Media Clips

COVERED CALIFORNIA BOARD CLIPS

June 25, 2019 – Aug. 6, 2019

Since the June 26 board meeting, Gov. Newsom and the California legislature passed new initiatives which will give hundreds of thousands gaining health coverage and provide new financial assistance. Also, Covered California released its preliminary rates for 2020 with a statewide average rate change of 0.8 percent. Nationally, the Affordable Care Act is again being challenged in the courts and the "Cadillac Tax" was repealed.

COVERED CALIFORNIA PRESS RELEASES AND REPORTS

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Articles of Significance

COVERED CALIFORNIA

News Release

FOR IMMEDIATE RELEASE
July 9, 2019

California's Initiatives Will Lead to Hundreds of Thousands Gaining Health Care Coverage With Lower Premiums and New Financial Help

- *California's individual market will see a preliminary rate change of 0.8 percent in 2020, which is the lowest change since Covered California's launch, due to new state affordability initiatives designed to lower costs and encourage enrollment.*
- *An estimated 922,000 people — including many middle-income Californians — will be eligible from a first-in-the-nation expansion of financial help that builds on the Affordable Care Act and lowers the costs of their health care coverage.*
- *Covered California projects that lowering health care costs and reinstituting the penalty on individuals who can afford coverage, yet choose to go without insurance, will result in 229,000 people becoming newly insured.*
- *All 11 health insurance companies return to the market for 2020, and a major national plan, Anthem Blue Cross, will expand — giving nearly all Californians a choice of two carriers, and 87 percent able to choose from three carriers or more.*
- *Downloadable comments from Executive Director Peter V. Lee (video).*

SACRAMENTO, Calif. — Covered California unveiled its preliminary rates for the upcoming 2020 coverage year, revealing how consumers will benefit from new state initiatives, and announced that a major carrier will be expanding into new areas and providing consumers with more choice.

The preliminary average rate change for California's individual market will be 0.8 percent in 2020, which is the lowest premium increase since 2014, and a fraction of the five-year actual average increase of 7.9 percent. The significantly lower rate change was driven by two new state affordability initiatives: the restoration of the individual

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mandate and new state subsidies that an estimated 922,000 consumers will be eligible to receive, which will lower the cost of coverage. Together, the initiatives are projected to increase the number of Californians getting insurance by an estimated 229,000 people.

“The bold moves by Gov. Newsom and the Legislature will save Californians hundreds of millions of dollars in premiums and provide new financial assistance to middle-income Californians, which will help people get covered and stay covered,” said Covered California Executive Director Peter V. Lee. “California is building on the success of the Affordable Care Act and bringing quality care and coverage within reach for more people.”

California’s Individual Market Rate Change for 2020

California’s individual market consists of an estimated 2.2 million people, including approximately 1.39 million enrolled through Covered California and the rest buying coverage directly from carriers in the individual market.

The new state initiatives resulted in premium *decreases* between 2 and 5 percent per carrier as health plans rolled back increases they had added to premiums in 2019 resulting from the federal action of zeroing out the Affordable Care Act’s penalty.

“The premium increase of less than one percent is not a ‘rebound’ from large increases in prior years,” said Lee, “This lower increase follows years of relative stability and will provide big savings to millions of California consumers.”

For those who enroll through Covered California, nearly nine out of every 10 receive financial help in the form of federal tax credits or subsidies, which will increase in the coming year with the addition of state financial help. Together, they will make health care more affordable.

The proposed rates, negotiated with Covered California, will be filed with regulators and are subject to their final reviews. Covered California will release preliminary rates for California’s 19 rating regions on July 17.

New State Subsidy Program

A Covered California analysis projects that an estimated 922,000 consumers will be eligible for the new state subsidy program that will help lower the cost of their coverage in 2020.

The consumers who are projected to benefit from the new state subsidies are:

- An estimated 235,000 middle-income Californians who previously did not qualify for financial help because they exceeded federal income requirements. They will be eligible to receive an average of $172 per household per month, which will

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help them save an average of 23 percent off their current premiums. Many of these consumers, particularly those who live in high-cost regions, will see significant savings with annual reductions in their health care premiums in the hundreds and even thousands of dollars.

- An estimated 663,000 Covered California enrollees who currently receive federal financial help. They will be eligible to receive an average of an additional $15 per household per month which will help them save an average of 5 percent on their current premiums.

- An estimated 23,000 Covered California enrollees whose annual household income falls below 138 percent of the federal poverty level (FPL), which is less than $17,237 for an individual and $35,535 for a family of four. They will see their premiums for the benchmark plan lowered to $1 per member, per month.

“California is addressing affordability by helping the lowest-income individuals as well as those currently paying extraordinary amounts of money towards premiums each month,” said California Health and Human Services Secretary and Covered California Board Chair, Dr. Mark Ghaly. “Providing this critical assistance means fewer people without insurance and lower health care costs for everybody.”

“For many Californians, this new financial help will allow them to expand their businesses, hire staff, purchase new equipment and continue pursuing their dreams,” Lee said.

The new state subsidies will only be available through Covered California. The amount of financial help consumers receive will vary depending on their age, their annual household income and the cost of health care in their region.

The program will limit how much any Californian will pay for their premium as a percentage of their income. For example, older individuals living in regions with high health care costs could receive significant amounts of financial help, while some younger consumers in lower-cost regions may already be able to purchase a benchmark plan for less than the share of income spent on premiums that is capped by the program.

Restoring the Individual Mandate After Federal Action Zeroed Out the National Requirement, Raising Costs and Undercutting the Affordable Care Act

California also enacted legislation to restore the individual mandate penalty for the upcoming 2020 coverage year. The penalty was zeroed out by Congress during the Tax Cuts and Jobs Act of 2017, which led to higher premiums in 2019 and likely contributed to a dramatic drop in the number of new consumers signing up for the coverage during the most recent open-enrollment period.

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Restoring the individual mandate was a key factor in driving premiums between 2 and 5 percent lower per carrier, with an average of 3.2 percent. Covered California estimates the reduced rates will mean Californians will save an average of $14 per month, or $167 per year, on their health care premiums in 2020.

“The winners of making coverage more affordable and once again requiring consumers to be insured are all 2.2 million people in the state’s individual market and all Californians who benefit from having more of their friends, family and neighbors insured,” Lee said.

The state mandate will be administered by the California Franchise Tax Board. People who choose to go without coverage they can afford in 2020 will be subject to paying the penalty as part of their annual state tax filing. Consumers whose health insurance costs do not exceed a certain percentage of their income could face a penalty of up to nearly $2,100 per family, which is based on 2.5 percent of household income or a minimum of $695 per adult, whichever is greater.

Click here for a fact sheet on the state subsidy program and individual mandate, including the income thresholds for the state subsidies - https://www.coveredca.com/news/pdfs/State_Subsidy_and_Mandate_Fact_Sheet.pdf.

Increased Competition and Consumer Choice

In 2020, 87 percent of Californians will be able to choose from three carriers or more, and 99.6 percent of consumers will have two or more choices, due to the expansion of a major national plan.

In the coming year, all 11 carriers will continue offering products across the state, and Anthem Blue Cross — which is currently only available in Northern California, Santa Clara County and the Central Valley — will expand into the Central Coast, parts of the Central Valley, Los Angeles County and the Inland Empire. Anthem Blue Cross will now be available to about 59 percent of Californians.

“Californians continue to benefit from having a very competitive market — with non-profit, locally controlled public plans and for-profit plans competing to meet consumers’ needs on a level playing field,” Lee said. “The fact that we have a major national plan re-entering major markets and that we’re ensuring virtually everyone across California has a choice in coverage is proof that when you have a competitive market it can work for both consumers and health plans.”

Consumers can find out what they will pay for their 2020 coverage starting during the renewal period in October, when they can visit Covered California’s website at www.CoveredCA.com and begin using the Shop and Compare Tool for 2020.

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Consumers who do not have health insurance will be able to begin signing up for 2020 coverage in the fall. Others with special qualifying life events, like losing their coverage or moving, can enroll year-round. Medi-Cal enrollment is also year-round.

Interested consumers should go to www.CoveredCA.com to find out if they qualify for financial help and find free local help to enroll. They can contact the Covered California service center for enrollment assistance by calling (800) 300-1506.

Table 1: California's Individual Market Rate Changes

	5-Year Average 2015-2019	2020 Plan Year	6-Year Average 2015-2020
Weighted Average Increase	8.4%	0.8%	7.1%
Actual Weighted Average Increase After Shopping and Saving*	7.9%	N/A	N/A
Lowest-Priced Bronze (unweighted)	6.7%	5.7%	6.5%
Lowest-Priced Silver (unweighted)	5.7%	- 4.3%	4.0%

*While the "weighted average increase" represents the premiums that Covered California negotiated with its 11 health insurance companies, consumers traditionally pay less than that amount because they can shop around for a better value. The "actual weighted average increase" shows what consumers actually paid after they switched plans and saved money.

COVERED CALIFORNIA

News Release

FOR IMMEDIATE RELEASE
July 19, 2019

Covered California Releases Regional Data Behind Record-Low 0.8 Percent Rate Change for the Individual Market in 2020

- *California's individual market will see an average rate change of 0.8 percent in 2020, which is the lowest change since Covered California's launch, due to new state affordability initiatives designed to lower costs and encourage enrollment.*
- *Given regional variations, consumers in some regions will see actual premium decreases, and those in many regions across the state will see little to no change in their rates, while others may see small increases.*
- *California's consumers could save even more, an average of -9.0 percent, if they shop and switch to the lowest-cost plan in the same metal tier.*
- *Covered California projects 922,000 people will be eligible for a new subsidy program that lowers the cost of their coverage, including 235,000 middle-income Californians who previously received no federal help.*
- *All 11 health insurance companies will return to the market for 2020, and three carriers will be expanding their offerings, giving nearly all Californians a choice of two carriers and 87 percent a choice of three carriers or more.*

SACRAMENTO, Calif. — Following up on the announcement that the average rate change for California's individual market will be 0.8 percent in 2020, which is the lowest premium increase since 2014, Covered California released regional rate data on Friday. Many regions across the state will see little to no change in their underlying rates (such as West Los Angeles, San Diego County and the Inland Empire), others will see an average rate decrease (such as parts of northern counties and parts of the Central Valley), and some will see modest increases (such as parts of the Bay Area and the Central Coast).

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“These regional rates confirm once again that health care is local and personal. It also affirms that the overall story is a good one for consumers across California,” said Covered California Executive Director Peter V. Lee. “Even before considering the positive impact of new state subsidies, many Californians will be seeing little change or even decreases in their underlying premiums.”

In addition, Covered California also released data on the statewide and regional average additional amounts that consumers would be able to save on their premiums if they shop around for the best deal. The average rate change for consumers who shop and switch to the lowest-cost plan in the same metal tier is -9.0 percent, which means that many Californians’ premiums will be even lower than their current premiums while maintaining the same level of benefits.

Consumers in Los Angeles, Orange, San Diego and Santa Clara counties, as well as the Inland Empire, could see average rate reductions of over 10 percent if they shop and switch (see Table 2: Covered California Rate Changes by Rating Region).

“Covered California’s competitive marketplace puts consumers in the driver’s seat by giving them the power to save money by switching plans and maintaining the same level of benefits,” Lee said. “Our health insurance companies know that if they don’t have the lowest rates possible, they are going to lose consumers.”

It is important to note that the average rate changes and savings from shopping and switching do not reflect the additional savings available from the new state subsidies that an estimated 922,000 consumers will be eligible to receive, which will also lower the cost of coverage.

The consumers who are projected to benefit from the new state subsidies are:

- An estimated 23,000 Covered California enrollees whose annual household income falls below 138 percent of the federal poverty level (FPL), which is less than $17,237 for an individual and $35,535 for a family of four. They will see their premiums for the benchmark plan lowered to $1 per member, per month.

- An estimated 663,000 Covered California enrollees who currently receive federal financial help. They will be eligible to receive an average of an additional $15 per household, per month, which will help them save an average of 5 percent on their current premiums.

- An estimated 235,000 middle-income Californians who previously did not qualify for financial help because they exceeded federal income requirements. They will be eligible to receive an average of $172 per household, per month, which will help them save an average of 23 percent off their current premiums. Many of these consumers, particularly those who live in high-cost regions, will see significant savings with annual reductions in their health care premiums in the hundreds and even thousands of dollars.

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“This first-in-the-nation program will make coverage more affordable for many middle-income Californians, such as small-businesses owners, entrepreneurs, contractors or workers in the gig economy,” Lee said. “Every consumer is different, and even without the new state subsidies in place yet, many will see their premiums go down in 2020.”

The new state subsidies will only be available through Covered California. The amount of financial help consumers receive will vary depending on their age, their annual household income and the cost of health care in their region.

As an example, a 62-year old couple in Oakland who earn $72,000 a year currently are not eligible for any financial help. Under the new state subsidy program, they could receive $1,700 per month in financial help, which would cover 70 percent of their monthly premium (see Table 1: New State Subsidy Scenario).

Table 1: New State Subsidy Scenario

Erin and Francis 62 years old Live in a high cost region Income: $72,000 425% FPL *Based on the second-lowest Silver (SLS) plan offered in Oakland, CA.*		Affordable Care Act Baseline	New California State-Based Subsidies
	Monthly Premium (SLS)	$2,414	$2,414
	Net Premium	$2,414	$714
	Net Premium Income Share	40.3%	11.9%
	Federal Premium Subsidy	$0	$0
	New California Premium Subsidy	$0	$1,700
	Silver Plan Medical Deductible – (family)	$5,000 NO deductible for out-patient care	$5,000 NO deductible for out-patient care

Together, the new state subsidies and California’s restoration of the individual mandate were key factors in driving down premiums in 2020.

“Thanks to these bold steps from California’s leaders, rates across the state in 2020 will be on average from 2 to 5 percent lower across the state than they would have been without these policies,” Lee said.

Covered California also announced that three health plans would be expanding their coverage areas, giving many Californians more choice and competition:

- Anthem Blue Cross — which is currently only available in Northern California, Santa Clara County and the Central Valley — will now be available to 59 percent of Californians as it expands into the Central Coast, parts of the Central Valley, Los Angeles County and the Inland Empire.

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- Blue Shield of California will expand its HMO plan into parts of Tulare and Riverside counties and add coverage in parts of Kings and Fresno counties.

- Chinese Community Health Plan will expand to cover all of San Mateo County.

“With a major national plan re-entering significant markets in the state, and other plans expanding their offerings, we’re ensuring virtually everyone across California has a choice in coverage,” Lee said. “Covered California is proof that when you have a competitive market, it can work for both consumers and health plans.”

As a result of the expansion, 99.6 percent of Californians will be able to choose from two carriers or more in 2020, and 87 percent of Californians will have three or more choices.

The proposed rate changes, negotiated with Covered California, have been filed with regulators and are subject to their final reviews. Consumers will be able to renew their existing plans or begin signing up for 2020 coverage in the fall. Click here for Covered California’s 2020 Rate Booklet: https://www.coveredca.com/PDFs/coveredca_2020_plans_and_rates.pdf.

California’s individual market consists of an estimated 2.2 million people, including approximately 1.39 million enrolled through Covered California and the rest buying coverage directly from carriers in the individual market.

The state mandate will be administered by the California Franchise Tax Board. People who choose to go without coverage they can afford in 2020 will be subject to paying the penalty as part of their annual state tax filing. Consumers whose health insurance costs do not exceed a certain percentage of their income could face a penalty of up to nearly $2,100 per family, which is based on 2.5 percent of household income or a minimum of $695 per adult, whichever is greater.

Click here for a fact sheet on the state subsidy program and individual mandate, including the income thresholds for the state subsidies: https://www.coveredca.com/news/pdfs/State_Subsidy_and_Mandate_Fact_Sheet.pdf.

Consumers can find out what they will pay for their 2020 coverage starting during the renewal period in October, when they can visit Covered California’s website at www.CoveredCA.com and begin using the Shop and Compare Tool for 2020.

Consumers who do not have health insurance will be able to begin signing up for 2020 coverage in the fall. Others with special qualifying life events, like losing their coverage or moving, can enroll year-round. Medi-Cal enrollment is also year-round.

Interested consumers should go to www.CoveredCA.com to find out if they qualify for financial help and find free local help to enroll. They can contact the Covered California service center for enrollment assistance by calling (800) 300-1506.

Table 2: Covered California Rate Changes by Rating Region

Rating Region	Total enrollment [1]	Avg. rate change	Shop and save[2]
Statewide Total	**1,391,697**	**0.8%**	**- 9.0%**
Region 1 Alpine, Amador, Butte, Calaveras, Colusa, Del Norte, Glenn, Humboldt, Lake, Lassen, Mendocino, Modoc, Nevada, Plumas, Shasta, Sierra, Siskiyou, Sutter, Tehama, Trinity, Tuolumne and Yuba counties	52,135	- 1.7%	- 8.4%
Region 2 Marin, Napa, Solano and Sonoma counties	51,181	1.1%	- 3.6%
Region 3 Sacramento, Placer, El Dorado and Yolo counties	80,775	1.8%	- 2.2%
Region 4 San Francisco County	34,315	6.6%	- 3.7%
Region 5 Contra Costa County	45,345	0.6%	- 5.5%
Region 6 Alameda County	63,835	1.9%	- 3.5%
Region 7 Santa Clara County	57,846	2.0%	- 14.1%
Region 8 San Mateo County	24,030	2.0%	- 4.8%
Region 9 Monterey, San Benito and Santa Cruz counties	26,155	1.0%	- 6.1%
Region 10 San Joaquin, Stanislaus, Merced, Mariposa and Tulare counties	72,323	- 5.7%	- 9.3%

Region 11 Fresno, Kings and Madera counties	33,878	3.4%	1.7%
Region 12 San Luis Obispo, Santa Barbara and Ventura counties	64,368	4.6%	- 2.3%
Region 13 Mono, Inyo and Imperial counties	13,401	- 6.9%	- 9.7%
Region 14 Kern County	17,537	- 0.5%	- 5.1%
Region 15 Los Angeles County (northeast)	172,381	2.6%	- 9.8%
Region 16 Los Angeles County (southwest)	216,567	0.1%	- 12.4%
Region 17 San Bernardino and Riverside counties	122,624	0.1%	- 10.4%
Region 18 Orange County	133,387	1.0%	- 16.5%
Region 19 San Diego County	109,614	0.2%	- 11.4%

[1] Effectuated enrollment for coverage in the month April 2019.

[2] Shop and Save refers to the average rate change a consumer could see if they shop around and switch to the lowest-cost plan in their current metal tier.

California individual insurance rates to increase slightly
Adam Beam

SACRAMENTO, Calif. (AP) — People who buy their own health insurance in California next year will see their rates increase by less than 1%, the lowest jump in five years that state officials attribute to a new law that taxes most people who refuse to buy coverage.

Rates will increase an average of 0.8% percent next year, according to Peter Lee, executive director of Covered California, the state-run health insurance marketplace. Specific rates charged by companies still must be approved by state regulators.

Most people in California — with nearly 40 million people — purchase their health insurance through their employer.

But about 2.2 million people purchase insurance on the individual market. Rates for those people have increased an average of nearly 8% every year since 2014, the first year former President Barack Obama's health care law went into effect.

Two things are happening in 2020 that state officials say will keep the rates in check: California will tax people who refuse to purchase insurance, and they will use the money they get from that tax to help middle-income people pay their monthly insurance premiums.

State officials believe the changes mean an additional 229,000 people will get health insurance coverage next year. More people having insurance lowers the risk for insurers, who can then lower rates, Lee said.

"It really is a win-win," Lee said.

The federal Affordable Care Act required everyone, with some exceptions, to purchase insurance or pay a penalty. The U.S. Supreme Court upheld that law, ruling the penalty was a tax. In 2017, Republicans in Congress eliminated the tax beginning this year.

Last month, Democratic Gov. Gavin Newsom signed a law to reinstate the tax in California, joining Massachusetts, New Jersey, Vermont and Washington, D.C., next year as the only governments in the U.S. to penalize people who don't buy health insurance.

But the tax has not always meant lower premiums. In 2018, when the federal tax was still in place, rates jumped 12.5% in California. Covered California spokesman James

Scullary said other federal decisions contributed to higher rates that year, including eliminating cost-sharing reductions.

Republicans in the California Legislature opposed the plan, arguing it was not fair to tax people for not buying insurance while the state also expanded taxpayer-funded health coverage to people who live in the country illegally.

“It didn’t change anything. They were paying it. They’ve been paying it for years,” Newsom said Tuesday about taxing people who don’t buy health insurance. “We can see premiums continue to skyrocket for everybody or we can stabilize the market.”

California will become the first state to offer subsidies to people who earn up to six times the federal poverty level — or about $150,000 a year for a family of four. State officials expect about 235,000 people will be eligible to get an average of $172 per month, which will lower their existing monthly premiums by an average of 23%.

Another factor helping keep costs low is more choices for consumers. Anthem Blue Cross, which only sells plans in Northern California, Santa Clara County and the Central Valley, announced Tuesday it would begin selling plans next year in Los Angeles County and elsewhere.

The expansion means 99.6% of Californians will have at least two companies to choose from, while 87 percent will have three choices.

“Health plans know that consumers that have a choice choose the best value for them,” Lee said. “That’s a key element in this premium increase being so small.”

Covered California says consumers will see lowest-ever premium hike for individual policies
Cathie Anderson

Covered California announced Tuesday morning that it expects an average premium increase of 0.8 percent for 2020 in the state’s individual marketplace, the lowest such rate change since the health insurance exchange started business in 2013.

Peter V. Lee, the executive director of Covered California, attributed the low rate change to bills passed by the California Legislature and signed into law by Gov. Gavin Newsom over the past six months.

The legislation includes a so-called individual mandate that will impose a state tax penalty on any California resident who does not maintain health insurance coverage

and offers state subsidies that will help an estimated 922,000 residents pay for insurance.

“The bold moves by Gov. Newsom and the Legislature will save Californians hundreds of millions of dollars in premiums and provide new financial assistance to middle-income Californians, which will help people get covered and stay covered,” Lee stated in a prepared news release. “California is building on the success of the Affordable Care Act and bringing quality care and coverage within reach for more people.”

Lee also noted that the legislative changes so improved insurer confidence that a major national insurer, Anthem Blue Cross, decided to return to offering coverage in much of the state.

After hearing news of the 0.8 percent increase, state Richard Pan, D-Sacramento, said: “That’s less than inflation. Think about that.”

Consumer advocate Anthony Wright with Health Access California hailed the 0.8 percent rate increase as proof that state policies defending and improving upon the ACA are working. Consumer advocates such as Wright had joined with academic experts and health insurers in pushing for the individual mandate and other changes that they said would allow make health insurance coverage more affordable.

“As a result of state actions, most Covered California enrollees will pay less for health insurance, as a lower percent of their income, than they do today, and many more will gain coverage that could not afford it before,” Wright said. “More people with health coverage not only helps individuals and families better plan for their financial future, but also helps stabilize the market, lowering costs for everyone.”

The federal law, enacted in 2010, was a congressional attempt to bring affordable health care coverage to all Americans. Besides giving states the ability to create health marketplaces where insurers could compete to win consumers, the measure also protected patients from losing insurance because of pre-existing conditions and established minimum coverage provisions that all policies must offer.

However, the law has been challenged almost from the time it was passed, and Tuesday, California Attorney General Xavier Becerra will lead a bipartisan coalition of 20 states in seeking to overturn a Texas judge’s ruling that the Patient Protection and Affordable Care Act is unconstitutional.

Judges in the U.S. Court of Appeals for the 5th Circuit are hearing arguments today in New Orleans from Becerra and the attorney general for Texas who is representing 18 Republican-led states that want the legislation overturned. U.S. Attorney General William Barr has said he will not defend the measure.

“If the Affordable Care Act were repealed, what would it mean?” Lee asked. “More than 20 million Americans would be at risk of losing their coverage. ...We would go back to the days of far more Californians without insurance. We’d go back to insurance

companies being able to select who gets covered. We'd go back to the days of health benefit designs that meant consumers didn't know what they were getting when they signed up and might be at risk for not having coverage when they needed it."

Gov. Gavin Newsom, speaking at an event in midtown Sacramento, said the Trump administration's efforts to roll back the Obama-era law will cost them. Insurers raise rates when they have a smaller risk pool, and that means the federal government will pay higher subsidies for Americans getting coverage..

"If we don't have a diverse risk pool, everybody's premiums go up," Newsom said.

