overruled by others in the administration.

The first change was a proposal to alter an index that is used to calculate how much money ObamaCare enrollees get in subsidies to help afford coverage, resulting in cuts.

Verma warned in the memo that the change would cause “coverage losses, further premium increases, and market disruption.”

But the administration went ahead with the change in early 2019 anyway. Administration estimates project that the move will save the government about \$1 billion per year in lower subsidy payments, but will result in 70,000 people dropping coverage.

The second change Verma warned against was a proposal to ban “silver-loading,” a workaround that helped prevent premium increases after President Trump canceled key ObamaCare payments to insurers in 2017. Verma warned in the memo that ending the practice would cause “significant disruption” and “substantial premium increases.”

The administration has not moved to end the practice since then, but officials have said the idea is under consideration, causing alarm among Democrats about the potential damage to ObamaCare.

The third change Verma warned against was ending automatic reenrollment, whereby ObamaCare enrollees’ coverage is automatically renewed for the next year unless they actively choose to end it or switch plans.

Verma cited estimates showing the move would cause 200,000 people to lose coverage.

That change has also not happened yet, but remains under consideration.

Three House Democratic chairmen, Energy and Commerce Committee Chairman Frank Pallone Jr. (N.J.), Ways and Means Committee Chairman Richard Neal (Mass.) and Education and Labor Chairman Bobby Scott (Va.), wrote to Azar on Thursday demanding more documentation about HHS’s analysis of the possible changes, and calling on Azar not to go through with them.

“We call upon the Administration not to finalize these proposed policies, which the Administration itself admitted would cause chaos in the individual market,” the chairmen wrote.

“I can confirm that we have received the letter,” an HHS spokesperson said Friday when asked for comment on the letter and Verma’s memo. “All congressional inquiries are taken seriously by the department and we will respond as appropriate in a timely fashion.”

A spokesperson for Verma referred questions on the memo to HHS.



The Health 202: Trump administration rule opens door to more people buying Obamacare plans

Paige Winfield Cunningham

In its latest move to roll back Obamacare regulations, the Trump administration is ironically opening the door to more people buying....Obamacare plans.

This afternoon, President Trump will announce from the Rose Garden the final stage of his three-pronged executive order aimed at giving Americans more health insurance options. Trump issued the order back in October 2017, trying to show he was carrying out his promises to pull back on the Affordable Care Act even after Congress had spent the summer trying – and failing – to repeal it.

But unlike Trump's first two regulations – which involved encouraging people to buy plans that might not fully comply with Affordable Care Act requirements – this latest rule would allow employers to send their workers into plans that do comply with the ACA.

Under the rule, which three federal agencies released yesterday, employers could opt out of providing workers with health coverage, instead giving them tax-free money to buy a health plan on their own. It lifts Obama-era restrictions from these tax-free accounts, known as Health Reimbursement Accounts, giving employers a way to ensure their workers get covered without having to actually administer a group health plan.

"The rule will provide hundreds of thousands of businesses a better way to offer health insurance coverage and millions of workers and their families a better way to obtain health coverage," Joe Grogan, director of the White House Domestic Policy Council, told reporters.

From Seema Verma, administrator of the Centers for Medicare and Medicaid Services:

[View image on Twitter](#)

[View image on Twitter](#)

Administrator Seema Verma ✓

@SeemaCMS

My Statement on the Administration's Action to Expand Access to Quality, Affordable Health Coverage Through Health Reimbursement Arrangements

<https://www.hhs.gov/about/news/2019/06/13/hhs-labor-treasury-expand-access-quality-affordable-health-coverage.html> ...

Health and Human Services Secretary Alex Azar:

Secretary Alex Azar ✓

@SecAzar

.@POTUS has promised Americans that he will put them in control of their #healthcare, and this expansion of health reimbursement arrangements provides millions of Americans with more options that better meet their needs:

<https://www.hhs.gov/about/news/2019/06/13/hhs-labor-treasury-expand-access-quality-affordable-health-coverage.html> ...

House Minority Leader Kevin McCarthy (R-Calif.):

Kevin McCarthy ✓

@GOPLeader

This is GREAT news from the Trump Administration → More health care options lead to better quality care. <https://twitter.com/USDOL/status/1139268334271303697> ...

US Labor Department ✓

@USDOL

.@USDOL, @USTreasury, and @HHSGov announced a final rule that will help expand access to quality, affordable health coverage. 800,000 workers at small and mid-size businesses and their families are expected to gain health coverage under the rule: <https://www.dol.gov/newsroom/releases/ebsa/ebsa20190613> ... #HRAs

Under the rule, employers could skip a traditional group plan and instead offer workers an HRA, from which they could withdraw funds to buy an ACA-compliant health plan in the individual market. Or, employers could continue to offer group coverage but also deposit money into a different type of HRA, one that could be used to buy additional benefits like vision or dental coverage. Under that second scenario, employees could choose to forgo the group coverage and use the HRA to buy a short-term health plan.

“This is the end and culmination of that executive order and closes out all the actions called for when President Trump signed the executive order,” Grogan said.

Of the 180 million Americans who get coverage from their employers, those who work for small firms are most likely to be affected by the new rule because they struggle the most to afford health coverage, officials said. Brian Blase, special assistant to the president on the National Economic Council, noted that there’s been a decline in small businesses that offer health coverage and pointed to data that even large employers are offering fewer insurance choices to their worker amid rising costs.

“We expect this rule will reverse those trends,” Blase said.

The Treasury Department estimates that 800,000 employers will eventually offer HRAs to more than 11 million workers and their families, although outside experts cautioned it’s hard to estimate how many firms might avail themselves of the new opportunity.

“This is really a very different way of doing things,” said JoAnn Volk, a research professor at Georgetown University’s Center on Health Insurance Reforms. “Instead of a group health plan the vast majority of Americans depend on, you could instead be given a fixed amount of money to go shopping on your own.”

The HRA rule has received much less attention from Democrats than the administration’s expansion of short term and association health plans. They’ve devoted much time and energy to blasting those plans, accusing the administration of allowing “junk” insurance that fails to cover many of the medical services consumers need. Last month, the House passed legislation reversing the expansion of short-term plans, using it as a fresh opportunity to highlight all the ways they say the administration is undermining the ACA.

From Rep. Lauren Underwood (D-Ill.):

Lauren Underwood ✓

@LaurenUnderwood

My first bill just passed the House! 🎉🎉🎉 An essential part of improving our health care system: banning junk plans that don't actually cover pre-existing conditions or vital services. H.R. 1010 does just that. Onward!

Sen. Tammy Baldwin (D-Wis.):

Sen. Tammy Baldwin ✓

@SenatorBaldwin

Trump's expansion of junk plans that don't have to cover people with pre-existing conditions puts more power back in the hands of big insurance companies. I'm going to the Senate floor again to call for a vote on my #NoJunkPlans Act.

In contrast, the HRA expansion has received mostly positive feedback. Employers and insurers have generally been in favor of it, although they’ve cautioned that without adequate protections it could result in employers sending their sicker, more expensive workers into the marketplaces while retaining group coverage for the healthier workers. That could in turn worsen the ACA marketplaces, driving up premiums for everyone.

The final regulation, which closely mirrors what the administration proposed last fall, tries to circumvent that problem by requiring that employers choose between offering a group plan or an HRA to all employees. If they choose the HRA option, they must offer

it on the same terms to all employees within the same class, like full-term workers versus part time workers.

"We commend the administration for taking what we believe is an important step toward greater flexibility in health care coverage," said Jim Klein, president of the American Benefits Council, which represents large employers. "We now call on lawmakers to work together to stabilize the insurance marketplaces, including measures to address costs."

The regulation could be helpful to some American workers whose employers offer coverage that's still unaffordable, Volk said.

"There may be individuals that are better off if their employer was offering coverage that was widely too expensive," she said. "And it might be good for the marketplaces because they'll get a lot of new bodies."

POLITICO PRO

California relies on federal funds to expand undocumented health coverage

Angela Hart

SACRAMENTO — California is poised to adopt a sweeping health care expansion that extends full Medicaid benefits to undocumented young adults — with the expectation that the Trump administration will foot some of the bill despite the president's aggressive stance against illegal immigration.

California will soon become the first state in the nation to provide full publicly financed health coverage to a segment of undocumented adults, a critical component of Gov. Gavin Newsom's long game to create a universal health care system in the nation's most populous state.

Federal law generally prohibits states from using federal funds to pay for undocumented health coverage. But California officials say they have a way to offset about a quarter of the expansion cost using Medicaid dollars — nearly \$24 million of the \$98 million price tag in the first year.

Federal law allows state reimbursement for emergency and labor and delivery care for undocumented immigrants, dating back to a 1986 law intended to prevent hospitals from dumping patients on the street.

California plans to bill the federal government for those services for an estimated 90,000 new undocumented enrollees age 19 to 25 in Medi-Cal, the state's Medicaid program, according to Department of Finance spokesperson H.D. Palmer. The state will pay for a

richer suite of Medi-Cal benefits on its own, including preventive and primary care, prescription drugs and hospitalizations.

The price tag will grow in future years, with total program costs projected at \$315 million in 2021. California will pay most of that — \$247 million — but bill the federal Centers for Medicare and Medicaid for the remainder. Those costs could rise and fall with changes in projected caseload and the use and intensity of services as more undocumented adults become eligible, according to the Newsom administration.

California officials are so certain that they're on firm ground that Palmer said if the federal government were to object, "Congress would have to overturn federal law that has governed this issue and been on the books since 1986 under the Reagan administration."

CMS confirmed Friday that California's approach appears to be legal as long as the state adheres to existing requirements in Medicaid law. Spokesperson Johnathan Monroe told POLITICO that "illegal immigrants who otherwise meet the requirements for Medicaid in any state are entitled to receive services necessary for the treatment of an emergency medical condition, which includes labor and delivery for illegal immigrant pregnant women."

The federal government already covers a portion of the overall cost of the state's expansion of full-scope Medi-Cal to undocumented immigrant children through age 18, a program that started in 2016.

The consensus among Newsom administration officials and health policy experts interviewed by POLITICO is that the state is well within its existing authority to use federal money to cover a portion of Medi-Cal costs for undocumented young adults. But the state must be careful to only seek federal reimbursement for emergency services and labor and delivery care, said Cindy Mann, who served as the federal Medicaid director under former President Barack Obama from 2009 to 2015.

"There is a federal part, but it's no different than what exists today," she said. "People who would otherwise be eligible for full-scope Medicaid but aren't because of their immigration status, the federal government pays for emergency Medicaid — emergency hospitalizations and labor and delivery."

California health officials "have to establish, to the satisfaction of the federal government, that they are only paying for emergency Medicaid services," Mann added. "The state is absolutely responsible for assuring that only the appropriate claims get sent to the federal government If they submit a claim and CMS says it's improper, CMS will recoup those dollars."

Carter Price, a senior mathematician and federal Medicaid expert with the RAND Corporation, a Washington, D.C.-based think tank, said California stands out as a state that's willing to test the boundaries of the low-income health benefit. Outside California, five other states and the District of Columbia have expanded their Medicaid programs to

cover undocumented children, according to the National Conference of State Legislatures.

"Folks are going to receive health care one way or the other," Price said. "It's fighting over how it's paid for."

Still, California could face political backlash from the Trump administration or the president himself, said Larry Levitt, senior vice president for health reform at the Kaiser Family Foundation. The president has sought to undo Obamacare, impose Medicaid work requirements and stem the flow of immigrants into the country — most recently by threatening tariffs with Mexico.

Even more directly, Trump last year proposed a "public charge" rule that would penalize green card applicants who have used public services, including Medicaid.

"This is now a different political context with immigration being such a flash point nationally and California stepping out in front and expanding coverage for undocumented immigrants," Levitt said. "Between the governor and the attorney general, California has certainly been a thorn in the side of the Trump administration ... and they have staked out positions themselves as public opponents, so I could imagine the Trump administration using this to score political points.

"But it's not clear to me how there could be retribution," he said.