The Republican-controlled Congress gutted key components of the Affordable Care Act — effectively doing away with the federal individual mandate, for instance, that gave a credit to taxpayers who bought insurance and penalized those who didn't. And, the Trump administration has refused to reimburse insurers for the discounts that the law requires them to offer.

Those actions led to uncertainty in the marketplace and double-digit rate increases in 2017. Covered California responded by allowing insurers to impose surcharges on the popular silver-tier policies to recoup the cost, and that staved off a mass exit of insurers.

Still, Anthem Blue Cross exited from offering insurance in many counties out of concerns about profitability. Now, Covered California announced Tuesday, Anthem plans to expand back into many areas of the state, meaning that 99.6 percent of Californians will have a choice of two insurers and 87 percent will have a choice of three.

Covered California officials estimate that the number of state residents getting insurance will increase by an estimated 229,000 people. The Golden State's individual health marketplace now numbers roughly 2.2 million people, according to estimates from Covered California, and 1.39 million of those individuals buy their policies through the Sacramento-based health exchange.

In a conference call with reporters, Lee said that, while no insurer is going to price their products in a way that would lose money, all 11 carriers know that consumers who have a choice will pick the best value.

"Consumers are in the driver's seat, and health plans know it," Lee said. "They did absolutely look at doing everything they could to have the most affordable products, and the 11 plans across California have made major investments in being the best products possible for California consumers. It's not a matter of Covered California pounding the table and saying, 'Lower rates.' It's rather the health plans seeing that,…if they don't have the lowest rates they can, they're not going to get enrollment."

The California subsidies will benefit roughly 235,000 state residents who do not qualify for premium assistance from the federal government because their income exceeds

limits and 663,000 Californians who currently receive federal subsidies and will now also get a state one.

About 23,000 Californians whose annual income is just 138 percent of the federal poverty level — $17,237 for and individual and $35,534 for a family of four — will be able to get premiums of $1 per member per month.

“The winners of making coverage more affordable an once again requiring consumers to be insured are all 2.2 million people in the state’s individual market and Californians who benefit from having more of their friends, family and neighbors insured,” Lee said.

Covered California estimated that this year’s legislative changes resulted in premium decreases of 2-5 percent. The insurers’ proposed rates are subject to regulatory approval.

The Bee’s Sophia Bollag contributed to this report.

San Francisco Chronicle

Covered California premiums to rise by smallest-ever amount
Catherine Ho

Health insurance premiums for the roughly 2.2 million Californians who buy health plans on the individual market — either through the state insurance exchange Covered California or directly from insurers — will go up less than 1% in 2020, Covered California officials said Tuesday.

The average statewide premium increase will be 0.8% — the smallest annual average premium increase in Covered California’s six-year history. In 2019, premiums increased nearly 9%.

Covered California Executive Director Peter Lee attributed next year’s modest rise to Gov. Gavin Newsom and state lawmakers’ budget deal, which will implement a new state individual mandate requiring Californians to have health insurance or pay a penalty. The penalty payments will fund new state subsidies for middle-income residents to help offset the cost of premiums. Both the mandate and the subsidies are scheduled to take effect in 2020.

About 229,000 more Californians will be newly eligible to receive the state subsidies, which officials hope will lead to roughly that many more people enrolling in insurance. The income eligibility to receive the new state subsidies is between about $48,000 and $72,000 per person per year — higher than the income eligibility for the federal subsidies provided by the Affordable Care Act, which cuts off at $48,000 a year. The

move is expected to benefit middle-income earners in high-cost areas like San Francisco who struggle to afford insurance but don't currently qualify for financial assistance from federal subsidies.

The state subsidies are projected to cost $429 million in 2020 and more each year after that. The subsidies will come out of the state's general fund, and officials expect much of the amount — $317 million in 2020 — to come from new tax penalties paid by people who don't have health insurance.

The tax penalty, to be paid to the Franchise Tax Board, will be $695 per person or 2.5% of household income, whichever is higher.

"I think it's exciting this is the lowest rate increase we've seen in Covered California's history," said Laurel Lucia, a health policy analyst who leads the health care program at UC Berkeley's Labor Center. "It is in line with the projections that bringing healthier enrollees into the individual market reduces premiums for everyone."

The federal mandate that was previously put in place by the Affordable Care Act was repealed by congressional Republicans in late 2017; the repeal took effect in 2019. California is not the only state to impose its own individual mandate — Massachusetts had one before the Affordable Care Act, and Vermont, New Jersey and the District of Columbia have done so more recently.

"This is a huge win for all Californians," Lee said. "It shows what happens when a state says, 'Let's take the Affordable Care Act and protect it and put it back to where it was before federal action, and build on it, and expand affordability."

Covered California officials plan to release rates for each region next week.

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With ACA's Future In Peril, California Reins In Rising Health Insurance Premiums
Barbara Feder Ostrov and Ana B. Ibarra

Premiums on California's health insurance exchange will rise by an average of 0.8% next year, the lowest increase in the agency's history, state officials announced Tuesday.

Covered California Executive Director Peter Lee credited two new statewide initiatives for keeping the proposed rate hikes low: Next year, California will be the first state in the country to offer state-funded tax credits to middle-class enrollees, which will be paid for in part by a new tax penalty on Californians who don't have health insurance.

“It shows what happens when a state says, ‘Protect the Affordable Care Act and build on it to make the system work for all Californians,’” Lee said.

Covered California estimates that the state-based tax credits, in conjunction with the new state tax penalty, will result in 229,000 newly insured Californians.

The average rate hike for 2020 is far lower than this year’s average increase of nearly 9% — and the five-year average increase of 8.4%. Covered California began offering health plans in 2014 to individuals and families who purchase their own insurance as part of the state’s implementation of the Affordable Care Act.

Most Covered California enrollees receive financial assistance based on their incomes.

California’s announcement of 2020 Obamacare rates comes at a precarious moment for the federal health law: Oral arguments were set to start Tuesday in a landmark lawsuit filed by a group of Republican attorneys general who want the entire health law overturned. The 5th Circuit Court of Appeals in New Orleans heard oral arguments in the case, known as Texas v. United States. California Attorney General Xavier Becerra is leading a group of Democratic attorneys general in defending the Affordable Care Act.

The Trump administration, through the Department of Justice, has declined to defend the law. Depending on what happens at the appeals court, the health law could reach the U.S. Supreme Court before the 2020 presidential election.

The Trump administration has taken other steps to hobble Obamacare, including shortening the annual open-enrollment period for the federally run health insurance exchange, healthcare.gov, and drastically slashing funding for enrollment outreach efforts. Administration officials have said that a replacement plan for Obamacare will be unveiled soon.

In addition to California, some other states have reported low rate increases or decreases for 2020. Washington state last month announced an average 0.96% increase for next year. Maryland announced an average 2.9% rate reduction for 2020. But some exchanges may continue to see more significant increases. Earlier this year, for example, New York proposed an 8.4% rate increase.

Matthew Fiedler, a fellow with the USC-Brookings Schaeffer Initiative for Health Policy, said California’s “relatively subdued” rate increase shows that insurers expect the state’s new health insurance requirement and tax credits to help bring healthier people into the market — and are responding with lower premiums for consumers.

However, Fiedler said, “everything California is doing depends on the Affordable Care Act remaining in place.” Few if any states would be able to spend enough to make up for the elimination of federal tax credits that help some income-eligible people purchase health insurance, he said.

Lee said the 11 health insurers participating in Covered California would return next year, and Anthem Blue Cross, a national plan, will expand its offerings in the state. Anthem's expansion comes after it pulled out of some regions in 2018. The insurer will expand into the Central Coast, parts of the Central Valley, Los Angeles County and the Inland Empire, Lee said.

Nearly all Californians will have a choice of at least two insurers, Lee said.

California is divided into 19 pricing regions, and not all 11 plans participating in the exchange next year will be offered in each region. In some regions, the rate increase will be higher than the statewide average. In others, it will be lower.

What consumers ultimately pay depends on where they live, their income, how much coverage they want and their choice of insurer.

The health exchange is expected to release proposed rates by region on July 17; state regulators must approve them.

Consumers who choose bronze-level plans, which have the lowest monthly premiums but the highest out-of-pocket costs for medical care, will see an average 5.7% increase in rates, according to Covered California. Those who choose silver plans — which come with cost-sharing subsidies for people whose incomes qualify — will see an average premium decrease of 4.3%.

California's new financial assistance for middle-class consumers, combined with the average rate decrease for silver plans, may encourage some people who previously bought less-expensive bronze plans to move up to silver plans. Silver plans provide more coverage with lower out-of-pocket costs for medical care, said Anthony Wright, executive director of the consumer advocacy group Health Access.

This year, nearly 31% of Covered California enrollees chose bronze plans, which are not eligible for cost-sharing subsidies.

"As the Trump administration seeks to blow up the Affordable Care Act, California is succeeding at making it better," Wright said.

Open enrollment for 2020 is expected to start in October. State lawmakers are weighing whether to extend the enrollment period to Jan. 31. Open enrollment for 2019 coverage ended on Jan. 15.

The 2017 Republican tax bill eliminated the federal tax penalty for not having insurance, which took effect this year. But California lawmakers recently agreed to implement a state-level insurance requirement and tax penalty, joining Massachusetts, New Jersey, Vermont and the District of Columbia.

The new individual mandate for Californians starts in 2020. The penalty for not having insurance will mirror the one under the Affordable Care Act, which was $695 per adult

(and $347.50 per child under 18) or 2.5% of annual household income, whichever is greater. That can amount to thousands of dollars a year.

The revenue from the penalty, plus other state funds, will help pay for state-based tax credits for roughly 922,000 people who purchase insurance through Covered California. As part of the 2019-20 state budget signed by Gov. Gavin Newsom last month, the state will pledge $1.45 billion over the next three years for this effort.

Under the deal, California will become the first state to offer financial aid to middle-income enrollees who make between 400% and 600% of the federal poverty level — many of whom have been struggling to pay their premiums. That's between about $50,000 and $75,000 a year for an individual and between about $103,000 and $154,500 for a family of four.

Under the Affordable Care Act, people who purchase plans through Covered California and other health insurance exchanges are eligible for federal tax credits only if they make between 138% and 400% of the federal poverty level. People who earn more than 400% of the federal poverty level get no federal aid.

The majority of the state-based financial aid would go to roughly 235,000 of these middle-income people. The average household tax credit in this category would be $172 per month, according to Covered California.

Some state financial aid will also go to 663,000 low-income enrollees who already qualify for federal tax credits. The average household tax credit for those who make between 200% and 400% of the federal poverty level — roughly between $25,000 and $50,000 for an individual and $51,500 and $103,000 for a family of four — would be $15 a month, Covered California estimated.

About 1.4 million state residents purchased health plans through the exchange this year, according to Covered California. In January, the agency announced that new enrollment fell by nearly a quarter, with 295,980 new sign-ups, compared with 388,344 last year. Plan renewals, on the other hand, increased by about 7.5%.

The decrease in new enrollment was steeper than expected for 2019 — and the agency blamed it primarily on the elimination of the federal tax penalty for not having insurance.

An analysis by the Kaiser Family Foundation earlier this year showed that older adults who earn just above the income cutoff, and live in rural areas, have an especially hard time affording their premiums. (Kaiser Health News, which produces California Healthline, is an editorially independent program of the foundation.)

In California, older residents of far northern counties — such as Shasta and Modoc — and the Central Coast counties of Monterey and San Benito are among those who spend the highest percentage of their incomes on premiums, the analysis found.

POLITICOPRO

Covered California premiums to jump less than 1 percent in 2020
Angela Hart

SACRAMENTO — Covered California rates will rise less than 1 percent in 2020 and enrollment in the state-run health insurance marketplace will grow by nearly 230,000 newly insured Californians, according to new data released Tuesday.

Premiums for the 2.2 million Californians in the individual market are projected to grow an average of 0.8 percent next year — significantly lower than originally anticipated, said Peter Lee, executive director of Covered California.

That is a direct result of an individual health care mandate and expansion of subsidies approved this year by Gov. Gavin Newsom and the Democratic-controlled Legislature, Lee told POLITICO in an interview.

"California is once again making it the law of the land to have health insurance, as it was under the Affordable Care Act," Lee said. "And middle-class Californians who may be spending 20 or 30 percent of their income on health insurance premiums will get first-in-the-nation help."

Advanced by the Democratic-controlled Legislature and signed into law by Newsom, California this year adopted a $215 billion budget that requires citizens to have health coverage or pay an annual tax penalty of nearly $2,100 per year per family or $695 per adult, whichever is greater. The budget also includes $1.5 billion over three years to expand premium subsidies for low- and middle-income people earning up to 600 percent of federal poverty, higher than the federal threshold set under Obamacare.

As a result of the new state policies, the 11 health insurers selling coverage through Covered California retreated on the rate hike they'd initially drafted, Lee said. Rates for 2020 likely would have risen 7 to 9 percent, comparable to the five-year average growth rate of 8.7 percent.

"No doubt if this hadn't been in place, the biggest losers would have been tens of thousands of unsubsidized middle-class Californians who would have decided they were priced out of coverage," Lee said.

The 2020 increase is the lowest rate hike Covered California has seen since it was created in 2014. It comes as President Donald Trump and his administration are seeking to undo the Affordable Care Act, with oral arguments beginning today in a federal appeals court case that will be instrumental in determining whether Obamacare remains in place.

California is leading the charge defending Obamacare, with 19 other Democratic-led states also on board. At the heart of the case is whether the federal health care law can stand without the individual mandate for most Americans to purchase coverage or pay a tax penalty. The Trump administration and 18 Republican-led states argue that Obamacare became unconstitutional after Congress zeroed out the penalty in 2017.

"It's like the tale of two cities," Lee said. "We in California have been committed to leaning in, to building on the Affordable Care Act and making it work for both low-income people and the middle class. But we have a governor and a Legislature who are saying the end point is not the Affordable Care Act."

Lee said California's creation of its own health coverage mandate alone lowered would-be rate increases by as much as 5 percent.

Under the subsidy package, Californians already eligible for state and federal financial assistance to purchase coverage will receive a $12 monthly premium cut on average, according to Covered California. Higher-income people previously ineligible for subsidies will see average monthly savings of $144. The actual savings depend on a person's age, county of residence and income.

Nearly 1 million people who purchase coverage on the exchange will be eligible for new and existing premium subsidies. An estimated 235,000 middle-income residents earning 400 to 600 percent of federal poverty will be newly eligible for assistance, with average monthly premiums dropping 30 percent. That income range is $49,960 to $74,940 for an individual or $103,000 to $154,500 for a family of four.

Nearly 700,000 low-income people will see an average 9 percent monthly cost cut, and 23,000 people in poverty who don't qualify for Medi-Cal will have their monthly premiums reduced to $1.

Covered California is also seeking to lower costs by increasing competition. It is expanding the coverage options available by adding Anthem Blue Cross as an option to parts of the Central Valley, Los Angeles County and the Inland Empire.

The addition means 87 percent of Covered California customers will have three health insurance options to choose from. Lee argued that will help control rising health care costs.

"If you have three health plans competing with each other, it means consumers are driving plans to be as cost-effective and quality conscious as possible," Lee said.

The rates head next to the Department of Managed Health Care and the Department of Insurance for review. Covered California is expected to finalize them in October. They are set to take effect in January, when the coverage mandate will begin.

Washington Examiner

California expects leveling off of premiums following Obamacare expansion
Kimberly Leonard

Premiums for Obamacare plans in California are expected to rise less than 1% in 2020, a mild increase that officials credit with changes the state made to its healthcare provisions.

State officials announced the rate increases Tuesday ahead of a court challenge Obamacare faced in New Orleans in which Republican state officials planned to argue that the law needs to be thrown out. California has been supportive of Obamacare and has expanded it: Democratic Gov. Gavin Newsom signed a bill into law in June that expands financial help for premiums for more people and adds a penalty on the uninsured.

Premium increases for Obamacare plans have been difficult for many of the law's customers, who have been unable to keep up with higher costs and have been siphoned out of the market.

Premiums had increased in California by an average of 7.9% a year since 2014, but that trend appears to be leveling off in 2020. Preliminary data show premiums will rise by an average 0.8%. That's the lowest that the state's Obamacare marketplace, called Covered California, has seen since the plans took effect in 2014.

Further, all 11 health insurers who sold Obamacare plans in California for 2019 are returning in 2020, and Anthem Blue Cross will expand to more counties.

Peter Lee, the executive director of Covered California, called the preliminary rates a "huge win for Californians" in a phone call with reporters Tuesday, and said that the results underscored that states have the opportunity to go beyond Obamacare. He encouraged other states, and even Congress, to take similar action.

In 2020, an estimated 922,000 Californians are expected to pay less for their health insurance coverage if they buy it through Covered California. This will occur as a result of a bill Newsom signed into law in June that would allow people to receive subsidies to pay for coverage if they make up 600% of the federal poverty level, or roughly $75,000 a year for an individual.

Previously, people could only get help to pay for coverage if they made up to 400% of the federal poverty level, the rate that is set under Obamacare nationally.

State lawmakers also reinstated an unpopular part of Obamacare, which fines people if they do not obtain health insurance. The uninsured will pay a penalty of $695 per adult or 2.5% of their income, whichever is higher, if they don't have coverage in 2020. The penalty will go toward paying for the Obamacare expansion state lawmakers passed.

"You need to have health insurance in California, it's the law," Lee said. "If you don't, there's a penalty."

State officials credit the changes with lowering premiums from what they would have been by between 2% and 5% for next year, but other states that did not implement California's changes are also expecting a similar leveling out of premiums. In 2019, most of the country already saw a reduction in premiums, which was a first.

Still, it's clear what individuals pay for coverage will go down because the state government is kicking in new help.

For example, an estimated 235,000 middle-income Californians who previously did not qualify for financial help will be eligible to receive an average of $172 per household per month, which will help them save an average of 23% off their current premiums. An estimated 663,000 people who already get help are going to also see a reduction of roughly 5% a month in their premiums.

What Obamacare customers ultimately pay for coverage depends on how much financial help they get, where they live, whether they smoke, and how old they are.

Currently, 1.39 million people sign up for coverage through Covered California and another 800,000 purchase coverage directly from an insurer. Both of these customers are part of what is known as the "individual market," the group of people who buy coverage on their own because they don't get it through a job or a government program. Many of these individuals are self-employed or work for a small business.

State officials plan again to spend $110 million on marketing and outreach about the law. The amount trumps what the federal government pays to market the law in most states. The Centers for Medicare and Medicaid Services spends about $10 million for marketing its exchange, called healthcare.gov, which is the website most states use, and another $10 million on navigators that help people sign up for coverage.

POLITICOPRO

POLITICO California Pro Q&A: State HHS Secretary Mark Ghaly
Angela Hart

SACRAMENTO — Leading California's largest state health agency wasn't on Mark Ghaly's radar when aides to Gov. Gavin Newsom approached him this spring, he told POLITICO in an exclusive interview. Ghaly said he was "pretty happy" serving as the director of health and social impact for the Los Angeles County Chief Executive Office.

But Ghaly, 44, didn't flinch when the offer came to serve as secretary for the state's Health and Human Services Agency, a massive government bureaucracy that operates more than a half-dozen departments administering Medi-Cal, public health initiatives and a range of social services.

"This was always a job that I would say, if it was offered, I would move a lot of things in my life to be able to do it," Ghaly said.

A pediatrician and veteran public health official, Ghaly has previously served as deputy director of the Los Angeles County Department of Health Services and medical director for a San Francisco community clinic. He is a Democrat and commutes to Sacramento from Los Angeles, where he lives with his wife, Christina Ghaly, director of the county's Department of Health Services.

This transcript has been edited for length and clarity.

What drew you to the health care field?

I think the whole reason I went into medicine is to really focus on underserved, low-income individuals. At the end of the day, health care becomes a final resting place for a lot of society's hardest issues.

If you're lonely, you're hungry, you're sick — a lot of that ends up in the emergency room. So having the chance to participate in health care was a real privilege.

Public health brought it to a larger level of thinking, globally but also locally about populations and communities. I often think about health care as very separate from health. Health includes health care but also improves upon your ecosystem, your home, your community — access to a lot of things that many of us take for granted.

Six months into my UCSF residency, I found myself in Bayview-Hunters Point. I said I can't overlook this. I really dug into adolescent health issues. We developed the first team clinic in Bayview at the time.

What kind of work did you do at the clinic level after that?

When I came to the Southeast Medical Center, it was really urgent care-heavy and I love urgent care, but sometimes for low-income communities we only offer urgent care because there's this arrogance or assumption that low-income people can't get so organized to come into primary care.

They can't keep the 9:30 a.m. appointment, they can't be fasting for labs. So we moved away from an urgent care mentality to much more of a primary care team-based mentality.

I remember trying to be as creative as I could with every public position I had in trying to build these teams with providers and nurses and medical assistants and community health workers to really try to wrap around the patients assigned to each provider.

And that really guided a lot of how I view health care.

Do you have a history of working with Newsom before he became governor?

I wouldn't say there was a lot of history but certainly, the first community homeless connect project. He had an effort, and it was largely based downtown and they would do these big events around homeless engagement, service delivery.

The first one outside of Civic Center was at Bayview, and we did it annually at my clinic, so I had the chance to interact with him there a little bit. Then Healthy San Francisco launched at the front door of our Southeast clinic as well.

It wasn't a deep amount of work, but yeah. And lot of the things I think about in terms of how can you actually build an access program that makes sense, how can we actually get to bigger and better coverage for folks? I feel like I have real, on-the-ground sense of what the challenges are in doing that.

It gets bigger and bigger as you get from Bayview to Los Angeles to the state, but it's the same building blocks.

Is there a potential conflict working with your wife in Los Angeles?

People have been concerned about the conflict. She's such a strong partner, you know we're super supportive of each other.

I joke and say they hired the wrong Ghaly for the job. I think she's brilliant and effective and all those things but certainly, some of the decisions that we make at the state level have serious impact on LA County.

I think our attorneys have successfully found a place where we can be involved as much as possible until a pretty clear line.

What happens when there is a conflict?

On both ends we have to defer decisions, take ourselves out of conversations and hopefully not even be involved in them. So there are some key things that she is going to have sit on sidelines on or I will have to sit on the sidelines on.

It would be anything where there is going to be a direct contract between her department and my authority as secretary.

The state is sanctioning mental health plans for failing to meet network adequacy standards. Do you support that?

Certainly there is a diversity of approaches and mindsets on how we deliver different types of services, including mental health services, across California and there could be scenarios — and I think we're running into those now — where despite a number of efforts, we're not getting the results that we believe can help deliver the outcome of timely good quality care that is accessible.

So one of the only levers we have is occasionally withholding funding through sanctions.

My bent on all of this is to try to do partnerships first, and a corrective action plan is one form of trying to identify root causes and then addressing them in a way that hopefully is more supportive than guess what, you get this fine.

I do think that the broader conversation of how does California get to a mental health system that works, I think we are unlikely to be successful in that pursuit if we leave every county to do its own version of a mental health system.

This is a tough place we're at. Here's a group of people who have committed their careers to trying to do the right thing for people with mental health and behavioral health needs and then here's a bunch of folks who say, well, we hold a lot of the dollars, we don't feel like the outcomes are good enough.

It's not bad tension. It's tension that hopefully will get us, if we don't come in with just a bunch of sticks ... I think we hopefully will find a path through it all.

What's the ultimate goal, from your perspective?

If you say, look, we want a mental health system that provides care first and jail last, it's a very different structure. That's the kind of outcome that is amazing to try to build around.

So it's not to eliminate local control or local ingenuity, but it is to say, look, there's some foundational things that we need to build upon and we need to make sure we're all marching toward some core metrics that will — a half a decade from now, really allow us to say, man, we have a better mental health system than we did.

Today, it doesn’t work. There’s no doubt.

Way too many people end up homeless on the streets, in jails, in prisons. We have an important opportunity to really address this.

Do you support the state's new coverage mandate?

I think by encouraging people to have coverage, one of the key benefits is expanding your risk pool, and this is going to support people to do that.

California is implementing an executive order on drug purchasing. What are your thoughts on carving out prescription drugs as a fee-for-service benefit, even across Medi-Cal managed care plans?

I think the guidance is really to ensure that we’re engaging and talking to stakeholders about concerns on such a shift so that we don’t end up losing core services and things that we’ve worked really hard to achieve in health care like more coordinated care, better chronic disease management.

A lot of that is [hinged] on medications and medication management and the concern that by carving it out, you suddenly create a divide in information that’s really valuable at the point of care for patients.