Because the Trump administration doesn't consider the portion of expanded health care services it'll pay for a new entitlement, it appears California is safe from Trump administrative backlash. But not from the wrath of his 2020 campaign, considering his rapid response director, Andrew Clark, lashed out Monday on Twitter against California Democrats for "providing health care to illegal immigrants" and "taxing people (legal residents!) who don't have health insurance."

Newsom, in an exclusive interview this week with POLITICO, said that kind of attack doesn't bother him.

"I'm sure rhetorically he'll have at it, but so what," he said. "I have no doubt that someone who doesn't believe in expanding health care would be opposed to a state that is If I'm going to be worried about Donald Trump's feelings, and Tucker Carlson's feelings and Fox News' feelings, then I won't be taking care of the people in this state and I won't be doing justice to this position and to millions of Californians that will benefit because of our health care expansions."

Democrats argue that universal health care, including coverage for undocumented residents, will ultimately help control rising costs by reducing expensive emergency room visits and ensuring a healthier population.

But legislative Republicans said they're concerned about using taxpayer dollars for non-citizen health care and how Trump may respond to being an unwilling participant in California's Medi-Cal expansion to undocumented immigrants.

California still needs federal approval for expansions of opioid treatment and optional Medi-Cal benefits previously cut during the recession. Higher Medi-Cal provider payments also require federal signoff, as does a \$63 million proposal to provide free coverage for low-income seniors, half funded by the federal government.

The state also plans to ask CMS to approve an extension of its managed care organization tax and, come 2020, a new Medicaid waiver to administer a broad range of health care, mental health and homelessness prevention innovations. Those are worth billions of dollars.

"There's a lot of concerns that with the ongoing political battles between the Newsom administration and the Trump administration, that money gets pulled back, which would have further adverse effects that could cause more pressure on the general fund," said Assemblyman Devon Mathis (R-Visalia). "We've seen this happen in recent months with high-speed rail. Ultimately what happens is our citizens and their families are the ones that suffer."

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

Trump's assault on Obamacare was much more damaging than previously thought

Michael Hiltzik

Donald Trump opened his presidency in January 2017 with a series of salvos aimed at the Affordable Care Act, the signal achievement of his predecessor's administration.

It has long been assumed that these attacks reduced signups during the crucial final weeks of open enrollment for 2018 insurance policies. New data parsed by two experts at Duke University and the University of North Carolina show how steep the reduction was. Spoiler: It was huge, and devastating.

That's because the drop-off was concentrated among the healthiest group of potential enrollees. They're the ones who often wait until the last minute to sign up, and therefore were still pondering their options on Inauguration Day, Jan. 20, and up to the enrollment deadline of Jan. 31.

"It's a flip of a coin whether they're going to sign up at all," David Anderson of Duke, the paper's lead author, told me. Because they're healthier and thus cheaper to cover, losing them from the overall insurance pool means higher premiums for everyone else.

The very first executive order of Trump's term, issued on Jan. 20, signaled that enforcement of the ACA's individual mandate effectively would cease. The order encouraged the Department of Health and Human Services to "waive, defer, grant exemptions from, or delay the implementation" of any parts of the ACA if it found they would "impose a fiscal burden" on individuals or states. Trump pledged to repeal the ACA, which he assailed as a failure and a "disaster." He canceled TV and radio advertising scheduled for the end of January urging people to enroll.

All this signaled that the atmosphere surrounding the law had dramatically changed. The general effect was noticeable, with enrollments for 2017 via the federal government's healthcare.gov website, which handled signups for more than 30 states, falling by about 400,000, or more than 4%, from 2016.

The paper by Anderson and Paul Shafer of UNC, which is published in the peer-reviewed *Journal of Health Politics, Policy and Law*, focuses on the final two weeks of open enrollment for 2017. They found that enrollment fell by a stunning 30% in that period compared to the same period a year earlier under President Obama, when outreach, advertising and hands-on enrollment assistance was robust. That's enough to account for at least a percentage point or two in increased premiums.

"The lack of political support for the law by the incoming administration seemingly had an immediate and significant downward effect on Marketplace enrollment nationwide," Anderson and Shafer write.

"Messaging matters," Anderson says, "especially for the least attached chunk of the population."

It's important to consider the difference between the late and early enrollees. Most people have a decent sense of their likely medical costs for the coming year, barring a surprise injury or diagnoses.

As Anderson observed in a blog post, "Folks who know that they are likely to incur ... \$100,000 or more in claims are very likely to sign up for health insurance that is community rated, guarantee issued and heavily subsidized no matter what the messaging regime is.... They will crawl through glass for coverage."

State by state drop-offs in ACA enrollment after Trump's inauguration reached more than 80% in some states.

These are people with chronic diseases or ongoing, expensive disease treatments; those eligible for an ACA plan probably signed up even before election day on Nov. 8, 2016. (Open enrollment started on Nov. 1.) They wouldn't wait until the last minute, in part because enrollments after mid-January would be effective only on March 1.

"Folks who think it is likely that they will be in the bottom 50% of the US healthcare spending distribution (\$0-\$1,000 in total spend) tend to enroll late," Anderson blogged.

“They are the ones who need strong encouragement to go onto the Exchanges and buy.”

They’re also strongly needed by the insurance pool. According to Matthew Fiedler of the Brookings Institution, the late enrollees tend to be 15% to 27% cheaper to cover than the pool as a whole. In effect, they’re subsidizing the general population. This may look unfair, superficially, but of course they’ll benefit if they get surprised by an injury or illness, and in time they’ll age into the population that tends to incur higher costs.

Most people incur modest medical spending during any given year, but they’re the enrollees most needed by the health insurance pool.

Trump, as is well known, has followed his initial assaults on the ACA with consistent sabotage. He cut outreach, advertising and enrollment assistance to the bone for 2018 and later kept pressure on congressional Republicans to repeal the law. He’s moved to widen access to junk insurance plans that the ACA aimed to eradicate, with the fatheaded claim that because they’re cheaper they must be better for consumers. As recently as this weekend, he claimed to have a replacement law in the works.

Not all these steps have worked out as Trump expected. His cancellation of reimbursements to insurers for premium and deductible subsidies they’re required to offer the poorest enrollees led to an increase in federal premium subsidies generally, which actually made most ACA plans more affordable for subsidized consumers. And the steady drumbeat of threats against Obamacare has actually made it more popular among the general public, which has become fully alive to how Republican repeal would jeopardize their health insurance coverage.

There may be more arrows in Trump’s anti-ACA quiver. Republicans are seemingly aware that this isn’t a good look for them, as the Democrats have made protecting Americans’ health coverage a central plank in their platform, and used it to rout the GOP in 2018 House races.

POLITICOPRO

Taxpayer advocates say California's health coverage mandate is a tax, but experts say not so fast

Angela Hart

SACRAMENTO — Democratic lawmakers are expected this week to approve a health budget bill to reinstate the requirement for Californians to have health care coverage or pay a tax penalty — despite Republican opposition and legal threats from taxpayer groups arguing the way California is passing it constitutes an illegally imposed tax.

The coverage mandate, set to go into effect in January 2020, would require most Californians to have health insurance or face annual tax penalties of \$695 per adult per year or 2.5 of annual household income — whichever is higher.

California would then join New Jersey, Vermont and the District of Columbia, which have enacted state-level individual health coverage mandates after President Donald Trump and the Republican-controlled Congress in 2017 zeroed out the individual mandate tax penalty under Obamacare, as part of a federal tax overhaul. Without an enforcement mechanism, the health care mandate is effectively useless.

The state-level coverage mandate faces little resistance in the California Legislature, where Democrats hold supermajority power in both houses. Lawmakers are poised to vote on the health budget bill enacting the mandate this week, sending it to Gov. Gavin Newsom. The Democratic governor considers it a major component of his sweeping health care agenda and is slated to sign the bill into law next week.

But the state's swift rollout could be stymied. Taxpayer advocates, arguing that forcing people to carry health coverage or pay a tax penalty is the same as passing a tax, are vowing to sue the state of California if lawmakers approve the plan without abiding by California's two-thirds vote threshold needed to pass new taxes.

"There's no reason for California to adopt any new taxes, but if they attempt to impose it with less than two-thirds of each house, the odds are very high that we will litigate the issue," said Jon Coupal, president of the Howard Jarvis Taxpayers Association. "On the question of is this a tax or is it not a tax, there is no higher authority in the United States of America than the U.S. Supreme Court, and it says the individual mandate, in the context of Obamacare, of course is a tax so it's a pretty clear issue."

The Legislature and the Newsom administration, however, say they only need a simple majority vote.

"This is a penalty and, under the state Constitution, this is deemed to be a majority vote measure," said Department of Finance spokesperson H.D. Palmer. "The state is imposing this penalty ... not the federal government, so it is state law and the state Constitution that governs this measure."

Legal experts on state and national health care law and policy say the 2012 U.S. Supreme Court decision, in which Chief Justice John Roberts said the individual mandate under the Affordable Care Act falls within Congress's taxing power, may influence a legal case in California, but the federal court's ruling does not trump the California Constitution or set in place rules for how the state must go about passing its own health coverage mandate.

Just because the U.S. Supreme Court said it can be considered a tax, that has no bearing on whether California passes it as a tax or a penalty, experts said.

"How to characterize what the California Legislature is up to is not a matter of federal law — it's a matter of state law, and the U.S. Supreme Court has nothing to say about the meaning of state law," said Nicholas Bagley, a law professor at the University of Michigan specializing in federal health care law who has argued in support of Obamacare. "The way you characterize what is and isn't a tax may differ between the California courts and the federal courts. They are two different legal systems, and it's totally OK for them to reach two different legal conclusions."

"The Supreme Court case was all whether the U.S. Congress had the power to adopt a particular law. That doesn't really bear on the scope of California's power to adopt a similar statute," Bagley said.

Ann Marie Marciarille, a law professor specializing in health care law at the University of Missouri-Kansas City, said though there legal areas in which federal law would preempt state law, she doesn't believe this one would.

"If this went to court, it would be about the applicability of the California state Constitution," Marciarille said. "Doesn't mean it wouldn't be a terrific fight."

California Republicans in both houses have voiced opposition to the health coverage mandate in recent weeks, casting it as a flawed public policy that taxes poor and middle-income Californians who, without employer-sponsored coverage, are struggling to afford rising health insurance premiums in a state that has also seen housing costs skyrocket.

While the matter received little debate at a budget committee hearing Wednesday, the health budget bill passed — but without Republican support. In brief comments, Sen. John Moorlach (R-Costa Mesa) suggested the mandate should be characterized as a tax, but finance department officials rejected that assertion.

"We believe under California law it is a penalty and not a tax," said Vivek Viswanathan, chief deputy director for budget at the Department of Finance, responding to Moorlach.

Political tension over the mandate, the most unpopular Obamacare provision, was evident even among some Democrats. During the vote, two Democratic lawmakers walked out of the committee room, declining to vote on the overall health budget bill. One is Sen. Melissa Hurtado (D-Sanger), who represents the Central Valley and previously raised concerns about requiring people to have something they can't afford.

Newsom and Democratic lawmakers say California needs the mandate and corresponding power to impose an annual tax penalty to encourage more young, healthy people to join the individual market and to forestall further drops in coverage.

Having a robust level of healthy people in the market will help stabilize rising health insurance premiums, which increased nearly 9 percent this year — a jump exchange officials say is largely a result of the federal axing of the individual mandate tax penalty.

California is also counting on revenue generated from fining the uninsured to pay for a massive increase in state-funded health insurance subsidies. As part of a pair of identical health budget bills made public this week, California for three years beginning in 2020 will offer deeper subsidies to offset health insurance premiums for low- and middle-income Californians.

Penalties are projected to generate \$317 million in 2020 — a year after the mandate takes effect, followed by \$336 million in 2021 and \$353 million in 2022.