And the last thing you want to do is save money on drugs but find that you drive more people to hospitals because their meds are not as well-coordinated.

I think people’s primary concern — we’re balancing how do you achieve good high quality, value-based care while making care more affordable. That’s not just in the employer market or the private market but that means also affordability in the public programs like Medicaid.

So there’s a real opportunity in thinking about how do we reduce the overall cost of care in California by getting better value on drugs, while maintaining some of these great achievements in care and sort of advancing chronic disease management that is so hinged on medication.

How is the drug purchasing initiative going?

I think we're really trying to see how bulky California can be. Who wants to join?

If it’s really big, I think there’s probably more leverage, and if it’s not as big, then there’s going to be less leverage.

Everybody recognizes that that’s one of a bunch of tools around how do maximize rebates and ensure we're lowering the total cost of a drug across its total pathway — not just what we buy it for, but how it moves between hands and gets into the hand of the patient.

Should we expect other moves in this area?

Of course there's opportunities to really force the conversations with the drug companies and the manufacturers around whether there can be more transparency and more clear process around price-setting.

How do you think about California's drug efforts broadly?

I see it as three things — there's bulk purchasing, there's the movement from managed care to fee-for-service and then there's the 340B element. I separate them out only because some people view this as California opting out of the 340B program and that's just not the case.

California believes and will always believe in trying to get the best price for what we're buying and 340B is a vehicle for certain institutions to get a very good price on certain medications.

The second two are about bulk purchasing. You're talking about being the buyer of drugs — not just the purchaser of drugs.

The state is also expanding Whole Person Care. How involved are you in that effort?

I led and conceived the project for Los Angeles County. And we were the biggest applicant for the funding, We did a ton of exciting work.

In many ways, that's my baby and I care deeply about it.

You get to focus on some of the most overlooked and hard-to-reach people and some of their needs.

I mean 90 percent of LA's project went to people incarcerated and who are homeless, so that's a pretty incredible opportunity. We tested a bunch of housing-based models, some models of providing care behind bars — all of these things that are hard to do in traditional Medicaid, we had a chance to do.

At the end of the day, though, Whole Person Care, when you really try to dumb it down, is: What does the whole person really need, and how does it address their health and how can we find a way to provide it for them?

San Francisco Chronicle

Covered California health rates rising 6.6% in SF — highest in the state
Catherine Ho

San Francisco residents enrolled in health insurance through the state exchange Covered California will see their average premium rise 6.6% in 2020.

That's a bigger increase than any other other region in the state will see, according to figures released Friday by Covered California, and it's significantly more than the statewide average increase of 0.8%.

Most of California's 19 regions will see rates rise between 0 and 3% next year. Some regions are individual counties, such as San Francisco, while other regions group together multiple counties, such as the region that includes Marin, Napa, Sonoma and Solano counties.

Covered California, the insurance marketplace created by the Affordable Care Act, sells health insurance to about 2 million residents who do not receive insurance through their employer. More than half receive federal financial assistance, based on their income, to help pay for the plans. About 34,000 people in San Francisco are enrolled in Covered California plans.

The unusually high jump in San Francisco appears tied to one health plan, Chinese Community Health Plan HMO, which is raising its rates nearly 20% and driving up the average increase for the entire region, according to a breakdown of each region's insurance plans and rates released by Covered California. Chinese Community Health Plan has nearly a quarter of San Francisco's Covered California customers. The other major health insurers in the region, the Kaiser Permanente HMO and Blue Shield PPO plans, raised premiums 1.6% and 3.5%, respectively.

"The cost of care is going up considerably and the cost of doing business in San Francisco continues to rise," said Chris Kelly, marketing and sales director for Chinese Community Health Plan. "We work in a very low margin business. We also had low rates to begin with. We did a lot of research and came back with what we felt was the most competitive pricing."

Kelly said CCHP's customer base of about 25,000 people, all in San Francisco and San Mateo counties, is smaller than that of the larger insurers Blue Shield and Kaiser, which are more able to spread costs out across a larger base.

The majority of San Francisco customers, 80 percent, should see premium increases at least partially offset by increases in financial assistance, said Covered California spokesman James Scullary. The remaining 20 percent could switch to a cheaper plan

and save money on premiums, though plans with lower premiums typically have higher co-pays and deductibles.

THE SACRAMENTO BEE

Sacramento area's insurance rates will rise 1.8 percent in 2020; some will see savings
Cathie Anderson

Covered California on Friday released the estimated 2020 rate changes for health insurance in each of its 19 pricing regions, and residents of the four-county Sacramento region will see average increases of 1.8 percent on the individual marketplace.

That means premiums will actually drop slightly for some local consumers. Covered California's release noted that, if consumers chose the lowest-price plan in their same metal tier, they could cut their rates by 2.2 percent. The average statewide premium increase is 0.8 percent.

"These regional rates confirm once again that health care is local and personal. It also affirms that the overall story is a good one for consumers across California," said Covered California Executive Director Peter V. Lee. "Even before considering the positive impact of new state subsidies, many Californians will be seeing little change or even decreases in their underlying premiums."

The Sacramento-area rate change compares favorably to San Francisco County, where rates will jump by 6.6 percent on average. Even San Franciscans can cut their rates if they shop around, though, by as much as 3.7 percent, according to the 2020 rate booklet.

While the rate change in El Dorado, Placer, Sacramento and Yolo counties looks low in comparison to San Francisco, it is higher than in 11 other pricing regions in the state.

Rates will decline, on average, for residents of four pricing regions — the 22 Northern Counties; the San Joaquin, Stanislaus, Merced, Mariposa and Tulare region; the Mono, Inyo and Imperial region; and the Kern County region — even if they maintain the same plans.

In three pricing areas — southwest Los Angeles County; the Inland Empire; and San Diego County — premiums will average about the same as they did last year.

Consumer advocate Anthony Wright said, if state residents shop and switch plans, they could see their premiums decrease by an average of 9 percent. In some places such as Orange County, he said, switching could lower premiums by as much as 16.5 percent

Some shoppers, Wright said, might also take advantage of the opportunity to select a silver-tier health plan with lower deductibles rather than keep the higher-deductible bronze plan they chose last year to save money. Health insurance sold through Covered California and on the individual market are sold in four levels of coverage: bronze, silver, gold and platinum. As the metal category increases in value, the size of co-pays and deductibles declines.

“In our high-cost-of-living state, at least a third of Californians were choosing ‘bronze’ high-deductible plans with little coverage in order to afford premiums,” said Wright, executive director of Health Access California. “Thanks to the investments in this year’s state budget and other state actions to safeguard us from the Trump Administration’s sabotage of our state’s health care system, those consumers will get more financial support than ever before.”

Earlier this year, the California Legislature and Gov. Gavin Newsom have put in place new state subsidies that will help an estimated 922,000 residents pay for their health insurance and established a so-called individual mandate that will impose a state tax penalty on any California resident who does not maintain health insurance coverage.

The California subsidies will benefit roughly 235,000 state residents who do not qualify for premium assistance from the federal government because their income exceeds limits and 663,000 Californians who currently receive federal subsidies and will now also get a state one.

For instance, Covered California noted that a 62-year-old Oakland couple who earn $72,000 a year would not qualify for any federal help but could receive $1,700 per month in help under the state subsidy program. That would cover 70 percent of their monthly premium, the agency said.

About 23,000 Californians whose annual income is just 138 percent of the federal poverty level — $17,237 for and individual and $35,534 for a family of four — will be able to get premiums of $1 per member per month.

“This first-in-the-nation program will make coverage more affordable for many middle-income Californians, such as small-businesses owners, entrepreneurs, contractors or workers in the gig economy,” Lee stated in the news release. “Every consumer is different, and even without the new state subsidies in place yet, many will see their premiums go down in 2020.”

Kaiser Permanente executive Bill Wehrle said he applauded the actions of the governor and the Legislature to support expanded access to high-quality, affordable care and ensure coverage for as many Californians as possible.

“California is showing that sound policies bring real benefits for consumers – including better rates,” said Wehrle, Kaiser’s vice president of health insurance exchanges.

Covered California estimates that the legislative changes will get an estimated 229,000 people to buy health insurance. The Golden State's individual health marketplace now numbers roughly 2.2 million people, according to Covered California, and 1.39 million of those individuals buy their policies through the Sacramento-based health exchange.

The changes in law also spurred three insurers to expand the areas they cover. Anthem Blue Cross, for instance, shrank its geographic footprint to Northern California, Santa Clara County and portions of the Central Valley after the Republican-controlled Congress eliminated the individual mandate. Now the insurer is expanding its presence to the Central Coast, Los Angeles County, the Inland Empire and more of the Central Valley.

Many Sacramento-area residents will be able to choose from as many as four insurance carriers — Blue Shield, Health Net, Kaiser Permanente and Western Health Advantage — but some will have only one option.

Blue Shield is offering both health maintenance organization and preferred provider organization plans. Local consumers in its HMO will see rate increases ranging from 1.7 percent to 7.6 percent, while its PPO customers will see rate hikes of 3.5 percent to 8.6 percent. On average, Blue Shield said it expected a 1.9 percent increase in rates for its HMO members and 5.4 percent for PPO members.

Health Net PPO said its rates will increase by 4.5 percent. Kaiser said its members could see rate cuts as high as 5.4 percent and rate increases of 6.8 percent, but on average, its premiums would go up by 0.9 percent. Consumers in the Western Health HMO could see their rates drop by as much as 3.8 percent or increase by as much as 9 percent. On average, it estimated a 4 percent rate increase.

THE PRESS DEMOCRAT

Covered California's health insurance premiums slated for small increase in North Bay
Alexandria Bordas

Health care premiums next year for North Bay residents insured through the Covered California marketplace will increase by the smallest amount since 2014, when the health exchange was launched under the federal Affordable Care Act.

Premiums for Covered California's Region 2, which includes Sonoma, Marin and Napa counties, are expected to increase by 1.1% in 2020, state officials said. About 51,000 people are enrolled in health insurance through Covered California in those counties.

State health care advocate Anthony Wright said Monday he expects the modest rate increase will attract more people to enroll in Covered California, especially in the Santa Rosa area.

"In Santa Rosa, it is a high cost of living for everything, including and especially health care costs," said Wright, executive director for Health Access California, which lobbies for high quality and affordable health care.

"We all know that the cost of living across Northern California is much more than almost anywhere else, so this is a big and important step to extend our health care coverage across the state," he said.

Statewide, the premium increase next year will be slightly lower than in the North Bay — up 0.8%.

Larry Hicks, spokesman for Covered California, said the health insurance exchange is projecting such small premium increases in 2020 because of an increase in enrollment and a state budget that provides more subsidies to defray the cost of health insurance for low- and middle-income residents and reinstitutes the state's mandate for individuals to buy coverage if they aren't covered by an employer group plan.

"The Affordable Care Act originally focused our goal on getting as many people as possible insured," Hicks said.

"Now with the help of more government subsidies, we are getting new funding to help the middle class, or roughly 235,000 people in the state."

Beginning next year, an expanded state subsidy for health insurance will help those making between $50,000 and $70,000 annually.

The new state subsidies are part of $335 million in investments in the state's 2019-2020 budget. Additionally, those who fall under the $50,000 annual income range will continue to receive assistance through ongoing state and federal health insurance subsidy programs.

Also, three insurers — Anthem Blue Cross, Blue Shield of California and Chinese Community Health Plan — plan further expansion of health coverage across the state next year.

The push by the California Legislature to help the middle class afford health insurance was in response to what Wright called an attack on health care that began about two years ago by the Trump administration.

“After we had a couple of rough years from a tough administration that was trying to sabotage our health care system, California took big steps to ensure we are protected and everyone gets the coverage they need,” Wright said.

How California Is Moving the Needle on Coverage and Costs: An Interview with Covered California Leaders
Christina Cousart

California Gov. Gavin Newsom’s new budget has infused significant funds to make health care coverage sold through its health insurance marketplace (Covered California) more affordable and has made new subsidies available to middle-income individuals earning between 400 to 600 percent of the federal poverty level (FPL).

• California’s new subsidy program assists those earning up to 600% FPL (e.g., $72,840 per year for individuals or $150,600 for a family of four in 2019).

• California estimates 922,000 individuals would be eligible for new or enhanced subsidies in 2020, and 187,000 new individuals could enroll in its marketplace.

• California is also reinstating a penalty for those who do not have health insurance.

The budget allots $429 million in 2020 to provide new subsidies and builds on current federal premium subsidies that help fund individuals earning 100 to 400 percent of FPL.

To learn more about California’s new initiative, NASHP spoke with Covered California Executive Director Peter Lee and Director of Policy Katie Ravel. They also discussed their implementation plans for the 2020 coverage year.

What prompted development of this coverage initiative?

PL: Many people have been left out of accessing coverage — especially the middle class and those who are undocumented — and our governor and legislature wanted to take concrete steps to get the state toward universal coverage. On Governor Newsom’s first day in office, he laid out his agenda, calling for the federal government to reinstate the individual mandate and expand subsidies available through the marketplaces. Meanwhile, our legislature has also been committed to building on what the Affordable Care Act (ACA) did to expand coverage.

KR: Last year, the legislature required Covered California to develop options to improve coverage affordability for low- and middle-income consumers in the state.

What was California's approach in developing this initiative?

PL: We had four goals driving our work; decrease the number of uninsured; address affordability concerns of those who are insured; make sure what we did would be affordable for the state; and deliver options that could be implemented in the short term.

KR: To start, we wanted to build on the main levers of the ACA and ultimately move the needle on coverage and cost. We formed a workgroup inclusive of consumer advocates, insurers, providers, and legislative staff members. We provided them with education about the basics of how our programs currently work and how Covered California is structured in addition to reviewing data about current affordability challenges. We worked with economists Wesley Yin from the University of California at Los Angeles and Nicholas Tilipman from the University of Illinois at Chicago to model the impacts on coverage and cost of various affordability policies including enhanced premium and cost-sharing subsidies, reinsurance, and reinstatement of a coverage mandate.

NASHP's 32nd Annual Health Policy Conference, Aug. 21-23, 2019 in Chicago, features several sessions that highlight recent state innovations to increase health insurance access, lower costs, and stabilize markets. Learn more and register to attend these and other sessions.

States on Fire: Innovations to Increase Health Care Access and Lower Costs
Affordability, Public Options, Reference Pricing, and More
How State Marketplaces Are Preserving Choice, Affordability, and a Healthy Market Risk
PL: We were able to prepare a good product that laid out the options and informed legislators and advocates about the pros and cons of each. From this work, they could clearly understand what an investment of additional funds would get you in terms of increased coverage and affordability. The information we gathered helped steer us away from other options like reinsurance or reducing cost sharing for marketplace plans.

KR: When it was clear that the intention was to launch a program in 2020, the most turnkey option was to increase subsidies. Ultimately, the best way to drive enrollment is to make premiums more affordable.

Why is it important to include a coverage mandate?

PL: Policymakers almost universally recognize the sensibility of the individual mandate. There is empirical evidence that a mandate has an impact on driving people to get insured. Massachusetts is one example, they have a long-standing state mandate and was the only state to see an increase in new enrollment after the federal mandate went away.

Once legislators were able to come together and recognize that lack of a mandate [and associated drops in enrollment and increases in premiums] was most hurting the middle class who do not qualify for federal subsidies, it made sense to marry those policies together; reinstitution of a mandate, with penalty funds supporting those who were at the “subsidy cliff” [400 percent of FPL, the point at which individuals no longer qualify for federal subsidies]. Sixty percent of the new enrollment we project due to these policies in 2020 will actually be motivated by the penalty. Approximately 80 percent of overall funding allotted for subsidies will go to those [earning] between 400 to 600 percent of FPL.

What other work was required to bring policymakers on board with this subsidy plan?

KR: What was most important was that we were able to produce concrete estimates of how each policy choice would impact enrollment and affordability. Data made the choices real. Legislators understood the impact they could have if these initiatives were passed. We spent a lot of time diving into the data to better understand the health care costs for Californians whose incomes are over 400 percent of FPL. It was eye opening! Some, especially those nearing Medicare eligibility, would have to pay nearly 35 percent of their premium to purchase a benchmark health insurance plan.

PL: That people have to pay tens of thousands of dollars a year in health plan premiums is unfair. People are really hurt by the federal subsidy cliff. However, for this to work, we were talking about a lot of money, and had lot of politics to get through. These policies are complicated, and it took years of Covered California becoming a trusted part of health policy discussions to get here. It was important for us to bring awareness about what was actually doable, especially in quick-turnaround. There is no way we would be implementing as soon as 2020 if it were not for the workgroup.

Through our reports and data, we told the story of the local impact of these policies. In our workgroup report, we provided examples of hypothetical families, but presented them in a way that most policymakers could relate to — policymakers had heard from “people like them” in their communities for whom our insurance system was not working. Having that data to make things local is an important role for the state-based exchanges.

Plan year 2020 is quickly approaching. How will Covered California be able to implement this law so quickly?

PL: A critical part of our planning was early engagement with our carriers. We engaged them to work through importation questions like: Could our systems even work with theirs to add a state subsidy? What were their deadlines to price products anticipating changes might come as soon as plan year 2020? The plans have confidence we will aggressively market these changes, and anticipate this will lead to lower rates for plan year 2020.

Also helpful is that we modeled everything off what already existed under the ACA and leveraging as many existing processes as we can. We are using the same rules for the mandate as exist under federal law and subsidies will be distributed using the same mechanics in place for advanced premium tax credits.

KR: On the technical side, there are three main buckets we're focused on for implementation: we'll have to make changes to our eligibility rules engine, then figure out the money flow for the subsidies, then how to reconcile the subsidies at the end of the year based on income changes. We have been coordinating regularly with our design team and carriers to develop and test new systems and processes. We're also working closely with our state tax agency on the subsidy reconciliation piece.

PL: The partnership with the tax agency is new for us. We recognize that it is part of our collective job as agencies of the state to make sure that people are insured, so we are working hard on how we inform consumers that they have better options than to pay the penalty. Our intent is not to penalize individuals, but rather to make sure that people are insured.

How will Covered California raise awareness about these changes?

PL: We are currently doing market research on what messages will resonate best with consumers. We recognize that passage of a mandate does not necessarily mean consumers will automatically be aware of and comply with the law, so we are planning a marketing strategy to increase awareness. Rather than focus on the penalty, our ads will focus on the fact that the mandate is now the law in California and that we are making coverage even more affordable. We want to drive people to come in and shop for coverage.

What else should we know about California's new initiative?

PL: Importantly, these proposals are just stopgaps for what California believes should be federal responsibilities [e.g., to enforce a mandate and to provide subsidies that make coverage more affordable for all]. The penalty is written so that it is in effect until the federal one is reinstated. As for the subsidies, the program is only set to run for three years. We believe this will greatly benefit Californians in the short-term, but don't want it to be the long-term solution. In the absence of leadership from the federal government, states can step up, but ultimately the federal government needs to step in.

VC Star.
PART OF THE USA TODAY NETWORK

Covered California rates set to climb 4.6% in Ventura County
Tom Kisken

Covered California premiums will rise an average of nearly 5% next year in Ventura, Santa Barbara and San Luis Obispo counties.

Leaders of the health insurance exchange created by the Affordable Care Act announced earlier this month statewide rates will rise an average of 0.8%, the lowest increase in Covered California's six-year history. New data released for the 19 pricing regions across the state show premiums will rise in some areas and fall in others.

Rates will climb an average of 4.6% in Region 12, encompassing Ventura, Santa Barbara and San Luis Obispo counties. The hike is the second highest in the state, behind only the 6.6% increase in San Francisco County.

About 64,000 people in Region 12 were enrolled in Covered California plans as of April. Data from December showed about 34,000 Ventura County residents were enrolled.

In Mono, Inyo and Imperial counties on the eastern edge of the state, the average rate will drop 6.9%. In Kern County, which shares a border with Ventura County, rates will fall 0.5%.

Covered California leaders called the increases "modest." They attributed the rise in Ventura County's region to the cost of care in the area and the overall health of people covered by an insurer.

They said people in Region 12 can still see their premiums drop an average of 2.3% if they compare plans and switch to the lowest-price offering in their current tier.

Blue Shield's PPO rate, the plan picked by about 62% of the residents in the region in 2019, is set to rise an average of 5.8% in 2020 for Region 12. Premiums for Blue Shield's HMO are set to rise an average of 2.1% with rates of Kaiser's HMO expected to rise 3.9%.

Anthem Blue Cross pulled its Covered California plans out of Ventura County before 2018. The insurer will return to Region 12 with 2020 coverage.

New state subsidies have been added so that more than 230,000 middle income Californians will be newly eligible for aid. And subsidies will increase for more than 660,000 people with earnings between 200% and 400% of federal poverty levels..

Marin Independent Journal

Marin's rates to rise 1.1% in state health insurance exchange
Richard Halstead

Marin residents purchasing health insurance via the California insurance marketplace established under Obamacare are expected to see their health care premiums increase an average of 1.1% in 2020.

Covered California, an independent part of the state government whose job is to make California's health insurance marketplace work for consumers, announced earlier this month that statewide individual insurance premiums will rise by an average of 0.8% in 2020.

Marin's slightly higher figure was calculated as part of region that also includes Sonoma, Napa and Solano counties.

The statewide average is the smallest increase in rates since 2014, when the state's health exchange was launched under the federal Affordable Care Act. Last year, Covered California premiums statewide jumped an average of 8%.

"Actually, most Covered California consumers will actually see a decrease in their premiums," said Anthony Wright, executive director of Health Access, a statewide health care consumer advocacy organization based in Oakland. "That is because of actions that California has taken to counter the Trump administration's efforts to sabotage the Affordable Care Act."

At the national level, with Obamacare still under siege from the Trump administration and congressional Republicans, Democratic presidential candidates debated this week whether to make advocacy for a government-run single-payer system an election issue.

"It's good that presidential candidates are talking about how we can take additional steps rather than debating about whether to repeal the Affordable Care Act," Wright said. "Health Access has long supported a single-payer, Medicare for all solution, but we also support other reforms that will provide immediate help to consumers in the meantime."

According to Covered California, the significantly lower rate change is because of two state affordability initiatives: the restoration of an individual mandate to purchase health insurance, and new state subsidies that an estimated 922,000 consumers will be eligible to receive.

California is the first state in the country to offer state-funded tax credits to middle-class enrollees. An estimated 235,000 middle-income Californians who previously didn't qualify for financial assistance will be eligible to receive an average of $172 per household per month. Another 20,000 Californians at or below the poverty line will get their premiums reduced to nearly zero.

"I absolutely think that Marin residents will be assisted by this," said Kari Beuerman, assistant director of the Marin County Department of Health and Human Services. "The important thing to note in Marin is the high cost of living. Working families need all of the help they can get."

The number of Marin residents enrolling through Covered California peaked in 2016 at 12,720 and was 12,310 as of March 2019, the lowest number since the creation of the exchange.

Beuerman said the decrease in Marin enrollments through Covered California also might be because of people becoming ineligible for subsidies after increases in their income.

"Every January when the minimum wage goes up, fewer people qualify for any type of assistance or subsidies," she said.

Covered California is projecting that an additional 225,000 Californians will enroll for health care through the state's exchange because of the new financial help that was included in the 2019-2020 state budget.

The budget includes $1.5 billion dollars over three years in state subsidies to help low- and moderate-income Californians. Affordability assistance has been extended to people earning six times the poverty level — around $75,000 for an individual, and $150,000 for a family of four.

Covered California executive director Peter Lee said, "The bold moves by Gov. Newsom and the Legislature will save Californians hundreds of millions of dollars in premiums and provide new financial assistance to middle-income Californians, which will help people get covered and stay covered."

California's actions came in response to moves by the Trump administration and congressional Republicans to undermine Obamacare. The elimination of the individual mandate to purchase health insurance in 2017 resulted in higher premiums in 2019 and likely contributed to a drop in new consumers signing up for coverage during the most recent open-enrollment period, which ended in January.

The Trump administration has also taken other steps to weaken Obamacare: dramatically cutting funding for enrollment efforts and shortening the annual open-enrollment period.

In addition, a lawsuit filed by a group of Republican attorneys general claims that Congress' decision to scrap the individual mandate penalty rendered the law unconstitutional. The case is being heard in the 5th Circuit Court of Appeals in New Orleans and could reach the U.S. Supreme Court before the 2020 presidential election.