The state kicked in \$450 million in general fund money to bolster the subsidies, for a total of \$429,000 in state subsidies in the upcoming budget year beginning July 1. Next year the subsidy revenue will grow to \$480 million and \$547 million in year three. The spending is expected to lower premiums \$10 to \$100 per month for Californians up to 600 percent of federal poverty — far higher than the income threshold set under Obamacare.

Subsidies will also zero out premiums for low-income people who haven't worked enough hours in their lifetime to qualify for Medicare but have too much in the bank to qualify for Medi-Cal. It would also cover premiums for Californians who would qualify for Medi-Cal but don't because of their immigration status, including asylum-seekers, those under temporary protected status and temporary visa holders.

They will sunset after three years, while the mandate will remain law. "This is a deep commitment to the middle-class and working families," Newsom told POLITICO in an interview last week. "I think it's spectacular."

CaliforniaHealth —REPORT—

For Many Low-Income Californians, Health Care is Still Too Expensive

Claudia Boyd-Barrett

Despite health coverage gains under the Affordable Care Act, many low-income Californians are still struggling to afford medical care, with more than half reportedly delaying treatment because of cost, a recent survey found.

Almost a third of state residents making under 200 percent of the federal poverty level—about \$49,000 annually for a family of four—said they had problems paying medical bills in the past year, according to the survey of more than 1,400 people conducted by the Kaiser Family Foundation and California Health Care Foundation.

Affordability barriers prompted 55 percent of low-income people or their household family members to delay getting medical or dental treatment in the past year, such as

check-ups, tests, prescriptions and mental health care. By comparison, 36 percent of higher-income residents and their family members delayed care, the report found.

Even when they did get medical or dental care, a majority of low-income Californians had difficulty paying for it. Almost three quarters of low-income residents said they had to cut spending on other household items to pay medical bills, and about 6 out of 10 said they'd gutted their savings, put off vacations, or had to borrow money from family or friends to pay their medical bills.

"Affordability is really a problem among low-income Californians when it comes to health care," said Lunna Lopes, survey analyst with the Kaiser Family Foundation. "We found it pretty striking to look at low-income Californians ... compared to wealthier residents."

California has the highest poverty rate in the nation, when taking into account the state's housing costs and other basic living expenses. Almost one in five state residents lives in poverty.

A recent budget deal approved by the state legislature is expected to ease some of health care expenses burden on low and moderate-income families. The budget, which is still awaiting Gov. Newsom's approval, expands subsidies for people who purchase health insurance on the state's Covered California exchange. It also reduces the amount of money some seniors have to pay toward coverage under the state's Medi-Cal health insurance program, a situation known as the "senior penalty."

"This budget includes significant new help for Californians to better access and afford coverage," said Anthony Wright, who leads Health Access California, a statewide coalition of dozens of health care consumer advocacy groups. "This includes big steps toward a more affordable and accountable and universal health care system."

Nevertheless, it's unclear whether the budget will ease another major concern for low-income residents: access to providers, including mental health practitioners. Low-income Californians were more likely than wealthier residents to report that their community lacked enough hospitals, primary-care doctors and specialists.

Access to mental health care and substance-use treatment was a particularly big concern. About half of all Californians surveyed said they were concerned about a lack of access to these types of services.

"It was quite surprising to see mental health access come across as a real priority," Lopes said. "That's not just among low-income Californians but among all Californians."

New Trump insurance rule could help Obamacare — or hurt it

Paul Demko

The Trump administration's latest health insurance initiative could deliver a surprising enrollment jolt for Obamacare. Or it could become the newest headache for a law the administration detests.

Administration officials touted last week's rule expanding health reimbursement arrangements as the final piece of its efforts to promote alternatives to Obamacare coverage, after making it easier to enroll in short-term and association health plans exempt from some major Affordable Care Act coverage requirements.

More than 11 million people are eventually projected to enroll in the tax-advantaged HRA plans provided by their employer to purchase individual coverage, including 800,000 who were previously uninsured, according to administration estimates. That would represent a roughly 50 percent enrollment boost to the individual market, likely reversing the trend of small annual enrollment declines in the Obamacare exchanges over the past few years.

"The rule will provide hundreds of thousands of businesses a better way to offer health insurance coverage and millions of workers and their families a better way to obtain coverage," Joe Grogan, head of health policy for the Domestic Policy Council, told reporters last week.

Workers who receive the new individual HRAs could use that money to shop for ACA coverage on or off the exchanges. However, they would not be eligible for premium subsidies.

Many insurance experts are skeptical the administration's gaudy enrollment projections are likely to pan out. Gary Claxton, a vice president at the Kaiser Family Foundation, said companies in a tight labor market could be reluctant to make big benefit changes and risk antagonizing workers who value job-based coverage.

"There's always this belief that employers are looking for ways to cash out and leave," Claxton said, but he thinks the notion is misguided.

Rachel Levy, who was a top IRS tax policy analyst during ACA implementation, added that it's incredibly difficult to gauge how the insurance market will respond to complex changes. For example, about 24 million people were originally expected to purchase exchange coverage, more than double the current enrollment level.

"I'm happy that I'm not the one needing to come up with those numbers because there are a lot of open questions right now," said Levy, who is now with Groom Law Group.

Among the biggest immediate concerns about the HRA rule is the administration's decision to make it effective in 2020, with the enrollment season roughly four months away, despite warning from state-based marketplace officials they won't have time to inform shoppers about the new options.

"This kind of confuses people in a process it's already tough for them to manage anyway," said Kevin Patterson, CEO of Connect for Health Colorado. "We just worry about that additional complication of another option."

Christen Linke Young, a health policy fellow at the Brookings Institution, also worries the HRA option will make it harder for shoppers to figure out if they're eligible for subsidies. That increases the risk they might inadvertently access financial assistance that they don't qualify for — and then eventually have to repay.

"Anyone who's trying to figure this out is going to move through HealthCare.gov or their state exchange and not encounter the right questions that will help them make the correct eligibility determination," Young said.

Insurance experts also fear that employers could exploit the new HRA flexibility to dump sicker and more expensive workers onto the exchanges, driving up premiums for everyone else in the marketplaces.