California Legislature OKs health insurance mandate
Adam Beam

SACRAMENTO, Calif. (AP) — The California Legislature voted Monday to tax people who refuse to buy health insurance, bringing back a key part of former President Barack Obama's health care law in the country's most populous state after it was eliminated by Republicans in Congress.

The tax now heads to Democratic Gov. Gavin Newsom, who proposed a similar plan in January — an indication he will likely approve it.

The federal Affordable Care Act required everyone to buy health insurance or pay a penalty. The U.S. Supreme Court upheld the law, ruling the penalty was a tax.

In 2017, Republicans in Congress eliminated the penalty — beginning this year — as part of an overhaul of the federal tax code.

The bill passed by Democrats in California would reinstate the tax, effective Jan. 1. No Republicans voted for it. One Democrat in the state Assembly — Rudy Salas Jr. — voted against it.

The penalty won't apply to everyone, including people living in the country illegally. Lawmakers on Monday also approved a bill that would expand government-funded health insurance to low-income young adults living in the U.S. illegally.

People in prison and those who are members of an American Indian tribe are also exempt, mirroring what had been in the federal law.

Democrats say the plan is part of their efforts to make sure everyone in California has health insurance.

If the bill becomes law, California would join Massachusetts, New Jersey, Vermont and Washington, D.C., next year as the only governments in the U.S. to penalize people who don't buy health insurance.

It would also make California the only state to use money it gets from the penalty to help people who earn as much as six times the federal poverty limit pay their monthly health insurance premiums.

That means a family of four earning up to $150,000 a year would be eligible.

“These new subsidies will impact almost 1 million Californians and help them get the health care access that they deserve,” said Democratic Assemblyman Phil Ting of San Francisco.

Republican state Sen. John Moorlach said in 2014 that 82% of Californians who paid the penalty for not having health insurance had taxable incomes of $50,000 or less.

“This trailer bill will take money away from people making $30,000 to $50,000 a year and give it to people making between $75,000 and $130,000 a year,” GOP Assemblyman Jay Obernolte said. “That makes no sense.”

The state has already extended government health benefits to children living in the country illegally. The plan approved Monday would extend that coverage to people as old as 25.

While the proposal easily passed the Legislature, it brought a rebuke from Democratic Sen. Maria Elena Durazo from Los Angeles. She criticized the bill for not providing health care coverage to people 65 and older living in the country illegally.

“We’ve missed an opportunity to create fairness and inclusion,” she said.

KHN
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New Budget Boosts Health Coverage For Low-Income Californians
Ana B. Ibarra

Ann Manganello survives entirely off her Social Security stipend: $1,391 a month.

That doesn’t amount to much in the pricey desert enclave of Palm Springs, Calif. — especially for someone who contends with a host of expensive medical problems, including a blood vessel disorder, complications from a recent stroke and frequent bouts of colitis.

“Right now, I don’t really have the money to do much. I just stay here and that’s it,” Manganello said with a sigh, sad at the thought of being stuck in her apartment.

Because she is 71 and has a low income, Manganello qualifies for Medi-Cal, the state's Medicaid program for disadvantaged people, as well as Medicare, the public insurance program for people 65 and older.

But there's a catch: Her monthly Social Security check puts her slightly above the income level for free care under Medi-Cal. So, she reduces the amount of income counted for Medi-Cal eligibility by buying a dental insurance policy she doesn't really need, just so she can qualify for the free coverage and avoid a $672 monthly deductible.

Things are expected to change next year for Manganello and others in similar situations. In the state budget for 2019-20, legislators approved $62.4 million to help about 25,000 older people and those with disabilities get free Medi-Cal. Gov. Gavin Newsom must sign the budget by June 30.

That's one of several major investments the $215 billion budget makes in Medi-Cal enrollment and services. About 13 million Californians — or about a third of the state's population — have Medi-Cal.

The spending plan also includes money to restore medical benefits that were cut 10 years ago during the recession, such as podiatry and speech therapy. It also provides full Medi-Cal coverage to low-income young adults ages 19 through 25 who are in the country illegally. That will make California the first state in the nation to offer full Medicaid benefits to unauthorized immigrant adults.

Plus there's $30 million for outreach and enrollment and $769.5 million to boost the amount Medi-Cal pays participating doctors and dentists.

For Manganello, who worked as a manager for a signage shop in Buffalo, N.Y., before moving west, qualifying for free Medi-Cal would make a tangible difference in her life.

"I could cancel that extra insurance and buy myself a medical alert bracelet. I would also have some money to maybe pay off some other medical bills," she said. "It would help with groceries, things like Depends. And maybe I could go out to lunch once in a while."

The Medi-Cal expansions in the budget represent another radical departure by California from the federal government on health care and immigration. In addition to cracking down on illegal immigration, the Trump administration is pushing policies, such as work requirements for Medicaid enrollees, that often lead to reductions in enrollment.

The budget measures also bring California a step closer to Newsom's goal of achieving universal health care coverage. The state's estimated 1.8 million unauthorized immigrants, for example, make up roughly 60% of the state's remaining uninsured residents.

“It seems like what has occurred in California this year is a very conscious, systematic and well-designed effort to close gaps” in coverage, said Judy Solomon, a senior fellow at the Center on Budget and Policy Priorities.

Many other states face similar coverage gaps but few can afford to address them, Solomon said.

‘Senior Penalty’

Most adults who don’t have a disability and are under 65 are eligible for free Medi-Cal with incomes up to 138% of the federal poverty level, or about $17,200 for an individual.

But adults in Medi-Cal’s Aged and Disabled Program have to meet stricter income requirements — up to 122% of the poverty level, or just under $15,240 a year for an individual.

If, like Manganello, they make slightly more than that, they must pay a certain amount of their health costs — essentially, a deductible — before Medi-Cal coverage kicks in. That can translate into hundreds of dollars or more per month.

Linda Nguy, a policy advocate at the Western Center on Law & Poverty, said that many people are simply skipping medical care because they can’t afford the deductible.

“We call this the senior penalty, because basically you’re being penalized with a stricter eligibility limit based fully on your age or disability,” said Amber Christ, an attorney with Justice in Aging, a nonprofit advocacy group focused on senior poverty.

Many states that expanded their Medicaid programs under the Affordable Care Act also have this disparity, Christ said. The 2019-20 California budget would end it by raising the income eligibility threshold for that group to 138% of the poverty level.

Restoring Benefits

During the Great Recession, California, like many other states, cut several Medicaid benefits that aren’t required by the federal government.

Starting Jan. 1, Medi-Cal will restore five areas of coverage: audiology, optical services, podiatry, incontinence supplies and speech therapy.

“People of all ages wear glasses, so this can really benefit anyone,” Nguy said. “But things like podiatry, audiology, speech therapy are probably of most benefit to people with chronic conditions.”

The new budget includes $17.4 million for these services, which could disappear again in 2022 unless lawmakers decide to extend them.

Optional benefits are usually the first to go in bad economic times, and bringing them back can take years. Full dental benefits, also cut during the recession, were restored for adults in Medi-Cal last year.

Immigrant Coverage

Lawmakers allocated $98 million to offer free health coverage for unauthorized young immigrant adults who meet the income requirements, starting next year. Of this, $74.3 million will come from the state, while the rest will come from funds the federal government provides for labor and delivery and emergency care only.

About 90,000 young adults are expected to become eligible in the first year.

Covering young adults became the most controversial health care issue in this year's budget. Republicans criticized the effort, arguing that Medi-Cal should be fixed before it is expanded.

"Every day, my district offices get calls from my constituents who are unable to see a doctor, even though they are technically covered by Medi-Cal, because so few doctors in my district are able to take the low reimbursement rates that Medi-Cal provides," state Assemblyman Jay Obernolte (R-Big Bear Lake) said before the Assembly's budget vote on June 13.

In 2016, California started offering full Medi-Cal benefits to unauthorized immigrant children. The state's current-year budget allocates $365.2 million to fund that coverage. In February 2019, 127,845 kids were enrolled in the program.

The New York Times

The Lessons of Washington State's Watered Down 'Public Option'
Sarah Kliff

For those who dream of universal health care, Washington State looks like a pioneer. As Gov. Jay Inslee pointed out in the first Democratic presidential debate on Wednesday, his state has created the country's first "public option" — a government-run health plan that would compete with private insurance.

Ten years ago, the idea of a public option was so contentious that Obamacare became law only after the concept was discarded. Now it's gaining support again, particularly among Democratic candidates like Joe Biden who see it as a more moderate alternative to a Bernie Sanders-style "Medicare for all."

New Mexico and Colorado are exploring whether they can move faster than Congress and also introduce state-level, public health coverage open to all residents.

But a closer look at the Washington public option signed into law last month, and how it was watered down for passage, is a reminder of why the idea ultimately failed to make it into the Affordable Care Act and gives a preview of the tricky politics of extending the government's reach into health care.

On one level, the law is a big milestone. It allows the state to regulate some health care prices, a crucial feature of congressional public option and single-payer plans.

But the law also made big compromises that experts say will make it less powerful. To gain enough political support to pass, health care prices were set significantly higher than drafters originally hoped.

"It started out as a very aggressive effort to push down prices to Medicare levels, and ended up something quite a bit more modest," said Larry Levitt, senior vice president for health reform at the Kaiser Family Foundation.

So while Washington is on track to have a public option soon, it may not deliver the steep premium cuts that supporters want. The state estimates that individual market premiums will fall 5 percent to 10 percent when the new public plan begins.

"This bill is important, but it's also relatively modest," said David Frockt, the state senator who sponsored the bill. "When I see candidates talking about the public option, I don't think they're really grasping the level of opposition they're going to face."

During the Affordable Care Act debate, more liberal Democrats hoped a public option would reduce the uninsured rate by offering lower premiums and putting competitive pressure on private plans to do the same. President Obama backed it, saying in 2009 that such a policy would "keep the private sector honest."

The public option came under fierce attack from the health care industry. Private health plans in particular did not look forward to competing against a new public insurer that offered lower rates, and fought against a government-run plan that they said "would significantly disrupt the coverage that people currently rely on." The policy narrowly fell out of the health care law but never left the policy debate.

Congressional Democrats have started to revisit the idea in the past year, with health care as a top policy issue in the 2018 midterm elections.

"During the midterm elections, Medicare for all was gaining a lot of traction," said Eileen Cody, the Washington state legislator who introduced the first version of the public option bill. "After the election, we had to decide, what do we want to do about it?"

Ms. Cody introduced a bill in January to create a public option that would pay hospitals and doctors the same prices as Medicare does, which is also how many congressional public option proposals would set fees. The Washington State Health Benefit Exchange, the marketplace that manages individual Affordable Care Act plans, estimates that

private plans currently pay 174 percent of Medicare fees, making the proposed rates a steep payment cut.

“I felt that capping the rates was very important,” Ms. Cody said. “If we didn’t start somewhere, then the rates were going to keep going up.”

Doctors and hospitals in Washington lobbied against the rate regulation, arguing that they rely on private insurers’ higher payment rates to keep their doors open while still accepting patients from Medicaid, the public plan that covers lower-income Americans and generally pays lower rates.

“Politically, we were trying to be in every conversation,” says Jennifer Hanscom, executive director of the Washington State Medical Association, which lobbies on behalf of doctors. “We were trying to be in the room, saying rate setting doesn’t work for us — let’s consider some other options. As soon as it was put in the bill, that’s where our opposition started to solidify.”

Legislators were in a policy bind. The whole point of the public option was to reduce premiums by cutting health care prices. But if they cut the prices too much, they risked a revolt. Doctors and hospitals could snub the new plan, declining to participate in the network.

“The whole debate was about the rate mechanism,” said Mr. Frockt, the state senator. “With the original bill, with Medicare rates, there was strong opposition from all quarters. The insurers, the hospitals, the doctors, everybody.”

Mr. Frockt and his colleagues ultimately raised the fees for the public option up to 160 percent of Medicare rates.

“I don’t think the bill would have passed at Medicare rates,” Mr. Frockt said. “I think having the Medicare-plus rates was crucial to getting the final few votes.”

Other elements of the Washington State plan could further weaken the public option. Instead of starting an insurance company from scratch, the state decided to contract with private insurers to run the day-to-day operations of the new plan.

“It would have cost the state hundreds of millions of dollars just to operate the plan,” said Jason McGill, who recently served as a senior health policy adviser to Mr. Inslee. He noted that insurers were required to maintain large financial reserves, to ensure they don’t go bankrupt if a few patients have especially costly medical bills.

“Why would we do that when there are already insurers that do that? It just didn’t make financial sense. It may one day, and we’ll stay on top of this, but we’re not willing to totally mothball the health care system quite yet.”

Hospitals and doctors will also get to decide whether to participate in the new plan, which pays lower prices than private competitors. The state decided to make

participation voluntary, although state officials say they will consider revisiting that if they're unable to build a strong network of health care providers.

Most federal versions of the public option would give patients access to Medicare's expansive network of doctors and hospitals.

Although Mr. Frockt is proud of the new bill, he's also measured in describing how it will affect his state's residents. After going through the process of passing the country's first public option, he's cautious in his expectations for what a future president and Democratic Congress might be able to achieve. But he does have a clearer sense of what the debate will be like, and where it will focus.

"This is a core debate in the Democratic Party: Do we build on the current system, or do we move to a universal system and how do we get there?" he said. "I think the rate-setting issue is going to be vital. It's what this is all about."

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POLITICO

Legal experts: Court's new Obamacare inquiry likely won't doom law
Paul Demko

Legal experts are downplaying new questions from a federal appeals court about whether Democratic supporters of Obamacare can defend the health care law against a lawsuit challenging its constitutionality.

The surprising inquiry on Wednesday sparked alarm among Obamacare advocates that the appellate court could decide the law's supporters lacked the standing to appeal a federal judge's December ruling that invalidated all of Obamacare, leaving the law's future uncertain.

However, a day later, legal experts said they believe the 5th U.S. Circuit Court of Appeals will ultimately find the 20 Democratic-led states fighting the lawsuit have standing because they would clearly suffer major financial harm if the entire law was scrapped.

"That harm is very, very clear," said Katie Keith, a Georgetown Law professor who writes extensively about health care legal issues. "You're going to gut Medicaid expansion and tax credits. Just the financial impact alone should be more than enough for standing."

The Democratic-led House of Representatives, which joined Obamacare's legal defense earlier this year, is also facing questions about standing.

The 5th Circuit said its questions were prompted by the Trump administration's recent decision to change legal strategy in the lawsuit brought by more than a dozen red states. The Justice Department originally argued only the Affordable Care Act's high-profile insurance protections should be struck, but in March it said U.S. District Court Judge Reed O'Connor's ruling against the entire law should be upheld.

Kermit Roosevelt, a constitutional law expert at the University of Pennsylvania Law School, said the 5th Circuit's questions about standing aren't necessarily an indication the court is ready to jettison the appeal. He said it's possible just a single judge could be hung up on the standing issue.

"It's not a promising sign because it's another way that [ACA supporters] could lose, but it also doesn't seem like a strong legal theory," Roosevelt said. "Another weapon has appeared, but it's not as far as I can tell a very dangerous weapon."

The 5th Circuit has not yet said which three-judge panel will hear oral arguments, scheduled for July 9 in New Orleans. The court has asked for briefs on the standing question by next week.

Even if the 5th Circuit ultimately determined no one could legitimately appeal the lower court decision against Obamacare, it's not clear that ruling would immediately take effect.

Ironically, such a move could doom the Republican-led lawsuit. It's possible the 5th Circuit could vacate the lower court ruling, and the case would die. Obamacare would remain the law of the land.

"Then it's as if nothing ever happened," said Michael Rosman, general counsel for the conservative Center for Individual Rights. Conservative legal expert Jonathan Adler made a similar point in a post on the Volokh Conspiracy blog.

But even if the 5th Circuit says Democrats can't defend the ACA and leaves the lower court ruling in place, that's not the end of the legal battle. Democrats fighting the lawsuit could ask the Supreme Court to reconsider the standing issue.

There would be another complication in this scenario. When O'Connor ruled against Obamacare, he never issued an injunction blocking ACA enforcement, so his ruling had no immediate practical effect. Presumably, the Republican-led states behind the lawsuit would ask him to issue an injunction halting the law.

"It's not altogether clear whether or not the plaintiffs in this case would be able to get an injunction," Rosman said. "They didn't get it the first time."

And the legal quagmire could get even murkier. If O'Connor issued an injunction, it's not clear anyone would be left to challenge it — in this scenario, the Democrats would still lack standing in the case, said Roosevelt, the constitutional law scholar. That would essentially leave Obamacare's fate entirely in O'Connor's hands.

“You've got the problem of the nationwide injunction from the district court on steroids, because now it's unreviewable,” Roosevelt said. “And not only is one district court deciding this issue for the entire country, no one else can affect that decision, which in practical terms is crazy. That really shouldn't happen.”

Trump, California governor spar over immigrant health care
Adam Beam

SACRAMENTO, Calif. (AP) — California’s governor vowed on Monday to continue expanding taxpayer funded health benefits to adults living in the country illegally next year, ensuring the volatile issue will get top billing in the 2020 presidential election as Democrats vying for the nomination woo voters in the country’s most populous state.

Democratic Gov. Gavin Newsom signed a $214.8 billion operating budget last week that includes spending to make low-income adults 25 and younger living in the country illegally eligible for the state’s Medicaid program. California is the first state to do this, with an expected cost of $98 million to cover about 90,000 people

Democrats in the state legislature had pushed to also cover adults 65 and older living in the country illegally, as well as all adults regardless of age. But Newsom rejected those proposals because they were too expensive — about $3.4 billion for all adults living in the country illegally in California.

But Monday, Newsom told a crowd of supporters at Sacramento City College “we’re going to get the rest of that done.”

“Mark my words,” Newsom said. “We’re going to make progress next year and the year after on that. That’s what universal health care means. Everybody, not just some folks.”

If Newsom follows through, it will ensure California’s legislature will be debating the issue at about the same time California voters are voting for a Democratic presidential nominee. The state has an outsized role in the selection process this year because its primary is scheduled for March 3.

Republicans seemed to welcome the debate. Speaking to reporters on Monday, President Donald Trump said California doesn’t “treat their people as well as they treat illegal immigrants.”

“At what point does it stop? It’s crazy what they are doing,” he said. “And it’s mean. And it’s very unfair to our citizens, and we’re going to stop it. But we may need an election to stop it, and we may need to get back the House.”

Newsom’s comments highlight how quickly Democrats have embraced using tax dollars to provide services for people living in the country illegally. Former Democratic President Barack Obama’s health care law dramatically expanded Medicaid coverage in 2014, but only for people living in the country legally.

Last week, all 10 Democratic presidential candidates during the second night of a televised debate raised their hands when asked if they supported expanding Medicaid to cover people living in the country illegally. They included front-runners like former Vice President Joe Biden, Vermont U.S. Sen. Bernie Sanders and California U.S. Sen. Kamala Harris.

“I think the anti-immigrant stance by the Trump administration has in some sense created this as the bigger issue,” said Larry Levitt, executive vice president for health policy at the Henry J. Kaiser Family Foundation. “The Trump administration has pushed Democrats even further to defend immigration and provide services to people who are already here.”

California’s $214.8 billion operating budget, which took effect Monday, also brings back an Obama-era tax on people who refuse to purchase private health insurance. State officials will use the money from the tax to help middle income families — including families of four who earn as much as $150,000 a year — pay their monthly health insurance premiums.

“To Donald Trump: eat your heart out,” Newsom said.

Biden vows to bring back Obamacare’s individual mandate penalty for not having insurance
Jessica Bursztynsky

Joe Biden, former vice president and 2020 Democratic presidential hopeful, said Friday he would bring back the individual mandate, the penalty for not having health insurance, which was a pillar of the Affordable Care Act.

“Yes, I’d bring back the individual mandate,” Biden said in an interview on CNN. The individual mandate would be popular now, “compared to what’s being offered,” he added.

Biden played an integral part in crafting the ACA, commonly known as Obamacare. However, President Donald Trump eliminated the individual mandate in 2017 by signing the Republican tax bill, effective the 2019 tax year.

Nearly all of the Democratic presidential hopefuls support some kind of government health-care plan. While he does not support of “Medicare for All,” Biden said people should have the option to buy into Medicare if they want it.

“If you provide an option for anybody who in fact wants to buy into Medicare for All, they can buy in,” the Democratic presidential front-runner said.

Biden also took a nuanced approach Friday, saying he supports providing emergency health care for undocumented immigrants in the U.S.

“I think undocumented people need to have a means by which they can be covered when they’re sick,” Biden said. “In an emergency, they should have health care.”

At last week’s Democratic presidential debate, all 10 of the hopefuls on stage, including Biden, Sens. Bernie Sanders, Kamala Harris and Kirsten Gillibrand, raised their hands in support of care for people in the country illegally.

Biden on CNN was threading the needle on the issue, talking about taking care of the health needs of undocumented immigrants in emergencies. “How do you say, ‘You’re undocumented. You’re going to die, man.’”

Providing wide access to health care would prove to be contentious, with many polls saying Americans do not support coverage for undocumented immigrants.

The 2010 Affordable Care Act, which passed when Biden was former President Barack Obama’s vice president, largely excluded the undocumented from buying into U.S. health-care programs.

After the debate, President Donald Trump tweeted against the move.

“All Democrats just raised their hands for giving millions of illegal aliens unlimited healthcare,” Trump said. “How about taking care of American Citizens first!? That’s the end of that race!”

However, Trump’s rhetoric was not surprising to Biden. “This is part of what Trump is playing on,” he said, playing on people’s fears of having open borders and people flowing into the U.S.

Biden said providing health care to people who are sick “is just common decency.”

Appeals court puts Trump abortion restrictions on hold again
Gene Johnson

SEATTLE (AP) — Trump administration rules that impose additional hurdles for low-income women seeking abortions are on hold once again.

The 9th U.S. Circuit Court of Appeals in San Francisco on Wednesday vacated a unanimous ruling from a three-judge panel and said a slate of 11 judges will reconsider lawsuits brought by more than 20 states and several civil rights and health organizations challenging the rules.

The rules ban taxpayer-funded clinics from making abortion referrals and prohibit clinics that receive federal money from sharing office space with abortion providers.

Critics say the rules would force many clinics to find new locations, undergo expensive remodels or shut down.

The Justice Department did not immediately respond to an email seeking comment. The agency previously said its position “is supported by long-standing Supreme Court precedent, and we are confident we will ultimately prevail on appeal.”

Federal judges in Washington, Oregon and California blocked the rules from taking effect. U.S. District Judge Michael McShane in Oregon called the new policy “madness” and said it was motivated by “an arrogant assumption that the government is better suited to direct women’s health care than their providers.”

A three-judge panel of the 9th Circuit overruled them two weeks ago. The judges called the rules “reasonable” and said they align with a federal law that prohibits taxpayer funds from going to “programs where abortion is a method of family planning.”

With that decision vacated, the injunctions issued by the lower court judges are once again in effect. It’s not clear when new court arguments will be held.

“We are profoundly grateful the preliminary injunction is back in place,” said Clare Coleman, president of the National Family Planning and Reproductive Health Association, which is involved in the cases.

She said the U.S. Department of Health and Human Services had not yet been enforcing the new rules, even though the three-judge panel's ruling had given it the green light to do so.

The rules affect organizations that provide, and women who receive, health care through Title X, a 1970 law designed to improve access to family planning services.

Among them is Planned Parenthood, which had called the now-vacated panel decision "devastating." It serves about 1.6 million of the 4 million low-income patients who receive health care through Title X.

Abortion is a legal medical procedure, but federal laws prohibit the use of Title X or other taxpayer funds to pay for abortions except in cases of rape, incest or to save the woman's life. Abortion opponents and religious conservatives say Title X has long been used to indirectly subsidize abortion providers.

If allowed to take effect, the administration's new policy would mark a return to rules that were adopted in 1988 and subsequently upheld by the Supreme Court. Under the Clinton administration, those rules were abandoned in favor of a requirement that the clinics provide neutral abortion counseling and referrals upon request.

Those challenging Trump's approach have pointed to the Affordable Care Act, which bars the government from creating unreasonable barriers to medical care or interfering with communications between the patient and provider.

5 ways Trump is undermining Obamacare without the courts
Tami Luhby

Washington (CNN) Obamacare is facing its next big court challenge this week, but regardless of what the judges decide, President Donald Trump has already succeeded in hobbling the landmark health reform law.

Trump has been trying to dismantle Obamacare from the first day he took office. Hours after his inauguration, he signed an executive order directing agencies to interpret regulations as loosely as possible and to minimize the financial burden of the law through waivers, exemptions or delays.