The administration took several steps meant to prevent this. The final rule requires insurers to treat all members of an employee class — seasonal workers, for example — the same in terms of coverage options, and it sets a floor for how many workers must be part of a class. Insurance experts generally praised the safeguards but said the HRA rule is still likely to make the ACA risk pool less healthy and more expensive.

"No safeguards can change the fact that this setup is going to be the most attractive to the sickest firms," said Young.

Josh Archambault, a senior fellow at the conservative Foundation for Government Accountability, said smaller firms with very few options for affordable coverage are likely to see HRAs as an attractive option. He said that could include seasonal workers in the tourism industry that are likely to skew younger, potentially improving the ACA risk pool.

"You may be feeding younger, healthier people into the market just as much," Archambault said. "It's not logical to me that you would say in all markets, in all instances, all employers are going to make it worse."

There's also some concern employers could use HRAs to funnel workers into short-term plans, which don't typically cover pre-existing conditions and many benefits required under Obamacare. Although the administration's HRA rule bans the purchase of short-term plans with individual HRAs, it authorizes another type of account that could be used to purchase non-ACA coverage. These "excepted benefit" HRAs are capped at \$1,800,

with annual adjustments for inflation, and must be offered in conjunction with employer-sponsored coverage.

Meg Murray, CEO of the Association of Community Affiliated Plans, worries that employers could simply make the group health plans so expensive for workers that they could only afford to buy short-term plans with their HRA funds.

“We have been very concerned about ... the impact on real people's lives who buy these plans and are snookered into thinking they're getting something cheap, and it turns out they don't cover what they think,” Murray said.

But most insurance experts are skeptical there will be significant uptake of the excepted benefit HRAs, meaning there wouldn't be widespread siphoning of workers into short-term plans.

It will likely be years before the impact of the HRA rule can be gauged, and like other recent Trump health insurance initiatives, it could face lawsuits. The Trump administration's efforts to expand short-term and association health plans are both tied up in legal challenges. California Attorney General Xavier Becerra and other Democratic attorneys general argued the earlier proposed HRA rule violated the ACA, though they haven't filed any lawsuits.

“We've seen a lot of litigation from all fronts,” said Levy of the Groom Law Group. “And so I think it's certainly reasonable to expect that somebody is going to think about challenging this.”



Trump Mounts New Push on Health Care Ahead of 2020 Election

Stephanie Armour

President Trump is planning a series of marquee actions on health care that coincide with his re-election campaign, part of an effort to gain ground on the issue while Democratic presidential candidates debate how far to go in expanding federal coverage.

Mr. Trump on Monday plans to issue an executive order aimed at forcing the disclosure of the hidden prices that insurers, hospitals and doctors negotiate for care. It would direct federal agencies to issue guidance and regulations.

Health-care changes are already in the works. Hospitals are deeply concerned about an outpatient rule expected in July because it could mandate first-ever disclosure of prices starting next year, according to two people familiar with the regulation.

Other federal rules aimed at lower drug prices are looming, including a plan to reduce seniors' out-of-pocket costs by curbing rebates to middlemen. Another would limit Medicare drug prices by linking them to lower costs in other countries.

Mr. Trump also wants to release a new Republican health plan—an elusive goal for the party—by late summer. The proposal is being drafted by administration and agency officials, according to a person familiar with the work who said “it is getting done.”

“We will create a great health-care system based on honesty, transparency, more options and far-lower costs for much better care,” the president said Tuesday at his re-election rally in Florida.

But the actions are also part of a concerted push to focus on a top issue driving voters in 2020: health-care costs. It's a major shift from 2016, when Mr. Trump's campaign speeches were peppered with references to health-care coverage and access.

“It's part of a strategy. He knows it's a pain point for voters,” said Katy Talento, who recently left her position as lead health policy adviser to Mr. Trump on the Domestic Policy Council. “He heard these stories from patients at roundtables and was outraged and directed his administration to get this done. When we were developing policy on what next does the president turn his attention to, it was cost.”

Democrats have a 17 percentage point advantage over Republicans in Americans' assessments of whom they trust more to handle health care, 40% to 23%, according to an Associated Press-NORC Center for Public Affairs Research poll from April. That longstanding advantage helped the party take seven governorships and the House in the 2018 midterm elections.

Democrats are also focusing on health-care costs, although the presidential candidates are largely saying broader solutions would come from Medicare for All or other shades of government-run health care. The Democratic field is divided over just how big the government's role should be.

More than two-thirds of people say that reducing health-care costs should be a top priority for the president and Congress this year, according to a January survey by the Pew Research Center.

The president's strategy faces challenges. Mr. Trump's initiatives on health care could be greeted with skepticism, even from fellow Republicans. Doubt has already dogged his promise of a new GOP health plan, a pledge Mr. Trump has made since his campaign days in 2016.

The president renewed his call for a plan in March after his administration asked a court to topple the entire Affordable Care Act. Congressional Republicans, wary of taking on the politically thorny proposal, rebuffed him. So Mr. Trump said he would pursue it other ways.

“It will be on full display before the Election as a much better & less expensive alternative to Obamacare...This will be a great campaign issue,” Mr. Trump tweeted April 3.

Mr. Trump sparked speculation this past weekend when he brought it up again on ABC News, saying a “phenomenal” plan would be released within two months. A number of Republicans and many in the health industry had assumed he had moved on.

“Voters are as likely to believe Trump is committed to reducing health-care costs as they are to believe Jeffrey Dahmer was a vegetarian,” said Jesse Ferguson, a Democratic strategist who served on Hillary Clinton’s presidential campaign.

Skepticism also exists because Mr. Trump promised to repeal the Affordable Care Act during his 2016 campaign and said “we’re going to have insurance for everybody.” Instead, Republicans struggled to rally around a plan to replace the ACA in their failed 2017 bid to repeal it.

Their actions also boomeranged. The health law gained in popularity and Democrats successfully used the failed repeal to portray the GOP party as a threat to coverage.

The Justice Department has asked the Fifth Circuit Court of Appeals to topple the ACA, but many Republicans are wary of another go round. Few have any appetite for the political risk of knocking down a popular plan and trying to come up with a replacement.

There are other risks to Mr. Trump’s proposals. His executive order to compel the disclosure of prices in health care is being tenaciously fought by industry, including hospitals and insurers. His pending rules that aim to curb drug prices have faced pushback from some of his own policy advisers, four people close to the discussions said. The clash could water down and has already stalled regulations, they said.

Democratic presidential candidates are also talking about ways federal government health plans can aid in reducing costs.

Former Vice President Joe Biden, at a Monday forum in Washington, talked up the idea of a premium-free federal insurance option. And Sen. Elizabeth Warren (D., Mass.) at a March town hall spoke about getting Medicare for All at “100% coverage in this country at the lowest possible cost for everyone.”

Candidates are also ramping up their messaging on issues such as abortion access and protecting coverage for people with pre-existing medical conditions. Their platform hinges on attacking Mr. Trump for his actions to water down the ACA. Priorities USA recently debuted ads with a focus on health care that criticize Mr. Trump for attacking the Obama-era health law.

Republicans, including the president, are firing back. They are portraying Democratic candidates as extreme for their support of Medicare for All or more-moderate versions such as a government-run option on the ACA health exchanges.

“Democrats ran on health care in 2018, and all they have done is talk about Robert Mueller and impeachment,” said Erin Perrine, deputy communications manager for Mr. Trump’s re-election campaign.

The president will tout actions his administration has already done to address costs, such as expanding access to cheaper insurance plans that don’t comply with ACA protections. Democrats say the initiatives sabotage the law and hurt consumers.

Mr. Trump’s coming actions that aim to address health costs, some political analysts say, play right into what voters want to hear.

“He has this instinct,” said Robert Blendon, a health policy professor at Harvard University. “In every talk he is giving, he’s talking about costs. It’s a real pocketbook issue. In the general election the most important health-care concern is not going to be coverage, it’s going to be health-care costs.”



The Health 202: White House is reviewing a new index to cut Medicare drug spending

Paige Winfield Cunningham

Eight months ago, President Trump vowed to bring federal payments for some Medicare-covered drugs more in line with lower prices for the medicines in other countries. It was a move that struck many as especially aggressive for a GOP administration but meshed with Trump's vow to lower the price of prescription drugs.

A proposed rule for the experimental international pricing index is being reviewed by the White House Office of Management and Budget as of Thursday, indicating the Department of Health and Human Services is finally moving forward on it after some delay.

There’s enthusiasm inside HHS for the index, which would tie the prices for drugs covered by Medicare and distributed by doctors to an average of lower prices paid in 16 other countries, where the government plays a much more active role in setting prices. But the drug industry and some conservative groups are fighting hard against it, and Sen. Chuck Grassley (R-Iowa), head of the powerful Finance Committee, poured cold water on the proposal after holding his fire for months.

“I’m gaining a view that I don’t think that this administration’s approach on international pricing is going to be to the benefit of the adoption of and research for modern drugs,” Grassley told reporters on Wednesday. “I’ve been slow arriving at that conclusion ... but I think I’ve studied it long enough now.”

Trump visited HHS at the end of October to unveil the index idea, saying it would resolve a “rigged” system in which the United States pays more than other nations for medicines. The idea is to save the government money by reducing payments for prescription drugs dispensed through the part of Medicare that pays for doctor visits.

While the index would apply to just a small percentage of the drugs paid for by Medicaid, it is one of the more robust actions the administration has proposed against skyrocketing drug prices. Last month, HHS finalized a rule requiring drugmakers to display the list price of medications in television ads. The agency is also working to finalize a rule essentially banning the rebates drugmakers pay to pharmacy middlemen, which are blamed for inflating list prices.

But the index proposal has particularly raised the ire of conservatives, who view it as akin to government price-setting. FreedomWorks has been especially vocal against the idea, dubbing it an “importation of foreign price controls.”

“It’s encouraging to see Senator Grassley come out to oppose the international pricing index,” said Dan Savickas, the group’s federal affairs manager. “No conservatives should entertain this idea and we need more legislators to come forward and publicly urge the administration to end their push for IPI.”

Pharmaceutical makers, which last year spent the most they had on lobbying since 2009, when the Affordable Care Act was being passed, are fighting hard, too. The index would result in delays for patients seeking medications, especially for cancer patients, the Pharmaceutical Research and Manufacturers of America wrote in a blog post earlier this month.

“It’s clear this far-reaching proposal would take the Part B program in the wrong direction,” wrote PhRMA’s Nicole Longo, director of public affairs. “We urge HHS to abandon the proposed demonstration and instead pursue reforms grounded in market competition and patient-centered care.”

PhRMA ✓

@PhRMA

Mounting evidence reveals international reference pricing schemes would result in significant negative consequences for #PartB patients and biopharma R&D. Learn more <https://onphr.ma/2JXXPMM>

The White House Office of Management and Budget noted the potential rule in its spring list of regulations that are in the works at HHS. The agency could provide more details in the regulatory agenda it is expected to release this summer.

Supreme Court agrees to hear Obamacare cases with billions of dollars at stake

Paul Demko

The Supreme Court on Monday agreed to hear a challenge from health insurers who argue the federal government owes them hefty Obamacare payments, stoking the possibility the Trump administration could be forced to pay out billions of dollars for a law it's tried to dismantle.

The insurers claim they are due money from an Obamacare program helping companies that attracted sick and expensive customers in the early years of the law's insurance marketplaces. The justices' decision to take the case means it will reconsider an earlier appellate court ruling that the federal government isn't on the hook for the payments.

The Supreme Court will consider combined cases from three small insurers, but its eventual ruling will serve as a precedent for dozens of other similar pending cases. Altogether, insurers believe they're owed more than \$12 billion.

This marks the fifth Obamacare-related case the Supreme Court has agreed to hear in almost a decade since the law's passage, and it may soon hear another — a constitutional challenge brought by Republican-led states and supported by the Trump administration.

Unlike that lawsuit or previous challenges to Affordable Care Act's individual mandate and subsidy scheme heard by the Supreme Court, the health insurer cases don't directly threaten the law's underpinnings. Nor do they address a deep partisan divide like two previous Supreme Court challenges over the requirement for employers to provide free birth control coverage under the ACA.