But after the Republican-controlled Congress failed to repeal Obamacare in 2017, Trump unleashed a series of executive changes to further undermine the law.

Trump has repeatedly said his administration would unveil a plan to replace Obamacare, though Republican senators have distanced themselves from that promise. He told ABC News in June that he'll release a plan in the next two months.

Donald J. Trump ✔ @realDonaldTrump
The Republican Party will become the Party of Great HealthCare! ObamaCare is a disaster, far too expensive and deductibility ridiculously high - virtually unusable! Moving forward in Courts and Legislatively!

Now, the Department of Justice is joining a coalition of 18 Republican attorneys general and others who are arguing this week before a panel of three appellate judges in New Orleans that a district court judge in Texas was correct when he found Obamacare unconstitutional in December.

Here are five other things the President has done to the Affordable Care Act:
Made it harder to sign up: Trump cut the Obamacare open enrollment in half, giving Americans only six weeks to pick insurance policies. He has also slashed funding for advertising and for navigators, who are critical to helping people sign up. At the same time, he's increased the visibility of insurance agents who can also sell non-Obamacare plans.

Broadened access to alternative plans: The President signed an executive order in October 2017 making it easier for Americans to access alternative policies that have lower premiums than Affordable Care Act plans -- but in exchange for fewer protections and benefits.

They include short-term plans. Trump officials lengthened their duration to just under one year, from three months. These plans are typically cheaper, but can also turn down people with pre-existing conditions or charge them higher premiums.

The administration also made it easier for small businesses or some self-employed people to band together to buy so-called association health plans, though this rule is on hold while it works its way through the courts.

Made enrollees pay more: Obamacare enrollees will find they have to pay more for health care and health coverage in 2020 because the administration is changing how some of the law's provisions are adjusted every year. That move means policyholders will have to pay 2.5% more out of pocket than they otherwise would have -- a change that would affect those in large-employer plans too, according to an analysis by the left-leaning Center on Budget & Policy Priorities.

At the same time, it will make the federal premium subsidies a bit less generous, saving the federal government roughly $1 billion annually for the next few years. But the administration says the changes will also lead to a decrease in enrollment by 70,000 people.

Also in 2017, Trump stopped funding subsidies that help reduce deductibles and out-of-pocket costs for low-income Obamacare enrollees, prompting insurers to raise premiums to cover the loss of these cost-sharing payments.

Let states alter Obamacare: The Trump administration last year told states that they could apply for waivers to make more substantial changes to their Obamacare marketplaces, including altering the rules for who is eligible for federal help paying monthly premiums. These premium subsidies are essential to keeping Obamacare functioning, experts say.

Required Medicaid recipients to work: Some 12.7 million Americans have gained coverage under Medicaid expansion, which broadened eligibility to all adults up to 138% of the poverty line, or about $17,250 for 2019. Some 35 states and the District of Columbia have opted to expand their programs.

But for the first time since Medicaid was established a half-century ago, the Trump administration is allowing states to require certain Medicaid enrollees -- particularly those who gained coverage under Obamacare -- to work in order to continue receiving benefits. Roughly 18,000 Arkansas residents were removed from the rolls last year before a federal judge put the federal approvals on hold.

Despite all of the President's actions, Obamacare has proven surprisingly resilient. Some 8.4 million people signed up on the federal exchange for 2019. Still, that's down from roughly 9.2 million who picked plans for 2017. Much of the drop stems from fewer new consumers selecting policies.

The New York Times

Appeals Court Seems Skeptical About Constitutionality of Obamacare Mandate
Abby Goodnough

NEW ORLEANS — A panel of federal appeals court judges on Tuesday sounded likely to uphold a lower-court ruling that a central provision of the Affordable Care Act — the requirement that most people have health insurance — is unconstitutional. But it was harder to discern how the court might come down on a much bigger question: whether the rest of the sprawling health law must fall if the insurance mandate does.

In 90 minutes of oral arguments on whether a federal district judge in Texas was correct in striking down the Affordable Care Act in December, two appellate judges appointed by Republican presidents peppered lawyers with blunt questions while the third judge, appointed by President Jimmy Carter, remained silent.

The two Republican appointees, Jennifer Walker Elrod, appointed by President George W. Bush in 2007, and Kurt Engelhardt, appointed by President Trump in 2018, seemed

particularly skeptical of the Democratic defendants' argument that Congress had fully intended to keep the rest of the law when it eliminated the penalty for going without insurance as part of its 2017 tax overhaul.

The arguments in the United States Court of Appeals for the Fifth Circuit were a stark reminder of the enormous stakes of the case, not only for millions of people who gained health insurance through the law but for the political futures of Mr. Trump and other candidates in the 2020 elections.

The case, which could make its way to the Supreme Court ahead of those elections, threatens insurance protections for people with pre-existing medical conditions and many other sweeping changes the 2010 law has made throughout the health care system.

It was filed by a group of Republican governors and attorneys general against the federal government, which carries out the law. But the Trump administration refused to defend the full law in court, initially saying only its provisions protecting people with pre-existing conditions should be struck down. Then, this spring, it said it agreed with the ruling that the law's requirement for people to buy insurance was unconstitutional now that Congress eliminated the penalty for going without it, and that as a result, the entire law must be dismantled.

That has left a group of 21 states with Democratic attorneys general to intervene to defend the law, along with the House of Representatives, which entered the case after Democrats won control of the chamber last fall.

A question at the heart of the case that was much discussed during Tuesday's arguments is whether the Affordable Care Act's mandate requiring most Americans to buy health insurance or pay a tax penalty remained constitutional after Congress eliminated the penalty. When the Supreme Court upheld the mandate in its landmark 2012 ruling that saved the law, its decision was based on Congress's power to impose taxes.

If the mandate is indeed unconstitutional, the next question is whether the rest of the Affordable Care Act can function without it. In December, Judge Reed O'Connor of the Federal District Court in Fort Worth said it could not and declared that the entire law must fall.

On Tuesday, Douglas N. Letter, a lawyer for the House of Representatives, was particularly insistent that Judge O'Connor had been wrong, telling the appeals panel that "the burden is on the other side to show Congress wanted this entire statute to be struck down."

The arguments did reveal some tensions between the Republican states that brought the case, led by Texas, and Mr. Trump's Justice Department. For example, a lawyer for Texas took issue with a puzzling new Justice Department position — revealed in a May brief — that the ruling should apply only in the 18 plaintiff states, not nationwide. The

Republican states would need to evaluate if they had “been the victim of a bait and switch,” said the Texas lawyer, Kyle D. Hawkins.

In another wrinkle, August E. Flentje, a lawyer for the Justice Department, appeared reluctant to answer questions from Judge Elrod about how applying the ruling only to the plaintiff states would work. He was also vague about another new and surprising position the administration mentioned almost in passing in its May brief: that some pieces of the health law, though not its insurance provisions, should be preserved.

“A lot needs to get sorted out and it’s complicated,” Mr. Flentje replied.

Judge Elrod also asked how the federal government would respond if a stay issued by the lower court after Judge O’Connor’s decision was lifted and its order striking down the law took effect.

“We think it’s great the stay is in place,” Mr. Flentje said. “Those things don’t need to get sorted out until there’s a final ruling.”

Over all, though, the panel spent the most time on the question of whether the rest of the law should fall if Judge O’Connor was correct in scrapping the insurance mandate — and Judge Elrod and Judge Engelhardt, based on their questioning, seemed to firmly believe he was. Judge Engelhardt asked Mr. Letter, the House lawyer, why Congress could not remedy the situation by writing a new health law or set of laws.

“They could do this tomorrow,” Judge Engelhardt said, leading Mr. Letter to dryly point out that Mr. Trump would need to sign off on new laws, too.

“And obviously the president would sign this, right?” he asked sardonically. “No, obviously not.”

“You can fix this, and the Supreme Court has told you how to do it,” Mr. Letter told the panel, referring to legal precedent that directs courts to limit damage to major statutes when considering which provisions to throw out. “Maintain everything you can that can stand on its own.”

But Judge Engelhardt and Judge Elrod kept referring to past statements, including from Supreme Court justices in an earlier case questioning the constitutionality of the health law, King v. Burwell, suggesting that the law’s other insurance provisions cannot work without the mandate. Those provisions include one that requires insurance companies to sell health coverage to anyone who wants to buy it, including people with pre-existing medical conditions, and another that requires the companies to charge the same price to everyone who is the same age.

Judge Engelhardt twice asked Mr. Letter why, if Congress fully intended to keep the rest of the health law when it eliminated the penalty for going without insurance in 2017, the Senate, which is controlled by Republicans, had not also sent a lawyer to make that case.

“Why would the Senate not also be here to say, ‘Oh, this is what we meant when we wrote this?’” he asked. “They’re sort of the 800-pound gorilla that’s not in the room.”

The appeals panel also spent a good chunk of the allotted 90 minutes asking questions on a third topic: whether the Democratic states and House of Representatives even have standing to appeal Judge O’Connor’s ruling.

To establish standing, a party has to show it has suffered a concrete injury that a ruling in its favor would redress. Samuel P. Siegel, a lawyer for California, told the appeals panel that throwing out the law would clearly injure the defendant states because they would lose hundreds of billions of dollars in federal funds they have received through the expansion of Medicaid and other provisions.

The court had also asked the parties in a letter last month what the appropriate conclusion of the case should be if the Justice Department, by no longer defending any part of the law, has “mooted the controversy.” But it barely addressed that question on Tuesday.

If the appeals court ultimately decides that neither the House nor the intervening Democratic states have standing, it could either let Judge O’Connor’s ruling stand or vacate it. In any event, the losing party will almost certainly appeal to the Supreme Court.

“All of this is going to be playing out against the backdrop of the 2020 presidential election,” said Nicholas Bagley, a law professor at the University of Michigan. He was among a bipartisan group of professors who argued in an amicus brief last year that the rest of the law should survive even if its mandate to buy insurance was found unconstitutional, and who have criticized the plaintiffs’ case as weak.

Democrats are already running ads against Mr. Trump and other Republicans over the case, including five state attorneys general who signed on as plaintiffs and will be up for re-election next fall. Protect Our Care, an advocacy group that supports the law, will start running digital ads this week against Republican senators considered vulnerable next year: Thom Tillis of North Carolina, Joni Ernst of Iowa, Cory Gardner of Colorado and Martha McSally of Arizona.

“The case, if successful, would result in a humanitarian catastrophe in this country,” Senator Chris Murphy, Democrat of Connecticut, said on the Senate floor on Tuesday. “Because the plaintiffs in the case, backed by the Trump administration, are arguing that the court should throw out the entire Affordable Care Act with nothing to replace it.”

The appeals court could take months to decide, but the Trump administration has said it will continue to enforce the many provisions of the law until a final ruling is issued — a position about which Judge Elrod expressed curiosity.

“It’s a choice, right?” she said to Mr. Flentje, the Justice Department lawyer, asking why the administration would keep the law afloat even after it had changed its position and agreed it was fully unconstitutional.

If the appeals judges uphold Judge O’Connor’s decision, the number of uninsured people in America would increase by almost 20 million, or 65 percent, according to the Urban Institute, a left-leaning research organization. That includes millions who gained coverage through the law’s expansion of Medicaid, and millions more who receive subsidized private insurance through the law’s online marketplaces.

Insurers would also no longer have to cover young adults under their parents’ plans up to age 26; annual and lifetime limits on coverage would again be permitted; and there would be no cap on out-of-pocket medical costs people have to pay.

Also gone would be the law’s popular protections for people with pre-existing conditions, which became a major talking point in last fall’s midterm elections, as Democratic candidates constantly reminded voters that congressional Republicans had tried to repeal the law in 2017.

Without those protections, insurers could return to denying coverage to such people or to charging them more. They could also return to charging people more based on their age, gender or profession.

The Kaiser Family Foundation, a nonpartisan research organization, has estimated that 52 million adults from 18 to 64, or 27 percent of that population, would be rejected for individual market coverage under the practices that were in effect in most states before the Affordable Care Act.

The Health 202: A judge ruled Trump administration can't mandate drug prices in TV ads
Paige Winfield Cunningham

The Trump administration has run up against a legal wall in its first big effort to lower drug prices. But there’s a good chance Congress will help it climb over.

Late last night, a federal judge blocked the administration’s new requirement for drugmakers to display the price of medications in television ads, saying the Department of Health and Human Services overstepped its authority with the regulation and would need approval from Congress. The decision came just a few hours before the rule would have gone into effect, my colleague Yasmeen Abutaleb reports.

The ruling is a slap in the face to President Trump and HHS Secretary Alex Azar, who have touted the effort as an important step in their broad initiative to ensure more price transparency for patients and ultimately force companies to reduce drug prices. The administration's rule prompted a lawsuit from three major pharmaceutical companies – Merck, Eli Lilly and Amgen — who argued it abridged their First Amendment rights to free speech.

HHS spokeswoman Caitlin Oakley said the administration is “disappointed in the court’s decision and will be working with the Department of Justice on next steps related to the litigation.”

“Although we are not surprised by the objections to transparency from certain special interests, putting drug prices in ads is a useful way to put patients in control and lower costs,” Oakley said in a statement.

Permission from Congress – even one so sharply divided down partisan lines – might not be terribly hard for the administration to obtain. The leader of the most powerful Senate committee with jurisdiction over the issue, Finance Chairman Chuck Grassley (R-Iowa), has teamed up with the chamber’s No. 2 Democrat, Sen. Dick Durbin (D-Ill.), on legislation to codify the regulation.

The two introduced their bill in May, saying it would ensure long-term implementation and clarity of the requirement HHS first proposed last fall and had just finalized at the time. “Knowing what something costs before buying it is just common sense,” Grassley then said in a statement.

Such bipartisan support is not enjoyed by several of the administration’s other proposals to lower drug prices, including a potential index being reviewed by the White House Office of Management and Budget linking the prices of certain Medicare drugs to lower prices in other countries (something Grassley has panned).

So there’s a good chance Congress could give the Trump administration a boost with this particular regulation, which would have required pharmaceutical companies to list the prices of any medications costing at least $35 for a month’s supply or a usual course of therapy.

The rule was also applauded by patient right's groups, although some analysts (and, of course the drugmakers themselves) argue that merely knowing the list price of drugs doesn’t help patients much because it doesn’t reflect discounts negotiated with insurers.

“Drug list prices have been shrouded in secrecy for too long,” AARP Vice President Nancy LeaMond said in a statement last night. “Today’s ruling is a step backward in the battle against skyrocketing drug prices and providing more information to consumers. Americans should be trusted to evaluate drug price information and discuss any concerns with their health care providers.”

CaliforniaHealthline

Hospitals Block 'Surprise Billing' Measure In California
Ana B. Ibarra

Citing fierce pushback from hospitals, California lawmakers sidelined a bill Wednesday that would have protected some patients from surprise medical bills by limiting how much hospitals could charge them for emergency care.

The legislation, which contributed to the intense national conversation about surprise medical billing, was scheduled to be debated Wednesday in the state Senate Health Committee.

Instead, the bill's author pulled it from consideration, vowing to bring it back next year.

"We are going after a practice that has generated billions of dollars for hospitals, so this is high-level," said Assemblyman David Chiu (D-San Francisco). "This certainly does not mean we're done."

Chiu said he and his team would keep working on amendments to the bill that address the concerns of hospitals while maintaining protections for patients.

Hospitals focused their opposition on a provision of the bill that would have limited what they can charge insurers for out-of-network emergency services, criticizing it as an unnecessary form of rate setting.

"Balance billing," better known as surprise billing, occurs when a patient receives care from a doctor or hospital — or another provider — outside of her insurance plan's network, and then the doctor or hospital bills the patient for the amount insurance didn't cover. These bills can soar into the tens of thousands of dollars.

In the absence of federal laws, many states have tried to formulate solutions to balance billing, but health policy experts suggest this issue would be best addressed by the federal government.

Congress is discussing different approaches but not without facing fierce opposition and lobbying from two influential groups: health insurers and providers, including doctors and hospitals.

Last week, the Senate Health, Education, Labor and Pensions Committee passed the Lower Health Care Costs Act, which would require insurers to pay providers no more than the median in-network rate in a geographic region for emergency and nonemergency care. But the American Hospital Association deemed the payment arrangement unworkable.

Getting buy-in from hospitals and other providers will not be easy.

“The system exists in a way that allows a subset of providers to stay out-of-network and charge very high rates,” said Christen Linke Young, a fellow at the USC-Brookings Schaeffer Initiative for Health Policy. “They’re basically exploiting the system.”

Chiu’s bill would have prohibited out-of-network hospitals from sending surprise bills to privately insured emergency patients. Instead, hospitals would have to work directly with health plans on billing, leaving the patients responsible only for their in-network copayments, coinsurance and deductibles.

The bill also would have limited the amount hospitals could charge insurers for each service, and the amounts would have varied by region.

That’s the part hospitals opposed.

“We’ve said from the beginning that we are supportive of protecting patients. Unfortunately, the proponents of the bill inserted a completely unrelated provision regarding rate setting,” said Jan Emerson-Shea, a spokeswoman for the California Hospital Association.

Emerson-Shea said that if the state sets prices, health plans would have little incentive to negotiate contracts with hospitals. If this provision were removed, the hospital association would support Chiu’s bill, she said.

“That provision doesn’t need to be in the bill if the bill is really about protecting patients,” she said.

Chiu disagrees. Protecting patients from high costs and capping what insurers pay hospitals are “inextricably related,” Chiu said.

If this provision were removed, patients might still face high costs in the form of rising insurance premiums as insurers try to recoup their costs, Chiu said.

“It is useless to protect patients from receiving a bill on the front end if hospitals can turn around and price gouge consumers on the back end. It’s like closing your front door and leaving the back door wide open,” he said.

In California, a 2009 state Supreme Court ruling protects some patients against surprise billing for emergency care, and a state law that took effect in 2017 protects some who receive nonemergency care.

But millions remain vulnerable to surprise bills, largely because California’s protections don’t cover all insurance plans.

Chiu's bill was designed to close some of the loopholes. "It is disappointing it couldn't get done this year" because more Californians will get hit with exorbitant balance bills in the meantime, he said.

The measure was prompted by the peculiar billing practices at Zuckerberg San Francisco General Hospital, located in his district.

Unlike most large hospitals, San Francisco General does not contract with private insurers. An investigation by Vox found that the hospital considered patients with private insurance out-of-network for emergency care and was slapping many of them with whopping bills. The hospital has since announced it has stopped balance billing patients.

The New York Times

Erasing Obamacare Could Undermine Trump's Own Health Initiatives
Margot Sanger-Katz

In court, the Trump administration is trying to get all of Obamacare erased. But at the White House, President Trump and his health officials are busily using the law to pursue key proposals.

Last week, the president highlighted a policy in the works meant to narrow the gaps between what drugs cost in the United States and overseas. On Wednesday, he signed an executive order to transform care for patients with kidney disease.

Both measures were made possible by a provision in the Affordable Care Act, and both would be effectively gutted if the administration's position prevailed in court.

In between, administration lawyers told a receptive panel of judges in New Orleans that the entire Affordable Care Act should be overturned.

"What they're doing now is tolerating this ambiguity between the flat-out rhetoric of 'repeal Obamacare' and the reality that they love many aspects of what was enacted in the Affordable Care Act," said Dan Mendelson, the founder of the health care consulting firm Avalere Health.

The crucial provision is known as the innovation authority. It allows Medicare and Medicaid to test strategies for paying for medical care in pursuit of ways to lower costs and improve the quality of care.

It is a very broad authority. Before Obamacare, most changes to Medicare required special legislation from Congress. Congress can move slowly, and medical industries tend to oppose provisions that would result in less spending on treatment. With the

innovation authority, the Department of Health and Human Services can introduce various experiments, and it has the power to take successful pilot programs national, without involving Congress.

That's a power that has been welcomed in an administration that has embraced broad executive power. Obama administration officials liked the innovation center power, too. But the Trump administration has gone further, experts said, in pursuing a variety of interesting ideas about how to reform health care delivery.

Alex Azar, the secretary of Health and Human Services, has pointed enthusiastically to this authority at times, telling reporters last year that his "pen has a lot of power."

When asked about the court case Wednesday, Seema Verma, a top deputy in the department, told Anna Edney at Bloomberg News that the department had a "plan in place" to preserve some parts of the health law even if the court overturned it. She mentioned the innovation authority specifically but did not give details on the plan.

Wednesday's announcement on changes in kidney care featured an executive order and a speech from the president. But the meat of the proposal was four demonstration projects begun under the innovation authority. One was devised to reshape how kidney care providers are paid and would affect around half of all patients with renal disease, a sweeping change.

The president talked about another top health care priority last week: his desire to lower the cost of prescription drug prices. He mentioned a policy under review that would make some of the prices charged by drug companies more aligned with those in other developed nations. That proposal, too, was authorized under the Affordable Care Act's innovation authority and would otherwise require a new law.

Other areas of experimentation include surgery, primary care and cancer treatment. Ashish Jha, a Harvard professor who studies changes in the health care delivery system, said the Trump administration had been ambitious and creative in trying new ways to use payment experiments to nudge medical providers toward higher-quality care.

But the administration's position in court could jeopardize all those initiatives. If the Affordable Care Act is overturned, as government lawyers have pushed for, the innovation authority will go with it.

That outcome would undermine large parts of the administration's health care agenda, Dr. Jha said: "I think the administration is going to be very hobbled in terms of their efforts to really improve the delivery system."

Los Angeles Times

Rising health insurance deductibles fuel middle-class anger and resentment
Noam N. Levey

WASHINGTON — Denise Wall, a Fresno-area schoolteacher with more than $2,000 in medical bills, was outraged to hear she could get free care if she quit her job and enrolled her family in Medicaid.

Brenda Bartlett, a factory worker in Nebraska, was so angry about $2,500 in medical bills she ran up using the coverage she got at work that she dropped insurance altogether.

“They don’t give a rat’s butt about people like me,” she said.

Sue Andersen, burdened with nearly $10,000 in debt through her family’s high-deductible plan, had to change jobs to find better coverage after learning she and her husband earned too much for government help in Minnesota.

“We are super middle class,” she said. “How are we stuck with everything?”

Health insurance — never a standard protection in the U.S. as it is in other wealthy countries — has long divided Americans, providing generous benefits to some and slim-to-no protections to others.

But a steep run-up in deductibles, which have more than tripled in the last decade, has worsened inequality, fueling anger and resentment and adding to the country’s unsettled politics, a Los Angeles Times analysis shows.

Many wealthy Americans — already reaping most of the benefits of the last decade’s economic growth — have weathered the dramatic increase in deductibles in recent years in part by putting away money in tax-free Health Savings Accounts.

Very poor Americans, millions of whom gained coverage through the 2010 Affordable Care Act, can see a doctor or go to the hospital at virtually no cost, thanks to Medicaid, the half-century-old government safety-net program.

Squeezed in the middle are legions of working Americans who face stagnant wages, insurance premiums that take more and more of their paychecks and soaring deductibles that leave them with medical bills they can’t afford.

“The system increasingly doesn’t work for this group in the middle,” said Drew Altman, longtime head of the Kaiser Family Foundation, or KFF, a California nonprofit that researches the U.S. health system.

“These people may have health insurance … but they can’t pay the bills.”

This middle-class squeeze and the class divisions it is exposing are among the corrosive effects of the high-deductible revolution, which The Times is exploring in a series of articles based on original research, academic studies and interviews with scores of American workers, doctors and experts.

Bill McInturff, a GOP pollster who has studied healthcare opinion for years, says frustration has turned into resentment for many working-class Americans struggling with high deductibles and healthcare costs.

“Among the most angry focus groups I have done in my career was [one] with working-class women in Maine talking about how much their healthcare and child care coverage was costing them compared to the women they knew on Medicaid,” he said.

Although a majority of workers remain content with their health benefits, a quarter now report feeling frustrated, according to a nationwide poll of Americans with job-based coverage conducted for this project in partnership with KFF.

One in seven is angry about their insurance.

The discontent is even more pronounced among workers with the highest deductibles: four in 10 report frustration, and nearly a quarter say they’re angry.

“I’m not hard-core political, but it kind of stings sometimes,” said Shawn Stevens, a 40-year-old father who’s rationed his own medical care to keep the family afloat and to ensure his daughter, who has autism, gets what she needs.

“You work and do what you’re supposed to, and you really pay the price,” said Stevens, whose family was on a high-deductible plan through his Home Depot job outside Detroit. They’re paying off nearly $1,500 in medical bills, and his wife, a hospital scheduler, took a second job bartending several nights a week.

Stevens, whose family makes about $48,000 a year, looked at enrolling his daughter in Michigan’s Children’s Health Insurance Program, a subsidized government plan for working families.

“They told me I made too much,” he recalled. “I thought, ‘I’m not poor enough? I feel pretty poor.’ ”

Most workers blame drug companies and health insurers for high healthcare costs, The Times/KFF survey found.

But deep partisan lines also divide Americans’ views of the affordability crisis.

Half of Democrats struggling with the costs of their job-based health coverage blame the Trump administration for the cost pressures.

Six in 10 Republicans fault the 2010 healthcare law, often called Obamacare.

The law, for the first time, guaranteed Americans could get insurance if they're sick.

It also gave millions of very poor working Americans access to Medicaid, which does not have deductibles. The expansion produced a historic drop in the number of Americans without health insurance.

But many health plans being sold on the law's insurance marketplaces have very high deductibles, mirroring the run-up that has happened with job-based benefits.

And although the expansion of Medicaid is broadly popular, it has highlighted the strains on U.S. workers and their families.

Two groups of workers — those with high incomes and those with low deductibles — are more likely to believe they have better coverage than Medicaid enrollees, who typically have to make less than $17,000 a year to qualify, The Times/KFF poll found.

But workers in households making less than $40,000 a year and those with the highest deductibles are more likely to say the health insurance system works better for people on Medicaid.

That includes people with deductibles of more than $3,000 for individual coverage and $5,000 for a family plan.

As deductibles and premiums have surged, a growing number of low-income workers who have job-based health benefits are enrolling their children in Medicaid and the related Children's Health Insurance Program, research shows.

But many workers cannot get the same cost-free government coverage for themselves.

Stevens, the Home Depot worker, said he doesn't begrudge those who need government assistance, recalling that when he was a child, his family was poor enough to qualify for Medicaid. But he said he missed the security that coverage offered.

"There was no fear," he said. "You didn't have to be afraid to go to the doctor."

Overall, four in 10 American workers said they had trouble affording healthcare in the last year, despite having job-based health coverage, The Times/KFF survey found.

That number, however, masks a large disparity in Americans' experiences.

Two-thirds of workers in households making less than $40,000 a year said they struggled to pay for healthcare in the previous year.

By comparison, fewer than one-third of workers with incomes of at least $100,000 said they had difficulty affording care, according to the poll.

This income divide is baked into the way employers provide coverage to workers in America: Companies with better-paying jobs have long offered more generous benefits.

In 2018, for example, workers at firms with higher wages had to pick up about a quarter of the cost of a family health plan, according to an annual employer survey KFF has been conducting for years. The employer paid the remaining three-quarters.

Americans who work for low-wage employers, by comparison, had to pay nearly 40% of the cost of a family health plan.

That meant workers at firms that pay less also got hit with an average of some $1,700 more in insurance premiums than their counterparts at better-paying employers.

That pay-based disparity didn't matter as much when deductibles were lower, giving low-wage workers some protections against large medical bills if they became ill.

As recently as 2006, the average deductible for individual coverage in job-based plan was just $379, adjusted for inflation, according to KFF.

But since the early 2000s, employers have rapidly shifted costs onto workers as they've scrambled to control their own healthcare spending.

The average deductible has more than tripled, to $1,350. More than a quarter of workers have plans with a deductible of at least $2,500.

Companies often didn't pay full attention to the extra burden on workers, said Michael Critelli, the former head of global technology firm Pitney Bowes.

"The average chief executive couldn't put themselves in the shoes of a worker trading off healthcare with paying a bill to stay in a home or an apartment," Critelli said. Pitney Bowes was among a handful of large employers that tailored health benefits to make it easier and more affordable for workers to get recommended care and prescription drugs.

Most top wage-earners, who already have more savings, are better positioned to adjust to higher deductibles.

But they got additional help from a change in tax law that accelerated the shift in health insurance, data show.

In 2003, President George W. Bush signed legislation allowing workers in high-deductible plans to put aside money in tax-free accounts that could be used to pay medical bills.

Conservative politicians and health economists touted Health Savings Accounts, or HSAs, and high deductibles as a way to give patients “skin in the game” and an incentive to shop for lower-priced medical care.

Shortly after the 2003 law was enacted, former House Speaker Newt Gingrich, a leading GOP booster of the accounts, predicted in a joint op-ed the law would “inevitably lead to lower prices, more affordability and more consumer choices.”

None of that happened.

Middle- and low-income workers, whose incomes and savings have barely budged in recent decades, hardly use HSAs, even as their deductibles have soared.

For wealthier Americans, by contrast, the accounts have become a generous savings and investment tool.

In 2013, for example, people with income greater than $100,000 accounted for less than 20% of tax filers, but 70% of total contributions made to HSAs that year, according to tax data analyzed by the congressional Joint Committee on Taxation.

By contrast, Americans with incomes below $40,000 made up nearly 50% of tax filers but made less than 6% of HSA contributions.

“There’s no doubt that these accounts have been far more valuable to higher-income people,” said Paul Fronstin, who directs the health research program at the Employee Benefit Research Institute, a Washington, D.C.-based think tank.

New research conducted by the institute in partnership with The Times shows just how much greater these advantages have been for the wealthiest workers.

Analyzing wage and insurance data from a large national corporation with an HSA plan, Fronstin and his colleagues found that employees with individual coverage who earned more than $150,000 in 2016 put more than $1,700 on average into their HSAs that year.

That was nearly three times as much as workers earning less than $75,000.

By the end of 2016, the high-income workers also had more than three times as much saved, averaging almost $6,500 in their accounts.

The higher-income employees also were nearly twice as likely to invest their accounts, a recommended strategy for maximizing the tax benefits of HSAs.

Related research by Fronstin indicates that workers with higher HSA balances use more healthcare, even accounting for differences in workers’ ages.

“All around, they are getting more bang for their buck,” he said.

Brittany Robb, 24, who recently began her first job at an architectural firm in St. Paul, Minn., said she dreams of building savings in the HSA that comes with her $2,000-deductible plan.

Even with a salary of $48,500, however, Robb can afford to put only $80 in the account every month.

“It doesn’t get me a lot,” she said, noting that bills for seeing a therapist and filling prescriptions quickly deplete the HSA and force her to ration her care.

“I feel pretty stressed about health insurance all the time.”

The Washington Post
Democracy Dies in Darkness

House Democrats join Republicans to repeal Obamacare’s ‘Cadillac tax
Yasmeen Abutaleb

In a rare bipartisan moment, House Democrats joined with Republicans to repeal the “Cadillac tax” on high-cost employer health insurance that was supposed to help pay for the Affordable Care Act.

The 419-to-6 vote is a first step toward achieving a long-sought goal of employers, labor unions and health insurers who have been pushing for full repeal of the tax for several years. Repealing the unpopular tax is one of the few significant measures related to the landmark health law that has won overwhelming support from lawmakers of both parties.

Democrats, many of whom grudgingly supported the cost containment effort as part of the landmark health-care law nine years ago, argued Wednesday that it would be a de facto tax on working families.

“Today, we’ll honor our promise to the hard-working men and women of the labor as we lift the Cadillac tax protecting health benefits that workers have negotiated,” House Speaker Nancy Pelosi (D-Calif.) said Wednesday.

Delayed repeatedly by Congress, the tax would impose a 40 percent excise tax beginning in 2022 on employer-provided health benefits that exceed $11,200 for an individual and $30,100 for a family. The idea was to reduce soaring health-care costs by discouraging employers from offering such generous plans, as well as to pay for the landmark law passed by a Democratic Congress in 2010.

The Senate has a similar bill with bipartisan support, but Senate Majority Leader Mitch McConnell (R-Ky.) has not yet said whether he will bring it up for a vote. McConnell has been reluctant to take up health-care legislation, Senate aides said, because Democrats probably would use the opportunity to criticize Republicans' and the administration's efforts to dismantle the Affordable Care Act.

Health economists warn that repealing the tax would add to the national deficit and increase health-care spending. The nonpartisan Congressional Budget Office estimated repeal of the tax would add $197 billion to deficits over a decade.

"The full repeal of the Cadillac tax would eliminate one of the most consequential policy levers to actually lower health care costs," said Benedic Ippolito, a health economist at the American Enterprise Institute. "When it comes to sensible policies about what to do about spending, ironically there's bipartisan, bicameral agreement that we absolutely shouldn't do anything."

The House passed the legislation using an expedited procedure that allows the chamber to pass a tax cut without an offset as long as there is a two-thirds majority supporting the measure.

Proponents of the measure argue that workers would bear the brunt of the tax, largely through decreased wages.

"The resounding, bipartisan passage of legislation repealing the 'Cadillac Tax' is a victory for families with job-based health coverage," said American Benefits Council President James A. Klein. "We urge the Senate to promptly approve the measure and send it to the president for signature."

If the tax does go into effect in 2022, about one in five employers offering health benefits would be affected unless they changed their offerings, according to an analysis from the Kaiser Family Foundation. The analysis also found that the tax would affect more employers over time — up to 37 percent of employers by 2030.

Republican and Democratic lawmakers have battled each other over the future of Obamacare since its passage. Republicans have vowed to repeal and replace the law for nearly a decade, but failed to do so repeatedly in 2017 when they controlled both chambers of Congress and the White House. In their overhaul of the tax code in 2017, congressional Republicans zeroed out the ACA tax penalty for those who did not purchase health insurance.

In the 2018 midterms, Democrats campaigned on health care — specifically protecting and strengthening Obamacare — which they credited with their taking back the House.

Los Angeles Times

Column: How Obamacare brought health coverage to the people, in four amazing charts

Michael Hiltzik

There are many elements to the conservative mantra that the Affordable Care Act is a "disaster" -- it's too expensive, it doesn't cover all that many people, it's driven up costs for everyone, etc., etc. None of this is news to anyone who follows healthcare affairs. Nor is the fact that these criticisms all are either false or misleading.

A new study from the Society of Actuaries graphically shows how false and misleading. It documents the sharp rise in coverage and medical utilization in the individual health insurance market starting in 2014, when the ACA's insurance exchanges began operating. The actuaries also document that costs and utilization trends in the large- and small-group market -- health insurance provided by employers -- remained stable, fell, or continued trends that already existed before the advent of the exchanges.

The report, a collaboration with the Health Care Cost Institute (hat tip to David Anderson of Duke), is crystal clear about the reasons for the jumps in coverage and utilization. Chiefly, the launch of the individual exchanges resulted in a "surge of pent-up demand in both previously uninsured populations and previously uncovered services."

Simply put, many of the new entrants into the health coverage market had been uninsured "due to preexisting conditions," which had resulted in their being refused coverage or offered insurance at inordinately high premium rates. The ACA, moreover, mandated coverage of conditions that previously had been routinely excluded from individual health plans, notably maternity services.

Before the ACA, insurers in the individual market charged women of childbearing age sky-high premiums for policies including maternity coverage, on the perfectly fair assumption that they would probably use it. That discouraged the entry of those women into the insurance market. "Similarly, male members or other members not likely to give birth would select individual coverages that excluded maternity so as to pay a lower premium," the actuaries observe.

Under the ACA, the cost of maternity care is spread among the entire insurance pool. That gives younger women more financial incentive to buy coverage. In effect, non-pregnant buyers subsidize pregnancy. Despite the idiotic posturing of conservatives (including President Trump's own Medicare and Medicaid director, Seema Verma) that maternity coverage should be optional, this is plainly the proper policy, as the cost of propagating the species shouldn't be imposed exclusively on women aged 18-45.

Finally, the actuaries' report gives the lie to the claim of conservatives and Trumpians that they're the guardians of consumers with preexisting conditions. Trump aired this canard most recently during his ghastly rally Wednesday in North Carolina, where it was sandwiched in among openly racist chants. Trump's claim was that "patients with preexisting conditions are protected by Republicans much more so than protected by Democrats, who will never be able to pull it off." Quite obviously, the Democratic-passed Affordable Care Act, which Trump is determined to destroy, brought those protections to consumers for the very first time. Trump would return the market to the exclusionary practices of the past.

Let's look at the actuarial findings graphically.

uninsured rate
(Kaiser Family Foundation, via Society of Actuaries)
Starting with the view from 30,000 feet, the changes in the individual health insurance market brought down uninsured and underinsured rates starting in 2014. The rates have crept up starting in 2017, when Trump launched his efforts to undermine the Affordable Care Act.

membership
(Society of Actuaries)
Membership in individual plans soared by more than 20% annually starting in 2014. Employer plans remained largely stable, with small-group plan growth falling slightly as members may have been shifted into ACA plans. Negative growth in the group market may have been a holdover from the recession.

utilization
(Society of Actuaries)
Inpatient stays per thousand members soared starting in 2014. This probably reflects the ACA's mandated essential health benefits, which required coverage of maternity and behavioral health services for the first time. The actuaries observe that previously uninsured patients were "more likely to access inpatient services through the emergency department for high-acuity situations as their initial encounter with the health care system, especially if they had conditions that had been neglected." This is an indication of the severity of the problem of lack of coverage for preexisting conditions before the ACA.

After the initial surge, the actuaries conjecture, the growth trend should flatten out "as members start to better control their chronic preexisting conditions through the utilization of other services and to establish relationships with primary care physicians."

claims
(Society of Actuaries)
That seems to be the case according to the chart above, which shows the rate of increase in claims per member per month beginning to decline in 2015.

Duke's Anderson makes a couple of pertinent observations about these statistics. He notices that small group and large group utilizations "tend to move in parallel to each other with large groups having slightly sicker or higher utilizing populations." That's to be expected, he says, because small employers have been less likely to offer insurance to employees, especially if they expect heavy utilization. (Think about a business employing lots of 20- and 30-year-old women, contemplating its maternity coverage claims.)

Anderson underlines the difference in inpatient rates between the individual market and the group markets before the ACA's changes; individual plans saw as little as one-third the inpatient utilization as the group plans. That's a testament to the efficiency of insurance company underwriting in the old days, when they kept people judged likely to need hospitalization out of the pool by refusing them coverage or pricing them out of the market. This is the supposed nirvana that Trump and the Republicans want to return to. It's a world in which you can't find affordable comprehensive insurance if a carrier finds even a history of hay fever in your record, but you can find a cheap policy that won't cover any real medical needs.

Bloomberg

Trump Win on Health Plans Advances Effort to Undo Obamacare
Andrew M. Harris and John Tozzi

The Trump administration can expand the sale of short-term health insurance policies that don't meet the standards of the Affordable Care Act, a federal judge ruled, advancing the government's efforts to undo Obamacare.

U.S. District Judge Richard Leon in Washington rejected challengers' claims that policies sold under a government regulation that took effect in October 2018 unlawfully undermine the ACA.

"Not only is any potential negative impact" from the rule "minimal, but its benefits are undeniable," Leon wrote in a 40-page ruling on Friday. He said there's no evidence the rule "is having or will have the type of impact -- substantial exodus from the individual market exchanges -- that would threaten the ACA's structural core."

Shares of companies that sell short-term health policies, including Health Insurance Innovations Inc. and eHealth Inc., jumped on news of the decision.

One of the plaintiffs, the Association for Community Affiliated Plans, said it plans to appeal the ruling.

“We think this is arbitrary and capricious on the part of the administration, and that it does not comply with Congress’s intent in the Affordable Care Act,” said Meg Murray, chief executive officer of ACAP, which represents nonprofit safety-net health plans.

Trouble for Republicans?
Congress passed the ACA, a milestone of President Barack Obama’s administration, in 2010 to make comprehensive coverage more widely available regardless of a consumer’s pre-existing health conditions. Friday’s ruling allows insurers to offer far cheaper plans to healthy people, freed from those protections and requirements.

That could lead to higher premiums for people in ACA-compliant plans by siphoning off healthier consumers from the ACA risk pool over time -- and potentially to a political headache for Republicans on an issue that fueled the Democratic takeover of the House last year.

The judge based his ruling partly on the elimination of the individual-mandate tax penalty in the GOP’s 2017 tax law. Some Republican senators have since said they didn’t intend their vote to undermine protections for people with pre-existing conditions.

Susan Collins of Maine was the only Republican to vote for a Democratic resolution opposing the short-term plan regulation in October.

“It is essential that individuals who suffer from pre-existing conditions are covered,” she said then.

Two years after the late Senator John McCain gave the thumbs-down to his Republican colleagues’ effort to repeal the ACA, the court case underscores the quickening tempo of President Donald Trump’s efforts to undo his predecessor’s signature legislative achievement.

Health Care Drumbeat
In March, another federal judge in Washington rejected the administration’s attempt to permit small businesses to band together to offer “association health plans” exempt from ACA rules, calling it “an end run around the ACA.” The same month, a third judge struck down administration-backed policies in Kentucky and Arkansas that required many people on Medicaid to work in order to maintain their eligibility for the health program for the poor.

Meanwhile, a federal appeals court in New Orleans is weighing a request to overrule a Texas judge’s decision late last year to strike down the ACA in its entirety, a move supported by the Justice Department.

“Today’s court decision is a clear victory for American patients who saw their costs rise and choices disappear under the Affordable Care Act,” Health and Human Services Secretary Alex Azar said in a statement Friday. “President Trump has shown that we can open up dramatically more affordable options for Americans who buy their own insurance while still always protecting patients with preexisting conditions.”

House Democrats, for their part, passed the Strengthening Health Care and Lowering Prescription Drug Costs Act this summer “to block the Trump administration’s cynical expansion of junk health plans,” House Speaker Nancy Pelosi said in a statement. “The GOP Senate must act on this bill to protect and strengthen the health care of the American people.”

Alternative to Obamacare

Those suing to overturn the Trump administration’s short-term health insurance regulation -- among them the American Psychiatric Associaton, AIDS United and the National Partnership for Women and Families -- argued that the rule thwarts Congress’s intent by permitting the plans to last as long as 364 days and to be renewed for three years. The Obama administration had limited them to three months. Leon heard arguments in the case on May 21.

The rule could create a longer-lasting alternative to ACA coverage that might lure healthier patients away from Obamacare, undermining the risk pools it depends on in offering its more comprehensive coverage, the plaintiffs argued. An attorney for the administration countered that there was a demand for policies cheaper than Affordable Care Act plans and that their availability hadn’t drawn people away from ACA coverage.

Trump Tells Court to Scrap Obamacare, Raising 2020 Risks

“No legislation pursues its purposes at all costs,” Leon wrote in rejecting the plaintiffs’ arguments. “To be sure, the ACA’s various reforms are interdependent and were designed to work together as features of the individual exchange markets. However, Congress clearly did not intend for the law to apply to all species of individual health insurance.”

The initiative to expand short-term coverage arose in 2017 after the Senate failed in its push for ACA repeal. In an executive order, Trump called for expanding access to short-term coverage, describing those policies as exempt from the ACA’s “onerous and expensive insurance mandates and regulations.”

Unlike Obamacare plans, the short-term policies don’t have to cover a standard set of essential benefits, and can be substantially cheaper. They also don’t have to pay out a minimum of 80% of the premiums they collect on medical care, an ACA rule that applies

to other health insurance. Companies offering the plans can refuse to insure people with pre-existing medical conditions.

Those practices were typical of the individual insurance market in many states before the ACA came along. Obamacare was intended to end them but permitted short-term plans to remain on the market.

At the end of 2017, about 122,000 Americans were enrolled in short-term medical plans, according to data from the National Association of Insurance Commissioners. Trump's policy could dramatically expand the market. Federal actuaries estimate that 600,000 more people might purchase short-term coverage in 2019 because of the rule.

House Democrats have derided short-term plans as "junk" insurance. The House Energy and Commerce Committee in March announced an investigation into 12 companies selling short-term policies.

The case is Association for Community Affiliated Plans v. U.S. Department of Treasury, 18-cv-2133, U.S. District Court, District of Columbia (Washington).

The New York Times

Politicians Tackle Surprise Bills, but Not the Biggest Source of Them: Ambulances
Sarah Kliff and Margot Sanger-Katz

After his son was hit by a car in San Francisco and taken away by ambulance, Karl Sporer was surprised to get a bill for $800.

Mr. Sporer had health insurance, which paid for part of the ride. But the ambulance provider felt that amount wasn't enough, and billed the Sporer family for the balance.

"I paid it quickly," Mr. Sporer said. "They go to collections if you don't."

That was 15 years ago, but ambulance companies around the nation are still sending such surprise bills to customers, as Mr. Sporer knows well. These days, he oversees the emergency medical services in neighboring Alameda County. The contract his county negotiated allows a private ambulance company to send similar bills to insured patients.

In most parts of medical care, you can choose a doctor or hospital that takes your insurance. But there are some types of care where politicians have begun tackling the

“surprise” bills that occur when, say, patients go to an emergency room covered by their insurance and are treated by a physician who is not.

Five states have passed laws this year to restrict surprise billing in hospitals and doctor’s offices. Congress is working on a similar package of measures, after President Trump held a news conference in May urging action on the issue.

But none of these new policies will protect patients from surprise bills like the one Mr. Sporer received. Ordinary ambulances that travel on roads have been left out of every bill.

“Ambulances seem to be the worst example of surprise billing, given how often it occurs,” said Christopher Garmon, a health economist at the University of Missouri-Kansas City. “If you call 911 for an ambulance, it’s basically a coin flip whether or not that ambulance will be in or out of network.”

Mr. Garmon’s research finds that 51 percent of ground ambulance rides will result in an out-of-network bill. For emergency room visits, that figure stands at only 19 percent.

Congress has shown little appetite to include ambulances in a federal law restricting surprise billing. One proposal would bar surprise bills from air ambulances, helicopters that transport patients who are at remote sites or who have life-threatening injuries. (These types of ambulances tend to be run by private companies.)

But that interest has not extended to more traditional ambulance services — in part because many are run by local and municipal governments.

Lamar Alexander, the chairman of the Senate Committee on Health, Education, Labor and Pensions, and a key author of a Senate surprise billing proposal, said in an email that surprise bills from air ambulances were the more pressing issue because federal law prevents any local regulation of their prices. “Unlike air ambulances, ground ambulances can be regulated by states,” said Mr. Alexander, a Republican from Tennessee. “And Congress should continue to learn more about how to best solve that problem.”

The ambulance industry has brought its case to Capitol Hill, arranging meetings between members of Congress and their local ambulance operators.

“When we talk to our members of Congress, what we really emphasize is that we’re a little different from the other providers in the surprise billing discussion,” said Shawn Baird, president-elect of the American Ambulance Association. “We have a distinct, public process. The emergency room isn’t subject to any oversight of that kind.”

Patient advocates contend that this public oversight isn't doing enough to protect patients, who often face surprise bills and forceful collection tactics from ambulance providers.

Anthony Wright, executive director of Health Access California, worked on a 2016 California law to restrict surprise billing. Initially, he thought it made sense to include ambulances in that legislation.

"It's our experience that ambulance providers bill quicker and are more aggressive in sending bills to collection," Mr. Wright said. "If they're being more aggressive, you might want legislation to deal with that one first."

But obstacles quickly began to mount. Some were about policy, like whether California would need to offset the revenue local governments would lose.

Then there were the politics. "There is the political reality that it's hard to go after an entire industry at once," Mr. Wright said. "It's hard to have a bill opposed by doctors and hospitals and ambulances. We did manage to get a strong protection against doctor billing, but that was an epic, brutal, three-year fight."

The California law that passed in 2016 did not regulate ambulance prices.

Patient groups elsewhere also say they ran into political trouble. Of the five states that passed surprise billing regulations in 2019, only Colorado's new law takes aim at ambulance billing — not by regulating it, but by forming a committee to study the issue.

"The surprise bills laws are hard enough to get," said Chuck Bell, program director for advocacy at Consumer Reports, who worked to pass a Florida surprise billing law in 2016. "You're struggling with health plans, hospitals and doctors and other provider groups. At a certain point you don't want to invite another big gorilla in the room to further widen the brawl."

On Capitol Hill, the ambulance services have been less aggressive than other health care providers in lobbying against their inclusion in reforms. But lawmakers have largely declined to even include them in the conversation.

Consumer advocates say the lack of state-level legislation has been a barrier.

"Since there are issues related to ambulances being run by municipalities, and, at the state level, there hasn't been a lot of model law to inform federal law, I think that's made

some members hesitant to wade into that space," said Claire McAndrew, the director of campaigns and partnerships at the health care consumer group Families USA.