"This is not an ideological challenge to the ACA," said Katie Keith, a Georgetown Law professor who tracks health care litigation. "This is more about previous Supreme Court precedent and whether the lower court got it right or not."

However, a ruling for the insurers would represent a politically awkward defeat for a Trump administration that's failed to rip out Obamacare, a priority for the president's base.

The insurers' case involves the Affordable Care Act's risk corridors program, which was among the safeguards built into the law to protect insurers from big losses in the early years of the new insurance marketplaces, given the difficulty of predicting how sick and expensive their new customers would be. Insurers whose customers proved more expensive than expected would receive payments, while those that underestimated costs would pay into the program.

However, many more insurers ended up qualifying for assistance than having to pay into the program, which expired in 2016. But Republicans balked at spending taxpayer dollars to cover the program's deficit — decrying it as a bailout for insurers — and blocked the federal government from making payments.

That contributed to skyrocketing premiums in the ACA's fledgling marketplaces after they launched in 2014, and it also helped push many nonprofit insurers seeded with Obamacare funds into financial collapse.

The Supreme Court's decision to take up the challenge likely won't have a significant effect on the marketplaces. After several years of turbulence, most insurers are turning a profit, resulting in growing competition and relatively modest premium hikes and decreases this year. Early signs suggest a similar pattern for 2020 plans.

However, the court could soon wrestle with another Obamacare case that puts the law's fate at stake. In December, a federal judge ruled that the elimination of the individual mandate penalty in the GOP tax cut rendered the entire health care law unconstitutional. An appeal of that controversial ruling, which most legal experts expect to be overturned, will be heard by the 5th U.S. Circuit Court of Appeals on July 9. The losing side is expected to ask the high court to review the case.

Insurers in 2016 filed the first lawsuits claiming the ACA guaranteed them payments from the risk corridor program, despite Congress's later decision to block taxpayer dollars. The Obama administration, and later the Trump administration, has fought the insurers in court.

Lower courts split on the merits of the legal claims. Oregon-based Moda Health won a \$200 million judgment, but the \$70 million claim from the now-defunct Land of Lincoln Health was rejected. A divided appellate court last June ruled against the insurers in a combined case, finding that Congress clearly took action to prevent federal payouts to the program.

Maine Community Health Options is the third insurer that had appealed to the Supreme Court to take up the issue. The cases will be consolidated and scheduled for one hour of oral arguments.

Nicholas Bagley, a professor at University of Michigan Law School who has written extensively about the insurer lawsuits, said the Supreme Court's decision to take the cases shows some justices have doubts about the lower court's ruling. It takes at least four justices to agree on hearing a case.

Though the cases don't address a larger central question about Obamacare, Bagley said they're bound to revive political arguments over the law.

"Anytime the law touches the Affordable Care Act, these questions become white hot," Bagley said. "I think we're going to see yet again a major fight over the promises that the government made and the promises that the government broke, and reopening those old wounds is bound to stir up some feelings on both sides."



Trump order seeks disclosure of hospital prices

Ricardo Alonso-Zaldivar

WASHINGTON (AP) — President Donald Trump will sign an executive order Monday that calls for upfront disclosure by hospitals of actual prices for common tests and procedures to keep costs down , administration officials said.

Health and Human Services Secretary Alex Azar told reporters the idea is to give patients practical information that they can use to help save money. For example, if a hospital charges your insurer \$3,500 for a type of echocardiogram and the same test costs \$550 in a doctor's office, you might go for the lower-price procedure to save on copays.

But insurers say the idea could backfire, prompting hospitals that now give deeper discounts to try to raise their own negotiated prices to match what high-earners are getting.

Trump's order will also require that patients be told ahead of time what their out-of-pocket costs like deductibles and copays will be for many procedures. It "will put patients in charge and address the drivers of high health care costs...increasing choice and competition," Azar said.

Little will change immediately. The executive order calls for a rule-making process by federal agencies, which typically takes months or even years. The details of what information will have to be disclosed and how it will be made available to patients must

be worked out as part of writing the regulations. That will involve a complex give-and-take with hospitals, insurers and others affected. Consumers will have to wait to see whether the results live up to the administration's promises.

Lack of information on health care prices is a widespread problem . It's confusing for patients, and experts say it's also one of the major factors that push up U.S. costs. The same test or procedure, in the same city, can cost widely different amounts depending on who is performing it and who is paying the bill. Hospital list prices, which are available, don't reflect what they actually get paid by insurers and government programs.

The health insurance industry said disclosing negotiated prices will only encourage hospitals that are now providing deeper discounts to try to raise their rates to match the top-tier facilities. "Publicly disclosing competitively negotiated proprietary rates will reduce competition and push prices higher — not lower — for consumers, patients, and taxpayers," Matt Eyles, head of the industry group America's Health Insurance Plans, said in a statement.

While the prices Medicare pays are publicly available, private insurers' negotiated rates generally are not. Industry officials say such contractual information is tantamount to trade secrets and should remain private.

Azar pushed back against that argument, saying insurers do ultimately disclose their payment rates when they send individual patients an "explanation of benefits." That's the technical term for the form that patients get after they've had a procedure or seen the doctor.

"Every time one of us goes to a hospital, within a couple of weeks there arrives an explanation of benefits that contains the list price, the negotiated price, and your out-of-pocket cost," Azar explained. "This is not some great state secret out there." He said "that information is out there, it just needs to be presented to patients at the right time, in the right format, so it can help drive decision-making for them."

Trump's executive order also calls for:

- Expanded uses for health savings accounts, a tax-advantaged way to pay health care bills that has long been favored by Republicans. Coupled with a lower-premium, high-deductible insurance plan, the accounts can be used to pay out-of-pocket costs for routine medical exams and procedures.

- A plan to pull together the government's various health care quality rating systems for hospitals, nursing homes, and Medicare Advantage plans, improving reporting of information to consumers.

- Expanding access by researchers to health care information, such as claims for services covered by government programs like Medicare. The data would be stripped of details that could identify individual patients.