Local governments generally finance their ambulance services through a mix of user fees and taxes. If ambulances charge less to patients, they typically need more government funding.

Municipal governments often publish the prices of their ambulance services online, and they can range substantially. In Moraga and Orinda, in the Bay Area, the base rate for an ambulance ride is $2,600, plus $42 for each mile traveled. In Marion County, Fla., the most basic kind of ambulance ride costs $550, plus $11.25 per mile.

In many communities, there is no choice of ambulances.

Older patients are not charged such fees. Medicare, which also covers some people with disabilities, pays set prices for ambulance rides — a base rate of around $225 for the most typical type of care, in addition to a mileage fee — and forbids the companies to send patients additional bills.

In Bucks County, Pa., where it is $1,500 for a basic ambulance ride, in addition to $16 per mile, the emergency medical service gets 78 percent of its revenue from ambulance billing, according to Chuck Pressler, the executive director of the Central Bucks Emergency Medical Services. The rest of the budget comes from taxes raised by local cities and fund-raising drives.

"There is an expectation that we just plant money trees, that people should come in and work for free," Mr. Pressler said of proposals to tamp down ambulance billing. "When was the last time you saw the police send out a fund-raiser? They don't have to do that. Why do we have to raise money to come get you when you're sick?"

Los Angeles Times

Column: New data show that failing to expand Medicaid has led to 16,000 unnecessary deaths
Michael Hiltzik

Adversaries of Medicaid expansion have always pointed to the lack of evidence that enrollment in Medicaid improves health and saves lives, and therefore the expansion is a waste.

A new study should put that argument to rest, permanently. The researchers found not only that the expansion of Medicaid under the Affordable Care Act brought appreciable improvements in health to enrollees, but also that full expansion nationwide would have averted 15,600 deaths among the vulnerable Medicaid-eligible population.

In other words, the 22 mostly red states that refused to accept expansion starting in 2014 caused 15,600 unnecessary deaths among their residents. “This highlights an ongoing cost to non-adoption that should be relevant to both state policymakers and their constituents,” write the study’s authors, charitably. Fourteen states are still holding out.

Medicaid expansion has been a litmus test for Republican governors and legislative leaders aiming to demonstrate their anti-Obamacare bona fides. They’re mostly in Deep South states and some havens of warped concepts of “freedom” such as Wyoming and South Dakota; some states such as Maine and Louisiana adopted expansion more recently when they replaced GOP governors with Democrats.

The authors of the new paper, a team led by Sarah Miller of the University of Michigan’s business school, recapitulate the sorry history of Medicaid expansion. The Affordable Care Act originally imposed it nationwide, with a provision that the federal government would pick up 100% of the expansion cost in its first three years, declining in stages to a permanent 90% share, where it stands now. That’s much more than the federal share of the traditional joint federal-state program, which covers mostly low-income households with children. The ACA expanded that to all households, including childless single persons and couples, earning less than 138% of the federal poverty level (or $17,236 for a single).

The expansion mandate was overturned by the U.S. Supreme Court in a 2012 decision by Chief Justice John Roberts. Possibly trying to strike a compromise that would allow him to uphold the constitutionality of the ACA as a whole, Roberts made the expansion voluntary state by state.

Since then, conservatives have worked hard to depict Medicaid as ineffective . They’ve done so by overinterpreting limited studies such as a 2013 study of a Medicaid expansion in Oregon. Critics focused on the researchers’ finding of “no significant improvements in measured physical health outcomes in the first 2 years” of expansion, but they overlooked the findings that the expansion did “increase use of healthcare services, raise rates of diabetes detection and management, lower rates of depression, and reduce financial strain.”

Conservative health policy commentator Avik Roy, for example, crowed that the result "calls into question the $450 billion a year we spend on Medicaid, and the fact that Obamacare throws 11 million more Americans into this broken program."

This sort of poison extends even to Seema Verma, a Trump functionary who despite being director of the Centers for Medicare and Medicaid Services has argued that the expansion hasn't been a success despite its enrollment figures and has been a leader in undermining the program by allowing states to impose premiums, work requirements and punitive disenrollments on patients. (Her efforts have been blocked by a federal judge, for now.)

Other studies have shown measurable success in health outcomes from Medicaid expansion. One study cited by Miller's team found a significant 8.5% reduction in mortality among patients with end-state renal disease after they enrolled in Medicaid. Another found a "decrease in rates of cardiovascular disease among adults ages 45-64 associated with state adoption of the ACA Medicaid expansions."

Miller's study focused on mortality rates among a sample of nearly 600,000 subjects who were aged 55 to 64 in 2014 and would be eligible for Medicaid under expansion--that is is, with income below the ceiling. They calculated mortality rates for the sample population starting in 2008. They found that mortality rates for the entire sample were consistent (and rising) until 2014, when expansion began. As Miller told me, "at the time the Affordable Care Act was implemented, they started diverging. Mortality rates went down in the states that expanded and continued climbing in the states that didn't."

Failure to expand in the holdout states, the researchers conclude, "likely resulted in 15,600 additional deaths ... that could have been avoided if the states had opted to expand coverage."

Their findings, they assert, tend to confirm "robust evidence that Medicaid increases the use of healthcare, including ... prescription drugs and screening and early detection of cancers that are responsive to treatment."

As the researchers point out, it should be "obvious that Medicaid would improve objective measures of health." The lack of empirical data has allowed naysayers to claim that the program doesn't work. That's an ever-harder argument to make. It's time for the critics to give it up.

POLITICOPRO

Medi-Cal providers voice concerns on Newsom drug purchasing overhaul
Victoria Colliver

In their first chance to discuss Gov. Gavin Newsom's prescription drug purchasing overhaul, advocates for Medi-Cal managed care plans and providers expressed concerns Wednesday ranging from the financial impact on safety-net clinics to disruption for low-income patients.

The Department of Health Care Services held a two-hour meeting after announcing Monday the state will start accepting proposals from firms to administer the state's shift of the pharmacy benefit from Medi-Cal managed care plans to a fee-for-service system.

Newsom, on his first day in office, issued an executive order outlining his plan to pool the state's purchasing power and make the state the largest single buyer of prescription drugs outside Medicare and the VA.

The state plans to have the new drug purchasing program in place effective Jan. 1, 2021. To get there, the state has set an Oct. 1 deadline to receive the administrative proposals and plans to award contracts by Nov. 5. The state is also preparing for a 4-6 month transition period that offers 90-day notices to beneficiaries.

Some organizations said Wednesday they fear that low-income patients that rely on Medi-Cal will get lost during the transition, especially with the fast timeframe laid out by Newsom. In the overhaul, the state will handle the pharmacy benefit for all 13.2 million Medi-Cal recipients, up from 2 million now.

"Almost 11 million managed-care beneficiaries will be impacted in some way," Brianna Lierman, CEO of Local Health Plans of California, told state health officials.

Lierman, whose group represents community health plans covering some 70 percent of Medi-Cal managed care beneficiaries, said the "aggressive timelines really don't allow for much robust discussion."

Another point of contention came from safety-net providers concerned about the financial impact that the proposed changes would have on their participation in a federal discount program called 340B. The system allows them to generate revenue by billing Medi-Cal managed care plans at higher rates than they receive through the 340B program and then use the money for other services, such as staffing, indigent care and other health programs.

James McCabe, pharmacy director for the West Oakland Health Council, said not being able to rely on that money would threaten the clinic's very existence.

"We just would not be able to keep our doors open," he said.

Jennifer Kent, director of the Department of Health Care Services, called on the providers to submit "validated data" to make their case about how they would be affected. "We are committed to having conversations with the 340B providers around the revenues they currently get, services they currently provide and whether the state is in a place to continue that in a different format," she said.

The Local Health Plans of California released a new report questioning state savings estimates, instead finding the carveout could increase Medi-Cal costs by $149 million in the first year and $2.2 billion over five years, for a 19.4 percent hike in net pharmacy expenditures over five years. The report, commissioned by the trade group that represents the state's local non-profit health plans and conducted by the Menges Group, based its findings on the experience of 13 other states that have carved out their Medicaid drug benefits.

But Mari Cantwell, the department's chief deputy director for health care programs, and Kent defended estimates the state made in May that the overhaul will save the general fund $393 million annually once fully realized.

The nonpartisan Legislative Analyst's Office is planning to produce its own cost savings estimate, but Ben Johnson, a health care expert in the office, could not give a timeline for the report. He said the Menges Group report is worth considering, but he questioned the value of relying on other states' experience in this matter.

The state will continue to hold private and public meetings on the program's rollout, Kent said.

Questions regarding the draft Request for Proposal should be submitted via email to CSBRFP1@dhcs.ca.gov by Aug. 5. The department created a separate email for questions and comments about the overall project at RxCarveOut@dhcs.ca.gov.

Despite calls to start over, US health system covers 90%
Ricardo Alonso-Zaldivar

WASHINGTON (AP) — America's much-maligned health care system is covering 9 out of 10 people, a fact that hasn't stopped the 2020 presidential candidates from refighting battles about how to provide coverage, from Bernie Sanders' call for replacing private insurance with a government plan to President Donald Trump's pledge to erase the Affordable Care Act and start over.

The politicians are depicting a system in meltdown. The numbers point to a different story, not as dire and more nuanced.

Government surveys show that about 90% of the population has coverage , largely preserving gains from President Barack Obama's years. Independent experts estimate that more than one-half of the roughly 30 million uninsured people in the country are eligible for health insurance through existing programs.

Lack of coverage was a growing problem in 2010 when Democrats under Obama passed his health law. Now the bigger issue seems to be that many people with insurance are struggling to pay their deductibles and copays.

"We need to have a debate about coverage and cost, and we have seen less focus on cost than we have on coverage," said Colorado Sen. Michael Bennet. He is among the Democratic presidential candidates who favor building on the current system, not replacing it entirely, as does Sanders. "The cost issue is a huge issue for the country and for families," Bennet said.

A report this year by the Commonwealth Fund think tank in New York found fewer uninsured Americans than in 2010 but more who are "underinsured," a term that describes policyholders exposed to high out-of-pocket costs, when compared with their individual incomes. The report estimated 44 million Americans were underinsured in 2018, compared with 29 million in 2010 when the law was passed. That's about a 50% increase, with the greatest jump among people with employer coverage.

"When you have 90 percent of the American people covered and they are drowning in their health care bills, what they want to hear from politicians are plans that will address their health care costs, more than plans that will cover the remaining 10 percent," said

Drew Altman, president of the Kaiser Family Foundation, a nonpartisan research organization that tracks the health care system. “When Democrats talk about universal coverage more than health care costs, they are playing to the dreams of activists and progressives ... much less to the actual concerns of the 90 percent who have coverage today.”

Sanders’ office responds that the Vermont senator’s “Medicare for All” plan would solve both the coverage and cost problems for individual Americans. Medical care would be provided with no deductibles or copays. No one would be uninsured or underinsured.

“The simple answer is that our health care system becomes more unmanageable for more and more Americans every year,” Sanders spokesman Keane Bhatt said in a statement. “This is not a system that needs a few tweaks. This is a system that needs a complete overhaul.”

But other countries that provide coverage for all and are held up by Sanders as models for the U.S. don’t offer benefits as generous as he’s proposing. If he is elected president, there’s no way of telling how his plan would emerge from Congress, or even whether something like it could pass.

Four other 2020 Democrats are co-sponsors of Sanders’ bill: Sens. Cory Booker of New Jersey, Kirsten Gillibrand of New York, Kamala Harris of California, and Elizabeth Warren of Massachusetts.

On the other side of the political spectrum, Trump is talking about big changes. His administration is seeking to have federal courts declare the entire Obama-era health care law unconstitutional, jeopardizing coverage for 20 million people, jettisoning protections for patients with preexisting conditions, and upending the rest of the 970-page statute, now nearly 10 years old.

The president says there’s nothing to worry about. Earlier this summer Trump told ABC News that he was working on a plan that would provide “phenomenal health care,” protect people with preexisting conditions, and would be “less expensive than ‘Obamacare’ by a lot.”

White House spokesman Judd Deere said in a statement that the Obama law was “sold and passed on a litany of broken promises” and now “Democrats are proposing even more radical government takeovers of our health care system.”

As president-elect, Trump promised a health plan but never offered one upon taking office. Instead he backed bills from congressional Republicans, including one he called “mean” during a private meeting.

Trump says he might come out with his new plan within months, but that passing it would hinge on his getting reelected and Republicans winning back the House in 2020 while keeping control of the Senate.

That's a bit of political deja vu.

Republicans controlled Washington back in 2017 when Trump, then-Speaker Paul Ryan, R-Wis., and Senate Majority Leader Mitch McConnell, R-Ky., tried for months to repeal and replace the Obama law, only to fail. The repeal effort was widely seen as contributing to Republicans losing the House in 2018.

Since then, many GOP lawmakers have tried to avoid the issue altogether.

Economist Sara Collins of the Commonwealth Fund, who led the study about underinsured Americans, says cost and coverage problems are intertwined. Citing the Democrats' debate over Medicare for All, she says what's missing from that discussion is that "one doesn't have to go that far in order to improve the financial situation for millions of people — you can do that with much more targeted, incremental policies."

POLITICOPRO

States make backup plans for Obamacare — but lack federal money to make them work
Renuka Rayasam and Dan Goldberg

If the courts throw out Obamacare, about a dozen states are at the ready with laws mimicking the federal consumer protections or creating high-risk pools that could help people maintain coverage. But the fail-safes require something states can't duplicate: tens of billions of dollars in federal subsidies that keep the ACA insurance markets afloat.

In states that want to preserve the patient protections, premiums would become prohibitively expensive as insurers adapt to a patchwork of regulations that guarantee coverage for people with preexisting conditions, mandate a baseline set of benefits, regulate how much older customers pay and establish high-risk pools for the sickest residents.

"The bottom line is … 5 million people could lose their health insurance," California Gov. Gavin Newsom said at a press conference at the recent National Governors Association meeting in Utah. "The magnitude is jaw dropping."

This harsh reality reveals the messiness of addressing fallout from repealing or striking down a law that is intertwined with nearly every aspect of health care. Congressional Republicans say they want to restore the politically popular protections for people with preexisting conditions should a court overturn the law. But that wouldn't forestall chaos in insurance markets.

"Every state is going to be scrambling to revisit a whole host of things," said New Hampshire state Sen. Dan Feltes, a Democrat who has been working on ACA backups in his state. "Without [subsidies], states will be left holding the bag and people will be left without health care and it's really unfortunate. … Every state would have the problem."

Preexisting conditions protections on paper lose their luster in the profit-and-loss-driven real world, and the high-risk pools favored by some conservative states require huge amounts of money — as states that tried either strategy in the decades before the comprehensive federal law learned the hard way.

"Even if D.C. and other states have taken steps to protect the consumer, especially people with preexisting conditions, it's going to be very hard to make sure that premiums stay affordable especially for people who receive premium tax credits," said Mila Kofman, executive director of the Washington, D.C., Health Benefit Exchange Authority.

The Urban Institute estimated that 15 states would lose at least 40 percent of their federal health funding if Obamacare disappeared — billions of dollars used to expand Medicaid and subsidize premiums for lower-income families purchasing private insurance on the individual market.

"There's no way that a state can step up here in a way that could fully protect their residents," said Sabrina Corlette, a research professor at Georgetown University's Health Policy Institute.

Earlier this month New Hampshire Gov. Chris Sununu became the latest to sign legislation that would offer many of the federal law's protections. But state Sen. Feltes, who sponsored the bill, acknowledged it wouldn't do much if the law disappeared entirely.

New Jersey, Nevada, Indiana, New York, Pennsylvania, Vermont, and Washington all have trumpeted the enactment of consumer-protection measures, leading some to wonder whether they're giving false hope to consumers.

“I do worry that sometimes the debate over the Affordable Care Act gets oversimplified to being just about protecting people with preexisting conditions,” Georgetown's Corlette said.

Louisiana Attorney General Jeff Landry, a Republican, believes his state has the nation’s most comprehensive replacement plan if the ACA is struck down. The law, which was signed by Democratic Gov. John Bel Edwards, includes a state-subsidized high-risk pool to limit insurers’ losses on sick customers.

“It is a step in the right direction,” said Brent Littlefield, a Republican strategist who worked with the AG’s office to craft the statute.

The law directs the state insurance commissioner to "estimate the necessary funding required" — but the statute doesn’t provide the risk pool money. And it would offer no help for the half-million Louisiana residents who could lose their Medicaid expansion coverage, and no premium subsidies on the individual market.

For an example of what can happen when a state enacts consumer protections without simultaneously offering premium subsidies, look at New York and Washington state. Both passed a suite of consumer protections decades ago but did not help residents afford their insurance (or penalize those who decided to forgo it). The result was an ever-increasing spiral of younger and healthier residents opting out and insurers raising premiums to cover the sicker pool that remained. The markets effectively collapsed.

Texas, which filed the multistate suit seeking to abolish the ACA, is now taking a wait-and-see approach. Unlike three dozen other states, it never expanded Medicaid so it would not be faced with replacing those funds. But more than 1 million Texans purchased insurance on the individual market this year, and the state receives billions of dollars through the ACA to help hospitals cover costs of treating uninsured residents.

The state enacted a law authorizing a temporary high-risk pool — using federal funds, if available — in case the courts rule in its favor. Texas had a high-risk pool prior to Obamacare, but with sky-high premiums so only the sickest residents signed up — if they could.

Lawmakers in Austin decided to hold off on further backup plans until they know the outcome of the lawsuit as well as the federal response, said Republican state Sen. Kelly Hancock, who sponsored the high-risk-pool legislation.

"If you try to do too much," he said, it could "backfire on you."

KFF Health Tracking Poll - July 2019: The Future of the ACA and Possible Changes to the Current System, Preview of Priorities Heading Into 2nd Democratic Debate

Ashley Kirzinger, Cailey Muñana, and Mollyann Brodie

Key Findings:

- Health care is playing a prominent role at the start of the 2020 presidential primary season with Democratic candidates offering competing proposals aimed at expanding coverage to more Americans. The latest KFF Health Tracking Poll finds a larger share of Democrats and Democratic-leaning independents preferring approaches that expand coverage building on the Affordable Care Act (55%) rather than replacing the ACA with a national Medicare-for-all plan (39%).

- The poll also finds a slight dip in overall favorability of the idea of a national Medicare-for-all plan. About half (51%) of the public now say they favor such a proposal compared to 56% in April 2019. On the other hand, nearly two-thirds of the public (65%) favor a public option, which would compete with private health insurance plans and be available to all Americans. But as with polling on Medicare-for-all, attitudes toward this change to the current health care system can be swayed by common arguments. For example, net favorability towards such a plan ranges as high as +53 and as low as -18 after hearing arguments either in favor of or against a public option.

- The survey finds that, while a majority of the public hold favorable views of Medicare (83%), the public also has largely favorable views of employer-sponsored insurance (76%) and Medicaid (75%). In addition, both those with Medicare coverage (95%) and employer coverage (86%) rate their own health insurance coverage positively.

- Health care, climate change, and issues affecting women are among the top issues that Democrats and Democratic-leaning independents want to hear the candidates discuss in the upcoming second Democratic presidential debate. Issues affecting women has consistently ranked among this group's top issues for the candidates to speak about and when asked specifically what they want to hear about, at least three in ten overall offer topics related to reproductive rights (33%) and equal pay (30%).

- With the ACA and its various provisions under legal threat from an ongoing federal court case, this month's KFF Health Tracking Poll probes the public on how important it is for different ACA provisions to remain in effect if the law is ruled unconstitutional. Most Americans say it is "very important" to them that each of the provisions included in this month's survey are kept in place.

US to set up plan allowing prescription meds from Canada
Ricardo Alonso-Zaldivar

WASHINGTON (AP) — The Trump administration said Wednesday it will create a way for Americans to legally and safely import lower-cost prescription drugs from Canada for the first time, reversing years of refusals by health authorities amid a public outcry over high prices for life-sustaining medications.

The move is a step toward fulfilling a 2016 campaign promise by President Donald Trump. It weakens an import ban that has stood as a symbol of the political clout of the pharmaceutical industry.

But it's unclear how soon consumers will see benefits, as the plan has to go through time-consuming regulatory approval and later could face court challenges from drugmakers. And there's no telling how Canada will react to becoming the drugstore for its much bigger neighbor, with potential consequences for policymakers and consumers there.

The U.S. drug industry is facing a crescendo of consumer complaints over prices, as well as legislation from both parties in Congress to rein in costs, not to mention proposals from the Democratic presidential contenders. Ahead of the 2020 election, Trump is feeling pressure to deliver on years of harsh rhetoric about pharmaceutical industry prices.

Making the announcement, Health and Human Services Secretary Alex Azar said the administration recognizes that prescription drug manufacturing and distribution is now international.

"The landscape and the opportunities for safe linkage between drug supply chains has changed," Azar said. "That is part of why, for the first time in HHS's history, we are open

to importation. We want to see proposals from states, distributors, and pharmacies that can help accomplish our shared goal of safe prescription drugs at lower prices."

Stephen Ubl, president of the industry group Pharmaceutical Research and Manufacturers of America called the plan "far too dangerous" for American patients. "There is no way to guarantee the safety of drugs that come into the country from outside the United States' gold-standard supply chain," Ubl said in a statement. "Drugs coming through Canada could have originated from anywhere in the world."

Most patients take affordable generic drugs to manage conditions such as high blood pressure or elevated cholesterol. But polls show concern about the prices of breakthrough medications for intractable illnesses like cancer or hepatitis C infection, whose annual costs can run to $100,000 or much more. And long-available drugs like insulin have seen serial price increases that forced some people with diabetes to ration their own doses.

Azar, a former drug company executive, said U.S. patients will be able to import medications safely and effectively, with oversight from the Food and Drug Administration. Azar used to be a skeptic of importation, and was once quoted dismissing it as a gimmick.

One prong of the administration's proposal would allow states, wholesalers and pharmacists to get FDA approval to import certain medications that are also available here. Trump had recently endorsed a new Florida law to allow importation.

Another part of the plan would allow drugmakers to seek approval for re-importation of their own drugs. This second provision would cover cutting-edge biologic drugs as well mainstays like insulin, and it could apply to drugs from other countries besides Canada.

Azar said complex regulations setting up the system could take "weeks and months." He called on Congress to pass legislation that would lend its muscle to the effort, making it harder to overturn the policy in court.

"The FDA has the resources to do this," said acting FDA Commissioner Ned Sharpless. "The agency is interested in considering any reasonable proposal that maintains the bedrock of safety and efficacy for the American consumer."

Importation has backers across the political spectrum.

Sen. Chuck Grassley, R-Iowa, chairman of the panel that oversees Medicare, is a longtime supporter. He and Democratic presidential candidate Sen. Amy Klobuchar of Minnesota have a bill to facilitate importation. Sen. Lamar Alexander, R-Tenn., who

chairs the health committee, welcomed the plan but said the key is whether importation can be done safely.

During Tuesday night's Democratic presidential debate , multiple candidates talked about the need to lower drug costs. Sen. Bernie Sanders, Vermont Independent, noted the disparity in U.S. and Canadian prices. "I took 15 people with diabetes from Detroit a few miles into Canada and we bought insulin for one-tenth the price being charged by the crooks who run the pharmaceutical industry in America today," he said.

The leading drug industry trade group, known as PhRMA, is a powerhouse that generally gets its way with lawmakers. It spent $128 million on lobbying in 2017, according to its most recent tax filings. But pressure on the industry is rising across many fronts.

In the Senate, Trump is supporting Grassley's bipartisan bill to cap medication costs for Medicare recipients and require drugmakers to pay rebates to the program if price hikes exceed inflation. Democrats in the House are pressing for a vote on a bill allowing Medicare to directly negotiate prices on behalf of millions of seniors. Separately, the Trump administration is pursuing a regulation that would tie what Medicare pays for drugs administered in doctors' offices to lower international prices.

Drug costs are lower in other economically advanced countries because governments take a leading role in setting prices. But in the U.S., Medicare is not permitted to negotiate.

Some experts have been skeptical of allowing imports from Canada, partly from concerns about whether Canadian suppliers have the capacity to meet the demands of the much larger U.S. market.

Backers argue that the prospect of competition will pressure U.S. drugmakers to reduce prices.

THE WALL STREET JOURNAL.
WSJ

Health Insurers Walk Delicate Line Against Democrats' Health Proposals
Anna Wilde Mathews and Stephanie Armour

As Democratic presidential candidates take aim at the health-insurance industry, companies are striking a delicate balance, trying to fight the plans without attracting the political spotlight or sparking investor alarm.

The health insurers are deploying a two-pronged approach. Collectively, a number of insurers are putting their might into a coalition mounting an aggressive campaign against Democratic health-care proposals billed as "Medicare for All." Television ads began running during Tuesday night's presidential debate. But individual companies are mostly staying out of the public fray.

"This is tricky for the plans," said Dan Mendelson, an operating partner at private-equity firm Welsh, Carson, Anderson & Stowe. "They don't want to, nor can they, go out hard as individual companies against those concepts."

Health insurers' business could effectively be eliminated under Medicare for All models championed by Sens. Bernie Sanders and Elizabeth Warren, which would set up national government-run coverage. Other Democrats, like former Vice President Joe Biden, want to let people buy into a public program like Medicare, which the industry also opposes.

Health care was a major focus during Tuesday night's debate, with moderates painting Medicare for All as unrealistic and likely to deprive some Americans of coverage they like. Mr. Sanders and Ms. Warren defended their approach and attacked the insurance industry.

Mr. Sanders referred to insurers "profiteering," and referred to ads against his plan running during the debate. Ms. Warren said insurers have "sucked billions of dollars out of our health care system, and they force people to have to fight to try to get the health care coverage that their doctors and nurses say they need." Former Maryland Rep. John Delaney said their proposals would end private insurance and make the Democrats "the party of subtraction." Mr. Biden has also criticized Medicare for All by saying it would raise taxes and imperil the Affordable Care Act.

The Medicare for All plans would represent “a mushroom cloud over the insurance industry,” said John Gorman, a former health-care consultant who is now an investor. He sees “a total logjam on any of this” as long as Republicans hold the Senate, as they are likely to do in the next election, but the insurers are “going to approach it with the full might and fury of their entire lobbying operation.”

The ad blitz from the industry-supported coalition criticizes Medicare for All as too expensive and limiting choice. Proponents of the idea say it would in fact lower U.S. health care spending and wouldn’t limit choice. Some estimates have put the cost of such an approach at roughly $30 trillion over a decade. The group, called the Partnership for America’s Health Care Future, also includes drug companies, hospitals and doctors. In addition to the six-figure campaign, the partnership plans to release surveys they expect will show public opposition to universal government health care, and policy analyses of the Democratic proposals’ impact.

A recent poll from the Kaiser Family Foundation found 51% of Americans favored a national Medicare for All plan, and two-thirds supported a government health plan that would compete with private insurance. But answers varied depending on what information was shared with respondents. What’s more, 76% said they had favorable views of employer-provided insurance.

For individual insurers, highlighting the issue risks signaling to investors that the Democratic plans could actually come to pass, analysts said.

The danger became clear earlier this year when UnitedHealth UNH -1.66% Group Inc. Chief Executive David Wichmann addressed Medicare for All proposals during a call with analysts to discuss first-quarter earnings, saying some could cause “wholesale disruption of American health care.” His remarks came a few days after Mr. Sanders targeted UnitedHealth in a tweet, saying, “When we are in the White House your greed is going to end.”

UnitedHealth’s first-quarter earnings were strong, but when Mr. Wichmann made his remarks, “the whole sector started selling off,” said Matthew Borsch, an analyst with BMO Capital Markets.

More broadly, health insurers’ stocks have been weighed down by investor concerns over policy issues including the Democrats’ plans, he said. For instance, their shares fell after House Democrats introduced a Medicare for All bill in late February.

A spokesman for UnitedHealth said the company “welcomes the renewed national discussion on how to achieve universal coverage,” a goal it supports. “The best way to

achieve that goal is through continued public-private partnerships and proven solutions that make health care more affordable and improve health outcomes."

The industry-backed push against the Democratic plans has been building since before last summer, when groups representing insurers, drug companies and hospitals helped form the partnership. The group worked to lobby candidates in competitive races during the 2018 midterm elections and worked against state proposals that resembled Medicare for All or government coverage buy-in options.

The partnership's members spent a combined $143 million lobbying in 2018, according to data from the Center for Responsive Politics.

Health insurers spent a total of about $100 million to try to defeat the Affordable Care Act. The industry was also behind television ads from the early 1990s featuring a couple known as "Harry and Louise," who were shown at their kitchen table worrying about aspects of President Bill Clinton's health-care plan. The ads were seen as helping to derail that effort.

This time, industry messaging relies partly on tapping former top Democrats to speak out against Medicare for All.

"If you look at all the proposals that move toward Medicare for All, clearly all of them are a slippery slope toward single payer" health care, said a spokeswoman for America's Health Insurance Plans, which launched its own six-figure ad buy on Medicare for All last year. "It's a government-run insurance system that removes choice from the American people."

The cross-industry partnership has already run media ads that say Medicare for All would lead to "One Size Fits All Healthcare" where consumers would pay more, wait longer and get worse care. One digital ads feature a mother unloading groceries and a businesswoman standing in an office, warning that public option, Medicare for All, or a Medicare buy-in will let government bureaucrats take over health care.

"We need to fix what's broken, not start over," one of the ads says.

Another digital ad says the plan won't address out-of-control costs. "Medicare for All makes for a great slogan, but if something sounds too good to be true, it usually is," the ad says.

During Tuesday's debate, Mr. Sanders and Ms. Warren strongly defended their proposals. Mr. Sanders said, under his plan, consumers wouldn't face deductibles or copayments and would have freedom to choose their own hospitals and doctors, and he

said health-care costs in Canada's government coverage system are lower than in the U.S. "Right now we have a dysfunctional health care system," he said.

Ms. Warren said her plan would bring down costs for middle-class families, adding that there are too many complicated forms now, which give insurance companies a chance to say no. "That's what we have to fight," she said.

Democratic candidates who support a government-backed competitor to insurance on Tuesday night said that approach would add competition and bring down costs without forcing people to give up their existing coverage.

Rep. Tim Ryan of Ohio said during the debate that the age of eligibility for Medicare should be lowered from 65 to 50. Sen. Amy Klobuchar of Minnesota said a public option, where people can buy into a federal government program, is a better way to go. "Clearly, this is the easiest way to move forward quickly, and I want to get things done," Ms. Klobuchar said.

San Francisco Chronicle

Editorial: Health care moves to the fore in 2020 election — while legal uncertainty looms
Editorial Board

The Democratic presidential candidates have been engaged in a vigorous debate about whether, and how, to expand the federal government's role in health care. It was issue No. 1 at this week's debates in Detroit. The battle lines range from all in on Medicare for All (Bernie Sanders, Elizabeth Warren) to mostly in (Kamala Harris, Pete Buttigieg) to slightly in (Joe Biden) to warnings that such a radical change could doom the party's chances in 2020 (John Hickenlooper, John Delaney, Michael Bennet).

Advocates of a single-payer system were quick to dismiss any challenges of a single-payer system — regarding cost, effects on already struggling hospitals, impact on the 150 million Americans with employer-provided coverage — as a "Republican talking point." That phrase was invoked so often that it has become a favorite Democratic talking point.

But even as the Democrats argue about who is being bold and who is being pragmatic, the reality is that the party's nominee will have quite a sales job in persuading Americans to change course a mere 10 years after President Obama's signature domestic achievement, the Affordable Care Act, barely passed in a Democratic-

controlled Congress. The final House vote on Obamacare was 219-212, without a single Republican vote.

As a political matter, the challenge will be to assure Americans who, time and again, have proved apprehensive about any change to their health care coverage — however flawed or expensive. A recent Kaiser Family Foundation Health Tracking Poll found that just 51% of the public now say they favor Medicare for All. What is telling about that number is it is down from 56% in April. The fact that Democrats are highlighting it in town halls, debates and interviews has not been moving the needle in the right direction, though Sanders and Warren remain in the top tier of the field.

For now, the argument is aspirational. Barring a shift of power in the Republican-controlled Senate, Medicare for All would have little chance of passage. But it's a debate worth having. The United States spends significantly more than other developed countries on health care even while trailing them in key indicators such as infant mortality and life expectancy.

However, lurking in the background is a legal challenge to Obamacare that could turn the issue from offense to defense for Democrats. A federal appeals court in New Orleans is considering arguments — supported by the Trump administration — that the ACA is unconstitutional. The case was filed by an alliance of red states after the Republican push to repeal the act collapsed in Congress. Attorneys general from blue states, including California, have put up a defense of the 2010 law that extended coverage to 20 million Americans and included such popular provisions as assurances that consumers could not be denied coverage because of a pre-existing condition and dependents could stay on a parent's plan until age 26.

Two of the panel's three judges — both GOP appointees — appeared sympathetic to the challenge during oral arguments. The appeals court is expected to rule in the next few months, and the case likely will end up in a conservative-majority U.S. Supreme Court, with the prospect of a ruling in the heat of the 2020 campaign.

If the high court invalidates Obamacare, the political impact could be substantial — and unpredictable — as Americans face the prospect of losing the limited options they have.

Los Angeles Times

News Analysis: Democrats ask if Americans are ready to give up job-based health coverage

Noam N. Levey

WASHINGTON — Sharp disagreements among the presidential hopefuls at this week's debates have crystallized a critical and explosive political question: Are Democrats willing to upend health coverage for tens of millions of their fellow Americans?
The party is closer than it's been in decades to embracing a healthcare platform that would move all Americans out of their current insurance and into a single government-run plan.

Plans pushed by three of the four leading candidates — Sens. Bernie Sanders of Vermont, Elizabeth Warren of Massachusetts and Kamala Harris of California — differ in their particulars but would all end the job-based system that provides coverage to more than 150 million people.

That's a hugely risky strategy, as more-centrist rivals reminded the three senators during the two nights of heated, sometimes confusing, debates.

Sweeping healthcare plans have never fared well in American politics.

For decades, voters repeatedly have punished presidents and Congresses — Democratic and Republican alike — who have threatened to take away existing health plans, no matter how flawed.

Just last year, the GOP suffered historic losses in the House of Representatives after the party's unsuccessful effort to roll back the 2010 Affordable Care Act, also known as Obamacare.

But at a time when rising insurance deductibles and medical bills are crippling growing numbers of American families, many Democrats on the party's left believe public discontent with the current system has changed that dynamic.

"It's time that we separate employers from the kind of healthcare people get," Harris said Wednesday night, acknowledging that her "Medicare for all" plan would, after a lengthy phase-in period, end job-based insurance.

Harris, Sanders and Warren have made Medicare for all a central plank of their campaigns, riding a wave of discontent over rising medical costs to call for a historic expansion of government insurance.

Their more-moderate rivals say the three have misjudged the public mood and that by overreaching, they would squander an opportunity to enact significant, if incremental, reforms.

A survey earlier this year by the nonprofit Kaiser Family Foundation found that support for a single government plan fell from 56% to 37% when respondents were told that it might involve eliminating private insurance companies or requiring more taxes.

“It doesn’t make sense for us to take away insurance from half the people in this room,” warned Colorado Sen. Michael Bennet, who is among many Democratic presidential candidates, including former Vice President Joe Biden, who back more limited approaches.

The more-centrist Democrats would preserve the current employer-based system, as well as state Medicaid programs and the insurance marketplaces created by the 2010 healthcare law.

They would add an additional choice to allow Americans to buy into a Medicare-like government plan, often called a “public option.”

“Every single person in America would be able to buy into that option if they didn’t like their employer plan,” Biden said Wednesday.

Critics on the left say that approach would ultimately cost more and would preserve an outsized role for private insurance companies.

“We have tried this experiment with the insurance companies,” Warren said from the debate stage Tuesday. “And what they’ve done is they’ve sucked billions of dollars out of our healthcare system. And they force people to have to fight to try to get the healthcare coverage that their doctors and nurses say that they need.”

But threatening Americans’ current health coverage has proved disastrous for previous Democratic efforts to expand protections, including President Clinton’s doomed initiative in the early 1990s.

The 2010 healthcare law was almost sunk by labor unions angry about a new tax on the kind of generous health plans many of their members enjoy.

And even though the law was designed to have minimal impact on the existing insurance system, President Obama faced a firestorm when a few million people found their health plans canceled after new rules took effect requiring plans to offer more-comprehensive benefits.

“Traditionally, fear of losing benefits — however flawed they may be — trumps hope of getting something better,” said Chris Jennings, an influential Washington health policy advisor who worked for Clinton and Obama.

Even Republican politicians have paid steep prices for proposing to disrupt the employer-based health insurance system.

When Arizona Sen. John McCain, the 2008 GOP presidential nominee, proposed a new system to give Americans tax credits to buy their own health plans instead of getting coverage through work, he was pilloried by then-candidate Obama.

Obama made the McCain proposal a centerpiece of his advertising strategy attacking the Republican nominee.

To be sure, as deductibles soared, more than tripling in the last decade, job-based health benefits have offered workers less and less protection, generating political anger.

More than half of Americans in an employer-provided plan report they or an immediate family member have delayed getting medical care because of costs in the previous year, according to a nationwide poll conducted last year by the Los Angeles Times and the Kaiser Family Foundation.

One in six said they had made a difficult sacrifice in the previous year to pay for healthcare, such as cutting back on food and other essentials.

The poll also found substantial anxiety among lower-income workers and those with the highest deductibles, with 4 in 10 reporting frustration with their coverage, and nearly a quarter saying they’re angry.

Backers of Medicare for all highlight these struggles in their calls for major change.

Medicare-for-all plans promise much lower out-of-pocket costs for American patients, eliminating high deductibles and premiums, but would raise taxes for some.

But even as millions of workers struggle with medical bills, most continue to express satisfaction with their health benefits, a paradox that has long characterized Americans’ views about healthcare.

Overall, close to three-quarters of U.S. workers with job-based coverage said they feel grateful, the Times/Kaiser Family Foundation poll found.

“Americans are famous for holding contradictory opinions,” said Mollyann Brodie , who oversees Kaiser’s polling. “This challenge illustrates the fundamental dilemma in getting people to trust the promise of lower costs and better benefits under a brand-new system.”

The incremental healthcare strategy pushed by the moderates hews more closely to the country’s political tradition.

Medicare and Medicaid covered far fewer people when the programs were created in the 1960s, but Democrats and Republicans gradually expanded eligibility for the government health plans, adding patients with kidney failure, poor adults without children and others over the years.

Similarly, Clinton and a Republican Congress created the Children’s Health Insurance Program in the late 1990s amid concerns about uninsured children from working-class families who made too much to qualify for Medicaid.

And the 2010 healthcare law focused on closing remaining gaps, providing money to states to expand their Medicaid programs further and establishing regulated marketplaces for Americans who didn’t get health benefits at work.

Whether an incremental approach will suffice this year for an angry Democratic electorate remains unclear.

“The public’s outrage and frustration with the cost and complexity of our current healthcare system … including employer-based coverage,“Jennings said, “is opening the door for change and closing it on those who are perceived as status quo defenders.”

POLITICOPRO

POLITICO Pro New Jersey: State sets course for state-based health insurance marketplace for 2020
Sam Sutton

New Jersey might have a state-based health exchange sooner than expected, according to a state Department of Banking and Insurance document provided to POLITICO.

The department has asked the Centers for Medicare and Medicaid Services for permission to operate a state-based exchange on the federal government's existing platform — healthcare.gov — which would give New Jersey more control over its insurance marketplace as it readies an independent platform in 2020.

Gov. Phil Murphy signed legislation in late June granting DOBI the authority to establish a state-based health exchange. A major component of the bill created a funding mechanism to support navigator services — groups that help consumers shop for Obamacare plans — whose funding had been reduced by President Donald Trump's administration.

Under the new law, health insurance companies offering plans through a state-based exchange on the federal platform would be subject to an assessment equal to 1 percent of each plan's monthly premium.

DOBI plans to use that assessment to fund $2 million for navigator services in the upcoming enrollment period and is preparing a request for applications to allocate that money, according to the department document.

The size of the assessment, and the amount of available funding for navigators, would be limited if New Jersey's marketplace remains under federal control.

Creating a semi-independent exchange on healthcare.gov represents an interim step that allows for "additional outreach and enrollment assistance to New Jersey residents for the upcoming open enrollment period," according to the document provided by DOBI.

The enrollment period for 2020 plans is scheduled to begin Nov. 1. The state insurance regulator hopes to have an independent state-based exchange fully operational in time to market plans for 2021.

Many New Jersey Democrats view those services as critical to boosting health insurance enrollment in 2020. Despite adopting reforms modeled on the Affordable Care Act in 2019, including a new law that requires residents to purchase some form of health coverage, the state's enrollment rolls dipped by around 8 percent in 2019.

Democratic leaders attributed the decline to the Trump administration's active efforts to weaken and eliminate major provisions of the ACA. A shortened enrollment period, coupled with limited funding for navigator services, almost certainly played a role in reducing the number of sign-ups, particularly in states whose marketplaces relied on healthcare.gov.

Total enrollment in states that relied on the federal exchange fell last year. It rose in the 12 states that operate their own exchanges.

"Establishing [a state-based exchange on the federal platform] will allow the state to better transition to a State-Based Exchange for plan year 2021, while providing additional outreach and enrollment assistance to New Jersey residents for the upcoming open enrollment period," the department said in a statement.

Los Angeles Times

Column: Health insurance companies are useless. Get rid of them
Michael Hiltzik

The most perplexing aspect of our current debate over healthcare and health coverage is the notion that Americans love their health insurance companies.

This bizarre idea surfaced most recently in the hand-wringing over proposals to do away with private coverage advocated by some of the candidates for the Democratic nomination for president. Oddly, this position has been treated as a vote-loser.

During the first round of televised debates on July 30 and 31, only four of the 20 candidates raised their hands when asked if they would ban private insurers as part of their proposals for universal coverage: Sens. Elizabeth Warren of Massachusetts, Bernie Sanders of Vermont and Kamala Harris of California, and New York Mayor Bill de Blasio. Harris later backed away, releasing a "Medicare for all" proposal that would accommodate private insurers at least for the first 10 years.

She should have stood her ground. The truth is that private health insurers have contributed nothing of value to the American healthcare system. Instead, they have

raised costs and created an entitled class of administrators and executives who are fighting for their livelihoods, using customers' premium dollars to do so.

"Health insurers have been successful at two things: Making money and getting the American public to believe they're essential," says Wendell Potter. He should know, since he spent decades as a corporate communications executive in the industry, including more than 10 years at Cigna.

The insurers' success in making themselves seem essential accounts for the notion that Americans are so pleased with their private coverage that they'll punish any politician who dares to take it away. But the American love affair with private insurance warrants close inspection.

Let's start by examining what the insurers say are their positive contributions to healthcare. They claim to promote "consumer choice," simplify "the health care experience for individuals and families," address "the burden of chronic disease" and harness "data and technology to drive quality, efficiency, and consumer satisfaction." (These claims all come from the website of the industry's lobbying organization, America's Health Insurance Plans (AHIP).

They've achieved none of these goals. The increasingly prevalent mode of health coverage in the group and individual markets is the the narrow network, which shrinks the roster of doctors and hospitals available to enrollees without heavy surcharges. The hoops that customers and providers often must jump through to get claims paid impose costly complexity on the system, not simplicity. Programs to manage chronic diseases remain rare, and the real threat to patients with those conditions was lack of access to insurance (until the Affordable Care Act made such exclusion illegal).

Private insurers don't do nearly as well as Medicare in holding down costs, in part because the more they pay hospitals and doctors, the more they can charge in premiums and the more money flows to their bottom lines. They haven't shown notable skill in managing chronic diseases or bringing pro-consumer innovations to the table.

Insurers cite these goals when they try to get mergers approved by government antitrust regulators. Anthem and Cigna, for example, asserted in 2016 that their merger would produce nearly $2 billion in "annual synergies," thanks to improved "operational" and "network efficiencies."

The pitch has a long history. The architects of a wave of health insurance mergers in the 2000s also proclaimed a new era of efficient technology and improved customer service, but studies of prior mergers show that this nirvana seldom comes to pass. The

best example may be that of Aetna's 1996 merger with U.S. Healthcare in a deal it hoped would give it access to the booming HMO market.

According to a 2004 analysis by UC Berkeley health economist James C. Robinson, the merger became a "near-death" experience for Aetna. The deal was expected to bring about "millions in enrollment and billions in revenue to pressure physicians and hospitals" to accept lower reimbursement rates, he wrote.

"The talk was all about complementarities, synergies, and economies of scale... The reality quickly turned out to be one of incompatible product designs, operating systems, sales forces, brand images, and corporate cultures." Aetna surged from 13.7 million customers in 1996 to 21 million in 1999, but profits collapsed from a margin of nearly 14% in 1998 to a loss in 2001.

Even when they don't happen, insurance merger deals cost customers billions of dollars. That's what happened when two proposed deals -- Aetna/Humana and Anthem/Cigna -- broke down on a single day in 2017. The result was that Aetna owed Humana $1.8 billion and Anthem owed Cigna $1.85 billion in breakup fees -- money taken out of the medical treatment economy and transferred from one set of shareholders to another.

In reality, Americans don't like their private health insurance so much as blindly tolerate it. That's because the vast majority of Americans don't have a complex interaction with the healthcare system in any given year, and most never will. As we've reported before, 1% of patients account for more than one-fifth of all medical spending and 10% account for two-thirds. Fifty percent of patients account for only 3% of all spending.

Most families face at most a series of minor ailments that can be routinely managed -- childhood immunizations, a broken arm here or there, a bout of the flu. The question is what happens when someone does have a complex issue and a complex claim — they're hit by a truck or get a cancer diagnosis, for instance?

"We gamble every year that we're going to stay healthy and injury-free," Potter says. When we lose the gamble, that's when all the inadequacies of the private insurance system come to the fore. Confronted with the prospect of expensive claims, private insurers try to constrain customers' choices -- limiting recovery days spent in the hospital, limiting doctors' latitude to try different therapies, demanding to be consulted before approving surgical interventions.

Indeed, the history of American healthcare reform is largely a chronicle of steps taken to protect the unserved groups from commercial health insurance practices.

When commercial health insurance became insinuated into the American healthcare system following World War II via employer plans, it quickly became clear who was left behind -- “those who were retired, out of work, self-employed, or obliged to take a low-paying job without fringes,” sociologist Paul Starr wrote in his magisterial 1982 book, “The Social Transformation of American Medicine.”The process even left those groups worse off, Starr observed, because insurance contributed to medical inflation while insulating only those with health plans. “Government intervention was required just to address the inequities.”

Insurers wouldn’t cover the aged or retirees, so Medicare was born in 1965. Insurers refused to cover kidney disease patients needing dialysis, so Congress in 1973 carved out an exception allowing those patients to enroll in Medicare at any age. (So much for addressing the “burden of chronic disease.”)

Individual buyers were charged much more for coverage than those buying group plans through their employers -- or barred from the marketplace entirely because of their medical conditions -- the Affordable Care Act required insurers to accept all applicants and, as compensation, required all individuals to carry at least minimal coverage.

The health insurance industry’s most telling contribution to the debate over healthcare reform has been “to scare people about other healthcare systems,” Potter told me. As a consequence, discussions about whether or how to remove private companies from the healthcare system are chiefly political, not practical.

The Affordable Care Act allowed private insurers to continue playing a role in delivering coverage not because they were any good at it but because their wealth and size made them formidable adversaries to reform if they chose to fight it. They were sufficiently mollified to remain out of the fray, but some of the big insurers then did their best to undermine the individual insurance exchanges once they were launched in 2015.

Even as individual Americans fret over losing their private health insurance, big employers have begun to see the light. Boeing, among other big employers, is experimenting with bypassing health insurers as intermediaries with providers by contracting directly with major health systems in Southern California, Seattle and other regions where it has major plants. It would not be surprising to see the joint venture of Amazon, Berkshire Hathaway and JP Morgan Chase try a similar approach in its quest to bring down costs.

That’s an ironic development, since the private insurers first entered the market precisely by offering to play the role of intermediaries for big employers. But instead of fulfilling the promise of efficiency and cost control, they became rent-seeking profiteers themselves.

There’s no doubt that it will take years to wean the American healthcare system off the private insurance model; Kamala Harris’s proposal may be merely a recognition of the necessary time frame. It’s true that some countries with universal healthcare systems preserve roles for private insurance, including coverage for services the government chooses to leave out of its own programs or providing preferential access to specialists, at a price.

But the private insurers’ central position in America’s system is an anachronism dating back some 75 years. The sooner it’s dispensed with, the better -- and healthier -- America will be. The next time a debate moderator asks presidential candidates if they favor doing away with private insurance, let’s see all the hands go up.